INNOVATIONS IN PAEDIATRIC AMBULATORY CARE

A Nursing Perspective

Edited by
EDWARD ALAN GLASPER & SUSAN LOWSON

Innovations in Paediatric Ambulatory Care

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Other books edited by Edward Alan Glasper

Child Care – Some Nursing Perspectives (1991)

Advances in Child Health Nursing (1993) (with Ann Tucker)

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Notes on Contributors

Maureen Ballentine is an experienced Hospital Play Specialist and is presently working as a Play Coordinator at Southampton University Hospitals NHS Trust.

Rachel E Bia is a Lecturer/Practitioner at the Children's Trust in Tadworth, Surrey.

Michael A Cooper is a Lecturer/Practitioner in Child and Adolescent Mental Health Nursing based at the University of Southampton's School of Nursing and Midwifery.

Ruth Davis fulfils the dual role of Diabetes Care Coordinator and Honorary Lecturer in Nursing at the University Hospital of Wales, Cardiff.

Margaret Evans is a former Lecturer in Paediatric Oncology Nursing and Nurse Consultant at the University of Southampton's School of Nursing and Midwifery.

Yvonne Fulton is a Teaching Fellow in Child Health Nursing at the University of Southampton's School of Nursing and Midwifery.

Edward Alan Glasper is Professor of Nursing and Director of Child Health Studies at the University of Southampton's School of Nursing and Midwifery.

Diane Gow is a Teaching Fellow in Child Health Nursing at the University of Southampton's School of Nursing and Midwifery.

Louise Hooker is the Wessex Cancer Trust Lecturer in Paediatric Oncology Nursing at the University of Southampton's School of Nursing and Midwifery.

Lorraine Ireland is a Lecturer in Child Health Nursing at the University of Southampton's School of Nursing and Midwifery.

Susan Jones is a Ward Manager at Bristol Royal Hospital for Sick Children and is also Chairperson of the RCN Society of Paediatric Nursing.

Paulajean Kelly was a former Clinical Nurse Specialist in Research within Tower Hamlets Paediatric Home Care Team, London. Her current post is as a Lecturer in Children's Nursing at City University.

Lesley Lowes is a Paediatric Diabetes Specialist Nurse at the Department of Child Health, University Hospital of Wales, Cardiff.

Susan Lowson is Quality Development Manager at the Southampton University Hospitals NHS Trust and former Senior Clinical Nurse to the Child Health Directorate.

Rachel McWilliams is a Family Information Nurse in the Children's Outpatient Department at the Southampton University Hospitals NHS Trust.

Sarah Palmer is a Paediatric Oncology Nurse at the Piam Brown Unit, within the Child Health Directorate of the Southampton University Hospitals NHS Trust.

Deborah Perriment is a former Child Protection Nurse Specialist at Southampton University Hospitals NHS Trust.

Linda Phillips is Manager of the Children's Outpatient Department within the Southampton University Hospitals NHS Trust.

Catherine Powell is a Child Protection Nurse Specialist within the Southampton University Hospitals NHS Trust and a lecturer in Child Health Nursing at the University of Southampton's School of Nursing and Midwifery.

Jim Richardson is Lecturer in Child Health Nursing at the University of Wales College of Medicine, Cardiff.

Helen Rushforth is a Lecturer in Child Health Nursing at the University of Southampton's School of Nursing and Midwifery.

Jeanne Smith is a Research Nurse in the Department of Social Medicine, University of Bristol.

Sharon Stower is the Senior Nurse Manager of Children's Services at the Queen's Medical Centre, Nottingham.

Anne Thompson works at the Royal Victoria Infirmary, Newcastle, where she is a Paediatric Macmillan Nurse.

Valerie Wilkins was the Programme Co-ordinator of the Medical Information Centre at the Hospital for Sick Children, Toronto, Canada.

Stephen Wright was formerly a Visiting Professor of Nursing at the University of Southampton's School of Nursing and Midwifery, and he is the Director of The European Nursing Development Agency (TENDA).

FOREWORD

The care which we, as a society, offer to children is a fundamental reflection of the values which guide our lives. Hence within healthcare the services which are developed for children should be at the forefront of development, drawing on wide-ranging knowledge which impinges not only on advances in medical technology but also on patterns of organisational care and personal, social and learning needs of children and their families. This text is to be welcomed since it blends these issues in such a way as to make them readily accessible to readers while pushing forward an understanding of new and innovative ways of providing care.

Neither ambulatory care nor the requirements to address children's needs within the context of their families is new. What may be seen as fresh is the progress which has been made on many fronts, which opens up a range of options which may not have been available in the past. Advances in telecommunications can overcome problems with access, blending the supportive educative skills of nursing with skilled diagnosis in nurse-led clinics can help to focus on problems which are meaningful to patients and their families, and providing access to information in a form which makes it accessible to those without a knowledge of healthcare fundamentally alters the relationship between care giver and recipient of care.

This leads me to one of the issues which I find most interesting, namely the shifting interrelations between both practitioners and patients and at an interdisciplinary level which are described in many of the chapters. First there is an underlying belief in the need to hold families together, to share care and information with them in order that a true partnership can be formed. Such a shift sounds simple but can easily become rhetoric. Yet it is fundamental to the manner in which relations are handled within the delivery of healthcare.

It is not only the relationships between health care workers and patients which are challenged. Further partnerships are demonstrated between nurses working in practice, education and research

in such a way as to bring together these specialist areas of skill. Yet another crucial partnership can be seen in the relationships which are emerging between primary and secondary care. At a time when there is a growing emphasis on care in the community, it is essential that the patients receive care which calls on the best of both worlds, a service at home, offered by those who are skilled in community care but in partnership with the highly specialised skills of secondary and tertiary services.

The authors of this text do not suggest that they can offer all the answers to ambulatory care for children. Indeed it would be foolhardy to do so since developments are occurring so rapidly. They do, however, offer a diversity of approaches, drawing on a wealth of experience and knowledge which will, I have no doubt, act as a valuable stimulus for others.

BARBARA VAUGHAN MSc DIPN DANS RNT
Visiting Professor – University of Bournemouth
Programme Director – Nursing Developments King's Fund

PREFACE

Ambulatory care is one of the fastest growing branches of health care in Western societies. The transition from tertiary inpatient care (which began for children in 1852 with the opening of the Hospital for Sick Children, Great Ormond Street, London, and culminated in the building of large district general hospitals) to an essentially primary health care-led health service has created the conditions necessary for the development of ambulatory care services.

Ambulatory care is the vehicle that will bridge the euphemistic service provision gaps that prevent a seamless web of care being delivered to children and their families. This text seeks to focus on innovations within ambulatory care but is not exhaustive. Indeed, the various chapters fail to reflect adequately the full range of recent developments, which is perhaps a reflection of just how proactive children's nurses are within the field. There is no doubt that children's nurses have led the way in the design, implementation and evaluation of ambulatory care services for families.

The renewed energies of children's nurses within this arena are also indicative of the growth in specialisation linked to the clinical nurse specialist movement that has concentrated on the area of ambulatory care. The technical sophistication of tertiary medicine, coupled to the changing roles of junior doctors, has also been a causative factor in placing ambulatory care in the spotlight of change. Nurses have been quick to grasp and exploit these new opportunities to promote their expertise. Their commitment to partnership with families has influenced the strategic development of many ambulatory care services, and this book is a tribute to those many children's nurses who are working tirelessly to improve standards of care and who challenge practice.

This book is offered as a series of chapters exploring the unique contribution that children's nurses can make to developing ambulatory care within a diverse range of clinical settings. Chapter 1 examines the growth of ambulatory care from a historical perspective

and details parameters of service delivery. Chapter 2 addresses the contentious issues of expanding roles within a paediatric A&E department, the area of ambulatory care most familiar to families given the evidence of childhood accidents. This chapter examines nurses' utilisation of skills more normally associated with doctors and documents the evolution of the A&E paediatric nurse practitioner. Chapters 3 and 4 examine the concept of information-giving as the key to family empowerment and debates the growing role of telecommunications as a vehicle to transmit information.

North American ambulatory care facilities now undergo accreditation by the Accreditation for Ambulatory Health Care Inc. Such accreditation emphasises the need for robust standards within the field of ambulatory care and highlights the importance of the discipline within the area of contemporary health care provision.

Chapter 5, which discusses the achievements of a King's Fund accredited nursing development unit situated within an outpatient department, is indicative of the profession's desire to develop services in the best interest of children and their families, and to ensure that 'families first' is the philosophy of care.

Chapter 6 concentrates on the medium of play and acknowledges the importance of therapeutic play in the overall delivery of ambulatory care and its function within the multidisciplinary team.

Chapters 7 and 8 investigate ambulatory care services for children with cancer and examine in detail the role played by paediatric Macmillan services.

Chapters 9 and 10 detail the growing phenomenon of nurse-led clinics and the development of clinical nurse specialism that has consistently linked itself to the growth in ambulatory care services.

Chapter 11, related to community nursing, is a timely reminder that less than 50 per cent of the UK is served by community paediatric nurses, despite the explicit recommendations of the NHS 'Children's Charter'. Paediatric community nursing services are destined to play a larger part in the development of ambulatory care services for children. It is, perhaps, a tribute to paediatric community nurses that advances in ambulatory care have, to a greater or lesser extent, been commensurate with their own success. A healthy primary health care service is essential if ambulatory care is not to become a euphemism for cost-cutting in cash-strapped health economies.

Chapter 12 concentrates on issues related to child protection. The victims of child abuse in its widest context are often first to be witnessed in an ambulatory care setting. The wide spectrum of abuse, which incorporates physical, sexual and emotional para-

meters, is likely to be a constant feature of some ambulatory care services, especially A&E departments. A sound knowledge of the protocols associated with child protection is an essential toolkit for the paediatric nurse working in an ambulatory care setting for it is here that the sharp end of deprivation is likely to be seen.

Chapter 13 considers the cultural sensitivities that paediatric nurses must process if they are successfully to harness the challenges of ambulatory care, and Chapter 14 relates the establishment of a community outreach programme for children with complex disabilities. It is often forgotten, or ignored, that children with the most complex of needs, that is, those with a learning difficulty and with or without profound physical disability, are at the sharp end of ambulatory care. The decline of longer-term institutional care long heralded in the professional press as the object of derision fails to recognise the sheer logistical problem for families attempting to care for their disabled children.

Chapter 15 examines the growth of paediatric day care long eulogised since the publication of the Court Report in 1976. The standard-bearer of ambulatory care, day care relies on many factors, principally a family able to cope.

Chapter 16 is very much a case study approach to a particular medical problem, which is growing in incidence among the childhood population. Diabetes is increasingly being managed in ambulatory care surroundings, thus avoiding inpatient stays.

Chapter 17 begins to address the management issues that have developed alongside the growth in ambulatory care. The 'hub and spoke' model described in this chapter should resolve some of the tensions and delineates the role of the differing sectors of the health care community.

Chapter 18 is the last chapter, but this is in no way intended to marginalise the subject matter, that is, mental health. This chapter, in using a case study approach, effectively concentrates the mind of the reader on the wide variety of psychological problems suffered by children and young people. Such children are managed in ambulatory care settings, and the result of the interactions, which are primarily nurse led, is a clear indicator of their success.

We hope you find the text a good introduction to the vast area of ambulatory care and that you find some of the descriptions of care both stimulating and inspiring. The cover illustration, *Journeying*, was chosen because of the nature of patients' progress through ambulatory care and the journey that inevitably occurs. *Journeying* is a textile, metal and glass artwork that was commissioned by the

Partnerships Art Programme on behalf of the Trust Chaplaincy Team for the Chapel at Southampton General Hospital. Faith and the experience of illness within life's journey were explored by the artist working with patients, staff and local community groups.

Local schoolchildren and inpatients from the children's wards were involved in the process. The birds show hope, energy, rebirth and celebration. The gold line that circles through the work indicates the lifeline and life's journey for the patient coping with transition and change. Areas where the lifeline crosses over another section indicate choice, decision-making and the opportunity for the patient to reflect – 'a time to think about the past and future questions'. The process of ambulatory care is constant for the patient, requiring flexibility and careful management. It is essential in all practice that the patients' and families' journeys are escorted by health care professionals constantly reviewing their practice and evaluating care.

E.A. GLASPER AND SUSAN LOWSON

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Ambulatory Care – The Scope of Practice

E.A. Glasper and Susan Lowson

Ambulatory care is defined as 'health services provided on an outpatient basis to those who visit a hospital or clinic and depart after treatment on the same day' (Mosby, 1995). Once the backwater of hospital medicine, ambulatory care is now beginning to play a dominant role in the shop window of the health service in the UK and further afield.

Historical background

The father of ambulatory care for children, Dr George Armstrong, established the first recorded dispensary for the infant poor in London in 1769 (Alpert, 1995). The British Dispensary Movement during the eighteenth and first half of the nineteenth century reflected the lack of inpatient provision for sick children. This did not come into existence until 1852 with the opening of the Hospital for Sick Children, Great Ormond Street, London, the UK's first children's hospital. It is perhaps ironic that the father of paediatric ambulatory care was highly influential in delaying inpatient care for children, postulating that children and their parents should not be separated (Miles, 1986). Armstrong further believed that parents would not be able to look after their children in hospital because of economic pressures. In these respects, he was particularly prophetic, but not perhaps in the way he intended. It is the area of ambulatory care that is perhaps more economically debilitating for parents than is inpatient care.

The rapid move towards community care has catapulted ambulatory care into the spotlight of change. The transition from traditional outpatient care to modern ambulatory care has been challenging for many units who have found themselves ill prepared

for change. Although professional children's nurses working in all areas of child care are now firmly committed to the concept of family-centred care and family advocacy, they have to reconcile the advantages of ambulatory care with the ability of parents to cope with the extra demands that this may entail.

Armstrong, with his famous quotation cited in many modern journal papers – 'To take a sick child away from its parents breaks its heart immediately' (Palmer, 1993) – was perhaps not fully appreciative of the appalling conditions in which children lived throughout this period of history. The slums of London so vividly described in the many novels of Charles Dickens, particularly in *Oliver Twist*, were a reality for the majority of children during the first half of the nineteenth century. Ambulatory care, which was the Dispensary Movement of that era, was insufficient to safeguard the health of children, and its failure to do so contributed to the opening of inpatient children's hospitals from 1852 onwards.

If poor ambulatory care provision was a contributory direct precursor of tertiary inpatient care for children in the nineteenth century, it must follow that excellence in tertiary care for children in the late twentieth century will be a precursor for the ascendency of ambulatory care in the twenty-first. Ambulatory care can, therefore, only flourish in a climate that has achieved, at least in terms expressive of good health, those objectives envisaged when the UK National Health Service (NHS) was created in 1947. Although health in late twentieth-century contemporary society is vastly different from that of the nineteenth century, it must not be assumed that the conditions that bred ill-health in its widest definition have disappeared. Far from it, for there remain elements of British post-industrial society that are as dangerous to child mental and physical health as were elements of nineteenth-century society, once described as the golden era of British capitalism.

It can be hypothesised that the transition of care from tertiary to ambulatory provision is still in its infancy, at least within the UK. Few would disagree that a robust primary health care service is essential if ambulatory care is to grow and prosper. Ambulatory care must not be seen in political terms as a cheap option for the care of children, although there are clearly fiscal benefits that accompany this development in care for Western governments.

The precursors to ambulatory care for children

Armstrong's views of inpatient care have been reiterated throughout the intervening years. The 1959 Welfare of Children in Hospital publication (Department of Health, 1959), a seminal document, proved to be a high watermark in the establishment of better care facilities for the families of sick children in hospital. The so-called Platt Report (after the Chairman, Sir Harry Platt) recommended that children should not be admitted to hospital unless absolutely necessary. Many of Platt's recommendations were based on the work of two pioneering child psychologists, John Bowlby and James Robertson, who articulated the pitfalls and negative psychological sequelae of an unaccompanied inpatient stay during childhood (Bowlby, 1951; Robertson, 1962). These laudable views must, however, be taken in context given that the potential dangers of non-hospital admission for children in the early days of antibiotic therapy would almost certainly have outweighed the potential psychological problems of an inpatient stay. Despite this caveat, generations of parents have expressed feelings of helplessness and inadequacy during their child's admission to hospital, when nurses have completely taken over their care.

This less than satisfactory state of affairs continued long after the publication of the Platt Report and did not improve substantially until after the founding of the National Association for the Welfare of Children in Hospital (NAWCH), now known as Action for Sick Children, in 1961. NAWCH accelerated the pace of change and became the champion of parents as consumers of health care; in many ways, it can be seen as echoing the voice of George Armstrong in campaigning for greater ambulatory care provision. While the Platt Report recommended that children should not be admitted unless absolutely necessary, there was little in the published text to promote ambulatory care. It is difficult to conceptualise how such a strategy might have been implemented in the absence of fundamental health policy change when there was little, if any, provision for the care of children in their own homes. The paediatric community nurse was still to be a future initiative.

Despite this, it is perhaps worthy of note that the current move towards day surgery, first reported in 1909 by Nicoll, was founded on the premise that the separation of a child from its mother might be harmful. This being so, it would almost certainly have been true that not separating a child from an environment that was a harbinger of disease would also have been harmful. In the early

years of the twentieth century, there were probably not many lower socioeconomic households in the UK where a child could have been successfully nursed at home following surgery. Although receiving little mention in the Platt Report (Department of Health, 1959) ambulatory care for children is implicit in the Court Report *Fit For the Future* (Department of Health, 1976).

Translating the rhetoric of government recommendations into action policy has taken decades, and the whole concept of day care provision for children has spread very slowly. The infrastructure to support a widespread embrace of ambulatory care philosophy is still being developed, and the seamless web of service envisaged in the Caring for Children in the Health Services' publication *Bridging the Gaps* (Thornes, 1993) is yet to be fully realised. Some of this is dependent upon a robust, efficient and effective paediatric community nursing service. Atwell and Gow (1985) have pioneered the recognition that caring for sick children can be managed at home and have thus paved the way for the development of paediatric community nursing services, at least in some UK community Trusts. Such services are far from universal, but at the very least form the foundation stones of ambulatory care services. The UK Children's Charter (NHS, 1996) published in 1996 expressly states that parents should have appropriate help and support from a community nursing team when their child requires care at home. Despite this clear commitment, there remain many areas of the UK that do not provide this service for the parents of sick children.

The increased use of day care services for children, coupled with earlier discharge from hospital, necessitates the development of a widely available paediatric community nursing service. The original driving force behind some such schemes was the need to provide care for children post-operatively following day surgery (Glasper *et al.*, 1989). Although this remains a high priority within many paediatric community teams, the repertoire of services has increased enormously, and much of the current trend in ambulatory care depends on their continued growth and development. This symbiotic relationship between a sophisticated primary health care sector and a decline in the need for tertiary inpatient care does not, however, always recognise that it is the parent who is the lynch pin in the provision of care for children, be they sick or well. Demographic changes in employment patterns are responsible for a strong female sector workforce with a corresponding decline in male sector employment. The continued availability of family structures neces-

sary to underwrite continued growth in ambulatory care must therefore be questioned.

This notwithstanding, it must be recognised that, although many parents are able to deliver excellent nursing care to their sick children, there will be many situations and occasions when they may be incapable of doing so. In these situations, it is the partnership between the nurse and the family (Casey, 1995) that will underpin the continued success of family-centred care within the community. Rickard and Finn (1997) highlight the reality that parents are often in a position of identifying the onset of symptoms in a child as he or she becomes ill. This reality should prompt health care professionals to accelerate the move towards partnership in which the role of the practitioner is to empower the family to make its members more efficient in the management of childhood conditions. The continued growth in ambulatory care provision for children under the auspices of the current UK health service will require further investigation of the partnership paradigm if the term is not to become a euphemism for cost-cutting service re-engineering, a strategy that places the burden of care on families who may be as ill equipped to cope as were their Victorian ancestors. Although the coping strategies were necessarily different in this time period, what is different about twentieth-century family-centred care is the disenfranchisement of the family from normal life health events, such as major illnesses, birth, deaths and other such crises, that were so common in the homes of Victorian families.

Family-centred care

The re-education of families in the provision of care to family members has been described by St John and Rolls (1996). They link the growth in tertiary inpatient care with the decline in the ability of families to cope with members who are ill. The nursing profession may, however, have underestimated the power of the family to act as an important deliverer of care. Only in harnessing this latent care provision will ambulatory care achieve the growth rate to which it aspires. The explosion in surgical and medical day care facilities for children is perhaps the most visible avenue that ambulatory care has taken since the publication of the Court Report of 1976 (Department of Health, 1996). Thornes' important work on behalf of Caring for Children in the Health Services (Thornes, 1991) was inspired by the enthusiasm related to day care and the widespread belief that

admitting children as day patients was an excellent way of providing good care. This was based on the prevailing philosophy of keeping children within their families, parents remaining the principal carers. Although Thornes' enquiry demonstrated that day care is an excellent strategy in dealing with many childhood problems, it nevertheless concluded that the process requires careful planning to avoid unnecessary stress on children and their families. It must be emphasised that ambulatory day care children do not only fall into a surgical category, but that day care also incorporates those children requiring medical interventions or investigations.

Perhaps the most important precursor of the development of ambulatory care for children in the closing years of the twentieth century is the Department of Health publication *Welfare of Children and Young People in Hospital* (Department of Health, 1991) and The House of Commons Health Committee reports (HMSO, 1997). The cardinal principle embodied within these documents is that children are admitted to hospital only if the care they require cannot be so well provided at home, in a day clinic or on a day basis in hospital. The far-reaching recommendations of this welfare document provide detailed guidelines for those involved with the care of children in A&E departments and day care units, among others. The publication of the welfare document coincided with the evolution of the purchaser/provider split within the UK health service, and it provided blueprints for the contracting of integrated patterns of child health care. Thus ambulatory care has begun to develop a higher profile.

The growth of ambulatory care

The Audit Commission report of 1993, entitled *Children First. A Study of Hospital Services*, has demonstrated that one child in four in the population attends an A&E department in any one year. Thus, for many children, their first contact with a hospital is through an A&E department. This makes A&E services the largest component of the ambulatory care sector of the health service. Despite these high attendance figures, A&E departments, in common with other areas of ambulatory care service, have not universally embraced the concept that children should have separate facilities. In an era when it is rare to find children being nursed with adults in inpatient settings, it is all too common to find A&E departments, outpatient departments and day care

wards still following this pattern. This situation is lamentable, and the challenge of the Audit Commission report (1993) is for those who provide or intend to provide ambulatory care facilities for children to implement the principles of child- and family-centred care. This will require some reallocation of resources but more importantly a change in attitude of staff towards ambulatory care provision. The British Paediatric Association (now the College of Child Health) discussion document *Flexible Options for Paediatric Care – a Discussion Document* (1993) supports the move towards greater ambulatory paediatrics.

Perhaps the greatest precursor of the transition of ambulatory care from poor relation to flagship enterprise was the publication of the NHS Management Executive Value for Money Unit publication *Outpatient Departments – Changing the Skill Mix* (Kelly and Taylor, 1990), in which major changes to the way in which outpatient departments operate were suggested. The implied suggestions embodied within this report galvanised many units into action. Some units, such as the Child Health Directorate at Southampton, used the information in this publication to focus their audit activities and subsequently re-evaluated the role and future of paediatric nurses in an outpatient setting. Other paediatric units, such as Nottingham, began to lead the way in the development of innovative outpatient services for children (Stower, 1991), transforming the traditional environment associated with low-status nursing to one in which nursing began to demonstrate greater versatility and competence.

The stark choice facing children's outpatient department nurses, following the publication of the skill mix document, was to innovate or perish. Units such as Nottingham and Southampton continued to re-evaluate the contribution of paediatric nurses to the emerging ambulatory care discipline. Paediatric nurses remain keenly aware of their unique role in the care of children and their families and have responded positively to the rapid emergence of ambulatory care as a discrete discipline. Within the span of a few short years, the paediatric nursing profession has reacted to the ambulatory care challenge and has positively responded in a way that has addressed in a forthright manner those criticisms of its former mode of care delivery. The criticisms were undoubtedly justifiable – ambulatory care in one of its former guises as an outpatient service was the area of low status in nursing terms, the area in which to relocate those nurses who were deemed unsuitable for the higher-status inpatient care, those nurses who were musculo-

skeletally damaged: the 'bad backs' of the profession. It is perhaps fortunate that the professional aspirations of nursing have coincided with the growth in ambulatory care. Stower's description of the nurse-led clinics at Nottingham and the explicit Nottingham children's charter standards, which pre-date the publication of the NHS Children's Charter (NHS, 1996), are evidence of the willingness of paediatric nurses to adapt to changes in service provision for children and their families.

Clinical nurse specialism and ambulatory care

In addition, the evolution of the clinical nurse specialist has had an enormous influence on the development of paediatric ambulatory care nursing. 'Specialism/advanced practice' and 'nurse consultant' are terms that lack clarification but are often used interchangeably. Terms such as 'clinical nurse specialist' have gradually crept into the language of nursing over the past 10 years and have become part of the nomenclature associated with the profession. Although practice nurses in primary health care have led the way, it is the field of ambulatory care that has seen the most rapid development of clinical nurse specialism. In some countries, principally North America, ambulatory care clinical nurse specialists have to be Master's-degree prepared. This is helping to redress the balance of history, where it was the least qualified nurses, rather than the best, who worked in the area. Specialism in paediatric ambulatory care nursing has followed the growth of medicine as it has become increasingly mechanistic.

However, paediatric nurses have embraced specialism not because of medical expediency, especially in the light of the crisis caused by the reduction in junior doctors' hours of duties, but instead to promote the art and science of nursing. As Jacox and Norris (1977) have stated, 'Nursing is not second class medicine but first class health care.' In a similar vein, ambulatory nursing care is not second-class care but an area of excellence in practice. The emerging ambulatory care nurse specialists do not see their role as providing high-tech care at the expense of psychosocial care, and during this, the early years of their development, it will be important that such roles are firmly rooted in paediatric nursing rather than in medicine. The rapid introduction of ambulatory care nurse-led clinics makes such a stance vital, but there are still some who believe that the further development of the paediatric clinical nurse specialist will only fragment the patient and his family along medical model lines.

The seminal publication *Child Health Rights* (British Paediatric Association, 1995) has much within it for those seeking further to develop ambulatory care facilities for children and their families. In particular, the environment for health care is highlighted, and specific guidelines related to clinic times, protected areas for children, confidentiality and health promotion are detailed.

The environment for ambulatory care

The environment of ambulatory care areas such as A&E and outpatient departments has traditionally been neglected, and they are often dull, uninviting and even frightening places for children. Some areas that have not developed separate children's ambulatory care services often expose children to hostile sights and sounds. Some Canadian children's hospitals, such as the Children's Hospital of Eastern Ontario, have responded positively to the challenge of ambulatory care and have developed extremely sophisticated day attendance services. The creation of a non-threatening environment for children is evident in the infrastructure of the ambulatory care department. The design of this outpatient department was crystallised by Carlyle Designs Associates, a young company specialising in interior design for children's hospitals. Fronted by Anne Carlyle, the company has expertise in the design of public environments, concentrating on progressive environments for children. The firm's designs are comprehensive and multidisciplinary, including interior space planning, design, furniture and special product design and graphics, and exhibit and signage designing. Signage is particularly important in health care institutions, and bold imaginative strategies are necessary if families are to benefit positively from the hospital experience. It is a salutary fact that good design and use of colour costs no more than poor design and poor colour choice. Brown plastic chairs, battleship grey-painted walls and the absence of toys are not conducive to a positive visit to any institution.

It is widely believed that the physical environment of an ambulatory care area can have an important influence on child development, noise and crowding being reputed to have negative influences. The beneficial effects of an enriched environment are particularly important, given that children develop by interacting with the social and physical world in which they live. Children live in the here and now, and movement, sound, forms, colour, light, odour and touch are of great importance when designing a

child-centred environment. Paediatric ambulatory care areas should be the hub of the child-centred wheel, where it is possible to provide opportunities for children to learn to move and to learn by moving. This will maximise motor capabilities within safe tolerable limits, instead of having the usual institutional aim of stopping children's movements by eliminating physical activities such as running and jumping.

Therapeutic play in ambulatory care areas

Although the use of play specialists within inpatient settings is widespread, the employment of play specialists within the arena of ambulatory care is less well developed. Hospitals such as the Hospital for Sick Children, Toronto, Canada, have extensive child life (play/education) departments, and there is full coverage within the ambulatory care areas. This cover extends to individual outpatient clinics, where the aim is to help children cope positively with the outpatient experience. The use of play specialists in all areas of ambulatory care, including A&E departments, should aim to create a situation that encourages children to participate in meaningful learning activities. Opportunities for constructive play can counteract the discomfort, boredom and frustration that are associated with long waits in ambulatory care areas.

The increasing use of ambulatory care settings for children's surgery has raised the profile of pre-admission programmes for children and their families. Such programmes aim to inoculate the children and their families against the stresses of the hospital experience. Ellerton (1994) evaluated a Canadian programme using a control and experiential group numbering, in total, 75 families. The results demonstrated that fewer children and parents in the programme group reported high anxiety levels while awaiting surgery. In a similar study, Glasper and Thompson (1993) reported that for some families, despite an invitation, attendance at the pre-admission programme was impossible for a variety of reasons. Attempts to improve attendance among the day case families, through the use of mailed personal invitations and information sheets, proved only partially successful. The ramifications of this for play specialists within ambulatory care are considerable, and a greater imaginative use of preparatory programmes on the day of the initial outpatient visit is required.

Paediatric ambulatory care as a developing area of nursing

Some ambulatory care units, such as those within the Southampton University Hospitals Trust Child Health Directorate, have demonstrated a proactive attitude towards the barrage of changes impacting on them. The staff at Southampton, rather than adopting a passive reactive attitude, applied to the London-based King's Fund for a grant to create a nursing development unit. The grant bid was shortlisted and was eventually successful in allowing the Southampton paediatric ambulatory care unit to become the UK's first paediatric outpatient nursing development unit (NDU). The status of 'nursing development unit' has facilitated an acceleration of change that would probably have taken much longer without the pump-priming benefit of the NDU award. Lowson (1995) has described the development of the paediatric NDU and discusses the ambulatory care staff's commitment to change and innovation with the aim of promoting family advocacy. The benefits of NDU status have allowed the unit to become the shop window for innovations throughout the Southampton Child Health Directorate (Campbell *et al.*, 1992).

Stower (1993) highlights, in discussing the benefits of quality measurement, the reflective element of innovations in ambulatory care provision for children. The modern health services of the Western world are now firmly committed to the concept of evidence-based care. Therefore, any children's nurses embarking on the path of change must build into their studies the appropriate evaluative techniques necessary to generate the data that will provide the evidence of its efficacy. Without such evidence, it is unlikely that innovative schemes will secure long-term funding.

The scope of ambulatory care provision for children and their families

This textbook is intended to explore some of the key developments in ambulatory care provision for children and their families in the UK and elsewhere. It is not an exhaustive text, and new developments are constantly evolving. The challenge of ambulatory care is only just beginning, and, as with many new disciplines, the academic base remains fluid and relatively unwritten. It is hoped that the following chapters will help the reader to explore the differing

and emerging facets of this developing field of paediatric nursing, which is becoming greater than the sum of its parts.

It is perhaps fitting that this chapter, which began with Dr George Armstrong and the past, should return to the past and examine the role of the domiciliary nurse of the same period. Anne Marie Rafferty (Rafferty, 1995) gives a fascinating insight into why the hospital became the dominant focus for nursing care in the mid-nineteenth century, using the fictional character Nurse Sarah Gamp, created by Charles Dickens in his 1844 novel *Martin Chuzzlewitt* to illustrate the character denigration of the nineteenth-century domiciliary nurse. Rafferty argues that the medically orchestrated character assignation of the independent ambulatory care nurses of the period caused a loss of nursing autonomy, which nurses have been trying to reacquire ever since. Perhaps this new age of ambulatory care will help nurses to regain their lost autonomy and recover the independence of their nursing ancestors in the provision of care for the families of sick children.

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2

Expanding Roles and Practice within Paediatric A&E Departments – The Children's Nurse Practitioner

Susan J. Jones and Jeanne M. Smith

Every year, about a quarter of the child population of the UK will attend an A&E department. Some of these children will have relatively minor illnesses or injuries, but, regardless of the nature or severity of their presenting complaint, it is vital that they have access to specialist facilities and appropriately trained staff. Many hospitals have responded to patient need by reviewing service provision and extending the scope of nursing practice in order to meet the needs of all client groups, but in paediatric emergency care, the evolution of the children's nurse practitioner role has the potential to improve effective care for children and their families in the A&E department. Before looking more closely at this role and the challenges that such service developments present, it is worth looking at the background to children's attendances at A&E departments and the current state of emergency paediatric provision.

Children and A&E

The children and families who attend A&E departments (Figure 2.1) come with a wide variety of illnesses and injuries, and their care needs may be acute or life threatening, or may fall into those categories that could be managed by the primary health care team. However, regardless of the nature or severity of their illness or injury, it is well established that the health care needs of children and their families differ greatly from those of adults, and that children up to the age of 16 need