Five Reasons to Attend the CLC Annual Conference in Chicago

The Child Life Council’s 29th Annual Conference on Professional Issues will take place May 26 – 29, 2011 at the Sheraton Chicago Hotel & Towers in Chicago, Illinois. Here are just a few of the benefits of attending:

1. **Make lasting connections** by networking with other child life specialists and sharing your collective knowledge and experiences.

2. **Earn up to 22 Professional Development Hours**, with 16 PDHs included with basic registration and an optional 3-6 additional PDHs available for attending a half or full-day pre-conference intensive (separate registration fees apply).

3. **Explore the largest exhibit hall in CLC conference history**, with 56 participating organizations offering products and services that support the work of child life specialists.

4. **Experience the power of Professional Community** at the largest annual gathering of child life professionals in the world. The Annual Conference is truly a unique experience, offering unparalleled opportunities to meet and learn from your peers.

5. **Bring the conference home** by sharing what you’ve learned with the rest of your team.

Register now to secure admission to all of your first choice sessions and events. Registrants are encouraged to take advantage of the CLC discounted room rate of $159 per night plus tax (single or double occupancy). We are anticipating a sold-out room block, so make your reservations today!

For detailed information and to view the complete conference program, please visit the Annual Conference section of the CLC Web site at www.childlife.org/AnnualConference/.

The Child Life Alphabet

**K IS FOR KANGAROO CARE**

Elizabeth Ray, MA, LSW, CCLS
Rainbow Babies & Children’s Hospital, Cleveland, OH

Child life specialists need to keep themselves informed of best practices in the developmental care of the pediatric patient and family. In the NICU and newborn nursery, kangaroo care (KC), or skin-to-skin contact, is one such practice. Some nurseries have integrated KC into the developmental care plan for high risk, low birth weight, or premature infants, as well as for stable full-term infants.

KC temporarily recreates the soothing comfort experienced in the womb. For infants designated safe to breastfeed, this intervention allows self-regulatory access. Parents or parent-designated caregivers can provide KC by holding their diapered infant upright against their unscented, recently cleansed skin. The infant is placed underneath the parent’s clothed chest, between the breasts. Both parent and infant may be covered with a blanket, and the infant may need to wear a cap. Ideally, KC can be provided several times during a day and for periods of up to three hours, as tolerated by the infant and the parent.

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Prioritizing International Growth in Child Life

In 2001, then-CLC president, Sheila Palm, appointed an International Task Force to identify child life specialists in expanding international locations and related professional groups around the world. The Task Force found individuals and groups in countries like New Zealand, South Africa, Mexico, The Philippines, and Japan who were focusing on pediatric patients and families. The goals of these groups ranged from attempting to get their hospital to acknowledge the rights of pediatric patients and families to finding funding from their ministry of health to forming a fledgling organization for professionals meeting the developmental and psychosocial needs of pediatric patients and families.

While CLC’s focus ten years ago was to identify child life programs around the world, today we have more programs than ever on the international child life front, and CLC is working to help support these programs in achieving their goals. These goals, to a degree, remain similar to those of ten years ago; however there are more programs in more countries, all working hard to achieve what is needed for children and families in each place. Many of these needs were expressed in person at what was touted as the first international child life conference held in Padova, Italy, in late 2010.

The world is becoming a smaller place, and CCLSs are meeting the needs of pediatric patients and families wherever they might live, and contributing to the work of others despite the distance.

Dr. Carlo Moretti, a 2010 CLC International Scholarship recipient who attended the 2010 Annual Conference in Phoenix, planned the conference in Padova during the conference. Attendees from across Europe were there to learn and network, and many told of the struggles they are facing to implement child life in their countries. Overall, the conference was excellent and reminded me that we are on the right track as we refocus on international issues that affect CLC.

As a result of what we learned in Padova, I formed a new International Task Force in the fall of 2010 to explore these ongoing issues. Co-chaired by Toni Millar, CLC President-Elect, and Board of Directors member Sharon Granville, this Task Force has an international membership of CCLSs. As its work has just begun, they have already been contacted by CCLSs involved in research in other countries, CCLSs looking to provide monetary and hands-on involvement with international endeavors, and individuals and groups from other countries asking for advice as they advocate for family-centered care in their hospitals. The world is becoming a smaller place, and CCLSs are meeting the needs of pediatric patients and families wherever they might live, and are contributing to the work of others despite the distance.

Please help the International Task Force by informing them of existing projects of which you are aware or in which you are involved and communicating ways you are able to support initiatives happening in other countries. The membership list and objectives of the International Task Force can be found at www.childlife.org. We look forward to hearing from you!
As child life specialists, we have wagered our careers on the notion that psycho-social intervention makes a difference in children’s and families’ experiences with health care. It’s the reason we went into this field. We have seen many times how preparation and participation can transform a potentially frightening experience into a manageable one. It is something we know.

Even though we are sure of the impact we can have with our interventions, it is still important to go back to the basics once in a while to reaffirm what we already know. The Focus article presented in this issue brings us back to the basic knowledge that what we do in our every day jobs has an impact on children’s lives.

The reasons for going back to basics are many, and two come quickly to mind. The first is that we can always learn something new by going back to the basics. Have you ever made a recipe or played a game so many times that you could do it without referring back to the recipe or instructions? I’ve done both, and after a time of cooking on my own, or playing by heart, I’ve looked back at the basics—the recipe or the instructions—and I’ve been surprised by something I’d forgotten. Sometimes experience allows us to look back at the basics and learn something we hadn’t understood before. Musicians have this experience when they’ve learned a piece well, and then looked more closely at the score and noticed nuances that were there all along. I suspect that even the most seasoned professional among us who reads the Focus article will learn something new, remember something that they’d forgotten, or see something in a new light.

Another reason for going back to basics is that research helps us look at the basics from a different angle. This is something our profession needs in order to advance. We need to be able to present evidence that what we know to be true, in our hearts and from our experience, is backed up by fact. It helps to have the support of such an article to back up our knowledge when searching for funding, or requesting to be present in the procedure room, or explaining our role to a frightened parent. This is an article that can be shared with others in the workplace and with those who don’t know, as we do, that child life works.
Special Events and Special Visitors: Creating a Child Life Liaison Role with the Trust

Carrie Card, CCLS, and Kirsten Getchell MS, CCLS
Children’s Hospital Boston, Boston, MA

Creation of a Role

Child life specialists have a variety of roles depending on the environment in which they work. From supervision of playrooms and procedural preparation to special visitors, donor tours, and patient interviews/photos, a child life specialist collaborates with different members of the healthcare team and people from outside of the healthcare environment.

For years, child life specialists at Children’s Hospital Boston received numerous calls from the Trust, the philanthropic arm of the hospital in charge of all fundraising, requesting patient stories and pictures, donor tours, and special visitors. Certain child life specialists would get the bulk of requests, while others would receive none. When asked, child life staff reported they felt overwhelmed with the numerous requests while balancing direct patient care and they were not sure when they could say “no” due to scheduling conflicts and/or appropriateness for children and families. On the other hand, the Trust did not know whom to call for requests and whom to “bounce ideas off.” Neither child life nor the Trust knew the full extent of either’s roles and responsibilities. This disjointed relationship between the child life department and the Trust was unsystematic and haphazard.

To address these issues, a liaison role was created to act as a “go between” with the Trust and child life services. The creation of this role came about as a result of discussion between two colleagues, feedback from the child life staff, and dialogue with the child life director. This liaison role, and the guidelines established for utilizing the liaisons, has helped to create a more efficient system of communication and collaboration.

Role and Responsibilities of the Liaisons

The liaisons serve as a direct line of contact and communication for child life services and the Trust. The liaisons collaborate with the Trust to organize, schedule and maintain special visits, host donor tours, as well as provide patient stories and photo/video opportunities. When a referral or request is made, the liaisons first ask a few questions: “Is this appropriate to offer patients and families? Will a child life specialist be able to fulfill the request? If so, which unit/area would be most appropriate? What is the Trust looking for?”

Once the plan is solidified, the liaisons notify the child life director, and plan what works best for all, thinking first and foremost about the patients and families. Depending on the type of request, different paths are followed as outlined below.

Corporate and/or Private Donor Tours

The guidelines created request an email or phone call 24-48 hours in advance of donor tours. Tours occur between the hours of 10:00 am and 4:00 pm. A child life specialist explains the role of child life and shows an inpatient unit and a playroom and/or teen-room. The importance of the donation to the hospital related to child life is detailed. Child life encourages group sizes to be no more than 10 people.

Special Visitors/Celebrities

Special visitors, such as professional sports teams and celebrities, visit the hospital often. When planning a visit, many things are taken into consideration including timing, special interests of the visitor, and the possibility of media. The liaisons encourage visitors to come between 11:00 am to 4:00 pm, as that is often the best time for patients, families, and staff in the hospital setting.

Prior to the visit, the liaisons decide which unit/area will be visited, and forward an “agenda/itinerary” for the visit. On the day of the visit, the liaisons greet the visitors in the lobby with Trust staff, security, and a doctor. The child life liaisons explain the importance of the guests’ visit and its role in creating a positive hospital experience, and review infection control procedures and confidentiality requirements. At the same time, the child life specialist on the unit identifies patients/families to be visited. If media are covering the visit, additional Trust staff begin pre-consenting 15 minutes prior to the visit.

The child life specialist responsible for that specific area/unit is “in charge” of the visit and facilitates visits in the activity room and at bedside. If a project is requested, the child life liaisons determine a developmentally appropriate project. After the visit, the liaisons help to coordinate a “thank you” to be sent to the visitors.

Special Events

When a special event is proposed by the Trust, the liaisons decide if the event is appropriate and doable within the hospital setting, taking into consideration infection control and safety policies. If deemed appropriate, the liaisons identify the best location for the event to take place. Meetings, conference calls, and email communication take place to identify the agenda for the day. The liaisons act as resources for questions regarding developmentally appropriateness and safety of events and materials (arts and crafts, games, shows/acts).

The liaisons create and distribute flyers to notify patients, families, and staff of the event. They provide assistance during set-up and clean-up, and remind staff to bring patients and families to the event. The liaisons are the “go-to” people if there are any questions, concerns, and/or challenges on the day of the event. Following the event, the liaisons collect feedback from child life, patients, and families.

Patient Stories and Pictures

When fielding requests for patient stories and patient pictures, the liaisons identify which unit/area most be appropriate, taking many factors into consideration (e.g., diagnosis, patient’s age, whether the request is for a newspaper story or video story). With this information, the unit child life specialist(s) is notified of the request, and helps to identify eligible patients and families. All names are collected by the liaisons, and then forwarded to the Trust. The day of the patient interviews/photo shoot, the liaisons act as resources and help with any troubleshooting that may be needed.

Statistics

Recording and sharing statistics has become extremely beneficial in validating the role of the child life liaisons. A spreadsheet was created to record the statistics from donor tours, special visitors, events, and patient stories/pictures including time (preparation, at event, follow-up), child life involvement, Trust contact, and any other pertinent information.

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The Josh Cares Fellowship Program at Cincinnati Children’s Hospital Medical Center

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Josh Cares Senior Child Life Fellow, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH

Imagine giving birth to a baby with severe cardiac and other life-threatening health issues. The baby is dependent on a tracheotomy and ventilator, in addition to a gastrointestinal feeding tube for her nutritional needs. You are a mother who has serious heart issues yourself, your husband works full time, and you are raising two other young sons as well. You also live two hours away from Cincinnati Children’s Hospital Medical Center (CCHMC) where your baby receives around-the-clock medical care. Because of these circumstances, it is very difficult for you to get to the hospital more often than once a week.

Now imagine that there is someone at the hospital who visits with your daughter every day. That person holds your daughter, sings to her, comforts and supports her during her many tests, procedures, and treatments. That person also takes photos of your daughter regularly and sends them to you so that you and your family can see how she is growing and changing. That person helps your family stay connected to your precious daughter. That person knows that you would be there if you could, but she is there when you cannot be. That person is a Josh Cares Child Life Fellow.

The Josh Cares Fellowship program at CCHMC has been in existence since 2005 and continues to grow and thrive. The inspiration for the program was the life of Josh Helfrich, a charismatic 10-year-old boy who was critically injured when he was struck by a car while riding his bicycle. Josh spent several days in the Pediatric Intensive Care Unit (PICU) at CCHMC and died in September, 2004. In the midst of their intense grief and mourning, Mark and Ann Helfrich reflected that many of the children were alone and did not have the consistent presence of their families. Ann and her employer decided to create a foundation to offer support and companionship for those children, and called it Josh Cares in honor of the memory of Josh. For the past five years, CCHMC has partnered with Josh Cares to offer children and families intensive support while they are in the hospital. Fellows are paid employees of Children’s Hospital and receive benefits through the hospital as well. Josh Cares, a non-profit organization that is continually raising funds to support the fellowship positions, pays CCHMC directly to fund the salaries of the fellows. Josh Cares has grown extensively, from funding two full-time positions in 2005 to six full-time fellowship positions today. Two fellows work with patients and families in the Newborn Intensive Care Unit (NICU) and four, including one senior fellow, float to any other units where children’s families are not consistently present – including the PICU, the Cardiac Intensive Care Unit (CICU), the transplant unit, and the Transitional Care Center (TCC) where patients are dependent on tracheotomies and ventilators.

The six fellows working in the Josh Cares program today are all Certified Child Life Specialists. Typically, the fellows are recent college graduates who want to expand their clinical experience and have an intensive learning experience before seeking a permanent position in a hospital. (The fellowship requires a one-year commitment). The senior fellow is the point person for the Josh Cares organization and is a permanent child life specialist position. The senior fellow also assists with hiring and orienting new fellows to the program. The fellowship allows for an increased depth of experience for the child life practitioners and a new, increased depth of experience for the child life council.

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A Child Life Specialist in the Role of Research Assistant: Imagine the Possibilities

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Many child life specialists participate in diverse experiences as they build their careers while engaging in work with children, youth, and families in health care settings. Although it seems the pathway to achieving the status of Certified Child Life Specialist can be somewhat prescribed, many of our professionals follow paths with twists and turns along the way. The accumulation of experiences that can be obtained over a period of years of school and employment can be surprising. Consider the achievements of Brenda Gordley, CCLS, as she skillfully applied her child life skills and abilities in related programs and eventually settled in the position of research assistant for a leading psychosocial research team at the University of Iowa.

Brenda completed a child life internship back in 1995, building on the combination of psychology and pre-nursing studies achieved as an undergraduate. She then got her feet wet initially providing float coverage as a child life specialist at Children's Hospital in Omaha, Nebraska. Eventually, she worked her way into a permanent part-time position covering the preoperative care, med surg, and pediatric intensive care units. Not unlike others waiting for the opportunity to join a program full-time, Brenda worked a variety of part-time positions to make ends meet, purposefully choosing assignments related to child life. She was fortunate to apply her expertise in adjunct services within the Children's Hospital at Omaha. As coordinator of the Junior Volunteer Program, Brenda proved herself as a leader. During this time, Brenda initiated recognition for outstanding junior volunteers in the form of a scholarship award. The process of establishing the scholarship required the communication of a vision for the program as well as ongoing fundraising to sustain the scholarship. At the same time, Brenda had also joined a professional consulting group conducting health care related research. There, she gained skills in conducting telephone surveys and employee training. Eventually, she made her way to Peoria, Illinois, as a full time child life specialist and provided care and leadership.

The diversity of opportunities for child life specialists in the health care setting is really something to be explored and celebrated. A leader at heart, Brenda provided service well beyond direct patient care as the chair of the Pediatric Champions Committee and as a representative on a variety of service teams: pain management, sedation and analgesia team, and advocacy committee, to name a few. She worked with internship and practicum programs in affiliation with local academic faculties as well as led efforts for change in service delivery on care teams. Eventually, Brenda returned to the University of Iowa Children's Hospital where she has flourished as a Senior Child Life Specialist, gaining unique opportunities and experiences. Most recently, Brenda has been contracted as a Research Assistant. She will return to child life programming next summer.

After years of service related to child life practice, the skills and knowledge of a child life specialist can contribute greatly to a research team. Who doesn't consider themselves a jack-of-all-trades on a daily basis in the work of child life? Just as the provision of child life care requires a team approach, so does research. A review of Brenda’s research-related activities clearly demonstrates the transference of competencies across roles on teams. In her associated roles on a research team, Brenda has had her hand in a number of projects relevant to and supportive of child life practice. She has collaborated on the development of a coaching index, created an imagery CD, consulted on a teaching video, and developed materials for parent education ... co-authored educational materials, posters, journal articles, and presented at local and international conferences.

She has collaborated on a coaching index, created an imagery CD, consulted on a teaching video, and developed materials for parent education ... co-authored educational materials, posters, journal articles, and presented at local and international conferences.
This study examined the impact of psychosocial intervention on procedure-related distress in children being treated for laceration repair in the pediatric emergency department. Prior research demonstrates that emergency department visits for injured children are highly stressful experiences, especially when they include a painful procedure. This pilot study explored the impact of an intervention, which included preparation and distraction on procedure-related distress in children treated for laceration repair in the emergency department. Method: Distress and parent ratings of satisfaction were compared between children who received individualized preparation and distraction interventions for laceration repair provided by a child life specialist and children who received no intervention. Twenty-four subjects, aged 3 to 13 yr, were recruited from a pediatric emergency department within a university medical center. Patients receiving the intervention were provided with preprocedure age appropriate information relating to the laceration repair and distraction during the procedure. Results: Results showed that children who received psychosocial intervention had lower observed distress behaviors during suturing compared with patients who did not receive the intervention. Results also showed that parents of patients who received the intervention perceived less distress in their children and rated their overall care significantly higher. Conclusion: These findings have significant implications for children's health care and supporting family needs when a child enters the emergency department.
A quasi-experimental study was conducted using a convenience sampling procedure. The sample consisted of 24 patients receiving laceration repair at the pediatric emergency department. The intervention group consisted of 7 children who received individualized preparation and distraction from a child life specialist. The naturalistic comparison group included 17 children who received standard nursing care before and during the laceration repair. The following exclusionary criteria were applied: children and parents who did not fully speak and comprehend the English language, children with a developmental disability, children with injuries that would be repaired with a method other than stitches, children with other significant injuries in addition to the lacerations that requires stitches, children in a situation in which another individual was seriously injured in the incident that hurt the child, and situations in which other extreme emotional or physical trauma was present. Thirty children met inclusion criteria for the study; 4 declined to participate. Data were incomplete on 2 participants because of staffing limitations.

Table 1 shows the subject characteristics for control and intervention groups. No differences were found between control and intervention subjects on age, gender, ethnicity, time of day, duration of visit, acuity, or location of laceration. Patients participating in the study had a mean age of 7 years (SD = 2.95) with a range from 3 to 13 years old. Eighteen were male children, and 6 were female children. Fifteen were identified as white (non-Hispanic), 2 black (non-Hispanic), 5 Hispanic (all white), and 2 Asian.

Patients were seen at various times throughout daylight and nighttime hours. The duration of emergency department visits ranged from 1 to 4 hours. Fifteen patients had head/face lacerations, and 8 patients had lacerations on extremities; none were body lacerations. The acuity of the injury was the same for all subjects (4 on a scale of 1 to 5, with 1 being the most critical), except for 1 subject whose injury acuity was 5.

All data were collected from a pediatric emergency department within a large university medical center on the East Coast. The pediatric emergency department is a Level I trauma center, treating >22,000 children a year. The study was approved by the institutional review board of the hospital.

**PROCEDURES**

Children entered the pediatric emergency department naturalistically and were triaged according to the standard hospital procedures. After triage was completed, the triage nurse notified the data collection nurse if an eligible child entered the emergency department. All eligible children and their parents were then approached by the data collection nurse. Those families giving consent and assent to participate in the study entered the protocol.

The interventions were provided by a certified child life specialist, trained to provide individualized psychosocial interventions, who staffed the pediatric emergency department 8 hours a day. Thus, a natural comparison group was obtained by comparing the experience of children who presented for laceration repair during the hours a child life specialist was on staff and able to provide interventions, with children who presented at times when no child life specialist was available. Given that the child life specialist was on staff only between 1 and 9 pm, time of day was examined as a potential confound.

A diagram of study design time line and measures is depicted in Figure 1. Data were gathered at 4 points (Fig. 1): (1) on entry into the study (“baseline”), (2) during the standard child life interventions or standard nursing care that takes place just before the suture procedure being (“presuture”), (3) during the suture procedure (“suture”), and (4) in the period after the completion of suturing (“postsuture”).

The psychosocial intervention consisted of preparation before the procedure, based on a standard protocol, and distraction during the procedure. The preparation protocol was standardized at 15 min and included child life specialist introduction to patient/family, explanation of the suturing procedure using a doll to demonstrate, and role playing each step of the laceration repair including age appropriate definitions. The child life specialist also asked the child and parents what normally helps them cope when they are stressed and would offer age appropriate distraction items and tools such as bubble blowing, distraction toys, singing, or talking. The specialist would then practice the technique with the child and then assist in using the distraction during the actual suturing.
Children were encouraged to ask questions and share their fears with the child life specialist who would address the children’s specific concerns.

The comparison group received standard nursing care before and during suturing without any individualized preparation or distraction during the procedure. Standard nursing care typically consists of wound cleaning, verbal explanation of the suturing procedure, general updates to the family, and addressing but not soliciting specific questions.

**MEASURES**

Children’s distress was observed and measured by a nurse using the Observational Scale of Behavioral Distress (OSBD; Jay SM, Elliott C, unpublished data, 1986), a measure used to record children’s behaviors over time. This measure allows for real-time assessment of 8 indicators of child distress in 15-sec intervals. The 8 measured indicators include information seeking, crying, screaming, requiring physical restraint (by staff or parents), showing verbal resistance (e.g., “no!” and “stop!”), requesting emotional support (e.g., “hold me” and “help me,” reaching out to be held), verbal pain (e.g., “ow!” and “it hurts!”), and flailing. Frequency counts for each of the 8 behavior categories are made within each interval. A weight is then applied to each behavior based on the intensity of distress communicated by that behavior (e.g., information seeking is weighted less than flailing, because flailing indicates greater pain/distress). The weighted scores for each phase are then summed, providing a “Total Distress Score.” The observations were obtained by the nurse unobtrusively and without disruption to the provision of care by the child life specialist, nurses, or physicians. The OSBD was administered for 5 min during the baseline period, for 15 min during presuture, for the duration of the suture procedure, and for 5 min during postsuture. The reliability and validity of the OSBD have been documented in a number of studies. In this study, reliability across 2 nurse raters was obtained on data from 3 participants. Reliability was calculated by dividing the number of agreements within each 15-sec interval by the total number of observations. The results of percent agreement ranged from 82% to 88%. The parent assessment of child distress asks the parent to rate how distressed they felt their child was during the suture procedures on a 5-point scale. The 12-item patient satisfaction questionnaire was designed for this study and used to assess parents’ impressions of the care they and their child received during the emergency department visit.

**RESULTS**

Differences in nurse-rated child distress by time, age, and group were analyzed by repeated-measures analysis of variance and paired and independent t tests. Group differences in parent ratings were analyzed by independent t tests. Given the small sample size, the distributions of scores on several of the measures were not normally distributed. Therefore, nonparametric analyses were also conducted. Results of parametric and nonparametric analyses were similar; thus, only results for parametric analyses are reported in this study.

**NONSPECIFIC FACTORS**

Time of day, duration of visit, and the location and acuity of the laceration were examined as potential covariates with distress ratings. Fourteen children were seen during the day, and 10 were seen at night/early morning (8 pm to 8 am). All of the children who received the interventions were seen during the day; 7 of the 17 children in the comparison group were seen during the day. Within the comparison group, distress ratings of the 7 patients during the day did not differ from the 10 patients seen during the night/early morning. Furthermore, within the daytime hours, time was not related to distress ratings (nurse or parent rated) among either group.

The duration of the visit was not related to distress ratings. Location of the laceration was also not related to observed distress (nurse or parent rated). Acuity of the injury was the same (4 on a scale of 1–5) for all patients, except for 1 patient with a 5 whose distress ratings were lower than average. Because time of day, duration, and the location/acytity of the laceration were not related to distress ratings, these variables were not included as covariates.

**DISTRESS RATINGS**

Figure 2 shows the results of the nurse’s ratings of distress on the OSBD for the intervention and comparison groups. Across all patients, there was a main effect of time (or phase of treatment). Ratings of observed

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**FOCUS SPRING 2011**

**Figure 1. Time line of study procedures.**

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To refer a seriously ill teen, please have them visit www.starbrightworld.org with the registration code CLS100.
The impact of psychosocial intervention was examined by repeated-measures analysis of variance (Fig. 2). Children who did not receive the intervention tend to show greater change in observed distress, F(3,66) = 2.22, p < .10, with a large increase in observed distress during suturing. In contrast, children who received the intervention showed significantly less distress during suturing, t(22) = 1.67, p = .05. There was a trend for lower average distress scores across all treatment phases for children who received the intervention, t(22) = 1.52, p = .07. When the age was included in the analysis, there was not an age x group effect; thus, the intervention effect does not seem to differ across age.

In addition, ratings on the parent assessment of child distress showed significant group differences (Fig. 3). When asked how much distress their child experienced, parents of children who received the intervention reported lower levels of distress (t(21) = 3.30, p < .01) compared with parents whose children did not receive the intervention.

**DISCUSSION**

The results from this study suggest that psychosocial interventions involving preparation and distraction can significantly decrease the observed behavioral distress for children being treated for laceration repairs. Prior research has demonstrated that children undergoing medical procedures in the emergency department will have high anxiety and distress levels.3-7 However, interventions that include psychological preparation and coping strategies have been shown to benefit patients and families.3-7 This study found that when rated by nurses or by their parents, pediatric emergency patients showed less observed distress if they received these interventions.

The type of intervention described in this study is most often provided by child life specialists who are specially trained to help children and families adjust to hospitalization, illness, and injury. Their interventions are specifically designed to alleviate acute distress, facilitate adaptive coping, and proactively prevent distress and minimize anxiety in hospitalized children undergoing medical procedures.3-7 Using their training and expertise in child development, child life specialists hold a unique position on the healthcare team, allowing them to assess and respond to individualized stressors experienced by children experiencing stressful or
painful procedures in the healthcare setting.

In most hospitals, the provision of psychosocial interventions is an integral part of a pediatric inpatient hospitalization; however, this is not the universal standard of care in emergency departments. More research is needed to validate the efficacy of those interventions routinely provided by child life specialists and substantiate the need for child life programming beyond general pediatric units in nontraditional areas such as emergency departments and outpatient settings. If providing psychosocial interventions can successfully minimize children's distress in the emergency department, then healthcare professionals have a responsibility to allocate resources and implement programs to support these efforts.

This study demonstrates the efficacy of psychosocial interventions in a pediatric emergency department as provided by a child life specialist. The preparation for medical procedures provided by child life specialists not only has been shown to lower children's fear and anxiety levels but can also promote long-term coping and assist children with future medical challenges they may encounter. According to the American Academy of Pediatrics Statement on Child Life Services, child life services must be an integral part of the constantly evolving children's healthcare arena to support the emotional needs of children and families in all inpatient and outpatient care facilities, including emergency departments. American Academy of Pediatrics also suggests that child life services can positively impact patient satisfaction. The results of this study are consistent with these suggestions, demonstrating a need for psychosocial interventions in outpatient and other nontraditional venues. More evidence-based research is needed, however, to demonstrate the impact psychosocial interventions have on the child and family. Future studies to determine whether the efficacy is due to some aspect of the intervention itself versus a nonspecific factor of the provider also would be informative.

As a pilot study, the most significant limitation was the small sample size. The fact that

**Figure 3. Parent ratings of satisfaction and child distress as a function of child life intervention.**

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**Child Life Council Announces New Program Review and Development Services**

CLC is pleased to announce the expansion of the Program Review & Development Service (PRDS) with the addition of specialized consultation and educational services. A detailed menu of topics now allows the client to select from multiple options which are designed to support the specific needs and resources of virtually any setting, including hospitals interested in developing a new child life service. These include:

**Focused Review/Consultation**

This “a la carte” service allows the client to design a consultation to meet their highest priority needs or interests, for example staffing models, growth strategies, interdisciplinary collaboration, or clinical supervision.

**Child Life Staff Development/Education**

Opportunities for professional development (PDH) will be offered by PRDS consultants on a variety of topics, including competency development, family-centered care education, and other topics as identified by the client.

**Child Life Team or Leader Development**

PRDS consultants may be engaged to facilitate half-day or full-day staff “retreats”. Mentorship or support towards the development of child life program leaders or leadership teams is also available.

**New Program Development**

To support the development of new child life programs, this comprehensive consultation will review the existing structure, explore areas of strength, and address goals for integration of child life services into the healthcare facility.

**Design Your Own Consultation**

If other program assessment or development priorities are needed, every effort will be made to design a consultation to meet the client’s unique goals. Please contact Shari Rager, Assistant Director at srager@childlife.org for further information.

For a complete Program Review and Development Service Menu, including pricing, please visit http://childlife.org/Program%20Review%20Service
the control group was much larger than the intervention group illustrates the lack of resources and trained professionals to provide psychosocial interventions. This lack of coverage also limited the hours during which patients in the intervention group could be seen. Time of day was not related to distress ratings within either group, and ratings during the day did not differ from ratings at night, at least among the comparison group. However, in future studies, it would be informative to examine the impact of interventions provided by child life specialists during both day and nighttime hours. It is also important to consider location and acuity of laceration because they may impact distress ratings, although we did not see an effect of these factors in this study. Although not significant, lacerations to the head may be more stressful than lacerations to the extremities. A larger sample would allow for further analysis with greater power to detect differences. Other subject characteristics and factors could also be examined in future studies, including the impact of family presence, socioeconomic status, previous emergency department, and other healthcare experiences. Another potential limitation was difficulty in randomization and blinding the nurses and their parents to the intervention, which may have contributed to reporting bias for those who received the intervention. Additional research can help better assess the types of preparation and distraction that are most effective with children and families to further validate and enhance the methods currently being used in child life practice. Objective physiological markers, such as change in heart rate, body temperature, or neurohormonal mediators, should also be included in future studies. A measure of parents’ distress or feeling of control, which could influence ratings of their child’s distress, would be valuable information to assess in a future, larger study. Finally, other benefits of these and other psychosocial interventions should be studied as well, including whether such interventions result in less resources needed for the procedure from a nursing and physician standpoint, quicker procedure time, use of less analgesics, and quicker discharge from the emergency department.

**References**


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**About the Views Expressed in Focus**

It is the expressed intention of *Focus* to provide a venue for professional sharing on clinical issues, programs, and interventions. The views presented in any article are those of the author. All submissions are reviewed for content, relevance, and accuracy prior to publication.

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Child Life Council
30th Annual Conference on Professional Issues

May 24-27, 2012
Washington Marriott Wardman Park Hotel
Washington, DC

2012 Call for Abstracts

The Washington Marriott Wardman Hotel sits on 16 garden acres in Northwest Washington, DC. It is conveniently located close to the National Cathedral and National Zoo. The hotel is a short Metro ride from the National Mall, Smithsonian Institutes, and various other historical monuments and museums.

Abstract submissions for the CLC 30th Annual Conference will be accepted through the CLC website beginning June 6, through July 31, 2011.

For more information visit www.childlife.org.

Milestones

Janet Cross, MEd, CCLS, Director of Child Life Services at Monroe Carell Jr. Children’s Hospital at Vanderbilt in Nashville, TN, has been promoted to the position of Director of Patient and Family-Centered Care at her institution.

Robert L. Quinn, MS, CCLS, was recently named to the Board of Trustees of The AIDS Foundation of Western Massachusetts, Inc., in Springfield, MA.


UPCOMING EVENTS

Hospitals and Communities Moving Forward with Patient- and Family-Centered Care
May 2 – 5, 2011
St. Louis, MO
Contact: Julie Ginn Moretz
Phone: (301) 652-0281
Email: jmoretz@ipfcc.org
Website: www.ipfcc.org/events/seminars.html
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Josh Cares Fellowship

Continued from page 5

specialists because the Josh Cares patients often have complex medical problems, which are very often complicated by difficult family/social issues. This means that children are in the hospital for an extended period of time (sometimes years) or they are patients who are chronically ill and are admitted frequently.

One question that is frequently asked of the fellows is “Why are so many children alone?” This is not an easy question to answer. Contributing factors include caregivers who must be at work to provide insurance, parents who are sick themselves, parents who have lost custody of their children, single parents who are not prepared to care for a medically fragile child, and caregivers who must stay at home to care for other children. Each child’s circumstance may be unique, but the goal of the fellows is always the same — to be a familiar, consistent, and supportive person in the lives of the children while they are in the hospital, and to provide support for their families as well.

A typical day for a Josh Cares fellow includes spending time with each patient by providing opportunities for play and normalization. Fellows are also available to prepare children for procedures and to provide procedural support and comfort. Fellows can follow their patients wherever they need to go in the hospital. For example, fellows accompany patients to radiology (for scans and x-rays), to the operating room (for surgery), and often to intensive care after surgery. In addition to supporting patients, fellows provide ongoing psychosocial support to families, including siblings and other caregivers. Fellows strive to keep families connected to their hospitalized child through phone calls, emails, and letters home. Fellows spend a lot of time creating memories for the children and their families by taking photos, making scrapbooks (along with lots of help from volunteers), and creating other keepsake art projects such as finger paint masterpieces. Fellows can also help facilitate celebrations for milestones such as birthdays.

Another responsibility of the Josh Cares fellows is to help build the Josh Cares program. Fellows often make presentations to current and potential donors, as well as lead group tours around the hospital. Fellows also participate in fundraising events outside of the hospital in order to increase awareness and to promote the development of this extraordinary program.

The future looks promising for Josh Cares. The program continues to expand and grow each year. The hope is to be able to serve every single patient and family in need at CCHMC. The dream is to expand the program to other hospitals around the country so that no hospitalized child is alone, lonely, or afraid.

“I Think I Understand”

Continued from page 5

my diagnosis, I have acquired a significant font of knowledge regarding current research and resources associated with my diagnosis that has served my patients, as well as my colleagues.

Disclosure does not, however, always result in unambiguous good. There exists a risk that the child will engage in counter-transference and thus take on the identical emotions regarding the diagnosis as the therapist. In doing so, the child is not engaging issues on their own terms, through their unique lens, and in turn does not process their feelings appropriately.

While my experiences have enriched my ability to help my patients, they have created challenges as well. Everyone’s medical experience is different, and one must be careful not to assume that their experiences can be generalized to all others, even those with the same diagnosis. Great variation exists in how patients encounter their fear, pain, and anxiety. It is my experience that this reality can never disclose my own medical issues. Certainly, identifying the appropriate context for disclosure is not always a simple task. I must assess the current physical and emotional well-being of the child and weigh the potential benefits and drawbacks to pushing that professional boundary. However, over the years I have found that if used in the appropriate context, the knowledge acquired by a child life specialist who has faced the same health challenges as a patient can have tremendous benefits to both the patient and their family.

Quite naturally, a child is often overwhelmed with information, but a child life specialist is trained and ideally situated to assess how much information can be processed in a healthy manner by the child. Moreover, it is my impression that many child life specialists choose the profession because of their life experiences with personal health issues or those of a loved one. This powerful motivation can, I believe, be channeled in a way that can help patients realize that there are others who can empathize with their struggles and fears and nonetheless conquer them on the way to a productive and fulfilling life.
SPECIAL REPORT: 2010 Member Survey Results

In October 2010, the Child Life Council launched an online Member Survey. We invited 2,565 active professional members to share their feedback regarding current member programs and services, as well as future priorities for the organization. More than 900 members (36%) responded to the survey, and their input will help to inform CLC’s strategic direction in 2011 and beyond.

YOUR RELATIONSHIP WITH CLC

According to survey responses, some of the most important reasons that child life professionals choose membership with CLC include:

- Keeping informed about issues facing the child life profession
- Taking advantage of professional development opportunities (such as the Annual Conference and CLC webinars)
- Having access to CLC membership benefits and programs, such as the CLC Forum listserve, Career Center, Member and Child Life Program Directories, the Bulletin newsletter, and Child Life News Monthly e-newsletter

Many others view membership with CLC as an important professional responsibility (83%), and a way to directly contribute to the child life profession (75%). The majority of members pay their own dues—only 13% get their dues covered by their employer—and CLC strives to honor that commitment by delivering a host of valuable benefits and services each year.

We were pleased to hear that nearly 90% of members believe that CLC is doing either a good or excellent job in providing updates on CLC programs, services, and events, as well as timely and relevant information on child life issues. Members also felt that CLC offers beneficial opportunities for networking in areas including the Annual Conference, committee activities, and discussion forums and other CLC Community tools. Overall, the CLC programs and services each year rated most useful included:

1. Annual Conference
2. Bulletin/Child Life Focus quarterly newsletter
3. Managing PDHs Online
4. CLC Forums (listserve)
5. Resource Library

WHAT SHOULD CLC CHANGE OR IMPROVE UPON?

While members generally responded very positively to CLC activities and services, one of the areas that rated lower were the opportunities CLC provides for meaningful volunteer and leadership involvement with the organization. This has been identified as an area for improvement in 2011 and beyond, and CLC is working on the process to make it more inclusive, with the goal of involving a more diverse group of child life specialists in leadership roles on the Board of Directors and on CLC committees and task forces.

When asked to share specific input on two products—the CLC website and the CLC Bulletin/Child Life Focus quarterly newsletter, members offered mixed feedback. While roughly 25% of respondents indicated that they found it easy to locate information on the CLC website, the majority (68%) had a more varied experience, finding some areas easy to navigate and others more difficult. In response to this and other feedback, later this year CLC will undertake an in-depth review of the strengths and weaknesses of the current website and evaluate the options for implementing updates and enhancements to create the “next generation” version of childlife.org. As we prepare for this project, we welcome your input at communications@childlife.org.

In the survey, CLC introduced the question of whether CLC members would prefer to continue receiving the CLC Bulletin/Child Life Focus in print through the mail, or if they’d rather have it delivered in electronic format via email. Opinions were relatively split, with 45% of members indicating a preference for electronic format, 20% favoring the traditional print-and-mail format, and 30% who would like to see it offered in both formats. At this time, CLC leadership has elected to preserve the print format of the Bulletin rather than migrate to an electronic version of the organization’s primary periodical, but will continue to weigh the options in the future.

In addition to helping us to better understand your relationship with CLC and specific areas where we can serve you better as a professional association, many members shared insights about their general professional experiences and what they perceive as being the key issues and challenges faced by child life professionals today. While members brought up a wide variety of concerns, there were several challenges that appeared most frequently in survey responses.

When asked about the most important issues facing them as individuals, many members pointed to a lack of credibility or knowledge of the child life profession. According to one member, the lack of support and respect from other professionals as a whole can be a challenge: “…people seem to be unaware of the training, background and expertise of a child life specialist.” Another pointed to the need to “…demonstrate cost-effectiveness to a hospital in traditional ways (billing codes) and finding ways to quantify the value of our services.”

Low salaries and limited funding for child life staff and programming, particularly in the midst of challenging economic times, were high on the list of concerns for many survey respondents. “The salaries are still low in general in the profession,” one member commented. “It has gotten a little better but still should continue to be a goal for the profession.” Many members were also interested in enhanced opportunities for professional development and education to improve their...
skills. One member said, “I manage a small program and I feel a constant need to keep myself up-to-date on issues common to all programs and any new ideas or products.” Another struggled with feelings of professional isolation, and, “…not having many opportunities locally for continuing education that is relevant to child life.”

In answer to a separate question addressing the profession as a whole, members highlighted many of the same concerns that affected them as individual professionals, including enhancing the reputation and credibility of the profession, improving salaries and funding, and the need for additional professional development opportunities. To this list, they added several other key issues, including the importance of developing new research and promoting evidence-based practice in the field. “Child life specialists need to engage in more research as well as publish more, not only in child life publications but in more widely-read journals,” said one respondent. Many felt that new research would be critical to helping child life specialists make the case for additional funding and positions. In general, the limited number of child life positions currently available, coupled with an increasing number of new professionals entering the field, worried many child life specialists. “We are educating a large number of child life students but there are not enough jobs for them,” said one member. A child life educator added, “Sometimes I struggle to advise students who ask for my advice on pursuing a child life career, simply because of how competitive the field has become.” A number of members viewed the expansion of child life into new areas, such as satellite facilities, outpatient areas, and consultation services, as being vital to creating opportunities to keep up with the demand for jobs.

**HOW DOES CLC USE THE DATA GATHERED IN THE MEMBER SURVEY?**

The results of the 2010 Member Survey were shared with the CLC Board of Directors at their November meeting, and CLC leaders are actively discussing the ways that the organization should address many of the issues that were raised by the members who shared their feedback. In some areas, the work has already begun, with updated assignments for current CLC committees and task forces, and the addition of several new task forces, including the International Task Force and the Professional Role Position Task Force, to tackle new projects for the organization. Later this year, the Board will be carrying out a strategic planning initiative to map out the strategic direction of the organization in 2012 and beyond, and feedback generated from the 2010 member survey will inform that process.

To all CLC members who took the time to respond to the survey, we thank you once again for your participation. If you have additional input to share with us, don’t wait for the next survey! We encourage you to contact us today at membership@childlife.org or 1-800-CLC-4515 with your thoughts and suggestions.

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**CLC 2011 Board of Directors Slate**

The Nominating Committee has developed its recommended slate of candidates for the 2011 Board of Directors election. The annual online election takes place from mid-March to mid-April. All professional members in good standing are eligible to vote, and should have received an electronic ballot via email on Tuesday, March 15.

The recommended slate is:

**President-Elect:**
Diane Hart, MA, CCLS, EDAC  
Director of Child Life, BC Children’s Hospital,  
Vancouver, British Columbia, Canada

**Treasurer:**
Trish Haneman Cox, MSW, MS Ed, CCLS  
Adjunct Faculty, University of New Hampshire,  
Durham, New Hampshire

**Director:**
Carla Oliver, MSW, CCLS  
Manager of Therapeutic Recreation and Child Life,  
The Children’s Hospital, Aurora, Colorado

**Director:**
Kimberly Allen, MS, CCLS  
Manager of Child Life, Children’s Medical Center at  
Medical College of Georgia, Augusta, Georgia

To learn more about the candidates, please visit:  

**Editor’s Note:** As we go to press, the slate has not yet been approved by the membership. The polls will close on Friday, April 15th, 2011.
K is for Kangaroo Care

Continued from page 1

Dr. Edgar Rey Sanabria, a pediatrician from Bogotá, Columbia, realized the scarcity of technology in developing countries. He envisioned and promoted KC in 1978 as a complement to available technological intervention. His research found that parent involvement in KC decreased infant morbidity and mortality despite inaccessibility to specialized equipment (Charpak, et al. 2004).

Several benefits of KC for healthy and at-risk infants have been documented. Research has shown that the reduction of stress and rapid calming effects of KC have also induced the occurrence and duration of quiet sleep (McCain, Ludington-Hoe, Swinth, & Hadeed, 2006). Less tension with more frequent and longer breastfeeding opportunities led to normalized increased weight gain of the premature infant (Ludington-Hoe, et. al., 2006). The intervention of KC contributed to a more stable respiratory pattern and brought about improved physiological and behavioral responses to pain (Ludington-Hoe et al.). The Bayley Scale for Infant Development indicated that infants who experienced KC demonstrated enhanced arousal at 3 months (Penalva & Schwartzman, 2006) with higher scores (cried less) at 6 months. KC was found to be responsible for the improved state of organization, habituation and orientation skills (Penalva & Schwartzman). Of profound interest is the decreased incidence and severity of nosocomial infections, severe illness, and fewer cases of respiratory tract disease thus reducing the length of hospital stays (Conde-Aguedelo, Diaz-Rossello, & Belizán, 2003).

Benefits of KC for mother and father have also been documented. Remarkably, during KC a mother’s breasts naturally regulate blood flow to either increase or decrease circulation in that area to adapt to her infant’s temperature needs (Ludington-Hoe et al., 1993). KC has also been shown to enhance the parent-infant bond. Having parents connected to their infant in this important way of daily developmental care increases the frequency for teaching and assessing by the interdisciplinary team (Dodd, 2005). Resilience and feelings of confidence, competence, and satisfaction were also reported to increase among parents involved with KC (Tessier, et al., 1998; Kirsten, Bergman & Hann, 2001).

In order for infants to attempt KC they must meet certain criteria, including a stable respiratory status, temperature, and other vitals. Some conditions, including apnea episodes and umbilical arterial venous catheters, can make KC prohibitive. Discussion is needed with each infant’s medical team to determine the infant’s eligibility for KC.

When nursing staff determines that an infant can tolerate KC, child life specialists can help support the parents by supplying comforting items, such as a comfortable chair, supportive pillows, and foot stools; as well as providing helpful tips such as reminders to eat/use rest room prior to session and keeping drinking water nearby. Child life specialists can also suggest ideas to parents to help make the experience more rewarding to the KC provider, including bringing a favorite book or music recordings (low volume) to enhance the experience, if desired.

To promote KC among parents and their support systems, child life specialists could consider inviting a NICU nurse and/or lactation specialist to speak on the topic of KC at an ongoing NICU family support group or other forum. This opportunity can offer further education, discussion, camaraderie, and support between staff and families.

Child life specialists can offer additional support to parents by discussing possible concerns that may prohibit them from giving KC. Sibling adjustment to the new baby, disrupted routine due to parent time with the new baby, and sibling care issues may be a few of many factors dissuading frequent and extended visitation. If siblings must accompany their parent during visits, hospital-sponsored sibling support such as periodically supervised play room, patient closed circuit TV, or group art may be advantageous. Also inform the parent of the interventions/activities that the sibling can be involved in at infant’s bedside or at home, such as drawing a picture to be placed near the isolette or writing about their future with the new sibling. Such activities will help to strengthen the sibling bond while letting the parent focus, however briefly, on the newest family member.

The KC experience is a powerful and transforming interaction that helps the entire family cope with the emotional challenges associated with caring for a high-risk neonate. The child life specialist is an integral member of the multidisciplinary team that informs, sensitively encourages, and shares with the family the “baby step” triumphs of being ready for KC.

Knowledge of this essential intervention for parents and their fragile or stable newborn is a basic principle of family-centered care. Understanding the developmental benefits of KC enables the child life specialist to gain clinical competency, thus providing enhanced education and support to the family.

REFERENCES


RECOMMENDED ONLINE RESOURCES:

http://www.prematurity.org/baby/kangaroo.html
http://fpb.case.edu/Kangaroo/biblio.shtml
Special Events

Continued from page 4

The spreadsheet and the statistics that are calculated provide a window into the amount of time and effort that Trust events involve from the child life liaisons.

OUTCOMES

The institution of the liaison role has elicited positive feedback from members of the child life department, the Trust, and unit staff, including nursing. Staff members from each group have commented on the increase in communication and collaboration, which has positively affected the success of events and the satisfaction of those involved.

One of the most important benefits of the liaison role is the opportunity for child life and Trust staff to work together and understand each other’s roles in the hospital environment. Members of the Trust team have commonly asked what the job of a child life specialist entails, providing the liaisons with the ability to share the role of child life in the hospital and raise awareness of the profession. The collaboration has led to a united front during events, allowing things to run smoothly and seamlessly.

Funding is important to all units and child life programming. As a result of the donor tours, many donors are now asking how their monetary donation can go directly to child life programming. This benefit is just one example of the impact that the liaison role has had on the hospital as a whole by leading to an increase of money received through donations.

FROM LIAISON ROLE TO FULL-TIME POSITION

In 2006, the child life liaisons were asked to participate in 22 events and lead one donor tour. In 2010, the liaisons were asked to assist with 49 events and 17 donor tours. The greater number of requests, as well as the increased time commitment associated with the larger number of events, has necessitated the expansion of the roles and responsibilities of the liaisons. The child life director and Trust representatives met recently to review the liaison role, and as a result a 30-hour paid position has been created for a Trust Child Life Specialist, with dual reporting to child life and the Trust.

HELPFUL HINTS FOR CREATING YOUR OWN LIAISON ROLE

There are several key elements that were essential in creating and maintaining the child life liaison role. We learned that it is essential to:

• set clear goals,
• define the child life liaison role and responsibilities as they relate to the Trust,
• find an ally within each team,
• maintain continuous open communication,
• plan group meetings to bring all team players together,
• maintain documentation and spreadsheets, and
• go forward with determination, flexibility, and the ability to give and take.

CONCLUSION

Since the creation of the child life liaison role five years ago, sports teams and celebrities have visited, special events have occurred, and donors have learned more about the child life role. The liaisons have witnessed the benefits of this role, ensuring visits and events are developmentally appropriate and beneficial for patients and families. These visits have helped to provide a positive element in the overall hospital experience. With determination, communication, and collaboration, this role can be implemented in other hospitals.

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Continued from page 4

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CLC Calendar

APRIL
15  Deadline for Bulletin and Focus articles for Summer 2011 issue
18  CLC 29th Annual Conference registration deadline

MAY
1   Deadline for written requests to withdraw from Spring administration of the Child Life Professional Certification Exam
26  Child Life Professional Certification Examination, Chicago, IL
26-29 CLC 29th Annual Conference on Professional Issues, Chicago, IL

JUNE
6   Call for Abstracts opens for 2012 Conference
30  Deadline for recertifying by Professional Development Hours (PDHs)
30  Deadline for applications for the fall administration of the Child Life Professional Certification Exam for those educated outside the U.S. and Canada

JULY
15  Deadline for Bulletin and Focus articles for Fall 2011 issue
28  CLC Webinar: Changing the Culture of Comfort and Care in Pediatric Health Care
31  Call for Abstracts deadline for 2012 Conference

WHY ATTENDEES COME TO ANNUAL CONFERENCE

If you need more encouragement to register for the 29th Annual Conference on Professional Issues, you don’t have to take our word for it! Each year, your peers have great things to say about the Annual Conference. Here are some actual comments from members who attended last year’s conference in Phoenix:

“The child life community is filled with awesome, intelligent, powerful, and moving people. I love when it all comes together into one amazing event!”

“The professional ‘charge’ you get from being with over 950 child life specialists is priceless. I left feeling really inspired and ready to educate others.”

“The workshops were excellent. I truly feel like I learned a great amount from the speakers and presenters.”

“There seemed to be more relevant workshops for those of us who have been in child life for 20+ years. More research, more depth for advanced classes.”

“Great variety of exhibitors and the [attendees] were truly interested in learning about their products.”

“I liked that we had many different options in all different areas of expertise.”

“I thought this was one of the best, most organized conferences by CLC. I encourage staff to come away with at least one objective/idea from each session. Those expectations were exceeded.”