ACLPBulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

SPRING 2018 | VOL. 36 NO. 2

In Focus:

Season of Giving: Applying LEAN Concepts to Improve the Process of Holiday Gift Donations

PAGE 28

ASSOCIATION OF
Child Life Professionals

ACLP Bulletin

ASSOCIATION OF Child Life Professionals

CONNECT WITH US

TABLE OF CONTENTS

IN THIS ISSUE:

PAGE 12

PAGE 16

CHILD LIFE FOCUS:

from the Executive Editor
Katherine L. Bennett, MEd, CCLS

Etched in Concrete

"I've got a job for you."

This statement from my daddy could elicit anything from groans and complaints to running and hiding from me and my brother. The jobs were often some type of outdoor manual labor (hauling wood, raking pine straw) or assisting him on a home maintenance project (replacing a water faucet, repairing a faulty electrical outlet). They were often tedious, physically demanding, and time consuming. The "jobs" were, in my mind, things that kept me from doing the truly important things in my life…like playing Atari, riding my bike, or rearranging my model horse collection.

One particular job was impactful to me, more so recently than it was at the time. At the beginning of a hot summer, my dad announced that we were building an addition onto our house. How exciting! He then went on to say that we were going to do as much of the work ourselves as possible to keep costs down. Feelings of excitement began transitioning to trepidation over this new project. My brother and I soon learned that digging and pouring the foundation was to be one of the jobs that our family would take on. Measure, dig, pour, smooth, and build. That seemed easy enough.

Have you ever built a foundation? I mean, physically *build* a foundation into the ground? Obviously, it was not as easy as I initially thought. We spent hours measuring, drawing, and marking off the footprint of the new addition in the yard. Then, we spent days digging (with shovels in the hard Alabama clay soil) trenches into that footprint. Next, to save money on concrete, we began filling the trenches with old brick fragments left from the original construction of our home. These fragments were hauled, one wheelbarrow load at a time, from another part of the property to the trenches. This task also took days. Did I mention it was summer in the south? Finally and mercifully, the concrete truck arrived from the plant with professionals to pour the concrete while my brother and I watched. This part was fun! We even got to help smooth it, and probably THE most exciting part: carve our names into it. That was significant to us. It will always be there, no matter what happens to the structure built atop it.

On a recent trip home I visited the now empty home of my great-grandparents. I walked the yard that I'd played in (and mowed…a past "job") and found the remains of their old garage, the foundation being the only thing remaining. I traced the imprint of my great-grandfather's name and then found the tiny handprint of my grandmother, who had been a small child when the foundation was poured. I was overcome with feelings of permanence, loss, nostalgia, and completeness.

Etched in Concrete

These imprints in the foundation remained, true and strong, despite the structure's condition. I can't see the place in my parents' home where my brother and I etched our names into the foundation we helped build, but I have faith it is there.

Likely, many of you have had similar experiences, if not in actual construction then in carving or imprinting into concrete. I return to the idea of a strong foundation in this Spring 2018 issue of *ACLP Bulletin* for a few reasons.

First, the lineup of articles in this issue is diverse yet well-connected to the foundational work of child life specialists. Readers will find content building upon the topics of development, play, normalization, and coping. In addition, this issue's *Focus* article, "Season of Giving: Applying LEAN Concepts to Improve the Process of Holiday Gift Donations," takes a systematic look at increasing the efficiency of a process of normalization that so many child life professionals experience annually. The authors' methods and analysis of something so common in pediatric health care opened my eyes to other ways of improving program efficiency and effectiveness, whether they involve things, people, or both.

Finally, it is necessary to address that the recent decision to rescind the advanced degree requirement for certification as a child life specialist has caused many of our professional paradigms to shift. There are many options for learning more about the rationale of the decision, the history leading up to the decision, and the proposed next steps following the decision, including the article by ACLP's CEO Jennifer Lipsey, MA, in this issue. Regardless of how much your perspective or direction or daily work may have been altered by this perceived change in expectations and directions, I encourage you to examine the foundations of your own work, the child life profession's work, and the work of the profession as an entire community. Our foundations are why we continue to build by showing up to work and serving on committees and teaching students and learning more, and are still best articulated, in my opinion, in our mission statement:

"We, as child life professionals, help infants, children, youth, and families cope with the stress and uncertainty of illness, injury, and treatment. We provide evidence-based, developmentally appropriate interventions including therapeutic play, preparation, and education to reduce fear, anxiety, and pain."

Above all else, this is what is engraved in our foundation, and what remains, even when the structure is shaken. 🏃

President's Perspective
Eileen M. Clark, MSM, CCLS

Coming Together

Over the course of my career, I have appreciated the opportunity to apply the unique skill set of a child life specialist that I obtained through my training, education, and experience working with patients and families. I have learned that this enhanced skill set can be transferred to other social and professional circumstances. I am sure many of you have the ability to lend a quick analogy to further an explanation or enlist a deeper appreciation of a complex concept. In addition, this skill set can be used to blend disparate ideas when in a design phase of a process improvement initiative.

While patterns may be disrupted and change exposes new opportunities, we will continue to be successful as a greater community when we apply the same techniques that foster resiliency with the patients and families we serve.

Child life is embarking on initiatives that honor the very foundation of integrity, trust, and credibility that we strive for when working with patients, families, and staff. While patterns may be disrupted and change exposes new opportunities, we will continue to be successful as a greater community when we apply the same techniques that foster resiliency with the patients and families we serve. We recognize that resiliency in patients and families is a response to change in their lives, and that adapting to changes is a sign of growth and development. Similarly, as a profession, our resiliency will allow us to bounce back from challenges that arise as we adapt to the evolving environment of healthcare. Our ability to adapt to changes will result in positive growth.

Child life professionals share patient stories that highlight triumph amid tragedy, give voice to the tired, and promote strategies that are instrumental in helping families achieve a positive outcome.

This professional strength has been sought after and recognized by several new and developing partnerships. ACLP has embraced multiple opportunities presented by our partners in psychosocial care in recognition that our impact can be greater together as opposed to relying on a single voice. The cumulative efforts of the partnership work truly capture ACLP's commitment to increasing organizational strength and promoting awareness about child life. Thus far, we are honored to have the following supporters' leverage as outlined below:

- Children's Hospital Association (CHA) and ACLP are collaborating on a *Speak Now for Kids* campaign as a means to engage members and their patients and families in relevant public policy initiatives focused on patient care. Speak Now for Kids is a child advocacy network focusing on raising awareness of the unique challenges children and families face in a changing healthcare system. The online network offers a platform addressing important issues affecting children's health care.

- The Beryl Institute, a group working to promote the patient experience, led ACLP through the creation of the first white paper examining what the patient experience field can learn from child life specialists. (For those who are unfamiliar, a white paper is an in-depth report that explores an issue and presents an organization's position on that issue.) ACLP and Beryl will continue to exchange opportunities and insight as both recognize child life as an essential element to the mutual goal of impacting the patient experience. Two additional opportunities include shared engagement/presence at ACLP and Beryl Institute Annual conferences and collaboration with the ACLP Partnership Development and Patient Experience Committees to participate in developing a blog and webinar promoting child life.

- Corporate sponsors like Disney and Zott (formerly GameChanger TV) continue to support our members through generous

Gaining Strength and Momentum

contributions designed towards offsetting member costs, while gaining greater insight into how their programs and services can be improved to support our members' work with patients and families. Activities include partnering with the patient experience work, sponsoring facets of the ACLP Annual Conference, and supporting the ACLP Diversity Scholarship opportunities.

- Hope for Henry and ACLP are actively working toward co-hosting a second meeting focused on *Reimagining the Patient Experience*, inviting experts in technology, hospital administration, hospital design, and child life to refine initial ideas that were created in the first meeting that took place last November.

Beginning in the fall of 2018, ACLP will begin efforts in the design and development of the next strategic plan. The ACLP leadership and board of directors are dutifully aware of the evolving demands within the healthcare industry. The impact of demonstrating education, training, and clinical practice standards; partnership development; and fiscal health will be focal points for the next horizon in healthcare and association management, and our strategic plan will reflect ACLP's alignment with these trends while remaining focused on our mission.

In her book, *Turning to One Another*, Margaret Wheatley says, "There is no power greater than a community discovering what it cares about." She encourages the reader to ask what is possible. She reminds us to be brave enough to start conversations that matter. Child life specialists create healing environments that build on the strengths of patients and families; coming together as a child life community builds on the foundational strengths of the profession and creates potential to extend the impact of this important work.

Milestones

The child life profession lost a friend and advocate in March when **T. Berry Brazelton, MD**, passed away shortly before his 100th birthday. Like child life specialists, Dr. Brazelton focused his career on child development and the importance of relationships in supporting optimal psychosocial health. He was an advocate of parental hospital visitation when policies were still quite strict, a believer in the power of play, and an early proponent of patient- and family-centered care.

Brazelton's research on newborns led to the understanding that infants' own qualities and behaviors contribute to their relationships with their caregivers and culminated in the development of the Neonatal Behavioral Assessment Scale (NBAS), which has been widely used in research and in pediatric practice. In addition to his work with medical professionals, Dr. Brazelton spoke directly to parents though his popular books on child development, parenting, and family relationships.

His career took him from a private pediatrics practice to Harvard professor to best-selling author to founder of the Brazelton Touchpoints Center, which seeks to empower families and communities to contribute to children's development in positive ways.

In June 2007, child life specialists had the opportunity to experience Dr. Brazelton's expertise along with his charm and wit, when he gave the Emma Plank Keynote Address at CLC's 25th Annual Conference on Professional Issues. His work had an impact on the child life profession; child life will continue to support children and families in ways that would make Dr. Brazelton proud.

Child life specialists pose with Dr. Brazelton at CLC's Annual Conference in 2007.

Balancing Continuity and Change

Moving forward always involves both continuity and change, and that's especially true at this point in our organization's history when change is prominent in the news. The strong foundation underpinning child life provides long-term stability and offers direction as we decide where to direct our time and resources. Every day, ACLP staff and volunteers are engaged in many activities, projects, and initiatives that keep our association at the forefront of pediatric psychosocial care. I'd like to share some highlights with you.

ACLP continues to demonstrate healthy growth in membership, expertise, diversity in practice, and partnership development. Because our growth felt like it was happening at a rapid rate, the board and staff did a thorough investigation and assessment into the pace of the association's expansion. In order to honor the commitments, expectations, and deliverables that the association produces, ACLP leadership agreed that a preferred state was one that was focused on efficiency and effectiveness. In staying with common practice, the board looked at the association's activities, priorities, and resources with the goal to become narrow and deep in impact instead of far and wide in scope. The resulting reorganization took many shapes, but perhaps most noticeable to our volunteers was some alterations to their committees.

2017 began with 11 staff members, 12 board members, and at least 54 working groups. As the year progressed, it became clear that some of the working groups were at a loss for strong direction or engagement. Staff and board liaisons shared similar feedback, challenged by wanting to be effective support systems to their volunteer groups as the realities of finite time and expanding workloads continued to evolve. From the CEO perspective, an association whose infrastructure grows too big risks greater breakdown in communication, disappointed volunteers, and conflicting priorities to the point of stagnation. It was time for a maintenance check and renewal. Hence, 2017 ended with leadership dissolving seven working groups; moving three to an advisory capacity; and restructuring one. The next phase of committee reorganization will be to update charters and charges informed by the 2018 Strategic Plan that will be developed and solidified by the end of the year. Evaluations of our working groups will continue in an effort to honor our volunteers' time, energy, and expertise. Smaller, defined goals will be explored as opportunities for engaging the experience of the membership couple with ongoing, evolving targets. We remain in awe of the content wisdom, dedication, and passion each group member contributes. This annual evaluation of committees' recommendations and direction not only keeps leadership apprised of essential information, but promotes member engagement and helps to reduce the likelihood of volunteer member burnout as well.

We've been working diligently to restore a much-loved and much-utilized tool, and I'm happy to report that the *Resource Library* has returned–now as an updated, filterable directory that will continue to be refreshed by our hard-working Professional Resources Committee. The reinstatement of the library took far longer than anticipated due to the immense volume of content and complex categories. Our website development team was ill-prepared to have such thoughtful organization to the content and struggled with adjusting product templates to meet the design of the library. At last, the work is finished and we are excited to launch the first iteration of the library and will gather feedback to further refine it.

Our focus on providing up-to-date resources doesn't end with the Resource Library. The ACLP Store has expanded to include new volumes and second editions of publications, including *The*

Balancing Continuity and Change

Handbook of Medical Play Therapy and Child Life and *Meeting Children's Psychosocial Needs Across the Health-Care Continuum (2nd edition)*. Both titles have been added to inventory and we're honored to offer book signings by contributing authors of both publications at our conference. In addition, we anticipate adding the second edition of *The Handbook of Child Life* to the bookstore in April, and we'll have signings of this book at conference as well.

Speaking of the 2018 Child Life Annual Conference, it is now just a month away! The Conference Program Committee and ACLP staff are excited to welcome many of you to the Washington, DC, Metro area. We have an impressive lineup of pediatric health-care advocates presenting at the Opening and Closing Sessions, Plenary Sessions, Professional Development Workshops, and Pre-Conference Intensives. Conference kicks off with an inspiring talk by Eytan Young, MD, FACS, the Keynote Speaker at the Opening General Session. Dr. Young is a specialist in pediatric otolaryngology at the Iowa ENT Center, and is a champion of child life. Laurie Strongin, Keynote Speaker at the Closing General Session, is the CEO and founder of the Hope for Henry Foundation, and her talk will send you home inspired. Both of these speakers have benefitted from the presence of child life in their lives, and we're fortunate to have the opportunity to be motivated by their passion for your work with patients and families.

Along with opportunities for learning and earning PDUs at this year's conference, be ready to have fun!

For the first time, the Welcome Reception will have extended hours to include a dance party. The "Throwback Thursday" theme is the 80s, so come prepared with your best retro outfits and dance moves. The Welcome Reception is just one of several *networking opportunities* where attendees can meet with peers and reconnect with friends and colleagues. The exhibit hall is also a networking venue where attendees can meet representatives from companies and charities whose products and services align with child life. Don't miss the ACLP booth, where we will have book signings, a demonstration of the Professional Data Center, the Child Life Store, and more. Last but not least, please join me in thanking our sponsors for their generosity and support of the child life community. You won't want to miss this opportunity to be at the largest gathering of child life specialists in the world. There's still time to register online before the April 16th deadline. I look forward to seeing many of you at conference!

We know that communication is vital and time is short, so we invite everyone to learn more about ACLP's strategies and news via our new podcast series: *#ChildLife - The ACLP Podcast for the Child Life Community*. The podcast is another way in which we are using member feedback (e.g., too many emails, too little time) and social/digital trends to expose everyone to topics, news, and interviews relevant to the child life profession. Use it to find out what is new—and what is continuing—in the child life community. 🏃

M is for Mentorship

Hilary Woodward, MS, CCLS
NEW YORK-PRESBYTERIAN/MORGAN STANLEY CHILDREN'S HOSPITAL, NEW YORK, NY

Abigail Rainey, CCLS
RILEY HOSPITAL FOR CHILDREN AT INDIANA UNIVERSITY HEALTH, INDIANAPOLIS, IN

As a new child life specialist three years ago, I was eager and excited to begin a mentor relationship with an experienced child life specialist. I hoped to enhance my clinical knowledge and skills, but my mentor proved to be a much greater asset than I could have imagined. In the first month of working with my mentor, my department went through significant change, and I unexpectedly transitioned into a new role. My mentor was gentle and kind as she listened to me express fear, nerves, frustration, and sadness about having to move from a population of children and staff I loved to a unit that was foreign to me. She gently encouraged me to explore why I was feeling the emotions I was experiencing, and challenged me to learn about change, professional growth, and leadership as I navigated the following months. She helped me close out of one unit well, and enter the unknown with confidence and an open mind. She was integral in helping me develop professional skills that I have used and expanded on since. Today, my mentor and I are now working in the same department, and I credit her for helping me soar when I wanted to bury my head and hide.

— Abigail Rainey, CCLS

The benefits of working with a mentor are many: access to an advisor who has navigated similar experiences, a listening ear, a guide who can assist with developing new skills. In its truest form, though, mentorship is a reciprocal relationship. Ideally, both the mentor and mentee give and receive value freely (Sandberg, 2013). While becoming a mentee can be a vehicle for career growth, reflection, and skill building, so can becoming a mentor.

I first became a mentor after being encouraged to do so by a child life colleague who I deeply admire and respect. I now realize that she gave me the push because she knew all the ways that being a mentor would help me grow. Through mentoring, I gained frequent opportunities to practice active listening while deepening my own reflective practice, particularly as I processed the experiences my mentee shared and considered how to draw on my professional strengths and shortcomings to provide the best possible support. I also had the pleasure of watching my mentee shine; seeing the intelligence, skill, and joy that she brings to her work continues to inspire and rejuvenate me, and I remain grateful for the opportunity to connect with her.

— Hilary Woodward, MS, CCLS

Becoming a mentor (and encouraging others to mentor, as well) could be a crucial step toward making a broader impact on the child life profession. Morgan, Lynch, and Lynch assert that "when individuals commit to service, it's not too long before they spark positive service behavior from others around them. And beyond the intrinsic value of helping others, this ripple effect can often be used to address pressing . . . challenges" (2017, p. 130). Possibly, the ripple effect of individuals participating in mentorship could further develop child life as a whole, as a collective skillset for tackling challenges and supporting fellow professionals deepens and grows. The need for this skillset is further articulated by the Child Life Competencies, which state that Certified Child Life Specialists must "seek advanced practice mentors and peer supervision" as part of their professional responsibility to continuously self-reflect (Association of Child Life Professionals, 2016).

Topics that are crucial to the professional development of child life specialists (including formal and informal leadership, advocacy, professional engagement, and self-reflection) can be explored within the context of mentorship.

Examining the success of widely-adopted mentorship practices in the corporate and medical worlds provides additional urgency and relevant models with which to expand mentorship to child life. For example, 70% of Fortune 500 companies offer formal or informal mentorship opportunities. These companies identify higher employee retention, more engaged employees, and a stronger team as benefits of these programs (Schooley, 2011). Similarly, resident physicians who are involved in mentorship programs may grow in professionalism and build richer connections with other doctors (Ramanan, Taylor, Davis, & Philips, 2006). The Journal of the Association of American Medical Colleges states that:

> Institutions should build dynamic, bidirectional mentorship programs that engage all members of the hierarchy. Such programs have been shown to nurture professional identity formation and create a

sense of supportive community, the latter of which is known to be one of the best protective factors for burnout. (McKenna, Hashimoto, Maguire, & Bynum, 2016, p. 1198)

Many of the successes boasted by corporate and medical mentorship programs could likely translate easily to mentorship within child life. Topics that are crucial to the professional development of child life specialists (including formal and informal leadership, advocacy, professional engagement, and self-reflection) can be explored within the context of mentorship. Connections can be built across different settings, locally, or even internationally. Burnout can be addressed, and tools for self-care can be developed.

The foundation and structure of the mentor/mentee relationship play a key role in its efficacy. Formal programs that pair participants and offer guidelines for their interactions can provide this base. The Association of Child Life Professionals offers one such *program* for Certified Child Life Specialists who wish to be mentors or mentees. Seeking a mentor independently, however, can be another way to access the benefits of mentorship.

When aiming to build a mentor/mentee relationship outside the context of a formal program, Sheryl Sandberg (Chief Operating Officer of Facebook and *New York Times* bestselling author) asserts that "the strongest [mentor/mentee] relationships spring out of a real and often earned connection felt by both sides" (2013, p. 67). According to Sandberg, such a connection can flourish when a mentor identifies strengths and potential in a mentee that they would like to help foster (2013). Therefore, aspiring child life mentees may be well-served to network with others in the field, then build a professional relationship when genuine connection is sparked. While asking a stranger to be a mentor is less likely to be effective, Sandberg suggests that a quick connection can be made if the information shared is concise, focused, and tailored specifically to the individual who the potential mentee wishes to approach (2013).

Once initiated, mentor/mentee interactions should focus on problem solving, rather than venting about feelings or frustrations. Mentees should be prepared with goals, questions, a positive outlook, and clear respect for the mentor's time and efforts (Sandberg, 2013). Mentors can help their mentees not only by

providing encouragement, but by sharing constructive feedback, challenging a mentee's ideas, or presenting an alternative viewpoint. These elements can be important at all stages of one's career, and experienced professionals may benefit both from being a mentor and from being mentored (Morgan, Lynch, & Lynch, 2017).

As child life specialists, we often teach students that we are our own best resource for supporting patients and families. We are also our own best resource for supporting each other. Expanding mentorship allows us to optimize our collective resources, and each individual contribution (whether as mentor, mentee, or mentor recruiter) is crucial to our profession's development. We all have something to teach, and something to learn; we all have a role to play in ensuring that child life keeps pace in the dynamic professional landscape. 🏃

REFERENCES

Association of Child Life Professionals (2016). Child life competencies. Retrieved from http://www.childlife.org/about-aclp/purpose-mission-values/official-documents/child-life-competencies

McKenna, K. M., Hashimoto, D. A., Maguire, M. S., & Bynum, W. E. (2016). The missing link: Connection is the key to resilience in medical education. *Academic Medicine: Journal of the Association of American Medical Colleges*, *91*(9), 1197-1199. doi:10.1097/ACM.0000000000001311

Morgan, A., Lynch, C., & Lynch, S. (2017). *Spark: How to lead yourself and others to greater success*. Boston, MA: Houghton Mifflin Harcourt.

Ramanan, R. A., Taylor, W. C., Davis, R. B., & Phillips, R. S. (2006). Mentoring matters: Mentoring and career preparation in internal medicine residency training. *Journal of General Internal Medicine*, *21*(4), 340-345. doi:10.1111/j.1525-1497.2006.00346.x

Sandberg, S. (2013). *Lean in: Women, work, and the will to lead*. New York, NY: Knopf.

Schooley, C. (2011). *Drive employee talent development through business mentoring programs*. Cambridge, MA: Forrester Research.

What does the Change in Degree Requirements Really Mean?

Jennifer Lipsey, MA

Controversial. No other word better describes the advanced degree requirement that was introduced to the child life community in 2012 and 2013. The requirement, its evolution, and its recent revocation, have created quite a stir within the child life community as leaders, ACLP members, and students continue to grapple to understand.

The advanced degree requirement was initially born out of the Strategic Plan of 2012-2014 under the goal of "Credibility: Promote the credibility of the child life profession." The third objective under this goal was "By November 2013, complete planning and put in place a process whereby effective beginning in 2020, all new Certified Child Life Specialists must hold an advanced degree from an academic program that has been accredited by CLC" (CLC Strategic Plan 2012-2014). The Academic Preparation Task Force 2020 was created with a charge to recommend the steps, create a timeline, and develop policies and procedures to meet the objective. The task force stepped up to the challenge and produced recommendations for the board to formally approve. The first of these was that by 2022, all *newly* Certified Child Life Specialists must hold a master's degree in child life or a master's degree with a concentration or emphasis in child life from an academic program accredited by CLC.

The task force also recommended that in 2025 all *newly* Certified Child Life Specialists must hold a master's degree in child life from an academic program accredited by CLC.

The current Strategic Plan 2015-2018 expanded on the goal of strengthening professional credibility, supporting progress towards program endorsement and accreditation with the inclusion of a new goal to strengthen certification. The 2015-18 Strategic Plan provides a directive that ACLP's certification program become accredited by the Institution for Credentialing Excellence (ICE). Through its accrediting division, the National Commission for Credentialing Agencies (NCCA), ICE has been accrediting certification programs for 30 years and has accredited over 300 credentials in many industries, including those in the healthcare arena. In our pursuit of NCCA accreditation, we have come to a greater understanding and appreciation for credentialing industry standards and where we need to improve. Of particular interest are the following points:

1. To become accredited, our certifying body (the Child Life Certifying Committee [CLCC]) needs to be able to demonstrate that they have full authority over certification-related matters including eligibility, testing, maintenance, and recertification for the CCLS credential. Any undue influence by other bodies, including the ACLP Board, puts our certifying program outside of industry best practices. Because the 2013 advanced degree requirement was originated by the board and not from CLCC's evidence or procedures, the 2013 advanced degree requirement demonstrates that the board exerted undue influence on our certifying body. This threatens our ability to retain credibility and the potential for NCCA accreditation. Although the board's creation of the goal was made with good intentions of promoting credibility and elevating the profession, the board had not been informed about the NCCA standard around undue influence until recently. An NCCA reviewer has been working with the CLCC to align with NCCA standards and reiterated this standard of certification authority without undue influence during his evaluation. The CLCC did not have evidence from the 2013 Job Analysis verifying the need for an advanced degree and therefore had never stated that such a requirement was necessary. However, the requirement was born and carried by ACLP leadership who felt it would elevate the profession.

2. To rectify this situation and separate the board from decisions about certification, a proposed bylaws revision will be put forth to the ACLP membership this spring that

would grant CLCC authority to have final decision-making authority over essential certification decisions rather than making recommendations to the board, as they currently do. The new bylaws would establish the Child Life Certifying Commission, which would remain an entity within ACLP but have full discretion in certification matters.

3. In addition to establishing the credibility of our credentialing process, we needed to go back and address the board's earlier decision about the advanced degree requirement. The board felt that retaining our certifying body's credibility (and the integrity of the CCLS credential held by 5800 professionals) was of critical importance. Thus, the difficult decision to revoke the 2013 board motion for the advanced degree was made in December 2017. Any future decisions about eligibility requirements must be made by CLCC, without influence from the ACLP Board.

4. As we move forward with NCCA accreditation, the first NCCA *standard* requires that we identify our target population; we have identified this as the minimally competent, entry-level child life specialist. This means that we are assessing what knowledge and skills an individual would need to have on the job, day one. While it is clear that the child life market may demand more of practitioners, it is evident that there are many bachelor's-prepared child life specialists thriving in the field. That said, the ACLP Board of Directors is still recommending that child life specialists not be satisfied with the bare minimum and continues to recommend graduate education. There is a distinction between the requirements for certification and the realities of the marketplace; the minimum requirement for certification does not always meet employers' requirements. Because the CCLS credential is assessing for minimum competence at the job entry level and the fact that there is significant competition in the child life job market, many employers are seeking candidates who have exceeded the expectations for an entry-level practitioner. As with any competitive field, applicants are expected to augment their resumes with relevant education and training that expresses their determination to enter the field.

5. Moving forward in our pursuit of NCCA accreditation, CLCC has begun the next Job Analysis (JA), an evidence-based process that will inform eligibility requirements beyond 2019. CLCC will determine the minimum requirements for the entry-level CCLS and explore the potential for an advanced-level credential. The board and membership will be kept apprised of the JA findings.

There are two concrete ways to be involved in setting the future direction for certification. The first is participation in the JA verification survey. Because it is a relatively small panel of subject matter experts that will create the draft exam blueprint, it is essential that other child life specialists have the opportunity to weigh in on their work. After a panel meeting in February, the professional test developers with whom we work began creating a validation instrument in the form of an in-depth survey, which will be sent to thousands of child life specialists for input. Please make every effort to complete that survey when you receive it. Secondly, consider becoming involved with the certification program through the volunteer interest form process. The Certifying Committee is comprised of roughly 50 individuals who serve in a variety of positions. As with all volunteer-driven organizations, ACLP cannot function without the active engagement of our members.

While rescinding the requirement for an advanced degree has been controversial, this difficult decision was thoughtfully made based upon the most up-to-date information about best practices surrounding credentialing and objective evidence. As trying as it may be, please be assured that this decision represents the board's efforts to do what is best for the CCLS credential and the child life profession. ⭑

2018 Job Analysis

The Job Analysis (JA) is an evidence-based process that identifies the activities of a job and the qualities needed to perform them. The JA is the foundation on which the child life certification exam is built and is required by the National Commission for Credentialing Agencies (NCCA) standards. An end result of the JA is a very detailed job description which identifies the major domains and the specific tasks a minimally-competent, entry level child life specialist may be expected to have the capacity to perform. The JA uncovers the knowledge, skills, and abilities (KSAs) that are necessary for the competent performance of those tasks. It further identifies the elements that may be needed to obtain those KSAs, such as educational and/or clinical experiences. Any changes in tasks, KSAs, or identified pre-qualification requirements will be reflected in the JA study.

CLCC conducts JA studies approximately every 5 years as a matter of course. The current JA has been scheduled for some time and was begun in February of this year. The process began with a meeting of subject matter experts who have met multiple criteria, including education level, in their selection. Forty percent of the panelists hold a master's degree or higher. We anticipate that the varying levels of education will promote a better understanding of what it takes to achieve the level of competence that we are assessing.

To learn more about the JA, listen to the second episode of ACLP's new podcast, *#childlife.*

Making Her Mark in Child Life History:
CELEBRATING JOAN TURNER, PHD, CCLS

Jessika C. Boles, PhD, CCLS
MONROE CARELL JR. CHILDREN'S HOSPITAL AT VANDERBILT, NASHVILLE, TN

Long before I would earn the Certified Child Life Specialist credential, "Joan Turner" was a name I recognized and admired. Joan seemed to play a central role in many domains at that time, whether editing *Child Life Bulletin*, serving on the Research and Scholarship Task Force, presenting at the Annual Conference on Professional Issues, or authoring peer-reviewed articles about the social and familial contexts of childhood illness. Her impacts on child life professionals' clinical competency, professional identity, and public presence are multi-dimensional and irrefutable. It is for these reasons, and many more, that Joan Turner, PhD, CCLS, is the 2018 recipient of the Association of Child Life Professionals' Distinguished Service Award.

Joan has been a member of ACLP for over 30 years, during which she has given more than 20 years of service to various committees, task forces, and organizational projects, and has dually served the Canadian Association of Child Life Leaders. She began her career like many child life specialists, completing her Master of Science degree in Human Ecology at the University of Manitoba and then taking her first child life job as a specialist in the orthopedic unit at the Health Sciences Centre Children's Hospital in Winnipeg. In her eleven-and-a-half year tenure at the hospital, Joan was "one of the strongest advocates for child life that we knew," said her former coworker, Renee Ethans, CCLS, and "was always developing her knowledge and skills base, keeping abreast in the field, and then readily sharing that knowledge . . . she was eager and innovative in using child life skills in new areas in our hospital." It is this passion for teaching and learning that led Joan to seek her doctorate in human development and family studies at the University of Missouri-Columbia.

> *In her eleven-and-a-half year tenure at the hospital, Joan was "one of the strongest advocates for child life that we knew," said her former coworker, Renee Ethans, CCLS, and "was always developing her knowledge and skills base, keeping abreast in the field, and then readily sharing that knowledge . . . she was eager and innovative in using child life skills in new areas in our hospital."*

While completing her PhD, Joan's skills as an educator were formally recognized when she was given the Graduate Student Teaching Award in 2000, which was a preface to the great work to come. Once her dissertation was complete, she was quickly hired by Mount Saint Vincent University as an assistant professor in the department of child and youth study. Several years later, she received tenure in this position where she today continues to inspire the students fortunate enough to learn under her guidance. According to Donna Varga, PhD, Chair of the Department of Child and Youth Study, Joan is not only an "astute student supervisor" who is "generous with her time," but also "an inspiring educator whose collegiality and leadership in the department has enriched the lives of students."

Joan's educational efforts have extended far beyond her students into our professional conferences and publications.

She has given countless presentations on issues relevant to the coping, developmental, and psychosocial needs of children and families, as well as workshops and interactive sessions on conducting and analyzing research for child life specialists. Twelve of these presentations have been given at annual child life meetings, whereas others have promoted child development, health, and learning initiatives at the Mental Health in the Early Years Conference, Society for Research in Child Development, and the National Children's Cancer Conference.

Archiving and maintaining the history of the child life profession has been a primary focus for Joan during her recent years with the association. Civita Brown, MS, CCLS, shares that Joan, as a member and chair of the Archives Committee, "embraces every project with an enthusiasm and insight that is truly amazing. Her mind is constantly active and engaged, generating new ideas and asking new questions to further our understanding of the history of child life and thus the future of our field." Joan then shares these historical insights in a variety of print formats; she currently holds the title as the most prolific author featured in *Child Life Bulletin*, in addition to beginning the highly successful, and ever-continuing "Alphabet" column. According to colleague and former co-editor Anne Mohl, PhD, CCLS, "she truly sees the written documentation of progress in our profession as the foundation on which to educate future child life specialists, re-energize practicing professionals, and inform and

inspire those outside of the field." As co-editor and co-author of *The Pips of Child Life* (2014; 2016) series, Joan has helped to solidify the legacy of our profession's founders while at the same time contributing to her own legacy of inquiry, scholarship, and service.

It is difficult to sum up the many achievements of Dr. Joan Turner into one succinct article, especially when her daily involvement in the field of child life continues to grow and solidify our profession's place in the lives of children and families. Her work in the clinical, academic, and literary sectors has not only improved child life practice, but also the thousands of lives impacted by child life specialists. Perhaps the best way to recognize Joan's work is to document her contributions alongside names like Emma Plank, Mary Brooks, or Rosemary Bolig. As shared by Civita Brown:

> Joan emulates the outstanding qualities of the pioneers in child life. She is dedicated to the field, understands the importance of play for all children, believes in advocating for families in all settings, respects theory as well as practice, and is an excellent educator and promoter of child life . . . She is a leader in the child life field who sets the bar high and makes us all want to work harder to reach it.

Joan, thank you for giving us the knowledge, courage, and voice to work harder for our field and for patients and families. 🏃

Selected Publications by Joan Turner, PhD, CCLS:

Turner, J. (in press). Theoretical foundations of child life. In R. H. Thompson (Ed.), *Handbook of Child Life* (2nd Ed.). Springfield, IL: Thomas.

Turner, J. & Dempsey, V. (2017). Preschoolers' health care play: Children demonstrating their health literacy. In L. Rubin (Ed.), *Handbook of Medical Play Therapy and Child Life: Interventions in Clinical and Medical Settings*. New York, NY: Routledge.

Houser, N. E., Roach, L. Stone, M. R., Turner, J., Kirk, S. F. L. (2016). Let the children play: Scoping review on the implementation and use of loose parts for promoting physical activity participation. *AIMS Public Health, 3*(4), 781-799.

Turner, J. & Brown, C. (2016). *Pips of Child Life: The Middle Years of Play Programs in Hospitals*. Dubuque, IA: Kendall Hunt.

Turner, J. & Brown, C. (2014). *Pips of Child Life: The Early Years of Play Programs in Hospitals*. Dubuque, IA: Kendall Hunt.

Turner, J. & Fralic, J. (2009). Making explicit the implicit: Child life specialists talk about their assessment process. *Child and Youth Care Forum, 38*(1), 39-54.

Turner, J. (2006). Representations of illness, injury and health in children's picture books. *Children's Health Care, 35*(2), 179-189.

Turner, J. (2005). A place for attachment theory in child life programming: The potential to assess the quality of parent-child relationships. *Child and Youth Care Forum, 34*(3), 195-207.

Focus on the Flame: A Look at Burnout After a Few Years

Maddie Dumas, CCLS

OUR LADY OF THE LAKE CHILDREN'S HOSPITAL, BATON ROUGE, LA

My favorite professor once told me that the trajectory to burnout in the helping professions is about seven years. While I haven't found an official study on that statistic, as I look at my seven-year anniversary card from my hospital, I can't help but sigh and wonder if I'm there. Herbert Freudenberger defined burnout as "emotional and physical exhaustion displayed by some human service workers in health care agencies" (Heubner, 1993, p. 40). Some days, I repeatedly question whether I'm *really* helping the patients on my census; I still get frustrated when nurses don't call for procedures, and I feel defeated when a doctor gives a new diagnosis talk without me. Does my job matter? Should I try a different field? Am I just tired? Of course, these are all signs of a burned out child life specialist. I have told myself since that day in college that I would not be a statistic, yet I'm standing here, holding the fire extinguisher.

As child life specialists, we know that it's all about perspective: it's not just an IV catheter, it's a special straw. Today, my patient is Batman, and from here on out, we are not to call him Christopher. This medicine

> *Utilizing what I know, I grabbed a bottle of bubbles and a baby doll. I quickly introduced myself, presented the doll as a quick rapport builder and started blowing bubbles with this child. She immediately calmed down; she even tried to catch a few bubbles. A hush fell upon the room and the grandmother leaned in to read my name tag again. I heard her whisper "child life specialist," making a mental note.*

sounds like a rocket ship and we are about to blast off on a new adventure. We have to see things differently to be effective. Albert Ellis's *Rational Emotive and Cognitive-Behavior Therapy* tells us that "it is largely our thinking about events that leads to emotional and behavioral upset" (Albert Ellis Institute, 2014, para. 2). Sometimes we have to look at our situation through a different lens.

Not too long ago, a doctor asked me if I felt my job was obsolete with the invention of the iPad. My observing intern looked at me, eyes wide, mouth agape, waiting for me to respond. Only moments before rolling back to the operating room, this patient and I were shooting Nerf basketballs, pretending to be Stephen Curry and LeBron James. His port—named Raphael, after the Teenage Mutant Ninja Turtle—was about to drink some "milk" and he was about to snooze for a little while so he could get his IT chemo. These were things an iPad wouldn't know. I smiled and said "Not really," and continued my plan for supporting the child.

My intern and I later debriefed, recognizing the fact that for such an educated man, the doctor was uneducated about the field of child life. So we taught by example. The next time I had a patient with a new diagnosis of osteosarcoma, I asked about collaborating with him to teach and explain. He obliged, but stood close by as I educated this 10-year-old girl. He watched a light bulb go off in a way that didn't when he'd taught her parents only moments before. Not only did she understand, but she was already processing and coping with the news. He caught me later and said, "Hey, the way you explained that was pretty incredible!" My intern joked later that an iPad couldn't do that either!

My perspective could have shifted at his questioning of my position. I could have let his misconception squelch my chutzpah. I could have said, "Yeah, I am worried about my necessity as a child life specialist now that parents or nurses can simply hold an iPad in front of

patients to block an IV start." When we feel burned out, we tend to retreat to unhealthy, inaccurate, negative thinking. But some self-reflection directs me to what I know to be true: We are not replaceable. That day, I rekindled my fire.

Child life specialists know about perspective. Just yesterday, a patient's grandmother asked the nurse if she could give her grandchild anything for pain. The 2-year-old was crying and inconsolable. The nurse didn't have orders to give anything else, and shrugged her shoulders. Utilizing what I know, I grabbed a bottle of bubbles and a baby doll. I quickly introduced myself, presented the doll as a quick rapport builder and started blowing bubbles with this child. She immediately calmed down; she even tried to catch a few bubbles. A hush fell upon the room and the grandmother leaned in to read my name tag again. I heard her whisper "child life specialist," making a mental note. I explained that the bubbles could not only provide a calm activity, but that they could also help her granddaughter practice deep breathing. I modeled for a few more rounds, and then handed the bubbles over to the family. Just like that, it was all better. It was

a textbook child life encounter. Where some may say "nothing to be done," a child life specialist says "what else can we try?" A grandmother felt helpless, then empowered.

There are days when I hope against hope, pray against all odds, and avoid saying those little superstitious words that jinx a hospital day. Those days I feel like I just can't take anything crazy. Inevitably, the trauma comes. I eventually leave for the day after hugging a mother I just met, and I get a little misty eyed with that full feeling in my heart, knowing that I made someone's day a little better. My perspective shifts a little to help me come to work another day.

If I dwell on a statistic, I'm sure I will be on a path to complete burnout. When I refocus on what matters and see how much I still have to learn, how many lessons I have to teach, and how many little lives I have to impact, I feel like I'm carrying the Olympic torch, rather than a light up toy. I am holding a flame that continues to burn brightly. I may not have a gold medal, but I have lots of stories to tell. After all, the patients in these stories are what make this job what it is. So, on to year eight. 🤸

REFERENCES

Albert Ellis Institute. (2014). *Rational emotive & cognitive-behavior therapy*. Retrieved from http://albertellis.org/rebt-cbt-therapy

Huebner, E. S. (1993). Professionals under stress: A review of burnout among the helping professions with implications for school psychologists. *Psychology in the Schools, 30,* 40–49. doi:10.1002/1520-6807(199301)30:1<40::AID-PITS2310300107>3.0.CO;2-F

WHEN COPING STYLES CLASH:

The ADAA Pathway to Support Competing Coping Efforts

Sarah Daniels, CCLS
ST. JUDE CHILDREN'S RESEARCH HOSPITAL, MEMPHIS, TN

Megan Arleth, MA, CCLS
NOVANT HEALTH HEMBY CHILDREN'S HOSPITAL, CHARLOTTE, NC

A main goal of child life intervention is to encourage patients and families to develop the coping skills necessary to meet the challenges of hospitalization and illness. Although coping with stress is an individual effort, the patient and the family experience stressors associated with hospitalization together. Often, as patients undergo painful medical procedures and process new information and diagnoses, their ability to adapt is directly related to their caregiver's involvement and coping (Zeitlin & Williamson, 1994). Child life specialists are thus tasked with effectively assessing the stressors and coping efforts of multiple individuals throughout hospital events, and then providing support to help achieve a positive outcome for all. If the child and the caregiver simultaneously have different needs for support, the conflict can create pressure for the child life specialist to prioritize supporting a single individual.

In these interventions, it is important for the child life specialist to identify and recommend interventions that encourage effective coping for the entire family. Despite many efforts to consistently achieve this goal, there are times when specialists leave a room feeling as though they have not supported the patient and family to the best of their abilities. After hearing and experiencing these scenarios, we reflected on the challenging outcomes of these interventions and decided that something should be done to address the need for an easier way to navigate these demanding cases. With a desire to improve our services, we reflected on case examples and consulted the theoretical foundations of child life for answers. Throughout this process, we ultimately assessed a need to develop a pathway for guiding future child life interventions serving individuals who utilize competing coping efforts. The following article introduces the Assess, Discuss, Act and Achieve (ADAA) pathway that we developed to help child life specialists walk through the steps of ADAA when managing clashing coping styles of patients and caregivers.

Stress and Coping

People react and respond to challenges differently from one another. The way that a person perceives a stressful event, or stressor, leads to the type of stress that they feel (Lazarus & Folkman, 1984). There are three domains of stress that an individual may experience: cognitive, emotional, and physical stress. The type of stress that a person feels during or following the stressor provides insight into how they can best cope with that stress. The most important key to coping appropriately is goodness of fit, meaning that an effective coping effort will utilize resources available to the person to

meet the demands of stress (Zeitlin & Williamson, 1994).

Determining the goodness of fit of a coping effort requires a deeper understanding of the types of coping efforts and stressors present in each intervention. There are four main types of coping efforts, including problem-focused, emotion-focused, psychological, and physiological efforts (Zeitlin & Williamson, 1994):

- A problem-focused coping effort addresses the questions, "What is the problem and how can I solve it?"

- An emotion-focused coping effort addresses the questions, "What am I feeling now, how do I want to feel, and how can I help myself feel that way?"

- A psychological coping effort addresses the questions, "What am I thinking and how is that related to my physical and emotional feelings? How do I need to think instead to improve my physical and emotional feelings?"

- A physiological coping effort addresses the questions, "How does my body feel and how can I physically release any tension?"

Although coping efforts can be taught and reinforced, if a person routinely uses a certain coping effort in response to various stressors, this type of coping effort broadens to describe their coping style (Zeitlin & Williamson, 1994). The development of the ADAA pathway came about through the observation that patients and caregivers evoke varying coping efforts based on their perceived type of stress, which contributes to clashing coping styles.

Some authors and theorists attempt to depict the stress and coping process through models, including Zeitlin and

Williamson's four-step coping process (1994) and Lazarus and Folkman's transactional model of stress and coping (1984). The former shows the four steps of stress and coping: The first step determines the meaning of the event, the second step develops an action plan, the third implements the coping effort and results in an outcome, and the fourth step evaluates the effectiveness of that outcome (Zeitlin & Williamson, 1994). While this process demonstrates the internal and external resources contributing to stress and coping, it only examines the stress and coping process of one individual, and does not offer suggestions for navigating the process between multiple people.

The transactional model of stress and coping posed by Lazarus and Folkman (1984) examines how stress occurs between the person and the environment. There are two occurrences of stress appraisal in this model: The primary appraisal occurs the moment when the individual assesses a situation as threatening or stressful to themselves personally, and the secondary appraisal takes place when the individual seeks resources from the environment that they can use to best cope with stress. This model explicitly identifies both problem-solving and emotion-focused coping behaviors as possible efforts for coping. Although this is another model that explains many important features of the individual stress and coping process, it does not highlight the occurrence of two people enduring stress together and then performing the secondary appraisal in differing ways.

As child life specialists, it can be extremely challenging to observe and attempt to assess the components of the stress and coping process for more

When Coping Styles Clash: The ADAA Pathway to Support Competing Coping Efforts

than one person concurrently. We offer the ADAA pathway as a concise visual tool that specifically details our role in helping more than one person move through the stress and coping process to achieve positive outcomes.

ADAA Pathway

The ADAA pathway of supporting interrelated stress and coping is a visual resource to utilize while providing services to multiple individuals experiencing the stressors of hospitalization. The ADAA pathway is divided into four sections, or stages, of practice (see Figure 1). At the foundation, the child life specialist begins to use the ADAA pathway with the assessment process during a stressful event and ends with achievements that follow provision of services.

Step 1: Assess. The assessment stage requires the child life specialist to

evaluate the types of stress and coping occurring during the intervention. Imagine walking into a room and already noticing that a child is coping differently from their caregiver. The child life specialist should attempt to dive deeper and assess the specific type (problem-focused, emotion-focused, psychological, or physiological) of coping efforts being utilized by each person. A child life specialist is trained to quickly identify what is stressful to the child and the caregiver, but should also reflect on why that is stressful and how each person is attempting to cope, and with which resources. Making

this proper and thorough assessment will help navigate challenging coping experiences.

Step 2: Discuss. The next stage of the pathway is the discussion phase. After the child life specialist makes an assessment and works to quickly support the patient and family in the moment, they should return to the patient or caregiver and address the differences that were observed. The child life specialist might acknowledge that the event was stressful for everyone, and that it can be difficult for caregivers to support themselves and their child simultaneously. In this conversation, the child life specialist should attempt to learn whether or not the individual describes the efforts that they used during that particular instance as being consistent with their overall coping style.

Step 3: Act. After the conversation, the child life specialist can better under-
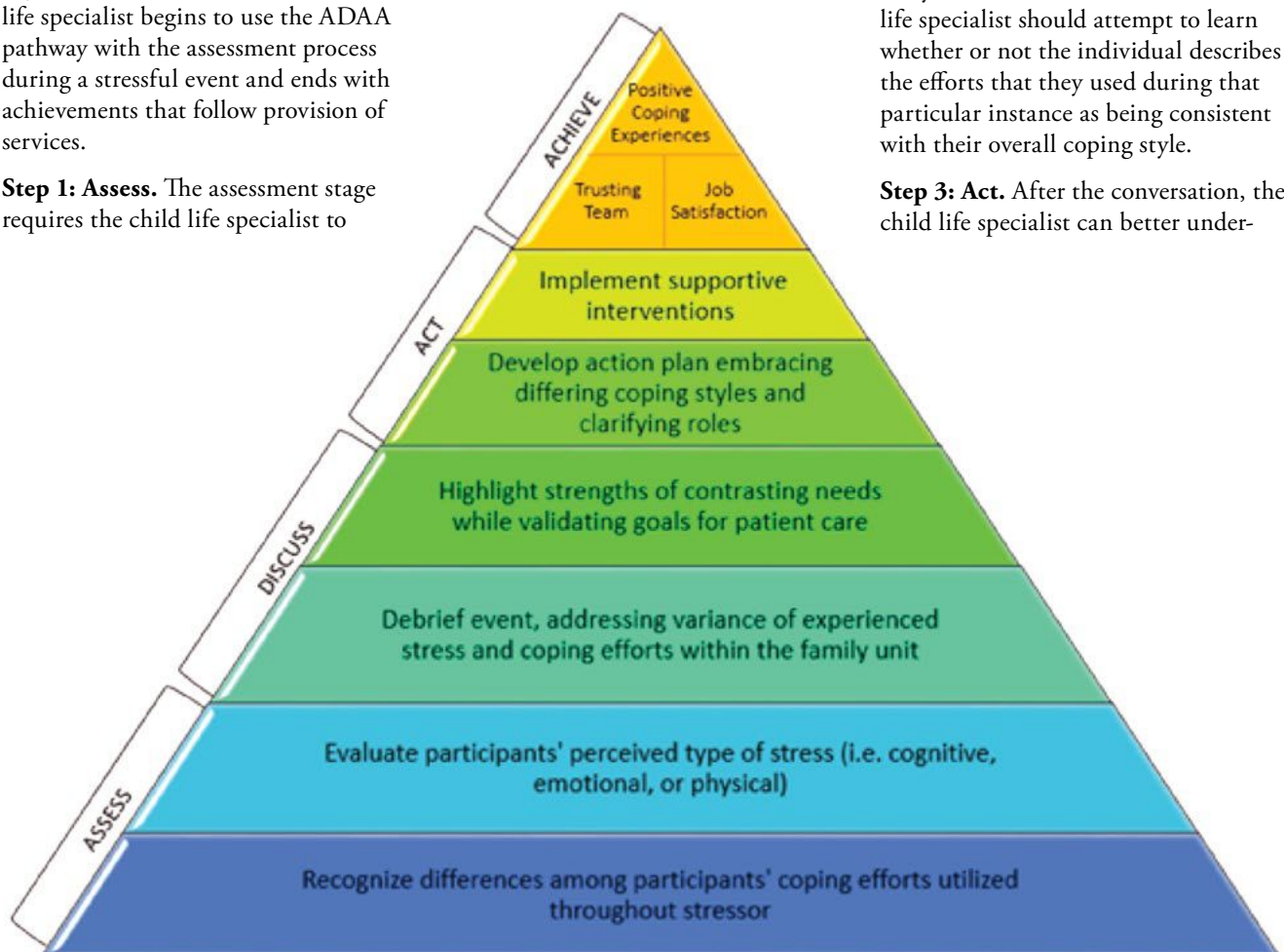

Figure 1. The ADAA Pathway.

stand how this family will continue to experience stressors in the hospital together. If it seems that the patient and caregiver will continue to use competing coping efforts in future events, the child life specialist should take action to make a plan that will allow the family to cope positively with similar and new stressful experiences. These plans should incorporate ways to merge both the caregiver's and the patient's coping preferences. While this merge will look different for each patient-caregiver dyad, it might look like one or both individuals learning to compromise their understanding of the stressors present and learning to use the most effective coping efforts available.

Step 4: Achieve. The final phase of the pyramidal pathway is the achievement phase. In this phase, there are no stages, but rather outcomes that occur simultaneously. These outcomes are a trusting medical team, positive coping experiences, and job satisfaction.

Case Example

A child life specialist entered a room to provide support during an I.V. start to a 10-year-old female patient in an outpatient oncology clinic. During the procedure, the child life specialist observed the mother physically turning the patient's face away from the procedure and attempting to engage the patient in distracting conversation. The child life specialist observed the patient's efforts to strain against her mother and watch the I.V. stick occur.

Assess: The first step was to recognize the differences among participants' coping efforts utilized throughout the stressor. The child life specialist assessed that the child was using problem-focused coping efforts, seeking information about the needle poke, as

evidenced by her desire to watch the procedure. The mother, on the other hand, was using emotion-focused coping efforts, as shown by her attempt to distract the patient from the IV start. The next step of the assessment stage is to evaluate participants' perceived type of stress (i.e. cognitive, emotional, or physical). Based on her unfamiliarity with the hospital setting as a new patient, and her problem-focused coping efforts, it was assessed that the patient's type of stress was cognitive and physical. The mother's type of stress was emotional.

Discuss: The next step was to debrief the event, addressing variance of experienced stress and coping efforts within the family unit. In this case, it was important to have a conversation with the patient's mother. The child life specialist validated that it is stressful for her to watch her daughter endure new challenges, and her efforts to distract her daughter were well intended and comfort-motivated. The child life specialist also acknowledged that the daughter's attempt to cope with the new procedure was different from the mother's; she did not want to be

distracted, and received comfort from being able to watch and learn about the needle stick. The child life specialist then asked the mother if this seemed typical for their coping styles with other stressful events. After sharing and gathering this information, the next step was to highlight strengths of contrasting needs while reinforcing goals for patient care. To maintain trust and respect the mother's efforts, the child life specialist affirmed how important her presence was for helping her daughter cope. The child life specialist also identified the strength of the patient's desire to gain control over her experience at the hospital. Finally, the child life specialist validated that there was a shared goal among everyone in the room for the patient to tolerate the poke successfully.

Act: In this stage, the goal was to develop an action plan embracing different coping styles and clarifying roles. For both the patient and mother, it was important to allow the mother to provide emotional comfort to her daughter and for the patient to continue to seek

When Coping Styles Clash: The ADAA Pathway to Support Competing Coping Efforts

information. The child life specialist suggested a plan where the patient's mother could continue to use distracting conversation along with a supportive hand hold while the patient was able to watch the nurse throughout the procedure. Additionally, the child life specialist suggested that medical play would be an important intervention for this patient, so that she could ask questions and make plans prior to new hospital events. The next step was to implement supportive interventions, which the child life specialist did by remaining present in future needle sticks and reminding the patient and her mother of the coping plan.

Achieve: In this case example, the child life specialist wanted to find a way for the intervention to work smoothly for everyone, despite the observed differences in coping styles, which placed additional burden on the nursing staff performing the procedure. The child life specialist's role was to help navigate this experience so that everyone could successfully complete the task at hand, but she felt uncertain about who to support first in this situation. After following the steps of this pathway, the child life specialist felt confident about the support that was directed toward the mother and the patient, and appreciated the feedback from the medical team about trusting the role of a child life specialist in preparing future families who may endure similar challenges.

Conclusion

In a profession holding an array of expectations, from advocate, to educator, to support person, to play promoter, it is increasingly important to recognize and validate the challenges associated with navigating different coping efforts. Using the ADAA pathway as a visual resource in approaching challenges in the workplace will allow child life specialists to reframe the complex demands of our job into a more simplified manner, so that the individual responsibility feels manageable. This tool addresses the need for more resources in the field of child life which support the specialist through navigation of often challenging interventions requiring profound assessment, multifaceted support, and compassionate reflection. The ADAA pathway is a resource for students and professionals alike to strengthen their step-by-step approach to tackling more difficult interventions while maintaining a mindset of family-centered and self-care. We hope this tool will provide encouragement to specialists who are looking to affirm their ability to effectively negotiate child life services for all types of coping styles. 🏃

REFERENCES

Lazarus, R., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer.

Zeitlin, S. & Williamson, G. G. (1994). The coping process. In *Coping in young children: Early intervention practices to enhance adaptive behavior and resilience* (pp. 7-22). Baltimore, MD: Brookes.

2019 ACLP Annual Conference Call for Papers

The ACLP 37th Annual Conference will be held in Chicago, IL, April 11 to 14, 2019, and it's time now to start thinking about presenting. Do you have an innovative idea or a research project you'd like to share with your colleagues? Consider sharing your work with more than 1,000 child life professionals at the Annual Conference. It is never too early to start planning an engaging presentation on a topic of importance to your profession.

The Conference Program Committee invites you to plan now to _submit an abstract_ during the submission window of June 1 to June 30, 2018. Member and attendee feedback continues to indicate a need for presentations related to advanced-level topics, leadership, and child life in alternative settings. In addition, there is demand for topics addressing the core competencies, especially ethics and assessment. Conference presentation formats range from posters to panels, so there is a format to fit your topic and presentation style. Participate in making the 2019 conference a rousing success!

Embracing Technology for the Hospitalized Child

Kristen Brady

MASTER'S STUDENT AT VANDERBILT UNIVERSITY

Screen time has been a controversial topic since the introduction of smartphones and tablets in the mid 2000s. By 2013, it was estimated that 61% of American households with children owned at least one Apple device, including smartphones and tablets (Wartella, Rideout, Lauricella, & Connell, 2013). These numbers continue to grow, indicating just how ingrained technology has become in our society. Despite the prevalence, there continues to be widespread fear of the effects of technology, especially in the lives of children.

In 2011, one year after the iPad was introduced to the market, the American Academy of Pediatrics (AAP) released a recommendation for parents to limit their children's screen time to no more than two hours per day (AAP, 2011). This standard provided parents with a clear structured recommendation, but the AAP didn't justify its reasoning for recommending that specific number of hours and failed to provide guidance on best practices for facilitating these elusive two hours of screen time.

In the hospital setting, screen time tends to be even more ubiquitous in the lives of children. Most hospital facilities equip every room with a television as the main source of entertainment. Waiting rooms often leave parents and caregivers in a situation where a smartphone or a tablet is the only portable entertainment they have at hand. Further, when travel time to and from hospitals is considered, there

Embracing Technology for the Hospitalized Child

are additional hours that can be challenging to fill with active play. While the original goal of the AAP statement was to encourage active, engaging, or imaginary play in place of screen time, it is difficult to adhere to AAP guidelines in a hospital setting where wait times and screens are pervasive staples.

Rather than dismiss screen time entirely, child life specialists can serve as advocates for meaningful, educational, and social uses of it. This evolving attitude toward screen time is reflected in the adjusted AAP recommendation, released in 2016, which advises the following for young children's screen time:

- Children younger than 18 months should avoid the use of screen media entirely.

- Parents of children 18 to 24 months of age should find high quality programming and watch or play the material with their children to help them understand and interpret what they're seeing.

- Parents of children 2 to 5 years old should limit screen time to one hour per day of high quality programs and co-view the media with their children to help them understand what the child is seeing and apply it to the real world.

> *If screen time is going to be part of a child's day-to-day life, caregivers should be encouraged to engage in co-viewing with active mediation to make screen time a social learning experience.*

- Children ages 6 and up should have consistent limits of time spent with screens.

These newer guidelines reflect an essential update in research on children and media: the importance of *co-viewing*. The emphasis on co-viewing media content relies on the concept of *active mediation*, where caregivers and child hold conversations specifically about media and its content. Active mediation plays an important role in helping children distinguish media fiction from the real world, comprehend educational content, and directs a child's attention to the

Daniel Tiger's Neighborhood

learning objective of a show (Collins, Sobol, & Westby, 1981; Cantor & Wilson, 1984; Singer & Singer, 1998). Co-viewing addresses an important misconception about screen time for children: the idea that playing on an iPad or watching television is only an independent activity. If screen time is going to be part of a child's day-to-day life, caregivers should be encouraged to engage in co-viewing with active mediation to make screen time a social learning experience.

It should not be surprising that children can learn prosocial skills from media, based on what we know from social learning theory. Unfortunately, Bandura's social learning theory is rooted in the Bobo doll study (Bandura, Ross, & Ross, 1963) that served as a catalyst for psychologists to fear the learning of violence through television. However, one could also interpret the study as hopeful, since it also suggests that children can learn prosocial behaviors after what they see modeled in media (Strasburger, Wilson, & Jordan, 2014). One of the original studies that explored this concept took place in the 1970s, when researchers found that preschoolers who watched *Mister Rogers' Neighborhood* had higher levels of task persistence, rule obedience, and helping behaviors following their viewing of the prosocial program (Friedrich & Stein, 1975). New research has examined the *Mister Rogers*-inspired show, *Daniel Tiger's Neighborhood*, to find that children ages 2 to 6 had higher levels of empathy, self-efficacy, and emotion recognition following a two-week period of viewing the series (Rasmussen et al., 2016).

This article is not intended to reject the evidence-based standards set by the AAP, as they serve an important role in screen time recommendations for children in the home.

Rather, the goal is to build off of these recommendations and provide a positive space where caregivers can feel empowered to use screen time more effectively for their children during a time, such as during hospitalization, when more than the recommended amount may be inevitable or hard to avoid. Below are some suggestions that child life specialists can offer caregivers to help them positively engage with their child during screen time:

- **Ask higher level thinking questions related to the content.** One way you can facilitate learning is by helping your child translate information from the screen to the real world. For example, you can say to a child: "Daniel Tiger is sad because someone took his toy. How do you feel when someone takes your toys?"

- **When your child reads an e-book, read with them.** Treat it like a regular book that you would read together and ask questions throughout.

- **Use commercial breaks as a time to talk about what you just watched on TV.** Help your child to understand the plot and recognize the key lessons from the show.

- **Search for games that allow for imaginative and cooperative play.** iPad applications can serve as a safe alternative for toys, but they don't need to eliminate imaginative play. For example, there are applications that can create a virtual tea party where you can create imaginary play, even in an environment without toys.

- **Create consistent limits of screen time to establish a normal routine.** These limits may be adjusted from restrictions set at home to reflect the different hospital environment, but it can still be beneficial to create a sense of normalcy and routine by discussing new limits.

These recommendations take some of the fear away from screen time and allow child life specialists to support parents in their use of technology. The issue of screen time can be daunting for parents, especially in the hospital setting. Through using a strengths-based outlook, child life specialists can help parents find meaningful ways to incorporate technology into their child's life to promote positive development in and out of the hospital setting.

REFERENCES

American Academy of Pediatrics (2011). *Media and Children*. Retrieved from https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/pages/media-and-children.aspx

Bandura, A., Ross, D., & Ross, S. A. (1963). Imitation of film-mediated aggressive models. *The Journal of Abnormal and Social Psychology*, *66*(1), 3-11.

Cantor, J., & Wilson, B. J. (1984). Modifying fear responses to mass media in preschool and elementary school children. *Journal of Broadcasting, 28,* 431-443.

Collins, W. A., Sobol., B. L., & Westby, S. (1981). Effects of adult commentary on children's comprehension and inferences about a televised aggressive portrayal. *Child Development, 52,* 158-163.

Friedrich, L. K., & Stein, A. H. (1975). Prosocial television and young children: The effects of verbal labeling and role playing on learning and behavior. *Child Development, 45,* 27-38.

Rasmussen, E. E., Shafer, A., Colwell, M. J., White, S., Punyanunt-Carter, N., Densley, R. L., & Wright, H. (2016). Relation between active mediation, exposure to Daniel Tiger's Neighborhood, and US preschoolers' social and emotional development. *Journal of Children and Media, 10*(4), 443-461.

Singer, D. G., & Singer, J. L. (1998). Developing critical viewing skills and media literacy in children. *The Annals of the American Academy of Political and Social Science, 557*(1), 164-179.

Strasburger, V. C., Wilson, B. J., & Jordan, A. B. (2014). *Children, adolescents and the media* (3rd ed.). Thousand Oaks, CA: Sage.

Wartella, E., Rideout, V., Lauricella, A., & Connell, S. (2013). *Parenting in the age of digital technology: Report for the Center on Media and Human Development, School of Communication, Northwestern University*. Retrieved from http://cmhd.northwestern.edu/wp-content/uploads/2015/06/ParentingAgeDigitalTechnology.REVISED.FINAL_.2014.pdf

Child Life in Kenya: Overcoming the Challenges of Certification

Elizabeth W. Ng'ang' a - Kabuthi, BA, CCLS

SHOE FOR AFRICA CHILDREN'S HOSPITAL
MOI TEACHING AND REFERRAL HOSPITAL
ELDORET, KENYA

Child Life is a fairly new concept in Kenya and more so in the continent of Africa. It goes way back to the year 2000 when two visiting doctors' wives paid a visit to Moi Teaching and Referral Hospital (MTRH) Paediatric wards in Eldoret, Kenya and found there were no activities for the many desolate and miserable children confined to bed for days, weeks, and months.

This bleak picture gave birth to a two hour daily play session in the hallway. It was joyfully embraced by children, parents, and staff. The misery in the wards slowly turned into moments of laughter, joyful giggles, endless running up and down the hallway, and happier, more cooperative children. Bedridden children were not left out, and soon it was a scramble for the few available play resources.

These play sessions transformed and first grew into an all day play program and then a model child life program in Eldoret, Kenya, after Morgan Livingstone, CCLS, CIIT, MA, from Toronto, Canada (and Child Life Director for WE C HOPE, an eye cancer foundation), voluntarily offered training, shadowing, mentoring, back-and-forth communication, preparation, and rehearsal, all geared towards preparing the team for the certification exam. This culminated in the seven child life health workers sitting for the ACLP (then the Child Life Council) certification exam in September 2015 which was a first and great achievement!

Preparing for the exam was quite a challenge. Convinced that helping children cope with hospitalization was our

The team in Kenya studying for the certification exam.

primary goal, we were determined to undertake the CLC's certification exam in 2015 in spite of its challenges. Judith Duncan, MEd, CCLS, came to Kenya to offer Child Life 101, and we all received certification from Cambrian College in Sudbury, Ontario.

In Kenya virtually everything is done with paper and pen: class work, grading and examinations, as well as hospital records. Few own computers, and even fewer have personal access to the internet. (Most of our population regards a high school diploma as high achievement.) About 15% of Kenyan graduates go on to higher education. Few of us had taken multiple choice tests, and none of us had ever taken a computer examination- definitely not an online exam. We tried to imagine what the exam would be like, but I must admit, it was much more complicated than anything we had seen previously as it interwove the various domains into many questions.

Morgan Livingstone faithfully provided study aids through emails. Our director subscribed online to child life study programs and printed copies for everyone. She even bought materials for us. We studied hard!

On the day of the examination, we were all promptly ready to begin. However, there were technical difficulties since Eastern time in the U.S. is 8 hours behind. We worked several hours with a night technical team in the U.S., causing our nerves to frazzle as we waited over 6 hours before the examination began.

In an effort to create a global program to reduce stress and prepare hospitalized children worldwide, here are some suggestions from our experience and questions to open dialog about what it means to be certified by the ACLP:

1. Are there ways the ACLP can provide certification materials for countries with varying resources to prepare for its certification examination without compromising applicants' educational requirements and certification standards?

2. Are there ways the ACLP can anticipate gaps in technology resources and expertise and work with potential certification testing sites to make appropriate accommodations?

Despite the challenges, two members passed the exam. Passing on first attempt gave me so much joy and satisfaction, a feat I greatly cherish. I put in lots of hours of reading in order to get acquainted with the framing of questions from previous exams. I have so much pride and joy to be a Certified Child Life Specialist, among the first in Kenya! 🏃

Extracorporeal Membrane Oxygenation (ECMO)

Sara Reynolds, CCLS
TEXAS CHILDREN'S HOSPITAL, HOUSTON, TX

Extracorporeal Membrane Oxygenation, or ECMO, is the most common type of mechanical circulatory support in infants and children. ECMO works by taking over the function of a patient's heart and lungs through tubes (cannulas) that remove the blood from a patient's body and pushes the blood through a machine outside of the body that removes the carbon dioxide and oxygenates the blood before returning it back to the body. ECMO is indicated for patients in acute respiratory or heart failure, septic shock, recovering from major surgery, or as a bridge to lung or heart transplant. ECMO is initiated by placing one to two cannulas into the large blood vessels in the neck, groin, or chest, and the cannulas are connected to the ECMO machine, where circulation begins. (To see a photo depiction, visit *this website*; Cincinnati Children's Hospital Medical Center, 2015.) While most patients on ECMO will receive medication to remain asleep and comfortable, sometimes patients are able to wake up and interact.

To facilitate understanding, an ECMO machine and teaching doll were created to use as a resource with patients, parents, and siblings as a preparation tool prior to initiation of ECMO or sibling visits. As most patients are intubated and sedated while on ECMO, this teaching doll has been modified to allow for a breathing tube to be used during preparation. This teaching doll has removable "cannulas" that can be attached to the appropriate location of the body to show the implant site on the patient, as well as an "ECMO" machine to demonstrate how ECMO works and what it will look like in the patient's room.

Materials Needed

- Hard bodied baby doll (around 12-18' in length is best)
- Endotracheal (ET) tube kit
- Red acrylic paint
- Small box (e.g., glove box)
- White Paper
- Strong tape (Tegaderm, packing tape, etc.)
- Drill or scalpel

Directions for Making Teaching Doll with ECMO Support

1. In a hard-bodied baby doll, create a small opening in the mouth with either a drill or scalpel.

2. Connect the ET breathing tube together and place inside the baby doll's mouth. Secure with medical tape (see Figure 1).

3. Using leftover tubes from the ET tube kit or smaller IV lines, cut two smaller tubes to 12-18 inches in length. Use a syringe to fill each tube with red paint. Let dry.

4. Place red tubes under two gauze pads and secure to baby doll with Tegaderm or tape to make a "patch" (see Figure 2).

5. Cover small box with white paper. Draw appropriate symbols and signs to depict appropriate monitoring.

6. Cut two small holes in one side of the box. Place the two red "cannulation" tubes inside the holes on the box. Place the "patch" in the appropriate cannulation site (neck, groin, or chest) to demonstrate ECMO cannulation and circulation (see Figure 3).

Figure 1. The breathing tube connected to the doll.

Figure 2. The painted tubes are secured to the abdomen and covered with gauze.
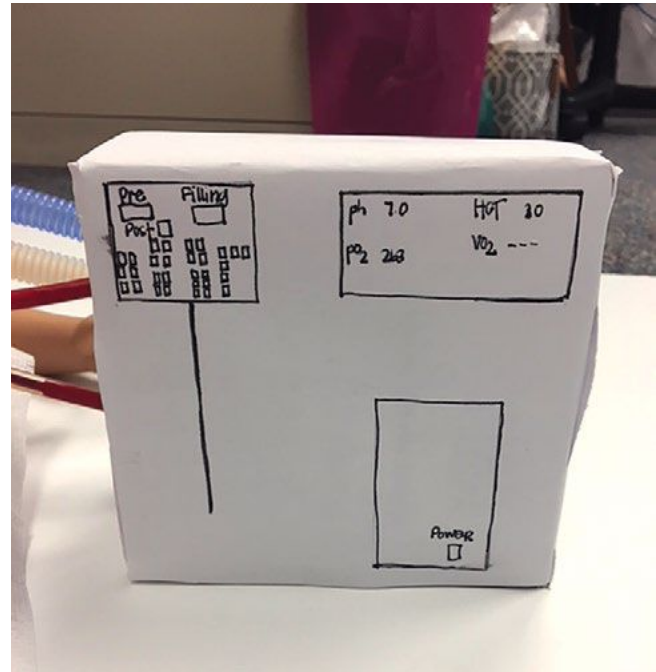
Figure 3. The ECMO machine.

Finished Product

The ECMO cannulas and machine have been connected to an intubated baby doll to be used as a preparation tool for patients and families to better understand ECMO (see Figure 4).

While this has been a successful tool to use for educating patients and families, it has also been used as a tool to assess visitors' readiness to see critically ill patients. The ECMO machine is large and the presence of blood is visible, and not every visitor (child or adult) is comfortable with this type of environment. Using this small-scale teaching modality in a safe environment allows the visitor an opportunity to choose whether a visit to the patient room would be emotionally beneficial.

Figure 4. The ECMO machine connected to the doll.

REFERENCE

Cincinnati Children's Hospital Medical Center. (2015). *Extracorporeal membrane oxygenation*. Retrieved from https://www.cincinnatichildrens.org/patients/child/encyclopedia/treat/surgery/ecmo.

SPRING 2018 | VOL. 36 NO. 2

Child Life Focus

ABSTRACT

Holiday donations, though well intended, cause significant "downstream" consequences for pediatric hospitals in reacting to this generosity. This article explores the development of an "Elf Workshop," one children's hospital's effort to embrace the opportunity of charitable gift giving, as a system which applies LEAN tools, such as the 5S process, to explore an ongoing process improvement strategy that is widely employed across the healthcare marketplace. LEAN process improvements are centered around the core idea that process change should be patient/customer focused (as opposed to system/clinician focused) with an aim towards creating more value for customers in the most efficient way possible. These efficiencies hold the lofty goal of driving out all waste in a process until there is zero waste in the process and the most value to the customer. In this article, the Elf Workshop process is described, LEAN concepts are summarized, and direct application of these concepts to the holiday donations are offered to streamline processes. The data collected at one hospital over five years clearly demonstrates that a well-organized system can yield tremendous benefits both direct (return on investment [ROI] estimate of $346,322.40) and indirect (increased network of skilled volunteers and philanthropic giving). This paper also identifies steps taken to create process efficiencies aimed to increase the quality and quantity of appropriate donations and decrease the work load on child life specialists, thus increasing their ability to offer quality clinical care to children in need. Active attention will be paid to lessons learned in the administration of this process for others who are interested in taking this journey..

Season of Giving:
Applying LEAN Concepts to Improve the Process of Holiday Gift Donations

Michael Campbell, Ph.D, LCSW
SAINT LEO UNIVERSITY, SAINT LEO, FL

Samantha Garrett Klaff, MS, CCLS
NEMOURS CHILDREN'S HOSPITAL, ORLANDO, FL

Background

Each year, as the holiday season approaches, thousands of caring community members set their sights on the more than 400 children's hospitals across North America (American Academy of Pediatrics Committee on Hospital & Child Life Council, 2014) with one aim in mind: "Bring joy to the sick children who will spend the holiday in the hospital!" This altruistic spirit yields ample sentiment of good will and piles upon piles of charitable donations which come with clear downstream consequences, such as mountains of stuffed animals that may cause infection control risks to children with respiratory compromise, or well-intentioned toys that are not developmentally appropriate for the intended target group.

As the health care marketplace is disrupted by the prospect of change, health care systems have turned to donations as an ever-growing source for revenue (Cleverley & Cleverley, 2004). Another area for creative cost reduction is found in the effective leveraging of volunteerism as a complimentary opportunity to help stem current health care financial instability (Bruno & Fiorillo, 2012). Neither of these opportunities replace the professionals who ensure quality care (Anderson et al., 2014), but they can be engaged to help respond in some small way to what the Institute for Healthcare Improvement has identified as the triple aim in hospital

settings: improving the patient experience of care, improving the health of populations, and reducing the per-capita cost of health care (American Hospital Association, 2017).

Effective partnership with philanthropy and volunteer departments in hospital settings can be challenging, but when done well, a symbiotic relationship can form towards that triple aim (Ertas, 2016; Healy, 2000). These direct benefits can be realized for the departments involved and their institution as cost savings or increased revenue (McAllum, 2014; Pietra, 2011). Additionally, there are indirect benefits that come in the form of improved patient experience and the cultivation of engaged volunteers (Donoghue, Graham,

Mitten-Lewis, Murphy, & Gibbs, 2005; Giles et al., 2006; MacDonald & Barrett, 2016). Though they are by no means a systemic fix, philanthropy and volunteerism can be leveraged to produce important gains in this complex healthcare marketplace.

Another aspect of healthcare shift can be found in the ever-growing embrace of efficiency process improvement strategies, such as Six Sigma and LEAN production, championed in the automotive industry and grafted onto other business models, such as healthcare, to reduce waste and bring more value to the end user or customer. In this article, we chronicle one children's hospital's effort to embrace this opportunity through the coordinated use of philanthropy and volunteerism combined with Six Sigma and LEAN

Table 1.

5S Overview

5S PROCESS	DEFINITION
Sort	This step focuses on the elimination of any unnecessary clutter. Tools, supplies, materials, and equipment are sorted by function, and all essential items to complete process functions are kept and the remaining items are eliminated until only the essentials remain.
Set in Order	All items have a predetermined location based on their application in the given process flow. Labels and color coding may be used here to ensure items are organized and efficient in both storage and access.
Shine	In this step, the work area should be properly and thoroughly cleaned and a clear plan is designed to keep it this way every day.
Standardize	All active participants in the process are included in the creation of a set of standards that will become the new norm for the workspace. These standards will require some oversight and enforcement until the new standards are a habit.
Sustain	This step calls for discipline to sustain the positive changes made in the 5S. By setting up a formal system with regular training and communication, the 5S procedures will remain a habit.

production techniques to turn a potential challenge into a smoothly-run process that achieves success.

LEAN and Six Sigma in Healthcare

Stemming from the 1980's efforts in total quality management (Schweikhart & Dembe, 2009), LEAN and Six Sigma techniques have been applied to many industries in an effort to discover waste and inefficiency in processes. For this Elf Workshop project, these two methodologies were employed for systemically augmenting the donation process. These two strategies were chosen because of their previous relevancy to the healthcare setting. As a paradigm for process management, LEAN or LEAN production "…involves a set of principles, practices, and methods for designing, improving and managing processes" (Schweikhart & Dembe, 2009, p. 2). The LEAN methodology is based on the Toyota Production System and has been attributed to their maximization of automobile production efforts. Waste, in the lexicon of LEAN, takes many forms and is born of multiple and often well intended efforts to use anecdotal or prior knowledge to drive decisions versus the use of systematically derived data and data analytics to assess and sustain change (Stevens, 2006).

The origins of Six Sigma were introduced and implemented by the Motorola and IBM companies for their manufacturing production lines (Scalise, 2001; Woodard, 2005). They emanate from a spirit of efficiency and have a goal of increased quality through the elimination of waste in which the DMAIC (define, measure, analyze, improve, and control a process) is used to guide decision making (Scalise, 2001).

The healthcare sector specifically has seized on these novel approaches to try and revolutionize the industry. In healthcare, Six Sigma techniques have been applied to laboratory services (Elbireer, Le Chasseur, & Jackson, 2013), surgical care (Feng & Manuel, 2008), and clinical and translational research efforts (Schweikhart & Dembe, 2009) that all aim to improve care through the reduction of process variation. One element of this process improvement effort, a 5S technique, explores effort to improve the way a system is designed to *sort*, *set in order*, *shine*, *standardize* and *sustain*.

Methodology

This study employs a retrospective review of data derived from the economic return on investment (ROI) produced from the implementation of Six Sigma and LEAN process improvement to the efforts of one child life department in the effective management of accepting in-kind gift donations during the holidays. The study explores the relative gains and costs associated with this program and maps the annual ROI produced (dependent variable). In framing this study, it is important to fully explain the study setting and the Elf Workshop (EW; independent variable) in order to operationalize the data and results.

Study Setting

Nemours Children's Hospital opened in the fall of 2012 as a brand new freestanding children's hospital. It is a 95-bed comprehensive academic medical center with an adjacent suite of ambulatory subspecialty clinics, an emergency department, and

surgical center. The child life department at Nemours Children's Hospital was established with 4.0 FTE child life specialists who devoted their clinical hours to acute care, critical care, surgical services, and the emergency department. The team had over twenty years of collective experience and had worked at several freestanding children's hospitals prior to working for Nemours. As a newly-formed team in a newly-formed children's hospital, all aspects of care, including the accepting of holiday donations, were new processes with no precedent to draw from, so there was freedom to be creative in designing new processes.

Nemours Children's Hospital (NCH) opened on October 22, 2012, nine days before Halloween and two months before Christmas, which, for many child life departments, is the busiest time of year. Holiday season traditions had yet to be established and the team worked to identify the stakeholders and community partnerships for gift in kind donations. For the 2012 holiday season, the child life team was unsure how donations would arrive and to what extent they would have capacity to manage the donations.

At its opening, NCH was the third children's medical facility in the central Florida area and the assumption was that donations would be sparse due to the timing of the opening and the relative novelty of NCH. As the data suggests, the first holiday season brought in the lowest donation total, but by no means was it sparse, and the donations were steady throughout the two weeks prior to the Christmas holiday. The initial plan to reallocate a closet in a fifth-floor play space became quickly overwhelmed, and the team recognized the need for a dedicated plan for year two and beyond. In early 2013, partners were engaged to shape a better plan.

Child life, in collaboration with leadership, sought out the help of the hospital's Continuous Improvement Team (CIT) to identify a process and plan for donations for the holiday season and for ongoing management of donations throughout the year. The CIT is a dedicated resource in the hospital system whose team has specific and extensive training in LEAN techniques. CIT is deployed as needed to partner with local units to identify their process issues and apply techniques, such as the 5S process, to improve their workflow. CIT worked with the child life team to map a formal structure (see Appendix) for

accepting donations that could be utilized by several internal groups (greeters and volunteers who staff the public-facing hospital welcome center) to provide consistency and ease of implementation. Once fully mapped, the new process identified the child life team as the lead program – enlisting the participation of volunteer services, hospital security, concierge/greeting, and the philanthropy department.

These stakeholders were engaged to identify opportunities for process improvement and to acknowledge their contribution to the process successes. The feedback provided by these ancillary teams helped fuel the 5S adaptations and changes (see Table 2), which built the framework for the process and streamlined the acceptance of donations for several years. By streamlining the process and utilizing stakeholders from other

disciplines, ownership was expanded and responsibility shifted from child life to other departments, therefore granting child life the flexibility to focus on holiday programming and direct patient care.

Elf Workshop and 5S

The EW evolved as a revised process to receive the considerable in-kind donations that were received at this children's hospital. As noted in Table 2, there have been many iterations of change to this process and it is anticipated that more changes will occur as needs evolve. Over the course of the five years, the child life team, working in close concert with trained LEAN/5S experts, have continuously mapped, tracked, and refined the EW process to reduce waste and improve efficiency. The needs for some of the changes were intuitive and clear, while

Table 2.

Six Sigma 5S Process Improvements at NCH

5S PROCESS	DEFINITION
Sort	· Define the rubric for what to do with the items and materials received (keeping, sharing, dispose of) · Define the rubric for the placement / organization of sorted materials that are being kept (age group, type of application, location for use) · Define the rubric for redistribution of items that are not kept
Set in Order	· Establish a calendar for holiday events that includes staff assigned to manage / staff the Elf Workshop (EW) · Establish a physical space for sorting and distributing donations during the holiday season that is easy to set up, maintain and take down – this space tends to vary over time · Training on the sorting process to support volunteer involvement
Shine	· Establish and adjust the process for EW set up and take down · Coordinate with housekeeping staff for routine trash pick up · Routine audits to ensure that the process for storing donations in correct storage locations is followed to avoid clutter / trip hazards · Clear a process for the child life team to store, access, and utilize the donations from the EW throughout the year
Standardize	· Develop, review and publish a donation wish list to the hospital web page by mid-October (requesting donations of specific toys and materials of relevance to hospitalized children) · Establish process for receipt and documentation of donated goods · Train / retrain stakeholders on the receipt of donated goods process · Create signage to hang in the Elf Workshop based on sorting rubrics · Define and implement a process for the creation and distribution of a personalized "thank you note" to each donor
Sustain	· Establish and sustain a process for setting up and taking down the EW with a clear and documented visual with map and photos · Build and execute a checklist guided process for dismantling the space with identifiers for reordering necessary supplies prior to reestablishing the space for future holiday seasons · Establish and engage a process for ongoing evaluation of the process · Establish process for gathering, maintaining and using key metrics (such as the value of gifts in kind received, number of donors, hours of time dedicated to the EW) to drive ongoing process improvement

Table 3.

Return on Investment formula for Elf Workshop

GAINS FROM ELF WORKSHOP	COST OF ELF WORKSHOP
estimated value of donations	program supplies
hours of volunteer time *	direct labor cost *

· Replacement cost set at $24.04 hourly based on median salary (Child Life Council, 2013)

others were complex and required much deliberate thought and planning. One of the core aspects of change centered around the intentional application of the 5S tenets (*sort*, *set in order*, *shine*, *standardize,* and *sustain*) to help increase the relative ROI with each iteration of the EW (see Appendix).

Assumptions and model for measurement

In investment literature (Levenson, 2012), the classic ROI formula holds that the value of the ROI is equal to the gain from the investment (what the institution gets out of the investment such as in-kind gifts and volunteer support) minus the cost of the investment (what the institution has to put into the investment such as reallocated staff time and set up/supplies; Pan, Wiersma, Williams, & Fong, 2013). The ROI formula converts to a percentage which has the inherent value of being easily understood and effectively comparable to other time points using the same formula and inputs. For this study, the investment in question is the development and implementation of the EW and the formula can be expressed as the gains from EW minus the cost of EW (see Table 3).

Applying this formula to the study variable, the reported gains from the EW are found in the estimated value of donations plus the hours of volunteer time, which are used as

a substitute for the deployment of the child life specialist and estimated at 1 times the replacement cost of the child life specialist. It could also be argued that, based on the philanthropy literature, this EW program also gains from charitable good will and increased exposure from current and prospective donors. Without an identifiable value in the literature for this, though, it will be noted as an incidental gain and thus not included in the formula.

The EW implementation also has inherent and incidental costs. The formula used for inherent costs included sunk costs (a cost that has already been incurred and thus cannot be recovered) for program set up such as shelves, carts, and miscellaneous office supplies, which are noted in Table 1 as a one-time cost in the first year. In addition to these sunk costs, the cost of labor to facilitate receiving, stocking, and storing of the donations is included. This direct labor cost (a cost that is clearly defined and measurable) is estimated based on the replacement cost for the redeployment of the child life specialists from their clinical role to facilitate the EW. Indirect labor costs (which are less clear and often require clarified assumptions if included) for this model arguably could include an offset for cost-shifting as nursing staff and other members assume the role that the child life specialist had been rendering. As there is no literature for estimating

this cost-shifting impact and to maintain a conservative approach, these indirect costs of the replacement will be noted in the discussion but omitted from the model.

The effective analysis of the EW requires a clean account of the data. A retrospective review of annualized reports was conducted by the research team to create an actionable data set for analysis. One critical assumption of labor costs pertains to the overall capacity of the market system. In this study, that relates to the capacity of the hospital system to manage children in need of care and is often referred to as the "hospital bed capacity" (Giancotti, Guglielmo, & Mauro, 2017). The issue of hospital efficiency is well studied, but each hospital has to factor its unique circumstances to create the optimal ratio of occupied to open beds to ensure a financially viable model.

As such, this study takes place in a moderately sized children's hospital (95 beds) that estimates full efficiency when 80% or more of its beds are full. As this study is conducted in the early winter months of late November to late December, which carries with it a concurrent flu season, it is not surprising that the data from 2012-2016 indicate that each day involved in the study was consistently at or above the 80% occupancy threshold. Table 4 offers the annual gains and costs associated with the EW from 2012 to 2016.

Results

Data was captured from the opening of the hospital in 2012 through the holiday season in 2016. Data in Table 4 reflects the known gains and costs, as well as the analysis of the ROI discovered in annualized and

Table 4.

Elf Workshop Data for 2012-2016

	GAINS (DOLLARS)			COST (DOLLARS)			ANNUAL ROI
YEAR	DONATIONS	VOLUNTEER *	TOTAL	DIRECT *	SET UP COST	TOTAL	
2012	$ 15,000	$ –	$ 15,000.00	$ 1,830.00	$ 1,521	$ 3,351.00	$ 11,649
2013	$ 58,000	$ –	$ 58,000.00	$ 2,537.60	$ –	$ 2,537.60	$ 55,462.4
2014	$ 79,500	$ 240.40	$ 79,740.40	$ 3,196.40	$ –	$ 3,196.40	$ 76,544
2015	$ 95,000	$ 480.80	$ 95,480.80	$ 1,903.20	$ 500	$ 2,403.20	$ 93,077.6
2016	$ 109,687	$ 1,464.00	$ 111,151	$ 1,561.60	$ –	$ 1,561.60	$ 109,589.4
						TOTAL ROI	$ 346,322.40

*Presented in dollars as measured in hours of replacement costs

cumulative results. These data suggest a clear pattern of increasing ROI annually, though the rate of increase seems to be transitioning towards a plateau.

A review of the trend lines for the gains and costs of the EW (see Figure 1) indicates that between the third year (2014) and the fifth year (2016), the intersection of increasing gains and reduced costs offers compelling support for applying 5S strategies as a tool to add value to the patients through reducing wasted effort, resources, and time. Moreover, these strategies appear to have had a sustained effect, which magnifies the potential ROI as there is persistent decline in direct costs and a simultaneous increase in gains through volunteer time. This shift underscores the importance of 5S strategies which drive towards reduced variation in process, secondary to a clear and standardized work flow. In other words, streamlining the process makes it easier to implement, reduces errors, and allows for data collection to assess how intentional changes impact the workflow.

Discussion and Limitations

The complex and shifting landscape of healthcare calls for innovative approaches to meet the triple aim (patient experience, improving health, and reducing cost) in hospital settings (American Hospital Association, 2017). These data offer a compelling analysis which strongly supports the application of 5S strategies to a highly labor-intensive pro-

cess such as the receipt of holiday donations. It appears that the 79% increase in ROI clearly noticed from year 1 to year 2 is likely due to a combination of factors including the increased contribution of partner stakeholders as well as the application of 5S strategies. It is not uncommon to realize significant improvement with a coordination of efforts, but it is unlikely to be sustained if there is not a constant watchful eye on the process.

Increased ROI realized in year 3 (28%), year 4 (18%) and year 5 (15%) signal that the sustained efforts to maintain the 5S strategies is paying off, not only in increased in-kind donations, but also in reduced direct costs which in turn ensured that more children receive the clinical interventions of child life specialists as a part of their care. Simultaneously, the hospital system benefits from increased exposure through the goodwill garnered by having a smooth and efficient donation process for philanthropy and a clear and engaged role for volunteers to help the process (Hassay & Peloza, 2009). Anecdotal reports suggest that volunteering for the EW is one of the favorite activities for volunteers and could be an excellent area for future research on other aspects of child life practice that could benefit from the application of LEAN concepts to reduce waste and increase efficiency/effectiveness with patient care.

The conversion of direct costs to volunteer time has the added benefit of increasing staff morale within the child life team. As noted

earlier, this time of the year is arguably the most chaotic, stressful, and labor intensive for child life staff. When the child life team has to take time from the daily patient care and planned holiday celebrations, they can and typically do experience added stress from their divided desire to manage programmatic needs (managing donations) and the needs for direct patient care. The development of routine roles allowed the team to more effectively deploy in both the EW and in the clinical roles they play daily, which arguably reduces stress and increases job satisfaction, as anecdotally observed in statements from the child life team involved in this study.

This study demonstrates some key findings, but also has important limitations. A clear limitation in this model is that there is a relatively small sample size (n=5 years) from only one hospital site to explore, and the data reported were collected from stakeholders' accounts of the process and not through more objective data capture tools. Future research could improve on this data collection issue by exploring multiple sites in a more longitudinal design. Additionally, there is no direct accounting of the direct costs related with coordination of the EWs to set up the initial 5S process (multiple meetings across many stakeholder groups took them away from their known roles) and in the annual reengagement set up across the various stake holder groups for each EW roll out. A more comprehensive analysis should look at these up- and downstream costs as well as the direct gains and costs realized in the active EW time period. Arguably, these direct costs are more than offset by having child life specialists actively involved in direct patient care as opposed to cost shifting to others on the healthcare team, but this speculation could be more accurately accounted for in a future study.

Despite these known limitations, the outcomes of this study demonstrate that the application of 5S strategies to the labor-intensive process of holiday donations can have multiple benefits that can be sustained over time. The opportunities to reduce costs for toys and supplies are met with the gains from increased networking for philanthropy and volunteers to create clear benefits to the hospital system. The investment of time in the process reduces stress during a challenging holiday season and efforts to decrease costs and increase gains indicates a strong ROI for the EW.
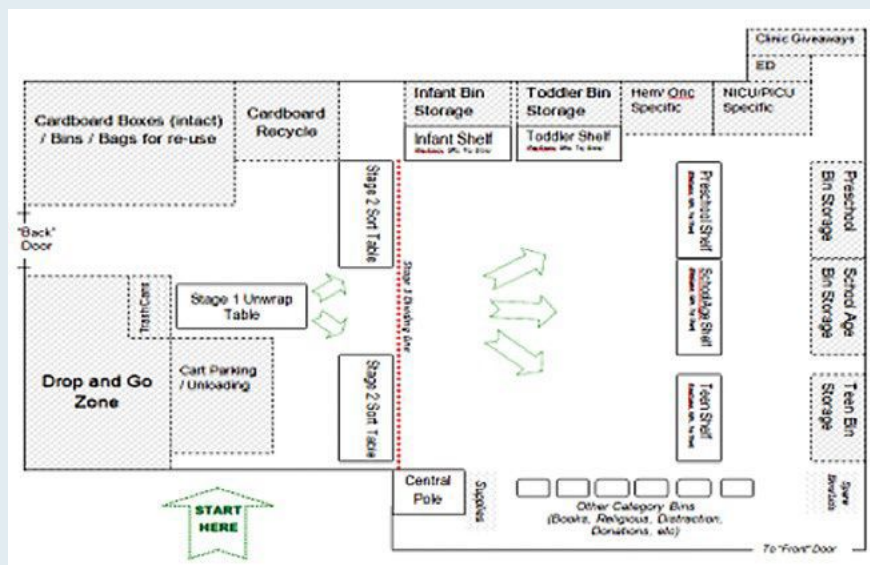
Figure 1.

Elf Workshop Five-year trendline

Elf Workshop Trendlines for Gains over Costs
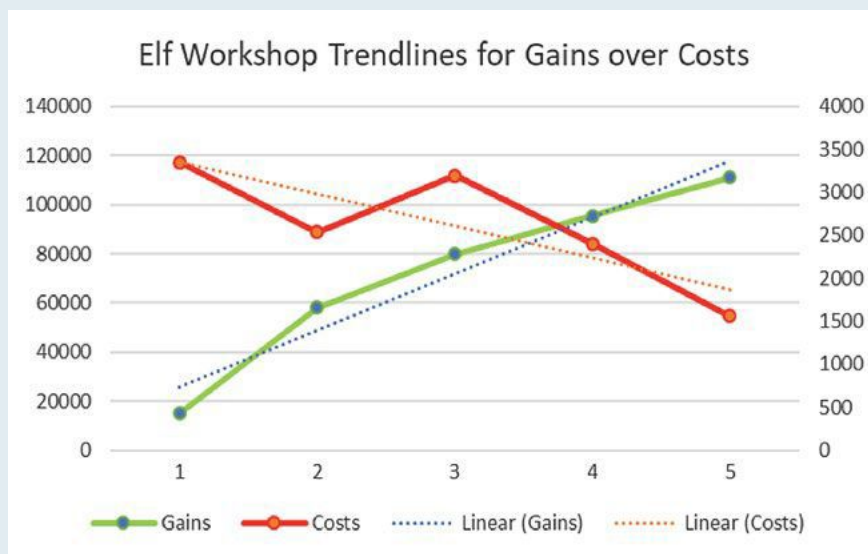
Appendix

Floor plan for the Elf Workshop demonstrating 5S design

In the future, there is clear opportunity to engage volunteer support on an increasing basis once the formal structure is more clearly established. Efforts to preplan the supply chain need, such as itemized accounts of annualized use of crayons, books, toy cars, and craft kits, can help steer the donations to more tailored intake. Finally, this process reinforced the importance of collaborative communication across teams/stakeholders. As the data suggests, opening up these lines of communication can help with problem identification and problem solving, staff buy-in for process change, and the improvement of process change. The rigorous use of LEAN and 5S principles can serve as a framework for eliminating wasted time, effort, and resources and, if done diligently, can help to sustain these efforts over time. 🏃

References

American Academy of Pediatrics Committee on Hospital Care & Child Life Council (2014). Child life services. *Pediatrics, 133,* 1471-1478. DOI: 10.1542/peds.2014-0556

American Hospital Association. (2017). Engaging health care volunteers to pursue the triple aim. Retrieved from www.aha.org/volunteers/tripleaim.shtml

Anderson, N. D., Damianakis, T., Kroger, E., Wagner, L. M., Dawson, D. R., Binns, M. A. ... BRAVO Team. (2014). The benefits associated with volunteering among seniors: A critical review and recommendations for future research. *Psychological Bulletin, 140*(6), 1505-1533.

Bruno, B., & Fiorillo, D. (2012). Why without pay? Intrinsic motivation in the unpaid labour supply. *The Journal of Socio-Economics, 41*(5), 659-669.

Child Life Council. (2013). Child Life Compensation Study. Retrieved from https://www.childlife.org/docs/default-source/the-child-life-profession/2012salarysurveyreportcomplete_uploaded.pdf?sfvrsn=8

Cleverley, W. O., & Cleverley, J. O. (2004). Philanthropy: The last frontier for capital funding. *Journal of Healthcare Management, 1,* 290-295.

Donoghue, J., Graham, J., Mitten-Lewis, S., Murphy M., & Gibbs, J. (2005). A volunteer companion-observer intervention reduces falls on an acute aged care ward. International *Journal of Health Care Quality Assurance, 18*(1), 24-31

Elbireer, A., Le Chasseur, J., & Jackson, B. (2013). Improving laboratory data entry quality using Six Sigma. International *Journal of Health Care Quality Assurance, 26*(6), 496-509.

Ertas, N. (2016). Millennials and volunteering: Sector differences and implications for public service motivation theory. *Public Administration Quarterly, Fall,* 524-558.

Feng, Q., & Manuel, C. M. (2008). Under the knife: A national survey of six sigma programs in US healthcare organizations. International *Journal of Health Care Quality Assurance, 21*(6), 535-547.

Giancotti, M., Guglielmo, A., & Mauro, M. (2017). Efficiency and optimal size of hospitals: Results of a systematic search. *PLoS ONE, 12*(3), e0174533.

Giles, L. C., Bolch, D., Rouvray, R., McErlean, B., Whitehead, C. H., Phillips, P. A., & Crotty, M. (2006). Can volunteer companions prevent falls among inpatients? A feasibility study using a pre-post comparative design. *BMC Geriatrics, 6,* 11.

Hassay, D. N. & Peloza, J. (2009). Building the charity brand community. *Journal of Nonprofit and Public Sector Marketing. 21*(1), 24-55.

Healy, K. (2000). Embedded altruism: Blood collection regimes and the European Union's donor population. *American Journal of Sociology, 105*(6), 1633-1657.

Levenson, N. (2012). Academic ROI: What does the most good? *The Resourceful School, 69*(4), 34-39.

MacDonald, J. M., & Barrett, D. (2016). Companion animals and well-being in palliative care nursing: A literature review. *Journal of Clinical Nursing, 25*(3-4); 300-310

McAllum, K. (2014). Meanings of organizational volunteering: Diverse volunteer pathways. *Management Communication Quarterly, 28*(1), 84-110.

Pan, D., Wiersma, G., Williams, L., & Fong, Y. S. (2013). More than a Number: Unexpected Benefits of Return on Investment Analysis. *University Libraries Faculty & Staff Contributions.* Retrieved from http://scholar.colorado.edu/libr_facpapers/1

Pietra, D. D. (2011). *Trends in U.S. healthcare volunteer hours.* Retrieved from http://www.psdvs.memberlodge.org/Resources/Documents/Trends_in_Annual_Volunteer_Hours_Within_Healthcare_Nationwide_April_2011.doc

Scalise, D. (2001). Six sigma: The quest for quality. *Hospitals & Health Network, 75*(12), 41.

Schweikhart, S. A., & Dembe, A. E. (2009). The applicability of Lean and Six Sigma techniques to clinical and translational research. *Journal of Investigative Medicine, 57*(7), 748-755.

Stevens, D. E. (2006). *The leveraging effects of knowledge management concepts in the deployment of Six Sigma in a health care company* (Doctoral dissertation). Retrieved from ProQuest Information and Learning Company.

Woodard, T. D. (2005). Addressing variation in hospital quality: Is Six Sigma the answer? *Journal of Healthcare Management, 50*(4), 226.

The ELF Workshop Through the Lens of 5S

Michael Campbell, Ph.D, LCSW
SAINT LEO UNIVERSITY, SAINT LEO, FL

Samantha Garrett Klaff, MS, CCLS
NEMOURS CHILDREN'S HOSPITAL, ORLANDO, FL

Child life specialists know all too well the joys of community donations, especially during the holidays. One free standing children's hospital had the opportunity in the winter of 2012 to start from scratch with their holiday donation process. Nemours Children's Hospital opened to the Orlando community eight days before Halloween and less than eight weeks before Christmas. This happy and hectic time is familiar to the child life team but many in the hospital administration were unaware of the significance of the timeline between opening and the first holiday season.

This article will elaborate on the implementation of a holiday donation process in a free-standing children's hospital after opening and the steps taken in the following five years to provide a framework and process for managing community partnerships and donations while maintaining coverage for patient care and special events. For the first holiday season, the child life team anticipated small levels of community donations as the hospital was the third facility in the Orlando area providing pediatric care to children, and the two other facilities have well established child life programs and strong partnerships and ties with the community.

The initial plan was to sort donations by developmental age groups (infants, toddlers, preschool, school age, and adolescents) in a storage closet. Two weeks before the hospital's first Christmas in 2012, the team of child life specialists (the team) was elated and overwhelmed to realize the community outpouring would be more than we could initially handle. After that holiday season, we convened and requested the support of the continuous improvement (CI) team to help devise a process utilizing the 5S concepts to manage donations and to incorporate ancillary teams within the hospital to streamline all gift in kind donations. Having previously worked with the CI team, the team was confident CI would provide us the strategies and framework (5S method) necessary to move forward and to offer ways to refine the process each year.

The 5S methodology integrates five principles: **sort**, **set in order**, **shine**, **standardize,** and **sustain**. Utilizing this framework, the child life team evaluated the first year's success and focused on the challenges and how to reduce those moving forward. We invited members of the hospital team (environmental services, volunteer services, the development office and marketing and communications) to speak with us on their experiences and how the team could work together to streamline the donation process hospital wide. We spent a week with the CI partners to "walk through" the holiday donation season on paper and then build the processes and the actual Elf Workshop structures for the second holiday season.

The Elf Workshop (EW) is both a series of processes and a physical place. The processes of the EW, such as donation receiving, sorting, and storing, are informed by the tenant of 5S with the aim of efficiency. The 5S

The 5S methodology integrates five principles: sort, set in order, shine, standardize, and sustain. Utilizing this framework, the child life team evaluated the first year's success and focused on the challenges and how to reduce those moving forward.

informed structures of the EW include the shelving used in the physical floor plan, the space dedicated annually to sort and store donations, and the space dedicated to house the shelves and tools used to recreate the EW on an annual basis. Consideration was given to the materials needed for the workshop, keeping in mind that the workshop would be transient and needed to be stored during the off season. This provided interesting challenges as the workshop was designed in one space and had a new location each year for three of the five years!

Sort

To start, the team began with the **sorting** stage. We carefully outlined the needed tools, supplies, and materials. This included purchasing necessary shelving that would be easy to assemble and disassemble as well as stackable plastic storage bins for sorting and storing donations. A flow schematic was drawn up to clearly identify sorting and storage areas to delineate the necessary space to be efficient, and previous donations were then organized and sorted by function to ensure that all essential items to complete process functions were available while the remaining items were eliminated. For instance, in the first year of the hospital's opening, the team used a small cart to accept donations, and we found early on that this small cart was a poor tool for receiving since it was typically not large enough to manage the initial donation and it left no space for addi-

tional donations that arrived and were unplanned. The EW process evolved to have a much larger resource to both transport and house donations. This initial process failure and many others were discussed in the EW planning stages. The child life team was able to walk through our thought processes on how items could and would be sorted to help eliminate the need to change the set up frequently during the second holiday season.

We worked to create a clear visual for what they or volunteers needed to do with supplies obtained and donations received to ensure a routine process. This included written directions with photographs explaining what donation items were kept for in-hospital use. Clear rubrics were created to outline the management of donations that were not to be kept by the hospital (i.e., items that did not meet infection control standards or posed a choking hazard). These items were to be shared with partner agencies in the local community through a clearly defined process. Some items received were not appropriate or safe and were discarded. These rubrics served to further define the placement/organization of the gifts by age group, type of application, or location for their use within the health system. In total, these rubrics served to provide routinization and clarity of process, which helped to ensure that child life specialists and volunteers were sorting donations in a standard

The ELF Workshop Through the Lens of 5S

way. At the end of each holiday season, the standard process was revisited to provide opportunity for consolidation, change, or reflection on how items were sorted and used.

Set in order

Next the team **set things in order** using labels and color coding, along with other visual aids, to ensure that items were organized and efficient in both storage and access. One of the challenges after donations season is integrating the donations into routine use. Identifying the main areas of use (diversion, gifts, arts/crafts, stuffed animals, and clothing) helped to streamline getting those items into the correct storage for utilization throughout the year. Establishing these large "buckets" for donations helped to create the framework for the actual workshop and the integration of developmental levels for additional sorting.

A critical evolution of the "set in order" phase was the establishment of a designated physical space for sorting and distributing donations during the holiday season within the EW. This space was repurposed during the non-holiday time and moved in location within the hospital system. Having clearly defined parameters of the minimal space needed ensured that once space was secured, the EW was easy to set up, had the capacity to be maintained in place, and there was a clear process to take down the EW and set it in designated storage until the next holiday. Staffing this space with volunteer support called for education, and we provided initial and ongoing training on the sorting process to support volunteer involvement as new volunteers were added. Training guides were posted with necessary photographs in the EW for quick and easy use. The EW volunteers and child life staff had access to a dedicated phone

for ease of communication regarding questions and concerns that arose while maintaining the EW space.

Additionally, the child life team set in order the holiday special events calendar and sought out feedback from other hospital teams to streamline that process as well. A detailed calendar was established for managing holiday events, including identifying staff assigned to manage/staff the EW, with volunteer support, for defined timeframes throughout the day. We evolved to identify a designated EW child life staff member for mornings and afternoons to ensure that EW volunteers had an identified contact and to ensure that staff members did not have competing patient care duties to divide their time. This provided a streamlined point of contact for donors and volunteers as well as the hospital security team seated at the hospital greeter's desk. This process was critical as it allowed the child life staff to coordinate our assigned donation shifts with patient care responsibilities in an effort to ensure patient care coverage as a first priority during an often high-census respiratory season.

Shine

Following the 5S framework, the team moved to **shine**. As it implies, shine is ensuring that the process remains clean. In the case of the EW, managing

donations and the various containers that they would arrive in provided a unique challenge for maintaining the space and not being overrun with trash and cardboard. We worked closely to coordinate with environmental services (EVS) staff for routine trash and cardboard box pickup since the EW sorting and storage location was in a non-patient care location. This coordination took place in advance of the EW set up to allow lead time for the EVS team to reassign staff to manage the temporary need. Ongoing daily communication with the EVS team helped facilitate trash removal and the ability of their team to quickly bring cleaning supplies when requested. Additionally, providing the EVS and security team with cookies during the holidays increased collaboration and cooperation during the stressful weeks leading up to Christmas and the peak donation flow days. This little bit of customer service shine went a long way to build cohesion and teamwork during those stressful moments.

CI experts utilize audits to ensure that the processes are being maintained and workarounds are not occurring. Audits were done by various stakeholders to ensure that the process for storing donations in correct storage locations was followed to avoid apparent clutter, and most importantly to avoid trip hazards which can easily accumulate

Table 1

Shine: Processes to Store, Access, and Utilize Donations

PROCESS	OUTCOME
Storage	· Define bin sizes to fit established shelving · Control weight/size for movement · Organize to accommodate existing transportation tools (carts/wagons)
Access	· Clear process for set up and take down keeps the area clean/clear · Process is organized and thus sustainable
Utilize	· Use clear/see-through bins which allow for consistent size and visualization in sorting · Clear bins allow visualization audits to be easily conducted · These audits allow for current/future inventory management

with the rapid influx of donated bikes and toys. In addition, the facilitation of EW provided a central location for data collection on types of donations, the financial impact of the donations, and the type of work completed and by whom to help frame for administration the impact of gifts-in-kind for child life and the hospital. Shine challenged us to establish a clear and clean process to store, access, and utilize the donations. We outline these processes in Table 1.

Standardize

Standardization was integrated throughout the establishment of the EW and helped the child life team to understand what was in storage, what was needed for patient care, and what was desired in donations to augment clinical practice throughout the year. This reflection within the team occurred in early October to help plan for the holiday season as well as provide time to publish the hospital's wish list. By spending the time in October, we could frame the need to the community and help eliminate unnecessary donations that were cumbersome to manage and not effective or helpful to the team.

One clear example of standardization can be illustrated in the team's way of thanking donors. We recognized the power of a personalized thank you; however we could not completely personalize a note to every single donor. Instead, we worked to define and implement a process for the creation and distribution of thank you cards that were sent to donors. Each donor was mailed a handwritten thank you card with a standardized response and a photo of a thank you banner that showcased artwork of the children in the hospital. The incorporation of the children's artwork was essential to ensure that the donors felt a connection to the institution, and the standardization of the thank you card process assisted in

reducing the time spent sharing appreciation to individual donors during the busy holiday/donation season. The child life team used this process to build continuity with donors since networking is a key tool in establishing connections in the community.

Finally, the child life team worked tirelessly to sustain the EW over time and invested time to refine the process each year. We worked to establish and sustain a process for setting up and taking down the EW using a clear and documented visual that included a map and photos. A formal system of assessment and reassessment was conducted to review both process compliance (audits of the cleaned workspace) and outcomes (routine cataloging of gifts received and resources invested in terms of both time and supplies).

We engaged hospital leadership at the start and close of the EW to review the checklist used to guide the process for dismantling the space. This checklist helped to drive the process for reordering necessary supplies prior to reestablishing the space for future holiday seasons which made setting up future EW sites much smoother. We

evaluated the process for gathering, maintaining, and using key metrics to drive ongoing process improvement through a stakeholder check-in that included members from the child life team, volunteer services, security personnel, housekeeping and hospital leadership after the EW concluded. Debriefing with those actively involved, both within and outside the child life team, provided opportunities for refinement and enhancement that increased collaboration and communication within the departments (EVS, security, philanthropic arm, volunteer services, and child life.) The rigorous application of these 5S principles has guided the team to improve care for children and maximize returns from the EW, and could be a model for other teams interested in improving their workflow processes. Integrating the 5S framework provided much-needed structure to the overwhelming holiday season and offered a concrete method to reflect on the successes and challenges of the season. Holiday donations no longer feel like a year end burden to manage, but rather a process that unfolds throughout the year (see Figure 1).

Figure 1. *Elf Workshop (EW) evolution throughout the year.*

EXPLORING COMMUNICATION DIFFERENCES:
Complications Children with Developmental Disabilities Face in Medical Settings

Angeles Nunez, MS, CCLS, CPMT
WOLFSON CHILDREN'S HOSPITAL, JACKSONVILLE, FL

Children with developmental disabilities often face challenges in medical settings where their families and health care providers may be left unsure of how to best interpret the child's behaviors and nonverbal communication. This is a fundamental topic for many child life specialists and it has become more relevant in recent years as the diagnosis rate for several disabilities has increased, underscoring the importance of refreshing our knowledge in order to continually help our patients to the best of our abilities. In order to best support the children in this population and create a more welcoming and inclusive environment, health care providers will need to have a basic understanding of developmental disabilities and know how to properly assess the child and family while utilizing the appropriate communication strategies.

According to the American Psychiatric Association (2013), neuro-developmental disorders, also known as developmental disabilities, are characterized by impairments of personal, social, academic, or occupational functioning. In medical settings, children with developmental disabilities may not be able to interpret or express pain the way typically developing children do. The child's inability to communicate pain and emotion may result in increased frustration, anxiety, and/or challenging behaviors. An important factor to consider is that the lack of verbal language does not mean the child cannot communicate. While verbal language may be lacking, the child is constantly communicating through their body language and behaviors.

A child's difficulty with verbal communication can cause a strain between the patient and healthcare provider, due to either the subtleness of the stress response or the overwhelmingly overt response. This leaves the child frightened, without support and without a way to communicate (Andrews, 2015). This can lead to not only a stressful experience, but a traumatic one for the child and family. The needs of children with disabilities are very similar to the needs of typically developing children

but can be more difficult to interpret. As child life specialists, we need to support this population by reminding health care providers about how medical experiences can affect children with disabilities differently and how their distress or discomfort may be expressed.

The Effect of Medical Care Experiences on Children with Developmental Disabilities

Children with developmental disabilities often have co-existing disorders such as epilepsy, language disorders, attention deficit-hyperactivity disorders (ADHD), and intellectual or sensory integration disorders (American Psychiatric Association, 2013). These children encounter medical settings more frequently than typically developing children, experiencing an overall greater number of physician visits, non-emergency care visits, hospital care, and hospital emergency care visits per year (Muskat et al., 2015). They are at a higher risk for having an accident or injury and are more likely than typically developing children to be taking long term medications (Muskat et al., 2015). Children with developmental disabilities are more likely to have higher levels of anxiety as well as behavioral problems (e.g., noncompliance, self-stimulatory and self injurious behaviors) than typically developing children (Johnson & Rodriguez, 2013). This population often feels pain and discomfort in response to stimuli that typically developing children would not find uncomfortable (e.g., a hug, the texture of the bed sheet, or the smell of the nurse's perfume; Andrews, 2015). Factors in the hospital setting that can affect children in this population and contribute to increased levels of distress are the child's hypersensitivity to auditory, visual, or other sensory stimuli and the child's overall sensory defensiveness, which is the child's aversion to certain environmental elements

An important factor to consider is that the lack of verbal language does not mean the child cannot communicate. While verbal language may be lacking, the child is constantly communicating through their body language and behaviors.

(Johnson & Rodriguez, 2013). Other contributing factors include unfamiliar settings and unfamiliar people. While the basic needs of children with developmental disabilities are very similar to those of typically developing children, meeting their needs may be more difficult in an environment that these children cannot control (e.g., sensory stimuli such as loud noises and smells that can occur unexpectedly and lead to a sensory overload).

Ways that Distress is Expressed in This Population

Children with developmental disabilities may have hyporesponsive (delayed or absent response to stimuli) or hyperresponsive (exaggerated, often negative response to stimuli) reactions during what we would believe to be simple medical procedures, such as having a stethoscope placed on the chest or having a bandage placed on the injured site (Johnson & Rodriguez, 2013). Cognitive impairments may affect the child's understanding of procedures and their use of coping mechanisms. These children may display socially unacceptable behaviors, or have heightened anxiety and uncommon coping styles that can add further complexity to their process of preparation and coping in a variety of settings including medical settings (Johnson & Rodriguez, 2013). A sensation such as pain can sometimes be communicated through nonspecific and maladaptive behaviors, leaving room for others to misinterpret the emotions being expressed. If healthcare providers do not have adequate knowledge of developmental disabilities and

are unaware of the different strategies that can be used with this population, the child is left to be misunderstood and their family is left without support.

Assessing This Population

As child life specialists, part of our role is to educate families and healthcare providers on how children communicate and interpret their surroundings. During initial assessment, it is important to include questions for the family regarding the child's environmental triggers, which can be any stimuli in the environment that can cause behavioral and/or emotional outbursts.

Questions to ask during assessment may include:

- How does the child react to new people or new environments?
- Is the child sensitive to noise or touch?
- How does the child communicate?
- What techniques do you use to calm the child? Is the child able to self-calm?
- Does the child have any preferences (i.e., items, colors, textures, words)?
- Is there anything the child considers intolerable (i.e., items, colors, textures, words)?
- Has your child had a previous negative experience in a medical setting?

Autism Speaks, n.d.; Johnson, Lashley, Stonek, & Bonjour, 2012

It is essential to work closely with

Exploring Communication Differences

families to learn how the child interacts and communicates (e.g., visual supports such as social stories, visual schedules, first-then boards) and about inflexibility or adherence to routine and transitions. Using techniques that have been successful in the past can improve the child's understanding of the experience, reducing anxiety and the possibility of behavior outbursts (Autism Speaks, n.d.). Social stories are often used to prepare children for unfamiliar people and places; this can easily be adapted for medical preparation by breaking down the procedure into visual and auditory steps. When creating a social story, it is essential to remember to customize each story for the individual child, making sure that it is developmentally appropriate and every step of the process is included. Typically, social stories will have pictures and words, and the specificity of the steps will vary depending on the developmental level of the child (i.e., while some children may have a very detailed 10-page social story, another child may only need a 3-page social story with just the basics). First-then boards can also be created in order to encourage the child by clarifying a preferable item/activity after the non-preferable activity (i.e., first use inhaler, then play with toy cars). Visual supports can include printed pictures, drawings, or actual photos of the child
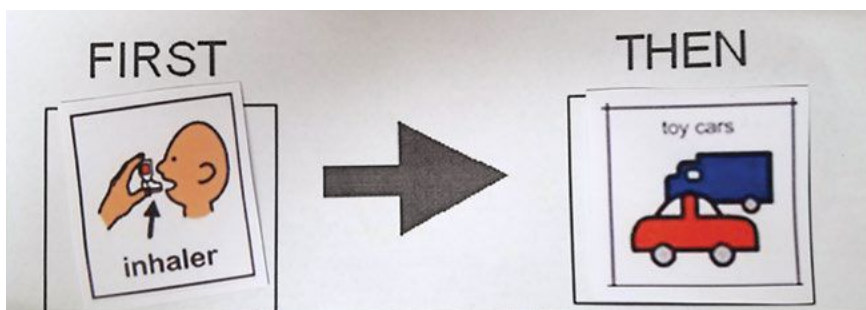
and healthcare providers they will be working with. An important means for understanding a child with developmental disabilities is to pay attention to their body language and reactions to different situations; learning to understand how the child may be feeling can help to avoid outbursts (Buchholz et al., 2016). Triggers can be environmental, such as excessive stimuli, or internally driven, such as fear, pain, or separation from parents (Johnson et al., 2012).

Child Life Interventions

As child life specialists, we work closely with families to learn how each child communicates and how to best help the child cope in medical settings. We need to ensure that healthcare providers are approaching the children in this population with awareness and that they are being assessed continually in order to provide the best care. Often children with developmental disabilities are triggered when their routine

changes; even small changes in routine can determine whether the child will continue to cooperate and cope. During preparation, it is important to provide children with simple steps that they can follow, along with visual supports in order to allow for a sense of control in the environment. It may also be helpful during advanced preparation to send visual supports home with the family in order for the child to become familiarized with the events that will occur (Buchholz et al., 2016). As child life specialists, we must remind healthcare providers and the interdisciplinary team about the strategies that can be used with this population. Advocacy is the key to supporting these patients and families. Each child, despite their diagnosis, has a different temperament and may react differently to different situations. Care needs to be individualized and it cannot be assumed that each child with a developmental disability is the same. 🏃

REFERENCES

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.

Andrews, V. (2015) Interpreting silent cries: Providing child life services to children with severe cognitive impairment and altered states of consciousness. *Child Life Council Bulletin, 33*(4), 8-9,

Autism Speaks (n.d.) *Taking the work out of blood work: Helping your patient with autism*. Retrieved from https://www.autismspeaks.org/

science/resources-programs/autism-treatment-network/tools-you-can-use/blood-draw-toolkits

Buchholz, M., Nilsson, S., & Thunberg, G. (2016). Strategies that assist children with communicative disability during hospital stay: Parents' perceptions and ideas. *Journal of Child Health Care. 20*(2), 224-233.

Johnson, N.L., Lashley, J., Stonek, A.V., & Bonjour, A., (2012). Children with developmental disabilities at a pediatric hospital: Staff education to prevent and manage challenging behaviors. *Journal of Pediatric Nursing. 27*(6),

742-749.

Johnson, N. L., & Rodriguez, D. (2013). Children with autism spectrum disorder at a pediatric hospital: A systematic review of the literature. *Pediatric Nursing, 39*(3).

Muskat, B., Burnham Riosa, P, Nicholas, D. B., Roberts, W., Stoddart, K. P., & Zwaigenbaum, L. (2015). Autism comes to the hospital: The experiences of patients with autism spectrum disorder, their parents and health-care providers at two Canadian paediatric hospitals. *Autism, 19*(4), 482-490.

ACLP Conference:
Bring the Inspiration Home

Ashley Currie, MS, CCLS
HEALTH SCIENCE CENTRE, CHILDREN'S
HOSPITAL, WINNIPEG, MB, CANADA

Dawn Kidder, CCLS
HEALTH SCIENCE CENTRE, CHILDREN'S
HOSPITAL, WINNIPEG, MB, CANADA

Attending the ACLP conference affords child life specialists opportunities to expand their clinical skills and network with child life professionals worldwide. Attendance shows commitment to staying current and acquiring knowledge, incorporating new knowledge into practice, and sharing this knowledge with child life colleagues and other health care professionals.

As a long time attendee and a first time attendee, we found the 2017 ACLP conference to be exceptionally beneficial. One session especially, "You Want Me to Use Comfort Positions? YES!" delivered by JoHannah Orman, MEd, MA, CCLS, and Jennifer Rodemeyer, MA, CCLS, inspired both of us to revisit the idea of comfort positions and examine how they are currently utilized within the Health Science Centre, Children's Hospital, Winnipeg.

As child life specialists familiar with comfort positions, we assessed that our facility was not consistent in utilizing these techniques as a standard practice in comforting children during medical procedures. We observed that often the mindset of getting the procedure done as quickly as possible with limited choices was more common than we cared to admit. We realized that in our daily collaboration with nurses we were in a position to provide reeducation on comfort positions and advocate for their use. We came back from the ACLP conference revitalized and passionate about the wealth of knowledge we had obtained and eager to incorporate new techniques. But what was the next step? Why were we so excited? And where did we go from here?

Why were we so inspired?

The presenters at the session asked an important question; "When should comfort positions be used?" Their answer: "ALWAYS!" During every procedure there is often an opportunity to place a child in a position where they are most comfortable and comforted. This intervention supports family-centered care approach and allows opportunities for children and families to gain more control and caregivers to have a more satisfying experience. The presenters of this conference session described how they managed to elevate the usage of comfort positions to a new level in their practice. By developing a policy and competency statement about comfort positioning, they were able to train staff, thereby empowering multiple disciplines to deliver these techniques to patients and families. As Certified Child Life Specialists, we were familiar with the universal "hug hold," but felt limited to this specific technique. Learning the variations to comfort positions and being able to practice them and see visual representations of them during the conference presentation was a huge inspiration to us, and a large part of why we felt compelled to really utilize this information within our facility.

What have we done with all this enthusiasm?

While this presentation was fresh in our minds, we immediately put into practice what we had learnt with our

ACLP Conference: Bring the Inspiration Home

closest teammates, the nurses. One opportunity arose when we followed up on a consult from dentistry, a department unfamiliar with child life. The consult was to support an anxious child and the team was ready to use a papoose board, essentially restraining the child. We initiated a dialogue to discuss comfort positions, and were able to propose to the staff that we use a modified comfort position where the caregiver was able to still hold the child and have some control during the procedure. The caregiver felt included and the patient was compliant. The staff was happy to have an alternative to the papoose board to better support this family.

The outpatient oncology clinic offers numerous chances to collaborate with both families and nurses, and without hesitation, we welcomed several opportunities to initiate and practice different comfort positions with nurses in this area. Of particular interest was the use of the chest-to-chest position for an NG insertion on a 4- year old child. The parent, child, and nurse were on board with trying this position, and the procedure was completed with minimal distress. After the procedure, we facilitated a dialogue to debrief with the parent and nurse, and to make modifications for future experiences. With each new NG insertion we honed our skills. During one of the earlier procedures, the NG was placed incorrectly and the nurse immediately blamed it on the comfort position technique. However, through continued positive dialogue between the child life specialist and nurse, the nurse admitted, "We can't be certain it was the comfort position that was the problem, and we will continue to try, because we know this is best for the child." A parent, having experienced this procedure both with a comfort position and without stated, "My child won't be rolled up like a burrito again." We continue to offer this chest-to-chest position of comfort to our families for this procedure, as well as others where it is appropriate.

Who can we share this with?

Experiencing is believing! One clinical resource nurse, pleased with the results of using comfort positions, shared, "Child life specialists can't be the only ones who know comfort positions, nurses need to know this too. I am going to talk about comfort positions at all orientation sessions for new oncology nurses." This was not only validation that nurses do see the benefits of comfort positions, but presented an opportunity to participate in the educational process with nurses.

Curious if comfort positions were included in early pediatric nursing education we reached out to the clinical practice-child health course leader at the Red River School of Nursing in Manitoba who informed us, "There is little theory [about comfort positions] and no skills lab currently being taught to new nurses in training." We have since been invited to collaborate with the school of nursing to develop a pediatric module for nursing students. The school is committed to the collaborative process and has shared with us that they have access to the funding to develop resources.

How do we put this into practice?

Almost one year after the conference, we are still committed to this process. We know that developing a new standard of practice will not happen overnight, but by collaborating with nursing, we will be able to reach more staff and help train more people to become competent in the skill of using comfort positions. The opportunity for continued networking that conference presenters offered has been extremely beneficial, and we have been in touch with them for support along the way. We have incorporated new knowledge to guide our education process in developing resources. The process we followed post conference included:

- Sharing new knowledge
- Inviting opportunities to practice these new techniques in a clinical setting
- Initiating dialogue with staff and families
- Encouraging and celebrating each success
- Staying current with evidence-based practice
- Staying persistent and not giving up.

We feel privileged to be part of the ACLP community, which has enabled our professional growth. Something we first heard in the closing session of the ACLP's 2017 conference sums up our experience:

If you want to go fast, go alone.

If you want to go far, go together.

African Proverb

REFERENCES

Orman, J. & Rodemeyer, J. (2017, May). *You want me to use a comfort position? Yes!* Paper presented at the Association of Child Life Professionals Annual Conference, Las Vegas, NV.

Shining a Light on Internship Accreditation

Erin K. Munn, MS, CCLS
ON BEHALF OF THE INTERNSHIP ACCREDITATION OVERSIGHT COMMITTEE

In January 2016, ACLP reached a milestone many years in the making: The first applications for clinical internship program accreditation were submitted for official review, and in the spring of 2016, the first child life internship programs received accreditation. This milestone served as a turning point for our profession, as child life internship accreditation moved from idea to reality. Numerous ACLP groups and task forces participated in the development of internship accreditation and the procedures designed to evaluate, enhance, and publicly recognize quality child life clinical internship programs. Ultimately, accreditation serves to promote the interests of students and the child life profession as a whole through assurance that accredited programs meet professional standards and requirements for educational quality and operational integrity.

At the conclusion of the second year of the process, 51 internship programs have successfully completed the accreditation process and are now listed on the *ACLP webpage listing of accredited internships*, with 12 more programs currently in the process of submission and review.

This past fall, the Internship Accreditation Oversight Committee (IAOC) surveyed key stakeholders in the internship accreditation process—child life students and internship programs—to learn more about the impact accreditation has had in the first two years. Two surveys were created, one specific to gathering student feedback and one for internship programs. The surveys were made available via the respective discussion forums of the ACLP Community (the Students and Interns Forum and the Internship Coordinators Forum).

> *Being accredited tells learners that we take our role to guide them towards their goals very seriously. While they are committed to learning, giving their best, and developing in their career quest to become a child life specialist, we too are committed to working hard and being our best. Accreditation means that we commit to continually strive for excellence, accountability, and intentionality in our program to assure students receive our best.*
>
> *—Caroline McIntire, Children's Mercy*

Student Perspective

The IAOC received a total of 60 responses to the student survey. All respondents resided in the United States, and 98% identified as female. Of the 60 respondents, 85% reported being aware that there is an internship accreditation process, while 15% of respondents reported being unaware of internship accreditation. For the 85% indicating awareness, additional questions provided greater insight into their understanding of accreditation as well as its potential influence on behavior. In response to the question "What does accreditation status mean?", several themes came through, with accreditation being defined as having "met rigorous standards set by ACLP," and accredited programs being described as "comprehensive," "well-rounded," and "best suited to prepare" students for the exam and to be "successful child life specialist[s]."

Two questions were asked related to the influence of accreditation status on internship choice. In response to the question "How important is it to you that you complete an internship at an accredited site?", 65% identified this as being important or somewhat important, 17% reported being neutral about the importance of accreditation status, and 17% identified accreditation of internship sites as somewhat unimportant or unimportant. Drilling down a little further, respondents were asked "If offered two internship positions,

Shining a Light on Internship Accreditation

one at an accredited site and one at a non-accredited site, would accreditation status affect your decision?" Seventy-four percent responded that yes, accreditation would affect their decision.

Program Perspective

The IAOC received 43 responses to the survey from internship coordinators, with 16% of those responding reporting from an accredited internship and 84% from a program not accredited at the time they completed the survey. Respondents from programs who had not submitted for accreditation identified barriers of needing more information about accreditation (74%) and not believing that accreditation would benefit their program. Among respondents who reported feeling that accreditation would not benefit their

program, themes included too many applicants already, not enough time or staff to offset potential benefits, new and/or small programs, not enough time to complete application, and not meeting required criteria (with structural differences such as rotation lengths being the most commonly reported reason for not being able to meet the standards).

Respondents from programs who had

To be one of the first programs that received accreditation by the ACLP validated to us that it doesn't matter about our program size. . . . Our team can proudly say that we have prepared a professional who will positively impact the lives of countless children and families.

—Amy Derchak, Mission Children's Hospital

achieved accreditation by the time of the survey identified a number of benefits. Several words appeared over and over in respondents' reflections on the meaning of accreditation to their program: accomplishment, pride, and validation. Respondents highlighted that receiving accreditation served as a validation of the quality work and training being provided by their staff as well as an example of the program's

Application Tips from Accredited Programs

- Start early; many programs recommended beginning program self-evaluation 12 to 16 months before the application deadline.

- Budget for the accreditation fee and create a plan for the staff time involved.

- Ask for help from others in the department. Many programs reported having a student committee or task force to share the numerous responsibilities, such as de-identifying and converting documents to pdf format, updating student materials (in-services, reference lists, schedule or calendar examples), proofreading, and editing.

- Be patient and pace the work. As you review and gather your materials for the application, take the opportunity to go beyond just reporting what your program already does — identify opportunities for improvement and make changes as you go.

- Be thorough and provide supporting documents that expand on the narrative responses and serve as evidence in every section. Look for gaps and put additional systems in place to clearly document program practices. Many programs reported that creating documents that formalized their programs' unwritten practices strengthened their internships overall, ensuring consistency and operational integrity.

- Explore the application portal before beginning to upload your application materials. You will receive access to the application portal 2 to 3 months prior to your application due date.

- Enlist colleagues one more time to proofread and edit, with two, three, and four sets of eyes. Have at least the same expectations of attention to detail and carefully following directions as you expect of students who apply to your internship. Fresh eyes are especially helpful to catch the things that those who have read and revised the same section multiple times may not notice anymore.

- Reach out to the IAOC at *InternshipAccreditation@childlife.org* at any point if you have questions.

commitment to students and the child life profession as a whole. Some benefits were identified as stemming from the application preparation process, not only as a result of the accreditation designation. Several respondents noted that, although the application process was time-consuming and involved the efforts of multiple staff members, it also created engagement and connection within the department, re-energized staff around student programming, and brought about a deeper understanding of internship education. Other respondents described the value of going through the accreditation process in assisting with educating administrators about the importance and significance of internship programming and highlighting their department's contribution to broader organizational goals.

Though accreditation is still in its early days, several respondents did report observing an increase in the number and quality of intern applicants since becoming accredited, and other respondents noted the down-stream benefit of seeing an accredited internship experience on the resume of a job applicant as providing a level of assurance in the quality of a potential job applicant's training.

Summary

For the IAOC, three key points stand out for identifying next steps:

- Among students, there is awareness of internship accreditation as an indicator of quality and program accreditation status as a factor in internship choice.

- Accredited programs highlighted the benefits in the accreditation process itself, not only as a result of receiving the accreditation designation.

- The most significant barrier identified by programs that had not pursued accreditation was the need for more education on the process.

With a better understanding of how these key stakeholder groups view internship accreditation, the committee has been working to update existing education materials, like the *informational webinar*, and to develop new resources, including an internship accreditation information guide that has been shared on the internship coordinators' and program leaders' discussion forums. The IAOC extends our thanks to the students and program staff who took the time to respond and share their perspectives on the value of accreditation. 🏃

We have seen an increase in candidates from top tier academic programs along with an increase in the number of applicants. We have more students coming from out of state, which only enriches our program.

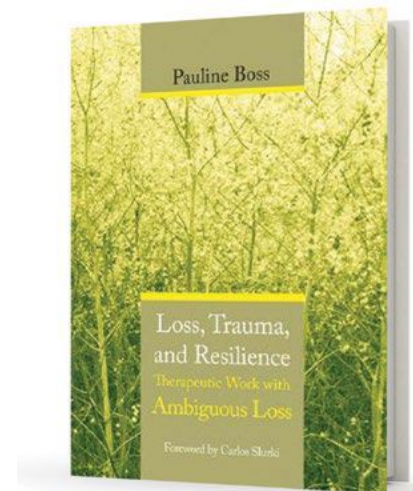—Adina Bodolay, Mattel Children's Hospital

Loss, Trauma, and Resilience: Therapeutic Work with Ambiguous Loss

By Pauline Boss (2006). New York, NY; Norton

In 1999, Pauline Boss, Emeritus Professor and Clinical Supervisor of Marriage and Family Therapy at the University of Minnesota, published her seminal book, *Ambiguous Loss: Learning to Live with Unresolved Grief*. Boss's theory of ambiguous loss was a major contribution to understanding loss experiences in family stressors that are not necessarily tied to death—losses that child life professionals encounter in their daily work. Ambiguous loss acknowledges loss that comes without resolution, and Boss conceptualizes through her research that this kind of loss can freeze the grief process and involve uncertainty (1999). Boss hypothesizes that ambiguous loss is different than ordinary loss in that individuals have to live with a great deal of vagueness. Boss's *Loss, Trauma, and Resilience: Therapeutic Work with Ambiguous Loss* (2006) followed her first book, and although this book is not recent, it has significant implications for practice and teaching in the child life profession. Child life specialists deal explicitly with losses families face as they navigate their children's healthcare issues. In *Loss, Trauma, and Resilience*, Boss provides specific guidelines as to what practitioners can do to help individuals process loss, and she makes a direct connection to loss-related trauma. Boss writes with the lens of both a research scholar and a practitioner from her long-time career as a therapist, and the chapters are rich with integration of her experiences with individuals and families dealing with ambiguous loss and severe trauma.

There are three major sections to Boss's book that are easy to follow, with the first providing an in-depth overview of her ambiguous loss theory. The second section provides detailed therapeutic goals for practitioners, and the final section, "Epilogue: The Self as Therapist," asks readers to reflect on their own experiences with loss, trauma, and resiliency. Integrated throughout are examples from Boss's years of work with families, from those of missing U.S. soldiers during the Vietnam War to family members who lost loved ones in the terrorist acts of September 11, 2001. Readers will find these examples from her work both powerful and helpful in defining the meaning of ambiguous loss for individuals and families.

For anyone not familiar with Boss's theory of ambiguous loss, Part I, "The Developing Theory of Ambiguous Loss," provides a comprehensive background of the development of the theory and an overview of Boss's research. In this chapter, Boss challenges clinicians to listen, empathize, and provide validation when trauma occurs, thus providing tools for individuals and families to cope with this kind of uncertainty. Child life professionals are profoundly aware of the need to do this; additionally, child life professionals understand that you do not have to experience death to experience loss. Boss shares two central

principles, the first being "leaving without goodbye, physical absence/psychological presence" (Boss, 2006, p. 7). Child life professionals can connect this concept to their work with siblings. For example, when a brother or sister at home experiences the physical disconnect from his or her parent and sibling who spend significant amounts of time away from the family home, child life professionals help bridge what can often be enormous gaps in the physical presence for these families. The second principle, "goodbye without leaving, physical presence/psychological absence," (Boss, 2006, p. 7) will be recognizable to those child life professionals who work with patients who are alive and physically present, yet experience drastic personality changes due to their diagnosis or treatment protocols. Examples of this concept include patients whose personalities change because of the location of a brain tumor or who are not lucid due to their medication, as well as the caregiver who struggles with being psychologically present with family members due to the overwhelming distractions and worries for the patient.

An additional theme from this section that strongly resonates with child life work is that of the psychological family. Child life professionals honor the *psychological family* in their work with children and families and find creative ways to keep family members connected: patient to siblings; patient to their peers; caregivers/parents to their

children at home, to their community, to their co-workers, and to each other. As Boss states, "The psychological family thrives when the only way to stay connected is in the mind's eyes." (2006, p. 27), and no one is better at supporting families needing to stay connected psychologically than child life professionals and other psychosocial staff working in patient care.

Part II, "Therapeutic Goals for Treating Ambiguous Loss," addresses objectives that include helping families find meaning in their experiences with ambiguous loss, tempering mastery of the need for closure, and normalizing ambiguity. In each chapter within this section, Boss offers clear guidelines that are helpful, including examining those things that have the potential to hinder success. This practical advice is easily transferrable to the work of child life. For example, Boss discusses using narrative for finding meaning in ambiguous loss by acknowledging the powerful ways that individuals find meaning in telling their stories. This fits well with the tools child life professionals utilize in their work with patients and their families: using photo voice (telling one's story with photography), journaling, using expressive art and music, joining support groups, etc., as ways for patients and families to tell their stories regarding their healthcare experiences. A second example occurs as Boss discusses the concept of *naming the problem*. She states, "Labeling the problem as ambiguity helps people

begin their coping process. Knowing what the problem is, they are better able to move forward, make decisions, and gradually make sense of what they are experiencing" (2006, p. 90). This mirrors the work that child life professionals do to help children and families make sense of their world as they navigate the many complex aspects of healthcare.

Part III, "Epilogue: The Self of the Therapist," challenges practitioners to recognize ambiguous loss in their own lives and examine their comfort levels with ambiguity. The work Boss lays out here can easily be adapted to the child life profession. The Child Life Competencies (Association of Child Life Professionals, 2016) challenge us to be self-reflective, and this section provides an opportunity to do this in the areas of traumatic loss by examining how we as practitioners manage our own stress, reconstruct our personal identify after a personal loss, and remain hopeful. The questions Boss poses for self-reflection are perfect for coworkers to process and discuss with each other in groups. Additionally, Boss validates that professionals working with trauma-related loss can feel a lack of closure in their work, thereby creating pockets of ambiguity throughout their professional lifespan.

Loss, Trauma, and Resilience has many applications for child life professionals in practice and teaching. As members of psychosocial and medical teams, child life professionals can provide

training and discussions to assist other staff in recognizing and acknowledging ambiguous loss and the impact that these losses can have on families. Concepts of ambiguous loss can be incorporated into various aspects of child life programming such as grief and bereavement, student clinical training, school transition programs, and emergency department interventions. Additionally, there are a growing number of professionals teaching child life courses or serving as adjunct faculty in relevant curriculum used in preparing future child life professionals. Ambiguous loss can be woven into a number of these courses, including grief and bereavement, trauma, lifespan/life course development, and child life theory.

Those Certified Child Life Specialists who are engaged in disaster relief work will find strong connections to this book. Clinicians working in trauma settings, in the great diversity where child life professionals practice beyond the hospital setting, will find apt guidelines to follow and/or adapt to their own work with children and families dealing with loss that can often be unexplainable and difficult to understand and grasp. Losses of home, safety, possessions, time, health, family patterns, community, security, etc., are all within the realm of ambiguous loss and the boundaries of child life work.

One drawback to Boss's book is the

STEP 2:
Document Process, Identify Failures, and Analyze Root Causes
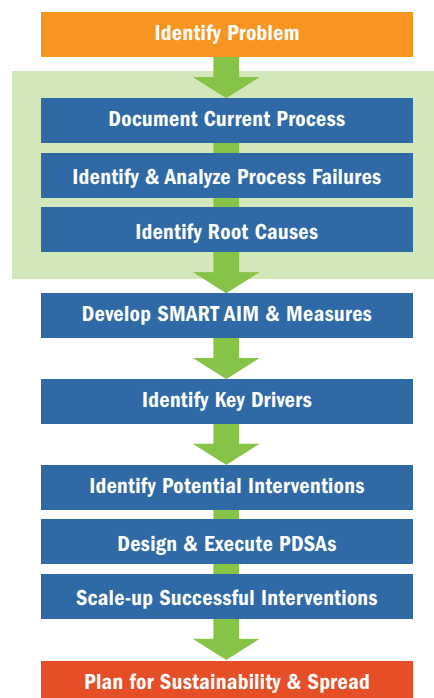
Megan Cassani, MA, CCLS
RANKEN JORDAN PEDIATRIC BRIDGE HOSPITAL, ST. LOUIS, MO

Annette Bonjour, MS, CCLS
CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER, CINCINNATI, OH

In the previous *ACLP Bulletin* article, "Implementing EBP into Child Life Practice," the first five steps in the EBP practice model were reviewed and the concept of quality improvement (QI) was introduced. After an EBP statement is developed and there is evidence to make a practice change, QI can lay the framework for implementing EBP (Birkett & Froh, 2017). The combination of QI methodology and EBP implementation can lead to long-lasting, sustainable change by identifying the underlying cause of a problem or practice issue, organizing an improvement plan, creating specific interventions to address underlying causes, and testing interventions on a small scale (Birkett & Froh, 2017). Supporting long-lasting change is important to ensure that staff c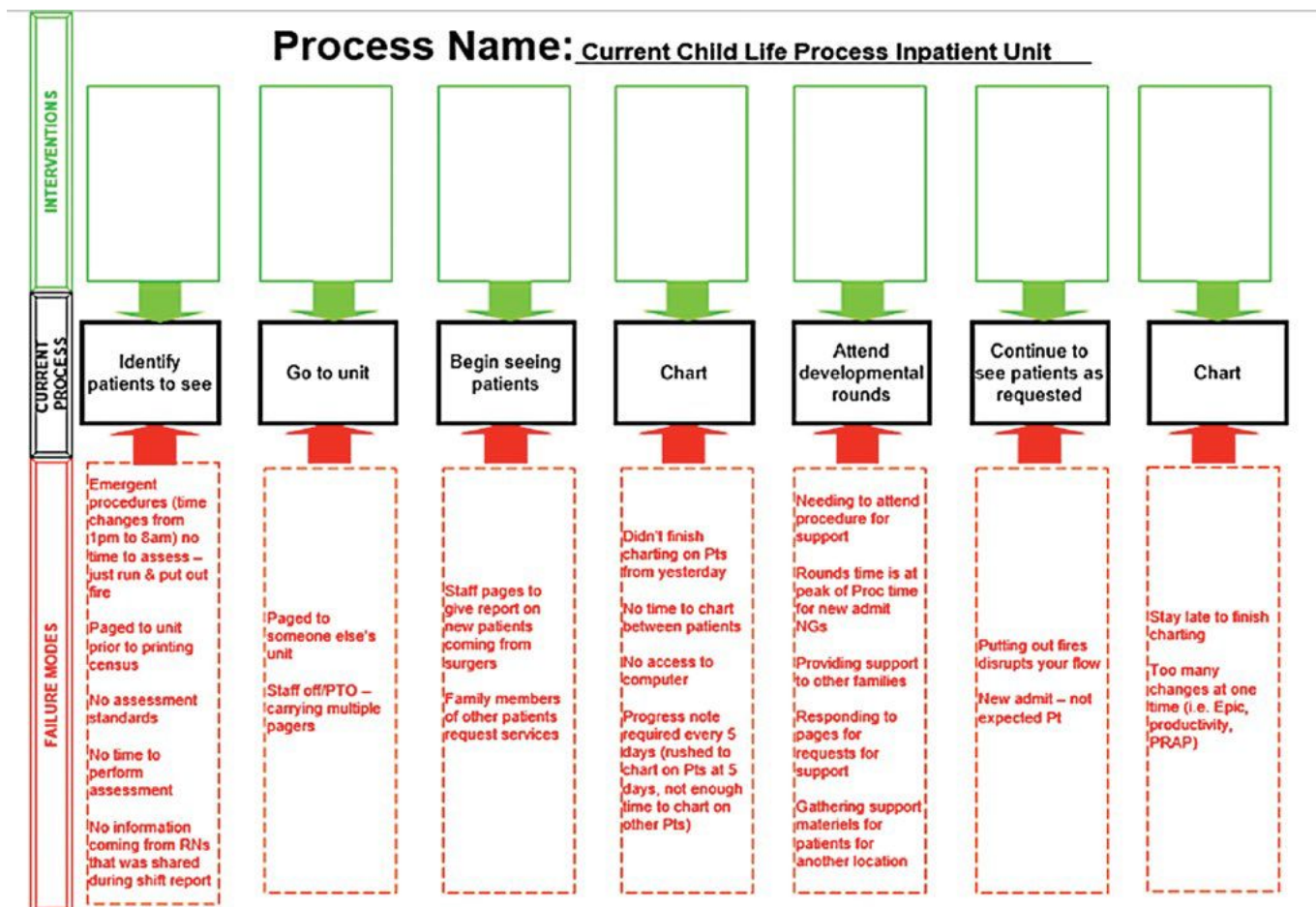ontinue to use the best practice in daily work, rather than reverting to previous forms of practice (Birkett & Froh, 2017). It is important to make QI changes to meet or exceed patient and families expectations (Liddle & Bonjour, 2014).

Identify Problem

Document Current Process

Identify & Analyze Process Failures

Identify Root Causes

Develop SMART AIM & Measures

Identify Key Drivers

Identify Potential Interventions

Design & Execute PDSAs

Scale-up Successful Interventions

Plan for Sustainability & Spread

Before any change can be made, it is important to understand and document the current process or system. Gathering feedback from different microsystems within the larger mesosystem, or established way of doing things, may lead to the most objective observations. For example, microsystems within a hospital may consist of physicians, nurses, child life specialists, families, etc. Additionally, forming focus groups of patients and parents may be beneficial in identifying the customer perspective. A Gemba Walk, or observational walk through of the current work or process, is a great way to start the process (Center for Public Health Quality, n.d.).

During this time, important things to be observed and documented include: the documentation of each step of the process, the time it takes to complete each process step, the time it takes to complete the entire process, any wait times between each process step, and all items or processes that may be seen as not useful to patients, families, and staff members (Center for Public Health Quality, n.d).

Following the documentation of the current process, the next step of QI is to identify any potential failures. Failure modes and effects analysis (FMEA) is a step-by-step approach to identifying all potential service failures (Tague, 2005). These "failure modes" can be

Process Name: Current Child Life Process Inpatient Unit

INTERVENTIONS

CURRENT PROCESS

| Identify patients to see | Go to unit | Begin seeing patients | Chart | Attend developmental rounds | Continue to see patients as requested | Chart |

FAILURE MODES

- Emergent procedures (time changes from 1pm to 8am) no time to assess – just run & put out fire
- Paged to unit prior to printing census
- No assessment standards
- No time to perform assessment
- No information coming from RNs that was shared during shift report

- Paged to someone else's unit
- Staff off/PTO – carrying multiple pagers

- Staff pages to give report on new patients coming from surgers
- Family members of other patients request services

- Didn't finish charting on Pts from yesterday
- No time to chart between patients
- No access to computer
- Progress note required every 5 days (rushed to chart on Pts at 5 days, not enough time to chart on other Pts)

- Needing to attend procedure for support
- Rounds time is at peak of Proc time for new admit NGs
- Providing support to other families
- Responding to pages for requests for support
- Gathering support materiels for patients for another location

- Putting out fires disrupts your flow
- New admit – not expected Pt

- Stay late to finish charting
- Too many changes at one time (i.e. Epic, productivity, PRAP)

Figure 1. *Failure models and effects analysis (FMEA) allows a detailed examination of the steps of a process (in the center boxes), including the identification of what may cause each step of the process to become derailed (in the red boxes). Once the failure modes are identified, interventions to address these barriers to success can be planned (and entered into the green boxes).*

defined as any potential or actual errors that could affect patients and families. FMEA prioritizes errors based on how serious the consequences are and then encourages action steps to be taken to eliminate or reduce failures. FMEA takes place at the beginning of QI, so steps can be taken to eliminate any failures during future implementation. FMEA is to be used when a process, product, or service is being designed or redesigned; when an existing process or service is applied in a new way; when developing a control plan for a new or modified process; when improvement goals are planned for an existing process or service; when analyzing failures of existing processes or services; and periodically throughout the duration of QI (Tague, 2005).

Figure 1 provides an example of an FMEA done by a team of child life specialists who completed a QI project. The identified problem in child life practice was having no standardized assessment process across all points of care, leading to supportive services not being aligned with patient needs. The steps involved in the current child life process are documented in the black boxes. At this particular hospital, child life specialists start their day by assessing which patients to see; however as documented in the red box below this first step, this assessment step is often derailed by a number of unexpected events. Child life practice often con-

sists of "putting out fires" rather than prioritizing care based upon patient vulnerability and psychosocial needs.

Following the identification of all potential failures, a potential root cause of each failure mode is determined, using the knowledge and experience of the team and a root cause analysis tool (Bonjour, 2014). A root cause analysis tool is used to identify why an event occurred so that steps can be taken to avoid future occurrences (Rooney & Vanden Heuvel, 2004) by working backwards to determine the underlying cause for a breakdown in the process. Figure 2 provides an example of a root cause analysis tool that was completed

Step 2: Document Process, Identify Failures, and Analyze Root Causes
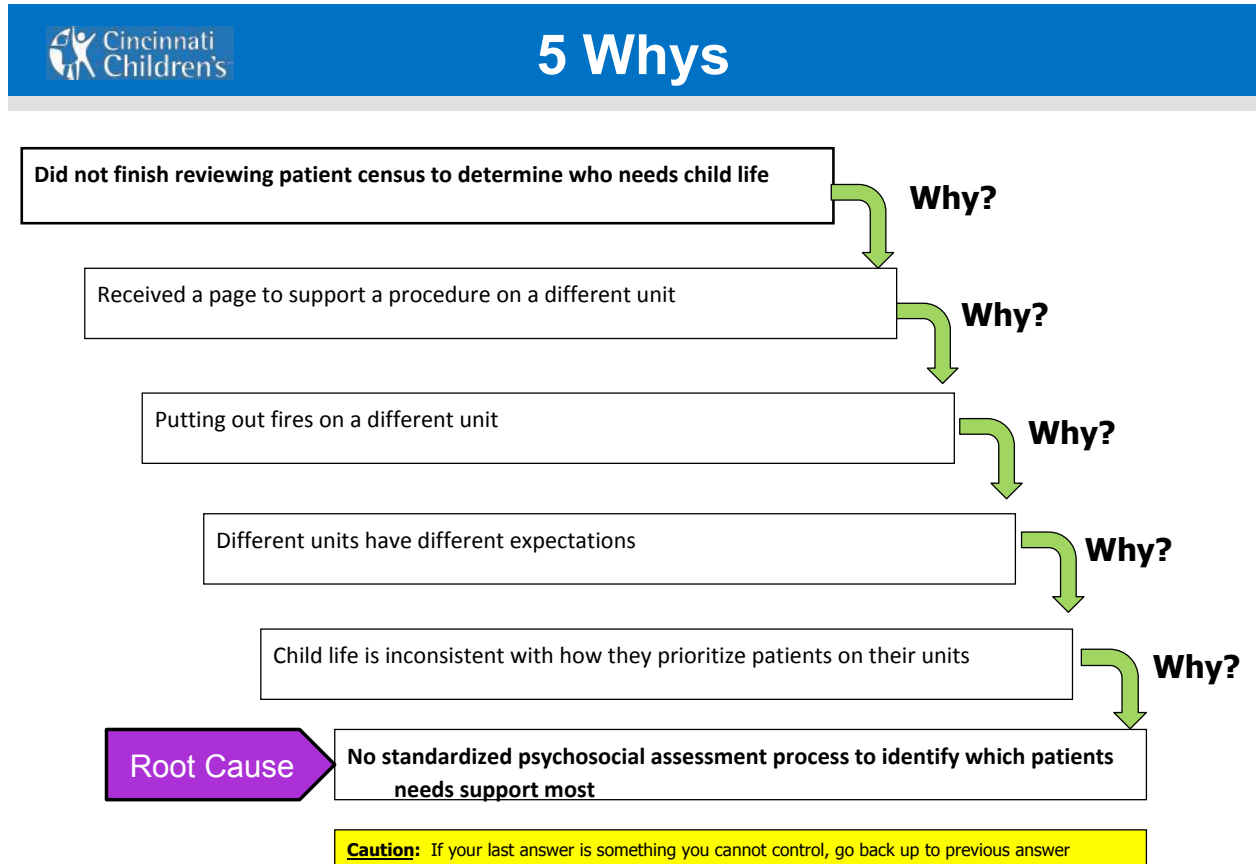
Figure 2. *An example of a tool that can be used for root cause analysis. The "5 Whys" encourage looking backwards to find the original cause of the failure.*

for the same QI project referenced in Figure 1. After the child life team asked the "5 Whys," they landed on having no standardized psychosocial assessment process as one of the main reasons why they were "putting out fires" rather than prioritizing care based upon patient needs (Bonjour, 2014). In addition, for each root cause, it is important to identify current controls that keep failures from reaching patients and families. After completing the root cause analysis, you will be ready to dive into the next step of QI.

The next *ACLP Bulletin* article in this series will address the next step of QI: developing a SMART aim and measures. Continue to follow this series as we delve into the QI process, and *access past articles on our blog*. ⚕

REFERENCES

Birkett, K. & Froh, K. (2018). Implementing EBP into child life practice: An introduction to quality improvement. *ACLP Bulletin*, *36*(1), 38-41.

Bonjour, A. (2014). *Standardized assessment in child life*. Evidence-Based Inquiry Grand Rounds, Cincinnati Children's Hospital Medical Center, Cincinnati, OH.

Center for Public Health Quality. (n.d.). *Step by step guide to implement quality improvement*.

Retrieved from http://www.amchp.org/Transformation-Station/Documents/QI%20Step%20by%20Step%20Guide.pdf

Liddle, M. & Bonjour, A. (2014, Nov.). *Learning evidence-based practice and quality improvement: Following a team of child life specialists in their journey to create a more comfortable injection experience*. 19th Annual Midwest Child Life Conference. Milwaukee, WI.

Rooney, J. J., & Vanden Jeuvel, L. N. (2004). Root cause analysis for beginners. *Quality in Progress*. *37*(7), 45-56.

Tague, N. R. (2005). *The quality toolbox*. Milwaukee, WI: ASQ Quality Press. *35*(2), 30-33.

Wittenberg, B. (2017b). EBP, one step at a time: Step 5 - Develop the evidence-based practice statement. *ACLP Bulletin*, *35*(4), 38-40.

Loss, Trauma, and Resilience:Therapeutic Work with Ambiguous Loss

continual use of therapists' jargon (treatment, clients, therapy), but this does not erase the power of the book's practical applications to the child life profession. I have personally seen this impact in my own professional research. Over the past several years, I have collected data from qualitative interviews with caregivers as they navigate their lives around their

children's healthcare crises. It has been powerful to see evidence in their stories of the multiple losses they collectively face throughout their journeys. In the dailiness of their work, child life professionals are beautifully positioned to witness real life examples of ambiguous loss and assist families in *naming* and *validating* these losses. I highly recommend this book as a tool in

assisting families with understanding ambiguous loss and sharing strategies for coping. 🏃

Opinions about the books reviewed in ACLP Bulletin are those of the individual reviewer, and do not reflect endorsement by the Association of Child Life Professionals.

REFERENCES

Association of Child Life Professionals. (2016). Child life competencies. Retrieved from http://www.childlife.org/about-aclp/purpose-mission-values/official-documents/child-life-competencies

Boss, P. (2006). *Loss, trauma, and resilience: Therapeutic work with ambiguous loss*. New York, NY: Norton.

Boss, P. (1999). *Ambiguous loss: Learning to live with unresolved grief*. Cambridge, MA: Harvard University Press.

CoverMe™
Disposable Cover

Finally
a disposable cover for mamaRoo® & other swings & rockers!

- Protects swings and rocker beds from moisture and stains
- Helps comply with infection control guidelines
- Single-patient use in hospitals or at home
- Made in the USA
- Same material as used for surgical scrubs
  Medical grade, breathable, waterproof, 100% polypropylene
  Latex-free. Meets AAMI PB70 Level 3 testing

**New
Hospital Discount On
mamaRoo® Swings**
Contact 4moms
hospitals@4moms.com

Contact us for samples or to place your order.
orders@sandboxmedical.com   sandboxmedical.com   T 877.396.1551

SandBox Medical
Doing good things for babies & saving hospitals money

# Today's Conversations are Tomorrow's History

Joan Turner, PhD, CCLS
ACLP ARCHIVES MANAGEMENT GROUP

"If we want to move forward ahead, we must know what happened in the past — we must have an historical perspective."

— BJ Seabury

FRIDAY PROGRAM DETAILS

REGISTRATION
9:00 a.m.-2:00 p.m.

ORIENTATION FOR NEW MEMBERS
12:30-1:30 p.m.

Barbara Jeanne Seabury, M.A., Director, Child Life, Rhode Island Hospital, Providence, Rhode Island, and,
Ruth B. Kettner, C.C.L.S., Director, Child Life, Children's Hospital, Winnipeg, Manitoba.

This session presents a history and orientation to the Child Life Council.

Back in the day, the Child Life Council Annual Conference was organized in conjunction with the Association for the Care of Children's Health Conference. The year 1987 figured as the 22nd Annual conference for ACCH and the 5th for CLC. The CLC membership was relatively small at that point in time (with fewer than 650 in attendance; Turner, 2016)—cozy enough for the membership to mix and mingle to a degree not possible at today's large-scale venues. I am fascinated when I see the promo for the "Orientation for New Members" featuring the late Barbara-Jeanne (BJ) Seabury and Ruth B. Kettner. Because I know Ruth, as she was my director at the time, I have a distinct impression of the impact she would have made on newcomers to the profession. Her warmth and charm would surely have enamoured the novices as they ventured into new experiences. In contrast, I must simply rely on my imagination in order to conjure the feelings evoked through contact with the now legendary BJ. The year 1987 marks my entry into child life—the newbie left at home while my colleagues went off into the big world of the conference. Given the opportunity, I would have been honoured to witness BJ and Ruth at the orientation and experience their renditions of child life history and practice. For those present at the meeting, those conversations are now history.

And here I am over 30 years later and the tables have turned. Just this evening I participated in a telephone interview with an aspiring child life student, a young "leader and scholar" located approximately 950 miles away. In her email asking to talk to me, she wrote, "… *I am currently a junior at University. I am a child and family studies-psychology major, and plan to pursue a career in child life. I am also in the Leadership Scholars*
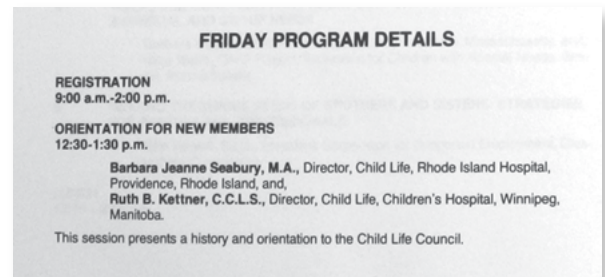
program, for which I am doing a project that requires me to email leaders in my future field." During our conversation, I was able to provide my orientation to child life and the history of child life. I spoke of the prospect that collaboration with colleagues can afford to young leaders; of the inspiration, motivation, commitment, and creativity that I observe in my colleagues; of the essential ingredient of relationship-building as key to working with children, families and students. Importantly, I pointed out that our conversation today will be the history of tomorrow; that her role in participating in and documenting this exercise of talking with five child life leaders—particularly when shared beyond the walls of her university—can be reflected on in her later years when she, too, is a leader in child life. I also encouraged her to prepare an essay for publication in a future *ACLP Bulletin* as a way to connect to the profession, identify a mentor, and contribute to both the future and history of the profession.

I wonder who in the membership attended that orientation for new members in Halifax in 1987 or another year when BJ and Ruth held court to welcome members into the world of child life?

Those conversations of the past are indeed our history —stories to be told to future generations of child life specialists as they find their way into the profession. 🏃

REFERENCES

Turner, J. (2016). Conferences: Where child life specialists gather, in J. Turner & C. Brown (Eds.), *The Pips of Child Life: The Middle Years of Play Programs in Hospitals*, 95-108.

Supporting Siblings

Rosemary Hawkins
GRADUATE STUDENT, TOWSON UNIVERSITY, TOWSON, MD

Throughout my undergraduate and graduate career, I have spent time in the classroom learning about family dynamics, the stressors related to hospitalization, the benefits of therapeutic play, and much more. I am a second year graduate student pursuing a master's degree in child life, administration, and family collaboration, combined with a post baccalaureate certificate in autism studies. While in the child life field as a volunteer, as a practicum student, and as a child life assistant, I have seen the subjects and theories I have studied come to life through my interactions with children and families. When working with families, I have always been intrigued by the role of siblings in the family system. As an individual with three siblings, I understand the impact siblings have on one's life. Early in my volunteering, it became clear that when a child has a hospitalized sibling, the family dynamic is impacted in a variety of ways. My interest in the topic and my experiences have inspired me to learn more about child life services for siblings.

I currently co-facilitate a therapeutic program for siblings of children who have medical diagnoses. The majority of the participants have siblings with autism spectrum disorder (ASD). As of 2008, ASD affects one in 68 individuals (Centers for Disease Control and Prevention, 2016). Using family systems theory to guide my studies and observations, I have considered the impact that one family member's diagnosis has on the family as a whole. As more individuals are diagnosed with ASD, more families are affected and thus qualify for healthcare interventions and support services.

As I've co-facilitated the sibling support group, I have observed siblings interacting with each other and sharing their similar experiences. I have heard them express their thoughts, joys, worries, and other emotions, including feeling forgotten or left out in their family. In addition, siblings often expressed frustrations about their brothers or sisters being bullied or treated differently. These disclosures make me realize that the siblings of children with ASD have unique and challenging roles. They are not only siblings, but also advocates, confidants, and protectors. I often find myself thinking about the significant roles they assume at such a young age.

By participating in therapeutic programming, I have helped support siblings as they share their insights and stories with one another. The various games and activities give the siblings a time for therapeutic expression and opportunities for normative play. By normalizing the environment through play, siblings become comfortable sharing their stories and building relationships. We often begin our sessions with icebreaker games, one of which requires participants to line up from youngest to oldest without talking to each other. The participants have to find alternative ways to

communicate. This game has sparked conversations about their siblings' alternative communication methods and devices. What stands out to me are the comments the siblings make to one another, such as, "Yeah—my brother does that, too!" and "It's annoying when other people can't understand my sister!" I recognize that the support these children receive from their peers in the group helps them gain a sense of community. After sessions, their parents often express gratitude for this opportunity for their children.

Witnessing the sibling participants connect and form bonds over shared experiences has reinforced what I have studied about the psychosocial benefits of familial support. As connections are made, I cannot help but recognize that there may not be this camaraderie without such therapeutic interventions to support self-expression. Through my participation in these support groups, I have gained insight into the importance of patient- and-family-centered care that Certified Child Life Specialists provide when tending to the needs of the family as a whole.

My experiences with patients and their siblings have influenced my vision of the child life specialist I hope to become. Before I worked with patients' siblings, I never thought about siblings' needs and specific resources for siblings. Now I believe it is imperative for siblings and other family members to feel supported. A variety of resources should be available to them, and I plan to advocate for sibling support services within the hospital and community. I have worked with families in healthcare settings and have observed the emotional impact that the experience has on the sibling of the hospitalized child. I want to give the sibling an opportunity to express themselves and meet others who are in similar situations. As part of providing patient and family centered care, I will strive to integrate sibling support services so that they never feel "forgotten." 🕴

REFERENCES

Centers for Disease Control and Prevention. (2016). Autism spectrum disorder: Data & statistics. Retrieved from https://www.cdc.gov/ncbddd/autism/index.html

ACLP Calendar

APRIL

16   Online registration deadline for the 2018 *Child Life Annual Conference*

MAY

3-6   2018 *Child Life Annual Conference* in Washington, DC metro area

JUNE

1-30   *Abstract submission* for 2019 Child Life Annual Conference in Chicago

JULY

1   Submission deadline for *ACLP Bulletin and Focus articles* for consideration for the Fall 2018 issue

AUGUST

TBD   Initial *Mary Barkey Clinical Excellence Award* nominations due

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

SEPTEMBER

TBD   Supporting documentation for *Mary Barkey Clinical Excellence Award* nominations due

OCTOBER

1   Submission deadline for *ACLP Bulletin and Focus articles* for consideration in the Winter 2018 issue

27   Deadline to apply for the November administration of the *Child Life Professional Certification Exam*

31   Deadline to apply to *recertify through PDUs*

Upcoming Events

MARCH 23, 2018

Great Lakes Association of Child Life Professionals — Student Symposium

Ann Arbor, MI

Visit the *GLACLP website* for more information.

Webinars

The schedule of presentations for 2018 is almost finalized, and webinars on a wide variety of topics are planned, so you are likely to find something that will appeal to your interests. Webinars are still available at reduced pricing, making this an economical way to enhance your professional development from your home or office computer. For details of each session and to register for a webinar, see the *webinar schedule* page on the ACLP website. Check back often, as the schedule will be updated as new sessions are added!

Unless otherwise noted, ACLP webinars are scheduled on Wednesday afternoons from 2:30 to 4:00 pm Eastern time. Attendees earn 1.5 PDUs for each webinar. Individual and group rates are available.

Webinars are also a great way to share your expertise with the child life community; if you're interested in submitting an abstract for consideration, please see the instructions for doing so at the bottom of the *webinars page* on the ACLP website.

APRIL 11, 2018
Meeting Families Where They Are: Using Assessment to Get There

MAY 16, 2018
"What's Going on in that Teenager's Brain?" Understanding the Adolescent Brain and its Effects on Hospitalization

JUNE 6, 2018
A Blueprint for Building Interdisciplinary Support Groups

JUNE 27, 2018
The Tongue Depressor Challenge, and Other Medical Maker Stories

JULY 25, 2018
After Dread Comes Opportunity: How to Develop Conflict Resolution Skills that Get it Done

AUGUST 15, 2018
The Building Blocks of Competence: Exploring Grief Work and School Collaboration

AUGUST 29, 2018
Helping Teenagers Cope with Parental Illness and Loss

SEPTEMBER 19, 2018
Along for the Journey: Supporting Patients With Chronic Illness Through Life Transitions

SEPTEMBER 26, 2018
Understanding and Honoring Emotion Work in the Child Life Profession

OCTOBER 3, 2018
Difficult Conversations Do Not Come with a Script: Adapting to the Unique Needs of Families at End of Life

NOVEMBER 14, 2018
Creating a Sharing Place: Grief Support Both In and Out of the Hospital

Earn your master's in child life at Bank Street virtually from anywhere in the country.

Now, more than ever, Certified Child Life Specialists are needed to act as advocates and support children and young adults with acute and chronic medical encounters, and challenging life events. In addition, child life specialists provide information, education, emotional support and guidance to patients and their families.

As a nationally recognized program, Bank Street prides itself on its cutting-edge, dynamic, interactive online instruction with ongoing teacher and advisor presence.

Bank Street
Graduate School of Education

Office of Graduate Admissions
gradadmissions@bankstreet.edu
212.875.4404 / www.bankstreet.edu/childlife

CHILD LIFE
ANNUAL CONFERENCE
www.childlife.org

Connect & Cultivate
May 3–6, 2018
Gaylord National Harbor Resort, MD
Washington, DC Metro Area

Where else can you meet with more than 1,000 Child Life Professionals?

Each year ACLP brings together more than 1,000 child life professionals at the **Child Life Annual Conference** — the world's largest gathering of child life professionals. It is an unsurpassed opportunity for attendees to enhance their professional development, gain fresh perspectives, meet with colleagues, and form new and lasting relationships within the child life community.

The **Child Life Annual Conference** advances the field by presenting the latest research, innovations, and techniques for Certified Child Life Specialists (CCLSs), educators, students, and other child life professionals at all professional levels.

- **NETWORK** with your peers.
- **EARN PROFESSIONAL DEVELOPMENT UNITS (PDUs).**
- **EXPLORE** the Exhibit Hall. Learn about new products and services that are of interest to the child life community.

ASSOCIATION OF
Child Life
Professionals

ONLINE REGISTRATION CLOSES APRIL 16!
Register online at **www.childlife.org**