

**HU Belgium**  
**HUMANISATION OF PEDIATRIC WARDS IN EUROPE:**  
**REASONS FOR SUCCESS AND FAILURES**

Brussels Symposium  
Friday 7 and Saturday 8 December 2001

**FINAL REPORT**

**I. Objectives of the International Symposium**

The major aim of the Symposium were:

- 1) To compare experiences on the development of children-friendly hospitals and the implementation of the Charter of Each in the European countries. The Charter, based on the Charter of Leyden (1988) was adopted in 1993 by most European countries.
- 2) To identify the major difficulties encountered in the implementation of the Charter in the different European countries.
- 3) To identify the main objectives and strategies to be developed to overcome these difficulties.

**II. An international survey**

An international survey was conducted before the Symposium. Representatives from the following countries took part to the survey: Belgium, France, Germany, England, Ireland, Italy, the Netherlands, Portugal, Switzerland, Sweden, Wales, Yugoslavia, and Japan. Participants were asked the following questions:

**Question:** Are you aware of a programme in your country intended to improve the conditions of children hospitalised ?

**Answers:** All representatives answered yes, except those from Yugoslavia.

**Question:** Does the programme refer specifically to the Charter of EACH ?

**Answers:** Most representatives answered that in some hospitals references was made to the Charter, while in other hospitals not. In Germany, Ireland, The Netherlands and Portugal, reference to the Charter was constant, while in England and Wales no reference was made to the Charter.

**Question:** Who was responsible for initiating, conducting and funding the programmes ?

**Answers:** In most countries, the programmes were initiated and conducted by Parents Associations and/or Welfare Associations. In Ireland, Switzerland and Sweden the programmes depended on local hospitals. In The Netherlands, an official body 'Kind en Gezin' conducted the programmes. In England and Wales, the Departments of Health were closely associated with the funding and development of the programmes.

**Question:** What are main priorities in the application of the Charter of EACH ?

**Answers:** In summary, the following articles of the Charter were considered of highest priority: article 4, then articles 3 and 5, then article 7, then 6 and 2, then 9, then 1 and 8.

**Question:** What are the main difficulties in the application of the Charter of EACH ?

**Answers:** In summary, the following articles of the Charter were considered the most difficult to apply: article 3, then 5, 6, 8 and 9, then 7, then 4, 10 and 2.

In summary, the articles most frequently cited in the survey were :

**Article 3 (Main priority and main difficulty of implementation)**

Accommodation should be offered to all parents and they should be helped and encouraged to stay. Parents should not need to incur additional costs or suffer loss of income. In order to share in the care of their child, parents should be kept informed about ward routine and their active participation encouraged.

**Article 4 (Main priority)**

Children and parents shall have the right to be informed in a manner appropriate to age and understanding. Steps should be taken to mitigate physical and emotional stress.

**Article 5 (Main priority and main difficulty of implementation)**

Children and parents have the right to informed participation in all decisions involving their health care. Every child shall be protected from unnecessary medical treatment and investigation.

**Article 6 (Main difficulty of implementation)**

Children shall be cared for together with children who have the same developmental needs and shall not be admitted to adult wards. There should be no age restrictions for visitors to children in hospital.

**Article 8 (Main difficulty of implementation)**

Staff whose training and skills enable them to respond to the physical, emotional and developmental needs of children and families shall care for children.

**Article 9 (Main difficulty of implementation)**

The team caring should ensure continuity of care for children.

**Question:** Would an official recognition of the Charter of EACH in your country help contribute to its implementation ?

**Answers:**

Yes, for all countries, except for England and Wales, where the Charter is largely implemented.

### **III. The two-day workshops**

Based on the answers to the survey regarding the articles considered as having the highest priority or that were the most difficult to implement, four workshops were organized.

Workshops:

1. Parents should be helped and encouraged to stay (**Article 3 of the Charter of EACH**).
2. Adequate information, reduction of stress and continuity of care (**Articles 4 and 9**).
3. Children shall not be admitted to adult wards; no age restrictions for visitors (**Articles 6**).
4. Trained medical staff, informed participation to medical decisions, protection against unnecessary treatment or investigation (**Articles 5 and 8**).

Each workshop included a Coordinator who conducted the debates, and a Secretary who reported the discussions during a plenary session.

The following paragraphs summarize the major conclusions and suggestions collected in the four workshops during the two days of discussion.

## **Issue I : "Parents should be helped and encouraged to stay"**

### 1. The presence and the role of parents

- 1.1. The presence of parents and siblings should be encouraged whenever possible, day and night, independently of the child's age or condition. Siblings of all ages should be allowed for visits. The presence of family members must be considered as a right, not as an obligation.
- 1.2. If parents are unable or unwilling to take an active role in the care of their child, the child is entitled to receive this care from a suitable substitute carer, who is accepted by the child, and who, in cooperation with the parents, can ensure continuity of care.

### 2. Information of the parents

- 2.1. Families should be instructed about their child's medical condition, in order to be competent to care for the child after his/her return home.
- 2.2. A special attention should be devoted to socially disadvantage families. They are less prone to assist their child during hospitalisation and are more at risk financially.

### 3. Information of the accompanying persons

- 3.1. Families should be informed regarding their presence in the hospital, in particular to adapt their behaviours to the needs and rules of the institution.
- 3.2. A framework should be clearly outlined within which the roles of the parents and the staff should be redefined, including their respective rights, responsibilities and duties.
- 3.3. The medical and the nursing staff should be educated to adequately cope with the presence and needs of families.

### 4. Support for the parents

- 4.1. Accommodation should be offered to all parents and they should be helped and encouraged to stay.
- 4.2. There is a need for adequate infrastructures if parents and/or families should stay in the hospital.

### 5. Financial support

- 5.1. Parents should not need to incur additional costs or suffer loss of income.
- 5.2. Adequate financial support should be granted to both the institution and the families to adapt to their respective needs during the stay of the family. This includes for the institution, adequate support of the extra workload and time devoted to the families. For the families, this implies adequate legal leave from work with support for extra costs.

### 6. Parents Associations

6. The role of parents associations should be defined, including their implication in the moral and financial support of the families, or their role in fund raising for the support of local programmes of children-friendly hospitals.

## **Issue II: "Adequate information, reduction of stress, and continuity of care"**

### 1. Adequate information

- 1.1. Children and families should receive adequate and appropriate information about the child's health condition, and treatment opportunities and limitations.
- 1.2. The accessibility of medical documents to family members should be clearly defined. Some difficult issues should be considered (mishandling, divorced couples, adolescent's privacy).
- 1.3. The notion of informed consent should be defined for the child as for the family. Issues relative to age and the right to refuse a treatment should be addressed.
- 1.4. Children should the right to refuse inclusion in clinical studies. Parents have the same right if the children are too small to express their own view.
- 1.5. Efforts should be devoted to the information of the public on pediatric health issues. A special attention should be given to migrant populations, more at risk of health problems and exclusion from information.

### 2. Reduction of pain and stress

2. Pain should be prevented and treated as efficiently as possible, including in emergency care units. A multidisciplinary approach is needed for the education of the health professionals as for daily care of the children.

### 3. The legal place of children

3. It was suggested that EACH investigates the place of children in national laws in Europe.

## **Issue III: "Children not be admitted to adult wards; no age restrictions for visitors"**

### 1. The need for hospitalisation

- 1.1. The rights and needs of sick children must be respected whether they are cared for at home or in hospital
- 1.2. Hospitals should favour the development of day-care centres, to develop working relations with family doctor, and to contribute to home care whenever possible.
- 1.3. Before being hospitalised, children should be introduced to the hospital environment and staff.
- 1.4. The medical staff should be educated in order to reduce the frequency of unneeded hospitalisations.
- 1.5. Referrals to primary health cares should be favoured by public information campaigns.

## 2. Pediatric wards

- 2.1. Within the hospitals, children should be concentrated according to their ages and needs.
- 2.2. Children should be admitted in children's wards, including pediatric intensive care units, and should not be admitted in wards for adults.
- 2.3. Adequate hospital environment and care should be developed for adolescents.
- 2.4. The transition from Adolescent Medicine to Adult medicine should be organized.

## 3. Continuous education for hospitalised children

- 3.1. It was suggested that pedagogic projects be included into the Charter, in favour of continuous education during the child's stay in hospital. In particular, continuous communication with the child's school should be favoured.
- 3.2. Efforts should be developed to favour play therapy.

## 4. Support

4. Adequate infrastructures and financial support should be developed to adapt the above suggestions.

## 5. Survey

5. It was suggested that a survey be conducted in Europe to evaluate the needs for treatments of children in hospitals, day-care centres or at home.

## **Issue IV: "Trained medical staff, informed participation to medical decisions, protection against unnecessary treatment or investigation"**

### 1. Continuous training on the needs of children, adolescents and families for health professionals.

- 1.1. Health professionals caring for children should have training and skills to respond to the physical, emotional and developmental needs of children and families.
- 1.2. Health professionals should received basic as well as continuing education on the needs of children. Experts should contribute to the education programmes. Psychologists should be included in the process.
- 1.3. Health professionals should be educated on the needs of adolescents.
- 1.4. All health professionals should be educated on optimal relation with children and families. Both basic and continuous education programmes should be developed.

### 2. A team to care for the hospitalised child

2. The care of children should rely on a team work, that includes the staff, the family and the child. In particular, multidisciplinary decisions should be favoured before investigations or treatments, including the family and the child, who may give his/her consent.

### 3. Adequate financial support

3. Pediatric departments should be adequately funded to include time for contacts with families.

## **IV. Conclusions**

The international meeting organized by HU offered the participants the chance to exchange their practical experience on "**HUMANISATION OF PEDIATRIC WARDS IN EUROPE: REASONS FOR SUCCESS AND FAILURES**". The active contribution of EACH was a major condition for the success of the meeting.

Most participants to the workshops underlined the need for a better integration of families within the hospital environment. Parents when present, contribute to the well-being of the child and to other aspects of hospital care, such as information, participation or pain control.

The presence of parents raise however new questions, such as the need to define a framework for an optimal collaboration between parents and health professionals, or the issue of financial support for both the institution and families to cope with their presence in the hospital.

## **V. Future developments**

It was hoped that the present summary document could serve as a useful tool for further meetings, organized throughout Europe, with the view to attach more human values to the medical care of children and adolescents within as well as outside the hospital.

Most participants raised great hope that national teams of volunteers, nurses and doctors will combine their efforts for an official recognition of the Charter, both nationally as at the European level.

**January**

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