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ACLP Bulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

SUMMER 2020 | VOL. 38 NO. 3



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from the **Executive Editor**
Kathleen McCue, MA, LSW, CCLS

What does “legacy” really mean? It’s a term that has been found increasingly in child life presentations, child life literature, and child life clinical discussions. At our national conferences, there have always been a few workshops that address the topic of legacy, especially in relationship to interventions provided at end of life. According to Merriam-Webster, legacy is defined as, “something transmitted by or received from an ancestor or predecessor or from the past (Merriam-Webster n.d.)” The Cambridge Dictionary adds that, “legacy is something that is a part of your history or that remains from an earlier time” (Cambridge Dictionary n.d.).

At this time of *ACLP Bulletin* leadership transition, I want to acknowledge the legacy that our outgoing Executive Editor, Kathryn Cantrell, PhD, CCLS, has left for all of us. Over the past four years, Kathryn has continued the development and expansion of *Bulletin*. She has raised the quality and rigor of the articles to an enhanced professional level, while always keeping in mind the need to encourage and support new authors. Kathryn has dedicated many volunteer hours each week to ACLP publications with special attention to developing the empirical insert, *Child Life Focus*, to represent the best of child life research and theory. At the same time that Kathryn was bringing life to a new publication, *Journal of Child Life (JCL)*, she was bringing life to her own new son, Bode, finishing her Ph.D., moving to full-time academic work, and supporting child life students in their discovery of the profession. She has now agreed to remain as Executive Editor of *JCL* for an additional year, to make sure that this journal will thrive and continue to grow. We are all grateful for the legacy that Kathryn Cantrell has established as part of the history of child life.

As I think about legacy, I feel the need to offer a warning to readers who are providing clinical services to children and families. We may be starting to use the term legacy to describe what are actually memo-

ry-making activities with our patients. Handprints of infants who have died, locks of hair from a mother for her children, and pictures drawn by children prior to a life-ending medical experience may all be very important memories for families. Each individual will need to decide if that concrete memory is something that is positive and something that they want. We should never automatically provide such memories, but, as we usually do in child life, explore with each family and each patient what would be valuable. And even when something is a valuable memory, that does not make it a legacy. Legacy usually has the component of advanced planning and thoughtfulness. Adults, teens, and some younger children can, when they choose, talk about their legacy wishes and make plans about how they want to be remembered. These are emotional and difficult discussions, and should never be entered into casually or automatically. Decisions about legacy are usually made well before death; the actual time of death, in an ED or an ICU, is often not the right time to discuss legacy, or even to consider memory-making options.

One more thought about legacy. In this issue of *Bulletin*, you will find an article about the impact of COVID-19 on child life students. I want to acknowledge the heroic allegiance to the families you serve on the part of all child life specialists who are still working at their hospitals. You put your own health and that of your family at risk every day that you go to work. Health care workers are being praised all around the world for their dedication and courage. It is a legacy to our profession that you are there doing your job, enhancing coping, and reducing anxiety in an arena that many others would choose to avoid. There may not be signs in windows thanking child life specialists like there are for doctors and nurses, but when we are able to move beyond the current situation, each of you will have contributed to establishing a legacy for child life not just as the people doing the “fun jobs,” but as those with as much devotion and commitment as anyone in health care. ✨

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Message from the Editors

This summer issue of *ACLP Bulletin* marks a change in the publication's leadership. After a decade supporting *ACLP Bulletin*, the *Child Life Focus*, and the *Journal of Child Life*, our Managing Editor, Anne Mohl, PhD, CCLS, is leaving her position to embark on a new role as child life specialist in the NICU at Johns Hopkins Children's Center.

In 2009, Anne first worked with *Bulletin* as associate editor. Following her 2010-2012 term as executive editor, she stepped into the managing editor position and began coordinating the entire publication process for *ACLP Bulletin* and its insert, *Child Life Focus*. Since 2013, she has been the publications' backbone: facilitating communication with authors, training volunteers, maintaining all publication guidelines and official documents, and above all, providing steady and meticulous edits. While in this role, Anne built an unwavering reputation as a supportive, enthusiastic, and conscientious colleague. Authors often commended her for helping them feel comfortable enough to share their voice. Maintaining two high quality peer-reviewed publications requires contact with thousands of stakeholders, and in each exchange, Anne exemplified a core value of child life. She consistently demonstrates that relationships built on trust, respect, and professional competence contribute to the development of confidence, resilience, and problem solving (as well as great writing). Anne's dedication to child life scholarship and research has been exemplified in her commitment to bringing the *Journal of Child Life* to fruition, a project that has spanned multiple years and editors.

When reflecting on her time as managing editor, Anne shared that her favorite parts were being inspired by all the people who wanted to share some aspect of their work in a way that would motivate and encourage others, working with a progression of talented and dedicated editors, and being part of making the dream of a journal into a reality. We will miss her sense of humor and her calming reassurance.

As we wish Anne luck on her next adventure, we welcome the talents of Keri O'Keefe. As Manager of Digital Education, Keri provides support and administration to several ACLP programs including online education, the *ACLP Bulletin* and *Journal of Child Life*, the Child Life Professional Data Center, and the accreditation and endorsement programs. Prior to joining ACLP, Keri's experience has been in teaching high school science and working at non-profits specializing in back-end operations and marketing. She enters the role with prior experience as executive editor for several membership publications with the Wisconsin Historical Society. With strengths in organization, project management, and strategy, Keri's skill set is coming at an ideal time as we streamline the publication process for both *ACLP Bulletin* and the *Journal of Child Life*. Keri is thrilled to be joining ACLP and to have the opportunity to support you as you help children and their families overcome life's most challenging events. She currently lives in Madison, Wisconsin, with her husband and their rescue dog, Meka. Welcome to *ACLP Bulletin*, Keri! We look forward to getting to know you more. ✨



President's Perspective

Kim Stephens, MPA, CCLS

As I begin my term as president of our association, I have been reflecting on the unprecedented times we have all been living and working through in our global community. It is difficult to put into words all that our members have experienced, both personally and professionally. However, I will try my best as we all have collectively witnessed, experienced, and accomplished so much that is significant and worthy of pause and recognition. Early in February and March as the news of COVID-19 began to grow, our members and association were already preparing to be on the forefront of care for patients and families. Forum posts quickly connected people sharing ideas and support. ACLP staff rapidly mobilized to create surveys to learn about the current challenges in our settings and the needs of our members. Grassroots child life support groups developed and grew on social media. Members shared new resources and education tools on our newly created COVID-19 resource page on the ACLP website. ACLP staff opened Zoom lines to create dedicated, safe places for members to connect. April arrived, and as the numbers of patients with COVID-19 grew, so did the restrictions in our workplaces and the impacts on our program staffing. CLCC and ACLP leadership continued to meet regularly to figure out how best to support our students and academic partners and create resources. Free self-care and telehealth webinars were offered by the association and individual members. Members continued to develop new and innovative ways to meet the needs of patients and families, both children and adults. Stories grew of programs and teams that were now serving adult COVID-19 patients and

their families - stretching our reach to new heights. As May and our annual conference approached, it became evident that we were moving into a new normal and connecting virtually with our patients and families, each other, and our association was here to stay. Throughout this all, one thing remained - our shared commitment to advancing psychosocial care and the emotional safety of children, youth, and families impacted by health care and significant life experiences. As we begin to move forward in this new phase and carry our vision forward, we will have to plan for how ACLP and the child life profession will look and operate as we come out of this crisis and enter a changed world. We need to adopt new approaches to delivering care because we know society will not go back to the "way things used to be." There will be a "new normal" in health care, new expectations from our patients and families, and a new outlook in all aspects of society. It is an opportunity for us to serve better, together. The ACLP leadership, staff, and Board of Directors are committed to helping every member support this vision. We are actively engaged in advocating and focusing on changes needed because of learnings from COVID-19. We will be a voice continuing to advocate for access to care and policies that support the needs of children and families everywhere. Together, we will come through this stronger, more courageous, more resolute, more capable, and more unified than ever before. I look forward to building our future with you as we work together to provide compassionate, personalized, and emotionally safe care for all we serve.

With sincere gratitude,
Kim ✨



CEO Shares

Jennifer Lipsey, MA

While many, including myself, are considering the ways in which COVID-19 has and will continue to impact our members' work, the association's programs and priorities, and general public resiliency, I have had a personal experience that has touched me profoundly in the past month.

While shopping at our local grocery store, a young boy (I would guess around six years old) came closer to me to look at granola bars on a lower shelf. I heard his caregiver call out, "come back here, don't get close to her." To which I looked at her, smiled and said, "no worries," assuming she was concerned about the boy respecting social distancing guidelines. The boy returned to the woman stating he wanted to see the different kinds of snacks near me and the woman stated, "you can't go near 'her.'" They're the reason this is all happening in the first place."

Shocked. Paralyzed. Dumbfounded. I looked at her and diplomatically replied, "well, that's not true." To which she responded, "of course it is. You should be ashamed of yourself. Go back to your country." I shrunk into myself, wanting to disappear into the floor. I noticed two other customers behind her, sharing our aisle, staring at us in silence. No one said anything. I turned, pushed my cart to the checkout lane and left without completing my grocery run.

I always imagined I would have some thoughtful, profound response to assert when faced with such aggression. Instead, I am haunted by my silence and paralysis, even more so by the bystanders' reticence. I came home, locked myself in the bathroom away from my daughter's ears and eyes and gave myself permission to feel the full force of pain, humiliation, and anger for 30 minutes. I called my parents who provided

sympathy yet also reminded me of how similar 'this' was to their days during and after the internment camps offering, "... it makes sense when you think about how we did (and do now) 'look' like the enemy." I was struck by how much this justification resonated with me. That of course people are afraid and lashing out at me/us when we share identifying characteristics of "the enemy."

After my half hour in full saturation of emoting and processing, I moved forward. I have shared the experience with colleagues and friends, all of whom have responded with love, support, and their own calls for redemption and justice. I was struck by ACLP COO, Bailey Kasten's, response in particular. Hers was an outpouring of sympathetic words combined with an unexpected gesture of donating to a non-profit directed at fighting racism. In a moment of feeling helpless to resolve my cognitive and emotional dissonance, she acted in a way that empowered her, me, and fought the underlying injustice of the pain.

This pandemic will leave many scars, some that may heal quickly and others that will leave their mark. I am privileged in so many ways – financial security, solid history of physical health etc. – but this pandemic managed to strike me and cause a sickness within that I had not anticipated. Bailey's response was the chicken soup for my soul - warm, comforting, and healing. These, so far, are my pandemic scars - leaving me questioning my confidence and competence in when and how I will respond to the deeper, societal issues that will continue to exist far beyond this coronavirus. What, besides a virus, threatens our ability to live, thrive, and remain hopeful? How can the Association and the child life community work to acknowledge and heal the wounds of our communities? I look forward to finding out as we work together to build resiliency for whatever comes our way. ✨

ACLP's Condemnation of Racism and Discrimination

Jennifer Lipsey

CHIEF EXECUTIVE OFFICER, ACLP

Bailey Kasten

CHIEF OPERATING OFFICER, ACLP

Kim Stephens

ACLP PRESIDENT ON BEHALF OF THE ACLP BOARD

Originally published online on June 2, 2020.

Our hearts are filled with sorrow, anger, and pain as violence and trauma again invade our communities and threaten the lives of our neighbors. The events across the country from this past week have been traumatic and painful for so many people. We have seen evidence of racism and discrimination that continues to cause harm to so many, including our own members and the children and families we serve. ACLP condemns racism and discrimination of all forms.

We join together in grieving and amplify the call for effective and sustainable change within ourselves, our community, and the public at large. We know that racism and discrimination can have long-term impacts on mental health. Racial discrimination is also recognized as a key social determinant of health and a driver of racial/ethnic health inequities. "Racism harms children's health, starting from before they are born," said AAP President Sally Goza, MD, FAAP. "A growing body of research supports this, and we cannot ignore the impact."

As child life professionals, our Child Life Code of Ethics, Principle 3 states that we "are called to ensure that all in our clinical care and with whom we work are not the subject of racism or discrimination." We must uphold this standard by advocating for systemic change in our workplaces and communities to overcome the policies and practices that continue to harm and traumatize our patients, families, colleagues, communities, and selves.

No one ever said being a child life specialist was easy. We will not be taking the easy way out of this either. We will not ignore, we will not look away, we will not quietly go about our business. We will tune in, listen up, and engage one another in thought-provoking discussions that will advance our sense of self, patient care, and purpose. And we will put those words into action.

In addition to adding our voices and advocacy to the larger efforts within our broader communities, let's also look inward to identify the various mechanisms in place within the child life community that preserve a state of homogeneity in race, age range, gender, thought, educational track, sexual orientation, and religion, and a restrictive prescription of how to become a successful child life specialist.

If you have lived experience, content expertise, thoughts, or insights that can further shed light on systemic racism and its impacts on you, your peers, patients, and families, then we need you to be a thought leader, writer, social ambassador, or presenter. If you've ever been marginalized, or identify as a minority, and care to share your experience and how it informs your professional evolution, we want you as a content creator, leader, and catalyst as well.

Social injustices like racism aren't someone else's problem. These are our problems to face, as your ACLP Board, ACLP staff, and ACLP volunteers. They are your problems to face as well. Standing together, we can galvanize our collective pain and experience into lasting change. ✨

ACLP's Commitment to Diversity, Equity, and Inclusion

As a follow up to ACLP's recent statement condemning racism and discrimination, here are more specific ways in which ACLP will uphold its commitment to Diversity, Equity, & Inclusion (DEI), followed by steps you can take.

ACLP'S Action Steps/Opportunities

1. We will actively seek out and engage minority students with the express purpose of increasing minority recruitment into the pathway to the profession.
2. We will expand the scope of standardized reading materials for child life academic preparation to include DEI content and a diverse array of authors, specifically authors of color.
3. We will require the use of these materials as a standard for academic program endorsement.
4. We will require that all academic programs applying for endorsement show proof of their institution's comprehensive antidiscrimination policies.
5. We will provide educational content on DEI for practicum and internship students and encourage all institutions offering child life practicums/internships to utilize this content.
6. We will make the content available free to child life practicum/internship students whose institutions do not teach the material.
7. We will make inclusion of this educational material a requirement for internship accreditation.
8. We will require that all clinical programs applying for internship accreditation show proof of their institution's comprehensive anti-discrimination policies.
9. We will continue to offer diversity scholarships to financially support minority students on their pathway to the profession.
10. We will formally ask the CLCC to include DEI topics in the next job analysis for the purpose of incorporating questions on DEI content on the certification exam.
11. We will ensure that our lineup of webinars and our annual conference include educational opportunities on DEI topics at both the introductory and advanced levels.
12. We will welcome colleagues from other health care professions, as well as members of the public, to engage in these educational opportunities and will ensure that our organization offers a membership category available to health care professionals and public members that includes discounts on educational webinars and conference registration.
13. We will continue to offer affinity groups for our minority members to increase support, growth, and retention in the profession.
14. We will ensure DEI remains an ongoing area of urgent focus throughout our organization by reserving time on the agenda at every board and staff meeting, as well as volunteer committee and task force meetings, for the discussion of DEI efforts and their impact on the groups' goals and work.
15. We will hold ourselves accountable to the commitments we make here in writing by reporting to our members on the progress of these efforts through town hall meetings, annual reports, articles in the ACLP Bulletin, and discussion at our annual meeting.

Personal Action Steps/Opportunities

Personal work:

1. Read. Solid activism requires personal reflection, insight, and awareness. You are responsible for seeking knowledge through insight and reflection. Use this Guide to

[continued on page 8](#)

ACLP's Commitment to Diversity, Equity, and Inclusion

Allyship, an evolving, open-source document, and this reading list to get started. ACLP will be beginning a monthly book club for members, starting in August with *Heavy* by Kiese Laymon.

2. Attend a workshop such as Undoing Racism to deepen self-awareness and insight as a way to continue increasing your racial consciousness.
3. Watch. These posts are small, easily digestible pieces designed to help you understand systemic racism, why blacklivesmatter vs. alllivesmatter, and white privilege.
4. Follow change catalysts on social media to keep up with relevant content and news as it becomes available. Great starting points are @theConsciousKid, @DrRayMD, Michelle Kim, and Child Life on Call: Antiracism and Discrimination Resources for Child Life. The next step is to follow who those change agents are following in order to further expand your worldview and access to change catalysts.
5. Listen. Listen to others and your own (external and internal) voice. What comes up for you when you listen to what others say? What makes you feel defensive, guilty, proud, comfortable, or uncomfortable? Dig in to understand and reflect on the sources of those reactions and how they may be caused by implicit bias and systemic racism.
6. Share. Share openly and be ready to receive feedback, encouragement, questions, or push back. Appreciate feedback and embrace the defensiveness that may arise within as a signal that additional work needs to be done to understand why you reacted in a certain way.
7. Do not expect to check off a list of actions and then consider your work done. Changing years of systemic racism requires internalization of the history, values, principles, and context for its existence. Systemic racism does not go away because individuals donate to causes or like social media posts, although those actions do help. True change requires lifelong learning, patience, compassion, and endurance and all of us working as a collective whole to instigate change.

Supplement your education and self-reflection with actions:

1. Donate to organizations supporting DEI and anti-racism work, such as:
 - NAACP
 - Southern Poverty Law Center
 - United Negro College Fund
 - Black Lives Matter
2. Take an implicit bias test, but understand it is not a perfect tool. Use the knowledge gained to create additional learning opportunities and to change practices and behaviors.
3. Talk with your children about systemic racism and white privilege or start by reading a book with them (www.eyeseeme.com is a great place to look).
4. Advocate. Write to your community, academic, and political decision makers to request what their action steps are for acting on their promise of change.
5. Vote. If you do not feel heard or supported by leaders, use your power to vote to create change.

Action Steps/Opportunities for Academic Faculties

Faculty specific:

1. Ensure curriculum includes DEI both as a specific area of academic focus and as an integral topic throughout all subjects.
2. Ensure reading lists (textbooks, research, and supplemental books) include authors of color.
3. Ensure simulation modules and case studies include actionable steps to address discrimination in health care settings, implicit bias, and prejudice.
4. Ensure curriculum includes reflective practice allowing students to learn ways to identify how their own race, culture, gender, and sexual orientation influence and impact clinical work.
5. Share information regarding child life academic programs with high school career

- counselors with intentional focus on schools with diverse populations.
6. Evaluate the student body composition within your program.

Action Steps/Opportunities for Clinical Sites

Staff specific:

1. Create discussions and professional development opportunities related to DEI:
 - Organize/facilitate monthly/quarterly book reviews and discussion groups with staff.
 - Encourage staff to engage in ACLP Affinity groups as appropriate.
 - Provide access to ACLP educational webinars on DEI topics.
2. Create an annual staff competency that focuses on DEI-related self-reflective practices. (Program leaders should actively and intentionally engage in ongoing discussions with staff on DEI focus.)
3. Ensure all department policies are aligned with DEI values.
4. Ensure recruiting and hiring practices are fair and equitable to all.
5. Intentionally and actively recruit minority candidates for practicums, internships, and employment opportunities.
6. Ensure a robust array of resources and play materials that represent children and youth of all races, cultures, orientations, and abilities.

7. Actively seek and engage in opportunities for staff to present information on the child life profession at community and school career fairs in minority neighborhoods and at schools with significant minority populations. Anchor these recruiting efforts with individual follow up and mentorship for minority students as they begin their pathway to the profession.

Clinical training program specific:

1. Advertise your desire to recruit minority candidates for practicums and internships on your website and other PR materials.
2. Require virtual interviews be offered as an option for practicum and internship candidates. Ensure that virtual interviews are weighted equally with in-person interviews when selecting candidates. Consider eliminating in-person interviews all together.
3. When presented with qualified candidates in excess of your available slots, prioritize selection of minority students.
4. Remove student fees for practicum and internship applications and placements. Use unofficial transcripts only during the application process. If your institution requires official transcripts, request them from students only after they have been offered, and have accepted, a student placement with your institution.
5. Create a scholarship fund to provide financial assistance to minority students during internship. ✨

Highlights from the 2020 Child Life Virtual Conference

Virtual Networking

Attendees had the opportunity to connect virtually for trivia, networking sessions, yoga, zumba, and more!

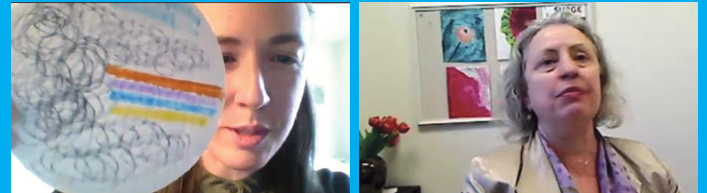


#selfreflection
#advocate
#ChildlifeBetterTogether
#childlife2020

LIVE SESSION:

Clinical Supervision Panel

The Clinical Supervision panelists provided a clear example of the importance of clinical supervision and the role of the facilitator. This session touched attendees on a personal level as many shared their reactions on the live chat.



"Seeing the feelings come out in Hilary and Diane is so impactful..."

"Beyond words...thank you for showing how powerful a virtual session can be."

LIVE SESSION:

From Cultural Competence to Cultural Consciousness

The panelists on From Cultural Competence to Cultural Consciousness: Demystifying Diversity Training in Child Life Services called for the diversification of the child life profession and modern, inclusive theories of child development.



What Attendees are Saying

"Awesome! Powerful! Informative! Accessible!"

"An enlightening presentation. I will go forward with this information."

"This was the most powerful keynote I have ever seen!"

"I want to commit to being proactive in intervening with the status quo within my work setting."

"This has been such a meaningful and empowering presentation!"

"We have so much work to do and I'm so glad ACLP is actively pursuing this topic."

2020 Child Life Virtual Conference Exhibitors

ACLP and the child life community appreciate the ongoing support of the exhibitors who have chosen to be part of our inaugural Child Life Virtual Conference. Learn more about their products, services, and educational opportunities relevant to child life by visiting each exhibitor's webpage.



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V is for Venipuncture:

Child Life Empowering Parents to be Partners at the Bedside

Lucy Raab, MA, CCLS
CHILDREN'S MERCY KANSAS CITY

“The family is the most critical part of a patient’s caregiving team.” — Michael Fisher, President and CEO, Cincinnati Children’s Hospital Medical Center and chair of Solutions for Patient Safety.

Child life specialists have a unique skill set that is inevitably intertwined with patient safety work. We are uniquely equipped to provide children and families with developmentally appropriate information, education, and resources to empower the patient and family to participate in health care, all of which are key elements to safe patient care. Reducing harm, both physically and emotionally, is critical to any work we do with patients and families.

Before proceeding with describing how child life at Children’s Mercy was able to impact patient safety work, I want to share a few terms and definitions that are helpful to clearly understand this work (see figure A).

In our daily work, child life specialists encounter numerous opportunities to observe and report potential threats to patient safety. One of the most common unintentional adverse events in hospitalized children is a PIVIE (Sangam, 2019). If left unaddressed, this can result in a serious safety event. As child life specialists,



by being aware and vigilant, we can assist in preventing this common problem from developing into a serious safety event.

continued on page 16

Figure A

TERM	ABBREVIATION	DEFINITION
Solutions for Patient Safety	SPS	Collaborative of children’s hospitals in both the United States and Canada working together to eliminate patient and employee/staff harm across all children’s hospitals.
Hospital Acquired Condition	HAC	An event that causes harm that could occur while a child is inpatient.
Peripheral Intravenous Line Infiltrate Extravasation	PIVIE	An intravenous line infiltrates when the IV comes out of the vein and fluid or medication leaks into the surrounding tissue.
Serious Safety Event	SSE	A deviation from generally accepted practices or process that reaches the patient and causes severe harm or death.

V is for Venipuncture: Child Life Empowering Parents to be Partners at the Bedside

Background

SPS launched in 2012 and identified PIVIEs as one of the HACs that occurs frequently. Children's Mercy, Kansas City, began partnering with SPS to explore how and when pediatric intravenous lines were infiltrating. Upon initiation of this work, Children's Mercy formed an interdisciplinary PIVIE HAC team, recognizing that a multidisciplinary approach would strengthen intended outcomes of reducing PIVIEs. A child life specialist was invited to participate to provide expertise in developmentally appropriate medical education and patient and family-centered care tenets.

Although child life specialists often participate in multidisciplinary groups, participating in a HAC team is a new concept for many. In May 2017, I began this work excited to take on a new adventure. The PIVIE HAC team that I joined consisted of a physician, a nurse on the vascular access team, a quality improvement coordinator, nurse educators, bedside nursing staff from medical surgical units as well as pediatric and neonatal intensive care, members of the wound care team, and a parent who also participates on the hospital-wide family advisory board.

The PIVIE HAC team partnered with SPS to design and implement the improvement work. In accordance with SPS guidelines, all improvement work related to the HAC must be sustainable within the organization. Therefore, although the goals are the same nationally, implementation to reach the goals is tailored to each individual institution (Williams, 2010).

In December 2018, the HAC team was charged with designing and implementing a family engagement project. The goal of this project was, and continues to be, to provide all families with education related to IV practices and signs and symptoms of infiltrates. Families receive this education upon admission and/or upon intravenous line (IV) insertion. The HAC team asked child life to lead this initiative, and I readily accepted this opportunity.

The first step in the PIVIE HAC family engagement project was to identify a "pilot unit," a patient care area to trial the project. In order to choose the pilot unit, the PIVIE HAC team evaluated two things: 1) infiltrate data collected from safety event reports related to intravenous infiltrates, and 2) which medical/surgical unit most frequently used the highest risk IV infiltrate medications. Based on this data, a 26-bed general medical/surgical unit that specialized in infectious disease was chosen as our pilot area.

As with any quality improvement project, it was imperative that key stakeholders were committed to and understood the value of the project. I collaborated with nursing leaders on the pilot unit to invite bedside nurses to participate. Together, we identified what needed to be completed prior to going live with the PIVIE HAC family engagement project: 1) creation of a family education document for teaching purposes, including translation of that document (see figure B), 2) identification of and education for all unit nurses regarding how to incorporate this task into nursing workflow, and 3) a survey to assess parent knowledge of intravenous lines both pre and post institution of the education program.

Data Collection

Before beginning the formal family education project, we wanted to gain baseline data. We created a brief survey to give to parents/caregivers after their child had an IV placed:

1. When your child's IV was placed, did you receive education regarding your child's IV? (signs of infection, swelling, pain, etc).
2. Have you looked at your child's IV for signs of swelling or infection throughout this admission?
3. Have you raised any questions or concerns to your child's nurse about their IV?
4. Please share with us anything that you want us to know about your child's IV and the education we gave you.

We collected this data for six weeks from approximately 15 caregivers. The results demonstrated that parents received very little or no education regarding their child's IV placement unless the parent specifically asked questions prior to or during the procedure. Parents were eager to be involved in their child's care and were often assessing their child's IV site on their own.

This baseline data led us to conclude that, indeed, a family education program was needed. Child life created a PIVIE Family Education Tool based on already-established SPS product, and nursing staff on the unit began using this tool with families. The PIVIE Family Education Tool was also often hung in the patient's room on the communication board as a reminder for families to watch for signs and symptoms of infiltrates. Data was collected during this phase, using the same brief survey that was given to families prior to the institution of the family education tool. Preliminary results showed trends that families were receiving the education and appreciative of the education. Feedback from

both families and nurses was positive and the project seemed to be going well.

This QI project did not come to a formal close. During data collection post initiation of the family education tool, hospital leadership identified that this initiative was extremely important and should happen immediately. QI project data collection was then halted, and a new standard of care was put into place hospital wide related to providing all families with PIVIE education.

Conclusion

At the time of this writing, the PIVIE HAC team is working

with all inpatient units, ambulatory areas, and the Emergency Departments to provide PIVIE HAC education to parents upon IV insertion with the goal of empowering families to speak up if they notice any signs or symptoms of IV infiltrate. The role of the child life specialist in this work continues to be invaluable. As a child life specialist, I continue to use my unique background and lens to help others on the team understand and consider potential family stressors, goals and needs. This project has been a conduit for exposing and educating others on the potential benefit of having a child life specialist as part of any multidisciplinary team focused on system-wide change and improvement, including patient safety initiatives. ✨

Figure B

Peripheral Intravenous Line (PIV) Safety

Many pediatric patients need a Peripheral Intravenous Line (PIV) in their veins to give medications and fluids. Children have smaller, and at times more fragile, veins than adults. The PIV may come out of the vein and fluid or medication could move into the nearby tissue. This can cause harm to the area where the PIV was placed. It is very important we notice if the PIV has moved as quickly as possible.

What does the care team do?

- Touches the PIV (even while patient sleeps)
- Looks at the PIV site
- Compares the PIV site to the other extremity
- Documents PIV assessment information

What can you do as a family?

- Partner with the nurse to keep an eye on the PIV site
- Share your understanding of care education
- Call the nurse if you have concerns about a PIV
- Help us plan checks to keep the PIV safe from harm

PS8310-058 (03/20)

TLC | For IV Safety: Touch, Look and Compare

Touch
IV site should feel:

- Soft
- Warm
- Dry
- Pain free

Look
IV site should be:

- Visible
- Dry
- Without redness

Compare
IV site should be:

- Same size as other side
- Without swelling

IV checks must happen even when asleep. Call your nurse if you notice anything different or if you have questions or concerns.

Children's Mercy

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Pause...the Impact of COVID-19

Carissa Howard, MS, CCLS

ASSISTANT PROFESSOR, M.S. IN CHILD LIFE PROGRAM AT AZUSA PACIFIC UNIVERSITY

Imagine being almost halfway through the most important training of your life thus far and having to press “pause.” Imagine being stuck in that state of pause, having no idea when things might return to “normal,” having to return home knowing that this current pause will add many more months of unexpected training at some point in the future. This is where our current students and interns are at. They have unexpectedly been told to pause their classes, plans, practicums, internships, anticipated certification exams, and dream careers. All this comes as a result of COVID-19 and our nation’s attempt to flatten the curve by staying home.

As a Certified Child Life Specialist (CCLS) providing direct internship supervision, my heart aches for my current interns. My interns had just reached the half-way point in their internship and were covering our pediatric unit independently. They were excelling as soon-to-be specialists and greeted each day with excitement and anticipation of

what new opportunities or experiences might be in store. My interns looked forward to taking the certification exam this summer and looking for their first “real jobs” as Certified Child Life Specialists. However, as a result of COVID-19, they have had to return home and are now doing virtual hours completing modules and various case studies. This is not at all what they had planned.

Like my interns, child life students across the nation have been forced to press pause on their anticipated trajectory. Whether they were a student in practicum or internship, they are all in the same boat now, no longer moving forward or finishing when they expected. They are stuck in a state of limbo between being a student and becoming a professional. So, what do we as professionals do to help and support our students as we wait for the world to return to normal? How do we help our own families and friends, our colleagues and our communities as we wait?

Many of us are familiar with the saying “look for the helpers.” It originated from the mother of Mr. Fred Rogers. When he was a child and would see bad things in the world around him, his mother would encourage him to look for the helpers, look for the people who were making a difference and helping others instead of focusing on the bad thing that happened. When we think of “helpers” during this time of uncertainty, we often focus on the health care heroes, first responders, the grocery store workers, or the delivery drivers. But what would happen if we each found our own ways to become helpers in our community?

Mother Theresa is famous for saying “do small things with great love.” What small things can we do to show love and support to the people and communities around us? We all have words of encouragement we can offer others, from chalk on the sidewalk or hospital grounds, to a letter in the mail or a quick message of hope or laughter via social media. If you know how to sew, join in making simple cloth face masks for your family, your neighbors, or a local hospital. If baking helps relieve stress for you, drop off treats on someone’s porch to let them know they are not alone. Call your local food bank or childcare center to see if they need help.

The reality of this whole situation, having to stay home and press pause on things, is that some of us now have extra time on our hands. This new found free time is a great opportunity for us to practice self-care or take up a new hobby, to learn a new skill or increase our knowledge of a specific population. Self-care might mean taking time to journal, read a new book, enjoy a nap, watch a new series, engage in exercise, spend time outside enjoying the sunshine, call your far away friends and family or come up with creative ways to connect with and support your friends and classmates, begin mentoring a student, or create new and innovative ways to help kids and their families with hospitalization. The sky is the limit!

The best thing we can all do is to continue to support and encourage one another. Take advantage of this pause and find small ways to encourage your coworkers, the students and interns in your life, your family, friends, and anyone else you might find in your circle of influence. Let them know that their feelings matter, that they are valued, and that they will get through this. Be available. Listen. Encourage. Support. Advocate. ✨

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*... Families and NICU nurses have been impressed and now consistently request them...
It makes my job easier knowing that I have a mobile made for these beds... the mobiles are super easy to clean and store and I love the ability to be able to record.”*

Vanessa A. Ya Lopez
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Erin Munn

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Janet Cross, M.Ed., CCLS, CPXP

ADMINISTRATIVE DIRECTOR, PATIENT AND FAMILY-CENTERED CARE, MONROE CARELL JR. CHILDREN'S HOSPITAL AT VANDERBILT



It is hard to imagine a more highly qualified candidate for the extraordinary recognition of the Mary Barkey Clinical Excellence Award than Erin Munn. Erin's child life colleagues describe her as smart, wise, and dedicated. These traits translate into a child life professional who consistently

practices with clinical excellence. Erin's commitment to leadership, research, and training of emerging child life professionals is clear in her accomplishments.

Erin has practiced child life for nearly 30 years, beginning her career in 1995 at Johns Hopkins Children's Center in Baltimore, Maryland. Early in her career, she demonstrated high levels of practice as she was one of two applicants selected to fill a newly created role within child life in 2003. This role paired clinical responsibility with the responsibility of providing mentorship to staff to build confidence and expertise in practice. Also, in 2003, Erin moved into the chair position for the Child Life Certification Committee, contributing to the early development of the child life specialist credential. Through her tenure at Hopkins, she continued to practice in clinical areas as well as manage the department's education and training programs. In 2006, Erin was elected President of the then-Child Life Council and led the organization through its 25th anniversary.

Erin moved to Nashville in 2011 to join the child life team at Monroe Carell Jr. Children's Hospital at Vanderbilt. Erin began at Monroe Carell as one of the cardiology child life specialists, covering

very robust cardiology and cardiac surgery services. Her work with this team helped define her as a child life clinical expert and ultimately was the foundation to support her advancement to the highest clinical expert ladder level at the hospital, Child Life Specialist 3. In September of 2018, Erin was selected as the child life specialist to join Team Hope. This is a collaborative program across the medical center changing the way health care teams care for newborns diagnosed with drug withdrawal symptoms at birth, also known as neonatal abstinence syndrome (NAS). The interdisciplinary team consists of health care specialists from the newborn nursery, neonatal intensive care unit, and an acute care unit, along with child life, social work and lactation consultants. Erin works with the lactation consultant to facilitate a weekly support group with expectant mothers who have used opioids during pregnancy, to prepare for the delivery and bonding experience when their baby arrives. Erin's expertise in infant development serves her well in this role as she coaches expectant moms in ways they can read their infant's cues and respond appropriately. The outcome is that new moms are prepared to bond with their child during the withdrawal process and beyond. Additionally, Erin participated in a round table with the U.S. Assistant Secretary for Health Administration and the First Lady of the United States of America, discussing strategy, value, and success in working with children and families with a NAS diagnosis.



Participation in Round Table with U.S. Assistant Secretary for Health Administration and the First Lady of the United States discussing strategies for working with children with NAS.

Erin's multiple publications demonstrate her expertise in developing child life intervention and practice with unique populations and in understanding the professional well-being of child life specialists. Most recently, she was a co-author on the published white paper by the Association of Child Life Professionals (ACLP), "A Value Proposition for Certified Child Life Specialists."

Erin's dedication to the child life profession is never more apparent than in her commitment to the education and training of future child life professionals and to ACLP. A true clinical expert, Erin's role as the Child Life Training Coordinator at Johns Hopkins and then as an intern supervisor at Monroe Carell has provided her a plethora of opportunities for education and training for child life students. Child life interns under Erin's supervision consistently share feedback about her ability to help them use developmental theory and evidence to guide their work and challenge them, so they truly build a skill base during their internship. Erin has successfully participated in the ACLP Mentor program, supporting career development and growth with her mentee. She also co-chaired the ACLP Internship Task Force, which authored the ACLP Internship Supervisor Manual, building the foundation for the continued growth and standardization of child life clinical training programs. Her participation in the ACLP Internship Accreditation Oversight Committee was yet another example of her dedication to student training. Other committee participation includes Research, Conference Planning, and Awards. She was a co-author for the first "Clinical Supervision Position Statement for the Child Life Council" in 2008.

Erin never stops learning and seeking information—a true characteristic of a clinical expert. She recently attended a two-week Canine Companions Inc. training workshop as the secondary handler to our hospital's new facility dog. She and the primary handler of the dog continue to practice simulated events and experiences as the dog acclimates to the hospital and working with children and families.

When I spoke with Erin and asked why she continues as a child life specialist she replied, "I fell in love with child life when I started volunteering with the Child Life Department at Arkansas Children's Hospital in 1990. I found my vocation and like many of us, I think, it felt like a calling." She also shared this quote from the book "Wishful Thinking: A Theological ABC" that resonated with her passion for child life: "The place where God calls you to is the place where your deep gladness and the world's deep hunger coincide." Her favorite part of child life is that sense of being fully present and immersed in a child's play world and the connection with others—building relationships with children and their families in the playful moments and the vulnerable ones, serving as a temporary companion along their journey and bearing witness to their courage, joys, sorrow, and resilience.

While her role as a child life specialist certainly defines a



2016 ACLP Conference

large part of Erin Munn, she also is active in learning and experiencing new things. She is an avid traveler, loves to try culinary delights of all kinds, and is an enthusiastic gardener, seamstress, and knitter. Erin identified two of her proudest moments as when she touched the Stanley Cup in 1992 (she is a huge hockey fan) as well as being crowned the Inaugural Lip Sync Battle winner in our Seacrest Studio.

Congratulations, Erin, on this very well-deserved award! Thank you for all of the great things you have contributed to the child life profession and ultimately to the care of patients and families. ✨



THE LANDSCAPE OF CHILD LIFE IN CANADA: Big Country — Diverse Programs

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Allison Sohanlal, MSc, CCLS

MCMASTER UNIVERSITY, HAMILTON, ON

Canada has had a unique and foundational role in the establishment of the profession of child life, seeing growth and evolution of programs over the past 35 years and providing services to a widely dispersed population across the provinces and territories. Early child life programs were established in tertiary care hospitals located in large urban centres, each serving a large catchment area that encompassed rural and remote northern communities. Today, child life programs also thrive in suburban and rural areas, serving a diverse population that reflects the multicultural fabric of our society. Hospital play programs in Canada and the

United States were developed through close collaborations among early pioneers from various child development and education backgrounds, which later led to the establishment of the Child Life Council (Turner & Brown, 2014). Remarkable characteristics of Canada, including the vast geography, diverse population, and unique commitment to multiculturalism and universal health care have had a significant impact on the delivery of child life services across the country.

What is the Population of Canada?

Population growth was high during the later half of the 20th century due to the baby boom (1946-1965) and strong migration into Canada. By 1959, the population of Canada reached 17.5 million. According to *Canadian Demographics at a Glance*, Canada experienced a larger baby boom than other G8 countries, resulting in a younger population (Statistics Canada Demography Division, 2016). Further comparison to G8 countries shows that between 2005 and 2010, Canada showed the strongest annual average population growth rate, about 1.1%, due to greater rates of immigration. The Canadian population of 37.5 million (World Population Review, 2019) is close to that of the state of California and includes eight million children and youth

(UNICEF Canada, 2019). Presently, immigration contributes significantly to the population growth and is attributed, in part, to inclusive Canadian perspectives such as multiculturalism, immigration, and refugee resettlement policies.

Where Do People Live In Canada?

Canada extends over 9.9 million square kilometers and is geographically the second-largest country in the world. Canada extends from the Arctic Ocean in the north to its border with the United States in the south, and from the Pacific Ocean in the west to the Atlantic Ocean in the east. Canada is made up of ten provinces and three territories; however, most Canadians live in a narrow belt near the southern border, leaving large sparsely inhabited regions in the north. According to World Population Review (2019), the overall population density of four people per square kilometer is contrasted with much higher density in urban centres. The city of Toronto, for example, has 2,930 people per square kilometer. In fact, more than half the population live in the multiple urban centres located in the provinces of Ontario and Quebec.

What Does Multiculturalism Mean in Canada?

Multiculturalism is an important component of Canada's landscape. In 1982, the Canadian Constitution adopted a "Charter of Rights and Freedoms" to protect multiculturalism (Canadian Immigrant, 2013). Diversity is part of our country's identity. While English and French are the official languages in Canada (Office of the Commissioner of Official Languages, 2019), there is significant diversity in cultures, ethnic groups, and languages among its residents. This is not just a result of refugee resettlement or immigration, but due to Canadians' belief in "the importance of preserving and enhancing the multicultural heritage of Canadians" (Government of Canada, 2014).

Canada is known for its refugee and humanitarian resettlement programs, particularly for Syrian refugees over the last few years. In addition, refugees from Nigeria, Haiti, India, and Mexico rank highest for their resettlement in Canada (Immigration and Refugee Board of Canada, 2019). Additionally, there are more than 1.4 million people in Canada who identify as indigenous persons and more than 600 First Nations communities that are represented by more than 60 indigenous languages (Government of Canada, 2018). Therefore, providing respectful services and supports tailored to the cultural needs of children, youth, and families is an important element of child life services.

How is Health Care Delivered Within Canada?

Given the distribution of the population, it comes as no surprise that tertiary health care centres are primarily located

in areas with the highest concentration of people. Thirteen large urban centres are home to children's hospitals. Access to health care is publicly funded, universal to all Canadian residents, and portable when travelling within Canada for medically necessary hospital and physician services (Government of Canada, 2016). Canadians receive medical care without paying out of pocket; however, the vast size of our country can lead to times when travel is needed in order to obtain specialized health care services. Acknowledgement of the additional stress on those children, youth, and families traveling or relocating to large urban centres for health care is reflected in the services provided by child life programs across the country.

“Pioneers in the Canadian Child Life field have been involved since the beginning Canadians made up 50% of the first Child Life Council Board of Directors and were integral in the development of academic and clinical training standards.”

— LeBlanc, 2018, para. 2

What Does Child Life Look Like Across Canada?

The Association of Child Life Professionals' Archives in Utica, NY, documents the early play and education programs in North America and notes the establishment of Montreal Children's Hospital in Quebec in 1936. More than 40 years later, the Canadian Pediatric Society "Child in Hospital" resolution advocated for organized play facilities, child life professionals to meet the psychosocial needs of hospitalized children, and open visiting policies and rooming-in facilities in pediatric units for Canadians (C. Humphreys, personal communication, January 14, 2020). Confirmation of this early commitment can be found in Larsen (1978): the Canadian Institute of Child Health reported that of the 180 general hospitals caring for pediatric patients in 10 provinces, 93% had play spaces and 37% of the play spaces had salaried staff (1977, cited in Larsen, 1978); and Post reported there were nine Canadian pediatric hospitals in 1978, all with dedicated play spaces and salaried staff (1978, cited in Larsen, 1978). Subsequently, child life programs at children's hospitals across Canada have been established to provide services to vast catchment areas including northern commu-

[continued on page 24](#)

The Landscape of Child Life in Canada: Big Country — Diverse Programs

nities. Today, Certified Child Life Specialists, non-certified child life specialists, and child life assistants can be found across the country.

Children's hospitals which are also teaching hospitals have the largest child life programs in Canada compared to the programs located in regional or general hospitals across the country. Currently, there are 13 dedicated children's hospitals in Canada providing specialized tertiary care for the pediatric population. Several provinces have one children's hospital serving the entire province and beyond (e.g., British Columbia, Saskatchewan, Manitoba, each with additional catchment areas that include service to northern communities such as the Yukon Territories, Northwest Territories, and Nunavut). However, the greatest growth in hospital-based child life programs is in smaller-community regional and general hospitals where children and youth receive primary and/or acute care closer to their homes. Approximately 77% of known Canadian hospital-based child life programs have one to three child life specialists on staff, with an average of 10 to 15 Certified Child Life Specialists in the larger programs, with some supported by child life assistants. The largest program is located at McMaster Children's Hospital, with a complement of 30 plus Certified Child Life Specialists.

Figure 1 presents the number of Certified Child Life Specialists across Canada (Association of Child Life Professionals, personal communication, September 16, 2019).

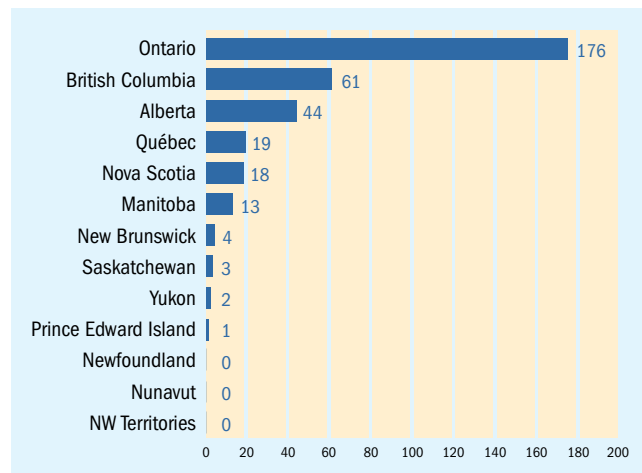


Figure 1
Number of Certified Child Life Specialists by Province/Territory

Education and training opportunities for child life specialists in Canada have adapted to the changing scope of practice

and the increasing opportunities outside of tertiary health centres. Originally offering a post-baccalaureate child life diploma starting in 1989, McMaster University now prepares graduates with a Master of Science in Child Life and Pediatric Psychosocial Care. Two streams of study are offered: preparation for child life certification and advanced practice in psychosocial care for Certified Child Life Specialists, nurses, physicians, psychotherapists, and others. Recently, the University of the Fraser Valley in British Columbia established a Child Life and Community Health graduate certificate program.

Canadian child life specialists provide child life services in a range of program settings beyond the hospital. For example, community organizations with specific child life programming include Ronald McDonald Houses, Gilda's Club, Kids' Cancer Care, Calgary & Area Child Advocacy Centre, Nanny Angel Network, Rotary Flames House, St. Joseph's Hospices, Kids Health Links Foundation's Upopolis Program, and Camp Brigadoon. Several Certified Child Life Specialists work in private practice. Many others work in the community or academia, applying their child life skills though they may not hold the job title of a child life specialist (e.g., behaviour specialists, grief and palliative care counsellors, infant mental health specialists).

“There is really great work happening in community hospitals. We have to share our best practices with others.”

— Peggy Wheaton

Access to Child Life Services for Smaller Communities

Three child life leaders across Canada, working in different health care settings, were interviewed to discuss the current focus of child life work in their communities. Each spoke to the provision of appropriate services and supports tailored for children, youth, and families, and acknowledged their needs in accessing health care in their communities.

Working in one of the most culturally diverse communities in Canada, Alex Christofides, MSc, CCLS, spoke to the need to adapt to population changes, given the increasing number of newcomers to Canada and refugees settling in the Toronto area (A. Christofides, personal communication, September 6, 2019). As a result of this influx, the hospital requires yearly staff training related to cultural diversity

and inclusion. The introduction of technology at Humber Regional Centre in Toronto, Ontario offers opportunities to accommodate diversity in innovative ways. The “interpreter on wheels” provides the flexibility of bringing a tablet attached to a rolling pole to the patient/family and utilizing a live interpreter via an online interpretive service. Similarly, Pepper, the hospital’s humanoid robot, has a tablet that a child life specialist can use for preparation and teaching; Pepper has also been found to be effective in supporting patients with autism spectrum disorder during procedures and as they go into the operating room. According to Alex, the outcome of integrating technology into practice “is spectacular.” The child life specialists at Humber Regional Centre use Pepper to facilitate modelling what the child needs to do, and children want to copy what the robot does.

Child life was integral in the development of the Pediatric Observation and Assessment Unit program in Moncton, New Brunswick, a unique initiative designed to improve the care provided to patients with behavioural and mental health challenges. Peggy Wheaton, BCS, B.Ed, CCLS, spoke of bringing the perspective of typical child development, the importance of play, and the need for expressive outlets, as well as individualized patient-and family-centred plans of care, to the pediatric and psychosocial team at Moncton Hospital Regional Centre (P. Wheaton, personal communication, September 9, 2019). Peggy emphasized, “Our voice and tenacity can affect change over time... [and] it is our professional responsibility to advocate and inform at a higher level [to executive leaders and administrators]. This type of advocacy is as critical as providing direct psychosocial care.” Child life expertise was acknowledged as an integral part in helping the team to appreciate the developmental and psychosocial aspects in addition to the behavioural and/or mental health challenges for patients and families. Child life had an important part to play in the successful development and implementation of this unit by engaging across disciplines, programs, and services. The unit allows children, youth, and families with complex behavioural, psychosocial, and/or mental health concerns that did not meet the threshold for a mental health admission to be assessed and supported through direct psychosocial care in their community.

Winter Ghostkeeper, BA, CCLS, was surprised at how easy it was to collaborate with colleagues at Alberta Children’s Hospital to build programs for families focused on bridging the gaps in psychosocial support in the community (W. Ghostkeeper, personal communication, September 10, 2019). Kid’s Cancer Care in Calgary provides unique programming



Photo by Lois Wolgemuth

Pepper, a humanoid robot used for preparation and support

to meet the psychosocial needs of pediatric cancer patients and their families. Child Life at Home allows a child or youth to be referred for coping support and receive up to six one-on-one sessions in their preferred location (in their home or at the Kids’ Cancer Care office). Cancer in the Classroom provides support for the transition back to the classroom by meeting with teachers and/or sharing information with classmates in a developmentally appropriate manner. The Kid’s Cancer Care child life specialist also helps families whose child is immunosuppressed connect with and utilize community-based services. This community child life program has identified gaps that families experience when they are primarily receiving services in clinics, in their own home, or when separated from community school due to immunosuppression. More importantly, child life provides respectful services and supports tailored to address the unique needs of children, youth, and families in smaller communities to

[continued on page 26](#)

The Landscape of Child Life in Canada: Big Country — Diverse Programs

enhance the child life services they receive when at their larger children's health centre for tertiary care.

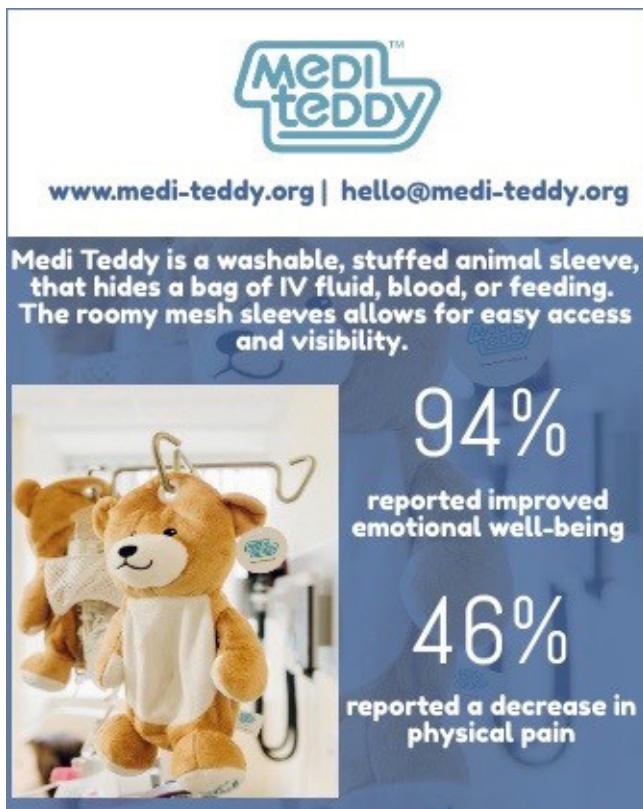
Big Country – Diverse Programs

Child life in Canada reflects the Canadian landscape. The small yet diverse population across the country requires child life leaders to identify ways to support children, youth, and families who are newcomers to Canada and those who may be receiving specialized care a great distance from their home communities. Smaller-sized Canadian child life

programs, as the interviewees suggest, are equally as innovative, passionate, and involved in shaping the psychosocial care services as their larger counterparts. The child life profession strives to mirror the diversity of its population in order to meet the psychosocial needs of all the children, youth, and families in their communities. As the Canadian child life professional community continues to expand, the commitment to the delivery of pediatric psychosocial care is represented by more and more voices speaking from all corners of the country. ✨

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The image is a promotional graphic for Medi Teddy. At the top, the Medi Teddy logo is displayed in a blue, rounded font. Below the logo, the website www.medi-teddy.org and email hello@medi-teddy.org are listed. The main text describes the product as a washable, stuffed animal sleeve that hides a bag of IV fluid, blood, or feeding, with roomy mesh sleeves for easy access and visibility. A photograph shows a brown teddy bear wearing the white mesh sleeve. To the right of the photo, two statistics are presented: 94% reported improved emotional well-being and 46% reported a decrease in physical pain.

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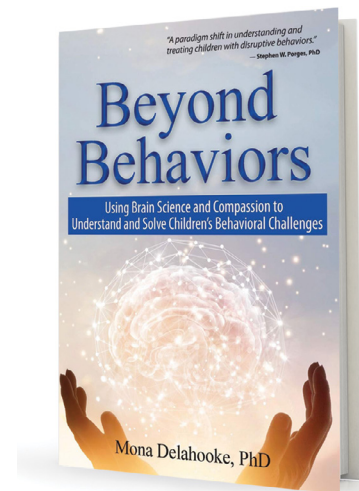
BOOK REVIEW

Katy Tenhulzen, MS, CCLS

CENTRAL WASHINGTON UNIVERSITY, ELLENSBURG, WA

Beyond Behaviors: Using Brain Science and Compassion to Understand and Solve Children's Behavioral Challenges

By Mona Delahooke, PhD



Understanding brain science is becoming fundamental to practice in many professions that promote social and emotional development, attachment, psychological health, and help clients process stress and trauma—all important goals of child life programming. For child life specialists who are new to the idea of incorporating neuroscience into practice, Mona Delahooke, PhD, explains how to apply these concepts to therapeutic support in an accessible and straightforward manner. Delahooke is a clinical psychologist with more than 30 years of experience with children and families. The author specializes in infant and toddler mental health and serves as a senior faculty member with the Profectum Foundation, which supports neurodiverse youth and adults. Although the author does not directly reference the behavioral needs of hospitalized children in this book, much of the content can be easily translated into child life practice. Delahooke integrates Stephen Porges' Polyvagal Theory (Porges, 2011) throughout, offering a brain-based perspective related to behavioral assessment, rapport-building, clinical intervention, and coping.

The science described in this book provides child life specialists with empirical evidence that could be used to emphasize the importance and effectiveness of child life interventions. Porges' concept of neuroception describes the neurological process which influences a person's perception of safety within environments and relationships, triggering a physiological response from our autonomic nervous system on one of three pathways: social engagement/connection, fight/flight, or shut down. This ongoing subconscious assessment of threat and safety results in adaptive behaviors – some of which are perceived as negative and prompt referrals to professionals such as child life specialists. In the hospital setting, there are many reasons children may not feel safe, which often leads to noncompliance, withdrawal, and other challenging behaviors. Delahooke highlights many other factors that may magnify children's behav-

ioral responses to stressful situations. Sensory processing, implicit memory, neurodiversity, trauma, and physical and psychological factors may impact children's threat detection system. This is useful for child life specialists when conducting assessments and providing behavioral support. Rather than simply focusing on compliance or extinguishing negative behaviors, assessing the adaptive function of behavior allows us to increase connection and co-regulation with children while providing cues of environmental and relational safety. Delahooke offers various strategies for each of these goals, which readers may find immediately useful in child life practice. When children are in an autonomic state of safety and connection, they are better able to access the thinking part of their brain that allows them to take in new information (such as diagnosis teaching) and to learn and practice coping techniques. Thus, the knowledge and skills gained in this book may lead to more effective child life teaching and coping support.

Beyond Behaviors includes handouts and worksheets that allow the reader to apply these brain-based approaches within their own practice. Some of the most applicable handouts for child life specialists include assessment checklists, scripts to teach children about what happens in their brain when they are stressed, and worksheets to help children identify and cope with big feelings. Also included are worksheets designed for professionals to assess their own reactions and ability to cope with stress. This self-reflection increases our ability to attune to children's emotional states in order to be empathic, build rapport, help children calm down and cope, and to plan appropriate support. Child life specialists are skilled at projecting external calm in the face of chaos and stress in the hospital setting. However, our own internal, autonomic reactions to stress and trauma influence our effectiveness and our ability to connect with children. Delahooke offers suggestions related to therapeutic use of self, mindfulness, and specific ways we can help children feel safer on a primal, neurological level.



To integrate all these ideas into practice, readers will learn from a variety of case studies which highlight children and families with diverse needs and backgrounds. Each case describes a unique challenge, ties brain science into the assessment, and explains why the interventions were effective. While these examples do help readers understand the application of neuroscience in supporting children and families, most of the case examples are in school or therapy settings. Although some cases discuss helping children who have previously experienced trauma, there is limited discussion in this resource regarding support for children who are presently coping with toxic stress and pain, such as hospitalized children. For child life specialists, it would be useful to have more information about how Polyvagal Theory can influence

support for children during acute trauma.

Although this resource does not address the unique stressors of hospitalized children, the case study examples and worksheets woven throughout the chapters will allow readers to practice applying the concepts that Delahooke has expertly and accessibly discussed. The appendix includes a resource list for readers who wish to dive further into topics such as Brain and Social Development, Mindfulness and Self-Compassion, Parent-Mediated Interventions, Polyvagal Theory, and Trauma-Informed Care. *Beyond Behaviors* is a great place to start for child life professionals, from students to advanced practitioners, who are interested in learning some basics about brain science and integrating it into their support of children and families. ✨

REFERENCE:

Porges, S. W. (2011). *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation*. W.W. Norton.

ARTICLE REVIEW:

Siblings' Lived Experiences of Having a Brother or Sister with Home Mechanical Ventilation

Brittany Wittenberg, PhD, CCLS, CFLE

LOUISIANA STATE UNIVERSITY, BATON ROUGE, LA

Megan Cassani, MA, CCLS, RWWP, CIMI

RANKEN JORDAN PEDIATRIC BRIDGE HOSPITAL, MARYLAND HEIGHTS, MO

Recently, the ACLP Scientific Advancement of Professional Practice Committee (SAPCC) began a journal club to critically review empirical research articles relevant to the child life profession and apply the article findings to the clinical practice of child life specialists. This column will consist of two sections: The first section will include research considerations for the article, and the second section will consist of implications for child life practice. The article reviewed was “Siblings’ Lived Experiences of Having a Brother or Sister with Home Mechanical Ventilation: A Phenomenological Hermeneutical Study” by the Swedish research team of Israelsson-Skogsberg et al. (2019), published in the *Journal of Family Nursing*.

Relevance to Child Life Practice

Modern medicine and technology continue to save the lives of more children who are traumatically injured or chronically ill. Due to these advances in medicine, more children can transition from hospital to home while still requiring home mechanical ventilation. The need for supportive services for siblings of chronically ill children is well-established (e.g., Inledon et al., 2013). Child life specialists are equipped with the unique knowledge to recognize that the entire family, including siblings, is impacted by a child’s chronic illness. Additionally, child life specialists are trained with skills to provide effective supportive services in the hospital and prepare siblings for their brother or sister’s transition home.

Article Summary and Considerations

The purpose of the study was to provide information on the day-to-day experiences of children who have a brother or sister that requires home mechanical ventilation (Israelsson-Skogsberg et al., 2019). In order to understand their life experiences, the authors chose a hermeneutic phenomenology research method and interviewed 10 siblings of children who required home mechanical ventilation (Israelsson-Skogsberg et al., 2019). Phenomenological methodology is used

to study the lived experiences of a person and to uncover the essential, shared meaning of their experiences (Laverty, 2003; Lindseth & Norberg, 2004). Hermeneutics is the interpretation of text to understand meaning (Ricoeur, 1974). Taken together, hermeneutic phenomenology is used to understand the essential meaning of a phenomenon through text interpretation (Lindseth & Norberg, 2004). Therefore, the researchers selected a hermeneutic phenomenological research method so they could best understand the daily experiences of siblings of children who require home mechanical ventilation and the meaning these siblings form from their daily experiences.

When assessing the quality of a research study, it is important to critically analyze the sample before making generalizations about the study results. For example, in this study, the sample consisted of 10 siblings with ages ranging from eight to 17 years (Israelsson-Skogsberg et al., 2019). The sample consisted of four boys and six girls, and three older, six younger, and one twin sibling (Israelsson-Skogsberg et al., 2019). When considering this sample, there is a wide variation among the ages of the siblings. The ages consist of the typical school-age and adolescent developmental levels. Participants from each developmental level may have qualitatively different experiences and levels of understanding regarding their siblings’ home care. This should be considered when reviewing the study findings.

In addition, this sample included a variation in older and younger siblings. Some of the literature on siblings of children with disabilities has discussed child birth order and gender as mediating factors when understanding who assists with sibling care (Lamorey, 1999). For example, if the sibling with a disability is the younger sibling, typically the older sister takes on a caregiving role and assists with household duties (McHale & Gamble, 1989), whereas younger siblings experience role reversal and take on a babysitting role for their older sibling with a disability (Lamorey, 1999). In general, when reviewing a research article, it is important to take a critical lens to the sample so that you know to whom the findings apply.

Implications for Child Life Practice

Israelsson-Skogsberg et al.'s (2019) findings can be applied by child life specialists in their interactions with multidisciplinary staff, caregivers, and siblings. Child life specialists can educate staff and caregivers regarding common reactions of siblings. Israelsson-Skogsberg et al. (2019) found that siblings often carry conflicting emotions, which may include worry, guilt, anger, and sadness. It is important that staff and caregivers are made aware of these common reactions as these emotions may manifest in a variety of behaviors and physical complaints. This awareness can assist caregivers in helping siblings label and express their emotions in a healthy manner. Additionally, it is important to note that siblings may have changes in their regular routines, such as different caregivers. Caregivers may benefit from support and "guidance" from a child life specialist on techniques to promote expression of feelings, positive coping skills, and predictability of routine.

When the child transitions home with home mechanical ventilation, medical professionals and equipment will accompany the child in the home, which can affect relationships within the family. Caregivers may benefit from education and guidance on how to support a sibling in the home environment from a child life specialist. Israelsson-Skogsberg et al. (2019) referenced suggestions that child life specialists can recommend to families. For example, child life specialists can encourage families to set aside a space in their home where there will be no medical equipment or health care professionals. This space would allow siblings to take a break



This patient's twin brother and father help to celebrate her birthday in the hospital, Ranken Jordan.

Photo by Ranken Jordan

from their role within the family, be themselves, and have friends over. Additionally, with a child dependent on home mechanical ventilation, caregivers often wear a variety of hats including parent, nurse, and therapist. Often, this takes time away from the other children. Child life specialists can encourage caregivers to set aside one-on-one time each week, consisting of a special activity or alone time with their siblings that does not involve home nurses or medical care.

Along with changes in the family relationship, a chronically ill child's transition often results in the termination of the relationship between the sibling and the child life specialist. Depending on the sibling's involvement in the child's hospitalization, they may have grown familiar with the additional support and attention from staff including child life. Child life specialists can bridge this gap by making appropriate referrals within the community, such as Big Brothers Big Sisters, and providing handoff to the sibling's school counselor. *

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MOMENTS FROM THE PAST

Volunteers: the Child Life Supporter

Amanda Geist-Sanborn, MS, CCLS

We all know them, we all love them, and we have all been them: volunteers. Volunteers are the silent supporters of the hospital and child life programs. By cleaning toys, prepping craft items, managing playrooms, delivering bedside items, and more, these individuals are critical to patient care by allowing child life specialists more time to spend with their patients.

Through the years, many have worked on developing a framework for how we orient volunteers and prepare them to work with patients. In 1992, The Association for the Care of Children's Health (ACCH) published the book *Volunteers in Child Health: Management Selection Training and Supervision* by Arlene Barry Kiely to standardize how we manage and work with volunteers. This book has been an invaluable resource to prepare future volunteers to work with hospitalized children.

Child Life General Orientation	Role of Student/Volunteer
Description of Pediatric Unit	Supportive Companion
Emotional/Developmental Effects of Hospitalization	Adapts to individual needs of Infants Active Child Passive Child Adolescents
Role of Child Life Specialist	Isolated/Bedrest/ICU Patient
Role of the Student/Volunteer	Language Abilities/Special Skills
Structure of Play Sessions	Make Observations
Scheduling/Complete Paperwork	Help Maintain Environment
Information for First Session	

Archived photos showing the role of a student or volunteer in a pediatric volunteer program from 1985.



Late 1960s – Volunteer playing cards with patients. Photo courtesy of Vanderbilt Historical Collection, Eskind Biomedical Library.

This archived document highlights one of the first set of guidelines for teaching and supporting volunteers. Volunteers were originally taught the importance of several key factors, including being flexible, having a committed schedule, and understanding the role of a pediatric volunteer. These factors were just as important during the creation of the volunteer programs as they are today.

Due to the COVID-19 pandemic, the child life profession has seen hospitals temporarily suspend volunteer programs for the safety of all those involved. This temporary suspension has impacted both patient care and the functioning of child life. We can now appreciate why our predecessors deemed volunteer programs so important and why it is useful to preserve information from the past to enhance knowledge in the future. The Archives Committee is encouraging programs to share historical documents and other relevant materials.

As volunteers return to helping us care for our patients, remember to thank them for the work they do in providing a more normal environment for hospitalized children everywhere. ✨



ACLP Calendar

JULY

- 1-31 Abstract submission for 2021 Child Life Annual Conference
- 7 Call for nominations for the 2021 Distinguished Service Award open
- 7 Call for nominations for the 2021 Mary Barkey Clinical Excellence Award open

AUGUST

- 1 2021 International Scholarship applications open
- 1 Your documents must arrive at the ACLP office by this date to ensure sufficient time for processing and approval before the August 10 exam registration deadline.
- 10 Deadline to apply for the August administration of the Child Life Professional Certification Exam
- 15-30 Child Life Professional Certification Exam Administration Testing Window
- 22 Deadline to submit transcripts and other documentation in time to apply for the 2021 Winter/Spring Internship

SEPTEMBER

- 5 Application deadline for the 2021 Winter/Spring Internship
- Mid Month Application deadline for Mentor Program
- 15 Applications and supporting documentation for Mary Barkey Clinical Excellence Award
- 15 Applications and supporting documentation for Distinguished Service Award

OCTOBER

- 1 Submission deadline for ACLP Bulletin articles for consideration in the Winter 2021 issue
- 31 Deadline to apply to recertify through PDUs

NOVEMBER

- 19 One Person Program Scholarship applications open

OCTOBER & NOVEMBER

In response to the global coronavirus pandemic, the traditional November testing window will be expanded to include October 1, 2020 – November 15, 2020.

Due to the predicted second wave of coronavirus cases and the potential for the closure of in-person testing facilities, candidates are encouraged to test earlier within this testing window if possible.

Registrations will be accepted on a rolling basis starting September 1 through October 27, 2020. No registrations for this testing window will be accepted after October 27, 2020. Candidates must register and pay for the exam through the ACLP website a minimum of 5 days prior to the desired test date.

DECEMBER

- 20 Your documents must arrive at the ACLP office by this date to ensure sufficient time for processing and approval before the January 5, 2021 deadline to apply for a summer 2021 internship.
- 31 Last day to reinstate lapsed CCLS credential

Calling All Mentors and Mentees!

Are you looking for “something more” in your career? A chance to practice new skills, an opportunity to reflect on where you’re headed, or a new professional connection?

The ACLP Mentor Program matches Certified Child Life Specialists seeking support to enhance their skills and/or further their careers with child life professionals who wish to be mentors. It operates on the belief that everyone has something to teach, everyone has something to learn, and every child life specialist is a leader.

Since the program’s inception, more than 130 pairs have been formed, reviewing skills and practices in support of the mentees’ goals, which ranged from serving as a child life advocate to administration, managing limited time, navigating chronic illness, and leading clinical supervision.

Applicants to the program (both mentors and mentees) may work in all areas of child life practice, including clinical settings, community-based work, academia, and formal leadership roles. Accepted applicants are matched based on interests and experience, creating the optimal foundation for joint learning. Mentees then set individualized goals related to their clinical skills, leadership abilities, personal effectiveness, or overall career

development, while mentors draw upon their own experiences, knowledge, and leadership skills to provide guidance.

The Mentor Program consists of structured elements over a six-month period, including monthly meetings of mentors and mentees (in person, or via phone/video chat) and monthly professional development webinars. Participants earn PDUs for completing the required webinars, and mentors are eligible for one additional PDU for their overall program participation.

Applications for the 2021 Mentor Program will be released in the fall of 2020. Help us spread the word! For additional information about the Mentor Program or to review applicant requirements, check out the Mentor Program page on the ACLP website today!

“The program gave me the opportunity to encourage another child life specialist by simply listening, validating, and then sharing my past experiences to help set her up for success. We navigated together through situations and were able to see progress and growth. I enjoyed how the program created a personal way to connect with another child life specialist from a different program to share honest thoughts and ideas, and solve problems in a safe, encouraging way.” — Former Mentor



Webinars

ACLP's 2020 webinar programming features new and updated ways to enhance your profession education. From search functionality to on-demand recordings, there is truly something for all learners to enjoy in our new portal.

JULY (TRAUMA)

Emerging Professional
From the Trauma Bay Through the Hospital Stay: Trauma-Informed Care for Pediatric Patients from Various Child Life Specialist Lenses

Wednesday, July 22, 1:00PM – 2:30PM EST

Established Professional
How Child Life Leaders Can Provide Planned Resources That Help Specialists and Teams To 'INSPIRIT' Resilience In Trauma Environments That Hold Risk of Compassion Fatigue

Wednesday, July 15, 1:00PM-2:30PM EST

JULY POP-UP WEBINARS

Free for ACLP Members

Creating Contactless Legacy Items in the Age of COVID-19

Friday, July 10, 1:30-2:30PM EST

It's Not the Shark, It's the Water: The Intersection of Whiteness and Child Life

Monday, July 13, 1:00-2:30PM EST

AUGUST (ASSESSMENT)

Emerging Professional
Playing with Grief: Perspectives from Two Child Life Specialists in Palliative Care

Monday, August 10, 2:00PM-3:00PM EST

Established Professional
Care of Gender-Expansive Children and Youth for the Child Life Specialist

Monday, August 17, 1:00PM-2:00M EST

AUGUST POP-UP WEBINAR

Free for ACLP Members

Pawsitive Coping: Facility Dogs as Child Life

SEPTEMBER (THE HOLIDAYS & CHILD LIFE)

Emerging Professionals
Call in the JOY! Mindfulness Practices to Care for YourSELF this Holiday Season

Wednesday, September 23, 1:00PM – 2:30PM EST

Established Professionals
Supporting Staff and Patients Through the Holidays

Wednesday, September 16, 2:00PM-3:00PM EST

A FEW NEW FEATURES WE DO NOT WANT YOU TO MISS:

Targeted learning: Each month ACLP will be hosting two live webinars— one targeted for emerging professionals and the other for established professionals—rooted in the same theme.

NEW subscription services: Our new subscription services offer learners the chance to join some or all of our live 2020 webinars at a discounted rate. Subscribers will have access to the on-demand recordings for these events in case watching live is not convenient.

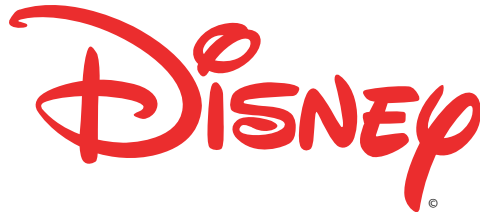
Webinar scholarships: To support ACLP's diversity goals, we will be offering several individual registration scholarships to each of our live webinars. Visit the online learning portal to complete the application. Be sure to visit ACLP's online learning portal to learn more about our new features and to explore the full 2020 programming schedule.

If you'd like to share your expertise and facilitate a webinar, please visit ACLP's webinar proposals page to provide us with information about your presentation. Presenters earn 2 PDUs per hour of presenting. We look forward to partnering with you as a facilitator!

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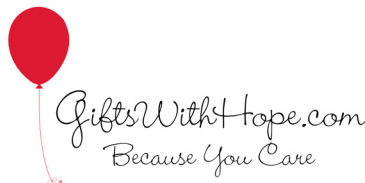
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