5b. THE MANAGEMENT OF CHILDREN DURING ANAESTHESIA, SURGERY AND RECOVERY: TURNING THE 21 PRINCIPLES INTO PRACTICE

If a day admission is to be successfully completed within the day, everyone involved in the child's management in the theatre suite must be aware that the child is a day patient, because there are clear differences in attitudes towards, and management of, day cases. This applies to anaesthetists, surgeons, nurses, operating department assistants, porters and everyone included in the care. In particular the ability of the anaesthetists to manage the child patient satisfactorily is a major factor in ensuring a favourable outcome.

Success for this short episode, which might be less than an hour, depends on previous careful planning, discussions and in many cases problem-solving. Even in a day unit with integrated day theatre, strict protocols are necessary to achieve an apparently simple throughput of patients. In less than ideal facilities, for example when the day ward is some distance from the theatre suite or when day cases are included on a mixed list, good co-operation and advanced planning are essential.

In this Part we expand the 21 principles covering the main issues that need to be considered in a theatre suite for the effective treatment of children as day patients. Suggestions are taken from the evidence submitted to the CCHS Committee. The main period covered is the time between leaving the day ward and arriving back post-operatively. Pre-operative procedures that take place on the day ward but will affect the management of the child in the theatre suite are cross-referenced. Co-operation with day ward staff and agreement over policies is clearly essential, and this section should be seen in the context of the 12 quality standards (Part 2b) and the 42 principles for a children's day programme (Part 2c).

ENVIRONMENT

This section covers design, layout, equipment and facilities.

43. The areas of the theatre suite in which patients are conscious and can observe their surroundings should have decorations/pictures to attract and maintain a child's interest.

(i) Child day patients may arrive in the theatre suite on foot and in an alert state. There may be a delay in the reception area and children will have to be kept occupied. It is best to choose pictures or posters to suit a wide age range, even adults. Pictures that include food should be avoided! Some hospitals, in which the ward is some distance from the theatre suite, have set up children's holding rooms with toys and videos. In Nottingham the parents and children in this area are looked after by a nursery nurse.

(ii) In the anaesthetic room, ceiling paintings are successful.

44. The anaesthetic and recovery rooms should have sufficient space to allow a parent to participate while the child is conscious.

It is widely recognised that children, although smaller, need more space than adults and this should be allowed for in planning new buildings or reorganisation of internal space.

(i) In the anaesthetic room there is likely to be a parent and escorting nurse in addition to the "regular" staff.

(ii) Increasingly a parent will be present in the recovery room, too, and space for an extra stool will be needed.

45. In general hospitals with a centralised recovery room, one or more spaces should be allocated to children and be fully provided with equipment of an appropriate size for children of all ages.

Nothing further to add.

46. In the recovery room arrangements should be made to separate children from adults as far as possible.

Often one side or section of a recovery room is more suitable for children because it can be more easily separated off, to shield the child from unpleasant sights or incapacitated adults. Curtains are used in many hospitals.

STAFF

47. Surgeons undertaking paediatric day surgery should have training in and experience of children's surgery. Day surgery should be undertaken only by consultants or surgical trainees under their supervision.

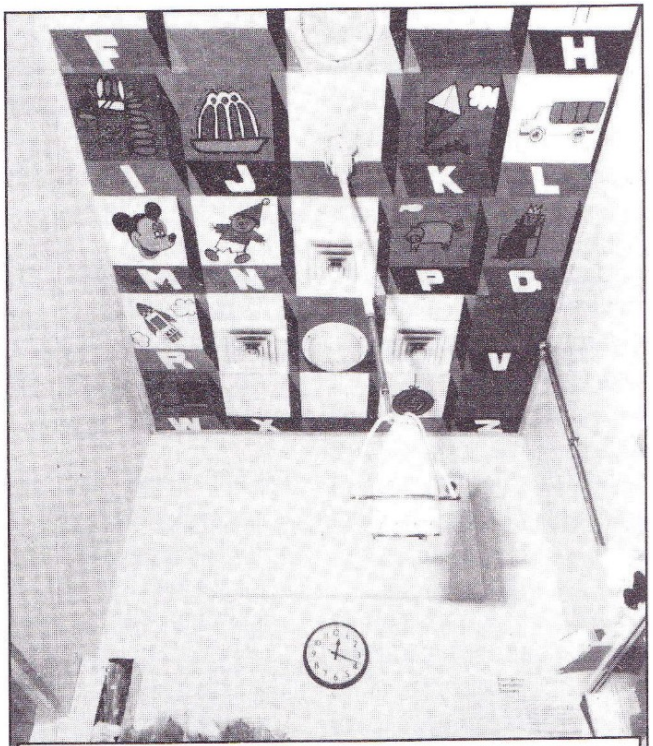
The Royal College of Surgeons of England (RCS 1985)

has emphasised that day surgery demands a high standard of expertise, higher perhaps than for a patient who will remain in hospital for some days after an operation. The NCEPOD report has raised the question of large numbers of general surgeons carrying out only occasional surgery on children (Campling et al 1990). This is not acceptable practice and one possible way forward is to appoint a general surgeon with paediatric experience and interest to deal with children's surgery, in line with current trends.

48. Anaesthetists undertaking paediatric surgery should have training in and experience of paediatric anaesthesia. Day surgery should be undertaken only by consultants or trainee anaesthetists under their supervision.

(i) NCEPOD has advised that the outcome of anaesthesia in children is related to the experience of the clinicians involved and recommended that anaesthetists should not undertake occasional paediatric practice (Campling et al 1990). The ability of the anaesthetist to manage children satisfactorily is a major factor in ensuring the success of a day programme for children. The division of anaesthesia might consider the nomination of one or two consultant anaesthetists who would develop and maintain a special interest and expertise in paediatric anaesthesia, and oversee the training and supervision of trainee anaesthetists in paediatric anaesthesia (Hatch 1984). These consultant anaesthetists would take responsibility for the paediatric anaesthesia service within the district and would normally be the anaesthetists for paediatric day surgery.

(ii) The current concern about paediatric expertise in both surgery and anaesthesia is a question not only of clinicians building up their skills, but also of the organisation of theatre operating lists, so that anaesthetists with paediatric experience are allocated to lists containing a majority of children (Hatch 1984; RCS 1985; Campling et al 1990).



Decorated ceiling of the anaesthetic room at Derbyshire Children's Hospital.
(Medical Illustration Department, Derby Hospitals.)

49. Theatre nurses and operating department assistants should be trained and experienced for both day surgery and work with children and parents.

Nurse managers have suggested that theatre nurses working with child day cases need further training in two aspects: the special needs of day admissions, including an understanding of pre-operative and post-operative care and the part that theatre staff play in the team, to ensure continuity of care; and how to work with alert children and alongside family members.

50. For the support of the parent there should be available a nurse or health care assistant accustomed to the routines of anaesthesia and recovery.

(i) In some units a nurse from the day unit is available to support the parent and remain with her until clear of the operating suite. In others, theatre escorts are used. Specific stress points that need to be covered are immediately following induction of anaesthesia and in the recovery room as the child resumes consciousness.

(ii) For other issues that need to be addressed by support staff, see Part 5a section 33(iii) and (vi).

ORGANISATION OF PATIENT CARE

This section covers interactions and communications that are not part of individual clinical care and institutional routines that are not part of treatment.

51. There should be close co-operation between the managers of the operating theatre department and the children's department to ensure that consideration is given to children's welfare in all managerial and organisational issues.

The children's department should be represented on any committees concerned with the planning, management, monitoring and audit of the operating suite.

52. Agreed guidelines should be drawn up by all interested parties to help parents who enter the theatre suite.

(i) When a parent is carrying, or accompanying, a child into the anaesthetic room it should rarely be necessary for her to change into theatre clothes. If special infection control measures are in force, a simple system should be devised to enable a parent and the day ward nurse to change quickly, so that the child is not left.

(ii) See section 57(i) for parents in the anaesthetic room. Written agreements on parents entering the anaesthetic room should be widely circulated to outpatient staff as well as staff in the day ward. Information on the following could be included on an advice sheet for parents: the infection control measures in force; an explanation that the anaesthetic room is separate from the operating theatre; the parent's role; the point at which the parent should leave and who will be there to support her.

(iii) Criteria should be agreed by professional staff to decide at which point the parent should be asked if she would like to sit by the child in the recovery room. It should be made clear that she might be asked to leave if there is an emergency in the room. There is an example of an advice sheet of this sort in appendix II.

53. When theatre lists are being prepared, the 12 quality standards for children's day admission should be kept in mind.

The CCHS Committee has received considerable information about the position of children on operating lists and it is clear that great care has to be taken in the construction of the lists. The following are some of the points raised.

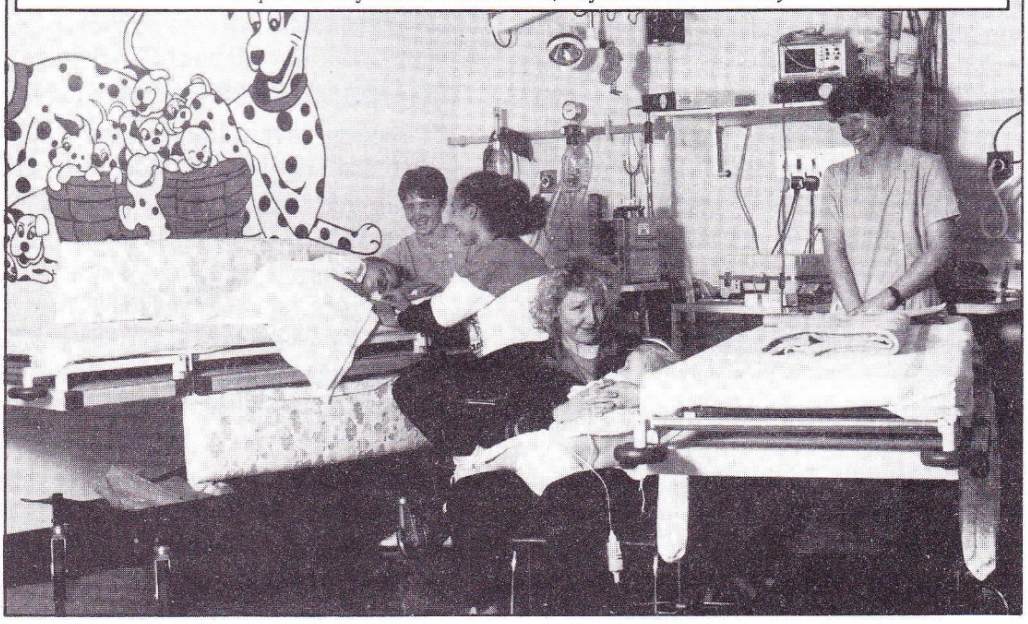
(i) The earliest and latest times for children's day operations should be agreed, within the wider opening times of the day unit. This is to allow time for preparation, which generally is longer than for adults, and for ensuring that the parent is clear on her responsibilities.

(ii) More attention needs to be paid to individual situations. A phone call in the case of a young infant on a feeding schedule would help to determine the optimum point on the list, which would reduce the risk of prolonged starvation.

(iii) In a mixed list of day and inpatient surgery it might not be appropriate to put the day cases at the end of the morning list, since any delay involving postponement could lead to considerable distress and even result in children being retained in hospital overnight (Crawford 1989). Lists composed entirely of day cases appear to cause fewer problems and allow more efficient management on the ward.

(iv) A mixed list of children and adults might be unavoidable, but care should be taken to keep adults out of the sight of children in the recovery room.

Parents in the recovery room at the Royal Manchester Children's Hospital, Salford Health Authority.
Department of Medical Illustration, Salford Health Authority



54. Clinical and managerial audit should be a regular part of the organisation and delivery of patient care for children in the theatre suite. Monitoring should also include the views of parents and older children.

(i) NCEPOD found that many surgeons were unable to discover how many children they had included in their operating lists (Campling et al 1990). The CCHS Committee feels that children should be identified separately.

(ii) The 12 quality standards (Part 2b) and the 21 principles (Part 2d) need to be audited regularly. In this way topics such as the number of day patients delayed due to a complication in previous major or intermediate surgery on the list, the proportion of parents accompanying children to the anaesthetic room, and parents supporting children in the recovery room will be regularly monitored.

(iii) There should be in-depth auditing of special items from time to time, for example the length of starvation. Our evidence suggests that children are sometimes starved for unnecessarily long periods. One study of ten children showed a range of actual fasting time from 8 hrs 10 mins to 23 hrs 55 mins (Crawford 1989). The situation seems to have improved little since 1972 when a major research project looked at the situation (Smith 1972).

DELIVERY OF PATIENT CARE

This section covers issues that are closer to the child and family during the episode of care, including some that draw attention to the need to exercise clinical judgement.

55. The anaesthetist should be responsible for the final check on the child's fitness for an operation.

See Part 5a section 35.

56. Every effort should be made to reduce the number of painful or frightening procedures while the child is conscious and to keep the admission as pleasant as possible.

(i) For venepuncture and the use of topical local anaesthetic cream, see Part 5a section 34(i).

(ii) For pre-medication see Part 5a section 36(i).

(iii) For comment on theatre gowns see Part 5a section 34(ii).

(iv) For delay in the operating list see Part 5a section 32(iv).

(v) For comments on taking an alert child to theatre see Part 5a section 34(iii).

(vi) For the need for day ward staff and parent to change into theatre clothes see section 52(i).

(vii) Children should be encouraged to bring their special toy or comforter with them into the anaesthetic room.

57. A parent should be enabled to be with the child, to help with the care whenever the child is conscious and should be given timely information and support. The final decision to allow the parent to be present in the anaesthetic room should rest with the individual anaesthetist.

(i) Our evidence suggests that the presence of parents in the anaesthetic room is now common practice and it usually provides support and reassurance for the child and a sense of participation for the parent. Parents need to be given information to enable them to make an informed choice about going into the anaesthetic room. The parent should have had the opportunity to discuss it with the anaesthetist, be well prepared and have received written information (section 52(ii) and Part 5a section 25(i)). Those parents who do not wish to accompany their child to the anaesthetic room should not be pressurised to do so and made to feel guilty about this decision.

(ii) For additional staff to support the parent see section 50.

(iii) Full information about the outcome of the procedure should be relayed to the parents at the earliest opportunity. See parent's comment in Part 5a section 33(iv).

(iv) For parents in the recovery room see section 52(iii).

58. During the induction of anaesthesia safety issues must remain paramount and if a parent is present she should have been prepared for her role by the anaesthetist and/or day ward staff.

(i) For preparation of parent see sections 52(ii) and 57(i).

(ii) For support of the parent see section 50.

59. Anaesthetic and analgesic techniques appropriate to day patients should be used. Adequate post-operative pain relief should be ensured.

(i) Regional and local anaesthesia techniques and wound irrigation with local anaesthetic drugs are commonly used methods which can produce long-acting, effective post-operative analgesia with minimal side effects.

(ii) Post-operative analgesic drugs should be prescribed before the child leaves the recovery room.

(iii) For oral analgesia after discharge see Part 5a section 38(ii).

60. Consideration should be given by the surgeon to the use of appropriate means of simplifying post-operative care and ensuring the comfort of the patient.

To simplify post-operative care the surgeon should consider the following means: subcuticular and absorbable sutures; irrigation of the wound with local anaesthetic; transparent and easily removable dressings.

61. For children there should be a one to one ratio of nurse to patient in the recovery area.

For additional staff to support parents see section 50.

62. The anaesthetist should see all children during the recovery period, either in the central recovery area or day unit and should have agreed the criteria and delegation for discharge from the day unit to home.

Nothing further to add.

63. The surgeon or a member of his team should see all children following day surgery before discharge from the day unit.

Nothing further to add.

5c. SOME COMMENTS ON SPECIAL UNITS OR SITUATIONS

Evidence to the CCHS Committee has indicated that certain categories of children require special attention. Some of this evidence is summarised in this chapter.

SPECIAL NEEDS OF CHILDREN WITH A DISABILITY OR A HANDICAP

The needs of children with a handicap should be met through mainstream services. A good quality service, integrated with primary and community services and based on individual nursing care plans, will provide the care needed.

With all children the role of the parent is crucial, but children and young people with a handicapping condition are likely to have a strong reliance on the parent. Sensory handicaps, such as hearing and sight impairment, make quick communication with strangers difficult. Care of specific aids, such as hearing aids, spectacles and calipers must be handled by someone who understands the child. The aids must be available until the last moment before the anaesthetic is induced and then returned immediately the child regains consciousness.

Preparation for the admission procedure and discharge will be of great significance for families in this category. If parents are to fulfil a supportive role, then adequate discussion and also good written communication is essential. A contact person with a telephone number is helpful so that parents can discuss problem areas, both before and after the admission.

Sensitive handling by all staff is necessary and the expertise of the parent valued, so that the parent can be confident and supportive of their child and work in partnership with the staff.

TERTIARY REFERRAL CENTRES

In tertiary referral centres, the pattern which appears to be emerging is of day admissions on, or attached to, specialist wards. This is particularly the case with nephrology and oncology but is also true in some centres providing specialist respiratory, gastro-enterology or endocrinology services. In surgery too, occasional day visits or a series of day admissions may be required. For example in orthopaedic surgery, a family might have to bring a child back to a tertiary centre for follow-up care after a major operation.

The advantage of using the inpatient ward is that the child meets familiar staff at each visit, whether as a day patient or as an inpatient, and that the staff have the necessary expertise and experience with the child's particular problem. This seems to work well, although occasionally the space appears inadequate and the ambulatory patients can dominate the ward. Some centres have set up day rooms attached to the ward. Others use the children's day unit for treatment of specialist as well as general paediatric conditions, and the specialist staff come to the day unit for the session.

The patterns of day treatment are that are developing in specialist centres are usually very individual. The CCHS Committee feels that they form an acceptable provision as long as they conform to the quality standards (Part 2b). In this way each child will be treated first and foremost as a child and an appropriate environment and staffing will be provided.

When specialised tests or procedures have to be undertaken at tertiary referral centres, the distance might make day case admissions unreasonable. One way forward is the provision of low-cost family accommodation near the hospital. The CLIC (Cancer and Leukaemia in Childhood Trust) houses in Bristol are of this type, providing home-from-home facilities for both the child and accompanying family. They allow a child to be managed on a day basis while far from home, even for a course of treatment involving admission on several successive days. Accommodation previously provided for the use of parents of inpatients may in future be used by children having treatment, as well as their families.

CHILD DEVELOPMENT CENTRES

Children with possible developmental problems usually undergo a comprehensive assessment in a child development centre on a planned basis. Such assessments may last from one day to a week or even longer in difficult cases but do not usually involve overnight stay. The resources of a special nursery or a specially designed area in an outpatient department will sometimes be used. On the whole this type of assessment does not fit well into a children's general day unit.

INVESTIGATIONS IN THE RADIOLOGY DEPARTMENT

An increasing number of day admissions for children involve the main procedure taking place in the radiology department. Many more children than adults are anaesthetised or sedated for these

procedures, since the test itself may cause considerable discomfort or require co-operation from the patient, for example in passing tubes or keeping still for prolonged periods. Others require pre-admission fasting or special diets. Except in children's hospitals or the rare district general hospital with paediatric radiology departments, these children should be admitted to the children's day ward, which will serve as a base for the day. They are thus included in the main body of this report and policies and protocols for their care should be based on the 12 quality standards and the principles recommended in Part 2. The CCHS Committee has received evidence from parents that insufficient thought has been given to preparation, support during the day and help in moving around confusing hospital sites.

THE PREGNANT SCHOOL CHILD

In 1986, in England and Wales, there were 4972 legal abortions for girls who were under the age of 16 at the time of conception.

Planned day admission occurred in 29% of those having their pregnancies terminated. The National Health Service provided 58% of the legal abortions performed for these girls, the remainder occurring in the non-NHS clinics.

Pregnant girls who are 14 or 15 years old are usually managed in the same gynaecological and obstetrical facilities as older women but, when the pregnancy is to be terminated, it is usual to accommodate them in a single room if this is available. Day admission is preferred for girls having abortion before the 13th week of pregnancy, providing they are collected from the unit by a responsible adult who will look after them closely for at least the next 24 hours.

Girls of 11, 12 and 13 years old are usually appreciably less mature than those of 14 and 15 years old and are best admitted to a suitable children's unit when termination of pregnancy is necessary. Ideally such a unit should have space reserved for adolescents. Unfortunately, there is not always a suitable children's unit on the same site as the gynaecological theatre and very young girls sometimes have to be admitted to the adult gynaecological ward.

Arrangements for dealing with pregnant girls under 16 years old vary from district to district. The case load experienced by each obstetrician/gynaecologist is low and few perform more than 3 abortions a year in this age group. Each consultant has to liaise with the social workers to provide a caring and efficient service within the resources available. Initial counselling involves helping the girl to come to a decision about her pregnancy. This is followed by ensuring that she understands how the pregnancy occurred, the future of the relationship that gave rise to the pregnancy and whether there is a need for contraception. Such counselling is started before the abortion or the birth of the baby but must be continued afterwards. The initial counsellor is often the social worker but arrangements for counselling vary and a wide variety of health professionals may be involved.

CHILD AND ADOLESCENT PSYCHIATRY

Both children and adolescents sometimes require diagnostic assessment and treatment at a far more intensive level than can be offered in the outpatient department and for these cases day admission should be considered. Given the need to see the child in a family context, the usefulness of day patient management is obvious and many districts have had day patient facilities for many decades. One of the problems in the past has been that this important work was not acknowledged in rigid indicators of clinical activity which were preoccupied with bed occupancy. Now many child and adolescent psychiatrists see a real need for an expansion in day centre services. Many more centres are actively developing day programmes and currently establishing operational policies.

The issues in child psychiatry are quite different from those in mainstream paediatric care. Children attend for fairly long periods on a regular basis. They almost invariably have a key worker and a team approach is used in their assessment and treatment. Care of parents and siblings has also to be considered. The major difference is that the care itself is part of the treatment, so very high levels of skill are needed by nursing, teaching and therapy staff.

One group of children in particular was brought to the attention of the CCHS Committee. These are children and adolescents who deliberately harm themselves or attempt suicide. As emergencies they cannot be formal day cases under the Korner definition. However they are commonly discharged later the same day or after a few hours' observation. There appears to be some conflict over where they are best nursed, and many paediatric nurses feel that their training does not equip them to deal well with such children on the children's wards. Further training can be obtained by means of the English National Board course ENB 603 in child and adolescent psychiatry.

There is also concern about the lack of follow-up care. Such children and adolescents should be assessed

before discharge by child psychiatrists. Many will then be followed up as outpatients, although a minority will need more intensive inpatient or day patient care in a psychiatric unit.

The evidence received by the CCHS Committee has raised the following non-clinical issues which managers should address. A nationwide consensus and standards would also be valuable.

- Does the child count as the only patient if you are working with the whole family? Most child psychiatric units are part of district general hospital management, but is the hospital site the best location or is a small separate site preferable?

- Considerable resources are required for the patients, parents and siblings. At the moment these are often inadequate and there is no agreement on who should provide them.

- Transport is a huge problem. Many patients come from the poorer section of our population. Disorganised families with small children find public transport difficult and long distances may be involved as units are widely spread. The NHS is reluctant to provide ambulances on a regular basis and Education and Social Services are rarely able to help.

- Communication is extremely important, often involving a need for close ties between Departments of Health, Social Services and Education.

- Administrative and secretarial support is essential because of the need for communication with so many outside professionals, which is time-consuming and difficult.

- Finally, it should be noted that disturbed children may be found in residential and day provision offered by the Departments of Education and Social Services. These facilities are not a substitute for day patient and inpatient facilities run by the health authorities. They have a quite different purpose. However, child psychiatrists will be heavily involved in giving advice and consultation to other health workers, and to schools and social services agencies (NHS Health Advisory Service 1986).

SHORT ACUTE EMERGENCY ADMISSIONS

Children's departments receive large numbers of very short admissions of acute cases, who are often admitted and discharged within 24 hours. They are not planned and thus have not been included in this report.

They are of three types: children needing treatment and observation, for example for acute exacerbation of asthma, ingestion of potentially harmful substances and head injury; those who need observation and reassurance for feeding problems or behaviour problems, especially when the parents are acutely distressed; and children arriving under an open door policy for chronic disorders, such as asthma, diabetes, cystic fibrosis or haemophilia.

These children pose particular problems as they are not only unplanned, except perhaps for a telephone call, but also unpredictable in number and length of stay. They are often nursed on the children's ward, but we have also received evidence of their successful admission to children's day case units and separate children's observation wards. Further study of these admissions would be valuable.

Finally we would like to remind those planning and delivering day services for children and young people that, wherever they are located and however special the circumstances, the 12 standards recommended in Part 2b should always be the basis for care.

Part 6
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Appendix I

ASA grades

AMERICAN SOCIETY OF ANESTHESIOLOGY CLASSIFICATION OF PHYSICAL STATUS

Class 1

The patient has no organic, physiological, biochemical or psychiatric disturbance. The pathological process for which operation is to be performed is localised and does not entail a systemic disturbance.

Class 2

Mild to moderate systemic disturbance caused by either the condition to be treated surgically or by other pathophysiological processes.

Class 3

Severe disturbance or disease from whatever cause, even though it may not be possible to define the degree of disability with finality.

Class 4

Severe systemic disorders that are already life threatening, not always correctable by operation.

Class 5

The moribund patient who has little chance of survival but is submitted to operation in desperation.

(From Buck N, Devlin H B and Lunn J N, (1987). *Report of the Confidential Enquiry into Perioperative Deaths.* Nuffield Provincial Hospitals Trust and the King Edward's Hospital Fund for London.)

Appendix II

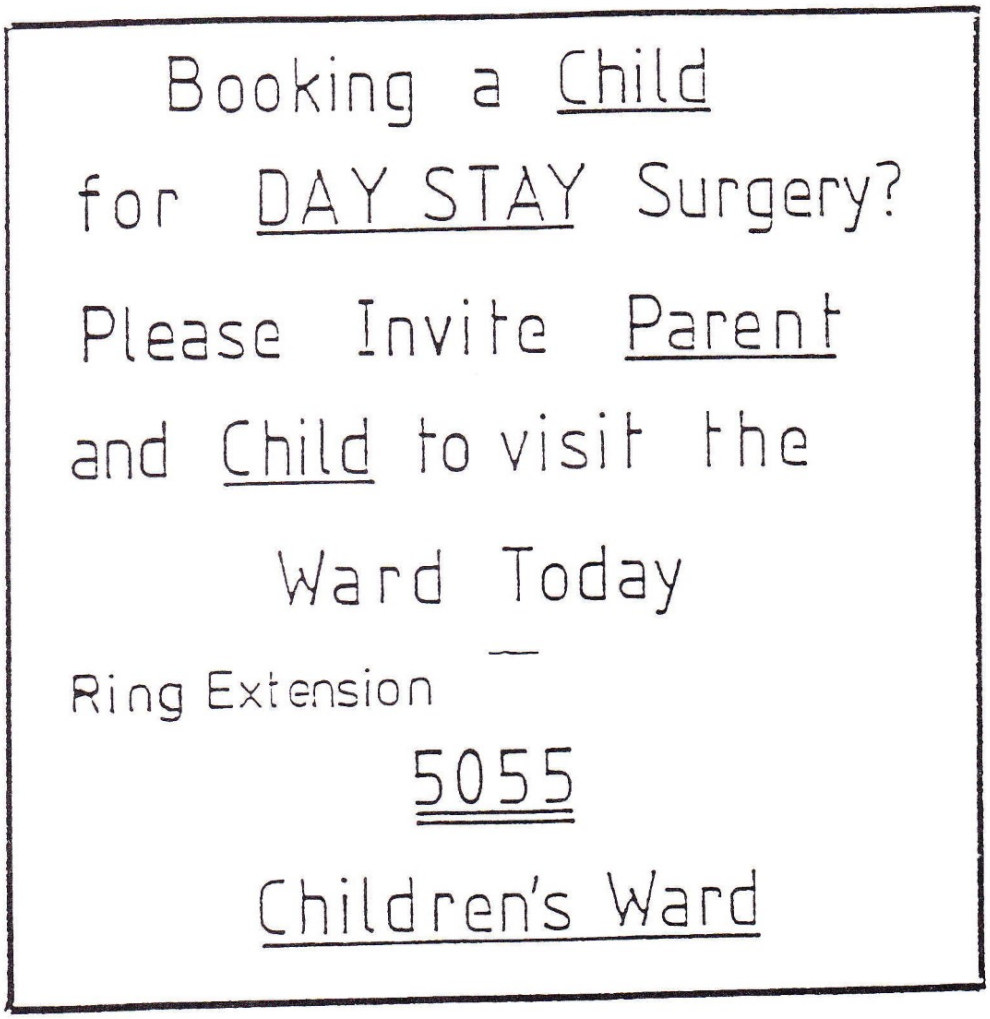
Examples of leaflets and forms

On the following pages interesting leaflets are reproduced as examples of the types of special documentation that hospitals are developing for day case admissions. Their inclusion does not mean that the CCHS Committee necessarily endorses the total contents.

1. Card displayed in outpatient department consulting rooms.
2. Invitation to a pre-admission preparation session.
3. Appointment letter for children's day care ward.
4. A special booklet for children's day surgery.
5. Shared medical and nursing day case sheet.
6. Guidelines for parents visiting the recovery room.
7. Parent's information sheet to prepare for a test in the X-Ray department.
8. A post-dischage information sheet for parents.
9. A parent-held letter for the district nurse.

1. CARD DISPLAYED IN OUTPATIENT CONSULTING ROOMS

From the Children's Ward, Nevill Hall Hospital, Gwent Health Authority



2. INVITATION TO A PRE-ADMISSION PREPARATION SESSION

From the Children's Unit, Ninewells Hospital and Medical School, Tayside Health Board, Dundee

TAYSIDE HEALTH BOARD

DUNDEE GENERAL HOSPITALS UNIT

Your Ref.

Our Ref.

Enquiries to:–

Ninewells Hospital and Medical School
Ninewells Dundee DD1 9SY
Telephone 0382 60111

Dear

As you are coming to stay with us soon, we would like you to come and visit us so we can tell you about the Ward. Please bring your mummy and daddy and brothers and sisters.

Come to Ward 30 Ninewells Hospital on .....

.....19....

PROGRAMME:

10.00 a.m.	INTRODUCTION
10.05 a.m.	WHAT THE WARD ROUTINE WILL BE
10.30 a.m.	"HOSPITAL PLAY" CHILDREN WITH PLAY LEADER (if they want to)
	PARENTS WITH NURSE
	This is a time for you to ask any questions that may be worrying you about coming in to hospital, or the operation.

WE HOPE YOU ENJOY YOUR VISIT

Ninewells Hospital and Medical School

3. APPOINTMENT LETTER FOR CHILDREN'S DAY CARE WARD

From the Day Care Ward, Children's Hospital, Sheffield

THE CHILDREN'S HOSPITAL, SHEFFIELD
DAY CARE WARD

Telephone 761111 ext. 3209

Dear .....

Please bring ..... to be admitted to the hospital as a day patient on

Day .....

Date .....

Time .....

If ..... has a cough, cold or any other illness, it is important to inform the ward immediately.

It is essential that a PARENT accompanies the child in order to sign the consent form. Parents are invited to stay all day.

It would be helpful if you could see that your child has a bath on the evening before admission, and that finger and toe nails are short and clean.

Your child is going to have an anaesthetic and it is essential that you do not allow

..... anything to eat or drink after .....

The bus or train is not a suitable form of transport to take your child home. If you are unable to arrange private transport, please discuss with the Ward Sister before the day of admission.

A visit from District Nurse will be arranged for the following day.

Yours sincerely

FEBRUARY 1990
DS/BAO
CH560

4. A SPECIAL BOOKLET FOR CHILDREN'S DAY SURGERY

From the Children's Unit, Southampton General Hospital

Dear Parent,
As you will be aware

is on the waiting list to be admitted to the Paediatric Day Ward. We hope that your stay on the ward will be as pleasant as possible and you will find the admission organised with this aim very much in mind. There will, however, be questions that you and possibly your child, will have about this admission and we hope this booklet will answer these.

The Paediatric Unit Office will shortly be contacting you about the date and time of admission, giving you about three weeks' notice. Full instructions regarding any particular preparation that may be required will be included. If your child should be unwell on the day of admission please let the office know in case the admission needs to be cancelled.

Tel: Southampton 0703 • 777222
Ext. 3054

Page 1

Page 2

The doctors, nurses and all the clerical staff are as informal as possible whilst taking particular care of children undergoing surgery.

Children are not expected to go to bed until after their operation and are encouraged to play on the ward with their parents' supervision. We have toys to cover all ages from one week to sixteen years of age. We also have a selection of books for all ages.

It would be helpful if you could arrange your own transport to and from the hospital which could save you time and avoid delays on discharge. You should not use public transport after your child has had an anaesthetic. A hospital car can be arranged in special circumstances but not for a specific time and for one adult and one child only.

There are public telephones in the reception area of the Paediatric Unit, G level, East Wing, which would enable you to phone home. If the family wish to contact you please ring Paediatric Day Ward on Ext. 4328.

It is important that children are prepared for a visit to the Day Ward for an operation. We suggest that you talk to your child to explain the reasons for coming and what will happen. Explain simply that he or she will have a special sleep and on waking the operation site may be sore but it will be getting better all the time. Please tell your child that you will be there all the time except during the sleep and that you will both be coming home on the same day. The information in this booklet will help you explain to your child what will happen.

If you have other children please arrange for them to be looked after for the day, including any who may be returning from school. If you have a young baby you may bring the baby with you (and feeds). We have a pram which can be used for the day.

ABOUT THE CHILDREN'S DAY WARD

PREPARATION

Continued

A SPECIAL BOOKLET FOR CHILDREN'S DAY SURGERY

From the Children's Unit, Southampton General Hospital

WHAT TO BRING WITH YOU

HOW TO GET TO THE DAY WARD

- Your Out-Patient appointment card (if you attend Southampton General Hospital) so that a follow-up appointment can be made before you leave. Children who attend Regional hospitals will be given a date for a follow-up appointment at their local hospital.
- A nightdress or pyjamas for your child to wear on the journey home.
- Your child's favourite toy or cuddly.
- An empty teacher beaker if appropriate, or milk feed if bottle fed.

You might like to bring a packed lunch for yourself (which may be consumed in the waiting area adjacent to the Day Ward) as refreshment facilities are situated some distance from the ward. Whilst your child is in theatre, tea and coffee can be bought at the Tea Bar on C Level, the League of Friends on D Level West Wing or at the beverage machine on G Level, East Wing.

The Children's Day Ward is situated on the Paediatric Unit, G Level, Centre Block at SOUTHAMPTON GENERAL HOSPITAL, Tremona Road, Shirley, a suburb to the north-west of Southampton. On arrival, the main car park immediately on your left, has two levels for public use.

On entering the hospital by the main entrance, go through the foyer, turn left along the corridor to East Wing Lifts. On reaching Level G, turn left on leaving the lift, go through two sets of double doors into Children's Day Ward. There are direction signs hanging from the ceiling as you step out of the lift.

ON YOUR ARRIVAL

We have six cots/beds for day surgery. The nursing staff or ward clerk will greet you and your child and will show you to a cot or bed as appropriate. All under-five year olds are given a cot for safety. A few facts regarding name, address, date of birth etc. will be checked against your child's notes; then you will be asked to undress your child down to pants/napkin and socks. Your child will be given a gown with tie-up tapes at the back. We then ask you to put your child on the scales to be weighed. A nurse will take the temperature, pulse and respiration rate whilst your child sits on your lap if young enough. Patients attending for dental treatment will be seen by the dentist who will check with you the treatment proposed.

A Doctor will be on the Ward from 8.30-9.00 a.m. and 12.30-1.00 p.m. to ensure that your child is fit for anaesthesia. Sometimes the examining doctor or anaesthetist decides that the child is not fit for anaesthetic because he has a cold or sore throat, in which event the child is discharged, to be admitted another day. It is important that you arrive on time and that you stay with your child throughout the time of admission apart from the actual operation.

The children are then encouraged to play until it is their turn to go to theatre on a trolley. Your child may be carried if preferred.

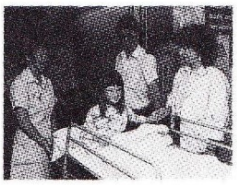
Continued

A SPECIAL BOOKLET FOR CHILDREN'S DAY SURGERY

From the Children's Unit, Southampton General Hospital

PREMEDICATION

RETURNING FROM THEATRE



Children old enough to co-operate will have an anaesthetic cream put on to the back of one hand (magic cream) covered by a transparent dressing to be left in place until the anaethetist takes it off in the anaesthetic room. This is to numb the vein which receives the anaesthetic injection. Some patients do not receive premedication. For those who do, a nurse will give an injection, as prescribed, into the top part of your child's leg. It does sting, but soon stops hurting and the child will be able to play again afterwards. The chief effect of the injection is to make the mouth dry, it does not cause sleepiness.

Depending on the approval of the anaesthetist, you may be able to go to the anaesthetic room with your child until he or she is asleep. This would require you to put on a coverall and overshoes.

Your child will be away from the ward for approximately three-quarters to one hour. We encourage parents to leave the ward for tea or coffee and have a break during this time.

Your child will have been woken in the Recovery Room downstairs before returning to the ward, but may be sleeping on arrival back in the ward, in which case we encourage you to let him or her wake up naturally. Many of the younger patients return to the ward awake, we would like you to encourage your child to rest, perhaps by reading to him/her. On return to the ward, small babies are given a glucose feed if not breast fed, followed by a half-strength feed later. Toddlers and older children are given a drink of water about half to one hour after return to the ward. We do not give anything to eat but we will advise you about feeding your child at home. This prevents the possibility of your child being sick on the way home. All children are expected to stay on their beds/cots or sit on parent's lap after the operation. You will be advised to put your child to bed on returning home.

Page 5

Page 6

DISCHARGE

Your child will be discharged between one and three hours after returning from the operating theatre, depending upon the type of operation. Children arriving in the morning are usually ready to go home by 3 p.m. and those arriving at 12.30 p.m. go home with parents by 7 p.m. depending on the position on the operating list. It will not always be possible for you to be seen by the surgeon after the operation as he will be operating on other patients at the time of your child's discharge. However, full information about the operation and any post-operative requirements will be given to you by the nursing staff and a doctor.

An advice sheet as well as an out-patients appointment will be given to you, either in Southampton or at your local hospital.

Arrangements will be made for a community nurse to visit you at home if your child has had a surgical operation. Children having dental treatment do not have a visit from the community nurse but you will be given a telephone number at the hospital in case of emergency.

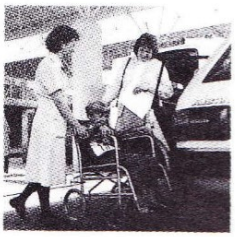
Children, once they are well enough to go home, are taken to your car by wheelchair or may be carried by a parent.

The sequence of care and timing may be affected by other activities within the Unit but we will keep you informed of any changes as soon as they are known to the Paediatric Day Ward staff.

We hope this information helps you to prepare your child for the visit to the Paediatric Day Ward. We look forward to meeting you and your child on the day of admission and will try and answer any queries you may have at that time.

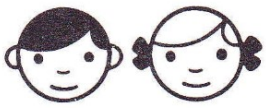
If you have any questions which you feel you would like to ask before admission, please do not hesitate to contact us on

Southampton 0703 • 777222 Ext. 4328.



5. SHARED MEDICAL AND NURSING DAY CASE SHEET

From the Children's Unit, Nottingham



DAY CASE SHEET

GUIDELINES

INTRODUCTION

This sheet is designed for use by all disciplines (including medical staff) for children admitted as day cases.

All the information may then be shared by the Health Care Team.

This document will replace the Nursing Process Documentation used for children admitted as day cases from admission to discharge.

NURSING COMMUNICATION/EVALUATION

This sheet may be used for all communication throughout the day of admission, using wherever possible, a problem solving approach. (The same as the Nursing Process documentation).

Procedures and investigations may be recorded under the action/intervention.

This form is flexible in it's use, and may be adapted to suit the needs of the child and primary nurse.

See following page

5. Continued

SHARED MEDICAL AND NURSING DAY CASE SHEET

Front of sheet

NOTTINGHAM HEALTH AUTHORITY

SHARED MEDICAL AND NURSING DAY CASE SHEET

DATE.....

I.D.LABEL		REASON FOR ADMISSION	
		ALLERGIES	
		CURRENT MEDICATION	
		G.P.	
NEXT OF KIN:	RELIGION:	PRIMARY NURSE	
TEL.NO.		CONSULTANT	
TEMPERATURE:	PULSE:	B/P:	RESPIRATIONS:
WEIGHT:	HEIGHT:	URINALYSIS:	

MEDICAL ASSESSMENT

Signature.....

5. Continued

SHARED MEDICAL AND NURSING DAY CASE SHEET

Back of sheet

NURSING COMMUNICATION/EVALUATION

PROBLEM	ACTION/INTERVENTION	COMMENT
		Signature..... Signature.....

TRANSFER TO HOME

Appointment Date:

Drugs to take home:

REFERRALS

Social Worker:

Dietitian:

Paediatric District Nurse:

Signature.....

6. GUIDELINES FOR PARENTS VISITING THE RECOVERY ROOM

From the Royal Manchester Children's Hospital

NURSING PRACTICE

GUIDELINES FOR PARENTS VISITING THE RECOVERY ROOM

Here at the Royal Manchester Children's Hospital it is our policy to invite parents to visit their children in the recovery room soon after surgery. We hope that the following information will give you some understanding of the recovery room routine and be of assistance, should you wish to visit your child there.

The recovery room is a five bedded area within the theatre suite. All patients who have undergone surgery or procedures in the X-ray Department, requiring a general anaesthetic, remain there for a minimum period of thirty minutes whilst they recover from the anaesthetic. Sometimes, following major surgery, it may be necessary for a child to stay in the recovery room for several hours before returning to the ward.

Please return to the ward after leaving your child in the anaesthetic room as it is important that we know where to contact you if you wish to visit your child in the recovery room. If you intend to visit any other part of the hospital, please ensure that you inform the nurse allocated to the care of your child. Please do not wait on the main corridor outside the theatres as it is not always possible to contact you there.

You are invited to the recovery room to comfort your child in the period soon after surgery. The nurse will make an evaluation of each patient and decide when the parent may be allowed to come to the unit. Several factors are taken into consideration. Some children take longer than others to wake up. You will not be called to the recovery room until your child has begun to wake up.

Whilst in the recovery room we request that you remain by your child's bedside. Please do not wander round the room. Chairs are provided and the bays are curtained to allow some privacy. The nurse will routinely record your child's pulse, respirations and blood pressure at frequent intervals. She will be happy to answer any questions you may have about your child and explain the purpose of any equipment that is in use. If necessary, she will call the surgeon to speak to you.

Do not be alarmed if you are not called immediately to the recovery room. The unit may be busy, making it impossible to have parents in the area. Unfortunately, lack of space in the unit means that we have to limit the number of visitors and on most occasions one parent only will be allowed to visit. Other children are NOT allowed to visit in the recovery room. Please do not come to the recovery room until you have been called by a member of the nursing staff.

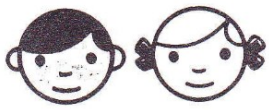
Some parents may find the experience distressing. It is not always necessary for you to stay with your child. If you feel at all uncomfortable please feel at liberty to leave the room. You may come back later if you wish, but please ring the bell outside the theatre suite, and wait to be escorted into the recovery room.

At any time, during your visit, it may be necessary to ask you to leave. You will be given a reason for this at the time. Please respect the decision of the recovery room staff.

Guidelines written by **Ann Day**
Sister (Recovery Room)
R.M.C.H.
Revised October '90

7. PARENT'S INFORMATION SHEET TO PREPARE FOR A TEST IN THE X-RAY DEPARTMENT

From the Children's Unit, Nottingham



MICTURATING CYSTOURETHROGRAM (MCU)

This is a special test that outlines the bladder, the tubes leading back to the kidneys (ureters) and the tube to the outside (urethra).

On arrival on the ward your child will be weighed, measured and we will check his temperature, pulse and blood pressure. We will then collect a sample of urine into a sterile container.

If blood tests are required we will apply some "magic cream" to your child's arm or back of hand to numb the area before the doctor inserts a small needle to obtain blood samples. The needle may be taped in place and left there until later.

If your child is young and/or anxious then medicine will be given to help relax him.

If your child is NOT on antibiotics please inform the nurse or doctor as this test is usually covered with antibiotics before and after for 48 hours.

For this test your child's clothes from the waist down are removed or he/she could wear a gown.

Babies are offered honey to passify them, as this test may upset them (let us know if you do not want honey offered).

A nurse and one parent can accompany your child down to x-ray where the nurse checks in at Reception and then takes you to the waiting area of rooms 1-5. There is usually a short wait before the nurse and parent put on a heavy lead apron and then enter the x-ray room.

The child is required to lie on the table under the x-ray camera. The doctor there will clean between your child's legs then drape the area with some sterile towels before inserting a fine catheter/tube into the urethra (the tube leading from the outside to the bladder).

The doctor will be watching this on a TV and take x-ray pictures with your child in different positions. Your child will pass this fluid out again while the doctor is taking x-rays.

You will be able to see this yourself on the TV screen.

The catheter is removed and after drying your child and re-dressing you can return to the ward.

If your child is still sleepy from the relaxing medicine he will need to stay until fully awake.

You should note that antibiotics are usually prescribed for this test if your child is not already on them. Please check this point with the doctor or nurse.

8. A POST-DISCHARGE INFORMATION SHEET FOR PARENTS

From the Children's Unit, Nottingham

INFORMATION FOR PARENTS

Your son has had a circumcision performed.

There are a few stitches but these will dissolve by themselves.

You can expect some swelling of the area during the first few days, which will be helped by giving 2-3 baths with salt added per day. If there is any bleeding or persistent swelling, do not hesitate to ring the ward (E 40) on Nottingham (0602) 421421 extension 3547.

There may be some discomfort for the first few days which can be helped by giving Paracetamol/Calpol and wearing loose cotton clothing.

Your child can eat and drink normally the day following the operation.

Your child may benefit from extra rest for the first few days and can return to school when he feels comfortable and is walking normally. As a rough guide this will be about a week.

He should not take part in any school games or ride a bike until seen in clinic, which will be approximately 6 weeks following the operation.

If you have any queries do not hesitate to ring the ward on Nottingham (0602) 421421 extension 43618.

9. A PARENT-HELD LETTER FOR THE DISTRICT NURSE

From the Children's Unit, Southampton General Hospital

SOUTHAMPTON GENERAL HOSPITAL
PAEDIATRIC DAY UNIT, LEVEL G, CENTRE BLOCK
TREMONA ROAD, SOUTHAMPTON SO9 4XY
TELEPHONE: (0703)796157 8 am - 7 pm
or 796486 7 pm - 8 am

SOUTHAMPTON & SOUTH WEST HAMPSHIRE
·HEALTH AUTHORITY·

PLEASE SHOW THIS TO THE DISTRICT NURSE

ADDRESSOGRAPH OR:

NAME: _____

ADDRESS: _____

_____

D.O.B. _____ HOSPITAL NO: _____

G.P.: _____

HOME TEL. NO. _____

CONSULTANT(S): _____

HEALTH VISITOR: _____

DISTRICT NURSE: _____

DATE OF ADMISSION AND DISCHARGE:

_____

DISCHARGE ADDRESS & TELEPHONE NO.(If different)

_____

_____

G.P.'S NAME AND ADDRESS (If different)

_____

_____

DIAGNOSIS _____

TREATMENT/MANAGEMENT (including medication)

If your child has had an operation and general anaesthetic he/she may feel unwell for several hours, so, on arrival at home please put him/her to bed.
Some children may require something for the pain he/she may have: Paracetamol syrup or tablets may be given. DO NOT exceed dose stated on the bottle.
If you are worried for the first 24 hours please contact the hospital.

FEEDS/DIET (he/she may have a light diet only or drink as preferred)

WOUND CARE
SUTURES TO BE REMOVED ON (DATE) _____
OP SITE TO BE REMOVED ON _____
DRESSING(S) TO BE REMOVED ON _____

Tick as appropriate

Care Of Plaster Card ☐

OUTPATIENT APPOINTMENT

Given ☐
To Be Sent ☐
Not Required ☐
TTO's Arranged ☐
N/A ☐

Ward Staff To Notify As Appropriate:	Direct Phone Contact	Message Left	Internal Liaison System
Health Visitor			
Paediatric Community Nurse			
District Nurse			

AFTER COMPLETION, THIS FORM IS TO BE GIVEN TO THE PARENT(S) ON THEIR CHILD'S DISCHARGE HOME.
SIGNED BY: _____ Primary Nurse/Sister/Staff Nurse/Enrolled Nurse

Appendix III

Evidence to the committee

ORGANISATIONS, INDIVIDUALS AND INDIVIDUAL HOSPITALS

In this list, hospitals are entered separately if their submission appeared to be independent of the health authority. Parents are not named individually because many offered critical comments on the understanding that anonymity would be maintained.

Addenbrookes Day Surgical Unit, Cambridge
Agnes Sophia Children's Hospital, Athens, Greece
Aid for Children with Tracheostomies
All Wales Chief Administrative Nursing Officers' Primary Health Care and Services for Children Group
AMI Portland Hospital for Women and Children, London
Association des Infirmieres Graduees de Pediatre, Brussels, Belgium
Association for the Welfare of Children in Hospital (Wales)
Association of Anaesthetists of Great Britain and Ireland
Association of British Paediatric Nurses
Association of Community Health Councils for England and Wales
Association of Health Care Information and Medical Records Officers
Association of Paediatric Anaesthetists
Asthma Society and Friends of the Asthma Research Council
Audit Commission
Australian Council on Healthcare Standards

Baum, Professor D
Booth Hall Children's Hospital, Manchester
Bristol Royal Hospital for Sick Children
British Association of Day Surgery
British Association of Operating Department Assistants
British Association of Otolaryngologists
British Association of Paediatric Surgeons
British Association of Urological Surgeons
British Medical Association
British Orthopaedic Association
British Paediatric Association
British Paediatric Nutrition and Pharmacology Group
British Paediatric Respiratory Group
British Paedodontic Society
British Society for Children's Orthopaedic Surgery
British Society of Paediatric Endocrinology
British Society of Paediatric Gastroenterology
British Telecom
BUPA

Carruth, Mr J A S
Casualty Surgeons' Association
Children's Hospital, Birmingham
Children's Hospital, Sydenham
Clayden, Dr G
CLIC (Cancer and Leukaemia in Childhood Trust), Bristol
College of Anaesthetists
College of Health
College of Occupational Therapists
College of Ophthalmologists
Community Paediatric Group
Confederation of European Specialists in Paediatrics
Crawford, Miss J
Cystic Fibrosis Research Trust

Dosseter, Dr J F B
Duchess of York Children's Hospital, Manchester

English National Board for Nursing, Midwifery and Health Visiting

Glasgow, Dr J
Graham, Professor P J
Groggins, Dr R C

Hardy, Dr J D
Hayhurst, Dr G K
Health Visitors' Association
Horton Day Care Unit, Banbury

Immunology and Infectious Diseases Group
Independent Hospitals Association including Nuffield Hospitals
Ipswich Hospital

Keenan, Dr P
King's Fund Centre, Quality Assurance Programme
Kingston Surgical Day and Sainsbury Unit

Landelijke Vereniging Kind en Ziekenhuis, The Netherlands

Malcolm Sargent Cancer Fund for Children
Mencap (Royal Society for Mentally Handicapped Children)
Molyneux, Dr E
Musgrove Park Hospital, Taunton
Myers, Mrs R, President, Society of Family Practitioners' Committees

National Association for the Welfare of Children in Hospital
National Association for the Welfare of Children in Hospital (Scotland)
National Association of Health Authorities and Trusts
National Association of Hospital Play Staff
National Association of Theatre Nurses
National Children's Bureau
National Confidential Enquiry into Perioperative Deaths
National Deaf Children's Society
NHS Information Management Centre
NHS Management Executive, Value for Money Unit
Nicol, Professor A R

Owen, Dr J R

Paediatric Radiographers' Group
Patients' Association

Queen Alexandra Hospital Day Care Unit, Portsmouth
Queen's Medical Centre, Nottingham

Radiology and Imaging Group
Recovery Interest Group
Royal Alexandra Hospital for Sick Children, Brighton
Royal Belfast Hospital for Sick Children
Royal College of General Practitioners
Royal College of Nursing of the United Kingdom
Royal College of Obstetricians and Gynaecologists
Royal College of Pathologists
Royal College of Physicians, Joint Committee on Higher Medical Training
Royal College of Physicians and Surgeons of Glasgow
Royal College of Psychiatrists
Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Royal Hospital for Sick Children, Edinburgh
Royal Hospital for Sick Children, Glasgow
Royal Liverpool Children's Hospital
Royal Manchester Children's Hospital
Rush Green Hospital Day Unit, Romford

Scaife, Mrs J
Southampton Eye Hospital
Southampton General Hospital
STEPS (National Association for Families of Children with Congenital Abnormalities of the Lower Limbs)
St James's University Hospital, Leeds

Tripp, Dr J

Valman, Dr H B
Voluntary Council for Handicapped Children

Walker, Dr N P J
Wells, Dr P G
Wessex Cancer Trust
Western General Hospital, Edinburgh
Wexham Park Hospital, Slough
Whipps Cross Day Care Unit, Leytonstone
Whiting, Mr M
Worcester Royal Infirmary

HEALTH AUTHORITIES AND BOARDS

Northern RHA
Trent RHA
East Anglian RHA
North West Thames RHA
North East Thames RHA
South East Thames RHA

South West Thames RHA
Wessex RHA
South Western RHA
West Midlands RHA
Mersey RHA

Darlington HA
East Cumbria HA
North Tees HA
South Cumbria HA
South West Durham HA
Sunderland HA

East Yorks HA
Leeds Eastern HA
Northallerton HA
Pontefract HA
Scarborough HA
Wakefield HA
York HA

Bassetlaw HA
Leicestershire HA
North Derbyshire HA
North Lincolnshire HA
Nottingham HA

Cambridge HA
East Suffolk HA
Huntingdon HA
West Norfolk and Wisbech HA
West Suffolk HA

Barnet HA
East Hertfordshire HA
North West Hertfordshire HA
Parkside HA
Riverside HA
South West Hertfordshire HA

Enfield HA
North East Essex HA
Waltham Forest HA
West Essex HA

Bexley HA
Brighton HA
Lewisham and North Southwark HA
Medway HA
Tunbridge Wells HA
West Lambeth HA

East Surrey HA
Kingston and Esher HA
South West Surrey HA
West Surrey and North East Hants HA

Basingstoke HA
Portsmouth and South East Hants HA
Salisbury HA
Southampton and South West Hants HA
Winchester HA

Aylesbury Vale HA
East Berkshire HA
Northampton HA
Oxfordshire HA
West Berkshire HA
Wycombe HA

Cornwall & Isles of Scilly HA
Exeter HA
Somerset HA
Southmead HA
Torbay HA

Bromsgrove and Redditch HA
Central Birmingham HA
Mid-Staffordshire HA
North Birmingham HA
Rugby HA
Shropshire HA
South Warwickshire HA
Worcester and District HA

Crewe HA
Macclesfield HA

Blackpool Wyre and Fylde HA
North Manchester HA
Preston HA
Salford HA
South Manchester HA

The Bethlem Royal Hospital and the Maudsley Hospital SHA
The Eastman Dental Hospital SHA

Eastern Health & Social Services Board
Southern Health & Social Services Board,

East Dyfed HA
Gwent HA
Gwynedd HA
Mid Glamorgan HA
South Glamorgan HA

Argyll and Clyde HB
Borders HB
Highlands HB
Lothian HB
Tayside HB

READERS OF THE FOLLOWING MAGAZINES AND JOURNALS

Family Circle
Good Housekeeping
Nursery World
Parents
Woman's Realm
Woman's Weekly

VISITS MADE BY MEMBERS OF THE COMMITTEE

Arrowe Park District General Hospital, Wirral
Booth Hall Children's Hospital, North Manchester
Bristol Royal Hospital for Sick Children
British Columbia's Children's Hospital, Vancouver
Children's Hospital and Health Center, San Diego, California
Children's Hospital of San Francisco, California
Children's Hospital, Sheffield
Children's Hospital, Sydenham
Frost Street Outpatient Surgical Center, San Diego, California
Medical Center at the University of California, San Francisco, California
Pacific Presbyterian Medical Center, San Francisco, California
Ronald McDonald House, San Diego, California
Royal Hospital for Sick Children, Glasgow
Royal Liverpool Children's Hospital (Alder Hey)
Sharp Post Surgical Recovery Center, San Diego, California
Southampton General Hospital
Southmead District General Hospital, Bristol
Surgecenter of Palo Alto, California

Appendix IV

A safe environment for children

Children are naturally curious. Most will arrive for day admission in an alert and active state and are likely to spend some time playing and exploring their surroundings. Unnecessary restrictions on the children are unacceptable and neither parents nor staff should have to be continually apprehensive.

Therefore, all wards and departments where children are nursed or treated should provide a safe environment. Such an environment is created by:

- implementing safety precautions and checking all areas of risk with the environmental health officer and a specialist engineer or craftsman as appropriate. Whenever building alterations are carried out, the exercise should be repeated.
- instructions for all staff on latent dangers and safety precautions. The subject should be on the agenda at Unit meetings, so that actual accidents, risks and suggested solutions are well-aired.
- parents advised of safety precautions in the admission booklet.
- satisfactory maintenance of the building, equipment, furniture and toys.
- general cleanliness.
- adequate staffing levels.

SAFETY PRECAUTIONS

1. An unobstructed view

- The play area should be central and in total view. A side room is only suitable if it can be staffed separately.
- The entrance should be visible in the interests of security and to prevent children straying.
- Partitions and doors should be glazed down to a height of a toddler's vision at about 600 to 800mm.

2. Windows

- Windows should be low enough to enable small children to look out without climbing on furniture.
- Safety glass should be used in all partitions and doors.
- Windows should be fitted with restrictor devices.

3. Floors and lower walls

Small children will normally spend most of their time in contact with these areas.

- The covering should be comfortable and easily cleaned.

4. Electrical fittings

- The lighting should be good.
- Electrical outlets should be covered.
- Flexes from fans, televisions and telephones etc. should be placed out of a child's reach.
- Fan blades should be adequately guarded and preferably made of rubber.

5. Heating

- Because of the age range, the temperature in the unit must be capable of being varied between 21°C and 24°C.
- Heating should be available in Summer for use on cold days, especially in rooms where patients will be changing and likely to be undressed.
- The exposed surface temperature of heat emitters and pipework must not exceed 43°C. Guard if necessary.
- Cots should never be placed against radiators.

- Domestic hot water should have its distribution controlled at a temperature of 52°C (± 2°C). There should be a suitable mixing arrangement (pre-set and locked) to provide blended water at a temperature not exceeding 43°C.

6. Restricted access

There are inevitably areas of a ward which contain dangerous equipment or harmful materials. Examples are kitchen and beverage areas with cookers, hot plates and heated food trolleys; utility rooms, cleaners' rooms and stores where drugs, lotions or cleaning fluids are kept; disposal areas where potentially infected rubbish is held; treatment rooms where medical or surgical equipment is kept.

- Doors should have high level latches.
- Drugs, disinfectants and cleaning fluids should be kept in locked cupboards.
- Instructions for the disposal of sharps must be meticulously followed.

7. Fittings and furniture

- The size should take account of small stature and reach of children, so that children are not tempted to climb.
- The positioning of basins, mirrors, shelves and worktops should be considered with safety in mind.
- Sharp corners should be avoided.
- Fixed equipment should be inspected for the possibility of heads or limbs getting trapped in fittings.

8. Toys

- All toys should meet BSI safety standards and be of sturdy construction, with no sharp or rough edges and no places where fingers can get stuck.
- Toys for younger children should not have small removable parts which can be inhaled, swallowed or pushed into orifices.
- There should be safe storage for large toys so that children cannot pull them on top of themselves.
- There should be high shelves or locked cupboards for the storage of craft materials with small pieces, to keep them out of the reach of small children.

9. Cots, beds and trolleys

- New cots should conform to BS 1694 (1990).
- Cot sides should always be replaced securely and checked when a child is left.
- Unoccupied cots should have the sides up to prevent a child climbing in.
- The majority of children admitted for the day can be nursed satisfactorily in fixed height beds. King's Fund beds are produced to BS 4886 (1988) and have a fixed height specification.
- When cot sides are added to beds, the adult design is not suitable. The bars must be more closely spaced, similar to the spacing on cots.
- If the ward is equipped with variable height beds, those with a "scissors" mechanism represent a potential danger. The Beds and Cots Working Group stated in 1973 that *"... Having regard to the fact that children are encouraged to be mobile, it would be possible for a child to be immediately adjacent to the bed but out of sight of the operator of the height adjustment mechanism. In these circumstances some part of the child's body could become trapped in the "scissors". The danger would be more extreme when the bed was being lowered, the weight of the superstructure and patient causing fairly rapid downward movement that could not speedily be checked even in the unlikely event of it being realised that the "scissors" were obstructed. Other features of the bed, e.g. tilt mechanism, could also represent hazards to naturally inquisitive children (whose strength and ingenuity should not be underrated). On these grounds the Group concluded that variable height King's Fund beds and beds of similar design ought not to be used in children's wards."*

An alternative is the Nesbit Evans Model 20600C Children's Variheight Bed (Anniversary King's Fund), which has a "handle wound mechanism" situated at the foot of the bed. For safety, when not in use, the handle folds away completely.

- If trolleys are used for recovery, children always need safety sides in place and should never be left alone.
- The normal issue of disposable (polythene) drawsheets and pillowcases is not safe for use with children and babies: 38 microns is the thickness for safety.

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