The Journal is edited and compiled by hospital play specialists and is published twice yearly. It exists to disseminate developments in the field of hospital play and to support hospital play specialists by providing information, contacts and ideas. We welcome unsolicited articles, news, photographs, illustrations etc. Publication in The Journal does not imply that the Editor or NAHPS agree with, or endorse the ideas expressed. The Editor reserves the right to adjust submitted material in close consultation with the publications committee. Reproductions of any material, in whole or in part must be accompanied by acknowledgement of source. Back issues and advertising rates are available on request. Acceptance of advertisements does not constitute endorsement of the products by NAHPS.

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Hi and welcome to the 43 edition of the Journal. This edition has gone out later than normal due to the distribution of the newsletter, which thanks to Angela White went out last month.

The theme for this edition is working/communicating with adolescents and I hope you’ll find useful and interesting articles on pages 10-22. My apologies go to Lorna Galbraith and Janette Turnbull, Play Specialists, Royal Hospital for Sick Children, Edinburgh for the errors caused in their article on transition in the last edition. This was due to technical problems which I’m glad to report have now been resolved. I’ve resubmitted their article which can be found on pages 14-15.

It’s an exciting time for the Play world with much work going towards the progression of our profession in the shaping of the new Hospital Play Specialist course and possibility of it becoming a foundation course and the work towards the application to the Health Professional council (HPC). In the coming months there will be a national survey sent out to you all to help collate the information required for the HPC application so please look out for this and make sure you send your answers back. More information on these two topics can be read on pages 5 and 6.

Thank you to all who have sent in articles. The next edition will come out in the Autumn with a planned theme of working in Theatres. The closing date for articles is Sept 14th. 

Sue Ware

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Commercial advertising in THE JOURNAL and inclusion of flyers and catalogues, 2008 rates:

**Catalogue/flyer:** £75 (If enclosed items increase mailing costs, the additional postage will also be charged.)

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For further information please contact: Sue Pallot
e-mail: suepallot@katrine.fsworld.co.uk
Welcome to the Spring edition of the Journal.

The National Executive Committee hopes you enjoy catching up with each others news and events from around the UK and will use this publication to develop valuable networking opportunities, so please keep your articles coming.

Thank you to those who sent us positive feedback from the Hugh Jolly Memorial Lecture in November. The afternoon workshop was led by Tony Lee, a psychoanalyst, who focused on communication and autism and the evening lecture was given by our former chair, Judy Walker who inspired us to take play into the 21st century. The evening was rounded off by awarding the Eve Latimer prize to Carolyn Horsfield, HPS student at Stanmore College. The NEC is considering presenting this special award to a registered HPS who has made innovative achievements in their professional practice. Please let us know what you think about this idea.

Your Association continues to send representatives to various organisations in order to ensure that play is recognised and integrated into paediatric care and this includes: The UK Committee on Children and Young People’s Nursing, The RCN guidelines on The Recognition and Assessment of Acute Pain in Children, Action for Sick Children - Voices of Children Project and the Health Professions Council working party.

It was disappointing to have to take the decision to cancel the managers'/seniors’ study day due to a lack of interest but we hope you will support the next Managers’ day on 24th April, the AGM and National Conference in July and the Hugh Jolly lecture on 22nd October. The future events committee have carefully planned these events to enhance our professional development so please put the dates in your diary now.

This coming year promises to be a busy one as NAHPS continues to work alongside HPSET in progressing the next stage of our training programme and, following a thorough consultation process with members of the profession, we hope the result will be a new course which is fit for purpose and at the appropriate academic level reflecting the skilled work of the HPS. As is the case with all education programmes, the need for change is often multi faceted and this is certainly the case for our profession. NAHPS members and registered HPS will continue to be updated throughout this process.
With the current programme of study coming to a natural end in April 2009, The Trustee’s main focus of activities this year has been to progress a new programme of study.

Issues from students, registrants and colleges over the last five years were used to inform the brief to develop a new programme of study. The brief being that the programme must be fit for purpose, accessible and financially sustainable.

In January a workshop involving Trustees, Programme Tutors and Community Hospital Play Specialists worked through the pro’s and con’s of the current programme and explored alternative models of delivery.

A small working party had further discussions over the months to refine the early findings into a realistic plan. In August a consultation document was ready for circulation and by November the results were published on our website.

It was encouraging that respondents indicated a change from a vocational programme to a Foundation Degree thereby increasing the academic level and the length of training. There was an overwhelming response for the Hospital Play Specialist to retain the 50% input in the training of students but the most surprising element in the results was that there was an infinitesimal requirement for distance learning.

We were delighted to have an official affiliation with the University of Shiruoka, Japan and Professor Chika Matsudaira. Specialist training for the Hospital Play Specialist Japan is already making an impact on the children in hospital and students from Japan have visited the UK to observe the best practise available. In late Spring we welcomed a contingency of professionals from Switzerland and Germany who had two days of intensive workshops and demonstrations in the Children’s Hospital at the University Hospitals of Leicester. Their mission was to observe the Hospital Play Specialist at work and to understand the difference that the HPS makes to the clinical outcome of children and young people with long term complex needs or to the emergency admission.

Subsequently two post graduate students visited to undertake research which will be used to benchmark the clinical outcomes in hospitals that have play staff against those in Europe that do not.

Registration and re-registration has continued at regular intervals throughout the year. This year it was heartening to have an upsurge of re-registrants and a general improvement in the standard of profiles returned.

It is only with the support of a dedicated administrator, committed Trustees and our volunteer web master that our organisation is able to continue with the level of work required to maintain a professional register, uphold standards of training and remain solvent in this period of economic downturn.

The year ahead will be one of continuous activity as Trustees will be working up the details of a Foundation Degree for Hospital Play Specialists. Plans of future work for the Trustees will be agreed and the ongoing work required for entry onto the Health Professions Council register will continue.

The Working Party has been meeting regularly over the last two years and prior to this, had met for some years. However, due to the lengthy process involved in documentation and a change in staffing from all areas, the previous working party had taken a well earned break from their duties. Nonetheless our newly formed working party began by asking what the benefits of HPC membership would be to our profession and it appears that this has not changed much from earlier rationale:

We believe it is essential to protect the public from unregistered and therefore unregulated practitioners along with the need to protect our professional title. The latter reason has probably gained more attention since the publication of the National Service Framework for Children and Young People which discusses at length the need for children to have regular access to a hospital play specialist. However, we are aware that there are hospitals recruiting to the post of hospital play specialist but not requiring the qualification to fulfil the name of the post.

Therefore, let us go back to our initial question – how is the public being protected against someone who is carrying out the work of a hospital play specialist but does not have the academic credentials? This practice devalues our work and professionalism.

The Health Profession’s Council initially assess an organisation’s eligibility to join by considering the following points:

- Invasive procedures
- Clinical intervention with the potential for harm
- Exercise of judgment by unsupervised professionals which can substantially impact on patient health or welfare

The points we intend to consider in response to these criteria include the vulnerability of the child/family when in the hospital setting. Risks associated with not having properly trained individuals when using preparation and distraction. With communication (or lack of it) being a major risk factor in assessment and management of treatment.

HPSET continue work on establishing a procedure for de-registration however, a disciplinary process needs to be linked with the code of professional conduct and ethics which is an essential and complex piece of work needing to be undertaken in order to progress our application. In addition to this, a proforma is being prepared to capture evidence required by the HPC.

At a meeting held at the HPC head office it became clear that the element of risk to the public is a key issue and the questions we need to consider in relation to this includes:

- Entry to the profession, including direct entry
- Ascertaining the % of direct entrants that are not registered with HPSET
- Demonstrate differences between Hospital Play Specialists and Play Therapists.
- Demonstrate the recruitment practice of a range of employers in relation to what they advertise for
- Supporting evidence to provide examples of cases of a disciplinary/dismissal nature

A National Survey will be conducted to help us establish an up to date picture of what is happening across the UK – the last survey took place in 2000.

Norma Jun-tai.
News from the South West

Our group continues to grow with new faces attending our September Study day hosted by the Frenchay Play team in Bristol. We welcome Dr Sue Dolby, Consultant Clinical Psychologist from Bristol Children’s Hospital and Dr Araminta Hull, Clinical Psychologist from the Haematology and Oncology Centre at the same hospital. The subject was:

“An Introduction to Visualisation and Guided Imagery”.

This is a powerful tool - Handle with care! The aims of the session were to provide a brief introduction to and taster of visualisation and guided imagery and to look at why, when and how these might be applied in clinical practice in order to raise awareness of something that could be developed and become part of our practice. The session involved role play and the information was well received by the members. Both Sue and Araminta made the morning a thoroughly worthwhile session giving us something small to take away and try – with care!

Sue Dolby works very closely with play specialists in her role and values greatly the work we do. The group is most grateful for their time.

Gill Caddy, Senior Play Specialist from the Royal Cornwall Hospital in Truro then gave us feedback from your experience at the Pacific Rim Conference in Auckland, New Zealand where she was a keynote speaker. We are proud of Gills’ achievements and the conference sounded like a wonderful experience as did her holiday in the beautiful county of New Zealand.

It was then onto business and plenty of time to debate the HPSET questionnaire. Members voiced their opinions on the way forward for our academic qualification and the future of our profession. Jo James our NAHPS executive committee member was then able to feedback to Norma.

We are also delighted that our member, Helen King, Senior Play Specialist at Birmingham Children’s Hospital is also presenting at an international conference in Gdansk, Poland at the European Paediatric Burns Congress. Helen’s subjects are “School Re – Integration” and “Therapy Led Discharge Clinics”.

Fran Greenaway, Play Specialist from North Devon District Hospital has together with colleagues from the MDT organised what sounds like a interesting and informative study workshop to be presented by Dr Bernie Whitaker who is a Pain Specialist with the Pain Team at Great Ormond Street. The day has been being accredited by the RCN. It’s aimed at a range of health professionals working with children and adults who face painful procedures or who need help with management of chronic pain. Fran said “We have invited him to do three individual study days based in Barnstaple, with a number of staff from different areas i.e. Fracture Clinic, A+E, Theatres, Pain Team as well as a several nurses and SHO's from our paediatric department. We are hoping to raise awareness amongst fellow colleagues and give a wider understanding of the techniques”
We wish Fran well with the day and look forward to feedback.
Our meetings for 2009 are as follows:
**28th March 2009** (note date change) – Musgrove Park Hospital – Play Therapy
**June 2009** (Date to be confirmed) – The Royal United Hospital Bath
**Sept/Oct 2009** – Bristol Children’s Hospital
( To be confirmed)

If you wish to know more about our study days for this year please contact us.
We always welcome new members from further a field or maybe you might need to contact one of you or would like a copy of our member’s database.
**Please contact Suzanne Heayns on suzanne.heayns@tst.nhs.uk for more information. Or ring on 01823 344957.**

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**NAHPS (Wales) Study Day 2008**

We held our fifth Anne Watkins memorial study day on Saturday 27th September. The speakers were Jane Hawkshaw talking about Play Wales and Joanne Jones who spoke about her job as Play Development Officer for the Vale of Glamorgan, her role is to develop inclusive play opportunities for all children aged 5-14 years of age. This includes play schemes and community based projects. Play Wales or Chwarae Cymru, is a national organisation funded by the Welsh Assembly to provide advice, support and guidance and upholds the children’s rights to play by providing quality play provision in their own communities. Jane explained how children use their environment to support their play, using a variety of materials, making choices and taking risks.

In the afternoon session we had a chance to play. We used our senses and got down to basics. We were blindfolded or given thick gloves to wear and had to hold and examine familiar objects using our remaining senses. We also had some "smelly" jars containing everyday smells and we had to identify them.

The session was very worthwhile as we all spend a great part of our days providing opportunities for play but have little chance to play ourselves. **Ann Jones HPS Swansea**

We held our AGM on January 24th in UHW Cardiff. It was lovely to welcome back members and see quite a few new faces. The group was updated on the NEC and what they are working on at present on our behalf.

The Welsh Branch of NAHPS will be coordinating Play in Hospital 2010. This was discussed in depth at our AGM where a Play in hospital committee was set up. There was an excellent response to ideas for posters and items to go into the mailings. Play in hospital week will be an ideal opportunity for us to show exactly what we do as a profession. If there are any members in Wales that want to be involved, then please email me with your contact details. I know some hospitals have been contacted already but we don't want to leave anyone out.

Our future meeting will be held on:
**Saturday March 28th** at Neville Hall Hospital, Abergavenny
**Saturday June 20th** at Glangwili Hospital, Carmarthen
**Saturday September 28th** - This is our Anne Watkins memorial Study Day. Held at Singleton Hospital, Swansea.

The study day will be taken by Hirstwood Training. They will cover multi-sensory training. Please contact me if you need further details.

Our meetings start at 10.30am. Please contact me if you want to know any more about these meetings.
**Afternoon Workshop and Hugh Jolly Memorial Lecture**

Weston House, Great Ormond Street, London.

**Workshop**

What does it take to relate? The case of Autism

The afternoon workshop was presented this year by Dr Anthony Lee, Child and Adolescent Psychotherapist BSc M.Psych Psych PhD. Tony held the delegates’ attention for the entire afternoon. We could have listened for longer but the pressure of his work load meant he had to leave us. His presentation provoked lots of questions and his style of delivery enabled delegates to take time to really think, to explore different angles and understand new and interesting perspectives. Lively dialogue amongst the delegates and questions to him showed both what we already knew and most importantly highlighted how much there is to learn about children who fall under the Autistic Spectrum.

**Hugh Jolly Memorial Lecture**

Bring hospital play into the 21st Century: perspective on leadership and learning.

We welcomed Judy Walker BH (Hons) HPSET Play Service Manager, University College Hospital NHS Trust to present the lecture and, as always, she was well rehearsed and informative despite finding at the last minute that an equipment failure left her without her power point presentation. Judy referred back to her early forays into Hospital Play and reflected on how far Play in Hospital has come but also gave pointers for the way forward. She stressed the importance of documentation, audit and personal and professional development as a means of presenting ourselves as a professional body that has an important part to play in the lives of sick children and within the professions that form the NHS.

**Angela White**
Outpatient Play Manager
Addenbrooks

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The National Executive Committee of NAHPS is looking for a volunteer to join the committee as Treasurer.

**Responsibilities to include:**

- Receiving and banking of monies.
- Writing cheques and acting as a signatory of the bank account.
- Keeping records of income and expenditure and reporting to the NEC.
- Preparation of annual budgets.
- Preparation of draft annual accounts for submission to the independent assessors.
- Ensuring NAHPS complies with the Charity Commission’s regulations.

The NEC meets in London five times a year and it is anticipated that the Treasurer would attend some or all of these meetings (Travel expenses paid)

Ideally the Treasurer will have experience of bookkeeping/accounting. Could suit a retired accountant. Work estimated at 2-4 hours per month (averaged over the year) although this varies depending on the time of year and there will be some weeks where no input is required. Work can be fitted around other commitments.

**If you know someone who might be interested please contact Sue Pallot at suepallot@katrine.fsworld.co.uk for further details**
# Developmental tasks of adolescence

When working, understanding and communicating with adolescents it’s important to have knowledge of their developmental progress, just as it is with Younger children.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Biological</th>
<th>Psychological</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Adolescence:</td>
<td>Early puberty (girls: breast bud and pubic hair development, start of growth spurt; boys: testicular enlargement, start of genital growth)</td>
<td>Concrete thinking but early moral concepts; progression of sexual identity development (sexual orientation); possible homosexual peer interest; reassessment of body Image.</td>
<td>Emotional separation from parents; start of strong peer identification; early exploratory behaviours (smoking, violence)</td>
</tr>
<tr>
<td>Mid Adolescence:</td>
<td>Girls: mid-late puberty and end of growth spurt; menarche; development of female body shape with fat deposition Boys: mid-puberty, spermarche and nocturnal emissions; voice breaks; start of growth spurt</td>
<td>Abstract thinking, but self still seen as &quot;bullet proof&quot;; growing verbal abilities; identification of law with morality; start of fervent ideology (religious, political)</td>
<td>Emotional separation from parents; strong peer identification; increased health risk (smoking, alcohol, etc); heterosexual peer interest; early vocational plans</td>
</tr>
<tr>
<td>Late Adolescence</td>
<td>Boys: end of puberty; continued increase in muscle bulk and body hair</td>
<td>Complex abstract thinking; identification of difference between law and morality; increased impulse control; further development of personal identity; further development or rejection of religious and political ideology</td>
<td>Development of social autonomy; intimate relationships; development of vocational capability and financial independence</td>
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Communicating with young people

Communicating effectively with adolescents requires both an interest in working with young people and a set of skills that can be learned along the way. Many health professionals do not like communicating with adolescents, as the stereotypical view of this age group is one of uncommunicative individuals unwilling to engage in communication with adults. Looking at this from a different perspective, communicating with adolescents can be exciting and rewarding and provide opportunities for engagement and health promotion at this dynamic stage in a young person’s life.

**Here are some tips for more effective communication with young people.**

Start by assuring confidentiality in any communication with a young person explaining what this means and when you might need to talk to another professional or a parent about a concerning issue that the young person communicates to you. Let the young person know that it is fine to share as much, or as little, as they wish to communicate. Be clear about follow-up and future communication. If the young person knows that there is another opportunity for communication or that this is an ongoing process, they may choose to share information at a different pace.

Try to see young people by themselves, as well as with their parents. There are many things that young people may not discuss with a parent present – like relationship issues, sexual health, drug or alcohol use. And other issues that they may want their parent to be present for – medication and treatment changes are two examples where adolescents often prefer a parent to be present. Offering opportunities for young people to be seen alone, or with a family member or a peer present, gives the young person a choice and some control over how communication happens.

Ask – don’t assume! In any communication with a young person, a good place to begin is by asking what the young person hopes to gain from the interaction. Do they want to be seen in the clinic? What hopes – and fears – do they bring to the communication? What information are they hoping to leave with? Do they want to be seen alone or with a friend or parent?

Be yourself. One thing that young people tell us is that they do not like to speak to adults who try to be cool or pretend to be what they are not. Being yourself includes being honest when you do not know the answer to a question. It is better to let a young person know that you do not have all the answers, but are willing to either find or signpost them to some answers. Signposting them to answers can also help to empower the young person and help them to find their own answers.

Use appropriate language – think about the age and stage of development of the young person you are communicating with, and try to use language that is as age appropriate as possible. Find out what the young person already knows and ask what they are hoping to gain through the communication. This can help the interaction get off to a good start.

Using an interview tool like the HEADSS can be useful and provide a framework for effective communication. This provides a range of questions centring around: Home – asking about a young person’s home life is usually a neutral place to start; Education / Employment – asking about this can give you
an idea of how a young person is spending their time and also of how they are doing in terms of academic or financial progress;; Activities including sports – asking about what type of activities a young person is engaged in gives an idea about what interests them and whether they prefer to do things alone, with friends or with family members, also whether they are sporty or prefer other types of activities; Drug use, including cigarettes and alcohol, and other drug usage can provide insight and provide an opportunity for health promotion as appropriate; Sex – this includes asking about relationships and provides an opportunity to talk about contraception; Suicide- talking about mood is an important part of communication with a young person and should be include asking about self-harm and suicide whenever you are concerned about the way a young person is presenting or about what they are telling you.

Great Ormond Street Hospital run regular in-house training on working with adolescents and topics include: communicating with adolescents; working with adolescents with complex needs; and transition to adult care. We are also linked to an e-learning Adolescent Health Programme which is in the process of being rolled out and is due to be more widely available in the near future. One of the modules included in this programme is ‘Communication and Consultation with Young People’ – watch this space!

Anna Gregorowski
Nurse Consultant – Adolescent Health

Youth Link: adolescent drop-in advisory service.

Sue Ware, Head of Play Services/Youth Worker and Nigel Mills, Clinical Nurse Specialist for Adolescents

The drive for this service came from our Trust’s objectives to promote adolescent services as a whole, with particular focus on the development of peer support, transition and sexual health services.

The aim of the service is to:
- Offer young people a ‘one stop shop’ where they can use recreational facilities, interact with other young people and access a wide range of information, advice and support in a relaxed, adolescent friendly environment.
- Provide dedicated space for young people, who can be underrepresented in terms of décor and health promotion within many specialist ‘child focussed’ centres.

The service facilitates key areas of adolescent development that are necessary in order for a young person to be able to gain independence and function within adult health services. This has been identified as a pre-requisite to a successful transition in national guidelines on transition (DH 2006 – transition: getting it right for young people). This will be conducive to the ‘transition skills checklist’ that is available for staff across GOSH to use as part of the trust’s overall transition process. Additionally, the service will provide a resource for staff using the ‘transition care pathway’ to refer young people for advice in areas such as sexual health. Reflecting the transition competency framework set out by the RCN, the service will incorporate:

- Self advocacy
- Independent health care behaviour
• Sexual health
• Psycho-social support
• Educational and vocational planning
• Health and lifestyle

Self-advocacy will be promoted by the provision of patient information on rights and responsibilities, transition, consent, confidentiality, health information and advocacy resources. Advice or tips on how to ask questions during appointments or ward rounds and how to choose key workers can be given. Also encouragement with thinking about their future and what they want from their health care team. Things like speaking to staff without parents being present and accessing services such as PALS can be discussed.

Independent health care behaviour will be promoted through encouragement to keep themselves informed of their own health condition and needs, knowing what medications they use, what they are for and how to access more. Encouraging them to keep essential phone numbers in their mobiles, such as GP, CNS, physiotherapists, consultant secretary, NHS direct etc. Advice on how to make their own appointments, how to access a GP, where their nearest A&E is, what to do & who to contact in an emergency will also be given. Patients will be encouraged to learn how to participate in or administer their own treatments. Advice on travelling to hospital independently or with friends can be given.

The need to improve sexual health services for young people was a major drive for the service. The literature on youth access to sexual health services highlights the need for confidential, friendly and anonymous advice on sexual health. Young people will be able to come to the drop in service for sexual health advice without peers, family or other members their enquiry. Sexual health will be promoted through the availability of information on contraception, prevention of infection and family planning. This will link in with national drives to reduce teenage pregnancy and chlamydia rates. Confidential advice will be available, as well as signposting or referral to appropriate resources. Encouragement can be given to speak to individual healthcare teams regarding the impact of specific conditions on sexual development, family planning, genetic counselling, and interactions between medications and contraception. This aspect of the service will be lead by the Adolescent CNS, who has completed contraception and sexual health promotion training.

Psychosocial support will be promoted through the availability of information about support groups and charities. The development of a chronic illness peer support programme will be a key part of the service, alongside the development of youth group. Advice and support on aspects such as coping with illness or altered body image, how to access appropriate counselling, psychology or mental health services will also be available.

Health and lifestyle will be promoted through the availability of information and educational materials on matters such as the impact of alcohol and drug use on their condition, plus guidance on maintaining a health lifestyle.

The Adolescent CNS (Nigel Mills) and Youth Worker (Sue Ware) take the lead for running and auditing the service. Consultation with the Adolescent Advisory Group, specialist adolescent units, speciality teams and young people will also inform the content and delivery of the service.

Great Ormond Street Hospital
Transition
Lorna Galbraith and Janette Turnbull
Play Specialists
Royal Hospital for Sick Children, Edinburgh.

“The purposeful, planned movement of adolescents and young people with chronic and medical conditions from child-centred to adult orientated health care systems”. Blum et al 1993.

We are hospital play specialists working in medical wards at the children’s hospital in Edinburgh. Over the years we have developed trusting relationships with the Cystic Fibrosis children and their families who attend the ward regularly for their treatment. We became increasingly aware that there was a lack of support at ward level during their transition to the adult services.

As suggested by Department of Health (1995) and the Cystic Fibrosis Trust (2006) adolescent/young people are aged between 10-18 years and should be in the discussion stages or in the process of attending transition clinics.

Blum et al 1993 suggests that delaying transition and lack of planning and preparation may cause developmental problems leading to adolescents/young people becoming dependant on care rather than taking responsibility. We are in agreement, as based on our own observation, we found some adolescent/young people became withdrawn, do not comply with treatment and voice opinions about not going or attending adult hospitals. The Royal College of Nursing (2004) and the CF Trust (2006) talk about the involvements of key-workers during transition and suggest key-workers ideally should be someone from the Paediatric team whom the adolescent/young person has a trusting relationship with. In our opinion this should be encouraged and the adolescent/young person has the right to choose their own key-worker. Based on our own experience this is often the Play Specialist.

Following further reading and research, our concerns for lack of support at ward level were discussed and we became involved with the cystic fibrosis team. We attended psychosocial meetings where our concerns, ideas and support for adolescent/young people and their families were taken on board and resulted in ourselves becoming fully involved in the smooth operation of the transition process.

Nuttall Nicholes (1992) states that: “Adolescents like health care professionals to care, listen and use language they understand”. As Play Specialists we did this, and so set about improving the transition process.

Working in partnership with adolescents/young people’s contracts and timetables were successfully introduced at ward level. A visit to Western General Hospital Edinburgh followed, where discussions and information was shared with adult services (Nursing and CF staff). Photographs were taken of the area and staff where the adolescents/young people would transition to. All other useful information was collected, i.e. ward information, visiting times, menu sheets, adolescent information leaflets, free diary to keep track of transition clinics, appointments and other important details. All this information was put together in a preparation folder. Also included was information informing the young person of a day out with the Play Specialist that would include a visit to the adult services.

Adolescent/young people’s quotes RHSC Edinburgh 2006
“The contract worked well as it allowed free time to leave the ward".

Adolescent/young people’s quotes RHSC Edinburgh 2006
“The contract worked well as it allowed free time to leave the ward".
“It was good to go out with the Play Specialist as this made me feel more confident when we visited the Western”.

“It was good to meet the CF Consultant and nurse as they were helpful and made me feel welcome; I am now feeling comfortable about the move”.

**Conclusion:**
The adolescents/ young people had been involved, and had been given the appropriate information, and knowledge required to help them feel confident about the transition. The paediatric team were left feeling they had supported and not let down the adolescents/ young person. Adult services were ready to receive the adolescent/ young person and had begun to build relationships with them. As Play Specialists we achieved our aim making as suggested by all the previously mentioned authors transition into a positive experience for adolescent/ young person, paediatric and adult multidisciplinary team.

A power point presentation on transition was prepared by ourselves and has been delivered to hospital play specialist students and at the Network Scotland play co-ordinators meeting.

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**Royal College of Nursing 2002,** Caring For Young People: Guidance For Nursing Staff.

The role of the Hospital Play specialist working with young people dealing with the effects of cancer.

I am currently a Play Specialist on a Haematology- Oncology Ward at the Royal Hospital for Sick Children, Edinburgh. My role will be very similar to many Play Specialists within this field. My daily routine consists of providing age appropriate play, preparing newly diagnosed patients for Hickman lines or port-acaths. I am also involved in preparing children for Radiotherapy masks and treatment.
I provide distraction for unpleasant procedures and work alongside the Multi Disciplinary Team. I work closely with the Families and siblings and build up a relationship and give support where needed. I also hold annual sibling days to enable the brothers and sisters to have a greater understanding of the treatment required.

My role is very varied and in addition to the above I have a special interest in the young people who attend our ward. I, along with the Nurse Specialist and other members of the Multi Disciplinary Team, are involved in taking them for weekends away (insert photograph 1 – Some of the young people from Edinburgh playing rounder’s) and to the annual Find your Sense of Tumour Conference.

My love for the job is hopefully apparent to all the families on the Ward. My special interests are working with the young people. The Teenage Outreach Nurse, Gill Harley and I work closely together. We run a young person’s group once a month on a Monday evening. We hold the group at a variety of venues that include ten pin bowling, meals out, pampering evenings. (insert photograph 2 – an example of a pampering evening).We have a good response considering that we don’t have a Young Persons Unit in Edinburgh. Teenage Cancer Trust is in the process of building 22 units in NHS hospitals just for teenagers and young adults with cancer. I feel it would be great if we were lucky enough to benefit from this. We do however have a Drop In Centre within the hospital grounds that we can access. This was set up two years ago (May 2006) through funding by local charities and the Sick Kids Friends Foundation. The young people can chill out on the comfy sofas, use the Internet, order pizza and have indoor activities.

Gill Harley and myself take part in the ‘Find Your Sense of Tumour’ (FYSOT) Conference, run by the Teenage Cancer Trust every 18 months. Further information can be found on the following website www.teenagecancertrust.org. I have been involved with taking a group from Edinburgh to the conference at Centre Parks for the last 3 years. This is a great opportunity for me to build on the relationships I already have with the young people.

As a group leader I am responsible for our group. My responsibilities include planning who goes, getting appropriate consent and making sure the weekend runs smoothly. We travel to Centre Parks on the Friday and enjoy the fun evening and disco. The conference is held on the Saturday and Sunday. It consists of talks, interviews on Survivorship, helping to empower the young people as they fight the debilitating physical and psychological effects of cancer. They can air and share their experiences, learn about fertility, developments on new treatments and join in complementary therapies such as head massage, reflexology and make overs and also music and dance workshops.

At the last conference we took a group of 21 young people and 7 helpers. We needed eyes in the back of our heads! This packed weekend takes its toll on the team of helpers. We’re not as young as we used to be, keeping up with the group’s energy and buzz for life is infectious. I found listening to and watching the group with their peer groups in the same situation very humbling and was very glad I had volunteered to take part. We are now planning FYSOT 2008 and we are ready!

“The conference gave me the ability to be normal. I had one of the best weekends of my life”. (Heather 23, Manchester)

By Helen Veitch
Hospital Play Specialist – Ward 2
Royal Hospital for Sick Children – Edinburgh
Perspectives in Adolescent Care.

The aim of this essay is to analyse an incident surrounding a female adolescent, suffering from bone cancer which involved an Activity Co-Ordinator (AC). The essay will aim to draw upon research of general adolescent development and of adolescents experiencing cancer. The key areas of focus will be exploring body image and self-esteem, followed by independence and rights to represent self incorporating issues of privacy and dignity. Finally it will address altruistic behaviour in adolescence. In conclusion it will aim to summarise the findings and reflect on the incident and how the A/C dealt with it and what was learnt for future practice.

Background

Heather (fictitious name) is a 17 year old young girl, who is quite large in stature, very shy, studious and by her own admission likes to keep herself to herself. Heather was first diagnosed with a Ewings Sarcoma of her wrist and underwent a years treatment of regular chemotherapy, followed by a course of radiotherapy. She finished treatment and returned 2 months later with a relapse in her upper arm.

The incident for discussion occurred when Heather came for her second treatment after her relapse and her hair had just began to fall out. Heather asked the Activity Co-Ordinator (A/C) to shave her hair off, because it was starting to fall out. It was decided to do this in a side room as Heather was very concerned that someone would see her bald. Heathers’ mother was present. Incidentally the only person that had seen her bald. As her head was being shaved Heather was talking the whole time. She voiced that she might cry and she also gave her mother permission to cry. She asked the A/C if she was feeling sad and she also asked for some hair to be kept. Her mother responded that she had some from before, but Heather said; “but its not the same hair, so I want to keep some”.

Adolescence is a time between childhood and adulthood. It is a period which incorporates both strong physical, cognitive and social/emotional changes. A transition from being dependent to becoming independent. The World Health Organisation (WHO, 1977) define the age of an adolescent between the ages of 10 to 20. Santrock (2003) suggests that most cultures today believe that adolescence begins between the ages 10 to 13 and ends around the ages 18 to 22. Santrock (2003) also refers to developmentalists who divide adolescence into two stages early and late. Early incorporating mostly the pubertal changes and late covering the period when the young person is becoming increasingly more independent and seeking their own identity. Eden et al (2005) suggest that when cancer strikes in adolescence it presents an additional stress to the already physical and psychological stress present. Following this belief Heather would be considered to be placed in the latter stage of adolescence as this essay will endeavour to portray.

Body Image

Adolescents are particularly vulnerable to changes in body image. They are in a stage were there is a strong need to conform and to be like their peers. It is a time when they are greatly pre-occupied with their appearance and are coming to terms with their own sexuality. A positive body image is a significant part of their identity and a great contributor to their self-esteem. An altered body image can therefore greatly impact on the young persons social and emotional well
being and greatly reduce their self-esteem. Santrock (2003) emphasise how the young person is pre-occupied with his/her appearance throughout adolescence and also refer to girls being more unhappy with their body image than boys throughout adolescence. Also cited here is Seiffge-Krenke (1998) who proclaims that girls tend to increase their dissatisfaction with their bodies as they go through adolescence, the reason being that their body fat is increased.

Many links can be made about Heathers hair, and the lack of it, in terms of her relationship with her body image and identity. Taylor & Muller (1995, p46) state: “Anxieties may become magnified when young people have an illness or disability, particularly if that illness or disability affects outward appearance...” It was a significant area for her to tackle and indeed this could be said is normal for a young adolescent girl, but specifically in Heathers' case the process and the results could suggest were ways of holding on to her identity and also adjusting to the inevitable change in her body image i.e. being bald again. Coleman & Hendry (1999, p.27) state that “marked bodily changes affects these aspects of identity, and represent a challenge in adaptation for most young people.” Erikson (1968) as cited by Coleman & Hendry (1999, p.60) “As far as adolescence is concerned, the task involves the establishment of a coherent identity, and the defeat of a sense of identity diffusion.”

Heather wanted her mother to save a piece of her hair since its re-growth of 2 inches and her mother explained that she already had a piece of hair from before. But it seemed that Heather specifically wanted the hair of that moment to be saved. Why? When speaking about identity, it could be that the 2 inch hair was a symbol of her identity at that moment, a symbol of what she has gone through the first time around and a symbol of strength that she as a person has gained from that process. It being shaved off could furthermore symbolize the loss of that identity and her need to preserve that gained strength somewhere. Most importantly and also crossing in to altruistic behaviour, the saving of that new hair, for Heather, was perhaps a symbolisation of the death that she maybe believes is near. In that case leaving something as recent as possible for her mother. Being bald again clearly was a big consideration and during her constant talking throughout the shaving process were comments about; which new bandanas she would wear and which matched her nightgowns etc. indicates that she was still trying to take care of her image within the restrictions of baldness. Having a choice of colours is still giving her a sense of freedom of outward expression of her image.

Self-esteem

Body image impacts highly on the adolescents self-esteem. Coleman & Hendry (1999) suggest that if the adolescent is not satisfied with their physical appearance it affects their level of self-esteem. Cited here is a quote in the works of Harter (1990, p.367) from an adolescent who says: “What’s really important to me is how I look. If I like the way I look then I really like the person I am”. Heather was taking great care of how she looked and by never showing her baldness to anyone apart from her mother suggests that her hair played a great part to her self-esteem. Lambeth, (2001) discusses the physical effects, hair loss being one them, of cancer and the treatment and how that can threaten body image and self-esteem. Another contributing factor to the adolescents self-esteem is the acceptance and approval of others i.e. their peers, not so much their families and close friends, but their peers in general.

Independence/rights to represent self

It could be argued that a fundamental part of being independent is to be able to represent self. The development of independence in the adolescent is typically demonstrated by an
increased desire to make their own decisions. The parents opinions become less central and the acceptance amongst their peers is most important. In achieving autonomy the adolescent has worked out his/her role in life (Eden et al, 2005). Eden et al also states “...the adolescent with cancer will have to face a change from being strong and healthy .....to needing the care of others.” (Eden et al, 2005, p.210). Heathers’ display of autonomy was indicated when she chose to take control and wanted to beat the inevitable process of her hair falling out by deciding to shave it all off. It is clear that throughout this ordeal: the loss of her hair was a very significant part of the illness to her and this was her coping strategy. The work of Seiffge-Krenke (1995) as cited by Coleman& Hendry (1999) found that after the age of 15 the young person has developed an increased ability to envisage several solutions to a problem and work out various coping strategies. When discussing the later stage of adolescence Schafe & Schafe states: “Adolescents are now able to maintain a higher level of cognitive thinking even in the midst of affect storms, states of confusion or new situations. The ability to consider an increased number of possibilities along with the ability to think about feelings abstractly...”Schafe & Schafe (1989, p.15). It could be considered that Heather displayed the above by asking an external member, other than her initial choice of her mother, to shave her hair off. This could also be a sign of altruistic behaviour, which will be discussed separately further on. Perhaps this action could be viewed as a display of strength, to bring an outsider into her world, and gathering up the confidence to represent herself and bare a part of herself, that she had up until then considered completely private. During the process of the shaving, she took control and vocalised her feelings ”I’m feeling sad, I might cry”. These as well as vocalising other things relating to her state of mind suggests that she was trying to take control, be independent and represent herself. It could also be said that during this shedding of her hair and exposing herself to an outsider enabled her to express herself verbally. It could suggest that in this way she actually engineered her own therapy session. Papadatou (1989) as cited by Taylor & Muller (1995, p.49) “suggests that even though the adolescent is dying it is important to give meaning and purpose to life in order to help the young person cope with the reality of the situation.”

Taylor & Muller (1995) also suggests that an adolescent that is about to die may be grieving his/her loss of their future.

It could be said that it was a big challenge for Heather to step outside from her family member and request an external member to see her bald and actually shave the hair off for her. She made a comment "Nobody apart from you and my mum has actually seen me without hair". Privacy has been a key issue for Heather, and indeed even during the shaving she was very conscious of anybody walking in and seeing her bald. She also verbalised a sense of feeling that her privacy had been invaded, as the day before, a male doctor had lifted up her PJ top for an examination and her reflection on this was: "He has seen more of me than anyone has". She also explained that in reaction to this incident, she nearly had a panic attack. A feeling of losing control. Coleman & Hendry (1999) discusses the importance of personal control in relation to coping in adolescence. Marcia (1966,1980,1993) cited in J Coleman & L Hendry (1999) discusses four identity statuses the third one being Moratorium, which could be considered relevant to where Heather is in her development. At this stage the adolescent is still not clear about his or her identity, but is looking at various options to reach a satisfactory identity.

Altruistic behaviour
Adolescents are often perceived as selfish and
to discover that there is a great deal of evidence of altruistic behaviour during this period. A study by Roker et al (1997,1999) of over 1000 14-16 year olds cited in Coleman & Hendry (1999) showed that over a period of a year 70% had donated money to charity, 40% had signed a petition, over 30% had helped out with a charity and about 13% were members of campaigning organisations. Furthermore Eisenberg & Fabes, (1998) as cited in Santrock, (1999 p.390) states that “Altruism occurs more often in adolescence than in childhood…”

It suggests that Heather displayed significant altruistic behaviour when first of all she wished for her mother to be present during the shaving process. Perhaps it was not just for her own support, but it was also for her mother to feel that she was still needed, as it was her that had originally been designated to do it. It is possible that the reason that she opted for an external member was to spare her mother for this ordeal. Santrock (1999) also refers to a recent study which found that when a mother showed more involvement in helping the young person it was reciprocated by more help in return Eberly & Montemayor, 1996). Heather also expressed to her mother that she wanted her to grieve if she needed to: "You can cry if you want to mum". It seemed as if she was trying to be strong for both of them. Santrock (1999) also state that altruism in adolescence is also thought to be more prevalent when there is “a close relationship between benefactor and recipient” (Clark & others, 1987 p.390). Finally when Heather specifically wanted her mother to have that piece of hair, suggests extreme altruistic behaviour in that she was perhaps preparing her mother for coping with her possible death and having at least something from that particular moment to keep after she has gone. The hair loss could also represent Heathers’ own symbol of her death. Marcia (1966, 1980, 1993) as cited by J.Coleman & L.Hendry (1999 p.63) could perhaps place Heather in the fourth stage here or at least getting close to it: “Identity achievement. At this stage the individual is considered to have experienced a crisis, but have resolved it on his or her own terms, and now to be firmly committed to…… an ideology and to social roles.”

Reflections of the A/C
This incident as it occurred was a profound experience for the A/C and several emotions were uncovered, some startlingly un-expectant. A sense of great sadness and empathy with both Heather and her mum. On reflection this incident has given the A/C a greater insight in the complexity of the emotions that surrounds the patients in her practice and has re-enforced the importance of keeping an open mind and not assume anything. Also the importance of looking into oneself and to make use of the clinical supervision available.

Conclusion
The essay has looked at the incident and examined it over four points. First Body image was addressed. It looked at the importance of body image in general in adolescence and then with the impact of an adolescent with cancer. Followed by how the young person expressed her anxiety about her body image. References were made from various sources which all points to the importance of body image to establish an identity for the young person. Furthermore it discussed independence and right to represent self. References were made to the cognitive development of the adolescent playing an important role in the development of independence. It suggests that a higher level of thinking is needed to be able to consider an increased number of possibilities and from there to be able to take control and express choice. Privacy/dignity was addressed and here references were drawn from the works of Marcia (1966, 1980, 1993) as cited by J.Coleman & L.Hendry (1999) on
would place the young person in the *Moratorium* stage, as she still appeared to struggle with certain aspects of her identity and privacy was of highest importance. Finally the essay looked at Altruistic behaviour and it gave several examples of the young person displaying this and also compared it to the works of Marcia (1966, 1980, 1993) as cited by J.Coleman & L.Hendry (1999) on Erikson’s four identity stages and here she could be considered to be placed in the fourth stage e.g. *Identity Achievement*. Additionally the reflections of the A/C was included, which in short highlighted the profound impact it had made on her and how it had exposed a different part of what her work entails and how it will influence her future practice. This will include not to make assumptions, keep an open mind and take up Clinical supervision when necessary.

Annika Davidson  
Activity Co-ordinator (Hospital Play Specialist)  
Adolescent unit UCLH Hospital London.

As part of our patient involvement programme Great Ormond Street have held two Young people’s listening event for anyone aged between 11 and 19 years of age. The trust has two Young people’s Champions who are ex patients in their twenties who help run the event and act as mentors to younger patients. The objective of the day is to give the patients the opportunity to tell the staff facilitating the day what they like and don’t like about the hospital and how health care professionals interact with them. September last year we focussed on producing a DVD of Young People’s views to use as a teaching aid for the trust.

Group sessions and individual diary room style sessions were set up and filmed. The young people were very enthusiastic and had lots they wanted to share with health care professionals regarding how they are consulted and what facilities they would like. I’m please to be able report that Play Specialists got a good press, with a couple of young people saying if it hadn’t been for play specialists they wouldn’t have got diagnosed or through their treatment. At lunch time it was arranged for a group of musicians to come in to provide some background music to the DVD and Brook agency who gave out sexual health information. This was all well received. With a group of young people joining the musicians to help produce the background sound track for the DVD.

The main points that came from the day were:

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**Young people’s listening event at Great Ormond Street Hospital.**
skills to assess this and pitch information at their individual patients levels/needs

- Give choices
- Listen and take care to communicate carefully and effectively with patients with disabilities, language or hearing difficulties
- Believe what patient is saying
- Remember dignity and privacy

Idea’s for leaflets were also drawn up and since the day one of the young people has drafted two leaflets entitled:

- How to speak to your friends about your condition
- How to speak to your patients

It was a great day and since September lots of behind the scene work has gone on to edit hours of film into a 10-15min DVD. Two versions are being used by the trusts training department as a tool to induct new staff’s and as part of a trust wide training session to help staff relate, listen, and respond to patients and families needs.

As Play staff we are very aware of these points and have been in the forefront of advocating the needs of our teenage patients since the first play schemes were set up way back in the sixties. As a professional group we have raised a lot of awareness for teenage patients over the se years but there’s still more to be done. With foundation trusts, the requirement for membership and more openness to user involvement there is now even better opportunities for patient’s voices to be heard.

By Sue Ware
Head of Play Services
Great Ormond Street Hospital

An insight into a teenage cancer patients journey
By Annika Davidson

Mark 16
Diagnosis: Osteosarcoma right Tibia

Background:
Mark lives with his parents and his older sister. The family is from Albania, but Mark has lived in England most of his life. His mother has a poor knowledge of English, but Mark and his sister are both fluent. His mother always accompanies him to hospital and sometimes his sister, but I have never met the father. Additionally Mark is a keen rugby player and
in the wound and this meant he had to spend a much longer time in the orthopaedic hospital, which also delayed his physiotherapy.

However, in December he was back with us resuming his chemo. He had also been told that he would not be able to play rugby again and was devastated. He was able to talk quite openly about that and also had good support from his school coach who visited him frequently. Then he had another setback and developed cellulitis. This now equated to his overall treatment being delayed by about two months. Ever since then he has not looked very well although he is always cheerful and appears to be coping well, I was sensing that he was holding a lot in. Mark participates in patient group whenever he is here and is very supportive of other patients. Also he was working really hard with his physiotherapy, but with little results.

The past month Mark has talked to me quite a lot about how he puts his trust in the consultant and he will do whatever she tells him and then he will get on with his life. Then just before his last treatment he decided he had had enough and he refused to come in. It took me a lot of persuading and coaxing to get him to come in for treatment and he finally relented. I was talking to him about it and it struck me how immensely honest he was about his feelings. He said that suddenly he felt he couldn’t do it anymore. He didn’t want to be the boy with cancer any longer and he just wanted to get on with his life. He knew it was illogical. When he eventually adhered to his last chemotherapy, he said it felt better for him.

Teenage patients frequently get to a point where they feel they can’t carry on with treatment and often the best way to support them is to just to listen and they normally problem solve for themselves and carry on with treatment.

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**FUN WITH MESSY PLAY: IDEAS AND ACTIVITIES FOR CHILDREN WITH SPECIAL NEEDS**

**TITLE:** FUN WITH MESSY PLAY

**BY:** TRACEY BECKERLEG

**PUBLISHED:** 15/10/2008 by Jessica Kingsley Publishers Ltd  [www.jkp.com](http://www.jkp.com)

**PRICE:** £12.99

**ISBN:** 9781843106418

This book is aimed at professionals working with children and families. It uses both academic and familiar language to describe messy play, emphasising the fun and learning elements of the different types with a varied and extensive list of activities. The book also explores and identifies the motor, language and cognitive skills and the play and development goals. All the senses are identified and examples given how messy play can help and notably how messy play can be used to help a child with an impairment.

Short case studies of children and messy play are used throughout the book to describe the activity and its purpose and pleasures. There is a useful chapter on preparation for messy play emphasising the fun element. There are many ideas familiar to the practitioner which serve as useful reminders; however there are also many new and exciting activities. There is a very interesting chapter on non-messy play for children and adults who are tactile defensive and provides suggestions for ways to engage children in a safe and non-threatening way, for example the use of wellington boots to walk through mud and various other mediums.

This is an easy book to use, with good illustrations of a child indulging in messy play and is recommended to practitioners and parents of all children, but especially for children with special needs.

Tina Clegg, Service Manager Children’s Services, Leicester Royal Infirmary
All Hospital Play Specialists should consider becoming a trained mentor to provide the greatest possible support to their learners.

As a Hospital Play Specialist working within a busy general medical ward, I am often asked to support various learners, some linked with the Hospital Play Specialist Course and also other professional courses within the multi-disciplinary team such as nursing, medical, physios etc. As Nurse Education (2003) states: “In reality students call on a variety of individuals during their placement experience depending upon who can best serve their needs at any one time’.

When working with learners I explain my role on the ward and within the multi-disciplinary team, also go through various situations I am involved in and show them some documentation I use.

To help educate the learner more effectively and enhance my own learning I decided to go on a course called ‘Facilitating Learning and assessment in Practise’ this course is available to all health professionals who work within the hospital environment and can assist in becoming a qualified mentor.

The course showed me how to work with learners more effectively showing me various strategies and techniques which I could use to bring out the best in my learner.

Encouraging me to look at my own working arena, which is the ward I work on both socially and physically, meaning what we provide as a ward and what we provide as a play team in order to help the learners develop. The course also provided me with appropriate language to use, bringing me up to date with the latest techniques used by the learner.

It showed me what other professionals provided for their learners and how, if we all work together using the same methods, it is more supportive for the learner.

As well as producing a portfolio this course was also classroom based with lots of different professionals coming together to discuss how they dealt with learners and what methods they use, so this in itself helped me to mix with other professionals and learn new ideas and techniques.

As a Hospital Play Specialist this course has benefited me within my work place as it has made me look at how I work with learners and what I, as a professional, can provide for them, so I can encourage their development more effectively. As Holloway.E (1995) states: ‘In practice the facilitator acts as a learning recourse, creating the necessary climate for learning and offering guidance as required’.

I feel I can now get the best out of my learner by providing them with the correct information and encouraging them to also go and learn on their own.

It also gave me the chance to look at the wards documentation (POLO) that is provided for the nursing learners and helped me think about adapting it to support Hospital Play Specialists learners in the future.

By doing this course it brings me up to date with other professionals within the hospital and keeps me abreast of the latest techniques and information. As Andrew.M and Roberts.D (2003) states: “Mentorship is widely relied upon just as a support mechanism for students but also as the main vehicle for the activities associated with learning, teaching and assessment of practice.’ When mixing with other professionals throughout the trust it promoted the role of the Hospital Play Specialist within the hospital.
Although everyone knows the basics of working with learners, I feel this course gives you more in-depth knowledge and understanding, so you as a facilitator can provide that little bit extra for the learner. It also challenges you to work more efficiently and effectively within your working environment.

Therefore, as a Hospital Play Specialist I would recommend doing this course or equivalent to enhance your learning and the learning of others.

Reference

Nursing Education Today (2003) Vol23 pg 474-481


BY: Marie Samuels ,Royal Victoria Infirmary
Newcastle

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