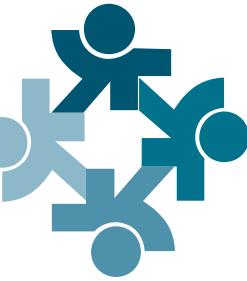


Bulletin

CHILD LIFE
COUNCIL



VOLUME 29 • NUMBER 3

SUMMER 2011



Sheila Palm, MA, CCLS

Sheila Palm, CLC 2011 Distinguished Service Award Winner

In 1993, CLC was a young organization, in the midst of separating from the Association for the Care of Children's Health (ACCH) to become the independent professional association that we know today. As Treasurer of the CLC Executive Board during the transition, Sheila Palm was responsible for working with the

executive director to establish the Child Life Council's first stand-alone budget. "I remember feeling very personally responsible for what was going to become of CLC as an organization," Sheila says of the experience. "That first year's budget really scared me. It was so much smaller than my own child life department budget!"

Luckily for the Child Life Council, Sheila is something of an expert at leading through times of transition. From helping the

Child Life Council take its first financial steps as an independent organization to managing the integration of two major child life programs into one department during a hospital merger, Sheila is known for her ability to lead with grace, intelligence, and quiet strength. In the 36 years since taking the child life director position at the Minneapolis Children's Medical Center (now Children's Hospitals and Clinics of Minnesota), her program has grown from a staff of three to nearly 50, and in that same time, CLC has grown from an organization of less than 100 to more than 4,500 members.

Sheila is proud of the work she has done to support the Child Life Council's growth over the years, describing CLC as "... a place where you can feel your own impact." And what an impact Sheila has made! In recognition of her many contributions to the field of child life, Sheila was selected as the recipient of the 2011 Distinguished Service Award, the Child Life Council's highest honor. First bestowed upon Emma Plank in 1988, the

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The Child Life Alphabet



L IS FOR LISTENING TO CHILDREN WITH SPECIAL COMMUNICATION NEEDS

Teresa Odom, MA, CCLS, Methodist Children's Hospital, San Antonio, TX and Jaime Bruce Holliman, MA, CCLS, Boston University Medical Center, Boston, MA

Hearing is an unconscious act, but listening is a focused skill. As child life specialists, it is part of our role to not simply hear, but to actively listen to what children are saying. Although it seems easy enough, in a busy hospital or clinic setting there is "noise" that can interfere with our ability to really listen. For instance, in the midst of admitting a child to the emergency department, many people including the nurse, nurse's aide, parent, and doctor may be talking at once while simultaneously helping the child to change into a gown, setting up equipment, assessing the

situation, and initiating a plan of care. Everyone is asking questions, sharing responses, and giving instructions. In this sea of noise and activity, the voice of the child can easily be drowned out unless someone is specifically focused on listening to him. Listening can be even more difficult when the child to whom we are trying to listen has a special need affecting his ability to communicate.

Children who have difficulty with verbal expression may use multiple channels to communicate their thoughts and feelings. These channels include spoken words, purposeful sounds, gestures, facial expressions, and body movements. Some children may also use more formal systems such as signs, sign language, or visual communication aids. When we are working with children who "speak" to us using one or more of these methods, remembering some key elements of listening can help us to be more effective in our work with this special population.

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PRESIDENT'S PERSPECTIVE



Finding Time for Play

Eugene Johnson, MA, CCLS, RN, CPEN, Children's Medical Center, Dallas, TX

Recently, I heard disturbing news from a mother at the hospital. She was sharing how her school-age child was

having some behavioral concerns in school and how the teacher was taking away his recess time to help focus the child on what is important. Upon further discussion, it turns out her child's class only has 30 minutes of recess per day, and this playtime is structured. The mother said that it is not unusual for her child to have one to two hours of homework when he gets home, further encroaching upon his freedom to play. Sadly, many children and teens live out this theme in their daily lives.

As child life specialists and developmentalists, we have always valued play for what it provides to the overall developmental (i.e., social, emotional, physical, spiritual, psychological) health of the child. In fact, when pediatric patients are facing difficult circumstances, child life specialists work hard to foster opportunities, sometimes precious moments, for unstructured play. This marriage of play and the profession of child life is seen in our historical roots. In the early days we were known, sometimes in the pejorative sense, as "play ladies." This label spoke to some of the essential needs and to family-

centered care, which we introduced to pediatric patients and advocated for in the health care setting. These early pioneers began the long road of offering play opportunities to patients and educating and advocating to staff for the rights of these patients to have these needs met. In today's health care crisis, we are called to continue to carry this same mantle.

Child life specialists must continue to keep play central to the work they do, and advocate for this right among pediatric patients and their families.

As I roll off as president of the Child Life Council, I would like to remind our members to continue to value play as an essential component of who we are and what children and teens need in their lives. Think of it this way: If we truly believe that play holds tremendous power to promote health and healing across so many developmental

domains (and there is a plethora of research to support this) then it needs to be highly evident in our practice. As my pastor says, what we value will be reflected in our checkbooks and how we spend our time. As an example, I highly value dessert, and my time and money are tied up in this priority. On the rare occasion when I have searched every kitchen cabinet and raided my children's secret stashes only to discover there were no sweets in the house, my wife (and accomplice) and I head off into the night to find what is rightfully ours. For child life specialists, play should hold a similar position of importance to us.

We can ask ourselves several questions to evaluate the importance of play in our practice: How much energy do I put into finding play opportunities for my "really sick" patients? Have I read any articles recently about the value of play? Would the patients/clients I work with say that I value play? Can I clearly and intelligently articulate the need for play in the life of the hospitalized child? Child life leaders can evaluate their level of commitment to play with the following questions: Does my budget reflect my value of play? Do staff have a variety of resources to support play opportunities for children from different cultures and backgrounds? Do staff have adequate education/supervision concerning play and the health care setting? Can I clearly and intelligently articulate the need for play in the life of a hospitalized child to my senior leadership? Do staff have adequate resources to support play for patients of all ages, infants to adolescents? Do staff feel that I value play? These are just a few questions to help us begin to evaluate play as reflected in our professional practice.

It is sad that most children and teens have such limited time in school and at home for unstructured play in their daily lives when we know how essential it is to their development. This limited opportunity to play, however, must not spill over into the health care setting. Child life specialists must continue to keep play central to the work they do and advocate for the right to play among pediatric patients and their families. All of the great child life specialists I admire hold strong to this tenet, and even keep play as a strong part of their personal lives. Let the value of play so fill our lives that it spills out of us at every turn and tumble.



Child Life Council Bulletin/Focus

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FROM THE EXECUTIVE EDITOR



Valuing Play as a Part of Our Work

Anne Luebering Mohl, PhD, CCLS

Even the best job has its exasperating moments mixed in among the fulfilling ones. One of the common frustrations of being a child life specialist is finding out too late that you have not been consulted when your services could have made a positive impact on a patient's experience. On a regular basis, the first indication to me that a child is undergoing something painful or frightening is the screaming I hear from down the hall. Or I'll hear through the staff grapevine about a patient's struggle with a physical change—wouldn't it have been nice if someone had thought that the CLS should have been consulted on that issue? And the excitement I feel when a staff member consults with me about a tough case—shouldn't communication like that be so routine that I don't have the feeling that something special is happening?

Although most of us feel confident about the scope of our work, we so often struggle to communicate our roles to our coworkers in other disciplines. And it's not for lack of trying. After explaining, demonstrating, and feeling like you've made a breakthrough—even with just one nurse—it can be frustrating, demoralizing, and even depressing because you are suddenly back to square one when the same situation is repeated. Who hasn't wanted to bang their head against the wall and scream, "Doesn't anybody else get it?"

I often think that part of the issue may be that others see our roles as divided between play and "real work." I have heard many times from coworkers in other disciplines that I have a fun job because I get to play all day. I know they see me doing many other things—preparing children for procedures, helping a teen understand a new diagnosis,

having a supportive conversation with parents, working with donors—but somehow play stands out in their minds. I often wonder if the reason for their view that a large portion of our job is frivolous is that they don't view play the same way as we do. They don't see the value of play beyond recreation, where we see it as the foundation of our work.

We all have our theories about why child life is valued and viewed the way it is, based on our experiences in the places we've worked. The *Focus* article presented in this issue explores the relationship between child life and nursing by asking nurses about their use of child life services. One exciting thing to know about this article is that the research was undertaken by nursing students. Their interest in this topic led them to ask some interesting questions and to design, administer, and analyze a simple survey in a preliminary attempt to address those questions. It is work like this that will help us see where misunderstandings about our roles arise, and will help us strengthen relationships within our interdisciplinary teams and enable us to become even more valuable to the patients and families we serve.

Child Life Council

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Upcoming CLC Webinars

CHANGING THE CULTURE OF COMFORT AND CARE IN PEDIATRIC HEALTHCARE

Thursday, July 28, 2011, 2:30 p.m. - 4:00 p.m.

Presenters: Crystal Tahvildar-Akbari, MS, CCLS and Kacey Shaw, CCLS

RECOGNIZING YOUR INNER RESEARCHER

Wednesday, August 10, 2011, 2:30 p.m. - 4:00 p.m.

Presenter: Joan Turner, PhD, CCLS

MAKING PLAY ACCESSIBLE: ADAPTING TOYS, COMPUTERS, AND PLAY MATERIALS FOR CHILDREN WITH DISABILITIES

Wednesday, September 21, 2011, 2:30 p.m. - 4:00 p.m.

Presenter: Deidre Omahen, CTRS

CHILD LIFE SPECIALISTS WORKING IN HOSPICE AND PALLIATIVE CARE SETTINGS: MAKING EVERY MOMENT COUNT

Wednesday, November 2, 2011, 2:30 p.m. - 4:00 p.m.

Presenters: Danielle Eaves, CCLS, CTRS and Tina Ulanowski, M.Ed., CCLS

All webinars are eligible for PDHs. For more information about the webinars, including topic summaries, speaker information, as well as webinar prices, please visit: <http://www.childlife.org/RelatedMeetingsAndEvents/CLCWebinars.cfm>.

Thanatology and Child Life: WORKING WITH CHILDREN AND FAMILIES AT THE END OF LIFE

Korie Roe, MA, CCLS, CT, Child Life Specialist/Bereavement Coordinator, George Mark Children's House, San Leandro, CA

It seems that at any conference I attend or in any newsletter I pick up pertaining to child life, there is an overwhelming interest in the area of death, dying, and bereavement. Many of us work directly with children who are at the end of an acute or chronic illness and are in the process of dying. How do we effectively help our patients and their families cope with death and bereavement when we ourselves struggle to understand these concepts?

Child life educational programs typically include a course or two surrounding death and the dying process, and they provide much needed introductory information. However, this just begins to scratch the surface of the breadth and depth of concepts within the area of death, dying, and bereavement. Continuing education in thanatology provides the child life specialist with expanded and comprehensive content that is necessary to successfully engage in the supportive role we play in end-of-life and bereavement services.

Being a CT (Certified Thanatologist) allows the child life specialist to draw from a specific set of skills when dealing with death and dying. The in-depth study you receive when completing training in thanatology is vast and covers topics of particular interest in child life including

- family systems,
- lifespan development,
- end-of-life decision making,
- assessment and intervention,
- religion and spirituality,
- cultural and societal norms,
- hospice and palliative care philosophy, and
- traumatic death.

According to Corr, Nabe, and Corr in their text *Death and Dying, Life and Living* (2009), the study of thanatology has four central dimensions that are critical to our work. Those dimensions can be broken down into these child life-specific categories and objectives:

expertise and breadth of knowledge through further education in thanatology, we can strengthen our ability to provide comfort and support to our patients and their families during this challenging time.

It is important to recognize that not every child life specialist will choose to have end-of-life care be his or her chosen area of expertise. Therefore, for those child life specialists who are not as comfortable with this area of support, I encourage you to collaborate with your fellow child life peers who identify themselves as having specialized training in the area of death, dying, and bereavement. These peers can provide much-needed guidance, support, and direction in this specialized area.

REFERENCE

Corr, C.A., Nabe, C.M., & Corr, D.M. (2009). *Death and dying, life and living*. Belmont, CA: Wadsworth.

RECOMMENDED RESOURCES

WEBSITES:

Association for Death Education and Counseling: www.adec.org

National Alliance For Grieving Children: www.nationalallianceforgrievingchildren.org

National Hospice and Palliative Care Organization: www.nhpco.org

Hospice Foundation of America: www.hospicefoundation.org

The Dougy Center: www.dougy.org

Center for Loss and Life Transition: www.centerforloss.com

BOOKS:

Balk, D. (2007). *Handbook of thanatology: The essential body of knowledge for the study of death, dying, and bereavement*. (6th ed.). New York, NY: Routledge.

Carter, B.S., & Levettown, M. (2004). *Palliative care for infants, children, and adolescents: A practical handbook*. Baltimore, MD: Johns Hopkins University.

Parkes, C.M., Laungani, P., & Young, B. (2000). *Death and bereavement across cultures*. New York, NY: Brunner-Routledge.

Worden, J.W. (2002). *Grief counseling and grief therapy: A handbook for mental health practitioners* (5th ed.). New York, NY: Springer.



Student Research: Knowledge and Beliefs of Pediatric Nurses Regarding the Utilization of Child Life Services

Sarah Booth, RN, BSN, Staff Nurse, Intermediate ICU, VA Palo Alto Health Care System, Palo Alto, California
Devon Grams, RN, BSN, Staff Nurse, Medical Oncology Unit, Sibley Memorial Hospital, Bethesda, Maryland

ABSTRACT

The purpose of this descriptive study is to determine the relative knowledge and beliefs of pediatric nurses about child life services, their level of utilization of child life services, and to determine what, if any, barriers exist that prevent nursing incorporation of child life services into daily practice. A written survey was administered to pediatric nursing staff at Georgetown University Hospital, and informal interviews were conducted with the nurse manager and child life specialist. Sixty-two percent of nurses opted to participate in the study. It was found that the most often requested services included toys/games/movies/play, representing 24% of respondents. The most prevalent barrier to referral was time, indicated by 64% of nurses surveyed. This information illustrates the challenges in administering a child life program in a large hospital with limited resources. The results provide information on specific barriers encountered by nursing staff and argue for the promotion of continued staff education. Child life specialists and nurses share a common goal of acting as educators, caretakers and patient advocates for patients and their families, and this study brings to light opportunities for continued improvement in program administration.

As patient advocates, nurses have a responsibility to prevent unnecessary traumatic experiences for patients under their care whenever possible. One way to successfully advocate for pediatric patients is by promoting an interdisciplinary approach to the care they receive. A vital member of this team approach is the Certified Child Life Specialist (CCLS). Studies thus far have demonstrated the benefits of utilizing the child life specialist, but have not specifically assessed nursing utilization rates or barriers to incorporation of their skills into standard patient care. With this lack of data, it is unclear whether nurses are adequately trained to appropriately integrate services into daily practice. This descriptive study was designed to 1) determine the relative knowledge and beliefs of pediatric nursing personnel regarding child life services, 2) assess nurses' level of utilization of child life services, and 3) determine what, if any, barriers exist that prevent incorporation of child life services into standard patient care.

Incorporating the child life specialist into daily nursing practice can have widespread positive impact on patients, their families, and the healthcare system. Child life interventions have been shown to be extremely effective in enhancing coping skills in children and families during hospitalization. However, more research is necessary to demonstrate that these programs can also be cost effective (American Academy of Pediatrics, 2007). Child life specialists may potentially shorten length of stay and decrease the need for pharmaceutical interventions, thereby reducing

hospital and patient costs (American Academy of Pediatrics). In this light, it is important to demonstrate that the services are being used effectively and appropriately.

Whereas all entities in the health care team play a role in promoting effective coping skills for the pediatric patient and their family, (Hasenfuss & Franceschi, 2003) the child life specialist is a critical member due to their extensive training in child development and their primary objective of normalization and continued cognitive growth in the pediatric population (Cole, Diener, Wright, & Gaynard, 2001). A child life specialist is particularly qualified at preventing unnecessary traumatic experiences for pediatric patients. It is challenging to attempt to mitigate fear in pediatric patients after a procedure has been initiated (Dreger & Tremback, 2006). If a child initially experiences pain, discomfort, or distress with a procedure, the child will typically associate subsequent procedures as negative and will experience increased stress in the future. In contrast, adequately preparing a child for a potentially painful or frightening intervention can make the procedure more comfortable for the patient, their caregiver, and the health care team as a whole (Dreger & Tremback). Reducing pain and anxiety in children has been shown to promote cooperation and behavior that supports healing (Brewer, Gleditsch, Syblik, Tietjens, & Vacik, 2006).

Preparation programs have been shown to alleviate anxiety and stress experienced by children and their families both before

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and after a surgical procedure (McGee, 2003, Brewer et al., 2006). Studies have consistently demonstrated that, compared to adults of an age-appropriate developmental level, children undergoing surgery and anesthesia induction demonstrate an increased level of peri-operative stress and anxiety (Brewer et al.). This anxiety can manifest itself in emotions such as anger, guilt, and fear (Justus et al., 2006). Preparation includes “rehearsal and supportive care” (Brewer et al., p. 14). Brewer et al. used a tool called “Child Drawing: Hospital,” developed by Catworthy, Simon and Tiedeman (1999, cited in Brewer et al.), to obtain information about anxiety levels from the children themselves. This study demonstrated that medical play, tours through the surgical areas, and education by a child life specialist significantly reduced anxiety levels in children up to one month post-operatively as compared to

the control group, who did not have preparation by a child life specialist. Child life specialists not only aid the patient and family in anxiety reduction, but also augment the nurse’s role by increasing compliance, reducing sedation and induction stress, and decreasing recovery time (Brewer et al.).

Nurses can work closely with child life specialists, parents, and other caregivers to provide consistent, therapeutic interventions that help the patient develop coping skills for painful and anxiety-provoking procedures.

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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Nurses can help decrease their patients’ stress levels and promote effective coping by referring patients to a child life specialist at the time of admission when interventions can be most effective. This measure ensures the involvement of the child life specialist throughout hospitalization and encourages follow-up care in the outpatient setting (Hasenfuss & Franceschi, 2003).

Nurses can support and advance the cause of reducing anxiety and stress in their patients. They are unique in their ability to share information with the child life specialist due to the significant amount of time they spent at the bedside. Nurses can work closely with child life specialists, parents, and other caregivers to provide consistent, therapeutic interventions that help the patient develop coping skills for painful and anxiety-provoking procedures (Hasenfuss & Franceschi, 2003). Nurses can view the child life specialist as an advocate with whom they can collaborate to alleviate stress in patients and families, and possibly reduce post-operative pain (Brewer et al., 2006). Having a partner to help educate families who show signs of anxiety can also augment the nurse’s role. A well-prepared and educated caregiver can help reduce the patient’s anxiety and be a source of information for a frightened child when the nurse and child life specialist may not be available (Brewer et al.).

Preparation can begin outside the hospital, when a procedure is first scheduled. When instituting a child life program at an outpatient radiology clinic, the organizers at Children’s Hospital in Boston strongly supported preparation through education and rehearsal at home before undergoing anxiety-provoking procedures (McGee, 2003). The preparation began one week prior to the procedure and consisted of contacting the parent or guardian to discuss the approach that would be taken with the patient (McGee). The author notes that clarifying expectations and answering questions were a primary goal in preparation for both patients and their families. These efforts empowered parents to answer questions posed by their children, and also defined the parents’ role in the medical procedure, thereby giving them purpose, and reducing the strain felt by the child (McGee). The child life specialist was also able to initiate dialogue between the family and staff, educating both parties about roles and expectations. This served to create a more positive experience for everyone involved (McGee).

A wide variety of pediatric patients can benefit from the services of a child life specialist. Without written protocols in place, it is left to the discretion of the nurse to determine which patients may benefit from evaluation by a child life specialist. Current studies are unclear regarding the relationship between anxiety and age, and anxiety and gender in children undergoing surgery (Brewer et al., 2006). Based on this uncertainty, it is unwise for nurses to base a decision to contact child life services on a patient’s age or gender. Consistent data does not exist to support these decisions, and as such, they should not be relied on as evidenced-based practice (Brewer et al.). Instead, it should be the role of the child life specialist to use his or her assessment skills to determine each child’s need for services. The pediatric population is diverse in the severity of their illnesses and perceived needs for intervention. Based on the findings from Brewer et al., no preconceptions of a child’s coping ability should be made before contacting a child life specialist. Children who have undergone multiple surgical procedures or spent prolonged time in a hospital have been shown to exhibit more signs of stress than children who are new to the acute care setting (Brewer et al.). In this light, no child should be excluded from the services of a child life specialist.

Interdisciplinary collaboration can have a positive impact on patient care and show far-reaching effects long after the patient has left the hospital (Justus et al., 2006). An example of this teamwork is the program *Meet Me at Mount Sinai*. Introduced in 1990, it is a partnership among the departments of nursing, social work, and child life. It has been designed to help reduce procedure-related anxiety, enhance knowledge and understanding, and decrease the risk of the “traumatic impact of surgery on longer-term physical and emotional recovery” (Justus et al., pg 9). Education, tours, and equipment are provided to patients and families specific to the upcoming procedure and age of the child. The equipment includes a doll, stethoscope, anesthesia mask, gloves, and bandages, and is designed to encourage the child to become familiar with the equipment he or she will see, thereby reducing fear of the unknown (Justus et al.). This program is an excellent demonstration of interdisciplinary collaboration.

Child life specialists and nurses can also form strong partnerships outside of the direct hospital setting. An excellent example of this collaboration is demonstrated in a study published by a nursing doctoral candidate. The nurse researcher postulated that using an Internet preparation program to educate adolescent patients (aged 10-16) about their upcoming procedure would result in higher levels of patient satisfaction and greater knowledge retention than using a traditional education program that required patients to learn in a classroom-like setting (O’Conner-Von, 2008). The results confirmed this hypothesis and showed statistically significant gains in knowledge and satisfaction from both the patients and their parents. This researcher collaborated with a child life specialist to review the Internet program for age appropriateness, due to their extensive knowledge of child development (O’Conner-Von). This type of collaboration can lead to wonderful innovations in patient care such as incorporating technology familiar and comfortable to the adolescent population, thus improving their overall hospital experience.

Interdisciplinary collaboration has become a mainstay in today’s fast-paced health care environment. Therefore, it is important to understand how health care professionals view the child life profession. One study assessed how nurses, physicians, social workers, and other members of the health care

team (including child life specialists) viewed the role of the child life specialist (Cole et al., 2001). The study assessed perceptions of the importance of the child life specialist to a patient’s psychosocial well-being, the power child life specialists are perceived to hold on the health care team, and their perceived responsibilities, each on a scale of 0 to 10. The authors found that people who spent a significant amount of time with child life specialists rated them higher on the psychosocial well-being scale than those who spent less time with them. When asked to rate personal power on the team, more than half of the respondents scored the child life specialists below 5 out of 10. Fifteen percent of the nurses surveyed felt that patient support was a primary responsibility of the child life specialist compared to 89% of the child life specialists. Fifty-eight percent of the child life specialists surveyed felt that family support was a primary responsibility, while only 10% of nurses and none of the social workers responded this way. More than 50% of nurses surveyed found amusing and entertaining to be primary roles, while 8% of child life specialists agreed. The study concluded that due to the many perceptions of the role of the child life specialist, education of all staff is a vital intervention to increase awareness (Cole et al.). This study was an informative demonstration of the perceived role of child life specialists and their role on the health care team. The results indicate a need for additional education about the positive impact they can have on the children with whom they interact.

METHOD

DESIGN

This is a descriptive study designed to assess the knowledge, attitudes, and beliefs of nurses toward child life specialists, and to identify barriers surrounding utilization. The study was approved by Georgetown University’s Institutional Review Board and followed the recommended ethical guidelines outlined for social and behavioral studies.

SURVEY INSTRUMENT

A twelve-question survey was created and included both open- and closed-ended questions. The survey included questions to assess knowledge of services provided by the child life specialist, services most requested by nursing staff, methods of contacting the child life specialist, the nurse’s observation of

service benefits, barriers to referral, and demographic information (see Appendix A). Respondents were offered the option of providing their name and contact information if they wished to provide further information to the researchers. Nurses who chose this option were contacted, but no follow-up interviews had been conducted at the time of this writing. Two PhD nurse researchers reviewed the survey. Its validity was not examined during this preliminary study.

PARTICIPANTS

Participants in this study were pediatric nursing personnel employed in the pediatric intensive care, hematology/oncology, and general pediatric units at Georgetown University Hospital (GUH), a large urban teaching hospital with 51 pediatric beds. Nursing staff was chosen for this study due to their primary contact with pediatric patients, their opportunity for collaboration with the child life specialist, and their role in providing comprehensive care, including psychosocial support. This convenience sample was chosen based on their willingness to participate in the study and the timeliness of contacting them. Of the forty full-time

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nurses who work on these units, 62% opted to participate in the study.

PROCEDURE

The researchers coordinated with the pediatric nurse manager to offer the survey to nursing staff. The survey and consent forms were placed in an unsealed envelope and offered to nurses by the clinical manager. Instructions were printed on the outside of the envelope. Completed surveys were sealed in envelopes and then returned to the nurse manager, who returned them to the researchers. Surveys were filled out on a voluntary basis and the researchers were not present when they were administered. Each completed survey was evaluated by simply tallying results using Microsoft Excel.

RESULTS

Among the staff surveyed, 84.4% (n=27) were registered nurses, 9.3% (n=3) were nursing assistants, and 6.2% (n=2) were nursing administrators. The number of

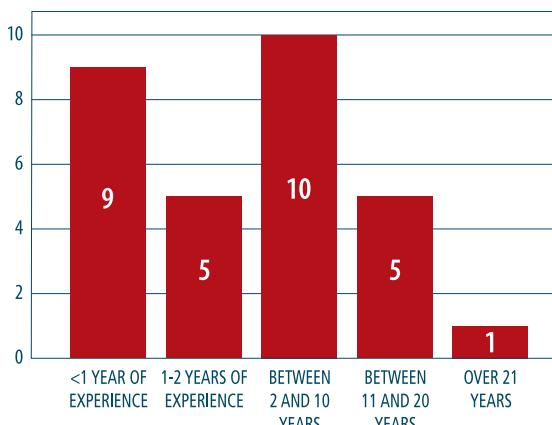


FIGURE 1. YEARS OF NURSING EXPERIENCE

nursing staff who worked in each unit was also examined. The pediatric intensive care unit (PICU) employed the largest percentage of respondents, 39% (n=16). The next largest group worked in multiple units, comprising 15% of the sample (n=6). Three of the respondents were patient technicians working in multiple units. Twelve percent (n=5) of respondents worked in the hematology/oncology unit, and 23% (n=10) worked in the general pediatric unit. Twelve percent

(n=5) of nursing staff identified themselves as working on the pediatric transplant unit.

Years of experience as a nurse ranged from less than one year to twenty-eight years, with an average of 5.2 years (see Figure 1). To calculate the average, nurses who had less than one year were counted as 1, and nurses who had mid-year experience were rounded up to the next year. The majority of nursing staff responding to the survey had two years or less of nursing experience, comprising 47% of the respondents. Data on gender was not collected.

All of the 32 nursing staff surveyed responded that they knew about the child life program. This is a strong indicator that child life is an established presence in the pediatric units. Eighty-four percent of respondents (n=27) have referred a patient to a child life specialist, indicating common usage among nursing staff. Of the five respondents who have not referred a patient, two were recent graduates who stated that they had not been working long enough to make a referral.

Nurses identified patients for referral based on individual perceptions of need. According to the nurse manager, there is no formal policy on which to rely to generate referrals (T. Conlon, personal communication, October 28, 2008). Respondents indicated that the decision to refer a patient to the child life specialist was based primarily on the procedure performed. Family request and severity of illness were also frequently mentioned (see Figure 2).

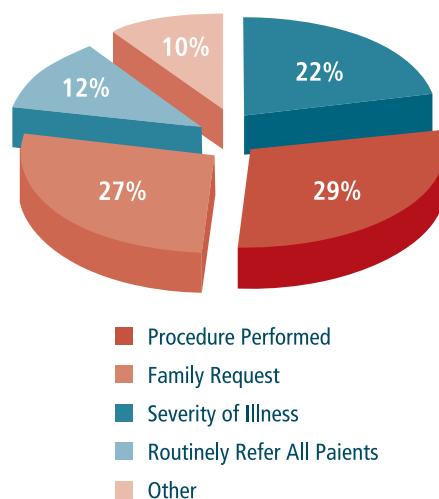


FIGURE 2. REASONS FOR REFERRAL TO THE CLS

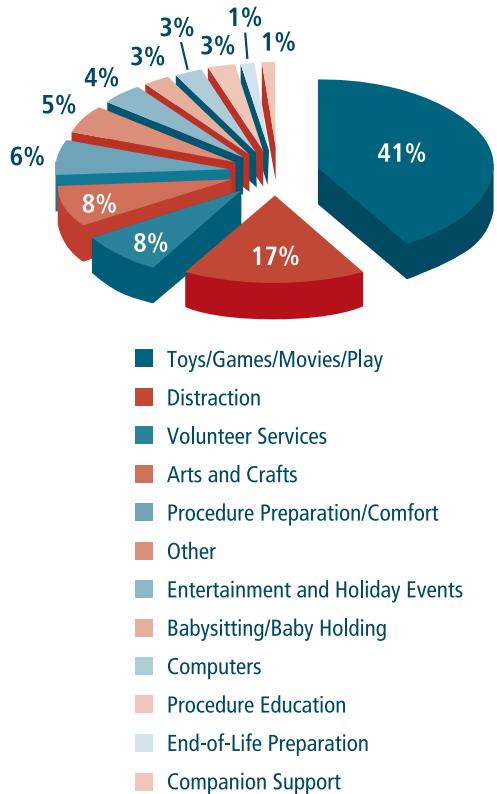


FIGURE 3. MOST REQUESTED CHILD LIFE SPECIALIST INTERVENTIONS MADE BY NURSING STAFF

Within the units assessed, the nurse-to-patient ratio varies based on patient acuity. In the PICU, the nurse-to-patient ratio is approximately one nurse to two patients. Twenty-five percent of PICU nursing staff indicated that they routinely refer 100% of the patients to the child life specialist. Thirty-eight percent (n=6) of PICU nurses stated that the number of patients they refer varies by patient load and shift. In hematology/oncology and the general pediatric unit, the nurse-to-patient ratio is 1 nurse to every 3.5 patients. Of these patients, nurses reported referring 68% per shift. Throughout all units, survey responses indicated that nurses carry an average patient load of 2.6 per shift with a referral rate of 1.4 per shift.

Respondents were asked to list three child life services they most often request. The nurses surveyed identified referring patients to the child life specialist to provide toys, games, movies, and play most often. "Distraction" was identified as the second most common reason to refer a patient to a CCLS. (see Figure 3).

To assess knowledge regarding overall services provided by the child life specialist, nurses were asked to list three additional child life services beyond the ones they most frequently requested. The services identified most frequently included play/movies/board games, procedure preparation, and entertainment/holiday/birthday parties. Additional services identified ranged from art and music to sibling support, and are detailed in Figure 4. The most frequent responses were "toys/games/movies and play", representing 41% of the total responses (See Figure 4).

The nurses were asked to rate their opinion of the overall benefit of child life interventions. Sixty-two percent (n=20) of respondents indicated that they felt child life interventions were beneficial more than 75% of the time. Fifteen percent of respondents rated child life interventions as beneficial 51-75% of the time. Three percent of respondents rated child life interventions to be beneficial 26-50% of the time. The remaining 3% felt that child life interventions were beneficial less than 25% of the time.

Nurses surveyed were asked to identify barriers that prevented them from referring patients to the child life program. The child life specialist being unavailable at the time of

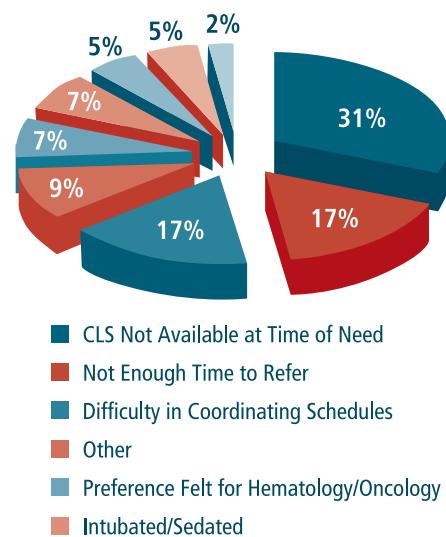


FIGURE 5. BARRIERS TO REFERRAL

need was identified as the most prevalent barrier to utilization, representing 40% of those surveyed. Not having enough time to make a referral, difficulties in coordinating schedules with the child life specialist, and a perceived preference of the child life specialist for the hematology/oncology unit were also identified as common barriers (see Figure 5).

Twenty-five percent (n=8) of the respondents chose to include their name to provide further information. All eight of those people were contacted either by phone or email and were offered an anonymous forum to provide additional information about nursing interaction with the child life program at GUH. As of the printing of this paper, none have chosen to provide further information.

DISCUSSION

Collectively, 64% of responses indicated that time, in some form, served as a barrier to making a child life referral. This implies that some patients in need of psychosocial support may not be receiving adequate intervention. The availability of the child life specialist was noted as the primary barrier to making a child life referral while lack of the nurse's time to make a referral was the second most identified barrier.

The survey results indicate that services nurses identified are largely activities that can be provided by volunteers, such as distributing toys, games, and movies. Only 28% of nurses surveyed reported utilizing the child life specialist for services requiring her spe-

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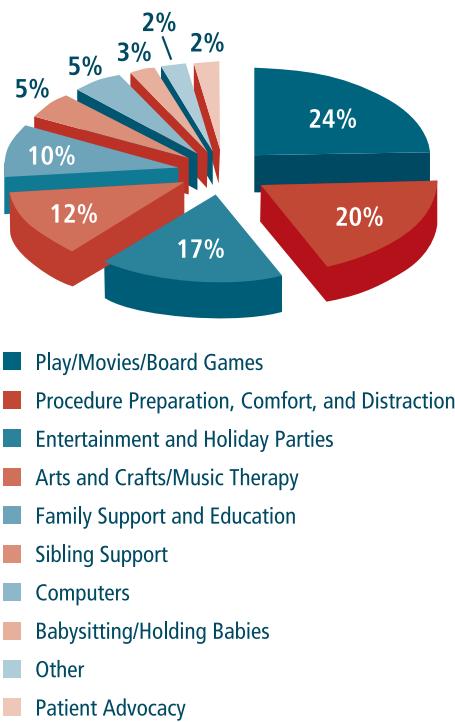


FIGURE 4. ADDITIONAL CHILD LIFE SPECIALIST SERVICES IDENTIFIED

continued from Focus page 5

cialized training. The child life specialist at Georgetown University Hospital confirmed the survey findings that providing distraction, art projects, and video games are the most frequent services requested (L. Kim, personal communication, October 13, 2008). The child life specialist also provides non-medical preparation and support for tests, surgeries, and other medical procedures, therapeutic medical play using special dolls, stuffed animals, and medical equipment, activities to continue normal growth and development of infants, children and adolescents in hospital patient rooms and/or activity areas, and sibling support, among many other services. At the time of this study, staff education provided by the child life specialist included a one-hour in-service for all newly hired nurses, a yearly Grand Rounds seminar, and one-on-one teaching as needed (L. Kim, personal communication, October 13, 2008). Expanding the staff education program to include regular updates about the child life program and highlight current research would enhance the child life specialist's role within the health-care team and create a stronger partnership

with the nursing staff.

The researchers had hypothesized that time constraints and lack of awareness of the child life program prevented nurses from incorporating the child life specialist into daily patient care. The survey findings, however, indicate that the nurses are fully aware of the existence of the program, but that their perception of the types of interventions provided may not reflect the optimal therapeutic potential of the child life specialist. Further research could focus on nurse's perceptions of "play" and whether they see a therapeutic benefit to its incorporation into pediatric nursing.

The child life specialist interviewed confirmed a prevailing perception among nursing personnel that she favors working with hematology/oncology. The child life specialist pointed out that the lines of communication with hematology/oncology are better established, and this may account for the perceived preference (L. Kim, personal communication, October 13, 2008).

In addition, further investigation is needed to assess the nature of the perceived benefit of child life services. Respondents regarded child life services as beneficial greater than

75% of the time. However, it was not clear from where this perception emerges. Do nurses regard child life services as beneficial as they facilitate the nurses' ability to provide patient care, or are child life specialist services beneficial because they promote the psychosocial and developmental needs of the patient, or both? It is also important to examine why 25% of respondents felt that the child life interventions were not beneficial. Further research could examine strategies for collaboration between nurses and child life specialists that would ultimately lead to less traumatic experiences, shorter hospital stays, reduced need for pain medication, and decreased patient and family anxiety.

STUDY LIMITATIONS

This study had certain limitations. The survey did not request the nurse to differentiate between volunteer and child life specialist-specific activities. Some responses were open to interpretation by the nurses. For example, the word "play" could be interpreted as medical play or time spent with a board game. While both activities can be therapeutic, the child life specialist would facilitate medical play, while volunteers could provide games. To verify whether these findings are consistent or indicative of an under-sourced child life program, future studies could compare programs in multiple hospitals to assess this perception of nursing personnel towards child life activities.

Given these limitations and the small sample size, it is not possible to generalize the findings. However, the data could indicate a potentially prevailing issue occurring in hospitals of similar size with comparable resources, and highlight areas for further research and development.

RECOMMENDATIONS

Nursing staff should continue to make referrals, regardless of perceived barriers of time or patient need. Without documentation that the child life specialist is both in demand and is an effective and crucial member of the health care team but is unable to meet patient needs due to high patient-to-child life specialist ratio, there is little incentive for hospitals to make changes to child life staffing. For nurses perceiving a lack of their own time to make a referral, their unit secretaries could be utilized to make referrals during the shift, or they could anticipate the need for a referral at the start of a shift and

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communicate directly with the child life specialist during morning report. Support staff could also be added to assist the child life specialist with administrative tasks and volunteer management, enabling the child life specialist to have additional time to complete child life interventions. In addition, with computerized charting becoming more mainstream, systems could be designed to generate an automatic referral based on diagnosis, procedure, patient assessment, and current status, thus significantly cutting down on time spent either looking for the child life specialist or to make a new referral. Many hospitals are now making use of pocket computers that can be utilized so that the child life specialist would not need to return to her office to retrieve emails and phone calls.

Time management is essential when coordinating with a child life specialist. Play time and procedure rehearsal time for the patient need to be incorporated into other time-consuming activities for which the nurse is responsible (Hasenfuss & Franceschi, 2003). These activities, such as medication administration, dressing changes, feeding, venipunctures, emergencies, and coordinating diagnostic procedures, are not always predictable with any hospitalized population. The pediatric population can be especially unpredictable, therefore nurses and other direct care staff need to be supported by the hospital system with which they work in order to fully realize their potential for providing comprehensive care. Addressing time management includes personal, unit-wide, and system-based opportunities for improvement. These issues must be addressed before simply asking staff to better manage their time.

The current psychosocial needs of the pediatric population and associated demands provide an intensive workload for the single child life specialist overseeing the pediatric units at GUH. The child life specialist to patient ratio at Georgetown University Hospital is 1 to 51. The American Academy of Pediatrics (AAP) published a policy statement in 2006 recommending a child life specialist to patient ratio of 1 to 15-20 (American Academy of Pediatrics, 2006). The AAP noted that patient acuity and mobility status, and the unique characteristics of the unit's population need to be taken into account when implementing the guideline. The perception that the child life specialist favors the one unit over another may

be because she spends more time on that unit simply due to strongly established lines of communication, and not due to preference for the unit or its patients. This is an area where having another child life specialist available would be highly beneficial for the nurses, patients, and families. Incorporating support staff or adjusting responsibilities could enable the child life specialist to focus more attention on continued staff education and patient interventions. Enhanced education for nursing staff is needed to promote positive outcomes that child life activities can have on patients and families. All participants involved in caring for children have a similar goal: To utilize all available resources in order to improve patients' well-being. Bringing to light the challenges in administering a program like child life gives everyone the opportunity to address the issues and develop strategies for improvement and for providing holistic care for every patient.

CONCLUSION

Research surrounding child life specialists continues to demonstrate their essential role in serving the pediatric population (American Academy of Pediatrics, 2007). This study has demonstrated that the child life program at Georgetown University Hospital has an established presence in the pediatric units. It indicates opportunities for continued growth within the program. It also illustrates areas for continued education for all members of the health care team. Child life specialists serve an essential role in promoting effective coping and development in pediatric patients through play, education, and self-expression activities, as well as providing valuable information and emotional support to parents, siblings, and family members (American Academy of Pediatrics, 2007). Resources would be well spent to continue to grow the child life program at this hospital that so strongly serves its pediatric population.

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APPENDIX A

NURSING SURVEY: CHILD LIFE SERVICES

1) Are you familiar with the Child Life Program at Georgetown University Hospital?
 Yes No

2) Have you ever referred a patient to a Child Life Specialist?
 Yes No (please skip to question #8)

3) If you answered 'yes', how do you identify whom to refer? (Please check **all** that apply)
 Severity of illness I refer all my patients
 Procedure performed Other: _____
 Family request

4) How do you most often contact Child Life Services to make a referral? (Please check **one**)
 Phone In person
 Email Other: _____
 Charting system

5) How many patients do you have per shift? _____ How many of these do you refer? _____

6) What services offered by the Child Life Specialist **do you use** most often?
1. _____
2. _____
3. _____

6a) Please list three **additional** services provided by the Child Life Specialist:
1. _____
2. _____
3. _____

7) How often do you find Child Life intervention to be beneficial to the patient?
 > 75% of the time 51-75% of the time 26-50% of the time < 25% of the time

8) What are your reasons for not referring a patient? (Please check **all** that apply)
 I don't have enough time to contact the Child Life Specialist
 Difficulty in coordinating schedules with Child Life Specialist
 The family does not see the need for a referral
 I do not find the Child Life Specialist interventions to be beneficial to the patient
 Child Life Specialist is not available when I need them

9) If there are any other reasons you choose not to submit a referral, please list them here:

On which nursing unit do you work? PICU Hem/Onc General Pediatric Unit
What shift do you normally work? Days Nights Other
How many years have you been a nurse? _____ years

If you would like to be contacted to provide further confidential information, you are welcome to include your name and contact information here.

Name:
Contact:

Thank you for your participation!

Child Life Alphabet

Continued from page 1

FOUR KEY LISTENING SKILLS TO REMEMBER:

1. Listen to what the patient is saying:

For the verbal patient, what words are being used? Is the patient asking questions or making statements? Is the child talking about the people, the environment or the activity in the room? Is he articulating his feelings or stating facts? The content of the child's conversation will help you to determine the level of expressive and receptive language development and to decide on the best place to begin your intervention. Pay close attention to the tone and volume of the spoken words. Is the child whispering as if sharing a secret or is he shouting over the other voices in the room?

2. Look at body language: Is the child hiding under the covers or curled into a fetal position? Is he making eye contact with anyone? Is the patient combative or submissive when approached? Accurately assessing body language can be especially important when working with a patient who has trouble with verbal language. An outstretched arm can say "stop" and hiding under the covers can communicate fear or anxiety. Enlist the help of parents when deciphering body language and other non-verbal communication; they can help you understand what a typical sign of distress or an atypical action may look like. Verbalize your assessment to the child and ask if you are correct. For example, say "I see that you are covering your whole body with the blanket. Are you hiding from us? Is that because you feel scared?" Take note of any repetitive motions of the hands or other parts of the body, and determine if it is appropriate to provide a manipulative toy or transitional object to help occupy fidgety hands and bodies. If the patient is agitated, rocking, or becomes non-verbal, minimize communication with the patient, recognizing that he may be unable to focus in that moment, and continue the interaction when the patient has reached self-control. When a child with autism, for example, becomes combative or begins to exhibit self-stimulating behaviors, we can interpret these as a sign of distress or discomfort and may consider advocating for a short break to allow the child to become calm.

3. Look at the environment in the room:

Is there anything you can change in the room to make it easier for the patient to talk or for you to listen? Are there unnecessary people in the room? Is the TV on too loudly? Is anyone talking on the phone? Can you close the door or curtain? Minimizing distractions will be calming for the child but will also allow you to focus on listening. Whenever possible, also turn your back to a clock or TV that could draw your eye away from the child.

4. Let the child with special needs have a voice: What does the child need to communicate effectively? Does he have access to all the tools he typically uses to communicate? Is there anything that could be provided to assist with communication such as a computer, pictures, or drawing supplies? Does the patient sign? If so, are his hands free or is there medical equipment that is hindering movement? Let your words and actions empower the child. Tell him that the things he has to say are important and that you are here to listen to him, and then stay and listen, even if the topic seems unimportant.

Example: Kenny is an 8-year-old boy with a diagnosis of autism who is admitted to the hospital for kidney transplant evaluation. Kenny is verbal but has difficulty responding to questions appropriately, changes subjects frequently, and struggles with the social dynamic of conversation. Kenny functions on a very strict routine and uses both electronic and non-electronic visual aids at home and at school. Although Kenny has been a long-time dialysis patient and is typically cooperative with medical interventions, it has been a very long day of testing, and the child life specialist has been called to help with one last blood draw.

When the child life specialist arrives, Kenny is standing on his bed shouting, flailing his arms, and sometimes covering his ears. His words are delivered between grunts in short phrases and at a very loud volume; "Loud, loud, loud. 1, 2, 3. Loud. Out. 1, 2, 3. Mom loud. You loud. You loud. Kenny loud. Too loud. TV. No, no, no. Stop. Now." The people in the room, two staff members and his mother, are trying to speak over him, reason with him, and encourage him to cooperate with the blood draw.

Interpretation and Response: By simply listening to Kenny's words, the child life specialist concludes that Kenny believes the room is too loud,

and in order to make himself heard or to drown out the noise in the room, he too is shouting. The mother confirms that Kenny's flailing arms and antsy behavior on the bed are a sign of frustration and impatience. The child life specialist advocates for a break, and the two staff members step out of the room. Kenny immediately quiets, sits down on the bed and begins to watch TV.

Both the child life specialist and mother attempt to explain to Kenny the importance of the final blood draw, but each time he puts his finger to his lips telling them "shh." The child life specialist asks the mother about any tools used at home and school to help Kenny and learns that he has a visual schedule on which he depends. Because both the child life specialist and mother agree that it would be helpful to use a similar schedule during hospital admissions, the child life specialist asks her to describe some important components of this schedule.

The mother starts with waking up and works her way through the schedule until she reaches 4:00 pm; she explains that each day at 4:00 pm (it is 4:45 pm), Kenny is allowed to watch 1 hour of television, typically Sesame Street (or "1, 2, 3" as Kenny calls it). The mother and child life specialist use the dry erase board in the room to quickly create a schedule that includes "TV time," which ends at 5:00 pm followed by the blood draw. After a few minutes, the child life specialist tells Kenny it is time for the nurses to return for the procedure. Kenny nods and, although his frustration with the initial situation lingers, he is able to cooperate with the procedure. For the duration of this admission to the hospital and at the transplant admission, the CLS, Kenny, and his mother plan to work together to implement tools from the home and school environments in the hospital environment.

In this situation, the child life specialist listened to what the child was saying by interpreting his words and his actions and responded by making small changes in the environment to accommodate the child's typical communication skills, thereby empowering both the child and mother in the hospital setting. Listening is a key part of building rapport with all children, both typically developing and those with special needs, and ultimately the same skills, patience, and concentration, are required to be an active listener to children in both populations. Each child will be different and have different communication skills and needs, which means that we as professionals must be flexible and self-aware as we utilize different listening skills.

CLC 2011 Distinguished Service Award

continued from page 1

Distinguished Service Award is presented once a year by the CLC Board of Directors to an individual who has made significant contributions to the development of the child life profession.

Sheila's inspiration to become a child life specialist began with her family. Her father was a surgeon and her mother was a research medical technologist, so working in health care always felt like a natural fit for her. During her undergraduate years at Colorado State University, she first explored a career in speech pathology, then in nursing, but increasingly she felt that her true niche would be working with children. She applied to the child life training program at Johns Hopkins, and it was during her time there, under the mentorship of internship coordinator Pat Johnson, that Sheila had what she calls her "aha moment." "That's when it all really started to make sense to me," she says.

After graduating from Colorado State with a bachelor's degree in Child Development and Family Relationships, Sheila got her first job as a child life specialist at Minneapolis Children's Medical Center. She was quickly named director of the child life department, where she spent nearly 20 years transforming a 3-person program into a team of 18 staff members. Under her leadership, the Minneapolis Child Life Department established a student internship program, a pre-surgery preparation program, and pet therapy, grief support, and school reentry services, among many other programs. With her encouragement, Minneapolis Children's was also an early adopter of closed-circuit television for patients, beginning back in 1978.

In 1993, Sheila was presented with a new challenge when Minneapolis Children's Medical Center merged with a competing children's hospital located in St. Paul to create the new health system, Children's Hospitals and Clinics of Minnesota. Sheila was selected as the child life director and took the lead in integrating the two departments into one cohesive team. The process of merging the two organizations lasted several years, and it wasn't always easy. "There were some rivalries between the employees from each hospital, and you could see that emerging even among the child life specialists," Sheila remembers.

To build a sense of unity, they created cross-functional teams with child life specialists from each facility. These groups work together on projects that serve both locations.

"It's where I really developed my philosophy on leadership and how it's really not about one person. It has to live in everyone," Sheila says. Accordingly, she involves her staff in decision-making and encourages them to take ownership of projects. This engaging style of leadership is critical to the success of the department, with one group working at the Minneapolis campus and the other working in St. Paul, and Sheila splitting her time between the two facilities. In the years since the merger, Sheila has worked with the department staff to launch a number of additional programs at Children's of Minnesota, including sibling support and bereavement services, music therapy, a horticulture program, a family resource center, and website education for patients. After having spent many years working with the Family Advisory Council, she initiated a Youth Advisory Council, currently in its eighth year, which has set a standard followed by many organizations nationwide.

Beyond her work within her own institution, Sheila continually shares her expertise with other hospitals and child life programs, both in her capacity as a reviewer on the CLC Program Review and Development service and as an independent consultant. In the wake of her own department merger, she worked as a program consultant for Egleston and Scottish Rite Hospitals (now Children's Healthcare of Atlanta) to support the two programs through a hospital merger similar to the one she had managed at Children's of Minnesota. More recently, Sheila has been active in supporting the Priyanka Foundation, a Minnesota-based nonprofit organization dedicated to establishing child life programs for chronically ill children in India. Sheila sits on the board of the foundation, and together with CLC member Priti Desai, PhD, MPH, CCLS, she serves as an expert resource.

Sheila's history of volunteer leadership with CLC is equally as impressive as her list of career accomplishments. On the CLC Board of Directors, she held the positions of

Treasurer from 1992 to 1994, Certification Liaison and President-Elect from 1998 to 2000, and President from 2000 to 2002. As immediate-past president in 2002, she was there to provide stabilizing leadership as a member of the search committee seeking a replacement for outgoing executive director Deborah Brouse. Sheila has been a member of a long list of CLC committees and task forces over the years, serving as chair of the Finance, Nominating, and Membership Committees. Most recently, she chaired the Conference Program Committee that planned the recent Annual Conference in Chicago. She is also currently a member of the International Task Force, the Recertification Task Force, and the Past President's Council.

In addition to her work on the Board and CLC committees and task forces, Sheila has been involved at one time or another in the development of a number of Child Life Council publications and official documents, including academic and clinical standards, the Certification Candidate Manual, Program Review Guidelines, and most recently, she was a member of the task force that developed CLC's position statement on clinical supervision. Along with former Distinguished Service Award recipients Jerriann Wilson and Linda Skinner, Sheila served as co-editor for the most recent edition (2006) of the *Guidelines for the Development of Child Life Programs in Health Care Settings*. "I really feel so privileged to continue to work alongside people like this," says Sheila. "It's the beauty of the Child Life Council – you get to know so many people you wouldn't normally come into contact with through your work on committees and other projects . . . you grow as a professional and you grow as a leader, and you make some great friends along the way!" Sheila also values her work with CLC because it has allowed her to stay on the cutting edge of what is happening in the profession, and she has been able to bring that knowledge back to benefit her program.

"For me, part of the motivation is knowing our history. I've had the privilege to work with some of the founders of child life and the framers of CLC, and in that way I've touched our beginnings. Seeing what we have accomplished is truly remarkable, and I want to share that excitement with the younger generation . . . One of the most important things I can do as a leader is to help them to understand that they are not

just on the receiving end of all of this knowledge, to encourage them to see themselves as part of that continuing evolution and growth. We all have something to contribute, whether it's volunteering on a committee, presenting at conference, or contributing to the literature that supports child life practice."

For all child life specialists, Sheila believes it will become increasingly important to focus on leadership and advocacy skills, in addition to clinical skills, particularly with the shifting landscape in health care. She encourages all child life specialists to, "... be prepared, contribute to evidence-based practice, and apply that knowledge to address care issues. We are going to be taking a leap forward, and child life needs to be creative, flexible, and adaptable. We need to think about what we bring to the table . . . what solid skills that you can deliver that have value and improve health care."

When asked what advice she has for future child life leaders, Sheila encourages all child life specialists to focus early on their professional development. "Learn to be self-reflec-

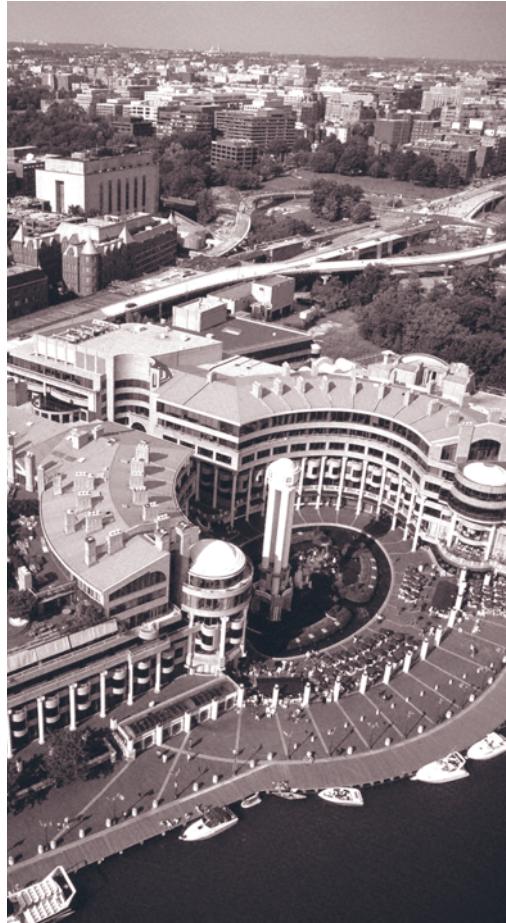
tive and find a mentor," she says. "Getting those outside opinions can be really valuable and help you to see new possibilities for how you can grow as a professional. Rather than sitting where you are, look at where we would like to be."

Though it may be hard to believe that Sheila has any time at all for personal pursuits on top of such a busy and productive work life, she makes it a priority to take time to go adventuring outdoors. She visits Colorado to go skiing at least once every season, and she has also tried snowcat skiing (off-trail, down-hill skiing that is accessed by a snow tractor, not a ski lift). She was a member of the Girl Scouts through her senior year in high school, and for the past 12 years, she participates in an annual reunion with members of her troop, where they enjoy activities such as hiking, canoeing and camping. She loves to travel, and one of her favorite places to visit is Norway, where she has family.

Of course, Sheila's most recent trip didn't take her nearly as far as Norway. The Annual Conference in Chicago took place

just a few hundred miles away from her home in Minnesota. But while the physical distance was relatively short, the Distinguished Service Award presentation at the closing general session represented a milestone in a much longer professional journey, one in which Sheila has generously shared her time, efforts, and wisdom to advance the child life profession. And for all that she has contributed in her remarkable career, Sheila says, "I have received as much as I have given." We certainly hope this is the case, because Sheila's leadership and dedication have been instrumental in progress of both the Child Life Council and the child life profession. If you weren't able to attend the award presentation last month, please join us in celebrating Sheila's contributions by sending her a note of congratulations through CLC Community!

Stay tuned for the Fall 2011 issue of the Bulletin, which will include a feature article detailing the accomplishments of Lissy Zaremba, MA, CCLS, winner of the 2011 Mary Barkey Clinical Excellence Award.



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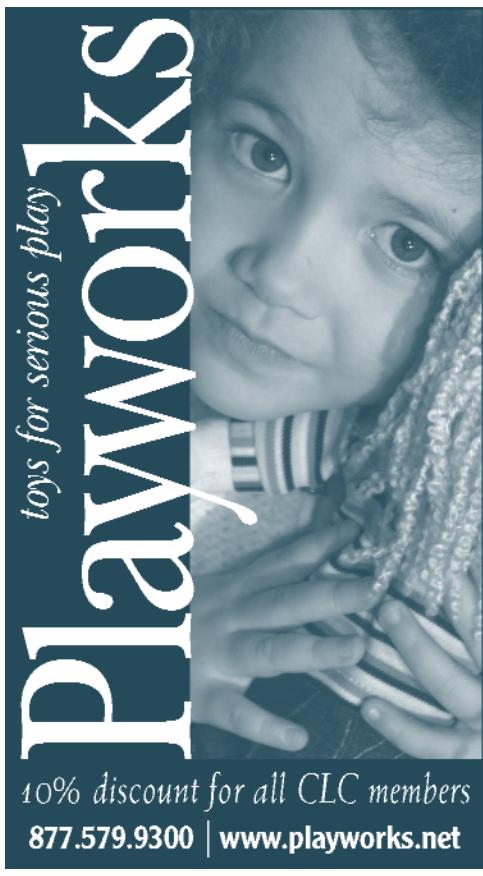
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WASHINGTON, DC

Abstract submissions for the CLC's 30th Annual Conference will be accepted through the CLC Website no later than July 31, 2011.

NEW FOR 2012—ONE HOUR PRESENTATION TIME SLOTS!

For more information on the call for papers, please visit
<http://www.childlife.org/files/2012ConferenceCallforPresAbstracts.pdf>

Presenting at conference is an exciting opportunity for professionals to share their passion and expertise with others in child life. CLC's call for papers, the process for submitting an abstract, is open to all levels of child life professionals and is the first step toward presenting at conference. CLC's Annual Conference is the largest meeting of child life professionals and gives presenters an opportunity to make an impact on the child life profession. Conference presenters have the ability to hone their research and speaking skills, while demonstrating their professionalism and promoting their own institution. Quality, organized abstract submissions are the foundation for creating a successful conference. Become a part of this process by submitting an abstract for 2012!



Child Life Council

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SUMMER 2011

CLC Calendar

JULY

- 15 Deadline for *Bulletin* and *Focus* articles for Fall 2011 issue
- 31 Deadline for abstract proposals for the 30th Annual Conference on Professional Issues

AUGUST

- 31 Deadline for applications for the November administration of the Child Life Professional Certification Exam for those educated within the U.S. or Canada

SEPTEMBER

- 7-10 CLC Board Strategic Planning Meeting
- 22-25 CLC 2012 Conference Planning Meeting

OCTOBER

- 15 Deadline for *Bulletin* and *Focus* articles for Winter 2011 issue
- 15 Deadline for written requests to withdraw from November Administration of the Child Life Professional Certification Exam
- 31 Late Deadline to recertify with Professional Development Hours (late fee and additional paperwork required)

NOVEMBER

- 1-15 Child Life Professional Certification Exam Administration Testing Window

Coming Soon: 2012 MARY BARKEY CLINICAL EXCELLENCE AWARD NOMINATIONS

Do you know a CLC member who is worthy of the Mary Barkey Clinical Excellence Award? The CLC Nominating Committee invites you to consider nominating a colleague beginning in August 2011. More details will be available soon through the CLC website at www.childlife.org.

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