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Hospitalization of the Child

Part II

Eren Kum, Ph.D.* / Nurgün İlgen, M.S.**

Preparations for Hospitalization and the Preventive Factors in Hospitalism

Hospitalization requires extra tasks from the child when his capacity already is handicapped by his illness and separation from his familiar surroundings.[13, 28, 33] The negative impacts of these factors on parents and children, both receive proper attention in most hospitals of the western countries. The policies and procedures in these hospitals aim to reduce anxieties caused by separation and bodily injury. Certain, change in regular hospital practices seem to minimize the adverse effects of hospitalization and separation on children.[9, 11, 13, 19, 20, 24, 33, 34, 35, 36]

We can discuss these changes in a number of different approaches:

1. If possible, the mother should stay with and care also for the child. "While it is true that is easier to care for children without the parents interfering and that children cry less without their parents",[28] it is psychologically impossible to place a child away from parents in a hospital without alarming him in any way.

Mahaffy,[17] studied the effects of hospitalization on children admitted for tonsillectomy and adenoidectomy. He observed that the group cared by mother demonstrated lower body temperature, pulse rates, systolic blood pressure, compared to the one cared by the nurses. The "without-mother" group also voided in a longer period, took less fluids with more difficulty and showed higher incidence of crying and vomiting. Therefore, it would not be wrong to say with Mahaffy that children nursed by their mother, show less anxiety and fear and are more cooperative during hospitalization. On the other hand, Mahaffy's findings in relation to vomiting, voiding and crying indeed needs considering further our routine nursing care of children.

* Associate Professor of Pediatric Nursing, School of Nursing. Hacettepe University, Ankara.

** Instructor in Pediatric Nursing, School of Nursing, Hacettepe University, Ankara.

Fagin,[37] after comparing ill children of roomed-in and not roomed in mothers, found a non-significant difference between regressive behaviors of the pre-and-post hospital periods. Fagin's experimental group consisted of children ranging in ages from 1,5 to 3 years. In this study the group of children whose mothers did not stay with them in hospital showed reactions to mother's leaving them, displayed, changes in appetite, in manners of eating, sleeping, and voiding. All of these were evaluated as regressive behavior and were found to be more significant than those demonstrated by the other group.

Recognizing the validity of these findings, many hospitals within the western societies, have established some rooming-in facilities in their pediatric units. There exist many obstacles, however, which prevents this approach from being put into routine practice. Post[36] lists these obstacles as follows:

a. It is a fact that doctors and nurses are not informed much about child psychology. Some doctors prefer to tell the parents to come and get their child when they feel that the hospitalization should come to an end. Nurses may display similar attitudes also, believing that the mothers disturb children and therefore should not visit them.

b. Nurses feel that they have to be more careful when functioning with the mother around, and that makes them feel uneasy.

c. Unfortunately nurses seem to hold on to an old belief which regards playing with child as useless and practice such belief widely. To them having clean beds, rooms and discipline at work seem more important.

d. Sometimes the child develops closer relations with the nurse than those with the mother in an attempt to refuse the mother. In such cases, mother needs some assistance to understand the child and to develop new relations with him.

e. Hospital expenses increase a great deal by the rooming-in of the parent.

f. Staying in hospital with her child keeps mother away from her housework and from other members of the family.

2. If the mother cannot stay with and take care of the child, the child should receive the frequent care and attention of a limited number of hospital personnel. Assigning different nurses for different routine patient care may be practical, but may cause more harm than providing support for the sensitive child. The trust and love that develops between the child and one particular nurse through nursing, care and physical contact, when mother is not around, is very important. Establishing

close relations with one nurse only will answer the child's need for mother to a certain degree. If we fail to provide such basic needs as love and trust the child may regress during hospitalization. Some authors,[24, 32] therefore, recommend the following:

a. Especially in the long term care of little children the practice of the case-assignment system.

b. The practice of assigning the same personnel to small children throughout the period of their hospitalization.

However, such care is possible only if the nursing care is provided by permanent staff members, and the students are assigned to observe or to intervene only as a learning experience. Assigning numerous personnel to the care of the child will be a somewhat destructive approach.

3. To lengthen the visiting hours and to shorten the stays in hospital. Kunzman[38] states that "the child is accustomed to having his needs met at home rather than in hospital." For better understanding of the child's hospital experience, Kunzman provides a comparative table which is given below.

COMPARING THE CHILD'S SITUATION AT HOME AND IN HOSPITAL

Situation at Home	Situation when Hospitalized
1. Consistent persons or person who provide nurturing	1. Many nurses, doctors and staff may assume some or all of nurturing roles
2. Family associations	2. Family associations limited
3. Familiar environment	3. Strange environment
4. Routine daily activities	4. Unfamiliar hospital routines
5. Regular play with peers	5. Limited or no play with peers
6. Changes in environment	6. Limited changes in environment
7. Usual school and extracurricular activities	7. Very limited school and extracurricular activities
8. Independence appropriate to growth and development level	8. Loss of independence

No matter how much of the nurturing the nurses and the doctors assume, the successs of such substitution depends on the policy of hospital visits and to the contribution of parents in staying with him and helping the staff in his care.

4. Hospital experience must be modified to meet the child's endurance. The pleasantness of the hospital experience of children can be influenced by play. Toys and play are the work and tools of a child

for self-expression and non-verbal communication.[3, 38] In hospital situation a very sick child will naturally lose interest in play as he is too ill to bother. When the child feels better, though, his desire to play becomes again an important part of him. Thus child's engagement in a play activity is an indication of him feeling better.

5. Preparation of the child for hospital admission and treatment. The patient's mental preparation will include the provision of various kinds of information;[39]

a. Factual information about what is to occur,

b. Predictions about what the patient himself is likely to experience,

c. Reassurance in the form of optimistic statements and recommendations which will give a sense of control and thereby reduce the feelings of helplessness.

Wu repeats Piaget's comments as follows: "Fifty percent of the thinking of a child of five years of age is egocentric. The child is interested only in that which affects or has relevance to himself. Therefore, information in preparatory communication should be focused on him, as how he will feel or what he can do during the activity."[39] In other words the child should be told of what will happen at the hospital and why it will happen in as simple words as possible so that he can understand. On the other hand, according to Anne Freud[39] the timing of such preparation is very important and it varies from child to child. If the preparation is done too early time will be left for his imagination to start working. If it is done right before hospitalization then there will not be enough time for the ego to ready itself for defense. Perhaps we should say a few words about the different requirements of the various age groups by referring to some of our previous paragraphs.

There is not much that can be done for the preparation for hospitalization of a toddler since he cannot accept the idea that the mother will really leave him. Therefore especially for this age group, efforts should be spent to keep the mother and the child together as much as possible. In contrast, a preschooler's level of verbal communication makes it easy to prepare him for hospitalization. Since he is not much interested in the mechanism of the procedure, but in what will be done to him and why, the content of the information should be concentrated on answering such questions.

Fantasy becomes more important for most children than reality. This age group in particular need some assurance against pain and illness not to think of them as punishment. Örsten and Mattson suggest

that painful and frightening procedures such as constructive surgery, allergy tests and adenoidectomies should be postponed until after 3 to 4 years of age. Jackson et al[34] recommend that such treatment methods as enemas and venipuncture be kept to a minimum. Insertion of things into anus, especially by a stranger, should be avoided whenever possible. Preparation of the school-age child for hospitalization is very much the same as that of the preschool child.

Nursing Care

Yörükoğlu defines a healthy child as a child who is loved by others and who can play games.[42] The definition or the basic needs of a hospitalized child is not much different than this definition. To a child, hospital is a place which shelters children like him, but, at the same time, a place full of strange people and things. In such a strange world his only security is the love and protection he will receive from the people around, people who are total strangers to him. Can nurses provide such needs? Mahaffy believes that the "kindness and care a nurse extends to a hospitalized child can only supplement, not replace, that given by the child's mother."[17] Branstetler's study[12] indicate that children of 14 to 36 months accept care from an affectionate mother-substitute, and will also form some attacking behavior toward such substitute.

To evaluate nurse-child relations and their effect on hospitalization, the attitudes of different age groups should be reviewed shortly:

a. Communication with the infant: Verbal communication with an infant is not possible. Despite of that the conversation will be one-sided, the nurse should talk about and explain the routine treatment she does for the child. The infant's auditory sensitivity to pleasant sounds, and his sense of touch to tender handling should not be neglected. In other words these are some non-verbal communication approaches creating in him trust for others. To be held and to be rocked are pleasing experiences for the infant. However, around the age of eight months, when the child is developing fears towards strange people and voices he will consider all strangers as non-trustworthy until he becomes quite familiar with them.

b. Communicating with the toddler: Around the age of two the child can start communicating through speech, but at the beginning of a hospitalization experience he may not use this capacity because of shyness. It should not be forgotten that the child cooperate only when he is given simple instructions to follow. The nurse must accept him regardless of his loud, violent and negative behaviors, giving all these to his

particular age. Thoughtless and bargaining remarks as "stop crying or mommy will never come back" should never be used, especially for this age group when they are ill and separated from their parents for the first time. According to Ambler,[14] when a toddler misbehaves the nurse should remember that she cannot discipline him as his mother does at home. Nurses providing sufficant stimulation for the child will be able to lesson the need for discipline.

The effective pediatric nurse must realize that tears, aggression, complaints, withdrawal and regression are the child's ways of releasing his tension. Besides, the changes taking place in his needs as a result due to separation of illness of cause his behavior to change. Independent activities such as feeding and dressing himself and toileting may be lost. These and other behavior changes should be regarded as wide behavioral changes and need close attention and understanding form nurse.[4, 13, 14, 21, 40]

c. Communicating with the preschool child: Around the age of 4 and 5, the child cooperates more with adults and enjoys pleasing them. Since he likes being helpful at this age, nurse can make use of such attitude in the care of other patients and praise him in return. Another unique characteristic of this age group is their limited concept of time. Yesterday, today and tomorrow, would have little meaning for this child. For example a sentence such as "your mother will come this afternoon", would not mean much to him as far as time is concerned. A more effective way to inform him will be as follows: he will eat his breakfast, play a while, eat lunch with friends again, then will come the visiting hour when all parents will be at the hospital, so will his parents. If such factors are kept in mind when dealing with the preschooler, communication may become easy and fun for the adult.

d. Communication with the school-age child: At the early school ages the child shows interest in the standards set by the adults. Later on although he continues to act polite towards adults, he also shows resistance and becomes critical sensing the adult authority interfering with his wishes and plans. Because of such attitude, the school-age child can be a difficult patient for the nurse. At this age for a child usually full of energy being restricted to bed rest can also cause certain problems. Directing the child's attention and energy to various objects around him the nurse can establish an effective communication with him and carry out her tasks.

e. Communicating with the adolescent: It is important for the adolescent to realize that others at his age have problems similar to or same as his. To serve to this effect the adolescent should be placed in an environment

with his age group, where he will show a rapid adjustment to hospitalization. On the other hand, his body becomes the focus of attention for the adolescent because of the physical changes taking place. While shyness and modesty gains importance, lack of privacy within the hospital may disturb him a great deal. Because of the various bodily changes frequent mood changes makes communication with him very difficult. Therefore, on one approach will work with the adolescent as in the other age groups.[21, 41]

Thus we have concluded our short review of children's reactions to illness and hospitalization, doctors and nurses. Let us complete our words with Anna Freud's fine recommendation to all interested in the topic. Freud stresses the importance of assuring the hospitalized child that

"He is still very much loved,

He is not being punished

He is getting better."

Both nurses and mothers should put these things into words to all children, however, small and however happy they seem to be."[31]

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