

Preoperative counseling of child patients from the age of 6 to 9

A counseling folder for surgical child patients

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Abstract <p>The purpose of this bachelor's thesis was to create a counseling folder for the pediatric surgical ward of Central Finland's Central Hospital. It is aimed for children, who are coming to an operation and for their parents. The counseling folder is meant to be used for preparing the child and his family for an operation. The child's surgical care pathway is presented in the counseling folder by pictures and captions. The child and his parents can go through the folder at the pediatric ward before the operation. The counseling folder is aimed for both elective and emergency child patients.</p> <p>The information used to create the folder and this thesis was based on earlier researches and literature. The main features, which came up in the researches and literature were the following: relieving child's fear and pain, counseling and emotional support of the child and his parents, the parents participation in their child's care, the child's perceptions and feelings of fear and pain according to his level of development and the importance of pain assessment and postoperative pain management. The theoretical basis of the thesis was defined to focus on children from the age of six to nine years, but the folder is also suitable for younger as well as older children. In addition to the concrete folder, it was also provided to the pediatric ward in form of a cd, so that they can put it on display in the Internet on the health care district's web-page.</p>		
Keywords Children's surgical nursing, Preparation for surgery, Operation, Family-centered nursing, Child's fear, Child's pain, Counseling		
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1 INTRODUCTION

When a child gets ill, the first one to take notice is the child's family. Normally a family has its own coping strategies and they can cope with the illness at home on their own. When the child is in need of hospital care, the family can get apprehensive and fearful. The hospital itself has been known as a very stressful place for families and their children. (Glasper & Richardson 2006, 114.) Nursing processes in general cause emotional distress for children and their families and are a risk factor for the implementation of nursing care. Also it can delay the healing process of the child after the operation. (Korhonen, Kaakinen, Miettinen, Ukkola, Heino 2009a, 3.)

The purpose of patient counseling is to assure the safety of the child in every stage of the nursing process. A child's feeling of safety is dependent on the parent's possibilities to support their child during perioperative nursing process. Therefore adequate counseling of the parents is essential and strengthens their capability to prepare their child for the operation. (Korhonen et al. 2009b, 1.)

Children should always be carefully prepared for operations and they should be allowed to take part in their nursing care (Pelander 2008, 88). Good counseling and emotional support decrease stress and increase coping skills. Unknown situation and fear become easier to handle when the child has been given enough information of the upcoming operation beforehand. (Hiitola 2004, 135.)

One important way to approach children is through play. Playing is an essential form of activity, which works as a tool for processing new information via thought as well as action. Another essential factor in playing is its strength and meaning to the child as a way to express different feelings. Playing should always be part of children's nursing interventions since it supports children's natural development. (Hiitola 2004, 141.)

The researches that were used were rather difficult to find. The topics that we are focusing on in our thesis appeared in the literature, which was reviewed and the aim was to define the most important factors that influence child's hospitalization and expectations from operation.

Key words used in the search included: Child and preparation for surgery, child and surgery, family and hospital, child hospitalization, pain in general, child's pain and child's fear. These search words offered us useful information supporting our main topic of the thesis.

The references were searched from library of University of Applied Sciences and the Universities databases, also from EBSCO, Cinahl, Academic Search Elite, Linda, Arto, Aleksi, Duodecim, Journals@Ovid, Terveystietti and the internet. Furthermore, we used literature written by health care professionals.

The purpose of this thesis is to make a counseling folder, which will give an accurate information and emotional support for the child and his family. The counseling folder is going to be in use at the children's surgical ward in Central Finland's Central Hospital. The folder is going to have pictures with descriptive text beneath them. The final version will be in two languages, English and Finnish. Our folder can also be made into a leaflet to be given home with the family during a preoperative visit. A counseling folder called Antti-Fantti already exists at the pediatric ward but the idea of our thesis was to make an updated and more informative version for a child and his family. The aim of our thesis is to promote the counseling given in the surgical pediatric ward.

2 PEDIATRIC NURSING FROM THE AGE OF SIX TO NINE

2.1 Nursing a child patient

Nurses need to have knowledge of the ways in which children express their feelings to assess and manage pain. If the child has fear or anxiety it should

be processed before the operation because these feelings increase the physical and emotional discomfort. Therefore the nursing staff needs to listen and give time to the child and his family. (Pölkki 2002, 28.)

According to Einon (2001, 108) the nursing staff has to wait patiently for the child to tell what he wants to tell, he should not be forced to talk. The staff needs to respond and show interest towards the child. Positive feedback is crucial for the child to feel comfortable in difficult situations. In addition, independence and making decisions will make the child more interested in his own care.

2.2 Developmental level affecting understanding of the child from the age of six to nine

Piaget has a theory of children's development. He observed his own children's development, and his theory is based on these observations. Piaget was convinced that children's ability to think and reason progresses through a series of stages. He divided cognitive development into four stages. First stage being from birth to two years of age, and it is called the sensor motor stage. Second stage he called the preoperational stage; it is from two to seven years. Third stage he named the concrete operational stage; which is from seven till eleven years. The fourth stage is the formal operational stage; it starts approximately at eleven and continues throughout life. (Smith, Nole-Hoeksema, Fredrickson & Loftus 2003, 79.)

In this thesis the focus is on six to nine-year-old children. According to Piaget's theory children at this age are in the late preoperational stage (6-7) and in the concrete operational stage (7-9). In the preoperational stage the children learn to use language and learn which images and words represent specific objects, meaning that they learn to connect a picture of a teddy bear to the word and actual object. They understand the meaning of words and that they can use words to communicate with others. At this stage thinking is still egocentric and it is difficult to understand the viewpoint of others. Children in the concrete operational stage can already think logically about objects and events, but their thinking is still concrete. They cannot understand abstract

concepts, so things have to be explained to them in a suitable way for their age. (Smith et al. 2003, 79.) Most children around the age of eight start to imagine future possibilities and are able to connect a cause and its effect, such as disease and pain. It increases the co-operation of the children in painful procedures. (Pölkki 2002, 27.)

A child in school age needs to know the truth about his illness. He is able to understand what is told to him, and considers his own actions how to handle the illness. Emotionally he is at a stage of development in which he tries to deny and hide his feelings and pain (Pölkki 2002, 27-28). A child at this age is also scared, and if there is not enough information about the situation, fear can get overwhelming. A school aged child is able to search information by himself. That is why it is very important for the parents and nursing staff to make sure the child is getting the right information. The information the child searches by himself, might be wrong, or he could have misunderstood the information he found. (Ivanoff et al. 2006, 92.)

The upcoming operation is explained to the child by the primary nurse. Pictures can be used to help to visualize the upcoming operation and also seeing and touching equipment helps to reduce the child's fear. The more the children are prepared for the unknown, the better they cope with it. A scared child should not be forced on any situation that they are afraid of and child's fear should never be understated. (Glasper & Richardson 2006, 122; Ivanoff et al. 2006, 91-92.)

2.3 Child's fear from the age of six to nine

Fear is one of the basic emotions of a human being, and it is an integral part of development of a person (Flinkman & Salanterä 2004, 122). "According to Miller (1979) children's fear change with age and become more complex, varied and realistic and may be influenced by sex, social class and family relationships" (Mahat & Scoloveno 2006, 35). Furthermore, in different cultures children perceive their fear differently. Also parent's perception about their child's fear differs; they either underestimate or overestimate their child's fear. (Mahat, Scoloveno & Cannella 2004, 302.)

Wolman (1979) divides fear into three categories: Native- and developmental fear, and fear what has been learnt by a traumatic event. Native fear is acting differently in different stages in life, developmental fear is connected with development stages, and traumatic fear is connected with a traumatic event. Any fears arising from experience that involve medical procedure or personnel are called medical fear. (Flinkman & Salanterä 2004, 122.)

According to Piaget, children's fear is proportional to their cognitive development. Children cannot name any realistic target, and are afraid of issues that their parents teach them to, for example the traffic (Järviluoma 1999, 23-24). Children's fears at the age of four to eight are connected with their imagination. They are afraid of bogeymen, monsters, and supernatural matters (Flinkman & Salanterä 2004, 122). Even though children's fear is connected with their imagination, when they attain school age, children can think more concrete. Concrete thinking makes children more aware of realistic fears, such as physical danger and fear of the pain. Furthermore, when children attain school age, they might not show their fear and they use passive resistance in a situation where they feel pain. This is caused by children wanting to behave acceptably but also they do not know what the expected behavior from them in the hospital is. In addition, children fear sleeping, staying alone or losing their mother. (Järviluoma 1999, 24; Pölkki, Pietilä, Vehviläinen-Julkunen, 2003,18.)

When a child begins his school career his fears are related to the new environment, such as failure to success and abandonment from his friends and parents. A seven year old child's fears remain regarding staying alone, getting lost or fear of the dark. Also fear of dying is influencing the child in the age of seven to eight. Furthermore, if a child's emotional status is already shaken, or the child is tired, he is more susceptible to fear. (Järviluoma 1999, 24, 26.)

2.4 Child's medical and surgical fear

Medical fear is defined as fear arising from any experience that involves medical personnel or procedures, by Steward & Steward (1981). According to

Piaget (1967), at the age of seven a child starts to develop a logical reasoning ability and therefore is able to view the situations logically. Moreover, a school-age child can perceive the medical experience as a frightening threat. (Mahat & Scoloveno 2006, 35.)

Broome and Hellier (1987) have studied about healthy children's fears of medical experiences. Fears have been self-reported, and stated that the fears that these children had were: fear of spreading the illness the child had, fear of getting an injection, fear of having an operation, fear of being away from home and fear of getting their finger stuck. Study made by Broome three years later with healthy children stated that the most fearful issues were: being away from home, staying in the hospital for a long time, going to the hospital and getting an injection. In addition, school age children were afraid of missing school while being in the hospital. (Mahat & Scoloveno 2006, 35-39.)

According to Squires (1995), reasons that produce stress levels in children concerning medical fear are: unfamiliar people, routines and places including hospital clothing and food and play, exposure and stranger doing medical examination, medical jargon, shame and pain, and also seeing parental anxiety (Justus, Wilson, Walther, Wyles, Rode, Lim-Sulit 2006, 35-36). Other study has been done with Spanish-speaking elementary school students about their surgical worries (1999), and it stated that surgical worries have been correlatively positive with medical fears. It also stated that children who never had an operation were more worried about the surgical operation. (Méndez, Quiles & Hidalgo, 2001, 271.) Furthermore, one more study had stated, (Rennic, Johnston, Dougherty, Platt & Richie 2002) that children who were seriously ill, children who had more demanding operation done and younger children suffered more fears (Pölkki et al. 2003, 19).

As well as hospitalization has its own aspects of fear, so have surgical operations, which can be divided into five dimensions:

1. Physical discomfort, mutilation and death
2. Separation from parents and trusted adults
3. Fear of the unknown and unfamiliar, for example, hospital environment

4. Uncertainty about how to behave and what is acceptable in the hospital environment
5. Loss of autonomy, control and competence. (Bentley 2004, 21; Justus et al. 2006, 35.)

When a child is undergoing an invasive procedure there are certain “stress points” which are especially difficult for the child: separation from parents at the time they are being transported to the operation theatre, venipuncture, and anesthesia induction. Also most disturbing situations for children in invasive procedures are negative repercussion of surgery, problems or an unsuccessful operation, and pain. (Justus et al. 2006, 36; Méndez et al. 2001, 271, 278.)

3 COUNSELING

3.1 Importance of counseling

Patient counseling is an integral part of nursing patients as well as nursing profession generally. When counseling has been done successfully it has a good impact on health, and health behavior of the child and his family, but also to the national economy (Kääriäinen & Kyngäs 2006, 6). In addition, in successful counseling the patient has a better chance of getting his opinion heard and possibility to influence his own care. (Salanterä, Virtanen, Johansson, Elomaa, Salmela, Ahonen, Lehtikunnas, Moisander, Pulkkinen & Leino-Kilpi 2005, 218.)

In this thesis the emphasis is on the emotional support where the detrimental implications to health and emotional life can be eased or prevented. By emotional support we mean helping the patient with his arising feelings and thoughts from the upcoming operation. To be more precise, it is a method to help maintain and increase the safety of the family, and to minimize the anxiety rising from the unknown. This simply means giving information for the child and the family of the upcoming operation. It also means having a

conversation with the family on how the operation will affect them in everyday life. (Korhonen et al. 2009a, 6, 12; Pölkki et al. 2003, 20.)

3.2 Counseling a family

Counseling situation should be arranged with plenty of time and an environment with no distractions. The family should be encouraged to discuss their thoughts about the upcoming operation. Especially with school aged children it is crucial to discuss hospitalization and thoughts arising from it, because they do not necessarily show their fear. (Pölkki et al. 2003, 21.)

Parents should be encouraged to participate in their child's care and counsel their child as one of the caring methods. Nursing staff can provide the needed counseling material for the family, which they can go through with their child. This way the family can act as a liaison and be in an active role in their child's care but also to relieve their own anxiety about their child being hospitalized. Good communicating between family and health care professional and also hearing family's wishes has been rated highest in the quality of care. (Pelander 2008, 29, 32; Justus et al. 2006, 39.)

*Parents should be encouraged to take an active role in preparing their child for surgery and **must**, as the experts on ways their child deals with stress and as the primary providers of post operative care at home, be included in preparation. (Justus et al. 2006, 38).*

3.3 Counseling children

Counseling of children is done in a slightly different matter than counseling of adults. Children need more information, counseling, learning and understanding to make their own conception about issues in their life. Also children need more time to understand and process new issues which they experience. Counseling could only be successful if the child feels that he is safe, and finds the issue interesting enough. Counseling makes the child feel

safer and gain trust for the nurse. (Hiitola 2004, 132-135; Kääriäinen & Kyngäs 2006; Pelander 2008, 80.)

Information to the child can be given in several methods; verbally, in writing and especially with children, effective way of doing counseling is through entertainment and educational activities, such as toys, plays and videos. Counseling should be done in the language what child is able to understand, but still in the presence of the parents. (Hiitola 2004, 133; Pelander 2008, 80.) Counseling should be started at home by parents and it should continue the period when child is in the hospital (Ivanoff et al. 2006, 105). In every pediatric ward there should exist some kind of counseling material (Pölkki et al. 2003).

3.4 Written patient education material

Stays in the hospital have shortened, and patients urge to participate in their own care has increased. It has brought increasing need for written patient education material. Well made written education material can contribute on patient's motivation as well as the experience that the patients will gain from the hospital. It also gives the information the patient needs from his situation. Often written patient educational material is essential to support verbal teaching. With written patient educational material the patient can remind himself about the instructions when necessary. (Salanterä et al. 2005, 218; Torkkola, Heikkinen, Tiainen 2002, 29.)

Written patient education material has to be a clean-cut from its typography, and accurate from its text. The material has to contain at least the next information: who is it for, purpose of it, to whom to contact when needed. By Bernier & Yasko (1991) the material should also answer the questions: What, why, how and when. Content of the text has to be easy to understand. The sentences should not be either too long or too short so that the text cannot be misunderstood. In addition, foreign words should be avoided, especially in the children's education material. (Salanterä et al. 2005, 219-220.)

The children's written education material should contain pictures. Pictures make the children become interested in the material. Children's educational material can have either just pictures, or there can also be writing with

supportive pictures. In a picture book the text and the pictures are equal, whereas the text of a pictorial book has a more powerful meaning, and the pictures in it are supportive. Pictures are needed to awake the interest for the book, maintain the interest, but also to understand the book better. Usually pictures have a positive effect. (Ylönen 2000, 46-47.)

4 CHILDREN'S SURGICAL AND PERIOPERATIVE NURSING FROM THE AGE OF SIX TO NINE

4.1 Hospital admission

The most important duties of a pediatric nurse are the physical and psychological preparation of the child and his family as the child is admitted to the hospital for examination and care. A child patient is usually admitted to the hospital with a referral, or suddenly after an accident. Into the surgical ward the child can also be admitted from another ward, or even from another hospital. If possible, the child should be forewarned before he is being hospitalized. During the preparation period the child should honestly be informed why he was admitted to the hospital, what is going to happen at the hospital and how long he has to stay there. When a child has been prepared well enough for the hospitalization he is able to create coping strategies for himself based on his own preconception. The child and his parents feel vulnerable when they are taken from their own environment; they are afraid and feel they are not in control. Many families will not be seeking for medical tension for their child because of this. (Glasper & Richardson 2006, 114–115; Jokinen, Kuusela & Visa 1999, 9; Vilén, Vihunen, Vartiainen, Sivén, Neuvonen & Kurvinen 2006, 345.)

Planned admission is usually arranged for a surgical reason, and also for a medical reason. In a planned admission the child is usually fairly healthy but becomes ill at the hospital by a planned procedure, such as surgery. In this kind of a situation the family and the child are aware of the upcoming procedure and can start their preparations for it. Also support services are available for the family if they are in need of any information about the

upcoming procedure. This way the integrity can be kept and the family can feel in control at all times. (Glasper & Richardson 2006, 123.)

In an unplanned admission in case of unexpected illness the child and his family cannot be prepared. Uncertainty about the future; treatments, functioning and cosmetic consequences cause major stress for the whole family. In these situations relationship between parents, child and nursing staff has a huge effect on the coping of the family. Nursing should not only focus on the child but the whole family. How the relationship is built could also have an effect in the later life when getting ill or going to the hospital. This means that the family has to have someone they can trust, to make them feel safe and to get honest information from. (Ivanoff et al. 2006, 101; Åstedt-Kurki et al. 2008, 47.)

4.2 Family in the hospital environment in case of child's hospitalization

How the family is copes with the illness, has to do with the earlier experiences and losses in the family's life. Also maturity and the age of the parents and the child have their own effect on how the family accepts the illness. In addition, the family's emotional atmosphere affects how the child feels about the illness. (Ivanoff et al. 2006, 90.)

A parent has a liability for their child. This does not mean parents should cope with parenthood on their own. Especially when a child is ill, parenthood must be supported. Family's positive resources and coping can depend on it. One important task for the nursing staff is to support the family's resources and strengthen them. Foundation for this is to find out and value the family's habits and their expertise about their own family. (Åstedt-Kurki et al. 2008, 64.)

Children expect their parents to take care of them and to entertain them in the hospital. The role of the parent in the child's care is crucial. Parents help their child to cope and relieve the fear caused by the hospitalization. If the parents feel unsure about their nursing skills, the nursing staff should educate and motivate them to nurse and spend time with their child. However, the parents should not be blamed and they should not feel guilty if they cannot be present at all times. (Pelander 2008, 87.)

In addition, parents are experts in knowing their child and his behavior and feelings. Parents expect that their expertise is taken into consideration when nursing their child at the hospital. Reason for the parents to take part in their child's nursing, and to take responsibility of their child, has to do with supporting the family's habits and everyday life while staying in the hospital. (Åstedt-Kurki et al. 2008, 64.)

Family members' knowledge about their child's illness, resolution and how to get help are the main issues to be discussed when a child has become ill. Nursing staff has to be honest; the situation has to be explained so that it is understandable and logical. As a result of this, the family can understand what to expect and how their life may change in the future. They understand the reality of the situation. When the situation of the ill child becomes clear, the family can start to think about their own resources and chances to survive. Based on the received information the family can be in an active role in taking care of their child, but also in making the decisions and influencing the situation they are in. (Paunonen et al. 1999, 322-323; Åstedt-Kurki et al. 2008, 45.)

4.3 Experiences of a child when hospitalized

A child feels afraid when he is admitted to the hospital. Also the child might feel that he is being punished by something he did, and therefore is in the hospital. These misconceptions must be rectified and the child must be given the accurate information about hospitalization. (Ivanoff et al. 2006, 90; Justus, Wilson, Walther, Wyles, Rode & Lim-Sulit 2006, 37.)

The child's reaction to the hospitalization should be considered. For example, the child's reaction is directly in comparison to the parents' reactions and feelings. Therefore trust of the parents must be gained by the health care professionals to ease the parents' anxiety, but also for the child to trust the person providing the care (Justus et al. 2006, 37). The child's anxiety will reduce if the parents have started the preparation for the hospitalization, but also for the intervention of the medical operation. (Glasper & Richardson 2006, 122.)

Getting ill when growing up, and when living skills are just developing, can be difficult. For example, walking or getting out of the diapers have normally been learned but in the hospital environment those skills may degenerate for a while (Ivanoff et al. 2006, 90.)

Children who are admitted to hospital often develop behavioural problems, perhaps as a result of separation from parents and disruption of family life. These problems may manifest as an alteration of sleep pattern, bed wetting and regression of developmental milestones. (Aitkenhead, Smith, Rowbotham 2007, 665.)

A child has a certain rhythm that he has been taught. This rhythm is going to change when a child is hospitalized. The child has learnt to do things by himself but in the hospital everything is done for him. These issues can make the child feel like he is losing his autonomy. (Ivanoff et al. 2006, 90.)

An adult and a child do not experience the hospitalization in the same way. A child has his own vision about the world, so if the reality and the child's own vision do not match, it can be very threatening for the child. Besides, the child cannot differentiate a painful or painless operation. Everything is frightening, and feels uncomfortable. For the child everything seems to take an eternity, for example, staying in the hospital or even just a pinprick. Furthermore, a child has a normal need to perform, which in some cases has to be prevented, for example, because of bed rest. To be bedridden has been listed as one of the biggest stressors for the child while being in the hospital (Pelander 2008, 82). Regardless, most of the children cope mentally well in the hospital. (Ivanoff et al. 2006, 90.)

4.4 Preparation of a child and his family before an operation

The purpose of preparing a child for an operation is to avoid uncomfortable situations and experiences. A good preparation may turn these negative feelings into tolerable, even developing experiences. The child needs time to gather his resources to survive in an unfamiliar situation and his own perceptions are not enough in coping with an unknown situation. When a child

is afraid he uses most of his energy to orientate himself to a new and unknown situation. (Vilen et al. 2006, 347; Hiitola 2000, 89.)

Preoperative care of a child patient include psychosocial and physical preparation for surgery. The goal of preoperative preparation is to alleviate the child's fear associated with the unknown and to also reduce stress and anxiety related to surgery. Psychosocial preparations include playing, for example different toys who demonstrate the child's surgical treatment and process and medical equipment such as a stethoscope or syringes that the child can play with. Physical preparations include for example fasting and premedication. (Ball & Bindler 2008, 428.)

In reference to Kortessalmi, Lipsanen, Piispanen & Vuorela (2009) preoperative preparations of a child and his family are divided into three main groups: Preparations related to general suitability for surgery and legal documents, counseling and preparations directed to a child on a certain level of development and the guidance and preparations of the parents. The preoperative phase is the basis for the entire surgical nursing process.

The preparation offers the child an opportunity to find out information as well as time to predict and understand the upcoming events and procedures concerning him. A good preparation also has a positive impact on the child's recovery from the operation and well- prepared children tend to have less pain after the operation than children who have not been prepared at all. In addition, children who have been prepared for surgery and who have been supported throughout their hospital stay have less emotional problems than children who have not been prepared (Justus et al. 2006, 35). When the child realises that the practices related to the preparation were similar to the real situation, he is able to create coping strategies for similar situations in the future. (Vilen et al. 2006, 347; Hiitola 2000, 91.)

According to Hiitola (Vilen et al. 2006, 347.) the preparation of a child patient include creating trust and trustworthy environment, giving appropriate information, utilizing all senses when giving information, using play as a tool for preparation, modelling and practising, strengthening the coping strategies,

preparing the parents and creating support networks such as staff members, other children and families.

While being hospitalized a sick child needs something pleasant to do such as playing. Regardless of the illness it is recommended for a child patient to be able to be happy and play at any time he aspires to. Different types of activities work as therapy as well. Playing is a natural way for the child to prepare himself for fearful and unknown situations (Kortessalmi et al. 2009). Not only is the child's normal development facilitated by playing, it also provides the child an opportunity to get familiar with health care, to express his anxiety and get control over little-understood situations. (Ball & Bindler 2008, 430; Vilen et al. 2006, 349). In addition, Vilen et al. (2006, 349.) state that the meaning of playing for a child patient at the hospital can be described as follows:

- produce the child's happiness, pleasure and experiences of success as well as support the child's healthy features
- improve treatment and rehabilitation
- help the child to adapt himself to staying at the hospital and cope with his illness
- prepare the child for operation / procedure
- prevent the disadvantages of hospitalization and take care of the child's needs comprehensively
- help the child to release his energy and desire for action as versatile as possible.

Preparation for operation should be made as close to the actual day of the operation as possible. "One author recommends one day between preparation and admission per year of age" (Justus et al. 2006) in toddlers and school aged children. Other school age children may advantage of preparation given earlier depending upon their level of development. (Justus et al. 2006, 39.)

A school-age child is capable of receiving versatile information concerning his illness and procedures and treatments related to it. It is typical for a school-age child to be active, have a strong desire for autonomy, rightness,

developed verbal expression and accumulation of understanding what comes to physiology, amount of hobbies, fear of losing capacity and fear of death. The child also has the right to know why it is necessary for him to go through an operation and what possible physical changes are going to take place in his body afterwards. The issue of pain and pain management should also be discussed with the child. (Vilen et al. 2006, 347; Muurinen & Surakka 2001,101.)

4.5 Preparation for anesthesia and surgery

When the perioperative staff meets the child patient, they should make the child feel welcomed and treated as a unique person according to his age and the level of maturity. Introducing is important, thus, the child will feel more comfortable. The operation room has to be quiet and everyone in the staff should be aware of this. The child might feel very frightened in the operation environment and disturbances might cause more anxiety. Before child's arrival to the operation room, all the secondary equipment should be removed. (Woodhead & Wicker 2006, 279.)

Before a child can be anesthetized he must be checked by the anesthesiologist for anesthesia suitability. Being suitable for anesthesia requires good health status and sorting out any possible risk factors, such as illnesses that run in the family, and making sure the child has no allergies concerning pain medications or has no previous history of complications during anesthetizing. The check-up by the anesthesiologist is to be completed to avoid cancelation of the operation, and on the other hand, to prevent any possible complications related to anesthetizing. Children do not usually need any laboratory investigations before an operation, only in cases of chronic illness. Most operations only require information of the child's blood type, level of hemoglobin and the amount of hematocrite. ASA- classification is useful when evaluating a child patient's risks during anesthesia and surgery. (Ryhänen 2000, 429; Taivainen & Manner 2006, 465-466; Woodhead & Wicker 2006, 273-274; Kiviluoma 2002, 76).

When examining a child patient the possibility for an acute respiratory passage infection should be taken into consideration, since respiratory conditions increase the risk for airway complications during anesthesia. Usually if a child is suffering from fever higher than 38 celcius degrees, bad cough and purulent secretion the operation ought to be cancelled. However, if the child has an acute otitis, an elective operation should be cancelled but an emergency operation can be done during an antibiotic medication treatment. If the child has a chronic illness such as a heart disease, diabetes or such he should be examined beforehand at the hospital before the operation takes place. (Ryhänen 2000, 429; Kiviluoma 2002, 76).

Preparing a child for anesthesia requires mental preparation. There should be no discussion in front of the child concerning words such as “cutting” or “removing something”. Words that should rather be used are for example “treatment” or “procedure” or “operation”. It is also useful to introduce the equipment to the child, which are included in the operation. More information could be offered through a guide or the hospital’s web page. If possible it would also be recommended that the child would be able to meet the anesthesiologist and the anesthesia nurse beforehand to increase the amount of information and to reduce fear and anxiety. It may be worthwhile to also mention the possibility for local anesthetic (EMLA-cream) and premedication. Typical premedications used among children belong to the Benzodiazepines group, for example Midazolam and Diazepam. The premedication is given either orally, per rectum or nasally and the purpose of premedication is to sedate and calm down the child as well as reduce the need for the actual anesthetics. (Taivainen & Manner 2006, 465; Kiviluoma 2002, 77; Ivanoff et al. 2001, 155.)

Anesthesia inhibits the normal protection mechanisms of the organs and therefore increases the risk of aspiration during anesthesia. Fasting is obligatory before the patient can be put to sleep. Children who are attending an elective surgery can drink clear liquids such as water or juice still two hours before anesthesia. Children over the age of one should not eat four to six hours before anesthesia. In addition, the evening before the operation the child must be bathed or showered. The condition of the skin, especially from

the area of operation, is examined when changing into hospital clothes. (Taivainen & Manner 2006, 468; Kiviluoma 2002, 77; Ivanoff et al. 2001, 155.)

4.6 Recovery

The child patient's parent should be welcomed into the recovery room if the overall situation allows it. Different hospitals have different policies about letting parents to the recovery room, for example, in order to prevent the parents seeing the more critical patients. For the child's benefit he should be taken to his parents as soon as his condition allows it. The pain medication should be adequate before the transfer to the paediatric ward. (Aitkenhead, Smith & Rowbotham 2007, 666; Woodhead & Wicker 2006, 281.)

After the anesthesia there may and will most likely occur some side-effects in the recovery room such as nausea and restlessness. A good preventive pain management can reduce anxiety and restlessness but cannot erase them completely. Children who have just woken up from anesthesia where they have been deeply sedated cannot evaluate properly the pain that they are experiencing and therefore it must be done by the recovery room nurse. (Kokki 2006, 493; Taivainen & Manner 479.)

4.7 Hospital discharge

During the recovery process the child is most likely going to be away from day care or school and therefore the parents need to arrange outside help or skip work to be able to take care of the child at home. It is important for the parents to be aware when the child can return to his normal daily rhythm. When the child's primary nurse contacts the family the day after the discharge the parents have a possibility to ask for further information and go through the home care instructions. At the same time the nurse will get useful information of the family's experiences of hospitalization. The home call also supports the continuity of the care and certainty of the parent's nurturing skills. (Ivanoff et al. 2001, 154.)

5 CHILDREN'S PAIN AND POSTOPERATIVE PAIN MANAGEMENT

5.1 Physiology of pain

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (International Association for the Study of Pain).

Pain can be caused by different kind of irritants which can lead to tissue damage. Pain is felt as an unpleasant and scary feeling. Earlier experiences have an effect also on the future feelings of pain. Sense of pain differs from other senses, because it activates the sympathetic nervous system same way as fear and anger. (Bjålie, Haug, Sand, Sjaastad. Toverud 2008, 105-107.) Sense of pain is the most crucial sense of a human being. Pain can be either sudden – acute pain or longer lasting – chronic pain. Pain is caused by nerve impulses, which are passed along by specific sensor nerve fibres. Nerve fibres have divided into nerve endings, which have pain receptors in them. Most nerve fibres react to extreme temperatures and strong chemical and mechanical irritants. Tissue damages can affect directly to pain receptors. Usually the receptors are however activated indirectly by chemical compounds, which are released or formed in damaged tissues. These chemical compounds are for example prostaglandins, histamine, bradykinin and some enzymes. Irritants which activate pain receptors cause nociceptic pain which can be divided into somatic pain (surface pain and deep pain) and visteralic pain (visceral pain) (Bjålie et al. 2008, 105-107.)

5.2 Child's perception of illness and pain

Children of all ages feel pain. The physical and mental development phase of a child defines how the child experiences pain and expresses it. School-age children can understand simple relationships between pain and disease but they have no precise understanding of the cause of the pain. They are also able to realize the need to go through painful procedures and monitoring or

treating the disease. School-age children may connect pain with the feeling of anger and recognize psychological pain related to grief. (Ball & Bindler 2008, 475.)

Pain experience is always affected by fear. A child should be explained in a most suitable way for his age the meaning of illness, pain, hospital, examinations and care. Parents should explain to their child that pain is not a punishment. (Kankkunen 2003, 32.) Other factors can also influence the child's response to acute or chronic pain, such factors are for example, cognitive-behavioral factors, such as stress, coping skills and psychological adjustment, biological factors including genetics, gender, medications and pain processing, also environmental factors, meaning parents pain experiences and coping skills as well as school and social relationships. (Ball & Bindler 2008, 474.)

5.3 Pain assessment

Pain assessment has two purposes; to evaluate the quantity of pain and the quality of pain. It is the adult's responsibility to notice the child's pain and to relieve it. The first rule of observing pain is that changes in child's behaviour can derive from pain. Children's thinking is self-centred and they think that other people can know how they feel, so they do not understand to ask for help even though they feel pain. It is difficult for children to describe pain verbally, but usually already a two-year-old can reliably express pain, so it is good to ask the child to show where it hurts and what type of pain he is feeling although a two-year-old usually cannot evaluate the intensity of the pain. A pre-schooler can already express pain verbally. Young children do not understand that acute pain does not last long. (Kankkunen 2003, 31-34.)

Interviewing a child and his family before going to an examination gives a good view of the expectations and fears of the family. The aim of the interview is to solve the child's and the parents' earlier experiences of examinations, procedures, as well as the child's feelings of pain and how he has behaved in these kinds of situations. During the interview it is good to get to know a suitable pain measurement instrument with the child. If possible, it is good to

ask the child himself some questions related to the hospital stay, operation and pain, for example to whom the child tells if he is having pain. (Jokinen, Kuusela & Lautamatti 1999. 23-26.)

The nurses' responsibility is to make observations of the child patient's pain, to measure it, treat it and document it accordingly. In addition, the child's age should be considered when evaluating pain. A school-aged child is capable of expressing pain by himself and a child's pain should always be documented according to the child's exact words. It is important to be accurate and systematic when it comes to documentation since it helps realizing the state of the pain and its course. (Keituri 2007a; Muurinen & Surakka 2001, 130.)

As assessing children's pain, different type of measurement instruments can be used to help the child to describe how much pain he is in. The following instruments can be used to assess the pain of children aged from six to nine years. Some of the measurement instruments are used by observers such as nurses, and others can be used by the child himself. The Observation Scale of Behavioural Distress assesses pain with 11 categories. It is aimed for children older than three years. Parents' Postoperative Pain Measure (PPPM) helps parents to assess their child's pain and to medicate them the right way. It consists of 15 questions concerning child's behavioural changes. This scale can be used for two to twelve year olds. It is the only measurement instrument, which can be used at home [attachment 1. Parent's Postoperative Pain Measure (PPPM)]. Face scales, such as the Wong-Baker face scale, can be used for over three year olds. It has six faces, from a smiling face to a crying face (attachment 2. Pain-face Scale). Visual Analogue Scale (VAS) is used with children older than four years. In general it is a 10-cm line from "absence of pain" to "worst pain experienced" (attachment 3. VAS). The Children's Global Rating Scale (CGRS) is recommended to be used to measure pain in children aged four to eight years. The measure has five wavy lines, the wavier the lines are, more severe the child's pain is. A Coloured Analogue Scale is reliable measuring pain in children aged over 5 years. It is a coloured line, in which the colours go from green to red with yellow in between. It also has numbers from one to ten and words to describe the level

of pain so it can also be used for older children (attachment 4. Coloured Analogue Scale). (Kankkunen 2003, 35-36.)

TABLE 1. Children's pain measurement instruments.

Observer use

Instrument	Recommended age group
Observation Scale of Behavioural Distress	Older than 3 years
PPPM	2-12 years

Self-rating use

Instrument	Recommended age group
Face Scales	Older than 3 years
VAS	Older than 4 years
The Children's Global Rating Scale	4-8 years
Coloured Analogue Scale	Older than 5 years

There are some physiological reactions happening in the body, which can be used to observe child's pain. These reactions are able to tell acute, short-term and sharp pain felt in the body. Body functions to be observed in this case are: increased heart rate, saturation, which means the level of oxygen in the blood, and sweating. The heart rate first decreases and then increases in acute pain, the saturation for that matter decreases because of pain and is that way suitable for observing pain for example during a procedure. A child who is pain free is curious of things happening around him or is sleeping naturally unlike a child who has some pain or severe pain (Kokki 2006, 493). When a child is in pain his crying, facial expressions, and sleeping may change. (Kankkunen 2003, 32-33; Pölkki 2002, 43.)

Children's pain is difficult to assess, because they feel that pain is so overwhelming that they cannot separate pain from other emotions, for example distress and anxiety. Sometimes children do not want to express

their pain openly, because they might feel that it is their fault or they are afraid of being punished. Even though, they may behave calmly and they are not protesting against the pain anymore, it does not mean that they do not have any pain. Although there are many ways to assess children's pain, the developmental status and coping strategies of the children make the pain evaluation challenging for the parents at home. (Kankkunen 2003, 34.)

5.4 Pharmacological pain management

Ethical instructions of nursing advice nurses to alleviate a person's suffering. Declaration of children's rights demand painlessness in examining and care. In Nordic countries as ethical instructions for children's nursing are also used the guidelines of NOBAB (Nordisk förening för syke barns behov). According to these guidelines the examining and care of a child patient is based on planned procedure which does not cause pain. Everyone has a right to get relief for their pain beforehand (e.g. EMLA) and they are entitled to know what is to be done and how it feels like. (Nobab.fi)

Children's post-operative pain is mostly treated with Paracetamol but nowadays also NSAID's (Non-steroidal anti-inflammatory drugs) have become more popular in children's post-operative pain management. Opioids are only used when treating severe pain such as difficult injuries, during anaesthesia and post-operatively in the recovery room and ward. (Pokela & Ryhänen 2001, 127; Kokki 2006, 496.) Paracetamol is the most common pain medication used among children. It is used for treating mild and semi severe pain. Paracetamol can cause injurious effects in the liver when overdosed. (Kokki 2006, 495-496.)

The same opioids that are suitable and safe to use with adults are also suitable for child patients. However, opioids can have differences in their pharmacokinetics between individuals, which make it very important to observe the correlative of the drug to the child. The most serious consequence from large amounts of opioids usage as children's pain medication is respiratory depression. First there is analgesia, secondly sedation and if the amount of opioids is still too much it can lead to hypoventilation. There may

also appear symptoms in the central nervous system from large amounts of opioid usage. When a child has had an overdose of opioids he should immediately be treated with an opioid antagonist called Naloxon. Also Benzodiazepines and opioids mixed together tend to cause respiratory depression. Other less harmful side-effects include itching, nausea and vomiting. In addition, a long-term use of opioids tends to cause drug tolerance and addiction. Examples of opioids are fentanyl, alfentanyl, morphine, oksicodone and codeine. Morphine is the most effective and approved analgesic for children from the opioid group. (Pokela & Ryhänen 2001, 127-128; Ball & Bindler 2008, 479; Mildh 2001, 157-158).

NSAID's are quite commonly used in children's post-operative pain management together with opioids to prevent the need of opioids in the first place and also to reduce their negative side-effects. NSAID's as pain medication for children are sometimes enough on their own in smaller operations or injuries. NSAID's do not have a preventing effect and the first drug dose is therefore given in the recovery room after the operation. Thus, it can be seen that the operation went according to the plan and the child has no post-operative bleeding. The pain management can be rationalised by giving the child both Paracetamol and NSAID together. It is not useful to give two or more NSAID's at the same time. Examples of typical NSAID's are Ibuprofein, Ketoprofein and Naproxen. (Pokela & Ryhänen 2001, 128-129; Kokki 2006, 496.)

Local anaesthesia is an efficient way to treat post-operative pain in children, although there are some serious side-effects to be considered, which are harmful to the heart and central nervous system. Different kinds of local anaesthetics include:

1. Levoanesthetics such as levobupivacaine and ropibupivacaine
2. Epidural pain medication, either as a single anaesthetic or a constant anaesthetic (infusion). Epidural pain medication can be rationalized with opioids and adrenalin. (Kokki 2006, 497-498.)
3. PCA (Patient-Controlled Analgesia) for administering an intravenous

analgesic such as morphine by using a computerized pump (Ball & Bindler 2008, 481).

4. Lidocain 0,5-1% with or without adrenaline for anaesthetizing mucuous membranes
5. EMLA- emulsion for anaesthetizing the surface of the skin before e.g. peripheral intravenous cannulation.

(Kokki 2006, 497; Pokela & Ryhänen 2001, 132.)

5.5 Non-pharmacological pain management

Children's pain management is a challenge for health care providers. The pain medication itself is not enough in reducing or deleting a child's pain completely since pain is a comprehensive experience. A child may experience fear and anxiety almost the same way as they experience the procedure that will most likely cause pain and therefore the importance of non-pharmacological pain management methods are emphasized. (Pölkki 2002, 56.)

To assure proper pain relief, non-pharmacological pain relieving methods are an essential part of pediatric patient care together with the actual pain medication. Such methods, in reference to previous researches, have been used succesfully, especially with older children who have the ability to c o-operate and have reached adequate metacognitive maturity. (Pölkki 2001, 484.)

Children's pain management consists of analgesia and complementary therapies. The non-pharmacological methods consist of a variety of approaches that do not include the use of analgesics but make the pain more tolerable. Children need sufficient pain medication but also complementary therapies can be helpful sometimes in reducing anxiety and unpleasantness of painful procedures. (Ball & Bindler 2008, 479; Pölkki 2001, 484.)

Children's non-pharmacological pain management methods include a familiar nurse or especially a parent present who creates the feeling of safety and trust, eliminating any unnecessary noise, peaceful surroundings that create a

more comfortable feeling to the child. Other non-pharmacological methods include helping the child to find a comfortable position to ease the pain, listening to the child's wishes, comfort by words and acts such as fondling and holding the child's hand. Also reading or just talking to the child, massage, rewards such as small toys or stickers after the procedure and encouragement throughout the operation. In addition, the child's attention can be drawn into somewhere else during the operation or he can watch the operation if he wishes. (Keituri 2007b; Muurinen & Surakka 2001, 129-130.)

TABLE 2. Children's non-pharmacological pain relieving methods

Cognitive behavioral methods	Imagery	Distraction	Preparatory information	Relaxation	Positive reinforcement
Physical methods	Application of heat and cold (thermal regulation)	Massage and cutaneous stimulation	Positioning	Electro-analgesia (TENS)	
Emotional support	Presence	Comforting	Touch		
Other	Helping with daily activities	Creating a comfortable environment			

(Ball & Bindler 2008, 486-488; Pölkki 2002, 56; Pölkki 2001, 484.)

6 THE IMPLEMENTATION OF THESIS

The topic was chosen, defined and approved in the theme seminar at the end of year 2008. At the time we were in co-ordination with the employer at the children's ward and discussed about the upcoming task and their wishes according to the counseling folder. The written part of the thesis was started in the beginning of January 2009. In the mean time the literature review was done.

We started working on the folder after we had a formal meeting with the employer in October and also the required permissions were obtained. The content of the thesis was constantly modified but the main topics have remained the same. The photographs were taken at the hospital in October with permission from the hospital and from the family. After this the test folder was taken for evaluation to the children's surgical ward. The test folder was evaluated by the tutoring nurses at the ward. Changes were made to the final counseling folder and it was modified according to the nurses' views in November.

The written part of the thesis was done by November and was given for evaluation to the tutoring teachers and the board of thesis. The presentation of our thesis will be in November in our school and the counseling folder will be presented at the pediatric ward in December.

As we sorted out same kinds of researches done concerning our topic, we found a few similar thesis', one was made in 2007 in Satakunta University of Applied Sciences: "Leikkaukseen menevän lapsipotilaan ja vanhempien ohjaaminen" written by Urponen and Vihermaa. Also one thesis which was closely related to our topic was called "Perioperatiivinen sairaanhoitaja leikki-ikäisen lapsen preoperatiivisella kierrolla Keski-Suomen keskussairaalaassa" written by Peltoniemi ja Suominen in 2007 at the Jyväskylä University of Applied Sciences. In addition, a thesis called "Myöhäisleikki-ikäisen lapsen valmistaminen päiväkirurgiseen toimenpiteeseen ja siihen liittyvien pelkojen lievittäminen" was discovered written by Koponen and Mannonen in 2008 at Stadia University of applied sciences. Furthermore, two similar web pages

were found that discussed the topic of preparing a child for an operation. One was found from Helsinki University Hospital's website and was a virtual tour from an operational department. The other was found from Sairaanhoidajaliitto website and contained guidelines for preparing a child for an operation at home and at Oulu University Hospital.

One of the latest topic related researches was found from hotus.fi webpage and is called "Leikki-ikäisen lapsen emotionaalinen tuki päiväkirurgisessa hoitotyössä". It is used as a guideline for nursing care and was also used as one reference in our thesis. In addition, an article made earlier was discovered, which was closely related to our topic. This article discusses about child's needs during hospitalization and is called "Lapsi tarvitsee sairaalassa hellyyttä, läsnäoloa ja tietoa" and the article can be found from the magazine "Lapsen maailma".

Our counseling folder differs from the virtual guidance material at the Helsinki University Hospital's website because their web page only contains very basic information about surgical child patient's care pathway. Oulu University Hospital has very similar counseling material than ours but in addition, they have two different alternative materials, of which one will be sent home before the hospital admission. Other material found was mostly based on professional literature but did not contain any concrete guidance material for the child or his family. Guideline for nursing care "Leikki-ikäisen lapsen emotionaalinen tuki päiväkirurgisessa hoitotyössä" was only aimed at the health care professionals.

7 DISCUSSION

7.1 Reasons for choosing the headlines and the method for the thesis

The idea of our thesis emerged from the previous counseling folder in the pediatric ward, which was in the need of updating. The previous counseling folder is aimed at children who are attending an operation and its purpose is to prepare the child for the operation.

At first we had several ideas of what form the guide should be in for example a cd, leaflet to be given to the parents at the polyclinic, or virtual leaflet on the webpage of the hospital. The idea for the counseling folder was developed based on the pediatric ward nurses' opinions. A concrete counseling folder can be used with both emergency and elective patients. In addition, it is recommended for the parents to read the folder together with their child. A concrete folder gives the opportunity for the parents to participate in their child's care but also to discuss the issues arising from the operation itself together with the child.

The age group of children had to be defined and based on the theory found ; it was defined to the age from six to nine. This particular age group seemed interesting because of their specific stage of cognitive development in understanding informative writing and urges to learn new things. The topics, which are discussed in this thesis, came up constantly in the literature review and played a key role in a child's and his family's hospitalization.

The development task of this thesis can be reasoned by the positive outcomes of good counseling. The counseling was an essential part in this thesis since it is one of most important factors in modern nursing interventions. Besides, we discussed the issue of children's post-operative pain management because it is an essential part of children's surgical care. Since our thesis considers the child's emotional support and recovery from surgery, knowing the possibility of good pain management helps the child in preparing himself for the surgery but also speeds up the healing process.

As a continuation of our thesis topic we discovered one possible topic, which emerged from the theoretical basis: Children's postoperative pain management at home would require proper home care instructions for the parents. In the theoretical basis of our thesis the concerns of parents came up as their incapability to treat and evaluate their child's postoperative pain because of insufficient nursing counseling or instructions.

To attain the best possible result with the content of the counseling folder it was evaluated twice by tutoring nurses from the pediatric ward in the Central

Hospital of Central Finland, and also once by study advisor and tutoring teachers from Jyväskylä University of Applied Sciences. Changes were discussed and made suitable for both, authors and partner in co-operation. We were all very satisfied with the final version of the counseling folder.

TABLE 3. Feedback from the test folder by the pediatric ward's tutoring nurses.

Successful matters:	Developmental matters/ improvements:	Does the folder respond to families' needs?
<ul style="list-style-type: none"> - The photos are excellent - The content of the folder proceeds logically - The folder as a whole is good and clear - The text is well written for children - The English version is very useful 	<ul style="list-style-type: none"> - The word "fear" should not be used - It cannot be promised that a nurse or parent is always beside the child - The words such as a monitor, clip or clothespin are not suitable 	<ul style="list-style-type: none"> - Most likely it is easier for children and their families to perceive hospitalization after reading the folder - The folder responds well to families' needs - The folder as a whole is good and clear - We are very pleased to have a new folder to the ward

According to Ylönen (2000, 46-47) children's educational material should contain pictures, because they awake the child's interest for the material and according to Einon (2001, 106) the material should also correspond with their level of cognitive development. The content of the material should be easy to understand and foreign words should be avoided. (Salanterä et al. 2005, 219-220.) Based on this theory found it was decided that the pictures play an important role in our counseling folder and it is written in a form understandable for children from the age of six to nine.

The problems that we faced while making the thesis were: Difficulties in cooperation between the hospital and authors, changes inside the group of authors, schedule arrangements, tight schedule and exiguity of tutoring.

7.2 Ethical considerations

One very important part of the counseling folder was the photos taken at the hospital. We were obligated to ask permissions from the head nurse of pediatrics because the use of hospital's facilities was necessary. Also the permission from the parent and child who appeared in the photos was needed. The whole photo shoot was set up and therefore we did not need permission from the ethical board.

The content of the folder was also provided for the hospital's use in form of a cd. Thus, the hospital has the opportunity to download the folder to their web page. The permission for the web distribution has been requested from the people appearing in the photos.

REFERENCES

- Adams C. 2006. What is Visual Pain Scale. ergonomics.about.com
- Aitkenhead, A., Smith, G., Rowbotham, D. 2007. Textbook of Anaesthesia. 5th edition. Netherlands: Elsevier.
- Ball, J. W. & Bindler, R. C. 2008. Pediatric nursing, Caring for children. 4th edition. New Jersey, USA: Pearson Education, Inc.
- Bentley, J. 2004. Distress in children attending A&E. Emergency nurse 12, 4, 20-26.
- Bjålie, J. G., Haug E., Sand, O., Sjaastad øystein V. & Toverud, K. C. 2008 Ihminen: Fysiologia ja anatomia. Helsinki: WSOY.
- Chambers C., Finley G., McGrath P., Walsh T. 2003. The parents' postoperative pain measure: replication and extension to 2-6-year-old children. Pain 105, 437-443.
- Einon, D. 2001. Lapsen hoito ja kehitys, Terve, tyytyväinen ja tasapainoinen lapsi. Portugal: Otava.
- Flinkman, T. & Salanterä, S. 2004. Leikki-ikäisen pelot päiväkirurgisessa toimenpiteessä. Hoitotiede 16, 3, 121-131.
- Glasper, A. & Richardson, J. 2006. A Textbook of Children's and Young People's Nursing.
- Hiitola, B. 2000. Parantava leikki. Tampere: Tammi.
- Hiitola, B. 2004. Toimenpiteisiin valmistamisen haasteet. In the book of Lasten ja nuorten hoitotyön käsikirja. Editors: Koistinen, P., Ruuskanen, S. &

Surakka, T. Helsinki: Tammi.

Kiviluoma, K. 2002. In the book of Lasten ja nuorten sairaudet. Editor: Huttunen, N-P. Porvoo: WSOY.

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Ivanoff, P., Risku, A., Kitinoja, H., Vuori, A. & Palo, R. 2001. Hoidatko minua? Lapsen, nuoren ja perheen hoitotyö. 1st edition. Porvoo: Werner Söderström Osakeyhtiö.

Ivanoff, P., Risku, A., Kitinoja, H., Vuori, A. & Palo, R. 2001. Hoidatko minua? Lapsen, nuoren ja perheen hoitotyö. 3rd edition. Porvoo: Werner Söderström Osakeyhtiö.

Jokinen, S., Kuusela, A. & Lautamatti, V. 1999. "Sattuuko se?". Lasten kliiniset tutkimukset. Helsinki: Kirjayhtymä.

Justus, R., Wilson, J., Walther, V., Wyles, D., Rode, D. & Lim-Sulit N. 2006. Preparing children and families for surgery - Mount Sinai's Multidisciplinary Perspective. Pediatric Nursing 32, 1, 35-41.

Järviluoma, A. 1999. Lapsen pelot 6- ja 8-vuotiaana. Master's thesis – dissertation of Pedagogic. Jyväskylä University.

<https://jyx.jyu.fi/dspace/bitstream/handle/123456789/8793/1752.pdf?sequence=1>.

Kankkunen, P. 2003. Parents' Perceptions and Alleviation of Children's Postoperative Pain at Home After Day Surgery. Doctoral thesis-dissertation of Social sciences. University of Kuopio

Keituri, T. 2007a. Lapsen kivun hoito. Sairaanhoidajan käsikirja. Article published on 22.3.2007. Accessed on 25 February 2009 and on 6 September 2009.

http://www.terveysportti.fi/terveysportti/ekirjat.koti?p_db=shk&p_haku=hoitotiede.

Keituri, T. 2007b. Lapsen valmistaminen näytteenottoon ja toimenpiteeseen. Sairaanhoidajan käsikirja. Article published on 22.3.2007. Accessed on 6

September 2009.

http://www.terveysportti.fi/dtk/shk/koti?p_haku=lapsen%20kivun%20hoito

38

Kokki, H. 2006. In the book of Anestesiologia ja tehohoito. Editors: Rosenberg, P., Alahuhta, S., Lindgren, L., Olkkola, K. & Takkunen, O. 2nd edition. Helsinki: Kustannus Oy Duodecim.

Korhonen, A., Kaakinen, P., Miettinen, S., Ukkola, L., Heino, R. 2009a. Leikkikäisen lapsen emotionaalinen tuki päiväkirurgisessa hoitotyössä - Hoitotyön suositus. Hoitotyön tutkimussäätiö. Article published on 20.5.2009. Accessed on 1 September 2009.

Korhonen, A., Kaakinen, P., Miettinen, S., Ukkola, L., Heino, R. 2009b. Leikkikäisen lapsen emotionaalinen tuki päiväkirurgisessa hoitotyössä - Hoitotyön suositus henkilökunnalle. Hoitotyön suositus. Hoitotyön tutkimussäätiö. Article published on 20.5.2009. Accessed on 29 October 2009.

Kortesalmi, R., Lipsonen, A., Piispanen, M. & Vuorela, E. Preoperatiivisten valmistelujen kehittäminen OYS:n lasten ja nuorten klinikassa. Suomen Sairaanhoidajaliitto ry 2009. Accessed on 3 November 2009.

http://www.sairaanhoidajaliitto.fi/ammattilliset_urapalvelut/julkaisut/sairaanhoidaja-lehti/9_2004/muut_artikkelit/preoperatiivisten_valmistelujen/

Kääriäinen, M. & Kyngäs, H. 2006. Ohjaus – tuttu, mutta epäselvä käsite. Sairaanhoidaja 79, 10, 6-9.

Mahat, G., & Scoloveno, M. A. 2006. Nepalese school-age children's self-reported fears and coping strategies related to medical experiences. Journal of cultural Diversity 13, 1, 34-39.

Mahat, G., Scoloveno, M. A. & Cannella, B. 2004. Comparison of children's fears of medical experiences across two cultures. Journal of pediatric health care 18, 6, 302-307.

Méndez, F. X., Quiles, M. J. & Hidalgo, M. D. 2001. Children's surgical worries questionnaire: Reliability and validity of a new self-report measure. Children's health care 30, 4, 271-281.

Muurinen, E. & Surakka, T. 2001. Lasten ja nuorten hoitotyö. Helsinki: Kustannusosakeyhtiö Tammi.

Mildh, L. 2001. Opioidit lasten postoperatiivisen kivun hoidossa. *Finnanest* 34, 157-158.

Paunonen, M. & Vehviläinen-Julkunen, K. 1999. Perhe hoitotyössä, teoria, tutkimus ja käytäntö. Porvoo: WSOY.

Pelander, T. 2008. The quality of paediatric nursing care - Children's perspective. Turku: Painosalama Oy.

Pokela, M-L. & Ryhänen, P. 2001. Kivunhoidossa, sedaatiassa, yleisanestesiassa ja paikallispuudutuksessa käytettävät lääkkeet. In the book of *Lapsi ja lääke*. Editors: Kouvalainen, K., Rantanen, P. & Uhari, M. Hämeenlinna: Kustannus Oy Duodecim.

Pölkki, T., Pietilä, A-M. & Vehviläinen-Julkunen, K. 2003. Kirurgisten lapsipotilaiden pelkoja sairaalassa. *Sairaanhoitaja* 76, 10, 18–21.

Pölkki, T. 2002. Postoperative pain management in hospitalized children – focus on non-pharmacological pain relieving methods from the viewpoints of nurses, parents and children. Kuopion yliopisto: Summary of Doctoral thesis. *Finnanest* 2003, 36, 1, 56-57.

Pölkki, T., Vehviläinen – Julkunen, K. & Pietilä, A. 2001. Nonpharmacological methods in relieving children's postoperative pain: a survey on hospital nurses in Finland. *Journal of Advanced nursing* 34, 483-492.

Ryhänen, P. 2000. Anestesiologia. In the book of *Lastentaudit*. Editors: Raivio, K. & Siimes, M.A. Helsinki: Kustannus Oy Duodecim.

Salanterä, S., Virtanen, H., Johansson, K., Elomaa, L., Salmela, M., Ahonen, P., Lehtikunnas, T., Moisander, M-L., Pulkkinen, M-L., & Leino-Kilpi, H., 2005. Yliopistosairaalan kirjallisen potilasohjausmateriaalin arviointi. *Hoitotiede* 4, 17, 217–228.

Sheridan, M. 2003. From Birth to Five Years, Children's Developmental Progress. Great Britain: T J International Ltd.

Smith, E., Nolen-Hoeksema, S., Fredrickson, B. & Loftus, G. 2003. Atkinson & Hilgard's Introduction to Psychology. 14th edition. Wadsworth. Cengage Learning.

Vanni A., Schaal C., Renato C., Fernando S. 2004. Is the periprostatic anesthetic blockade advantageous in ultrasound-guided prostate biopsy. International braz j urol 30, 2.

Taivainen, T. & Manner, T. 2006. In the book of Anestesiologia ja tehohoito. Editors: Rosenberg, P., Alahuhta, S., Lindgren, L., Olkkola, K. & Takkunen, O. 2nd edition. Helsinki: Kustannus Oy Duodecim.

Teddyberfriends online store
www.teddybearfriends.co.uk

Vilen, M., Vihunen, R., Vartiainen, J., Siven, T., Neuvonen, S. & Kurvinen, A. 2006. Lapsuus – erityinen elämänvaihe. Helsinki: WSOY.

Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P. 2001. Wong's Essentials of Pediatric Nursing. 6th edition. St. Louis. Mosby Inc

Woodhead, K. & Wicker, P. 2006. Textbook of Perioperative Care. China: Elsevier.

Ylönen, H. 2000. Loihditut linnut -Satujen merkitys lapselle. Tampere: Tammer-Paino Oy.

Åstedt-Kurki, P., Jussila, A-L., Koponen, L., Lehto, P., Maijala, H., Paavilainen, R & Potinkara, H. 2008. Kohti perheen hyvää hoitamista. Porvoo: WSOY Oppimateriaalit Oy.

ATTACHMENTS

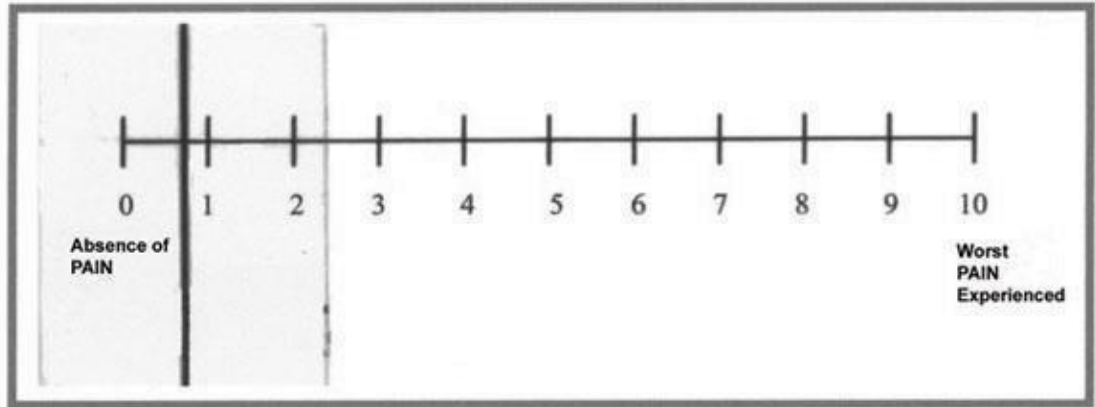
Attachment 1. Parent's Postoperative Pain Measure (PPPM). Chambers

My child's behaviour	Yes	No
	score 1 point each	score 0 points each
Complains more than usual?		
Cries more easily than usual?		
Plays less than usual?		
Does not do the things he/she usually does?		
Acts more worried than usual?		
Quieter than usual?		
Has less energy than usual?		
Refuses to eat?		
Eats less than usual?		
Holds the sore part of his/her body?		
Tries not to bump the sore part?		
Groans or moans more than usual?		
Looks more flushed than usual?		
Wants to be close to you more?		
Takes medicines that they usually refuse?		
Total Score		

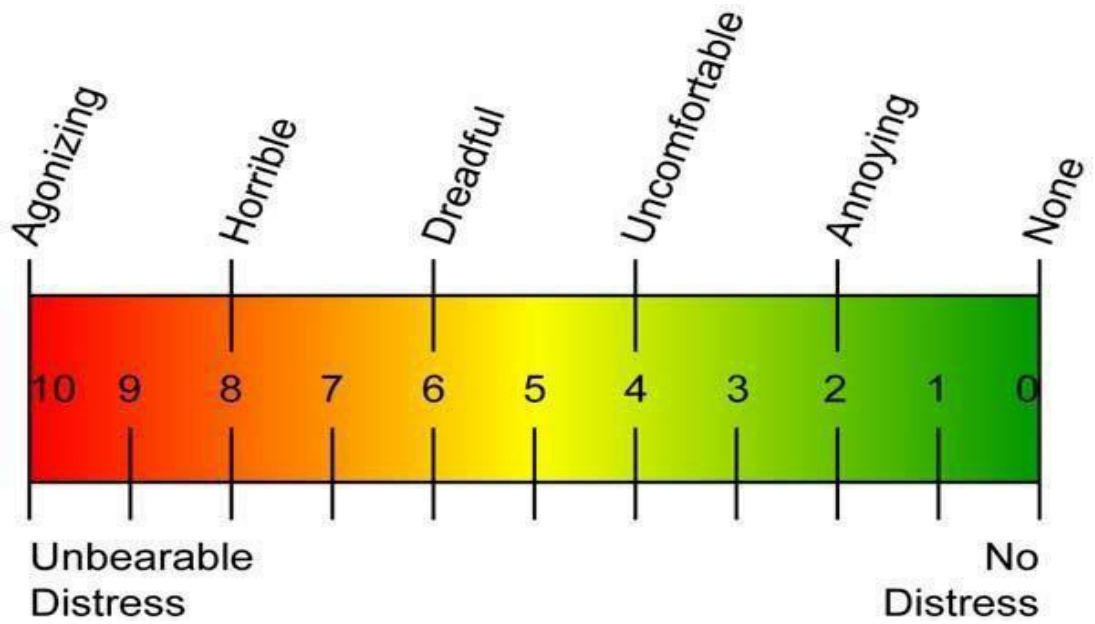
Attachment 2. Pain-face Scale. Wong-Baker



Attachment 3. VAS. Vanni



Attachment 4. Coloured Analogue Scale. Adams



Attachment 5. Palautelomake**PALAUTELOMAKE**

Mitä hyvää kansiossa oli?

Mitä parannettavaa/ kehitettävää?

Palveleeko kansio perheiden tarpeita?

Attachment 6. Agreement



JYVÄSKYLÄN AMMATTIKORKEAKOULU
JAMK UNIVERSITY OF APPLIED SCIENCES

1 (2)

SOPIMUS OPINNÄYTEYHTEISTYÖSTÄ

Sopijaosapuolet

toimeksiantaja _____ n

edustaja _____,

Yhteystiedot (osoite, puhelin, sähköposti) MARJA. PELTONEN @ KSSKOP.FI

Jyväskylän ammattikorkeakoulun

opinnäytetyötä ohjaava(t) opettaja(t) Marjo PalovaaraKatri Huuskola

ja

Yhteystiedot (osoite, puhelin, sähköposti) _____

opiskelija(t) Heidi Kangas, Christina Färnäs,Taina Järvenpää

Yhteystiedot (osoite, puhelin, sähköposti) _____

Opinnäytetyön aihe

Opiskelija laatii opinnäytetyön aiheesta

Ohjauksen ja lapsen leikkimateriaalin valmistelusta

Ohjaus

Ammattikorkeakoulu vastaa opinnäytetyön ohjauksesta. Ammattikorkeakoulu ja opettaja eivät ole konsulttivastuussa työstä.

Dokumentointi

Työstä laaditaan Jyväskylän ammattikorkeakoulun opinnäyteohjeen mukainen kirjallinen esitys joka luovutetaan toimeksiantajalle ja ammattikorkeakoulun kirjastoon julkaistavaksi.

Oikeudet

Opinnäytetyön tekijänoikeudet kuuluvat Opiskelijalle. Toimeksiantaja saa rinnakkaisen käyttöoikeuden teokseen sen valmistuttua. Muut mahdolliset teollisoikeudet ja tekijänoikeudet ovat toimeksiantajan omaisuutta.

Keksinnöt

Jos opinnäytetyön tekijä on osallisena keksintöön, joka patentoidaan, mainitaan hänet yhtenä keksijöistä. Mahdollisesta keksintökorvauksesta sovitaan erikseen noudattaen Jyväskylän ammattikorkeakoulun keksintöohjeen linjauksia.

Työsuhde

Mahdollisesta työsuhteesta tai työstä maksettavasta palkkiosta toimeksiantaja ja opinnäytetyön tekijä sopivat erikseen. Opinnäytetyötä tekevät opiskelijat ovat Jyväskylän ammattikorkeakoulun tapaturmavakuutuksen piirissä mikäli heillä ei ole työsuhdetta opinnäytetyön toimeksiantajaan.

Opinnäytetyön julkisuus

Jyväskylän ammattikorkeakoulu noudattaa opetusministeriön suositusta ettei opinnäytetöihin sisällytetä salassa pidettävää aineistoa ja että opinnäytteet ovat julkisia heti, kun ne on hyväksytty. Arvioitavaan opinnäytetyöhön ei sisällytetä toimeksiantajan liike- tai ammattisalaisuuksia, vaan ne jätetään työn tausta-aineistoon.

Luottamukselliset tiedot

Toimeksiantaja sitoutuu ohjauksellaan myötävaikuttamaan siihen, että opinnäytetyöhön ei sisällytetä luottamuksellista aineistoa. Toimeksiantajan nimeämälle edustajalle varataan mahdollisuus tutustua opinnäytetyöhön viimeistään kaksikymmentä (20) päivää ennen aiottua tarkastukseen luovuttamista. Toimeksiantajalla on oikeus vaatia muokkauksia opinnäytetyöhön, mikäli julkaiseminen vaarantaa mahdollista Toimeksiantajan patentin hakua tai muuta immateriaalioikeudellista suojaamista tai sisältää Toi-



meksiantajan luottamuksellisia tietoja. Kieltävä päätös tulee perustella. Opiskelijalla on oikeus saada aiheisto, jonka sisällyttämiseen opinnäytetyöhön Toimeksiantaja on antanut kielteisen päätöksen, muokattavaksi yhteistyössä Toimeksiantajan kanssa ja opinnäytetyö jätettäväksi tarkastukseen sen jälkeen kun Toimeksiantajan etuja haittaavat kohdat on poistettu. Mikäli Toimeksiantaja ei edellä mainittuna määrääikana vaadi muutoksia opinnäytetyöhön, on opiskelijalla oikeus jättää opinnäytetyö sellaisenaan tarkastukseen.

Opinnäytetyön esitys

Opinnäytetyön esitys on aina julkinen. Työn teettäjä ja tekijä määrittävät yhdessä esityksen sisällön siten, että esitys ei loukkaa salassapitosopimusta.

Salassapito

Ohjaava opettaja ja opinnäytetyön tekijä ovat velvolliset pitämään luottamuksellisina ja salassa kaikki toimeksiantajan liike- ja ammattisalaisuudet. Mikäli toimeksiantaja sitä vaatii, tehdään opinnäytetyötä koskeva erillinen salassapitosopimus.

Vastuut

Sopijaosapuolet ovat vastuussa toisilleen sopimusrikkomuksen aiheuttamista vahingosta. Vastuun ulkopuolelle on rajattu välilliset vahingot. Vastuun syntyminen edellyttää tahallaan tai törkeällä huolimattomuudella aiheutettua sopimusrikkomusta.

Tätä sopimusta on laadittu kolme (3) samasanaista kappaletta, yksi (1) kullekin sopimuksen osapuolelle. Sopimus astuu voimaan allekirjoitushetkellä.

Julkaisu

Opinnäytetyön ja sen tiivistelmän saa julkaista myös elektronisesti.

Kyllä Ei Toimeksiantaja pidättää oikeuden päättää
elektronisesta julkaisemisesta myöhemmin

Paikka ja aika

JYVÄSKYLÄ 27. 10. 2009

Allekirjoitukset

Toimeksiantajan edustaja, JUUKA PELTOKORVA 44

Ohjaava opettaja

Ohjaava opettaja

Opinnäytetyön tekijä

Opinnäytetyön tekijä

Attachment 7. Photoshoot and web distribution agreement

Agreement

16.10.2009

We are three nursing students from the Jyväskylä University of Applied Sciences and we are making a thesis about how to prepare children for an operation. As a part of the thesis we are producing a counseling folder for the pediatric ward. There are going to be pictures in the folder and descriptive writing beneath them. There are two copies of this agreement, one for each participant.

I Biljana Milosavljevic and my son Jan Rusila can be photographed in the hospital environment. I agree that the photos can be used in a counseling folder, which will be in use at the pediatric ward in the Central Hospital of Central Finland. In addition, I agree that the photos can be put on display in the Internet on the health care district's web-page.

16.10.2009 Jyväskylä

Appearing in the photos:

Thesis authors:



Biljana Milosavljevic



Heli Karjalainen



Christina Förnäs



Tiina Järvenoja

Attachment 8. Agreement of using teddy bear pictures in the folder

Postiviesti

Vastaa Lue myöhemmin

Postiviesti Ominaisuudet

Lähettäjä: "Teddy Bear Friends"
<business@teddybearfriends.co.uk> perjantai - 13 marraskuu, 2009 11:59

Jakelu: Tiina Järvenoja <tiina.jarvenoja.snp@jamk.fi>

Aihe: Re: Bachelor's Thesis to Jyväskylä university of applied sciences

Viestin liitteet: Mime.822 (3285 tavua) [Näytä] [Tallenna nimellä]

Hi Tiina

Thanks for your enquiry. You are welcome to use these pictures in your folder. Good luck with your degree.

Regards

Kevin O'Sullivan
Teddy Bear Friends

----- Original Message -----
From: "Tiina Järvenoja" <tiina.jarvenoja.snp@jamk.fi>
To: <enquiries@teddybearfriends.co.uk>
Sent: Wednesday, November 11, 2009 6:14 PM
Subject: Bachelor's Thesis to Jyväskylä university of applied sciences

> Hello!

>

> We are three nursing students from Jyväskylä university of applied
> sciences. We are doing our bachelor's thesis about preparing a child for
> surgery and making a counseling folder for pediatric surgical ward at the
> Central Hospital of Central Finland. We wanted to ask if you would
> consider giving us a permission to use a few pictures of your teddy bears
> in the folder? There were two teddy bears that would appear in our folder,
> Nurse Bear and Doctor teddy bear. We are kindly asking you to give us your
> answer as soon as possible.

>

>

> Sincerely
> Tiina Järvenoja, Heli Karjalainen, Christina Förmäs

>

Attachment 9. Counseling folder



Lapsipotilaan sairaalamatka

Lasten kirurginen osasto

Child patient's hospital journey

Children's surgical ward

Keski-Suomen Keskussairaala
Lastenosasto 1K, Keskussairaalan tie 19
40620 Jyväskylä
♥ Puh: lastenkirurgia (014) 269 2831



Kansion esittely

Tämä kansio on tarkoitettu sinulle, joka olet tulossa toimenpiteeseen. Tästä kansiosta löydät tietoa tulevasta toimenpiteestä ja sen valmisteluista. Kansion avulla pääset tutustumaan sekä osaston arkeen ja toimintaan että toimenpidesaliin. Tämän kansion tarkoituksena on antaa sinulle ja perheellesi tietoa tulevasta sairaalassaoloajastasi. Lisätietoa käytännön asioista, mm. vanhempien ruokailusta sekä osaston päiväohjelmasta saat osaston hoitohenkilökunnalta.

Tämän kansion ovat laatineet Jyväskylän (AMK) sairaanhoidon opiskelijat osana heidän opinnäytetyötään yhteistyössä lasten kirurgisen osaston hoitaji en kanssa.

Introduction

This folder is aimed for you who are attending an operation. From this folder you can receive information of the upcoming operation and preparations related to it. The ward's everyday life and its activities, as well as the operating theatre will be introduced to you in this folder. The aim of the folder is to give you and your family information about your hospitalization. More information about practical issues such as parent's eating possibilities and ward's daily programme you can get from the nursing staff.

This folder has been made by nursing students from the Jyväskylä University of Applied Sciences as a part of their thesis in co-operation with the nurses from the surgical pediatric ward.



TERVETULOA OSASTOLLEMME!

Kun tulet vanhempiesi kanssa osastollemme, sinulle nimetty hoitaja tulee vastaanottamaan teidät ja esittelee osastoa sinulle ja perheellesi.

WELCOME TO OUR WARD!

When you and your parents arrive to our ward, your named nurse will meet you and introduce the ward to you and your family.





Haluat varmaan nähdä osaston
leikkihuoneen, jossa voit myöhemmin
leikkiä.

You are probably interested in seeing the playroom
with different toys and activities
where you can play later on.





Kun hoitaja on esitellyt osastoa, hän vie teidät omaan huoneeseenne. Hän kyselee muutamia kysymyksiä sinulta ja vanhemmiltasi liittyen sairaalassa oloosi. Ympärille katsoessasi huomaat mitä kaikkea kivaa huoneestasi löytyykään. Sinulla saattaa olla myös huonetoveri.

After presenting the ward your named nurse will take you and your family to your own room and asks a few questions relating your stay at the hospital. Have a look around the room and see what you can find. You may also have a roommate sharing the room with you.





Pian sinulle puetaan sairaalavaatteet ja hoitaja laittaa käteesi taikavoidetta, joka auttaa unikorkin paikoilleen laittamisessa. Jos jokin on sinulle epäselvää, kerro siitä hoitajallesi ja vanhemillesi niin he voivat auttaa sinua. Halutessasi vanhempasi voivat jäädä osastolle ja osallistua hoitoosi.

Soon you are going to put on hospital clothes and the nurse will apply some magic cream on your hand, which will help in putting on the dream cork. If you have any questions, please let the nurse or your parents know about it so that they can help you. Your parents can stay at the ward and take care of you if you wish.





Kohta hoitaja antaa sinulle lääkkeen, joka tekee olosi uniseksi. Sen jälkeen on hyvä käydä pitkälleensäängylle. Halutessasi voit ottaa oman unikaverin viereesi. Vanhempasi voivat olla kokoajan vierelläsi osastolla.

The nurse will now give you medicine, which makes you feel a little tired, so it is best to lie down on the bed. If you like you can have your sleeping buddy next to you. Your parents can stay at the ward with you at all times.





Lastenosaston hoitaja vie sinut sängyssäsi toimenpidesaliin. Vanhempasi voivat tulla saattamaan sinut toimenpideosaston ovelle tai jäädä osastolle odottamaan paluutasi. Kun saavut toimenpidehuoneeseen, sinua ovat siellä vastassa toimenpidehoitajat. Hoitaja on luonasi koko toimenpiteen ajan.

The pediatric nurse will take you in your bed to the operating theatre. Your parents can come with you all the way to the operating department's door or wait for you at the ward. When you arrive to the operating theatre there are nurses already waiting for you. There will always be at least one nurse taking care of you.





Toimenpidehuone näyttää tältä. Sängyn yläpuolella on kirkkaat valot ja sängyn vierellä on erilaisia laitteita.

The operating theatre looks like this. There are bright lights above the bed and different equipment around the bed.





Sinulle kiinnitetään siniset tarrat rintakehäsi, joihin tulee liikennevalojen väriset johdot kiinni. Niistä hoitaja ja lääkäri näkevät sydämesi lyönnit.

Blue stickers with colourful lines will be placed on your chest, where the nurse and the doctor can see your heart beating.

Sormeesi laitetaan pieni laite, joka kertoo voinnistasi.

A small clip will be placed on your finger, which tells about your well-being.



Käsivartesi ympärille laitetaan tarralla kiinnitettävä paksu nauha. Tämän laitteen avulla seurataan sinun vointiasi.

A cuff attached with a sticker is going to be placed around your arm. With the device your well-being is being observed.





Käteesi laitetaan unikorkki sille kohdalle, johon taikavoide laitettiin.

You will get a dream cork on your hand to the same spot where the magic cream was put on.

Unikorkista hoitaja ja nukutuslääkäri voivat antaa sinulle lääkettä ja sinä nukahdat.

Through the dream cork the anaesthesiologist and the nurse can give you medicine and you will fall asleep.



Värikäs lentäjän maski laitetaan lähelle kasvojasi, josta saat hengitettävää lääkettä.

A colorful pilot's mask will be placed near your face and it will give you inhalative medicine.





Huonetta jossa heräät hoitaja vierelläsi, kutsutaan heräämökksi. Toimenpide on nyt tehty. Vanhempasi odottavat sinua lastenosastolla ja näette toisenne pian.

The room where you wake up with a nurse beside you is called a recovery room. The operation has now been done. Your parents are waiting for you at the pediatric ward and you will see them soon.





Jos sinulla on kipeä olo, hoitaja antaa sinulle kipulääkettä, jotta olosi paranee. Kipumittarin avulla voit helposti kertoa olostasi hoitajalle tai vanhemillesi. Illan tullen vanhempasi voivat nukkua huoneessa kanssasi.

If you feel ill or nauseous, the nurse will give you medicine to make you feel better. A good way to show how you feel is using a pain scale. When the evening comes your parents can stay and sleep in your room.





Toimenpiteen jälkeen saat ensin juomista ja myöhemmin voit taas syödä osastolla normaalisti, mutta ensin hoitaja tarkistaa vointisi.

After the operation first you can get something to drink and then later on you can eat normally, but first the nurse must check on you how you feel.

Voit myös halutessasi leikkiä heti kun vointisi sen sallii.

You can also start playing as soon as your well-being allows it.





Vointisi kertoo hoitajille ja lääkärille milloin olet valmis lähtemään kotiin. Ennen kotiin lähtöä lääkäri tutkii sinut vielä kerran. Hoitaja kertoo sinulle ja vanhemillesi kotihoito-ohjeet, jotta vanhempasi voivat hoitaa sinua kotona.

Your well-being is telling us how long you will stay at the hospital. Before going home from the hospital the doctor will examine you so that you are healthy enough to go home. A nurse will give you and your parents some homecare instructions, so that they know how to take care of you at home.





PIKAISTA PARANEMISTA JA HYVÄÄ KOTIMATKAA!

GET WELL SOON AND HAVE A NICE JOURNEY HOME!