1953

A study of the evidence of need for health education on the part of hospitalized children and their parents.

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Field Study
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A STUDY OF THE EVIDENCE OF NEED FOR HEALTH EDUCATION ON THE PART OF HOSPITALIZED CHILDREN AND THEIR PARENTS

A Field Study

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Wilma E. Peterson

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CHAPTER I

INTRODUCTION

Keliher[1] studied the factors leading to satisfaction or dissatisfaction on the part of staff nurses employed in the pediatric unit of Hospital X.

One of her findings was that an opportunity to give good care to patients increased satisfaction and conversely lack of opportunity to do so increased dissatisfaction. One of the suggestions for improving care of children was to improve parent teaching. To that end, three staff nurses and one head nurse attempted to identify the areas of health education needed by parents. They observed parents and children. Through anecdotal records they recorded their observations and also the questions which parents voluntarily asked.

This study was interrupted. The four nurses terminated their services because of marriage and home responsibilities. Hospital X is a teaching center for three medical schools. Simultaneous to the resignation of the cooperant nurses, there were new appointments to the medical staff. A typical period of readjustment followed. The medical staff

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[1]Helen Keliher, Unpublished Study in Hospital X. Boston University, School of Nursing, 1952.

had to become acquainted with the existent policies of the pediatric unit. Both the medical and the nursing staffs needed to learn the guiding philosophy of the respective groups.

During this period of reorientation the accumulated anecdotal records had been categorized and filed.

This present study was undertaken to capitalize on the work previously done by these four nurses and to reactivate the interest of the present nurse staff in improvement of patient care through parent education.

Statement of the Problem

The problem becomes one of identifying the needs of the parent and the child. It can be stated in the following manner:

How can an analysis of the needs for health education expressed by the parents and the child and the needs observed by nurses during the hospitalization of the child on the pediatric ward of a general hospital be utilized by the pediatric nurse staff to improve care to patients?

It centers around two main areas:

1. What evidence is there of need for health education on the part of these hospitalized children and their parents?

2. How might the nursing staff use this information in improving the plans of nursing care?

Purposes of the Study

The purposes of the study are to:

1. Reactivate interest in analyzing parent's' and children's health education needs as a basis for improving nursing care.

2. Compare two methods of identifying needs, namely, through anecdotes of nurses observations and questions voluntarily asked by parents with those questions elicited through directive interview.

3. Utilize the findings to consider with the nurse staff how these might be used to improve patient care.

Limitations of the Study

There are certain limitations in the study. It could not be expected that the present nurse staff would have the same depth of interest in the anecdotes already collected as did those who had been active participants in keeping the notations. Utilization of the findings are confined to the interpretation of the data to the group and their stage of readiness to apply them at this time.

No attempt is made to isolate needs for health education on the basis of the length of the hospitalization, the age of the child, the age of the parents, the educational or financial background of the parents, the number ofchildren in the family or variations in the fathers' or mothers' needs.

Scope of the Study

An exhaustive study of the problem is a long term project. The present investigation will be completed within a period of four months' time. It will consider the evidence of health education needs of the children admitted to the pediatric department of Hospital X, and their parents. The study will be concerned with those needs manifest by children from three to twelve years of age and their parents.

The first purpose of the study is to reactivate interest in analyzing parents' and children's health education needs. Therefore, the cooperation and interest of the staff will be sought. At the present time there are 27 graduate nurses employed as staff and head nurses on the eight units of the pediatric department.

Secondly, the study proposes to compare two methods of identifying needs. It will utilize the data already available. These data consist of 1735 observations of health education needs of 234 hospitalized children and/or their parents. The observations were made daily for 16 hours and extended over a period of six and one half months. These data will be supplemented by the expressions of need indicated in questions voluntarily asked by parents of hospitalized children. The voluntary questions will be recorded for one week by the 14 nurses working with children of the

age group included in the study.

The needs for health education identified by these two sets of data will be compared to the findings from directive interviews. Parents of hospitalized children will be interviewed by 72 nursing students. These interviews will be completed within a week.

Thirdly, since the study proposes to utilize the findings to consider with the nurse staff how these might be used to improve care to patients, the categorized findings will be presented and discussed at five group meetings. These group meetings will run concurrent with and immediately following the collection of the data.

Methods

Several methods were used in the study of the problem.

To ascertain evidence of need for health education by hospitalized children and their parents the following devices were used:

1. Anecdotal notes which had been previously recorded by staff nurses were categorized, tabulated, and presented to the present staff.

2. Questions that parents voluntarily ask the nurse staff were recorded. Replies to the queries were also noted.

3. Directive interviews were conducted to elicit parents' problems relative to their hospitalized child.

These interviews were conducted by nursing students.

To determine how the nursing staff might use this information for improving the plans for nursing care, group meetings were held concurrent with and immediately following the collecting of the data.

Presentation

At the outset (Chapter II) the background of the problem is presented through the philosophy underlying the study and a description of the agency in which the investigation was conducted.

The methods used in the study are discussed in Chapter III.

The data are examined (Chapter IV) in terms of the evidence of need for health education by hospitalized children and their parents. The findings from the three sets of data are presented. The common areas of need are discussed. A comparison is made between two methods of identifying needs. The results of the discussion of the findings with the nurse staff are described.

The summary of the findings appears in Chapter V. On the basis of identified areas of need for health education, conclusions are made relative to improving patient care through parent education. The study concludes with recommendations suggested by the evidence.

CHAPTER II

PHILOSOPHY AND SETTING

The purpose of this chapter is to present the background of the study. It attempts to accomplish this purpose by:

1. Developing the philosophy underlying the study.
2. Describing the setting in which the problem was studied.

The Philosophy

The twentieth century was hopefully heralded by the Swedish author, Ellen Key, as the "Century of the Child." However, the first fifty years have not lived up to this prediction.[1] A brief retrospective view brings into focus a complex half-century characterized by international and national unrest, advances in transportation and communication and extensive scientific research. The interaction of these advances have contributed to producing an increasingly complicated milieu for family living.

Research and advances in the physical sciences have been followed by an augmentable interest in the development of the social sciences. Insomuch, that a new emphasis has

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[1] Katharine Lenroot, "The Children's Decade," The Child, 14:112, January 1950.

been placed upon the understanding of human behavior. In an effort to determine why men behave as they do, social scientists focused their attention upon the study of man and his normal reactions as a social being. Freud, one of these social scientists, observed from his studies of deviant behavior that many of man's Emotional Problems of Living,[2] resulted from unfulfilled childhood needs. This discovery turned the flood light of research upon the family group in an effort to determine the effect of the home environment on the development or hindrances to development of integrated personalities.

It became apparent that little was known about the child and his behavior patterns. Up until this time the child had been accepted as a miniature adult, but now this concept gave way to a study of his growth and development.[3] The work spearheaded by Gesell and his associates, was soon being duplicated in child study centers across the nation. This movement resulted in the popular developmental philosophy of child care and guidance.[4] It recognized

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[2]Spurgeon English and Gerald Pearson, Emotional Problems of Living, p. 11. New York: W.W. Norton and Company, 1945.

[3]As early as 1923 the National Research Council sponsored a committee on child development.

[4]Arnold Gesell and Francis Ilg, The Infant and Child in the Culture of Today, p. 5. New York: Harper and Brothers, 1943.

the unique individuality of each child and his inalienable right to grow and develop according to his own pattern.[5] It encouraged "human discipline of the child through guidance and understanding."[6] As the new philosophy gained momentum it made its impact on the home through books, pamphlets, magazines, the radio, the school, and the child health clinic. This resulted in conflict in the lives of the parents reared in the "good old days" according to a vastly different pattern of discipline.[7] Consequently, today's parents are caught in the dilemma between a contemporary culture incompatible with that of a generation ago. Randolph Smith,[8] in describing the role of today's parents, has said, "It is more difficult to be a good parent than to be a good teacher, or doctor, or lawyer, or anything else."

Yet many young people leave high school and college and enter marriage without adequate preparation for this important role.[9] It follows, therefore, that the community

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[5]Gesell, op. cit., p. 10.

[6]Gesell, loc. cit.

[7]George Preston, The Substance of Mental Health, p. 16. New York: Rinehart and Company, Inc., 1943.

[8]Marguerite Rudolph, "A Parents Workshop," Childhood Education, p. 369, April 1953.

[9]English, op. cit., p. 315.

ought to provide programs which supplement these deficiencies in preparation for parenthood.

The nurse, by virtue of her work in the community, touches the lives of parents at the most crucial moments of joy and sorrow.[10] Both sociologists and psychiatrists agree that this intimate contact with the family is conducive to a helpful relationship which other professional personnel do not enjoy.[11,12] This privileged position carries with it responsibility--responsibility to participate in parent education. Miss Nightingale[13] supported this premise in her writings and gave equal import to the training of nurses and the teaching of parents. In a letter addressed to a nurse engaged in teaching nurses, she[14] said: "Till every mother knows how to manage her babies, till every child has a chance of health, we are only on

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[10] Mary Chayer, Nursing in Modern Society, p. 163. New York: G.P. Putnam's Sons, 1947.

[11] Harry Bakwin, "Psychological Implications for Early Child Care," The American Journal of Nursing, 51:7, January 1951.

[12] Gerald Caplan, Lecture notes, Seminar Maternal and Child Health.

[13] Dorothy Rood, The Nurse and Parent Education, p. 4. New York: Bureau of Publications, Teachers College, Columbia University, 1935.

[14] Florence Nightingale, "Letters dated May 28, 1897, addressed to Miss Scovil," Photographic reproductions in The American Journal of Nursing, 11:368, November 1911.

the threshold of training." Half a century later Rood's study[15] re-emphasized the fact that parent education is the responsibility of every nurse.

Furthermore, the public expects nurses to be health educators. In addressing the fortieth annual convention of the National League of Nursing Education, Mrs. Roosevelt[16] expressed these expectations in the following manner:

> "I think as new ways of life are opened up to us that we are going to find more and more that we expect our nurses to show us how to live from the physical standpoint so that we may be a healthier, happier people. Of course, as they teach us how to live better from the physical standpoint, they will teach us how to live better in our minds and in our hearts, for we cannot do the kind of work that we are obliged to do without realizing that mind and body react on each other and also that hearts have a great deal to do with the lives that people lead."

Finally, contemporary nurse educators, as Stewart,[17] are convinced that health teaching continues to be the responsibility of the nurse. Yet, Brown's[18] findings and

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[15] Rood, op. cit., p. 64.

[16] Eleanor Roosevelt, "What Does the Public Expect from Nursing?" Procedings from the Fortieth Annual Convention of the National League of Nursing Education, p. 72. New York: The League, 1934.

[17] Isabel Stewart, The Education of Nurses, p. 301. New York: The Macmillan Company, 1947.

[18] Esther Brown, Nursing for the Future, p. 42. New York: Russell Sage Foundation, 1948.

Chayer's[19] conclusions indicate that nurses are not fulfilling this important function. The former speaks of the "paucity of nurses with sufficiently broad educational and professional backgrounds to carry on teaching functions," while the latter refers to the "low-level" of health teaching. They both attribute these conditions to deficiencies in the traditional pattern of preparation for nurses.

Many schools of nursing have evaluated and reconstructed their curricula in order to prepare their students to be better health educators. Nevertheless, these advances are not sufficient. Nursing might well recognize the urgency expressed by the President's Commission[20] in reporting on adult education: "We cannot wait for the preparation of the next generation, we must improve what personnel we have in the field now."

The question, then, becomes one of considering how the nurse engaged in child care at the present time can be assisted to function more effectively as a health educator. Education has been defined as the structuring of the environment in order to promote changes in behavior. However, the nurse cannot hope to change the behavior of

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[19]Mary Chayer, Nursing in Modern Society, p. 181. New York: G.P. Putnam's Sons, 1947.

[20]Report of the President's Commission on Higher Education, Higher Education for American Democracy. p. 100. Vol. I, New York: Harper and Brothers, 1947.

others until she is able to understand, accept and change herself.[21]

This concept of self understanding is not new. Socrates prescribed, "Know thyself." In recent years, a renascence of this ancient philosophy has occurred as a result of the psychoanalytic approach to mental health.

Much has been written of the need for understanding in nursing. Brown[22] states that the nurse for the future will have "the ability to listen and direct action and verbal expressions on the basis of a sound understanding of human behavior and human relationships." The same thought has been expressed by the Expert Committee on Nursing of the World Health Organization.[23] They stated: "Nursing is the conscious practice of human relationships." This understanding is particularly important in pediatric nursing. Lonigan[24] has gone so far as to state that "understanding is the soul of pediatric nursing." The pediatric nurse

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[21]Harriet Kandler, "The Relations of Nursing in Personnel Work," Dynamics of Human Relations in Nursing, p. 82. Andover, Mass.: The Andover Press, Ltd., 1950.

[22]Brown, op. cit., p. 84.

[23]World Health Organization Technical Report, Expert Committee on Nursing, p. 1. Toronto: Ryerson Press, June 1952.

[24]Barbara Lonigan, "Nursing of Children in a Dynamic Basic Nursing Curriculum," A Dynamic Basic Nursing Curriculum, p. 119. Washington, D.C.: The Catholic University of America Press, 1951.

should understand her actions, reactions, feelings, attitudes, prejudices[25] and the reasons underlying her choice of pediatric nursing.[26] Only insofar as the nurse develops this self understanding is she able to accept herself and bring about changes in her behavior that will lead to more effective relationships. Besides this understanding of self, the pediatric nurse should understand herself in relation to "her patient, his family and co-workers."[27]

In addition to this understanding of the fundamentals of human behavior the pediatric nurse needs to accept and understand the child as a "growing, ever-changing, special human being"[28] whose developmental pattern can be impinged upon by illness.[29] Based on these empathetic qualities she will be able to interpret the child's behavior and manifestations of need. She will be enabled to plan care which will make provisions for meeting these needs. She

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[25]Ursula Cox, "Hints on Parent Education," Paper presented at the Seventh English Speaking Conference on Maternity and Child Welfare, London, June 2, 1937. Reprinted from Mother and Child, London, July 1937 in: Public Health Nursing, 30:48, August 1938.

[26]Ruth Frank, "Parents and the Pediatric Nurse," The American Journal of Nursing, 52:76-77, January 1952.

[27]Margaret Bridgman, Collegiate Education for Nurses, p. 143. New York: The Russell Sage Foundation, 1952.

[28]Lonigan, op. cit., p. 115.

[29]National League of Nursing Education, A Curriculum for Schools of Nursing, p. 467. New York: The League, 1937.

will be able to interpret these needs to others participating in the child's care. Furthermore, the pediatric nurse needs to be able to understand and accept parents and their behavior for she must learn to look beyond the immediate happenings to find the underlying cause for their reactions. On the basis of this acceptance of the parent the pediatric nurse will establish the foundations for a helpful relationship. She can thence help "parents to understand themselves and their own feelings in the relationship with their own children."[30] Again, as she develops her ability to interpret the needs of the parents she can plan care that will meet these needs and interpret them to others participating in the family care.

This functional understanding of the fundamentals of human behavior leads to good interpersonal relationships that permeate the atmosphere of the pediatric department. The parents sense these good relationships and develop a feeling of security and good will towards the staff responsible for the care of their child. This security is in turn transferred to the child and provides an intrinsic and extrinsic environment conducive to recovery. Not only is this environment conducive to recovery but it fosters learning and changed behavior. For, "Only when mothers find their world neighborly and sympathetic can they give

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[30] Lawrence Frank, "Families and Schools," Our Children Today, p. 248. New York: The Viking Press, 1952.

their best to their families."[31] However, this is a complex re-educative process, for barriers to learning and to change have been formed as a result of negative emotional experiences in the course of personality development.[32] These negative emotional experiences have been felt by nurses in schools of nursing where authoritarianism has prevailed and consequently learning has been inhibited. Leaders in the advanced preparation of nurses for psychodynamic nursing recognized the possibilities of the group process as a means of promoting re-education. They based their beliefs on the observations of the success with which the group process was being utilized in industry and education.

Initial interest in the study of interpersonal relationships in small groups was instigated by Freud's study of the family.[33] These early observations of group interactions stimulated Lewin and other social psychologists to study groups wherever they formed. This research has resulted in a growing body of knowledge relative to the dynamics of group behavior. These findings have been applied

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[31] Anna Wolf, "Shall We Blame the Parents?" Our Children Today, p. 158. New York: The Viking Press, 1952.

[32] Theresa Muller, The Nature and Direction of Psychiatric Nursing, p. 245. Philadelphia: J.B. Lippincott Company, 1950.

[33] Robert Merton, "Introduction," The Human Group, p. XVIII. New York: Harcourt, Brace and Company, 1950.

in a diversity of circumstances ranging from a utilitarian application in industry to an academic application. An example of the former application is found in the Tavistock Clinic[34] in England. Their staff of industrial consultants offer services aimed at resolving social conflicts in the field of labor management relationships. An example of the latter application is the success with which the tool has been used in academic work by Cantor.[35] He recognized that the prevailing pattern of education with its emphasis on facts failed to prepare its graduates for successful, happy living. He found that the graduates were not equipped to establish satisfactory interpersonal relationships. He introduced and utilized the group process in two social science courses. He[36] sums up the results of this teaching method in the following words:

> "Negative projection or resistance gives way to positive willing. They struggle with themselves to recognize their ideas, attitudes and feelings. They gain self confidence, and a willingness to be responsible for their own opinions. New integrations of data and self are achieved."

Experts in the field of curriculum development found

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[34]Franklyn Haiman, Group Leadership and Democratic Action, p. 40. Boston: Houghton Mifflin Company, 1951.

[35]Nathaniel Cantor, The Dynamics of Learning, pp. 296. Buffalo: Foster and Stewart Publishing Corporation, 1950.

[36]Ibid., p. 281.

that well planned curricula drawn up by authorities did not guarantee effective changes in school programs. They concluded that the human relations factor was the forgotten element in curriculum change.[37] As a result of this discovery, the present philosophy[38] in curriculum reconstruction has become "the curriculum develops as a result of the development of the teachers personality."

This unprecedented research and study of group dynamics has resulted in the formulation of certain principles which became the guiding philosophy in the selection of methods for this study. No attempt is made to evaluate the use of the group process on the basis of these principles. The number of group meetings held during the course of the study were too limited to justify evaluation.

Principle 1: "The only circumstances people fully understand are those they have themselves experienced. The only ideas they fully grasp are those in whose formulation they have participated."[39]

Emerson stated this principle in philosophic words in The American Scholar, "Only so much do I know as I have lived."

It was believed that interest in analyzing parents'

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[37]Kenneth Benne and Muntyar Bozidar, Human Relations in Curriculum Change, p. 3. New York: The Dryden Press, 1951.

[38]George Sharp, Curriculum Development as Re-education of the Teacher, p. v. New York: Bureau of Publications, Teachers College, Columbia University, 1951.

[39]Haimon, op. cit., p. 51.

health education needs could only be reactivated as the nurse staff participated in collecting supplementary data to that already available. Furthermore, the nurses would need to develop a personal awareness of parents' needs and be active participants in formulating plans to improve patient care through parent education.

Principle 2: "Decisions which are a synthesis of a group's own efforts elicit more solid and enduring support than the edict of one man."[40]

This principle was substantiated by Lewin during the war years. He proved that housewives who participated in making decisions on how to save food, increased their food saving habits to a greater degree than the women exposed to the usual methods of persuasive appeal.

It was recognized that a plan to improve care to patients through parent education would be more lasting if the nurse staff reached their own decisions.

Principle 3: "Democratic leadership[41] enables a society to draw upon all the human resources that are available to it."[42]

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[40] Ibid., p. 52.

[41] Democratic leadership and the dynamic group process are interdependent upon each other for one cannot exist without the other. Therefore, in principles 3 and 4, the words group process might be inserted in place of democratic leadership.

[42] Ibid., p. 53.

It was recognized that the use of group thinking and discussion might stimulate suggestions and plans for improving patient care that would not otherwise be presented.

Principle 4: "Democratic leadership creates strong, responsible, self-reliant individuals who cannot so easily be pushed around by the first tyrant who comes along."[43]

This principle emphasizes the educative process that results from the application of the group process. It was believed that the continued use of the group process would result in growth on the part of the individual nurse. Furthermore, the nurse participants would develop a conviction that parent education is the responsibility of the nurse. They would then be health educators wherever they were employed.

Principle 5: "Democratic leadership builds a group which will not fall apart if something happens to the leader."[44]

Principle 6: "Those who disagree with group decisions are free to express their discontent, even though they might have to abide by the decision."[45]

This principle is supported by modern psychiatry and psychology. Both fields recognize the value of an emotional

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[43] Ibid., p. 53.

[44] Ibid., p. 54.

[45] Ibid., p. 55.

catharsis. People are more willing to accept the decisions of the group if they have had an opportunity to voice their opinion.

Principle 7: "There is no particular virtue in social unit unless it has been achieved through diversity and is constantly subject to the ever-changing pressures of individual differences."[46]

It was recognized that change is a gradual, continuous process. Therefore, group planning for improvement must be an on-going process.

Principle 8: "The method of making social decisions is as important as the decisions themselves, inasmuch as means are inseparable from ends."[47]

It was recognized that the process was as important as the decisions. The application of group discussion of common problems was as important as the decisions reached for through the process re-education and insight would be developed.

The Setting

The pediatric department of Hospital X is housed in a 9-story building designated to the care of children. The building is complete with clinical laboratories, formula room, x-ray room and teaching facilities.

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[46] Ibid., p. 55.

[47] Ibid., p. 57.

It is administered from eight head nurse units. Six of these units admit children from three to twelve years of age. The remaining two units are designated for infants from birth to three years and include facilities for premature infants.

In 1952, there were 8,118 admissions.[48] The average daily census is 150. A resolution of this daily total of patients into types of conditions shows 65 children treated as medical patients, including 18 premature infants; 60 children treated as surgical patients; 15 children with aural and eye conditions and 10 children with miscellaneous conditions. The average length of hospitalization is nine days.

Admissions to the pediatric building are through the admitting department of the hospital. The parent, or parents, accompany the child to the assigned head nurse unit where a history is taken by one of the medical staff. Hospital and departmental policies are explained to the parents by the nurse in charge. Accident cases receive treatment in the emergency operating or plaster room before being admitted to the assigned head nurse unit.

Hospital policies require that all requests for information regarding a patient's condition be channeled to the head nurse, or the staff nurse in charge of the unit

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[48] Information from hospital statistics.

during her absence.

Parents are permitted to visit their child for one hour each afternoon. One parent may visit in the evening for one half hour. On Sunday afternoons and holidays the child may have three visitors. Legal guardians are allowed the same visiting schedule as parents.

The graduate nurse staff in the department consists of one administrative supervisor, two assistant supervisors,[49] one clinical instructor, nine head nurses and nineteen staff nurses. Of the 27 graduate nurses who participated in the study, two had fulfilled the requirements for a bachelor's degree; eleven were enrolled as part time students in advanced programs of nursing; nine had accumulated credits toward a degree but were not enrolled as part time students during the time of the study.

The staff nurses attend the in-service education program conducted for the graduate nurses of the entire hospital. They may attend weekly medical rounds. Staff nurses who have shown ability and interest in the education of nursing students have assisted with the clinical teaching program.[50]

An average of 75 nursing students rotate through the

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[49]The two assistant supervisors are in charge of administering the evening and night nursing services.

[50]Helen Keliher, Unpublished Study, p. 86. Boston University, School of Nursing, 1952.

department for three months' experience in child care. Approximately 25 of these students are enrolled in the School of Nursing conducted by Hospital X; the remainder of the students are from affiliating schools.

Authorization to conduct the study was granted by the Director of the School of Nurses, the Medical Director of the Hospital and the Assistant Chief of Pediatrics. The Administrative Supervisor and the Clinical Instructor assured their support and gave permission to utilize the available data.

CHAPTER III

METHODS USED IN THE STUDY

The Background of the Anecdotal Records

The four nurses who participated in keeping the anecdotal records were selected because of their interest in the project. They were given an orientation period to help them improve their powers of observation and to help them select significant anecdotes. During this orientation the nurses kept daily diaries of the activities performed while on duty. They met with the Clinical Instructor to discuss the findings from the diaries and attempt to predict areas which would indicate parental and child needs. If the incident occurred while the nurse was giving care to the child it was recorded under the category nurse-child relationships. Likewise, if the observation of a need arose in the contact with a parent, it was recorded as a parent-nurse relationship. The nurses spent time during the afternoon and evening visiting hours in observing interactions between the parents and the child.

The head nurse unit which served as an observation field admitted girls from four to twelve years for surgical treatment. This particular unit had been selected because the tempo permitted time to make and record observations.

The head nurse and two staff nurses made observations during the day while the graduate assigned to evening duty continued to record anecdotes. They observed all the children. Since these anecdotes were recorded at various stages of the child's hospitalization, several of the observations might reiterate one particular need. Only on rare occasions were anecdotes written of an observation between a nursing student and a patient.

During the period that the nurses were keeping the anecdotal records thier attention was focused upon the fact that parents often requested information regarding the selection of toys and play materials to suit the age and the condition of their child. The nurses expressed the fact that they felt inadequate to deal with parents' requests and to suggest diversional therapy. The nurses also noted that many of the toys brought to the children were poorly selected. This observation stimulated the graduate nurses of the department to take action. With the cooperation of the nursing students they arranged an exhibit of coloring and reading materials in the classroom. Articles were arranged according to three age groups: six to eight, eight to ten and ten to twelve. Story telling was illustrated for the four to six year group. The maximum price of any article was fifty cents. The parents were given a personal invitation to attend and nurses were present to

discuss these displays with the parents and offer suggestions. Terse captions were used to highlight important points.

Interest in the project was gratifying. The resultant changes in the toys and play materials brought by the parents were indicative of the success of the endeavor. Several parents made contributions to the display in the form of articles which their children had outgrown but which met the requirements of a good toy.

Methods Used in the Study

The first method of the study was to present the anecdotal records to the nurse staff in tabular form, in order to acquaint them with the findings. In view of the success with which the group method had been utilized in the previous study[1] it was felt to be the method of choice in presenting the findings to the staff. This belief was further substantiated by Principles 3 and 8 as discussed in the philosophy underlying the study. Consequently, a group meeting was held with the 27 nurses working in the pediatric department. The findings from the anecdotal records were reviewed, the proposed study was interpreted and the cooperation of the nurses in the present project was sought.

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[1] Helen Keliher, Unpublished Study in Hospital X. Boston University, School of Nursing, 1952. Pp. 129.

The group agreed to participate.

The second step in the study was to record the questions which parents voluntarily ask nurses. It was believed that if the nurse staff participated in collecting data the second step in reactivating interest in analyzing parents' and children's need for health education might be accomplished. This belief was founded on Principle 1. It was also felt that the recording of voluntary questions would indicate the needs that parents of hospitalized children express to the nurses staff. The nurses were requested to record parents' questions along with a brief statement of their reply. Objectivity was encouraged by the omission of identification on the notations. It was hoped that the recording of the answers given to parents might stimulate self-analysis of replies. No attempt was made to determine the attitude of the nurses toward the device.

The six head nurses and eight staff nurses who worked on units giving care to children from three to twelve years recorded the parents' voluntary questions.

The third method of the study was to determine what evidence of need for health education could be elicited by interviewing parents. It was felt that the use of this method might show that there were problems that had not been evidenced by the anecdotal records or the voluntary questions. It was also believed that the comparison of the

findings from these data would be significant for the improvement of care to patients through parent education.

The nurse staff were reluctant to interview parents. The available findings, therefore, from nursing students' interviews with parents were utilized in the study.

As an assignment in Child Growth and Development the nursing students had been requested to ask parents if they had problems relative to their hospitalized child that they felt the nurse could help them solve. The assignment was based on a belief similar to the philosophy underlying the development of the nursing abilities Check List.[2] In other words, if the areas wherein parents expect to receive help from nurses could be isolated, these findings might serve as a guide in selecting the course content relative to child care for nursing students. Two direct learning outcomes could be expected. The nursing students would gain beginning skill in conversing with parents and would become cognizant of the problems faced by families

A conference was arranged with the students through the cooperation of the Clinical Instructor. At this time the study was outlined to the students. They agreed unanimously to permit the investigator to utilize the findings from the interviews in the study.

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[2] Mary Shields, "A Project for Curriculum Improvement," Nursing Research, 1:4, October 1952.

The fourth method used in the study was to meet as a group to compare the findings from the three sets of data and to discuss how these findings might be utilized to improve care to patients. This method was selected on the basis of Principles 1, 2, 3, 4, 7, 8.

A total of five group meetings were held. The first meeting was used for interpretation of and orientation to the present study. The findings from the anecdotal records were also discussed. The four subsequent meetings were used to present and discuss the findings from the data; to identify problems common to the group and utilize group activity in the solution of the problems. A permissive atmosphere was fostered at the group meetings. Leadership from within the group was encouraged.

CHAPTER IV

THE FINDINGS

Treatment of the Data

To ascertain the evidence of need for health education on the part of hospitalized children and their parents the individual findings from the anecdotal records, directive interviews, and voluntary questions were analyzed in terms of major areas of need. The findings were further studied in terms of the types of needs in each of these major areas. These types of needs were arranged in descending rank order of frequency.

The types of problems revealed by each device were also classified, irrespective of major categories, in descending rank order of frequency. The results are presented in Appendix A.

To compare the three groups of data the findings were translated into percentages. These were computed on the basis of the total number of observations and questions revealed by each device.

Evidence of Parental and Child Needs for Health Education Observed by Anecdotal Records

The distribution of anecdotal records according to the number and percentage of observations in each of the three major categories, namely: child-nurse, parent-nurse, and

parent-child can be clearly seen in Table I.

TABLE I

Numbers and Percentages of Anecdotes in Terms of Three Major Categories as Recorded in 1735 Observations by Three Staff Nurses and One Head Nurse June 1, 1952 - December 15, 1952

Category	Total Observations Number	Per Cent
Child-Nurse	945	61.4
Parent-Nurse	487	31.6
Parent-Child	107	7.0
Totals	1539*	100.0

Source: Compiled from information obtained from anecdotal records.

*196 of the observations were not recorded in terms of the three categories.

It would appear that nurses tend to make most of their observations in terms of the patient. Observations of parent-nurse relationships tend to be made only half as frequently, while observations of interactions between the parent and the child are considerably reduced.

It is evident that the number of anecdotes written in the parent-nurse and parent-child category would be influenced by the restricted visiting schedule. However, it

would seem that the importance of parent-child relationships did not loom large on the part of the nurses. Had they realized the full import of the interactions between the parent and the child it is reasonable to suppose that they would have seized more opportunities to record observations in this area.

The observations recorded in the anecdotal notes lent themselves to grouping under the following headings: hygiene, habit formation as eating, sleeping and bowel habits, play, special behavior problems, need for orientation of patient and parents to hospital, need for preparation of parent to assume home care of patient, parents' requests for information regarding miscellaneous diseases, especially the benefits of a tonsillectomy and adnoidectomy, requests for social service, and concern over continuance of child's education. These headings are arranged in descending rank order of frequency. Table II shows this distribution of anecdotal records in terms of the number in each area of observation.

From Table II it can be noted that 43 per cent of the total recorded observations related to hygiene. The inference seems to be that the nurses felt these areas were the most significant to record. It should be noted, however, that this type of observation decreased as the study period progressed, while observations in other areas increased.

TABLE II

Areas of Health Education Needed by 234 Hospitalized Children and Their Parents in Terms of the Number in Each Category
June 1, 1952 - December 15, 1952

Area of Observation	Total Observations Number	Per Cent
Hygiene	752	43.4
Habit formation	270	15.6
Play	270	15.6
Special behavior problems	176	10.1
Need for orientation to hospital	98	5.6
Need for preparation for home care	98	5.6
Information regarding miscellaneous diseases	34	2.0
Requests for social service	31	1.8
Concern over continuing education	6	0.3
Totals	1735	100.0

Source: Compiled from information from 1735 anecdotal records by three staff nurses and one head nurse.

The areas where health education relative to hygiene are needed by hospitalized children and their parents are shown in Table III.

TABLE III

Areas of Health Education Relative to Hygiene Needed by 234 Hospitalized Children and Their Parents in Terms of the Number and Percentage in Each Category as Recorded in 752 Observations June 1, 1952 - December 15, 1952

Hygiene	Child-Nurse		Parent-Child		Parent-Nurse	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Care of nails	194	25.8				
Bathing	173	23.0	3	0.4		
Care of hair	169	22.4				
Care of teeth	87	11.6			42	5.6
Pediculosis (treatment and prevention)	46	6.1				
Feet: Shoes	19	2.5				
Arches	11	1.5				
Menstruation	3	0.4			5	0.7
Totals	702	93.3	3	0.4	47	6.3

Source: Compiled from information obtained from 1735 anecdotal records by three staff nurses and one head nurse.

It becomes apparent that there is a need for health education of the patient and the parent.[1] Ninety-three per cent of the observations relative to hygiene were grouped in the child-nurse category. The nurses expressed the belief that the daily hygiene in the hospital taught many of these children habits they were not accustomed to at home. The nurses overheard three children telling their mothers that in the future they must bathe every day. They also felt that much exemplary teaching was done by the personnel in the process of carrying out the daily routines of the ward. This would seem to suggest that health teaching can be accomplished with patients of the age group included in the study.

There were twenty-six notations to the effect that no attempt had been made to secure treatment for carious teeth. Another forty-two notations revealed difficulty in getting the parents to bring in a tooth brush[2] though they brought many other things. It is evident that there is a need to develop an awareness of the importance of dental hygiene.

Five mothers sought advice relative to telling their daughters about menstruation. Three patients who had their

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[1]The anecdotal records were used as a fact-finding device. Emphasis was not placed upon recording the follow through on the observed need.

[2]Tooth brushes are supplied only to the "needy" patients in Hospital X.

TABLE IV

Guidance Relative to Habit Formation Needed by 234 Hospitalized Children and Their Parents in Terms of the Number and Percentage in Each Category as Recorded in 270 Observations June 1, 1952 - December 15, 1952

Habit Formation	Child-Nurse		Parent-Child		Parent-Nurse	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Eating						
Convalescent nutrition					71	26.3
Normal nutrition					39	14.5
Anorexia					23	8.5
Between-meal snacks					14	5.0
Forcing food			16	5.9		
Manners	9	3.4				
Pica	4	1.5				
Evacuation						
Number of stools					21	7.8
Laxatives, enemata					61	22.6
Sleeping						
Question of naps					12	4.5
Totals	13	4.9	16	5.9	241	69.2

Source: Compiled from information obtained from 1735 anecdotal records by three staff nurses and one head nurse.

first mensus while in the hospital had had no preparation in this respect.

The interest and concern of parents in regard to habit formation is indicated in Table IV. The evidence seems to indicate that parents are concerned over normal and convalescent nutrition.[3] This observation has implications for health education. It would seem to indicate a readiness for learning on the part of the parents.

Observations of needs relative to the child's play are shown in Table V.

It is noted that eighty-eight of the anecdotal records of parent-child interactions were in the area of play. It is noted, also, that there is an apparent need to help grownups understand the role of play in the growth and development of the child. The nurses commented on the fact that both parents and nurses are guilty of "taking over" and assisting the child too frequently in his play.

Hospital policies did not permit children to have comic books at the time the anecdotal records were kept. This regulation must be considered in interpreting the fact that twenty-nine parents asked questions about comic books.

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[3]The information available to the investigator did not indicate whether the interest in normal nutrition arose spontaneously from the parent or if the conversation was initiated by the nurse.

TABLE V

Guidance Relative to Play Needed by 234 Hospitalized Children and Their Parents in Terms of the Number and Percentage in Each Category as Recorded in 270 Observations June 1, 1952 - December 15, 1952

Observations Relative to Play	Child-Nurse		Parent-Child		Parent-Nurse	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Assisting children, "taking over"	53	19.6	88	32.6		
Group play	73	27.1				
What to give the child at various age levels					27	10.0
Question of comic books					29*	10.7
Totals	126	46.7	88	32.6	56	20.7

Source: Compiled from information obtained from 1735 anecdotal records by three staff nurses and one head nurse.

*Hospital policies did not allow the child to have comic books.

In regard to special behavior problems, Table VI, it is noted that nail biting was the problem most frequently observed by the nurses and likewise that it is a source of

TABLE VI

Health Education Relative to Special Behavior Problems Needed by 234 Hospitalized Children and Their Parents in Terms of the Number and Percentage in Each Category as Recorded in 176 Observations June 1, 1952 - December 15, 1952

Special Behavior Problems	Child-Nurse		Parent-Child		Parent-Nurse	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Nail biting	64	36.4			22	12.5
Masturbation	14	8.0			4	2.3
Nose picking	5	2.8				
Head rocking	1	0.6				
Temper tantrums	9	5.1			2	1.1
Thumb sucking	7	3.9			3	1.8
Smearing	4	2.3				
Enuresis					6	3.4
Bad dreams					9	5.1
Fear of the dark					24	13.6
Sleep walking					2	1.1
Totals	104	59.1			72	40.9

Source: Compiled from information obtained from 1735 anecdotal records by three staff nurses and one head nurse.

concern to parents.[4]

There are 14 notations relative to masturbation in the child-nurse category but only four to correspond with this in the parent-nurse column.

It is interesting that there were no recorded observations of parent-child interactions in the area of special behavior problems.

There were 34 notations indicating that parents seek the nurse's advice in regard to medical conditions, as the advisability of surgery for diseased tonsils and adnoids, Table VII. It is evident that parents expect nurses to possess this type of information. Furthermore, it substantiates Caplan's[5] belief that parents look to the nurse as a sister. This feeling of kinship makes it easier for the parent to approach the nurse. Nonetheless, her opinion and advice is accepted since she is regarded as a "wise sister."

Three parents asked questions pertaining to faulty hearing; four asked about eye defects.

Two notations showed that nurses spoke to parents regarding strabismus and myopia.

Requests for social service were presented to the

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[4]Available information did not indicate whether the parent or the nurse initiated the conversation.

[5]Gerald Caplan. Lecture notes, Maternal and Child Health Seminar.

TABLE VII

Information Relative to Miscellaneous Diseases Requested by Parents of 234 Hospitalized Children in Terms of the Number and Percentage in Each Category as Recorded in 34 Notations
June 1, 1952 - December 15, 1952

	Child-Nurse		Parent-Child		Parent-Nurse	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Tonsillectomy, adnoidectomy					22	64.7
Circumcision					2	5.9
Rheumatic fever					1	2.9
Faulty hearing					3	8.8
Eye defects					6	17.7
Total					34	100.0

Source: Compiled from information obtained from 1735 anecdotal records by three staff nurses and one head nurse.

nurse by 31 parents. Table VIII. Economic and legal problems were the most common. Social workers have interviews with all parents. The requests were expressed before the social worker had made her contacts.

Six parents were concerned over their child's education. These problems were referred to the school teacher.

TABLE VIII

Miscellaneous Needs of 234 Hospitalized Children and Their Parents in Terms of the Number and Percentage in Each Category as Recorded in 1735 Observations June 1, 1952 - December 15, 1952

	Child-Nurse		Parent-Child		Parent-Nurse	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Need for orientation to hospital					98	5.6
Need for education relative to home care					98	5.6
Social service requests					31	1.8
Concern over child's education					6	0.3

Source: Compiled from information obtained from anecdotal records by three staff nurses and one head nurse.

The educational needs of the children are met by a full time school teacher. Instruction begins upon the doctor's request.

An equal number of observations were made in regard to the need for orientation of parents and children to the hospital and the need for education of parents relative to

home care. It was felt that much of the lack of cooperation in regard to hospital policies could be traced to insufficient orientation to the hospital and the department. The need for and the possibilities of a suggestion sheet for parents had been discussed. No further action was taken.

Evidence of Parental and Child Needs Revealed By Directed Interviews

Of the total interviews 171 were conducted with parents whose children were three to twelve years of age. The findings from these interviews are included in the study. This yields a mean of 2.37 problems elicited by each student.

Analysis of the interviews revealed the following problematic area, listed in descending rank order of frequency: concern over home care, child guidance, eating habits, prophylaxis, special behavior problems, child's immediate condition, need for support, others[6] requests to speak to the doctor, and questions relative to hospital policies.

The distribution of the problems in terms of the number and percentage in each major category can be clearly seen in Table IX.

It is significant that problems relative to home care

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[6]Four parents stated they had no problems.

TABLE IX

Problem Areas Relative to Child Care and Guidance Expressed by 171 Parents of Hospitalized Children in Terms of the Number and Percentage in Each Category April 14, 1953 - April 21, 1953

Problem Area	Number	Per Cent
Home care	53	31.0
Child guidance	30	17.5
Eating habits	24	14.0
Prophylaxis	19	11.1
Special behavior problems	16	9.4
Child's immediate condition	13	7.6
Need for support	6	3.5
Others*	4	2.3
Hospital policies	3	1.8
Speak to doctor	3	1.8
Totals	171	100.0

Source: Compiled from information obtained from directed interviews conducted by 72 nursing students.

*Four parents stated they had no problems.

should be presented most frequently and that parents' concern regarding child guidance should rank second. This

latter finding was also noted by Rood.[7]

The types of problems parents presented relative to home care are shown in Table X, in terms of their frequency of occurrence.

It is evident from the data that parents of hospitalized children are concerned over home care. They wanted to know how long the child would need to stay in bed, when he could go up and down stairs, when he could resume outdoor activity, how soon following surgery he could ride a bicycle, and when he could return to school. They wanted to know what foods would be best for the child during convalescence. Mothers were particularly concerned about the care of surgical incisions and how to do the dressings. They had problems associated with lengthy convalescence as shown in the following questions:

> "How would you amuse a five year old who will have a long convalescence? What things would interest her?"
>
> "How can I keep her from being too active for a few weeks so she can rest before she attends school again?"
>
> "How can I keep my son quiet following rheumatic fever?"
>
> "How can I make Cynthia realize the importance of bed rest?"

It would appear that parents expect nurses to know

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[7]Dorothy Rood. The Nurse and Parent Education. p. 40. New York: Bureau of Publications, Teachers College, Columbia University, 1935.

TABLE X

Problematic Areas Relative to Home Care Expressed by 171 Parents of Hospitalized Children in Terms of the Number and Percentage in Each Category April 14, 1953 - April 21, 1953

Area	Total Problems	
	Number	Per Cent
Degree of exercise	14	26.4
Convalescent nutrition	9	17.0
Care of incision and dressings	9	17.0
How to restrict activity and keep child occupied	7	13.2
General home care	7	13.2
Use of laxatives and enemata	3	5.7
Correct use of crutches	2	3.7
Giving medication	1	1.9
Others*	1	1.9
Totals	53	100.0

Source: Compiled from information obtained from directed interviews conducted by 72 nursing students.

*One mother was an epileptic. She stated that she felt inadequate to care for her child.

how to meet the total needs of a child whose activity is restricted. Furthermore, they expect nurses to be able to give them suggestions as to how they might meet these needs at home.

Some of the requests for information showed the parents' concern over the general management of home care, as illustrated by the following questions:

"How will I be able to take care of her when she is home?"

"How will I take care of her when I take her home?"

"How should I care for my child while she is recuperating at home?"

"How will I treat her when I take her home?"

These findings relative to the types of problems faced by parents in planning for the home care of their child have implications for health teaching. An analysis of the findings yields pertinent information as to what, when and how to teach. The types of problems presented to the nurses can be assumed to be representive of what parents need to learn about the home care of their child. This information could be utilized in selecting basic content for parent education. Provisions would be necessary for adaptation of this content to meet the needs of the individual family. Study of the parents' problems in relation to the stage of hospitalization at which they were presented would yield information as to the timing of health teaching. Further study of the frequency and

grouping of the problems would help to determine the method of teaching. For example, the evidence suggests that discussion groups might be utilized in preparing families to assume the home care of children who will require long convalescence.

The types of difficulties parents presented relative to child guidance, expressed in terms of their frequency of occurrence, are shown in Table XI.

The problems frequently posed as "how can I?", "what can I do?" seem to indicate the feeling of responsibility which people have toward parenthood.

There is evidence of insufficient knowledge of child growth and development on the part of the parents for they did not seem to know what to expect of the child at the various age levels. Evidence also suggests lack of information relative to the developmental philosophy of child guidance. These factors are illustrated in the following questions:

"How can I stop my child from asking so many questions?"

"How can I teach a three year older to do things properly?"

"How can I make Patsy play after school instead of lying around listless?"

It is interesting to note the types of problems relative to child guidance represented in this group of 30 questions. They ranged from the everyday difficulty to the less common problem typified by the mother who wanted

TABLE XI

Problems Relative to Child Guidance Expressed by 171 Parents of Hospitalized Children in Terms of the Number and Percentage in Each Category April 14, 1953 - April 21, 1953

Area	Total Problems	
	Number	Per Cent
Teach obedience	4	13.5
Overcome shyness	3	10.0
Overcome selfishness	3	10.0
Develop independence	2	6.7
Teach siblings to get along with each other	2	6.7
Reason with a child	2	6.7
Deal with crying when the mother leaves	2	6.7
Help child to adjust to home life following prolonged hospitalization	2	6.7
Deal with overtalkativeness	1	3.3
Deal with excessive questions	1	3.3
Deal with profanity	1	3.3
Teach child to talk	1	3.3
Stimulate interest in active play	1	3.3
Tell child of father's death	1	3.3
Help child with reading	1	3.3
Select books	1	3.3
Teach child to do things properly*	1	3.3
Teach retarded child**	1	3.3
Totals	30	100.0

Source: Compiled from information obtained from directed interviews conducted by 72 nursing students.

*The child in reference was three years of age.

**One of the hospitalized children was a mongolian idiot.

to know how to tell a child of his father's death, or the mother who wanted to know how to teach her child who was a mongolian idiot.

The distribution of difficulties relative to the formation of good eating habits are shown in Table XII.

TABLE XII

Problems Relative to the Formation of Good Eating Habits Expressed by 171 Parents of Hospitalized Children in Terms of the Number and Percentage in Each Category April 14, 1953 - April 21, 1953

Area	Total Problems	
	Number	Per Cent
Anorexia	12	50.0
Overeating	4	16.7
Dislike for vegetables and milk	4	16.7
Manners	2	8.3
Wean child of bottle	2	8.3
Total	24	100.0

Source: Compiled from information obtained from directed interviews conducted by 72 nursing students.

The problems ranged from anorexia to overeating. One father stated that half his children had no appetite while the other half ate too much.

The apparent concern regarding anorexia would reinforce the observation made earlier that parents need to

know more about child growth and development.

Leaders[8] in this field have found that much of the anorexia in childhood can be traced to the child's growth process and his immediate physiological needs. They have observed that growth does not occur at a uniform rate but rather as a series of increases followed by plateaux. The child's appetite fluctuates according to the phase of growth he is experiencing. It follows then, that if parents were aware of this phenomenon of growth they would be able to accept the child's refusal of food. Conversely, the lack of this knowledge causes parents to become concerned over the refusal of food. The child soon learns that he can gain attention by refusing to eat and thus many problems relative to food habits develop.[9]

The evidence, also, showed a need to help parents develop an awareness of the influence of adult food habits upon the child's eating pattern.

The types of information sought by parents in regard to prophylactic measures are shown in Table XIII.

Parents showed concern over the prevention of diseases. They wanted to know the significant indications

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[8]Benjamin Spock, The Common Sense Book of Baby and Child Care, pp. 207, 340. New York: Duell, Sloan and Pearce Inc., 1946.

[9]Anderson Aldrich and Mary Aldrich, Feeding our Old-Fashioned Children, p. 88. New York: The Macmillan Company, 1941.

TABLE XIII

Information Relative to Prophylactic Measures Requested by 171 Parents of Hospitalized Children in Terms of the Number and Percentage in Each Category April 14, 1953 - April 21, 1953

Area	Number	Per Cent
Prevent pediculosis	4	21.0
Signs and symptoms of illness	4	21.0
Prevent colds	3	15.8
Follow up care through outpatients department	3	15.8
Prevent accidents in the home	2	10.5
Prevent reoccurrence of disease and complications	2	10.5
Care of deciduous teeth	1	5.4
Totals	19	100.0

Source: Compiled from information obtained from directed interviews conducted by 72 nursing students.

of illness, how soon to call the doctor, how they could prevent colds, and how they could prevent the spread of colds amongst the members of their family. They also wanted to know what services were available through the outpatient department and what follow up would be necessary for their child. There were two requests for information relative to the prevention of accidents in the home.

It is recognized that the sampling is limited. However, the findings seem to suggest that the pediatric nurse

is in a strategic position for health teaching. The findings further seem to suggest that the nurse engaged in the actual nursing care occupies an even more strategic position. She knows both the patient and the parents and has a closer relationship with the family. Therefore, it would seem advantageous for the bedside nurse to be aware of teaching opportunities and be prepared to give information relative to the prevention of disease and the maintenance of health.

It is significant that parents recognize special behavior problems and that they are willing to discuss them with nurses. The types of behavior problems presented are shown in Table XIV.

The questions indicate that parents want to know three things, namely: is it normal, why does the child indulge in this behavior and how can it be corrected. These requests are shown in the following examples:

> "Why does my child suck her thumb, she's seven years old? How can I break her of it?"
>
> "If he keeps up this thumb sucking will I have to forcibly stop him?"
>
> "Should John still be wetting his bed at his age (five years)? What can I do to break him?"
>
> "What can I do to stop my son from bed wetting, I have tried everything, even threatening?"

The evidence seems to indicate that parents regard this type of problem as an entity and not a manifestation of an underlying difficulty.

TABLE XIV

Requests for Information Relative to Special Behavior Problems Expressed by 171 Parents of Hospitalized Children in Terms of the Number and Percentage in Each Category
April 14, 1953 - April 21, 1953

Area	Total Problems	
	Number	Per Cent
Thumb sucking	4	25.0
Masturbation	3	18.7
Enuresis	3	18.7
Soiling and wetting*	3	18.7
Temper tantrums	2	12.5
"Nervous" child	1	6.4
Totals	16	100.0

Source: Compiled from information obtained from directed interviews conducted by 72 nursing students.

*One of the problems relative to toilet training was presented by the mother of a child who was a mongolian idiot.

Requests for information relative to the child's immediate condition are shown in Table XV.

There were two types of information requested by parents relative to the child's condition. The first type was of this general nature: the kind of medication used, why, and what results could be expected, would a cystoscopic examination be painful, would the child have an anaesthetic for the examination and would a child develop an immunity

TABLE XV

Information Relative to the Child's Immediate Condition Requested by 171 Parents of Hospitalized Children in Terms of the Number and Percentage in Each Category April 14, 1953 - April 21, 1953

Area	Total Requests	
	Number	Per Cent
Child's immediate condition	13	68.4
Seeking information indicative of need for support	6	31.6
Totals	19	100.0

Source: Compiled from information obtained from directed interviews conducted by 72 nursing students.

to pulmonary tuberculosis as a result of tubercular peritonitis.

The second type of question seemed to indicate the parents' need for support. Examples of these questions are:

"Will my child get well?"

"Do you think this heart operation is necessary? Will it make him better? Will his blood be better?"

"I am worried about my child's present illness."

"Will my child have scars from these burns?"

This type of request indicating need for support on

the part of the parents and children has significant implications for nurses engaged in child care. These implications will be discussed under the findings from the parents' voluntary questions.

The grouping of miscellaneous problems is illustrated in Table XVI in terms of the frequency of occurrence.

TABLE XVI

Miscellaneous Responses of 171 Parents of Hospitalized Children in Terms of the Number in Each Category April 14, 1953 - April 21, 1953

Area	Number
No problems or unconcerned	4
Hospital policies	3
Desire to speak to doctor	3
Total	10

Source: Compiled from information obtained from directed interviews conducted by 72 nursing students.

It is interesting that only four parents stated they had no problems. The mother who expressed unconcern admitted there were many things regarding child care she needed to learn. However, she did not feel it was necessary for her to be concerned at the present time, for the

lady who looked after her children would care for the hospitalized child upon his discharge from the hospital.

Two mothers stated that they had no problems. They had large families and felt they knew how to care for children. The fourth mother had been the eldest of a large family and had participated in the care of her siblings. She felt competent to look after her four children.

There were only three questions relative to hospital policies. One parent wanted to know if he needed an appointment card to bring his child back to the hospital for minor surgery. A second inquiry pertained to comic books.

This use of the directive interview technique shows what can be learned about parents' problems by the application of a simple device. Success is based upon the establishment of a helpful relationship with the parents. The display of interest in the parent as an individual provides an environment in which parents can talk about their difficulties.

Evidence of Parental and Child Needs Revealed By Voluntary Questions

A total of 130 questions were presented to the nurses during the week. This yielded a mean of 9.28 questions per nurse.

The questions and replies were classified under the following headings, listed in descending rank order of frequency: requests for information relative to the child's

immediate condition, questions indicative of the need for understanding and support, information regarding hospital policies, time of child's discharge, place and time to see doctor, home care, child guidance and the continuance of the child's education.

Table XVII indicates the number and percentage of questions in each of these categories.

The types of information relative to the child's immediate condition requested by parents are shown in Table XVIII.

In analyzing the parents' voluntary questions relative to the child's immediate condition, it was noted that 40 per cent of their inquiries lent themselves to grouping under three areas of concern. First, the parents sought information regarding the treatment the child was receiving and why it was being done. Second, they wanted to know about the child's general condition. Third, they requested information about the child's symptoms as temperature and cough. This concern of the parents in the immediate condition of the child will be discussed later in the study.

There were, also, requests which seemed indicative of the parents' and the child's need for support and understanding. Parents who approached the nurse with a group of questions which they presented without pausing for an answer were classified in this area. The following questions are illustrative:

TABLE XVII

Areas of Information Requested by Parents and Hospitalized Children in Terms of the Number and Percentage in Each Category April 22, 1953 - April 29, 1953

Area of Information	Total Questions	
	Number	Per Cent
Child's immediate condition	57	43.8
Indicative of need for understanding	19	14.6
Hospital policies	18	13.5
Child's discharge	16	12.3
Place and time to see doctor	10	7.6
Home care	7	5.4
Child guidance	2	2.0
Child's education	1	0.8
Totals	130	100.0

Source: Compiled from information obtained from 130 voluntary questions recorded by 14 graduate nurses.

"How is my child? What are they doing for him? Does he sleep? Does he cry all the time? I'm so worried I can't sleep." Likewise, these statements and questions from a child were regarded as evidence of the need for support. "Nurse, my eye pains me something awful. Oh, it's

bleeding. Nurse, it's bleeding. Is that bad? Am I going to see again? Nurse, can I eat? I'm hungry. Why doesn't the doctor say I can have breakfast?"

TABLE XVIII

Information Relative to the Child's Immediate Condition Requested by Parents of Hospitalized Children in Terms of the Number and Percentage in Each Category
April 22, 1953 - April 29, 1953

	Number	Per Cent
Child's immediate condition		
Treatments - what are they doing, why.	20	26.3
How is my child?	17	22.4
Symptoms - temperature, cough, rash	15	19.7
Evacuation	3	3.9
Eating	2	2.6
Indicative of need for understanding		
Parents	10	13.2
Child	9	11.9
Totals	76	100.0

Source: Compiled from information obtained from 130 voluntary questions recorded by 14 graduate nurses.

These requests which seem to indicate the parents and the children's need for support were present also in the findings from the directed interviews. They have significant implications for nurses engaged in child care. They relate to the understanding of human behavior developed in the philosophy of the study. The pediatric nurse should be cognizant of the fact that it is not just what the family say but how they say it, that is important and indicative of need. Second, the evidence indicates the need for the pediatric nurse to be able to listen. The parents feel that they are understood when someone will listen to their problems. Third, there are indications to show that the nurse needs to know when and how to interject statements and questions that will draw the parents out and help them to express their difficulties. The pediatric nurse skilled in the techniques of the interview can make this contact with the family at the time of hospitalization a helpful experience.

In recording the voluntary questions both those of the parents and the children were noted. It was felt that information might be accumulated regarding the hospitalized child's needs. The only type of questions from the child that reached the level of the graduate nurse were in the area of need for understanding. It can be assumed that the routine questions of the child are presented to the person administering the bedside care. This person has a

warmer and more sustained relationship with the patient. This observation would indicate the need for carefully selected personnel for the pediatric unit. The entire personnel should have a liking for children, an understanding of the child and his needs, and be able to deal effectively with his queries and manifestations of need.

The parents' questions relative to hospital policies and seeing the doctor are shown in Table XIX.

There was evidence of requests to bring additional visitors and for exceptions to be made regarding the policy of bringing in food. It would suggest the need for improved human relations in respect to interpretation of hospital and departmental policies. "We all resent domination."[10] If people are given a reasonable explanation for a regulation they will tend to comply. On the other hand, impersonal signs fail to stimulate compliance to policies for, "We all want all we can get."[11] The introduction of a suggestion sheet for parents during this study was evidence of the success that can be achieved by one simple device. The application of human relations from the initial contact in the admitting department, throughout the orientation to the hospital, and the hospital stay would

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[10] Joseph Dooker and Vivienne Marquis, The Supervisors Management Guide, p. 11. New York: The American Management Association, 1949.

[11] Ibid., p. 17.

tend to stimulate cooperation from the consumers of nursing.

TABLE XIX

Information Relative to Hospital Policies and Seeing the Doctor Requested by Parents of Hospitalized Children in Terms of the Number and Percentage in Each Category

	Number	Per Cent
Hospital policies		
Extra visitors	8	28.6
Food and sweets	7	25.0
Comic books	2	7.1
Directions to blood bank	1	3.6
Seeing doctor		
Time and place to see doctor	10	35.7
Totals	28	100.0

Source: Compiled from information obtained from 130 voluntary questions recorded by 14 graduate nurses.

There appeared to be some difficulty in arranging for parents to talk with the doctors. The doctors on the Pediatric service are present at the afternoon visiting hour specific days of the week to discuss the child's needs

and care with the parents. Nurses commented that on these days there were few questions from parents. The doctors from the four visiting surgical services see parents at various assigned stations in the pediatric department in one of the main buildings of the hospital. Parents stated that it was sometimes difficult for them to contact the doctor assigned to the care of their child.

The types of information requested by parents relative to the discharge of their child from the hospital and questions regarding the home care are shown in Table XX.

The data from the parents' voluntary questions did not show how long the children were in the hospital nor how much teaching was done.

There was evidence of the parents' lack of truthfulness in dealing with the child. It seemed difficult for the parent to face the child's crying when separation was inevitable. Two parents requested the nurses to tell the child a falsehood to prevent crying. In both instances the nurses explained the need for truthfulness. They reassured the mother that the child's attention would be diverted and suggested that she wait outside the unit until the crying subsided.

The nurse staff expressed the opinion that they felt a real problem existed in the lack of truthfulness on the part of parents in dealing with their hospitalized child. They felt the problem was particularly in evidence during

the admission of the child to the hospital. The findings seem to indicate that pediatric nurses need to be prepared to deal with this problem through effective reasoning with the parents.

TABLE XX

Information Relative to Discharge and Home Care Requested by Parents of Hospitalized Children in Terms of the Number and Percentage in Each Category
April 22, 1953 - April 29, 1953

	Number	Per Cent
Child's discharge		
When can child go home	9	39.2
Routines of discharge	7	30.4
Home care		
Convalescent diet	4	17.4
Degree of activity	3	13.0
Totals	23	100.0

Source: Compiled from information obtained from 130 voluntary questions recorded by 14 graduate nurses.

Common Areas of Need Revealed by the Three Groups of Data

To determine the common areas of need revealed by the three approaches to parents' problems, the findings from

each method were translated into percentages. These percentages were computed on the basis of the number of problems in each category in relation to the total problems presented by the device.

Three areas of need were found to be common to the three groups of data, namely: the need for orientation of parents to hospital policies, parents' requests for information regarding the child's condition, and the parents' need for preparation to assume the home care of the child. These common areas of need can be clearly seen in Table XXI.

The initial problem area pertained to orientation. This area of need had been identified in the anecdotal records. However, the increase in problems in this area shown by the voluntary questions seems to indicate that orientation to the hospital is of more concern to parents than was observed by nurses as evidenced by interviews. The repetitious nature of the parents' voluntary questions led the nurse staff to take action in an attempt to facilitate orientation by providing copies of routine information.

The second common area of need pertained to the parents' requests for information regarding the child's condition.

The 4.7 per cent notation opposite 'concern over child's immediate condition, as observed in the anecdotal records, refers to 81 notations relative to the evacuant

TABLE XXI

Health Education Needs in Terms of Percentage of Times a Specific Problem Was Stated as of Concern to Hospitalized Children and Parents June 1, 1952 - December 15, 1952, April 14, 1953 - April 29, 1953

	Anecdotal* Records	Voluntary Questions	Directive Interviews
Hospital policies	5.6	13.5	1.8
Seeing doctor		7.6	1.8
Requests for social service	1.8		
Child's condition	4.7	43.8	7.6
Reassurance		14.6	3.5
Child's education	0.3	0.8	
Time of discharge		12.3	
Home care	5.6	5.4	31.0
Prophylaxis	2.0		11.1
Need for health education	43.4		
Habit formation			
Eating habits	10.1		14.0
Sleeping habits	0.8		
Special behabior problems	10.1		9.4
Child guidance		2.0	17.0
Toys and play materials	15.6		0.5
Others**			2.3
Totals	100.0	100.0	100.0

Sources: Compiled from 1735 anecdotes, 130 voluntary questions, 171 directed interviews as recorded by 90 nurses (72 of these are students).

*Each one in terms of 100 per cent.

**Four parents stated they had no problems.

habits of the child. The recorded incident was stimulated by the parents' desire to know if the child had had a bowel movement. Since the conversation was initiated from a concern over the child's present condition, the notations were placed under this heading.

The parents' concern over the child's immediate condition loomed large in the voluntary questions. There are many factors which contribute to the parents' concern over the child. If the nurse recognizes these factors it may aid her in understanding parents and their needs, for, "To condemn closes the opportunity for a helpful relationship; to understand helps to make such a relationship a reality."[12]

The nurse should recognize the fact that the parents' concern over the child is natural by virtue of their position as a parent. Second, she should be aware of the fact that the parents may experience a sense of failure in their role as parents when it becomes necessary to place the care of the child in the hands of strangers. The parents' reactions to the hospitalization are also influenced by the fact that they cannot be present throughout the day to see what is taking place. This desire to know what is going on is stated in a principle of human relations, "We all

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[12]Leslie Robert, "Why We Predetermine What Others Should Be." Seminar in Human Relations in Nursing. p. 34. Andover, Mass.: The Andover Press, Ltd., 1950.

like to be in the know."[13]

The third common area of need that appeared in the three groups of data was relative to the home care of the child.

Concern over home care was equal in the findings from the anecdotal records and the voluntary questions. However, the requests for information were increased when the interview technique was used.

The fact that health teaching relative to home care should be shown as an area of need in all three sets of data has implications for nurses. It seems to support the tenet that health teaching is an integral part of nursing care. Furthermore, this evidence of parent interest in and concern over home care seems to indicate a state of readiness for learning activities. Burton[14] states this principle of learning in the following manner, "The learning experience, initiated by need and purpose is likely to be motivated continuously by its own incompleteness." The need for learning has been presented by the child's illness. The purpose, also, is present for parents are, as a rule,

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[13]Joseph Dooker and Vivienne Marquis, The Supervisors Management Guide, p. 14. New York: American Management Association, 1949.

[14]William Burton, The Guidance of Learning Activities, p. 213. New York: Appleton, Century-Crofts Inc., 1944.

anxious to do their best for their children.[15]

It follows, therefore, that the immediate concern over the child's illness and the existent concern regarding the future maintenance and promotion of the child's health has provided a setting for learning activities. The nurse, in planning care for the child and his family, should capitalize upon this psychologically sound, advantageous environment for health teaching, demonstrations, etc.

Comparison of Two Methods of Identifying Parents' Need for Health Education

The findings were further studied in terms of comparing two methods of identifying needs, namely, through anecdotes of nurses' observations and questions voluntarily asked by parents with those questions elicited through directed interviews. It is recognized that the sampling from the voluntary questions and the directive interviews are limited, however, there were findings which seemed significant because they tended to reoccur.

It was noted that there was a shift of needs between the problems identified by the two methods. This was shown by the seemingly significant increases and decreases in the frequency with which problems were presented. Interest and

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[15] Josephine Croytor, "Teaching in a Pediatric Clinic," Public Health Nursing, 33:669, November, 1941.

concern over home care was increased six times when the interview technique was utilized. Interest in prophylactic measures were increased five times when the nurses went to the parents and offered to be helpful. Interest in and concern over child guidance was increased eight times when the interview technique was used, while concern over health education relative to hygiene was not identified in the interviews.

The inference seems to be that parents have problems that differ from those which the nurses observe. Furthermore, these needs are not identified unless nurses seek to establish a helpful relationship with the parents and to draw out their problems through conversation.

It was also noted that there were different levels of concern presented according to the method used to identify the need. The expressions of need through the anecdotes and the voluntary questions were for the most part of the here and now variety. While the needs identified by the directed interviews were almost equally divided between the problems present prior to the hospitalization and plans for future care and maintenance of health. The questions relative to the child's immediate illness were limited in number. The directed interviews brought out many problems that did not come to the surface when the first method of identifying needs was utilized. These findings are brought out most clearly in the areas of child guidance and special

behavior problems.

There were no recorded observations of the parents' need for help relative to child guidance in the anecdotes. There were only two indications of need identified by the voluntary questions, and further the circumstances seemed to indicate that the parents were not aware of their need for help. The problems in reference were the lack of truthfulness on the part of the parent in dealing with the child. On the other hand, 17.5 per cent of all the problems brought out by directed interview lay in this area of need for help regarding child guidance. The sampling showed a variety of needs ranging from everyday happenings to the less common problems.

Special behavior problems were identified with almost equal frequency in the anecdotes and the findings from the directed interviews. However, it is to be noted that the findings revealed by the later device were of a deeper level. Almost 50 per cent of the special behavior problems identified by the anecdotal records were in regard to nail biting, while this problem did not appear in the directed interviews.

Since these different levels of needs were shown by the directive interview technique used as a diagnostic device, it would seem to indicate further use of the device with an emphasis not only on identification of problems but on follow through. Further, it seems to indicate the

possibilities of non-directive interviews to draw out parents' problems and to help them gain insight by discussing their problems. The nurse skilled in the techniques of the interview could go on to discover the cause behind the symptom reported by the parent. She could learn about the food habits of the adults in the family that might be influencing the problem of food dislikes, anorexia or overeating.

The establishment of a helpful relationship with the family would tend to provide security for both the parents and the child through confidence in the personnel responsible for the child's care. Follow through on identified problems would result in improved care to patients.

Utilization of Findings To Improve Patient Care

In order to determine how the nurse staff might use this information in improving plans for nursing care, five group meetings were held with the graduate nurses of all the head nurse units.

At these meetings the findings from the three data collecting devices were presented and compared. Group discussion centered about how these findings might be utilized.

The nurses' attention was focused upon the repetitious nature of the parents' voluntary questions as a result of recording the requests for information. This observation was expressed by several of the nurses at the second group

meeting. The members suggested and discussed the advantages of a printed sheet of instructions for parents. They agreed that the presentation and explanation of a printed form at the time of admission would release nursing time otherwise spent in giving repetitious information. Parents would be able to review this information in their own homes. Better cooperation between the parents, patients and the staff could be anticipated as a result of increased information regarding hospital and departmental policies. In discussing the explanation of policies to parents it seemed that not all the nurse staff were familiar with the reasons that led to the formulation of the regulations. Some time, therefore, was spent in discussion and clarification of policies. As an outcome of cooperative planning and pooling of suggestions, the staff prepared a trial suggestion sheet for parents. A copy of the form appears in Appendix B.

The suggestion sheet has now been in use for six weeks. The group agreed that questions relative to routines and policies had been reduced. One nurse stated that the only question of this nature that had been presented to her was in regard to the location of the specified place to see the doctor. Another reported that the father of a child with repeated admissions had requested a form before she had had time to prepare it. The father stated he would like to have a form despite the fact that he knew the hospital

regulations.

Suggestions for a revised form are being submitted by the nurses. It has been suggested that parents' comments also be noted and utilized in future revisions. It would seem that human relations between parents and the nursing staff will be improved as a result of this simple device.

The group also discussed the need for a handbook to present information of a permanent nature in greater detail. A steering committee was appointed to direct the work. To date, they have secured booklets from several hospitals in the New England area that utilize this type of a public relations device. Initial suggestions for content have been made at the group meetings. A member who has had experience in editing and art work has agreed to be responsible for the art production involved in this venture. The interest and cooperation in these two activities has been encouraging.

The nurses' response to the need for a suggestion sheet for parents was based upon the readiness of the group. The felt need was common to all and the group was ready to work towards a solution of the problem. The group did not seem ready to utilize the information further during the time limits of the study.

CHAPTER V

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Summary of Findings

This study was made up of two parts.

The first part of the study consisted of identifying areas of need for health education of parents and their hospitalized children. To accomplish this, three data collecting devices were utilized, namely: anecdotal records, voluntary questions and directed interviews.

The data accumulated from the anecdotal records were tabulated and analyzed. Parents' voluntary questions were recorded by the nurse staff. The findings from these questions were classified according to appropriate categories and studied in terms of evidence of need for health education. Parents were interviewed relative to problems they had in regard to their hospitalized child and how the nurse could be helpful to them. The data collected by this device were categorized, also, and studied.

The second part of the study consisted of determining how the nurse staff might utilize the findings from the triad data to improve care to patients through parent education. To that end, five group meetings were held with the nurse staff to present the grouped data and learn where

the group would like to start planning for improved care.

The data presented showed areas of need for health education. Certain areas of need were common to all these groups of data, other areas were common to two groups, while some needs were identified in only one area. The major evidence of need for health education was shown regarding: hygiene, habit formation, special behavior problems, the play needs of the child, home care of the child, child guidance and prophylactic measures.

From the presentation and study of the data it was noted that the application of a simple device, as a direct question, appeared to reach deeper levels of need. These deeper needs were most clearly shown in the areas of child guidance and special behavior problems.

The interest of the nurse staff in finding a way to get the simpler form of questions answered through a guide sheet, indicates that active participation in collecting data coupled with group discussion in interpretation thereof are effective methods in reactivating interest in the improvement of nursing care through parent education.

The areas selected by the nurses for initial planning and activity leading to improved care were areas where their interest lay, areas where they felt a need for improvement and felt secure in working.

The use of visual aids in teaching in connection with

the anecdotal records shows that parents can be interested in learning. The project was handicapped by the lack of facilities.

Conclusions

The study began with two questions for which an attempt has been made to find answers, namely:

1. What evidence is there of need for health education on the part of hospitalized children and their parents?

2. How might the nursing staff use this information in improving the plans of nursing care?

The findings from the study show:

1. There is a need for health education on the part of parents and their hospitalized children. These needs are evidenced through physical manifestations, behavior, verbal expressions, questions presented to nurses, and through interviews. The similarity of problems regarding health education indicates the use of group teaching for parents faced with like problems.

2. There are different levels of parent and child needs. To determine these different depths of needs in the study, a simple device was used. Parents were asked if they had problems in regard to their hospitalized child that they felt the nurse could help them solve. It is recognized that there are hazards involved in probing too deeply to get at the psychological basis of problems unless the problems can

be referred to the proper sources. In the study no attempt was made to determine how the nurse can relay this information to the doctors responsible for the child's care.

3. There is a need to prepare parents to assume the home care of the child. This health teaching needs to start early in the hospitalization.

4. The development of skill in interviewing parents is an important part of the pediatric nurse's equipment. While needs can be identified through the questions parents voluntarily ask nurses, the deeper level of problems revealed in the limited sampling would indicate the possibilities of this device. However, the reluctance of the nurse staff to interview parents and discover their real needs seems to indicate that nurses do not feel secure in going to parents and conversing with them for the purpose of being helpful.

5. There is need for better direction of parents and children during the early period of hospitalization. The orientation to the hospital should be made as quick and easy as possible for the parents and the child. This would release time to discover the broader problems and to plan for remedial activities.

6. The present hospital policies regarding information to the parents about the child's condition does not seem to satisfy the parents. If sufficient time is not available

for the medical staff to see parents it would seem advisable for the medical and nurse staff to meet in conferences to discuss a satisfactory solution to this problem.

Recommendations

The findings from the study indicate the following recommendations.

1. Formation of interest groups amongst the nurse staff. For example, one group might study and develop plans for education of the parents relative to the home care of their child. Plans for group teaching of parents should be considered particularly in those areas where there are a group of similar health problems. The findings indicated that group teaching might be utilized in the preparation of parents to assume the home care of a child faced with a lengthy convalescence. The nurse staff might utilize home equipment in teaching and demonstrating the care of a child on bed rest. Improvised equipment could be demonstrated. The classes should be informal, characterized by a permissive atmosphere, group discussion and a sharing of problems.

Interest groups might be formed to build up a supply of visual aids for health teaching.

The success of the display of toys and play materials shows the possibilities of this type of teaching device. A strategic area might be selected on each unit for a

teaching display. The displays could be rotated between the six head nurse units designated for the care of children of the same age group. While displays designated to teach parents of children below three years of age could be alternated between the two floors admitting infants. The visual aids should be selected in terms of both parents and children. The study indicated that teaching can be accomplished with the older patients. The displays might be supplemented by suitable pamphlets for the family, as those available through the government printing agencies. Suggestions might be made as to where further information could be obtained.

The displays should be evaluated on the basis of appeal and degree of interest shown by the parents and the children. Revisions could be made on the basis of these experiences and observations.

The cooperation and advice of the medical staff should be sought in developing these teaching projects.

Areas of parent and child needs for health education identified by this study could be utilized, namely:

a) The play materials and books available in the department from the previous display might be supplemented with further equipment, revised on the basis of past experiences and utilized for teaching.

b) A display or series of displays might be

centered about the nutritional needs of a well child with adaptation of needs for the convalescent child.

c) Teaching aids to present information relative to habit formation. There seems to be a real need for teaching in regard to eating habits. This display would seem to follow the teaching relative to nutrition. Information relative to bowel habits and the use of cathartics seemed to be indicated.

d) Displays geared to develop an awareness of the value of dental hygiene seem to be indicated. Also teaching relative to general hygiene is needed. This area should be chiefly geared to meet the appeal of the patient.

e) The problem of accident prevention in the home could be presented by visual aids. This would be particularly valuable where the child has been hospitalized because of an accident.

f) Teaching relative to disease prevention and the indications of illness seem to be indicated.

g) Teaching aids could be utilized to present information on the preparation of the child for the hospital stay. The need for truthfulness in dealing with the child could be emphasized.

h) Visual aids could be used to present information on child growth and development and child guidance.

2. The development of skill in the use of directive

and non-directive interview technique by the nurse staff. It is doubtful if this skill could be built up through the interest groups. It would rather seem that the formation of an In-Staff Education Program in the pediatric department would be necessary to accomplish this end. Skilled experts could be utilized to present the techniques of interviewing in a challenging manner. This would tend to create an interest in the utilization of the device by nurses to improve care to patients through parent education.

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APPENDIX A

Health Education Needs of Parents of Hospitalized Children as Observed in 1735 Anedcotes Recorded by Three Staff Nurses and One Head Nurse June 1, 1952-December 15, 1953, Arranged in Descending Rank Order of Frequency

Observations Recorded in Nurse-Child Relationship

1.	Care of finger nails	194
2.	Bathing	173
3.	Care of hair	169
4.	Care of teeth	87
5.	Children observed in group play	73
6.	Nail biting	64
7.	Nurse taking-over or assisting child with play	53
8.	Pediculosis (treatment and prevention)	46
9.	Properly fitted shoes	19
10.	Masturbation	14
11.	Support for arches	11
12.	Lack of manners in eating	9
13.	Temper tantrums	9
14.	Thumb sucking	7
15.	Nose picking	5
16.	Smearing	4
17.	Pica	4
18.	Need of preparation for menstruation	3
19.	Head rocking	1
	Total	945

Observations Recorded in the Parent-Child Relationship

1.	Assisting or taking-over child's play	88
2.	Forcing food	16
3.	Children telling mothers of their need to bathe daily upon discharge from the hospital	3
	Total	107

Observations in the Parent-Nurse Relationship

1.	Convalescent nutrition	71
2.	Laxatives and enemata	61
3.	Care of teeth	42
4.	Normal nutrition	39
5.	Social service requests	31
6.	Question of comic books	29
7.	Toys for the child at the various age groups	27
8.	Fear of the dark	24
9.	Anorexia	23
10.	Nail biting	22
11.	Advisability of tonsillectomy and adenoidectomy	22
12.	Number of stools	21
13.	Between meal snacks	14
14.	Question of naps	12
15.	Bad dreams	9
16.	Continuation of child's education	6
17.	Enuresis	6
18.	Eye defects	6
19.	Preparation of daughter for menstruation	5
20.	Masturbation	4
21.	Thumb sucking	3
22.	Faulty hearing	3
23.	Advisability of circumcision	2
24.	Temper tantrums	2
25.	Sleep walking	2
26.	Rheumatic fever	1
	Total	487

Observations Not Recorded in Terms of the Three Major Categories

1.	Need for orientation of the child and the parents to the hospital	98
2.	Need of preparation of the parents to assume home care of the child	98
	Total	196

Health Education Needs of Parents of Hospitalized Children as Recorded in 171 Directed Interviews Conducted by 72 Nursing Students April 14-21, 1953, Arranged in Descending Rank Order of Frequency

1.	Degree of exercise upon discharge	14
2.	Information regarding child's disease	13
3.	Anorexia	12
4.	Convalescent nutrition	9
5.	Care of incision and dressings	9
6.	Restrict child's activity and keep child occupied during convalescence	7
7.	General home care	7
8.	Indications of need for support	6
9.	Teach obedience	4
10.	Overcome overeating	4
11.	Overcome dislike of vegetables	4
12.	Prevent pediculosis	4
13.	Signs and symptoms of illness	4
14.	Deal with thumb sucking	4
15.	No felt problems	4
16.	Hospital policies	3
17.	Speak to the doctor	3
18.	Use of enemata and laxatives	3
19.	Overcome selfishness	3
20.	Overcome shyness	3
21.	Prevent colds	3
22.	Follow up through out patients department	3
23.	Deal with masturbation	3
24.	Deal with enuresis	3
25.	Deal with soiling	3
26.	Correct use of crutches	2
27.	Develop independence	2
28.	Teach siblings to get along	2
29.	Reason with a child	2
30.	Deal with crying when the mother leaves	2
31.	Help the child to adjust to home life following long hospitalization	2
32.	Teach manners	2
33.	Wean a child of the bottle	2
34.	Prevent accidents in the home	2
35.	Prevent recurrence of disease	2
36.	Deal with temper tantrums	2
37.	Give medications	1
38.	Deal with overtalkativeness	1
39.	Care of deciduous teeth	1
40.	"Nervous child"	1
41.	Others*	1
	Total	171

*One mother was an epileptic. She stated that she felt

inadequate to care for her child.

Health Education Needs of Parents of Hospitalized Children Expressed in 130 Voluntary Questions Presented to 14 Graduate Nurses April 22-29, 1953, Arranged in Descending Rank Order of Frequency.

1.	Treatments (what are they doing, why)	20
2.	Child's condition	17
3.	Symptoms as temperature, cough, rash	15
4.	Parent's indication of need for support	10
5.	Time and place to see doctor	10
6.	Child's indication of need for support	9
7.	Child's discharge	9
8.	Extra visitors	8
9.	Bringing in food and sweets	7
10.	Routines regarding discharge	7
11.	Convalescent diet	4
12.	Evacuation	3
13.	Degree of activity upon discharge	3
14.	Child's appetite	2
15.	Reason comic books are banned	2
16.	Parent requested nurse to tell child a falsehood to reduce crying	2
17.	Directions to blood bank	1
18.	Child's education	1
	Total	130

APPENDIX B

HOSPITAL X

Children's Dept.

Your child _____(name) is admitted on Children's_____. The doctors who are caring for him are on the _____Service. Dr. _____ is assigned to care for him/her. The doctor may be seen daily (Except_____&_____) in _____ at _____P.M.

VISITING HOURS

You may visit your child daily at _____P.M. and _____P.M. (except Sundays & Holidays). Only the mother and father or the legal guardian are allowed to visit. Both may visit in the afternoon. Only one parent at night. Interchange of visitors is not permitted; please do not ask for such a concession since we wish to be equally fair to all patients and parents.

HOSPITAL & DEPARTMENTAL POLICIES

1. No food may be given the children except 2 oranges daily.
2. We suggest you bring your child's favorite toy in to help him to adjust.
3. Toys given to the children should consider their physical safety and emotional well being-i. e.-no needles, scissors, inflammable materials etc.
4. No responsibility may be assumed by the hospital for the loss of articles left with the children. We

suggest that valuable articles, money, or articles of sentimental or religious value should be taken home.

We urge you to be truthful to your child while he is in the Hospital. Procedures and events may be painful and unpleasant; the child is best equipped to face the facts if he knows what may happen than if he does not.

For additional information or explanation of policies please see the head nurse Mrs.)
Miss)_____.