

Section 5

Supporting materials

CFH Information Sheets

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

Additional information sheets available on the CFHI website:

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

CFH Information Sheet 1: Adversity and problem solving

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

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

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

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

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

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

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

Some facts about adversity

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

Intervention to stop, or help a child cope with adversity, needs to:

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

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

Some simple rules for solving problems

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

CFH Information Sheet 2: Advocacy

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

Some facts about advocacy

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

Some simple examples where advocacy can be helpful:

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

Some global issues for advocacy

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

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

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

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

References

O'Hare BAM, Venables J, Southall DP: Child health in Africa: 2005 a year of hope? Archives of Disease in Childhood in press

Fustukian S, Keith R, Penrose A. 80 Million Lives, Meeting the Millenium Development Goals in child and maternal survival. London: Grow Up Free From Poverty Coalition / Save the Children; 2003

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

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

It is the systematic critical review of the way a specific aspect of healthcare is provided, managed or given, to see if:

- ❑ This is the 'best possible'
- ❑ The outcome for an individual child and their family is/was the 'best possible'
- ❑ Any improvements can be made.

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

Structured audit involves looking at the use and management of resources.

Process audit involves looking at the policies, procedures, clinical guidelines and other job aides to see if these are being followed and/or are achieving their objectives

Outcome audit involves looking at the way health care is given, its outcome and how the child and families' quality of life is affected by the healthcare experience

Audit meetings provide excellent opportunities for:

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

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

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

The audit cycle has four parts:

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

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

This important coordinator for audit needs to:

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

It works best if the coordinator for the audit is skilled at:

- Problem solving
- Facilitating
- Dealing with conflict
- Sensitively and constructively dealing with health workers who are performing poorly
- Basic data analysis
- Communicating (adequate and appropriate communication is important part of the audit cycle).

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

For example how to collect information for a mortality audit

Before an audit meeting, review the relevant clinical records and if possible talk to the families of each case/child before the audit to gain their views and opinions about what happened (this needs to be done sensitively, preferably by a health worker who the family know well. They need to be seen again after the audit to be told the outcome. In our experience families welcome this opportunity to express their views, providing it is not too soon after the death. They also welcome improvements in care that arise because of their child's death).

The following data are useful:

- Days of illness prior to presenting
- Date and time of first presentation to a health worker
- Date and time of first treatment given
- Signs child presented with (were these emergency or priority signs? (*See Standard 8*))

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

Some of the aspects of children's healthcare that benefit from audit include:

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

How to audit deaths

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

Selection criteria can be based on:

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

Best practice is for everyone who was involved in the care of the child/children to attend. Each death needs to be discussed and decisions made about:

- The probable main cause of death
- Other possible causes
- Contributing conditions (other health related problems identified by health workers or caregivers)
- Modifiable/avoidable factors are then identified and classified as:
 - Carer or family related
 - Administrative
 - Related to poor care given by health workers in primary care
 - Related to poor care given by health workers at referral centre - (triage, emergency care,

diagnosis etc)

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

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

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

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

Child and family satisfaction audit

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

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

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

Examples of possible questions include:

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

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

Adverse or critical event audit

Examples of events that can benefit from this type of audit include:

- Re-admissions within 48 hours of going home
- Night deaths
- Near misses where a child has nearly died

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

Referral process audit

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

Other service standards (including the ‘Child Friendly Healthcare Standards’*), practices, policies and guidelines

This type of audit could be about topics such as:

- Immunisation coverage
- Breast feeding rates at discharge from maternity unit and at other key times if data collection possible
- Malnutrition rates
- Obesity rates
- Parent smoking rates
- Access to relevant health information
- Young persons sexual health
- Teenage pregnancy rates
- Accident rates
- Age at diagnosis of different types of disability
- Child protection policies and guidelines
- Quality of health information provided to schools on individual children
- Other national, country, district or local guidelines

Within wards and clinical departments, many infection control activities can easily be audited. These include:

- Compliance with sharps policy
- Reporting and management of injuries from sharps
- Isolation practices
- Decontamination of equipment
- Waste management
- Hand washing
- Cleaning
- Food handling and kitchen hygiene
- Compliance with antibiotic policy
- Practice can also be effectively audited against written, evidence-based procedures e.g. surgical scrub procedure.

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

CFH Information Sheet 4: Cleaning

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

Methods of cleaning include:

1. Normal cleaning

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

2. Disinfection.

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

3. Sterilization.

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

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

Cleaning materials (cloths, mops, sponges and other materials)

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

How often should things be cleaned?

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

Who should clean?

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

Special health workers need to be employed to keep a health facility clean. These health workers (the cleaners) should:

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

Information about providing water that is safe to drink

If water is not safe to drink, the micro-organisms that make it unsafe can be destroyed by:

- ❑ Boiling it for 1 – 5 minutes (a minimum of one minute is needed)
- ❑ Disinfecting with:
 - Iodine 3 – 4 drops for each litre of clear water – mix well and wait 30 minutes before using)
 - Chlorine.

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

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

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

Information about cleaning hands/hand hygiene)

To keep hands as clean as possible ‘best practice’ is:

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

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

Information about cleaning spills of blood and other body fluids

To reduce the risk of a healthcare related infection from contact with body fluids these should be cleaned up immediately, wherever they are.

For spills on hard surfaces best practice is:

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

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

Information about cleaning laundry (laundry means any materials used when giving health care such as bed linen, towels, flannels, clothing, cleaning materials and others).

If laundry is dirty or soiled it needs washing. Best practice in a health facility is to:

- Separate dirty laundry that has been contaminated by body fluids, or is likely to be infected, from ordinary dirty laundry and store these different types of dirty laundry in separate bags immediately
- If possible wear gloves when handling dirty laundry and always wash hands afterwards.
- Make sure there are no sharps or other solid items in the dirty laundry
- Wash all laundry at temperatures above 60 degrees C (to kill micro-organisms laundry should be washed at temperatures of not less than 65 degrees C for ten minutes, or not less than 71 degrees C for 3 minutes) – other methods of disinfection before washing are best used for materials contaminated by body fluids that will be damaged at these temperatures.

Information about cleaning equipment

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

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

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

Information about cleaning the environment, fixtures, fittings and furniture

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

Information about cleaning toys

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

Example of a policy for cleaning and maintaining toys

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

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

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

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

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

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

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

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

Job aides are written or pictorial reminders about specific aspects of care.(see website for examples and details) They help, or remind health workers how to, give the 'best possible' health care for a specific problem or issue. They include:

- Guidelines for treating a specific health problem
- Algorithms such as those for basic life support (BLS) and the Integrated Management of Childhood Illnesses (IMCI)
- Treatment pathways, drug doses.
- Lists of signs and symptoms for triage categories.
- Growth charts, developmental milestones.
- Hand washing guidelines placed near all the sinks in a health facility

Guidelines and job aides:

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

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

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

1. Create a small multidisciplinary team (*see information sheet 11 for information on team working*) of either interested volunteers or elected representatives from all the groups likely to be affected by them, including a parent and child representative
2. Consult all the health workers likely to be affected by the introduction, or up-dating, of a guideline or other job aide, and parents and children too, if possible, so that:
 - Any organisational or individual barriers to their introduction and use can be identified
 - Attempts to overcome these barriers can be made before their introduction
 - Ownership is shared (individuals are more likely to use the guideline if they feel they have contributed to them and therefore share their 'ownership')
 - The opinions and views of those on the receiving end can be incorporated
3. Find and review all existing guidelines used by the clinical area, healthcare environment, country or international community as:
 - It saves time to use or adapt an existing guideline rather than 're-invent the wheel'
 - It is sensible to comply with existing country guidelines, as long as they are evidence based and up to date.
4. Find and use the evidence to support the proposed guideline/job aide:
 - For an existing guideline, review the evidence for this to make sure it is up-to-date and correct (unless the guideline is from a reputable source, is well referenced and dated with a recent date)
 - Search the literature widely for quality evidence using the internet (if available) and reputable sources of information
 - Remember to write down how this search was made and the information source/s
 - Interpret the evidence wisely and match it to the resources available
 - Translate the evidence into medical and nursing care for the health workers in the healthcare environment
 - Use the written evidence to provide references for the guideline
5. Before introducing the guideline/job aide:
 - Get agreement from the director/chief of the healthcare environment, the heads of departments and key clinical task coordinators for its use
 - Get agreement for the date for starting to use it
 - Finalise and all agree the content of the guideline and its references
 - Remember to date the guideline
 - Arrange education sessions for all health workers likely to be involved or affected
 - Arrange a date for its review or audit
6. Arrange an early review by the core working party to amend the guideline if necessary as:
 - The evidence for medical and nursing care can change as new research is published

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

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

8. Avoid failure:

Most failures to standardise the care given are because:

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

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

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CFH Information Sheet 6: Data Management

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

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

Reasons for keeping records

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

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

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

3. To obtain information about other important indicators for children's health, such as breastfeeding and immunisation rates, that can be used to:

- Support advocacy for increased resources
- Monitor performance of programs, services and individuals e.g. road traffic accidents
- Monitor effectiveness of healthcare interventions
- Confirm that 'standards' of healthcare have been achieved at their best possible level of practice
- Plan or change policies and systems of care

4. To facilitate research

When deciding what information to collect it is important to:

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

Best practice is that any data collected is:

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

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

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

Best practice for a health record or any other information recording system is for it to be:

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

2. Standardised data collection and examination means that:

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

3. Data protection means:

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

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

The Management of data

To ensure data accuracy, quality, standardisation and protection, these activities need to be **managed and organised effectively**. For this to happen, best practice is for all healthcare organisations and healthcare environments to have a **data management team** with a lead health worker to coordinate data related activities.

The team needs to:

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

The **record cycle** starts when a child attends. It includes:

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



Inefficient record storage!

Computer systems

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

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

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

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

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

‘Wisdom, knowledge and skills are for sharing not owning’

How can you continue learning?

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

Continuing Professional Development (CPD)

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

Continuing Medical Education (CME):

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

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

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

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

The principles of lifelong learning include:

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

There are many different ways to learn:

- Formal learning such as attending training courses, lectures, conferences, courses, journal clubs, critical reading groups, workshops and seminars and small group interactive learning .

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

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

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

How can you put learning or new skills into practice?

Changes of practice and attitude do not always follow learning as:

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

If you are a junior health worker it is easier to do this if you are helped, guided and supported by a senior colleague (a mentor) who is committed to the changes in practice and attitude needed. Your mentor might be your manager or a more senior health worker. Their role is to empower, enable and help your efforts by:

- Supporting and encouraging you
- Making sure you have everything you need
- Helping you anticipate barriers to success and work out ways of dealing with them
- Publicising your successes

Things you can do to help your mentor:

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

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

Sharing learning

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

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

People you may need to share with include:

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

Ways you can share your learning include:

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

CFH Information Sheet 8: Looking after health workers

To perform well, health workers need to have the best possible physical and mental health. Best practice to ensure this includes access to:

- Adequate food and clean drinking water while working
- Preventive health measures such as immunisations, needle-stick injury management and lifting advice
- Care of their physical and mental health problems.

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

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

Being unhappy leads to discontent and demoralisation. Unhappy demoralised health workers are unlikely to:

- Be motivated to change
- Be able to express their views and opinions freely, especially if they have no real job security
- Improve the care they give to children and their families
- Be able to give the 'best possible' care

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

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

Other factors that contribute to a contented and motivated health worker

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

Good terms of employment include:

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

- Healthcare for employees
- Adequate resources to do the job

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

More about stress

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

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

Particularly stressful events for health workers include:

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

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

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

- ❑ There are higher divorce rates and marriages are more ‘at risk’ as health workers are often torn between meeting patient’s needs and family needs (doctors are often described by their partners as ‘controlling perfectionists’)
- ❑ Mental illness may be present in greater than 30%, women being at greater risk, up to 46%.

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

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

Summary of factors that can lead to discontent, stress and burn-out include:

- Major changes in workplace
- Little personal say about how to do the job
- Poor communication up and down
- Poor recognition of individual worth
- Inability through personal circumstances to work flexible hours
- Excessive hours of work
- Competing demands on time
- Inadequate resources
- Lack of support programs

How to protect yourself against these mental health problems?

You can lessen the effects of stress and emotional distress and reduce the risk of burn-out and other mental health problems by:

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

Activities that can reduce and/or prevent unhappiness, stress and burn-out include:

1. Regular small group meetings to discuss important current issues

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

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

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

How to be a good employee!

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

Bad employees:

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

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

Finally a senior health worker or manager can abuse others by:

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

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CFH Information Sheet 9: Mission statements

What is a mission statement?

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

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

Why are mission statements important?

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

Where should they be?

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



Statements of intent hanging in a hospital entrance hall

Who owns a mission statement?

It is ‘owned’ by the health workers that work in the healthcare environment.

Who decides what a statement will say?

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

What does it need to say?

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

Examples of mission statements from the CFHI pilot sites

Example 1

The Baby Unit

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

April 2000

Example 2

Neonatal Intensive Care Unit, Mulago Hospital, Kampala, Uganda The Ten Commandments of the Newborn



The ten commandments of the newborn (written by health workers on behalf of the newborn)

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

Example 3:

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

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

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

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

Example 4

The children's unit at Ulster hospital, Northern Ireland Adolescent charter

When you are in hospital:

- Where possible you will be cared for in a separate unit that is furnished to meet the needs of young people

- You can wear your own clothes and bring in your own things

- You will be cared for by qualified staff who will try to understand your physical and emotional needs, and respect your needs for privacy and independence

- You will be treated with sensitivity, honesty and tact at all times

- You will have the right to information and to make informed decisions regarding your care

- You will be able to discuss your physical and emotional needs in confidence

- You will be able to have your parents visit at any time and to stay overnight if you wish. You will be able to have you family and friends visit

- You can refuse to take part in research or student teaching. You can ask for a second medical opinion if you wish

- You will have facilities for recreational activities and a quiet area

All care will take into account your cultural and ethnic needs, disabilities and chronic illness (as appropriate)

- You will be given 'house rules' (drawn up by other young people) which you will be expected to follow

CFH Information Sheet 10 How to solve problems?

***'If at first you don't succeed, try, try, try, again. Then quit. There's no use being damn fool about it':
W C Fields***

There is nothing new about solving problems as we do this every day of our lives. Some problems are more easily solvable than others. In a healthcare environment problems are often complex and affect many different people. In this situation it is better to solve them using the advice and guidance of others (a team approach).

The principles of problem solving include:

1. Defining the problem/s after listening to everyone affected by it/them
2. Prioritising these, if there is more than one problem
3. Selecting/choosing a problem for acting on
4. Recognising barriers against solving the problem/s and forces that may help to solve it/them, such as people or materials
5. Seeking some possible solutions/courses of action from those affected and if possible also from others who have faced similar problems
6. Considering (evaluating) these and selecting the best feasible solution/s
7. Trying out (implementing) possible solution/s
8. Evaluating the results (audit) to see if the problem has been solved and acknowledging everyone's efforts
9. Trying out other possible solutions if problem not solved
10. Reviewing other problems from the list and repeating the process

1. Defining the problem

- Some problems and their solutions are obvious, but some are difficult to understand and solve. Some of the reasons for problems may be overlooked, or their significance not properly understood, unless you talk to everyone affected by it.
- The main problem may be due to several different problems each with different causes, so break a problem down into all its different parts and decide which are the most important and need solving first. Unless you find the true problems you are unlikely to make it better.
- Do not make assumptions about the cause of a problem. If you do, it is likely that your solution will not work. Talking to everyone makes finding a workable solution more likely, especially if those you consult know more about the details of the problems causes than you do.
- Remember one person's problem list may be very different to that of another!

2. Prioritising problems

- Generally the discussions you have when defining the problem will help with prioritising the problems in order of importance.
- Gaining the agreement of all involved (key stakeholders) for the final priority order is the best approach.
- If agreement is not possible an independent view may aid consensus, compromise and agreement.

3. Selecting a problem/s for action

- This is usually the one top of the priority list, but not necessarily if this seems too difficult
- Involve those that may have to implement the solutions in the selection of which to tackle first
- The easier to solve problem may be best tackled first as success encourages and motivates
- If there are lots of problems it is better to select only a few to act on first. If you try to solve too many at the same time you may fail to solve any of the problems.

4. Recognising barriers to solving the problem and forces aiding implementation of possible solutions

- Look at these before you start. It is better to find a barrier earlier than later
- Use any forces that may help makes successful problem solving more likely

5. Seeking possible solutions

- The more complex the problem, the more consultation and assessment are necessary
- Listen and respect the views of those closest to the problem as their ideas about possible solutions usually work best.
- Seek a wide variety of possible solutions
- Some people are more able to identify possible solutions than others.
- The solutions most likely to succeed are those that are 'owned' by those involved
- Ask how health workers in different healthcare environments have solved similar problems
- There always are solutions, identifying these is the challenge!

6. Considering all the possible solutions and selecting the 'best possible' (the project)

When deciding which is the 'best possible' it is usually the:

- Easiest, providing you think it will be effective
- Most feasible with the resources immediately available
- Solution favoured by the majority of the team

7. Implementing (trying out) the solution/s selected – taking action

Before making the changes it is a good idea to make a detailed plan that states:

- What the goal is (usually this will be fully to solve the problem)
- How it is going to be achieved (the details of the plan/plan the project)
- Who is going to do it (delegation)
- How you are going to ask or persuade others that it is a good idea and to do it (motivate them)
- How are you going to see whether you have achieved the goal/s and solved the problem
- When are you going to do the evaluation (usually after completion of the project)
- How are you going to acknowledge/reward the team effort. You do not always need money or materials for this. Open recognition and praise is very effective

8. Evaluating the results

Look at what has happened to see if you have solved the problem in the best possible way. To do this you can look at the:

- Intended and unintended impact/s of the solution you have tried, both good and bad, and the evidence to support these.
- Performance of the planned solution (project) (was it a good solution?)
 - How did it work, were the others able to do what was in the plan, was it too difficult, did the goals need to be clearer?
 - Were there enough resources (human and material) to make the plan work?
 - Was it affected by unexpected changes?
- Lessons learned - think about and identify the lessons learned (the things that went well and the things that could be done differently or better next time) by the team, organisation and by the children and families that were affected

Each of these three ways of looking at what happened impacts on the other two. Compare the results you get against the goals you set and remember that sometimes unexpected findings are very important. Then make recommendations for next time and share the results/findings with everyone involved.

9. Trying out other possible solutions.

This needs to be done if the problem is not completely solved. If you think that it is not possible to solve the problem with your existing resources write a **project proposal** to take to others outside your organisation.

10. Reviewing other problems from the list and **repeating the process**. You need to keep doing this as there are always new problems to solve.

Finally remember to acknowledge and reward everyone's efforts and to share the solutions that worked for you with others. Having successfully undertaken a small local project, for example implementation of correct hand washing, in your unit/health facility, this might help persuade sponsors that you have the appropriate skills and experience to warrant their continued funding/support for a larger project.

CFHI information Sheet 11: Team Working and leadership

When there are a large number of health workers in the organisation, health facility or healthcare environment, a team approach to problem solving and to planning, organising and delivering healthcare is best.

A multi-disciplinary team is a team of health workers that may include doctors, nurses, staff from professions allied to medicine, and others who have contact or involvement with the child in the context of the team's activities. For example a team may include a microbiologist, an infection control nurse, a ward clerk, a cleaner, a teacher, a play worker and others.

This team approach can be used in many different situations and at many different levels in a healthcare environment or organisation. If there are many different teams in the same health facility all responsible for a different vision, or with a different purpose, their team leaders need to communicate with each other. Wherever possible they need to avoid duplication of activities and report to a leader responsible for all the teams related to his/her area of responsibility.

Most teams work better when:

- There is a leader to manage and coordinate the team's activities.
- This leader is approved of and respected by all members of the team, or in a large team by a clear majority
- The team is as small as possible
- Team members represent those most affected by its activities (it has a representative from each group of health workers, or from each area affected, and includes a parent or older child patient representative, if possible or appropriate)
- Team members share a clear vision (such as improving the healthcare given), or purpose (such as planning healthcare, organising a department's activities, solving problems etc.) There are agreed, clearly defined goals or aims for achieving the vision or purpose The groups represented by team members are consulted whenever possible before any action or decisions are taken on their behalf
- A team member representing a group of health workers reports back to their own leader or manager about the team's activities. *For example a nurse reports to her senior/head nurse.*



An example of a team approach to a single problem, but who is the leader?

A team approach may solve a single problem quickly (See information sheet 10 for more information about problem solving), however most teams have long-term visions and purposes. Teams like this need to meet regularly. Progress with the goals and aims needs to be discussed, and further activities planned.

'Great leaders are almost always great simplifiers, who can cut through argument, debate and doubt to offer a solution everybody can understand': Michael Korda

'With the best leaders when the work is done the task is accomplished'. The people say "we have done it ourselves": Loa Tsu, Chinese philosopher 700BC

A team leader's role is to:

- Identify the skills within the team members early
- Never underestimate the skills of other team members
- Create a defined role for each member that uses their particular skills effectively
- Respect and support other team members
- Ensure good working relationships between team members and with others
- Communicate effectively within the team and with those represented

This team approach can be used in many different situations and at many different levels in a healthcare environment or organisation. Ideally if there are a large number of teams in the same healthcare environment all responsible for a different vision, or with a different purpose, their **team leaders** need to communicate with each other, avoid duplication of activities and report to an overall manager responsible for all the teams related to his/her area of responsibility within the environment or organisation.

To ensure a cohesive approach to delivering healthcare a **team member** who represents a group of health workers also needs to report to/communicate with their own leader/manager. For example nurse members of any team in any health environment need to report back to the head nurse of the organisation or health facility. This applies to all groups of health workers.

Being a leader means:

- Recognising that change is needed
- Knowing where you want to go or what you want to achieve (the vision)
- Enthusing others who may help, or benefit from it, to share the vision
- Motivating, empowering and developing others to help you put the vision into practice
- Making something complex appear simple and easy to understand
- Managing conflict positively
- Dedication and hard work
- Celebrating success

The skills needed to be a good leader include:

- Vision
- Courage, a conviction that you are right but the willingness to also accept that sometimes you will be wrong, and take responsibility for this!
- Motivation
- Passion and enthusiasm
- Energy
- Integrity
- Consistency
- Communication skills
- Interpersonal skills (empathy and social skills), understanding people and how to support them and get the best out of them
- Good judgement
- Knowing when to concentrate on the vision, when to be flexible and when to focus energies on the details of the tasks (planning and implementing). Generally the details are best delegated to others.
- The ability to delegate as you cannot do everything yourself. If you try to, it is likely that nothing will be done as well as it could be. You will not be as effective if you are trying to do too much!
- Self-awareness (a knowledge of your own strengths and weaknesses)
- Diversity and expertise, although others can provide the latter

- Ability to finish the tasks required to achieve the vision

There are many different styles of leadership.

These include:

1. **Collaborative/democratic** – the leader shapes, develops and guides a team that leads by consensus
 2. **Autocratic/dictatorial/coercive** – everyone does what the leader says without question
 3. **Laissez-faire** – the leader delegates to a team allowing the team members to do whatever they want
- Each of these three types of leadership work well for specific situations

Collaborative leadership:

Works well when:	Does not work well when:
There are different issues involved and the problems are complex	The issues and problems are simple
The problems have many possible solutions	There is usually a single solution to most problems
The leader does not have the skills and knowledge to deal with the details of all the issues	The leader is autocratic and think they know best
There are team members with the skills to deal with each of the important separate issues	Team membership does not reflect the important issues
The team member for an issue is skilled and respected and acts as a representative for those involved in this particular issue	The team member for an issue is not skilled, or not respected or does not represent the views and opinions of others involved
Authority for the different issues is delegated with boundaries clearly set and known by all	Authority is not delegated to team members or the boundaries of the authority are not clearly defined or followed
Team members respect each others roles and skills	There is little respect for each others roles and skills
The team is able to work well together	The team are unable to work together well
The team is able to meet frequently	The team are unable to meet regularly
Team members communicate well with those they represent	There is poor communication with those that a team member represents

Autocratic leadership:

Works well when:	Does not work well when:
The situation is simple with a limited number of likely problems	The situation is complex with many possible and differing problems
There is a single obvious best solution to most problems	There are many possible solutions to these problems
There are a limited number of different issues involved	There are many different issues involved
The situation is replicated in the same way frequently	The situation is variable
Followers or team members all agree that the leader has unique skills, talents, knowledge that is much superior to their own	Followers or team members have opinions of their own on the issues involved and believe they know as much about or more about some or many of the issues involved as the leader
The leader is willing to get involved in all the details	The leader is not willing to get involved in details
The leader has the capacity to be involved in the details	The leader does not have the capacity to be involved in all the details
The followers changes frequently	The leader is unwilling or unable to be always available to the team
The team, if there is one, is remote	There is a good pro-active team

An example of when autocratic leadership works well is a ward staffed with temporarily employed nurses when it is best if there is tight control and rules about how things are done.

Laissez-faire leadership:

Works well when:	Does not work well when:
The team is composed of a small number of similar individuals who share the same goals	The team is large or diverse
One solution to a problem is as good as any other	The situation and problems are complex
The team members know each other very well and are in frequent contact with each other	The team is remote

Although there is a place for all these types of leadership, a healthcare environment is usually complex. It encompasses many diverse issues and activities and is staffed by many skilled health workers **leadership is likely to work best.**

If this collaborative leadership model is adopted it will result in more ideas, better insight and cooperation, more manageable demands on the leader and the projects and solutions are more likely to work and be sustainable. It is less likely to waste valuable time and energy.

When using this model of leadership, best practice for the leader is to:

- Choose team members to represent each of the important functions and activities
- Balance the team
- Find out the individual strengths and unique skills of each team member
- Use these strengths and skills effectively
- Communicate well upwards and downwards to other health workers
- Delegate authority but make it very clear what and how much is delegated - set the boundaries clearly
- Set up procedures for communicating (*See example of a communication matrix*)

An example of a communication matrix

The methods of communications considered most appropriate to use for the different groups of people involved with the pilot project for the Child Friendly Healthcare Initiative

Methods	CAI leadership and support and operational staff	CFHI Team (Sue, Andrew and Carol)	CFHI Advisory Committee	Professional Organisations	Donors	Other NGOs	Pilot Hospitals and CFHI coordinators	Health workers from other sites	Global Organisations ((WHO, UNICEF)	UK Ethics	Governmental	Media	Parent Organisations	CAI Members
Team Meeting		4												
CAI Magazine	4				4									4
Advisory Committee Meetings			4											
Minutes of committee meetings			4											
E-mail	4	4	4	4	4	4	4	4	4	4		4	4	
Web Site	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Presentations							4	4				4	4	
Posters														
Newsletter														
Meeting/Hospitals														
Telephone/Fax	4	4	4	4	4	4	4	4	4	4		4	4	4
Letters	4	4	4	4	4	4	4	4	4	4		4	4	4
Postal updates/fliers	4													
Reports about pilot sites	4	4	4		4		4	4	4		4			
Others														

Other thoughts on leadership

1. A leadership based on facts is better than leadership based on emotions.
2. Leadership is the shift in moving from developing yourself to developing others. Use your skills and strengths to gather your team then lead, involve, delegate, manage and enable so that the visions are implemented.

3. Leadership based on accepted beliefs and moral values works best as it treats people equally, respects everyone in the team and seeks and welcomes new ideas, initiatives and innovations. It is open, humble and has integrity.
4. Leaders need to be in training every day of their lives. They have constantly to adapt to the crises and problems that arise around them, but they also need to train for a purpose.
5. Full engagement in leadership requires coping strategies that draw on physical, emotional, mental and spiritual (this means being in touch with your values) energy. Each of these sources of energy needs training and rituals. Like physical training, all of these sources require recovery time before you can draw on them again, for example
 - Physical recovery time is rest
 - Emotional recovery time can be focussing on a happy thought/experience from outside
 - Mental recovery time can be sleep or meditation
 - Spiritual recovery time can be time alone to reflect on your values and beliefsAll great leaders and sportsmen have recovery rituals for these energies. We are creatures of habit, so build rituals to sustain your sources of energy and to avoid compromising recovery do not take emotional baggage into your recovery times.
6. If you wake in the middle of the night, never look at the clock but use the strategies that work for you to shut out any fear, anxiety and stress.

Example of a health facility management team:

Team members

Finance Manager <i>Responsible for</i> ↓	Facilities Manager <i>Responsible for</i> ↓	Human Resources Manager <i>Responsible for</i> ↓	Chief Nurse <i>Responsible for</i> ↓	Manager of all Clinical Services <i>Responsible for</i> ↓	Administration Manager <i>Responsible for</i> ↓
Management and control (team leader)	Estate management	Personnel	Nursing	Clinical departments	Secretariat
Accounting	Engineering	Human Resources	Quality assurance	Laboratory services	Legal services
Paymaster	Building	Manpower	Patient services	Imaging (Radiology)	Administration
Budgeting	Transport	Planning	Catering	Therapists	Data management
Procurement	Utilities (electricity, sanitation and water)	Occupational health		Pharmacy	
Information	Laundry			Others	
	Maintenance				
	Cleaning				
	Waste disposal				
	Capital planning				
Training	Training	Training (lead for continuing professional development)	Training	Training	Training

Each team member is responsible for the areas listed above and for representing and supporting (providing leadership to) their health workers. The leader of this team can be elected by the team members, although in many countries this is usually the director of the health facility.

It is especially important for the head nurse to be in a health facility management team and to provide professional leadership as nurses are:

- A health facility's single largest human resource
- Present 24 hours a day
- See all the strengths and weaknesses of the organisation
- Know what patients need

Unfortunately in many disadvantaged countries nurses have a low status, poor training (very basic, often without any specialist training or very little), no professional organisations and are unable to contribute to service planning and decision-making.

References

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