一、選擇題 (每題 5 分，共 15 分) ※ 注意：請於試卷內之「選擇題作答區」依序作答。

1. 下列關於膽道閉鎖 (Biliary atresia)的診斷與治療的敘述何者正確?

(A).初診斷時嬰兒的成長發育及活力有下降的情形

(B).嬰兒的尿夜顏色會較淡(淺色尿液)

(C).血中間接型膽紅素 (indirect bilirubin)會增加

(D).手術治療以出生後 60 天內最佳

2. 兒童懷疑罹患泌尿道感染，並以留取中段尿液的方式進行細菌培養檢體收集時，菌落數大於以下哪一個數值即為有意義?

(A).>1/mL

(B).1000/mL

(C).10000/mL

(D).100000/mL

3. 兒童以靜脈注射高劑量免疫球蛋白治療疾病時，在 11 個月之內不宜接種下列哪些疫苗?

①水痘疫苗、②卡介苗、③日本腦炎疫苗、④德國麻疹疫苗、⑤流感疫苗

(A).①④

(B).②⑤

(C).①②③

(D).③④⑤

二、問答題：(五大題、共 85 分) ※ 注意：請於試卷內之「非選擇題作答區」依序作答，並應註明作答之大題及小題題號。

1. 丹佛發展測驗是護理領域常用來評估兒童發展之工具，請回答下列兩題：

(1). 此測驗適用的年齡範圍為何? (2 分)

(2). 此測驗包含了哪幾個面向? (8 分)

2. 兒童的生長與發展有許多原則，如具有方向性、連序性、順序性、關鍵性及節律性…等。請說明什麼是「順序性」? (5 分) 當您在協助發展遲緩的兒童之發展時，您如何依「順序性」原則設計您的介入措施? (10 分)

3. 寡尿是診斷兒童是否發生休克的徵候之一，請問為何休克時會出現寡尿的現象? (5 分) 兒童的尿量正常為多少? (5 分)

4. 發燒是兒童患有感染性疾病的重要徵候之一，發燒(fever)與體溫過高(hyperthermia)有何不同? (10 分) 發燒(fever)的機轉為何? (15 分)

5. 請閱讀下列所附之文獻，並以<u>中文</u>回答下列問題：

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(1). 此研究的研究目的為何? (4 分)

(2). 此研究的研究對象為何? (4 分)

(3). 此研究中，量性資料方面重要的研究發現有哪些? (12 分)

(4). 基於此研究的研究結果，您認為如何運用在臨床兒科照護中? (5 分)

Title: The impact of restrictions to visiting in paediatric intensive care during the COVID-19 pandemic

Abstract

Background: Restrictions to hospital visiting were mandated during the COVID-19 pandemic, with variability in the degree of restriction imposed. At times, paediatric intensive care units (ICU) restricted visiting to one parent/carer. Views of parents/ carers and ICU staff about changes in the visiting policy are not well understood.

Study Design: This is a Service evaluation involving questionnaire survey incorporating rating scales and free-text comments. Inner-city specialist children's hospital. Parents/carers of children on ICU between December 2020–March 2021 and staff who were working on ICU during May–June 2021. Parents and staff on ICU were invited to complete a questionnaire focusing on their experience of being or working on ICU. Quantitative data were analysed descriptively and free-text comments were thematically analysed.

Results: Completed questionnaires were received from 81/103 (79%) parents/carers and 217/550 (39%) staff. The majority of parents (n = 60;77%) and staff (n = 191;89%) understood the need for the one-parent visiting policy but acknowledged it was a source of considerable stress. More staff than parents agreed it was appropriate other relatives/friends visiting was not permitted ($Z = 3.715; p < .001$). There was no association between parents' satisfaction with their child's care and views about the visiting policy. However, staff were more likely to report an impact on their ability to deliver family centred care if they disagreed with the policy.

Conclusion: The COVID-19 visiting policy had a clear impact on parents and staff. In the event of any future threat to open-access visiting to children in hospital, the potentially damaging effect on children, parents, and staff must be considered.

1 BACKGROUND

In March 2020, when the WHO declared COVID-19 a global pandemic, health care systems had to rapidly introduce measures to reduce the spread and impact of the virus. The WHO recommended that 'numbers of visitors and visiting periods should be highly restricted' and in April 2020, NHS England mandated severely restricted visiting to hospital inpatients. There were some exceptions such as parents of paediatric inpatients, and for Paediatric Intensive Care Units (PICU) (including neonatal intensive care units) this was frequently translated into a one-parent only visiting policy. Individual PICUs in the UK varied in how they implemented this—some only allowed one parent to visit for the entirety of the PICU stay whilst others allowed a second parent to take over after a fixed period. Globally, most PICUs implemented changes in caregiving policies, with some units prohibiting any family visiting.

Liberal caregiver visiting policies and parental presence at the bedside are a core tenet of Family Centred Care (FCC); restrictions imposed because of the pandemic severely undermined this principle,with consequences for families and staff. Few studies have addressed the effects of visiting restrictions in paediatric settings but reduced parent-infant bonding, disrupted family relationships, and increased stress have been identified. Whilst the increased burden on staff because of the need for different ways of communicating with and supporting families during the pandemic has been highlighted, views of staff delivering care to children in ICU have rarely been systematically elicited. Our aim, therefore, was to capture views of both parents of children who were inpatients in ICU during a period of restricted visiting and of staff caring for them.

2 METHODS

2.1 Setting

Our inner-city hospital provides specialist care to children aged 0–18 years and has separate paediatric, neonatal, and cardiac intensive care units (ICU). During the pandemic, another ICU was set up solely to treat COVID-19 positive patients. Visiting during the height of the pandemic was restricted in all ICUs. Across all of the four

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ICUs, from April 2020, one parent only was allowed to visit and no extended family were permitted to visit. In August 2020, this restriction was changed to allow two parents to visit (but no extended family) but in December 2020, it was reduced again to one parent at the bedside but that parent could change. In January 2021 the restrictions were tightened further so that the one parent at the bedside could not change for the first 2 weeks of the child's stay, after which the parents could alternate on a weekly basis.

2.2 Participants

Parents of children in ICU between December 2020–March 2021 were invited to complete a paper-based parent-reported experience measure (PREM), focusing on their experience of being on ICU during the pandemic. Staff in all ICUs were invited to complete an electronic staff-reported experience measure (SREM) during May/June 2021, focusing on their experience of caring for children on ICU during the pandemic or working on ICU during this time. Medical and non-medical professionals and administrative staff who worked on the ICUs were included.

2.3 Questionnaires

A PREM for parents was developed by our PREM team. Topics included delivery of care, use of personal protective equipment, technology for virtual meetings, perceived personal vulnerability in relation to COVID-19 and the visiting policy. The questionnaire comprised 64 questions with the opportunity to provide free-text comments. Questions were primarily five-point Likert scales in which respondents were asked to rate their level of agreement with specific statements, together with demographic questions about the parent and child. All questionnaires included an explanation about why we were asking families to complete them and what would happen to responses. Parents were assured of their anonymity (no identifying details were collected) and we had no knowledge about who completed a questionnaire. Paper questionnaires were left for families at their child's bedside and there was a box for returning completed forms on each unit.

Following a similar approach, the PREM team also developed a SREM. Questions covered similar topics to the parent PREM and staff could provide additional comments. All eligible staff were emailed an electronic link to the questionnaire and several reminders were sent. Staff were also assured of their anonymity and were told responses could only be accessed by the PREM team (who were not part of the ICU structure).

3 RESULTS

Completed questionnaires were received from 81/103 (79%) parents/carers and 217/550 (39%) staff (Table 1).

3.1 Visiting policy

The majority of parents (n = 60;77%) and staff (n = 191;89%) strongly agreed/tended to agree on the need for visiting restrictions in ICU, with no significant differences between the two groups ($Z = 1.304; p = .192$). However, only 38% of staff strongly agreed/tended to agree it was appropriate that the two-parent rule was reduced to one parent only being allowed to visit (Figure 1). Individual staff groups differed, with a greater proportion of ICU nurses than allied health professionals and non-ICU based staff strongly agreeing/tending to agree it was appropriate only one parent could visit ($Z = 2.80; p = .005$). Two-thirds (n = 148; 69%) of staff strongly agreed/tended to agree that both parents/carers could have been safely permitted to visit on ICU during the pandemic. Perhaps surprisingly, 60% of parents strongly agreed/tended to agree it was acceptable the carer at their child's bedside could not change (Figure 1).

In contrast, views regarding people other than parents being allowed to visit showed different patterns of responses. Most staff (n = 183;85%) strongly agreed/tended to agree it was appropriate only parents/carers were allowed to be on ICU (parents were not asked this question). A smaller proportion of parents than staff strongly agreed/tended to agree it was appropriate that relatives/friends visiting was not permitted (Figure 2; $Z = 3.715; p < .001$). Although not significantly different, more staff than parents strongly agreed/tended to agree it was appropriate that sibling visiting was not permitted (Figure 3; $Z = 1.230; p = .219$).

Just over half of parents (n = 44;56%) strongly agreed/tended to agree they were able to access emotional support needed from family and friends, which differed significantly ($Z = 5.237; p < .001$) from staff perceptions of

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parents' ability to do this (Figure 4).

There were significant positive associations between parents' perceptions of their ability to access emotional support and their agreement with the one-parent ($r = .457; p < .001$), sibling ($r = .345; p = .002$) and other relative/friend ($r = .498; p < .001$) visiting policies. Similar associations were seen for staff perceptions of parents' ability to access emotional support with regard to the one-parent ($r = .347; p < .001$) and sibling ($r = .236; p < .001$) policies but not with the other relative/friends ($r = .092; p = .207$) policy. There was also a significant association between staff's agreement that they could deliver FCC effectively and their agreement with the one-parent ($r = .419; p < .001$) and sibling ($r = .186; p = .008$) visiting policies. In contrast, parents' satisfaction with the care provided to them by the ICU team was not associated with any aspect of the visiting policies.

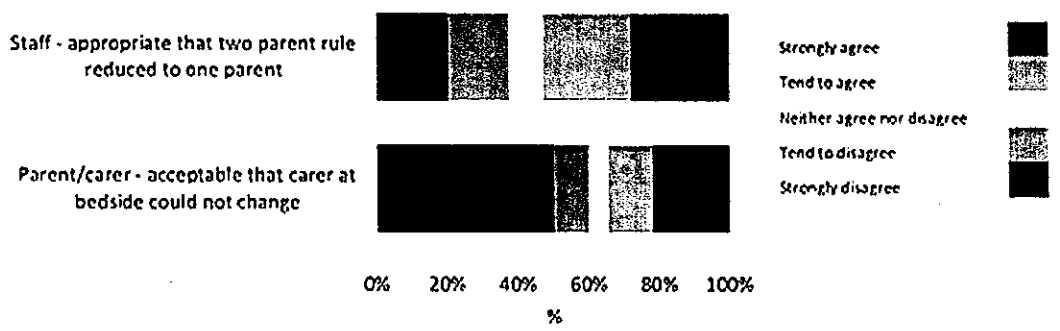

Figure 1 Appropriate that two parent rule reduced to one parent only being allowed in ICU areas

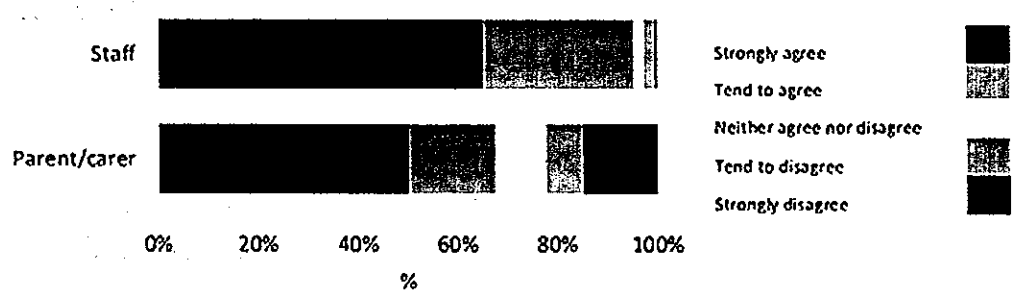

FIGURE 2 Appropriate that other relatives/friends visiting not permitted

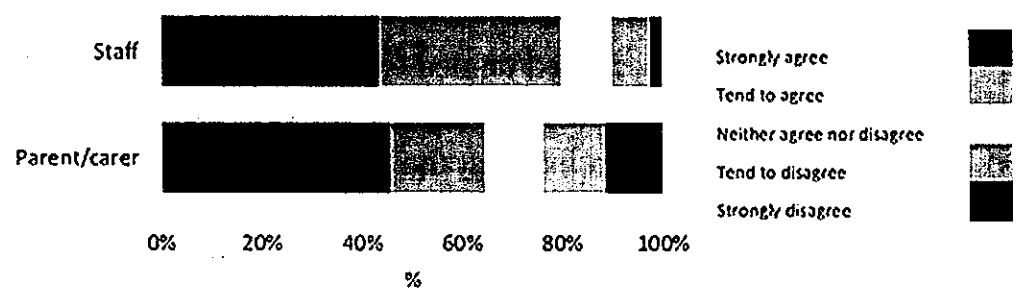

FIGURE 3 Appropriate that sibling visiting was not permitted in ICU areas

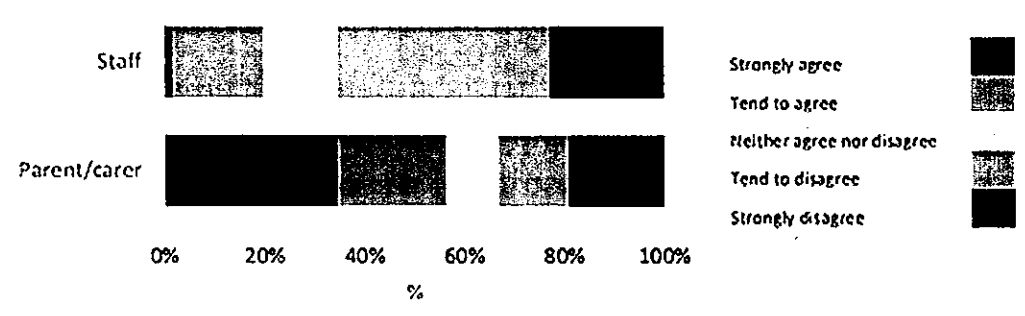

FIGURE 4 Able to access emotional support from family and friends

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