ABC of 1 to 7

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SERVICES FOR CHILDREN: ACCIDENT AND EMERGENCY DEPARTMENTS AND INPATIENTS

Accident and emergency departments

Accidents and emergencies in children are usually managed in the main department, where about three-quarters of the patients are adults and where few of the nursing and medical staff have any postgraduate paediatric training. In most hospitals a member of the paediatric team is on call to give a second opinion to the accident and emergency officer. Equipment of appropriate size for varying ages can only easily be available if a resuscitation room is equipped specifically for children. A separate waiting room, consulting room, and drug cupboard may also reduce many of the disadvantages of children being seen in a mainly adult department.

In many inner city areas the accident and emergency department provides a great deal of primary care, particularly at evenings and weekends. If the paediatric senior house officer on call spends most of his time giving primary care he may find it difficult to fulfil his other commitments, which may include resuscitation of the newborn, management of infants on ventilators, and care of severely ill children.

Admission to hospital

Although it has long been DHSS policy that children should be admitted only to children's wards, this has not been implemented in many hospitals, partly because of the persistence of specialised units for ear, nose, and throat surgery and ophthalmology, where children and adults are nursed in the same ward. Children need nurses and ancillary staff attuned to their needs to prevent unnecessary distress. Although the admission of a mother with the child may reduce this trauma some mothers are daunted by the unwelcoming attitudes of staff and primitive accommodation.

Indications for admission

The severely ill child clearly needs to be admitted. Children with problems needing admission include those with fractures requiring operation or traction and those with suspected acute appendicitis. Some children need urgent medical investigations—for example, a lumbar puncture—and others have urgent social and medical reasons such as non-accidental injuries. Some medical patients need nursing and treatment that cannot be provided at home, such as intravenous treatment for bronchial asthma or oxygen and tube feeding for bronchiolitis. Complex problems may need the opinions of several specialists, who may be better co-ordinated by a short admission, though most investigations can now be performed in a day care unit. Severely ill children needing intensive monitoring or ventilation are usually nursed on the intensive care unit, managed jointly by the paediatrician and anaesthetist in charge of the unit.

Admission procedure

When direct admission is sought the family doctor usually discusses the problem with the paediatric senior house officer. This telephone conversation helps to clarify the problem and decide whether there are any special social reasons contributing to the admission. Arrangements can also be discussed for a possible early discharge or ways of avoiding admission. The average length of stay for paediatric inpatients is three to four days but if beds are to be available for every admission requested the average occupancy cannot exceed 70%. This means that during epidemics patients may have to be discharged sooner than usual and followed-up in the day care unit or outpatient clinic.

Common reasons for admission

The sudden deterioration that may occur in infants with bronchiolitis or severe asthma has encouraged family doctors to send these patients into hospital. Some of these children could be nursed at home if the family doctor visited them often enough to admit them if they deteriorated. But general practitioners are under pressure from parents to admit children to hospital. Such expectations are hard to resist if there are beds available, and children may be admitted for a short period during the acute phase of the illness. Children with a first febrile convulsion are usually admitted to exclude meningitis and to allay the parents' fears.

The introduction of effective prophylactic drugs appears to have persuaded parents that they do not have to wait a week or so for the natural history of an asthmatic attack to take place. Many units now have an open-house system so that a child with a severe attack can be seen in the day care unit and be admitted if his attack is not quickly relieved. This early treatment may result in more children being admitted, but they have symptoms for a shorter period and miss less school. Repeated admissions also indicate that the management is ineffective and needs to be changed. Most medical investigations can now be carried out in a day care unit, and about a third of the paediatric surgery at present performed in the inpatient ward could be carried out in a day care unit.

Nurses in paediatric wards

The shift system results in each child being nursed by six to eight different nurses each week, despite the fact that each nurse may look after the same group of children each time she is on duty. The mother is therefore the only person who can provide continuity of care for a child, and the admission of the child without the mother is likely to aggravate any feeding or behaviour problems.

Mothers

The attitudes of staff towards mothers determine whether the mothers want to stay. The ward sister will set an example and show that the mothers are complementary to the nurses and not usurping the nurses' role. The resident mother needs basic comforts including a folding bed, a cupboard for her clothes, a bathroom, and a sitting room where she can chat to other mothers. And she needs to know where to find linen, make tea, and obtain a meal. A list of guidelines will give her more confidence. Some prefer to go home for short periods, especially in the evenings, and they should be encouraged to do so. If a mother does not want to stay in the unit she should not be pressed. Normal siblings can stay with the patient and the mother. More than half of mothers will stay with their children if they are given the opportunity and this should not be related to the child's age. Some anaesthetists allow the mother to go with the child to the anaesthetic room.

In the ward the mother can carry out the usual care, including feeding, changing, and bathing. She can also take the child for investigations and can keep fluid charts, collect urine, and in some cases observe the flow of intravenous fluids. During admission the mother learns more about nursing a sick child and gains confidence. The nurses can assess the mother's competence in managing the child and her attitude towards him and find it easier to assess the appropriate time for discharge. Student nurses may learn a great deal from an experienced mother about the skilled and sensitive care of a young child.

Play is a child's work, not simply amusement. A skilled play leader can help the child to play out the events of the admission by allowing him to handle syringes and other equipment and she can discover with the mother how the child feels. Most wards have a part-time or full-time schoolteacher.

Staff strain

If the admission policy is working well most of the children on the ward are acutely ill. Many are discharged shortly after they begin to improve so the wards no longer have convalescent patients. The short period of admission and the high discharge rate for each bed produce continuous emotional strains on the nursing and junior medical staff as well as putting extra pressure on the secretarial staff. The high rate of admissions is similar to that in an intensive care unit, but the allocation of nurses does not usually take this into account. Staff morale and quality of care can easily fall when nursing and medical staff are working continuously under this high pressure. Many units do not have the funds to bring the nursing establishment up to an adequate level and others would find it difficult to recruit enough nurses even if funds were available. Providing more day care is often the only solution compatible with providing a continuous service to the child community.

Infectious diseases

The most common infectious disease requiring admission is acute gastroenteritis. Most children with acute gastroenteritis can be managed at home, but those requiring intravenous fluids or those with poor social conditions may need admission. Ideally these children should be nursed in an annexe to the children's ward. Properly designed cubicles with double doors allow barrier nursing and help to prevent cross-infection. Unless the mother is admitted with the child emotional and social isolation is an inevitable consequence of the physical isolation. Social and emotional problems present before admission may be increased by admitting these children to an adult infectious diseases unit because paediatric nurses are essential. Children with measles, chickenpox, mumps, or scarlet fever rarely need to be admitted, although they may be severely ill for a short part of the disease. Children with heavily infected eczema and those with leukaemia who have developed chickenpox are best managed in a barrier-nursed cubicle on a children's ward.

Preparation for admission to the paediatric unit

An admission booklet prepares the mother and child for what they can expect in the ward. Several of these booklets are specially prepared with children in mind and include pictures which they can colour in before arrival. For planned admissions the child can be shown round the ward after finishing the outpatient consultation. As a large proportion of the child population will be admitted or seen at hospital at some stage a few schools arrange trips to the local hospital. There are now several excellent books written for children about hospital and the mother can inform herself about ward life as she reads about it to the child.

The newborn

The largest number of infants in hospital are newborn infants, who may account for 3000 admissions a year, compared with 2000 in the paediatric wards. Most of these babies are completely well and in many units they stay next to their mothers throughout the 24 hours. The length of stay depends on the policy of the unit. During his stay the infant should be examined at least once by a member of the paediatric staff and in some units will also be examined by the obstetric junior staff. The mother is taught to care for her infant mainly by the midwife in the antenatal and neonatal period. Some wards also have nursery nurses.

About 15% of newborn infants need more intensive nursing care. Most of these infants weigh less than 2000 g at birth, are preterm, have had perinatal asphyxia, or have respiratory problems. Some have feeding difficulties or need phototherapy. To avoid separating the infants from their mothers some units have provided nurses with special neonatal training on postnatal wards. This can reduce the number of infants going to the special care unit from 15% to 7%.

Although frequent visiting by parents or relatives has been practised in children's wards for several years, this approach has come only recently to special care units. If the nursing staff welcome the mother she will not be afraid to visit the unit frequently to touch, change, feed, and later breast-feed her infant.

Some units (regional intensive care units) receive babies of extremely low birth weight and those needing artificial ventilation. An increasing number of mothers are transferred to these units before delivery to minimise birth asphyxia and avoid transporting a sick infant. Separation of a mother from her family may be unavoidable and visiting difficult because of the distance and cost.

Nurses may find it stressful to work in such a unit, especially at night, when staff shortages are common. The design of units with large windows so that the staff can see the sunrise, trees, and birds may reduce this feeling of isolation, although it may make it more difficult to maintain constant temperature.

The special care unit often has a separate establishment of nurses who do not work in any other part of the hospital. In Britain most consultant paediatricians divide their time between the care of newborn and older children. The registrar may have special responsibilities for the newborn during the day but is often on call for the whole department at night. Senior house officers are often responsible for both the newborn and older children at night but mainly for one or the other during the day.

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