THE AUSTRALIAN ASSOCIATION FOR INFANT MENTAL HEALTH (Inc.)
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Infants in Hospital

*Nicolina Rotundo**

In 1958 James Robertson wrote: "The aftermath of a lengthy stay in hospital, in the early years, is commonly an extended period of serious maladaption and unhappiness for the child and serious difficulties for the family to whose care he is returned".

Although the work of Robertson and others has given impetus to many important changes in visiting and admission policies in children's hospitals, continued attention to the needs of young children and their families during hospital stays is very necessary.

Lyth (1982) has emphasised the vital role of the mother and family members during the young child's hospitalisation. The obvious value to ill infants is not only in having parents nearby but also in having them in the familiar role of caring for them. Successful attachments are based on: 1. "Services" such as feeding, bathing, changing, etc. 2. "Social functions" such as talking, touching, smiling, etc. and 3. Most importantly, the mother's capacity to deal with the infant's distress, to understand and react sensitively to his cries, to soothe his fears, to comfort and to reassure him. Each mother-infant pair has its own idiosyncratic pattern of interaction which helps make the world feel like a safe place for the infant. Sustaining of this attachment, and use of it to minimise the distress to the infant of the unavoidable negative consequences of illness and hospitalisation is clearly one of the objectives of maternal presence in hospital.

Even for devoted mothers, a hospital can be a strange place, and her ideas about her role in helping her child may be confused. Moreover, there can be subtle and not so subtle obstacles from the side of the hospital which interfere with the mother showing her concern for the child. Lyth makes the important point that exhortation does little to increase maternal presence. It serves only to increase maternal guilt and anxiety. The hospital must recognise its own responsibility in considering what support and help can be given to encourage the mother to optimise her presence.

Information on policies of care, facilities for mothers, visiting times, who can visit and so on is crucial. Adequate introduction to nursing unit managers, team leaders and the nurse assigned to the case with a description of her role and handover at shift changes can go a long way to overcoming the feelings of alienation often felt by mothers in this environment. The role of the mother must, in addition, be supported not only by talk but also by the action of the staff. If the nurses take over all ordinary child care, the mother is consulted about few aspects of her child's routine and in addition she is constantly asked to leave during examinations, rounds and treatments it is easy for her to begin feeling unnecessary, futile and inadequate, feelings all too easily engendered in mothers already under stress.

Each mother accompanying her child

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* **Senior Clinical Psychologist**
Westmead Hospital,
Westmead, NSW 2145

From the Editor

During the past 10 to 20 years many changes have taken place in hospitals to accommodate the emotional needs of infants and their parents. The achievements made to date need to be maintained and further improvements initiated. This newsletter will help to keep pace with current thinking and new developments in this important and evolving field.

Renate Barth

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Lessen the Fears, Reduce the Tears

The Work of the Association for the Welfare of Children in Hospital

*Eva Langley**

Some 15 years ago when my 3-year old niece went to hospital to have her tonsils out, parents were barely allowed to visit their children and they certainly would not have dreamt of "living in". Play facilities, let alone play programmes did not exist and, apart from a few toys in a corner, there simply was nothing in the wards to help children retain a sense of normalcy in the strange, overwhelming surroundings. Today most hospitals encourage, or at least accept unrestricted parental visiting; many offer overnight stay for a parent to reduce "separation anxiety" in the young patient. Children's wards are full of colour. Toys and play are recognised as essential and play staff and play programmes are active in the paediatric wards of larger hospitals. The same pattern emerges in the recognition of the psychosocial needs of hospitalised neonates and very small children. In the intensive care nurseries of today, even infants in humidicribs receive from parents and staff their fair share of human touch.

The spectacular change in the non-medical aspects of paediatric hospitalisation over the past decade is due, in no small measure, to the activities of the Association for the Welfare of Children in Hospital (AWCH). This voluntary organisation was founded in 1973 by a group of professional and non-professional people: doctors, nurses, parents, and interested members of the community – who, by the way, still share in the membership of the Association.

From its inception, AWCH has advocated quality paediatric care for all sick and handicapped children (age bracket 0-18), child-friendly hospital design, provision of play and education, parent participation in care, improved inter-professional and professional / parent communication, etc. The Association has set itself the triple task of ensuring that the non-medical needs of sick and hospitalised children (and their families) are clearly formulated, well understood and fully met throughout the health care system.

This three-pronged approach has been evident in all the Association's undertakings, beginning with its first public statement of principles and practical guidelines in 1974. The AWCH "Recommended Health Care Policy for Children and their Families" (Medical Journal of Australia, Vol.2, N°2, Supplt., 1975) declared the official policy of the then Health Commission of NSW, adopted by other States and endorsed by the Natl. Health and Medical Research Council. It is evident from various recently published Health Department guidelines that the "Policy" continues to serve as a yardstick to measure the quality of paediatric principles and practices in the health care system.

For the past 17 years, through National Headquarters and AWCH Library in Sydney, as well as its State Branches, the Association has been working towards the original goals, alert to changes in public policy, health technology and community expectations that may affect children. True to the original AWCH blueprint, involvement at both the policy-making and grassroots levels remains essential. A few examples may suffice:

1a) In the former category belong the numerous AWCH submissions, each defining a special area of needs (neonates, aboriginal/migrant/ handicapped children, State wards etc.) and setting out the principles and practices that best meet those needs. State or national surveys carried out by the Association have put AWCH in a position of strength in assessing issues arising from paediatric hospitalisation.

b) At the grassroots level, AWCH groups provide volunteers for school & pre-school visits to hospital and for play schemes; provide transport for parents visits; distribute "Hospital Kits" or "Activity Books" to children. Some raise funds for specific purposes, operate telephone advisory services, etc, etc.

2) AWCH provides information and education to professionals, parents, and interested members of the community in a number of ways, amongst them by making speakers available to talk to professional and parent groups and by organising conferences and seminars on timely topics. In 1990, seminars in Perth (Provision of care during induction of anaesthetics) and in Sydney (The impact of architectural design in paediatric health care facilities) attracted wide-ranging interest.

3) AWCH publications, from posters and pamphlets to conference proceedings and small monographs are powerful tools of spreading knowledge and information. Special mention should be made of "Children in Hospital", the quarterly published by the NSW branch and circulated Australia-wide. Original articles, reports of latest local and overseas developments, and AWCH news keep readers attuned to the ideals and concerns of the Association.

4) The AWCH Visiting Grandparent Scheme ("Granny Scheme") which has been successfully initiated in several Sydney hospitals, meets the parenting needs of the unaccompanied child and is a practical demonstration of hospital-supported community involvement in the emotional care of the paediatric patients. (See article on page 8). Hospital staff have often commented on the improvement in the morale and general health status of young children, notably of infants, brought

* Founding librarian of AWCH Library (1975-1986) and current editor of the quarterly "Children in Hospital"

about by the provision of substitute mothering care.

5) Last but by no means least, the Australia-wide reference library and resource centre, AWCH Library*, plays a central role in the provision and dissemination of information. Established in 1975 with funds granted under the Federal Community Health Programme, the library now functions within the framework of the University of Western Sydney, Nepean.

AWCH Library was the first "special library" in Australia to successfully build up integrated printed and audio-visual collections on psychological aspects of paediatric health care, handicapped children and general child development. As a reference library, and with the help of its computerised database, it can supply user-defined bibliographies, together with photocopies if so requested, on subjects from hospital design to parent participation in care, from the impact of the death of a newborn to cancer in adolescents, and so on. Its unique audio-visual collection covers the subject interests of the Association: hospital and health, family support, infants, play and education in hospital, paediatric AIDS, etc. and is perhaps the most powerful tool in changing attitudes, bringing understanding and triggering action. The services of the library, including the lending of films and videos, are free.

The Association for the Welfare of Children in Hospital is looking to the future with confidence, ready to shoulder on-going tasks. Circumstances may change; the progress in medicine and technology has already affected the type and duration of paediatric hospitalisation; the altered career patterns of women are having a profound effect on parenting roles; but the basic AWCH philosophy as to the child care component of good paediatric hospital care remains a valid guiding principle.

*** AWCH Library, Uni. of Western Sydney – Nepean.**
Enquiries: (02) 685 9317. Audio-visual bookings: (02) 685 9318.

AAIMHI Workshop

BOOKINGS ESSENTIAL

Transition From Coupling To Parenting

November 17, 1990, 9.30 a.m. – 1.00 p.m.

Workshop Leader
Dr Carolyn Quadrio

Dr Quadrio is Co-ordinator of Postgraduate Psychotherapy, School of Psychiatry, University of NSW, Sydney. She is a family therapist and systems theorist and her research is in the area of women and mental health.

The workshop will explore the transition from the diadic relationship of husband and wife to the triadic relationship of parents and child. How do people cope with this transition? What problems do they present? How can we facilitate the process?

Venue: 15 Cooper Street, Double Bay, Sydney 2028

Cost: $50.00

Enquiries: Keryl Egan on (02) 328 6813 or
Beulah Warren on (02) 339 4440

Registration and cheque payable to:
AAIMHI, PO Box 39, Double Bay NSW 2028

Jesmond Child Health Centre to Close

The State Government has again brought down the hammer on a Public Health Unit with the announcement that the Jesmond Child Health Centre in Surry Hills has been ear-marked for closure and is to be relocated to Pagewood. The Centre provides services without cost to families in the Eastern suburbs, City of Sydney and the Municipalities of Waverley and Woollahra. It is the only Public Community Health Centre in the area. Some of the problems the Centre assists with include: Child abuse and sexual assault, emotional and behavioural problems, development and physical health problems, speech and language disorders. Staff from the Centre also provide: consultation to staff at pre-schools, schools, government and non-govement agencies dealing with disturbed youth and children.

Staff have been informed that the Centre will be relocated to Eastgardens General Community Health Centre at Pagewood by 17 December, 1990.

"Staff have made representations and detailed submissions to preserve the service in its current location but the Director of Community Health has terminated the consultation process," said Mr Gibson.

For further information contact:
Jeff Fanning, PSA Industrial Officer (02) 290 1555.

Impact of Architectural Design in Paediatric Health Care Facilities

It has been widely recognised that the architecture and interior design of buildings can have a great impact on the way people feel and behave. This is a particularly important issue to consider when designing a hospital or other health care facility where patients and their families are very vulnerable and in need of a supportive environment. In the context of the planned move of the Royal Alexandra Hospital for Children from Camperdown to Sydney's west, Ms Jill Hall (Co-ordinator of the Design Resource Centre, Washington, DC) was brought in to consult on the design of the new facility. The Association for the Welfare of Children in Hospital, NSW, organised a workshop at the Children's Hospital, Camperdown, entitled "The Impact of Architectural Design in Paediatric Health Care Facilities" which included a keynote address by Ms Hall and a panel discussion with experts in this field. Those readers who are interested in the material presented at this workshop will find detailed information in "Children in Hospital", Newsletter of the Association for the Welfare of Children in Hospital, Vol 16 Nº2, June 1990.

International Survey of Support for Parents of Premature and High Risk Infants

Conducted by Brown Medical School, USA in Conjunction with Parent Care Inc.

The survey is concerned with both peer support for parents of preterm and high risk infants and support services for parents. The results of this survey and a mailing list of those who respond to the survey will be sent to each person or organisation who responds. This is to establish an international network of people who provide such services.

If you are interested in participating in this survey please contact Zack Boukydis Ph.D., Bradley Hospital, 1011 Veterans Memorial Parkway, East Providence, Rhode Island 02915 USA

Infants in Hospital

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to hospital is going to have her own limitations. Individual characteristics of mother and child, as well as the extent and complexity of medical treatment required, are going to be only some of many factors affecting such. The role will be different for each, with staff needing to make important judgments about what each mother is capable of, taking care not to push her beyond her capacity. Most mothers would want to accompany their child when painful or frightening procedures are carried out but some would not or could not. It is important at these times that an assigned nurse is available to take over from the mother that cannot, and to support and give information to the mother that is going to accompany her child, so she can be maximally effective. Similarly, all children at times become too much and it is important that an overstressed mother can feel OK about walking away and temporarily leaving her distressed or ill child in the hands of the staff.

Lyth has suggested that while it is usually assumed that in a children's ward the "unit of care" is the child, if maternal presence it to be optimised it becomes appropriate to extend the boundaries of the "unit of care" to include the family and especially the mother. Staff, while surrendering some of their direct contact with the child, must take on the equally taxing responsibility of supporting and at times training the mother in the special aspects of care her child may need now. Administrators are often blind to this new role for staff, assuming that if mothers are there, fewer nurses are necessary. Unfortunately, without the available staff to support, allay anxieties, answer questions and generally help the parents and child alike, the benefits of maternal presence can soon be whittled away. If the parent does not cope with hospitalisation, his or her ability to sustain the child, and the child's ability to cope in turn will be adversely affected.

Clearly, small units which allow staff rotations to be kept to a minimum and limited to a close and intimate group would facilitate the development of close attachments and supportive relationships. Unfortunately, although such staffing needs may be recognised as ideal in principle, their implementation appears under threat in many paediatric wards in Sydney due to frequent staff shortages and increasing use of agency nurses.

Lyth has also drawn attention to the many ways the hospital environment can differ both physically and psychosocially from the normal home environment. While some of these changes are necessary, others are not and could be eliminated. In her own intervention Lyth advocated: 1. the physical restriction of access to the infant unit in order to decrease the busy-ness of the ward and the number of contacts the child must endure, 2. the making of the unit as small as possible in size as well as staffing to be closer in size to a home environment, and 3. the presence of mother or nurse in all contacts between the child and people outside the unit so that such contacts can be less distressing.

In principle, many of these changes are now well accepted by medical professionals. Close examination often shows however that in practice some changes still need to be made in policies of paediatric wards before we can say that the opening quotation by James Robertson is completely irrelevant to the current population of children discharged from our hospitals.

References

Lyth, I.M. The psychological welfare of children making long stays in hospital. Tavistock Institute. Occasional Paper Nº 3, 1982.

Robertson, J. Young children in hospital, Tavistock, London, 1958.

Other Seminars, Conferences and Activities

November 20 and December 11, 1990
Workshop "Understanding Maternal Grief" by M. Nicol

Venue: YWCA, Wentworth Avenue, Darlinghurst, Sydney

Enquiries: Anne Carr (02) 223 6777

November 29, 1990, 8 pm
Lecture "The Woman's Unconscious Use of Her Own Body" by Dinora Pines

Venue: Rozelle Hospital Conference Centre

Enquiries: Sydney Institute for Psycho-Analysis

April 1991
Tenth Congress of the World Federation of Occupational Therapists. The theme will be "Focus '90 – The Directions in Close Up".

Venue: Dallas Brooks Convention Centre,
300 Albert Street, East Melbourne.

Enquiries: Louise Read, The Congress Secretary
Sue Woods & Associates Pty Ltd
1st floor, 387 Malvern Road, South Yarra, Vic 3141

April 26-28, 1991
Pacific Rim Meeting of the World Association of Infant Psychiatry and Allied Disciplines. The theme of the Conference will be "Mothers, Fathers and Families: Transition to Parenthood"

Venue: Monash University, Royal Children's Hospital, Melbourne

If you are interested in attending and/or presenting a paper, poster or workshop contact Wyeth Clinical Meeting Service
PO Box 148, Parramatta NSW 2124

May 9-12, 1991
Golden Jubilee Scientific Meeting of King George V Hospital for Mothers and Babies

Venue: Schlink Education Centre
Royal Prince Alfred Hospital, Sydney

Registration: Wyeth Clinical Meeting Services
PO Box 148, Parramatta 2124

July 28 - August 2, 1991
11th International Congress of the World Confederation for Physical Therapy in England

Enquries: Congress Secretariat, World Confederation for Physical Therapy Congress, 55 New Cavendish Street, London WIM 7RE UK.

September 8-13, 1991
Fifth Early Childhood Convention. The theme of the Conference will be "Impact of Change on Early Childhood Services and Families"

Venue: Dunedin, New Zealand

Enquiries: Lynn Foote, Max Gold
Dunedin College of Education,
Private Bag, Dunedin, New Zealand

Thursdays 9.00 .am to 4.00 pm
A Private Clinic for Sleeping Problems for Infants and Their Parents

Norma Tracey
11 Mars Road, Lane Cove 2066, Phone (02) 417 2028

Neonatal Pain – Nursing Issues

*Kay Spence**

Over the past few years there has been an increased awareness in clinicians to the neonate in pain. Several factors have contributed to this change, namely an increase in knowledge of the capabilities of the newborn brain, the advent of neonatal intensive care nurseries with many invasive procedures and growing concern regarding the effects of inappropriate environmental stimuli on the developing central nervous system.

There still remain several myths about newborn pain. For example that there is no direct correlation between tissue damage and pain, that the infants do not feel pain and thus do not need pain relief, and that prescription of pain relief would cause addiction.

Nurses caring for infants in the intensive care nursery must take responsibility for the assessment and management of pain and there has been a heightened interest in developing more objective and reliable assessment methods (Franck, 1986). The assessment of neonatal pain should include both behavioural and physiological components:

Behavioural Assessment
Some authors describe cry as the most useful index for assessing pain. However, it needs to be acknowledged that sick newborns may not always be able to show their pain by crying (Annand & Hickey, 1987). It is therefore useful to assess other behavioural expressions of pain such as: facial expression, posture, body movements and also palmar sweating in the mature infant. The assessment needs to take into consideration other factors (unrelated to pain) that may influence the baby's behaviour such as abnormal movements caused by fitting or hypoglycaemia.

Physiological Assessment
Useful physiological measures of pain are heart rate, blood pressure and transcutaneous oxygen levels. It is important to have continuous measurements of these indices in order to relate them to the various procedures/interventions performed.

Discomfort in infancy is not only caused by internal factors but can also be influenced by external stimuli. In the intensive care environment, noise from incubators, phones and voices together with bright lights and frequent handling for many invasive procedures constitute some of these factors. In recent years there has been an increase in the attention paid to alter the infant's environment. Some hospitals have started to modify noise and lights by using shades in the crib, dimming of lights, introducing quiet periods for the whole unit and encouraging people to speak softly. It can also be useful to introduce ear plugs for the baby.

Nurses in the intensive care unit often experience emotional pain at having to inflict pain on their patients. Traditionally nurses have been carers. However, with the expansion of the nurse's role they are acquiring more advanced technical skills (e.g. cannulation) and they also find themselves in the position of having to inflict pain while at the same time providing comfort. This may become a conflict so there is a need for peer support to help the nurses cope with this situation.

References
Annand, K. & Hickey, P. Pain and its effects in the human neonate and fetus. New England Journal of Medicine 1987, 317, 21: 1321-29.

Franck, L. A new method to quantitatively describe pain behaviour in infants. Nursing Research, 1986, 35, 1: 28-31.

*** Clinical Nurse Consultant**
Neonatal Unit, The Children's Hospital, Camperdown NSW 2060

Parents Ask to Remain with their Sick Baby

Looking at the Accommodation Needs of Patients while their Baby is in Newborn Intensive Care

Helen Hardy and Sheila Sim***

Introduction

The process of transition to parenthood is fraught with uncertainties, particularly for parents whose babies have been admitted to Newborn Intensive Care (NIC). We found surprisingly little reference in the literature to the specific accommodation needs of mothers and families in this situation. Being asked for ideas for the design of the new Children's Hospital, soon to be moved from Camperdown and rebuilt in western Sydney, seemed a perfect opportunity to examine these needs in more detail, particularly in consultation with parents themselves. Sick newborns do require a range of medical services and technology; but even though these medical needs of the baby are paramount, the baby remains a person with concurrent psychological needs and a place in his or her family. The layout of a Neonatal Intensive Care Unit (NICU) should therefore ideally function in such a way that it helps to maintain the family's sense of unity at a critical time in their baby's life experience. Parents' views about accommodation were sought by means of a questionnaire.

The Neonatal Intensive Care Experience

The Parents

Becoming a parent in our modern western society inevitably involves some negotiation between the inner dreams and fantasies, and the reality of the labour, the reality of the baby, and how that baby carries on his or her relationships with the wider world, and especially the parents. There is unavoidably some readjustment and re-definition for both parents and baby. How much more jarring and disruptive then is the experience of having a sick newborn.

The parents have been preparing themselves for parenthood – often conscientiously reading everything in print, thinking, planning and talking. The unexpected arrival of a tiny or sick newborn can precipitate feelings of unpreparedness, high anxiety, fear and powerlessness, and catapults the family into intense involvement with an alien world of high technology and a range of health professionals. The shock of the unexpected induces an acute sense of unreality, and parents often express a sense of being adrift in a nightmare.

For some parents whose baby is admitted to a NICU, their first concern is to begin building a long term relationship with their baby, but for others whose baby does not survive, their main concern is the quality of the short time that they are able to spend together. Being close to the baby is a high priority for both.

The Baby

There is no reason to suppose that hospitalised newborn infants are any less in need of parental care than well babies, and it may be that their need is greater. All children are helped in gaining a sense of completeness by having someone who can fill in for them the details of their life from the period before their own memories are readily available. Sharing the encounter with the stresses of neonatal intensive care may be of critical importance in integrating this experience. Being able for example, to look through the family photograph album that includes pictures of the baby together with his or her parents, could be helpful to an older child in coming to an understanding of this period of his or her infancy and with the comfort of knowing that parents were there too.

Even in intensive care, babies have been shown to make better progress, both medically and developmentally if they receive care which reduces stress and incorporates sensitivity to their behavioural cues (Als, 1986). Parents normally respond in this way to their babies and children, to provide an appropriately facilitating and protective environment.

Newborn babies and their mothers already "know" each other quite well, and it appears to be in the best interests of both the ultimate well-being of the baby, and the integrity of the family, that this relationship be allowed to evolve with the least possible disruption. (Richards 1978; Klaus & Kennell 1982 a; Garrow 1983)

The Unit

The science and practice of neonatology have expanded beyond imagination since the days of the premature baby exhibitions of the early 1900's. Even with improved technology, the quality of life for the "graduates" of NIC is always a concern for parents and staff.

One of the more important and intangible factors contributing to the baby's outcome is the quality of the handling and comfort the baby receives. Thus, modern NICU's are concerned with meeting the emotional needs of babies and their families. One way of doing this is by making the hospital environment more conducive to parents remaining in touch with their baby. Most units know the value of providing information and discussion with parents about their baby's progress, about his particular condition, and about the routine of the unit. Units have provision for parents to stay in touch by phone or in person. Staff sensitively encourage active contact between parents and baby (cuddles, touching, participation in routine care). The mother is also assisted to express breast milk, and to establish breast feeding, particularly by living in just before discharge. There are open visiting policies, toy boxes for siblings, parents' groups, notice boards with photographs and letters of progress about past patients... a plethora of ways of maintaining the family as a unit in this crisis, of minimising the feelings of being powerless and out-of-control, of alleviating anxiety and facilitating continuity between the baby and his parents, particularly his mother.

Views on Parent Accommodation

Most of the provisions that are made in NICU's are based on the thinking and research of experts such as M. Klaus, J. Kennel and D. Garrow (Reynolds, 1979; Klaus & Kennel, 1982 a & 1982 b; Garrow 1983). In recent personal communication, Dr Garrow and Dr Kennell pointed out the value and feasibility of minimising the separation of sick babies in NICU's from their mothers. In the special case of transfer of a baby to a NICU in a children's hospital, arrangements also have to be made for the mother and close family members if the integrity of the mother-infant unit is to be maintained.

In an attempt to ascertain the views of parents on the best way of providing for their accommodation while babies are in NIC, a questionnaire was sent to most parents whose babies had been admitted for more than a day to the NICU at the Children's Hospital at Camperdown, between July and December 1988. 262 questionnaires were sent. Seven families could not be traced, and those from outside Australia were not contacted. Half the families included were from outside the Sydney metropolitan area.

Parents were asked to indicate the type of accommodation they would ideally have chosen for themselves and their families during their baby's admission. A covering letter from the Director of the Unit was

* Occupational Therapist, The Children's Hospital, Camperdown NSW 2060
** Social Worker in Charge, Royal Hospital for Women , Paddington NSW 2021

Type of Accommodation / Time of Stay	In a room for mother right next to the nursery (with appropriate medical and nursing care for mother) (%)	In a room for mother, father or close family member, near to but separate from the ward. (%)	Hostel or motel type family accommodation within the hospital grounds. (%)	Living at home or with relatives or friends. (%)
The first few days or weeks	85	21	19	1
For a few days just before discharge or transfer	19	42	34	2
From time to time during your baby's stay	7	20	23	3
Most of the time	23	28	36	8

are presented in the table above. Since more than one category could be required concurrently, people were asked to mark as many boxes as necessary. For example, early in the admission a mother may wish to be where her baby is, while motel style facilities might at the same time be needed for the father and young children of the family. Although not generally available in NIC, particularly in a paediatric setting, rooming was amongst the alternatives suggested. Parents were also invited to offer any other ideas or comments that they felt would be helpful to the planners of the new hospital.

Of the 262 families surveyed, 89 (34%) returned the questionnaire. As shown in the table above, 85% of these parents would have nominated combined accommodation for mother and baby during the initial period of the admission. Comments accompanying the completed questionnaires indicated that this would have been the preference of some parents at other critical times during the admission as well, or when a baby was terminally ill. Twenty three per cent would have preferred this form of accommodation for most of the time their baby was in hospital.

For the majority of respondents, accommodation for the mother a little further away from her baby, and with provision for other family members became the preferred choice after the early part of the admission. Most parents would have chosen to be nearby either most of the time or intermittently, and particularly just before discharge. Only a small number would have elected to remain at home or away form the hospital.

Although the number of families represented in the results of the survey may not be an unbiased sample of a NICU population, the pattern of choices made by parents reflects the observations of clinicians at The Children's Hospital. As an admission progresses mothers and family members frequently feel able and ready to focus on issues apart from the baby. Concerns that have been temporarily set aside in the crisis of the baby's transfer might include the needs of older children, the family home and pets left behind unattended (often in remote parts of New South Wales) and relationships with friends and extended family. Parents are generally acutely aware of the impact on siblings of this dramatic event, and the need to minimise separation and confusion. Notes added to the questionnaires referred to such issues.

Parents also stressed the basic facilities new mothers would appreciate in a new hospital. Places where mothers could breast feed and express in comfort and privacy, where they could rest during the day-time and where they could prepare snacks, without needing to leave the ward area, were mentioned.

Other comments explained the choice for accommodation close to the NICU, and included the following examples: "I would prefer to sleep with my baby." "When my baby was critical and not expected to survive I wanted to be as close to her as possible". "Whenever possible I would have liked to stay right next to my baby. When things were very critical I would have liked my husband and I to be able to stay near". "I think it is very important for both mother and child to have the father there all the time, close by".

In summary, parents gave a clear message that in the initial period especially, what they most valued and felt to be essential, was the opportunity to be physically close to their baby, allowing them to maintain the fragile links with their baby that admission to the unit had interrupted.

Conclusion

This article presented a case for the importance of sick newborn babies remaining with their mothers. Additional support for this contention has been provided by the parents who responded to a questionnaire enquiring about accommodation needs for parents and families while their baby is in Neonatal Intensive Care.

Acknowledgements

The parents who kindly responded to the questionnaire.

Dr. Andrew Berry, Head of the Department of Neonatology, The Children's Hospital, Camperdown, who asked for ideas for a new Neonatal Intensive Care Unit.

Dr Michael Adena, who assisted in evaluating the questionnaires.

References:

Als, H et al. Individualized behavioural and environmental care of the very low birth weight preterm infant at high risk for bronchopulmonary dysplasia: Neonatal intensive care unit and developmental outcome. Paediatrics 1986;78, 6:1123-1132.

Garrow DH. Special care without separation: High Wycombe, England. In: Davis JA, et al, eds. Parent - baby attachment in the premature infant. Suffolk: Croom Holm, 1983;223-231.

Klaus MH, Kennell JH. Parent-infant bonding. SL. Loius. Mosby, 1982 a.

Klaus MH, Kennell JH. Interventions in the premature nursery: Impact on development. Paediatric Clinics of North America, 1982, 29:1263-1273.

Reynolds D. Mum's the word for baby in hospital. Nursing Mirror 1979 29: 20-22.

Richards MPM. Possible effects of early separation on later development of children – A review. In: Brimblecombe FSW et al, eds. Separation and special care baby units. Clinics in Developmental Medicine Nº 68. London: Heinemann. 1978.

Deadline for next AAIMHI Newsletter – 10 December, 1990

Please send letters to the Editor, newsletters, announcements, short articles etc. to:

The Editor
AAIMHI
PO Box 39
Double Bay NSW 2028
Australia

Telephone contact:
Renate Barth (02) 339 4440

The "Ward Granny Scheme"

A Valuable Concept in the Care of Children in Hospital

*D. Dunbar**

Over the last four years the "Ward Granny Scheme" has played an important role in caring for children at the Royal Alexandra Hospital for Children in Sydney. It has also been established at the Prince of Wales Hospital for Children and at Royal North Shore Hospital, and efforts are being made to incorporate the scheme into other hospitals with paediatric beds.

In the last decade or so open visiting hours and parent accommodation have become common features of major children's hospitals, thus allowing parents to stay in close contact with their hospitalised children. However, it has become apparent that for a variety of reasons some families cannot take advantage of these opportunities. They may have other young children who need their care, they may have heavy work commitments and high mortgages, they may be ill themselves, they may be too apprehensive, traumatised or weary, or they may simply need a break away from their child to recuperate themselves. It is for these families that the "Ward Granny Scheme" was established. The scheme was initiated in Sydney in 1986 by the Association for the Welfare of Children in Hospital (AWCH) to provide unaccompanied hospitalised children with consistent substitute care. Following a one year pilot study at the Royal Alexandra Hospital for Children in Sydney, the following principles were established:

1. Maintaining a workable contact between parents and granny by:
   * obtaining parental permission before a child is appointed a granny;
   * obtaining parents' agreement to a particular granny; and
   * trying to avoid competition between parents and granny.
2. A granny is only permitted to be involved with one child at any one time.
3. A granny should be available to visit according to the needs of a child, taking into consideration the child's age and condition and the amount of contact with immediate family and other relatives.
4. Grannies do not stay in contact with the child once it is discharged home (except at the invitation of the family).

Prospective grannies are recruited via the media (TV, radio and newspapers) and are formally screened in terms of time availability, references, medical and psychological conditions.

Only about 25% of interested applicants meet the above criteria and become grannies. No formal training is provided. However, an orientation day is held for new grannies, where they talk about the principles of the scheme and how to handle difficult situations (e.g. saying goodbye both on a daily basis and the final goodbye). An essential part of the scheme consists of weekly supervision sessions to help the grannies deal with emotions and situations they find difficult (e.g. hospital procedures, difficulties with staff and concerns about the child's treatment plan).

Currently negotiations are under way to introduce the granny scheme into other hospitals in Sydney.

** Co-ordinator of the Ward Grandparents Scheme and member of the AWCH (NSW) Management Committee. 8 Kyeema Parade, Belrose 2085.*