

PLAY AS A PRIMARY NURSING INTERVENTION
FOR THE HOSPITALIZED CHILD

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CHAPTER I

INTRODUCTION

During hospitalization, a child is exposed to a variety of new and unfamiliar people, places, routines, sounds, and smells. The nurse can be the key health care person in the life of the hospitalized child. Even if there is an organized play group in the hospital, the nurse must be the provider of many hours of additional play experiences for the child. Many nurses and other workers are able to define "good care" for the hospitalized child, but implementation is often lacking in the care actually given to the child. There is a lot of valuable literature currently available regarding the psychological aspects of a child's illness and the meaning of hospitalization; however, much of this literature is not incorporated in the approach to the overall care of the hospitalized child. Play should be directed at facilitating the hospitalized child's adjustment to the hospital, to himself, to his illness, and to life in general, thereby contributing to his social and emotional well being.

One means of utilizing this valuable information would be through the development of a standard of care

for the need and use of play. This standard of care could be developed by the use of clinical nursing judgments, and subsequent nursing diagnosis. The heart of professional nursing can be described as making observations of the patient, making inferences based on these observations, and then taking the appropriate actions.

STATEMENT OF THE PROBLEM

Relative to the defined population, the problem of this study was to determine what data nurses select in order to make a clinical nursing judgment to use play as a therapeutic intervention.

STATEMENT OF THE PURPOSE

The purposes of this study were to:

1. Identify the data base nurses consider necessary in order to make the choice to use play as a nursing intervention
2. Identify play components used by nurses in daily nursing care activities
3. Begin development of a standard of nursing practice as determined by the American Nurses' Association related to the emotional care of the hospitalized child

BACKGROUND AND SIGNIFICANCE

Imperative to understanding the value of play for the hospitalized child is a definition of the concept of play. The American College Dictionary (Barnhart 1961) lists fifty-three definitions of play. Some of these definitions include:

. . . exercise or action by way of amusement or recreation; fun, jest, or trifling; to act the part of; any such form of diverting activity, often undirected, spontaneous, or random; carrying on of a game. . . (Barnhart 1961:29).

The American College Dictionary also lists work, or toil, as the antonym of play. Webster also defines the term play in the following manner.

. . . to engage or take part in a game; to perform or execute a task for amusement; act in character or take part in; to pretend to engage in (Webster 1967:469).

Central to all efforts that are now being made on behalf of the child is the recognition of the need and importance of play, from the earliest play of an infant, on through the preschool years, the years of elementary school, and into adolescence. Play is the way the child explores and orients himself to the actual world of space and time, of things, animals, structures, and people. Through play one learns to live in our symbolic world of meanings and values, or progressive striving for deferred

goals, and at the same time exploring and experimenting and learning in his own individualized way (Frank 1964).

Despite this concern for the child and the growing recognition of the significance of a child's play, many people still are not clear about the meaning of a child's play. Part of this confusion arises from the old Protestant ethic concerning work and play, with the feeling that while work is good, play is somehow questionable, if not bad or sinful. For this reason it is important to define play as the child's work (Frank 1961).

Every child must also face the basic question of, "Who am I?" Because the child lacks the mental skills and is unable to use the resources open to adults, the child seeks in play to discover himself--"to learn who and what he is, what he can do, and how he can relate himself to things and situations, to persons and groups" (Frank 1963: 7). Much of the basic orientation to social life is achieved in the preschool years, primarily in the child's play where, day after day, the child faces in miniature or symbolically all the crucial tasks of human living. What the child learns in play usually becomes the core of his subsequent life (Frank 1963).

In developing an understanding of the philosophy of play in pediatric nursing, the professional nurse must use this and any other acquired knowledge constructively

by making play an important focus in her nursing care activities. It is the nurse's role to focus on the child rather than on just his sickness. As nurses acquire more insight into the developmental and psychological needs of children, they will perceive the importance of a hospital setting that is more home-like (Hott 1973).

Although play and its functions are not completely understood, existing knowledge indicates that it is crucial for the mental health of the child. Erickson (1940:98) wrote: "to play is the most natural autotherapeutic measure childhood affords . . . the child uses it to make up for defects, suffering, and frustrations" (Erickson 1940:98).

The young child is striving to acquire and develop a sense of unity of his personality and capacity to feel integrated. He is also developing a capacity to relate to external reality. The objective world is never the same as we perceive it from our subjective experience (Win-cott 1969). Berman gives another insight:

In the early years, the child is extremely impressionable. He tends to learn more through the modality of anxiety than by means of an objective appraisal of his experiences. Experiences once learned in this context cannot be easily unlearned or relearned and so become enduring patterns of adaptation (Berman 1955:55).

Behavior patterns learned by a child within the context of a hospital can be a positive or detrimental

experience and can be aided greatly by the use of play.

In play, even a quite, small child will attempt to overcome unpleasurable experiences. In play, he overcomes painful reality and is assisted in mastering his instinctual fears and internal dangers by projecting them into the outer world and letting them run their course (Klein 1969:246).

Throughout childhood, the expenditure of energy for growing and learning is controlled by the emotional responses of experiences along the way from all the people who touch the child's life (Capland 1973).

Play offers more than tools for building personality and a sense of achievement; play experiences enable a child to cope constructively with the realities of life (Capland 1973). The young child, through play, expresses feelings of fantasies, fears, and conflicts, in an effort to cope and thereby move toward more mature psychological behavior (Petrillo and Sanger 1972).

Every child, healthy or ill, is continually faced with experiences which cause resentment, deprivation, and/or crises. Illness and hospitalization constitute major stresses in early development. They create a profound change in a child's life style--separation from the security of parents and home routines. The child is suddenly at the mercy of a hostile environment--unfamiliar sights, sounds, smells, and strange people who inflict pain. Play has the

unique quality to help restore some of the normal aspects of living and provide the child with an opportunity to reorganize his life, thereby, reducing anxiety and establishing a sense of perspective (Capland 1973). If there is no opportunity for play, destructive and unmanageable behavior is the frequent outcome (Petrillo and Sanger 1972).

Childhood appears to be a trial run where the child is given the time he needs to find out about himself, other people, and the world in which he lives. Play is a means to serve the child and allow the child to meet these important needs of life (Capland 1973). Play is an autonomous activity where the child can assimilate the outside world to support his ego. Play also allows the child mastery of his world and the ability to affect his environment. Through play, the child can follow any impulse, and has complete freedom of choice with none of the boundaries and restrictions that cannot be given to him in the adult world (Petrillo and Sanger 1972).

Since it is impossible to determine exactly what goes on in a child's mind, or to get the child to talk like an adult, specialists who work with children have found that much can be learned about a child from watching him play. During play, the child is able to reveal both his imaginary and real life. Because play is the

most important natural form of expression of the young child, it can reveal his inner conflicts and immaturity (Capland 1973).

Play is helpful in making the hospital a more familiar place--toys are a universal sign of friendliness. By using play, a trusting relationship can be established and create a sense of independence and accomplishment because play gives the child control over a portion of his environment. Play can also be an outlet for anger and frustration (Scipien 1975).

Hugh Jolly (1969) in his article "Play is Work," stated that if play is essential for the child in ordinary life, it is more important in hospital life. Play in the hospital adds a new dimension to medical care both by providing a protective cushion for the child and by supplying means to understand the child's feelings more fully. On the basis of this and other information concerning play arises the question of how nurses make a clinical judgment to use play as a therapeutic intervention and why is it important for nurses to make these judgments and inferences?

Clinical Judgment

According to Mills (1971), judgments in nursing practice hold the key to improved patient care and are the

defining attributes of professional practice. The author stated that, "it is within the bases for judgment that our nursing theory resides and within those bases that gaps in our theory reside" (Mills 1971:161).

Analysis of the act of judgment can only lead to a greater appreciation of its implication for nursing. Such a theoretical analysis of practice is essential to the further progress of nursing as a profession (Doona 1975). Also of importance in establishing nursing as a profession is the theoretical analysis of clinical inference.

Katherine Kelly (1966) wanted to determine a need for nurses to be interested in the process of clinical inference. Kelly further stated that,

. . . since all inferential or diagnostic tasks are central to all nursing practice, an understanding of this process is important to those who are actively engaged in giving direct care to patients as well as those who are responsible for the education of nursing students (Kelly 1966:23).

Lenski (1955) identified seven independent functions of the professional nurse based on studies of judicial reviews. One of these independent functions made nursing diagnosis, for the first time, a recognizable independent essential and legal function of the nurse, because this function required no prior medical orders for its validity. The author summarized as follows:

The observance of symptomatology of physical and mental conditions and needs, requiring evaluation or application of principals, and the social sciences (Lesnik 1955:259).

Kelly enumerated features that characterized the nurse-patient inferential situation. These features are: (1) the inferences nurses make have a high social significance; (2) the inferences nurses make are based on probabilistic and incomplete data; (3) the inferences nurses make are followed by immediate action, and (4) the inferential task is complex. There is little known about specific kinds of inferences made by nurses or about how they select and utilize information available to them in making the inference. This is a very much needed area of information in nursing (Kelly 1966).

The generic Standards of Nursing Practice, published by the American Nurses' Association in 1973, clearly points to the significance given by the professional organization to the step in the nursing process called nursing diagnosis. The standards are designed to be a means for determining the quality of nursing practice. Incorporated within a typology of diagnostic labels would be the principle that would clearly state what judgments about the health care status of the patient are to be considered nursing diagnosis, as distinct from diagnosis of other

health professionals. The determination would be the beginning of looking at the quality of nursing practice (Roy 1975). Therefore, the purpose of this study will be as follows: What data base do nurses utilize in order to make the clinical nursing judgment to use play as a therapeutic intervention for the hospitalized preschooler?

DEFINITION OF TERMS

For the purpose of this study, the following terms were identified:

1. Nurse -- an individual licensed to practice in one of the fifty United States whose function is to assist a patient to perform those activities he cannot perform unaided at the moment (Yura and Walsh 1973).

2. Play -- recreational activity, fun, entertainment, amusement; the spontaneous activity of children with or without the use of toys; a child's work; teacher of meanings and values; a mode for orientation to space, time, things, structures, people, and animals; a means to explore and experiment in an individualized way; a means for a child to discover who he is, what he is, what he can do, and how to relate to himself, to things, and to situations.

3. Emotional Care -- allowing the hospitalized child to acknowledge his feelings and expressions through play

or talking. If this is done, the child can learn to deal with his environment promptly and appropriately. The child's growing maturity helps him to cope with future pain and frustration (Mason 1965).

4. Standards of Nursing Practice -- providing means for determining the quality of nursing which a client/patient receives regardless of whether such services are provided by a professional nurse or by a professional nurse and nonprofessional assistants (American Nurses' Association 1973).

5. Therapeutic Play -- a series of experiences planned to yield some specific outcome for the child. Can be used with the hospitalized child by any professional nurse. Therapeutic play can be conducted in the playroom, child's bedside, or any other convenient area. The goal of therapeutic play is to give the nurse insight into the child's needs and feelings. The nurse reflects back to the child only his verbal expressions--never his nonverbal ones (Green 1974).

6. Preschool Age -- period usually defined as encompassing the years approximately 2-6 years.

7. Hospital Induced Behaviors (reactions to illness) -- fear of unfamiliar environment, fear of abandonment and punishment, fears related to body integrity (mutilation

and body image), and communication fears causing the child to use the defense mechanisms of regression, repression, denial, withdrawal, displacement, sublimation, projection, and fantasy (Scipien 1975).

8. Developmental Tasks -- a task which arises at or around a certain period in life of an individual, successful achievement of which leads to happiness and to success with later tasks; while failure leads to unhappiness in the individual, disapproval by society and difficulty with later tasks (Havighurst 1972).

9. Incident -- any observable list of human behavior sufficiently complete in itself to permit inference to be made about the person performing the act (Fivars and Gosnell 1966).

10. Critical Incident -- a phenomena that makes a significant difference in the outcome of the behavior; it must contribute either positively or negatively to the accomplishment of the aim of the activity (Fivars and Gosnell 1966).

11. Judgment -- a form of thinking based on cognition of various relationships and achieve knowledge of a state of affairs (Schilder 1951).

12. Clinical Nursing Judgment -- the method of acquiring evidence and organizing clinical thought used by

a nurse when presented with multiple cues related to the patient in the clinical situation (Feinstein 1967).

13. Cues -- signs, symptoms, and other information related to the patient which are available to the nurse (Kelly 1964a).

14. Inference -- a conclusion or judgment drawn from data (Kelly 1964a).

15. Decision Making -- a course of action selected from presenting alternative actions (Grier 1964).

16. Nursing Diagnosis -- the process of determining the patient's presenting symptoms as a basis for instituting nursing measures to promote the patient's welfare (Yura and Walsh 1967).

DELIMITATIONS

The delimitations for this study were:

1. The sample was obtained from one general hospital in the Southeastern area of the United States
2. The sample population consisted of registered nurses employed in the inpatient area of the hospital
3. The sample was male and female

ASSUMPTIONS

The assumptions for this study were:

1. Play is needed by all children because "to play is the most natural autotherapeutic measure childhood affords . . . the child uses it to make up defects, suffering, and frustrations" (Erickson 1940:98)
2. Play is a necessary component of the total care for the hospitalized child

SUMMARY

In summary the researcher has tried to give the reader a beginning insight into the nurse's role and the value of play for the hospitalized preschooler. The continuation of this idea will be explored in the remaining chapters of this study. The review of literature, Chapter II, discloses theories of development, play, clinical judgments, and related research already completed.

The procedures for collection and treatment of data presents the methodology which was used in the study and gives actual incidents, facts, and performances as they occurred. This is covered in Chapter III of this study.

The analysis of data, which is discussed in Chapter IV, gives a complete, accurate description of the results

and interpretation of the findings and statistics used in the study. And, finally, in Chapter V a summary of the entire study; an exposition of all the possibilities derived from the study; an identification of significant elements obtained from the study which were directed to the appropriate people, and recommendations and suggestions for further study.

CHAPTER II

REVIEW OF LITERATURE

The review of literature for this study will be divided into four major areas: (1) theories and behaviors of growth and development of preschoolers; (2) theories and values of play; (3) theories and value of clinical judgment; and (4) related research already existing concerning play and clinical judgments. The presentation of theories related to growth and developmental tasks will begin with those developed by Erickson. Erickson's theories were chosen for several reasons. One being that he recognized the interaction between individuals and culture as contributing to personal growth, as demonstrated by the developmental stages of psychosocial as well as psychosexual characteristics. Each stage of development described by Erickson gives positive and negative outcomes of the crisis involved (Erickson 1968). Erickson's stages of development that will be discussed include: (1) the sense of autonomy, and (2) the sense of initiative. Erickson described these two theories as the two dominant personality growth phases of the preschool years (Erickson 1968).

If all goes well in infancy, a firm sense of trust will be developed and established by the preschool years. On this foundation of a sense of trust, the child builds a sense of autonomy, and on autonomy and trust the child's sense of initiative is built. The success of the child's preschool interactions determines the adequacy of the sense of initiative which the child develops (Smart 1972).

The stage of autonomy begins as the two year old starts experiencing the power of "doing" and "deciding." The preschooler has many independent modes of locomotion to exploit and choose from. Talking also brings independence and control over both self and others, thereby strengthening the preschooler's sense of autonomy. The average increase in vocabulary from 18 months to 2½ years is from 20 to 446 words according to M. E. Smith (1926). This increase in the child's vocabulary represents a great many things, ideas, activities, and people brought into the child's area of influence. Even more important is the power of cooperation. The preschooler is developing the ability to decide whether or not he will cooperate with people. There are many opportunities for the child to choose and decide even with adult limiting; for example, whether to hug and kiss or finish dinner (Erickson 1968).

The most renowned aspect of autonomy is the area of toilet training. This is a symbol of the entire stage of developing autonomy. "In the normal course of events in Western Society, the child exercises autonomy as he brings his sphincters under control and takes on toileting patterns approved by his family" (Smart 1972:233).

The negative side of a healthy stage of autonomy is a sense of shame and worthlessness. This occurs when the child cannot choose and act independently enough; when his choices and actions result in disaster; and when adults use shaming as a method of control (Erickson 1968).

Development of initiative is the dominant phase in the latter period of the preschool years. This stage usually begins around four years of age. The child begins to explore the physical world with his senses and the social and physical world with questions, reasoning, imagination, and creative abilities. Love relationships with parents are very important. It is this stage where the child puts bears in his ears, or plays the role of a mother or doctor; imagining how he would feel if he was really doing the task himself (Erickson 1968).

Conscience begins to develop at this period and begins regulating initiative and imagination. The child begins to take the voice of his parents in himself, saying

what he can and cannot do. The development of initiative also includes noticing how other people solve their problems by imitation. Children imitate not only parents but peers, older children, and other adults. Guilt is the negative development of initiative (Smart 1972).

The developmental theories of Piaget that are concerned with preschoolers, will also be discussed. These theories include: (1) preoperational thought; (2) concept of time; (3) concept of space; (4) concept of classes; (5) concept of quantity and number; and (6) concept of causality. Piaget's stages of development describe intelligence and how it is acquired. Each stage of development is built on the last one by reorganizing the stage and adapting it closer to reality. These concepts are discussed because they demonstrate the very important fact that the preschool child thinks differently from anyone else. Contrary to the adult's expectation, the preschooler does not think like a grownup (Pulaski 1971).

Representational thought is why the period of preoperational thought is distinctly different from the sensory motor period of infancy. The child is no longer confined to interactions of the here and now; he can think about objects, people and actions that are not present.

This idea is demonstrated by imitative and imaginative play (Piaget 1963).

This period of preoperational thought usually lasts from 18 months or 2 years to approximately 7 or 8 years, and describes a child who functions in a way directly dependent on his immediate and direct experience (Pulaski 1971). In this time, the child is creating mental structures which will eventually result in logical thinking. This is accomplished through the child's interactions with people and objects, which is in the form of two complementary processes: assimilation and accommodation (Piaget 1958). Through these two forms, assimilation and accommodation, the child learns the properties of toys, materials such as clay and ways of manipulating objects through "logics--mathematical experiences" (Piaget 1966). While the preschooler is going through this period of preoperational thinking, his thought processes have certain characteristics that distinguish them from concrete logical operations which follow this period, and these characteristics are as follows:

1. The young child cannot think from any point of view except his own, and he does not realize that he is limited in this fashion.
2. Perceptions dominate the young child's thinking. He is greatly influenced by what he sees, hears,

or otherwise experiences at a given moment. (This is illustrated in Piaget's experiment of pouring beads from one glass container to another glass taller and thinner than the first. When asked whether there are fewer or more beads in the second glass, the child answers either that there are more because the level has risen or that there are fewer because the glass is narrower. The child centers either height or width, more often on height which is more salient. Perception becomes more flexible (decentered) with increasing maturity.

3. Reasoning at this age is from the particular to the general, rather than from general to particular.
4. Preschool thinking is relatively unsocialized. The young child feels no need to justify his conclusions, and if he did, he would not be able to reconstruct his thought processes so as to show another person how he arrived at his conclusion (Smart 1972:233-235).

Unlike the operational child, ages 7 to 12, who is free from the ties of immediate perception, the pre-operational child is unable to move forward and backward in space and time on the mental plane. As a result, the preoperational child who has lost a toy will search every room; the operational child can sit still and recall where he has been until he logically deduces where he must go to find the toy (Pulaski 1971).

Also during this time, the preschooler is organizing his experiences into concepts of time, space, classes, quantity and number, and causality. Piaget terms the

period before the preschooler is able to conceptualize (until around four years) as preconceptual thought which is the first half of the preoperational period. The second half is called intuitive thought and is characterized by judgments being made on the basis of perception rather than on reason (Ginsburg and Oppen 1971).

The concept of time consists of three operations. The first operation deals with the child's understanding of bodily rhythms and seriation of events (states that occur in regular patterns such as hunger, eating, fullness). The second operation the child learns in relation to time is the repetitions of stimuli in patterns. And finally, the third operation necessary for the nature of the time concept is duration. Duration involves appreciation of the intervals between events (Piaget 1969).

Space concepts, during the preoperational period, are still egocentrically related to the child's body, movements, and perceptions. The child's progress toward objective space concepts depends on his body experiences, perceptions, and the concepts which adults offer him (Piaget 1958).

Piaget demonstrates the egocentric space concept by the mountain test. Three forms which resemble mountains are placed on a table. Then a doll is placed first at one

side of the table, then the other side. The child is asked to choose from the pictures what he thinks the doll would see from the various positions. A child under seven or eight has no understanding of this concept because he cannot conceive of the mountains looking different from the way he is viewing them because his space concepts are still tied to his own perceptions (Piaget 1958).

Piaget stated that classification and seriation are learned simultaneously because the processes are complementary. When a child is less than five years, he cannot put objects into a series, but between the years of five and six he can. Even though the five or six year old can put objects in a series, he will have great difficulty finding the correct place for an object omitted from the series, but at around seven he can do it easily (Piaget 1965).

The concept of class in the preoperational child cannot be conceived as an object belonging simultaneously to two classes--such as wooden red blocks belonging to red things and wooden things. Nor can they understand subclass (Piaget 1965).

Causality concepts fall under the same egocentric concept of space time and number. In all types of problems, the preoperational child deploys his attention in

limited ways. He focuses on one dimension of a situation rather than on all aspects of the problem. Piaget found that the young child seldom expresses causal relations. In describing a situation, the child simply states that A and B occurred; he does not say that A caused B. Instead of being related one to another, the two events are juxtaposed; that is, placed one after the other"(Ginsburg and Oppen 1971:110).

Although understanding of developmental stages is the key to relating to children, the nurse must know what to expect at each stage of development in order to best facilitate the child's adjustment to hospitalization. The nurse should not expect to remember all details of each stage, but instead, review all details of each stage of growth and development in preparation to care for the child. For example, based on the typical concrete thinking of a very young child, an understanding of how fearful fantasies and misconceptions in regard to the concept of anesthesia is possible. (In preparation for surgery, a young child was told he would go to sleep like he does at night. This was upsetting to the child not because he was afraid of going to sleep, but of waking up when the surgeon cut him with the knife. His reasoning was that if he was sleeping at home in his bed and someone

cut him with a knife, he would certainly wake up; therefore, what was to prevent him from waking up on the operating table? This child needs help to understand the difference between natural sleep and sleep from anesthesia.

It is also important for nurses to look at hospitalization through the eyes of the child. Often adults have great difficulty understanding how big, bewildering, and confusing the world can sometimes seem to a young child (Kunzman 1972). Adults may interpret hospitalization in terms of reason, logic, and practical necessity, but the child views the experience in terms of his psychic reality, that is, the fears, anxieties, and fantasies that are aroused by the hospitalization (Freud 1965).

Over the years, much attention has been given to the deleterious effects that hospitalizations have on the child (for example, separation from the mother was discovered to be the chief traumatic factor for the younger child). Without the child's customary source of comfort and support, the child is deprived of the basic trust and security that he particularly needs during illness, despite the kindness of nursing care. The restriction of the child's ego because of the focus of attention on the body leaves it less able to handle other psychic demands and fears are magnified. Along with separation and illness, the threat of

procedures and a strange and lonely environment created regression to a more immature behavior as a protective maneuver. The young child frequently interpreted the events of his hospitalization as punishment and he reacted with withdrawal, hostility, or apathy.

These are a few of the deleterious effects identified over the past twenty years of research concerning the effects of hospitalization on children (Mason 1965). It is not enough to be able to recognize what these effects are; of greater concern is the child's solution to the problem, and how well the child deals with the anxiety of the hospitalization will determine, in part, his future mental health. Helping the child toward mastery of his experience will provide valuable assests to his growth and development (Kunzman 1972). For nursing, this responsibility is particularly great. Nurses, because of their twenty-four hour-a-day responsibility, their large numbers in proportion to other staff members, and the intimacy of their interactions with patients, hold key positions for determining the environment and experience of their patients (Petrillo 1968).

Play is a resource that is available to the nursing staff in helping the child toward mastery of the hospital experience. However, to some people, the term play still has an unfortunate connotation (Kunzman 1972).

Play is thought of merely as an unimportant activity to fill up the day (Kunzman 1972). Or in other cases, play is considered necessary only for the disturbed child who is in need of play therapy on a formal basis with a psychiatrist (Brooks 1970). For these reasons, it is important to define the concept and value of play at this time.

All sources reviewed (Brooks 1970; Kunzman 1972; Capland 1972; Patrillo and Sanger 1972; Erickson 1964; Murrin 1969) defined play as the child's work, the means through which the child learns; the way he spends most of his working hours. Toys are the child's tools for play. Through play, a child may deal with feelings he may not know he has or cannot put into words (Kunzman 1972).

Play activities provide an opportunity for self expression, as well as for exploring and experimenting with sensations, movements, and relationships through which the child learns to know himself and to develop his concepts of the world. Play encourages the development of a productive, well integrated human being (Robertson 1954).

Axline (1947) describes play as a natural means of communication for the child, through which he can act out his accumulated fears, tensions, frustration, insecurity, and aggression. By releasing these accumulated fears and tensions, the child is free to grow and to

expand (Axline 1947). Play sessions involving the child and nurse can develop and foster communication, thereby allowing the nurse to discern the child's needs, tensions, and unique perception of his environment (Lockwood 1972). Growth and development of the child continues despite hospitalization, and for the sick child, play aids him in regaining gradual independence through enjoyment of group experiences. There are countless situations during hospitalization that do not allow the child to make decisions; in the play, the possibility for the child to make decisions, to be powerful and to be in control of the situation occurs (Kunzman 1970).

The Caplands (1972) in their book, The Power of Play, present data that substantiate their hypothesis, "that the power of play is all pervasive" (Capland and Capland 1972:xi). They do this by presenting such concepts as: play has the unique power for building body control and interpersonal relations; play provides a base for language learning and investigation; play is the most dynamic childhood learning method; and play provides mastery of an imaginary world.

Margaret Lowenfield (1967) gives us another view of the concept of play. She states:

Play is an essential function of the passage from immaturity to emotional maturity. Any individual without the opportunities for adequate play in early life will go on seeking them in the stuff of adult life (Lowenfield 1967:58).

Petrillo and Sanger (1972) state that play is a natural phenomenon that leads to learning, and fosters and reflects the complexities in the style of emotional development. Through play the young child expresses his feelings, fantasies, fears, and conflicts in an effort to cope with them and thereby moves toward psychological maturity. Petrillo and Sanger view play as an important diagnostic tool because it increases knowledge of the child's mental life--his deeper reactions to events.

Dramatic play lets the child relive important life experiences. Children repeatedly act out painful scenes not to persevere the pain, but to attempt to make the pain understandable and bearable. The child will incorporate those parts of the situation that are endurable and add others as their self assurance and courage grows. This is one way the child has to bring under control feelings of frustration that are often experienced (Capland 1972). Because of this major concept, the nurse could provide the child with a means of working off anger, after a painful procedure has been experienced. And although the procedure may hurt just as much the next time, the child will have

had an opportunity to be familiar with all its various trappings, and the ego will have been reinforced (Scahill 1973).

Play with puppets also allows the child to act out feelings and experiences. Puppets allow the child to be the producers, directors, and actors in their action play. Puppets have qualities which make them especially inviting and give the child a three-dimensional media with which the child can create the dramatic life into anything and everything (Capland 1973).

Whether play is implemented on a formal basis as used by psychiatrists, or as free play created by the child, it provides a real source of data experienced and fantasied by the child. This mechanism assists the child in at least three unconscious objectives: (1) working through his life experiences to achieve some understanding, resolution, or meaning of them; (2) assuming the role of others in his environment; (3) notifying the sympathetic adult observer of his inner most concerns and needs (Scipien 1975).

As nurses, we often must take advantage of small amounts of time with the child. Play can be used during bath time, dressing time, or bed time; play does not have to involve structured games or toys. Play can be initiated

anytime the nurse is with the child or when a group of children are together (Kunzman 1972). In order to understand how nurses make judgments concerning play, the next section of this review of literature will be concerned with the concepts and value of inference, judgment, and decision making.

Making judgments is a central task in nursing practice. It is, in fact, a primary skill in the cognitive domain of nursing. Although this seems quite obvious, the complexity of the act is hidden in its familiarity. It is this familiarity that has impeded precise definition, analysis, and appreciation of judgment as crucial activities in nursing situations. Consequently, conscious awareness and deliberate use of judgment in nursing practice has remained at a primitive level. Yet, over the last twenty years there has been a recognizable trend toward greater investigation of the cognitive domain of nursing. The intensification of these studies demonstrates a recognition by modern nursing of its responsibility to provide knowledgeable care along with other professionals. Therefore, perceptual and action skills are being substantiated by cognitive skills. Judgment, as a cognitive skill is seen by the profession as essential to a nurse's ability in perceiving needs for nursing care and in providing care (Doona 1975).

Ray (1962) hypothesized a knowledge of independent judgment as the unique body of knowledge of nursing. Kelly (1968) corroborated this hypothesis by stating that making judgments and acting on them are essential activities of nursing practice. Nurses are legally responsible for their judgments in practice and this further emphasizes the need for thoughtful and deliberate judgment making (Donna 1975).

The observational task of the nurse in the early years of nursing consisted of three activities: (1) observing; (2) recording; and (3) reporting. A more realistic and precise description of the nurse's observational function is now being reported in nursing literature. The observation function now is concerned with three specific operations: (1) observation; (2) inference; and (3) decision making. All three functions are in the cognitive domain. The second and third tasks--making a judgment about the state of the patient and determining the appropriate nursing action to take--are clearly intellectual tasks (Kelly 1966). Recognition of this function is important, because many of the tasks which nurses make are cognitive; therefore, these tasks require that the nurse make inferences about the state of the patient (Hammond 1966). Hammond (1966) also stated that the nurse is faced with many more "uncertainty-gearred tasks" than "certainty

geared tasks" when inferring about patients. ("certainty-geared task-tasks-tasks that involve a fixed univocal relation between cause and effect; uncertainty task-uncertain task-uncertain palpable data presented by the patient") (Hammond 1966:29).

Hammond (1966) goes on to say that in order to improve nursing knowledge of the cognitive tasks which face the nurse daily, it is necessary to discover what inferences the nurses make about the state of the patient, what information the nurse has available on which she can base her inferences, and toward what goal the inferences are made. Hammond also describes two main types of inferences. These are:

1. Theoretical inferences -- necessary relations between cues. If A is observed, then A must be present.
2. Empirical inference -- occurs on the basis of past experience alone. If always, or frequently been associated with A, then if A is observed, A is certainly, or probably present (Hammond 1966:29).

Hammond (1966) describes intuitive inference as inferences being based on observed empirical information, with or without complete understanding, and are usually based on data obtained with instrumentation. Hammond goes on to state that it is his contention that nurses'

inferences about the state of the patient are more intuitive than logical.

Judgment processes are also a vital part of the decision making process. Schaefer (1974) describes decision making as "the act of choice following deliberation and judgment" (Schaefer 1974:1852). The decision based on these steps defines the course of action that is to be followed. For the decision to be effective, it must be communicated so that the decision can be known, accepted, and followed (Schaefer 1974).

Of importance to all these concepts is the related research that has been done. This research demonstrates the need for knowledge concerning the above concepts and the findings of importance in understanding these concepts. Therefore, the next section of this review of literature will consist of research done in the areas of clinical inferences and research done concerning the use of play.

Dincher and Stidger (1976) reviewed the literature from the last twenty years and determined that there was still a lack of tools to measure the ability to make clinical nursing judgments. Therefore, the purpose of their study was to develop an instrument to measure this ability. Dincher and Stidger selected a written clinical simulation in which the examinees recorded their decisions

about the situations. The implications for nursing obtained from this study were:

1. One test cannot adequately measure the phenomenon of nursing judgment. A battery of tests is needed.
2. The need for nursing education and service to be concerned with the area of clinical judgment is imperative to the preservation of the profession (Dincher and Stidger 1976:284).

Hanson and Thomas (1968) examined decision making in public health nursing. This study gave differences in priorities of advising medical care and priorities for home visits based on the different types of nurse's education and work experiences. In another study conducted by Grier (1976), which investigated the quantification of patient care decisions, it was demonstrated that: nursing decisions can be quantified, and that decision theories should be taught to students because the decision theory focuses on the essential aspect of the nursing process. The findings of these studies also stress the importance of judgment making in nursing.

Kelly (1964b) and Hammond (1964) did extensive research on the judgment process in nursing and the relationship to patient care. They undertook an empirical analysis of,

- (a) the kinds of inferences and decisions nurses make about patients, (b) the cues which nurses use

as a basis for such inferences, and (c) the action which they take as a consequence of their inferences.

This research demonstrated that nurses deal with multiple cues and multiple responses, not single cues and single responses; the nurse's working environment is probalistic and uncertain; nurses find using textbook pattern of cues inappropriate; nurses develop their own system of inference and were very consistent in their use of the system; and finally, nurses were effectively able to cope with patient situations when data about the patient are not complete.

Also of importance to this study is the research that has been done in the area of play therapy and hospitalization of the child. The following research information will be presented to identify the importance of play.

Cassell and Paul (1967) conducted a study on forty children, three through eleven years, who were admitted to a hospital for cardiac catheterization. This study was done to determine the effects of brief puppet therapy on the emotional responses of the children hospitalized for this procedure. The results of this study were that children who received brief puppet therapy not only were less disturbed during the cardiac catheterization, but also expressed more willingness to return to the hospital for further treatment.

Lockwood (1972) also conducted a study to ascertain if situational doll play between the child and the nurse would alter the level of stress and anxiety which the child experiences during the period of hospitalization prior to surgery. The data analysis of this study concluded that the situational doll play employed in this study did not affect the preoperative level of stress experienced by the children. The anxiety-defense of the children treated with situational doll play decreased significantly, and the focus of the stress reaction significantly decreased in the doctors and/or medical procedures category.

Juanita Flemming (1973) in her study "Understanding Hospitalized Children Through Drawings," wanted to determine if projective drawing identified differences between hospitalized children and children who were never hospitalized. The conclusion was that drawings and stories from pictures are two excellent methods of obtaining data that lead to further understanding of the child, and that utilization of these techniques in nursing assessment should be considered.

The study, "Effects of Hospital on Coping Behaviors of Children," by M. H. Rose (1974) demonstrated:

1. Children showed similar changes in their behavior during hospitalization and largely reverted to prehospital behavior after hospitalization

2. Reaction to and recovery from the hospital experience resulted from both the stress and support which the child encountered or perceived

3. Findings indicated that children do have the capacity to cope with stressful situations provided that they have some help and support

Another study done in 1970 by Wooten, Wood, and Barnes demonstrated that a nurse can utilize the technique of social reinforcement to change the play behaviors of a group of children from delayed development to a normal level of development.

Florence Erickson (1960) did a study to answer four questions about the effects of hospitalization on four year old. They were: (1) are four-year old hospitalized children able to use clinical equipment to express their feelings about intrusive procedures? (2) What methods do they use to cope with their feelings? (3) How to they interpret these procedures, and (4) What attitudes do they show toward personnel who administer intrusive procedures? This information was gained from the use of a play interview. From these interviews, her hypothesis

when given opportunity for play with clinical equipment and other accessories for projective play, four year old hospitalized children are able to express their feelings concerning procedures they have experienced was confirmed. Her study also revealed that through play, children struggle to solve problems related to age level, life situation, and their fears about what was happening around them (Erickson 1960).

And, finally, Boyle, a psychology doctoral student, used puppet play proving the hypothesis--the use of puppets will be more effective in alleviating the fears of children than the usual verbal explanations of procedures. This research was so successful that puppet play was not only advocated for the use of procedure teaching, but also as a tool which helps children express fears, fantasies, and anxieties. Through play, it was demonstrated that the child was more related during the procedure and the parents had a better understanding of what was happening (Bailey 1967).

In summary, if the child perceives hospitalization as a threatening and stressful experience, it seems logical to expect the nurse to alter the environment in order to promote a situation in which the child can effectively cope with these threats and stresses. Play is a natural

means of communication for the child, through which the child can act out his accumulated tension, frustration, insecurity, and aggression. By releasing these accumulated fears and tensions through play, the child is free to grow, to expand (Axline 1947). Play sessions involving the child and the nurse can foster communication, thereby enabling the nurse to discern the child's needs, tensions, and unique perception of his environment.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

In order to determine the purpose of this study--i.e., what data base nurses utilize in order to make the clinical nursing judgment to use play as a therapeutic intervention for the hospitalized preschooler--the following methodology was used.

Type of Study

This study was conducted by the descriptive research process and will utilize a nonexperimental method of obtaining data (Abdellah 1965). This study was developmental and exploratory in nature and assisted in the discovery of information necessary for the measurement and correlation of nursing judgments, and the use of play for the hospitalized preschooler (Abdellah 1965).

Setting

This study was conducted in a nonprofit private children's hospital in a Southeastern United States metropolitan area of over 744,000 people. The inpatient areas of the hospital (first, second, and third floors which are the general medical surgical units for children from birth to fifteen years) were used to obtain the data. A well-

lighted conference room was used to explain the study's purposes to the members of the nursing staff. This conference room was also used by the nurses who volunteered to participate in the study to answer the questionnaire and patient situations.

Population

Written consent was obtained from the hospital to use the facilities and approach subjects during the investigational phase of the study (Appendix A). The subjects for this study were registered nurses employed full and part time on the first, second, and third floors of the inpatient area of the hospital, who are on an eight hour tour of duty during a one week period. The subjects were informed regarding the purpose of the study, anonymity of their participation, and were allowed the opportunity to refuse or consent to participate in the data collection phase of the study. The information was presented to each subject by means of an introductory letter (Appendix B) at the time of encounter and verbally by the researcher. Each subject who consented to participate in the study signed a consent form stating that they understood their involvement and voluntarily agreed to participate (Appendix B). Demographic information regarding age, sex, and amount of

professional experience was collected but was not used to limit the sample for the study. The sample was collected by the convenience sampling method. The investigational phase of the study extended from 10:00 A.M., November 1, 1977, to 5:00 P.M., November 7, 1977. During the investigational phase of the study, twenty-five registered nurses were admitted to the study population.

Tool

The development of the data collection tool used for this research project is based on the following framework of Kelly (1964b) and Hammond (1964) and Dincher and Stidger (1976). Kelly (1964b) and Hammond (1964) described in detail the theory and method of Brunswick's Representation Design, which these authors used to study clinical inference in nursing. See Appendix C for complete model. The diagram (Appendix C) gives three types of measurements:

1. The relationship between the sign or symptom and the state of the patient. This is a measure of ecological validity.
2. The relationship between the cue and the nurse's dependence on the cue. This is a measure of cue utilization.
3. The relationship between the inference and the state of the patient. This is a measure of the nurse's achievement.

If a nurse places too much reliance on a sign that has little or no validity, or if she ignores

a cue with high validity, her achievement will be low (Kelly (1964b:320)).

Initially, Kelly (1964b) and Hammond (1964) planned to follow a procedure that was developed to present patients to nurses that would permit quantitative analysis of both the subjective and objective weightings attached to various cues, but they faced two important problems. These were:

1. The conditions or state of the patient in which the nurse makes inferences such as pain, anxiety, or shock, cannot be measured objectively;
2. The signs or cues used by nurses in making inferences vary in degree and intensity and do not lend themselves to precise measurement (Kelly 1964b:321).

Plans were made as a result of those consequences to make an empirical study of the sign/symptom/action complex in nurse patient situations. These plans were also based on the findings that although nursing literature frequently refers to the significant and important decisions made by nurses, no list of the kinds of inferences and decisions made by nurses could be found, nor was there any information about the situations faced by nurses in their daily activities. The Brunswick Lens Model (Appendix C was expended to include nursing actions and goals (Kelly 1964b)).

Based on all of these findings, Kelly (1964b) developed one hundred descriptions of patients which were

given to nurses to read and indicate: (1) the state of the patient, (2) the action which should be taken in response to the patient, (3) the nurse's estimate of the value of each one, and (4) the nurse's estimate of the certainty of each one (Kelly 1964b). This is one of several patient situation type tools that have been developed for researching nursing inference.

Another variation of this concept was developed by Dincher and Stidger (1976). These authors identified a need for an instrument to measure nurse's ability to make clinical judgments. They developed a written clinical situation format because it allowed presentation of multiple cues. This technique is applicable to any sequential decision process in which the following skill range is required: skill in assessing priorities, skill in eliciting data, skill in interpreting data, skill in using a variety of resources, skill in avoiding unnecessary and wasteful actions, and skill in manipulating the situation to alter it and in monitoring the effects of the manipulation and readjusting decisions or actions to respond to the changed situation. Inherent in each of these skills is the need to make judgments (Dincher and Stidger 1976).

As a result of the review of literature, the researcher adapted a patient description and questionnaire

to determine what information nurses use to make a judgment concerning play (Appendix D). These descriptions and questionnaire were submitted to a panel of four experts. The panel consisted of the director of a school of nursing and three maternal child health faculty members. All members to the panel had their Masters degrees (two in maternal child health nursing and two in education). They reviewed the situations and the questionnaire and selected the cues, judgments, and actions for the situations. They agreed on the answers that were provided for them in the questionnaire. For the purpose of validating the instrument, the researcher determined the rate of agreement acceptable would be that at least three out of the four panel members agreed.

The nurses participating in the study were asked to select and list specific cues they would use to make judgments concerning play, and the actions they would take. After the situations were completed, the nurses then answered the questionnaire concerning play. A pilot study was conducted to pretest the instrument.

On the basis of a pilot study, that was conducted October 1977, on the fourth floor of a large privately owned hospital in a metropolitan area of over 744,000 people in the southeastern United States, the instrument

was tested. The fourth floor is a pediatric floor in which the ages of children range from birth to fifteen years. A well lighted conference room was used to explain the study's purpose to the members of the nursing staff. This conference room was also used by the nurses who volunteered to participate in the study. Written consent was obtained from the hospital to use the facilities and approach the subjects during the pilot study (Appendix A). The subjects for this pilot study were ten registered nurses employed full and part time on the fourth floor and who were on an eight hour tour of duty during the two day period of investigation. The subjects were informed regarding the purpose of the study, anonymity of their participation, and had the opportunity to refuse or consent to participate in the data collection. This information was presented to each subject in the form of an introductory letter (Appendix B) at the time of encounter and verbally by the researcher. Each subject who consented to participate in the study signed a consent form stating that they understood their involvement and voluntarily agreed to participate (Appendix B). The sample was collected by convenience sample method during the pilot study phase that extended from October 28, 1977 to October 31, 1977.

The pilot study was used to further validate the instrument and to test its usefulness with a small number of subjects with similar characteristics of the proposed study population. No changes were made in the instrument as a result of this pilot study.

Collection of Data

The data for this study were collected by convenience sample method in the nonprivate children's hospital in a metropolitan area of over 744,000 people in the southeastern United States from November 1, 1977 to November 7, 1977. The patient description and questionnaire developed by the researcher was used to gather the data. Each subject was seated at a desk in the conference room of the hospital and was given a copy of the instrument. The researcher presented the instrument and awaited its completion by the subjects. Verbal as well as written instructions were given to explain the instrument (Appendix D). The subjects were given the tool and completed the form in thirty-five minutes.

Treatment of Data

The treatment of the data consisted of the following features. The demographic data, collected to describe the sample more fully, was analyzed to determine if there

was a correlation between the findings on the patient situations and the demographic items (i.e., does education influence the decision to use or not to use play as a part of nursing care?). The Student's t test was used to analyze this data.

Each cue, identified by the judges, was put in a list and assigned a value of one. These values were totaled and each situation had a predetermined score which was the basis on which the participants' scores were determined. The scores were tabulated for total cue selection by individuals and by total sample. Comparisons of the scores were done to identify range, mean, and median.

Content analysis on the nursing actions and judgments were tabulated and the findings were classified by the researcher for presentation in this study. The questionnaire was coded and correlations were made with the other information obtained.

Summary

Chapter III has presented the methodology used in this study. The results of the analysis appear in Chapter IV of the study and are augmented by tables and descriptive explanations.

CHAPTER IV

ANALYSIS OF DATA

This study was concerned with identifying what data nurses selected in order to make a clinical nursing judgment to use play as a therapeutic intervention. Twenty-five registered nurses were involved as subjects in this study. The results of the study are presented in this chapter.

Description of the Sample

The sample population consisted of twenty-five registered nurses who were on an eight hour tour of duty during a period from November 1, 1977, to November 7, 1977. Table 1 lists each subject according to the demographic data acquired from the questionnaire.

Table 1 also presents the age range, which was from 20 to 50 years with the majority being in the age group 20-29 years. There were twenty-three females in the study and two males in the sample population. The average length of total nursing experience was seventy-eight months with the range between 5 months to 300 months of experience. Seven registered nurses (28 percent) were graduates with a baccalaureate degree in nursing, 11 registered nurses (44

TABLE 1
DEMOGRAPHIC DATA OF THE SAMPLE POPULATION

<u>N*</u>	<u>Age Group</u>	<u>Sex</u>	<u>Basic Education Program</u>	<u>Total Months Experience in Nursing</u>
1.	20-29	F	Diploma	72 Months
2.	40-49	F	Diploma	300 Months
3.	30-39	F	Diploma	120 Months
4.	30-39	F	Associate Degree	48 Months
5.	20-29	F	Diploma	60 Months
6.	30-39	F	Diploma	108 Months
7.	20-29	F	Associate Degree	84 Months
8.	30-39	F	Diploma	108 Months
9.	20-29	F	Diploma	42 Months
10.	30-39	F	Associate Degree	72 Months
11.	30-39	F	Baccalaureate	96 Months
12.	20-29	F	Associate Degree	18 Months
13.	20-29	F	Diploma	15 Months
14.	20-29	F	Associate Degree	5 Months
15.	20-29	F	Diploma	48 Months
16.	20-29	F	Associate Degree	30 Months
17.	20-29	F	Diploma	108 Months
18.	40-49	F	Baccalaureate	120 Months
19.	30-39	F	Baccalaureate	48 Months
20.	30-39	M	Associate Degree	24 Months
21.	40-49	F	Diploma	144 Months
22.	30-39	F	Baccalaureate	120 Months
23.	20-29	F	Baccalaureate	24 Months
24.	30-39	F	Baccalaureate	108 Months
25.	20-29	M	Baccalaureate	24 Months

N* = 25

percent) were of a diploma program, and 7 registered nurses (28 percent) were graduates with associate degrees in nursing.

Presentation and Analysis of Data

Content analysis and the Student's t test provided the basis for interpreting the data. Content analysis is "a method of studying and analyzing communications in a systematic objective and quantitative manner to measure variables (Kerlinger 1973:525). Content analysis is usually done to determine the frequency of various communication phenomena (Kerlinger 1973). Content analysis can also be described as a method used to make descriptive statements concerning an attitude, word or concept, frequency, a change or social condition (Treece and Treece 1977). The Student's t test is a statistical comparison of means (Spurr and Bonini 1973).

Subjects were required to identify the cues they would select to make a clinical nursing judgment and the actions they would take based on the cues and judgments selected. Each cue was assigned a value of one. Table 2 presents the values of scores from the total sample. Total cue scores of each subject were obtained by adding the individual scores of total cues selected from Situations I

TABLE 2

VALUES OF THE SCORES TOTAL SAMPLE

<u>Subject(N)*</u>	<u>Situation I</u>	<u>Situation II</u>	<u>Total Cue Selection</u>
1	5	2	7
2	5	2	7
3	3	2	5
4	3	2	5
5	2	2	4
6	8	2	10
7	4	2	6
8	4	2	6
9	3	2	5
10	1	2	3
11	8	3	11
12	5	2	7
13	5	2	7
14	3	2	5
15	4	2	6
16	7	3	10
17	8	3	11
18	8	3	11
19	5	2	7
20	3	2	5
21	5	2	7
22	7	2	9
23	4	2	6
24	6	2	8
25	7	2	9
			176

N* = 25

and II. Situation I had a total possibility of eight cues to be selected and Situation II had a possibility of three cues selected. The possible range of scores for the individual was from 0 to 11. Individual scores ranged from 3 to 11 with the average score of 7. The total sample selected was 176 cues out of a possible 275. Sixty-four percent of all possible cues was selected.

Cue selection of Situations I and II were also compared to the demographic information age, education, and experience. These comparisons of the means were made by using the Student's t test. There was no significant difference statistically between age and cue selection; between education and cue selection; nor between experience and cue selection in either Situation I or II.

Table 3 demonstrates frequency and percentage of cue selection for the sample. Cue number 3 for Situation I (96 percent) was the most commonly selected cue and followed by cue 5 and 8 (92 percent). Cue 1 of Situation I was least chosen (20 percent). In Situation II, cues 2 and 3 were selected most often (96 percent) and cue 1 selected least often (16 percent). See Appendix E for further explanation of cues.

TABLE 3
FREQUENCY AND PERCENTAGE OF CUES

Cues in Situation I	Number of Subjects Choosing the Cue	Percentage
1	5/25	20
2	17/25	68
3	24/25	96
4	12/25	48
5	23/25	92
6	10/25	40
7	9/25	36
8	23/25	92

Cues in Situation II	Number of Subjects Choosing the Cue	Percentage
1	4/25	16
2	24/25	96
3	24/25	96

Table 4 demonstrates the range, mean, median, and mode of Situations I and II. The mean in Situation I was five out of the possible eight cues. In Situation II, the mean number of cue selected by the sample was two out of four possible cues.

Judgments were examined in regard to individual and total scores. The possible range of individual scores was 9-11 and 0-275 for the sample. Table 5 presents the

TABLE 4
RANGE, MEDIAN, MODE, AND MEAN OF
SITUATIONS I AND II

	Situation I	Situation II
Range	7	3
Median	5	2
Mode	3	2
Mean	5	2

TABLE 5
SCORES OF TOTAL SAMPLE OF JUDGMENTS

<u>Subject (N)*</u>	<u>Judgment Selected</u>
1	6
2	5
3	4
4	4
5	5
6	8
7	6
8	5
9	4
10	5
11	10
12	6
13	5
14	5

TABLE 5 (continued)

<u>Subject (N)*</u>	<u>Judgment Selected</u>
15	4
16	7
17	10
18	9
19	5
20	4
21	5
22	8
23	5
24	7
25	<u>9</u>
Total Score	151

N = 25

scores of the sample. Individual scores ranged from 4-11 with the average score of 6. The total score was 151 (54 percent) of a possible 275. This figure shows that nurses could identify 54 percent of all appropriate judgments.

Nursing actions were examined in regard to individual and total scores. The possible range of scores for nursing actions was 0-12 for individual and 0-300 for the sample. Table 6 presents the scores of the sample. The individual scores ranged from 3-11 with the average score of 6. The total score was 154 (51 percent) of a possible

TABLE 6
TOTAL NURSING ACTIONS SELECTED

Subject (N)*	Action
1	5
2	5
3	4
4	4
5	5
6	10
7	5
8	6
9	4
10	3
11	11
12	6
13	6
14	4
15	3
16	6
17	10
18	11
19	7
20	6
21	6
22	8
23	8
24	7
25	6
Total Score	154

N = 25

300. This figure shows that nurses could identify only 51 percent of all appropriate nursing actions.

Table 7 presents the data for frequency of occurrence of nursing actions for Situation I by all subjects. Only three nurses selected nursing action 1 and nursing action 3 and 8 were selected by 21 of 25 nurses.

Table 8 presents the data for frequency of occurrence of nursing actions in Situation II by all subjects. No nurses selected nursing action 3 and only four nurses selected nursing action 1. Nursing action 2 was selected most frequently by the subjects. See Appendix F for more detailed explanation of nursing actions 1-8 (Situation I) and 1-4 (Situation II).

The following data deal with information gained from the questionnaire. Twenty of the twenty-five nurses stated that they frequently used play as part of their nursing care. Five stated they sometimes used play as part of their nursing care. On a scale of 1 to 10, with 10 as the highest possible score to place play, ten nurses chose 10 on the scale for play, nine nurses chose 8 on the scale for play, and six chose to place play on number 5 of the scale. In responding to the question of who should provide play for the child in the hospital, nine nurses said everyone coming in contact with the child, eleven nurses said

TABLE 7
FREQUENCY OF OCCURRENCE OF NURSING ACTIONS IN
SITUATION I

Subject(N)*1	Nursing Actions							%
	2	3	4	5	6	7	8	
1				X		X	X	38
2	X	X					X	38
3				X	X		X	38
4						X	X	25
5		X	X	X				38
6	X	X	X	X		X	X	88
7		X	X	X			X	50
8		X	X	X			X	50
9			X		X		X	38
10			X	X				25
11	X	X	X	X	X	X	X	100
12			X	X	X		X	50
13			X	X	X		X	50
14			X		X		X	38
15							X	13
16			X		X	X	X	50
17		X	X	X	X	X	X	88
18	X	X	X	X	X	X	X	100
19		X	X	X	X		X	63
20		X	X	X	X		X	63
21		X	X	X	X			50
22			X	X	X	X	X	75
23		X	X		X		X	50
24		X	X			X	X	63
25		X	X	X	X			50

N* =25

TABLE 8
FREQUENCY OF OCCURRENCE OF NURSING ACTIONS IN
SITUATION II

Subject(N)*	<u>Nursing Actions</u>				%
	1	2	3	4	
1		X		X	50
2		X		X	50
3		X			25
4		X		X	50
5		X		X	50
6	X	X		X	75
7	X				25
8		X		X	50
9				X	25
10		X			25
11	X	X		X	75
12		X		X	50
13		X		X	50
14		X			25
15		X		X	50
16		X		X	50
17	X	X		X	75
18	X	X		X	75
19		X		X	50
20		X		X	50
21		X		X	50
22		X		X	50
23		X		X	50
24		X		X	50
25		X		X	50

N* =25

caring for the child should provide play for the child, and five nurses said a combination of the nurse and a play therapist should provide play for the child. Fifteen nurses stated that uses of play were part of their curriculum in their nursing education and eleven stated no. Eleven nurses defined play as the child's work, means of expression of feelings, and a means of communication. Four nurses defined play as recreational fun activities of a child that involve a learning process. Five nurses defined play as a means of allowing one to escape from reality, work through anxieties and be creative. One nurse said play was an important part of the child's life. Four nurses defined play as the spontaneous activity with or without other children or toys fostering creativity in the child.

Summary

From the results of the analysis of data obtained from the patient situations, nurses selected 64 percent of the cues, 54 percent of the appropriate judgments, and 51 percent of the nursing actions. Individual scores demonstrated that cues, judgments, and nursing actions about growth and development were selected the least. Individual scores also demonstrated that the nurses could list play as an intervention but could not specifically use play in

a given situation. Demographic data revealed no significant difference between cue selection and age, experience, or education of the nurses who were subjects.

Also based on the analysis, emotional care, as defined in this study, is one of the components necessary to be assessed in the total care of the child. The data identified in the analysis does fit the format of nursing standards developed by the American Nurses' Association (Appendix G), and all the standards address the data collected in this study.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This study was conducted to identify what data nurses select in order to make a clinical nursing judgment to use play as a therapeutic intervention. The purposes were to: 1) identify the data base nurses consider necessary in order to use play as a nursing intervention; 2) identify play components used by nurses in daily nursing care activities; and 3) begin development of a standard of nursing practice as demonstrated by the American Nurses' Association, related to the emotional care of the hospitalized child.

The research was conducted in a nonprofit private children's hospital in a metropolitan area of over 744,000 people. Sampling was done by convenience method. Twenty-five registered nurses comprised the sample population. A simulated patient situation and questionnaire constructed by the researcher was utilized to collect the data from each of the participants in this study. The data collection phase extended from November 1, 1977 to November 7, 1977.

The analysis of data was conducted by content analysis and the Student's t test. The results of this analysis were used to identify what data nurses select in order to make the decision to use play as a nursing action.

Further analysis of data showed that cues, judgments, and nursing actions concerning the specific psychosocial characteristics of the preschooler were least chosen. The information collected from the questionnaire demonstrated that the subjects could define play and describe it as a needed aspect of nursing care. Individual scores in judgment and nursing actions demonstrated that the subjects could not identify any specific play components used in daily nursing care activities. Demographic data was statistically compared to the cue selection and no significant differences were found.

Conclusions

The purposes of this study were to: 1) identify the data base nurses consider necessary in order to make the choice to use play as a nursing intervention; 2) identify play components used in daily nursing care activities; and 3) begin development of a standard of nursing practice as demonstrated by the American Nurses' Association related to the emotional care of the hospitalized child.

Information identified from the data analysis permitted the researcher to draw the following conclusions:

1. The percentage of cues selected by the nurses was 64 percent
2. The percentage of judgments selected by the nurses was 54 percent
3. The percentage of nursing actions selected by the nurses was 51 percent
4. The demographic items, age experience and education, when compared statistically to the cue selection showed no significant difference
5. Psycho-social characteristics of the preschooler were of the least chosen cues, judgments, and nursing actions
6. Information from the questionnaire demonstrated that nurses could define play and its importance to the hospitalized child
7. Nurses could not list specifically any play components used in daily nursing care
8. In Situation II of the patient situations, the nursing action 3 (providing Jon with therapeutic play after his tonsillectomy and adenoidectomy) was not chosen by any of the subjects in the study

9. The data identified in the analysis does fit the format of nursing standards developed by the American Nurses' Association, and all the standards address the data collected in this study

At the present state of development, the patient situations and questionnaire are recommended to be used only as a guide for understanding the way in which nurses select data in regards to cue selection, judgment, and nursing actions about the state of a patient. Because the emotional care of the child in the hospital is necessary for quality patient care and because nurses engage in the judgment process, it is essential that methods be explored to assist the nurse in identifying the components of these concepts.

Recommendations

The following recommendations are offered for subsequent research studies in the area of play and clinical nursing judgment:

1. Further research to define concepts of clinical nursing judgment
2. Additional investigation into implications of the process and methods utilized for nurses in making clinical nursing judgments

3. Further research to study the relationship of cues and nursing actions by increasing sample size
4. Investigation of the utilization of clinical nursing judgments and its effects on professional development of registered nurses
5. Further study to identify a standard of nursing practice related to the emotional care of the hospitalized child
6. Further study to determine the use of play as a daily nursing action
7. Investigation of the utilization of growth and development principals in the caring of children
8. Further study to determine the need for hospital inservice programs concerning methods and values of therapeutic play
9. Investigation of methods to refine and revise the data collection tool of this study

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APPENDIX A

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Texas 75235

HOUSTON CENTER
1130 M.D. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Baptist Memorial Hospital
GRANTS TO Charlotte Ward

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

What data nurses select in order to make the clinical nursing judgment to use play as a therapeutic nursing intervention

The conditions mutually agreed upon are as follows:

1. The agency (may) (~~may not~~) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (~~may not~~) be identified in the final report.
3. The agency (~~wants~~) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (~~unwilling~~) to allow the completed report to be circulated through interlibrary loan.
5. Other: _____

Date 10/28/77

Baptist Memorial Hospital
by Robert F. Scates
Signature of Agency Personnel

Charlotte Ward
Signature of student

Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original -- Student; first copy -- agency; second copy -- T.W.U. College of Nursing.

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Texas 75235

HOUSTON CENTER
1130 M.D. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Le Bonheur
GRANTS TO Charlotte Ward-Lawson

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

What data nurses select in order to make the clinical nursing judgment to use play as a therapeutic intervention

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report. *p ap.*
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan. *p ap.*
5. Other: _____

Date 10-31-77

Suzanne McClutcher
Signature of Agency Personnel

Charlotte Ward-Lawson
Signature of student

Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original -- Student; first copy -- agency; second copy -- T.W.U. College of Nursing.

TEXAS WOMAN'S UNIVERSITY

Human Research Committee

Name of Investigator: Charlotte Ward-Larson Center: Dallas

Address: 693 S. Belevvedere Date: November 7, 1977

Memphis, Tenn. 38104

Dear Ms. Ward-Larson:

Your study entitled Plas As A Primary Nursing Intervention
For the Hospitalized Preschooler

has been reviewed by a committee of the Human Research Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education and Welfare regulations require that written consents must be obtained from all human subjects in your studies. These forms must be kept on file by you.

Furthermore, should your project change, another review by the Committee is required, according to DHEW regulations.

Sincerely,



Chairman, Human Research
Review Committee
at Dallas Center.

APPENDIX B

Dear Nurse:

As part of the requirements for a Master of Science degree, I have developed an instrument for the measurement of perceptions of clinical inference levels of the pediatric nurse. A clinical inference is defined as a conclusion or judgment drawn from data.

Studies have shown that the need for nursing education and nursing practitioners to be concerned with the area of clinical judgment is imperative for the preservation of the nursing profession. This need can be filled by the development of a means of measuring effectively how decisions are made.

I would like your volunteer participation in this study to examine what factors nurses use to make inferences and how they follow up on these judgments. You will be asked to complete three forms: (1) a sheet containing demographic information, (2) a questionnaire, and (3) two patient situations. Your identity will not be revealed in the study and your responses will only be identified by a number given at the time you fill out the forms. The time involved will be approximately thirty minutes. You are requested not to discuss your participation and/or other information regarding the study with other members of the staff until after the data collection phase is complete.

A copy of the final research report will be available to you in the Nursing Office after November 1977. A staff meeting will be scheduled to discuss the results of this study with you.

If you agree to anonymously participate in this study by filling out the demographic sheet, patient situations, and the questionnaire, please read and sign the attached consent form. Thank you for your cooperation.

Sincerely,

Charlotte Ward-Larson, R.N.

TEXAS WOMAN'S UNIVERSITY

(Form B-- Oral presentation to subject)

Consent to Act as a Subject for Research and Investigation:

I have received an oral description of this study, including a fair explanation of the procedures and their purpose, any associated discomforts or risks, and a description of the possible benefits. An offer has been made to me to answer all questions about the study. I understand that my name will not be used in any release of the data and that I am free to withdraw at any time.

Signature _____ Date _____

Witness _____ Date _____

Certification by Person Explaining the Study:

This is to certify that I have fully informed and explained to the above named person a description of the listed elements of informed consent.

Signature _____ Date _____

Position _____

Witness _____ Date _____

APPENDIX C

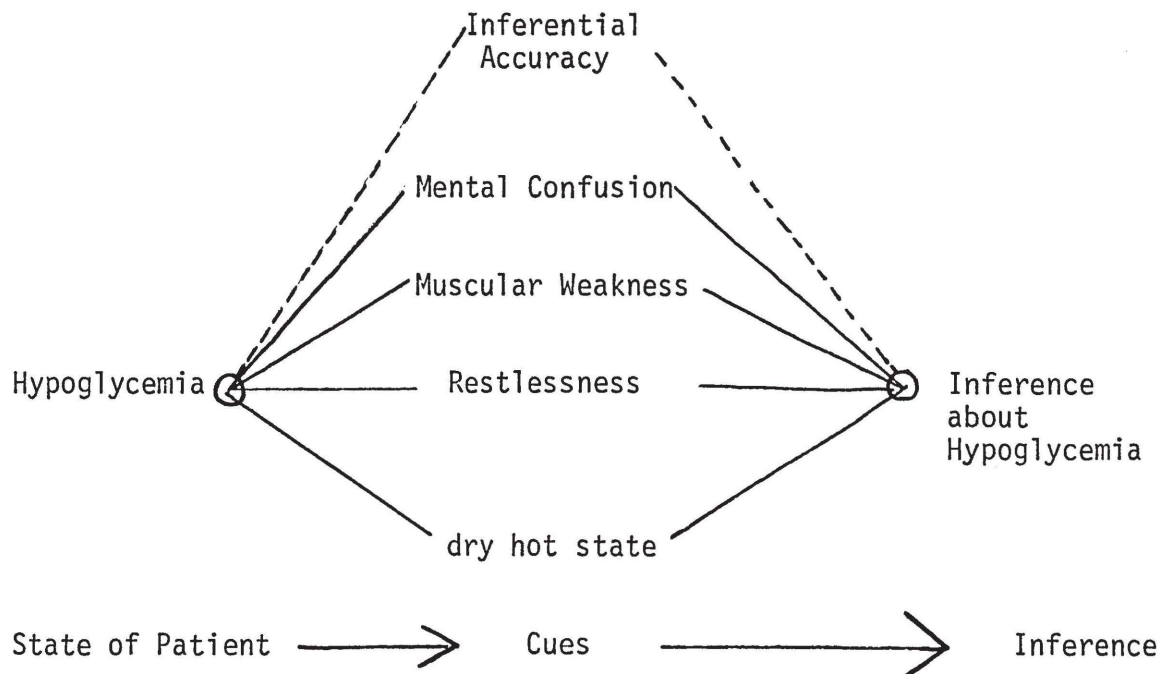


Figure 1: Signal System

From this diagram, it can be determined:

1. On the left side is the state of the patient or condition about which the nurse makes inference
2. In the center are signs and symptoms which indicate the presence of the condition
3. On the right is the inference made by the nurse about the state of the patient

SOURCE: Katherine Kelly. 1964b. An approach to the study of clinical inference in nursing, part III, utilization of the "Lens Model" method to study the inferential process of the nurse. Nursing Research. 13, 4:320.

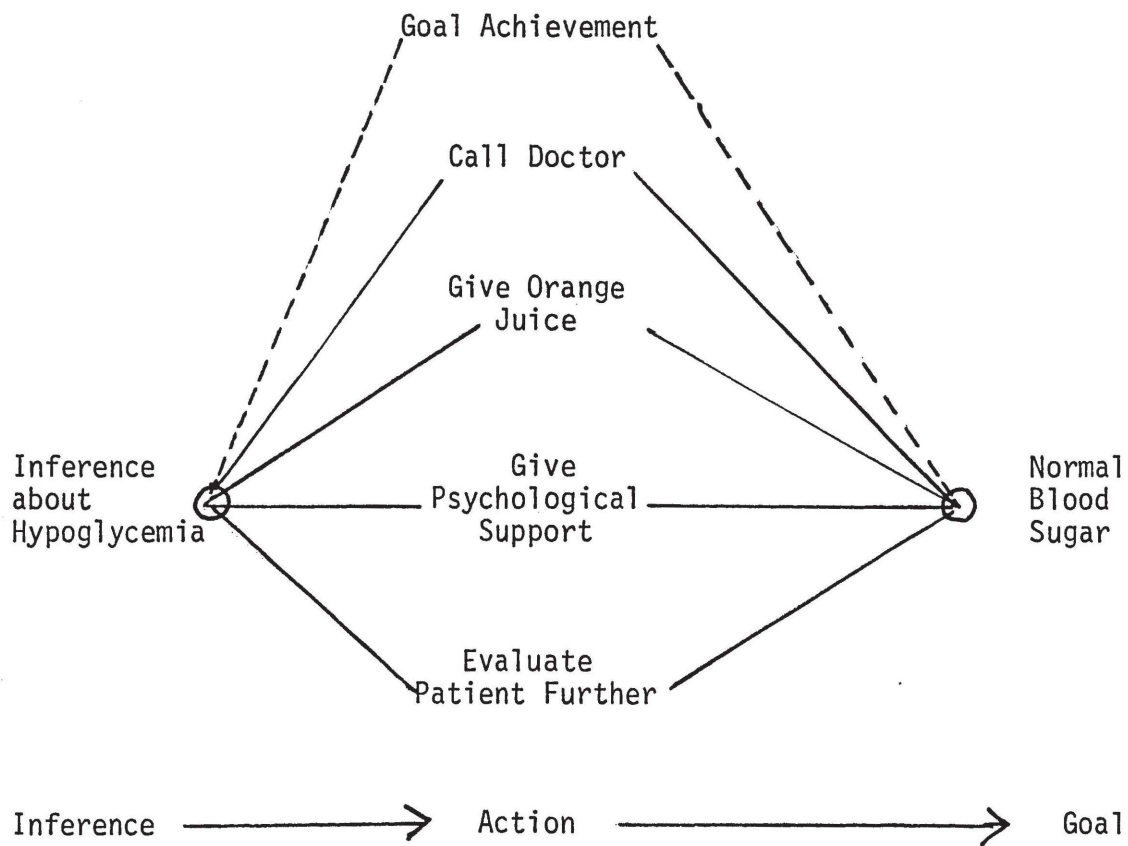


Figure 2: Action System

SOURCE: Katherine Kelly. 1964b. An approach to the study of clinical inference in nursing, part III, utilization of the "Lens Model" method to study the inferential process of the nurse. Nursing Research. 13, 4:321.

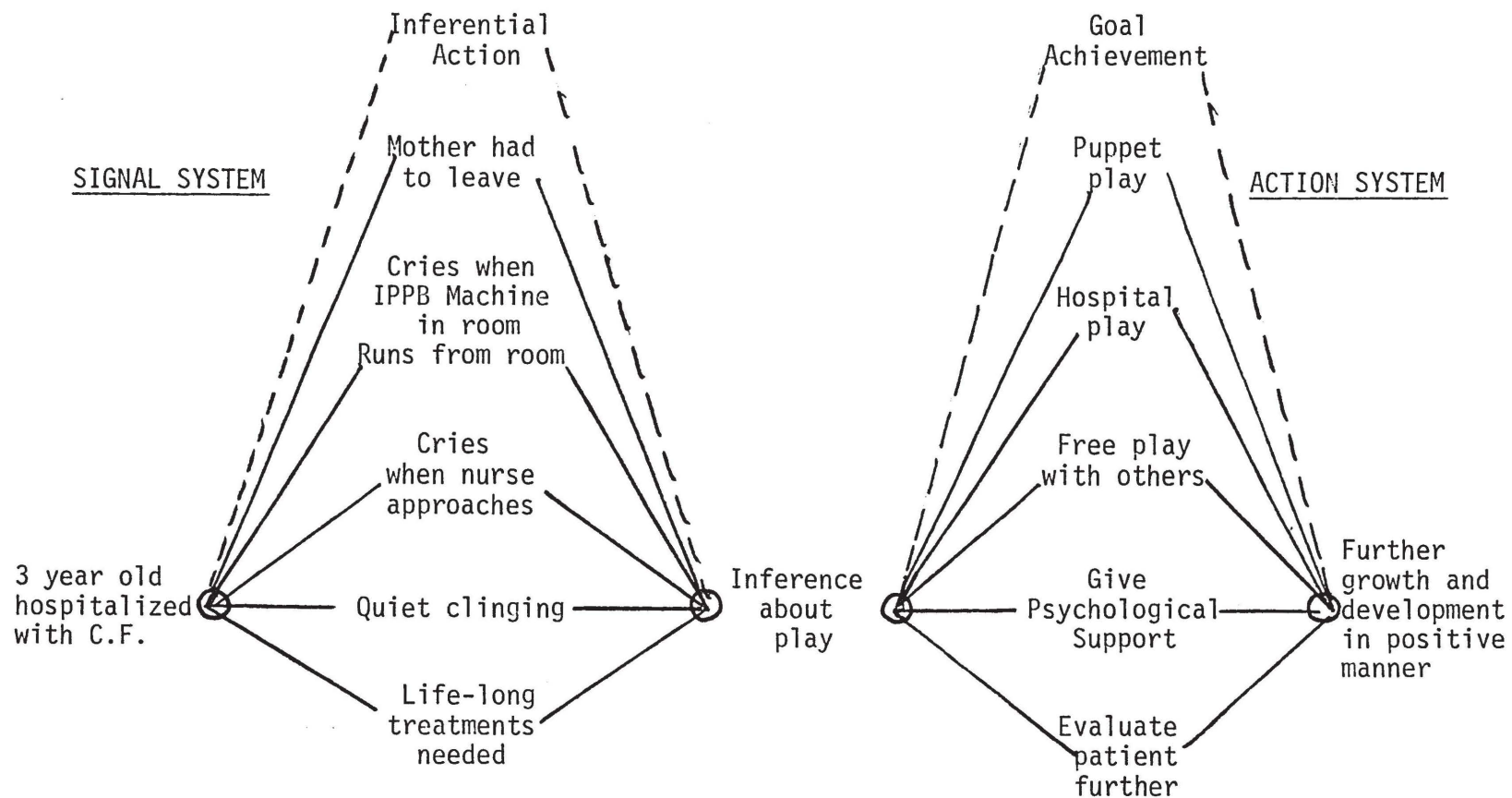


Figure 3: Signal and Action Systems

SOURCE: Katherine Kelly. 1964b. An approach to the study of clinical inference in nursing, part III, utilization of the "Lens Model" method to study the inferential process of the nurse. Nursing Research. 13, 4:319-322.

APPENDIX D

INSTRUCTIONS

After filling out the demographic information, please respond to the following situations by identifying any data (cue) given in the situations and what judgments follow the identification of the data. After the identification of the data and judgments, please describe what actions you would take in dealing with the problems identified.

After answering the situations, please answer the attached questionnaire in your own words.

A list of definitions is provided in order to aid your understanding of the terms used in the situations.

Thank you for your participation in this study.

DEMOGRAPHIC INFORMATION

Please check the appropriate response by filling in the spaces where indicated:

SEX: MALE _____ FEMALE _____

AGE: (20-29) _____ (50-59) _____
 (30-39) _____ (60-69) _____
 (40-49) _____ (70-79) _____

DATE OF GRADUATION FROM YOUR NURSING PROGRAM: _____

TYPE OF EDUCATION: Associate Degree _____
 Diploma _____
 Baccalaureate Degree _____
 Master's Degree _____

ADDITIONAL EDUCATIONAL EXPERIENCES:

Work Shops _____
Conferences _____
Staff Meetings _____
Graduate Courses _____
Inservice Programs _____

HOW OFTEN ARE THE ABOVE SELECTIONS ATTENDED: (i.e., once a year, etc.)

PRESENT POSITION: _____ HOW LONG? _____

FULL TIME _____ PART TIME _____

TOTAL LENGTH OF NURSING EXPERIENCE? _____

Thank you!

DEFINITION OF TERMS

Judgment -- a form of thinking based on cognition of various relationships and achieved knowledge of a state of affairs.

Clinical Nursing Judgment -- the method of acquiring evidence and organizing clinical thought used by the patient in the clinical situation.

Cues -- signs, symptoms, and other information related to the patient which are available to the nurse.

Inference -- a conclusion or judgment drawn from data.

Decision Making -- selecting a course of action from several alternative actions.

Nursing Diagnosis -- the process of determining the patient's presenting symptoms as a basis for instituting nursing measures to promote the patient's welfare.

SITUATION 1

Mike Jones is a pale three-year-old boy with thin arms and legs and a large protruding abdomen. He is twenty-eight inches tall and weighs twenty-five pounds. He was very quiet and clinging to his mother when carried to his room but began to cry as soon as the nurse approached him. Several days after admission, Mike's diagnosis of Cystic Fibrosis was established. Once the diagnosis was confirmed, Mike and his mother were introduced to therapy that would be continued at home. The therapy included postural drainage, aerosol therapy with IPPB, breathing exercises, expectorants, pancreatic enzymes, antibiotics, and multivitamins. Mike cries and runs out of the room when he sees the positive pressure machine. Mrs. Jones had to go home and will not return until tomorrow evening. Mike is confined to bed only at nap time.

Mrs. Jones returns the next evening and stops to say to you, "I'll never be able to get Mike to cooperate with the postural drainage three times a day. And how will I ever get all those medicines into him without a battle?"

Cues	Judgments or Inferences	Actions Taken

Situation 2

You walk into the waiting area to bring four-year-old Jon Smith to his hospital room. Jon is being admitted for a tonsillectomy and adenoidectomy tomorrow morning. As you greet Jon and his mother and invite them to come with you, you notice Jon is smiling and looks very happy. Mrs. Smith, however, appears tense and is staring straight ahead. She glances at you when Jon says, "Oh, we're not staying. I'm going to visit my grandma as soon as Mommy talks to the doctor." Mrs. Smith whispers to you that she has been unable to prepare Jon for his surgery. "He's too young to understand about it, and honestly, nurse, I just didn't know what to tell him. It was all I could do to get him to leave his friends and come with me."

Cues	Judgments or Inferences	Actions Taken

QUESTIONNAIRE

Please answer the following questions:

1. How do you define play?
2. Do you use play as part of your nursing care: Yes No
If yes, how often? Frequently Seldom Never
3. On a scale of one to ten (with ten the highest possible score) where would you place play?
1 2 3 4 5 6 7 8 9 10
4. In what situations do you see play as being appropriate nursing intervention: For example, if the child were withdrawn. Give as many examples as you choose.
5. Who do you think should provide play for the child in the hospital?
6. Were theories of play (or uses of play) a part of your curriculum in your nursing education? Yes No
If yes, name the theory (or theories).
7. What features would you identify as being important in delivering quality nursing care to the pediatric patient? For example, a daily bath.

APPENDIX E

RECOMMENDED CUE SELECTION
FOR SITUATION I

1. Three year old admitted to the hospital.
2. 28 inches tall, weighs 25 pounds, pale,, questionable diagnosis of cystic fibrosis.
3. Quiet and clinging; cries and runs when nurse enters the room.
4. Home treatments necessary for remainder of life span.
5. Cries and runs out of room when IPPB machine enters.
6. Mrs. Jones gone home.
7. Confined to bed only at naptime.
8. Mrs. Jones concerned about how to carry out Mike's care at home.

RECOMMENDED CUE SELECTION
FOR SITUATION II

1. 4 year old admitted to the hospital for tonsillectomy and adenoidectomy.
2. Smiling and happy. States, "not staying, going to grandmother's."
3. Mother tense and nervous. Unable to prepare Jon for his hospitalization.

Appendix F

RECOMMENDED NURSING ACTIONS TO BE TAKEN
IN SITUATION I

1. Develop nursing care plan around the psycho-social characteristics of three year old with chronic illness.
2. Obtain a diet history. Utilize lab findings to assess extent of pathology. Devise a teaching plan, in understandable manner, for Mike and Mrs. J.

Play techniques--puppet play can be helpful with Mike at mealtime if eating becomes a problem.

3. Allow for time to get acquainted with Mike. Spend time with Mike when no treatments or medicines are due. Use time to play with Mike--puppets, doctor, nurse, needle play, dolls, etc. to allow him to express his feelings about his hospitalization and give him some control over a situation. Assign same nurse to care for Mike on every shift if possible.
4. Allow gradual introduction to Mike and Mrs. Jones about the care to be done at home, so not to overwhelm them with too much information. Use play techniques--do postural drainage, IPPB Rx, on doll, let Mike do this too. Let Mike, when possible, choose what Rx to do first, i.e., which medicine to take first. Use puppets to help in giving of treatments and medicines. Allow gradual takeover to all treatments by Mrs. Jones before discharge, so she can develop confidence in her care for Mike.
5. Explain very carefully to Mike about the machine and why he needs the treatment. Explanation must be done in the context of a three-year-old's thinking patterns

(pre-operational, egocentric, concrete, etc.). Let Mike give treatment to doll, puppet. Have nurse join in with Mike in treatment and breathing exercises. Leave machine, or model in room with Mike, if possible, before treatments so he can become more familiar with the machine.

6. Allow Mike to talk on phone to mother every day until mother returns. Assign some person each day (and shift) to care for Mike. Review the effects of separation of mother on preschooler and plan care accordingly.
7. Use time to play with Mike in room or playroom. Let Mike choose type of play--free play, hospital play, etc., thereby allowing him to master his feelings of anger, fear, frustrations, etc. and giving him some control over his environment. Also observe Mike playing with others on the unit to determine growth and development levels, communication of ideas, etc.
8. Allow Mrs. Jones to express her feelings about Mike's illness and the prognosis, and how it will affect other family members, etc. Develop very comprehensive discharge plan for Mrs. Jones on her level of understanding.
 - a) review growth and development
 - b) demonstrate methods of play to aid in doing treatments
 - c) gradually let Mrs. Jones become more active in Mike's care. 1-2 days before discharge, let Mrs. Jones be in complete charge of Mike's care. Then her to verbalize her feelings.

- d) plan for Mrs. Jones to talk to other parents with c.f. children
- e) make proper referrals

RECOMMENDED NURSING ACTIONS TO BE TAKEN
IN SITUATION II

1. Develop nursing care play around the psycho-social characteristics of a four-year-old admitted for tonsillectomy and adenoidectomy.
2. Gradually introduce Jon and his mother to the hospital environment, explaining to Jon that he is staying. Use play techniques to explain to Jon that he will have to stay in the hospital for a few days. Use puppets, etc. to tell Jon a story about a little boy who needed his sore throat fixed, what is going to happen, and how. Allow Jon choices when possible, etc.
3. Before discharge, plan therapeutic play using hospital setup and dolls to let Jon express his feelings about coming to the hospital and the things that happened to him. Allow him to assimilate and understand what has taken place.
4. Allow Mrs. Smith to express feelings. Provide her with information about growth and development aspects of children.

APPENDIX G

STANDARD I

The collection of data about the health status of the client/patient is systematic and continuous. The data are accessible, communicated, and recorded.

Rationale:

Comprehensive care requires complete and ongoing collection of data about the client/patient to determine the nursing care needs of the client/patient. All health status data about the client/patient must be available for all members of the health care team.

Assessment Factors:

1. Health status data include:

- _____ Growth and development
- _____ Biophysical status
- _____ Emotional status
- _____ Cultural, religious, socioeconomic background
- _____ Performance of activities of daily living
- _____ Patterns of coping
- _____ Interaction patterns
- _____ Client's/patient's perception of and satisfaction with his health status
- _____ Client/patient health goals
- _____ Environment (physical, social, emotional, ecological)
- _____ Available and accessible human and material resources

2. Data are collected from:

- _____ Client/patient, family, significant others
- _____ Health care personnel
- _____ Individuals within the immediate environment and/or the community

3. Data are obtained by:

- ☐ Interview
- ☐ Examination
- ☐ Observation
- ☐ Reading records, reports, etc.

4. There is a format for the collection of data which:

- ☐ Provides for a systematic collection of data
- ☐ Facilitates the completeness of data collection

5. Continuous collection of data is evident by:

- ☐ Frequent updating
- ☐ Recording of changes in health status

6. The data are:

- ☐ Accessible on the client/patient records
- ☐ Retrievable from record-keeping systems
- ☐ Confidential when appropriate

STANDARD II

Nursing diagnoses are derived from health status data.

Rationale:

The health status of the client/patient the basis for determining the nursing care needs. The data are analyzed and compared to norms when possible.

Assessment Factors:

1. The client's/patient's health is compared to the norm in order to determine if there is a deviation from the norm and the degree and direction of deviation.
2. The client's/patient's capabilities and limitations are identified.

3. The nursing diagnoses are related to and congruent with the diagnoses of all other professionals caring for the client/patient.

STANDARD III

The plan of nursing care includes goals derived from the nursing diagnoses.

Rationale:

The determination of the results to be achieved is an essential part of planning care.

Assessment Factors:

1. Goals are mutually set with the client/patient and pertinent others:
 - _____ They are congruent with other planned therapies
 - _____ They are stated in realistic and measurable terms
 - _____ They are assigned a time period for achievement
2. Goals are established to maximize functional capabilities and are congruent with:
 - _____ Growth and development
 - _____ Biophysical status
 - _____ Behavioral patterns
 - _____ Human and material resources

STANDARD IV

The plan of nursing care includes priorities and the prescribed nursing approaches or measures to achieve the goals derived from the nursing diagnoses.

Rationale:

Nursing actions are planned to promote, maintain and restore the client's/patient's will-being.

Assessment Factors:

1. Physiological measures are planned to manage (prevent or control) specific patient problems and are related to the nursing diagnoses and goals of care, e.g. ALD, use of self-help devices, etc.
2. Psychosocial measures are specific to the client's/ patient's nursing care problem and to the nursing care goals, e.g. techniques to control aggression, motivation.
3. Teaching-learning principles are incorporated into the plan of care and objectives for learning stated in behavioral terms, e.g. specification of content for learner's level, reinforcement, readiness, etc.
4. Approaches are planned to provide for a therapeutic environment:
 - _____ Physical environmental factors are used to influence the therapeutic environment, e.g. control of noise, control of temperature, etc.
 - _____ Psychosocial measures are used to structure the environment for therapeutic ends, e.g. paternal participation in all phases of the maternity experience
 - _____ Group behaviors are used to structure interaction and influence the therapeutic environment, e.g. conformity, ethos, territorial rights, locomotion, etc.
5. Approaches are specified for orientation of the client/ patient to:
 - _____ New roles and relationships
 - _____ Relevant health (human and material) resources
 - _____ Modifications in plan of nursing care
 - _____ Relationship of modifications in nursing care plan to the total care plan
6. The plan of nursing care includes the utilization of available and appropriate resources:
 - _____ Human resources--other health personnel
 - _____ Material resources
 - _____ Community

7. The plan includes an ordered sequence of nursing actions.
8. Nursing approaches are planned on the basis of current scientific knowledge.

STANDARD V

Nursing actions provide for client/patient participation in health promotion, maintenance and restoration.

Rationale:

The client/patient and family are continually involved in nursing care.

Assessment Factors:

1. The client/patient and family are kept informed about:
 - _____ Current health status
 - _____ Changes in health status
 - _____ Total health care plan
 - _____ Nursing care plan
 - _____ Roles of health care personnel
 - _____ Health care resources
2. The client/patient and family are provided with the information needed to make decisions and choices about:
 - _____ Promoting, maintaining and restoring health
 - _____ Seeking and utilizing appropriate health care personnel
 - _____ Maintaining and using health care resources

STANDARD VI

Nursing actions assist the client/patient to maximize his health capabilities.

Rationale:

Nursing actions are designed to promote, maintain and restore health.

Assessment Factors:

1. Nursing actions:

- _____ Are consistent with the plan of care
- _____ Are based on scientific principles
- _____ Are individualized to the specific situation
- _____ Are used to provide a safe and therapeutic environment
- _____ Employ teaching-learning opportunities for the client/patient
- _____ Include utilization of appropriate resources

2. Nursing actions are directed by the client's/patient's physical, physiological, psychological and social behavior associated with:

- _____ Ingestion of food, fluid and nutrients
- _____ Elimination of body wastes and excesses in fluid
- _____ Locomotion and exercise
- _____ Regulatory mechanisms-body heat, metabolism
- _____ Relating to others
- _____ Self-actualization

STANDARD VII

The client patient's progress or lack of progress toward goal achievement is determined by client/patient and the nurse.

Rationale:

The quality of nursing care depends upon comprehensive and intelligent determination of nursing's impact upon the health status of the client/patient. The client/patient is an essential part of this determination.

Assessment Factors:

1. Current data about the client/patient are used to measure his progress toward goal achievement.

2. Nursing actions are analyzed for their effectiveness in the goal achievement of the client/patient.
3. The client/patient evaluates nursing actions and goal achievement.
4. Provision is made for nursing follow-up of a particular client/patient to determine the long-term effects of nursing care.

STANDARD VIII

The client's/patient's progress or lack of progress toward goal achievement directs reassessment, reordering of priorities, new goal setting and revision of the plan of nursing care.

Rationale:

The nursing process remains the same, but the input of new information may dictate new or revised approaches.

Assessment Factors:

1. Reassessment is directed by goal achievement or lack of goal achievement.
2. New priorities and goals are determined and additional nursing approaches are prescribed appropriately.
3. New Nursing actions are accurately and appropriately initiated.