

# STANDARDS FOR THE CARE OF CHILDREN AND ADOLESCENTS IN HEALTH SERVICES



The Royal Australasian  
College of Physicians



association for the wellbeing  
of children in healthcare



CHILDREN'S  
HOSPITALS  
AUSTRALASIA

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## Introduction

The Standards for the care of children and adolescents in health services have been developed for use in the Australian healthcare system. The goal of the standards is to ensure that quality care is provided in an environment that is safe and appropriate for the age and stage of development of the child or adolescent.

The medical and psychosocial needs of children and adolescents differ from those of adults requiring health services and as a result children and adolescents have unique vulnerabilities and patient safety risks [1-5]. Consequently, it is critical to provide separate facilities for children and adolescents in all areas of the health service where they are cared for.

Potential risks arising from co-locating children / adolescents with adults in health services include;

- The rights of children and young people are not respected.
- Physical, psychological or sexual harm from other patients, staff or visitors.
- Compromises in quality of care for children/adolescents if care is provided by staff without education and training in the care and treatment of children and young people or if the available equipment is inappropriate in size or design.
- Inadequate or inappropriate parent/carer and family support and involvement in care.
- Interruptions to normal development if opportunities for play, leisure and education are not provided.
- Unnecessary trauma from witnessing distressing sights and sounds.
- Compromises in the care of children/adolescents when paediatric staff and resources are diverted to provide care for adult patients.
- Compromises in quality of care for adults if they are placed on a paediatric ward and staff are not experienced in caring for adults.
- Compromises in quality of care for adults if adults feeling ill are disturbed by either noisy children or the continued presence of the child's family, which is a key component of family-centred care.

## Development of the Standards

The Standards were developed by an expert multidisciplinary working group led by:

- The Royal Australasian College of Physicians (RACP), Paediatrics & Child Health Division
- The Association for the Wellbeing of Children in Healthcare
- Children's Hospitals Australasia

Together with the support of:

- The Paediatric Emergency Medicine Society of Australia & New Zealand
- The Australasian College for Emergency Medicine
- The Australian Medical Association
- Australian College of Children and Young People's Nurses
- The Australian Paediatric Society (formerly the Regional & General Paediatric Society)
- Australian College of Rural and Remote Medicine
- The Australian Council on Healthcare Standards

The members of the working group members are listed in Appendix 1.

The Standards have been developed using a combination of research evidence, published best practice standards and expert consensus. The development process used the best practice principles of the ISQua International Principles for Health Care standards and the Australian Productivity Commission best practice principles for standards development. Stakeholder feedback was sought through extensive stakeholder consultation on the draft Standards,

followed by pilot-testing of the revised Standards in six Australian health services of varying sizes and locations. Metropolitan, regional and rural hospitals were represented.

## Intended Use

The Standards have been developed for linkage with the ACHS Evaluation and Quality Improvement Program 4th edition (EQuIP 4) which is the most widely used independent health care assessment and accreditation process in Australia.

## Definitions

- The term child refers to someone aged between 0 and 12 years of age and the term adolescent refers to someone aged between 12 and 18 years of age.
- The term parent / carer refers to the parent(s) or person(s) that takes legal responsibility for the child / adolescent and provides direct care. This includes birth parents, step parents, adopted parents, foster parents, legal guardians, custodial parents or other appropriate primary care givers.
- The Standards utilise the following definitions throughout;  
“**Must**” : The standard is a requirement. There is research to support the standard or there is a clear risk of harm to the children / adolescents if the standard is not followed.  
“**Should**” : The standard is a recommendation. The standard is based on best practice guidelines and expert consensus.  
“**May**” : There is scope for the health service to consider alternatives to what is suggested.

## Application

These standards apply to any Australian health service where children / adolescents are cared for. The Standards are relevant to all areas of the health service where children and adolescents are attended to;

- |                                      |                            |
|--------------------------------------|----------------------------|
| - Inpatient Wards                    | - Outpatients              |
| - Intensive Care Units <sup>1</sup>  | - Ambulatory Care          |
| - Emergency Departments <sup>2</sup> | - Community Health Centres |
| - Day-Care Facilities                | - Child Health Centres     |
| - Surgery <sup>3</sup> and Recovery  | - Mental Health Units      |

## Aims and objectives

1. To recognise that the medical and psychosocial needs of children and adolescents differ from those of adults and that this is reflected in the health services provision of effective and safe, quality care through;
  - a. Recognising rights
  - b. Child, adolescent and family friendly health service facilities
  - c. Child and adolescent specific equipment
  - d. Appropriately trained staff
2. To draw attention to the importance of providing separate facilities for children and adolescents in all areas of the health service where children and adolescents are cared for.
3. To encourage proactive risk-assessment practices.

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<sup>1</sup> NSW Health Policy: Children - Management of Seriously Ill in Adult Intensive Care Units [6]

<sup>2</sup> The Australian College of Paediatrics and The Australasian College for Emergency Medicine Policy: Hospital Emergency Department Services for Children [7]

<sup>3</sup> Australasian Association of Paediatric Surgeons: Guidelines for Practice of Paediatric Surgery in Australasia [8]

# Standards for the care of children and adolescents in health services

**Goal:** The environment in which care is provided is safe and appropriate for the age and stage of development of children and adolescents.

## 1. Rights

- 1.1. The rights of children and adolescents are upheld at all times and they and their families are always treated with respect, sensitivity and dignity.
- 1.2. The special needs of children and adolescents must be respected as must their rights to be consulted and informed about their care and treatment [9-11].
- 1.3. Parents / carers must be consulted and kept informed about the care of their child or adolescent [12-14].
- 1.4. Consideration must be given to the rights of all children and adolescents to be involved in decision making about their own health. In particular, cognitively mature adolescents have the right to make decisions relating to their own health and to maintain their privacy, including in respect to their parents / carers [15].
- 1.5. Policies and guidelines specific to the health service should be developed that reflect the rights of all children / adolescents and their families. The policies and guidelines should be informed by the United Nations Convention on the Rights of the Child (UNCROC) (adopted by the General Assembly November 1989. Ratified by Australia and binding from January 1991.)
- 1.6. The cultural beliefs and practices of all persons attending the health service must be respected and taken into consideration when providing care. A cultural safety framework must be in place to allow effective and respectful communication with Indigenous families and families from culturally and linguistically diverse (CALD) backgrounds.  
This includes;
  - Respect for culture knowledge, experience, obligations
  - No assault on a person's identity
  - Families to be treated with dignity

## 2. Facilities

- 2.1. Children and adolescents are cared for in a safe and appropriate physical environment designed, furnished and decorated to meet their needs and developmental age [13, 16].
  - 2.1.1. A designated paediatric area or ward should :
    - a. Be easily observed and supervised at all times.
    - b. Include a designated sound proof treatment room to conduct procedures
    - c. Include an isolation area for infectious children
    - d. Allow access to toilet and bathroom facilities that are designated for children's use only. If it is not physically possible to have separate toilet or bathroom facilities a parent or staff member should accompany the child.
    - e. Provide play facilities in and out of the ward, including outdoor facilities.
    - f. Have age-appropriate decorations, furniture, equipment and ample light.
    - g. Address physical, safety and security measures for safeguarding children.

h. Provide play, entertainment and education materials which are developmental age-appropriate and protect children from psychosocial harm. When ages are mixed the needs of the youngest children should be considered.

2.1.2. Facilities for parents and carers to stay nearby to their child must be provided; for example a lounge chair or folding bed in the ward or a chair in the Emergency Department [13]. Allowing parents to stay with their children in hospital has a positive impact on child and parent stress and increases the child's coping ability [17-22]

Additional facilities for the parent / carer;

- Facilities for nutrition, such as a kitchenette with fridge and microwave must be provided.
- Facilities for breast feeding and for breast milk storage must be provided.
- Amenities such as a shower and toilet must be provided.
- Facilities for siblings such as a family room and/or accommodation for the family unit may be provided.

2.1.3. Children, adolescents and parents / carers should be consulted during the planning of new health facilities or refurbishments [10]. Resources are available to support organisations in engaging children / adolescents in decision-making.<sup>1</sup>

2.2. Children and adolescents must be cared for on wards that are appropriate for their age and stage of development and must be physically separated from adult patients [13]. Actual age is less important than the needs and preferences of the individual child or adolescent [23].

2.2.1. Adult patients should not be accommodated in paediatric / adolescent areas.

2.2.2. Children and young adolescents should not be accommodated in adult wards.

2.2.3. Ideally adolescents should only be admitted to a designated adolescent area. Admission of adolescents must take into account their psychosocial history, relevant medical history and their suitability to be accommodated in either a paediatric or an adult ward. The risks must be assessed by the Nursing Unit Manager in consultation with the attending physician. Consideration should also be given to the adolescents own wishes and preferences.

2.2.4. Sensibly flexible approaches may be adopted in certain cases. For example, on rare occasions the care of a profoundly disabled adolescent or an adolescent with a terminal illness may be better provided on a paediatric ward even though the patient is over the usual age limit. Wherever facilities allow choice, the views of the child or adolescent about where they would prefer to stay should be taken into account and respected [23].

2.2.5. In the event of an unavoidable circumstance when separate accommodation for children / adolescents and adults is not possible, the health service must identify designated areas where children and adolescents can be accommodated. Health service policies, guidelines and risk management strategies that are based on best available evidence and practice must be in place to specify the requirements for a safe and appropriate physical environment to protect the children / adolescents.

Example strategies;

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<sup>1</sup> NSW Commission for Children and Young People Taking Participation Seriously. Available from <http://www.kids.nsw.gov.au/kids/resources/participationkit.cfm>

- a. Physical constraints; Health services must plan ahead to provide a separate physical area for accommodating unwell children. As interim measures, health services must have guidelines for maximising the segregation of children from adults. Examples include; identifying and utilising existing structurally segregated areas to place children, identifying and utilising a hierarchy of patient spaces in order of least exposure of children to adult patients, and providing the best possible non-structural segregation possible where structural segregation is unavailable. A similar approach should be used to provide age appropriate furnishings and equipment for paediatric patients.
  - b. Difficulties with managing patient flow; Health services should have in place forward plans to reduce average bed occupancy to 85% in an effort to reduce bed block which negatively affects appropriate ward placement [24].
  - c. Extraordinary circumstances; Health service policy / guidelines must be in place to protect the interests of children / adolescents in case incapacity to appropriately place patients arises unexpectedly due to infectious outbreaks or the like.
- 2.2.6. When transporting children and adolescents around the hospital they must be accompanied by an appropriate person and they must not be left unattended at any time.
- 2.3. For social reasons children may benefit from being accommodated in a group setting rather than in single rooms, except in certain circumstances where there is a risk of cross-infection. For example; infectious patients or patient groups at risk such as Cystic Fibrosis and Oncology.
- 2.4. Adolescents should be admitted to the most developmentally appropriate area which is consistent with their best interests and wishes.
- 2.4.1 Some adolescents may strongly desire the privacy a single room affords. In general, however, adolescents may prefer to be located alongside other people of their own age who are more likely to meet their need for social interaction. This facilitates the provision of age appropriate entertainment, education needs and additional privacy [23, 25-27].
- 2.4.2 Where separate adolescent facilities are not available, adolescents should be grouped together in a paediatric ward. In this situation an adolescent recreation space or activities relevant to adolescents should be available.
- 2.5. In emergency and outpatient departments, intensive care units and surgery recovery areas there should be:
- a. Separate children / adolescent waiting and treatment areas that can be easily observed from a staff base and that are appropriately decorated, furnished and equipped with play equipment or entertainment facilities [13, 16].
  - b. Physical separation that provides a barrier for both sights and sounds between children / adolescents and adult patients, so that children / adolescents are not exposed to potentially frightening behaviour; and equally, so that adults feeling ill are not disturbed by noisy children [28].
  - c. Time separation between children / adolescents and adult patients in outpatient areas, if physical separation is not possible. For example, separate appointment times are organised.
- 2.6. Children and adolescents with behavioural problems, antisocial behaviours or psychiatric conditions that pose a threat to themselves or other patients should be admitted to a specially designated area in the paediatric or adolescent ward. Where not available, reasonable options should be considered to ensure the safety of the child and other patients. A decision should be made by the Nursing Unit Manager and / or

attending physician and should include specialist paediatric and mental health consultation.

- 2.7. Where shared sub-specialty services are required for a child, the child should be accommodated in the children's designated area and not routinely in a specialist area. Extraordinary clinical circumstances may dictate that a child / adolescent may be kept in an adult area for short periods, where clinical equipment or expertise are considered essential to the safe care of the child; for example ventilation prior to transfer to a specialist children's facility, recovery from surgery, ICU monitoring etc.
- 2.8. When shared sub-specialty services are required for adolescents, the adolescent should be consulted as to their preference for accommodation, unless specific equipment or expertise is required which can only be provided within the sub-specialty area.
- 2.9. Policies and guidelines for the transition of adolescents with chronic health conditions into adult care must be in place<sup>1</sup>.

### **3. Equipment**

- 3.1. Children and adolescents are cared for utilising equipment that is specifically designed to meet their needs, size and developmental age.
- 3.2. Developmental age and size appropriate medical, resuscitation and diagnostic equipment must be available at all times. This includes warming equipment specific for newborns in emergency departments, operating theatres and recovery.
- 3.3. Safe developmental age and size appropriate bedding must be available (cots, bed rails, high / low beds).
- 3.4. Play, entertainment (phone / television) and education equipment, which may include internet access to facilitate schooling and contact with peers, should be available for all age groups [29].

### **4. Staff**

- 4.1. Children and adolescents are cared for by staff specifically trained to meet their physical, psychosocial, developmental, communication and cultural needs.
- 4.2. All staff involved with children and adolescents in health services must comply with any relevant statutory "working with children check" scheme. Where no statutory scheme applies pre-employment checking standards must include;
  - i. Child protection training (updated annually)
  - ii. Criminal record checks
  - iii. Disciplinary action history
- 4.3. In all areas of the health service where children and adolescents are cared for all clinical staff must be trained in paediatric life support. Basic paediatric life support skills are sufficient in most areas of the health service where children are cared for. In clinical areas such as the Emergency Department, inpatient paediatric medical and surgical wards, surgical recovery areas and day care facilities, life support training should be at the advanced life support level i.e. Advanced Paediatric Life Support (APLS), Paediatric Advanced Life Support (PALS) or similar [23].
- 4.4. Staff involved in the care of children and adolescents should have special training to recognise and meet the special health, psychological, developmental, communication and cultural needs of children and adolescents [11-13].

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<sup>1</sup> NSW Health Transition Care website: <http://www.health.nsw.gov.au/gmct/transition/what.html>



- 4.4.1. Health services routinely admitting children / adolescents should have at least one registered nurse on duty at all times who has skills consistent with those described in the Australian Confederation of Paediatric and Child Health Nurses (ACPHN) Competency Standards [30] or in the case of mental health facilities, Child and Adolescent Mental Health qualifications.
- 4.4.2. Health services routinely admitting children / adolescents should use a risk assessment strategy to ensure that safe staffing levels are in place to meet the safety and care needs of children / adolescents.
- 4.4.3. All clinical staff who routinely care for children must have knowledge, training and skills in;
  - a. Paediatric pain management <sup>1</sup> [31]
  - b. Developmentally appropriate communication
  - c. Cultural competency, accessing Aboriginal Liaison Officers and the use of Health Care Interpreters.
- 4.4.4. Children have a basic need for play and it is a critical communication tool which can help the child understand their treatment and assist in recovery [29, 32, 33]. Health services with an inpatient ward for children should endeavour to meet the need for play for all children irrespective of the length of the hospital stay. A play program supported by a staff member or volunteer trained in Play Therapy and / or experienced in play may be provided.
- 4.4.5. Access to schooling should be provided to meet the ongoing educational needs of school-age children / adolescents staying in hospital. This may occur via an appropriately qualified person, by video or by internet. This is particularly important for chronically ill children / adolescents and those with multiple admissions.
- 4.5. The parent / carer must be considered as an integral part of the ward team and acknowledged as a primary care giver.
- 4.6. Health services should allow timely access to social work support for families in distress.
- 4.7. All staff caring for children and adolescents must have access to the following resources:
  - a. Paediatric Pharmacopoeia
  - b. Paediatric clinical practice guidelines
  - c. Poisons helpline

An annual review of the content of these resources and their accessibility is required to ensure that they are kept up-to-date.

- 4.8. As an absolute minimum, any health service admitting children / adolescents must have access at all times to a resource person with paediatric clinical experience and expertise which accord with the following staff standards; 4.2, 4.3 and 4.4. For rural and remote services this may include resources such as tele- or video- conferencing [34-37].

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<sup>1</sup> The Royal Australasian College of Physicians Guideline Statement: Management of Procedure-Related Pain in Children and Adolescents [22]

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## Appendix 1: Working group members

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