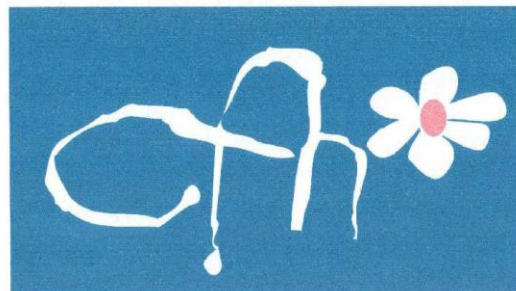# Child friendly healthcare
A manual for health workers

By Sue Nicholson and Andrew Clarke
Edited by Sue Burr and David Southall
Abridged by Alice and Oliver Ross

child friendly healthcare

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Preface

This is an assessment and implementation manual about 'Child Friendly Healthcare' (CFH) written for health workers who plan, organise, provide or give care to children and their families. The manual defines CFH by translating the articles of the United Nations Convention on the Rights of the Child (UNCRC) into simple CFH 'Standards' that are applicable to everyday healthcare practices. It provides a method and process for assessing these and a simple structure for making any wanted or needed improvements so that children and their families everywhere can receive the 'best possible' healthcare, regardless of circumstance.

The Child Friendly Healthcare Initiative (CFHI), a child health quality improvement program, was developed by Childhealth Advocacy International (CAI), Charity No: 1071486, in collaboration with The United Nations Children's Fund (UNICEF), The Child and Adolescent Department of Health and Development of the World Health Organisation (WHO), the Royal College of Paediatrics and Child Health (RCPCH), UK and the Royal College of Nursing (RCN), UK. The Community Fund, UK funded its pilot project.

The initial pilot development phase for the Child Friendly Healthcare Initiative finished at the end of 2002 and the manual was written, edited and abridged in the period that followed. Consideration of differing publishing options delayed the manual and tools being put into an easily accessible format until now. During that time numerous changes and developments have been instigated and moved forward, at local, country and global levels – including many that have been influenced by the work undertaken and shared by the CFHI project. However despite the time elapsed, the messages, truths, principles and practical methods promoted by the Child Friendly Healthcare Initiative remain as valuable and needed as ever.

Dedication

This manual is dedicated to the many hundreds of children and their families and health workers from seven main countries who participated in the pilot project, and whose thoughts, views and opinions it expresses. In addition we thank many other individuals from a variety of organisations who have given their valuable time and support to help develop the CFHI, and to our own families for their patience and understanding over the last three years.

Abbreviations

AIDS: Acquired Immunodeficiency Syndrome
BFI: Baby Friendly Initiative
CAI: Child Advocacy International
CFH: Child Friendly Healthcare
CFHI: Child Friendly Healthcare Initiative
DFID: Department for International Development (UK)
EACH: European Association for Children in Hospital
EPI: Expanded Program for Immunisation
HIV: Human Immunodeficiency Virus
IMCI: Integrated Management of Childhood Illness
IMF: International Monetary Fund
IFMS: International Federation Medical Students
ORS: Oral Rehydration Solution
ORT: Oral Rehydration Therapy
PQCG: Paediatric Quality Care Group
WFP: World Food Program
WHO: World Health Organisation
WTO: World Trade Organisation
UNICEF: United Nations Children's Fund
UNCRC: United Nations Convention of the Rights of the Child
UNMIK: United Nations Mission in Kosova
RCPCH: Royal College of Paediatrics and Child Health (UK)
RCN: Royal College of Nursing (UK)   UK: United Kingdom

How to use this book

This book is intended to help any health planner or health worker assess the level of healthcare received by the children and their families and make improvements working towards the 'best possible' resulting care. Its contents may also help parents and other carers of children.

The book is directly relevant to the healthcare of all children and its chapters are designed to be of practical assistance. It can be read as a whole, but is divided into 5 sections to assist in gaining quicker understanding of specific topics.

- **Glossary**
- **Section 1** explains why a Child Friendly Healthcare Initiative (CFHI) is needed, discusses the principles involved and its relationship with the United Nations Convention on the Rights of the Child (UNCRC). 'Child Friendly Healthcare' (CFH) is defined.

- **Section 2** describes and discusses each of the 12 'Child Friendly Healthcare' Standards and their supporting criteria.

- **Sections 3 and 4** explain how to find out if you are 'Child Friendly' and how to use the findings from an assessment to 'make it better', that is to plan, make and acknowledge improvements. They also explain how others can help you. The concepts, ideas and processes in these chapters are not new, but simplified in this book.

- **Section 5** explains useful activities that support 'best possible' practice. It contains useful examples collected during visits to the health facilities participating in the development of the program.

- **The Appendix which is to be placed on the website www.cfhiuk.org** contains **'**The CFH Toolkit'. The tools cover the assessment of all the aspects of healthcare for children and their families. Tool 1 is designed to help identify, prioritise and select CFH Standards for improvement; Tool 2 provides a more detailed assessment of the chosen aspect of care including identification of the level of care currently provided and, if not the 'best possible', suggests improvements by planning and implementation of realistic, and sustainable development.

The appendix also contains examples of the following forms and policies:
- An evaluation form
- A format for writing an assessment report
- A policy for preventing and managing a needle stick injury
- Data that can be collected to provide information about a population's health
- A toy safety policy
- A consent form
- Essential equipment, medical supplies and drugs for emergencies
- Job aides
- Organising and running a training course
- Writing and funding a project proposal

Biographies

Dr Meriel Susan Nicholson FRCP, FRCPCH, FRIPH
Project Director for the pilot of the CFHI
Sue is a retired Paediatrician with a wide experience of child health and paediatrics. Her working career included time spent as a family planning doctor, a general practitioner, a community health doctor and a hospital consultant. Although she practiced as a general paediatrician, special interests have included developmental paediatrics, child protection, school health, neonatal medicine, infection control, rheumatology, International Child Health and the training of doctors and other health workers. She was a member of EACD (European Association of Childhood Disability), an associate police surgeon and a fellow of 3 Royal Colleges. Although interests outside medicine are centred round her 4 adult children and 6 grandchildren, she is also an accomplished skier and gardener.

Andrew Clarke BSc, RN (Child), RHV
Project Officer for the pilot of the CFHI – now Honorary CFHI Director
Andrew is a paediatric nurse and Specialist Community Practitioner in public health. He currently divides his time between the United Kingdom where he works as a community Health Visitor in East Lancashire, and Nepal where he is employed as Health Advisor (practice and development) for the children's charity Child Welfare Scheme.
His interests span across international maternal and child health, but particularly in care giving practices (attitudes and approaches), symptom control, utilising communities as vehicles for change, child protection and clinical innovation with low resources.
Andrew is married with two young children and a helpful family – whose ongoing support makes his international work possible and whom he'd like to thank.

Sue Burr OBE FRCN HFRCPCH RSCN RGN RHV RNT MA
Sue Burr held a variety of posts in hospital, community, and educational settings focusing on the nursing of children prior to being appointed the Royal College of Nursing's (RCN) first Adviser in Paediatric Nursing in 1984 a post she held till her retirement in 2002.

Sue's career spanned many changes and her interest and passion was that the psychosocial needs of the child and their family, with parents being real partners in care, should progress alongside developments in nurse education and clinical advances.

As an active member of various national and international organisations such as Board member of UNICEF UK & Trustee of Action for Sick Children and Contact A Family Sue was committed to multi-agency/multi-professional working.

Sue's appointment in 1995 as a Specialist Adviser to the House of Commons Select Committee on Health's Inquiry into Services for Children was in recognition of her standing and achievements in UK health policy.

Dr. David Southall OBE MBBS MD FRCPCH
David Southall is honorary medical director of Childhealth Advocacy International. He is the chair of the working party for CFHI. His main interests are the safe and effective management of emergencies in pregnancy, infancy and childhood. He has published many papers concerning the protection of children from abuse and is active in developing child protection systems for poorly resourced countries. He is particularly worried about the concept of suffering and how little attention is drawn to this in current international programs for mothers and children. He is also active in developing palliative care systems for disadvantaged countries. He has directed the development of many teaching materials for managing emergencies as well as a textbook of International Child Health Care.

He is a consultant paediatrician active in acute general paediatrics in the UK National Health Service and was Foundation Professor of Paediatrics at Keele University before his retirement.

Alice Leahy BA, MBBS, MRCP, Msc
Consultant paediatrician at Southampton General Hospital and lead for paediatric resuscitation; mother of five

Oliver Ross MbChb, FRCA
Consultant paediatric anaesthetist at Southampton, medical humanitarian experience, five children (same ones as Alice above)

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9. Mission Statements *with examples*
10. Problem solving
11. Team working and leadership *with an example of a health facility management structure*

Examples of the following are on the CFHI website:

- An evaluation form
- A format for writing an assessment report
- A policy for preventing and managing a needle stick injury
- Data that can be collected to provide information about a population's health
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Website: http://www.mcai.org.uk

CHILD FRIENDLY HEALTHCARE INITIATIVE

GLOSSARY OF TERMS

ADVOCACY in this context means speaking on behalf of children and/or their families who are either unable or unwilling to speak about their unmet needs, situations, or people that make them unsafe, or abuse of their rights. It is acting as a 'voice' for someone who has no 'voice' or is unable to use it.

ASSESSMENT /SELF-ASSESSMENT is the process of measuring the quality of an activity, service or organisation. It is a method for:

- Arriving at an objective view of current performance
- Finding a base-line for the measurement of continuous improvement
- Identifying evidence to validate judgements
- Highlighting areas that show where performance is satisfactory or good
- Highlighting areas that require further improvements
- Seeing the way forward as part of a cycle of continuous improvement

ATTITUDES are complex mental processes that motivate behaviour and are thought to influence the way we process information.

A CARE PATHWAY *(patient pathway)* is the exact story of a child's healthcare from the time of arrival at a health facility to the time of discharge or death.

A **CARE PLAN** is a written document that is developed with the parent/carer and child, if old enough. It details the roles and responsibilities of everyone involved in the child's care and when this requires reviewing.

A **CARER** is a person nominated by a parent/s or the state to provide care for a child in place of a parent/s.

A **CHILD** is a person up to their 18th birthday/the age of 18 years (UN)
An **older child** is a child around the age of seven and older. Common sense is needed in interpreting 'an older child' as children will vary in their maturity and willingness to answer questions.
A **young child** is usually less than seven years of age, although sometimes a younger child will be able to answer questions designed for the parents and older children
An **adolescent** is a person in the 10 – 19 years age group *(WHO)*
A **vulnerable child** is a child whose right to survival, development, protection or participation is not being met or is compromised

CHILD FRIENDLY HEALTHCARE is 'the best possible' health care provided by health workers who work together to minimise the fear, anxiety and suffering of children and their families by supporting and practicing the 12 Child Friendly Healthcare 'Standards' promoted in this book, and who advocate for their child patients.

COLLABORATIVE means working together.

CONSULTATION is a social interaction during which the opinions of everyone involved are sought before a decision is made.

CORE DATA SET is a minimum set of information related to a specific healthcare problem. It includes demographic, treatment and outcome data.

CRITERIA provide the more detailed and practical information on how to achieve each CFH standard. They can be described as structure, process or outcome criteria. They illustrate the standard and provide a way of measuring it. (c*riteria describe activities to be performed, whereas standards state the level at which they are to be performed. An essential criterion is one that must be met*)

- **Structure criteria** are the resources required in order to carry out the process stage of a standard eg policies, procedures, documents, personnel, training, equipment
- **Process criteria** are the actions undertaken by staff in order to achieve certain results. For examples, assessment techniques and procedures or patient education
- **Outcome criteria** are the desired effect of care in terms of patient responses, behaviour, clinical condition, level of knowledge, satisfaction with care

DISABILITY is a lack or impairment of a particular capability or skill (*The Child with a Handicap by DMB Hall)*

ETHNICITY concerns nations or races, it is about the customs, dress, food of a particular racial group or cult.

EMOTIONAL MATURITY is reached when a person acts and behaves responsibly, is able to contribute to the well-being of their community, and understands and is able to meet and support a child's individual emotional needs.

FOOD SECURITY (GLOBAL) is a state of affairs where all people at all times have access to safe and nutritious food to maintain a healthy and active life, and where there is no risk of house-holds losing physical and economic access to adequate food (The State of Food Insecurity in the World 2003 Monitoring progress towards the World Food Summit and Millennium Development Goals. Food and Agriculture Organisation of the United Nations ISBN 92-5-104986-6).

GLOBALISATION is the process of increasing economic, political and social inter-dependence and global integration that takes place as capital, traded goods, persons, concepts, images, ideas and values diffuse across state boundaries (*WHO definition*)

A HANDICAP is any condition that prevents or hinders the pursuit or achievement of desired goals. Sheridan M 1969

HEALTH is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.   The Definition has not been amended since 1948.

HEALTHCARE is informed advice, assessment, monitoring, assistance or treatment given for health reasons. It includes preventive, investigative, curative, palliative and supportive care.
Appropriate healthcare is the 'best possible'* healthcare given without compromising the care given to other children sharing the same health worker, health facility or health service.
Effective health care is healthcare that achieves its objectives.
Evidence-based healthcare is based on a process of systematically finding, appraising and using contemporaneous research findings to support the healthcare given.

A healthcare related policy is a written principle that governs an activity that health workers must follow, about how to do something that must be followed by all health workers (a must do) for example an evacuation policy, a drug safety policy, a hand washing policy and others.

A system of care is a clear detailed method for dealing with a situation, event or problem.

A **HEALTHCARE ENVIRONMENT** is any place where a patient is given informed advice, assessment, monitoring, assistance or treatment.

A **HEALTH FACILITY (HF)** is an environment designated and funded for providing health care.

An '**In-patient' HF** is a hospital or other institution where users stay overnight for health reasons (ie. are resident)

A **HEALTHCARE PROVIDER** is any organisation or individual that is in any way responsible for planning, organising and/or providing health care.

A **HEALTHCARE ORGANISATION** is any authority that is responsible for providing healthcare services.

Primary or community services are those health services whose health workers usually see the child and family first. They are usually located near the child's home and give basic health care to a child living at home whose health problem is not serious enough to require admission to a health facility, or an opinion from another more skilled health worker.

Secondary/referral level/specialist services are those provided and given by children's health workers who see a child referred from primary care for a second opinion, or a specialist opinion, about their health problem. They are usually able to admit a child for overnight healthcare and include all types of hospital care.

A **HEALTH WORKER** is any person employed to give any form of health care, or who is working as a volunteer.

A professional health worker is any person with a health or health related qualification who is employed to give any form of health care, or who is working as a volunteer.

A skilled health worker has experience and special training to equip them for the job they are doing. They may or may not have a professional qualification relating to children's healthcare.

A key health worker is an identified individual with special responsibility, for example for a child/family or a project/program such as infection control

HYGIENE is the principles and practices relating to cleanliness

An INDUCTION TRAINING/PROGRAM is a program of learning activities designed to enable new health workers to a clinical area, type of health care or employment to function effectively in their new job.

An INFECTION is the state or condition in which the body, or part of it, is invaded by a pathogen that, under favourable conditions, multiplies and causes a health problem. A pathogen is a micro- organism capable of producing disease.

Infection control is a program of activities that investigate, prevent and control the spread of infections and the micro-organisms which cause them.

A healthcare acquired/related infection is an infection acquired while receiving any type of healthcare or related to receiving healthcare. A hospital acquired/related infection is an infection acquired while attending or resident in a health facility.

A **pathogen** is a micro-organism that can cause disease.

The INTEGRATED MANAGEMENT of CHILDHOOD ILLNESS (IMCI) is a World Health Organisation Program for delivering healthcare to children. It has very clear management, treatment and referral pathways and an associated training program for the health workers who implement it. (www.who.int/child-adolescent-health/integr.htm)

MONITORING is the process of collecting information about performance. Monitoring may be intermittent or continuous.

OUTCOME is a measure of the effects, beneficial or adverse, which a person experiences as a result of care, treatments or services they have received.

PEER REVIEW is a review of a service by those with expertise and experience in that service, either as a provider, user or carer.

A POLICY is a principle about how to do something that must be followed by all health workers, for example, a hand washing policy. It is usually written.

A PROGRAM is a planned series of events for a purpose

A PROTOCOL is a written recommendation, rule or standard to be followed in a situation where a rational procedure can be specified. *For example, a plan of action, an antibiotic protocol for a certain condition/s, assessment and treatment of shock*

PSYCHO-MOTOR DEVELOPMENT is a combination of motor and psychological (mental, social, behavioural and emotional) development

RISK ASSESSMENT and MANAGEMENT is a systematic approach to assessing and managing risk. Its aim is to reduce loss of life, financial loss, loss of health worker availability, health worker, child and carer safety, loss of buildings, equipment or reputation.

A SAFE MOTHERHOOD PROGRAM includes healthcare during pregnancy, during delivery, after delivery and advice given about sexual health, breastfeeding and family spacing.

SANITATION means the infrastructures and equipment for preserving public health and protecting people from harmful contamination; for example keeping the water supply and waste disposal safe and secure.

SKILL MIX is a term given to a general process of reviewing and, if necessary, changing the ways in which traditional health care is delivered to patients.

SOCIAL WORK is the provision of advice and practical help for problems resulting from social circumstances. A social worker supports vulnerable people.

A STANDARD is an agreed level of performance, appropriate to the population addressed. It is observable, achievable, measurable and desirable

Generic **STANDARDS** are standards that apply to most, if not all clinical services

A SYSTEM is a clear detailed way of dealing with a healthcare situation, event or problem.

A TOOL assesses performance against a standard. Tools include interviews (open, semi-structured or structured), questionnaires, structured observations, checklists and benchmarking.

Section 1

Why a 'Child Friendly' Healthcare Initiative (CFHI)?
An introduction
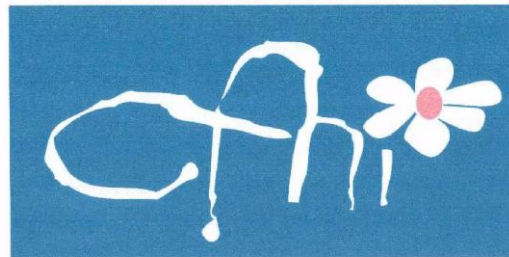
child friendly healthcare initiative

Why is Child Friendly Healthcare important?

The aims and objectives of the CFHI are to improve the quality of health care given to children and families across the world and to reduce unnecessary fear, anxiety and suffering during and because of a healthcare experience. It does this by promoting the CFHI standards that define 'Child Friendly Healthcare' and through an assessment and improvement programme, with designated Gold, Siver and Bronze standards support health workers in providing the best possible healthcare for children and their families.

Despite the huge efforts of many health workers, a large number of health improvement programs at local, national or international level, and the humanitarian aid provided to disadvantaged countries by the international community, children are still:

- Needlessly dying, or becoming disabled, from treatable diseases and accidents
- Suffering unnecessary pain
- Experiencing unnecessary fear, anxiety and suffering during and after a healthcare experience, because their mental and psychosocial health needs are being overlooked.

Such healthcare contravenes the articles of the United Nations Convention on the Rights of the Child (UNCRC) and continues in every country in the world, rich and poor. During the pilot project for this initiative over six hundred health workers, parents, carers and children in hospitals in eight countries were interviewed between May 1999 and December 2002. Even in the most disadvantaged health facilities, there were many examples of excellent care, but everywhere there was care that can only be described as very 'child <u>un</u>friendly'.

It is not surprising if health workers do not meet a child's mental, emotional and social health needs when many children in the world do not have even their basic health needs met, but it is even more unforgivable if these needs are overlooked when resources are such that a high level of healthcare is possible.

The first duty of a nurse is 'to the patient do no harm' Florence Nightingale 1889

Worldwide most children's health workers work hard to provide the 'best possible' health care for each child and their family. However many feel overwhelmed, undervalued and uncared for and many do not know what the 'best possible' care could be. The result is a lack of incentive to make the efforts required for change. Allied to this is the belief that many resources are needed for change, leading to a sense of helplessness when these are absent or hard to come by.

Care of critically ill children in Africa

Others feel that they do not need to change, failing to recognise that good care can always be better. There is always the need to constantly review provision of care to meet changing needs as the needs of any society and its children change in response to new threats to health, such as changes in the economy or population movements.

The quality of healthcare varies enormously between countries, between different healthcare environments in the same country and within different clinical areas in the same health facility. It is usually more dependant on the health workers responsible than on the resources available. Many improvements can be made without an increase in existing resources by changing behaviours and

attitudes, creating more opportunities for sharing knowledge and skills, better leadership and team working and understanding and practicing the articles of the UNCRC.

During the pilot study, many of the health workers interpreted what 'Child Friendly Healthcare' means differently. There was a lack of awareness about the UNCRC and many misconceptions about the contents of its articles. Senior health workers in positions of authority, believed that children's rights and 'Child Friendly Healthcare' (which they often thought was only about play and communication) were not important priorities as they were much too busy looking after ill children. These health workers when questioned more closely knew little about the articles of the UNCRC. In many of the countries visited the UNCRC was not in the nursing or medical school curricula, nor was it a topic usually covered by life-long education/training opportunities.

Every health worker in every country from the Government Minister to the health worker that cleans the toilets, often the lowest paid and least valued health worker yet amongst the most important, has an essential contribution to make to the provision of healthcare. Virtually all the world's countries have ratified the UNCRC, so health workers have a responsibility to follow its philosophies during their daily work. The CFHI has developed simple 'Child Friendly Healthcare' Standards that translate its articles into every day health practices.

Promoting, assessing and supporting these 'CFH Standards' will contribute to sustainable improvements in the quality of healthcare received by children and families across the world, whatever the circumstances.

A reminder about the United Nations Convention on the Rights of the Child

UNCRC adopted by the United Nations assembly on 22nd November 1989, is a legal International document of unprecedented scope. The convention with its 54 articles is the most widely accepted International convention in the world with all but one country ratifying it. It is about a child's right to

- **Survival** (to life and healthcare),
- **Protection** (from all forms of abuse, exploitation or neglect),
- **Development** to their fullest potential physically, mentally and socially),
- **Participation** (to be informed, able to express their opinions freely and to have their views taken into account).

'In the middle of difficulty lies opportunity' Albert Einstein)

A reminder about the UNCRC found in a ward in a hospital in Pakistan

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The articles of the Convention, which were developed following wide global consultation and research, apply to every child from birth to 18 years of age without discrimination. They focus on a child's best interests and, although they reinforce the role of the family as the main carers and protectors, they also re-affirm the State's responsibility to provide legal and other protection. The Convention is different from other human rights laws as it recognises that, because of the special vulnerability of children, they need special laws and care to support their nurture and protection. It respects cultural values but also highlights the importance of international cooperation.

By ratifying the Convention's 54 articles, 192 governments of the world's 193 countries have pledged to review their national laws and practices to comply with these. A democratically elected International Committee monitors compliance via mandatory five-year progress reports from these countries.

The Convention is divided into three parts.
- Part 1 (the main part) contains the 41 articles that relate to children's rights.
- Part 2 has four articles that are concerned with a country's implementation and monitoring of the convention; in particular a country's obligations to actively inform their citizens about the convention and to contribute to the monitoring committee.
- Part 3 contains nine articles about its administration.

The articles that relate directly to children's health care are:
Article 2: Equal rights to care with no discrimination for any reason
Article 3: Whenever an adult makes any decision about a child or takes any action that affects the child this should be what is best for the child
Article 6: The right to live
Article 7: The right to a name and nationality, and to be cared for by parents
Article 9: The right to remain with parents, or in contact with parents, unless this is contrary to the child's 'best interests'
Article 12 and 13: The right to receive information and express views and ideas freely
Article 19: The right to be protected from any form of harm including violence, neglect, and all types of abuse
Article 23: The right of those with a disability (physical or mental) to lead a full and decent life within their community
Article 24: The right to the highest standard of health and medical care attainable (the best possible healthcare). In this article 'States' are advised to place special emphasis on the provision of primary and preventive health care, public health education, and the reduction of infant mortality, to encourage international cooperation in this regard and to strive to ensure that no child is deprived of access to effective health services
Article 27: The right to a standard of living adequate for physical, mental, spiritual, moral and social development'
Article 28: The right to education (school-type learning)
Article 30: The right of a child belonging to an ethnic, religious or linguistic minority to enjoy their culture practice their religion and use their language
Article 31: The right to rest and play
Article 38: The right to be protected from and during armed conflicts, and not to be recruited to take part in hostilities, especially before 15 years of age
Article 42: Is about the duty of the state to ensure that children's rights relating to health are made known

In countries that have ratified the UNCRC, all health workers at all levels have a duty to ensure that its principles are followed during their day to day delivery of healthcare to children and families. The CFH 'Standards' enable them to do this by translating the articles into everyday healthcare practices

What is different about the CFHI from other programs?
- It has a global mandate since it derives its principles from the articles of the UNCRC
- It is not prescriptive or dictatorial (imposed by a higher authority) but belongs to all health workers
- The suggested practical approaches of the assessment and improvement program are relevant and applicable to health workers and health planners at all levels, in any healthcare environment and in any country, as they have been developed with the help of health workers and families in many different countries and health care environments.
- It can be used for self-assessment or can be supported by invited external assessors
- Its assessment process seeks the ideas and possible solutions to problems from the health workers, children and their parents/carers thereby giving them a voice in helping to develop their own services and healthcare systems
- It enables and empowers local health workers to solve their own problems and find a way forward, however small, to improve the care they give to children and their families
- Any health care improvements made as a result of the program reflect what health workers want, what children and families want and what is feasible
- It raises levels of awareness by promoting what is possible and sharing good ideas
- It is a vehicle for other local, country and international programs, especially those seeking standards. It aims to promote all other validated programs.
- It can easily be modified and adapted to suit local circumstance
- It is low-cost or cost-neutral

What are the programs guiding principles?
1. Child Friendly Healthcare at its best possible level of practice

2. All activities to be based on the rights of the child linked with the responsibilities and duties of health workers in partnership with parents/carers, other significant family members and friends to meet these rights within the healthcare context.

3. Planned improvements arising from the program to be compatible with a country's own plans for health and acceptable to the countries' health care providers at organisational level.

4. To be a positive, encouraging and motivating experience for children, families and health workers.

5. To seek the views and opinions of children and their families in the assessment process and reflect these in the prioritising, planning, and implementing of improvements.

6. The views and opinions of all involved health care workers *(managers, health professionals, other types of health worker such as ward cleaners, porters, security staff, engineers etc)* to be sought in developing and implementing the program and to be reflected in the prioritising, planning, and implementing of improvements.

7. Barriers to providing the best possible CFH and the forces to create changes that achieve this to be identified by the assessment process.

8. The focus for improvement to be on making the best and most appropriate use of existing resources and systems of care, facilitating changes of attitude and behaviour, and optimising the skills, approaches and knowledge of health workers.

9. Planned improvements in healthcare to be:
   - Facilitated by encouraging the sharing of good ideas, examples of good practice, skills and knowledge within a healthcare environment and from other healthcare environments in the same country and other countries
   - Facilitated by empowering health workers to identify and prioritise their problems, find their own solutions to these and to function better by raising their awareness to the possibilities
   - Enabled by promoting team problem solving approaches
   - Acceptable to the religious, ethnic and cultural beliefs of the people involved providing these are compatible with the articles of the UNCRC
   - Appropriate, sustainable and where possible achievable within the available resources
   - Implemented in a prioritised staged way
   - Any support for improvements from outside the healthcare environment to be provided first by harnessing and coordinating any existing international humanitarian aid and other possible in-country support.

10. Advocacy to be encouraged and used at an appropriate level to seek more resources or additional support (new humanitarian aid projects), when without such input the healthcare available is significantly compromised.

11. Regular review and evaluation of all activities

The history of the CFHI program

The idea for a global initiative dedicated to improving the healthcare experiences of children and their families originated within the medical and nursing professions in the UK in the early 90's following the adoption by the United Nations General Assembly of the Convention on the Rights of The Child (UNCRC) on 22nd November 1989.

The concept of developing 'Standards' of care based on the articles of the UNCRC was influenced by the work of a number of other non-medical organisations dedicated to the well being of children.

In 1996 a small delegation presented a proposal for a CFHI based on such 'Standards' to UNICEF New York, who supported the idea. In 1999 a grant was received from the Community Fund UK by Child Advocacy International (CAI), a non-governmental organisation and now the lead agency for the CFHI, to undertake a pilot project for the Initiative in hospitals in the UK (also funded by a small grant from UNICEF UK) and in hospitals in five other countries.

In November 2000, a first draft of these 'Standards' was published in *Pediatrics* [1] and later the same year the Child and Adolescent Department of Health and Development of the World Health Organisation offered technical support to the project followed by help with identifying hospitals in four countries, in addition to those in the UK, where the pilot project was acceptable to the regional and country UNICEF and WHO representatives.

The remit of the pilot project was to research and consult widely to develop the CFH Standards and their supporting criteria, to promote and support child friendly healthcare practices, and with the help of the health workers and families in the chosen hospitals to develop the methodology and processes to assess

and improve 'Child Friendly Healthcare'. These are described in this book. The CFHI is guided by an 'Advisory Committee'.

The number of sites that contributed to the pilot project was limited by the time and resources available. More countries and health facilities have requested inclusion in any 'second phase' pilot. However the tools and methods developed have been designed to help health workers make progress with 'Child Friendly Healthcare' themselves without the need for an officially supported program.

Who 'owns' CFH?

'Wisdom, like knowledge and skills, is for sharing not owning'

Child Friendly Healthcare does not belong to any organisation or individual, it belongs to every health worker who practices it. The initiative to promote CFH and the program to assess and improve care has no formal accrediting body and is therefore currently owned by the health workers who use it.

What is 'Child Friendly Healthcare'?
 The best possible' integrated health care provided by health workers who minimise the fear, anxiety and suffering of children and their families by supporting and practicing the 12 Child Friendly Healthcare 'Standards'.

Who else can promote 'Child Friendly Healthcare'?
Any committed health worker who is familiar with its practices and principles can promote CFH by sharing information about the CFHI and the UNCRC with others in the same healthcare environment, in other healthcare environments in the same country and with health workers in other countries. 'Child Friendly Healthcare' belongs to every health worker that looks after children and families whether they are involved in planning, organising, providing or giving care.

What is the 'best possible' healthcare?

The practice of CFH Standards at their best possible level of practice.
The **best possible**:
- Considers the child's 'best interests'
- Covers the preventive, investigative, curative and palliative aspects of health care taking into account the most up-to-date evidence-base for each care given
- Is affordable and effective
- Is appropriate, taking into account the resources (human and material) and technology available and the needs of other children sharing these
- Is child centred* (see below)

What are a child's 'best interests'
For healthcare to be in a child's **'best interests'**, any action or decision taken on behalf of a child must:
 - Accommodate the circumstances of the situation
 - Consider the child's needs and safety to be paramount
 - Consult the child (whenever possible) and relevant others
 - Balance this with the wishes and needs of the parents and other carers wherever possible
 - Incorporate common sense
 - Look at both present and future needs
 - Be reviewed regularly and revised if circumstances change (be flexible)

*What is 'child centred' health care?

Health care that:
- Meets the needs of the individual child and their family
- Is given by skilled health workers in partnership with parents/carers and children
- Is given in areas that are suited to the needs of the individual child and family
- Takes account of a child and family's normal daily routines and experiences and attempts to ensure that these are disrupted minimally only in the 'best interests' of the child
- Supports a child and family's response to their individual problems

The CFH Standards cover all aspects of children's healthcare so inevitably overlap. Although numbered they are of equal importance. They apply to:

- A child of any age
- A child of any developmental level, including whether or not the child has a disability
- Any type of health care problem
- Health workers in any country
- All types of health worker

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Section 2
The 'Standards' and their supporting criteria

'Child Friendly Healthcare' is the best possible integrated healthcare provided by health workers who minimise the fear, anxiety and suffering of children and their families by supporting and practicing the following 12 standards:

1. Keeping children out of hospital (and other health facilities or institutions) unless this is best for the child: _Relates to CRC Articles 9, 24, 25, 3_

2. Supporting and giving the 'best possible' healthcare: _Relates to CRC Articles 2, 6, 23, 24, 37_

3. Giving healthcare safely in a secure, clean 'child friendly' environment: _Relates to CRC Article 3_

4. Giving 'child centred' healthcare: _Relates to CRC Articles 5, 9, 14, 37_

5. Sharing information and keeping parents and children consistently and fully informed and involved in all decisions: _Relates to CRC Articles 9, 12, 13, 17_

6. Providing equity of care and treating the child as an individual with rights: _Relates to CRC Articles 2, 7, 8, 9, 16, 23, 27, 29, 37_

7. Recognising and relieving pain and discomfort: _Relates to CRC Article 19_

8. Giving appropriate resuscitation, emergency and continuing care for very ill children: _Relates to CRC Articles 6, 24_

9. Enabling play and learning: _Relates to CRC Articles 6, 28, 29, 31_

10. Recognising, protecting and supporting vulnerable or abused children: _Relates to CRC Articles 3, 11, 19, 21, 20, 25, 32, 33, 34, 35, 36, 37, 39_

11. Monitoring and promoting health: _Relates to CRC Articles 6, 17, 23, 24, 33_

12. Supporting 'best possible' nutrition: _Relates to CRC Articles 3, 24, 26, 27_

There are four 'supporting criteria' common to all the CFH Standards, and although omitted from the beginning of each of the descriptions of the 12 standards below, in the interests of space, their importance cannot be overemphasised.
Each of these 4 topics are covered in detail in **Section 5**

- **Mission statements**.

- **Education and training**. Healthcare standards will not be met unless all healthcare workers have the motivation and the facilities to keep up to date with current practices. They must also receive training to allow them to work in line with improved standards.

- **Data collection and management**. This a key component of an effective, functioning health care system.

- **Audit** Participation in audit is an essential process for all those involved in provision of healthcare. It ensures that necessary changes are made to meet with accepted standards, and that all aspects of healthcare are kept continually under review

'Health care providers, organizations and individual health care workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and their families by ensuring that they keep a child in a hospital, or other health facility, only when this is in the child's 'best interests'.

A day care unit in Pakistan for children with respiratory illness
Children are observed through the day and sent home at night if well enough

Supporting criteria

1. Primary (community) and secondary (specialist) health workers for children and pregnant women work together to provide services that:
- Are accessible
- Are free or easily affordable
- Share policies (such as Integrated Management of Childhood Illness)
- Use jointly agreed referral pathways
- Include the views of children and families and consult health workers in primary or secondary facilities when they plan these services
- Are 'needs' based

2. Health services for pregnant women and children (including the newborn) with any type of health problem that includes:
- Primary (community) health services
- Secondary (referral level/specialist) 'out-patient' services with policies for admission, review (to see if it is in the child's best interests to remain under the care of the secondary service), and discharge (referral back to back to the community services):
- Secondary in-patient services with admission, daily review (to see if it is in the child's best interests to remain in the health facility) and discharge policies, day care, and outreach services that support care in the child's home:

3. Programs to prevent illness and injury (preventive services) that include:
- Systems/policies to identify and support vulnerable children and their families:
- Health monitoring, screening and promotion programs
- Strategies to protect unborn children such as a 'safe motherhood' program

Discussion

Best practice is to recognise and treat children with illnesses, disabilities and other physical or mental health problems in the community as soon as possible as this can prevent children needing a hospital visit or admission. Also to admit children, or place children in institutions, only if appropriate health care cannot be given at home. Care at home is always preferable. When care at home is not appropriate, fear anxiety and suffering can be minimised by making the hospital experience as 'child friendly' as possible.

A child friendly ward entrance (looking from the ward to the hall and lifts)

Good community preventive health programs that include health education, to help parents recognise when their child is ill, health screening, the monitoring of children's growth and development and the close monitoring of pregnant women (safe motherhood programs) can limit the number of children needing hospital care. Ideally this type of high quality health care is provided by comprehensive primary health care services that are appropriate, effective, affordable and easily accessible to all families, regardless of their financial status.

Doctors and nurses are expensive to train and employ. Overseas training programs in rich countries are not always appropriate for disadvantaged countries. Doctors and nurses receiving training in rich countries may want to use the skills they have acquired in the well resourced health services they have become accustomed to and be inclined not to return to their own poorly resourced country. The International Community has a responsibility to discourage, not encourage, this migration, and to advocate for better working conditions for health workers in their own countries rather than poach workers to support their own health services.

A team comprised of different types of health worker with appropriate delegation of tasks can make health care more accessible to more people. In countries where doctors and nurses are scarce, or not affordable, effective early healthcare can be given to children by generic health workers (ideally from the local community) trained to provide a lower level of basic care using guidelines for managing the

common conditions (for example WHO's Integrated Management of Childhood Illness (IMCI) Program with it's clear referral guidelines and early management/treatment strategies). The few trained doctors and nurses can then be deployed to support them and provide a higher level of care in the centres. This system is cost-effective and works well in Nepal with its sparse population and remote villages.

Such innovative systems to use skills effectively can also improve the delivery of healthcare in communities in advantaged countries. For example, a peripheral hospital under threat of closure in Northern Ireland, UK is now staffed solely by nurses who use guidelines to assess and treat minor accidents and emergencies, and have tele-communication support from doctors in the nearest large centre.

Tele-medicine technology that enables doctors working many miles away to see x-rays and give advice to the nurses providing the service locally

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In advantaged countries, even when accessible, affordable integrated health services do exist, children are still admitted to and remain in hospital unnecessarily. Some of these admissions can be prevented by:
- Effective triage when first seen
- Rapid same day access to a referral level (specialist) opinion if needed
- Appropriate emergency management and treatment
- Good communication between all health workers to limit unnecessary delays in treatment and discharge
- Specialist care supervised by referral level/specialist health workers given at home when possible
- 'Referral/specialist level' day care facilities whenever possible for assessment, investigation and treatment so that children can sleep at home if they live nearby

A 'Child Friendly' day surgical unit

Many children with complex or chronic illnesses (for example mental health problems, asthma, diabetes, disability and others) can be successfully managed at home if there are specialised referral services with attached out-reach services that can provide the necessary support for parents. Care in the home is of course only feasible when these resources are available, the children live within easy reach of these services and home conditions are satisfactory.

Standardised admission, daily review and discharge policies, and verbal and written discharge plans can reduce the length of time a child remains an in-patient. Best practice is to develop these in collaboration with parents and primary care and/or other relevant community professionals. To be effective they need to include a diagnosis or reason for the child's admission, a prognosis and clear instructions concerning any actions, treatment or follow-up necessary that will have implications for carers and health care staff in the community**.** There are clear advantages to writing this information into parent-held child health records

Arrangements for follow-up by the hospital, if this is necessary, and/or prescribing and dispensing drugs for taking home need to be made well before the child is due to leave so that unnecessary delays for a family are minimised. Delay in dispensing drugs or a long wait to be discharged for any reason is unacceptable practice.

Best practice is for the length of stay in an in-patient health facility to depend on research evidence integrated with local knowledge, and evidence based treatment regimes which should be adopted for the common childhood conditions. Children should not be kept in hospital for unethical treatments such as painful intra-muscular injections (when oral drugs would work equally well), for treatments that can be given at home, or for the convenience of health workers.

In all countries, but particularly in many poorly resourced countries, children are sometimes abandoned in health facilities. These children often receive inadequate nutrition with minimal stimulation (developmental and play opportunities) and no normal one-to-one care. An attachment to a single carer is essential for a child's long-term mental health and development so discharge rapidly to caring foster families rather than institutions is best practice.

Advocacy by health workers for early fostering and/or adoption for abandoned children and/or those in need of protection and care is important.

Finally good data management, regular audit leading to evaluated change, and joint education/training opportunities for all health workers (community health services and the referral level services) will all contribute to meeting this Standard thereby keeping children with their families at home as much as possible.

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STANDARD 2: Supporting and giving the 'best possible' healthcare

'Health care providers, organisations and individual health workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and their families by ensuring that they support the 'best possible' healthcare'.
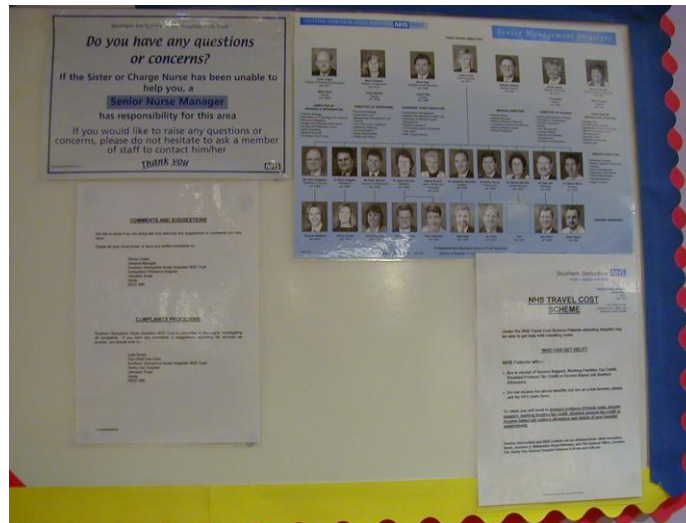
A board with information for parents/carers about how they can ask questions or share a concern. It gives information about who to contact and how, showing photographs of those responsible for the different aspects of management and healthcare.

Supporting criteria

1. **A transparent (open) management team for a health facility who delegate:**
   - The management of all the important support services to lead health workers who are accountable and responsible for the organisation, quality, budget and training for their service
   - Important healthcare tasks (such as immunisation, infection control, breast feeding, resuscitation child protection, audit, lifelong learning and others) to lead health workers who have responsibility for the policies, job aides, quality of practice and training

2. **Open management of health workers that:**
   - Appoints and dismisses health workers, validates qualifications, assesses suitability for employment, has a health worker identification system, enables safe staffing levels, identifies and addresses intimidation (bullying) and has system for disciplining health workers
   - Screens health workers for health problems, provides advice about the prevention of work related medical, psychological and emotional problems and supports those in individual health workers when these occur

3. Provision of **effective investigative and therapeutic health support services** relevant for the level of care given.

4. Provision of **effective general support services** (such as security, food preparation, laundry, cleaning and other services) relevant for the level of care given and the type of health care environment.

5. **Essential material resources** relevant for the level of care given and the type of health care environment, including:
- Health facilities that are suitable for the level of care given and needed
- Appropriate, effective, safe and sustainable clinical and non-clinical equipment (essential list of equipment compatible with WHO recommendations)
- A free or affordable, safe, secure supply of essential drugs and disposables with standardised policies for their use (essential lists compatible with WHO recommendations)

6. Appropriate **evidence-based systems of care, policies, clinical guidelines and other job aides** that are known about and used by all the health workers working in the same healthcare environment.

7. Lifelong (during and after training) **learning** (education/training) opportunities (self, internal and external) about the UNCRC and Child Friendly Healthcare and access to published research and other healthcare literature.

9. Effective management of written information (**data**) that includes the use and organisation of health records, coding systems for health problems and the collection and examination of reliable data for important key indicators about children's health.

10. Multidisciplinary clinical **audit** linked to evaluated change/s for all health workers *(See Section 5)*.

11. Access to **ethical advice** on clinical and research issues for all health workers

12. **Risk management procedures** owned and run by local health workers linked to wider risk analysis at hospital and national level. *Covered in Standard 3*

Discussion

'In order to give the best possible care to children and families, health workers need to integrate the highest quality scientific evidence with clinical expertise and the opinions of the family'
(Moyer VA. Elliot EJ. Preface in 'Evidence Based Paediatrics and Child Health).

Health care of any type that is in a child and family's 'best interests' has to be balanced with what is possible, and with the needs of other children sharing the same health worker, health facility or health service.

It is the responsibility of health workers at an organisational level to ensure these services, structures, resources and activities are in place. It is the responsibility of the health workers who give the care in partnership with the child and family to access, use and participate in these. If this is not possible because they either do not exist, or are of low quality, health workers have a responsibility to advocate for these and to continually try to 'make it better'. Advocacy is an individual and collective responsibility inspired by strong, but open and accountable leadership that delegates.

There is evidence to show that support services and generic clinical tasks (such as immunisation, breastfeeding advice, infection control, child protection and others) are usually of higher quality when delegated, providing the nominated health workers are also given the authority to effectively coordinate the task and to develop, monitor and maintain the quality of its practice. When developing their services best practice for these coordinators is to:

- Follow any existing evidence-based recommendations made by WHO and other International and National Organisations
- Acquire and regularly update their skills and knowledge
- Consider the evidence-base for their actions and policies

Lifelong learning opportunities and access to the evidence that supports 'best possible' healthcare are essential requirements for health workers if they are to increase their skills. Best practice is therefore for all professional health workers to have access during working hours to a library that has up to date medical and nursing books and journals, to the Internet, and to general and specialist professional continuing life-long education/training. However it is important to remember that access to evidence and other learning opportunities does not necessarily lead to a change from poor practice to good practice.

Policies, standardised systems of care, clinical guidelines and other job aides all contribute to supporting the best possible healthcare. However to be used successfully they need to be 'owned' and their value recognised.

Job aides in Pakistan showing pathways of care to be followed in emergencies

Danger signs in pregnancy from Bangladesh

Health workers, both professional and non-professional, are valuable. Striving to provide the 'best possible' healthcare is challenging and stressful, physically, intellectually and emotionally. It is therefore not surprising that health workers are more likely, than the general population, to develop work-related physical and mental health problems. Open terms of employment and being mentored and nurtured by employers helps prevent their loss to the country, health service and health facility. Systems for the support and care of the 'care givers' are essential if they are to provide the best possible service.

Good data management is also important as reliable and appropriate data are needed to support all aspects of health care planning and provision, audit and advocacy. This starts with the clinical record, includes the recording of high quality information, the effective organisation and management of records, the reliable coding of disease and the collection and examination of this information to produce reliable statistics for the key childhood indicators of health. All health workers have a vital part to play in this chain.

Effective manual data management in Moldova reflected by this well organised low-cost storage system

The final criterion for providing the 'best possible' health care is to have access to reliable independent advice on the many ethical issues associated with clinical practice and research.

However difficult, best practice is to allow and make time (without compromising patient care) for these important support activities during normal working hours. All these support activities are described in more detail in later sections of this book, especially in Section five which explains the best way to do these.

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STANDARD 3: Giving healthcare safely in a secure, clean 'child friendly' environment

'Health care providers, organisations and individual health workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and their families by ensuring that they give healthcare safely in a secure and clean *'child friendly' (See Standard 4)* environment'.

Supporting criteria

1. Effective security and general safety policies and systems of care to protect children, carers, visitors and health workers from accidents or other dangers while they are in a health facility.

2. Policies and systems that are used by everyone to keep equipment and health care environments clean enough to minimize the risk of acquiring a healthcare related infection

3. Other general infection control policies that are used by all health workers to minimize the risk of acquiring a healthcare related infection

4. Systems and policies that are used by all health workers to minimise work related physical, emotional and mental health problems in health workers

5. Evidence-based clinical guidelines and other job aides that are followed by all professional health workers in the healthcare environment. These include ones about hand hygiene, fire safety and evacuation, no smoking where there are children, the dangers of advertising, safe sharps disposal, and management of needle stick injuries, lifting patients, food safety, laundry safety, safe waste disposal and radiation protection. *(See also standard 2)*

Discussion

Every health worker has a responsibility to give healthcare safely and to make sure that the places where they give care are as secure, clean and 'child friendly' as possible.

Clean, safe 'Child Friendly' ward in a hospital in Wales

It is very important to protect themselves and the children and families from dangers, also to protect possessions from damage, loss or theft. Possible personal dangers for children, parents/carers, visitors and/or health workers include:

- Physical harm, for example abduction or a deliberate injury
- An accidental injury from unsafe equipment, fittings, electrics, furniture, buildings
- An unwanted side-effect from any system of care or treatment program
- A healthcare related infection
- A work related injury or illness such as HIV/AIDS, hepatitis, back injury or a stress related mental health problem.

To prevent all these dangers best practice is for health workers and families to work together to identify possible problems and solutions to prevent these. Health workers need to be able to report openly about any security or safety concerns, without fear of losing their job or harming their career prospects. Families need to be able to voice their concerns without fearing that their child's healthcare may be adversely affected. Best practice is for all health facilities to have an effective system to assess, prioritise and investigate these concerns properly.

To give healthcare safely there need to be enough health workers to look after the children that need healthcare throughout the twenty-four hours. All too often in many of the countries visited during the pilot project many health workers were present during the working day but very few during the late afternoons, evenings and nights. Children are ill throughout the 24 hours, therefore staff need to be allocated in safe numbers for every time period. Best practice is always to have enough health workers on duty to ensure each individual child's safety. When there are few health workers it is even more important to distribute these sensibly

To help limit the number of clinical mistakes, best practice is for everyone to use the same policies and guidelines for giving healthcare programs and treatments, and also to use other job aides as reminders. To develop a sense of ownership these need to be developed and introduced following wide consultation. It is also important for clinical guidelines and other job aids to be compatible with WHO and/or other International guidelines, and with any country and/or regional guidelines.

Examples include:

- security, cleaning, waste disposal, hand washing and the control of infection.
- common investigations and clinical procedures, blood transfusion.
- lifting patients
- the use of drugs and disposables and quality control measures for these that will minimise harm caused by unnecessary or inappropriate treatment.
- safe and appropriate use of blood and blood products

A hand washing reminder, but the sink is unsafe as it has a taped crack

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Responsibility for these and the management and prioritisation of risk can be delegated to named lead health worker/s who is/are given the authority to develop, monitor and change these as well as coordinate related activities.

Safety and security for people and possessions will also be helped by:
- The use of name badges by health workers and a method for identifying inpatient children, such as wrist bands
- A security system and/or security health workers at the entrances of health facilities
- Lockable storage facilities: but not for emergency equipment as this needs to be immediately available
- Having a system for children, families and health workers to report and investigate accidents, drug administration errors and infections acquired during an in-patient stay
- Accounting for health facility property
- Accountability for, and secure storage of drugs and other disposables
- Giving an individual named health worker the responsibility for protecting equipment, books and other items
- Using a structured system to reduce or eliminate losses due to accident or misadventure (Risk management). The aim of risk management is to improve the quality of care by identifying and reducing risks that might result in damage to a patient, visitor or health worker, or result in a complaint and/or litigation

To minimise the dangers associated with a fire or other disaster, best practice is for all individual health workers to:
- Know about evacuation, fire management and other general safety measures, and to contribute to any disaster practices.

Other ways to reduce accidents and harm include:
- Keeping the utilities (electrical circuits and plumbing), buildings, fittings, medical and other equipment and furniture in a good state of repair by good organisation and management, regular maintenance, risk-prioritised repairs and funding.
- Protecting children, their carers and health workers from radiation by using safe x-ray machines, lead aprons, gonad protectors and guidelines for 'which health problems need an x-ray and which do not'

Gonad protectors of different sizes

Gonad protectors for children of all sizes in an x-ray department

- Safety gates to help prevent children leaving a ward and on stairs that children may use.

Safety gates on the third floor of a building

- Window safety catches or locks to prevent children falling from opened windows.
- Banning possibly harmful advertising from a health facility, for example of formula milks
- Not allowing smoking in areas where there are children, oxygen cylinders or flammable liquids/gases

No smoking sign on a children's ward in Eastern Europe

Reducing healthcare acquired infections

Healthcare related infections cause unnecessary deaths and suffering in children and their families and also incur large costs to a health service. They affect at least 10% of all hospitalised patients in the advantaged countries and probably a higher percentage of patients in the disadvantaged countries. These infections may be acquired because a child shares the same facilities and equipment with others, from the environment, especially the work surfaces or directly from health workers. Only a very small number are caused by visitors or by other patients.

The effectiveness of hand washing and the cleanliness of the washing facilities and toilets in a health care environment correlate well with the healthcare acquired infection rate.

The infections are caused by the micro-organisms that are always around in a healthcare environment. They contaminate the hands and uniforms of health workers and colonise the sinks and other equipment.

Why is cleaning so important?
At least half of healthcare related infections can be prevented if health workers keep their hands, their uniforms, the environment and the equipment scrupulously clean to reduce the number of organisms around. It is essential that each individual health worker examines their own practice, keeps up-to-date with infection control policies, especially hand-washing and follows such policies themselves as well as ensuring that other health workers also comply.

Effective hand washing is the most important way a health worker can prevent a healthcare acquired infection
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A bucket used to flush an adjacent nurse's toilet: there are no spare parts to repair the flush mechanism, which broke a year previously, no soap and no method of hand drying

What is needed to keep hands clean?
- Enough clean toilets with nearby sinks for hand washing and a facility for hand drying
- Enough clean sinks and showers that are easy to use
- Knowledge about the importance of hand washing
- Strict hand-washing policies.
- Hand washing reminders at all sinks (when and how)
- A secure and adequate supply of soap

Soap on a string: An effective way to prevent it from being stolen

38

The only facility for washing kitchen utensils and hands in a hospital kitchen in Eastern Europe.

An effective, clean, accessible resource for hand washing in a children's ward in the UK   There is no excuse for not keeping your hands clean if you have this resource.

When there are no resources for buying paper towels, cut up material squares used once only, then laundered are just as effective

- ❑ A method for drying hands properly
- ❑ Effective methods for handling and disposing of bodies, specimens, human waste, body fluids and other waste, including a method for separating the different types of rubbish.
- ❑ A good example set by senior health workers (the pilot project confirmed that they are the worst offenders) and a culture for hand washing
- ❑ A water supply that is:
    1. Secure (never runs out)
    2. Clean and safe to drink (and is regularly tested for dangerous micro-organisms)
    3. Adequate in amount for drinking and for cleaning
    4. Hot for washing and cleaning procedures (For safety ideally hot water should be stored at 65 degrees C, distributed at 60 degrees C and then reduced to 43 degrees C to be used from the taps)
    5. Accessible in all areas where children are given healthcare

- ❑ An alcohol based product to use for hand cleaning when it is not possible or practical to wash hands
- ❑ Clean clothes always worn by health workers
- ❑ A 'no touch' policy that is followed by everyone. This means not touching anything or anyone unless essential (the affectionate hugging of children is an essential act that must be allowed) and only after hand washing.

What else needs to be clean?
Food
Hygienic food preparation, handling and storage (see The World Health Organisations' ten steps to Hygienic food preparation) will reduce the possibility of a food-born illness. Poor hand washing, frequency and technique, is strongly linked to food poisoning.

Unhygienic, unsafe parents/carers kitchen

Laundry
All bedding/curtains/towels/flannels must be regularly washed with a detergent/disinfectant. Access to Industrial quality washing machines is preferable. Water temperatures of at least 60 degrees C and preferably above should be used to destroy the micro-organisms on clothes and other materials. The uniforms of health workers need to be kept clean and used only in the same clinical area to prevent moving micro-organisms from one clinical area to another. If health workers visit more than one clinical area they should change uniforms or clothes between each area or wear disposable protective clothing over their own clothes when they move to a different clinical area

Unhygienic personal laundry facilities at a hospital in Asia

The equipment and furniture and the whole of the hospital including the grounds must also be kept scrupulously clean.

> A scrupulously clean environment is the responsibility of each and every person in the health care environment

Health workers who clean are best supervised by professional health workers and given adequate status and pay that recognises the importance of the work they are doing. They need access to sufficient cleaning agents and materials, preferably colour coded for the different areas to be cleaned and induction training about the health facility's policies and cleaning systems.

Effective and supervised cleaning policies and systems for cleaning the entrances, corridors, wards (floors, walls, window-sills, light fittings and curtains), toilets and washing facilities, kitchens and all other areas in a health facility will contribute to reducing risk of acquired infections and should cover:

- Cleaning methods used for all these different areas, also fittings, fixtures, furniture, bedding and other non-clinical equipment
- Cleaning frequency
- Cleaning materials and for what - colour coding of cleaning cloths/materials for use on different surfaces can be helpful.
- Use of cleaning agents, including disinfectants in appropriate dilutions for the task
- Effective management of spills of body fluid (blood, urine, vomit, faeces and saliva etc.)
- The cleaners or, if cleaners are not always available, others need to be trained and supervised by the senior health worker for the clinical area.
- Waste disposal systems and waste separation. Safe waste disposal systems and policies will prevent body fluids, faeces, drugs and disposables being a danger to others.

A **budget for cleaning** is essential.

Entrances of health facilities should screen visitors' shoes for dirt, corridors need to be cleaned at least twice a day with a disinfectant and ward areas need to be kept scrupulously clean. The priority is the adequacy and state of the toilets and washing areas/bathrooms. Best practice is for these to be kept scrupulously clean throughout the twenty-four hours by frequent cleaning and disinfection (See also Section 5 for more information about how to clean).

> All these issues may be seen as costly for a health service but save costs when balanced against the cost of the increase in hospital stay due to infection, the additional medications needed and the sometimes unnecessary deaths.
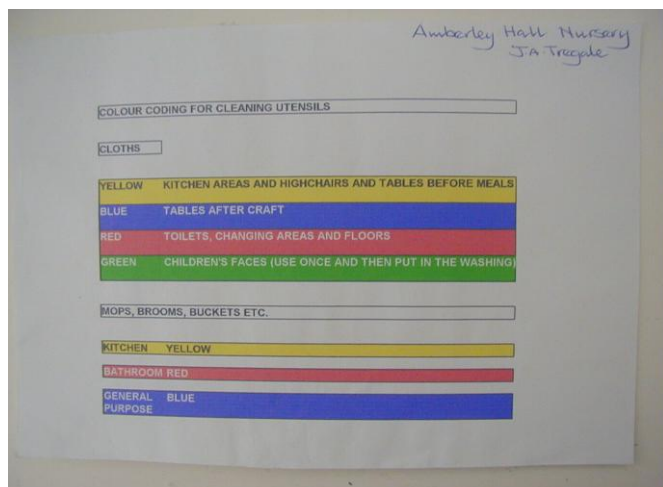
A method for using different coloured cleaning cloths for different surfaces

What else can be done to reduce the risk of a healthcare related infection?

Micro-organisms become more difficult to treat if they develop a resistance to antibiotics. This occurs if antibiotics are used indiscriminately. Best practice is for every health facility to develop and use an antibiotic policy to control and restrict the use of antibiotics. For this to be effective all prescribing health workers need to respect and follow the policy.

Other ways of reducing infection include**:**
- Limiting the number of people who look after a child. The risk of cross contamination is reduced if a child's parent/carer does as much of the child's care as possible and the number of health workers who have contact with the child is limited, particularly in high-risk areas such as intensive care
- Avoiding crowding. Adequate space between beds will also limit the risk of cross-infection

Unnecessary over-crowding of babies in a ward in Eastern Europe

- Having a system to ensure that equipment, surfaces and other objects are cleaned before use by another child
- Having a lead health worker and when resources permit an infection control team to develop and supervise all the infection control practices following wide consultation.
- Having a wound management policy (including an umbilical cord management policy)
- Having healthy staff

Best practice is for all health workers to have regular training about these security and safety issues and an opportunity to audit compliance with the policies to see if these are achieved at the 'best possible' level with the resources available**.**

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STANDARD 4: Giving 'child centred' healthcare

'Health care providers, organisations and individual health workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and families by ensuring that they provide 'child centred' care'.

A child should not be separated from their parents, unless this is in their 'best interests'
Article 9 of the UNCRC

Excluding parents can add significantly to the worry of both child and carer. In contrast, involving them has been shown to reduce many potential stress factors, improve coping mechanisms and compliance, and reduce time spent in hospital

Supporting criteria

1. Healthcare that meets each individual child's needs given by skilled and named health workers in partnership with children and carers:

2. Healthcare ideally given in areas separate from adult patients. These areas will have facilities and resources that are suitable for children of different developmental ages, their carers, breast feeding mothers and visitors*:*

3. Supportive care (general and psychosocial) for children and families:

Discussion

In some countries children are still separated from their parents and families when admitted to a hospital and in others, although mothers are allowed to stay with their children during the daytime, they are often unable to sleep near their child at night. In most, fathers have little if any access to their hospitalised baby or child, despite a lack of evidence to support the many reasons given for their exclusion given to us during the pilot project for the CFHI. It costs very little, or nothing, to allow families free access to their children in hospital and the benefits of this are far greater than any possible disadvantages. In countries where fathers have free access, concerns have not been realised.

If a young child with limited understanding is separated from a parent they feel abandoned. This feeling can cause intense suffering, similar to the suffering and grief felt by an adult when a loved person dies, and may have a permanent impact on future mental health. To avoid this emotional damage, care given at home and by familiar carers is always best whenever possible. When this is not possible and 'inpatient' care is in the 'best interests' of the child, emotional suffering can be minimized if a parent (or another carer familiar to the child chosen by the parents) is encouraged to remain with and support the child at all times, especially during procedures, If a child is asleep, unconscious or anaesthetised it is even more important that a parent/carer is there when they wake. An ill child needs the reassurance of their family's love and care even more than they normally do. Best practice is also to enable other family members and close friends to visit frequently and freely, with restrictions only when this is in the child's best interests.

'Child Friendly' hospital ward

Health workers need to always respect the parents' role as the main carers. This means helping parents/carers to care for their child as they would at home by working in partnership with parents/carers. This includes enabling the child to follow their familiar routines wherever possible.

Mother using her own mosquito net

Mother contributing to the special care of her premature baby

> **Elements of partnership include:**
> - Openness and honesty
> - Respect and trust on the part of both
> - Freedom to express oneself
> - Sensitivity
> - Commitment to sharing
> - Understanding
> - Mutual support
> - Empowerment
> - Flexibility
> - Sharing, including rights and responsibilities
> - Mutual accountability
> - Agreeing to sometimes disagree
> - Being challenging
> - Accepting of each other's reality
> - Sharing a vision
> - Listening to each other
> - Not being manipulative

A kind welcoming attitude that shows respect for the individual child and family costs nothing but can minimise anxiety and fear making healthcare and treatment easier.

Best practice is to centre healthcare for each individual child and family round the needs of the child, not round the needs of the health workers or the systems of care and includes giving healthcare that is appropriate for the child's age and level of understanding. This is best planned in partnership with the child, if old enough, and with their parents/carers. Daily individual care plans made in partnership with the child and their parents/carers are also more likely to ensure that the care planned really does meet the child's needs.

Healthcare that meets a child's needs is more likely when this care is given by health workers who only look after children, and by those who are skilled and familiar with children's differing needs. For example a neonate will need a very different type of care to a child or a young person, as will children of differing ages who have a physical or learning disability. Unskilled, unqualified or newly qualified or appointed health workers, benefit from initial supervision by more experienced and/or skilled staff, as do the children and families they care for.

Looking after ill children of differing ages is a challenging task. Skills, experience and 'Child Friendly' behaviours and attitudes are best gained by:
- Learning about children during initial training
- Attending specialised education/training programs about children's healthcare
- Obtaining a specialist children's professional qualification
- Receiving induction training when starting a new appointment or starting work in a different clinical area
- Regular education/training that continues after qualification or basic training (continuing professional development - CPD)
- Personal life and family experiences.

The anxiety of children can be further reduced if a child becomes familiar with their main health workers. This familiarity can be achieved by allocating the same health worker to a child whenever possible so that

the number of different health workers each child sees is reduced (a patient allocation system). The use of this system can also help with the organisation of care and improve information sharing between health workers and families.

A simple reminder given to a child about their nurse for the day

Note: In some countries it might be more appropriate to use Nurse and surname

Research shows that a welcoming, stimulating, pleasant environment that provides opportunities to play and learn contributes to a faster recovery from illness, and faster catch up growth and development after a slowing or stopping due to illness. The minimum quality for a healthcare environment is one that is appropriate to the child's age and level of development and similar, or better, than found in the average family's home.

Such suitable environments are easier to provide when children are cared for in children's areas or wards with different specialties going to the children rather than children going to adult areas for specialist services. Many in-patient facilities do have separate areas for caring for children of different ages. It is best if this age separation is flexible and more concerned with developmental age than actual (chronological) age. If it is in the child's best interests to be cared for on an adult ward, it is important to ensure that the children are cared for in a special area of the ward and that they have access to the same range of stimulating opportunities, environment and care as provided in children's wards.

To minimise fear, anxiety and suffering during investigations and treatments, best practice is for treatment areas, X-ray departments and other areas used by children also to have 'Child Friendly' environments, and be staffed by health workers with 'Child Friendly' behaviours and attitudes. Stairs, long corridors, waiting areas and treatment rooms can all be especially frightening for children. These can be made 'Child Friendly' at little cost by using local materials and resources thus reducing a child's fear, anxiety and distress.

'Child Friendly' stairs, UK hospital

'Child Friendly' laboratory corridor in Moldova

'Child friendly' play corner in a waiting area, UK *'Child Friendly' treatment room, UK*

It is important that healthcare environments for children are easy for families to reach. Often children's wards are on the high floors of multi-storey buildings. Even if there is a lift, it is still difficult for parents to access these, especially if they are carrying their children, other children and/or other possessions. It is difficult to escape down many flights of stairs if the building needs evacuating, especially when carrying frightened children. It is important to provide access to and supervise outside play areas (especially beneficial to children recovering from illnesses).

Hospitals need to have suitable and adequate facilities for resident parents/carers including somewhere to sleep, preferably near the child (particularly if the child is breast fed or very young). For young children beds that provide enough room for both child and parent to sleep together can be beneficial. Best practice is to have a chair at the bedside for the parent/carer to sit on during the day, storage for their possessions, adequate washing and toileting areas, food and drink provision and a suitably furnished area for relaxation. Best practice is for these to be of the same standard as found in the average family home.

Mothers able to sleep opposite or next to their child/baby

It is also important to have private, suitably furnished areas for giving explanations and other sensitive information to parents/carers and for mothers to breastfeed, the latter with facilities for expressing breast milk The support, care and understanding parents/carers and families need if their child dies is best provided by their familiar health workers in an environment that is as pleasant as possible. Best practice is always to advise parents/carers about all the facilities, and to provide written or pictorial instructions about their use

Poverty is repeatedly shown to have a direct link with a child's health, educational achievement and emotional development. When a poor family is unable to meet their child's needs, the State has a duty to intervene by providing financial and other support. Health workers are ideally placed through their intimate knowledge of a family to identify poverty and other adverse psychosocial circumstances, and to support a family's response to their individual problems. Best practice is to identify any special difficulties or problems for the child and family by asking about these early, ideally in the initial history taking. Any special difficulties and problems need to be taken into account when planning care and supported as much as possible. This support includes referring a child and/or their family to a social welfare or similar service, if these exist.

To prevent additional anxiety, fear and suffering, it is particularly important to support the emotional needs of all ill children and their families.

Audit can include children and parent 'satisfaction surveys', looking at the number of children cared for in adult wards without access to the facilities available to children compared with the number cared for in separate children's areas

Finally health workers also need support if they are to cope with the considerable stresses imposed by giving this child centred care in partnership with parents. Access to support systems enable health workers to avoid the 'burn-out' that may lead to incapacity and/or deprive the health service of their skills and experience *(See also Section 5).*

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STANDARD 5: **Sharing information and keeping parents and children consistently and fully informed and involved in all decisions.**

'Health care providers, organizations and individual health workers, share a responsibility to advocate for children and to reduce the fear and suffering of children and their families by ensuring that they keep parents and children consistently and fully informed and involved in all decisions'

Supporting criteria

1. The wearing of name badges by all health workers who also introduce themselves to children and families:

2. A system for making children and families aware of their rights to information:

3. Policies, systems and/or practices that ensure children and families are given sufficient understandable information about:
   - Their specific health problem/s
   - Any changes in their condition
   - Investigations and procedures

(these make it easier for them to contribute to decision making, to give fully informed consent and to share any necessary special care)

4. Giving information to children and families about the ward facilities and routines, and about relevant general health issues:

5. Interpreters who are available, and used when necessary

6. Systems to investigate and address complaints, positive comments and to seek the opinions, views and ideas of all health workers, children, their parents and families

7. The sharing of healthcare related information by health workers in a way that enables consistency of information giving to children and families, confidentiality, and clinical effectiveness

8. Ways of sharing non-clinical (general) information between health workers that are effective.

9. Having and using communication tools, appropriate for the circumstances, to aid effective communication (information sharing), especially for summoning help urgently

Discussion
People who use health services need to know what to expect, how to use the services provided, who to complain to if something goes wrong and how to do this, and to be fully informed in a way that they understand about anything that might affect them. These issues are best covered in a written statement that is prominently displayed in the healthcare environment

Successful organizations are good at sharing information, ensuring the participation of all their employees and clients and of meeting their clients' individual needs. This culture for information sharing minimizes misunderstandings, mistakes, disappointments and complaints. To provide the 'best possible' healthcare, information needs to be shared effectively with parents/carers and children so that they understand what will happen to them, and are able to share in the decision-making and fully participate in the healthcare needed.
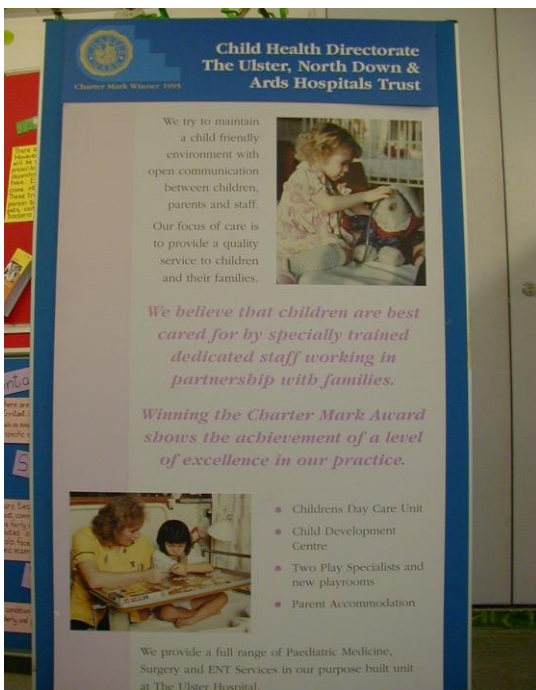
Ward rules

An example of a mission statement

Early morning meeting in Moldova for all senior health workers to share information.

To share information effectively, it is necessary to have:
- A culture in the healthcare environment that encourages the sharing of information and enables participation
- A chain of responsibility and accountability that prioritises information sharing
- A positive attitude to sharing information (the desire to share), and to work together with colleagues (team working) in partnership with children and parents
- The skills to share information effectively (so that it is fully understood) and consistently

- A system that keeps sensitive information confidential. Protecting confidentiality is vitally important unless this is not in the child 'best interests', or you have permission from the child and/or their parents to break this.
- Different methods of information sharing for different circumstances
- 'Job aides' for use as reminders, such as 'how to break bad news'
- Tools to aid information sharing, such as information boards, telephones, pager systems etc
- Privacy, mutual respect, compassion, time, and patience.

Health workers know the names of their patients and their families. Children and families want and have a right to know the names of the health workers looking after them. Best practice is therefore for all health workers to wear identification (such as name badges) and to introduce themselves to the child and family.
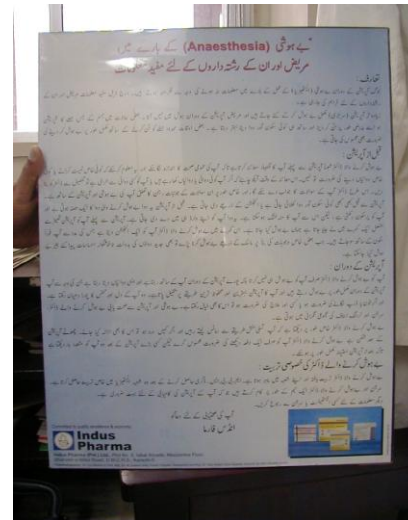
Information for parents about their child's anaesthesia and what will happen after surgery

The information health workers give to parents/carers and children may not be understood for a variety of different reasons. These include:
- The language is not the first language of the child or parent receiving the information
- The information content is not understood as knowledge of the subject matter is limited
- The format and/or words used are not easily understood
- The parent/carer or child does not want to hear what is said or is not ready to hear this
- The parent/carer or child is partially deaf
- Too much information is given at once
- The recipient is distressed, anxious or upset and therefore is not receptive (does not 'hear')
- There is not enough privacy

To avoid these problems, best practice is for health workers to have education/training opportunities for learning communication skills, about the importance of protecting confidentiality and about the evidence based suggestions for giving information, particularly for transmitting bad news.
These 'rules' include:
- Privacy and no interruptions such as a telephone ringing, a knock on the door and other interruptions.
- Introducing yourself, say who you are and what your role is
- Making sure the child or parent/carer has a close family member or friend with them if possible

- Having a second health worker present (a doctor/nurse combination works well)
- Explaining what information you intend to share and finding out before giving this what the child or parent/carer already knows
- Giving information honestly and kindly in the child or parent/carer's first language (via an interpreter if necessary)
- When it is appropriate, trying to give any positive or reassuring information first, before giving information that children and families will find difficult
- Using words that child or parent/carer is likely to understand without being patronizing. Use of pictures or mime or sign language may be helpful
- Getting regular feedback by asking child or parent/carer to tell you what you have said
- Giving the recipient the opportunity to ask questions
- Remembering that small amounts given at frequent intervals are better than too much at a time or large time gaps without information
- Backing up with written or pictorial information whenever possible
- Arranging a time to give more information
- Asking if there is anyone else in the family the child or parent/carer would like you to share the information with
- Showing compassion but remaining in control of your own emotions
- Getting permission to share with others as necessary

> Children and families need to feel confident about the abilities of those who look after them. Loss of this confidence can cause much anxiety and distress.

Some individual health workers can feel protective about the families they look after. While this is usually good, it can sometimes create a dependence that causes families to lose confidence in the care given by other health care providers. This is made even worse if a competitive atmosphere develops between different health workers and health care environments, especially when one undermines the care of the other. Such undermining makes it difficult for families who may need the care that can only be provided by the denigrated health workers or health facility at some future time. It is therefore important for health workers working in different situations to support and communicate well with each other, to share and promote consistent good practice and to be positive about all who contribute to providing healthcare for children and families, even if mistakes have been made.

A simple way of telling mothers they are welcomed and supported to see their babies, also a hand washing reminder

Communication tools vary depending on the technologies available and the task. Even basic low cost tools such as hand bells for summoning help and hand made hospital signing systems will achieve objectives. The important priority is to identify what needs to be communicated and then to decide what method or tool to use. It is up to individuals to employ the technologies available in the most appropriate way. A well-sited communication board for sharing non-clinical information may be as effective as individual more expensive handouts. The important issues are that the information is put on the board, the board is easy to see, the information is understandable and in large enough print for people to read, or in pictorial format for families unable to read.

It is also important for parents/carers to be able to share information about their child with other family members and friends. The resources for and a system to enable this are of paramount importance, especially for distant family members.
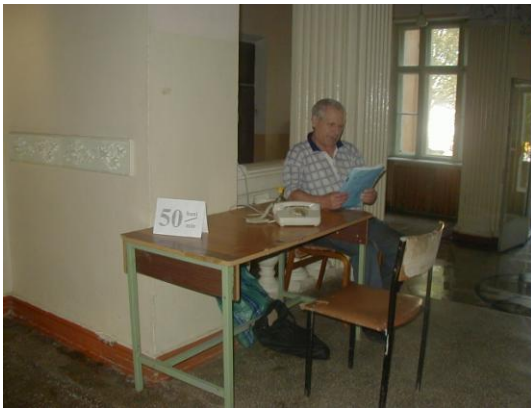
A low-cost private 'manned' telephone in a children's hospital in Eastern Europe. This enables parents/carers to contact their friends and relatives. Until the retired health worker in the picture persuaded the authorities to allow him to install the telephone, parents/carers had no secure way of contacting their relatives.

Finally best practice is to audit compliance with the policies and systems for information sharing and participation to make sure they are achieving their objectives.

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STANDARD 6: Providing equity of care and treating the child as an individual with rights

'Health care providers, organisations and individual health workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and their families by ensuring that children have equity of health care and by treating them as individuals without discrimination giving them culturally and developmentally appropriate rights to privacy, dignity, respect and confidentiality'.

Supporting criteria

1. Policies and systems of care that ensure equal access to and opportunities for preventive, investigative, curative and palliative health care that meet the needs of the individual child

2. Policies and systems of care that ensure there is no discrimination concerning age, sex, race, ethnicity, legitimacy, disability or any other reason

3. Policies and systems of care to ensure individuality (that include birth registration and use of the date of birth, a clinical record number, use of preferred name and language, provision of personal space, knowledge of personal preferences, access to and use of personal possessions and clothes).

4. Policies and systems of care that ensure respect and preservation of dignity from degrading and unnecessary procedures and treatments.

5. Policies and systems of care that ensure cultural and developmentally appropriate visual and sound privacy (especially when dressing, washing, toileting, when undergoing procedures, being given treatment and when dying; also provision of privacy for possessions):

6. Policies and systems of care that ensure written and verbal confidentiality.

Child recovering from pneumonia and receiving additional inspired oxygen through nasal cannula. He is tied to the bed to prevent him pulling out the cannula but this is unnecessary.

Discussion

Despite ratification of the UNCRC, inequity and discrimination continue to occur in most countries regardless of resources. A child's right to survival should not be dependant on their sex, age, legitimacy, whether or not they have a disability, their family' wealth, racial origin, religion, ethnic origin or any other

factor. Health workers are ideally placed to set an example to others by developing systems and policies to ensure there is no discrimination.

Equity of health care for children is dependant on many things. How far the family live from a health facility, whether there are health workers to provide care near a child's home, whether there is transport to a health facility and/or whether there is a health facility within easy reach, all influence equity. However the two most important influencing factors in many of the world's countries are the individual family's wealth and their knowledge about health.

In many countries there are often good private health services but inadequately resourced public services that are inaccessible to many families. Even if a child from a poor family does access the services, inequity remains if the family cannot find the money for investigations, necessary drugs and treatments or experience a lower level of nursing and medical care than others.

In well-resourced countries there can still be differing qualities of care given in different geographical areas and by different services in the same health facility. Children who are admitted to separate children's hospitals or to children's wards generally get better care and opportunities than children cared for on adult wards; for example they have better access to play facilities and specialised nursing skills. Some children looked after in a children's ward are also seen in adult facilities such as accident and emergency, x-ray and some surgical outpatient departments. These departments may not always meet the needs of the differing age groups of child patients who use their services.

Country and global inequity also exists for investigation and treatments, particularly regarding the availability and affordability of appropriate essential drugs and other clinical equipment. Advocacy to drug companies to make drugs more affordable in the disadvantaged countries often helps and needs to continue. Drug donations need regulation to ensure they are needed, appropriate for their purpose, of good quality and in-date. Drugs should not be tested without informed consent in any country and continued advocacy will be needed to ensure patient safety.

Equity is not only about giving the same care to each child, but is also about giving the care necessary to meet the individual child's health needs.

A child has a right to be recognised and respected as a unique person with individual physical, emotional, social and spiritual needs. Health workers can respect a child's individuality by ensuring that they:
- Approach a child in an age and developmentally appropriate way
- Use the child's preferred name
- Give a child their own health registration number at birth and ideally also a written birth certificate when there are the resources to do this
- Ask about and accommodate when possible and appropriate a child's likes and dislikes
- Allow personal space and personal possessions such as clothes and toys
- Seek, listen to and acknowledge the child's opinions, views and ideas
- Ensure that a child feels he or she always matters.
- Include any special needs in a child's daily care plan and make this plan in conjunction with the child and parents

A child also has the right to have their dignity preserved, their privacy respected and confidentiality maintained (all appropriate to age and culture). Frequently, these rights are not respected for a child. In addition to having policies and systems of care, constant vigil is needed by health workers to ensure that they do not contribute to any unnecessary fear, anxiety or suffering by failing to respect these rights.

Screens used to give visual privacy for a treatment area. Screens do not protect sound privacy.

The inclusion of education/training about the articles of the UNCRC and other human rights topics in the core training curriculum of students and in the regular life-long learning for health professionals will help all health workers understand and meet this Standard.

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STANDARD 7: **Recognising and relieving pain and discomfort**

'Health care providers, organisations and individual health workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and their families by ensuring that they recognise, assess and relieve the physical and psychological pain and discomfort of children.'

Supporting criteria

1. A separate pain and other symptom management/palliative care service/s with lead health professionals and/or multi-disciplinary team/s

2. Systems of care, guidelines and job aides (for example tools to assess and relieve pain) to help with symptom recognition, symptom assessment and restraint for procedures

3. Written guidelines, evidence based wherever possible, used by everyone to help with symptom relief, that include advice on the relief of different types of pain and other distressing symptoms **(both physical and psychological),** and on how to use non-pharmacological and pharmacological pain relieving strategies in the different ages groups:

4. Material resources including:
    - A safe, secure supply of free or affordable essential drugs for symptom relief that includes opiates and non-opiates
    - Distraction toys and other resources to aid non-pharmacological pain and other symptom management

5. The use of individual pain (and other symptom) plans made with the children and their parent/carer

6. Psychosocial support for children, families and health workers

Dressings of extensive burns, changed without adequate pain relief and without a parent present.

Discussion
The pilot project found large numbers of children in the participating countries suffering from uncontrolled pain and other distressing symptoms, both physical and psychological.

Improved technology and potential advances in care do not always protect or improve the treatment of these distressing symptoms and can on occasion be an additional cause. Routine procedures (without pain relief), such as dressing wounds are frequent causes of unnecessary pain and suffering for a child. In some countries it is common for a child to be paralysed by drugs or partially sedated without concurrent and appropriate pain relief.

The State has a role to play in making it better for children by not restricting or blocking the availability of vital pain relieving drugs (including opiates) due to security concerns or outdated and mistaken beliefs about their appropriateness for use in children and misplaced concerns about risks of addiction.

In countries where opiates are available, there may be a reluctance to use them due to these misguided beliefs and also a lack of understanding about how to use them. Whilst it is upsetting for health workers when they are unable to help a distressed child, the effects on the child and their family are much worse and can only be imagined, especially if the child has a chronic illness, a terminal illness or any other life-limiting condition.

It is ethically wrong and a failure of a health professional's duty for a child to suffer from uncontrolled pain or other distressing symptoms. This is particularly the case for a child who has a permanent disability that is associated with chronic symptoms or one who cannot be cured of their illness and may be near the end of their life. Relieving pain and distressing symptoms is not always about cure, but is about making the experience of living 'now' more bearable (that is improving the quality of remaining life).

Effective relief from pain and other distressing symptoms from birth to adulthood could be better if health workers:
- Were more aware of the suffering and discomfort that all children may experience (including newborn babies) due to pain and other distressing symptoms
- Always anticipating a child's pain and other distressing symptoms
- Gave a higher priority to relieving each individual child's pain and other distressing symptoms
- Made greater use of pain and symptom relieving drugs, both non opiates and opiates
- Understood and used simple non-pharmaceutical methods that can help (supportive, cognitive, behavioural and physical)
- Knew about and anticipated all the things that can make the experience of pain or other symptom worse.

To 'make it better' best practice is for health workers to have core (during initial training) and regular education/training opportunities on the recognition, assessment and treatment of pain and other distressing symptoms. Best possible practice is also facilitated by having, whenever possible, separate skilled health professionals who lead and guide the treatment of pain and other symptoms. Having a multidisciplinary team dedicated to symptom relief and other aspects of palliative care, and using standardised guidelines for managing pain and other distressing symptoms, are known to be effective ways of improving care and sharing good practice.

The child's normal health worker working together with the child and their carers (who know the child best) can often reduce pain and other distressing symptoms by:
- Planning each individual child's care as each child responds differently to pain and other distressing symptoms.

- Anticipating pain and taking effective measures and/or giving drugs before the symptoms occur, for example before a procedure or operation. Children with recurrent distressing symptoms should not wait for these to re-occur before receiving relief.
- Using pain/symptom assessment tools to help them recognise and assess a child's symptoms and guide the care they need.
- Giving drugs in a way that does not cause more pain and distress. Drugs are often still given in a way that is painful for the child, for example by intra muscular injection. The same drugs are frequently available and equally effective as an intravenous or oral preparation, often at a lower cost.
- Advocating for the child's needs to be met, if they are unable to meet these needs themselves.

Before using drugs, or where they are unavailable there is much that can be done to relieve suffering and make an unpleasant experience more bearable, such as:
- Being honest with the child and preparing them for what might be a painful experience can help them to cope. Anxiety and mistrust of health workers will make the experience worse
- Using appropriate play, stimulation and distraction to help in the management of pain and other symptoms
- Using heat, cold, touch and other comfort measures as these can sometimes help the distress of pain and other symptoms.
- Giving psychological support, simple kindness and involving parents and other familiar carers where possible.

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STANDARD 8: Giving appropriate resuscitation, emergency and continuing care for very ill children

'Healthcare providers, organisations and individual health care workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and their families by giving appropriate emergency care to children'.

*Emergency signs in children that need **immediate** assessment and treatment include:
- An obstructed airway (obstruction to breathing/choking)
- Severe respiratory distress (severe problem with breathing)
- Central cyanosis (blue mucous membranes)
- Shock (weak fast pulse + capillary refill longer than 3 seconds)
- Coma (unconscious and unresponsive)
- A convulsion (fit)
- Signs suggesting severe dehydration in a child with diarrhoea (any two of the following: lethargy, sunken eyes, very slow return of skin after skin pinching)

*Priority signs in children that need assessing and treating urgently (ideally within thirty minutes of arrival) include:
- Visible severe wasting
- Oedema of both feet
- Severe pallor of the palms of the hands
- Lethargy, drowsiness or reduced level of consciousness/responsiveness
- Continual irritability and restlessness
- Major burns
- Any signs of respiratory distress (any breathing problem)

A sick young infant ‹ 2 months old and a child with an urgent referral note from any other health facility/health worker should also be considered a priority.

*Reference:
The Management of the child with a serious infection or severe malnutrition – guidelines for care at the first referral level in developing countries, Department of Child and Adolescent Health and Development, World Health Organisation.

Supporting criteria

1. Provision of appropriate resuscitation/emergency and continuing care for very ill children, coordinated by lead health workers and, in a hospital, given by safe numbers of skilled health workers throughout the 24 hour period:
2. In any healthcare environment a system for **triage** (seeing the sickest children first) with:
- A policy for placing children into categories of severity
- Essential equipment such as thermometers, soap and towels, weighing machine, stethoscopes etc
- Job aides that include the WHO emergency and priority signs*, oral re-hydration volumes and methods of reducing a fever and managing convulsions, shock, respiratory failure, coma etc.
- A system for getting help:

And in a health facility **also***:
- A separate 'child and family friendly' area for triage

- A suitable 'child and family friendly' area for waiting families that has a free and adequate supply of safe oral fluids
- A private area for children who have died and their families

3. In any healthcare environment a system for providing appropriate **resuscitation and emergency care** with:
- A resuscitation policy
- Job aides for life support:
- 'Standardised' (used by everyone) clinical guidelines for managing the common emergencies
- Oxygen available at all times and in sufficient amounts with the equipment to administer it safely
- Essential* appropriate resuscitation equipment (clean, regularly checked and accessible)
- A secure supply of essential emergency drugs and standardised guidelines for their use:
- A system for getting help

And in a health facility also:
- A separate 'child and family friendly' area for resuscitating a child and giving emergency care preferably near the triage and/or assessment area
- A suitable 'child and family friendly' area for waiting families
- A private 'child and family friendly' area for children who die, and their families

*Essential means that all the equipment and drugs that are on the country's essential equipment and drug lists for providing acute care, if such lists exist, are available. For examples of essential equipment and drugs refer to 'International Child Health', 'Pocket Emergency Paediatric Care' and/or WHO's 'Management of the child with a serious infection or severe malnutrition and/or the Emergency Maternal and Child Healthcare (EMCH) programme.

4. In a hospital, a system for providing appropriate **continuing care** to very ill children in a 'child and family friendly' area, ideally separate from adult patients, that has:
- A monitoring policy that includes essential monitoring of vital parameters (for examples depending on resources heart rate, respiratory rate, oxygen saturation, blood glucose levels and temperature) and monitoring parameters
- Appropriate monitoring equipment
- Monitoring charts for recording vital parameters
- Oxygen available at all times and in sufficient amounts with the equipment to administer it safely
- Appropriate resuscitation equipment (clean, regularly checked and accessible)
- A secure supply of essential drugs and standardised guidelines for their use
- 'Child and family friendly' waiting area/s for families
- A separate 'child and family friendly' area for children who die and their families with culturally appropriate privacy

5. Systems for **transferring** very ill children with:
- Written policies for transfer to a hospital from the community or from a health facility, internal transfer within a hospital and for transfer from one hospital to another
- 'Standardised' clinical guidelines for managing the common emergencies
- Transfer of clinical information
- Skilled health workers for accompanying a child during transfer
- Access to safe and reliable transport for transfer
- Monitoring and other equipment for use during transfer
- Portable oxygen supply for transfer

- Portable suction equipment

6. Access to a service/s or system/s for providing psychosocial support to children, their families and health workers when suffering life threatening illness or injury

Discussion

The early onset of appropriate resuscitation and emergency healthcare in neonates, both before and after birth, and for very ill or injured children is essential as delays not only cause harm that may result in unnecessary death or handicap, but may also make early treatment less effective and more prolonged. Immediate triage to detect emergency and priority signs on arrival at a health facility (in a hospital available for the whole twenty-four hours), is essential. Children with emergency signs need to be treated immediately and those with priority signs urgently and before registration, to minimise unnecessary deaths and disabilities. (SEE WHO ETAT programme and the CAI/ALSG EMCH project).

As a child's condition can change rapidly, close monitoring by skilled health care workers is essential to detect the early warning signs of deterioration in very ill or injured children, also those undergoing surgery and those who have been given systemic analgesia and/or sedation

A children's area for giving emergency care in an adult accident Department

Summary

The most important issues for the care of an acutely ill child are in sequence:
1. Early recognition of severe illness by the family and community health care workers.
2. Immediate treatment where the child is living, by the community health care workers.
3. Early and efficient transport to the nearest primary or secondary referral health care facility for treatment, ideally with appropriate health care given during transport by health care workers.
4. Effective triage, that is available 24 hours a day, given on arrival.
5. Regular and effective monitoring of children at risk of deteriorating, with appropriate preventative interventions – effective care of very ill children.
6. Immediate implementing of any necessary emergency health care in the primary or secondary referral health care environment, by health care workers who are trained to do this and also have the necessary material resources readily available.

Triage in a Ugandan hospital

Monitoring in a high dependency/intensive care unit in Pakistan

The above system needs to be integrated and is dependant on a well-managed collaborative network of health care services, effective health education for parents, effective training for all health workers, efficient transport services and the necessary human and material resources. (See EMCH programme)

To ensure that health workers give the best possible emergency care and critical care, best practice is to develop and use guidelines and other job aides that act as reminders for life support and the common illnesses that can cause severe illnesses in children. Guidelines and job aides need to be accessible and evidence-based and used by everyone. Community, outpatient, and inpatient staff should all be trained together in emergency care.

Job aides for providing life support: see website for what is written on the charts

Training in emergency care in Kosova

Emergency equipment laid out for immediate access in the emergency department of a hospital in a poor country

Working together is vitally important to ensure the provision of the best possible care for the very sick pregnant woman and child in order to reduce mortality and morbidity.

The systems used should draw on the programs of Safe Motherhood, the Integrated Management of Childhood Illness, essential antenatal, perinatal and postpartum care, essential care of the newborn, basic life support (neonates and children), neonatal and paediatric life support and advanced paediatric life support and the new Emergency Maternal and Child Healthcare (EMCH) program.

To provide the best possible and appropriate care, best practice is also to have regular meetings to review the systems used to ensure they are achieving their objectives. All those involved in providing triage, resuscitation, emergency and critical care need to attend these audit meetings. Specific issues for audit must include the circumstances leading to childhood deaths.

Finally as there are many ethical issues to be considered when deciding what is appropriate care to provide, access to specialist ethics advice is helpful.

Kangaroo care. This is a good way of nursing babies in poor countries where incubators are too expensive

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STANDARD 9:   Enabling play and learning

'Health care providers, organizations and individual health workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and their families by ensuring that they enable children to play and learn'.

Supporting criteria for play
1.   Support for play that includes:
- For all children who are well enough - encouraging and helping children to play when they are awake, 'especially at the bedside' when a child is too ill or unable to get to an area set aside for play.
- In a hospital, a play service with a play worker/s who has been trained, or a lead health worker with the skills to set up and supervise play and the play materials

2. In a health facility, resources for play that include:
- A separate**,** safe and clean place to play in each clinical area, providing there is space available, that can be used by all children who are well enough
- Providing safe and culturally appropriate play materials. Alternatively, or in addition, encouraging parents to bring and use the child's own toys
- Secure storage for play materials so that they do not get stolen

3. Provision of advice to all children and families about safe and appropriate play materials (including toys) for use at home

4. The promotion and use of strategies involving play for**:**
- Recreation and stimulation of development
- Helping children to cope with their health problem (therapeutic play), for example play to distract, for procedure preparation, to help in the giving of information, for stress relief, for expression
- Helping to manage pain and other distressing symptoms.

Discussion
*'*State parties recognise the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child….' UNCRC: Article 31

'Play is a natural part of childhood and a vital factor in the mental, social and emotional growth of children' - National Association of Hospital Play Staff, UK.

Play is not just a way of passing time and entertaining children, but is an important way for well or ill children to make sense of the world around them. It also helps them cope with any special problems and difficulties and enables them to develop to their full potential. It is important to remember that an ill child is a normal child in an abnormal situation, so having sensory stimulation and the opportunity to play is even more important when a child is ill.

*Child patient playing
in a hospital corridor
in Pakistan*

Play and sensory stimulation within health care is often thought of as trivial or of little importance, despite its many benefits and the low cost involved. Many health workers (and sometimes parents) feel that an ill child has no need to play or be stimulated, and that this should wait until they are better. However, this underestimates the importance of play and it's role in helping an ill child.

*Malnourished
children and their
mothers learning
how to play in a
Ugandan
Hospital.*

Some of the reasons why play and sensory stimulation are important enough to be given a higher priority by health workers include:

1. **A faster recovery from illness**
   Research evidence shows that ill children who are given the opportunity to play get better faster than those that don't. Play is a normal part of every child's life, whether it is spontaneous ('free') or helped.

2. **Better physical, mental, emotional and social development**
   The physical and mental stimulation of play is vital to help children develop to their full potential. Body growth, muscle development, fine and gross motor skills, sensory skills and a child's ability to learn, interact socially and make sense of the world around them are all helped by play. Children who

are ill, injured, malnourished, developmentally delayed or who have a disability have an even greater need for play and the help to do this.

3. **Reduction of a child's anxiety and stress**
When a child is ill or in a healthcare environment, such as a hospital, many of the things that were familiar to the child disappear and are replaced with unfamiliar and often frightening situations, environments, people, smells and sounds that the child has no control over. Play helps a child to regain some familiarity and control over their surroundings and to understand some of the things that might happen to them by 'pretend' playing, drawing and talking. Bringing a familiar toy from home can also help. For children admitted for non-emergency treatment, an earlier visit to the hospital is helpful. Although play may happen spontaneously, a child who is anxious or frightened often withdraws and may need help to play.

Play materials used to help prepare children for procedures or operations

4. **Easier assessment, treatment and procedures leading to improved outcomes**
When a child is ill, distressed, anxious or frightened it can be difficult for health workers to make a good examination and assessment of the child's needs. Encouraging the child to play (within their capabilities if they are ill) often helps health workers to do this and can also help build a child's trust in them.

Many treatments and procedures are frightening, unpleasant or painful for children (for example changing a dressing and taking blood etc.). Play can be a distraction or a preparation for these.

Using play to prepare a child before a procedure by showing the child what is going to happen to them and allowing him/her to become familiar with some of the equipment used by health workers can help enormously. For example, a child can 'practice' the procedure on a doll, maybe by bandaging it or putting a tube down it's nose. This allows a child to gain some control. Asking their permission before the treatment or procedure and allowing them to help also gives them more control. This usually, even in quite young children, makes it easier for the health worker. Stories that explain about health problems, treatments or procedures also help.

From the child's point of view, refusing to comply with unpleasant treatments is reasonable behaviour. By using play many potential difficulties can be overcome, thereby improving compliance and the eventual outcome for the child.

5. **Better communication with the child**
   Health workers need to be able to communicate effectively with children to find out how they feel and to gain their views and opinions about what is happening to them or may happen in the future. This is difficult for health workers if a child is ill, frightened, anxious or distressed. Many children find it easier to express their feelings and distress through play rather than by using words. A child might also find it easier to talk about how he/she feels when they are playing. Play allows a child to express their anger or sadness, frustrations, fears and also happiness.

The aims of a health facility play service are therefore to aid normality, help children develop, communicate and contribute to and cope with their healthcare experience in the best possible way, in order to improve their health outcomes.

In a hospital some ways play can be supported are by:
- All health workers acquiring the skills to enable children to play
- Providing the best possible play opportunities in every clinical area used by or visited by children.
- Supervising play at the bedside where necessary and appropriate
- Employing skilled play specialists or nominated health workers to organise and supervise play by working together with health workers and parents/carers.
- Identifying separate and supervised play areas for child patients and for child visitors (who are not patients) where they can be left by a carer for a limited period of time.

Bare playroom before improvements   *Same playroom after improvements*

Best possible' or 'gold standard'(see later) play areas include:
- ➢ A separate supervised play area for all children in or near every clinical area.
- ➢ A noisy indoor play area
- ➢ A quiet indoor play area for activities such as reading and computing
- ➢ An outside play area for child patients and child visitors
- ➢ A room for watching television or videos or listening to the radio
- ➢ Appropriate and safe play materials

Health workers visiting the home or working in a community also have an important role in encouraging and supporting play to make it an enjoyable, stimulating and learning experience for the children and their families**.**

Supporting criteria for learning

A school room in a large children's hospital in the UK

1. Support for school type education/learning includes:
- Making possible continuing 'school type' education (learning) for each school age child who is in a hospital for more than a few days and is well enough
- Supporting and encouraging learning for children in other healthcare environments

2. **Resources** in a hospital or other residential health institution (such as those for children with physical and mental health and other learning disabilities found in some countries) that include**:**
- A lead health worker with teaching skills, or a specially supported teacher who comes into the health facility, to support learning and liase with a child's parents/carers and local school
- A separate place to learn that is safe and clean in the clinical area where continuing school type education can be given
- Actively encouraging children and parents to bring their own education materials or providing education materials
3. Systems to provide:
- Relevant information to individual schools about every individual child with a disability or health problem that affects or may affect their education
- Advice and information to schools about general health issues.

Discussion
Health problems and disabilities often interfere with a child's learning opportunities and their ability to learn. This may compromise their chances of reaching their full developmental potential. Many children in these situations are able to carry on 'school type' learning if this is promoted, enabled and supported by health workers.

Examples of compromised education include:
- The short periods of missed education during illness at home, for healthcare attendances and when a child is in hospital
- Long periods of disrupted school attendance due to a long hospital admission because of a severe illness or trauma.

- Frequent missed school attendance because of physical illness, learning difficulties or mental health problems
- The non-attendance of children who will be living (and dying) from chronic deteriorating diseases.

Every ill and disabled child has the right to a stimulating 'school-type' education (UNCRC). It is important that they are enabled to learn when they are able to, and for as long as they are able to.

Health workers can support this by:
- Providing a place for learning in the healthcare environment
- Encouraging children and families to bring their own learning materials when they are admitted to a hospital for more than a few days.
- Supervising learning for periods of time during the day
- Liaising with a child's teacher about health problems that may interfere with a child's school attendance or make learning difficult. For example many children have a variety of temporary or permanent physical disabilities, hearing or visual difficulties, or mobility problems.

Best practice is for health workers to have education/training about learning difficulties in children and about the implications for learning of some health problems and disabilities.

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STANDARD 10: Recognising, protecting and supporting vulnerable or/and abused children

'Health care providers, organisations and individual health workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and their families by ensuring that they recognise, protect and support vulnerable and abused children'.

Supporting criteria

1. The following important primary, secondary and tertiary activities are aimed at preventing ill treatment and abuse:

- Giving advice on parenting and other related issues to pregnant women, carers, young people, children and others.
- Systems to identify vulnerable families in which abuse might occur:
- Referrals to systems in the community (if they exist) to support vulnerable families:
- The prompt but confidential sharing of information and concern with other relevant disciplines such as other health workers, social welfare services, police, schools, playgroups etc.
- A knowledge of the country's legal framework for child protection
- Referral to a social welfare service (or similar support service-if it exists) that provides general and emotional support to vulnerable families, and to abused children and their families

2. For suspected abuse:

- A written statement (policy) to guide health workers which includes clearly defined procedures for managing children suspected of being abused
- Lead health workers (doctor and nurse) to coordinate activities with responsibility for policies, clinical guidelines for managing the child and family, monitoring the quality of the service and training
- Clinical guidelines to help with the recognition, diagnosis and investigation of child abuse that are available to all health workers
- Systems for protecting and supporting an abused child
- Systems for protecting and supporting the families of an abused child.

3. Keeping confidential written information about vulnerable families, abandoned children and abused children. Best possible practice is to have a confidential register of all abused children which can be accessed twenty-four hours a day:

Discussion

Many health strategies and other primary, secondary and tertiary prevention activities can support vulnerable children and families and help prevent child abuse and ill treatment**.**

Examples of activities aimed at preventing of child abuse include (WHO):

Primary prevention	Secondary prevention	Tertiary prevention activities
- Pre-natal and perinatal health programs - Child health monitoring programs - Promotion of good parenting - Raising public awareness about child abuse - Raising community awareness about the UNCRC - A social welfare system - School activities re: non-violence and the prevention of bullying	- A system for identifying vulnerable families - Family support systems eg home visits - Clear referral systems to support services for vulnerable families - Substance abuse treatment programs - Community based family centred support assistance and networks (social welfare system) - Accessible information about community services available for all families - Support services based in schools	- Early diagnosis - The working together of all organisations involved with abused children to ensure: - medical treatment - healthcare - counselling - management and support of victims - management and support of families - re-integration into the community and schools - Adequate child protection laws - Child Friendly criminal justice systems, including facilities for the court attendance and participation of potentially abused children

Children are more likely to be vulnerable, abused and/or ill-treated when environmental factors are adverse, when parenting is not good enough or when they themselves have problems that make their families more stressed, or their care more difficult.

Risk factors include:

Environment factors	Parent factors	Child factors
- Absolute or relative poverty - War or other 'natural' disasters (eg famine, earthquake, flood etc.) - Family displacement or refugee status - Confinement to a prison or other institution - Excessive family mobility	- Absence of one or both birth parents - Substance (drugs, alcohol etc) abuse - Domestic violence and/or marital relationship/family problems - Poor experience of parenting by parent/s - Very young or immature parent/s - Physical or mental health problems/emotional disturbance in one or both parents - Family already known to social welfare system - Evidence of poor parenting of a sibling/s	- A disability or learning difficulties - Low birth weight/premature birth - Prolonged separation from a parent (such as admission to a hospital) especially in the neonatal period - Female sex (in some cultures females are at risk of infanticide and have limited opportunities for education.) - One of a multiple birth - A 'difficult baby or child' or one who cries incessantly

WHO multilevel risk factors for child abuse

PARENT	CHILD	FAMILY	COMMUNITY/SOCIETY
• Young age • Single unsupported parent • Unwanted pregnancy • Poor parenting skills • Early exposure to violence or abuse themselves • Substance abuse • Inadequate pre-natal care • Physical or mental illness • Learning difficulties • Relationship problems	• Female Sex • Prematurity • Separation or poor bonding in neonatal period • Unwanted • Disabled physically or mentally • Delayed development, particularly soiling and wetting past developmental age • Difficult temperament (persistent screaming, attention deficit/hyperactivity disorder etc.)	• Size/density • Poor socio-economic status • Social isolation • High levels of stress • Family abuse/history of domestic violence	• Non-existent, non-enforced child protection laws • Decreased value of children (minority, gender, disabled) • Social inequalities • Organised violence (wars, small arms, high crime rates) • High social acceptability of violence • Media violence • Cultural norms

The legal framework required to protect children varies in different countries. In some there may be no framework at all despite ratification of the UNCRC, and in others advanced laws especially for children, for example the 1989 'Children Act' in England and Wales. Some countries that do have legislation do not have any framework for enforcing this and others have minimal legislation. Child abuse is often interpreted very differently and some countries do not have laws to protect children from enforced labour, recruitment as soldiers or to protect them if they are refugees.

Many disadvantaged countries place child protection programs low on their priority list, as they have so many other problems to solve such as border security, the provision of safe water and sanitation, affordable education and health systems, adequate employment prospects and securing their economy. However there is an obligation following ratification of the UNCRC for governments to move towards protecting children in a transparent way, whatever their problems. The International Community must continue to advocate for the global rights of children to be protected and the introduction of laws that will protect children where none exist.

Abuse, neglect or exploitation is less likely to occur if a country:
- Provides financial and other support for vulnerable children and families
- Ensures equal access to, and opportunities for, free healthcare and education for all children
- Supports educational programs that will improve parenting skills for the whole population
- Programs that identify and support vulnerable children and families *(see Standard 1)*
- Uses integrated, collaborative and standardised methods to diagnose, protect and support abused children.

Health care providers have a key role, together with other groups that work with children and families, in identifying, protecting and supporting vulnerable and abused children and their families. To do this effectively individual health workers have a responsibility to acquire the skills necessary to understand and use the preventive, diagnostic, protective and support systems that exist in their country, to advocate for these when they are absent and to collaborate with their colleagues in the other agencies and organisations that are involved with children.

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STANDARD 11 Promoting and monitoring health

'Health care providers, organisations and individual health workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and their families by ensuring that they monitor and promote health'.

Supporting criteria

1. A system for immunising children, scheduled and catch-up immunisations that complies with the country's program is coordinated by a lead health worker. Includes the safe storage and transport of vaccines and has standardised guidelines for the administration of vaccines and the management of adverse effects.

2. A system for monitoring the nutritional status of children, including growth, ideally part of a comprehensive integrated country program. The system includes standardised strategies for managing children with problems.

3. A system for monitoring a child's physical (motor and sensory) and psychomotor (mental, emotional, behavioural and social) development that is ideally part of any existing country program. It includes standardised strategies for referring children with suspected problems to specialist referral services for investigation and treatment.

4. Compliance with a country's health screening programs for children and systems for providing advice and healthcare for children with detected problems.

5. A health education program for children, and their carers that is appropriate, accessible and provides relevant advice and information in understandable language and format

6. A safe motherhood program whose health workers liaise with skilled children's health workers when there are problems with an unborn child and a child at birth or after birth.

A nurse making health education and other 'child friendly' materials in Pakistan.

Discussion

A child has a right to the nurturing (the word nurse comes from 'to nurture') and care that will help him or her survive, develop to his or her full potential and participate responsibly in society.

The responsibility for nurturing a child until they are fully developed lies with all adults. The child's parents, supported by the State when this is necessary, have the major responsibility but all adults who work with children also have a nurturing role. This is necessary if a child is to become a mature adult

capable of being a responsible member of their society, able to contribute to this society's development and well-being, and themselves to be an adequate parent.

Best practice is for the State to support the child and parents through legislation that protects the child, and also through other child and family services such as education, health and social welfare. The shared efforts of all the services and agencies that work with and for children are needed if a child's development is to be monitored and supported effectively. Preventive health services for children, such as a safe motherhood program to protect the unborn child, the preventive component of WHO's program for the Integrated Management of Childhood Illness (IMCI) and immunisation, health monitoring and health screening programs for children are therefore of great importance.

Screening activities, whether or not they are part of a countrywide program, need to be supported by systems that provide advice, counselling, support and appropriate healthcare for the child and family if a problem or abnormality is detected.

Monitoring nutrition in the unborn baby and child is an essential component of any health provision. Best practice is for the health worker to do this every time a pregnant woman or child is seen.

Monitoring child development is equally important and not costly. If one or more areas of development are thought to be delayed this needs early confirmation, investigation, and effective treatment, with standardised referral to specialist services where necessary. Unnecessary suffering due to a second child having the same genetic health problem might be prevented if the problem is detected early.

Health education materials used by health workers in Pakistan to teach all pregnant women attending the hospital about childcare

Growth monitoring facility in a children's out patients department in Pakistan

Children with disabilities are often discriminated against within families and communities. Health workers have an important role to play in increasing the community's understanding of the capabilities and needs of each individual child with a disability as well as increasing the community's awareness of some of their common causes.

Avoidable health problems, accidents and childhood pregnancies cause great fear, anxiety and suffering to children and families. All health workers have an additional responsibility to provide 'health education' on these and other topics that promote a healthy lifestyle, to raise awareness in parents so that they can give their child the 'best possible' care and to act as advocates for children when necessary.

However, it is important that health advice is not prescriptive, that it is relevant to the individual child and family and given at an appropriate time. For example it would not be appropriate to give such advice when a child was very ill, but to wait until the child was recovering and the parents less distressed.

Health education materials made by health workers play workers and children.

Both primary and secondary health workers need to have education/training opportunities that equip them with the knowledge and skills to meet these health preventive responsibilities. Audit of compliance with policies, programs and systems of care is important if their objectives are to be achieved in the best possible way.

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STANDARD 12   Supporting the best possible nutrition

'Health care providers, organizations and individual health workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and their families by ensuring that they support breastfeeding and the best possible nutrition for children.'

Supporting criteria

1. **Lead health worker/s** for giving support and advice about breastfeeding, feeding and nutrition using locally available foods

2. **Systems of care and policies for:**
- Protecting, promoting and supporting breastfeeding *(The WHO/UNICEF Baby Friendly Ten Steps to Successful Breastfeeding).*
- Assessing a child's nutritional status to identify a malnourished child and a child who is not growing normally:
- Meeting each child's nutritional needs, including, where necessary, giving micronutrient (vitamins and minerals) supplements and advice on special feeds and diets
- Ensuring safe food preparation and storage*:*
- The management of malnutrition, including providing enteral and parenteral feeding when appropriate.
- Outreach programs from the hospital to the community in managing and preventing malnutrition.

3. **Support for breastfeeding is provided:**
- In a maternity unit – the 'Ten steps to successful breastfeeding' have been implemented. Formal accreditation as a WHO/UNICEF Baby Friendly Hospital is the best possible level of practice if this is available in the country
- In the community – all systems of care are compatible with the Ten Steps to Successful Breastfeeding. Formal WHO/UNICEF baby Friendly accreditation is the best possible level of practice if this is available in the country
- In a health facility providing secondary care – support for breastfeeding for children attending or resident in a health facility, or their siblings, is compatible with the Ten Steps to Successful Breastfeeding'. Formal WHO/UNICEF baby Friendly accreditation is the best possible level of practice if if this is available in the country for paediatric wards

4. Other support for nutrition includes: in every health care environment enough safe drinking water for every child, parents/carer and health worker
Provision of the following medically indicated dietary supplements at no cost to parents/carers:
- Oral rehydration solutions, including ones appropriate for children with co-existing malnutrition
- Oral and parenteral micro-nutrient supplements
- Protein and energy supplements
- Special feeds and diets
- Usually (intravenous) parenteral fluids
- The oral preparations required for the management of malnutrition

And in a hospital or other residential healthcare facility also includes:

- Food security for children, pregnant women and breast feeding mothers
- A separate health worker/s to prepare food in dedicated clean areas

- The equipment to prepare and store food safely
- Supervision and assistance for a child who needs help with feeding

5. **The use of guidelines and/or other job aides** for:
- The nutritional composition of food
- Giving micronutrient supplementation
- Giving intravenous fluids
- Safe food preparation and storage
- Giving special dietary requirements
- Treating a child with severe malnutrition

Discussion

The term 'food' is used generically to describe all forms of "provided nourishment"

Under and over nutrition has a huge impact, not just on childhood survival, but also on the physical and psychosocial health of children and their health and survival as adults. The commonest global cause of death in the under fives is malnutrition, either alone or associated with diarrhoea, respiratory infections, measles, malaria, and HIV/AIDS. Children who fail to grow to their full potential in the first two years are unlikely ever to catch up (growth stunting). This stunting, which carries a later cost for adult health and quality of life, is still prevalent in many countries.

Under nutrition increases the severity and length of an illness and can cause apathy, depression and deterioration of social interaction. This is of particular significance in young children who would normally be developing their physical, social and other skills at a rapid rate. There is substantial evidence to show that under nutrition in young children, particularly in association with illness, leads to the stopping or slowing of development and even a loss of skills that may never be fully regained.

At the other end of the scale, largely in the developed countries, over-nutrition and childhood obesity are causing increasing health and quality of life problems.

Nutrition for a child begins ante-natally with attention to the mother's lifestyle and health during pregnancy. This is also a good time for health workers to give health education about breastfeeding and childcare as the quality of early nutrition is directly related to survival and later health. Following a recent review of the evidence, the recommendation of the Global Strategy on infant and young children feeding is: exclusive breastfeeding until six months of age followed by continued breastfeeding alongside complementary feeding up to two years of age.

Breastfeeding is best supported if maternity Units, children's wards and community children's services follow the UNICEF/WHO Ten Steps to Successful Breastfeeding which are.

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff
2. Train all healthcare staff in the skills necessary to implement the breastfeeding policy
3. Inform all pregnant women about the benefits and management of breastfeeding
4. Help mothers initiate breastfeeding soon after birth
5. Show mothers how to breastfeed and maintain lactation even if they are separated from their babies
6. Give newborn no food or drink other than breastmilk, unless medically indicated
7. Practice rooming-in, allowing mothers and infants to remain together 24 hours a day
8. Encourage breastfeeding on demand
9. Give no artificial teats or dummies to breastfeeding infants
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

During the initiation of complementary feeding at or after six months of age, safe water, food security, food safety and hygienic preparation of appropriate foods are paramount. Best practice is to recommend and use foods that are locally available and suitable for the age and developmental level of the individual child.

To encourage an appetite in ill children, food also needs to taste good and be well presented. Parents/carers need to be responsive to the child's demand and pace of eating. An ill child may not have their normal appetite, or be able to eat the foods normally accepted. Avoiding further deterioration by encouraging and helping them to eat is a simple but important part of care that is often overlooked by health workers.

It is essential that during every health contact:
- The child's nutritional state is assessed, including evaluation of growth
- The child's nutritional needs are correspondingly assessed, particularly in early childhood and during an illness
- Advice is given to carers about:
    - How to meet the child's needs in a stimulating age-appropriate way using locally available foods that are affordable
    - Safe food preparation and storage
    - Feeding techniques.

Mothers preparing low-cost local nutritious foods for their children in the nutrition ward in a Ugandan Hospital

To gain the necessary skills to provide this nutritional care, all health workers need to learn about nutrition as part of their core and continuing training programs. Best practice is for this training to include learning about the management of lactation, a knowledge of what is meant by 'nutrition' and nutritional status, what is needed for children to grow and develop normally and how best to treat a child with severe malnutrition. It is also important to acquire the practical skills that will enable health workers to identify and help a child with a feeding difficulty.

Malnourished children need nutritional support. The simplest and most cost-effective nutritional support is to provide enough appropriate local food for each individual child. In occasional very severe cases, when appropriate, the use of enteral or parenteral nutrition needs consideration. Parenteral (IV) nutrition is only likely to be available in well-resourced health facilities and should only be used when there is gastro-intestinal failure and nutritional needs cannot be met via the gastro-intestinal tract.

To minimise the deaths of children from severe malnutrition it is essential that all health workers have received education/training in the management of severe malnutrition and follow the WHO recommended procedures. In the early stages of treatment the risk of dying is high, sometimes because the treatments and foods given are inappropriate, or associated dehydration, hypothermia, hypoglycaemia, infection and electrolyte imbalance are not correctly treated

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www.babyfriendly.org.uk

Section 3: How 'Child Friendly' are you?
(How to assess the care you give)

This program for assessing and improving 'Child Friendly Healthcare' has been developed and piloted with the help of nine hospitals in seven countries. It works well in diverse countries and health services and although not dependant on health workers being familiar with the articles of the UNCRC or the concept of 'Child Friendly Healthcare' can be enhanced by this knowledge.

COMMIT to CFH
↓
PROMOTE CFH and PLAN an ASSESSMENT
↓
ASSESS
Stage 1 → Optional preliminary CFH assessment
↓
Meeting for feedback and selection of **'**Standard/s'
↓

ASSESS
Stage 2 → Detailed assessment of level of practice of a selected Standard/s
(Basic, bronze, silver or gold level of practice)
↓
Meeting for feedback and planning, if improvements are needed and wanted
↓
IMPROVEMENT PLAN
↓
IMPROVEMENTS
(With support if needed)
↓
ASSESS
Stage 3 → Re-assess selected Standard/s for progress
↓
Meeting for feedback and/or further planning
↓
ACKNOWLEDGE PROGRESS / IMPROVED LEVEL of PRACTICE
(to bronze, silver or gold)
↓
PLAN MORE IMPROVEMENTS
↓
**Repeat Stages 2 and 3 until all the CFH Standards are practiced
at the 'best possible' level** *(gold)*

Does the program work in any type of healthcare environment?

The program is easy and flexible enough to be used in any type of healthcare environment – the home, a primary care surgery/clinic/health house, a refugee camp, referral out-patients or any level of hospital or other residential facility that provides healthcare. It can be adapted to suit the circumstances.

Who can use the program?

It works equally well for all types of health worker who plan, organise and deliver healthcare either in the community or secondary/specialist environment. It can be used for self-assessment or for use by an outside assessor appointed to help.

Who else can promote 'Child Friendly Healthcare'?

Any committed health worker who is familiar with its practices and principles can promote CFH by sharing information about the CFHI and the UNCRC with others in the same healthcare environment, in other healthcare environments in the same country and with health workers in other countries.
'Child Friendly Healthcare' belongs to every health worker that looks after children and families whether they are involved in planning, organising, providing or giving care.

How long does it take to achieve the 'best possible' Child Friendly Healthcare?

Healthcare is a continuum of change. Improvements will always be necessary because of new discoveries and research. The program's simple methods and processes can be used indefinitely.

How to start the program?

The health workers responsible for managing and planning children's healthcare:
1. Commit their health facility or health service to 'Child Friendly Healthcare' and the CFH quality improvement program – it works best if all the senior doctors and nurses in a participating clinical area or other healthcare environment are motivated to improve and change. During the pilot project, less motivated health workers, who initially didn't want their clinical area to participate, saw the progress made in participating areas and then became keen for their clinical area to become involved too.
2. Appoint a CFH coordinator or coordinators
3. Decide whether to self-assess or to appoint an experienced external assessor/s to help
4. Plan an assessment

Who should coordinate the program?

A volunteer or a person selected from among the senior doctors and nurses working in the participating healthcare environment. The pilot project revealed that the program works best when coordinated and facilitated by a health worker who has the respect of their colleagues, and the authority to make decisions and initiate change. In order to engage the two largest professional groups, a nurse and doctor team works best. Good leadership, team working and problem solving skills are also of paramount importance.

The responsibilities of a CFH coordinator

The most important responsibilities of a coordinator are to:
- Promote 'Child Friendly Healthcare'
- Be committed to the 'best possible' level of practice for all aspects of healthcare for children and any changes that may be needed towards achieving this
- Supervise and contribute to the program

What other responsibilities does a CFH coordinator have?

For self-assessment the responsibilities include:

1. Organising and doing the assessments, including the administration and logistics
2. Organising the planning meetings and inviting the relevant people
3. Coordinating a collaborative plan for making improvements
4. Facilitating and supervising progress work in the participating clinical area/s
5. Liaising with the health workers responsible for support services and other key jobs relevant to the 'Standard' chosen for improvement
6. Supporting colleagues in the participating clinical areas who are trying to improve the care they give
7. Co-ordinating education/learning if this is identified as needed by the assessment
8. Acting as a mentor for any health workers from another country working alongside local health workers to help with the planned improvements
9. Providing regular feedback/reports on progress and prompt sharing of any problems or concerns with relevant others, including the external assessor
10. Sharing information regularly with other important stakeholders in children's health, including the director of the health facility or service, relevant supporting organisation and other senior children's health workers.

If an external assessor helps, the coordinator contributes to the program by:
1. Acting as the link person with the external assessor/s, before, during and after an assessment
2. Providing the external assessor with any requested pre-assessment information and any relevant in country research relating to 'Child Friendly Healthcare'
3. Looking after the external assessor during their visit
4. Acting as an interpreter or appointing an interpreter if one is needed
5. Organising translation of documents or other program related materials and distributing these.

Important jobs best led and coordinated by a named <u>lead</u> health worker/s include:

- 'Rights' issues: *Standards 4, 6*
- Family welfare: *all Standards (1,3, 4, 5, 6)*
- Disability/rehabilitation: *all Standards*
- Hygiene Promotion/Infection Control: *Standard 3*
- Pain and symptom control (Palliative Care):   *Standard 7*
- Resuscitation and emergency care: *Standard 8*
- Play: *Standard 9.*
- Education /school-type learning: *Standard 9*
- Child Protection: *Standard 10*
- Immunisation: *Standard 11*
- Health Promotion: *Standard 11*
- Breast Feeding: *Standard 12*
- Nutrition: *Standard 12*
- Clinical guidelines and job aides: *Standards 2, 7, 8, 10, 12*
- Continual Professional Development: *All Standards*
- Audit: *All Standards*
- Data management: *All Standards*
- Ethics: *All Standards*

To self-assess or use external assessor to help?

Self-assessment works best when the healthcare environment:
- Is managed transparently
- Is good at team working
- Has transparent employment and disciplinary procedures
- Has senior health workers who understand CFH and are committed to a continuum of assessing and improving practice
- Has adequate human and material resources
- Finds that most of the systems of care, facilities, policies, guidelines, educational opportunities etc. in the initial check-list (Tool 1, Part 1) are in place
- Delegates the responsibility for the support services and most of the important clinical jobs to different health workers
- Values all its health workers
- Respects and values the views and opinions of children and their families

Although self-assessment can work well there are many advantages to using in addition external assessors (health workers who do not work in the same health facility).

External assessors are more likely to:
- Be unbiased
- Protect confidentiality, especially of the senior health workers
- Gain a more open and honest expression of views and experiences
- Provide reports that are less open to challenge or manipulation
- Share information openly
- Raise awareness levels by sharing their wider experience
- Act as a catalyst or lever for change
- Provide a role model for team working if this is a new concept for the healthcare environment
- Empower health workers and families
- Have the contacts and skills to contribute to, facilitate and support change

Who should be an external assessor?
A children's health professional or manager with assessment skills who commands professional respect and is committed to CFH. In our experience it works best if an external assessor understands the culture and languages of the Country, although it can sometimes work well using interpreters.

About the CFH assessment improvement program

The objectives of a CFH assessment are to:
- Raise awareness about CFH thereby enabling and empowering change
- Help prioritise areas of care for scrutiny
- Assess the current level of practice of these prioritised areas
- Identify local problems and their possible solutions
- Identify barriers against, and forces for change
- Facilitate 'making it better' (making healthcare improvements)
- Where relevant, identify appropriate 'aid' projects to support local health workers in 'making it better'
- Identify issues for advocacy
- Identify change and/or progress after an agreed period of time

- Acknowledge changes, however small, so that health workers are motivated to continue making it better for the children, their families and themselves

About assessment

Before an assessment it is important to:
- Obtain consent for the program from the director (or equivalent) of the Health Facility and, if relevant, also the country's Ministry of Health. In some countries it is also useful to ask for support from the WHO and UNICEF Regional and/or country offices.
- Share information about the CFHI with the Health Facility director, and if relevant with the WHO and UNICEF country representatives and the Ministry of Health
- Do an initial brief self-audit against the CFH Standards. This is useful as it sensitizes other health workers to CFH, identifies areas of health care that the health workers think they do well and areas of care that health workers want to improve

Pre-assessment information for an external assessor that is helpful includes:
- The language/s used in the health facility
- A brief report on the services provided for children
- The number of children born, seen and/or admitted during a year in the health facility
- Mortality and morbidity statistics, if collected and any other data routinely collected
- The number of doctors, nurses and others employed
- The names of relevant service and other managers and coordinators of important jobs
- The names of the senior doctors and nurses with important responsibilities
- The results of a brief self audit carried out by the CFH coordinator and others
- A prioritised problem list

After an assessment the assessor/s:
- Bring/s together the results of the assessment and present/s these at meetings
- Provide/s a written report of the assessment and circulate/s this to all involved *(*See appendix on website for an example of a format for writing a report)
- Contribute/s to any plan for improvements decided on by health workers in participating areas
- Facilitate/s improvements if and when possible

The assessment process achieves these objectives by using a 'toolkit' that seeks to understand by observing, listening to and questioning the people who use and deliver the health care for children and their families. The toolkit finds the problems and the possible solutions to them from the children, their families and the health workers, and identifies the quality level of practice**.**

The assessment process focuses <u>not on resources,</u> but on how health workers manage and use the resources that are available to them, and on their attitudes, skills, practices and knowledge levels.

How long does it take to do an assessment?
The number of assessors and the time needed for an assessment is dependant on the size of the healthcare environment and the number of health workers employed. For most healthcare environments it should be possible for two assessors to carry out both a first and a second stage assessment within one week, and a third stage progress assessment in 2 – 3 days.

The views and opinions of a sufficient number of people will be needed to gain true representation. In a large healthcare environment it helps if the number of participating clinical areas is initially limited,

choosing those with the most motivated health workers. Other clinical areas can join the program at a later date.

The time needed can be minimized by:
- Meticulous pre-assessment information gathering
- Meticulous planning of an assessment, including estimating the number of questionnaires and the number of interviews with senior health workers and managers that will be needed
- Translating materials in advance if necessary
- Arranging interpreters in advance if these are needed for the interviews

Why are there three stages to the assessment process?
There are three stages because each has a different objective.

A Stage 1 assessment is optional but is particularly relevant in countries where 'Child Friendly Healthcare' is least developed, resources are scarce and the level of practice for many aspects of healthcare is likely to be basic. It gives preliminary information about the level of practice of all twelve CFH 'Standards' and complements the self-audit. It specifically:
- Finds out which Standards are practiced well and which not so well
- Identifies examples of good practice to share with others
- Identifies areas of care that could be easily improved
- Identifies the barriers to and forces for change
- Identifies issues for advocacy
- This information helps health workers choose and prioritise areas of healthcare within the CFH standards for a more detailed assessment of how well they are practiced.

In disadvantaged countries a Stage 1 assessment can be used to help plan 'humanitarian aid' projects. It has advantages over an unstructured assessment as:
- It is transparent and repeatable
- Systematically identifies missing or limited essential resources
- Seeks the views of all types, and levels of health worker
- Seeks the views and opinions of the families that use the service, therefore provides a balance between the needs and wishes of the families and the aspirations and wants of the health workers.

The CFH program may be the best way to identify appropriate sustainable 'humanitarian aid' projects

A Stage 2 assessment assesses the chosen and prioritised 'Standard' in detail. It will:
- Identify a quality level of practice (basic, bronze, silver or gold)
- Identify examples of good practice to share with others
- Find out the problems and their possible solutions
- Provide a framework to help health workers prioritise and plan needed, feasible and wanted improvements
- Further clarify issues for advocacy

A Stage 3 assessment is done after improvements have been made. It will:
- Find out if the planned improvements have happened or not
- Find out if the improvements made have achieved their objective: to 'make things better'
- Find out if the quality of practice is higher (for example has changed from basic to bronze)
- Identify barriers to progress and problems encountered during improvement activities
- Identify strategies for change that worked and the reasons why so that these can be shared with others
- Further clarify issues for advocacy

Stages 2 and 3 can be repeated indefinitely until 'Child Friendly Healthcare' is practiced at the 'best possible' level (all twelve 'Standards' practiced at Gold level).

Achieving objectives and a higher level of care motivates health workers to make further staged improvements

Levels of performance
'Going for Gold' is a well-known and used concept that works especially well in encouraging athletes to strive for excellence and their 'best possible' performance at the time and in the circumstances. The concept of using a medal system to identify excellence therefore seemed appropriate and complied with our objectives.

The three qualities of performance are gold, silver and bronze, with all other levels of practice called basic practice.

Diagram illustrating four levels of quality of care for each 'Child Friendly' Standard.

Level 1 Basic	Level 2 Bronze	Level 3 Silver	Level 4 Gold
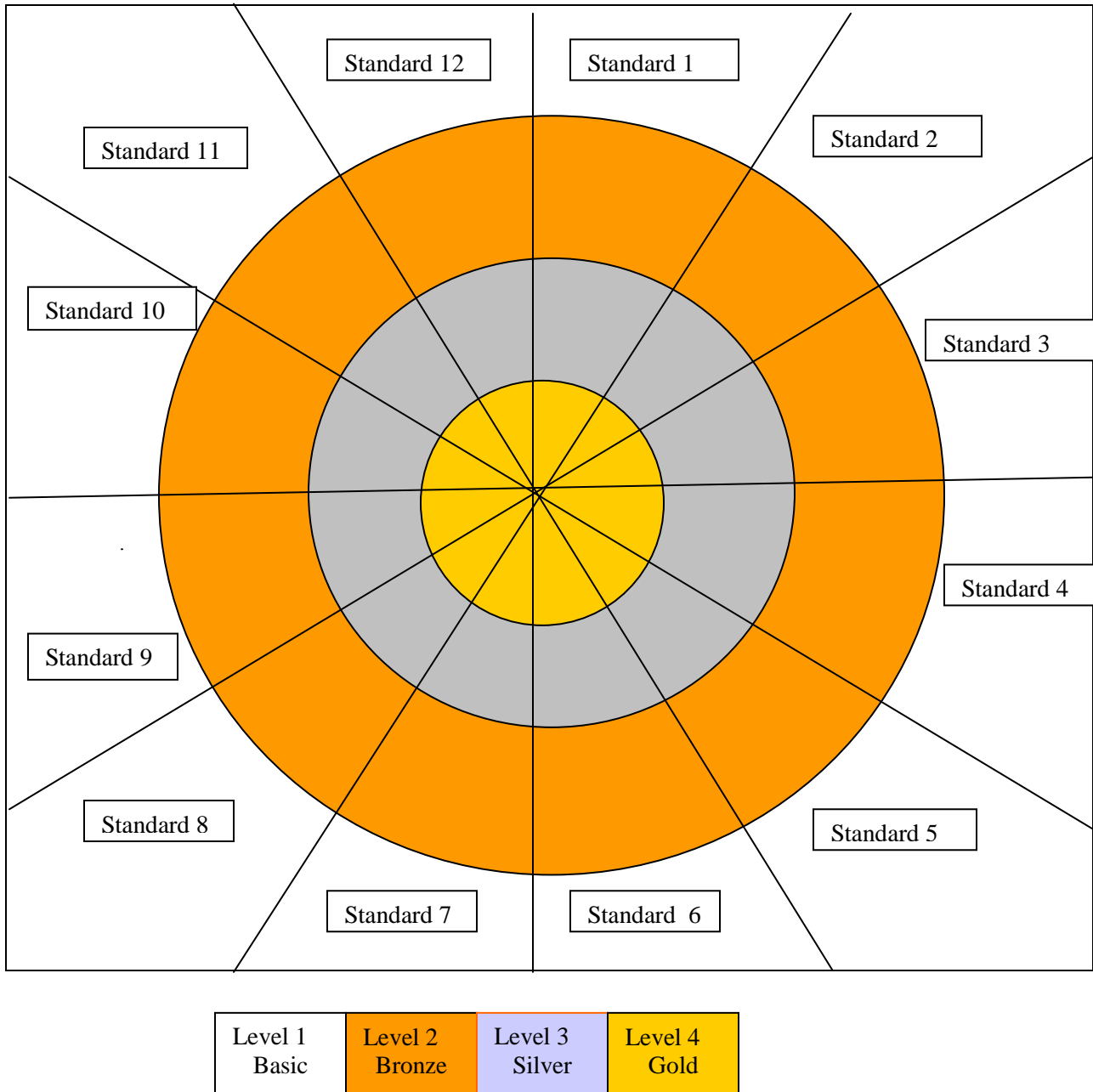
About the CFH Toolkit

The CFH Toolkit used for the three stage assessment program contains check lists about services, facilities, resources, systems of care, written statements about care, clinical guidelines and other job aides, data management, especially the quality of medical record keeping and monitoring charts, education/training opportunities, the quality of audit, and all other activities necessary to practice the 'Standards'. These check lists are supported by structured observations, interviews (open, semi-structured

and structured), questionnaires (including knowledge based questionnaires for some CFH Standards), and, after a stage 2 assessment, benchmarking for any planned improvements.

Child Friendly Healthcare Tool 1

For use in the Stage 1 assessment. It has three parts.

Part 1:

This is a short yes/no check-list. It is to be completed <u>either</u> by the local CFH coordinator with help from senior health workers responsible for the children's services, the support services, important jobs *(for example palliative care, play etc),* and other relevant health workers such as the senior children's doctors and nurses.<u>or</u> by an external assessor/s after he/her has talked to these senior health workers

If an external assessor completes the list, it is advisable for them to confirm what they have been told by direct observation. To do this, the external assessor needs to visit all the clinical areas in a health facility used by children and to see the facilities, systems of care, written statements about care, systems for data management, audit and educational opportunities and all the written protocols, policies and clinical guidelines. .

Part 2

This represents a semi-structured interview with health workers of all levels and types (professional and non-professional, including students). It contains questions designed to find out about their concerns, attitudes, opinions, knowledge levels and use of existing resources

Part 3

This is a semi-structured interview with parents/carers and when possible children, using short open-ended and semi-structured questions. This enables parents and children to express their views, ideas and opinions about their healthcare experiences; both good and bad.

Child Friendly Healthcare Tool 2

This is used in the CFH Stage 2 and 3 assessments**.** It has four parts.

Part 1
This is a detailed check-list that systematically reviews the organization and management of facilities, resources and other activities relating to each CFH Standard chosen for assessment

Part 2
This is a structured questionnaire (or interview) for each chosen standard . This is given to a random selection of professional health workers to complete. It helps assess the skill levels, attitudes, practices and education/training needs of health workers. For some of the 'Standards' it includes knowledge related questions.

Part 3
This is a semi-structured interview for each chosen standard with a random selection of parents/carers and/or children concerning their experiences relating to this 'Standard'.

How to identify the quality/level of practice of a CFH Standard?

The first three parts of the Tool 2 have been designed so that in addition to providing useful qualitative information about attitudes and experiences to help health workers prioritise and plan improvements, they can also be scored/quantitatively. Quantitative scoring makes it possible to identify and consistently standardise four proposed qualities of care (basic, bronze, silver and gold).

A scoring system that excludes questions seeking only ideas and possible solutions to problems needs to be developed and agreed by health workers in the participating country or individual health facility before they apply the program

This also makes monitoring changes easier and more accurate, and allows for comparisons to be made with other similar health facilities.
An example of a possible scoring system for a question from Tool 2: Part A for Standard 8

Question 8	**Data management** Health workers:		Score =
	• Make timely and detailed records about every resuscitation	Yes	1
	• Collect and examine the outcomes of every resuscitation	Yes	1
	• Collect and examine the outcomes for children who are very ill	Yes	1
	• Collect and examine information about the probable cause of the death	Yes	1

Total score = 4   Total possible score = 4   **Percentage score is 100%**

The total possible score for each part of the 3 of Tool 2 (A, B and C) is best calculated as a percentage of the total score possible. The percentages for each of the three parts can be added and divided by 3 to identify an overall percentage score that can be used to determine the level of practice (0 - 25% is basic care, 26 - 50% is bronze, 51% - 75% is silver and 76 - 100% is gold).

Score as a percentage	0 – 25%	**26 – 50%**	**51 – 75%**	**76 – 100%**
Quality level of care for a 'Standard'	Basic care	**Bronze**	**Silver**	**Gold**

For example:
> The scores after Standard 3 was assessed in the Children's Ward of hospital X (before improvements made) were as follows:
>> Part A: Score = 45% = **Bronze**
>> Part B: Score = 75% = **Silver**
>> Part C: Score = 15% = **Basic**

Therefore average score = 45% = **Bronze**

> After improvements were made, the scores for Standard 3 in this ward were:
>> Part A: Score = 55% = **Silver**
>> Part B: Score = 85% = **Gold**
>> Part C: Score = 40% = **Bronze**
>> $\therefore$ average score = 60% = **Silver**

Part 4
This is a series of benchmarks made for a Standard that is prioritised for making improvements

Benchmarking is the process of measuring the current status of an organisation or an individual's performance and comparing it with either past performance or to the accomplishment of others.

Benchmarking works best if each planned improvement is given four benchmarks.
The first is a statement about the current situation (basic care), the second and third stages are steps towards the goal (bronze and silver), and the fourth is the best possible quality of care hoped for after improvements have been made (gold)

Example of a benchmark

Basic practice	**Bronze**	**Silver**	**Gold**
Current practice	A first step towards best practice	A second step towards best practice	Best possible practice (The improvement planned)
Toilet for health workers never clean	Toilet clean some of the time	Toilet clean most of the time	Toilet scrupulously clean throughout the 24 hours

Part 4 provides the framework for improvements. This framework can also be used as a simple way to regularly monitor progress. It is a rapid method for seeing which objectives have been achieved either partly or in full, and which have not.

An example of an improvement

Sink in neonatal ward before (basic quality)   *Same sink after improvement (now bronze)*

Assessment meetings
Multidisciplinary meetings are essential before an assessment, for assessment feedback, and for planning improvements. They need to be attended by the key people, have an agenda and a 'chair' (leader), usually the CFH coordinator.

Information about the meeting, and any decisions made during the meeting, need to be shared with the health workers they affect.

A meeting is useful before an assessment to:
- Introduce an external assessor to key people, and sometimes the key people to each other as in our experience health workers in important roles have not always met all the people they relate to (putting names to faces).
- Share information about CFH and the CFH assessment process
- Answer questions
- Plan a realistic timetable and the logistics for the assessment processes

The main objectives of a meeting after an assessment are to:
- Provide feedback
- Answer questions
- Discuss issues and problems
- Share ideas
- Collaboratively plan prioritized, **feasible and staged** improvements
- Plan a realistic timetable for these planned improvements
- Decide a date for review of progress (a CFH Stage 3 assessment)

A CFH meeting in Uganda to plan healthcare improvements

The people who attend CFH meetings could include:
- WHO and UNICEF Country staff (if relevant and perhaps only to the first meeting)
- The director/chief of the healthcare environment or the deputy director
- The manager of children's services if there is one
- The senior children's doctor and nurse
- Senior health workers who manage clinical areas
- The senior health workers who manage support services or coordinate important clinical jobs (such as the coordinators for immunization, infection control, the management of pain, breast feeding, child protection and others) if relevant
- The CFH coordinator
- The external assessor/s
- Representatives from any NGO'S already working in the healthcare environment or country who might provide help and support

How do children and their parents/carers contribute to the assessment process?
The input of children and families is essential, welcome and sought during all three stages of the assessment process. It is a key aim of the CFHI assessment process and itself assesses communication and liaison with parents.

A mother asking to talk to the CFH coordinator in Pakistan

To a certain extent, the issues raised by children and their families will always be influenced by expectations and awareness of possible alternatives. However basic issues fundamental to either easing or increasing fear, unhappiness and distress can usually be identified.

It is vitally important to protect the anonymity and confidentiality of everyone who is interviewed as this allows children and families to express their views and opinions more freely. There are inherent problems with seeking information wherever there is a likely 'imbalance of power' between assessor and participant. This is a particular problem within a health care setting, where participants may feel their answers are not confidential or that care could be adversely affected. Families in many countries may have never been asked for their opinion in such a way before and may live in a climate of disempowerment and justified mistrust of officialdom. The interviewer must be impartial and trustworthy, with an independent translator if necessary (not relatives of the family or healthcare staff). Any verbal or written information acquired must not be traceable to an individual parent or child.

Families will respond best if they feel at ease, have privacy during an interview, are shown respect, understand the purpose of the interview and feel able to interrupt or stop it if they or their child needs attention.
The purposes of an interview should always be remembered. It is to gain an understanding of what is important to each individual child and family, what has been particularly good or difficult, what might make their experience better and what their ideas are about how to make things better for others with the same problems, if they think this necessary. It is best to explain the program in a way that is understandable. The interviewer needs to check that the child or parent/carer understands why they are being interviewed, and what will happen to their contribution, by getting feedback and welcoming questions. It is important to obtain consent for the interview after this explanation.

Questions need to be easily understood and may need to be omitted if they are not relevant, appropriate, cause distress or the parent/carer or child does not wish to answer. It is important not to coerce any child or family member into giving information or answering questions they feel uncomfortable about. If using an interpreter, look at and talk to the child or parent, rather than to the interpreter, and look at the child or parent when listening to the answers given through the interpreter to see if they are correct by watching

their body language. Use empathetic body language yourself, as showing care and respect will encourage a child or parent to say what they really think or feel

It is useful to have some form of distraction, such as a toy or a picture, to engage and amuse younger children when interviewing their parent.

Points of note concerning an interview with a young child
- It is not appropriate to ask young children questions about every aspect of care (questions developed during the pilot project were about Standards 4, 5, 6, 7 and 9).
- It is always best to interview young children when they are with their parents or other familiar carers.
- The person asking the questions needs to be skilled at interacting with children
- If a child appears upset or develops any distressing symptoms, it is best to thank them for their help and withdraw rather than persist with the interview
- Interviews need to be short.
- The words used need to be simple and easily understood by the child

Interviewer's checklist:
- Find a private place to conduct the interview
- Make sure the child or parent is sitting comfortably
- Tell the child or parents/carers your name,
- Explain who you represent and what work you normally do
- Explain the reason for the interview giving a brief explanation of the CFH program (better healthcare)
- If you are an external assessor explain that you do not work in this healthcare environment and do not personally know any of the health workers
- Explain that anything they say will be confidential, and that although important things they say may be shared with others, no-one will know who said these things
- Ask the parent/s or carer if they still agree to talk, or will allow their child to talk to you-(if they say no, respect this decision)
- Get signed consent for the interview or a thumb print (this still represents an individual, and may be more acceptable) - in some countries verbal consent is sufficient *(See section 5 for an example of a consent form).*

How many children and parents/carers should be interviewed?
As many as possible from each healthcare environment that is being assessed and best chosen randomly from those available (if only volunteers are interviewed there may be some bias in the answers they give.) Ideally the same number of parent/carer/children as health worker interviewers provides balance.
It does not matter if different parents/carers and children are interviewed before and after improvements are made. This commonly occurs due to time constraints, and will still allow comparative data to be gained

How do health workers contribute to the assessment process?
Involving as many health workers as possible in an assessment reveals how they manage and use their resources, helps understand their attitudes and assesses their skill and knowledge levels.

- **Senior health workers**
  Assessors need to work closely with the senior health workers in the healthcare environment responsible for children's services, the managers of support services and any coordinators for the important clinical jobs to complete the Part 1 check lists. Relevant senior health workers are also

asked to contribute in the same way as others by completing questionnaires for chosen CFH 'Standards'.

- **All other Health Workers**
  All types and seniority of health worker both professional and non-professional, including those in training, are either interviewed or asked to complete questionnaires. The detailed questionnaires for some parts of some 'Standard's will be most relevant for doctors and nurses; the views and opinions of other health workers will be needed for other parts.

Results may not genuinely reflect collective views if some health workers do not wish to participate or are unable to. It is therefore important to gain prior authority from senior health workers to ensure that full cooperation at all levels is possible.

Checklist for assessors:
- Decide on the total number of questionnaires needed and then number these
- Distribute and collect the numbered questionnaires
- Explain the program to the participating health workers or design an information leaflet to be handed out with each questionnaire
- Arrange a collection time or deadline for completing the questionnaires
- Agree on a method of collection
- Keep a record of the name of each health worker who has been asked to complete a questionnaire to check whether or not they have returned it
- Make sure the questionnaires are confidential and an individual cannot be linked to a specific questionnaire (no names or other identifiers on questionnaires)
- Follow up any questionnaires not returned

How many completed questionnaires are needed?
In a small health facility or clinical area all nurses and doctors should complete the Stage 2 questionnaires.
In larger health care environments or clinical areas a representative sample is sought. Ideally this sample is a manageable percentage of each type and seniority of health worker selected systematically and randomly from employment or duty lists. In practice unless careful planning is possible, selection may be more dependent on availability. In larger clinical environments ten nurses and doctors is the absolute minimum number needed.

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Section 4
'Making it better'
How to improve the care you give

'Child Friendly Healthcare' belongs to every the health worker that looks after children and families whether they are involved in planning, organising, providing or giving care.

The first photograph shows a chaotic, poorly organised, child unfriendly working environment. Mothers were not welcomed, only allowed to visit at certain times and did not share in the care of their babies. The mortality rate was high, health workers were de-moralised and both mothers and health workers unhappy.

The second photograph taken less than a year later shows a cleaner, well organised ward (although still overcrowded), unstressed health workers, parents free to come, go and share their babies care, a much improved environment with more information on the walls, child-friendly curtains and wall frieze. This was achieved by re-organising the way care was given, developing a team approach, sharing knowledge and skills, changing old behaviours and attitudes and making the environment friendlier and cleaner. All was achieved by the health workers themselves.

Important reasons for making it better are:
- Children are still dying and suffering needlessly when receiving healthcare
- There are always problems that need solving, regardless of circumstance or resource level
- It is always possible to improve on current practice as research evidence continues to show better outcomes from new or different methods of care and treatment
- Society is continually changing, bringing with it both new benefits and new threats to the health of children and families that need to be considered
.

Making it better for children by improving the care you give means making changes
Barriers to change
To make changes happen the barriers against change and the forces for change need to be recognised and fully understood. Some of the barriers to change are found outside and some inside the healthcare environment and some are more outside the control of ordinary health workers than others. They are also found in individual health workers.

> *'It's not the strongest of the species that survive, not the most intelligent, but the one most responsive to change' (Charles Darwin)*

External barriers (usually outside the control of the health workers in a healthcare environment)
- Adverse circumstances in the country (natural and man-made disasters)
- Complex healthcare bureaucracy
- Constantly changing policies at local and governmental level (instability)
- A low budget and poor planning for children's healthcare
- Poorly integrated primary and secondary healthcare services
- Many demands for change imposed by others
- Low salaries. Low pay means that supplementary income generation, such as private practice, is an important priority. This inevitably leads to inequity of care and a low commitment to provide the same standard of healthcare to all children.
- Poor job security so health workers fear voicing their opinions.
- Limited opportunity for professional advancement and little recognition of worth.
- Poor work environment (low investment in equipment and infrastructure)
- The unreasonable expectations of people who use the health services (complaints/litigation)
- A blame culture in society

Internal barriers (within the healthcare environment (can often be influenced by health workers)
- Little or no consultation with the children, their families and the health workers giving or supporting the care, by those planning services or systems of care. Often non-professional or junior health workers lack 'a voice'.
- Poor sharing and unequal distribution of resources
- Poor organisation of the material resources that are available
- Poor maintenance, especially cleaning, of the healthcare environment
- A vertical management structure with little delegation. This can restrict innovation and development
- No opportunities for education and for health workers to learn effective management and organisation skills
- No fair and open system for employing, dismissing or disciplining health workers
- No system for the recognising and praising the contributions of individual health workers or clinical areas
- Poor organisation and no standardisation of systems of care
- Poor organisation of human resources (frequent changes of carers, poor skill mixes)
- Poor support systems for health workers
- No, or little access to the world literature and the evidence-base for healthcare changes.
- Few standards, policies, guidelines and other job aides
- No opportunities made to review existing policies and guidelines to see if they achieve their objectives (audit)

Barriers in individual health workers
- A negative attitude and low morale
- Difficult personal circumstances that are taken to work and affect performance or time spent working
- Poor time management
- A lack of respect for others
- Lack of knowledge and skills or awareness of what is possible
- Reluctance to share skills, knowledge and resources

Forces that support change

Despite facing many of these barriers, health workers are frequently able to make simple but effective improvements in the care they give. Forces for change include:

External forces

- Stabilities in government (including Ministers of Health), in situation and in the country's boundaries
- Political vision within a country for improving children's healthcare (for example the Kosovan Department of Health and Social Welfare's visionary health policy for Kosova, February 2001). This vision works best if it is:
  - Shared by all the main stakeholders in children's health.
  - There is a detailed plan for its implementation with funding where necessary
  - Individual health workers are encouraged and supported to achieve the vision
- The desire and the support of the wider community
- Good working relationships with other stakeholders in children's health such as WHO, UNICEF and non-governmental organisations (NGOs)

Internal forces

- A collective commitment to make things better
- Sufficient skilled health workers to provide safe care. If there are too few health workers, it is difficult to introduce any changes that require extra effort or time, although 'many health workers' does not always mean the 'best possible' care or a collective commitment to change.
- Consistency of staffing in a ward or other clinical area, especially the senior staffing. However consistency of staffing can also be a barrier to change. Health workers often prefer to stay with what they know, rather than embrace new skills and change well-tried working practices
- A change of leader/s
- Fair and open management with delegation
- A culture of team working, especially team problem solving
- A system to consult service users (the children and families) and respect their views
- A collective respect for human rights and a named health worker responsible for coordinating related activities.
- Regular training/educational opportunities for all health workers and good human resources
- Good systems for sharing and disseminating information between health workers, such as in Moldova and Kosovo where all senior health workers meet to share information at the beginning of the working day. These meetings work best when they are not dictatorial or proscriptive and are attended by representatives of each type of health worker, each service and each clinical area concerned
- Established forums for discussion and case review, such as regular audit meetings. Those responsible for coordinating audit need to encourage attendance and ensure that everyone understands why audit is so useful.
- Access to the evidence base for practice.
- Clear standardised (the same and used by everyone) policies, guidelines and job aides with training (See Section 5: Information Sheet about Job Aides)
- A satisfactory, well-maintained working environment raises morale.
- Sharing resources and equipment
- An effective and efficient system for managing data (collection, circulation, collation and examination), Good data are essential for supporting plans for change, for showing that change works and for supporting advocacy for more resources.

In individual health workers
- ❑ Visionary leadership able to share visions, motivate and organize others. For example, the visionary leadership of a paediatrician in Mulago Hospital Complex, Uganda that improved care for the newborn, a new ward sister in Mulago that improved the care given on her ward and of a single-handed Cuban paediatrician in The Jubilee Hospital in South Africa who improved the care of very ill children.
- ❑ Ability to participate in team problem solving. Best practice is to organise staffing to meet the needs of children and their families and not to accord with the needs or traditions of health workers. It is best to use a team approach to decide how best to use the human resources available.
- ❑ Wanting and being given the responsibility and authority to coordinate an important healthcare task in a clinical area, such as infection control.
- ❑ Working well together with respect for the different skills of others.
- ❑ An individual commitment to making improvements
- ❑ All the senior health workers in a clinical area are committed to making changes/improvements as wanted and planned changes can be sabotaged if there is a powerful senior person not fully committed.
- ❑ An individual commitment to human rights, especially to the rights of children as others can be influenced by this, and by sharing knowledge about human rights.
- ❑ Trying to keep morale high by being a positive and good employee (See Section 5: Information Sheets on Adversity and Keeping Health Workers Happy). When the collective morale is high there is a collective desire to do better, such as found in the relatively small children's departments in Barnsley and Bridgend hospitals in the UK.

During the pilot project for the CFHI when most of these forces that support change existed in a pilot hospital, improvements in healthcare were continually being made and 'change' was a process not an event. When many of these forces were absent, although there were many visions for making it better, very little actually happened.

About improving care

To make changes that lead to improved healthcare for children and their families the barriers need to be overcome, and any forces that may help recognised and effectively used

'Great works are performed not by strength but by perseverance' Samuel Johnson

What helps to start, or speed up, the change process?
- Any type of unfavourable assessment or audit
- The setting of new 'Standards' for undertaking aspects of healthcare by a country's health planners
- The influence of an important person or group of people, such as a government minister or a parents' group
- The appointment of a new health worker with vision, particularly if this new health worker is in a position of authority in the organisation
- A difficult or unpleasant experience that causes health workers to look back at what has happened
- A complaint or suggestion made by a child or parent. In many countries children and parents are still not listened to or heard
- A learning opportunity or exposure to new experiences, such as a visit by an outsider who raises awareness about some issue or opens the eyes of health workers to what is possible

- New research evidence that shows that there is a better way of giving a particular aspect of care

Large changes need to be planned and resourced by those who plan and organise healthcare, but it is important to remember that many small low, or no cost, improvements can always be made by each and every health worker and often very small changes can have a huge impact on children's well-being It is these changes that the CFH improvement program focuses on.

An example of a small low-cost improvement of the environment

'Child friendly' curtains, cot covers and some balloons have improved the environment and motivated health workers to do more in this excellent day care unit in Pakistan

'Regarding change, remember that people can be excited about change but do not like to feel they are being changed'.

'A smile costs nothing' (The Minister of Health, Pakistan and others)

Positive welcoming 'child and family friendly' behaviour in health workers can make a big difference to how well a child and family respond to their individual health problem. Changing the negative attitudes found in some health workers, however difficult; can be of huge benefit to children and families.

Attitudes and beliefs influence all aspects of healthcare. They are difficult to change but best practice for every health worker is to have child and family friendly attitudes and behaviours, and to continually try to change any negative or destructive attitudes seen in others, especially those that interfere with providing the best possible care. You can do this by sharing your knowledge about 'Child Friendly Healthcare' and the evidence for this. This costs nothing except commitment and time.

When making improvements

- Prioritise aspects of care and start with a small but feasible project.
- Use a staged (step by step) approach. Completing a project successfully and seeing how it makes things better, gives the motivation, strength and confidence to tackle the next thing on the list.
- Use a team approach to planning and implementing your ideas and solutions with a representative from each group of health workers affected, and a representative to speak on behalf of the children and families.
- Share ideas, problems and solutions, both locally, nationally, and internationally, through publications, advertisements, the media, and at paediatric meetings
- Use human and material resources effectively (see section 5 'looking after health workers'). In countries that have few, or not enough, skilled health workers or cannot afford to pay them, it is best practice to train and employ less skilled people as basic health workers (not nurses or doctors). This enables the more expensive skilled doctors and nurses free to see only the very ill children and those with the most complex problems. In some countries such as Nepal , local people in isolated rural areas are trained to provide basic healthcare, helped by clear guidelines that are designed to help them recognise the patients that need to be referred to more skilled health workers at a distant centre. It is also important to recognise that older retired very experienced and skilled health workers can still contribute, but in less onerous ways than previously.
- **Actively support and acknowledge your colleagues**
  (See also Section 5 for more information about adversity and how to look after health workers)
  Ill or unhappy health workers are not able to provide the 'best possible' care and may leave the health service. So best practice is to support others actively and also to have formal systems for supporting and looking after the physical, mental and emotional health needs of health workers. This is cheap compared to the cost of the loss of health workers to a health service. So support and value each of your colleagues.

A paediatric surgeon in Eastern Europe who, although over 80 years old, is still employed to use her diagnostic, but not her surgical skills. She is well respected by her colleagues and prevents many children from having unnecessary surgery

A health worker sharing skills in Bosnia

Sharing knowledge in Barnsley, UK. Reading materials relating to children's healthcare found by individual health workers, and information learnt during courses and talks, were routinely put in this special area on a children's ward enabling all the other health workers on the ward to benefit.

Why acknowledge effort?

Acknowledging effort is of huge importance for many reasons. For children to learn and develop to their full potential, they need approval and sometimes rewards for the things they have done well, and guidance, not criticism or blame, for the things not done well. This is also best practice for adults as in this respect we do not change. Most health workers will improve their performance and skills if they are given approval, respect and reward for who they are and what they do. If they already have this, they will try to keep it; if they do not have it or are not given this in response to their efforts, they will become de-motivated, perform poorly and have no incentive to change.

A motivated acknowledged health worker in Uganda planning more improvements.

Acknowledgement of health workers by both individual families and communities is also important as appreciation of their care confirms that they are doing a good job. A culture for blame has a destructive effect on all aspects of the healthcare provided. It can also cause great distress and disillusionment in the health workers concerned.

Finally, public acknowledgement of good healthcare brings it to the attention of others, and by doing so can validate a previously unrecognised or under-valued health service or activity. This acknowledgement may also attract the resources needed to make it even better and enable the good healthcare to be shared with others.

How others can help (including humanitarian aid)

Others who can support improvements in healthcare include individuals, groups, organisations (governmental and non-governmental), different healthcare environments and health services. These 'others' may be from the same country, from a different country or from the international community. Advice and assistance that supports change includes:
- Agreed 'Standards' for children's healthcare (international, country, health facility and/or professional)
- Systems for monitoring, recognising and rewarding achievement of these Standards
- Health improvement programs
- Donations of money and/or material resources.
- Sharing expertise and opportunities for learning and skill-building
- Sharing good practice and solutions to problems that have been found effective in similar circumstances.
- Sponsorship
- Advocacy

There are many excellent global health improvement programs such as the Baby Friendly Initiative (BFI), the Integrated Management of Childhood Illness (IMCI), the Expanded Program for Immunisation (EPI), the Safe Motherhood Program and others. To work in the 'best possible' way these programs need to reach and support every health worker. They need to be easy for health workers to use and inexpensive, especially if new resources are not linked them. Unfortunately some are costly and need to be supervised by others making them difficult to introduce unless funding is provided by outside donors.

Very few health workers ever admit to having enough resources. Those that do are more likely to work in an advantaged country and/or in the private healthcare sector. In disadvantaged countries, even if scarce resources are managed and used in the 'best possible' way, these are still unlikely to support the sort of healthcare that health workers ideally wish to give.

Donated money and material resources can help if they are appropriate to the circumstances, are only needed for a temporary period or are sustainable after the donor leaves or discontinues their support. Donations need to be accompanied by advocacy for a higher healthcare budget for children and pregnant women. This must be part of every aid project, as in the long-term, a country cannot rely on aid, but needs to solve and resource its own problems.

The short-term unsustainable aid given in emergencies is very different to the sort of aid required to help develop children's healthcare services. It is important for donors to recognise and understand the distinction between the purpose, limits and features of 'emergency aid' and that of 'aid for development'.

Best practice for donors is always to question the appropriateness and context of their donations, to consider the possible negative impact of their actions with equal (if not greater) energy as they do the positive impact, and to ensure that those receiving aid are in a position to identify their real needs and also to recognise and say no to inappropriate donations.

Some of the examples of inappropriate aid seen during the pilot project:

- Cupboards full of donated infusion pumps in one country's main neonatal unit. All said to be broken but in reality all were in working order. These were incompatible with the local electric,

supply, the local health workers did not know how to use them, nor were they ready to change the basic way they gave fluids. They were also unaware of the benefits such a change could bring.

- An impassioned plea from a maintenance engineer asking that donors consult him before donating equipment that he would have to maintain (no repair manuals in his language came with the equipment), and in any case he would not be able to mend it as had no budget for spare parts.
- "Out of date" drugs and disposables that were unfamiliar and not prescribed in the country. These had to be destroyed at a cost to the health facility.
- A donation of adult resuscitation and basic monitoring equipment to a children's ward. There was no training on how to use it the donation. The equipment was not passed on to the adult unit where it could have been used more appropriately,
- A donated computer system for medical records not in use for over a year as there was no funding for it to be repaired, nor was the expertise available in the country to do this.

Ten suggestions for the donation of equipment

Only donate if this is:

1. Wanted by most, ideally all, of the health workers involved *(always consult widely with those who will be responsible for using it and maintaining it, before donating).*
2. Appropriate for the level of care that the local health workers are currently able to *give (for example if health workers currently give fluids through giving sets without chambers, it is more appropriate to give paediatric giving sets with chambers before donating syringe pumps that they may not be able to understand the need for or be able to use)*
3. Able to meet the local needs and circumstances *(for example donated anti-malaria tablets would be of no use in some countries)*
4. Compatible with the local electricity supply *(for example make sure that the donated item has the right type of plug, that there are sockets and that it will work with the local voltage)*
5. New or in a good state of repair, and preferably a make whose manufacturer has servicing and spares arrangements with the country or a nearby country
6. Accompanied by training for the health workers *(including education of a 'trainer' who can train others).*
7. Compatible with any existing similar equipment, if possible
8. Accompanied by instructions in the local language about what it is for, how to use it, how to mend it, how to clean it and where to get spare parts *(ideally spares should be affordable and available in-country wherever possible)*
9. Accompanied by funding for spares and maintenance if this cannot be provided by the recipients
10. Within its expiry date if there is one

These rules apply to donations of technology, drugs and other items

Donated learning materials need to be appropriate, wanted by and accessible to the majority of the recipients. They need to be in the language that is most easily understood, up-to-date and if they require technology, they should be usable and compatible with the local technology available.

Some examples of systems for getting easier access to low-cost learning materials and evidence bases include:
- The WHO 'blue trunk' library system – this delivers WHO and other books to enable a health facility to set up their own basic library. It also provides training and information about how to run a lending library, but needs funding by sponsors.

- The UK BMA/BMJ information fund – this donates and sends educational materials (BMJ books, CD-ROMs and journals) to successful applicants. It accepts and funds applications from institutions not individuals. It also enables more than 100 of the worlds poorest countries to have electronic access to the BMJ publishing group's 23 specialist based journals including its evidence- based compendium, 'Clinical Evidence' see www.bmj.com
- Book aid international. This is a UK non-governmental organisation that distributes the 'ABC of AIDS' and 'The International Manual of Child Health' to countries in Sub-Saharan Africa. www.bookaid.org/resources/downloads/ar.pdf
- TALC (teaching aids at low cost) is a UK non-governmental organisation that provides low cost books and teaching equipment to health workers at all levels in disadvantaged countries. www.e-talc.org or info@e-talc.org
- FreeMedicalJournals.com – www.freemedicaljournals.com
- Health Internet Access to Research Initiative. www.healthinternetwork.org

Sharing expertise with other countries

Sharing experience, expertise and knowledge with colleagues in other countries can contribute to improving healthcare.   However, it can also lead to further difficulties if certain factors are not considered properly. It is important not to impose your own practice unless this is appropriate. It is better to first identify what is the realistic 'best possible' practice that is appropriate to the environment and local circumstances, and then to work with local health workers to achieve this by building on their existing skills.

Locally made low cost drugs trolley from Pakistan

A visiting health worker also needs to:

- Be wanted by local health workers
- Know what local health workers want and expect (best understood and agreed in advance by both parties who must share a purpose if the visit is to be successful).
- Be appropriately experienced and skilled. Seniority in one country is no guarantee that a health worker will be able to work appropriately, effectively and understand the constraints of the different environment. A relatively junior health worker is more likely to teach others about things that they are already familiar with, or be bullied in to teaching inappropriate skills and not the appropriate, but perhaps more basic skills that will benefit the majority of children. For example, in a health facility

that provides basic monitoring and care for very ill children, it is more appropriate to focus on improving this before teaching how to intubate and provide assisted ventilation.

- Be capable of achieving the respect of local health workers
- Be versatile in their approaches and working methods
- Consider gender as this can be a factor that may affect a visiting health worker's ability to engage the local health workers
- Be able to communicate well at all levels. If the language of the local people is not spoken this can be a major handicap unless they are always accompanied by a very good interpreter.
- Be able to set realistic goals for themselves
- Be able to motivate others and teach by example
- Support learning and skill building by providing training and educational materials, especially if these are not or cannot be provided by the country
- Be able to show the reasons why what they do might be better than the existing local practice
- To act responsibly by ensuring that any teaching they do, or change they advocate, is appropriate to the environment and resources and can be sustained after they leave
- Be prepared to learn from the health workers they are visiting.

Those responsible for their placement in the country need to:
- Facilitate their visit by providing them with as much information as possible about the health facility and health workers they are visiting and the problems they face. An assessment prior to their visit, such as the CFH assessment, will provide them with all the information they need. It will guide and prioritise the help they can give to their disadvantaged colleagues and will help them set realistic goals to achieve during their visit
- Support them and facilitate support from their family and friends. It is important that they are provided with the resources to keep in regular contact with their family and friends via telephone or electronic mail where possible, especially if they are on their own in a country that is unfamiliar.
- Provide a named mentor or supporter who should contact them regularly to discuss problems, monitor their well-being and their activities, and provide any support needed.
- Ensure that they are protected as much as possible from local serious illnesses

Shared good ideas, good practice and solutions to problems
This does not mean importing inappropriate solutions that may work in completely different environments and circumstances. These may, and often do, make the situation worse.

Experience reveals that showing photographs and telling stories are useful and popular tools for sharing ideas and practices from other countries with paediatric health workers. For example after seeing the wall paintings in children's wards in other countries, health workers in one hospital arranged for a local artist to do the same in their wards.

A CFHI coordinator and interpreter in a ward play area.   The same children's area one year later

Sponsorship

Sponsoring or finding a sponsor for an individual health worker to improve their knowledge and skills in a more advantaged country is another way of helping to make it better, but only if the health worker returns to their own country after the learning experience to put this into practice. Often after a period of sponsorship, a health worker fails to return, or is unable to use their new knowledge and skills as these are not useful in their own country. Countries that host and train health workers from other countries have a duty to teach the skills that are needed rather than those only relevant to their own health service. They must encourage health workers to return to their country of origin.

A diabetic centre in Moldova funded and maintained by a sponsor from another country. The centre sees all children with diabetes, providing them with advice, counselling and free supplies of insulin, needles, syringes and blood glucose monitoring stick.

Play in a children's ward in Uganda sponsored by a hospital play department and a private children's nursery from another country.

Expertise, resources, advocacy and shared learning opportunities can all be provided within a 'twinning' arrangement with a similar health facility, department, clinical area, service or individual in another country. In both advantaged and disadvantaged countries, the sharing of experiences with colleagues can be both supportive and effective in improving practice.

Advocacy

An important way for others to help is to advocate for health workers, children and families living in disadvantaged countries. Advocacy by a visiting health worker may be successful, especially if this health worker is respected. (See Section 5 for more information on issues for global advocacy)

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Section 5
Supporting materials

CFH Information Sheets

1. Adversity and problem solving
2. Advocacy
3. Audit
4. Cleaning
5. Clinical guidelines and other job aides
6. Data Management
7. Lifelong learning and how to put this into practice
8. Looking after health workers
9. Mission Statements *with examples*
10. Problem solving
11. Team working and leadership *with an example of a health facility management structure*

Additional information sheets available on the CFHI website:

- An evaluation form
- A format for writing an assessment report
- A policy for preventing and managing a needle stick injury
- Data that can be collected to provide information about a population's health
- A toy safety policy
- A consent form
- Essential equipment, medical supplies and drugs for emergencies
- Job aides
- Organising and running a training course
- Writing and funding a project proposal

CFH Information Sheet 1: Adversity and problem solving

'Life is not the way it is supposed to be. It's the way it is. The way you cope with it is what makes the difference'. Virginia Satir

'I believe that it is what you do after a disaster that can give it meaning' Christopher Reeve

Adversity can be an event or situation that compromises a child's rights to survival, development, protection and/or participation. Adversity makes a child more vulnerable to actual physical, mental or emotional harm, or to abuse through exploitation or neglect.

Adverse events include natural and man-made disasters. Some examples of natural disasters include earthquakes, floods, hurricanes, extreme weather conditions, drought and personal disasters such as accidental separation from a parent, accidents, illness, and disability. Examples of man-made disasters are wars, famines, poverty, separation from a parent through divorce, exploitation or neglect or even just poor parenting for whatever reason.

Adverse situations are difficult circumstances, for example, poverty and other social or difficult family circumstances, including a health problem that requires hospitalisation.

An example of how an adverse situation can make a child feel

'Humiliation is the worst feeling, to be excluded and ignored and to be compelled and not given the space to express our needs, our feelings, our dreams'. A working child in Karnataka, India.

Some facts about adversity
- Outside intervention and/or help may be needed to stop or resolve the event or situation
- It is not the magnitude of the adversity that counts but the effect that it has on the individual - what may seem a small, insignificant thing for many people that can be easily absorbed, for a few people may be a catastrophe with far reaching effects.
- The impact that an adverse event or situation has on a child is dependant on many factors. These include what else is happening in the person's life at the time, the person's ability to cope, their degree of emotional and psychosocial vulnerability and the circumstances surrounding the adversity.
- After the adverse event or situation is over, help may be needed to recover fully, especially if 'resilience (self-healing)' is not good
- If adversity involves **any type of loss**, the grief process has to be endured and supported. Criticism and comments such as 'pull your self together' are not constructive and cause further damage to a vulnerable adult or child. Understanding is needed and an ability to listen and be there for that person until, and if, they are able to reach the other side of the grief process.
- Only someone who has grieved themselves can fully appreciate the suffering that cannot be avoided and is not the self inflicted suffering of choice. To be a victim or not, is more complex than merely being a question of individual choice. Victims need support if they are to recover, some more than others.
- Coming to terms with adversity and finding forgiveness for one's own possible contribution to this (if acknowledged), and for the contributions of others, can be a positive experience. It can lead to more tolerance and understanding of others, and an improved ability to help others (an example set by Nelson Mandela).
- Not all child victims find the forgiveness necessary to come to terms with the adversity they experienced and to move forwards. This failure to heal can cause long-term developmental and mental health problems. They might never develop to their full potential, become emotionally mature or contribute well to society.

Intervention to stop, or help a child cope with adversity, needs to:
- Be appropriate to the event or situation
- Be by people who have the appropriate resources, skills and attitudes
- Build on and promote a child's own protective factors (coping strategies)
- Avoid the term victim as this suggests helplessness, passiveness and defencelessness in the face of adversity
- Include listening, but ethical codes are also necessary to avoid further exposure to harm by insensitive questioning of children after an adverse event
- Combine cultural sensitivity and an understanding of developmental pathways
- Be evaluated, particularly with regard to later development in childhood

The adverse event or situation usually causes many problems for the child and their family. These will need solving either by themselves or with the help of their community and others (a team approach).

Some simple rules for solving problems

1. Define the problem/s after listening to everyone affected *(do not make assumptions about the cause of a problem. If you do, it is likely that your solution will not work. Talking to everyone makes finding the true cause/s of the problem more likely and therefore a workable solution more likely.)*
2. If there is more than one problem, prioritise these *(remember that the main problem may be due to several different problems each with different causes, so break a problem down into all its different parts and decide which are the most important to solve first)*
3. Look for the barriers against solving the problem/s and the forces that may help, such as people and/or materials *(It is best to identify these before you start)*
4. Decide on some possible solutions/courses of action *(after talking to those affected and if possible also to others who have faced similar problems. The more complex the problem, the more consultation is necessary)*
5. Consider/evaluate the possible solutions and select the best that is feasible, if possible with everyone's agreement *(the problem that is easiest to solve may be best tackled first as success encourages and motivates)*
6. Try this out/implement/put into action (if there are lots of problems it is better to select only a few to act on first. Trying to solve too many at the same time may lead to failure)
7. Evaluate the results to see if the problem has been solved *(think about and identify the lessons learned/the things that went well and the things that could be done differently or better next time)*
8. If not, try out other possible solutions until it is solved
9. Review other problems from the list and repeat the process
10. Always acknowledge everyone's efforts and share the solutions that worked for you with others.

CFH Information Sheet 2:   Advocacy

Advocacy in the context of Child Friendly Healthcare means speaking on behalf of children and/or their families who are either unable, or unwilling, to speak themselves about their needs, safety, or abuse of their rights. It is acting as a 'voice' for someone who has no 'voice' or is unable to use it.

Some facts about advocacy
*   Its aim is to make things better for the child and/or their family
*   It is usually targeted at people who are able to make decisions and have influence
*   Anyone can advocate and most of us do so in our daily lives, in many different situations. Often we are not aware of doing this.
*   Advocacy is for someone or some people.
*   It is usually done by someone, or done together with someone else, including with the child.
*   It can also be done through systems such as a law, healthcare 'standards' or a health improvement program *(the UNCRC is the most important law that advocates for children)*.
*   It can be about anything, even small things, if these are causing a difficulty or a problem for a child
*   Advocacy can be at many different levels. It can be to other health workers in your daily work, the family, the community, the local government or local organisations, the country government or country organisations, the international organisations or to religious organisations.
*   Health workers are ideally placed because of their unique knowledge of a child's needs and best interests. They have a responsibility to act as advocates for them.
*   It is important to have as many facts as possible concerning the problem –consult widely beforehand if possible and if the circumstances allow this
*   Advocacy must always consider a child's 'best interests'
*   Best practice, if possible, is to use advocacy with the child's and/or their families' consent/agreement
*   If done with the child or their family it can empower them, however care must be taken to avoid making things worse for the child

Some simple examples where advocacy can be helpful:

- Advocating to the ministry of health about the absence or shortage of an essential drug such as morphine or oxygen
- Advocating to a social services support system (if it exists) about a family 'in need'
- Using publications or other communication methods to highlight a problem in a health facility
- Advocating to government about the need for a health service which is equally available to all families regardless of their ability to pay
- Complaining to a manager about inadequate facilities for children, for example toilets which are unclean or the absence of play

Some global issues for advocacy

Health workers also have a responsibility to speak out about some of the important global issues that can affect children and families. These controversial issues include:

- *Antiretroviral drugs*: Advocacy for these for the millions of children who live in Africa and are HIV positive has led to decisions that will improve this situation. It is widely believed that poor countries do not buy generic drugs because they are threatened by penalties in the form of reduced trade or reduced aid. This should be investigated and reported if this is the case.
- *Specially prepared formulations of drugs for children:* health workers need to advocate to pharmaceutical companies (trade and generic) to produce drugs in doses and forms that can easily be prescribed for children to take once or twice daily. For example Cipla, the Indian generic drug manufacturers, will soon make available odivir, a once daily, three drug combination of anti-retroviral medication for adults. A similar preparation would be very beneficial for children with HIV infection.
- *Reduction of mother to child transmission of HIV*: Investigate the reasons behind not making nevirapine available to all mothers in Africa and one dose to their child. The concern stated about resistance is surprising as less than 50,000 of 30 million receive anti-retro viral drugs.
- *The Orphan issue*: In the next 20 years we are going to see a large rise in the number of orphans in Africa due to AIDS. There are currently 11 million and it is predicted that there will be 20 million by 2010. Family systems are already becoming saturated as the grandmothers (who often become the main cares) die. The orphan numbers swell about 10 years after the height of the prevalence in any country. For example in Botswana the current prevalence is near 40%, in 10 years there will be a terrible crisis. **We should advocate at a national level that as for all children orphans should receive free education, free essential healthcare and be fed at school and that this be supported by the large bilateral and multinational donors.** The alternative will be more children unsupported and unsupervised, in poverty, with poor health and vulnerable to abuse. This in the long term, one could argue, may provide the background for threats to social stability and security.
- *The Arms trade*: The arms trade is a disaster for poor people and civilians, especially children. Amongst many campaigners health workers from 'Child Advocacy International (CAI)' * have written a paper that is quoted widely both in the press and in medical journals. The fact that several rich countries promote (and gain huge financial benefits from) this trade by selling a large percentage of their products to developing nations, often on both sides of a conflict, needs to be further highlighted.
- *Debt:* The effect that debt has on healthcare and education for children has been widely reported and should continue to be a focus for advocacy. .
- *Trade:* The tariff barriers to trade and subsidies have a huge impact on poverty and child health. There is a continuing need to raise people's awareness about ethical shopping and the impact this has on a country's ability to provide healthcare and education. (See paper on Africa's children by Child Advocacy International B O'Hare, J Venables, and D Southall **Child health in Africa: 2005 a year of hope?** Arch. Dis. Child., Aug 2005; 90: 776 - 781.).
- *IMF and the World Bank:* The introduction of user fees and other structural adjustments made by the International Monetary Fund (IMF) and the World Bank are widely believed to have a devastating

effect on healthcare. There is a need to find an independent tool to assess the impact of many of these initiatives and report them. (See in Press Archives of Disease in Childhood)

- *Trans-nationals:* This power is highlighted by their lobbying of the World Trade Organisation (WTO) and the influence they have. There is a need for advocacy to ensure that the needs and interests of the less powerful (usually the poor) are represented.
- *Foreign Aid:* Some foreign aid does not actually result in sustainable development.

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CFH Information Sheet 3: Audit – what is it and how to do it?

Audit is one of the important supporting criteria for the CFH Standards as it improves the care given to children and their families. This means that it deserves a major commitment from all health workers

It is the systematic critical review of the way a specific aspect of healthcare is provided, managed or given, to see if:
- ❑ This is the 'best possible'
- ❑ The outcome for an individual child and their family is/was the 'best possible'
- ❑ Any improvements can be made.

Any healthcare activity can be audited in varying ways by a group of health workers meeting to share information gained from personal experience and/or medical records

Structured audit involves looking at the use and management of resources.
Process audit involves looking at the policies, procedures, clinical guidelines and other job aides to see if these are being followed and/or are achieving their objectives
Outcome audit involves looking at the way health care is given, its outcome and how the child and families' quality of life is affected by the healthcare experience

Audit meetings provide excellent opportunities for:
- Identifying problems
- Multidisciplinary learning
- Group problem solving
- Contributing to medical knowledge
- Planning changes that might improve the healthcare given
- Updating clinical guidelines and other job aides
- Advising managers
- Finding issues for advocacy
- Identifying examples of good practice for sharing with others

It is important that audit is not used to attach blame, but to identify errors, mistakes and problems, to learn from these and plan changes to prevent the same things happening in the future.

It is also important to protect the confidentiality of individuals, both patients and health workers.

1. Setting 'standards' for the quality of care provided and given, if these do not already exist
2. Assessing practice, quality and outcomes against these
3. Making improvements and changing practice where appropriate
4. Looking at what happens after change (evaluating the effects of change to see if they have achieved their objectives)

Audit is best planned, organised and supervised by a **named health worker with this responsibility** (coordinator).

This important coordinator for audit needs to:
- Arrange Dates for audit meetings
- Decide on the aspect of healthcare for audit (best agreed jointly in advance)
- Delegate information gathering and data collection to a named health worker/s for each audit in advance of the audit date. It is important for this health worker not to forget to ask the parents for their views and opinions about what has happened to their child and the impact this has had on their family when this is appropriate to the audit.
- Keep a record of meeting dates, aspects of care audited, those present, the findings, how any changes needed will be implemented, date for effect of changes to be re-audited
- Ensure that audit recommendations are reviewed and that recommended changes have been carried out and have achieved their objectives
- Tell all health workers in a health facility or organisation about the results of audit, and about any changes of practice that are recommended and agreed on by all involved.
- If appropriate share audit findings with parents/carers.

It works best if the coordinator for the audit is skilled at:
- Problem solving
- Facilitating
- Dealing with conflict
- Sensitively and constructively dealing with health workers who are performing poorly
- Basic data analysis
- Communicating (adequate and appropriate communication is important part of the audit cycle).

Good **data organisation and management** are needed for successful audit. Data may be needed about populations, about service specific issues or about outcomes. Routine data collection is easier if healthcare records and other forms designed especially for audit meetings are standardised.

For example how to collect information for a mortality audit
Before an audit meeting, review the relevant clinical records and if possible talk to the families of each case/child before the audit to gain their views and opinions about what happened (this needs to be done sensitively, preferably by a health worker who the family know well. They need to be seen again after the audit to be told the outcome. In our experience families welcome this opportunity to express their views, providing it is not too soon after the death. They also welcome improvements in care that arise because of their child's death).
The following data are useful:
➢ Days of illness prior to presenting
➢ Date and time of first presentation to a health worker
➢ Date and time of first treatment given
➢ Signs child presented with (were these emergency or priority signs? (*See Standard 8*)

➢ The triage category given to the child
➢ The diagnoses made when first assessed
➢ Drug treatment given
➢ Supportive care given
➢ Monitoring (frequency, what was recorded, how was it acted upon)
➢ Place of care within the ward (high-dependency, general ward, outpatients)
➢ Number of skilled health workers on duty at the time (was this 'safe?')
➢ Whether or not other complications occurred
➢ Date and time of death and who was present
➢ Details of any resuscitation attempt
➢ Any relevant history about the child and family
➢ What happened after the death and how the family were supported

Some of the aspects of children's healthcare that benefit from audit include:
1. Deaths
2. How specific health problems have been managed, including how each individual child with this problem has been cared for
3. Patient/carer and child (user) satisfaction (of service standards and other quality issues)
4. Adverse or critical events for example a serious infection acquired in the health facility, an unexpected death, a prescribing mistake, something that has particularly upset health workers and others
5. How children are referred to the specialty service/healthcare environment. and/or what happens when a child is referred
6. Other agreed systems of care, policies, procedures, job aides etc.

How to audit deaths
- Agree on how often to do this
- Collect the total number of deaths since the last audit and the causes.
- If there are more than a few deaths, select a sample of cases for discussion rather then attempting to cover all cases so that maximum attention can be given to the lessons that can be learned from each case.

Selection criteria can be based on:
- Diagnoses - focus on one or two diagnostic problems at each meeting but covering all of the main causes of death over the calendar year
- Indicators - focus on areas where indicators show problems in care (for example if there are more deaths in one clinical area, or for one clinical firm compared with another that is looking after similar problems, focus on the area/team with the most deaths)
- Priorities - focus on problems that should be overcome readily with existing resources
- Avoidable deaths

Best practice is for everyone who was involved in the care of the child/children to attend. Each death needs to be discussed and decisions made about:
- The probable main cause of death
- Other possible causes
- Contributing conditions (other health related problems identified by health workers or caregivers)
- Modifiable/avoidable factors are then identified and classified as:
  - Carer or family related
  - Administrative
  - Related to poor care given by health workers in primary care
  - Related to poor care given by health workers at referral centre - (triage, emergency care,

diagnosis etc)

When the main causes of any problems have been identified, best practice is problem solving as a team. Decide what steps can be taken to avoid similar deaths in future, agree on any feasible changes for improvement, who will be responsible for coordinating these within an assigned time, the date they will be reviewed and how to share the findings and plans with other health workers.

How to audit specific health problems in an individual child or group of children with the same problem

It is important to review how health problems have been managed in an individual child or a group of children with the same problem. This means looking at both the outcome for the child and at how the case was managed from the onset of symptoms up to the time of the audit/exactly what happened and when (integrated care pathway audit).

The health problem for audit is best decided on jointly at an earlier meeting and the relevant information collected before the meeting. The same principles apply in that the purpose is to review each case to see if there were any errors or problems that can be rectified so that they won't happen in the future and to identify what did go well to share this.

Child and family satisfaction audit

Ideally each healthcare environment and service will have a mission statement clearly displayed in clinical areas to inform healthcare users, and remind providers, about what is provided. This statement may include such things as the intent to:

- Have a maximum patient waiting time in outpatients
- Have a caring attitude
- Explain about health problems and their treatment
- Provide child friendly facilities - toilets, cooking, washing, play facilities

Any of these intents can be the subject for an audit. To find out whether parents are satisfied with the particular aspect of service provided, their views and opinions need to be collected before the audit meeting. This can be achieved in a number of ways including using a questionnaire or individual interview with a random selection of parents/carers, for example during routine discharge or exit interviews.

Examples of possible questions include:

- Were health worker attitudes caring/friendly?
- Were there any unnecessary delays?
- Was everything about your child's illness explained to you?
- Were facilities adequate? (for example were the wards and toilets clean; was there always soap; was there enough privacy; did you feel safe and secure; were the facilities for cooking, washing and toilet facilities satisfactory)
- Were you always asked for consent before a procedure?

The findings from questionnaires/interviews can be discussed at the audit meeting and changes made if problems are identified.

Adverse or critical event audit

Examples of events that can benefit from this type of audit include:
- Re-admissions within 48 hours of going home
- Night deaths
- Near misses where a child has nearly died

- Acquired infections
- Incorrect drug treatment such as either the wrong drug or the wrong dose, or a drug given by the wrong route.
- Newborns with severe birth asphyxia
- Serious accidents to patients or health workers
- Children running away from a hospital
- Self-discharges (children discharged by their family against the advice of health workers)
- Other events considered important or distressing by health workers

Referral process audit
Such as audit of IMCI referrals or of other integrated referral strategies. Ideally such an audit is best attended by the health workers making the referrals as well as by those receiving and managing them.

Other service standards (including the 'Child Friendly Healthcare Standards'*), practices, policies and guidelines
This type of audit could be about topics such as:
- Immunisation coverage
- Breast feeding rates at discharge from maternity unit and at other key times if data collection possible
- Malnutrition rates
- Obesity rates
- Parent smoking rates
- Access to relevant health information
- Young persons sexual health
- Teenage pregnancy rates
- Accident rates
- Age at diagnosis of different types of disability
- Child protection policies and guidelines
- Quality of health information provided to schools on individual children
- Other national, country, district or local guidelines

Within wards and clinical departments, many infection control activities can easily be audited. These include:
- Compliance with sharps policy
- Reporting and management of injuries from sharps
- Isolation practices
- Decontamination of equipment
- Waste management
- Hand washing
- Cleaning
- Food handling and kitchen hygiene
- Compliance with antibiotic policy
- Practice can also be effectively audited against written, evidence-based procedures e.g. surgical scrub procedure.

Audit can contribute to making it better for children in many different ways and is a vital support activity for providing a child and their family with the 'best possible' healthcare.

CFH Information Sheet 4: Cleaning

Keeping **yourself** (personal hygiene), **the environment** (surroundings) and **the equipment** in a health facility clean is a very important way of helping to reduce the number of healthcare related infections that happen in at least ten percent of people admitted to a hospital. It will also reduce the chances of you becoming infected.

Methods of cleaning include:

1. Normal cleaning
This is the commonest form of cleaning and the one used for most items. Normal cleaning is done using water and soap or detergent after removal of dust and dirt using a brush or vacuum cleaning system. It is the most important, but often the most neglected of the three processes. Equipment and materials that need to be sterilised or disinfected must be first cleaned using this method

2. Disinfection.
This gets rid of many micro-organisms but not the most resistant endospores. Liquid chemicals called disinfectants are used as cleaning agents**.** There are many different disinfectants. One of the cheapest and most effective is sodium hypochlorite (bleach). Disinfectants are active against most micro-organisms including HIV and hepatitis B, however, they do have a corrosive effect on metals and if used on fabric or carpet can bleach out colours. Hypochlorites in dilution (usually 0.1% solution) are contained in household cleaners available in markets throughout the world for domestic use. These household cleaners can be used in the hospital environment for general cleaning of all surfaces, but stronger solutions need to be used for cleaning anything that has been in contact with a body fluid such as blood, urine, faeces, and others, and for cleaning following outbreaks of dangerous infections. Hypochlorites are also available as tablets that make dilution easier. Chlorine solution should be used in tepid water, not hot, as hot water increases the release of chlorine vapours that when inhaled may be harmful to health workers.

3. Sterilization.
This gets rid of all forms of micro-organisms completely. The cleaning agents are steam under pressure, boiling water, dry heat and certain gases or strong liquid chemicals. This method of cleaning is used for items that need to be sterile. Ideally a single separately organised and staffed system for sterilising should be present in every healthcare facility that looks after ill children, especially if there is an operating theatre.

Which method is used for cleaning will depend on manufacturers instructions, common sense and local policies. As a generality, anything that has been in contact with an infected patient, a patient with a wound, or anything that is contaminated or likely to be contaminated by body fluids, should be at least disinfected and if possible sterilised.

Cleaning materials (cloths, mops, sponges and other materials)
Ideally these should be used once only then discarded, but this is not practical in many countries. Where this is not possible, best practice is to keep cleaning materials such as cloths and mops clean by disinfecting after each use. Different materials should be used for different areas and surfaces to avoid spreading the micro-organisms from one area or surface to another. A colour coding system for cleaning materials helps remind health workers what they should be used for or where they should be used. An example of colour coding is red for wash areas and toilets, green for isolation rooms, blue for general ward areas and yellow for kitchens. The same principle can be applied to materials used for different surfaces.

How often should things be cleaned?

When buying new items for use in a health facility it is important to use the recommended best practice cleaning instructions that usually accompanies them. If it is not possible to follow these and it is not possible to use an alternative cleaning method that is safe, the item should not be purchased or used. Cleaning should be done as often as is needed to keep everyone and everything in a health facility as clean as possible.

Who should clean?

Every health worker has a responsibility for making sure that their healthcare environment and all the equipment they use is clean. If a child is an in-patient, health workers should also ensure that they, their resident family carer and their visitors have the resources to keep clean (*In many countries the toileting and washing facilities provided in health facilities for families are minimal, and often dirty and inadequate for the numbers of people using them compared with those allocated to health workers*).

Special health workers need to be employed to keep a health facility clean. These health workers (the cleaners) should:
- Be supervised by those responsible for each different area
- Be valued and feel valued by having their efforts acknowledged
- Receive training about hygiene, infection control and the cleaning practices of the health facility, which should be easy to understand
- Have enough cleaning agents (cleaning solutions such as water, soap, detergents and disinfectants) and cleaning materials.
- Be part of the healthcare team

Information about providing water that is safe to drink

If water is not safe to drink, the micro-organisms that make it unsafe can be destroyed by:
- Boiling it for 1 – 5 minutes (a minimum of one minute is needed)
- Disinfecting with:
  - Iodine 3 – 4 drops for each litre of clear water – mix well and wait 30 minutes before using)
  - Chlorine.

The most familiar chlorine preparations are: sodium hypochlorite (bleach), a liquid compound that comes in packets or bottles or lime chloride, a white powder containing chloride mixed with lime The amount of chlorine to add to water to disinfect it depends on the strength of the chlorine preparation used. Any instructions on the packet or bottle relating to making water safe to drink need to be followed.

Frequent and appropriate hand washing, safe food handling and preparation, and safe waste disposal will help prevent water being contaminated with micro-organisms

Best practice is to have enough clean, safe water for drinking available in every health facility for children, their families and health workers throughout the twenty-four hours.

Information about cleaning hands/hand hygiene)

To keep hands as clean as possible 'best practice' is:
- To have clean, empty sinks, easy to get to and use in each area in a health facility
- Soap at each sink
- A method for drying hands at each sink
- Sink taps that can be turned on and off without using the hands (elbows)
- Everyone knows the best way to wash their hands and does this
- Everyone knows when to wash their hands and does this

- No rings (except wedding rings), nail varnish or watches are worn and sleeves are short or rolled up during patient contact
- Hand washing reminders at all sinks
- An alcohol hand preparation available to use between patients, especially if hand washing is not easily possible or needed frequently
- To have a system to remind everyone to wash their hands (wall charts etc.)
- To regularly audit hand washing to see if this 'best practice' is achieved

Information about cleaning spills of blood and other body fluids
To reduce the risk of a healthcare related infection from contact with body fluids these should be cleaned up immediately, wherever they are.

For spills on hard surfaces best practice is:
1. For each area to have 'spillage kits' immediately available containing all the items needed.
2. Immediately cordon off area where spillage is, to stop anyone getting contaminated.
3. Ask a colleague to bring the spillage kit.
4. Wearing gloves, place cloth/paper towel from spillage kit on to the spill.
5. Wipe up blood from outer edge to inside to avoid excessive spread.
6. Put sodium hypochlorite (bleach) solution, 5.25% 1:10 ratio (1 part sodium hypochlorite to 9 parts water which gives the high level disinfection of 5000ppm that is needed) on the area affected.
7. Leave solution on the spillage for 30 minutes to disinfect both HIV, which only actually takes 10 minutes, and possible hepatitis which takes 30 minutes
8. Wipe spillage area more thoroughly and mop area with the same strength disinfectant solution.
9. Soak the cleaning material for 30 minutes before sending it to the laundry for washing.
10. Finally wash the bucket used with the same disinfectant solution.

If the spillage involves glass first use a dust pan and brush to clear up the glass, then carry on as above. The dust pan and brush should then be soaked in the same bleach solution before it is used again.

Information about cleaning laundry (laundry means any materials used when giving health care such as bed linen, towels, flannels, clothing, cleaning materials and others).
If laundry is dirty or soiled it needs washing. Best practice in a health facility is to:
- Separate dirty laundry that has been contaminated by body fluids, or is likely to be infected, from ordinary dirty laundry and store these different types of dirty laundry in separate bags immediately
- If possible wear gloves when handling dirty laundry and always wash hands afterwards.
- Make sure there are no sharps or other solid items in the dirty laundry
- Wash all laundry at temperatures above 60 degrees C (to kill micro-organisms laundry should be washed at temperatures of not less than 65 degrees C for ten minutes, or not less than 71 degrees C for 3 minutes) – other methods of disinfection before washing are best used for materials contaminated by body fluids that will be damaged at these temperatures.

Information about cleaning equipment
Best practice is always to read and follow the manufacturer's recommendations. If these are not available, contact the manufacturer and find out how best to clean the item, or if this is not possible, use common sense and clean as for a similar item.

In well-resourced countries single use equipment for many things is best practice but when this is not possible, **all** healthcare equipment should be thoroughly cleaned by the most appropriate method before being used by another child. If equipment of any sort is shared, there is a high risk of cross-infection.

Best practice is that a bed and mattress is cleaned with disinfectant after each use.

Information about cleaning the environment, fixtures, fittings and furniture

Water, soap and detergents or disinfectants can be used as cleaning agents according to local availability and policy. Frequency of cleaning for different areas will depend on the type of soiling and local circumstances. Toilets and wash areas need special attention; best practice is that they are always clean throughout the twenty-four hours.

Information about cleaning toys

To reduce the risk of cross-infection toys need to be kept clean, especially if they are likely to be used by more than one child. Toys that cannot be cleaned, except those are not usually touched or handled by children (for example those used for distraction), should not be used. Best practice is that the play worker, or a named health worker, cleans communal toys after their use.

Example of a policy for cleaning and maintaining toys

1. Regularly check and clean all toys, at least once a week.
2. Pay particular attention to toys for babies and toys given to children who are at high risk from infection.
3. Take extra care with the toys used by children who are known to be infectious. Their toys need to be easy to clean, or toys that can be thrown away after use.
4. Always sterilise toys that babies put in their mouths, such as baby rattles and pacifiers, between patients. These must not be shared.
5. Throw away toys that are broken or dangerous immediately.
6. Always follow your infection control guidelines/policies

Hard toys: Clean all surfaces thoroughly with detergent and hot water, rinse and where possible dry to prevent water retention.

Electrical (battery operated) toys: Wipe all surfaces with either water and detergent or alcohol wipes and dry thoroughly.

Soft Toys: Wash after being used by a child. These toys must not be shared. Best practice is to machine wash at the highest temperature practical and dry quickly.

Paper, books, posters, etc: Wipe the surface of books and posters regularly with a damp cloth. Throw away soiled paper. Check stored books regularly for wear and tear, signs of mildew and any insect infestation and discard if found.

The control of infections is so important that allocating sufficient resources for effective cleaning is vitally important. Best practice is to delegate the coordination and supervision of cleaning and other aspects of infection control to a named health worker for each clinical area. The senior health workers need to support the appointed person and ensure that they have the authority and time to do this important job, and receive the respect of others. As health workers frequently change there is a constant need to train the new health workers, and remind the others, about best practice. Audit of both practice and policies will help ensure that cleaning is effective.

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CFH Information Sheet 5: Clinical guidelines and other job aides - what are they, how to develop them and how to make sure they are used?

'In order to give the best possible care to children and families, paediatricians need to integrate the highest quality scientific evidence with clinical expertise and the opinions of the family'. Moyer VA. Elliot EJ. Preface to 'Evidence Based Paediatrics and Child Health

Job aides are written or pictorial reminders about specific aspects of care.(see website for examples and details) They help, or remind health workers how to, give the 'best possible' health care for a specific problem or issue. They include:
- Guidelines for treating a specific health problem
- Algorithms such as those for basic life support (BLS) and the Integrated Management of Childhood Illnesses (IMCI)
- Treatment pathways, drug doses.
- Lists of signs and symptoms for triage categories.
- Growth charts, developmental milestones.
- Hand washing guidelines placed near all the sinks in a health facility

Guidelines and job aides:
- Aim to improve healthcare outcomes
- Help clinical judgement
- Make the treatment of a specific health problem the same (when the same healthcare for a specific health problem is given by every health worker, evaluation and comparison of care methods are possible)
- Need to be supported by up-to-date evidence.
- Need to be linked to audit

- Need to be reviewed regularly
- Need to balance the art and science of healthcare
- Need to be adaptable to the situation and circumstances
- Need to be compatible with existing country and International guidelines
- May help to reduce costs or enable comparison of costs
- May protect health workers from complaints and litigation

How to develop, introduce and update a clinical guideline or other job aide

1. Create a small multidisciplinary team *(see information sheet 11 for information on team working)* of either interested volunteers or elected representatives from all the groups likely to be affected by them, including a parent and child representative

2. Consult all the health workers likely to be affected by the introduction, or up-dating, of a guideline or other job aide, and parents and children too, if possible, so that:
- Any organisational or individual barriers to their introduction and use can be identified
- Attempts to overcome these barriers can be made before their introduction
- Ownership is shared (individuals are more likely to use the guideline if they feel they have contributed to them and therefore share their 'ownership')
- The opinions and views of those on the receiving end can be incorporated

3. Find and review all existing guidelines used by the clinical area, healthcare environment, country or international community as:
- It saves time to use or adapt an existing guideline rather than 're-invent the wheel'
- It is sensible to comply with existing country guidelines, as long as they are evidence based and up to date.

4. Find and use the evidence to support the proposed guideline/job aide:
- For an existing guideline, review the evidence for this to make sure it is up-to-date and correct (unless the guideline is from a reputable source, is well referenced and dated with a recent date)
- Search the literature widely for quality evidence using the internet (if available) and reputable sources of information
- Remember to write down how this search was made and the information source/s
- Interpret the evidence wisely and match it to the resources available
- Translate the evidence into medical and nursing care for the health workers in the healthcare environment
- Use the written evidence to provide references for the guideline

5. Before introducing the guideline/job aide:
- Get agreement from the director/chief of the healthcare environment, the heads of departments and key clinical task coordinators for its use
- Get agreement for the date for starting to use it
- Finalise and all agree the content of the guideline and its references
- Remember to date the guideline
- Arrange education sessions for all health workers likely to be involved or affected
- Arrange a date for its review or audit

6. Arrange an early review by the core working party to amend the guideline if necessary as:
- The evidence for medical and nursing care can change as new research is published

- Local difficulties with following the guideline may occur and these will need identifying quickly, as will their solutions
- To achieve standardisation of practice, regular audit of compliance with the guideline is needed to find the reasons for non-compliance and their solutions

7. Arrange regular core working party meetings to;
   1. Review existing job aides at regular intervals
   2. Create and introduce more job aides

8. Avoid failure:

Most failures to standardise the care given are because:
- ❑ Those affected by their introduction are not involved in their development. As they do not feel they 'own' them, they do not use them
- ❑ A culture collectively to provide the 'best possible' care does not exist in the healthcare environment

Using guidelines to standardise healthcare makes sense and contributes to giving the 'best possible' care.

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Royal College of Paediatrics and Child Health: Clinical Guideline appraisals available from at www.rcpch.ac.uk

CFH Information Sheet 6: Data Management

Meticulous and thorough data collection is an essential requirement of each of the CFHI standards

A Health Record is written information about the physical and/or mental health of a patient. Keeping a written record of the healthcare given, and collecting other important health related information is an essential part of a professional health worker's job.

Reasons for keeping records

1. To inform others (children, parents/carers and health workers) about what has happened to a child and/or what healthcare is planned. This contributes to consistent and seamless healthcare and avoids time wasting duplication and unnecessary repetition if all health workers respect and use the health record.

Parents and children often feel frustrated when asked the same questions by a succession of different health workers.

 2. To obtain information about a population of children, for example children with disabilities, so that their health needs can be assessed and appropriate intervention programs can be planned and resourced

 3. To obtain information about other important indicators for children's health, such as breastfeeding and immunisation rates, that can be used to:
- Support advocacy for increased resources
- Monitor performance of programs, services and individuals e.g. road traffic accidents
- Monitor effectiveness of healthcare interventions
- Confirm that 'standards' of healthcare have been achieved at their best possible level of practice
- Plan or change policies and systems of care

  4. To **facilitate research**

When deciding what information to collect is important to:
- ❑ Consider what it is for or why it is wanted/needed and what questions about health issues it hopes to answer
- ❑ Only collect what is really wanted/needed, what is possible and practical to collect and not more than is necessary
- ❑ Imagine how it will be used and/or presented before designing the method and format for collecting it. Make this as **simple** as possible
- ❑ Consider confidentiality issues

Best practice is that any data collected is:
1. As **accurate** as possible and of **adequate quality**
2. **Standardised** throughout the healthcare environment, health service and/or country
3. **Protected** (sensitive personal data is kept confidential)
4. It is also important that appropriate data are collected to provide international organisations and others with the information they request and/or need.

1. Accuracy and quality of information recording is dependent on:

- Understanding the value of recorded information (what it can be used for)
- A commitment to recording information, including the completion of forms
- The skills to:
  - Listen
  - Ask the right questions
  - Interpret the answers
  - Interpret the situation
  - Record this accurately
- Having enough time to do this. Best practice is to have sufficient time to record information during working hours without compromising patient care.
- How easy it is to use the data collection systems.
- Writing in health records legibly, promptly, truthfully, and always signing and dating each entry.

Best practice for a health record or any other information recording system is for it to be:
- As simple as possible
- Easy to identify so that it can be found quickly when stored (for example each child from birth can be given a health number that is used for all their health records. This individual numbering also avoids duplication)
- As few as possible for each child. To avoid duplication, best practice is for a single health record to be used by all health professionals involved with the child.
- Easily accessible to all health workers (and to the child and their parents/carers) but secure from people who do not need to see it
- Available when needed.

2. Standardised data collection and examination means that:
- The same information is collected by everyone
- The same way of recording the information is used *(the same format is used for collecting information throughout a health service)*
- The same information recording systems *(health record, investigation request and other forms or computer program)* are used throughout the health facility/organisation
- The data are analysed using the same methods *(for example if a coding system is used for coding health problems, it is best to use the same one throughout a country)*
- A good example of standardised data collection is for a country to also use parent held child health records. This requires a policy to use these country-wide. This requires a commitment from all health professionals to make an appropriate entry each time the child has a significant health problem or health intervention, for example an immunisation or an admission to hospital. Such records are especially useful when a child sees many different health professionals in a variety of different healthcare settings as it ensures there is a complete record of the child's healthcare with the parents/carers.

3. Data protection means:
- Ensuring that sensitive recorded personal health information is kept confidential (cannot be read or seen by others, or discussed with people who do not need to know)**.**
- Having a policy about this that is agreed and followed by all health workers.
- Regular training about, and audit of, this policy to enable health workers to see if it is working effectively.
- Including in the policy advice about the storage of records, who is authorised to write in them, who should be able look at them, what information from them can be shared and with whom.

- Having secure storage for records and a good system for monitoring those who access and borrow records. Ideally health workers from a different clinical area or service should get permission from a named person before accessing a record.
- Never leaving records in a place where unauthorised others can see them.
- Not writing children's names with their diagnoses, or other sensitive information, in a place (such as a board) that can be seen by other parents/carers or children.
- Understanding and following any legislation about data protection.

The Management of data

To ensure data accuracy, quality, standardisation and protection, these activities need to be **managed and organised effectively. For** this to happen, best practice is for all healthcare organisations and healthcare environments to have a **data management team** with a lead health worker to coordinate data related activities.
The team needs to:
- ❑ Develop, review and update (audit) the policies and systems used for collecting, examining, protecting (data protection policy), storing and retrieving data (data management policy).
- ❑ Develop, review and update (audit) guidelines for taking health histories and for making entries
- ❑ Have the authority to enforce these policies systems and guidelines.
- ❑ Be able to contribute to decisions on data collecting systems together with their Ministries of Health (If health workers are expected to complete forms, make entries into data collecting systems and to understand and value their importance, they also need to be consulted about their design).
- ❑ Train all health workers about all aspects of data management. Accuracy and quality is more likely if health workers receive appropriate and regular training about data management. This is especially important when new health workers start to work in a new healthcare environment, and before new forms are introduced or new information is asked for
- ❑ Be responsible for the **record cycle** and any **computer systems** for data recording and/or examination
- ❑ Be responsible for the overall quality of data management
- ❑ Have the necessary resources

The **record cycle** starts when a child attends. It includes:
- Rapid finding of records from any previous attendances
- Recording the new attendance to avoid duplicating any previous records
- Circulating records
- Ensuring that a summary is made of the attendance, and if possible a diagnosis at or before discharge
- Classifying the summary or diagnosis (using a disease coding system such as the ICD)
- Examining (analysing) and collating these codes regularly in the format required by the health organisation, international organisations and government
- Sharing this collated information with relevant professional health workers
- Indexing and storing/filing the record
- Having a policy for who can borrow health records and a system for this that enables them to be easily found when needed
- Protecting data
- A commitment from all health workers is needed for this record cycle to be efficient and effective.

Inefficient record storage!

Computer systems

Using computers to record, store and collate information can improve patient care as information can be shared and retrieved quickly thus minimising potentially harmful delays. However it is costly, needs a back-up system and cannot be used without extra training for all health workers. To use computerised systems effectively, the following are necessary:

- A secure electricity supply
- A budget for capital costs
- A budget for maintenance and spares
- A budget for printers and printer ink
- A budget for telephone costs and Internet subscriptions
- Standardisation of computer programs
- Computer programs that are linked and produce what is needed
- The expertise to maintain
- The expertise to use
- Training programs
- A commitment from health workers

Without these, computerisation will cause additional problems for health workers and fail to meet its objectives.

Data management activities contribute to, and support the best possible health care when performed well. Therefore they need to be adequately resourced.

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CFH Information sheet 7: Lifelong learning and how to put this into practice.

'Wisdom, knowledge and skills are for sharing not owning'

How can you continue learning?

Two terms that are often used to describe lifelong learning are:

Continuing Professional Development (CPD)
- This means improving skills and acquiring new skills through a continuum of experience and learning
- It is life-long
- It needs planning, commitment and access to learning opportunities.

Continuing Medical Education (CME):
- This is a systematic process of life long learning and professional development
- Its aim is to enable health workers to maintain and enhance their knowledge, skills and competence for effective clinical practice to meet the needs of children

Essentially these two systems are the same. Lifelong learning applies to everyone and not just to professional health workers. Everyone has a responsibility to continue learning and improving their practical and other skills, and also to share their knowledge and skills with others, so that the children and families will benefit.

Health workers need to look for the evidence for what they do from the published health literature. In many countries this is impossible or difficult for a variety of reasons.

Health workers who manage organise or plan care need to help others to access learning opportunities and the health literature. Most countries have large organisations such as WHO and UNICEF as part of their international community. These organisations and other non-governmental organisations working in the country do have access to healthcare literature, and can be approached for help.

The principles of lifelong learning include:
- Thinking about what you want and need
- If you are responsible for others, thinking about what they want and need
- Making a plan for your learning/the learning of others (personal development plan/s) then implementing it/helping others implement their plans
- Recording your learning activities, for example keeping a personal diary or portfolio of learning
- If you are responsible for others keeping a record of others learning

There are many different ways to learn:
- Formal learning such as attending training courses, lectures, conferences, courses, journal clubs, critical reading groups, workshops and seminars and small group interactive learning .

- Informal learning such as using distance learning programmes, participating in audit, presenting research, watching others (such as 'sitting-in' with or being closely supervised by someone with more experience and/or more skills), contributing to confidential enquiry panels, post-graduate examining, writing books and articles and doing research
- Self-learning such as using a library and reading books and journals, using the internet, making reflective notes

Best practice is to regularly experience a combination of all these different types of learning, although in practice it will depend on the resources and opportunities available to you.

Before starting to work in a new healthcare environment, it is especially important for a health worker to be sure they have, or acquire quickly, the skills and knowledge to give the type of healthcare needed safely. The provision of induction training about the policies, guidelines and systems of care used in the new environment helps to ensure this. When induction training is not available or possible, close supervision until the new health worker is sufficiently experienced and knowledgeable is an acceptable alternative.

How can you put learning or new skills into practice?

Changes of practice and attitude do not always follow learning as:
- Doing something differently never feels as comfortable as doing it the same familiar way
- It is not appropriate
- It turns out to be harder than you expect as:
    - You do not have the authority to persuade others to change
    - You have forgotten some of the details
    - You come up against an unexpected problem
    - Others criticise your efforts so you give up
    - You feel you are the only one making an effort
    - Others don't see the need for change
    - 'The system' or the 'hierarchy' get in the way

If you are a junior health worker it is easier to do this if you are helped, guided and supported by a senior colleague (a mentor) who is committed to the changes in practice and attitude needed. Your mentor might be your manager or a more senior health worker. Their role is to empower, enable and help your efforts by:
    - Supporting and encouraging you
    - Making sure you have everything you need
    - Helping you anticipate barriers to success and work out ways of dealing with them
    - Publicising your successes

Things you can do to help your mentor:
- Point out the benefits the children and families will get from the change (for example 'I know you are concerned about ….., when we make these changes they will do -----------').
- Mentors need to know what the mentee and others can expect to see happening differently.
- Ask the mentor how much and how often they want to hear about your progress – don't assume. The mentor may need a lot of detail in order to deal with colleagues, or may be happy to leave it to you. The mentor may have reporting targets and deadlines that you don't know about. Once you know, make sure you give what the mentor asks for.
- Ask if there is any other way you can help

It usually takes longer than you expect to make any significant changes in your own or others' practice. You can maximise your chances of getting a real and lasting improvement in practice by first planning to USE what you learn by sharing this with others.

Sharing learning
Start by deciding what you need to share, why you need to share this, who to share it with and how you can do this. It helps if learning aids are available (such as writing boards, flip-charts, overhead projectors or power point technology); but these are not essential.

The most important reason for sharing learning is to influence changes in the way care is given to make this better for children and families.

People you may need to share with include:
- Professional colleagues at junior, equivalent and senior levels
- Other health workers – cleaners, security guards, maintenance, drivers etc
- Children and their carers
- Other people who can help you – teachers, people of standing in the community
- People who may disagree with you and can get in your way
- Other people who have had the same learning experience

Ways you can share your learning include:
- Informally discussing what you have learned with your colleagues
- Organising a meeting about it or taking advantage of a meeting that's already happening, for example a departmental meeting
- Putting information on a bulletin board (paper or electronic), giving out leaflets or circulate a note about it
- Writing a newsletter about it (send to others on paper or by electronic mail), or writing an article to go in an existing newsletter
- Making up a story or a song about it, or getting the patients and their families to make one up
- Making some pictures about it and using them to decorate the ward
- Giving a formal presentation or organising a training course about it

CFH Information Sheet 8: Looking after health workers

To perform well, health workers need to have the best possible physical and mental health. Best practice to ensure this includes access to:
o Adequate food and clean drinking water while working
o Preventive health measures such as immunisations, needle-stick injury management and lifting advice
o Care of their physical and mental health problems.

The physical health problems of health workers are often well managed, but in many countries, mental health problems are neglected, especially the stress related problems caused by work.

Health workers only feel happy in their work and free from stress if their job is secure, their working conditions satisfactory, they feel they are doing 'a good job' and this is acknowledged both on a personal level by management, and by an adequate salary.

Being unhappy leads to discontent and demoralisation. Unhappy demoralised health workers are unlikely to:
- Be motivated to change
- Be able to express their views and opinions freely, especially if they have no real job security
- Improve the care they give to children and their families
- Be able to give the 'best possible' care

As it takes considerable effort, time and money for a health worker to become sufficiently skilled to provide effective healthcare, health workers are a valuable resource for a country. It does not make sense to have unhappy de-motivated or mentally ill health workers that leave either the health service or their country.

To keep health workers happy and well it is especially important to have systems in place to protect them from acquiring mental health problems due to their work, and to look after them when they do have these. It is also important to have transparent employment procedures (including job security) and adequate payment. These issues are a priority for those who plan and organise healthcare.

Other factors that contribute to a contented and motivated health worker
- Job satisfaction and sense of achievement
- Recognition and praise, when deserved
- Good leadership with consistency and fairness from managers
- Clarity of goals, the purpose of the job and expectations of performance
- A culture that encourages flexibility and innovation
- Being consulted/having a voice
- A sense of belonging and a feeling that what you do matters
- Being part of a successful team (team working) and knowing what constitutes success
- Working with people who are loyal and supportive, especially if you do not have strong family support
- Pressure within reason
- Varied and challenging work
- Having the authority, skills and respect to do the job well
- Learning new skills and having the opportunities to use these
- Opportunities for advancement
- Having a sense of morality, ethics, shared values and beliefs incorporated into your work
- Being protected from work related health problems (for example being given advice about safe lifting, and the prevention of and management of needle-stick injuries)
- Having physical health problems looked after, especially if the problem is work related

Good terms of employment include:
- Clearly stated goals and objectives for the job
- Reasonable pay
- Job security and transparent, fair and supportive disciplinary and dismissal procedures
- Interesting and stimulating work and the opportunity to make good use of your talents and skills
- A reasonable workload (that enables a good life-work balance)
- Opportunities for advancement/promotion
- A supportive culture and colleagues
- Learning and skill building opportunities
- Security and safety in the healthcare environment
- A good working environment

- Healthcare for employees
- Adequate resources to do the job

These all depend on the culture in the healthcare environment, the skill of the leaders/managers and the allocated resources for the job.

More about stress

One of the commonest mental health problems in health workers is stress. Poor terms of employment make stress more likely in any employee. However there are many additional causes of stress associated with being a health worker. Stress and anxiety are greater in clinical jobs than non-clinical, and in some specialities more than in others. Caring for children and families is especially stressful and requires special attributes that include:

- A genuine interest and empathy with children and their families
- A friendly "down to earth" personality
- Common sense
- A lack of interest in private income, providing the remuneration is sufficient to live at least as well as the average family. This is not the case in many countries where to survive health workers have to depend on additional income generation. In these countries, inequity of healthcare is inevitable.
- A broad, all round knowledge of children's healthcare
- The ability to communicate with all types of people well, especially across professional, cultural and ethnic boundaries and age groups

Particularly stressful events for health workers include:

- Carrying out an invasive procedure, such as a blood test, in a child
- Carrying out an invasive procedure in an upset child
- Not being able to do the procedure (in the case of venous access, it is a good idea to always stop after a maximum of three attempts, if this is possible, and let someone else try)
- Giving parents 'bad news'
- Being on call without a senior health worker to provide support
- Having to take responsibility before you are confident, or to deal with a situation when you do not know what to do (doubt in reasonable amounts creates a thorough health worker, in excess a tortured and inefficient one).
- When you do not have the equipment, drugs or treatments that the child needs
- When a child is very ill
- When a child dies
- Coping with distressed parents and families
- Making a mistake
- Having a complaint made against you
- When there is too much to do and as a consequence you know that care is unsafe

Some other facts about the mental health of health workers in some countries:

- ❑ Deaths from suicide, cirrhosis and road traffic accidents are higher in health workers than in the general population
- ❑ Women doctors are more likely to commit suicide than men, possibly as they are more empathetic and patients increasingly demand empathy
- ❑ Drug addiction and alcoholism are more common

❑ There are higher divorce rates and marriages are more 'at risk' as health workers are often torn between meeting patient's needs and family needs (doctors are often described by their partners as 'controlling perfectionists')

❑ Mental illness may be present in greater than 30%, women being at greater risk, up to 46%.

Health workers, especially doctors, often feel that sharing their feelings with others is a sign of weakness and therefore they try to cope alone when stressed and emotionally distressed. However, if their emotions and feelings become overloaded they are unable to function properly due to associated detachment (leading to cynicism and carelessness), a loss of short-term memory, sleep disturbance and difficulty with decision-making. Carelessness leads to mistakes, complaints and in well-resourced countries, litigation. These make the situation even worse and may lead to a persecutory anxiety. Another reaction to emotional stress can be to work even harder and to take on more commitments leading to inevitable 'burn-out'.

'Burn-out' is the end point of stress. This is a complex of psychological responses to the particular emotional stress of constant interaction with people in need. It especially affects health workers and other people with similar work.

Summary of factors that can lead to discontent, stress and burn-out include:
- Major changes in workplace
- Little personal say about how to do the job
- Poor communication up and down
- Poor recognition of individual worth
- Inability through personal circumstances to work flexible hours
- Excessive hours of work
- Competing demands on time
- Inadequate resources
- Lack of support programs

How to protect yourself against these mental health problems?
You can lessen the effects of stress and emotional distress and reduce the risk of burn-out and other mental health problems by:
1. Structuring and prioritising your time
2. Sharing your responsibilities and commitments (delegating with the authority to undertake the task)
3. Recognising stress and emotional distress and taking avoiding actions (developing stress coping strategies)
4. Learning to say no
5. Being open to help
6. Protecting your marriage, family and friendships, and by getting support from those close to you (secure family relationships and the support of close friends helps protect against stress).
7. Creating a forum for a group of colleagues to support each other (peer group support)
8. Using the local support/counselling services that are available, and if there are none advocating for these
9. Being in the right job for you
10. Being happy with your job content and terms of employment

Activities that can reduce and/or prevent unhappiness, stress and burn-out include:
1. Regular small group meetings to discuss important current issues

2. Special meetings after an upsetting or stressful event (such as a mistake, an accident in the health facility or an unexpected death) to discuss this, stop it happening again and provide support for those affected by the event.
3. Increased control of one's own job/s and autonomy in daily activities
4. Redesign of job to decrease or increase responsibilities
5. Introduction of flexible working hours
6. Formal orientation and induction training for new health workers
7. Employee support programs that include skilled counselling services
8. Multidisciplinary rehabilitation for those with 'burnout'
9. Early vocational counselling so that a health worker is doing the job that is right for their skills, talents and level of knowledge

Health workers are valuable; they have a greater risk of health problems therefore need looking after properly.

Although health workers need to be looked after properly by their employers but they also have a responsibility to be good employees.

How to be a good employee!

'Take care of your work and your work takes care of you' (Brigitte, South Africa)

Bad employees:
1. Complain and waste time
2. Are complacent: so be professional and sharpen your skills and add new ones.
3. Are invisible. Make an impression and be visible, volunteer for projects and help when others are overloaded
4. Are negative. So don't say bad things about colleagues or seniors/managers. This backfires when your unkind words finally reach their ears. If you have a grievance, control your emotions, calmly work out what you want to say, then tell your manager or the person concerned.
5. Are unreliable. Managers value employees who are trustworthy and conscientious. Delivering on every commitment you make is a key indicator of a reliable, responsible employee with integrity; so do this.
6. Have a poor relationship with their manager. Your relationship with your manager/senior/leader is critical for promotion. Do you make your managers life easier or harder? Do you take up concerns directly with him or her, or do you discuss it with others who cannot do anything about it.
7. Blame others. If you make a mistake, take responsibility. Accepting responsibility for your actions demonstrates your professional maturity.
8. Make the wrong friends. If you are in with the wrong crowd (the whiners, the laziest), break away. Associate with the successful people.
9. Mix personal problems with the job. Marital problems, financial difficulties or other personal problems should be left at home and not allowed to interfere with your work. However do tell your manager if you have got special problems. They may and should be able to help.
10. Are disloyal. You don't have to agree with every decision, but managers and your seniors appreciate loyal employees who understand the objectives and the problem, and who contribute actively to meeting the objectives and solving the problems.
11. Are not conscientious or don't do their work properly. For example they do not always know about or follow policies and guidelines. They spend time too much work time socialising with their colleagues or they do not look carefully at what they do to make sure it is the best way to do it.
12. Are dishonest, for example use work materials for personal use, make personal telephone calls without paying or are not honest about what they did or did not do.

So make yourself visible, **be honest**, **learn to welcome change, develop new skills, be flexible, review what you do, respect others property and remember the power of good communication**.

Finally a senior health worker or manager can abuse others by:
- Arriving late, leaving early or frequently being absent, especially during busy periods
- Being constantly away from their desk/office
- Using stationery and equipment for personal use and/or making unauthorised private phone calls, faxes, e-mails, photocopies etc
- Making unauthorised trips or detours with company vehicles
- Abusing relations with colleagues by constantly borrowing money or using their books, equipment and other possessions without permission.
- Leaving mistakes or unfinished work for others to sort out.

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CFH Information Sheet 9: Mission statements

What is a mission statement?
A mission statement is a written statement or charter about the health services provided. It includes the type and quality of care that children and their families can expect to receive and the arrangements for seeking a solution if something goes wrong.

Best practice is for all healthcare environments and services to have a mission statement about the healthcare they aim to give. These statements can express the intent of a hospital ward, a clinic, a specific service such as a palliative care or child protection service, a professional group, or of an individual health worker.

Why are mission statements important?
Children and their families are often less anxious and frightened about receiving healthcare for their child if they know what to expect. Health workers also need to know what they should be providing

Where should they be?
Best practice is to put the statement where everyone can see it such as the entrance to the health facility, department or clinical area.

Statements of intent hanging in a hospital entrance hall

Who owns a mission statement?
It is 'owned' by the health workers that work in the healthcare environment.

Who decides what a statement will say?
They work best if developed and approved by a team representing all the different health workers involved, parents and older children *(See information sheet 11 for more information about team working)*. The leader of the service or healthcare environment is ultimately responsible for it.

What does it need to say?
It needs to be short and say exactly what services, or care, are provided as simply as possible. It is easier to understand if it is written in local languages and uses simple words (or pictures). Ideally it should include the name of the health worker responsible for the service or healthcare environment and how to contact them if things go wrong. It needs to include the date it was written and a date for its review.

Examples of mission statements from the CFHI pilot sites

Example 1

The Baby Unit
Our philosophy is to create a warm, welcoming environment to help ease the anxieties encountered by parents and families when their baby is admitted to the unit. The care provided is holistic, looking at the physical, psychological and social needs of the newborn and their family. Parents are kept fully informed of their baby's progress at all times. Parents and siblings are encouraged to visit and/or telephone whenever they want, to touch and hold their baby, and to care for their baby as much as possible. The care continues from admission to discharge, and then into the community

April 2000

Example 2
Neonatal Intensive Care Unit, Mulago Hospital, Kampala, Uganda The Ten Commandments of the Newborn
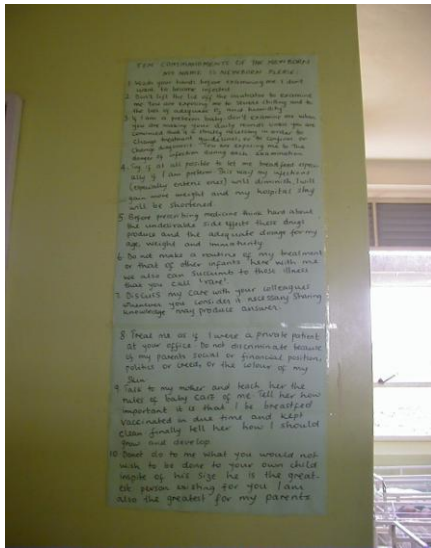
The ten commandments of the newborn (written by health workers on behalf of the newborn)

1. My name is ……………….... please use this when talking to or about me.
2. Wash your hands before examining me; I do not want to get infected
3. Do not lift the lid off, or open, my incubator unless essential as I will get cold and the oxygen and humidity levels that I need will be lost.
4. If I am born early, do not examine me on your daily round unless strictly necessary in order to change my treatment, or to confirm or change my diagnosis, as you are exposing me to infection every time you touch me.
5. Try if at all possible to let me breast feed as then my infections, especially enteric ones, will be fewer, my weight gain will be better and my hospital stay shorter.
6. Before prescribing medicine think hard about the undesirable side-effects these drugs can cause, and always make sure you give me the correct dose for my age, weight and level of maturity.
7. Treat me as an individual, and remember that my problem/s may not be straight-forward. Rare conditions do sometimes occur so watch me carefully.
8. Discuss my care with your colleagues whenever you think this is necessary, sharing knowledge may provide answers.
9. Talk to my mother and teach her the rules of baby care. Tell her how to look after my special needs. Tell her how important it is for me to be breastfed, kept clean, immunized at the right times and how to help me grow and develop.
10. Treat me as if I was a private patient or member of your family. Do not discriminate against me because of my parents' financial or social position. Remember that I am the most important baby in the world to my parents, just as your baby is the most important baby in the world to you.

Example 3**:**

A mission statement informing families about a play service in a local hospital in the UK

'Play is a necessary and essential part of every child's development and it is through play that children learn the skills they will use in their adult years.

Here at …………….hospital we recognise the importance of play and through the skills of qualified child care professionals we offer every child the opportunity of expression through the wide range of play materials we provide.

By supporting the child and his/her family we use play as a part of the child's normal every day life in a new and often daunting environment. We offer each child support before, during and after invasive procedures and offer a play area at ward level free of any medical intervention.'

The children's unit at Ulster hospital, Northern Ireland Adolescent charter

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When you are in hospital:
  - Where possible you will be cared for in a separate unit that is furnished to meet the needs of young people
  - You can wear your own clothes and bring in your own things
  - You will be cared for by qualified staff who will try to understand your physical and emotional needs, and respect your needs for privacy and independence
  - You will be treated with sensitivity, honesty and tact at all times
  - You will have the right to information and to make informed decisions regarding your care
  - You will be able to discuss your physical and emotional needs in confidence
  - You will be able to have your parents visit at any time and to stay overnight if you wish. You will be able to have you family and friends visit
  - You can refuse to take part in research or student teaching. You can ask for a second medical opinion if you wish
  - You will have facilities for recreational activities and a quiet area
All care will take into account your cultural and ethnic needs, disabilities and chronic illness (as appropriate)
  - You will be given 'house rules' (drawn up by other young people) which you will be expected to follow

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CFH Information Sheet 10 How to solve problems?

***'If at first you don't succeed, try, try, try, again. Then quit. There's no use being damn fool about it':
W C Fields***

There is nothing new about solving problems as we do this every day of our lives. Some problems are more easily solvable than others. In a healthcare environment problems are often complex and affect many different people. In this situation it is better to solve them using the advice and guidance of others (a team approach).

The principles of problem solving include:
1. Defining the problem/s after listening to everyone affected by it/them
2. Prioritising these, if there is more than one problem
3. Selecting/choosing a problem for acting on
4. Recognising barriers against solving the problem/s and forces that may help to solve it/them, such as people or materials
5. Seeking some possible solutions/courses of action from those affected and if possible also from others who have faced similar problems
6. Considering (evaluating) these and selecting the best feasible solution/s
7. Trying out (implementing) possible solution/s
8. Evaluating the results (audit) to see if the problem has been solved and acknowledging everyone's efforts
9. Trying out other possible solutions if problem not solved
10. Reviewing other problems from the list and repeating the process

1. **Defining the problem**
   - Some problems and their solutions are obvious, but some are difficult to understand and solve. Some of the reasons for problems may be overlooked, or their significance not properly understood, unless you talk to everyone affected by it.
   - The main problem may be due to several different problems each with different causes, so break a problem down into all its different parts and decide which are the most important and need solving first. Unless you find the true problems you are unlikely to make it better.
   - Do not make assumptions about the cause of a problem. If you do, it is likely that your solution will not work. Talking to everyone makes finding a workable solution more likely, especially if those you consult know more about the details of the problems causes than you do.
   - Remember one person's problem list may be very different to that of another!

2. **Prioritising problems**
   - Generally the discussions you have when defining the problem will help with prioritising the problems in order of importance.
   - Gaining the agreement of all involved (key stakeholders) for the final priority order is the best approach.
   - If agreement is not possible an independent view may aid consensus, compromise and agreement.

3. **Selecting a problem/s for action**
   - This is usually the one top of the priority list, but not necessarily if this seems too difficult
   - Involve those that may have to implement the solutions in the selection of which to tackle first
   - The easier to solve problem may be best tackled first as success encourages and motivates
   - If there are lots of problems it is better to select only a few to act on first. If you try to solve too many at the same time you may fail to solve any of the problems.

4. **Recognising barriers to solving the problem and forces aiding implementation of possible solutions**
   - Look at these before you start. It is better to find a barrier earlier than later
   - Use any forces that may help makes successful problem solving more likely

5. **Seeking possible solutions**
   - The more complex the problem, the more consultation and assessment are necessary
   - Listen and respect the views of those closest to the problem as their ideas about possible solutions usually work best.
   - Seek a wide variety of possible solutions
   - Some people are more able to identify possible solutions than others.
   - The solutions most likely to succeed are those that are 'owned' by those involved
   - Ask how health workers in different healthcare environments have solved similar problems
   - There always are solutions, identifying these is the challenge!

6. **Considering all the possible solutions and selecting the 'best possible' (the project)**
When deciding which is the 'best possible' it is usually the:
   - Easiest, providing you think it will be effective
   - Most feasible with the resources immediately available
   - Solution favoured by the majority of the team

7. **Implementing (trying out) the solution/s selected – taking action**
Before making the changes it is a good idea to make a detailed plan that states:

- What the goal is (usually this will be fully to solve the problem)
- How it is going to be achieved (the details of the plan/plan the project)
- Who is going to do it (delegation)
- How you are going to ask or persuade others that it is a good idea and to do it (motivate them)
- How are you going to see whether you have achieved the goal/s and solved the problem
- When are you going to do the evaluation (usually after completion of the project)
- How are you going to acknowledge/reward the team effort. You do not always need money or materials for this. Open recognition and praise is very effective

8. Evaluating the results

Look at what has happened to see if you have solved the problem in the best possible way. To do this you can look at the:

- Intended and unintended impact/s of the solution you have tried, both good and bad, and the evidence to support these.
- Performance of the planned solution (project) (was it a good solution?)
    - How did it work, were the others able to do what was in the plan, was it too difficult, did the goals need to be clearer?
    - Were there enough resources (human and material) to make the plan work?
    - Was it affected by unexpected changes?
- Lessons learned - think about and identify the lessons learned (the things that went well and the things that could be done differently or better next time) by the team, organisation and by the children and families that were affected

Each of these three ways of looking at what happened impacts on the other two. Compare the results you get against the goals you set and remember that sometimes unexpected findings are very important. Then make recommendations for next time and share the results/findings with everyone involved.

9. Trying out other possible solutions.

This needs to be done if the problem is not completely solved. If you think that it is not possible to solve the problem with your existing resources write a **project proposal** to take to others outside your organisation.

10. Reviewing other problems from the list and **repeating the process.** You need to keep doing this as there are always new problems to solve.

Finally remember to acknowledge and reward everyone's efforts and to share the solutions that worked for you with others. Having successfully undertaken a small local project, for example implementation of correct hand washing, in your unit/health facility, this might help persuade sponsors that you have the appropriate skills and experience to warrant their continued funding/support for a larger project.

CFHI information Sheet 11: Team Working and leadership

When there are a large number of health workers in the organisation, health facility or healthcare environment, a team approach to problem solving and to planning, organising and delivering healthcare is best.

A multi-disciplinary team is a team of health workers that may include doctors, nurses, staff from professions allied to medicine, and others who have contact or involvement with the child in the context of the team's activities. For example a team may include a microbiologist, an infection control nurse, a ward clerk, a cleaner, a teacher, a play worker and others.

This team approach can be used in many different situations and at many different levels in a healthcare environment or organisation. If there are many different teams in the same health facility all responsible for a different vision, or with a different purpose, their team leaders need to communicate with each other. Wherever possible they need to avoid duplication of activities and report to a leader responsible for all the teams related to his/her area of responsibility.

Most teams work better when:
- There is a leader to manage and coordinate the team's activities.
- This leader is approved of and respected by all members of the team, or in a large team by a clear majority
- The team is as small as possible
- Team members represent those most affected by its activities (it has a representative from each group of health workers, or from each area affected, and includes a parent or older child patient representative, if possible or appropriate)
- Team members share a clear vision (such as improving the healthcare given), or purpose (such as planning healthcare, organising a department's activities, solving problems etc.)There are agreed, clearly defined goals or aims for achieving the vision or purpose The groups represented by team members are consulted whenever possible before any action or decisions are taken on their behalf
- A team member representing a group of health workers reports back to their own leader or manager about the team's activities. *For example a nurse reports to her senior/head nurse.*

An example of a team approach to a single problem, but who is the leader?

A team approach may solve a single problem quickly (See information sheet 10 for more information about problem solving), however most teams have long-term visions and purposes. Teams like this need to meet regularly. Progress with the goals and aims needs to be discussed, and further activities planned.

'Great leaders are almost always great simplifiers, who can cut through argument, debate and doubt to offer a solution everybody can understand': Michael Korda

'With the best leaders when the work is done the task is accomplished'. The people say "we have done it ourselves": Loa Tsu, Chinese philosopher 700BC

A team leader's role is to:
- Identify the skills within the team members early
- Never underestimate the skills of other team members
- Create a defined role for each member that uses their particular skills effectively
- Respect and support other team members
- Ensure good working relationships between team members and with others
- Communicate effectively within the team and with those represented

This team approach can be used in many different situations and at many different levels in a healthcare environment or organisation. Ideally if there are a large number of teams in the same healthcare environment all responsible for a different vision, or with a different purpose, their **team leaders** need to communicate with each other, avoid duplication of activities and report to an overall manager responsible for all the teams related to his/her area of responsibility within the environment or organisation.

To ensure a cohesive approach to delivering healthcare a **team member** who represents a group of health workers also needs to report to/communicate with their own leader/manager. For example nurse members of any team in any health environment need to report back to the head nurse of the organisation or health facility. This applies to all groups of health workers.

Being a leader means:
- Recognising that change is needed
- Knowing where you want to go or what you want to achieve (the vision)
- Enthusing others who may help, or benefit from it, to share the vision
- Motivating, empowering and developing others to help you put the vision into practice
- Making something complex appear simple and easy to understand
- Managing conflict positively
- Dedication and hard work
- Celebrating success

The skills needed to be a good leader include:
- Vision
- Courage**,** a conviction that you are right but the willingness to also accept that sometimes you will be wrong, and take responsibility for this!
- Motivation
- Passion and enthusiasm
- Energy
- Integrity
- Consistency
- Communication skills
- Interpersonal skills (empathy and social skills), understanding people and how to support them and get the best out of them
- Good judgement
- Knowing when to concentrate on the vision, when to be flexible and when to focus energies on the details of the tasks (planning and implementing). Generally the details are best delegated to others.
- The ability to delegate as you cannot do everything yourself. If you try to, it is likely that nothing will be done as well as it could be. You will not be as effective if you are trying to do too much!
- Self-awareness (a knowledge of your own strengths and weaknesses)
- Diversity and expertise, although others can provide the latter

- Ability to finish the tasks required to achieve the vision

There are many different styles of leadership.
These include:
1. Collaborative/democratic – the leader shapes, develops and guides a team that leads by consensus
2. Autocratic/dictatorial/coercive – everyone does what the leader says without question
3. Laissez-faire – the leader delegates to a team allowing the team members to do whatever they want
Each of these three types of leadership work well for specific situations

Collaborative leadership:

Works well when:	Does not work well when:
There are different issues involved and the problems are complex	The issues and problems are simple
The problems have many possible solutions	There is usually a single solution to most problems
The leader does not have the skills and knowledge to deal with the details of all the issues	The leader is autocratic and think they know best
There are team members with the skills to deal with each of the important separate issues	Team membership does not reflect the important issues
The team member for an issue is skilled and respected and acts as a representative for those involved in this particular issue	The team member for an issue is not skilled, or not respected or does not represent the views and opinions of others involved
Authority for the different issues is delegated with boundaries clearly set and known by all	Authority is not delegated to team members or the boundaries of the authority are not clearly defined or followed
Team members respect each others roles and skills	There is little respect for each others roles and skills
The team is able to work well together	The team are unable to work together well
The team is able to meet frequently	The team are unable to meet regularly
Team members communicate well with those they represent	There is poor communication with those that a team member represents

Autocratic leadership:

Works well when:	Does not work well when:
The situation is simple with a limited number of likely problems	The situation is complex with many possible and differing problems
There is a single obvious best solution to most problems	There are many possible solutions to these problems
There are a limited number of different issues involved	There are many different issues involved
The situation is replicated in the same way frequently	The situation is variable
Followers or team members all agree that the leader has unique skills, talents, knowledge that is much superior to their own	Followers or team members have opinions of their own on the issues involved and believe they know as much about or more about some or many of the issues involved as the leader
The leader is willing to get involved in all the details	The leader is not willing to get involved in details
The leader has the capacity to be involved in the details	The leader does not have the capacity to be involved in all the details
The followers changes frequently	The leader is unwilling or unable to be always available to the team
The team, if there is one, is remote	There is a good pro-active team

An example of when autocratic leadership works well is a ward staffed with temporarily employed nurses when it is best if there is tight control and rules about how things are done.

Laissez-faire leadership:

Works well when:	Does not work well when:
The team is composed of a small number of similar individuals who share the same goals	The team is large or diverse
One solution to a problem is as good as any other	The situation and problems are complex
The team members know each other very well and are in frequent contact with each other	The team is remote

Although there is a place for all these types of leadership, a healthcare environment is usually complex. It encompasses many diverse issues and activities and is staffed by many skilled health workers **leadership is likely to work best.**

If this collaborative leadership model is adopted it will result in more ideas, better insight and cooperation, more manageable demands on the leader and the projects and solutions are more likely to work and be sustainable. It is less likely to waste valuable time and energy.

When using this model of leadership, best practice for the leader is to:
- Choose team members to represent each of the important functions and activities
- Balance the team
- Find out the individual strengths and unique skills of each team member
- Use these strengths and skills effectively
- Communicate well upwards and downwards to other health workers
- Delegate authority but make it very clear what and how much is delegated - set the boundaries clearly
- Set up procedures for communicating *(See example of a communication matrix)*

An example of a communication matrix

The methods of communications considered most appropriate to use for the different groups
 of people involved with the pilot project for the Child Friendly Healthcare Initiative

Methods	CAI leadership and support and operational staff	CFHI Team (Sue, Andrew and Carol)	CFHI Advisory Committee	Professional Organisations	Donors	Other NGOs	Pilot Hospitals and CFHI coordinators	Health workers from other sites	Global Organisations ((WHO, UNICEF)	UK Ethics Committee	Governmental Department	Media	Parent Organisations	CAI Members
Team Meeting		4												
CAI Magazine	4				4									4
Advisory Committee Meetings			4											
Minutes of committee meetings			4											
E-mail		4	4	4	4	4	4	4	4	4		4	4	
Web Site	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Presentations							4	4				4	4	
Posters														
Newsletter														
Meeting/Hospitals														
Telephone/Fax	4	4	4	4	4	4	4	4	4	4		4	4	4
Letters	4	4	4	4	4	4	4	4	4	4		4	4	4
Postal updates/fliers	4													
Reports about pilot sites	4	4	4		4		4	4	4		4			
Others														

Other thoughts on leadership
1. A leadership based on facts is better than leadership based on emotions.
2. Leadership is the shift in moving from developing yourself to developing others. Use your skills and strengths to gather your team then lead, involve, delegate, manage and enable so that the visions are implemented.

3. Leadership based on accepted beliefs and moral values works best as it treats people equally, respects everyone in the team and seeks and welcomes new ideas, initiatives and innovations. It is open, humble and has integrity.
4. Leaders need to be in training every day of their lives.   They have constantly to adapt to the crises and problems that arise around them, but they also need to train for a purpose.
5. *Full engagement in leadership requires coping strategies that draw on physical, emotional, mental and spiritual (this means being in touch with your values) energy. Each of these sources of energy needs training and rituals. Like physical training, all of these sources require recovery time before you can draw on them again, for example*
   - Physical recovery time is rest
   - Emotional recovery time can be focussing on a happy thought/experience from outside
   - Mental recovery time can be sleep or meditation
   - Spiritual recovery time can be time alone to reflect on your values and beliefs

   All great leaders and sportsmen have recovery rituals for these energies. We are creatures of habit, so build rituals to sustain your sources of energy and to avoid compromising recovery do not take emotional baggage into your recovery times.
6. If you wake in the middle of the night, never look at the clock but use the strategies that work for you to shut out any fear, anxiety and stress.

Example of a health facility management team:

Finance Manager *Responsible for* ↓	Facilities Manager *Responsible for* ↓	Human Resources Manager *Responsible for* ↓	Chief Nurse *Responsible for* ↓	Manager of all Clinical Services *Responsible for* ↓	Administration Manager *Responsible for* ↓
Management and control (team leader)	Estate management	Personnel	Nursing	Clinical departments	Secretariat
Accounting	Engineering	Human Resources	Quality assurance	Laboratory services	Legal services
Paymaster	Building	Manpower	Patient services	Imaging (Radiology)	Administration
Budgeting	Transport	Planning	Catering	Therapists	Data management
Procurement	Utilities (electricity, sanitation and water)	Occupational health		Pharmacy	
Information	Laundry			Others	
	Maintenance				
	Cleaning				
	Waste disposal				
	Capital planning				
Training	Training	Training (lead for continuing professional development)	Training	Training	Training

Each team member is responsible for the areas listed above and for representing and supporting (providing leadership to) their health workers. The leader of this team can be elected by the team members, although in many countries this is usually the director of the health facility.

It is especially important for the head nurse to be in a health facility management team and to provide professional leadership as nurses are:
- A health facility's single largest human resource
- Present 24 hours a day
- See all the strengths and weaknesses of the organisation
- Know what patients need

Unfortunately in many disadvantaged countries nurses have a low status, poor training (very basic, often without any specialist training or very little), no professional organisations and are unable to contribute to service planning and decision-making.

References

David Mencheon and Yi Mien Koh. Leadership and motivation. BMJ 2000 29 July Pages 2-3