CHILD, YOUTH AND FAMILY HEALTH:
Strengthening Communities

MARGARET BARNES AND JENNIFER ROWE

2nd edition

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FOREWORD
by Jeanine Young

I am honoured to have been asked to prepare a foreword for the new edition of this absorbing text for health professionals who care for infants, children, young people and their families across a wide range of health contexts and life stages.

A child’s health and wellbeing depends on what happens to them as individuals, as part of a family unit, as members of communities and as a member of the greater society as a whole. Evidence shows that the most effective way to protect and nurture children so that they have the chance to flourish is to strengthen their families and develop communities so that children can expect to grow up in an environment that meets their developmental needs.

The majority of our children grow up happy and healthy. Recent reports, however, have suggested that our young people are at a crossroads; with drug use, antisocial behaviour, depression, anxiety, suicide and other mental health issues on the rise. Some stress is brought on due to societal trends – the rise of individualism and consumerism; a decline in the sense of the community and of the importance of the family unit – with each of these trends potentially impacting mental health.

These trends have created a greater focus on the quality of family life and the health and wellbeing of family members, producing a significant demand for assistance as families and communities seek external support to assist them in achieving and maintaining a reasonable standard of living, health and wellbeing.

The intent of this book reminded me of the wise words of Franklin D. Roosevelt: ‘We cannot always build the future of our youth, but we can build our youth for the future’.

The approach used in this text is a strengths-based model. Both a philosophy of practice and a specific set of tools and methods, the strengths model is designed to facilitate a collaborative partnership between the child, the young person and their family and the health professional caring for them, by working with families where they are and with the strengths they have. Such an approach fosters resilience in the child, young person and their family which will enable them to cope with and bounce back from risks and adversity that they are very likely to face in our dynamic and rapidly changing society.
This text reveals the broad knowledge and skill base shared by the editors and contributors, which are essentials to practice in meeting the challenges faced by families today. The range of topics across the infant, child and youth continuum is impressive; and always firmly placed on the child and their family.

Fresh, contemporary content included in this revision highlight the progress made and the challenges we continue to face in the care of children in contemporary society. Chapter 5 addresses effective communication strategies using the family strengths model which, if used effectively, may operationalise family-centred-care approaches to actively engage children in decision-making about their own health care. Highlighted in Chapter 8 is the need for partnerships between health, education and community services that create integrated service models in early childhood support in order to achieve optimal life and learning outcomes for children. The unique issues and challenges faced during middle childhood and the role of child-centred care within family-centred frameworks are illustrated in Chapter 9 through scenarios that address acute management and common causes of injury and illness.

The contributors to this valuable text have succeeded in asking key questions relating to current family support systems and approaches, and whether these are meeting the needs of families. Embedded in the chapters is the message that we need to invest more time and energy in the continuing process of constructing shared frameworks of goals and values, and in developing a shared understanding of where we want to go. Health professionals, and particularly nurses and midwives as key health professionals working with families, are charged with taking up proactive leadership roles in providing direction to that process through effective policy, responsive service and program initiatives, research and evaluation and in the encouragement of a wide range of players to innovate and learn better ways to achieve those objectives.

Congratulations to the editors and to their colleagues who have shared their collective knowledge. This book demonstrates admirably the growing evidence base of our professions and signals the skills, growing maturity and professionalism of infant, child and youth services that strengthen and support families.

Professor Jeanine Young
FACN, PhD, BSc Nursing (1st Class Honours), Adv Dip of Nursing Care Registered Nurse, Registered Midwife, Neonatal Nurse
INTRODUCTION

Margaret Barnes and Jennifer Rowe

It is a great pleasure to introduce the second edition of Child Youth and Family Health. In this edition we provide a foundation for working with children, young people and families across a range of health contexts and life stages. In providing this forum, we highlight the valuable practice undertaken to support and nurture these client groups, across a range of settings. Contemporary policy, practice theory and competencies are discussed in context and all are informed by a strengths approach. In this way practice is constructed in a collaborative and partnership model, centred on working with families where they are and with the strengths they have. The text adopts a critical lens, so as not only to describe practice but also to highlight challenges and issues for readers to consider. Learning for beginning and advanced or specialised practice preparation is supported.

While the foundations of the text set up in the first edition remain, there are a number of additions and revisions. We welcome new contributing authors who have enriched the multi-disciplinary focus. These include Jane Taylor, Rachel Cole, Helen Stasa, Karen Ford, Rachel Reed, Anne Tietzel, Avril Rose, Anne Walsh and Penny Harrison. There are two new chapters in this second edition: Chapter 8 Health Promotion Through Early Childhood; and Chapter 9 Acute Illness: The Child and Their Family. All other chapters have been extensively revised and updated.

The book is organised in two parts. Part A provides an overarching survey of issues facing the health and wellbeing of children and young people and their families. In Chapter 1 the place of family in society, diversity, culture and health influences, as well as healthcare priorities, are discussed. Policy, service and program initiatives, the keys for effective leadership practice, are set out in Chapter 2. In this chapter the principles for sustainable health promotion programs are discussed.

In Chapter 3, there is an emphasis on the particular needs of Indigenous peoples, including a reflection on the social and political circumstance that has led to what continues to be poorer health and wellbeing than the rest of the population in both Australia and New Zealand. In Chapter 4 the reader is challenged to consider the complex and essential ethical and legal dimensions of practice within the overarching
INTRODUCTION

imperative of advocacy. Child centred communication with children and their families is the topic of Chapter 5 which also includes Family Strengths framework for healthcare practice.

Part B focuses on contexts of care in which nurses and midwives practise directly or indirectly to improve health outcomes. Chapters 6 and 7 focus upon the developing family, particularly women and parents during pregnancy and the first year of life and the centrality of attachment to infant, child and family. Chapter 8 focuses on health promotion in the early years. The international and national trend towards integrated, multi-sectoral policy and planning is articulated in this chapter, which demonstrates the alignment and synergies among health and education for young children. Chapter 9 addresses care and issues for children with acute illness. The demographic profile, practice settings and responses to illness and injury are discussed. Young people face a number of physical, developmental, psycho-social or behavioural challenges to their health and wellbeing. Further, they are vulnerable to the impacts of alcohol and drug use and abuse, unsafe sexual behaviour, mental health problems and violence. Recognition of the health issues facing young people has led to the development of national policy and strategic directions in Australia and New Zealand. These issues, practice challenges and solutions are set out in Chapters 10 and 12.

Two important and discrete areas of practice form the basis of Chapters 11 and 13. In Chapter 11, chronic illness in childhood is examined. Through two very different scenarios, the reader is taken into the world of the family who has a child with an ongoing health problem. The complexities of service and practice are discussed, showing the multiple, collaborative and partnership basis of effective healthcare. Finally, but not least, in Chapter 13 Grief and Loss are examined and the reader is given the opportunity to understand grief and loss from the position of children of different ages, and family members.
Chapter 9

ACUTE ILLNESS: THE CHILD AND THEIR FAMILY

Anne Walsh, Penelope Harrison

LEARNING OUTCOMES

Reading this chapter will help you to:

» understand the diversity of middle childhood
» identify common causes and settings of injury and differentiate between intentional and unintentional injury
» critique the role of child-centred care within a family-centred framework in regard to caring for the injured or acutely ill child in the family
» summarise the characteristics of the diverse age group that includes middle childhood by locating sources including population demographics
» understand the range of resources parents access for child health information including the role of practice nurses in child health care.
Introduction

During the ages of 5–12 years, children continue to develop cognitively, socially, emotionally and physically and overall tend to be relatively healthy. Cognitively, this period is called the ‘sensitive period’, due to the active role new experiences play in cognitive development (Knudsen, 2004). Children’s gross and fine motor skills continue to be refined, and they are able to ride bikes and skateboards, climb trees and generally enjoy testing their physical boundaries, often beyond their capabilities (Erikson, 1963). Middle childhood is an exciting time, a period in life when children gain independence from their parents through attending school and participation in sporting activities. In terms of health care, middle childhood is an area where there has been little research, representing the ‘forgotten years’ (Mah & Ford-Jones, 2012).

This chapter explores the reasons for the middle child’s contact with the health profession, injury and acute illnesses, and the impact these have on parents, siblings and the family in general. The forgotten years cover a broad area of childhood development from the 5-year-old with beginnings of independence in activities of daily living, such as dressing and bathing without supervision, to the pre-adolescent 12-year-old. With this comes the struggle over independence in activities where parents perceive a need for continued supervision and children strive for independence; sometimes there are negative outcomes. Injury is the main health concern in this age group: injury at home, school and sporting events, everywhere really. Through two scenarios, we will explore the impacts of common causes of injury and acute illnesses, their influences on children and their families. Engagement of children and family with the healthcare system is addressed through exploration of family-centred care, child-centred care and caring for a middle child and their family in both the community and hospital setting.

Middle-aged children and their families: Australia and New Zealand

On 30 June 2010, 10% of Australians were children aged between 5 and 12 years (Australian Institute of Health and Welfare, 2011). This equates to 1.4 million Australian children aged between 5 and 12 years. Ruby (see Clinical scenario 9.1) would have fallen within the 6% of these who were Australian children aged between 5 and 9 years (30 June 2010) (Australian Institute of Health and Welfare, 2011). The other 4% of these children were between 10 and 12 years of age. Most of these children lived in homes in major cities (66.0%). One-fifth (20.8%) were living in inner regional areas and one-tenth (10.3%) in outer regional areas, with smaller numbers living in remote and very remote areas of Australia (1.8% and 1.1%, respectively) (Australian Institute of Health and Welfare, 2011).

As families grow many difficulties are encountered. Sometimes, this results in divorce with children living between parents. In 2007 in Australia, Ruby would have been included in one of the 18.9% of single parent families in Australia (Australian Institute of Health and Welfare, 2011). There is a similar story in New Zealand where the steadily declining birth rate over the past 40 years has seen the estimated
Clinical scenario 9.1
Setting the scene: Injuries are common in middle childhood

Injuries can occur at any time in any place with children in their middle childhood years. Ruby is no exception. The scenario below describes a common occurrence in middle childhood.

School
Ruby Rodriguez is a 9-year-old girl in year 5 at her local primary school. Her parents, Claire and Joseph, are separated and Ruby lives with either parent on alternate weeks. This is Claire’s week. While waiting for her mother to pick her up after school, Ruby decided to have one last play on the monkey bars before going to the school gates to be picked up. Unfortunately, Ruby lost her grip and fell awkwardly from the monkey bars putting out her left hand to break her fall. Immediately upon landing on the ground, she felt a sharp pain in her left arm and began to cry. Crying and trying to support her sore arm, while also dragging her school bag, Ruby walked to the school gate. When Claire arrived and saw Ruby’s distress and then her distorted arm, she panicked. What should she do? Finally, after carefully settling Ruby in the back seat of the car, she drove Ruby straight to the local district general hospital.

Hospital
Upon arriving at the emergency department, Ruby was reviewed by Sally, the triage nurse, who instructed Claire that Ruby should not eat or drink until a doctor had seen her. Sally applied a sling to Ruby’s arm and encouraged her to rest her arm on a pillow. Ruby was reviewed by one of the doctors on duty and had an X-ray, confirming displaced fractures of her left radius and ulna. It was determined that a specialist doctor should review Ruby.

The orthopaedic surgeon informed Claire that Ruby needed to have an anaesthetic to enable him to realign the fractures and apply a plaster cast on her left arm. Claire now realised she would need to contact her estranged husband, Joseph. Upon receiving the news, Joseph left work immediately and came up to the hospital. Ruby went to the operating theatre soon after he arrived.

When Ruby recovered from the anaesthetic she transferred to the paediatric ward, arriving there at 11 pm. Ruby was asleep and unaware of her new surroundings. The ward nurse orientated Claire and Joseph to the ward and explained to them the ward policy of allowing only one parent to stay overnight at the bedside. It was decided that Claire would stay, as it was her week with Ruby.

Ruby recovered quickly. The next morning, following a healthy breakfast, the orthopaedic surgeon reviewed Ruby and discharged her. Claire received home care advice regarding plaster care and pain management and a discharge letter to take to her local general practitioner. Ruby was not to attend school until reviewed by the orthopaedic surgeon in the fracture clinic in one week’s time (on a Wednesday).

Home and community
Claire took this day and the following 2 days off work to care for Ruby, taking them to the weekend. Joseph negotiated time off work for the following week to continue to care for the injured Ruby until she could return to school the following Thursday. On Saturday, Ruby changed residences and stayed with her father. Claire gave Joseph all the literature she had received from the hospital. On Sunday morning, Joseph was concerned because Ruby was complaining of pain in her arm; however, he did not feel confident in giving Ruby the pain relief tablets Claire had left with him. He decided to ring the 1300 CHILDHEALTH line and discussed his concern with the nurse, who informed him of the potential side effects and the benefits of the pain medication. Following this, he felt confident to reduce Ruby’s pain without causing her any harm from the tablets.
proportion of children aged from birth to 14 years drop from 32.1% of the total population in 1969 to 20.5% in 2009, 892,600 children (Bascand, 2010).

Injury

Injury is common among this age group, often resulting from greater perceptions of their capabilities rather than their actual abilities and/or the influence of peers. Most of these injuries are unintentional or accidental, as Ruby’s was. Injuries most commonly occur in transport-related settings: in a car, as a passenger, sitting in the front seat (where they are anatomically, incorrectly supported by the seat belt or air cushion); riding a bike for fun or to and from school; and as a pedestrian at any time. Recreational injuries are common and include, as previously mentioned, bikes and quad (all terrain bikes) bikes, but they also occur in playgrounds, on skates, skateboards and skis and playing sport, e.g. football, tennis, horse riding (Australian Bureau of Statistics [ABS], 2010a; Centre for Community Child Health, 2006).

Unintentional and intentional injuries are the major cause of hospitalisation and death in middle-aged children in both Australia and New Zealand. For example, in Australia more children die as a result of transport accidents, drowning or assault (36%) than from neoplasm (19%) and other diseases of the nervous system combined (11%) (Australian Bureau of Statistics, 2006). In New Zealand, there is a similar story with fatal and serious non-fatal injuries from falls, motor vehicle accidents, pedestrian accidents etc (Gulliver, Cryer & Davie, 2010). The Injury Prevention Strategy in New Zealand has been effective in reducing the risk of fatal injuries from 14.0 to 11.4 per 100,000 person years from 1994 to 2007 (Statistics New Zealand, 2011). However, the risk of a serious non-fatal injury has increased from 55.7 to 72.9 per 100,000 person years from 1994 to 2009 (Statistics New Zealand, 2011). Between 2006 and 2007 in Australia there were 1462 per 100,000 children aged 0–14 years hospitalised for an unintentional injury (Australian Institute of Health and Welfare, 2009). In New Zealand 4976 children per total population were hospitalised in the public system during 2007–08 for unintentional injury.

Common causes

Falls continue to be the most significant cause of injury and hospital admission for this age group. With their belief in their ability to climb, children fall from bunk beds, trees, playground equipment or during sporting activities. Recreational equipment is involved in most injuries: climbing apparatus and monkey bars followed by trampolines, slides, swings and flying foxes (Kreisfeld & Harrison, 2010). Children aged 5–9 years are more prone to falls from playground equipment and three times more likely to be hospitalised than 10–14-year-olds. Children aged 5–9 years have the highest proportion of fractures, intracranial injuries, dislocations, sprains and strains, with fractures of the forearm the most frequent type of fracture (Helps & Pointer, 2006).

Drowning, thought to be a cause of injury and death in younger children, persists in this age group as they play in rivers, creeks and unsupervised in swimming pools.
and go fishing and boating. Burns also continue to occur though from different sources than in the earlier years. These burns are likely to be from experimentation and/or exposure to ignitable and flammable substances (school or play) (Australian Bureau of Statistics, 2006, 2010; Barker, Heiring, Spinks & Pitt, 2008a).

As little environmentalists, children interact with nature exposing themselves to potential risks from ticks and insect and snake bites, for example. In Queensland in 2007, 2311 children under 14 years of age were treated for spider bites; redback spiders accounted for 29% and only 1 bite was from a funnel web spider (Barker, Heiring, Krahn, Spinks & Pitt, 2008b). Australia’s insects and animals are amongst the most venomous in the world. New Zealand has a small number of venomous creatures biting children. The white-tailed spider arrived from Australia in the late 19th century. In 1980 the redback spider arrived (Slaughter, Beasley, Lambie & Schep, 2009). Both countries have venomous and dangerous marine creatures, a problem in countries where people have a love of water sports.

Children living on farms have a different injury profile. From the age of 5 years, they present with injuries from motorcycles and riding animals or being an occupant of an animal-drawn vehicle. Head injuries and lacerations are most common for children aged 5–9 years, and these children tend to stay in hospital for farm-related injuries for an average 2.8 days (Kreisfeld & Harrison, 2010).

Injury in middle childhood causes angst for parents. How do they keep their children safe while letting them experiment and trial their advancing skills? However, there are fewer resources available to parents of these children. Potential avenues for support include the school setting through parenting programs, previously formed groups from child health settings and work colleagues, family and friends. They also seek information online. Which of these sources provide evidence-based information?

School as a setting for injury

Ruby becomes a statistic. She was in the one-fifth of children injured at school every year. In 2008, 20% of all injuries to children aged between 5 and 13 years happened in a school setting. Falling was the most common cause of these injuries, accounting for two-thirds of all school injuries; of these, one quarter fell more than 1 m. Play equipment, as in the scenario, is a major culprit: 20% of school injuries happen on play equipment (Barker et al., 2008b). Ruby is a perfect example of this – ‘just one more play’. In the scenario, it is clear to Claire that Ruby needs urgent medical assistance. She was fortunate to have access to appropriate hospital and specialist services.

Another cause of injury in the Australian school setting is through intentional injury – bullying. In 2008, 3% of all primary school injuries were the result of bullying. Some 19–27% of Australian schoolchildren report being bullied at some time during their schooling. Primary school students, those in their middle childhood, are more likely to be bullied face-to-face, which can involve verbal or physical assault such as punching or kicking, necessitating children have contact with the healthcare system. Unseen outcomes from bullying can include psychological and/or emotional trauma (Ministerial Council for Education, 2011). Cyberbullying, with associated psychological/emotional trauma, is more common with high school students (Ministerial Council for Education, 2011). Please refer to Chapter 12 for further information about mental health needs in middle childhood.
Intentional injury

In Australia in 2006–07, the rate of hospitalisation for children aged 5 to 12 years relating to intentional injury was 20 per 100,000 (Australian Institute of Health and Welfare, 2009). Intentional injury includes injury from bullying, abuse and/or self-harm. In 2006–07, intentional self-harm was the reason for the hospital admission of 41 per 100,000 Australian children 10–14 years of age (Australian Institute of Health and Welfare, 2009). New Zealand children are at similar risk of intentional injury. There has been no change in the risks of serious fatal or non-fatal intentional injury from 1994 to 2007 (5.4 and 5.4 per 100,000 person years, respectively) (Statistics New Zealand, 2011).

There is a strong causal relationship between the health and wellbeing of children and the environment in which they grow up. The complex nature of child abuse and neglect has been widely acknowledged, nationally and globally, with governments developing strategies to address this. In their response to the need to protect Australian children the government, in collaboration with all states and territories, developed a National Framework for Protecting Australian Children (Council of Australian Governments, 2009). The New Zealand government worked in collaboration with regions and districts to develop the New Zealand Injury Prevention Strategy (Gulliver et al., 2010). When implemented, these strategies promote proactive, preventative practices and initiatives to improve children’s safety and wellbeing.

Nurses and intentional injury

Intentional injury is an area where nurses not only have a duty to care for the child and family, they also have a duty of care to report any suspected child abuse and/or neglect (Australian Institute of Family Studies, 2012). This can be an uncomfortable position for a nurse to be in, caring for the child and family when suspecting the family as the reason the child is now in their care. Often, intentional injuries go unreported or incorrectly identified as accidental and thus poorly investigated. Of concern is the shorter length of stay of children in the hospital system, limiting the opportunity for nurses to conduct a complete assessment and observation of at-risk children and/or their family.

Mandatory reporting of suspected child abuse and neglect is now a legal requirement. Those mandated to report child abuse vary across Australian states and territories. It is therefore imperative that nurses caring for these children are cognisant of their state legislation relating to child abuse and neglect. Prior to the legislated mandatory reporting, Piltz and Wachtel (2009) found that, even though reporting suspected child abuse was a mandatory requirement of all healthcare professionals, nurses who work in emergency departments were hesitant to report any suspicious injuries to Child Protection Services. The lack of education and experience in reporting their suspicions were the main explanations for emergency nurses’ hesitancy to formally report or even record their concerns in patient notes. The emergency nurses interviewed in this study reported they feared for their own safety and that of their family and did not trust Child Protection Services to act appropriately. Similar traits were found among community-based nurses who reported role conflict as the rationale for their hesitancy to report suspicions. They
argued that reporting clients to Child Protection Services would impinge on their role to implement strategies to assist and support the family (Piltz & Wachtel, 2009). In Australia in the early 2000s, police, school personnel, parents and guardians, friends, neighbours and other relatives were more likely to report cases of suspected child abuse than nurses (Australian Bureau of Statistics, 2003). Refer to Chapter 4 for a detailed explanation of advocacy and the legal implications of nursing children.

Family-centred care: implications for middle childhood and families

Family-centred care is an approach to planning, implementing and evaluating health care for children and adolescents; it is a partnership between healthcare professionals and families (Dunst & Trivette, 2009). As a concept it was originally concerned with paediatric hospital services; more recently, it has been adopted in community settings by many healthcare professionals (Frank & Callery, 2004). The concept of family-centred care is composed of:

- respect for the child and family
- appreciation of the importance of the family to the child’s wellbeing
- recognition of the importance of creating a partnership between the family and the healthcare team. (Frank & Callery, 2004).

It is a process of mutual respect. Family-centred care is for care planned around the family unit rather than the individual child (Shields, Mamun, Pereira, O’Nions & Chaney, 2011).

Nethercott (1993) recognised the necessity for the family needs to be viewed in context, and that there was a difference between parental involvement and parent participation. Lee (2004) argues for two approaches to family-centred care, functional and holistic. The functional model relates to the care directed by the nurse, who determines the parent’s involvement in their child’s care. The alternative is a holistic approach; this approach empowers the parents to be able to negotiate care decisions.

It is important to ensure parents are not intimidated by the unfamiliar hospital environment or daunted by the technology attached to their child. Ruby was admitted to hospital straight after her accident; Claire was very worried and concerned about Ruby. Parents often have no clear understanding of what is expected of them in the hospital setting (Frank & Callery, 2004; Young, McCann, Watson et al., 2006). Through family-centred care, roles and responsibilities are negotiated between parents and nurses. After being orientated and having ward policies explained, Claire and Joseph felt confident in participating in Ruby’s care. This was demonstrated by Claire and Joseph’s willingness for Claire to stay with Ruby; Joseph was happy going home knowing that he was acknowledged as one of Ruby’s carers.

Some parents want to be actively involved in their child’s care. Sometimes parents have cared for their sick child at home for days prior to the child’s hospitalisation, and they may be exhausted and in need of sleep. Parents can feel resentful when nurses do things for their child that they would like to do, or vice versa. This could be due to miscommunication or the parents’ belief that nurses expect them to do everything (Jolley & Shields, 2009). Resentment may be exaggerated by the parent’s
difficult defining their role due to the ambiguous boundaries of responsibility. Misunderstandings can usually be resolved; family and health professionals both want what is best for the child. Claire was scared of hurting Ruby and did not want to wash her after she returned from theatre. Fortunately, the ward nurse was understanding and demonstrated to Claire how to dress and undress Ruby while her arm was in a plaster cast. However, this is not always the case. At the end of the day family-centred care is a process of constant negotiation of roles and expectations, a partnership between the family and health professionals.

Parents

It is important to respect parents’ knowledge about their child and the current health issue. Parents are alert to variations in their child’s behaviour, changes from the norm, when to seek help. Health professionals must acknowledge parents’ expertise in knowing their child. Sharing information between parents and health professionals empowers the family and strengthens their therapeutic relationship with the health profession (Frank & Callery, 2004). The formation of a therapeutic relationship assists in ensuring that the child and their family are appropriately informed about how to care for their child in both the hospital setting and when they return home, in the community setting, and that they are aware of available resources to assist them with their child’s health care. This relationship is built on mutual respect and maintained dignity (Lundqvist & Nilstun, 2007). The child’s trusting relationship within their family must be valued and maintained during any period of acute illness or injury (Jolley & Shields, 2009). It is in the child’s best interest to have their family involved in their care. Nurses, however, must also be alert to inconsistencies and incongruities that may indicate abuse and/or neglect or a need for education/assistance.

Child-centred care: is the child important?

Paediatric care: child-centred or family-centred? This a common debate in paediatric health services. Child-centred care not only acknowledges the importance of family involvement in a child’s care but is intrinsically focused on the child’s needs (O’Hare & Blackford, 2005). Family-centred care purports that the care of the child is a collaborative process between the health service and the child’s family, assuming that parents will act in the child’s best interest. However, this model does not always address the interests of the child (Kerridge, Lowe & McPhee, 2005).

Concern for the child’s ability to determine care and to make decisions is a contentious issue. For those in middle childhood this issue becomes more obvious. Autonomy disappears when children enter any health setting (Lundqvist & Nilstun, 2007). However, children in the 5–12 years age group, particularly at the higher end of this spectrum, are able to make judgements on their desired outcomes when provided with information in a manner they can comprehend (Erikson, 1963). For example, something as simple as allowing Ruby to determine when she has a bath and who will assist her. A 12-year-old Ruby beginning puberty may not want her father to bathe her. Despite not having the legal ability to consent to treatment,
their involvement in determining aspects of their care and assenting to care must be encouraged (O’Hare, 2005). There is a fundamental need for health professionals to support and encourage their child client’s involvement in all decision making relating to their health.

**Contexts of care: hospital, community and home**

Most care of children occurs in the home and the community. In the community, nurses in general practice settings, ‘practice nurses’ and general practitioners provide parents with child health and development assistance (Walsh & Mitchell, in press). Tertiary care tends to be for injury and elective surgery, an acute illness or to address chronic conditions such as cystic fibrosis or cancer. Therefore, most will enter the hospital through emergency departments for 24-hour centralised service, as did Ruby.

**Care in the hospital**

Most communities in Australia and New Zealand are serviced by hospitals treating both adults and children. Only in metropolitan areas (capital cities) are there hospitals designed to exclusively treat children. Larger regional hospitals often have a specialist ward and services specifically targeting paediatric care. Ruby required specialist attention and admission due to her fracture.

Developments in technology and treatment have resulted in children experiencing more day procedures and earlier discharge from hospital with community follow-up programs including treatment and assessment by community child health services, practice nurses, nurse practitioners and general practitioners (Aylott, 2006; Smith & Coleman, 2010). This process assumes that the services will be available and pertinent information transferred between health sectors in a timely manner. Practice nurses report a gap in the translation of knowledge from hospital to community (Walsh & Barnes, 2012).

The nature of childhood admissions through injury and acute illness allows little preparation for hospitalisation, or for preparation of parents for caring for their injured/ill child once discharged. However, there are resources available to parents to prepare a child for hospitalisation, for example the Royal Children’s Hospital, Melbourne, virtual hospital tour (http://ww2.rch.org.au/info/tour.cfm) and children’s books about hospital and hospitalisation.

**HOSPITAL SETTING: NEEDS OF PARENTS AND FAMILY MEMBERS**

Every family responds to hospitalisation differently. Some take it in their stride but, for most, their experience will be fraught with varied levels of anxiety as it is a stressful life event. Reasons for anxiety include confrontation with a novel situation, fear of the unknown and separation from normality (school and home). Orientation
of the child and family to the ward environment can assist in allaying fears and concerns and address any myths and misconceptions about hospital care (Weaver & Groves, 2010).

**THE CHILD**

The hospital environment, with its strange sights, sounds and smells, is alien to most children (Crole, 2002). Children need a sense of normality in their environment through personal belongings and knowing the rules and their boundaries. Younger children in middle childhood, 5- to 7-year-olds, thrive on rules with their good–bad, reward–punishment morality; boundaries such as when the television will be turned off and maintaining their normal bedtime routine need to be implemented (Boon, 2011).

It is important to maintain a child’s pride and positive self-image. In a healthcare setting, they are often at risk of losing their dignity, restrained for often-painful procedures all in the name of their wellbeing. They may lose any sense of self and privacy for their maturing and sometimes suddenly changed body. In their eyes, they may be disfigured from scars or surgical incisions or proud of a plaster cast. Their autonomy disappears when they enter any health setting, which is a frightening experience, be it only for a short time (Lundqvist & Nilstun, 2007). However, children are resilient; they have a strong sense of a positive future (Zolkoski & Bullock, 2012).

**PARENTS/CAREGIVERS**

When an acutely unwell or injured child is hospitalised, it can cause great stress for the child’s parents and other family members (see Box 9.1). The speed at which their child changes from normal to a state of injury or illness, requiring hospitalisation, can vary from minutes to days. As in the scenario, Claire met an

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**Box 9.1 Research highlight: The hospital experience**

Parents experience emotional stress when their child has an acute illness or injury and caring for the acutely unwell or injured child has a significant impact. The role of carer changes and they have to adopt increased responsibilities, making immediate healthcare decisions for their child. There is no opportunity to comprehensively research their child’s health problem or access the usual support systems for information and advice (e.g. from friends or extended family).

How do parents and children rate the care they receive in hospital? A study by Pelander and Leino-Kilpi (2010) found children reported negative aspects of hospitalisation to include pain and painful procedures, long waiting times for appointments, illness symptoms and separation from family and friends. Children in isolation rooms negatively rated their restricted ability to explore their environment and to interact with other children. There is a need for isolation; the impact on the children’s quality of life while in isolation requires exploring. Little research addresses this problem. Interestingly, parents in this study rated waiting times as the most negative hospital experience. These findings highlight the need to keep children occupied and ensure pain management is timely and appropriate; hospitalised children need to maintain contact with the outside world.
injured and unhappy Ruby at the end of the school day. There was no opportunity for preparation; Claire simply had to respond.

Parents frequently face financial stress when they have a sick or injured child. In both nuclear and blended families it is common for both parents to work. The work environment is complex and varied. Some families can access their sick and/or family leave. However, the recent trend of casual or fixed contract employment means that these employees do not have access to entitlements such as sick leave (Australian Bureau of Statistics, 2010). As a result, families may be financially disadvantaged having to take time off work to stay with a hospitalised child and/or remaining at home to care for the sick or injured child.

Parents need to feel competent to care for their child at home. Hospital stays are generally short with restricted time for parent education. To address this, discharge preparation must begin on admission. Approaches to discharge planning come in many forms; it is important for health professionals to target education towards parents’ needs. It has been established that the most effective form of discharge education is a combination of verbal and written information (Johnson & Sandford, 2005).

Community setting: needs of child, parents and family members

Most care of children in this age group occurs in the home, recovering from injuries or during acute self-limiting viral illnesses. The school setting is a perfect breeding ground for cross-infection.

Clinical scenario 9.2
Setting the scene: Care of an acutely ill child in the home

Albert, a 5-year-old, lives with his parents, Phoebe and Kevin, and his 2-month-old baby sister, Lulu. Phoebe is breastfeeding Lulu and on maternity leave for another month. Albert is generally a healthy child. However, he has been unwell for the past 2 days and Phoebe has kept him home from school. He has had a ‘high fever’ of 38.5°C, his appetite has been poor and he has been ‘clingy’. Phoebe is concerned and googles Albert’s symptoms. Phoebe and Kevin’s neighbour’s 1-year-old infant had a febrile convulsion last month; his parents were terrified at the time and thought he might die. He is perfectly well now, having recovered from a self-limiting viral infection.

Fortunately, today is Lulu’s 2-month appointment at the child health clinic. While there, Phoebe asks the nurse for some advice about caring for a very miserable Albert. The nurse questions Phoebe about Albert’s symptoms and asks what she has been doing to care for him. Phoebe is reassured that she is caring for Albert correctly; the nurse repeats what Phoebe has read on the paediatric hospital website on the Internet: keep him comfortable, push fluids and watch his overall condition for signs of deterioration and, if this should happen, take him to see his general practitioner. When told that his temperature is really only mild Phoebe is confused; she thought a normal temperature was 37.0°C and Albert’s temperature of 38.5°C was much higher. Phoebe is relieved to be told it is not ‘very high’.
Chapter 9 • Acute Illness: The Child and Their Family

**PRIMARY HEALTH CARE**

In the community setting, these middle childhood children do not generally go to child health clinics, though they are available to them in some states. In Queensland, the care of children from birth to 18 years is available through community-based government-funded child health clinics. However, these clinics are generally utilised by parents with children from birth to 18 months of age (Kearney & Fulbrook, 2012). Middle childhood children often receive community-based primary health care in general practice settings, by practice nurses (Walsh & Barnes, 2012; Walsh & Mitchell, in press).

**In the home**

Middle children can undertake some of their own healthcare needs, such as bathing, eating and entertaining themselves and are used to being active and stimulated. When sick or injured, they may regress and prefer their parents to attend to some of their usual activities, such as making their bed, getting snacks ready, etc. This will increase the parents’ workload in addition to caring for the child’s specific health needs. In both scenarios, Albert and Ruby are in need of assistance. Albert is unwell and wants his mother’s company for comfort. Ruby needs assistance with many activities of daily living due to her immobile left arm.

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**Box 9.2 Practice highlight: Primary care nursing as a speciality**

In acknowledgement of the care provided by nurses in primary health care, general practice settings, a new nursing speciality has been identified and developed through the national Nursing in General Practice 2001 initiative (NiGP) (Jolley & Shields, 2009; Watts, Bell, Byrne, Jones & Davis, 2008). In 2001 the Australian Practice Nurses’ Association was formed (Watts et al., 2004). Through this program there was reimbursement from the Australian government to the general practice for specific care nurses provide to clients (Jolley & Shields, 2009; Watts et al., 2008). Initially, NiGP focused on chronic disease management in remote and rural settings to ensure equitable access to primary health care across Australia. The success of the program saw support for practice nurses in general practice in provincial and, finally, metropolitan areas. This was such a successful initiative that there has been continued expansion through both government initiatives and patient demographics (Jolly, 2007).

A move into the care of children and families came with the release of Medicare Benefit Schedule item numbers for immunisation and wound care in 2004 (Pascoe, Foley, Hutchinson et al., 2005). Further expansion occurred in 2008, through The Healthy Kids Check initiative, as the basic 4-year-old child health checks significantly extended practice nurses’ care of well and sick children (Department of Health and Ageing, 2010). Practice nurses, however, come from a wide range of nursing backgrounds and very few Australian practice nurses (14.9%) have experience with child patients, their developmental and healthcare needs or the needs of their parents (Walsh & Barnes, 2012; Walsh & Mitchell, in press). Practice nurses report their role to include phone and practice triage of children (86.7%); they provide care for asthma management (58%), fever (66.6%), wounds (79.4%) and immunisation (95.6%) and refer children (and parents) to appropriate community services and advise/counsel parents about behavioural problems (e.g., bullying, eating practices) (Walsh & Barnes, 2012).
Caring for these children in the home is both easier and more difficult than caring for younger children. They can entertain themselves with many different sedentary activities, such as computer games, watching movies, texting friends etc. Having a sick or injured child has a significant influence on family functioning. The child may need attention regularly through the day and night, interrupting sleep and increasing parental fatigue. Other children may feel neglected through the increased attention given to one child. Parents are in a new position, having to devote more time to the sick or injured child, and how to manage this can be challenging, incorporating it into normal activities of daily living and work. Parents report fatigue and relationship stress when children are acutely ill/injured; they worry about missing work, financial losses and the need to also care for other children (Walsh, 2007). They look to health professionals for advice on how to care for their child. Advice, as mentioned earlier, given in more than one medium (e.g. oral and printed form) is helpful.

FEVER

Caring for the child with a febrile illness can bring back bad memories. Albert is 5 years old, the upper age group where febrile convulsions occur, though it would be rare for a first febrile convulsion to occur at this age (Sillanpää, Camfield, Camfield et al., 2008). Phoebe and Kevin were worried about febrile convulsions. Though it is unlikely Albert would have a febrile convulsion, fears and phobias are common (Walsh, Edwards & Fraser, 2007). Nurses are ideally placed to alert parents to the benefits of fever in increasing the immunological processes to produce antibodies against the invading organism (Blatteis, 2006). When Albert is febrile, he must stay home from school to allow him to rest, so that his body can fight the infectious illness and to prevent spread of his illness to his classmates, teachers and friends (see Box 9.3).

Phoebe is not alone in her search for child health information. Parents seek information on how to care for an ill or injured child from many sources; they ask friends with children and their own parents (Walsh, 2007). More recently, the norm is to search online for information; parents do this for their own health (Walsh, Hyde, Hamilton & White, 2012). Parents look online for a number of reasons. Is their child sick enough to need to go to the doctor or could they wait till the morning? Following a medical consultation, parents search online to gain a better understanding of their child’s diagnosis and treatment. They need reassurance that they are actually doing the right thing for their child (Walsh, 2007; Walsh et al., in press).

Considering the dubious quality of some available online information, parent-reported actions following accessing online health information are concerning for health professionals. Parents report using online information to diagnose (43%) and treat (33%) their sick child; in an Australian study, 18% of parents reported altering their child’s health management to align with online information (Wainstein, Sterling-Levis, Baker, Taitz & Brydon, 2006). Younger parents, aged 20 to 35 years, are more likely to report using online information, with more women than men likely to engage in seeking health information online (Ybarra & Suman, 2008). In 2008, 9% of Australian parents reported the Internet as the least, greatly trusted child health information source (Khoo, Bolt, Babl, Jury & Goldman, 2008). The incongruence in this research highlights the urgent need for health professionals to provide evidence-based health sites to parents when advising them on how to care for their child.
Indigenous children

Indigenous children are over-represented in injury prevalence and associated morbidity and mortality in developed countries throughout the world, including Australia and New Zealand. Despite this, there is relatively limited research into this area and implementation of the recommendations and strategies from reports (Lennon, Haworth, Titchener et al., 2009). New Zealand children, overall, have poorer health than those in any other developed OECD country and children of Māori and Pacific Islander descent have poorer health than those of European descent. Māori and Pacific Islander children have higher rates of hospitalisation for serious infections, respiratory illnesses, acute rheumatic fever (50 times more likely) and meningococcal disease than other New Zealand children (New Zealand and Ministry of Pacific Island Affairs, 2011). Of concern is that many of these illnesses, for which these children are hospitalised, are preventable through primary healthcare interventions and improved housing conditions.

It is important to protect cultural safety and connection to country, language and culture in indigenous families with acutely unwell and/or injured children (Schmied et al., 2011). Indigenous families, such as New Zealand’s Pacific Island and Māori families, come from a strong socially cohesive society with high levels of social connectedness and strong participation in church life and volunteering. This cohesion promotes strength in feelings of belongingness; it has some protective health and social effects evidenced through the lower levels of considered and attempted suicide (Stanfeld, 2006). Social connectedness builds resilient and supportive communities and provides useful foundations for community health interventions (New Zealand and Ministry of Pacific Island Affairs, 2011).
Indigenous families living in remote regions of Australia face isolation and community separation if they need to leave their community to access tertiary-based services. This may result in cultural shock. Those who have moved from a predominantly indigenous community find themselves in a place where their cultural norms and mores are neither supported nor acknowledged (Tanner, Agius & Darbyshire, 2005). When cultural safety is practised there is support for the principal of solution-focused nursing, whereby family strengths are acknowledged and nurses focus on the values and resilience of the client and their family rather than on cultural differences (Barnes & Rowe, 2007). By identifying and supporting strengths, nurses can endeavour to support cultural fortitude rather than cultural shame.

Cultural differences and cultural misunderstandings often result from poor communication, poor care and/or a dysfunctional nurse–client relationship. However, by appreciating cultural differences health services, irrespective of the setting (hospital or community), can provide support for cultural needs in the diverse cultural client populations. Providing a safe environment when families may be experiencing a traumatic life event is paramount.

Conclusion

Middle childhood is a period of rapid growth and development when the transition from a child to an emerging adolescent occurs. These children are experiencing rapid expansion of their cognition, skills and knowledge. The school environment addresses many of their developmental needs through education, sports and social interactions. These team players are blossoming. Their social network expands, parents are no longer the centre/controller of all knowledge, peers become very important and teachers know best. Through new friendships, the need to conform is confronted and social norms are challenged. As an individual or member of a peer group, they are in harm’s way, with injury just waiting to occur as they test their developing skills and generally play.

Injury is their main reason for any contact with health professionals. Infectious diseases are on the decline due to the national goals of countries for immunisation and the continual development of new vaccines. Health care is generally community-based, with practice nurses and general practitioners, and visits to hospital for injury and complex or serious acute illnesses are few. Parents are therefore the primary carers of sick or injured children.

When children are in contact with health professionals, a family strengths model for care is essential. These children are beginning to care for their own health; we must build on their strengths and continue to educate and advise them for optimum health. The child must not be ignored through a family-centred orientation; child-centred care must remain a priority – it must be incorporated into the family-centred care model. There is an urgent need for research in this area to ensure these children receive the best possible care from the nurses with whom they are in contact. Most research is this area targets hospitalised children, yet these children receive the bulk of their care in the community.

Community involvement in acute care and higher acuity levels of hospitalised patients have resulted in increased parental responsibility. This increases parental fatigue and work-related pressures where a parent needs to take leave from work to
care for a sick or injured child. The need to access sick/family leave can increase parental stress. With more parents working there is a need for policy and attitude changes to enable parents to provide care for their children, and have access to paid leave when they themselves are ill. Meeting the healthcare needs of the middle child is complex. Health services must support family strengths and develop collaborative approaches to care.

**KEY POINTS**

- Children in their middle years are generally healthy.
- Medical/nursing assistance is more likely for injury than an acute illness.
- The needs of the hospitalised child are important to ensure independence and involvement in health decision making.
- They may be injured anywhere: school, home, sports, community.
- They are subjected to intentional injury at school through bullying and at home.

**CRITICAL QUESTIONS**

1. What are the needs of an acutely ill child in different settings? Are they different? If so why; if not why?
2. What is the impact on parents when their middle-aged child is injured?
3. What is the impact on parents when their middle-aged child is acutely ill?
4. What is the impact on families when a middle-aged child is ill/injured? How does this differ from the impact on the parents?
5. Explain the difference between family- and child-centred care.
6. Why is the middle childhood age group called ‘the forgotten years’?
7. How do these children’s needs differ in the general practice setting and the hospital setting?

**USEFUL RESOURCES**


Australian Indigenous HealthInfoNet: [http://www.healthinfonet.ecu.edu.au/?gclid=CLCRp-CkylECFamgQodkksADg](http://www.healthinfonet.ecu.edu.au/?gclid=CLCRp-CkylECFamgQodkksADg)


Kidsafe New Zealand: http://www.safekids.org.nz/


Raising Children in New Zealand: http://www.raisingchildren.org.nz/

Raising Children Network the Australian parenting website: http://raisingchildren.net.au/

Royal Children’s Hospital Melbourne: www.rch.org.au/


Starship Children’s Health, Auckland: https://www.starship.org.nz

Statistics New Zealand: http://www.stats.govt.nz/

The Children’s Social Health Monitor New Zealand: http://www.nzchildren.co.nz/

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