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PARENTS' AND HEALTHCARE PROVIDERS PERSPECTIVES ABOUT HOSPITALISED CHILDREN BEING VISITED BY OTHER CHILDREN IN NAIROBI, KENYA

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PARENTS' AND HEALTHCARE PROVIDERS PERSPECTIVES ABOUT HOSPITALISED CHILDREN BEING VISITED BY OTHER CHILDREN IN NAIROBI, KENYA

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ABSTRACT

Background: Throughout history, visitation of the hospitalised child has always been restricted. The subject of whether hospitalised children should be visited by other children has been accorded minimal attention.

Objective: To determine the current status of visitation of the hospitalised children and the parents and healthcare providers' views on hospitalised children being visited by other children.

Design: A descriptive study carried out using quantitative and qualitative methods in two phases

Setting: All paediatric wards at Kenyatta National Hospital and Gertrudes Children's Hospital.

Subjects: Nurses, paediatricians and parents of hospitalised children.

Results: A total of 161 parents participated in phase I of the study whereas 11 nurses not specialised in paediatric nursing, 13 paediatric nurses, 12 nurse managers, four paediatricians and 13 parents participated in phase II of the study. The study established that visiting of the hospitalised child by family members especially children aged below twelve years is severely restricted particularly in the public hospital. Despite this, however, majority of the healthcare providers and the parents acknowledged the importance of the hospitalised children being visited by other children. This is because it promotes healing, gives the sick child psychological satisfaction and relieves anxiety in the hospitalised child, the accompanying parent and the other children. The risk of exposing the visiting children to infection was cited as the main reason for the restrictions.

Conclusion: Both the healthcare providers and the hospitalised children's parents appreciate the importance of the hospitalised child being visited by other children. There is a need to review healthcare policies to make provision for hospitalised children to be visited by other children.

INTRODUCTION

Overcrowded, unsanitary and sub-standard living arrangements are critical factors in child health (1). It is taking cognisance of these factors that before the 1970s visiting even by mothers was restricted as they were seen as the means of introducing potential life threatening infections. The prevalent view of doctors and nurses was that children were better off removed to hospital and away from their poor unsanitary

homes and mothers who were unable to provide the care and treatment they required (2, 3). In the UK, between 1920 and 1974, children did not have access to their parents (4). Nursing care of children is described to have moved from care by families in the home, to care by professionals in the hospital and finally to care in the home or hospital by family and health care professionals (5).

Prior to the 1950s the care in hospital was influenced by medical knowledge about infection control and

strict child rearing theories which did not recognise the importance of parental presence (5, 6). Thus visitation by parents was either extremely restricted or completely restricted (7). Despite the progression, however, in the Kenyan setup it is observed that visiting is still restricted to a few hours per day. Hospital visiting in Kenya is further restricted to adults only but not children aged below the age of twelve years meaning that the child's siblings never get to interact with him while in hospital. It is on this note that the study set to examine the parents' and healthcare providers' views about hospitalised children being visited by other children.

The study answered the following questions:

- What is the current practice of visitation of hospitalised children?
- What are the parents' and healthcare providers' views about hospitalised children being visited by other children?

MATERIALS AND METHODS

A descriptive cross-sectional mixed quantitative and qualitative study was carried out at the paediatric wards at Kenyatta National Hospital (KNH) and Gertrudes Children's Hospital (GCH). The target population included nurses, paediatricians and parents of the hospitalised children. The sample size for parents was calculated using Fisher's formula. A sample size of 161 was determined for the parents. Multistage stratified random sampling was used in the selection of the parents. For those that participated in the in-depth interviews, data were collected until redundancy was reached. A total of six focused group discussions were conducted. The focused group discussions were constituted separately for each category of participants and the participants from the two hospitals were not mixed. This yielded two focused groups for the parents, two for the nurses not specialised in paediatric nursing and two for the paediatric nurses.

Data collection involved the use of questionnaires, with both structured and unstructured questions, in-depth interviews and focused group discussion guides. Researchers provided verbal explanations about the purpose and nature of the study and the

potential for benefit or harm before requesting written consent from participants. Questionnaires were used to collect data from the parents during phase I of the study. In-depth interviews were conducted with the nurse managers and the paediatricians. Each key informant was interviewed once for about one hour. Focused group discussions were conducted for parents, nurses not specialised in paediatric nursing and paediatric nurses. The interviews and focused group discussions were recorded and field notes were taken to enrich and clarify the interview data. The recorded data were later entered into a computer and transcribed for further analysis.

Quantitative data were coded and analysed using descriptive statistics aided by the computer programme "Statistical Package for Social Science (SPSS) Programme" version 16.0. Significance testing was done by Chi-square and multiple regressions at 95% confidence level. Results are presented using tables and figures. Qualitative data from the open-ended questions was grouped together and organised in themes and compared to the quantitative responses. The qualitative data from the interviews and focused group discussions was organised into themes aided by Nvivo 9.0 and presented in themes and narratives.

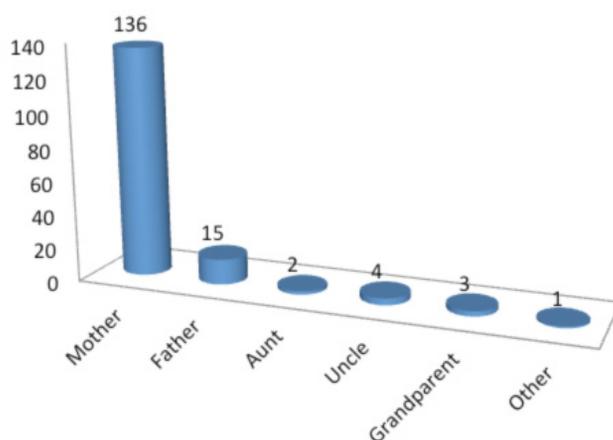
The study was approved by the School of Nursing Sciences and the Board of Post-graduate Studies, University of Nairobi. Permission was also granted by Ethics Committees of the two institutions and the National Council of Science and Technology, Kenya.

RESULTS

Parent's socio-demographic characteristics: A total of 161 parents participated in phase I of the study. Out of these, 106 were from KNH and 55 from GCH. They were drawn proportionately from all the paediatric wards in the two hospitals. Table 1 presents the socio-demographic characteristics of the parents.

Although most of the hospitalised children were taken care of by their mothers or fathers, some were taken care of by people who were not necessarily their parents. As displayed in Figure 1, 84.5 percent (n=136) of the caretakers staying with the children in the ward were the children's mothers.

Figure 1
Care taker's actual relationship with the child



Current practice on visitation during hospitalisation: The parents were asked whether they had other children at home and whether the children visited the one who is hospitalised. Most of them (69.6%, n=112) had other children at home with majority of them (81.3%, n=91) indicating that the children didn't visit the one

in hospital and only 21.4% acknowledging that they did come visiting. As indicated in Figure 2, they did not visit mainly because the hospital does not allow (60.7 %, n=55), they stay far from the hospital (26%, n=24) and fear by the parents that the child may acquire infection (5.2%, n=5).

Figure 2
Reasons for children not visiting

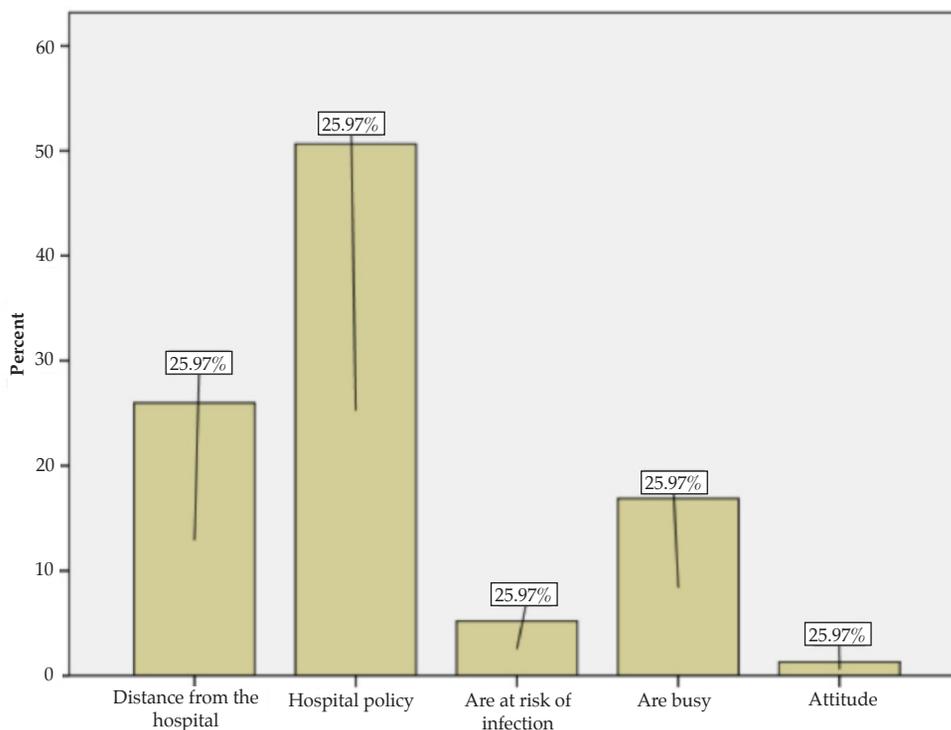


Figure 3
Parents' views on other children visiting the one in Hospital

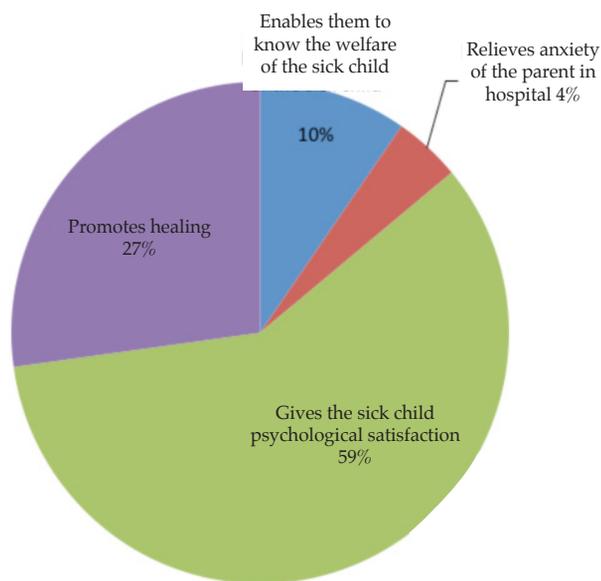


Table 1
Socio-demographic characteristics of the parents

Characteristic	Frequency	Percentage
Age (years)		
15-25	42	26.1
26-35	89	55.3
>35	30	18.6
Total	161	100.0
Sex		
Male	19	11.8
Female	142	88.2
Total	161	100.0
Level of education		
No education	2	1.3
Primary school	39	24.4
Secondary school	67	41.9
College	25	15.6
University	27	16.9
Total	160	100.0

Table 2

Association between the caretaker's socio-demographic characteristics and importance of the hospitalised child being visited by other children

Categorical variable	Frequency	Percentage	X ²	P-value
Level of education	113	70.6	7.46	0.11
Hospital where child is admitted	114	70.8	3.61	0.16
Sex	114	70.8	2.68	0.10
age	114	70.8	9.47	0.009
Actual Relationship with the child	114	70.8	12.2	0.03

Table 3

Regression results for the care taker's age and actual relationship with the child on the importance of other children visiting the hospitalised child

Variable	Uns. B	SEB	Beta	t	Sig. of t (P-value)
PQ1	-0.139	0.052	-0.203	-2.662	0.009
PQ6	0.112	0.041	0.212	2.775	0.006

Constant=1.705; R = 0.302; R²= 0.091; Adjusted R² = 0.080; Se = 0.437; df = 2,157; F = 7.872; Sig. = 0.001
Where:

PQ1= parent's age; PQ6 = Actual relationship with the child; Uns. B = Unstandardised Co-efficient; SEB= Standard Error of B; Beta = Standard co-efficient; R = Multiple Correlation co-efficient; R²= Co-efficient of determination; Se= Standard error of the estimate; df = degrees of freedom of the model, F= Analysis of Variance co-efficient Sig. = Significance (p) value of the model

In regard to current practice on children visiting their hospitalised sibling, the study sought the information from key informants comprising nurse managers and paediatricians. The responses given revealed that the private hospital upheld the practice acknowledging that it yielded multiple benefits. The public hospital, on the other hand, advanced a divergent view that did not support the practice. In explaining why they allow other children to visit the hospitalised children, one of the respondents from the private hospital explained as follows:

"We do allow, because you realise most adults who come, they come not to see the child but the parent. There is so much interaction with the parent rather than the sick child, but if the other siblings come to see or other friends from school, you realise the child cheers up and comes up when they see the other children." (R04)

In explaining factors put into consideration even as they allow children to visit, one of the managers gave the following explanation:

"Being family-centred, it is our desire to have siblings visit, but we have to balance that against the risk because the child whom they are visiting may not be having a contagious illness, but other children in the ward may be, but when a child is admitted for long we do make arrangements for them to visit quite

frequently. Acute problems/ short stay we only allow the parents. This is meant to protect the well child but we would not have a problem having them in the compound, play grounds but not in the ward where they are at risk." (R03)

The respondents from the public hospital indicated that children do not visit. One of the respondents gave the following scenario:

"From 12 years and below they cannot come in, they are restricted by the security officer so the parent comes and picks the other child and then comes back. The aim of refusing is because they feel they will abscond in the pretext that this is not the sick child and also because they can pick infections from the hospital." (P02)

Another respondent also gave the following explanation:

"Hospital policy – no visiting by children so as to protect them from nosocomial infections and also to prevent them from bringing in infections, for example, we have been admitting children with malaria and they end up getting measles, chicken pox, other infections in the ward because another child came with that because of exposure. So we are protecting the children inside and also the children from outside. This is a varied reason but it can be reviewed because no research has been done." (KR04)

Parents' views on hospitalised children being visited by other children: The study sought the parents' views on children visiting the ones in the hospital. Majority (70.2 %, n=113) thought it was important whereas 29.2 percent (n=47) thought it wasn't.

Psychological satisfaction for the sick child and promotion of healing were among the key reasons for supporting the idea (Figure 3). One of the parents gave the following explanation:

"It is very healthy to allow siblings, schoolmates, churchmates to visit. The healthcare providers should understand the distress parents go through. May be there be a place where they meet." (P2)

On explaining the effect of restriction on children visiting, one of the parents gave her experience as follows:

"At least they allow because they forget the other children or the parent who is in the ward because like me, when I go home my child does not see me as her mother, she tells me, 'bye, we'll see you', she calls me aunt." (P7)

In emphasising the negative effects of restricting children visiting their siblings in the ward, another parent gave her experience with her children as follows:

"Me, I will be very happy if they come because my daughter tells me, she has missed the child, and she is stressed and always asks, 'How can my mother and sister leave me?' Let them create somewhere." (P5)

Those that thought it is not important for children to visit gave acquisition of infection and psychological trauma as the main reasons.

Association was determined between the parents' socio-demographic characteristics and the importance of the hospitalised child being visited by other children. On Chi-square test, the parents' age and actual relationship with the child exhibited a statistically significant association with their view on the importance of hospitalised children being visited by other children whereas their sex, level of education and hospital where the child is admitted had no significant association (Table 2).

The predictive ability of the set of independent variables (parent's age and actual relationship with the child) on the dependent variable (important other children visit) is established by regression. Multiple regressions reveal that the two independent variables significantly explain 9.1 percent of the variance in the dependent variable (Table 3).

The model, whose prediction is significant at 99 percent confidence level, is illustrated below.

Important for other children to visit = 1.705 - 0.139PQ1 + 0.112 PQ6 +/- 0.437 Se (Model 1)

In this model, the actual relationship of the child has a direct relationship with the parent's view on the importance of other children visiting the hospitalised child whereas the age has an inverse relationship with the dependent variable.

Healthcare providers' views on hospitalised children being visited by other children: The perceptions of the various categories of healthcare providers are presented below.

Paediatricians

The paediatricians fronted divergent views as regards children visiting hospitalised children. Although they were all in support that children need to be visited by other children, some of them expressed some reservations. Here are some of their responses:

"They should come but should be in a controlled environment because they are anxious, the parent or sibling is not there for some time and then they get the sad news that the sibling has died and they have not seen them for two to three months - this brings a negative impact on them. The sick child brightens up when they see their siblings." (GP02)

One of the paediatricians, in comparing private and public hospitals and acute and chronic conditions gave the following expression:

"Public hospitals should exercise caution before opening it up in the clinical areas as this would be risky. But for chronic conditions, we should allow. 'I have seen families where a child with cancer was almost forgotten'. For acute conditions, it is safer to wait at home." (GP03)

Another respondent suggested that consideration should be given to the status of the hospitalised child by stating the following:

"I don't believe that children should not visit, dependent on the cases. For things that are not scary, that will not give them nightmares, they should come and see. For highly infectious or scary states, that they can be barred. Otherwise they need to visit and play with them." (KP01)

One of the paediatricians from the public expressed the importance of children visiting but alluded to the fact that there is need for policy review and restructuring of the environment:

"Especially if these are their siblings, it is a very good idea; they encourage the child and give him or her a sense of normalcy and contact with the outside world. The risk is to the visiting child. Once parents understand that risk, it is ok with us. We need to encourage the hospital management to change their views and also the operating environment within the hospital. So infection control improvement and this has to be two way." (KP04).

One paediatrician did not support children visiting on account of protecting them from infections. Her explanation was as follows:

"I have passion for infection control, so I will not encourage. Children are risky and vulnerable due to their low immunity and practices like touching the floor and they will be our next clients. If the child is very sick, then the family will actually understand that psychologically even for the younger children, it is not very healthy to see their sibling ill. They can support in terms of talking to them on phone, writing to them but only be allowed to interact when the other sibling is able to interact with them." (KP03).

She suggested that if children are to visit, there is need to have structures in place for family visiting such that they do not come to the ward but the sick child, if possible, comes out to meet them.

One of the paediatricians from the public hospital gave the following explanation as regards children visiting their hospitalised siblings:

"Is a traditional concept that children are likely to be infected and hospital is full of infection. If a child is very sick, it may make sense, but in general ward, children cheer up when they see other children but adults can never. I think on individual cases, we need to allow above certain ages. Research needs to be done." (KP04)

One of the paediatricians involved in training in commenting about hospitalised children being visited by other children gave the following explanation:

"It is important, if it was possible, the child in the hospital should have his own house with the siblings all the time. We don't allow the siblings because we don't have the space; the simple reason is to protect them from cross infection. Like in KNH, it is a lousy system; we have children in the third floor, where do they play? Children's wards should be in the ground floor with an open space where they play after procedures. This one is pathetic." (PL01).

Nurse Managers

Almost all the nurse managers from the two hospitals supported the idea that children in hospital should be visited by their siblings and friends even if it is on specific days. This, they explained, is part of treatment, hastens the process of recovery and shortens the duration of hospitalisation. One of the respondents, in commenting about the adult visitors, made the following statement:

"They should be allowed because most of the time the visitors who come are coming to see the mother." (GNM05)

Another importance of children visiting is to the fact that it will serve as a learning experience for them so that they can exercise infection prevention practices.

"The child requires others. It is also good to know that children can get sick, they can take caution like playing in a stupid way." (KNM02)

In considering the ward environment in the teaching and referral hospital, one of the nurse managers was of the view that it may not be appropriate for children to visit. Here is her expression and suggestion on way forward:

"It may be a little difficult in the time being. The day rooms that were meant to be used for play and have siblings to come to visit them have been converted to wards due to increase in cases of cancer. May be we can organise and put seats on the corridor so that the family meets there. We can have an open day and we allow relatives to come with their children and they meet their sick relative. Something I need to explore." (KNM05)

One of the nurse lecturers gave the following explanation as regards to hospitalised children being visited by other children:

"We want children to keep in contact with one another. If the worry is that the child will be infected, what happened before the child came to the hospital? My role is to ensure that as they come, they should not get infected. Preventing them from coming to visit others does not help the situation. Put in place measures to protect them from getting infected but not preventing them from really coming to visit - look at the WHO definition of health." (NL02).

Non-paediatric Nurses

The non-paediatric nurses expressed divergent views concerning the idea of children visiting hospitalised siblings and/or friends. Whereas the idea is noble, they all thought it is important to consider the advantages and disadvantages and to assess the hospital and ward set-up.

Paediatric nurses

All the paediatric nurses from the two hospitals were of the opinion that hospitalised children should be visited by fellow children acknowledging that it plays a key role in therapy. To aid achieve this, they suggested the need for the hospitals to have designated areas besides the wards or specific days of the week, change their policies on visitation and parents be explained to the importance of children visiting. They further suggested that emphasis be put on infection prevention especially in hand hygiene. One of the paediatric nurses from the teaching and referral hospital gave the following scenario:

"What I have seen in 3rd floor, the parent comes with the kid, the kid is retained at the security desk, the parent goes to the ward and comes back and then they go."

At least it is not good; the hospitalised one does miss home especially the chronically ill." (KPN02)

Another respondent from the private hospital gave the following suggestion:

"Advocate for siblings, classmates and even church mates but keep hand hygiene and room restriction." (GPN01).

DISCUSSION

This study has established that visitation of the hospitalised child by other family members was highly restricted by hospital policies. It has further established that this is more severe on children visiting, especially in the hospital. This practice is in contrast to the practice at St. Jude's Hospital, Australia where the hospitalised child's siblings are freely allowed to visit and are explained the condition of their sibling (8). This indicates that in the Kenyan set up, the status of care of hospitalised children is at the level of the pre-family centred care period of the developed world whereby restriction of visiting was practised (2, 4, 9).

Despite majority of the parents and healthcare providers supporting the idea of children being visited by other children, some of them felt this should not be the case as the visiting children will be at risk of acquiring infections from the hospital. These results concur with those by New Yorkers for Patient and Family Empowerment (10). In this study, the care taker's age and actual relationship with the child exhibited a statistically significant association with the importance of other children visiting ($p = 0.001$). The actual relationship with the child displayed a direct relationship implying the closer the relationship to the child the more they recognise the importance of the child interacting with other children. The age of the parents displayed an inverse relationship, whereby the younger parents felt it was important that other children visit the hospitalised child than the older parents. This would be because the younger parents might have left younger children at home and were also missing them as expressed during the focused group discussions as compared to the older parents.

The restriction for visiting was more for children aged below 12 years who were totally not allowed in especially in the public hospital. The main reasons for restricting children included fear that they are at risk of acquiring infections from the hospitals and that the hospitals are scarely hence causing psychological trauma to the children. This concurs with the findings by New Yorkers for Patient and Family Empowerment whereby, in their study of 99 hospitals in New York, they established that 43 percent of the hospitals had restrictions for children. The restrictions were indicated to be there throughout the year and in all

types of wards. This is different from other hospitals in the developed world. For instance, at Ontario, restriction is only during the outbreak of severe acute respiratory syndrome (SARS) whereas at Robert Wood Jonson Medical Centre, children are restricted in the acute wards because of swine flu but are allowed in the oncology wards.

Some of the healthcare providers and parents felt that the restrictions are baseless. This concurs with the statement by the American Academy of Critical Care Nurses (AACN) as reported by the New Yorkers for Patient and Family Empowerment. All respondents suggested the need for review of the policies on visitation. This is congruent with the suggestions given by the New Yorkers for Patient and Family Empowerment. Some of the suggestions given in this study included: Children be allowed to visit but be accompanied by adults and the hospitals to either have specific days when children visit or they set aside other places, besides the wards, where the children can visit.

In conclusion, family visiting of the hospitalised children is restricted to specific hours and children aged twelve years and below are not allowed to visit, especially in the teaching and referral hospital, for the main reason that they are likely to acquire infections from the hospital. The study further concluded that all the stakeholders acknowledge the importance of hospitalised children being visited by fellow children.

We therefore recommend that hospital administrations should review their policies on visitation so as to allow for unrestricted visiting of patients. In particular, they should put in place modalities to allow children to visit sick children and especially those with prolonged hospitalisations.

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