

CONSULTATION DRAFT

May 2002

New Zealand Standards for the Wellbeing of Children and Adolescents Receiving Healthcare

This draft has been developed from national and international documents relating to the wellbeing of children and adolescents in healthcare settings, and from responses received on earlier drafts.

We now invite your comments in the booklet provided with this document.

Comments will be received until: Friday 28th June 2002.

Please feel free to distribute this document to anyone who may be interested.



THE PAEDIATRIC SOCIETY OF NEW ZEALAND

This document has been compiled by a wide range of people and organisations who have contributed through providing information and making submissions. The committee has used this information and drawn on the literature available to support the standards.

The following is the committee which has compiled this document.

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The following organisations and individuals were offered the opportunity to comment and comments received have been incorporated where possible:

- Youthline
- Addison's Network
- Allergy Awareness Assn
- Arthritis Foundation
- Apert Network
- Alpha 1
- Angelman Syndrome Network
- Autistic Assn
- CANTEEN
- Child Cancer Foundation
- Child Health Network, College of Nurses, Aotearoa
- Congenital Adrenal Hyperplasia Support Group NZ
- COMFFORT
- Coeliac Society
- Cohen Syndrome Support Contact
- Disability Information North Shore
- Cleft Lip and Palate Support Group
- Chrons Ulcerative Colitis Support Group

- Cyclic Vomiting Syndrome Support
- Epilepsy North Shore
- Dystrophic Epidermolysis Bullosa Research Assn
- Down Syndrome Assn, Auckland
- Dyspraxia Support Group
- Lennox Gastaut/Intractable Epilepsy Parent Support Group
- Little Limbs
- Heart Children New Zealand Inc
- Kids Foundation
- Kidney Kids of NZ
- G.R.A.S.P.
- Little People of NZ
- Lymphoedema Support Network
- Lysosomal Storage Diseases Support Gp
- Ministry of Health
- Ministry of Youth Affairs
- Muscular Dystrophy Assn
- Nager and Miller Syndromes
- National Kidney Foundation
- Neurofibromatosis Support Group
- NZ Association for Adolescent Health and Development Inc
- NZCCS Information Service
- Parents of Vision Impaired
- Parent to Parent
- Perthes Disease Support Group
- Peter Watson: Senior Lecturer in Adolescent Health, University of Auckland
- Prader-Willi Syndrome Assn
- Parent and Family Resource Centre Inc.
- Young at Heart Ostomates Organisation
- Tracheostomy Support Group
- Tuberous Sclerosis Support Group
- Retinoblastoma Support Group
- Retina New Zealand Inc.

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Standards for the Wellbeing of Children and Adolescents Receiving Healthcare.

Introduction:

Health services for children and adolescents¹ aim to promote health and treat illness: the goal being to enable as many children and adolescents as possible to enter adulthood with their potential for health and wellbeing uncompromised. Increasingly it is recognised that the health of children and adolescents determines the health of adults. Children and adolescents are not just little adults. They are especially vulnerable and fragile in both physiological and psychological terms. The diseases they suffer are different, their responses to illness and injury differ both physically and psychologically. Children and adolescents therefore have needs that are distinctly different from those of adults. These special needs must be provided for during every step of health care delivery.

Historically hospitals were, and in some cases still are, miserable places for children and adolescents, where they were expected to conform to ward routines, were not allowed to play, were expected to lie quietly and where parents, siblings and friends were allowed to visit only infrequently, at specified times. The Platt Report (1959) and Australian Paediatric Association (1958) recommended that children have family centred care in an environment separate from sick adult patients. Over the past 50 years there have been a number of significant reports recommending more developmentally appropriate health care for children and adolescents.

Although a considerable amount of work has been done in New Zealand on this subject, and the lot of children and adolescents receiving healthcare has been slowly improving, no nationally accepted standards for their wellbeing when receiving healthcare currently exist. This document aims to set standards around meeting these needs and provides an audit tool to assess progress towards the standards.

The location, design and equipping of all parts of a healthcare facility impact on the well being and safety of children and adolescents and must be considered in all areas to which they have access.

¹ This document refers to all those aged 0 to 18 years. The term children is used to define those children/tamariki aged under 12 years and the term adolescent those adolescent/rangatahi aged 12 to 18 years.

This document is designed to apply to **all** healthcare settings. However it is recognised that while the requirements are important wherever healthcare to children and adolescents is provided, particular examples may not apply to all providers. A general practitioner, for example, may not be expected to employ a play specialist, but would be expected to have a play area and toys available for younger children and a developmentally appropriate area for adolescents.

Clinical Needs

Variation in size is the most obvious difference between adults and children and adolescents and requires that hospitals and other providers maintain an appropriate range of sizes in equipment. Small size requires special skills from specialised staff, and often more costly equipment. Small size also requires extra caution and more time to carry out procedures such as obtaining specimens, inserting intravenous lines and performing surgery. Young children are more prone to rapid physical deterioration because of smaller physiological reserves and immature immune systems.

A large number of studies have demonstrated improved outcomes in terms of days in hospital, complications, cost, and long-term mortality and morbidity when children and adolescents are treated in developmentally appropriate settings by staff trained in, and dedicated to, their needs. (Stringer 1997 NCEPOD 1989; Stark 1998; Jenkins et al 1995; Core Services Committee 1994/5; Buss 1997). Children and adolescents therefore need special care from specialist staff, ----- nursing, medical and allied health ---- in facilities designed to meet their needs.

Parents² have a crucial role in supporting their child, and the trained staff, through direct clinical care. Parents are the "specialists" in the care of their child, being uniquely tuned into the child or adolescents needs and astute to any small clinical change. All clinical care must recognise these key relationships and provide for the needs of parents, physically and emotionally, during episodes of healthcare.

The relationship of children and adolescents with their parents gradually evolves as they progress through developmental stages with increasing maturity. Healthcare in this age group must be alert to these changes. The **best interests** of the child or adolescent, which in most cases will be aligned to the **wishes** of the child or adolescent, should guide an appropriate level of parental involvement in care.

² Within this document the term parent is used to refer to biological, foster and step parents, as well as whanau and caregivers within other arrangements. Their importance is viewed mainly from the child or adolescents perspective.

Psychosocial Needs

The great advances which have been made in ensuring improved survival and medical outcomes for children and adolescents have not always been accompanied by commensurate attention to their emotional wellbeing, fear, distress and suffering. Advances in paediatric clinical physiology have enabled better understanding of disease processes. There has also been a rapid realisation that children and adolescents need more than medicine to get well. There is a significant amount of knowledge about how children and adolescents develop emotionally and physically, and about how trauma in the early years can severely impair later development. These findings have caused significant changes in the way children and adolescents are treated when receiving healthcare.

A considerable body of literature confirms that hospitalisation may have a negative impact on the development and learning of young children. It is now generally accepted that hospitalisation may result both in immediate disturbances of behaviour and developmental regression. It may also have long-term ill effects. (Douglas 1975; Quinton & Rutter 1976; Thompson 1985; Gaynard et al 1990). The McKinlay Report (1982, p.20), states that in order to counter the harmful effects of hospital, hospital admissions should be avoided wherever possible and there should be increased use of outpatients, home care or day stay admissions.

“Children and adolescents in hospital are vulnerable, and their wellbeing must be safeguarded.”

Illness in children and adolescents is distressing for them and for their families. It requires a highly skilled response from personnel who understand, and are trained in, their special needs. The psychological and developmental needs of sick children and adolescents differ considerably from those of adults. Many studies support the need for psychosocially sound healthcare as an essential service.

Adolescents have their own special needs both psychosocially and developmentally. They are neither child nor adult and should not be considered with either. Adolescents need separate services that are designed to meet their needs, and what they consider to be concerns. The transition of adolescents to adult services can be particularly challenging, especially for adolescents with chronic conditions. Special consideration and careful planning is essential at this time.

Frightening or distressing experiences can have a profound and lasting effect on a child's attitudes to health services and can have lasting effects on their psychological development. The physical environment must therefore promote psychosocial wellbeing. Activities such as play, recreation

and education cannot be regarded as a luxury. They are a necessity to ensure wellbeing by improving adjustment, normalising the environment, maintaining development and learning, and lessening anxiety, so as to minimise harm. Children and adolescents need developmentally friendly environments wherever they receive care e.g. GP surgeries, Plunket clinics, Outpatients, x-ray, laboratories and developmentally appropriate wards with clinical equipment being kept out of sight as far as possible, and with the provision of books, games and other recreational equipment. Continuing support from parents, family and friends who feel comfortable both physically and emotionally in the setting is also crucial.

Similarly, there has been insufficient attention to the active role children and adolescents can take during their treatment or hospitalisation. Children and adolescents should be offered the opportunity to be consulted as partners in the process of information sharing and decision-making about their health care needs.

A multi-faceted approach with professionals, families and the public working together towards a common goal can be a powerful force for change in healthcare practices so that these may better meet the special needs of children and adolescents.

Following incorporation of feedback from this comprehensive national consultative process, the standards will be a significant benchmark against which institutions, services and facilities should be audited.

The standards will operate under Article 3.3 of the United Nations Convention on the Rights of the Child:

'Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.'

These standards have been drawn from a wide range of literature and expert comment. A summary of some of the key provisions and documents on which they are based has been provided in Appendix One.

Children and adolescent's needs are paramount

Standard 1:

The best interests of the child or adolescent shall be the primary consideration throughout the structures and services of the healthcare provider. The healthcare provider shall deliver the highest possible standard of care for children and adolescents.

This means that the child's or adolescents needs, including their developmental, physical, emotional, cultural and spiritual needs come first - no one else's and that this is reflected in all aspects of the organisation's business. This principle also applies to the allocation of resources.

The Principle of First Call (UNICEF 1991) states:

"The essential needs of children should be given a high priority in the allocation of resources. A child's chance of development should be given first call on our concerns and capabilities. Children should be the first to benefit from our successes and the last to suffer from our failures."

The following key provisions and documents underpin this standard:

- The United Nations Convention on the Rights of the Child: Article 3 (1) 3 (2) and Article 24
- Child Health Strategy (Ministry of Health 1998)
- Well Child Tamariki Ora National Schedule (Ministry of Health 1996)
- The New Zealand Health Strategy (Ministry of Health 2000)
- Through the Eyes of a Child: National Review of Paediatric Specialty Services (Health Funding Authority 1998)
- The Code of Health and Disability Services Consumer's Rights (1996): Right 4 (2) (3) (4)
- Treaty of Waitangi
- The State of the World's Children (UNICEF 1991)
- Youth Health Action Plan Draft (Ministry of Health 2002)
- The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002)
- The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance With The UN Convention On The Rights Of The Child. (Southall et al 2000)
- Fit For The Future: The Report of the Committee on Child Health Services. (Court 1976)
- Disputes Document of Paediatric Society of New Zealand (Board of Paediatrics and Child Health of the Royal Australasian College of Physicians and the Paediatric Society of New Zealand. 2001)
- The Report of the Public Enquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol (The Bristol Royal Infirmary Inquiry 2001)
- The Review of Safeguards for Children Treated and Cared for by the NHS in Wales: "Too Serious a Thing" The Carlile Report (The National Assembly of Wales 2002)

Standard 1: This standard is achieved by but not limited to:

| Criteria: | Y/N/P | Action req. | Review date |
|---|--------------|--------------------|--------------------|
| 1.1 The District Health Board has a designated child & adolescent health manager who is responsible for planning & funding decisions across all health services | | | |
| 1.2 Contracts for services reflect evidence-based research on the needs of children and adolescents, and promote equitable access | | | |
| 1.3 Organisations have a designated person responsible for child and adolescent health and wellbeing issues | | | |
| 1.4 Clear and accessible systems are in place to receive feedback from children, adolescents and parents | | | |
| 1.5 All relevant committees, working parties and administration groups have a member appointed with relevant expertise to ensure that the interests of children and adolescents are taken into account. | | | |
| 1.6 Child experts outside the service are consulted when matters concerning the safety & well-being of children & adolescents are under consideration in planning or administration. | | | |
| 1.7 Systems to ensure the “Principle of first call for children” is considered whenever decisions are made that affect their services and facilities. | | | |
| 1.8 A well publicised, user friendly complaints procedure is available for use by children, adolescents and families | | | |
| 1.9 Systems are in place to resolve disputes between parents and health care professionals | | | |
| 1.10 All staff receive training and are audited on the application of the standards in this document | | | |
| 1.11 Policies and practices which promote the best interests of the child or adolescent are developed and maintained including: <ul style="list-style-type: none"> • Child protection • Family Violence Prevention • Compliance with Baby Friendly Hospital Initiative • WHO Code for Marketing Breast Milk Substitutes • Communication & Confidentiality with Adolescents • Guidelines for Adolescent Health Screening | | | |
| 1.12 There are policies and procedures in place which reflect an understanding of and acceptance by staff of normal developmental stages of children and adolescents | | | |
| 1.13 There is documented evidence of staff receiving regular training on these policies | | | |
| 1.14 Management and treatment of injuries and illness is evidence based | | | |
| 1.15 Staff who work with children & adolescents receive ongoing education & professional development, including interactive scenario-based teaching programmes. | | | |
| 1.16 Professional qualifications are validated. | | | |
| 1.17 All staff who work with children & adolescents receive professional support & affirmation of their work. | | | |

Holistic approach:

Standard 2:

All attendances for healthcare shall be used to promote, and advocate for, the holistic development and wellbeing of children, adolescents, and their families/whanau.

This means that in child and adolescent health a contact with a health care provider can be the opportunity for many child and adolescent health and family issues to be addressed at one time. In the long term this results in better health and less cost. Every contact with a health care provider creates an opportunity to enhance the wellbeing of children and adolescents. The focus must be on more than the problem in hand, taking stock of current health needs and provision of Tamariki Ora services.

Activities to improve health status e.g. finding a family a doctor, smoking cessation advice, behavioural guidance or accident prevention advice should be part of models of care across all settings. Children, adolescents and their families should then be receiving the full range of preventive and support services to ensure their full entitlement to preventative health care. There is considerable evidence that improving "connectedness" to services can have multiple positive health outcomes for adolescents.

The following key provisions and documents underpin this standard:

- Child Health Strategy (Ministry of Health 1998)
- Well Child Tamariki Ora Schedule (Ministry of Health 1996)
- The New Zealand Health Strategy (Ministry of Health 2000)
- The Primary Health Care Strategy (Ministry of Health 2001)
- The Code of Health and Disability Services Consumer's Rights (1996): Right 4 (2) (3) (4)
- The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance With The UN Convention On The Rights Of The Child. (Southall et al 2000)
- UN Convention on the Rights of the Child (Article 24)
- Ottawa Charter (World Health Organisation 1986)
- Youth Health Action Plan *Draft* (Ministry of Health 2002)
- The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002)
- Health Services For Children & Young People: A Guide For Commissioners And Providers (Action for Sick Children 1996)
- Fit For The Future: The Report of the Committee on Child Health Services. (Court 1976)
- The Budapest Declaration on Health Promoting Hospitals (1st Business Meeting of the International Network of Health Promoting Hospitals 1991)
- The Report of the Public Enquiry into Childrens' Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol (The Bristol Royal Infirmary Inquiry 2001)
- The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales: "Too Serious a Thing" The Carlile Report (The National Assembly of Wales 2002)

Standard 2: This standard is achieved by, but not limited to:

| Criteria: | Y/N/P | Action req. | Review date |
|--|-------|-------------|-------------|
| 2.1 All staff who have access to children and adolescents have a working knowledge of Tamariki Ora National Schedule | | | |
| 2.2 All clinical staff demonstrate a working knowledge of groups in the community that are available to support babies, infants, children, adolescents and their families | | | |
| 2.3 There is documented evidence of: <ul style="list-style-type: none"> • assessment of all aspects of child/adolescent's family life (including a HEADS assessment, housing, employment and education) • a plan to address identified need • communication with GP and well child provider (if different) • ongoing evaluation of care plan • referrals to appropriate services • use of health and development record book | | | |
| 2.4 Health promotion material is available in a variety of media, languages | | | |
| 2.5 Health promotion information is up-to-date, sensitively presented and easily understood. e.g. <ul style="list-style-type: none"> • well child care: accident prevention, breastfeeding, support, nutrition, dental care • growth & development • positive parenting • support services, healthy relationships • sexual health, contraceptive advice • stress management • healthy eating • smoking, alcohol & appropriate drug use | | | |
| 2.6 A well child information system is used to check health status of children and adolescents and to update regional records | | | |
| 2.7 Child and adolescent health outcome information is used to effectively modify the services delivered and the service availability, with constant work towards the removal of service gaps. | | | |
| 2.8 An epidemiological database is maintained which is specially related to the prevention of illness and injury and this information is communicated to public policy makers and to other institutions in the community. | | | |

Family-centred care

Standard 3:

Healthcare of children and adolescents shall be family-centred. The healthcare provider shall support a parent³ to stay with his/her child/adolescent and accompany and support him/ her during procedures.

This means that the family is the constant in the child/adolescent's life while the service and support personnel within those systems fluctuate. Policy development and service delivery should ensure that children and adolescents are not considered in isolation from their family and cultural contexts. The NZ Ministry of Health Child Health Strategy (1998), second principle for child health services states, "Child health and disability support services should be focused on the child/tamariki and their family and whanau."

There is growing recognition internationally that a family-centred philosophy should guide the organisation and delivery of health care to children and adolescents. Family-centred care is now widely considered to be best practice.

Care must also be taken to respect the developing maturity and independence of adolescents, and the changing relationship between them and their parents as they become more autonomous. This will vary between individuals and the circumstances surrounding their seeking health care.

The following key provisions and documents underpin this standard:

- United Nations Convention on the Rights of a Child
- The Code of Health and Disability Services Consumer's Rights (1996)
- The New Zealand Health Strategy (Ministry of Health 2000)
- Health Services For Children And Young People: A Guide For Commissioners And Providers (Action for Sick Children, 1996)
- The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance With The UN Convention On The Rights Of The Child. (Southall et al 2000)
- Fit for the Future: The Report of the Committee on Child Health Services. (Court 1976)
- Child Health Strategy (Ministry of Health 1998)
- Youth Health Action Plan *Draft* (Ministry of Health 2002)
- The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002)
- Through the Eyes of a Child: A Review of Paediatric Specialty Services (Health Funding Authority 1998)
- Hospital Accommodation For Children And Young People. (Health Building Note 23)
- Hospital: A Deprived Environment For Children (Save the Children 1989)
- Welfare of Children and Young People in Hospital (Department of Health 1994)
- Pediatric Excellence In Health Delivery Systems (National Association of Children's Hospitals and Related Institutions 1996)
- Moving Beyond The Medical/Technical: Analysis And Discussion Of Psychosocial Practices In Pediatric Hospitals (Stepanek 1995)
- Family Centered Care for Children Needing Specialized Health And Developmental Services (Shelton and Stepanek, 1994)
- The Report of the Public Enquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol (The Bristol Royal Infirmary Inquiry 2001)
- The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales: "Too Serious a Thing" The Carlile Report (The National Assembly of Wales 2002)

³ "Parent" throughout this document refers to a parent, family member, or caregiver sufficiently familiar to the child or adolescent so as to be able to provide emotional support and comfort

Standard 3: This standard is achieved by, but not limited to:

| Criteria: | Y/N/P | Action required | Review Date |
|---|-------|-----------------|-------------|
| 3.1 Children and adolescents are cared for in developmentally appropriate environments | | | |
| 3.2 All staff (health professionals, support, domestic and diagnostic) caring for children and adolescents have specific training on their specialised needs. | | | |
| 3.3 The healthcare provider has a written philosophy of family-centred care, and policy statements which require its implementation. | | | |
| 3.4 All practices are designed to optimise, so far as possible, the participation and convenience of the family including: <ul style="list-style-type: none"> • care in the most appropriate location • ambulatory services • clustered appointment times • appointments to enable both parents to attend | | | |
| 3.5 Care planning is undertaken with parents to enable them to provide the necessary care and treatment for their child | | | |
| 3.6 Parents are given full information, instruction and support for administering treatment | | | |
| 3.7 Parents are encouraged and supported to be with their child at all times | | | |
| 3.8 Free accommodation is provided in hospital as close to the child's bedside as desired | | | |
| 3.9 An environment is provided in which parents who need to care for a well child can have that infant with them in a safe environment. | | | |
| 3.10 Parents/caregivers are not charged for living expenses related to hospitalisation | | | |
| 3.11 Parent caring for their child in hospital are provided three free meals per day | | | |
| 3.12 The health care facility has a parent advisory body | | | |
| 3.13 Care providers, families, and those who receive care are integrally involved in strategic planning and evaluation of systems and service delivery, and in the development of new initiatives. | | | |

Treaty of Waitangi

Standard 4:

The healthcare provider will honour its obligations to Maori inherent in the Treaty of Waitangi and will provide culturally effective services to all children and adolescents, their families and whanau.

The Ministry of Health's Child Health Strategy (Ministry of Health, 1998) states that Maori whanau, communities and individuals have different and varied life styles. The diverse realities and choices made by Maori need to be respected and met by services, which take this into account. All Maori, including tamariki and rangatahi, have a constitutional relationship with the crown as outlined in the Treaty of Waitangi. The best possible outcomes for tamariki and rangatahi will be achieved by partnerships between 'by Maori for Maori' providers and mainstream providers, at all levels within the health sector and between government agencies.

The following key provisions and documents underpin this standard:

- Treaty of Waitangi
- He Korowai Oranga Maori Health Strategic Discussion Document (Ministry of Health 2001)
- Child Health Strategy (Ministry of Health 1998)
- The New Zealand Health Strategy (Ministry of Health 2000)
- Youth Health Action Plan *Draft* (Ministry of Health 2002)
- The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002)
- The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance With The UN Convention On The Rights Of The Child. (Southall et al 2000)
- United Nations Convention on the Rights of a Child (Article 30)
- The Code of Health and Disability Services Consumer's Rights (1996)
- New Zealand Standard Health & Disability Sector Standards (Ministry of Health 2001)

Standard 4: This standard is achieved by, but not limited to:

| Criteria | Y/N/P | Action req | Review date |
|--|-------|------------|-------------|
| 4.1 All staff are required to undergo regular Treaty training | | | |
| 4.2 The service provider has a documented "Bicultural Practice" policy, based on a stated definition of its Treaty obligations. | | | |
| 4.3 The service provider has written policies to ensure that Maori service providers have equal opportunity for skill development and training | | | |
| 4.4 There is documented evidence of regular evaluation of services to Maori and appropriate adjustments | | | |
| 4.5 Printed material is available which informs Maori of services being provided. | | | |
| 4.6 There are documented specific protocols for support of Maori tamariki, rangatahi and whanau, to meet their cultural needs | | | |
| 4.7 Formal processes are established for consultation with Maori which reflect the principles of partnership, protection and participation encompassed in the Treaty of Waitangi | | | |
| 4.8 Easy access is available for tamariki, rangatahi and whanau to Maori support and advocacy services | | | |
| 4.9 Whanau are involved in service delivery | | | |

Culturally safe practice

Standard 5:

The healthcare facility shall provide culturally safe services to all children and adolescents, their families and whanau.

This standard is endorsed by The Child Health Strategy (1998) principle six: Child health and disability support services should be culturally safe, culturally acceptable and value diversity. It is about services being flexible enough to respond in a safe way for all children and adolescents and their families.

Optimum health outcomes will be achieved when health and disability support needs, expectations and rights are met through culturally safe and effective service delivery.

The following key provisions and documents underpin this standard:

- Child Health Strategy (Ministry of Health 1998)
- The New Zealand Health Strategy (Ministry of Health 2000)
- United Nations Convention on the Rights of a Child (Article 30)
- The Code of Health and Disability Services Consumer's Rights (1996)
- New Zealand Standard Health & Disability Sector Standards (Ministry of Health 2001)
- Youth Health Action Plan *Draft* (Ministry of Health 2002)
- The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002)
- The New Zealand Disability Strategy (Ministry of Health 2001)
- Welfare Of Children And Young People In Hospital (Department of Health 1994)
- Health Services For Children And Young People: A Guide For Commissioners And Providers (Action for Sick Children 1996)
- The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance With The UN Convention On The Rights Of The Child. (Southall et al 2000)
- The Report of the Public Enquiry into Childrens' Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol (The Bristol Royal Infirmary Inquiry 2001)
- The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales: "Too Serious a Thing" The Carlile Report (The National Assembly of Wales 2002)

Standard 5: This standard is achieved by, but not limited to:

| Criteria | Y/N/P | Action req | Review Date |
|---|-------|------------|-------------|
| 5.1 Workforce policies reflect the local demographic and population priorities | | | |
| 5.2 Options and information are available in languages which reflect the population | | | |
| 5.3 The service provider has a detailed cultural practice policy, which defines cultural safety. | | | |
| 5.4 Qualified interpreter services are available in all settings | | | |
| 5.5 Staff are trained to recognise the need for interpreter services | | | |
| 5.6 Children/adolescents/families with special needs and/or disabilities, that may make communicating information more difficult, are given access to specialist services and/or equipment e.g. interpreters for the deaf, sign boards, etc | | | |
| 5.7 Consultation processes with communities are established | | | |
| 5.8 Community representation is sought for all policy development | | | |
| 5.9 Processes are in place to enable cultural groups to define 'culturally appropriate' | | | |
| 5.10 Children and adolescents receive services in a manner which recognises their cultural and individual values and beliefs | | | |
| 5.11 Hospitals admitting children and adolescents, including those from indigenous and ethnic communities, provide for their special dietary requirements, including: <ul style="list-style-type: none"> • food at appropriate times • developmentally appropriate food • appropriate food for weaning infants and for toddlers • developmentally appropriate food readily available a all times for toddlers | | | |

Admission to hospital only where necessary

Standard 6:

As much health care as possible shall be provided in the home and community. When children and adolescents are admitted to hospital, this should be as close to home as possible within the bounds of quality and safety, and consistent with good clinical outcomes.

This means that while children and adolescents must undergo the necessary investigation and treatment for the condition for which they are suffering, they should be subjected to the least possible disturbance of normal daily routines. In order to counter the harmful effects of hospitalisation, hospital admissions should be avoided wherever possible, and there should be increased use of outpatients, home care or day stay admissions.

It must be recognised that the need to admit children and adolescents to hospital requires assessment of the continuing ability of parents to cope at home, not solely the absolute level of sickness.

The following key documents underpin this standard

- UN Convention on the Rights of the Child
- Child Health Strategy (Ministry of Health, 1998)
- The New Zealand Health Strategy (Ministry of Health 2000)
- The Code of Health and Disability Services Consumer's Rights (1996)
- Welfare Of Children and Young People In Hospital (Department of Health 1994)
- Health Services For Children and Young People: A Guide For Commissioners and Providers (Action for Sick Children 1996)
- Through The Eyes Of A Child: Review Of Paediatric Specialty Services (Health Funding Authority 1998)
- Hospital Accommodation for Children and Young People. (Health Building Note 23)
- Youth Health Action Plan *Draft* (Ministry of Health 2002)
- The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002)
- Fit for the Future: The Report of the Committee on Child Health Services. (Court 1976)
- The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance With the UN Convention On The Rights Of The Child. (Southall et al 2000)
- The Report of the Public Enquiry into Childrens' Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol (The Bristol Royal Infirmary Inquiry 2001)
- The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales: "Too Serious a Thing" The Carlile Report (The National Assembly of Wales 2002)

Standard 6: This standard is achieved by, but not limited to:

| Criteria | Y/N/P | Action req | Review Date |
|--|-------|------------|-------------|
| 6.1 Assessment of the child, adolescent and family is undertaken within a family centred care context | | | |
| 6.2 Triage processes deciding on admission take into account the parents continuing ability to cope and offer quality care | | | |
| 6.3 All needs of the child/adolescent are assessed: physical, developmental, emotional, social, spiritual | | | |
| 6.4 The care of children & adolescents is interdisciplinary, involving such professions as hospital play specialists, hospital school teachers, social workers, and cultural support workers working with nursing, medical and allied health staff. Parents and other family members are integral to the team. | | | |
| 6.5 Professionals providing care in the home have postgraduate paediatric experience and evidence of ongoing education in child, adolescent and family health, including knowledge and understanding of developmental and psychosocial needs | | | |
| 6.6 The preferences of parents & families are taken into account when considering where the child/adolescent will be cared for | | | |
| 6.7 Mechanisms are in place for ease of communication between providers, and between providers and parents | | | |
| 6.8 Investigations and tests are undertaken as outpatients as appropriate | | | |
| 6.9 Policies, practices and programmes aim to minimise the length of inpatient stays | | | |
| 6.10 Hospitals provide for 'care by parent' for families to enable them to become confident in the management of their child's condition prior to discharge home | | | |
| 6.11 Access to tertiary services reflects the principles of Through the Eyes of a Child: eg outreach clinics, shared care | | | |
| 6.12 Documented requirements for supervision and mentorship for professionals working with children and adolescents and families | | | |

Information, participation and involvement in care and consent (children and adolescents)

Standard 7:

Children and adolescents shall have information conveyed in a manner appropriate to their age, understanding and culture; to privacy entitlements; to participate in decisions that affect them; to consent if competent; and to be actively involved in their care.

This means that children and adolescents are entitled to information pertaining to themselves, their condition and the treatment/services they are to receive, provided in a form, language and manner that they can understand. This may be presented in a variety of ways including, but not limited to: play, drawings, games, modelling, film, books, stories or one to one discussion. Children and adolescents should be informed and involved in decisions affecting them at a level that is appropriate to their maturity and understanding regardless of their capacity to consent.

The function of consent in the health context is to protect an individual's rights to bodily integrity and autonomy by allowing the person to determine what is done to him or her. It must be freely given, informed, and given by a person who is competent to do so. While there is lack of clarity about the capacity and legal entitlement of children and young people under 16 to consent to treatment without parental consent, good practice can compensate for uncertainties.

Children and adolescents who are competent to be part of a consent process should be included in that giving of consent. Information helps children and adolescents to feel more in control and to cope better. They should be involved in their care according to their age and understanding. Those with special needs may require particular attention to ensure that their rights to information are protected. Those with sensory impairments or communication difficulties, in particular, are vulnerable to isolation and the deprivation of information normally assimilated by sight, hearing and speech.

In addition to access to information, children and adolescents have the right to protection of information held about them. The right of a child or adolescent to retain some autonomy about the collection, storage and use of information pertaining to them depends on competence, not age.

The following key provisions and documents underpin this standard:

- Code of Health and Disability Services Consumers' Rights (1996)
- The Health Information Privacy Code (1994)
- Consent In Child And Youth Health: Information For Practitioners. (Ministry of Health 1998)
- Guardianship Act 1968
- Disagreements Between Professionals and Families about Health Care for Children, (Board of Paediatrics and Child Health of The Royal Australasian College of Physicians and the Paediatric Society of New Zealand. 2001)
- UN Convention on the Rights of the Child
- Better Times: Contributing to the Mental Health of Children and Young People A Resource For People Working With Children And Young People. (Ministry of Health 1999)
- Gillick v West Norfolk and Wisbech 3 WLR 830. (Area Health Authority and Department of Health and Social Security 1985)
- Welfare of Children and Young People In Hospital (Department of Health 1994)
- Child Health Strategy (Ministry of Health, 1998)
- The New Zealand Health Strategy (Ministry of Health 2000)

- The New Zealand Disability Strategy (Ministry of Health 2001)
- Youth Health Action Plan *Draft* (Ministry of Health 2002)
- The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002)
- New Zealand Standard Health & Disability Sector Standards (Ministry of Health 2001)
- Health Services For Children and Young People: A Guide for Commissioners and Providers (Action for Sick Children 1996)
- The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance With The UN Convention on The Rights of The Child. (Southall et al 2000)
- The Report of the Public Enquiry into Childrens' Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol (The Bristol Royal Infirmary Inquiry 2001)
- The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales: "Too Serious a Thing" The Carlile Report (The National Assembly of Wales 2002)

Standard 7: This standard is achieved by, but not limited to:

| Criteria | Y/N/P | Action req | Review Date |
|---|-------|------------|-------------|
| 7.1 Written protocols are developed on how children and adolescents are informed of diagnoses and how they are to be involved in treatment | | | |
| 7.2 Parents are given the information and support they require in order to support their child. | | | |
| 7.3 Children and adolescents routinely have the support of a parent, family member or other trusted person when receiving information | | | |
| 7.4 Information provided to children and adolescents is developmentally appropriate in content and means of communication e.g. play preparation programmes, booklets, videos, and interpreter service. | | | |
| 7.5 All clinical staff receive ongoing training/education in the principles and practice of informed consent | | | |
| 7.6 The specific requirements of informed consent as specified in the policies/procedures are implemented. | | | |
| 7.7 Information is provided to children and adolescents and families at all stages of their contact with a facility eg <ul style="list-style-type: none"> • Prior to admission (including pre-admission visits) • Emergency admission • Prior to all procedures • Throughout the child's stay • Prior to discharge | | | |
| 7.8 Children and adolescents are provided with opportunities for involvement in their care including ascertaining preferences and ensuring that these are taken into account without compromising their wellbeing and medical care | | | |
| 7.9 Staff are skilled at communicating with children and adolescents | | | |
| 7.10 Staff is well informed about children and adolescent's rights and needs. | | | |
| 7.11 Information about equipment and procedures has been developed that is appropriate to developmental stages. | | | |
| 7.12 Children and adolescents who are competent to participate in the consent process are included in the process of giving consent. | | | |
| 7.13 Staff are routinely made aware of, or have access to other staff with the relevant expertise, e.g. legal issues about the consent rights of children, adolescents, and their families | | | |
| 7.14 Children and adolescents are informed about: <ul style="list-style-type: none"> • what information is collected about them • when they can refuse to give information • when they can refuse to have it disclosed to others • when they can have access to it. | | | |

| | | | | |
|------|---|--|--|--|
| 7.17 | Written policies and practices are developed and maintained that respect the best interests of the child when parents/guardians disagree with, or refuse consent to, a treatment or procedure deemed clinically necessary | | | |
| 7.18 | There is a privacy policy which documents the rights of children and adolescents | | | |

Information, participation and involvement in care (family)

Standard 8:

Families shall be fully informed so that they can participate in all aspects of the health care of their child/adolescent, having regard to current law.

This means that parents are involved in shared decision-making with professionals. Information is presented in a manner suited to the recipients. The process involves professional expertise and the expertise of the family regarding choices that are consistent with their respective preferences, life circumstances and goals, the values they hold and their aspirations for their child/adolescent.

Adolescents must be given the opportunity to be heard in their own right. While the degree of maturity and ability to communicate with confidence varies between individuals, knowing they are respected for their increasing autonomy will assist them in expressing their views. For some, the support of friends or peers may be appropriate for discussing issues.

Where disagreement or conflict arises between parents and professionals about the health care of the child/adolescent, then consultation with colleagues, and ultimately the Court, may be necessary to ensure the child/adolescent's best interests are recognised.

Note – This standard should be read in conjunction with the previous standard. The two are interrelated.

Key provisions and documents underpinning this standard are:

- The United Nations Convention on the Rights of the Child.
- The Health Information Privacy Code 1994
- The Guardianship Act 1968 – s25
- Code of Health and Disability Services Consumers' Rights (1996)
- The Health Information Privacy Code 1994.
- Consent In Child And Youth Health: Information For Practitioners. (Ministry of Health, 1998)
- Disagreements Between Professionals And Families About Health Care For Children, (Board of Paediatrics and Child Health of the Royal Australasian College of Physicians and the Paediatric Society of New Zealand 2001)
- New Zealand Standard Health & Disability Sector Standards (Ministry of Health 2001)
- Gillick v West Norfolk and Wisbech 3 WLR 830. (Area Health Authority and Department of Health and Social Security 1985)
- Welfare Of Children and Young People In Hospital (Department of Health, 1994)
- Child Health Strategy (Ministry of Health, 1998)
- The New Zealand Health Strategy (Ministry of Health 2000)
- Youth Health Action Plan Draft (Ministry of Health 2002)
- The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002)
- Health Services For Children And Young People: A Guide For Commissioners And Providers (Action for Sick Children 1996)
- The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance With The UN Convention On The Rights Of The Child. (Southall et al 2000)
- The Report of the Public Enquiry into Childrens' Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol (The Bristol Royal Infirmary Inquiry 2001)
- The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales: "Too Serious a Thing" (The National Assembly of Wales 2002)

Standard 8: This standard is achieved by, but not limited to:

| Criteria | Y/N/P | Action Req | Review Date |
|---|-------|------------|-------------|
| 8.1 Parents/adolescents are encouraged to have one or more support persons of their choice present when significant information is being discussed. | | | |
| 8.2 Alternative support is available when safety may be compromised or another person's rights may be unreasonably infringed | | | |
| 8.3 Documented policies and practices are developed and implemented that fully respect the legal rights of families to privacy. | | | |
| 8.5 There is evidence of staff training in communicating with families in a non-judgemental and empathetic manner | | | |
| 8.6 Policies and practices recognise that families have a right to not participate in the healthcare procedures or treatment of their child, and to be assured that a staff member will support the child in their absence. | | | |
| 8.7 Policies and practices are developed and implemented which respect the legal rights of parents and guardians to be involved in decision making and consent to treatment | | | |
| 8.8 Documented policies are developed and implemented which protect the rights of the child/adolescent when parents disagree with treatment or refuse to consent | | | |
| 8.9 Documented policies are developed and implemented which fully respect the rights of adolescents to privacy | | | |

Protection from unnecessary pain and distress

Standard 9:

Healthcare providers shall take all steps to minimise physical and emotional pain, trauma and distress.

This means, "The emotional and psychological needs of children must be afforded a priority equal to that of their physical needs in order that immediate distress and/or long-term behavioural or psychiatric disturbance may be avoided." (Save the Children, 1989, p.31).

Children and adolescents should be treated in the right place by the right person(s) at the right time. Care should always be provided at the least intensive but appropriate level. This refers not only to places, but also to procedures, i.e. care should be taken with challenging or invasive events such as blood tests (not to order more than clinically necessary) to minimise the number of attempts at inserting intravenous lines and other invasive procedures.

Wherever children and adolescents are treated: in the hospital, community or home, it should be in an environment which is aimed at the promotion of health and the lessening of stress, with both emotional and clinical needs receiving constant attention. This is best achieved by grouping children and adolescents together, and giving families support and encouragement to participate in their care.

The following key provisions and documents underpin this standard:

- Code of Health and Disability Services Consumer Rights (1996)
- UN Convention on the Rights of the Child
- The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance With The UN Convention On The Rights Of The Child. (Southall et al, 2000)
- Fit for the Future: The Report of the Committee on Child Health Services. (Court 1976)
- Welfare of Children and Young People In Hospital (Department of Health, 1994)
- Health Services For Children And Young People: A Guide for Commissioners and Providers (Action for Sick Children, 1996)
- Pediatric Excellence In Health Delivery Systems (National Association of Childrens Hospitals and Related Institutions, 1996)
- Moving Beyond The Medical/Technical: Analysis and Discussion Of Psychosocial Practices In Pediatric Hospitals (Stepanek, 1995)
- Hospital Accommodation for Children and Young People. (Health Building Note 23)
- Child Health Strategy (Ministry of Health, 1998)
- The New Zealand Health Strategy (Ministry of Health 2000)
- The Primary Health Care Strategy (Ministry of Health 2001)
- Youth Health Action Plan *Draft* (Ministry of Health 2002)
- The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002)
- Disagreements Between Professionals and Families about Health Care for Children, (Board of Paediatrics and Child Health of the Royal Australasian College of Physicians and the Paediatric Society of New Zealand 2001)
- Better Times: Contributing to the Mental Health of Children and Young People A Resource for People Working with Children and Young People. (MOH 1999)
- Hospital: a Deprived Environment for Children? (Save the Children 1989)
- The Report of the Public Enquiry into Childrens' Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol (The Bristol Royal Infirmary Inquiry 2001)
- The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales: "Too Serious a Thing" The Carlile Report (The National Assembly of Wales 2002)

Standard 9: This standard is achieved by, but not limited to:

| Criteria | Y/N/P | Action req | Review date |
|--|-------|------------|-------------|
| 9.1 There is a commitment by the provider to minimise physical & psychological pain and distress throughout all services provided to children and adolescents | | | |
| 9.2 No children are admitted to adult wards or cared for alongside adult patients. | | | |
| 9.3 Adolescents are admitted to the most developmentally appropriate area which is consistent with their best interests and wishes | | | |
| 9.4 No adult patients are admitted to paediatric units. | | | |
| 9.5 Children and adolescents are protected, so far as possible, from sights, sounds and activities which may be distressing, especially if unrelated to their care. | | | |
| 9.6 An inter-disciplinary team develops, implements and evaluates standards for the minimisation of distress: e.g. <ul style="list-style-type: none"> • use of treatment rooms • pain management • behaviour management • restraint | | | |
| 9.7 All invasive procedures in the conscious child/adolescent are accompanied by adequate analgesia and appropriate psychological preparation and support | | | |
| 9.8 Physical restraint is kept to a minimum | | | |
| 9.9 Staffing practices (e.g. rosters) are structured to promote continuity of care, especially for young children. | | | |
| 9.10 Policies which promote the best interests of the child/adolescent are develop, implemented & evaluated including: <ul style="list-style-type: none"> • Child Protection • Family Violence Prevention • Baby Friendly Hospital Initiative • WHO Code for Marketing Breast Milk Substitutes | | | |
| 9.11 Staff recruitment policies ensure that all staff are screened for their safety and suitability. | | | |
| 9.12 Written protocols are developed and implemented to respond rapidly to any complaints or concerns arising from staff behaviour with children, adolescents and families. | | | |
| 9.13 There is a documented child abuse policy including staff responsibilities and action plans, and staff education requirements. | | | |
| 9.14 Volunteers are appropriately selected, trained, supervised and supported, and have access to opportunities for relevant ongoing education. | | | |
| 9.15 Written policies reflect the right of children and adolescents to the support of a parent or trusted person at all times, unless for some reason this could be shown to be not in the child/adolescent's best interests | | | |

Accommodation, facilities and equipment

Standard 10:

Accommodation, facilities and equipment shall be appropriate to the needs of children and adolescents. Accommodation and facilities shall be separate from those provided for adults. Facilities and equipment shall be designed, provided and maintained so as to ensure children and adolescent's safety, emotional wellbeing, sense of belonging and optimal development. Where possible, separate accommodation shall be available for adolescents.

This means that the design, equipment and staffing of facilities that admit children and adolescents must be appropriate to care for their individual developmental and emotional needs and wellbeing, and the needs of their families. Facilities should enable families to continue their primary role in the care of their child or where appropriate adolescent. There must also be facilities for developmentally appropriate play, recreation, creative and expressive activities, education, and social interaction.

When an older child or adolescent needs hospitalisation his/her particular needs should be assessed on a case-by-case basis and the ward to which they are admitted be decided by taking into account their best interests and their wishes.

The following key provisions and documents underpin this standard:

- NZ Code of Health and Disability Service Consumer Rights (1996)
- The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance with the UN Convention on The Rights of the Child. (Southall et al 2000)
- United Nations Convention On The Rights Of The Child
- The Child Health Strategy (Ministry of Health 1998)
- The New Zealand Health Strategy (Ministry of Health 2000)
- Youth Health Action Plan *Draft* (Ministry of Health 2002)
- The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002)
- The New Zealand Disability Strategy (Ministry of Health 2001)
- Early Childhood Regulations (Early Childhood Services 1998)
- New Zealand Health and Disability Sector Standards (Ministry Of Health 2001)
- Welfare of Children and Young People In Hospital (Department Of Health, 1994)
- Health Services for Children and Young People: A Guide for Commissioners and Providers (Action For Sick Children 1996)
- Health Environments for Children and their Families (Shepley et al 1998)
- Hospital Accommodation for Children and Young People. (Health Building Note 23)
- Adolescent Health, Current Issues (Department Of Health, 1990)
- Through The Eyes of a Child: A National Review of Paediatric Specialty Services (Health Funding Authority 1998)
- Guidelines For Hospital Based Child and Adolescent Care (The Australian Council For Healthcare Standards, 1998)
- Accreditation Standards for Health and Disability Support Services (The NZ Council for Healthcare Standards 1994)
- Better Times: Contributing to the Mental Health of Children and Young People A resource for people working with children and young people. (Ministry of Health 1999)
- The Report Of The Public Enquiry Into Childrens' Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning From Bristol (The Bristol Royal Infirmary Inquiry 2001)
- The Review Of Safeguards for Children and Young People Treated And Cared For By The NHS In Wales: "Too Serious A Thing" The Carlile Report (The National Assembly of Wales 2002)

Standard 10: This standard is achieved by, but not limited to:

| Criteria | Y/N/P | Action req | Review Date |
|---|-------|------------|-------------|
| 10.1 Regardless of hospital size, children and adolescents are cared for with others of a compatible age. | | | |
| 10.2 Larger hospitals provide specific facilities for adolescents, separate from both children and adults. | | | |
| 10.3 Develop, implement and monitor admission policies to ensure that adolescent' preferences about where they are cared for are taken into account. | | | |
| 10.4 Appliances and equipment appropriate for the clinical safety of children and adolescents are provided. This may include, but is not limited to: <ul style="list-style-type: none"> • maintenance of a range of sizes in medical supplies and equipment • resuscitation equipment • facilities for weighing and measuring children and adolescents | | | |
| 10.5 Treatment and procedure rooms are designed to ensure that a family member can be with their child. | | | |
| 10.6 The design of the physical environment fosters interdisciplinary collaboration, coordination of care and staff satisfaction. | | | |
| 10.7 Patient areas have natural light and windows are positioned so as to allow children and adolescents to see out. | | | |
| 10.8 There is sufficient designated space, including resource and administration space, for play, early childhood education and schooling. | | | |
| 10.9 The design process for new facilities or renovations is an ongoing, interdisciplinary, collaborative effort of all users of the environment | | | |
| 10.10 Areas accessible to young children are consistent with the <i>Early Childhood Regulations (Early Childhood Service) 1998</i> . Safety measures should include, but are not limited to: <ul style="list-style-type: none"> • appropriate window locks and door latches • safety glass at levels accessible by young children • safe water temperature • safe electrical outlets • storage of medications • protected heaters and fans • padding of sharp edges • appropriate security • non-slip surfaces • safety with piped gases | | | |

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|---|--|--|--|
| <p>10.11 Facilities and furnishings are comfortable, welcoming and developmentally appropriate to children and adolescents & families and include but are not limited to:</p> <ul style="list-style-type: none"> • facilities for parents/carers to remain overnight with their child/adolescent • a bed for a parent to sleep in beside or as close to their child as desired • facilities designed to allow parental support peri-operatively • an area for mothers to breast feed their babies • an area for formula warming • an area for nappy changing • easily accessible, free parking facilities • spaces and easy access for prams, push chairs and wheel chairs with good access at all doors for wheelchairs and double pushchairs • easily accessible, safe, outdoor play area. • easy safe access to all parts of facilities regardless of mobility, disability, and medical treatment • bathrooms, baths, showers and toilets with wheelchair and attendant access • disability friendly reception areas • availability of refreshments • telephone for external calls • laundry facilities • parents sitting room • toilets • kitchen | | | |
| <p>10.12 Formal processes ensure children, adolescents and families have input to facilities development and renovation.</p> | | | |

Staff Skills and Training

Standard 11:

Children and adolescents shall be cared for by staff whose training and skills enable them to respond appropriately to the clinical, emotional, developmental, educational and cultural needs of children, adolescents, and their families/whanau.

This means that all staff and volunteers involved in the care of children and adolescents shall be trained and competent in working empathetically with them, their parents and other family members and support people.

Children and adolescents require special care from specialist staff. Nurses, medical and allied health staff need paediatric training. Subtle but crucial changes in clinical state are best appreciated by those skilled in the care of children and adolescents who recover more quickly when the staff looking after them can communicate effectively with them, and have the specialist knowledge needed for their treatment. Additional staff such as hospital play specialists and hospital school teachers are necessary to assist with the psychosocial and developmental needs of children and adolescents. Where volunteers are employed, they may complement, but not substitute for, the employment of trained staff.

The following key provisions and documents relate to this standard:

- New Zealand Health and Disability Sector Standards (Ministry of Health 2001)
- Child Health Strategy (Ministry of Health 1998)
- The New Zealand Health Strategy (Ministry of Health 2000)
- The Code of Health and Disability Services Consumer's Rights (1996):
- Youth Health Action Plan *Draft* (Ministry of Health 2002)
- The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002)
- Ministry of Education (1998) Education (Early Childhood Centres) regulations.
- Pediatric Excellence In Health Delivery Systems (National Association of Hospitals and Related Institutions 1996)
- Welfare of Children and Young People In Hospital (Department of Health 1994)
- United Nations Convention on the Rights of the Child
- Moving Beyond The Medical/Technical: Analysis and Discussion of Psychosocial Practices In Pediatric Hospitals (Stepanek 1995)
- Health Services for Children and Young People: A Guide For Commissioners and Providers (Action for Sick Children 1996)
- Fit for the Future: The Report of the Committee on Child Health Services. (Court 1976)
- Better Times: Contributing to the Mental Health of Children and Young People A resource for people working with children and young people. (Ministry of Health 1999)
- The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance with the UN Convention on The Rights of the Child. (Southall et al 2000)
- The Report of the Public Enquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol (The Bristol Royal Infirmary Inquiry 2001)
- The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales: "Too Serious a Thing" The Carlile Report (The National Assembly of Wales 2002)

Standard 11: This standard is achieved by, but not limited to:

| Criteria | Y/N/P | Action req | Review date |
|---|-------|------------|-------------|
| 11.1 Recruitment policies include strategies to attract, educate and retain staff who are suitably trained and qualified to care for children and adolescents | | | |
| 11.2 The structure, administration and content of professional training programmes is consistent with the provider's philosophy of care for children and adolescents, and promotes consistency, continuity and coordination of care | | | |
| 11.3 Ongoing orientation and in-service education for all staff who have access to children and adolescents promotes the development of attitudes and skills relating to family-centred care and the psychosocial care of children, adolescents and families | | | |
| 11.4 Commitment to child/adolescent advocacy is demonstrated at all levels within the service e.g. <ul style="list-style-type: none"> • policies • procedures • orientation packages • performance appraisal • professional development. | | | |
| 11.5 Position descriptions, recruitment selection practices and performance evaluations recognise the special dispositions, knowledge and skills required for employees of child/adolescent's health services. | | | |
| 11.6 All volunteers working in paediatric settings are appropriately selected, trained, supervised and supported, and have access to opportunities for relevant ongoing education | | | |
| 11.7 All staff having access to children and adolescents receive regular updates on: <ul style="list-style-type: none"> • resuscitation • recognition and response to child abuse and family violence • well child care to support connection of families to care • community resources | | | |

Play, recreation and education

Standard 12:

Every child and adolescent receiving healthcare shall have access to, and opportunities to participate in, play, education and recreation.

This means that hospital play, education and recreation programmes should be available for all age groups, and incorporate early childhood education services for infants and younger children. Early Childhood Education Services for hospitalised children from birth to school entry age are eligible for licensing, chartering and part-funding from the Ministry of Education.

The educational needs of children and adolescents are inseparable from their health needs and their education is closely related to the therapeutic process. Interdisciplinary teamwork between medical and educational staff is important in order to move children and adolescents toward wellbeing. It is essential, therefore, that hospital educators (play specialists and school teachers) participate fully in healthcare teams.

Comprehensive play and preparation programmes are essential for all hospitalised children and adolescents and aim to:

- contribute to a more child and family-friendly environment and so minimise stress and anxiety in children and adolescents and their families
- provide activities and experiences which maintain, so far as possible, normal growth, learning and development
- assist in meeting any special developmental or other needs
- increase understanding and provide psychological preparation of children and adolescents for healthcare experiences so as to assist coping with, and mastery of, potentially challenging experiences
- facilitate expression of fears, feelings and misconceptions, and assist in resolving these
- speed physical recovery.

The following key provisions and documents underpin this standard:

- Education Act (1989)
- Education (Early Childhood Centres) Regulations (1998)
- Early Childhood Education Charter Guidelines: Statement of Desirable Objectives and Practices (Revised 1996)
- National Education Guidelines (1999)
- Hospital Play Specialists Association of Aotearoa/New Zealand Official Documents
- Child Health Strategy (Ministry of Health 1998)
- The New Zealand Health Strategy (Ministry of Health 2000)
- The New Zealand Disability Strategy (Ministry of Health 2001)
- Youth Health Action Plan *Draft* (Ministry of Health 2002)
- The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002)
- The Code of Health and Disability Services Consumer's Rights (1996):
- New Zealand Standard Health & Disability Sector Standards (Ministry of Health 2001)
- Pediatric Excellence In Health Delivery Systems (National Association of Childrens Hospitals and Related Institutions 1996)
- Fit for the Future: The Report of the Committee on Child Health Services. (Court 1976)
- Health Services for Children and Young People: A Guide for Commissioners and Providers (Action for Sick Children 1996)

- Welfare Of Children And Young People In Hospital (Department of Health 1994)
- UN Convention on the Rights of the Child
- Moving Beyond the Medical/Technical: Analysis and Discussion of Psychosocial Practices In Pediatric Hospitals (Stepanek 1995)
- The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance with the UN Convention on The Rights of the Child. (Southall et al 2000)
- The Report of the Public Enquiry into Childrens' Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol (The Bristol Royal Infirmary Inquiry 2001)
- The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales: "Too Serious a Thing" The Carlile Report (The National Assembly of Wales 2002)

Standard 12: This standard is achieved by, but not limited to:

| Criteria | Y/N/P | Action req | Review Date |
|---|-------|------------|-------------|
| <p>12.1 There is a comprehensive play, preparation and recreation programme in place for all children and adolescents Programmes incorporate:</p> <ul style="list-style-type: none"> • pre-admission information and/or visits; • support for families • activities to maintain children and adolescent's development and learning • therapeutic activities • preparation for, and debriefing from, potentially challenging experiences and procedures • procedural and post-procedural support • contributions by hospital play specialists to the education of other professionals | | | |
| <p>12.2 Hospital play programmes provided to children birth to school entry age are licensed and chartered by the Ministry of Education as Early Childhood Education Services</p> | | | |
| <p>12.3 There is a comprehensive programme in place to meet the educational needs of school aged students throughout the duration of their illness</p> | | | |
| <p>12.4 Links with the child's regular educational setting (Early Childhood Education or school) are maintained through the provision of schooling throughout the hospitalisation</p> | | | |
| <p>12.5 All children and adolescents have equitable access to education programmes (Early Childhood Education or school) regardless of their special needs and of their location within the facility (eg isolation, special care units, confined to bed)</p> | | | |
| <p>12.6 The involvement of children and adolescents in play, recreation and education programmes is incorporated within multidisciplinary planning for patient care, and implemented into daily hospital routines</p> | | | |
| <p>12.7 Provision is made for play and recreation activities to be available during weekends, public and school holidays</p> | | | |

Continuity and coordination between and within services

Standard 13:

Healthcare providers shall have systems to promote continuity and coordination between and within the various services working with children, adolescents, and their families/whanau.

This means that the full range of health services for children and adolescents from primary care through health promotion and surveillance, to the care of children and adolescents with special needs and disabilities, and the treatment of serious illness, are provided in a comprehensive and properly co-ordinated manner. This co-ordination is necessary within services as well as across services and between health and other agencies. Co-ordination is especially critical for those children and adolescents requiring frequent admission and those with chronic conditions and life threatening illnesses require continuity and support to enable them to stay out of hospital as much as possible. Similarly there should be appropriate co-ordination of support services after discharge from hospital. Attempts should be made to ensure children and adolescents are appropriately connected to primary care with opportunities to receive the whole spectrum of well child care as laid out in the Tamariki Ora National Schedule.

Artificial divisions between services can mean that, from the child/adolescent and family's perspective, services are fragmented and do not work together coherently to meet the needs of the family and to optimise outcomes. Fragmentation is likely to be worse for those children and adolescents and families with the greatest needs, as they come into contact with more services.

Modern information technology facilitates co-ordination and enhances the health care of children and adolescents. Its development and utilisation is essential.

The following key provisions and documents are relevant to this standard:

- Child Health Strategy (Ministry of Health 1998)
- The New Zealand Health Strategy (Ministry of Health 2000)
- Well Child Tamariki Ora National Schedule (Ministry of Health 1996)
- UN Convention on the Rights of the Child
- The Primary Health Care Strategy (Ministry of Health 2001)
- Youth Health Action Plan *Draft* (Ministry of Health 2002)
- The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002)
- The Code of Health and Disability Services Consumer's Rights (1996):
- New Zealand Health & Disability Sector Standards (Ministry of Health 2001)
- Health Services For Children and Young People: A Guide for Commissioners and Providers (Action for Sick Children 1996)
- Fit For The Future: The Report of the Committee on Child Health Services (Court 1976)
- Pediatric Excellence In Health Delivery Systems (National Association of Childrens Hospitals and Related Institutions 1996)
- Welfare of Children and Young People in Hospital (Department of Health 1994)
- Moving Beyond the Medical/Technical: Analysis and Discussion of Psychosocial Practices In Pediatric Hospitals (Stepanek 1995)
- The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance With The UN Convention on The Rights of the Child. (Southall et al 2000)
- The Report of the Public Enquiry into Childrens' Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol (The Bristol Royal Infirmary Inquiry 2001)
- The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales: "Too Serious a Thing" The Carlile Report (The National Assembly of Wales 2002)

Standard 13: This standard is achieved by, but not limited to:

| Criteria | Y/N/P | Action Req | Review Date |
|---|-------|------------|-------------|
| <p>13.1 Systems promote continuity and coordination of care throughout the child/adolescent's health care experience, with attention to critical transition points:</p> <ul style="list-style-type: none"> • Lead Maternity Carer to Well Child Provider • Neonatal Intensive Care to Paediatric Services • Intensive care to ward • community to hospital • hospital to community • child/adolescent to adult services • service to service • hospital to hospital • changes in condition • between education settings | | | |
| <p>13.2 Graduated transition to adult clinics is reflected in policies with either interchangeable clinics between both services or combined clinics with paediatric/adolescent specialist and adult physician</p> | | | |
| <p>13.3 Care providers, families and those who receive care are integrally involved in strategic planning and evaluation of systems and service delivery, and in the development of new initiatives.</p> | | | |
| <p>13.4 Key workers are available to all families where multiple agencies are providing care</p> | | | |
| <p>13.5 Systems for the exchange of pertinent information are structured to enhance communication:</p> <ul style="list-style-type: none"> • between the healthcare team, other professionals and families • between members of the health care team • between healthcare providers in different facilities • between the health care team and other professionals involved in the care of the child/adolescent | | | |
| <p>13.6 Information technology is provided and used effectively to enhance communication</p> | | | |

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Appendix 1:

The following are some of the key documents and provisions that set the scene for, and underpin the standards. Each standard is referenced to the relevant documents.

The Welfare of Children in Hospital --- Report of the Platt Committee. 1959 London: HMSO first recognised the special needs of children and their families and the recognition of the benefits of involving parents in the health care and treatment of their children.

Court SDM. 1976. *Fit for the future. The report of the Committee on Child Health Services. London: HMSO* Standard 1,2,3,6,9,11,12,13 recognised the need for integration of child health services and advocated a family-centred approach:

“We want to see a child and family centred service; in which skilled help is readily available and accessible; which is integrated in as much as it sees the child as a whole, and as a continuously developing person. We want to see a service which ensures that this paediatric skill and knowledge are applied in the care of every child whatever his age or disability, and wherever he lives, and we want a service that is increasingly oriented to prevention.”

The State of the World's Children United Nations Children's Fund (UNICEF) 1991. Standard 1

The essential needs of children should be given a high priority in the allocation of resources. A child's chance of development should be given first call on our concerns and capabilities. Children should be the first to benefit from our successes and the last to suffer from our failures.

The Code of Health and Disability Consumer Rights (1996): All standards

provides statutory protection for all consumers of health and disability support services. These need to be applied in a manner relevant to the child or adolescent's developmental stage and involve parents appropriately:

- The right to be treated with respect includes the right to personal privacy and is as important to a child or adolescent as to an adult
- The right to effective communication means taking into account the communication needs of the child or adolescent and the special skills and environment needed to ensure they hear and understand information on matters that affect them
- Right to informed choice: a child or adolescent as well as the parents need to have the appropriate information to make such a choice
- Support and the right to have someone with the child or adolescent who comforts and reassures them.

The Child Health Strategy Ministry of Health 1998

All standards:

identifies six future directions for the improvement of child health in New Zealand and highlights four priority populations: Tamariki Maori, Pacific children, children with high health and disability support needs and children from families experiencing multiple social and economic disadvantage.

The six future directions are

- a greater focus on health promotion, prevention and early intervention
- better co-ordination
- develop a national child health information strategy
- child health workforce development
- improve child health evaluation and research
- leadership in child health

The Vision is: Our children/tamariki: seen heard and getting what they need.

The strategy is based on nine principles with principle one as the most important:

- Children/tamariki should have their needs treated as paramount
- Child health and disability support services should be focused on the child/tamariki and their family and whanau
- Child health and disability support services should be available as close to home as possible, within the bounds of quality and safety
- Child health and disability support services should work together with each other and with staff from other sectors to benefit the child
- Child health and disability support services should be provided to achieve quality
- Child health and disability support services should be based on international best practice, research and education
- Child health and disability support services should be regularly monitored and evaluated
- Child health and disability support services should be culturally safe, culturally acceptable and value diversity
- Child health and disability support services should take into account the available resources.

Well Child Tamariki Ora National Schedule Ministry of Health (1996) Standard 1,2

describes the activities what every child and their family or whanau in New Zealand is entitled to receive in order to assist families to improve and protect their children's health

The New Zealand Health Strategy Ministry of Health (2000) All standards

has as two of its key principles:

- A high performing system in which people have confidence
- Active involvement of consumers and communities at all levels.

Ottawa Charter for Health Promotion (WHO, Health and Welfare Canada, Canadian Public Health Association. 1986) Standard 2

Defines health in a broad context and promotes an holistic approach to addressing health issues with an emphasis on enabling people to increase control over, and to improve, their health with a focus on prevention and promotion.

The Youth Health Action Plan (Draft: Ministry of Health 2002) All standards

proposes a shift in the way the health sector has traditionally seen young people - from being “at risk’ and as “a problem to be solved” - to being valued participants in the community’s efforts to create a healthier environment.

Part of the Action Plan involves building up the skills of the workforce and the body of knowledge around youth health issues which has been identified as a necessary adjunct to the extension of programmes and services for young people. The action plan creates opportunities for young people to actively participate and engage in health policy and service development. Young people want to be involved in decisions that affect them. They are clear about what they want from health services. The plan stresses that making this happen is up to everyone.

The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002) All standards

recognises that the wellbeing of young people is dependent on healthy connections with whānau, schools, peers, work and training, culture and environment.

He Korowai Oranga Maori Health Strategic Discussion Document (Ministry of Health 2001)

All standards and in particular Standard 4.

Treaty of Waitangi is New Zealand’s founding document and is based on 3 key principles:

- participation at all levels
- active protection
- mutual benefit and consultation

Māori models of health are holistic in approach. The ‘whare tapa whā ’approach to Māori health and healing, for example, comprises whānau (family and community aspects), tinana (physical aspects), wairua (spiritual aspects), and hinengaro (mental and emotional aspects) (Durie 1998). If each side of these works in harmony, there will be positive benefits to whanau health. In disharmony, whānau health will become unbalanced and may lead to inequalities in health status.

Whānau (kaumātua, pakeke, rangatahi and tamariki) is recognised as the foundation of Māori society. As a principal source of strength, support, security, and identity, whānau plays a central role in the wellbeing of Māori individually and collectively. The outcomes anticipated for whānau are:

- whānau are cohesive, nurturing and safe
- whānau experience physical, spiritual, mental and emotional wellbeing and have control over their own destinies
- whānau fully participate in te ao Māori and the institutions of wider New Zealand society
- whānau are able to give and receive support
- whānau have a secure identity, high self-esteem, and confidence and pride (*Whāia te Whanaungatanga:Oranga Whānau* 1998).

The United Nations Convention on the Rights of the Child Office of the Commissioner for Children. All Standards

The United Nations Convention on the Rights of the Child was ratified by the New Zealand Government, which means that both Government and non-government organisations have an obligation to abide by its principles. Included among the rights that the Convention recognises are the child/adolescent's right to:

- Take an active part in society
- Services which meet their needs
- Express their views and have them taken into consideration

The convention recognises every human being under 18 year of age.

Article 2 requires that state parties take all appropriate measures to ensure that the child is protected from all forms of discrimination or punishment on the basis of the status, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Article 3 requires that all actions concerning children and young people shall take full account of their best interests, and their best interests shall be a primary consideration. Also it requires that institutions, services and facilities responsible for the care and protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health in the number and suitability of their staff, as well as competent supervision.

Article 5 requires that States Parties respect the responsibilities, rights and duties of parents

Article 9 requires that States Parties ensure that a child shall not be separated from his/her parents against their will and further in Article 9 (3) that when separated shall respect the right of the child to maintain personal relations and direct contact on a regular basis, except if it is contrary to the child's best interests.

Article 12 requires that States parties shall assure to the child who is capable of forming her/his views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Article 13 requires that the child shall have the right of freedom of expression which includes freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.

Article 24(1): States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States parties shall strive to ensure that no child is deprived of his or her right to access to such health care services.

Article 28: Protects the child's right to education.

Article 30: Supports the cultural and religious rights of minority communities and indigenous people.

Article 31: Recognises the child's right to leisure, play and participation in cultural and artistic activities.

Disagreements Between Professionals And Families About Health-Care For Children (Board of Paediatrics & Child Health of the Royal Australasian College of Physicians and the Paediatric Society of New Zealand 2001) Standard 1,7,8, 9.

A discussion document that provides a recommended process when there is conflict between parents and the medical profession about the appropriate care of a child.

Consent In Child And Youth Health Information For Practitioners (Ministry of Health 1998) Standard 7, 8

Provides child and youth health practitioners with information about the ethical and legal requirements of consent. The document explores issues where there is a lack of clarity, and provides guidance which may assist in preventing difficult issues arising.

The Health Information Privacy Code (1994) Standard 7, 8

Under the Code children are entitled not only to information about themselves but the right to consent to treatment and services if they are competent. This is consistent with common law [Gillick, 1985]. However the Guardianship Act 1968 still adopts an aged-based approach to consent, rather than the understanding-based approach of the Code and Gillick. Thus, a parent/guardian is generally required to consent unless the child is of, or over, the age of 16 years. Consent issues concerning children adolescents can be complex. There are some circumstances where a child or adolescent of any age can give their own consent and the law does not require parental consent. These are abortion and contraception. However, it is usually advisable to

encourage the child or adolescent to involve their parents. Likewise, it is good practice to include children and adolescents in any consultation with their parent(s) when consent is being sought for other medical procedures or treatment.

New Zealand Health and Disability Sector Standards (Ministry of Health 2001)
Standard 4,5, 7, 8, 10,11,12, 13.

provide a framework for providers and consumers to be clear about their rights and responsibilities and are aimed at establishing consistently safe and reasonable levels of care and continuous quality improvement.

The Primary Health Care Strategy (Ministry of Health 2001) Standards 2,9,13.

Highlights 3 key future directions for primary health care including offering access to comprehensive services to improve, maintain and restore people's health, co-ordinate care across service areas and continuously improve quality, using good information.

The New Zealand Disability Strategy Making a World of Difference Whakanui Oranga (Ministry of Health 2001) Standard: 5,7,10, 12, 13

Promotes a vision of a fully inclusive society and presents a long term plan for changing New Zealand from a disabling to an inclusive society.

Better Times: Contributing to the Mental Health of Children and Young People A resource for people working with children and young people. (Ministry of Health 1999) Standard 7,9,10,11

This document aims to assist anyone working with children and young people to contribute to promoting their mental health. This includes helping early childhood workers, teachers, social workers and others to recognise and support children with mild and moderate mental health problems and to make appropriate referrals to specialists when necessary. This report complements other Strengthening Families initiatives aimed at enhancing the skills of specialist mental health staff and encouraging agencies to work together to ensure children and families receive the services they need.

The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol (The Bristol Infirmary Inquiry 2001) All standards

This comprehensive report describes the findings of an enquiry into the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984-1995 and relevant related issues. It describes the context in which events occurred and uses these findings to reach conclusions and make recommendations to help secure high quality care across the NHS.

The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales: "Too Serious a Thing" (The Carlile Report The National Assembly for Wales 2002)
All Standards

This report was commissioned to review the safeguards for children, and to recommend any necessary changes of policy for the safety and protection of children in the NHS in Wales. The primary function was to review policy rather than events. The cohort of children within the Review's remit included every person under 18 years old who, within Wales, was in receipt of, or liable to need, National Health Service provision at any level; and every child from Wales whose healthcare was provided outside Wales as part of their NHS treatment. Although the review is exclusively aimed at NHS service provision in Wales, the authors expect independent providers of healthcare to subscribe to the same standards. These should, where possible, be enforced through inspection and registration

Health Services for Children and Young People: A guide for Commissioners and Providers (Action for Sick Children 1996) Standard 2,3,5,6,7,8,9,10,11,12,13.

1. Services for children should recognise the rights of the child. This requires:
 - A respect for children and young people as individuals and recognition of their rights as outlined in the UN Convention on the Rights of the Child
 - Listening to the views of children, young people and their families in developing and reviewing services
2. Services for children and young people must be based on their needs. This requires:
 - A strategy that integrates all the services for children and their families – primary and community care, community child health, mental health services, acute care and services for children with disabilities and long term or life threatening disorders.
3. An integrated service for children and young people can only be achieved where health services work closely with local authorities, education and voluntary organisations. Progress towards this may be made through:
 - Using children's service plans as a basis for joint working
 - Appointing a single health commissioner for all children's services including child and adolescent mental health, within the health authority or board.

This quality review series claims:

- the rights of children, both as individuals and as family members, should provide a basis for commissioning and providing children's services
- Every child is unique. Sick and disabled children and their families therefore need a range of services that are flexible to meet their particular circumstances
- Standards developed with children, young people and their families are often the best indicators of quality.

The Child Friendly Healthcare Initiative (CFHI): Healthcare Provision In Accordance With The UN Convention On The Rights Of The Child. (Southall et al 2000) All standards

This report aims to set out proposals to develop a system of care that focuses on the physical, psychological, and emotional well being of children attending healthcare facilities, particularly as inpatients. It claims:

Modern medical technology and treatment regimens have improved survival of sick and injured children but this has not always been accompanied by commensurate attention to the wider wellbeing of children and young people, and to their fear, distress and suffering whilst undergoing treatment or care in a healthcare facility. (p 1046)

Hospital: a deprived environment for children? (Save the Children, 1989) p.31: Standard 3,9

"The emotional and psychological needs of children must be afforded a priority equal to that of their physical needs in order that immediate distress and/or long-term behavioural or psychiatric disturbance may be avoided."

Family-Centered Care For Children Needing Specialized Health And Developmental Services (Shelton et al. 1994) Standard 3

The key elements of family centred care recognise that the unbiased and ongoing exchange of information is necessary in order for parents to participate in their child or young person's care and decisions made about that care. Communication is an ongoing, reciprocal process between the child or young person, parents, family members and the health professionals. It involves shared decision making between parents and professionals. Information must be presented in a manner suited to parental understanding. The process involves professional expertise and the expertise of the family regarding choices that are consistent with their respective preferences, life circumstances and goals, the values they hold and their aspirations for their child

Te Taumata. Accreditation Standards For Health And Disability Support Services (The NZ Council for Healthcare Standards 1994) Standard 10

require that that “where children or adolescents are routinely treated or cared for in facilities which are not designed specifically for their care a separate area is assigned to them Children should not be admitted to adult wards or share other facilities with adults where separate facilities exist” (p.12).

The Australian Council for Healthcare Standards (Guidelines For Hospital Based Child And Adolescent Care 1998) Standard 10

Require that there be separate units for children, adolescents and adult patients and that a child and adolescent treatment/procedure room is also available.

Welfare Of Children And Young People In Hospital (Department of Health (1994) Standards 3,4 5,6,7,8,9,10,11,12,13

Provides a guide bringing together in a single document, relevant good practice guidance on the care of children in hospital in a form appropriate for providers and funders and states:

A good quality service for children

- Provides for the child as a whole, for his or her complex physical and emotional well being and not simply for the condition for which treatment or care is required
- Is child and family centred with children, their siblings and their parents or carers experiencing a ‘seamless web’ of care, treatment and support, as they move through constituent parts of the service.
- The report provides guidance for contracting for hospital services, delivery of hospital services, meeting children’s special needs, staffing and training.

The report is based on 7 basic principles:

- Children are admitted to hospital only if the care they require cannot be as well provided at home, in a day clinic or on a day basis in hospital
- Children requiring admission to hospital are provided with a high standard of medical, nursing and therapeutic care to facilitate a speedy recovery and minimise complications and mortality.
- Families with children have easy access to hospital facilities for children without needing to travel significantly further than to other similar amenities
- Children are discharged from hospital as soon as socially and clinically appropriate and full support is provided for subsequent home or day care
- Good health care is shared with parent/caregivers and they are closely involved in the care of their children at all times unless, exceptionally, this is not in the best interest of the child. Accommodation is provided for them to remain with their children overnight

- Accommodation, facilities and staffing are appropriate to the needs of children and adolescents and separate from those provided for adults. Where possible separate accommodation is provided for adolescents
- Like all other patients, children have the right to privacy, to be respected and to be treated with tact and understanding. They have an equal right to information appropriate to their age, understanding and specific circumstances. (P2)

Hospital accommodation for children and young people. (Health Building Note 23)
Standard 3,6,9,10

Provides guidance for the planning and design of a comprehensive children's department in an acute general hospital based on research, policy, and legislation and evaluation-in-use of hospital accommodation for children. In particular the policy reflected includes:

- Children and young people should be admitted to hospital only if the care they require cannot be as well provided at home or on a day stay
- Increased emphasis on the need to provide a comprehensive children's department where children and young people can receive continuity of care with others of their own age group
- The right of children to have their parents/caregivers with them at all times unless, exceptionally, this is not in the best interests of the child.
- Provision of accommodation should recognise the need of children and young people for privacy, play, recreation and education, suited to their age, clinical condition and development.

Adolescent Health, Current Issues Department of Health (1990) Standard 10

acknowledges the challenges faced by healthcare facilities in caring for young people, but nevertheless states that these "should not prevent the placement of teenagers together, where possible ... and for professionals to give due recognition and respect to the rights of the adolescent both as individuals and as a member of a particular cultural group, family/whanau" (p.12).

Pediatric Excellence in Health Delivery Systems (National Association of Children's Hospitals and Related Institutions 1996) Standard 3,9,11,12,13

describes a framework for improving the health and well being of children. It acknowledges that when there is rapid change in the health system children often get overlooked and acknowledges the harm that this can cause. The report provides standards for services across a continuum of care.

Moving beyond the Medical/Technical: Analysis and Discussion of Psychosocial Practices in Pediatric Hospitals (Stepanek 1995) Standard 3,9,11,12,13

Provides a framework for family centred care which it claims should be integral in guiding healthcare reform

***Through The Eyes Of A Child: A National Review Of Paediatric Specialty Services* (Health Funding Authority 1998) Standard 1,3, 6,10**

Confirms the needs for children's services to be developed separately from adult services and to be considered separately. It also includes the results of an extensive consultation with consumers.

***Health Environments For Children And Their Families* (Shepley et al 1998) Standard 10**

provides a review of the literature related to health care environments for children and families that guides designers and healthcare professionals on their journey towards socially responsible healthcare design.

***The Budapest Declaration on Health Promoting Hospitals 1st Business Meeting of the International Network of Health Promoting Hospitals (1991)* Standard: 2, 10**

Beyond the assurance of good quality medical services and health care, a Health Promoting Hospital should:

1. Provide opportunities throughout the hospital to develop health-orientated perspectives, objectives and structures.
2. Develop a common corporate identity within the hospital which embraces the aims of the Health Promoting Hospital.
3. Raise awareness of the impact of the environment of the hospital on the health of patients, staff and community. The physical environment of hospital buildings should support, maintain and improve the healing process.
4. Encourage an active and participatory role for patients according to their specific health potentials.
5. Encourage participatory, health-gain orientated procedures throughout the hospital.
6. Create healthy working conditions for all hospital staff.
7. Strive to make the Health Promoting Hospital a model for healthy services and workplaces.
8. Maintain and promote collaboration between community based health promotion initiatives and local governments.
9. Improve communication and collaboration with existing social and health services in the community.
10. Improve the range of support given to patients and their relatives by the hospital through community based social and health services and/or volunteer-groups and organisations.
11. Identify and acknowledge specific target groups (e.g. age, duration of illness etc.) within the hospital and their specific health needs.
12. Acknowledge differences in value sets, needs and cultural conditions for individuals and different population groups.

13. Create supportive, humane and stimulating living environments within the hospital especially for long-term and chronic patients.
14. Improve the health promoting quality and the variety of food services in hospitals for patients and personnel.
15. Enhance the provision and quality of information, communication and educational programmes and skill training for patients and relatives.
16. Enhance the provision and quality of educational programmes and skill training for staff.
17. Develop an epidemiological data base in the hospital specially related to the prevention of illness and injury and communicate this information to public policy makers and to other institutions in the community.