Consensus standards for the care of children and adolescents in Australian health services

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ABSTRACT

- The medical and psychosocial needs of children and adolescents differ from those of adults, and this should be reflected in the care they receive in all areas of a health service.
- Children and adolescents must be accommodated separately to adults to ensure that their unique needs are met and risks of harm are minimised.
- The *Standards for the care of children and adolescents in health services* have been developed by a working group of clinicians, health service providers and consumer advocates based on a combination of available research evidence, published best practice guidelines and multidisciplinary expert consensus. Stakeholder input was obtained through invitations to comment, and pilot testing of the Standards was conducted in six metropolitan, regional and rural hospitals.
- The Standards provide detailed recommendations in the areas of recognising rights; the provision of child-, adolescent- and family-friendly health service facilities; the availability of child- and adolescent-specific equipment; and the importance of appropriately trained staff.
- To facilitate implementation and allow ongoing performance monitoring, the Standards have been developed for use alongside the Australian Council on Healthcare Standards Evaluation and Quality Improvement Program.
- The Standards provide a vehicle to ensure patient safety and to facilitate the provision of high-quality care for children and adolescents in Australian health services.

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Children and adolescents make up a significant proportion of patients requiring hospital care each year in Australia. Data collected in the financial year 2006–07 indicated that children and young people (0–24 years) account for over one million hospital admissions annually and represent 14% of all hospital admissions.[1] The medical and psychosocial needs of children and adolescents differ dramatically from those of adults. As a result, children and adolescents requiring health care have unique vulnerabilities and safety risks.[2-4] Differences include the most basic of medical issues, such as distinct physiology and anatomy, and extend to differences in the types and range of diseases and disorders encountered and the types of treatments and pain-management strategies needed. Children and adolescents are also more vulnerable to intentional harms such as physical, psychological and sexual abuse and will have a greater need to be safeguarded during their stay in hospital than most adults.

The psychosocial and support needs of children, adolescents and young adults with significant disability differ from those of adults and are dependent on age and stage of development. Children and adolescents also present unique challenges for care in areas such as communication, consent and confidentiality.[5] Some children can be particularly nervous about going to hospital[6] and will react to the anxiety of their parents.[7] Frightening or distressing experiences can have lasting effects on a child's psychological development. In addition, poor experiences with treatment or hospitalisation can have a profound and enduring impact on attitudes to health care.

It is now 50 years since the Platt Report (1959, United Kingdom) and the Australian Paediatric Association (1958) recommended that children be provided with family-centred care in an environment separate from sick adult patients. Several significant reports recommending developmentally appropriate health care have followed.[8-11] Despite this widespread recognition, the co-location of children or adolescents and adults continues to be a common practice in Australia and overseas.[12-15] A national survey conducted in 2004 found that 35% of Australian hospitals did not routinely accommodate children and adolescents separately from adults.[14] In addition, since 1992 the number of separate paediatric wards had dropped by 30%.[14]

Standards recognising children and adolescents as unique users of health services are a relatively new priority in health care. The UK[10] and New Zealand[11] have led the way with national standards that aim to achieve child-centred hospital services that focus not only on the quality and safety of the medical care provided, but also on the quality and safety of the setting, environment and social supports. The measurement of child health care quality has also become a priority area in the United States,[16] and global projects such as the Child Friendly Healthcare Initiative have been undertaken.[17]

In Australia, several specialist colleges and individual organisations have developed policies and guidelines that focus on child and adolescent health care.[9,18-20] The *Standards for the care of children and adolescents in health services*[21] build on this guidance (Box). These are the first national standards to specifically consider the health care needs of children and adolescents and to address the co-location of children and adolescents with adult patients in health care settings. They are underpinned by the United Nations Convention on the Rights of the Child.[22]

Development of the Standards

The Standards were collaboratively developed under the auspices of the Royal Australasian College of Physicians (RACP) and are endorsed by the Association for the Wellbeing of Children in Healthcare, Children's Hospitals Australasia and the Australian College of Children and Young People's Nurses. A multidisciplinary working group of clinicians, health service providers and consumer advocates, convened by the RACP, followed the best practice principles of the International Society for Quality in Health Care *International principles for healthcare standards*[23] and the Australian Productivity Commission's best practice principles for standards development.[24] A subcommittee led the development of the Standards and circulated drafts to the full group for

Overview of the *Standards for the care of children and adolescents in health services*[21]

Aims and objectives

1. To recognise that the medical and psychosocial needs of children and adolescents differ from those of adults and that this should be reflected in the health services provision of effective and safe, quality care through:

a. recognising rights;

b. providing child-, adolescent- and family-friendly health service facilities;

c. providing child- and adolescent-specific equipment; and

d. appropriately trained staff.

2. To draw attention to the importance of providing separate facilities for children and adolescents in all areas of the health service where children and adolescents are cared for.

3. To encourage proactive risk-assessment practices.

Key outcomes

Rights: The rights of children and adolescents are upheld at all times and they and their families are always treated with respect, sensitivity and dignity.

Facilities: Children and adolescents are cared for in a safe and appropriate physical environment designed, furnished and decorated to meet their needs and developmental age.

Equipment: Children and adolescents are cared for utilising equipment that is specifically designed to meet their needs, size and developmental age.

Staff: Children and adolescents are cared for by staff specifically trained to meet their physical, psychosocial, developmental and cultural needs. ◆

comment. All working group members had an active role and agreed to the final recommendations. The Standards and associated RACP policy are available on the RACP website (http://www.racp.edu.au/page/policy-and-advocacy/paediatrics-and-child-health).

Literature review

A literature review was undertaken to identify research on the hospital-based care of children and adolescents and to identify existing international guidelines and standards. A search was conducted of electronic databases (MEDLINE, Cochrane Library, EMBASE, CINAHL and PsycINFO) for studies published between 1990 and July 2007, using the search terms "(standards OR guidelines OR policy) AND (child OR adolescent OR young person OR youth)". Limits of "English language" and "humans" were imposed. Reference lists of relevant articles and the websites of health care agencies (Association for the Wellbeing of Children in Healthcare [Australia]; UK Department of Health; World Health Organization; European Association for Children in Hospital; and the US Agency for Healthcare Research and Quality) were also searched. Additional specific searches were conducted on the topic areas of individual standards.

Three Standards were supported by National Health and Medical Research Council (NHMRC) Level I and II evidence[25] (Standard 2.1.2 — positive impact of family presence for children in hospital; Standard 4.4.3a — the need for specialised paediatric pain management; and Standard 4.4.4 — play therapy as an intervention). The NHMRC levels of evidence are not readily applicable to all areas of the standards and in most cases no Level I–IV evidence was available.

Linkage to the Australian Council on Healthcare Standards

To facilitate implementation and allow ongoing performance monitoring, the Standards have been developed for use as an Australian Council on Healthcare Standards (ACHS) Evaluation and Quality Improvement Program, 4th edition (EQuIP-4) in-depth review. EQuIP is the most widely used independent health care assessment and accreditation process in Australia. A linkage tool (also available on the RACP website) matches the Standards to the EQuIP criteria. In-depth reviews every 4 years allow repeated monitoring and encouragement of performance improvement. Both quantitative measures, such as bed-days, and qualitative measures, such as complaints monitoring, are required to measure compliance with the Standards.

Pilot testing

Six metropolitan, rural and regional health services from three Australian states voluntarily undertook self-assessment using the Standards and the linkage tool. Data were collected through an on-site written survey or a standardised telephone interview.

Health services were supportive of both the Standards development and content. Generally, two people were involved in conducting the assessment, which took 2 to 3 hours. All participants reported that the Standards were easy to follow and assess. Participants without previous EQuIP-4 experience found the process complicated at first, but did not have further concerns after going over the material in detail. Small or rural hospitals that could not meet some standards because of their size found the Standards were nevertheless useful to guide best practice, future planning and risk assessments.

There were several notable gaps in meeting the Standards in the health services where pilot testing was undertaken.

- The routine co-location of children and adolescents with adults in some hospitals.
- Fully trained paediatric nursing staff were not always available in sufficient numbers.
- Accommodation and facilities for parents and families were often restricted.
- Play spaces and the availability of trained play therapists were often limited.

Feedback

Feedback was received from stakeholders through a two-stage consultation process covering (1) their perspectives on the issue of co-location; and (2) formal consultation on the draft documents. Stakeholders included professional colleges (paediatricians, general practitioners, paediatric and child health nurses), child health and welfare groups, hospital industry groups and consumer groups.

State and territory health departments were asked to comment on whether the Standards sufficiently address the varying needs of health services and how health services might best be supported to use the Standards. Jurisdictions were supportive and acknowledged the importance of specialised child and adolescent health care, and many commented that the Standards would be a useful tool when planning future services. A key concern was compliance in smaller or rural health services and non-government organisa-

tions. Supporting documents such as local policies and a tool to enable reviews to be amended to apply to the local context were suggested. An audit tool was subsequently developed to assist in the process of reviewing against the Standards, and is available on the RACP website.

Summary of key Standards

Children and adolescents must be accommodated separately to adults

Standard 2.2: Children and adolescents must be cared for on wards that are appropriate for their age and stage of development and must be physically separated from adult patients.[8] Actual age is less important than the needs and preferences of the individual child or adolescent.[10]

By accommodating children and adolescents in developmental age-appropriate areas, it is possible to ensure that: children's rights are acknowledged and respected; child-, adolescent-, and family-friendly health service facilities are provided; equipment is the correct size and design; the most appropriately trained staff are available; and children and adolescents are safe while they are in hospital. Physical separation between children or adolescents and adults is needed in all areas of the hospital where young people receive care. This includes critical care areas such as emergency departments and intensive care units.

Facilitating family-centred care is essential

Standard 2.1.2: Facilities for parents and carers to stay nearby to their child must be provided; for example a lounge chair or folding bed in the ward or a chair in the emergency department.[8] Allowing parents to stay with their children in hospital has a positive impact on child and parent stress and increases the child's coping ability.[26-31]

Parents or carers and families play an important role in hospital care, and health services need to facilitate family-centred care and parental partnerships with staff. Services need to be culturally safe and respectful to all children and their families. Children want and need their parents' presence and support. Parents are experts in their child's health and will have a critical role in supporting their child and clinical staff by becoming directly involved in clinical care. Allowing parents to stay with their children in hospital can reduce stress for the child and the parents and optimise the child's coping ability.[26-31]

The wishes of the child or adolescent should be used to guide an appropriate level of parental involvement in care. As adolescents become more autonomous, it is important to respect their developing maturity and independence and the changing relationship between them and their parents. This will vary between individuals and the circumstances surrounding their need for health care.

Play, leisure and education are essential to promoting normal development

Standard 4.4.4: Children have a basic need for play and it is a critical communication tool which can help the child understand their treatment and assist in recovery.[32-34]

Standard 4.4.5: Access to schooling should be provided to meet the ongoing educational needs of school-age children/adolescents staying in hospital.

Wherever possible, hospital care should reflect the continuation of a normal routine and this should be independent of the length of the hospital stay. Children should have access to and be encouraged to participate in developmentally appropriate play and educational activities and programs.[8,9] For adolescents, the importance of holding on to the normal aspects of their life, such as friends, family, education and leisure, will impact on their experience of hospitalisation.

Children need to be able to play, and therapeutic play can help them understand their treatment and assist in recovery.[33,34] Play provides a pathway for dealing with potentially frightening experiences and can be used to involve children in making health care choices. The efficacy of play therapy in assisting with various emotional and behavioural difficulties has been demonstrated.[32] In addition, play interventions have been found to be effective in inpatient and outpatient areas for preventing and reducing anxiety and distress in the short term.[33] Play interventions may also be helpful for children coping with pain and adapting to chronic illness.[33]

Children and adolescents should be cared for by staff with specialist education and training

Standard 4.4: Staff involved in the care of children and adolescents should have special training to recognise and meet the special health, psychological, developmental, communication and cultural needs of children and adolescents.[8,9,35]

Staff must have specific knowledge of paediatric illness, and the appropriate technical skills. In addition, as children and adolescents have different information needs, communication skills and abilities to choose and consent to treatment than adults, staff need specific training and experience to ensure effective communication. Areas such as critical care units are predominantly concerned with adult care, and a recent UK audit has suggested that child and adolescent health care needs may be less likely to be met in these areas.[13] In this audit, one of the primary issues with shared facilities such as emergency departments and outpatient areas was the limited employment of nurses with recognised paediatric training.[13] In an Australian audit, less than 25% of nursing staff in children's wards were found to have relevant postgraduate education in child and adolescent nursing.[14]

Conclusions

It is important that children and adolescents receive the best and safest care possible. To make sure this occurs, it is both feasible and reasonable to have standards for health services that direct best practice in caring for children and adolescents. In fact, it is likely that the general public expect that such standards are already in place. The Standards and audit tools described here facilitate the provision of high-quality care and provide a practical way of ensuring patient safety. The inclusion of many diverse stakeholders and the engagement of jurisdictions in the development of the Standards have resulted in a set of tools that are practical, constructive and easy to implement.

Standards for the care of children and adolescents in health services Working Group (2006–2008)

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Australian health services are widely divergent, and, although it is intended that the Standards be used to direct practice in all health services, it is not anticipated that smaller hospitals will meet every criterion. Nevertheless, all services should be able to meet key standards and are encouraged to use the document as a framework for guiding care and as a basis for proactive risk-management strategies. The Standards actively direct the health service to look closely at what practices, policies and guidelines it has in place to warrant that children in its care are protected from harm.

Ensuring that children and adolescents receive safe, high-quality hospital care will require ongoing vigilance. In countries such as the UK and NZ where standards have been in place for several years, the practice of co-locating children and adults is still common and often routine.[12,15] Ongoing advocacy is critical for raising awareness of the importance of preventing co-location in hospitals and ensuring that the Standards are actively utilised. Reasons why Australian hospitals seek accreditation vary from state to state, and even in hospitals currently accredited by the ACHS, the EQuIP-4 in-depth review is not a mandatory process. Ideally, all health services should commit to continuous quality improvement and participate in national accreditation programs that include regular assessment of the adequacy of child and adolescent health services against these Standards.

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Competing interests

None identified.

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