Original Research

Border Crossings: Early Childhood Teachers' Experiences in Healthcare Settings

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Abstract

The experiences of eight New Zealand early childhood teachers in the months following their appointment as hospital play specialists were studied. This paper focuses specifically on the challenges they faced in acquiring role-related knowledge and skills, establishing a professional identity, and gaining a sense of belonging. Initially the teachers found the transition to their new role overwhelming and threatening to their understanding of themselves as competent teachers. Despite this, the teachers were found to be resourceful in coping with change, in building relationships, and in developing and adapting their practice.

Key Words: Hospital play specialist; novice practitioner; professional development; professional recognition; multidisciplinary teams

Introduction

At the present time, 15 hospitals throughout New Zealand employ staff to provide play programmes for children who are hospitalised. Staff members are primarily recruited from early childhood teaching but, as in Britain, are given the title 'hospital play specialist'. Staffing levels vary greatly, from sole practitioner to 10 or more full-time equivalent positions. Hospital play specialists are regarded as allied health members of multidisciplinary teams, and are governed by district health board regulations and by policies and procedures applicable to the particular units in which they work.

Most hospital play specialist services incorporate early childhood centres which are licensed and chartered by the Ministry of Education, and jointly funded by the health authority. Centres are required to comply with the relevant Ministry requirements, and the ward playroom is usually designated as the licensed space. Staff also work in unlicensed areas such as children's rooms to ensure that all children, including those confined to bed, are able to participate in the play programme.

Although providing for young children's ongoing learning is a key component of hospital play specialists' work, the role significantly differs from early childhood teaching. Consistent with practice internationally, the role incorporates healthcare play opportunities, teaching and rehearsing strategies to cope with potentially stressful healthcare events, and procedural support for children and young people. Hospital play specialists provide information and advice to families, and teaching sessions for students and colleagues from other disciplines (Francis, 1990; Thompson & Stanford, 1981). They may also contribute to

wider aspects of paediatric care through advocacy for healthcare policies, practices and environments that minimise harm and are developmentally supportive of children and young people (Child Life Council, 2002; Hospital Play Specialists Association of Aotearoa/New Zealand, 1999; Kayes, 1999).

There is no professional qualification offered in New Zealand to prepare hospital play specialists for aspects of the role that specifically address children's healthcare experience or the healthcare work environment. Instead, the majority of people appointed to the role have an early childhood teaching qualification and work experience in early childhood centres. Hospitals, however, are very different physical environments and have a different culture, one that shapes the language, meanings, traditions and practices within (Leonard, 1994). Accordingly, newly appointed hospital play specialists must learn how hospitals operate, and acquire practice skills and knowledge 'on the job' and through professional development opportunities.

Little is known about how early childhood teachers experience the transition from early childhood teaching to working in a hospital as a play specialist. The purpose of this study was to explore the day-to-day experiences of novice hospital play specialists as they became established in the role, in order to understand how they might be better supported.

Methodology

This small-scale qualitative study was designed to explore experiences of newly appointed hospital play specialists, from their perspective, and to allow their voices to be heard. It was informed by phenomenological philosophy as described by Heidegger (1927/1996) and by van Manen's (1990) approach to phenomenological inquiry.

In all qualitative studies, protecting participants' privacy is an important ethical issue. This was particularly the case in this study as most of the 60 or so hospital play specialists in New Zealand know each other and are familiar with each other's work environment. Thus, all quotations and perspectives are attributed to 'a participant' or 'novice hospital play specialists'. To further assist in maintaining confidentiality, participants were asked not to disclose potentially identifying information and, where necessary, identifying details were changed.

Eight prospective participants from a number of different hospitals and from both small and larger hospital play specialist services were identified and sent a letter inviting them to be part of the study. All eight agreed to participate. They were all qualified and experienced early childhood teachers. At the time of interview, six participants had worked as a hospital play specialist for less than a year. The other two participants had experienced the role for not more than two years.

Data collection involved individual, face-to-face interviews, conducted at venues around New Zealand chosen for convenience to the participants. Interviews commenced with reiteration of the purpose of the study and completion of consent forms. Participants were asked to recall incidents from their early months as hospital play specialists, and to talk about what happened and how they felt. The interview transcripts were explored for words and phrases that seemed to be particularly revealing. Subsequently, emerging understandings were refined through grouping and re-grouping the recounted incidents, discussion amongst the authors, and writing and re-writing until inter-connected themes and sub-themes became apparent. The credibility of the study was established by taking care that the findings accurately represented participants' experience, by ensuring that themes and sub-themes were drawn from the experiences of a number of participants, and carefully documenting the analytic process (Kayes, 2005).

A study such as this has inevitable limitations. Only a selection of illustrative quotes can be included in any account of the study and the small number of participants precludes generalisation of findings. The potential impact of culture and ethnicity on participants' experiences was not explored as this was not evident in participants' stories. Furthermore, gender issues were not addressed because at the time of the study no male hospital play specialists met the criteria for inclusion.

Findings

The findings that emerged from the data analysis are presented under three headings: (1) challenges to acquiring knowledge and skills; (2) establishing a professional identity; and (3) gaining a sense of belonging. The issues that arose are interwoven in ways that reveal a complex period of transition as the early childhood teachers adapted to their new professional role as hospital play specialists. Illustrative quotes are provided, which represent the shared experiences of all of the participants.

Challenges to Acquiring Knowledge and Skills

The participants in this study were delighted to have the opportunity to work in a healthcare setting. One described her appointment as achieving her "big dream", something that she had wanted to do "forever." For another, "when it came up in the newspaper, I thought, 'Yes, this is it, this is where I want to be'. I had a hugely positive feeling, as if this job has been waiting for me." However, an initial sense of excitement and of being in the right place was quickly tempered by the sense of having crossed the border into a completely new world.

Becoming accustomed to this world was challenging, and the effort required to familiarise themselves to the setting initially impeded participants in their efforts to acquire skills and knowledge specifically related to their role as hospital play specialists. For instance, the sensory impact of the physical environment made an immediate impression and was vividly described by participants: the sheer size of the hospital buildings, the heat, the lack of opportunities to be outside even during lunch breaks, and the unfamiliar smells, sounds and language. The pace of work was different too. Some participants relished the opportunity to spend more time with individual children, while others found the high turnover of children and ongoing loss of relationships difficult. One recalled that it seemed to be a "huge job and a huge place. It was like getting chucked in the deep end. The hospital was on red alert the whole time." The sense of being just one person in a huge organisation, together with the general sense of serious purpose and 'busy-ness' affected participants' confidence to approach others for simple information, or to have unfamiliar terminology explained.

The extent to which working in a hospital differed from working in an early childhood centre was unanticipated. One participant, with experience as a centre supervisor, described her initial impressions:

> The early childhood service here is nothing like I've ever known before. Your experience on one level seems to be not useful, the things that you used to do.… I expected to be confident and love what I was doing here, and it didn't happen. Going into that hospital environment, I honestly just felt that I went back to square one. It felt like someone had pulled the rug out from under my feet. I had to step out of that previous role and step into another one and it was a bit of a loss I suppose. It was quite hard really. I felt like a swimmer that was just floundering in the water and no one had thrown me a life-buoy. It was just awful, absolutely awful. It was horrible.… What I've found here is that it's almost like you've been taken

> from one country and planted in another, with a different language being spoken, and that's been quite overwhelming.

The sense of being overwhelmed shook participants' confidence and left them feeling, at first, that their former skills and experience were irrelevant. One described having to "unlearn" her past knowledge and skills, saying that she needed to, "close the [early childhood] door off and stop comparing then to now, because it's so different." In addition, participants discovered early on that there were many written and unwritten rules, even in the relatively familiar playroom environment. One participant explained:

> It was just making little mistakes. Just learning the hospital policies. Little things, like maybe walking into the playroom with a drink bottle, forgetting the 'no drink' rule. Forgetting to sign things out. Learning what my boundaries were. How to talk to children who were bringing up their operations, and how and when to steer them another way …learning when to say something, and when not to. Just the whole novice feeling.

This same participant recalled being almost paralysed by wanting to do and say everything correctly, so that "at first I found myself saying nothing As former teachers, participants were accustomed to ongoing evaluation of the appropriateness of their actions. However, in the hospital context the potential consequences of a small mistake, such as allowing a child who was 'nil by mouth' to have a drink, added new complexities and uncertainties to decision making. Outside of the playrooms, there were both visible and invisible barriers to negotiate. As one participant said:

> I found it really difficult to go into rooms at first. It took me ages. Just because often they'd have the curtain pulled, or you don't know who's in there. You don't know how many family members are there. You don't know what the child is like. You don't know what distress they're in. And just going in and sort of owning a role that you're not quite sure of yet. I mean, I didn't feel a play specialist yet and to have to go in and say "Hi, I'm …, the play specialist", felt very foreign and also very intrusive because it's a child's bedroom technically and [his or her] family's there.

Participants were uncertain about how to respect privacy, as well as being discomforted by claiming a professional identity, which they did not yet feel.

Establishing a Professional Identity

Where possible, to support their efforts to establish a professional identity, the novices looked to more experienced hospital play specialists for guidance. One recalled, "they were an incredible bunch of people. It was all positive." However, participants in small teams, or whose part-time hours limited interaction with others, were not able to readily access such support. The responsibility for finding out "the-way-things-are-round-here" often fell upon the new appointees. In some instances basic information was missing, "like knowing what a house surgeon is, what a registrar is." Participants' feelings of isolation and uncertainty about how to practise safely were exacerbated by insufficient information about hospital policies and practices, such as infection control requirements. In other situations, they were bombarded with overwhelming amounts of information, much of which was peripheral to their role.

Endeavouring to establish an identity as a hospital play specialist involved participants having to modify their expectations of what they could achieve:

> I know I am getting the ones [children] I can when I'm there. And that's something I think you just learn. Just, that's ok. I can't get the ones in the weekend and I can't get the ones that went to theatre before I got to work. So I think about what *else* I can do for that child. I mightn't have managed to do the prep beforehand, but I can do something afterwards. I can also just make sure they're ok.

In the process of accepting the limitations imposed by time and workload constraints, participants modified their initial assumption that they should work with all the children and adjusted their view of a hospital play specialist to accommodate the realities of the setting.

The hospital setting also required participants to make adjustments in practice, such as the provision indoors of what would usually be considered outdoor play activities. In this regard, participants found that they had to be particularly attentive to children with special needs and those confined to bed in order to ensure opportunities for the expenditure of physical energy. In addition, as relative 'outsiders' there were occasions when participants noticed the impact of hospitalisation on children and families more clearly than staff who were acculturated to this setting. This insight provided participants with opportunities to advocate for children and to re-frame children's behaviour as responses to the constraints imposed by illness and treatment rather than 'naughtiness'.

Conversely, participants expressed feelings of vulnerability when others assumed they had fully taken on the identity of a hospital play specialist at a time when some aspects of the role were still new to them, especially preparing children for procedures.

> There was a time of actually preparing a child for theatre and not *really* feeling ready for it. It's a bit like getting directions from someone who's tackled inner city Auckland a million times. They don't understand why you're feeling so scared about giving it a go yourself. They forget what it was like for them the first time they got in the car and drove. That's how I felt.

Playroom usage emerged as an issue that participants related to professional recognition. Hospital playrooms, whether or not they are licensed, are both a special place for children and families and the 'home base' for play specialists. In particular, playrooms are a place in which the play specialist can experience a sense of autonomy that might be hard to achieve elsewhere. Respecting the playroom as a space to play is one way other professionals can convey their awareness of the importance of play for hospitalised children. However, all participants described incidents when other staff used playrooms for purposes that compromised their availability for play, such as using them as meeting rooms. Participants also described occurrences where rooms were 'trashed' in the play specialist's absence.

Such experiences were very discouraging and some participants equated respect for the playroom with respect for their role. One made this explicit when she said, "I'm saddened that the service isn't valued enough, or seen as being important enough, to have an area that is physically ours without it being disturbed all the time." However, others responded to such events by taking positive action to maintain the playroom as a safe and stimulating environment for children:

> I was very particular about what people did in the playroom. When I first turned up, people were treating the playroom like it was a waiting room. It was getting tagged and it was disgusting and people were ruining things and breaking into cupboards. So, what I did was to sort out a lock, and I wrote down all the reasons why it would be beneficial to have a lock for

> the door. Once that was done it made my job a lot easier. I felt like, by doing this, it ensured there was a space for the children to use and I think people respected it more.… It became a special place for the children to go and people really looked after it and really respected it. And I think they respected the service better because they didn't just view the playroom as a place to get toys – they valued it as a place for children to use for therapeutic play.

Over time, as participants noted the positive changes they were making for children, their professional identity developed. This new identity included recognition that despite early misgivings, their skills as early childhood teachers were applicable to the hospital setting and provided a good foundation for the knowledge and skills they were acquiring as hospital play specialists.

> I think my confidence has grown so much. Just a *huge* amount. I'm more confident in what I say and in realising that I *do* actually know what I'm talking about. I did train for three years after all. I think when I first stepped into that environment, for a while that stuff went out the door because I felt that there was this little bit that I did know, and this huge bit that I didn't know. But now, drawing on what I *do* know and being a bit more confident as I learn, plus being in the environment for a longer period and knowing more about it.

Within just a few months of commencement, participants were reflecting on their practice in ways that showed their "situational confidence" (van Manen, 1990, p. 169) and their confidence in their own ability:

> I know the job well enough now 'text book' that I want to adapt it to be more therapeutic or more meaningful. Now I can relate it to particular children or particular incidences. Now I want to know how I can make it better and more meaningful for that child. In the beginning I probably went in and did a text book, 'Oh, here's a doll and here's how the luer goes in and this is what happens, and are you fine with that?' Now I'll go in and say, "So, what would you like to know?"

Nonetheless, all participants struggled to a greater or lesser extent to be recognised as a professional within the multidisciplinary team. They had come from settings where there was a shared understanding of their responsibilities as teachers. In hospital, they had been assigned a new role that was unclear to them and appeared to be only vaguely appreciated by their healthcare colleagues. Some felt their teaching qualifications and previous experience were under-valued or not seen as relevant to healthcare decision making. These experiences caused enormous frustration, leaving one person feeling "demeaned. I felt like wearing my degrees across my back."

One participant, however, considered her colleagues were "overly reticent" about their professional base, suggesting that new appointees need to be more assertive about their skills and about claiming a place within teams. Certainly, as professional recognition from healthcare colleagues was gained, it was prized as evidence of belonging. Many participants remembered specific occasions of collaboration or receiving a referral, which marked a point of change in their feelings of inclusion. Those who had not achieved this recognition found it difficult to contribute effectively to planning children's care.

Gaining a Sense of Belonging

Relationships with staff from other disciplines had a powerful and often negative impact on participants' confidence and ability to work effectively, and to their sense of belonging within the service. Participants sensed that professional boundaries and hierarchies existed, but these were seldom made explicit. Some participants described feelings of invisibility when their efforts to contribute were rebuffed or completely ignored. One told how her charge nurse, "didn't introduce me to the other staff at all, or include me in meetings. She didn't greet me, or say hello. None of that." Such negative early experiences left a long-reaching shadow so that for one participant, who subsequently resigned, "you never felt that you belonged."

Communication appeared to improve as participants became more familiar with their workplace, role, and the roles of others, and as their healthcare colleagues got to know them. For some, this mutual adjustment came about through processes established within the hospital play specialist team or ward. Others were very active in relationship building and in dissipating potential barriers prior to their occurrence. In addition, participants also became more understanding of the tensions inherent in working in a hospital environment. One participant explained:

> People are in a really stressed environment and anyone who says anything is going to get that [unwelcoming] kind of reaction. When I first started I looked for reasons in myself and what I had done. I've got over that now! I think that's an experience thing really.

Participants learned to recognise that the negative interchanges they sometimes experienced were entrenched in the culture of the hospital rather than personal. This realisation had an immunising effect, and made such exchanges less anxiety-provoking and less damaging to their sense of belonging.

In contrast to interactions with other health professionals, establishing relationships with children and families was one of the easiest aspects of the role. As one participant disclosed:

> The families instantly make a difference. They don't necessarily know it's your first day, so they instantly rely on you and it makes you feel as if you are part of things…. Straight away there were children who had already been there long term and I think they make that induction process easier – it's their environment and, if you respect it, that connects you to them.

Being perceived as sources of information and advice helped the new appointees see themselves as members of the healthcare team. Acceptance as a member of the healthcare team invested participants with a certain authority and helped them to maintain confidence in their skills when they were struggling to achieve a sense of belonging.

Facing these personal, professional and environmental challenges, one participant described "getting to know a new world" as initially overwhelming, but later identified it as an exciting aspect of the job. The amount of new learning that seemed daunting at the start was reappraised by another who said, on reflection, "I loved it. I loved all the new learning." Thus, past experiences were seen differently in the light of knowing how much they had gained. Frequently, participants judged the effectiveness of their actions and interventions by the impact they believed they had had on the child's experience. As one said, "Feeling like you've made a difference is a real buzz. That's the really big thing."

As these sentiments demonstrate, within just a few months of 'crossing the border' into the world of a hospital, participants had largely effected a successful role transition. One described her journey as follows:

> At the start I felt a bit lost, and didn't know if I was doing the right thing, and a lot of people thought I was the play lady. I knew the job was more than that but I didn't have much confidence to do things. Now I'm just part of the team. I just get in and do what I'm supposed to do.

Discussion

The findings of this study bring new understandings of the day-to-day lived experience of early childhood teachers appointed as hospital play specialists. Constrained interpersonal relationships with colleagues from other disciplines were shown initially to affect participants' confidence about becoming part of the healthcare team and contributing effectively to children's well-being. Participants also indicated a degree of exhaustion from having to "constantly put myself out there to explain what I did." These findings are consistent with studies in the United States, which demonstrate tensions in role understandings between child life specialists and other healthcare professionals (Cole, Diener, Wright & Gaynard, 2001; Hall & Cleary, 1988).

The emotional load of working with hospitalised children and young people has been widely acknowledged by others (Bolig, 1982; Holloway & Wallinga, 1990; Leff, Chan & Walizer, 1991; Munn, Barber & Fritz, 1996; Webster, 2004). In this study, however, the emotions hospital play specialists experienced were shown also to be a source of deep satisfaction from being able to provide support for children and families.

Experiences of 'not belonging' were common to participants in this study. Some participants found some degree of belonging through routine inclusion in ward events and meetings. Others in larger teams gained a sense of inclusion through regular times for reflective discussion with a more experienced hospital play specialist. Support of senior personnel, including play specialist team leaders and charge nurses, is essential to ensuring appointees feel welcome and to alleviate any sense of isolation. Although incumbent staff play an important part in making newcomers feel welcome, a two-way process of mutual understanding is necessary for effective communication to occur. This sentiment is consistent with Wertsch (cited in Rogoff, 2003) who suggested that "modifications in each participant's perspective are necessary to accomplish things together. The modifications are a process of development; as the participants adjust to communicate and coordinate, their new perspectives involve greater understanding." (p. 285).

Participants reported concern that they had difficulty in gaining professional respect. Issues with professional recognition may be an inevitable stage in the development of a small and relatively new profession (Holloway & Wallinga, 1990). The issue of professional recognition is compounded because some child life specialists in the United States and Canada and hospital play specialists in New Zealand have low levels of contact with other disciplines. Another compounding issue may be failure by these professionals to make their interventions visible by regularly documenting services in patient notes (Cole, 1998; Kayes, 1999). However, this study showed a number of strategies that individuals used successfully to raise their profile within their units, including actively building relationships within the multidisciplinary team, explaining their role, offering teaching sessions, advocating for the importance of play, and protecting how playroom spaces were used.

It was apparent from the findings in this study that newly appointed hospital play specialists may benefit from a 'novice period' or a 'credentialing' system. Such systems might allow

novice play specialists time to become familiar with the hospital environment and systems, and to recognise the relevance of their prior knowledge. It would also help them to gain competence to perform selected tasks, while removing expectations that they take on tasks initially beyond their skill level. Without adequate preparation, hospital play specialists are at risk of losing confidence in themselves, doubting the adequacy of their practice, and being exposed to the criticism of others.

In terms of providing support for potential hospital play specialists, prior experience of the role and of healthcare settings might soften the impact of moving from an early childhood setting to working in a hospital. Increased opportunities for early childhood student teacher practicum experiences in hospital settings would facilitate better understanding of the role amongst teachers. Provision for short-listed applicants to visit services prior to interview might be another strategy to provide some insight into the role of a hospital play specialist and enhance awareness of the adjustments applicants might need to make.

In addition, service managers and team leaders who are responsible for supporting skill development and good practice should help novice play specialists to successfully establish their professional identity and take their place as a multidisciplinary team member. Service managers need to plan, and allocate sufficient budget to ensure that new appointees have the learning opportunities they require, including time to work alongside other hospital play specialists. Moreover, all those involved need to recognise that, as experienced teachers, novice hospital play specialists bring established skills and ways of being with children that can readily be adapted to the hospital context.

Conclusion

Newly appointed hospital play specialists in New Zealand experience a gap between their existing knowledge and that required of a hospital play specialist. This gap poses a risk in terms of consistency of practice, the development of a shared understanding of the role by play specialists themselves and by others, and retention of hospital play specialists. Despite the challenges they faced, the novice hospital play specialists in this study emerged as actively pursuing professional growth and forming relationships that were "dynamic, negotiated and mutually influenced, rather than static and universal" (New, 1998, p. 265). Participants were resourceful in coping with crossing the professional border from the familiar world of early childhood to the foreign world of a hospital, and resilient in their efforts to build relationships and to find a personal and professional place within their healthcare teams. They showed, too, their ability to adapt their practice to the requirements of their new role and readily acquire new knowledge and skills. The study also revealed the deep satisfaction participants gained in recognising that they were contributing to their teams and making a difference to the lives of children and families.

The study achieved its initial purpose in giving insight into the ways novice hospital play specialists might be supported as they make the transition into their new role. Strategies identified included actions to alleviate isolation and set up communication channels with multidisciplinary team members, and establishment of a novice or credentialing system. Since completion of the study, a number of key initiatives consistent with these findings have been instituted. The extent to which they are effective in supporting novice hospital play specialists can only be determined by future studies of the novice experience.

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