Why is play important?

Play is essential for all aspects of a child’s ‘normal’ growth and development, enabling the child to advance emotionally, socially, physically and intellectually. Another very important reason for play is simply because it is enjoyable and fun for children, yet it has many functions. Play enables children to learn because while they are playing they are absorbing new information and processing it in such a way that it then becomes part of their knowledge base, and this, in turn, enables them to change or adapt their views and opinions. [This is how McMahon (2003) describes play]:

“Play is not a mindless filling of time or a rest from work. It is a spontaneous and active process in which thinking, feeling and doing can flourish since they are separated from the fear of failure or disastrous consequences.”

Play is important for children and adults alike. However, with play there are no limits or restrictions and children are free to be as creative, imaginative and adventurous as they choose to be. And because there is no right or wrong about playing there is no risk of undesirable consequences – unlike in the everyday world. [According to Lansdown] (Lansdown, 1996):

“The food and drink of mental growth, play, is an essential requirement for a child’s well-being and development.”

Play in hospital

Whatever the child’s previous experiences of hospital are, a visit to hospital can be not only a challenge, but also potentially frightening and very traumatic, whether as an inpatient or an outpatient. As emphasised above, play is vital for any child, including those in hospital. However, in a hospital environment, and for children who are unwell, play is intended to fulfil different functions, and is often used to fulfil a purpose. Such functions might include:

- to link to home
- to aid feelings of normality
- to provide an outlet for feelings and frustrations
- to reduce stress and anxiety
- to help the child to regain confidence and self-esteem
- to teach in an enjoyable way (eg. about procedures)
- to encourages involvement of families and siblings
- to facilitate communication for all children, whatever their age, stage of development, language, or ability
- to minimise regression
- to provide fun!

In addition, play is believed to help speed up recovery of children in hospital.

The role of the hospital play specialist

Hospital play specialists (HPS) are trained professionals who work within the paediatric team. They have completed the BTEC qualification in Professional Diploma in Specialised Play for Sick Children and Young People. The role of the hospital play specialist can vary significantly depending on the setting in which he or she is based. However, the fundamental role remains the same and includes:
organising activities
making the environment child-friendly
supporting patients and families (including siblings)
acting as the child’s advocate
using various techniques to help children to master and cope with anxieties
using play to prepare children for hospital procedures
contributing to clinical judgements through play-based observations
being an active member of the multidisciplinary team and to aid and/or support other professionals
working closely with the child psychology department
教 the value of play to other members of staff and volunteers
using play to promote development and prevent regression for children and young adults while in hospital (particularly important for long-stay patients and those in isolation)
developing and executing individual play programmes
using therapeutic play techniques to support the patient and their families during their stay in hospital
facilitating informed consent.

Young children often find it difficult to play spontaneously, particularly in a hospital environment, and when play does occur it isn’t always as productive as it would be if it was guided by a professional (Lansdown, 1996). [Taylor et al (1999) state:]

“In the absence of familiar persons, objects and routines and with the real or perceived threat of injections, medications and procedures, many children while hospitalised cannot spontaneously play.”

Additionally when a child is sick he or she may need specific help, possibly even physical help when movement is restricted, in order to facilitate play. This according to Walker (2006):

“While all paediatric staff can use play in their care of the child, the play specialist holds the responsibility for ensuring the essential functions of play are built into the fabric of the child’s journey through the hospital experience.”

Types of play

Messy play

This can take many forms and is a positive outlet for feelings and frustrations, allowing the child to gain confidence and cope with difficult situations. Messy play can be wonderful for initiating discussions with the child as an activity such as drawing or painting can often highlight any feelings – positive or negative – that the child may be experiencing. Furthermore, the child has created something personal to them, which they can keep. Some good examples of messy play are:

- painting with syringes
- sticking and cutting
- cornflour ‘gloop’ (mix cornflour (or custard powder) and water together, and add paint or glitter)
- play dough or salt dough (see Box*5.1)
- printing with paints.

Box*5.1: Simple dough recipes

Play-dough

1 cup flour (You can use the first cup/mug that comes to hand but use the same one for all the quantities require- a smaller cup will result in less play-dough)
1 cup salt
2 teaspoons cream of tartar
1 cup water
2 tablespoons oil
Food colouring (if desired)

Heat the oil in a saucepan. Add the other ingredients to the oil and cook, stirring throughout, for 3 minutes over a medium heat (or until consistency is like PlayDough™). Carefully tip the dough out of pan (it will be hot!!) and knead in the food colour if desired. (Colour may also be added initially, before cooking).

Salt dough
1 cup flour
[ ] cup salt
2 tablespoons cream of tartar
1 tablespoon oil
1 cup boiling water
Food colouring (if desired)

Mix and knead all the ingredients together. This dough is not sticky, does not dry out and does not require cooking.

NB: When using either of these doughs to be aware of the potential for cross infection. For health and safety reasons you should make separate dough for each patient or divide it up before play, and always discard it after use. However, if the same patient would like to continue playing with the dough later it can be stored in the fridge to stop it from drying quickly.

Imaginative play and role play

Examples of imaginative play are dressing up in healthcare staff costumes, playing with dolls and dolls houses, hospital toy sets and figurines such as PlayMobil™, train sets, puppets. Story telling also comes into this category.

Construction play

This includes any activity that involves building something. There are a variety of construction toys available including Duplo™, Lego™, StickleBricks™, Mobilo™, Octons™, Interstars™ and MegaBlocks™.

Physical play and physical activities

Many games and activities can be linked to the physiotherapy treatment. Hence it is valuable for healthcare professionals to first discuss the child’s needs with the physiotherapist where appropriate. Suitable games are throwing and catching a ball, kicking a ball, and making and throwing paper aeroplanes. Also use toys like balloon, sit-in cars, and dance mats.

Sensory play

This type of play can be especially beneficial to children with special needs or sensory impairments. This type of play might make use of musical instruments, fibre optic lights, bubble tubes, tactile toys, soap bubbles, ceiling mobiles, music CDs, story CDs and water play.

Interactive toys and games

These can often be useful as distraction toys because they actively involve children and take their focus away from their surroundings. Some ideas include board games, puzzles, computer games, cause-and-effect toys, and activity centres.

Therapeutic play techniques

“All staff concerned with children contributes to creating an environment which encourages children to play and supports parents. Play Specialists, unlike other staff, have as their major responsibility the social and emotional welfare of the child and family.”
These comments about the role of play specialists were made by the Play in Hospital Liaison Committee (Hogg, 1990). While the hospital play specialist will have gained a relevant qualification to develop his or her essential knowledge and skills required for the role, as professionals within a healthcare setting all should all be aware of the techniques available and the way in which they can be applied within their role.

Firstly, when approaching or interacting with any child there are a few essential things that should be considered at all times.

- Use appropriate language to the child’s age and understanding while taking into account the languages and words used by their parents or carers. Consistency enables healthcare professionals to build up a rapport (for example, a child may refer to a scar by using the word ‘zip’).
- A child will usually respond better if are approached at eye level.
- It is important not to forget body language and the use of hands to stress a point – essential to all forms of communication. Adults are aware of and respond to these communication cues, and this is no different with children.
- Remember that tone of voice is often as important as what is being said.
- The child or family may have specific needs, such as hearing or visual impairments. Children with special needs and those for whom English is a second language still benefit from explanations and attempts to communicate, whatever their level of understanding. Parents may benefit too. However, in such cases professionals need to be particularly aware of the language and tone of voice used to maximise the effectiveness.
- In hospital situations it is easy to overlook issues about general communication with children, although most of it is common sense.

There are ways that professionals can use play to make hospital experiences for sick children and their families more positive. The following information might help professionals put this into practice.

**Preparation**

The aims of preparation are to help the child to understand his or her illness and treatment, and to provide an opportunity to correct any misconceptions the child or family may have.

It is important to allow the child to express the whole range of feelings they may be experiencing through play activities. It can be very difficult to do this in a strange and unfamiliar environment. Preparatory play, therefore, aims to increase and improve the child’s ability to cope in the hospital setting. The process of preparation can return to the child the locus of control, by facilitating discussion of all options and allowing the child to participate and make his or her own choices. Examples of such choices are letting the child choose whether to have their medication as a liquid or tablets, or whether to have a local anaesthetic cream or cold spray for a blood test.

Preparation also gives staff the opportunity to build a rapport with the child and encourages trust which is crucial and of great benefit throughout the child’s time in hospital.

When there is little time available to prepare children it is vital that use is made of any information obtained from the parents or carers, who generally know the child better than anyone else. Such information can help in the selection of more appropriate techniques. A well-prepared child is less likely to suffer long-term psychological effects, which in turn will make any subsequent visits to hospital more positive. According to the National Association of Hospital Play Staff (NAHPS, 1987):

“Over the years, several controlled studies have been completed and they show that well-prepared children suffer less emotional trauma post-procedurally than children who have had no preparation.”

Using play to prepare a child is an effective way of gaining informed consent for the child and their parents or carers and siblings. This is of paramount importance before any procedure or treatment is carried out. The Department of Health (2003) describes the type of information that is required:
“Children, young people and parents need valid, relevant, accurate, up-to-date, easily accessible and well presented information, that is appropriate to their level of understanding, before they can decide whether to consent to, or refuse, treatment.”

Preparation can take many forms and it provides one form of support for a child going through the three stages of a planned admission. The three main stages are:

- the pre-admission period
- the admission
- the specific preparatory intervention.

Such preparation ensures that the child is well supported and informed throughout the experience as much as possible. Play preparation has many benefits but principally it may also contribute to a speedy recovery, and therefore can minimise the length of stay.

Encouraging children to attend a pre-admission group whenever this service is available is vital because it is a good opportunity for children and parents or carers to ask questions, to voice their concerns, to meet some of the staff, to visit relevant sites (theatres, recovery rooms) and to experiment with some of the equipment. Importantly it lays firm foundations for any subsequent preparatory techniques used.

Methods that might be selected in order to prepare a child for a procedure can be simple, such as spending a little time with the child and explaining the procedure in a suitably detailed yet age-appropriate manner, or showing the child the real tools and equipment used for the forthcoming procedure. Additionally this allows the child to meet the staff who will be involved, and this empowers the child by clarifying the choices open to them, enabling them to take part in deciding how things are done. Other useful techniques are looking at photograph books that show children who are experiencing the same procedure or situation, or reading story books about relevant life experiences, or role play with real equipment and dolls.

There are some important things to remember when preparing a child. Always try to implement the following principles.

- Be honest.
- Use appropriate and child-friendly language.
- Use the correct terms for equipment to avoid confusion.
- Stay calm and relaxed to instill confidence and reassure the child and family.
- Spend time with siblings whenever possible.
- Be aware that the child may not necessarily be fearful of the procedure itself but may be worried about the implications (with an intimate invasive procedure the child may be very embarrassed).
- Consider timing when undertaking preparation. For some young children doing this too early can exacerbate fears because they have a limited concept and understanding of time and so struggle to manage their fears in relation to this; but if done too late, when a child is already distressed, it may not be successful because stress impairs the ability to absorb information. Always be vigilant and look for non-verbal clues that the child is no longer paying attention.

**Needle play**

This carefully supervised play can be beneficial for children who have fears or phobias of needles; it can help to allay their fears considerably. The technique can be used for fear of other types of medical equipment.

It is important to remember that young children are animistic and confer life on inanimate objects. This is not surprising as many popular children’s television programmes feature machines that suddenly burst into life, a process known as personification. Many adults recall childhood fears of being swept into the vacuum cleaner or being sucked down the plug hole of the bath!

Some examples of needle play include the use of venesection dolls. These are specially designed to enable the child to ‘take blood’. Calico dolls can be personalised and used in a similar way. This form of play can be linked to desensitisation techniques.

There are four stages of needle play.
• **Stage*1: Assessment**—Discuss the benefits of needle play with parent or carers and the child. Allow the child and his or her parents or carers to decide whether they feel this would be beneficial, or appropriate. Explain that it often leads to a better understanding of the procedure and provides an opportunity for feelings to be discussed.

• **Stage*2: Preparation**—Warn the child about possible dangers of handling needles outside the needle play session. Demonstrate the procedure using appropriate equipment and visual aids. You need to ensure that you are well prepared for this and have all the correct information. Allow time for questions.

• **Stage*3: Procedure**—Follow the child through the procedure offering support and distraction therapy if this is what the child wants.

• **Stage*4: Post-procedure**—Give feedback to the child and praise their achievements, however minor. Discuss if further needle play sessions might be beneficial. It is important to recognise your limitations and involve other professionals if necessary (perhaps the psychologist).

For more information, see the National Association of Hospital Play Staff guideline on needle play (NAHPS, 2002).

**Post-procedural play**

This can take practically any form because one of its sole purposes after a procedure is to allow the child to evaluate the experience and make sense of what happened. It gives them the opportunity to discuss the parts of the procedure that went well and the parts that didn’t. It is important for revealing areas that could be improved should another intervention be required. Additionally, post-procedural play allows praising, rewarding and reinforcement of all the positive elements (Iles, 2007). Taking the time to do this can also enable staff to create a positive end to the experience, whether or not it was successful.

**Desensitisation**

Desensitisation can be a lengthy process in which the child is subjected to controlled exposure of an object or situation that they are afraid of. For example, it might begin by introducing a child to a butterfly needle in its wrapper, at the opposite side of the room, and may eventually progress to the child having the confidence to handle the butterfly needle directly. Obviously, this technique involves detailed planning and constant monitoring and must always be carried out under professional supervision. The technique is not always successful or appropriate, and so careful consideration is needed.

**Distraction therapy**

The primary aim of distraction is to take the child’s focus and attention away from the procedure itself. A wide variety of techniques and tools are used to do this. When distraction is successful it can help to form a temporary barrier between the child’s fearful mind and the physical experience of the procedure. This, in turn, can reduce any anxieties or perceptions of pain and take the child’s thoughts away from the emotional turmoil they may be feeling inside.

**Aspects to be considered**

- **Positioning**—Positioning depends hugely on the procedure and the specific circumstances, but there are always alternative positions, however small they may seem. For example, moving the pillow a little may mean the child is more comfortable, or moving the couch a little may allow one or both carers to be close and visible to the child.
- **Techniques**—All techniques must be age- and stage-appropriate
- **Timing**—Timing applies both to the distraction and to the medical staff. Good timing is essential, and it is important to ensure that staff members are aware of the situation and the plans which have been formulated. All the necessary equipment should ready and all staff well prepared for the procedure. Be ready as soon as the child says he or she is ready. It is also important to remember that children often get bored or lose interest quickly, so it is necessary to assess the situation constantly and adapt the distraction methods accordingly. If distraction
is commenced too early, the child’s focus may have been lost before the procedure has even begun.

- **Positive reinforcement**—All efforts of the child should be praised, no matter how small they may seem and whatever the outcome (eg. ‘Thank you for listening’ or ‘Well done for trying so hard’).
- **The people involved**—What does the child want? Who would be most supportive for the child? How many people are needed?

**Useful play activities and toys**

These play activities or toys are often useful for different groups.

**Babies and toddlers**

Multisensory toys, such as noisy musical toys, visually stimulating toys (mobiles and toys that light up or move), talking toys, bright ‘touch and feel’ books, and soap bubbles are really good for this age group.

**Young children**

Make use of children’s interests or hobbies. They can be easy sources of distraction for children who become very engrossed talking about something they really enjoy or that they have done. Interactive toys are often successful too because of the level of involvement required. Examples are pop-up toys, activity books, talking computers (like V-Tech[tm]), hand-held computer games, soap bubbles, story books and interactive books (such as the *Where’s Wally*[tm] books). Children in this age group usually have a vivid imagination that can be a useful tool and can prompt some interesting and distracting discussions. Use the distraction boxes made by Starlight Children’s Foundation whenever possible, particularly in emergency care situations. Such boxes contain all the play equipment needed for a distraction episode.

**Older children**

For this age group successful distraction can be found with interactive books (optical Illusions or the *Where’s Wally*[tm] series of books) and many kinds of games and activities (card games, counting games, telling jokes, playing ‘I spy’). Exploring the child’s interests and hobbies will also initiate discussions. Even if you know little about their interests, most children will be happy to educate you and will probably find your attempts to discuss them amusing!

**Teenagers and young adults**

Hand-held computer games are very good for this age group, as are videos, DVDs, music, and their own developed or practised coping techniques. In many instances a general chat about school or hobbies can make all the difference.

**Children with special needs**

For children with learning disabilities it is useful to elicit as much information from the parents or carers about their specific needs before considering any procedure. For example, if a child is visually impaired, try to be more vocal and also more aware of the tone of your voice. It is important for the nurse to know if the child can understand what is being communicated, even if the child finds it difficult to communicate or respond. Consider all five of the sense (sight, hearing, smell, touch, and taste). It is always a good idea to ask the child or their parents or carers about the kind of toys or activities they enjoy.

Remember that some children like to watch the procedure and take a more active role, even though this may not be a good idea. Whilst professionals can advise and help children to make a decision that will suit them best, the final decision is theirs. In a situation like this, whatever the outcome or the child’s response, it is often useful to approach things in a relaxed manner, offering lots of praise and reassurance. Explaining exactly what is happening in simple terms can help to reduce fear, and asking questions or finding a little light-hearted humour can help to relax children. Always involve the child in things, even if only a little.
When distracting children, even if the techniques don’t appear to be successful, the professional should still endeavour to continue. Changing the method or even just changing the approach a little may help. Either way, it’s not impossible to calm a child who appears to be distressed, so do keep trying!

Where possible, give parents or carers and other staff the confidence to distract the child if needed. Nominate just one person to be the distractor because too many distracters can have an undesirable effect. Empowering children with their own coping skills can ultimately help them to achieve independence and enable them to have more positive experiences in the future.

**Guided imagery**

Whitaker ([2003? See refs]) gives the following definition:

> “Guided imagery is a therapeutic technique that allows two people to communicate based on a reality that one of them has chosen to construe through a process of imaging.”

The choice of imagery is always the child’s and the adult should guide while being guided by the child’s own imagery. To practice this technique some training is recommended, but it can be used by play specialists, medical/nursing professionals and parent or carers alike. The technique can be effective and successful with any child as long as that child is capable of using their imagination. Imagery can be used with children in hospital as a coping technique, as well as a form of pain management. However, it should be used to compliment other traditional methods of pain control, not replace them.

Before attempting guided imagery, and after training, professionals should spend time with the child to build a rapport and learn a little more about them. They can begin with some basic relaxation (see below). However, as with any technique, this will not work or be appropriate for everybody. Each individual case will need to be reviewed in advance. It may not be suitable for children who have learning disabilities.

**Relaxation therapy**

A good way to begin relaxation therapy is with progressive muscle relaxation whereby regions of the body are relaxed in sequence, working from the toes, through the body, to the head and neck. Children sometimes find this quite difficult so it may help to encourage them to contract the chosen muscle initially. This focuses their attention on how it feels and enables them to then do the opposite, to relax the muscle. When the relaxation time is over, bring the child out of it slowly. Ask them to count backwards from 5, and to slowly open their eyes when they reach 1, for example.

Some therapeutic uses of both relaxation therapy and guided imagery are:

- to help control pain
- to control nausea and vomiting
- stress management.

As with guided imagery, relaxation can only be used as an adjuvant to control pain and not as a replacement.

Through the use of preparation, distraction and post-procedural play, the child can be encouraged to gain and practice their own coping skills. Irrespective of the play intervention selected, it cannot be overemphasised how important it is to assess the child’s individual needs and abilities as much as possible before attempting any preparation techniques.

However, hospital environments are unpredictable and when there is so much to consider not all attempts will be successful (and there is often an element of luck involved). The better informed the professional, the greater the degree of success. Measuring success in these play situations is not always straightforward, however. While evaluations of a play experience may be negative, there may actually have been a marked improvement compared to previous experiences. For some children, shouting can be an effective coping technique, so don't be discouraged.
How you can help the child in hospital?

Here are some ways you can help to make the child’s experience of hospital more positive:

- Involve a hospital play specialist as soon as possible.
- Start preparing the child at the earliest opportunity – it’s everybody’s job.
- Use age-appropriate language with the child.
- Be consistent with words the child and family may already use.
- Always be honest and encourage parents or carers to do the same.
- Don’t make promises you cannot keep (eg. ‘You won’t have to have a blood test’ ‘It won’t hurt’).
- Give praise and positive reinforcement.
- Work as part of a team (teamwork is essential).
- Communicate effective and appropriately.
- Be guided by the child.
- Don’t distract the child from the distracter (too much input will overwhelm and confuse him or her).
- Take time to play and interact with the child whenever time allows, to help build rapport and trust.
- Remember that parents are usually the experts.
- Remain relaxed and calm – the child may be easily affected by other people, which can affect his or her mood and responses.

References


Kingston Hospital NHS Trust *Hospital Play Specialists- A Professional Service since 1976* Hospital leaflet (undated)


National Association of Hospital Play Staff (2002) *Guidelines for Professional Practice No. 6: Needle Play*. NAHPS, Middlesex


Whitaker BH (XXXX) University of Ballarat, Victoria, Australia. *Distraction, is it this one?* Found via google?? Whitaker, B.H. (2003). “Distraction, relaxation and imagery as adjuvants to managing acute pain”, *Western Hospital, Department of Emergency Medicine. Continuing Medical Education Seminar, October 2003*. This was a course that i attended on 9th/10th and 24th of November 2006. The course was held at Weston House (Great Ormond Street Hospital for Children). The course was titled ‘Distraction Therapy and Guided Imagery’ and was presented by Whitaker BH (University of Ballarat, Victoria, Australia)
Useful websites

National Association of Hospital Play Staff
www.nahps.org.uk/

Starlight Children’s Foundation (for seriously and terminally ill children)
www.starlight.org.uk/

Distraction Therapy and Guided Imagery Course (Great Ormond Street Hospital Trust)
www.ich.ucl.ac.uk/education/short_courses/courses/distract/