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A survey of clinical resources for pediatric nursing in "X" Hospital

A SURVEY OF CLINICAL RESOURCES FOR PEDIATRIC NURSING IN "X" HOSPITAL

BY

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CHAPTER I

INTRODUCTION

The word pediatrics is derived from the Greek word pais, paidos meaning child and iateria meaning treatment.[1] When pediatrics as a specialty came into being in 1860 the emphasis was upon the fact that diseases of children were somewhat different from diseases of adults.[2] While it is difficult to establish the exact date when pediatric nursing became a specialized area, it is evident that nursing philosophy was consistent with this early concept and gave rise to objectives which provided for learning experiences to aid the student in an understanding of the etiology and symptoms of disease and the treatments, procedures, and routines necessary to restore the child to physical health. Today the scope of pediatric nursing is not limited to the restoration of physical health to the sick child but includes an understanding of the normal

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[1]Taber, Clarence W. Taber's Cyclopedic Medical Dictionary.

[2]Jeans, P. C., Wright, F. H., and Blake, F. G., Essentials of Pediatrics, p. 2.

growth and development of children and of their emotional and social needs in sickness and in health. Nursing educators who desire to select learning experiences in the care of children are guided by this change in emphasis from the disease and procedures to the understanding of children as growing and developing individuals with emotional and social as well as physical needs.

Statement of the Problem

At the suggestion of the Accrediting Service of the National League of Nursing, the faculty of "X" Hospital School of Nursing decided to explore the possibility of providing their students with learning experience in the care of children utilizing the clinical resources available in "X" hospital. This was a survey of the clinical resources in "X" Hospital to determine if they could provide satisfactory learning experience in the care of children for students in "X" Hospital School of Nursing.

Purpose of the Study

The purpose of this study was to take the initial step in a long range plan to provide instruction in both the care of mothers and children in "X" Hospital.

Justification of the Study

The students at "X" Hospital School of Nursing have experience in maternity nursing in the home school. The planned learning experiences are based on a concept of family-centered maternity care and include acquaintance with the theory of natural childbirth, observation in classes for expectant mothers, and experience in the care of mothers and infants who are reaping the benefits from the "rooming-in" philospphy.

Accepting the definition of maternal and child health as, "the promotion, protection, and conservation of the health of mothers throughout the maternity cycle and of the child from the prenatal period through adolescence,"[3] the faculty began to consider the relationship between the learning experiences in obstetrics and those in pediatrics. The students currently receive instruction in pediatric nursing through a twelve week experience at a children's hospital in an urban area. Since the faculty desired to provide more unified learning in pediatric and obstetric nursing, it seemed advisable to study the resources for the

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[3]Lanigan, B., "Maternal and Child Health," Dynamics of Clinical Instruction in Instruction in Nursing Education, edited by Gabig, M. and Lanigan, B., p. 135.

care of children in "X" Hospital to determine if it would be possible in this hospital to provide instruction in both these areas.

Scope and Limitations of the Study

This study was done in a general hospital with 241 beds but was limited to the pediatric unit providing care to the sick child, the formula room, and the children's clinics in the out patient department. This study did not include an investigation of the community resources, additional instructional staff, or other factors that must be considered before students can be transferred from their present learning experience in the care of children to that of "X" Hospital.

Preview of Methodology

The collection of data upon which to base an evaluation of the potential of "X" Hospital to provide learning experience in the care of children was done by observation of the clinical facilities in the pediatric service, formula room and pediatric clinics, direct questioning of supervisors, charge, and staff nurses in each area, the hospital administrator, assistant director of nursing service, and the nurse in charge of the admitting office, use of "A Guide

For Evaluating Child Care Facilities,"[4] and analyzing admission records. Accepted principles and standards for a pediatric unit served as a basis for evaluating the resources for the care of children in "X" Hospital.

Sequence of Presentation

Chapter II presents a review of the literature pertinent to the development of modern concepts of care of children in hospitals. The methodology and description of the setting of the study is given in Chapter III. This is followed by an analysis and presentation of the data in Chapter IV. Chapter V presents the summary, states the conclusion drawn, and lists the recommendations made from the study.

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[4]Class of 1951, Advanced Study in Pediatrics, Boston University. See Appendix A.

CHAPTER II

THEORETICAL FRAMEWORK OF THE STUDY

Review of the Literature

The broadening of the scope of pediatrics during the past thirty years is largely due to the astounding progress of medical science and an increased awareness of the relationship between the concepts of psychiatry and the optimum care of children.

In 1888 when Dr. Thomas Morgan Rotch was the first professor in the newly organized department of pediatrics at Harvard Medical School, the emphasis of his teaching was on the diseases of children.[1] Four decades later the objectives for instruction in the care of children were still emerging from a disease centered philosophy and hospitalization for the child meant isolation from his parents and from other children. Visiting hours were limited to once a week and then only if the parent were suitably garbed in gown and mask. Restraints were freely

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[1] Jeans, P. C., Wright, F. H., and Blake, F. G., Essentials of Pediatrics, p. 1

used to protect the child from bodily injury. The care of children in a hospital revolved around the treatments and procedures designed to restore the acutely ill patient to physical health. The emotional needs of a child separated from his mother went, for the most part, unmet.

With the advent of antibiotics, specific medicines and preventive measures, and increased knowledge in psychiatry, the diseases were better controlled and pediatric care broadened to include the emotional and social needs of the child. Pediatricians and nurses became aware that, "hospitalization may be a major emotional experience for the child."[2] With this awareness came an attempt to make the hospital more home-like and a happier place. On admission of the child parents were interviewed or given a questionaire[3] to determine those things to which the child had been accustomed at home. Such items as eating, sleeping, and toilet habits, number of children in the family, how the child related to others, the name he was accustomed to being called, and the preparation for

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[2]American Academy of Pediatrics, Committee on Hospitals and Dispensaries., "The Care of Children in Hospitals," Pediatric 14: 403, October, 1954.

[3]Hunt, Andrew and Trussell, Ray., "They Let Parents Help in Children's Care," The Modern Hospital 85: 90, September, 1955.

hospitalization were carefully investigated.

The admission procedure was modified to meet the child's need for adjusting to the hospital situation. If it seemed desirable the mother was allowed to undress the child and put him to bed.[4] She stayed with the patient as long as reasonably necessary for the child to accept hospitalization and parent separation. The nurse assigned to the child gave assistance to the mother in relation to what to tell the child when leaving, and the importance of leaving some article of her own[5] with him.

Restrictions on visiting hours were lessened and daily visits with the child became accepted practice.

There was recognition of the child's need for play through planned play activities adjusted to fit the needs of the individual child as determined by his age, emotional development, and degree of illness.

In the interest of providing a warm, friendly, home-like atmosphere, the walls were painted soft cheerful colors, the child's food was served in dishes appropriately decorated, and whenever possible the meal was served at a small table. Every opportunity to establish normal,

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[4] Ibid., p. 90.

[5] Robertson, James, Young Children in Hospitals, p. 81.

friendly, relations with his peers and with adults was utilized in an effort to meet the social needs and to make the hospitalization as pleasant as possible.

> In recent years, however, substantial data have accumulated indicating the psychologically detrimental effects of the hospitalization of children for illness or surgical procedures. Although the experience of being sick or undergoing the pain and discomfort of surgery is in itself traumatic, it has been felt that separation from the parent is the most important factor producing undesirable emotional reaction.[6]

This undesirable emotional reaction appears as a sequence of hospitalization.

> In the past twenty years or so there has been growing concern in the minds of psychiatrists and some pediatricians, and their colleagues in social work and nursing, with the problems of behavior in hospitalized children, and with the frequency with which such children show a change of personality after a stay in a hospital.[7]

According to Prugh[8] and others, it was principally the younger children who continued to show significant disturbance after hospitalization. Concerning this

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[6]Hunt, Andrew and Trussel, Ray, op. cit., p. 89.

[7]Robertson, James, op. cit. Forward VI by Milton J. E. Senn.

[8]Ibid., p. 15.

James Robertson writes,

> For most children under four years it is our observation that no amount of love and understanding will make up for the absence of the mother. When doctors realize how inextricably the emotional welfare is bound up with the physical welfare, provisions will be made for a parent to stay with the hospitalized child. If only in the interest of physical well-being, a consideration of the child's emotional needs must eventually take precedence over rules, schedules, and the polish on the floor.[9]

Daily visiting hours are inadequate for children under two years.

> The fact that a two-year-old 'settles down' under daily visiting is no more evidence of his well-being than the fact that he 'settles down' under weekly visiting. If daily visiting were adequate the children would not show distress during visits and afterwards, and would not be distrubed in their behavior when they return home. But they do show distress, and they are disturbed in later behavior.[10]

The ideal situation in many instances is for the mother to stay in the hospital with the child. "The next best thing to the mother's being in the hospital with her child is of course unrestricted visits by the mother, during which she tends him as she would at home."[11]

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[9] Ibid., p. 16.

[10] Ibid., p. 82.

[11] Robertson, James, op. cit., p. 76.

> Many hospitals are now considering adaptation of physical facilities, services, and procedures so that mothers can stay with and care for their children as much as possible. When this is done, effective supervision by the professional staff is necessary.[12]

From the above it is evident that the trend in the care of children today is to broaden the scope of pediatrics to include parent guidance as well as an understanding of the principles of child care. In such a situation where visiting is determined by the child's need and the parent's ability to cooperate, the nurse needs an understanding of the behavior of children and an awareness of the possible problems of parent-child relationships and their effect upon the individual sick child. When the parent has the ability to cooperate and the parent-child relationship is good, the parents have assisted by feeding the child, washing face and hands or giving of the bath as desired, and holding the child if the condition warrants. In keeping with this modern concept of pediatric care, parent education exhibits explaining toys for children in the hospitals, books for children, the well balanced diet, and the general care of the healthy child can be placed in out patient department

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[12]American Academy of Pediatrics, op. cit., p. 403.

waiting rooms and on the pediatric unit.

The broadening scope of pediatrics has changed the approach to the instruction in care of children given to student nurses. The ward teaching program is now centered on nursing care needs of the child as determined by knowledge of parent-child relationships, knowledge of child growth and development, the reaction of the child to specific illness, and the nurse's responsibility in providing the kind of care necessary to aid the child in recovering as quickly as possible. Experience coordinating the hospital and the extra hospital services is obtained by participating in the discharge preparation of a child who needs care by the public health nurse to whom he is directed by a referral system which gives detailed information relating to problems of his nursing care. The experience in the care of children is no longer confined to the hospital and the sick child but includes the community resources to gain knowledge of the growth and development of the well child.

While studies[13] have been done on various aspects of modern pediatric care, none relating to the physical

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[13]Prugh, Dane G., et al, "A study of the Emotional Reactions of Children and Families to Hospitalization and Illness," American Journal of Orthopsychiatry 23:70-106, January, 1953; Godfrey, A. E., "A Study of Nursing Care Designed to Assist Hospitalized Children and Their Parents

facilities of a pediatric unit seemed pertinent. This study is an evaluation of "X" Hospital in terms of its potential for providing a learning experience in the care of children for student nurses. The evaluation is based upon the degree to which the physical facilities, the available clinical experience, and the overall hospital policies provide an environment in which student nurses could learn to give the kind of care to children that is demanded by the broadening scope of pediatrics described in the literature.

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in Their Separation," Nursing Research 4 No. 2: 52-69, October, 1955; United States Public Health Service, the Hospital Facilities Section and United States Department of Labor, Children's Bureau, the Division of Research in Child Development, "A Type Plan for a Pediatric Hospital Unit," Reprinted from Pencil Points-Progressive Architecture 45:67-69, August, 1945.

CHAPTER III

METHODOLOGY

Setting of the Study

The pediatric unit consisting of twenty-five beds was dedicated at "X" Hospital in 1928. During the calendar year 1958 it was occupied at the rate of 94 per cent and the need for more beds and better facilities was acute. Therefore, in July 1959 a renovation period will begin and the completion of a forty-one bed unit is anticipated within ten weeks. The out patient department in which the pediatric and crippled children's clinics are held was built in 1958 and the formula room is located in the new obstetrical unit which was opened during the same year.

Tools Used to Collect Data

In 1951 the class in Advanced Study of Pediatrics at Boston University School of Nursing prepared "A Guide For Evaluating Child Care Facilities."[1] During a three

[1] Appendix A.

day observation period data in the pediatric unit, the formula room, and the pediatric clinic of the out patient department were collected and recorded on the guide.

In 1954 the American Academy of Pediatrics[2] made a report in which several principles for setting up a pediatric service were given. A compilation of many of these may be found in Appendix B and served as a basis for the evaluation of the data collected during the study.

Procurement of Data

The Architectural Drawing of the Future Pediatric Unit was obtained from the program of the Guild Gaieties[3] the proceeds from which will be given by the Women's Guild of "X" Hospital to facilitate the renovations.

Since "not uncommonly, the simplest and most economical method for obtaining facts is to go directly to the people who are in a position to know them and to ask for the desired information;"[4] this method was used in

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[2]American Academy of Pediatrics, Committee on Hospitals and Dispensaries, "The Care of Children in Hospitals," Pediatrics, 14:401-419, October, 1954.

[3]A Hospital and Community Talent Musical Show.

[4]Jahoda, M., Deutch, M., and Cook, S., Research Methods in Social Relations, Part One: Basic Processes, p. 160.

the procurement of data concerning the future pediatric unit. Conferences were held with the hospital administrator for this purpose. As a supplement to the three day observation period in the clinical areas similar conferences were held with the assistant director of nursing service, the nurse in charge of the admitting office, the supervisor in the out patient department, the personnel in the formula room, and the head nurse and staff on the pediatric unit in order to complete the items suggested by "A Guide For Evaluating Child Care Facilities."

Data concerning the per cent occupancy for the fiscal year 1957 and 1958 were procured from the office of the hospital administrator. The daily average census for the calendar year 1958 was procured from the nursing office. The admission records were kept on McBee Keysort cards in the record room. These cards were sorted by month and all admissions for tonsillectomies removed, counted, and placed in age groups. The remaining cards were sorted according to the sex of the child, and tabulated by distribution of age and the length of stay. The average length of stay for the year was then calculated. The cards were again combined and separated according to the diagnoses represented. The classifications of admissions by diagnosis and the conditions placed in each classification may be found in Appendix C.

The requirements for a learning experience in pediatric nursing were procured from the literature. The requirements of the Massachusetts Approving Authority and some documented suggestions for cufriculum content may be found in Appendix B.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

In this chapter the data is presented in the following sequence, physical facilities, personnel, nurse-child-parent relationships, and clinical experience. The format of presentation will consist of documented standards and principles followed by the findings of this study.

Physical Facilities

> If a hospital accepts children as patients, facilities separate from adult patients should be made available.
>
> A pediatric service to function should include a minimum of 12 to 15 beds.[1]
>
> Pediatric Nursing experience of twelve weeks was considered adequate on a service of 25 patients or more.[2]

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[1] American Academy of Pediatrics, Committee on Hospitals and Dispensaries, "The Care of Children in Hospitals," Pediatrics 14: 402, 405, 408, October, 1954.

[2] West, M., and Hawkins, C., Nursing Schools at the Midcentury, p. 37.

> In general, the grouping of patients in a children's ward by age is preferable to grouping by diagnosis.
>
> Patients admitted for 24-hour stay should not be placed in rooms with other hospitalized children.
>
> When several children are admitted for a short period -- such as for tonsillectomies or minor surgical procedures -- for overnight stay, they may be placed in a multiple bed room.
>
> Oxygen outlets in patients' rooms -- in spite of additional expense in construction -- are an obvious advantage.
>
> Mechanical suction should be readily available throughout the pediatric unit.[3]

Figure 1, The Architectural Drawing for the Future Pediatric Unit, represents a forty-one bed unit in which the infants from birth to two years will be cared for in the nursery. The flexibility of the facilities in other parts of the ward will permit the grouping of the children according to age. Since thirty-five per cent of all the admissions during the fiscal year, 1957-1958 consisted of children staying overnight and having tonsillectomies, a T. and A. room will be provided to facilitate separate placement for this group. A fog or high humidity room will be available for the children with respiratory

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[3]American Academy of Pediatrics, op. cit., pp. 412, 414.

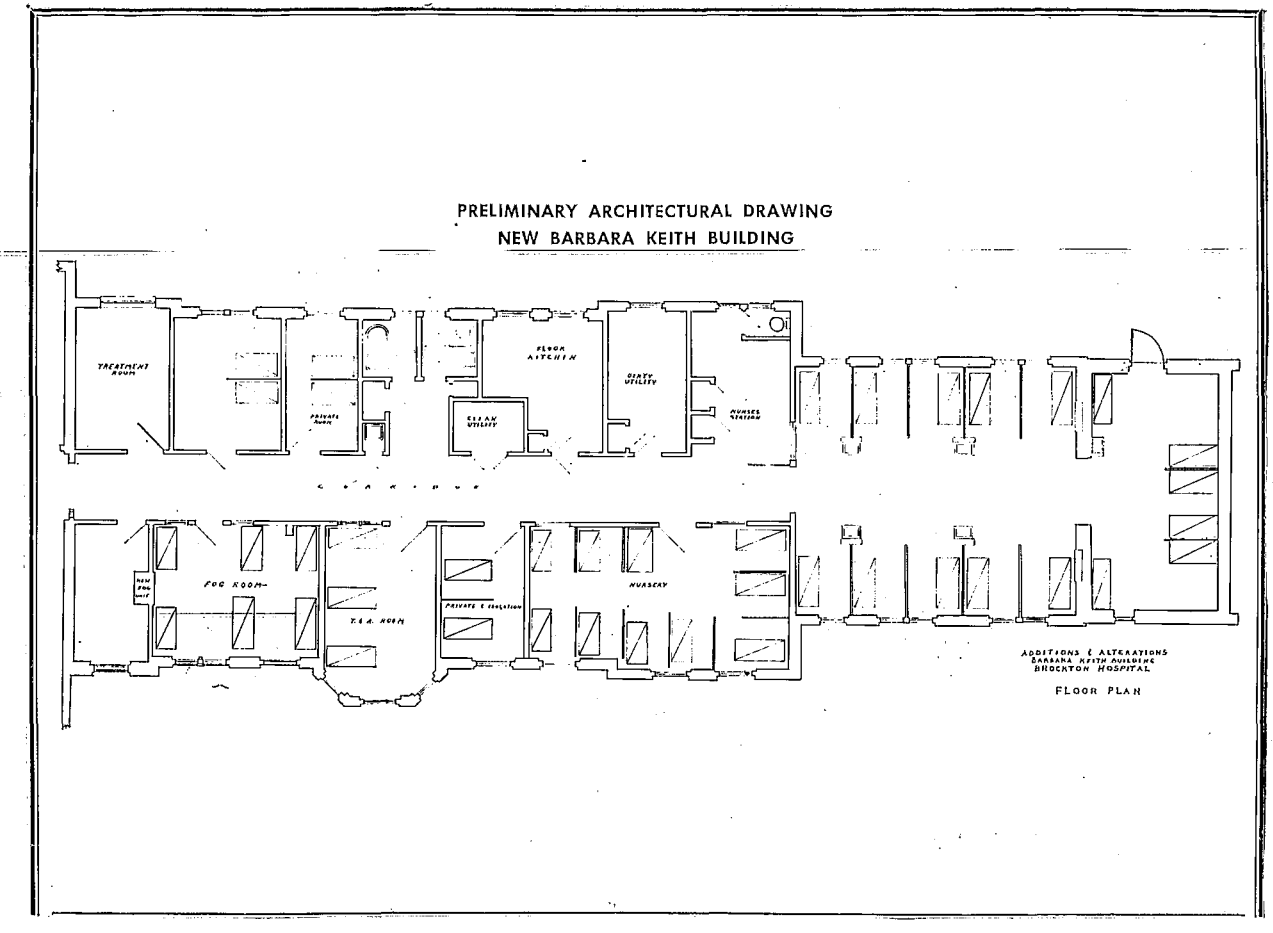

Figure I. The Architectural Drawing for the Future Pediatric Unit in "X" Hospital

conditions. In addition every patients' room will be equipped with oxygen outlets and wall suction.

> Children not only need protection from cross infection but, from a psychological standpoint, they need to be in the company of other children in surroundings as cheerful and homelike as hospital conditions will permit.[4]

Each room will contain a lavatory so that physicians and nurses may wash their hands before and after caring for each child. There will be a two bed isolation unit for the care of children who are under observation for communicable conditions.

In the two open wards partitions glazed with clear glass above the mattress level will be constructed so that children may see one another and the nurses may see the children at all times. Washable curtains are planned for use to secure privacy when desired. Each child's cubicle will be so arranged that individualized care may be given. There will be a crib of suitable size and a bedside table for storage of utensils used in his care. The upper portion of this table will be used as a place for him to keep his favorite toy. No provision for the storage of the

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[4]United States Public Health Service, the Hospital Facilities Section and United States Department of Labor, Children's Bureau, The Division of Research in Child Development, "A Type Plan for a Pediatric Hospital Unit," Reprinted from Pencil Points-Progressive Architecture, August, 1945.

child's clothes has been planned and it is expected that the parents will take them home. Throughout the patient area the walls will be painted in soft cheerful colors. There will be a bathroom with flush and washbowl scaled to size for children and a medium sized tub for those whose condition warrants the use of this room.

> The nurses' station should be situated preferably within the unit to save as many steps as possible and be so placed that easy access is possible to the rooms with the sickest children and infants.
>
> A utility room centrally located should be provided for each nursing unit.
>
> A separate room should be set up for examination and treatment.
>
> The treatment room should be located as far away as possible from patients' rooms.[5]

The plan for the renovated unit was made with a view to facilitating the nurses' work. For this reason service rooms will be centrally located in the unit. The nurses' station will be so placed that she will be near the nursery and the open wards which will be separated from her by glass partitions. She will be able to observe the children in these areas and foot travel between the nurses' station and the greatest number of children will be reduced to a

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[5]American Academy of Pediatrics, op. cit., pp. 413, 414.

minimum. Adjacent to the nurses' station will be the utility room and the floor kitchen. The treatment room, for obvious reasons, will be placed as far as practicable from the patient areas.

> Arrangements for handling the food-service must be provided by means of central tray service or floor pantries.
>
> The hospital should provide for the supervision of diets under a qualified dietician and preferably one who has had training in understanding children.
>
> Serving the child familiar foods in colorful dishes at a small table makes the hospital seem a little more like home.[6]

The diets will be prepared in the main kitchen under the supervision of a qualified dietician. The food will be taken to the ward in a heated truck and the trays set up in the floor kitchen by a registered nurse. Currently an incomplete set of children's dishes of nursery rhyme pattern is supplemented by regular hospital dishes. The practice of having additional favors and tray decorations for holiday seasons and special cakes for birthdays will continue in the new unit. The representatives from the dietary department will continue to visit the ward to

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[6]American Academy of Pediatrics, op. cit., pp. 409, 411, 414.

determine the needs, likes, and dislikes of the children and to give encouragement to the child who may be on a special diet. The evening meal will continue to be served around the small table in the open ward and those who are up and about will be encouraged to eat there while some of the smaller children will eat in the high chairs nearby. The nurses will continue to hold some of the younger children while feeding them.

> All hospitals providing maternity or pediatric services shall provide a well ventilated and well lighted formula room which shall be adequately supervised and used exclusively for the preparation of formulas.
>
> The formula room should be situated where danger of contamination is least, and where the most supervision can be given by a dietician or nurse. It should be located near the nursery, near the general diet kitchen, or near central supply room.
>
> It is recommended that the formula room be divided into two sections by a full-length partition, in which there is a sliding window. Such a division permits the exclusive use of one section as a cleanup room for receiving and washing glassware, nipples, and utensils; and of the other section for preparation, terminal heating and storage of formulas and special fluids.
>
> The supervisor of the formula room should have had special training in formula preparation and in sterilization procedures. She should train and supervise all formula room personnel. Workers in the formula room should have no contact with patients who have infectious conditions.
>
> In hospitals where the formula preparation does not require the full time services of a nurse or

> dietician, the remainder of her working day may be spent in some clean area such as the central supply room, regular newborn nurseries, or diet kitchen. Formula room personnel should wear scrub gowns and caps.[7]

The formulas for the pediatric unit are prepared in the formula room located near the nurseries in the obstetrical department. This compact, well lighted, adequately ventilated room has an approximate floor space of fifteen by eleven feet. The dirty area for receiving and washing glassware, nipples, and utensils is near the door and accessible without actual entrance into the formula room. While there is no full length partition between the dirty and clean areas they are definitely treated as separate units. The number of formulas varies with the needs of the maternity and pediatric services but ranges between one hundred and twenty to two hundred a day. The following equipment is arranged for maximum efficiency, an autoclave, a wash sink, a work table, a refrigerator, cupboards, and a scrub sink. The formulas used in the nurseries are kept in a cooler which is accessible from the corridor as well as from the formula room and therefore makes it unnecessary for anyone except

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[7] American Academy of Pediatrics, Standards and Recommendations for Hospital Care of Newborn Infants Full Term and Premature, pp. 22, 23.

the formula room personnel to enter the room. The formulas used by the pediatric unit are stored in the refrigerator on that unit.

The formula room is under the direct supervision of the graduate nurse in the nurseries who trained and supervises the nurse aide who spends her time either in the preparation of formulas or in the central supply room. Anyone entering the formula room is required to wear a clean gown and head gear. All personnel have pre-employment physical examinations and annual chest X-rays.

Personnel

> The most effective functioning staff for a pediatric service is organized with a permanent physician-in-chief to provide continuity in policy and operation of the service.
>
> Every hospital regardless of size, should have on its nursing staff at least one nurse with preparation and experience in the care of children, who can be responsible for the instruction of other nurses, workers, and mothers who may care for children or infants in the hospital.
>
> In many hospitals auxillary nursing personnel may supplement the professional nursing staff in furnishing the services needed by children. It is necessary that the hospital provide them with special training for the duties they are to perform under the supervision of the nurse in charge.
>
> All personnel working with children in the hospital should receive special orientation and

training to understand children -- their growth, their development, and their behavior.

Inservice training and orientation of all personnel working with children or having contact with children should be provided in every hospital.

There is need for graduate nurses to have continued opportunity for additional training and experience in the care of children.

There should be adequate graduate nurse coverage in the pediatric service at all times with supervision by nurses trained not only in pediatrics but in the clinical specialties represented in the service.[8]

At the present time the pediatric service is organized with a permanent physician-in-chief in charge. There is no nurse with advanced preparation in the care of children. There are auxillary nursing personnel who supplement the care given by the professional nursing staff. No special orientation and training are given to the personnel in the understanding of children, their growth, their development, and their behavior. There is no inservice education for any level of worker. A graduate nurse is present in the pediatric unit at all times.

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[8]American Academy of Pediatrics, Committee on Hospitals and Dispensaries, op. cit., pp. 405, 407, 409, 416, 418.

Nurse-Child-Parent Relationship

> The atmosphere of the pediatric unit should be as homelike as possible -- relaxed, friendly, and informal.
>
> It is most important to the child, to be as much as possible under the care of the same nurse.
>
> It is important that every nurse serving children, in addition to her knowledge of diseases in children, should comprehend their normal growth and development and should understand the emotional impact of hospitalization upon the child and his parents.
>
> Occupational therapy should be provided for all children who must remain hospitalized for more than a few days.
>
> If a child must remain in a hospital for a prolonged period and his illness is such that school work is possible, adequate educational opportunity should be provided in the hospital.[9]

From October 1957 through September 1958 the per cent occupancy on the pediatric service ranged from 76 to 116. A morning visit to this congested ward gave the impression of tension and frustration on the part of those attempting to give complete nursing care to the child. Patient assignment was geared as much toward getting the work done as toward the child's having one nurse give him most of his care. However, a survey of the unit during

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[9] Ibid., pp. 407, 410, 411.

map time indicated a quiet place darkened by drawn shades. The silence was broken by an occasional child calling, "Nurse, Nurse." (No call bells were in use at the time of this study.) Just prior to the afternoon visiting hours the ward bristled with activity as the auxillary and graduate personnel went from crib to crib calling the children by name, getting the older ones into high chairs and wheel chairs where they could observe television, moving cribs into the line of the screen, feeding the infants, and making ready for the time when, from the nursing staff's point of view, there would be just too many people in too small an area, and following which it would take some time to restore the quiet of the nap hour!

There was no play room and no planned play program, but a few extra toys were stored in a paper bag in the inner portion of the nurses' station. Now and again one of the graduate nurses came in to see if there was one that would be useful to one of the children she thought needed something more than was stored at his bedside.

> It is recognized that infants and younger children need their mothers and that separation is not desirable when this can be prevented.
>
> Mothers can be of help to the hospital and a benefit to the child by assisting in the care of their children in the hospital; and when the presence of the mother is good for the child, her assistance should be encouraged.

> Participation by mothers in the hospital routine, however, should not be attempted unless it can be appropriately organized and supervised.
>
> Parent teaching is a very important function of the professional staff engaged in the care of children, and space should be provided for it.
>
> Every pediatric unit should have recreational space for children to enjoy group play and to have their meals at tables with other children when they be up and about.[10]

While the mother will be allowed to accompany the child from the admitting office to the ward, if current admission practice prevails, it is unlikely that she will be encouraged to undress him or to remain until he is willing to accept hospitalization and parent separation. Daily visiting will be permitted and the mothers will be encouraged to bring into the hospital the child's favorite toy and to hold him if his condition warrants it. Mothers will not, however, be expected to give any other care to their children. There will be two semi-private rooms located near the treatment room, away from the central activity of the ward, which may be used either by very sick children who require a quiet area or by a parent and a child in a rooming-in setting. This practice will be permitted rather than encouraged and determined by the

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[10] American Academy Pediatrics, op. cit., pp. 403, 408, 411, 414.

child's need and the parent's desire to be with the child.

In the present plan there is no provision for space where parents and doctors could hold a consultation in privacy or students and instructor could hold a ward conference. No provision has been made for a playroom. There will be a small table and chairs and a television set in the open ward.

> It is desirable that the plan of treatment during convalescence have continuity with the therapy given the patient in the acute phase of his illness.
>
> The responsibility for arranging for suitable convalescent care or facilities devolves in a measure upon the hospital accepting a child for treatment at the acute stage of an illness.[11]

The type of patient cared for on the pediatric unit seemed to be such that there was little need for referral to extra hospital service. There was no established referral system and the arrangements needed by the occasional patient were made through the cooperative effort of the charge nurse and the personnel in the admitting office.

> Any hospital which has an organized pediatric service must give serious consideration to

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[11]American Academy of Pediatrics, op. cit., p. 405.

making its ancillary and professional services available to ambulatory patients.[12]

The following clinics in the out-patient department of "X" Hospital were most commonly attended by children, pediatric, crippled children, orthopedic, surgical, and eye, ear, nose, and throat. Attendance at all clinics was by appointment and the mothers and children were not just so many numbers but were expected visitors who waited their turn in a large well lighted, well ventilated, waiting room. There was an ample supply of lollipops but other than that no effort was made to amuse the children or allay the restlessness while they waited. When their turn came the family was summoned by name rather than by number and the children talked with as if they were old friends of the doctors and nurses. The parent was referred to as Mother or "Mommy". The clinics were conducted by physicians with interns working under their guidance. The out-patient rooms were well equipped and there was opportunity for good parent-nurse-child relationship in this area.

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[12] Ibid., p. 404.

> The scope of the service to be undertaken by the hospital must be determined in the light of the needs of the community.[13]

"X" Hospital served the community by admitting 1743 children to the pediatric unit from October 1957 through September 1958. Figure 2 and Table 1 indicate that the patients seemed to be almost evenly distributed among those having a tonsillectomy, the ill infant, and the children with conditions other than diseased tonsils.

The daily average patient census for the calendar year, 1958, ranged from 20.9 in August to 29.5 in February and is shown in detail in Table 2. The average length of hospitalization for all admissions exclusive of tonsillectomy was 6.44 days. Since approximately thirty-five per cent of the admissions were in the latter group, the length of hospitalization for the entire census tends to be less than six days. Table 3 indicates 44 per cent of all admissions stayed two days and 15 per cent of admissions excluding tonsillectomies were hospitalized only two days.

> It is desirable that children up to 12 or 16 years of age -- at least -- be cared for in the pediatric unit under the pediatric service.[15]

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[13] American Academy of Pediatrics, op. cit., p. 404.

[14] Ibid., p. 408.

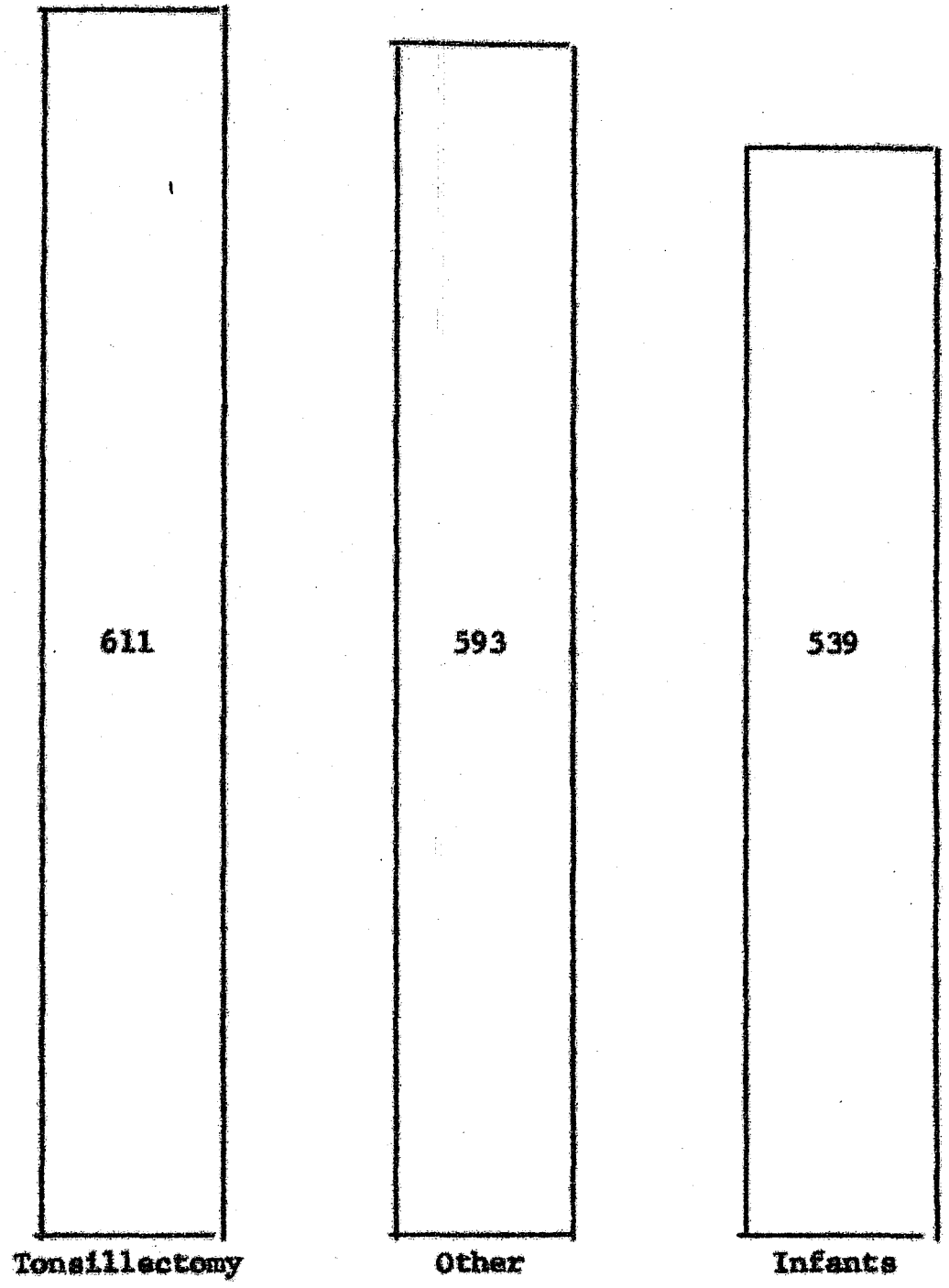

Figure 2. Major Distribution of Admissions to the Pediatric Unit in "X" Hospital, October 1957-September 1958

TABLE 1

SEASONAL DISTRIBUTION OF ADMISSIONS BY DISEASE CONDITION

OCTOBER 1957 - SEPTEMBER 1958

Diagnoses	Sept.-Nov.	Dec.-Feb.	Mar.-May	June-Aug.	Total
Tonsillectomy	150	159	138	164	611
Respiratory	46	75	82	55	258
Gastrointestinal	30	32	40	40	142
Eye, Ear, Nose and Throat	33	19	30	41	123
Orthopedic	21	18	20	33	92
Neurological	14	12	20	27	73
Diarrhea	10	19	27	11	67
Accidents	19	9	16	14	58
Hernia	17	14	9	15	55
Skin	12	3	6	9	30
Genital	9	5	6	4	24
Urinary	5	2	7	6	20
Burns	3	3	5	3	14
Other	70	47	21	38	176
Totals	439	417	427	460	1743

TABLE 2

DAILY AVERAGE CENSUS OF PEDIATRIC UNIT

JANUARY - DECEMBER 1958

Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
28.2	29.5	25.1	23.9	27.8	25	23.09	20.9	21.5	21.1	23.1	23.4

TABLE 3

LENGTH OF STAY ON PEDIATRIC UNIT

OCTOBER 1957 - SEPTEMBER 1958

Days	Per Cent of Total Admissions	
	Including T. & A.	Excluding T. & A.
1	4.4	6.8
2	44.0	15.0
3	8.1	12.3
4	7.5	11.5
5	7.2	11.0
6	6.2	9.6
7	4.4	6.8
8	4.0	6.1
9	2.5	3.8
10	2.0	3.0
11	1.4	2.3
12	1.4	2.3
13	0.9	1.5
14	0.9	1.5
More than 14	5.3	6.5
Totals	100.	100.

The admissions represented all groups from the newborn through thirteen years of age. Figure 3 shows the distribution of patients in the pediatric ward classified according to age groups, the infants, 0-2 years, the preschool child, 3-5 years, the school child, 6-10 years, and the preadolescent, 11-13 years. Table 4 indicates the manner in which these age groups are distributed throughout the seasons of the year.

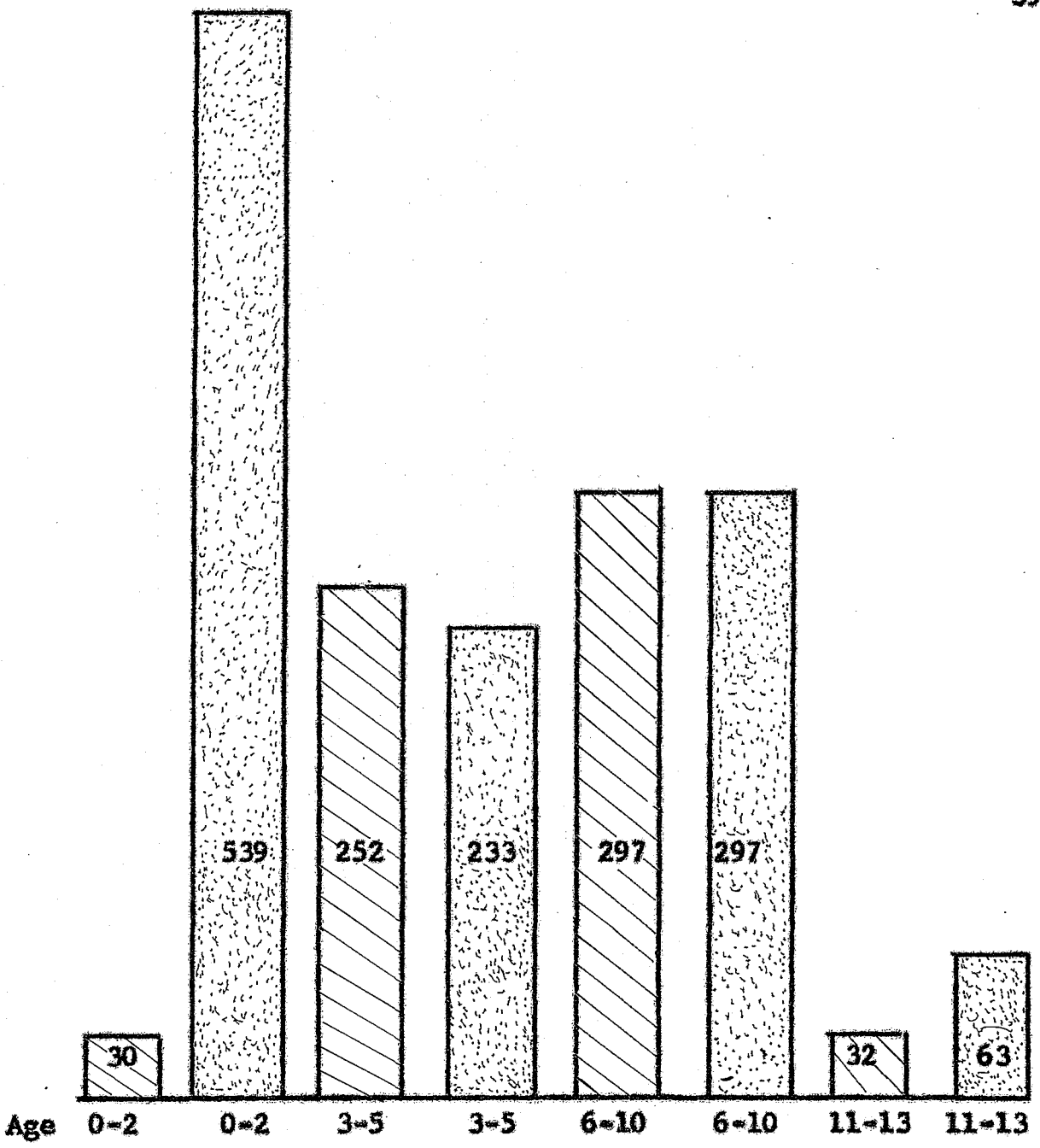

Figure 3. Patients on the Pediatric Ward Classified According to Age Groups, October 1957 - Spptember 1958

TABLE 4

SEASONAL DISTRIBUTION OF PATIENTS ADMITTED TO THE PEDIATRIC WARD CLASSIFIED ACCORDING TO AGE GROUPS OCTOBER 1957 - SEPTEMBER 1958

Seasons	0 - 2 years		3 - 5 years		6 - 10 years		11 - 13 years	
	T. & A.	Other	T. & A.	Other	T. & A.	Other	T. & A.	Other
Sept. - Nov.	14	121	65	73	59	78	12	17
Dec. - Feb.	6	147	66	44	82	58	5	9
Mar. - May	4	156	60	47	66	75	8	11
June - Aug.	6	115	61	69	90	86	7	26
Totals	30	539	252	233	297	297	32	63

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This study was done in "X" Hospital to determine its potential for providing learning experience in the care of children for the students in the school of nursing associated with this hospital.

During the past year "X" Hospital has built a new out-patient building, opened a new obstetrical unit, and is about to start complete renovation of the pediatric unit. It is a busy, progressive, and very much alive hospital that is very rapidly changing from a small to a much larger unit. The physical facilities in the pediatric unit will provide for the grouping of children according to age, isolation of the children under observation for communicable disease, separate room for the care of patients with tonsillectomies, a fog room for the treatment of respiratory conditions, and two open wards for the care of older children. Each room will be equipped with oxygen outlets, wall suction, and lavatories. The nurses'

station and service rooms are centrally located and the treatment room is removed from the main patient area. No provision has been made for a consultation room for doctor-parent, nurse-parent, or instructor-student use. There will not be a playroom. The open porch removed during the renovations will not be replaced.

There is friendly, interested, and cooperative graduate nurse coverage in the pediatric unit at all times. There are auxillary personnel to supplement the care given by professional nurses. There is no nurse in the area with advanced preparation in the care of children and there is no inservice education program.

The admission procedures do not seem to encourage the parent to remain with the child as long as reasonably necessary to permit the child to accept hospitalization and parent separation. There are daily visiting hours, the parents do bring into the hospital the child's favorite toy, and some effort is made on the part of the nurses to question the parents concerning likes, dislikes, and habits of the children. The parents may hold the patient but are not encouraged to participate in any additional care of the child such as feeding or bathing him. In the new pediatric unit rooming-in will be permitted but not encouraged.

At the time of this study the ward was congested and the nursing personnel seemed to be under tension and frustration. No child was assigned to a single nurse for complete care and the work organization appeared to be designed with as much consideration being given to the completion of the work load as to the individualized care of the child. The personnel seemed interested in the children and within the limits of the time, space, and equipment provided, attempted to meet the emotional and social needs of the child by celebrating his birthday, decorating his tray, allowing him to eat with others around a small table, calling him by name, locating his toys, adjusting his crib or chair so he could watch the television, and attempting to comfort him during his separation from home and mother by words, smiles, and such deeds as holding him and seeking to divert his attention from his problem to a more pleasant idea or object.

The admissions were representative of all age groups and at no time during the year was there an absence of any one of them. The disease conditions did not include the unusual which require the attention of a specialist, since these tend to be referred to the children's hospitals in Boston. The types of illness were evenly distributed throughout the year so that sampling

of nearly all of them was possible in each season of the year. The length of hospitalization tended to be six days or less.

The formula room is located in the obstetrical unit, is supervised by a graduate nurse who trained the nurse aid in formula preparation and in sterilization procedures. There is provision for separation of the dirty and clean areas, for the preparation of formulas using clean technique, for refrigeration of the formulas, and for washing and sterilization of bottles and nipples after use.

The out patient department maintains clinics for the care of children which are conducted by qualified physicians assisted by internes. The unit is new, the equipment is modern, and in sufficient amount. There is family-centered emphasis in the clinics and there seems to be available experience in the nurse-parent-child relationship in this area.

Conclusion

The potential of "X" Hospital in terms of its usefulness in providing a learning experience in the care of children for student nurses is determined by the philosophy of the faculty concerning what kind of care they believe should be given. If the faculty desires to prepare

nurses to give only adequate physical care, the hospital appears to be now ready to offer learning experience to students. If, however, the faculty accepts the concepts of modern pediatric nursing and believes that students, in addition to being able to give physical care, should have experience in the nurse-parent-child relationship and be prepared to recognize and, to a beginning degree, meet the emotional and social needs of the child, then consideration should be given to delaying the transfer of students to this area until

1. Unlimited visiting hours are permitted;
2. The nursing personnel is such as to appropriately organize and supervise participation of mothers in selected hospital routines involving child care, and
3. A planned program of play is in operation.

Recommendations

On the basis of this study and the principles for establishing a pediatric unit set up by the American Academy of Pediatrics, the writer recommends that before the utilization of "X" Hospital for student experience in child care is attempted that:

1. The hospital have on its nursing staff at least one nurse with post graduate preparation and experience in the care of children for the administration of the pediatric unit and the supervision of the nursing service therein.

2. An inservice education program in modern concepts of pediatric nursing be provided for all personnel giving care to children.

3. Consideration be given to the provision of a planned recreational program for patients which might include:
   a. Additional wall decorations
   b. Music in the form of tape recordings or phonographic records
   c. A movable toy cart for the storage of play materials between periods of use
   d. The use of volunteer workers in the play program.

4. Unrestricted visiting be allowed for all parents of patients on the pediatric unit.

5. Provision be made for a conference room equipped with black board and chairs which could serve as a consultation room for doctors and parents, inservice education program for personnel, and for ward conferences for student nurses.

6. A study be done to determine:
   a. The resources available in the community for instruction in child care.
   b. If class room space is available in the educational unit for teaching pediatric nursing throughout the year.
   c. The additional library books and periodicals that would be required in the instruction in child care.

7. A job description be developed for a clinical instructor in pediatric nursing who would be employed at least three months prior to the date of the first class.

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APPENDIX A

BOSTON UNIVERSITY SCHOOL OF NURSING

NU-324

A GUIDE FOR EVALUATION CHILD CARE FACILITIES

Prepared by

The Class of 1951 -- Advanced Study of Pediatric Nursing

GUIDE FOR EVALUATION OF PHYSICAL SETUP AND EQUIPMENT OF PEDIATRIC UNIT AND NURSERY

Exc. Good Fair Sat. Poor

I. Location of the Unit

- A. Adequate floor space
- B. Possibility for expansion without structural changes?
- C. Maximum quiet?
- D. Good exposure for sunlight?
- E. Good exposure for fresh air?

II. Adequacy of Structural Safety

- A. Resistance of materials to fire;
  1. Walls
  2. Floors
  3. Furniture
  4. Curtains or drapes
- B. Audible fire alarm other than telephone?
- C. Exits
  1. Provide for horizontal exit of pts?
  2. Exits well marked
     a) Lighted and marked for directional signs to street or nearest area of safety?

Exc. Good Fair Sat. Poor

3. Exits free from obstruction?
4. Fire doors to wall of section of the ward as a smoke barrier?
5. Adequate extinguishing equipment
   a) Regulations for fire control clearly visible?
      Directions for operation of equipment in sight?
   b) Separate extinguishers for oil and grease fires which may originate in kitchen?

III. General Appearance of Unit with Size and Space and Equipment a Measure of Efficiency

A. Rooms and cubicles
   1. Is the furniture adequate and suitable?
      Beds, bedside tables, chair, curtains?
   2. Are there call bells or signals?
   3. Are the tables equipped for each pt?
      Basins, bedpan, kidney basin, brush, comb, tooth-brush, soap dish and soap, towels and wash-cloth?

Exc. Good Fair Sat. Poor

B. Treatment Room
   1. Is it centrally located?
   2. Is emergency equipment available? Suction, oxygen, stimulants.
   3. Is equipment available for various types of cases for examination, treatments, dressings, etc.? Oroscope, opthalmoscope, sphygmonanometer, Iv. and clysis sets, L.P. sets, syringes, needles, sterile goods.
   4. Is the furniture suitable and adequate? Tables, stools, gravity poles, lights.
   5. Is there a central supply service?

C. Kitchen
   1. Are the sink space and sterilizers adequate for proper care of the dishes.

D. Diet Kitchen
   This is taken up in the section with the Formula Room.

E. Medicine Cabinets
   1. What is the location?
   2. Is the cabinet well-lighted?
   3. Are the narcotics locked separately?

Exc. Good Fair Sat. Poor

4. Are the supplies adequate? Hypo tray, medicine trays, and glasses.

F. Service Rooms
   1. Utility rooms:
      a) What is the location?
      b) Is the equipment adequate? Sterilizer, gas stove, scales, enema sets, stock supplies, linen hamper.
      c) Is there adequate space for supplies? Toilet paper, kleenex, throat sticks, soap, etc.
   2. Maid's closet
      a) Is there a window?
      b) Is the equipment adequate?
   3. Linen closet
      a) Is the linen supply adequate?
   4. Conference room
      a) Is this equipped to facilitate teaching?
   5. Admission room
   6. Waiting room
   7. Tub room

G. Nurses' Station
   1. Does the location facilitate work and does it give a view of the ward?

Exc. Good Fair Sat. Poor

2. Is the desk space adequate?
   Head Nurse
   Student Nurse
   Secretary
3. Is the bulletin board space adequate?
   Time slips
   Assignments
   Teaching materials

H. Infants Unit
1. Are the provisions for the care of infants adequate and suitable?

I. Is there adequate sink space throughout the unit? Is there a bedpan sterilizer?

IV. Lavatory Facilities

A. Patients
1. Scaled to size?
   toilet bowls?
   wash bowls?
   mirrors?
2. Flush system of toilet adequate for promoting good health habits?
3. Bath-tub pedestal?
4. Faucets -- Hot water punch type? Out of reach of child in tub?

B. Nurses lavatory separate?

Exc. Good Fair Sat. Poor

V. Sanitation

A. Closed plumbing
B. Public Utilities
   1. Water supply
   2. Sewerage
C. Heat
   1. Radiators and heating pipes covered or recessed for safety?
D. Lighting -- artificial
   1. Non-glaring? Provision for emergency light?
      a) Indirect?
      b) Corridor?
      c) Dome?
      d) Wall brackets?
      e) Night lights?
      f) Allowance for reading in bed?
E. Disposal of waste
   1. Incinerator?
   2. Waste baskets?

F. Ventilation
   1. No draft
   2. Windows barred or screened
   3. Provisions for removal of odors from ward

VI. Storage Space

Lockers for patients' clothing and toys

VII. Provision for admission of Prematures

Transfer of infants from outside the hospital

Transfer of infants from the obstetrical ward

	Exc.	Good	Fair	Sat.	Poor

VIII. General Equipment

Stretchers -- Provision for safety
Wheel chair
Rocking chair
Laundry hampers
X-ray view box
Paper towel racks
Radio
Television
Record Player

COMMENTS AND RECOMMENDATIONS:

Good points -- above average:

1. Beds, furniture, curtains and drapes in color -- pastels preferable.
2. Bed curtains which pull without noise.
3. Flush hoppers
4. Adjustable over-the-bed tables with a moveable section in the top backed with a mirror. This can be used for a play table, to prop a book, or as a dressing table.
5. Sides on childrens' stretchers.
6. Dish washer and sterilizer combination.
7. Stainless steel for sinks, kitchen cabinets, tray carts and trays.
8. Trays equipped so they can be stood up over the patient in bed.
9. Clothes chute.
10. Autoclave in each ward utility room.
11. Adjustable wall lamps.
12. Suction in each unit.

13. Oxygen piped into each unit.
14. Desk for the dietitian in the ward kitchen.

COMMENTS AND RECOMMENDATIONS:

WAYS OF EVALUATING PLAY AND RECREATION FOR A PEDIATRIC UNIT

I. Objectives

Does it seek to:
A. Meet the child's play needs within the hospital?
B. Establish the importance of basing the play program upon the child's emotional needs rather than merely upon his physical and social needs?
C. Make the play program flexible to permit the children to benefit from whenever they are free to do so?
D. Recognize the play program as an essential part of the student nurse's total pediatric experience?

II. Personnel

Does it have:
A. An adequate nursing staff for the patient load during the play hour?
B. A director of the play program who is prepared and qualified in child guidance and in play technic?

Pediatric Nursing

III. Playroom

A. Is the playroom well located? Apart from the Pediatric ward?
B. Does it allow for free bodily movement?
C. Is there good ventilation? heating? lighting?
D. Are the wall decorations and color simple, soft and gay?
E. What provisions are made for outdoor play and recreation?

IV. Equipment Facilities

A. Are there varieties of play materials and books for the different age group and conditions?
   1. For bed patients?
   2. For ambulatory patients?
B. Are the tables, chairs, et cetera suited to the childrens' height?
C. Does each child have a place to keep his toys, books et cetera?
D. Are toys free from sharp edges and poisonous paints and kept in repair?
E. Is music provided?

COMMENTS AND RECOMMENDATIONS:

Pediatric Nursing

EVALUATION OF A DIET KITCHEN SITUATED IN A PEDIATRIC UNIT

INTRODUCTION

In evaluating a diet kitchen situated in a pediatric unit, it is felt that the following four objectives should be kept in mind. They are:

1. To provide nutritious feedings for the children in the most palatable form.
2. To ensure provision for individual differences in likes and size of servings.
3. To ensure accuracy in the serving of therapeutic diets.
4. To provide for maximum efficiency in serving.

It is upon these objectives, that the following form for evaluation is based.

CHECK LIST

Instructions: The check list is divided into two main questions, each to be rated Excellent, Fair or Unsatisfactory. Sub-questions in each section may be answered Yes or No, and thereby used as a basis for rating the central questions:

	Exc.	Fair	Unsat.
I. Are the physical facilities adequate?			
A. Is there a centrally located room provided in the unit for serving of diets? Yes No			

Pediatric Nursing

	Exc.	Fair	Unsat.
B. Is the following equipment provided? stove or hot plate, dish warming closet, Refrigerator, Cupboards, Sterilizer, Sink	Yes	No	
C. Whether food is prepared in this room or sent from a main kitchen, is there a means of keeping the food hot during serving?	Yes	No	

II. Does the procedure of serving diets meet the objectives?

A. Is there a definite system of serving of food under the supervision of a graduate nurse of dietitian?	Yes	No
B. Are the trays served on an individual basis with consideration of each child's age and appetite?	Yes	No
C. Is the menu provided entirely suitable for children?	Yes	No
D. Is sufficient food and beverage left in the kitchen for optional between meal nourishment?	Yes	No
E. Are the soiled dishes adequately washed and sterilized?	Yes	No

Pediatric Nursing

	Exc.	Fair	Unsat.
III. Does the procedure meet the objectives?			
A. Are the bottles and equipment washed thoroughly in the dirty area?	Yes	No	
B. Is there a definite procedure for preparation using clean technic and terminal heating which is acceptable to standard recommendations?	Yes	No	
C. Is adequate refrigeration of prepared formulae maintained in separate refrigerator?	Yes	No	
D. Are sanitary methods of transportation of formulae employed?	Yes	No	

COMMENTS AND RECOMMENDATIONS:

EVALUATION OF A FORMULA ROOM

INTRODUCTION

In evaluation of any type, objectives must first be determined. In case of any formula room for preparation of infant feedings, it is felt that there are two main objectives to be strived for. They are namely:

1. To ensure the safety of the infant, in regard to both accuracy of feedings and prevention of infection.

2. To provide for maximum efficiency in preparation.

The following form for evaluation is prepared on the basis of these objectives:

CHECK LIST

Instructions: The check list is divided into three main sections, each headed by a central question. The main questions are to be rated Excellent, Fair or Unsatisfactory. Sub-questions in each section may be answered Yes or No, and thereby use as a basis of rating the central questions:

Exc. Fair. Unsat.

I. Are the physical facilities adequate?

A. Is there a separate room provided in a clean area? Yes No

B. Is the room divided into two sections, with provision for a clean and dirty area, preferably having separate entrances? Yes No

C. Is the following equipment provided?
Autoclave
Wash sink
Work table
Scrub sink
Refrigerator
Cupboards Yes No

D. Is the equipment arranged for maximum efficiency? Yes No

Pediatric Nursing

		Exc.	Fair.	Unsat.
E.	Is the room well-lighted and ventilated?	Yes	No	
F.	Are floors, walls and equipment easily cleaned?	Yes	No	

II. Is the personnel adequate and qualified?

A.	Is there a well-qualified graduate nurse or dietitian in charge with no other responsibilities?	Yes	No
B.	Is there an adequate program of clinical teaching for students in this area?		
C.	Do the personnel have periodic physical exams?	Yes	No
D.	Is there an adequate program for training non-professional personnel?	Yes	No
E.	If the personnel are assigned elsewhere is it in a clean area?	Yes	No
F.	Do the personnel wear clean gowns and headgear in the formula room?	Yes	No

COMMENTS AND RECOMMENDATIONS:

GUIDE FOR CRITERIA FOR EVALUATION OF NURSING CARE ON A PEDIATRIC UNIT

	Yes	No
I. Teamwork		
A. Is there adequate staff to meet the child's physical and emotional needs?		
1. Infants -- 5.5 hours/ 24 hour period.	___	___
2. Children -- 4.3 hours/ 24 hour period.	___	___
B. Is there evidence of teamwork among the members of the hospital staff?		
1. Members of the nursing staff	___	___
2. School teacher	___	___
3. Dietitian	___	___
4. Occupational therapist	___	___
5. Doctors	___	___
6. Social service worker	___	___
7. Physical therapist	___	___
8. Play teacher	___	___
C. Is there a sharing of information between the nurses concerning a child's likes, dislikes or any other particular findings concerning an individual child?	___	___
II. Parent-Nurse-Child Relationship		
A. Nurse-child relationship		
1. Does the nurse call the child by his first name?	___	___
2. Is her approach friendly and reassuring?	___	___
3. Does the nurse show a sensitiveness to the child's emotional needs?	___	___

Pediatric Nursing

	Yes	No
a) Stopping to talk to him	___	___
b) Holding him	___	___
c) Showing genuine affection, understanding and sympathy through her manner, facial expression and tone of voice.	___	___
4. Does the nurse attempt to maintain the child's former activities (if he is physically able)?	___	___
a) Allow him to dress, wash and eat by himself if he has been accustomed to doing such?	___	___
5. Is there any evidence of health teaching?	___	___
a) brushing teach		
b) washing hands before eating		
6. Does she demonstrate a knowledge of growth and development and attempt to improve or increase it?	___	___
a) The child's play needs and proper selection of toys?	___	___
b) The child's need for affection?	___	___
c) The child's need for companionship -- introduction to others on the ward?	___	___
d) Understanding of his response to illness and separation from his parents with an attempt to alleviate his fears through simple explanation?	___	___

Pediatric Nursing

	Yes	No
7. Does the nurse show him how to make his needs known?		
a) Use of the call light or bell?	___	___
8. Does the nurse encourage the child's learning?		
a) Answering his questions	___	___
b) Helping him when needed	___	___
c) Participating in his play when she is wanted	___	___
d) Carrying on the conversation at the child's level	___	___
e) Helping him to develop a socially accepted behavior according to his age	___	___
f) Helping him to enter group activity	___	___
9. Is one nurse assigned to care for the child over as long a period of time as possible to help promote security and reduce the number of adjustments to make?	___	___
10. Is there evidence of continuing the child's sociological needs?		
a) Group leaders	___	___
b) Religious leaders	___	___
11. Does the nurse help create and guide the child's creative interests? i.e. hobbies.	___	___
B. Parent-nurse relationship		
1. On admission or soon after, is specific information gained from the parents concerning the child's		
a) Habits and activities -- eating, dressing alone	___	___

	Yes	No
b) Eating habits -- likes and dislikes	___	___
c) Sleeping habits -- soundly or wakeful	___	___
d) Toilet habits	___	___
e) Favorite activities and toys	___	___
f) Association with other children	___	___
g) Particular words and expressions	___	___
2. Are the parents allowed to accompany the child to the ward on admission?	___	___
3. Is there discussion of hospitals policies concerning		
a) Visiting hours	___	___
b) Bringing food in	___	___
c) Who to call concerning the child's condition	___	___
d) How to get in touch with the doctor	___	___
4. Does the nurse try to gain the parent's confidence and alleviate their fears?	___	___
a) Through a friendly, sympathetic and reassuring manner	___	___
b) Introduction to the ward setup and playroom	___	___
c) Are the mother's questions answered by the nurse in a manner which is clear and which gives her a sense of reassurance?	___	___

III. Visiting Hours

A. What are the visiting hours
B. Are there flexible rules and regulations ___ ___

	Yes	No
1. Parents allowed to hold children?	___	___
2. Parents allowed to feed children?	___	___
3. Parents allowed to bathe children?	___	___
C. Is there opportunity for parent teaching?	___	___
D. Is it utilized?	___	___
1. Demonstration to parents and practice by the parents of special procedures the child may have at home?	___	___
2. Insulin: feeding child with cleft lip: care of colostomy?	___	___
3. Explanation of equipment needed at home -- where to get it adaptation to home care.	___	___

IV. Comfort and Happiness

A. Is there evidence of the nurse participating in the child's activities?	___	___
B. Is the child occupied?	___	___
C. Do the restraints restrict the child's activities too much?	___	___
D. Is the child adequately and appropriately clothed?	___	___
1. Proper size	___	___
2. Kept in repair	___	___
3. Whether ambulatory or not	___	___
E. Is a specific time set aside for a nap period?	___	___
F. Is the environment conducive to rest (quiet, shades drawn, treatments done before nap time)?	___	___
G. Is the child clean, clothes and bed linen changed as needed?	___	___

Pediatric Nursing

	Yes	No
H. Is there provision for comfortable position?		
1. adequate support when sitting up	___	___
2. over bed or bed table when eating and playing	___	___
I. Are precautions taken not to discuss the child's condition within his hearing distance?	___	___
	___	___
V. Treatments and procedures:		
A. Is there adequate and true explanation of treatment to alleviate the child's fear?	___	___
B. Does the nurse comfort the child after the procedure and praise his behavior?	___	___
C. Are the dressings neat and fastened securely?	___	___
D. Does the nurse talk to and reassure the child during a procedure?	___	___
E. Are medications prepared in such a way as to make it more pleasant experience?	___	___
1. Avoiding force	___	___
2. Crushing tablets if child has difficulty in swallowing them?	___	___
3. Application of principles	___	___
4. Economy of time and materials	___	___
5. Use of teaching opportunities	___	___
6. Workmanship as measure by		
a) comfort	___	___
b) appearance	___	___
c) adaptation	___	___
d) completeness	___	___

	Yes	No
VI. Safety Factors		
A. Is there adequate restraint during treatments to prevent injury:		
B. Are the crib sides kept up?	___	___
C. Are the medications, equipment, pins closed and kept out of the child's reach?	___	___
D. Is care and discretion used in taking temperatures?	___	___
E. Are glass irrigating tips and medicine droppers, glass drinking tubes rubber tipped? (paper straws are better)	___	___
VII. Nutrition		
A. Is there provision for individual diets to consider the likes and dislikes?	___	___
B. Is the diet presented in a way conducive to good eating habits?	___	___
1. Allowed to take his time?	___	___
2. Are foods forced upon him?	___	___
C. Does the nurse hold a small child while feeding him?	___	___
D. Is there provision for dining room style for convalescent children?	___	___
E. Is there explanation of and encouragement to the child on a special diet?	___	___
F. Is there careful planning of a limited fluid intake to meet the child's needs and demands? i.e. spread out over a period of time.	___	___
VIII. Discharge		
A. Is there evidence that the parents and patient have had		

	Yes	No
advanced preparation for discharge?		
1. Supervision of parents carrying out special treatments?		
a) Feeding of child with cleft lip		
b) Care of a colostomy		
c) Administration of insulin		
2. Final check on special equipment needed at home.		
B. Has the teaching been done in a way adaptable to the home situation?		
C. Has the teaching been a continuous process from the time of admission?		
D. Is there evidence that the child has been referred to the VNA or other agencies if necessary and have the parents been notified of the referral?		
E. Have the doctor's orders been interpreted to the parent's understanding?		

IX. Observation and Notations

	Yes	No
A. Is there any evidence that observations are made of the child's behavior patterns?		
B. Are these observations written in detail in the nurses notes?		
C. Is there any evidence of the utilization of these observations?		

COMMENTS AND RECOMMENDATIONS:

GUIDE FOR EVALUATION OF REFERRAL SYSTEM AND WELL CHILD CONFERENCE

	Yes	No
I. Does the hospital provide an educational program for nursing personnel that fosters good working relationships with community agencies through an understanding of the agency's contribution to child care? Does this program include:		
A. In-service program of staff education	___	___
B. Student instruction in functions of community agencies	___	___
C. Student observation in Out-Patient Clinics (indicate in hrs.)	___	___
D. Student experience in Out-Patient Clinics (indicate no. of wks)	___	___
E. Student experience in community agencies (indicate type and duration)	___	___
F. Student observation in community agencies (indicate type and duration)	___	___
G. Educational program is conducted by:		
1. Nursing instructor with Public Health Background	___	___
2. Public Health Nurse from the community	___	___
3. Representative from the community agency	___	___
H. Planned interagency conference to allow exchange of information between hospitals and agencies.	___	___

Pediatric Nursing

	Yes	No
II. Does the referral system encourage integration of hospitals and home care, promote optimum use of community resources and contribute to the education of the nurse?		
A. Is the hospital referral plan initiated through the:		
1. Doctor	___	___
2. Head Nurse	___	___
3. Student nurse	___	___
4. Social Worker	___	___
5. Group discussion of medical and nursing personnel	___	___
6. Others (specify)	___	___
B. Is the following information included:		
1. Patient's attitudes and needs	___	___
2. Patient's acceptance of hospital care	___	___
3. Type of care received	___	___
4. Instruction given the pt. or his family regarding his condition.	___	___
5. General health and care at home	___	___
6. Points which may be helpful to the home nurse regarding new drugs and unusual treatment	___	___
7. Medical orders given by the doctor	___	___
8. Social information known to the nurse or medical social worker	___	___
9. Patient's correct name and address	___	___
10. Space provided for comment by other workers	___	___
C. Is there information about the agency readily available to the person initiating the referral such as:		

	Yes	No
1. Type of service rendered by the agency (or individual doctor)	___	___
2. Name and address of the agency	___	___
3. Telephone number of the agency	___	___
4. Name of the person to contact in the agency	___	___
5. Eligibility requirements	___	___
D. Is information given to the family about this agency such as;		
1. Type of service given	___	___
2. Address	___	___
3. Name of person they should contact	___	___
4. Routines, such as date and time of appointment	___	___
5. Personalized information that leads to family confidence in the use of this particular agency	___	___
III. Does this hospital or community provide for the maintenance and continuity of all aspects of child health through a well organized child health clinic or congerence?		
A. Is there adequate personnel to care for the family and child's needs such as:		
1. Pediatrician	___	___
2. Public Health Nurse	___	___
3. Nutritionist	___	___
4. Dentist	___	___
5. Psychiatrist	___	___
6. Clerk	___	___
7. Volunteer workers	___	___
B. Is there a consultation service available when clinic personnel is inadequate to meet the needs of the family or child, such as;		

	Yes	No
1. Child Guidance Clinic or Psychiatric consultation service (specify sources)	___	___
2. Nutritional consultation service (specify source)	___	___
3. Dental consultation service (specify source)	___	___
C. Is the program organized to provide for continuous health supervision of infant and child primarily through the education of parents in:		
1. Mother's classes	___	___
2. Demonstrations	___	___
3. Group conferences	___	___
4. Individual conferences to interpret doctor's findings and recommendations	___	___
5. Follow-up home visits for observation and further instruction	___	___
6. Patients scheduled so that time is allowed for teaching	___	___
D. Is the clinic equipped with facilities or aids for parent teaching such as;		
1. Class or demonstration room	___	___
2. Blackboard for teaching purposes	___	___
3. Demonstration material for preparation of formula or nutrition class	___	___
4. Audi-visual aid equipment	___	___
5. Table or rack for literature on child care	___	___
6. Educational posters	___	___

IV. Does the program provide for the needs of the group to be served through the provision of adequate facilities and activities to meet

	Yes	No
the objectives of a well-planned Child Health Conference?		
A. Is the waiting room, clean, spacious and equipped with:		
1. Comfortable chairs for adults and children	___	___
2. Adequate light and heat		
3. Toilet and lavatory facilities with soap, paper, towels and running water.	___	___
4. Sanitary water fountain	___	___
5. Covered container for waste	___	___
B. Is there some provision made for recreation with suitable play materials available to the children while in the clinics?	___	___
C. Is the history room so arranged as to provide privacy for the family and child and conducive to individual care?	___	___
D. Is the dressing room so arranged as to provide privacy for the family or child with equipment such as:		
1. Hooks and hangers for clothes	___	___
2. Table or shelf for personal belongings	___	___
3. Clean gowns, halters or drapes for the individual to be examined.	___	___
4. Hamper for linens	___	___
5. Waste dispenser	___	___
E. Is the examining room equipped to provide complete physical examinations and to carry out preventive procedures?		
1. Desk for Doctor	___	___
2. Examining table	___	___
3. Adequate light	___	___
4. Comfortable chairs	___	___
5. Adequate supplies	___	___

	Yes	No
6. Mobile table-trays with examining equipment and immunization materials		
7. Space or area for isolation of child with an infection	___	___
8. Equipment sterilizer	___	___
9. Sheets (cloth or paper) changed between pts.	___	___
10. Safe techniques in procedures such as: injections, ear examinations, temperatures, etc.	___	___
11. Equipment and facilities for:	___	___
a) Immunization	___	___
b) Urinalysis	___	___
c) Blood Test	___	___
d) X-ray	___	___
F. Is the history on each child complete with the following types of information included:		
1. Sociological data as it pertains to the child and his family	___	___
2. General health of the child and family	___	___
3. Mother's health during pregnancy	___	___
4. Developmental factors (including physical and emotional)	___	___
5. Types of childhood diseases	___	___
6. Record of immunization	___	___
7. Notes on operations or accidents experienced by the child	___	___
8. Recommendations for future care of the child	___	___

	Yes	No
G. Is the clinic personnel interested in participating in programs to insure the health and welfare of the community such as:		
1. Sanitary inspections in the community	___	___
2. Inspection of water and milk supplies	___	___
3. Inspection of schools	___	___
4. Provision for community recreation -- parks, playgrounds, swimming pools.	___	___
H. Is the health status of the personnel appraised through		
1. Periodic x-rays	___	___
2. Periodic physical examinations	___	___
3. Evidence of emotional stability	___	___
4. General appearance	___	___
I. Is a post-clinic conference planned for the personnel to:		
1. Discuss problems	___	___
2. Aid in closer working relationships	___	___
3. Aid in setting future goals for health supervision of the child and family	___	___

COMMENTS AND RECOMMENDATIONS:

APPENDIX B

BASIC PRINCIPLES UNDERLYING HOSPITAL CARE OF CHILDREN

The Committee on Hospitals and Dispensaries of the American Academy of Pediatrics was given a generous grant of financial assistance by the Pet Milk Company, St. Louis, Missouri, which enabled the committee "to distill out, insofar as possible, what appears to be the basic principles underlying hospital care for children during this era of rapid change in the nature of pediatric care."[1] The following principles are quoted from the report of this committee.[2]

> "If a hospital accepts children as patients, facilities separate from adult patients should be made available.
>
> It is desirable that children up to 12 or 16 years of age -- at least -- be cared for in the pediatric unit under the pediatric service.
>
> In general, the grouping of the patients in a children's unit by age is preferable to grouping by diagnosis.
>
> One of the most important over-all principles of hospital construction is flexibility. The

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[1] American Academy of Pediatrics, Committee on Hospitals and Dispensaries, "The Care of Children in Hospitals," Pediatrics 14: 401, October, 1954.

[2] Ibid., pp. 401-419.

everchanging concept of child care calls for con stantly altered physical arrangements.

It is desirable that the hospital furnish an environment which is as adaptable as possible to the needs of the child for safety and feeling of security.

Deviation from standard (or adult) sized furnishing and equipment should be avoided except where necessary to meet the needs of the child.

The nurses' station should be situated preferably within the unit to save as many steps as possible and be so placed that easy access is possible to the rooms with the sickest children and infants.

Patients admitted for 24-hour stay should not be placed in rooms with other hospitalized children.

When several children are admitted for a short period -- such as for tonsillectomies or minor surgical procedures for overnight stay, they may be placed in a multiple bed room.

Oxygen outlets in patients' rooms -- in spite of additional expense in construction -- are an obvious advantage.

Mechanical suction should be readily available through out the pediatric unit.

Parent teaching is a very important function of the professional staff engaged in the care of children, and space should be provided for it.

An admitting and consultation room should be provided, that can also serve as an office for resident or staff physicians.

A separate room should be set up for examinations and treatment.

The treatment room should be located as far away as possible from patients' rooms.

Visitors' room, consultation and treatment rooms are usually grouped as a unit for convenience in the admission and discharge of patients and for patient-physician conferences.

Arrangements for handling the food-service must be provided by means of central tray service or floor pantries.

A utility room centrally located should be provided for each nursing unit.

If the climate is favorable an open porch or terrace should be provided where beds can be wheeled out.

The scope of the service to be undertaken by the hospital must be determined in the light of the needs of the community.

It is now generally believed that it is most desirable to provide care for the child in his own home whenever it is possible.

Any hospital which has an organized pediatric service must give serious consideration to making its ancillary and professional services available to ambulatory patients.

It is desirable that the plan of treatment during convalescence have continuity with the therapy given the patient in the acute phase of his illness.

The responsibility for arranging for suitable convalescent care or facilities devolves in a measure upon the hospital accepting a child for treatment at the acute stage of an illness.

The atmosphere of the pediatric unit should be as homelike as possible -- relaxed, friendly, and informal.

It is recognized that infants and younger children need their mothers and that separation is not desirable when this can be prevented.

Mothers can be of help to the hospital and a benefit to the child by assisting in the care of their children in the hospital; and when the presence of the mother is good for the child, her assistance should be encouraged.

Participation by mothers in the hospital routine, however, should not be attempted unless it can be appropriately organized and supervised.

The most effective functioning staff for a pediatric service is organized with a permanent physician-in-chief to provide continuity in policy and operation of the service.

Leadership and supervision of the pediatric service should always be vested in a qualified pediatrician when one is available.

The nursing service in the pediatric unit should be directed and supervised by a nurse who has had special pediatric nursing training and experience in the care of children. When such a nurse is not available to a hospital, the hospital should afford an opportunity for the nurse selected to have charge of the children's unit to secure additional special training

It is important that every nurse serving children, in addition to her knowledge of disease in children, should comprehend their normal growth and development and should understand the emotional impace of hospitalization upon the child and his parents.

Every hospital regardless of size, should have on its nursing staff at least one nurse with preparation and experience in the care of children, who can be responsible for the instruction of other nurses, workers, and mothers who may care for children or infants in the hospital.

Nurses who are to accept responsibility for supervision or direction of hospital services and for training other nurses or auxilary nursing personnel should have formal training and experience in the principles of administration and clinical teaching.

There should be adequate graduate nurse coverage in the pediatric service at all times with supervision by nurses trained not only in pediatrics but in the clinical specialties represented in the service.

All who care for children should be aware of the special needs of children and the forms of behavior to be expected at different age levels.

It is most important to the child, to be as much as possible under the care of the same nurse.

The hospital should provide for the supervision of diets under a qualified dietician and preferably one who has had training in understanding children.

If a child must remain in a hospital for a prolonged period and his illness is such that school work is possible, adequate educational opportunity should be provided in the hospital.

Occupational therapy should be provided by trained personnel for those children whose illness requires it.

Recreational services on a less formal and specific basis [than occupational therapy] should be provided for all children who must remain hospitalized for more than a few days.

The use of reliable volunteer help as well as parents is especially suitable [for informal recreational service] and should be encouraged by the hospital.

Every pediatric unit should have recreational space for children to enjoy group play and to have their meals at tables with other children when they can be up and about.

In many hospitals auxillary nursing personnel may supplement the professional nursing staff in furnishing the services needed by children. It is necessary that the hospital provide them with special training for the duties they are to perform under the supervision of the nurse in charge.

All personnel working with children in the hospital should receive special orientation and training to understand children -- their growth, their development, and their behavior.

In-service training and orientation of all personnel working with children or having contact with children should be provided in every hospital.

There is need for graduate nurses to have continued opportunity for additional training and experience in the care of children.

Even the smallest hospital with a pediatric unit can afford, at the very least, a program of in-service training in pediatric care.

A pediatric service to function practically should include a minimum of 12 to 15 beds."

The Commonwealth of Massachusetts
REQUIREMENTS AND RECOMMENDATIONS FOR APPROVED SCHOOLS OF NURSING
Issued by Approving Authority for Schools of Nursing and Schools of Practical Nursing
January 1, 1956

There is no reference to pediatric nursing in this publication except:

"These Requirements and Recommendations supersede any Rules or Regulations previously promulgated for Approved Schools of Nursing by the Approving Authority for Schools of Nursing and Schools of Practical Nursing -- except the Minimum Curriculum and Syllabus for Schools of Nursing issued on May 15, 1944, and the Requirements governing Clinical Practice issued on July 26, 1944."

Requirements -- Massachusetts Approving Authority for Schools of Nursing. July 26, 1944

*Pediatric Nursing
Daily average for infants and children under 12 years of age is 10 exclusive of diseased condition of tonsils and adenoids

Total time required is .....12 weeks
Minimum pediatric nursing
Segregated non communicable service and
Ratio of medical to surgical cases
at least 1:2 ..... 8 weeks

Remaining four weeks may be spent
in the following manner
Communicable Disease Nursing
Segregated children's ward
with
Daily average of
10 patients ..... no more than ..... 4 weeks

Orthopedic Nursing
Infants or
children ..... no more than ..... 4 weeks

Handicapped Child
Service ..... no more than ..... 4 weeks

Nursery School ..... no more than 2 or 3 weeks

Out Patient Department
(Infants and Children,
and well baby
conferences) ..... no more than ..... 2 weeks

** The Formula room experience should be limited to actual learning situations. A Minimum of 16 hours is considered adequate for the average student.

* The utilization of clinical experience may be expanded by the requirement of 36 hours of nursing service per week providing there is a good teaching program.

** See Canice, Sister M., "Technicians in the Formula Laboratory," Nursing Outlook. Vol. 7 Number 3 page 154, March 1959 for further discussion of the formula room.

Current Thinking in Curriculum Content

"The Professional Nurse who is to undertake the care of children in a hospital should have included in her educational background not only the basic scientific and social training for nursing but also training and experience that will provide her with an applicable knowledge of:

The growth and development of a child;
Normal emotional development;
Typical reactions of children to disease;
Appreciation of community facilities for the various areas of concern for children;
The psychiatric, economic, and social impact upon the family of serious illness in the child;
Special problems attendant on care of the new born infant;
Care of communicable disease."[3]

"Pediatric Nursing experience of twelve weeks was considered adequate on a service of 25 patients or more."[4]

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[3]American Academy of Pediatrics, op. cit., p. 418.

[4]West, Margaret and Hawkins, Christy, Nursing Schools at the Mid-Century, p.

APPENDIX C

CLASSIFICATION OF ADMISSIONS BY DIAGNOSIS

Accidents

Ingestion of foreign substances
Immersion
Gunshot wounds

Blood Dyscrasia

Hemophilia
Purpura
Anemia

Burns

Congestive heart failure
? Rheumatic fever
Congenital heart

Convulsions

No other diagnosis given

Cystic Fibrosis

Only one admission with this diagnosis

Diabetes

Only one admission with this diagnosis

Diarrhea

Ear, Nose, Throat

Mastoiditis
Otitis media
Dental work
Tonsillitis
Nasal polyps

Eye

Cyst on eyelid
Injury to the eye
Squint
Infected eyes and eyelids

Gastro-intestinal

Appendectomy
Acute abdomen
Intussception
Infectious hepatitis
Mesenteric adenitis
Neurogenic colitis
Pyloric stenosis
Penetration wound of abdomen
Retal bleeding
Ruptured spleen
Volvulus

Genital

Circucision
Hydrocele
Phimosis
Undescended testicle

Hernia

Neurological

Cerebral palsy
? Concussion
Encephalitis
Epilepsy
Head injury
Menigitis
Tetany

Medical

No other diagnosis given

Orthopedic

Concenital hips
Club feet
Fractures (femur, wrist, skull, ankle, finger.)
Hammer toe
Trigger finger

Pediatric study

No other diagnosis given

Respiratory

Asthma
Croup
Bronchitis
Laryngo-tracheo-bronchitis
Penumonia
Pneumonitis

Skin

Plastic surgery
Lacerations
Cellulitis of face and leg
Dermatitis

Surgical

No other diagnosis given

Urological

Cystitis
Hematuria
Pyelitis
Stricture of urethra

Boarders

Newborns who were born outside the hospital and hospitalized soon after delivery or babies transferred from obstetrical department following discharge of mother.