The Child’s Experience of Single Room Isolation

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Aims of the session

- To explore the background to the study concept
- Review the literature
- Understand the underpinning methodology, methods and recruitment strategy
- Present and discuss the findings and themes in context of current practice
- Provide conclusions to the study
Study concept

• Clinical academic pathway
• Research question derived from rotational practice within remit of infection prevention
• Child at centre of question and way to answer clinical question
• Observed that children in isolation have a different experience
Literature Review

- Limited adult literature – coping, emotional response, social isolation, physical environment, PERSONAL Protective Equipment (PPE)

Paediatric literature review:


- **1990s** (1 study) Isolation deemed a stressor (Kronenberger et al, 1998)

- **2000-2017** (6 studies) separation, parental burden, PPE impairing relationships, desire to cheat on isolation rules (Chan et al, 2007; Koller et al, 2006; McKeever et al, 2002; Rotegard & Sykepleievitenskap, 2007; Russo et al, 2006; Wu et al, 2005)
Study question

What is the child’s experience of single room isolation whilst in hospital?
Methodology

• Child centred methodology
• Social construction (Guba & Lincoln, 2005)
• Narrative inquiry (Engel, 1999; Kohler-Riessman, 1993, Labov, 1972)
Setting

- Regional hospital with 10 paediatric wards
- Regional specialist centre for a number of specialities
Sampling

Purposive sampling:

• Children aged 6-17 years
• Parents of children who were isolated
• Clinical practitioners working with children in isolation
Data Collection Methods

• Video diary methods (2 participants)
• Retrospective interviews (semi-structured)
Recruitment

Prospective and retrospective

- Children n=8
- Parents n=12
- Staff n=21

All participants were asked to provide insight into the CHILD’S experience
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Diagnosis</th>
<th>Type of Isolation</th>
<th>Length of Isolation</th>
<th>Previous Isolation Experience</th>
<th>Who participated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lara</td>
<td>12</td>
<td>Pulmonary Ciliary Dyskinesia</td>
<td>Protective/Source</td>
<td>2 weeks</td>
<td>Hospitalised once before: 1 week in isolation</td>
<td>Lara</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(in video diary and no follow up interview)</td>
<td></td>
</tr>
<tr>
<td>Simon</td>
<td>16</td>
<td>Spinal Tuberculosis</td>
<td>Initially in source isolation with suspected respiratory tuberculosis</td>
<td>2 weeks</td>
<td>No experience of hospitalisation or isolation</td>
<td>Simon</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(in video diary and follow up interview)</td>
<td></td>
</tr>
<tr>
<td>Harriet</td>
<td>6</td>
<td>Haemolytic Uraemic Syndrome, presumed Ecoli</td>
<td>Source</td>
<td>7 days</td>
<td>No experience of hospitalisation or isolation</td>
<td>Harriet and Mum</td>
</tr>
<tr>
<td>Eloise</td>
<td>17</td>
<td>Infective diarrhoea (Crohn’s Disease)</td>
<td>Protective</td>
<td>2 days</td>
<td>Hospitalised once before: nursed in a bay for 2 days</td>
<td>Eloise and Mum</td>
</tr>
<tr>
<td>Imogen</td>
<td>9</td>
<td>Acute Myeloid Leukaemia</td>
<td>Source and protective at different times in three different hospitals</td>
<td>Multiple admissions to isolation, longest 6 weeks</td>
<td>Hospitalised intermittently since diagnosis 9 months ago: protective isolation during bone marrow transplant, source isolation for RSV, protective isolation when on shared care ward and on main bay on oncology ward.</td>
<td>Imogen and Mum</td>
</tr>
<tr>
<td>John</td>
<td>6</td>
<td>Cystic Fibrosis</td>
<td>Source and protective</td>
<td>10 days</td>
<td>One previous admission at 6 months of age to protective isolation</td>
<td>Mum</td>
</tr>
<tr>
<td>Erica</td>
<td>8 months</td>
<td>Mitochondrial Disorder, haemorrhagic hydrocephalus with VP shunt, hypertrophic cardiomyopathy, hypothyroidism, obstructive sleep apnoea and gastroesophageal reflux. RSV</td>
<td>Source</td>
<td>First 5 months of life in hospital in main bays between three different hospitals. Subsequently has been admitted 5 times to 4 different wards, for up to 3 weeks; of these 3 times were in isolation up to 2 weeks at a time.</td>
<td>Experience of main ward in 3 hospitals and experience of isolation on different wards</td>
<td>Mum</td>
</tr>
<tr>
<td>James</td>
<td>7</td>
<td>Cystic Fibrosis and pseudomonas</td>
<td>Source and protective</td>
<td>7 days</td>
<td>4 previous episodes of hospitalisation; all in isolation</td>
<td>James and Mum</td>
</tr>
<tr>
<td>Jessica</td>
<td>14 months</td>
<td>Bronchiolitis RSV</td>
<td>Source</td>
<td>4 days</td>
<td>3 previous episodes of hospitalisation – in isolation and main bay when cohorted with other children with RSV.</td>
<td>Mum</td>
</tr>
<tr>
<td>Rachel</td>
<td>2</td>
<td>EBV Encephalitis</td>
<td>Source</td>
<td>5 days</td>
<td>One previous experience of hospitalisation in isolation for 8 days</td>
<td>Mum</td>
</tr>
<tr>
<td>Freddie</td>
<td>2</td>
<td>Hand, foot and mouth – Enterovirus</td>
<td>Source</td>
<td>8 days</td>
<td>No previous experience of hospitalisation or isolation</td>
<td>Mum and Dad</td>
</tr>
<tr>
<td>Nicholas</td>
<td>12</td>
<td>C Difficile Crohns</td>
<td>Source</td>
<td>2 days</td>
<td>1 previous experience of hospitalisation on main ward</td>
<td>Nicholas and Mum</td>
</tr>
<tr>
<td>Sophie</td>
<td>14</td>
<td>Cellulitis, Impetigo – Staphylococcus Aureus</td>
<td>Source</td>
<td>5 days</td>
<td>No previous hospitalisation or isolation experience</td>
<td>Sophie and Mum</td>
</tr>
</tbody>
</table>
Data Analysis Methods

Narrative analysis approach (Kohler-Riessman, 1993):

- Attending to the story
- Telling the story
- Transcribing the story
- Analysing the story

Codes from each participant/family, categorised to themes
Themes

- Coping
- Control
- Community/separation
Coping

- Children – distraction, explanation of isolation, parental presence

- Parents – distraction, familiarity, guilt on leaving/burden of staying

- Staff – preparation, lack of stimulation made the situation more challenging, familiarisation with hospital/ward made it easier for families
Control

- Children – Need for time out of isolation, resignation to fate of being in isolation

- Parents – Resignation to isolation precautions, parental/nursing blur role, familiarity with the ward altered how in control the family felt,

- Staff – Parents can continue “normal life”, staff concerns about safety, reliance on parents, guilt, inconsistent isolation “rules”
Community

- Children – “missing out”

- Parents – separation from family, lack of peer/staff support, stigma

- Staff – families miss out on community, separation from ward activities, stigma associated with being in isolation
Discussion

- Different perspectives produce different findings and cross over of findings
- Sample size and heterogeneity
- Length of time for data collection
- Clinical academic role
- Need for child at centre of the study
- Child centred methods – recruitment and benefit
- Clinical question and impact on practice
Conclusions

- Psychosocial care in isolation for the child and family must be considered/prioritised in care
- Care ratio numbers must be considered for children in isolation
- Need for consistency in terms of isolation precautions
- Need for candour when in isolation
- Further research is essential
- Use of the child’s perspective is essential in paediatric specific research and child-specific research methods
References


References


Acknowledgements

FLORENCE NIGHTINGALE FOUNDATION RESEARCH SCHOLARSHIP 2012-2013
HELEN RUSHFORTH AND JACQUI PRIETO- EDUCATIONAL SUPERVISORS,
UNIVERSITY OF SOUTHAMPTON
UNIVERSITY OF SOUTHAMPTON CLINICAL ACADEMIC CAREER PATHWAY
ALL THE PARTICIPANTS WITHOUT WHOM THIS STUDY WOULD NOT HAVE BEEN POSSIBLE

Acknowledgements
Any questions?

THANK YOU FOR LISTENING