

ACLCP Bulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

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ASSOCIATION OF
Child Life
Professionals



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Spring 2024 | Vol. 42 No. 2

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Front Cover Photo Submitted by Anna Snee, CCLS

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As shared previously, in 2022, the Internal Revenue Service (IRS) officially recognized CLCC as a 501(c)6 under the parent organization ACLP, a 501(c)3. According to the IRS, certification dues are considered Unrelated Business Income Tax (UBIT) and cause major tax penalties annually for ACLP. However, certification dues are exempt from tax penalties under 501(c)6 IRS rules. ACLP's accountant and audit firm advised that it would be in our best interest to have this structure changed for tax reasons. This new structure means the CLCC has a separate governing board, bylaws, policies, and budgets. However, there is still a need for shared resources with ACLP because certification dues do not fully support all certification operations (i.e. staff, technology, materials, etc.). The image below illustrates how the organizations function:

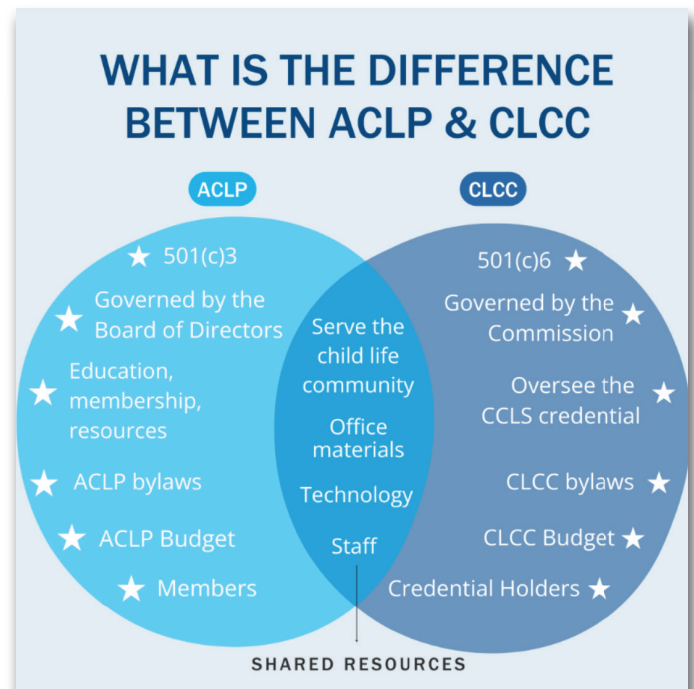
CEO Shares

by Alison E. Heron, MBA, CAE

As the vibrant hues of spring begin to paint the world around us, I wanted to take a moment to extend a warm welcome to this beautiful season of renewal and growth.

While farewells are never easy, they also mark the beginning of new chapters. I am delighted to introduce Mary Buday, who will join us as the new Director of Certification. Mary has a proven track record in overseeing, improving, and growing board certification programs in healthcare and education. We are excited to have Mary on staff and confident she will significantly contribute to the certification program within the Child Life Certification Commission (CLCC).

Change is inevitable, but it's the catalyst for advancement and innovation. Embracing it ensures our continual evolution towards greater excellence and impact.



As we embark on the continued transition of the ACLP and CLCC organizations, let's rally together to ensure a smooth transition and reaffirm our collective commitment to advancing the field of child life.

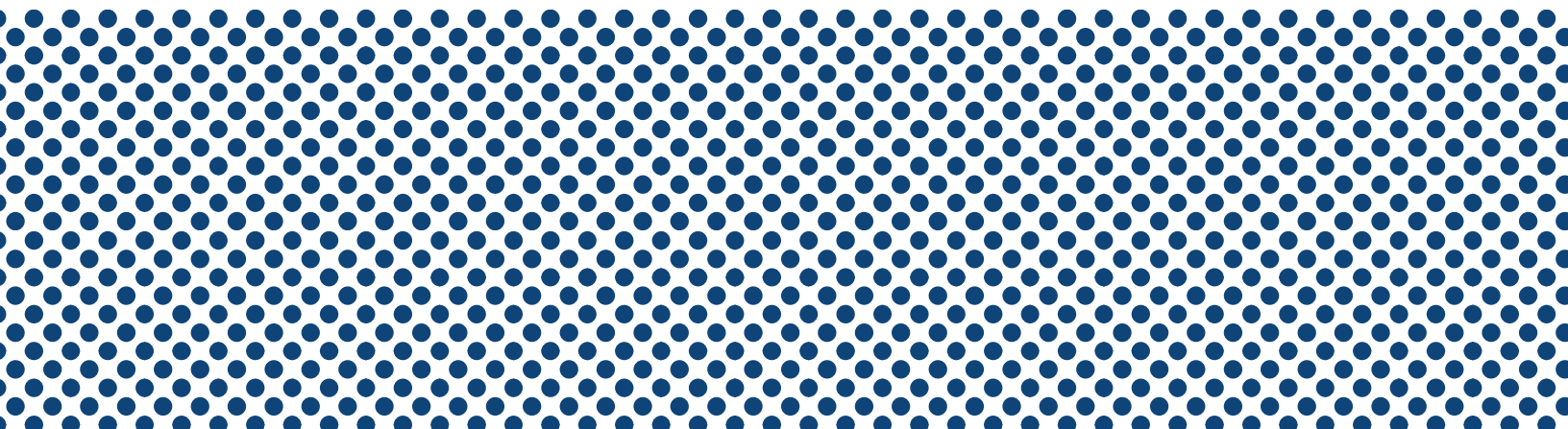
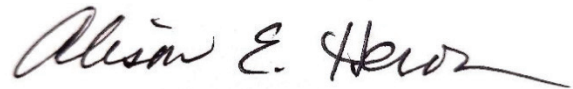
The 2024 Child Life Conference in San Antonio, TX, is an opportunity for our community to come together again to celebrate our shared dedication to enhancing the lives of children and families. This year's conference promises to be an exceptional gathering of passionate professionals, thought leaders, and advocates in the field of child life. With diverse workshops, presentations, and networking opportunities, this event is designed to inspire, educate, and empower all who attend.

To our valued members and attendees: Your unwavering commitment to excellence in child life drives our association's success. This conference is a testament to your dedication, and I encourage you to take full advantage of the enriching sessions and discussions that await you. Let us seize this opportunity to learn from one another, share best practices, and strengthen our collective impact.

To our esteemed sponsors and exhibitors: Your generous support makes this conference possible. Your contributions enable us to provide an enriching and memorable experience for attendees while furthering our mission of advancing the field of child life. We are deeply grateful for your partnership and look forward to showcasing your products, services, and expertise throughout the event.

We are committed to ensuring that our community has access to the resources and education necessary to excel in child life. For those who cannot attend the conference in person or may have missed a session, I am pleased to announce the availability of our 2024 Conference Lightning Pass package shortly after the conference concludes. The Lightning Pass package is designed to ensure that attendees and members who cannot attend the conference in person can still engage with the highly regarded sessions and content with over 12 PDU credits. It's an excellent opportunity to stay connected, continue learning, and earn professional development credits from the comfort of your own space.

Thank you for your continued support and dedication to our shared mission. I look forward to the exciting journey ahead as we continue to make a difference in the lives of children and families.





President's Perspective

by Alisha Saavedra, MA, CCLS

This time of year always brings a sense of anticipation and excitement! As the Board of Directors and ACLP staff prepare for the May 2024 board meeting, strategic planning session, and annual conference, it is an opportune moment to reflect on this past year and set our sights on a blossoming future.

I am eager to dive into the upcoming board meeting, where we will begin charting the course for ACLP's next term. It is also a pivotal time for current and incoming board members, as well as our committees, task forces and work groups, as they prepare to transition into new leadership.

The board meeting agenda items will focus on committee, task force, and work group board reports that communicate a summary of their progress and applicable action items for the board to consider i.e., recommendations or requests for direction/clarity. In addition to our pledge to advance work around Diversity, Equity, and Inclusion (DEI), the board must remain focused on how ACLP can serve as a strong voice of support in tackling the current challenges being experienced by all stakeholders.

Following the board meeting, one of the most critical opportunities this year is ACLP's Strategic Planning Meeting. Facilitated by Lowell Aplebaum from Vista Cova, this two-day event will bring together members of the Board of Directors, ACLP staff, and a diverse cohort of ACLP members. Our primary goal is to fulfill our fiduciary duty by assessing our current progress in key areas and initiatives, understanding shifts within the workforce and industry, and developing a roadmap for the future.

Preparations for this meeting included gathering survey data and soliciting input across all stakeholder groups. This information provides critical insight into how ACLP can best align itself to meet both the present and future needs of our membership and the broader child life community. Data from this survey will be utilized during the Strategic Planning Meeting to drive discussions and recommendations.

One example of a continuing point of interest that came up in the survey data from United States-based child life professionals is the pursuit of licensure for the child life profession in the US. Although strategic discussions on licensure have taken place at the board level previously, no formal decisions or actions have been initiated. This multi-year endeavor occurs on a state-by-state basis and requires action from child life professionals within their respective states. At the meeting, participants will utilize insights from the survey data when considering how ACLP can engage with those

who may decide to lead the charge in their state. To gain further insight into licensure, read this Point/Counterpoint article featured in the [Winter 2021 issue of ACLP Bulletin](#), where two child life professionals consider the advantages and disadvantages of licensure for the profession.

As an organization, we remain committed to the ongoing necessity of advocacy on behalf of child life specialists and those aspiring to join the profession. This advocacy ensures that the profession continues to receive the support and recognition it merits.

This year, the annual conference provides a range of content that is reflective of current challenges and opportunities within the profession. Topics such as burnout, fostering academic and clinical partnerships, supporting emerging professionals, and enhancing professional development for middle leaders will all be covered. I am especially looking forward to being in community with our conference attendees, presenters, exhibitors, and sponsors and connecting through collaborative exchanges of ideas.

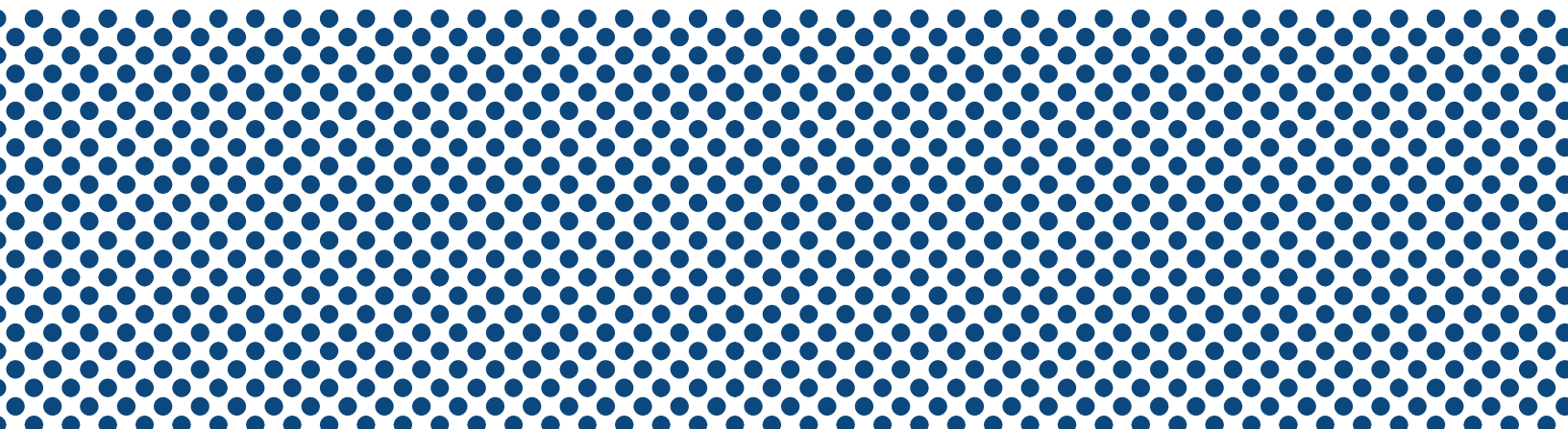
Our opening keynote speaker, Kathleen Bartholomew, RN, MN, sets the tone with her presentation, acknowledging the significant challenges child life specialists often face when colleagues are unable to comprehend the depth and expertise of our professional role. Having

had the pleasure of conversing with Kathleen, I found an immediate connection as we exchanged stories about various encounters within healthcare culture that can profoundly impact the well-being and job satisfaction of child life specialists. I look forward to hearing her insights on how we can utilize tools like storytelling to bolster our confidence and advocate for ourselves in a way that not only advances the recognition of our individual roles but also elevates the child life profession.

As I prepare to pass the gavel on to the incoming President, Sarah Patterson, I am confident in ACLP's ongoing growth and adaptability alongside our members. Our foundation is strong, guided by a clear vision, and driven by an unwavering commitment to advancing the child life profession. Collaborating with our Board of Directors, ACLP staff, committees, and members has been both an honor and a privilege. Looking forward, let us embrace the future with optimism and determination, recognizing that individually we are one but through our collective efforts, we will continue to impact the lives of our fellow child life colleagues, aspiring professionals, and those we serve.

With warmest gratitude,

Alisha Saavedra, MA, CCLS





From the Executive Editor

by Shannon Dier, MS, CCLS

This is my final column as Executive Editor for ACLP Bulletin. I have truly cherished the last four years as part of the editorial team. I have had the privilege to work with so many amazing child life professionals who are eager to share their story with this community. I am continually amazed by the work that my peers are doing, by their insights and their passion, and by their vulnerability as they share of themselves in this public way.

I have always been fascinated with the power of stories. As a child, it began with a love of reading and the way a story could transport you into another time, another, or another person's experience. As I grew older, I began to realize how

narratives influence the way we see the world, how the words that we use and the stories that we tell about events that have happened, whether to us as individuals or to a society, have the power to shape what we think.

As child life specialists, we use stories everyday in our work. Some ways are obvious: using a preparation book that narrates the process of going to surgery, reading a picture book alongside a therapeutic activity about feelings, or even writing a chart note about a patient encounter. Stories are also woven into child life work in more subtle ways. When we advocate, we narrate the patient and family's concerns from another perspective, carefully choosing our words to have the most impact for that particular audience. When a child has experienced trauma, we try to help them frame the story of what happened in a way that ends with a sense of safety.

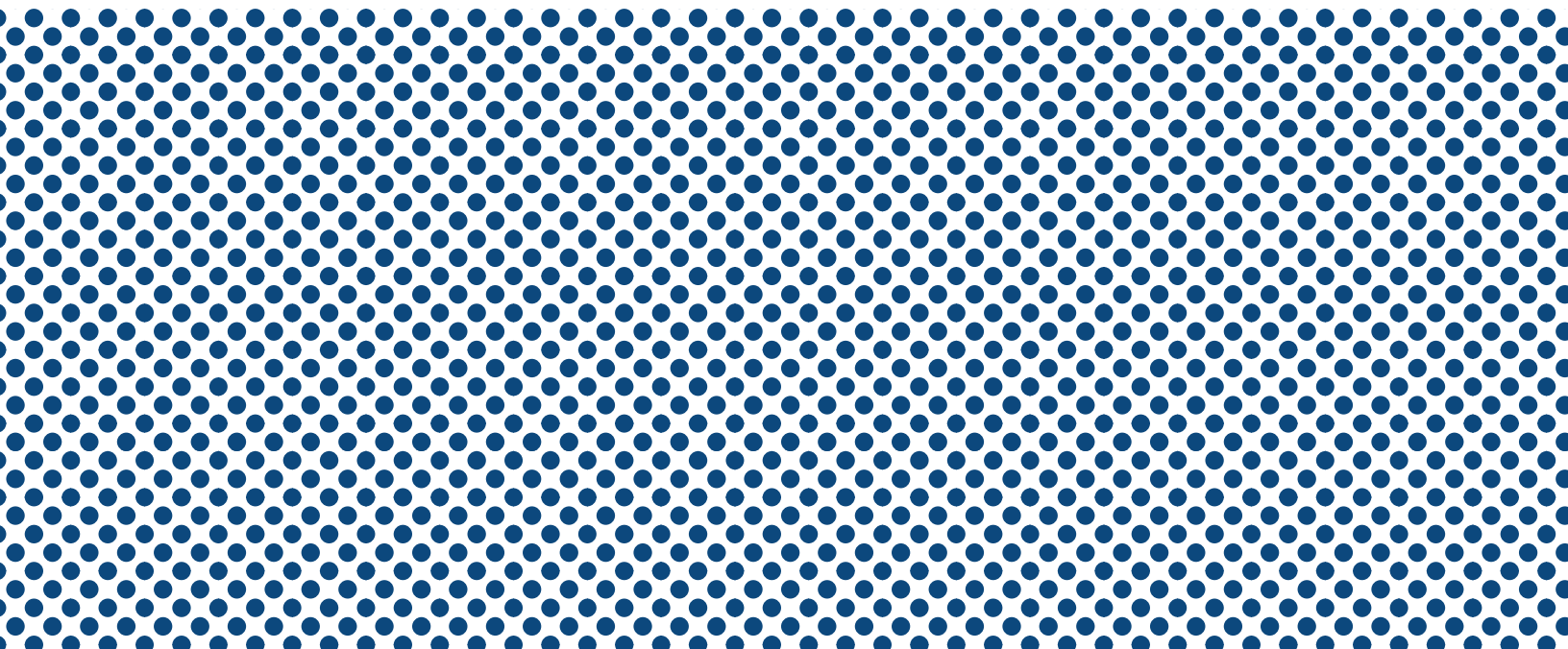
Stories also shape our professional identity. The first question of every child life interview is almost always, "Tell us about you. How did you end up pursuing child life?" And the answer is a story, our own story, the one that we tell over and over through all the steps of entering the field and finding a job. This story explains our reasons for doing this work, and it reminds us why we keep going when the journey is hard. Because this work is not easy. We become a part of each patient and family's story as they go through challenging times, and they become a part of ours.

I think a lot about the stories that we carry as child life specialists. Having worked with chronic patients for many years, I hold many sad stories and also many beautiful, poignant, amazing stories; sometimes my stories are all of these things all at once. I know many of you hold stories like this too. The challenge is that there aren't many places where we can tell these stories or many audiences who would understand what they mean and why they matter so much.

ACLP Bulletin is one of those few places where our community can share the stories of our work. Stories that encourage reflection, share innovative practices, and celebrate success and growth. In this Spring issue, Belinda Hammond reflects on her experiences as an adult patient with children who needed child life support. Lauren Holley shares how a child life specialist can support children involved in research studies, and Amy McGory describes a unique program that brings together a love of reading and love of dogs to better support hospitalized patients. We also celebrate Julia Mendoza and Lucy Raab as this year's Mary Barkey and Distinguished Service award winners. As you read this issue, I encourage you to think about the stories you can share and consider writing for Bulletin.

Now, as I reflect on the close of this chapter, I want to take a moment to express my gratitude for the colleagues who have helped to shape this part of my story. For all of our committee members who continue to invaluable feedback and support to get each issue ready. For Kathleen McCue, an incredible mentor and clinician whose insight was a blessing as we navigated unprecedented times. For Keri O'Keefe, who continues to amaze me with all she manages behind the scenes. And for Morgan Morgan, our incoming Executive Editor, in whose capable hands I confidently leave Bulletin, knowing there are only more good things to come.

Warmly, Shannon



WELCOME TO THE BOARD ROOM

Meet the President-Elect, Sarah Patterson, MSc, CCLS



Sarah Patterson, MSc, CCLS, (She/Her/Hers)
Associate Professor & Curriculum Coordinator, McMaster University

Q: Tell us a little more about your child life journey.

In May 1992, I started my child life internship. At that point I had no idea of the amazing career I had ahead of me. I have had the opportunity to work in several different areas and patient populations as well as internationally within our field of practice. During the last 32 years, most of my clinical practice has been within solid organ transplant population, although I have spent

time working in the intensive care, emergency room, outpatient clinics, and several other areas. Recently, I became a full time academic which has been an interesting road for me to pivot to. Pain management and pill swallowing were initially my passion for years. Now, I am quite interested in child life and simulation-based learning and education.

Q: What inspired you to serve as a board member?

Simply stated, I was nominated. At the time, I remember feeling imposter syndrome and fear of failing the people who nominated me. I went through the application and interview process and after my first board meeting, I was overwhelmed at how incredibly respectful and engaging the board was! As always, it's the people that make the difference. ACLP is full of amazing child life individuals who volunteer to make our profession better. After my time as a board Director ended, I was inspired to become the next President because of all of you!

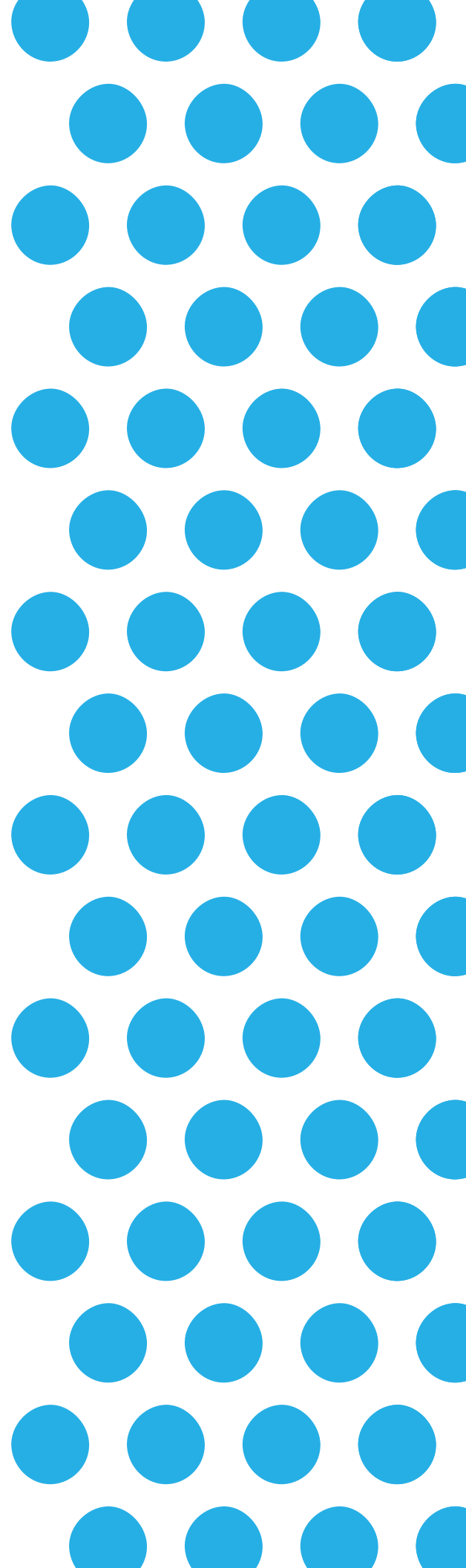
Q: What is the Board working on right now that you are most excited about?

The Board always works on interesting projects that complement our mission, vision, and strategic plan. I am very passionate about the Emotional

Safety Initiative, and we are continuing to expand this work from the Emotional Safety Summit II we hosted last June. This excites me as it translates into our profession and throughout healthcare.

Q: What is one of their hopes for the child life profession or where do they see it in the future?

My hope for the child life profession is that we continue to work on the pipeline to the profession so that everyone interested in joining the field can pursue this profession. This means current barriers are eliminated for education, internships, salary, and employment which will help to improve the burnout we currently see from these issues. I also hope that we can continue to expand where child life services are offered and integrated, continue our global outreach, expand our collaboration, and increase recognition for all the amazing professionals in the field, both now and generations to come.



CHILD LIFE BEYOND THE HOSPITAL:

How One University is Utilizing Child Life Services in Research

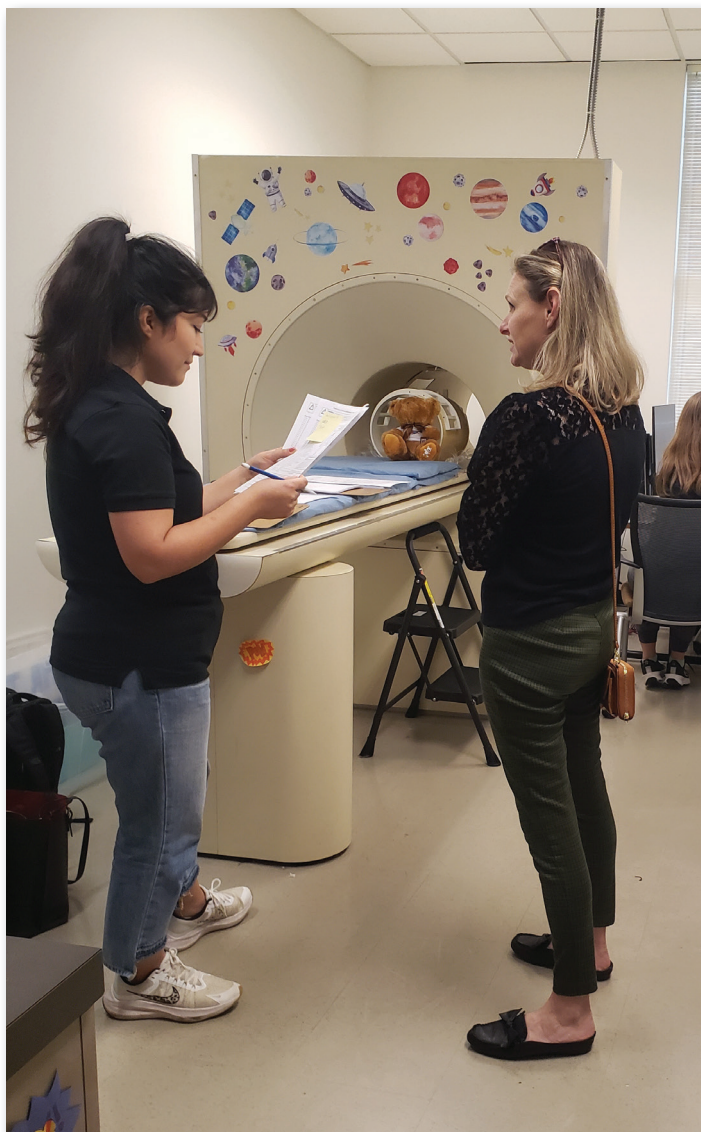
Lauren Holley, MS, CCLS, CPST, Youth Development Institute, University of Georgia

As the reach of child life services goes beyond the hospital setting, professionals continue to explore how the skills and experiences of child life specialists can support children and families within our communities and internationally. Concurrently, as a relatively young profession, child life's involvement in research is vital to our progression. This article will explore the experiences of a child life specialist serving as part of a research team at a large university system.

The Youth Development Institute

The Youth Development Institute at the University of Georgia focuses on research related to neurobiological development, resiliency, and adolescent risk and drug use. Recently, the team received a grant from the National Institute of Health (NIH) to conduct a study with low-income, rural youth ages 6-8. This study explores how psychological factors, biological markers, and environmental impacts interact to influence resiliency. The first part of this longitudinal study involves two phases: a home visit and a visit to





the imaging center on campus for a non-sedated MRI. The primary investigators (PIs), Dr. Assaf Oshri and Dr. Charles Geier, professors within the Department of Human Development and Family Science felt strongly that they wanted to hire a child life specialist to work with the participants, specifically during the MRI scan phase of the study. Dr. Assaf Oshri stated: "I have had the privilege of training and teaching many child life specialists. I have long recognized the potential benefits of having a child life specialist on board to alleviate the challenges faced by participants during the fMRI process... This decision was driven by a commitment to not only advance our research but also ensure the well-being and comfort of our young participants."

Dr. Oshri reached out to the Child Life Program Director at the university to inquire about potential

child life specialists in the area who might be interested in working within the research lab, and I was one of the professionals contacted. When I received the inquiry from the research lab, I was immediately intrigued. In my experience, many child life specialists have to advocate for their non-hospital role. This position was unique in that they reached out to me, having already recognized the value that a child life specialist could bring to their project. The need for child life services in non-sedated MRI scans is well documented (Rudder et al., 2019; Tyson, et al., 2014; Kinnebrew et al., 2020), but what about in the context of a research setting working with young children?

As I walked into the research lab a few weeks later to start my new role, I realized that I would be a one-person team. Additionally, because the study was waiting for official Institutional Review Board approval, I was a child life specialist with no children or families to work with yet. Fortunately, this allowed me time to begin planning and to decide how to develop the child life services designed for the study.

Developing a child life program for research support

I spent the first few months developing the child life support program. As with other child life roles, some services are very standard, such as implementing a documentation system, creating preparation materials, and reaching out to non-profits for supplies. One example of a unique preparation strategy I've been able to implement is a pre-visit MRI "play and learn" session. Before each visit, I invite the participant and their caregiver to join me on a Zoom call where we play a game, look at pictures of the imaging center, and listen to the MRI sounds. This allows me to build rapport, provide education, and begin the preparation process before the child arrives.

Another typical child life responsibility is to make the environment more child friendly. The imaging center on campus is used by many research groups, including animals, and our study is bringing in some of the youngest participants. I've created an interactive, child-friendly bulletin board that welcomes families into the center.

We've also purchased an area rug and child-friendly sheets for the MRI scan room. I have also found a lot of support from non-profit organizations. Hope For Henry provides an MRI gameboard paired with popular prizes that I use during the MRI preparation portion of the visit. The Starlight Foundation donated MRI-safe gowns for participants as well as toys that have been helpful for siblings who come to the visits. Additionally, Hugaroo and Bear Givers have both donated stuffed animals so that every child who comes in has the option to carry a comfort item with them in the MRI machine. These additional items have helped me to create a robust and supportive program for children and their families.

On the other hand, as the only child life specialist on the team, I've been tasked with some unique jobs. When I first began, we frequently talked about the logistics of the study and how we could build rapport and establish long-term working relationships with our participants. I was able to offer small but impactful tweaks here and there to help improve family relationships and humanize the research experience. For example, the study includes the use of eye-tracking glasses, so I suggested getting glasses for everyone in the room to wear so that the experience is inclusive and fun for everyone. Additionally, we implemented "Sibling Kits" where we created bins with materials that mimic the study design so siblings present at the home visit can be involved and engaged. This small attention to detail is where child life can be extremely helpful when it comes to working with families and creating positive relationships.

Educating and collaborating with a diverse team has become a priority as my role has evolved. Our research team comprises graduate students, undergraduate students, and part-time and full-time research staff. Workers and students come from various backgrounds, including healthcare, psychology, human development, and family science. I've been able to focus on educating our team members on how to work with children in stressful situations and how to incorporate emotional regulation activities into the research protocol. Specifically, we implemented two games at the beginning of the visit to help the child ease into the visit and allow the researcher to build

rapport with the child. Additionally, I have helped to ensure our child surveys use developmentally appropriate language, incorporate visual cues, and provide alternative definitions if a child does not understand a survey item. The more I work with the team on the study logistics, the more I see how the goals and skills of a child life specialist are valuable in this setting.

Program development also involved support from child life organizations and individuals as I navigated developing a one-person program. Through the Child Life on Call circle community and app, I have continued support and feel like I have my own child life team. Being connected to a university with a child life academic program has also provided a unique partnership. The graduate students have had the opportunity to tour the center, learn about my work, and contribute ideas



to the program development. They identified a particular need to support siblings who may attend the imaging center and have provided me with materials and ideas for engaging siblings during this visit.

As with many child life roles, my day-to-day schedule varies. Each day when I come in, I prioritize the tasks that need to be done first. My highest priority is to make sure that we are prepared for our next family visit. This could mean printing out sibling activity packets, preparing MRI game boards, restocking supplies, and ensuring roles and responsibilities are outlined for each member of the team. My next priority is assisting with our community engagement team. This may include helping put together activities for a community STEAM event, reaching out to potential participants, or attending community events. In addition, large research projects such as this one require many protocols to ensure we are ethically compliant, efficient, and consistent. With each new visit, we find ways to improve our process. and every small change or improvement requires several hours of work to update our protocols and communicate those changes to the team. This has allowed me to learn a lot about the research process and how I can continue to utilize my skill set throughout the lab.

Expanding the role of child life services

My experience demonstrates that research support is another opportunity for the expansion of child life services outside of the hospital. Many universities have imaging centers on campus with research labs that are working with children and families. This role also gives aspiring child life students at the university an opportunity to observe child life and apply what they are learning in a different setting. Additionally, through this role, I will have access to certain data points regarding the potential impacts that preparation, education, and the involvement of a child life specialist can have on the ability of a child to complete an MRI scan without sedation. My goal is to be able to utilize that data to continue demonstrating the invaluable work that child life specialists do and contribute to the expanding body of research on child life services.

Importantly, child life involvement can improve the research process for children and families in much the same way as child life specialists working in the hospital setting. As Dr. Oshri explains, "I recommend hiring a Certified Child Life Specialist (CCLS) for a research team because their specialized training in child development and stress management is crucial for creating a supportive environment for young participants. Their presence can significantly enhance participant engagement and data quality and integrity, ensuring that the research process is both ethical and effective".

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DOG TALES:

Story Time in Seacrest Studios

Amy McGrory MA CCLS, Child Life Specialist II,
Cincinnati Children's Hospital Medical Center

Dog Tales is a half-hour weekly show through Seacrest Studios that is broadcast in all the inpatient rooms, outpatient clinics and satellite campuses at Cincinnati Children's Hospital Medical Center (CCHMC). With one of our facility dogs (Chevy or Leica) as my primary "co-host," Dog Tales is a weekly preschool story-time with a theme. The theme is based on the season, special events, or patient interests. I include about 5 books that highlight the theme. There is a regular opening and closing song, as well as an additional song related to the theme. For example, we explored baseball last week, since Opening Day in Cincinnati had just occurred. We also sang "Take me out to the ball game" during our "7th inning stretch."

We have also used Dog Tales as the venue to introduce new facility dogs to CCHMC and to celebrate dogs' birthdays. Patients can watch, call in, co-host with me, or join us in the studio and watch the show live. The purpose of this article is to showcase a child life intervention that promotes normalization of the hospital setting and to provide an example of collaboration between Seacrest Studios and child life. It has become a unique way to broaden the reach of our facility dog interventions.

Dog Tales provides a wonderful opportunity for normalization and fun in the hospital. Patients and families watch from their rooms when not feeling well or come down to the studio for an outing: in wheelchairs, halo traction, with their medical poles, oxygen tanks or whatever they may need. If other kids/families are in the studio, there is a natural opportunity for socialization and emotional support. It is also a way for kids



in isolation to see and interact with the facility dogs. As a child life specialist, through this regular program on Seacrest, I have found opportunities to provide education, family-centered care, and sibling support. Dog Tales also combines three of my passions: reading, animals, and child life. Encouraging and supporting literacy in the hospital has always been a part of my practice as a child



life specialist. Dog Tales is a great way to provide exposure to books and to share books that facilitate and encourage emotional expression. In addition, hearing books being read aloud (in a traditional story time) helps to incite curiosity and interest in reading. After watching or participating in the show, kids earn a brand-new book. Dog Tales is especially beneficial to many of our long-term hospitalized patients with limited resources who may not have easy access to books.

Structure of the Show

Each weekly show has a theme, such as the start of the season or the holidays of various religions or cultures, including Hanukkah, Christmas, Kwanzaa, Diwali, St. Patrick's Day, Cinco de Mayo, and others. I choose books based on the theme and check them out from my local library. I have an "educator card" from the library, which means I can request teacher collections, check out as many books as I want, and incur no fines. Different weekly themes and a variety of books and songs enable me to incorporate and celebrate many diverse themes and cultures. For example, to celebrate Read Across America Day, one year I read *Green Eggs and Ham* in English and another

CLS read the same book along with me, page by page in Spanish. We sometimes celebrate "author of the day" where we read only books from a featured children's book author, such as Eric Carle or Mo Willems. Once a month, I have a music therapist join me for another level of engagement for our audience. They play keyboard or guitar and bring extra instruments for the patients to play.

I also remain flexible to new ideas and events. During Fire Prevention week this past year, I invited a neighborhood firefighter to come in for an on-air interview, take questions from the audience and read one of the books I had chosen. Last year, I had a special guest host the show during National Disability Awareness month. The guest was an employee of CCHMC and had a disability that required use of a wheelchair. She was interviewed by me on the show, and we read several books that were authored by individuals with disabilities or were about individuals with disabilities.

The structure of the program is similar to a weekly preschool story time at the library. Although the program is tailored towards the preschool crowd (ages 3-6), I carefully select books that may also appeal to school-age kids. However, the dog is sometimes the main attraction, so we end up drawing in patients of many age groups. We start each show with the song "The more we get together, read together, sing together," and close with "There was a hospital (who) had a dog and Chevy was his name-O...C-H-E-V-Y)!"

At the start of each new month, I include my large interactive, perpetual preschool calendar to review the days of the week, sing our new month song and look at special dates throughout the month. We also discuss the season and the current day's weather, and call for any patient birthdays this month. Besides my opening and closing songs, we sometimes have a theme song in the middle of the several books we read that day. I also have a "story board" when I will tell a story (for example, *The Very Hungry Caterpillar*) on a felt board or an ABC or counting song or rhyme. The creative possibilities are endless.

An especially enjoyable show for patients and viewers is when we have a patient or sibling guest co-host. Recently, I had an 11-year-old co-host

who helped pick the theme of the show and read several books on air. She also independently made a sock puppet to help share a story and add some commentary. I recently had 3 older siblings host and visit with Chevy while their infant sibling was a patient in the NICU. The parents were so grateful to have a break from the intensity of that situation and provide a fun opportunity for the siblings while remaining in the hospital. I have had patients host more than once, host even when they were still in the PICU, or host from their rooms, using the remote equipment that Seacrest provides. I remember one patient stated that it was “the best day of his life” after co-hosting the show with me and one of the dogs. Patients can have a recording of the show from Seacrest Studios, which they can share with friends/family when processing their hospital journey.

Not long ago, one of our hospital schoolteachers reached out to me after a long-term patient had co-hosted Dog Tales. The patient had chosen an “early reader” book about Fiona, a hippo at the Cincinnati Zoo. Fiona has a unique connection to our hospital because two of our NICU nurses helped save Fiona’s life when she was born prematurely and needed an IV to receive fluids. Fiona’s story captivated this long-term patient and sparked his interest in reading. The hospital schoolteacher was so excited that the patient

found an early reading book that was interesting to him at an ideal independent reading level. I was able to help the teacher find several more of these early readers to ensure continued reading success for this young patient.

The inpatient hospital stay can be overwhelming. Providing normalizing and educational opportunities, such as a regular story time, go a long way to providing family-centered care while relieving some stress. Having a facility dog as a partner makes the story time even more playful and entertaining. To top it off, the patient receives a facility dog trading card (and often a personal note from the dog) along with a book of their choice to add to their home library. These books are often donated to the hospital. The facility dogs can even “pawtograph” the patient’s book with their unique pawprint stamp. Broadcasting the story time on Seacrest Studios provides easy access to all patients, even those in isolation or unable to visit with the facility dogs. It is gratifying as a CLS that, through Dog Tales, we help to provide patients with some agency, when so much of the hospital experience is beyond their control.



FROM CCLS TO PATIENT:

A New Perspective on Child Life Support for Children of Adult Patients

Belinda Hammond, EdD, CCLS, CIMI, Eastern Washington University (Cheney, WA); Child Life Connection (Lompoc, CA); Hearts Connected (Atlanta, GA)

If you had asked me two years ago about the need for child life presence beyond pediatric units, I'm sure I would have had a positive take. Still, my recent personal experience showed me why having a Certified Child Life Specialist (CCLS) available to families on adult hospital units is so important. Even though every hospital provides medical care to parents of children, not all

hospitals provide child life services. I wondered what support looked like when there was no CCLS present for those children, and after being a CCLS for almost 25 years, I, unfortunately, found my answer while spending 7 weeks in hospital away from my children—the needed medical intervention: a heart transplant.

I spent two weeks at a local community hospital near my home, but my family was unable to visit while I was local and without much medical equipment. The remaining 5 weeks were at a hospital 3 hours from home. It was such a surreal feeling to be in a “big city” hospital, the hospital where I completed my child life internship long ago. What was hugely different this time was that I was now the patient! I was moved to the ICU and equipped with a ventricular assist device (VAD) that aided my heart functioning but required me to remain in bed attached to a great deal of equipment until the transplant could be complete. While the VAD moved me up on the transplant waitlist, there was no guarantee that a donor heart would be found in time.

Having been a CCLS for many years, I was able to provide interventions by phone or Zoom for my children, then 13 and 17. I spoke honestly with my children about my diagnosis, how I was feeling,





and what the equipment in my room looked like. There were times I wasn't up for using my camera phone when the kids called, but when I planned my calls, I was able to talk about my Swan-Ganz Catheterization (SWAN) as it was within the view being captured by my phone. I asked my kids questions and always answered their questions to the best of my ability. What concerned me was the idea that my kids were trying to protect themselves and me by not asking all their questions. What I hoped for was a CCLS who could support my children with those questions without concern for protecting me.

The ICU had a supposedly strict policy about not allowing children to visit the unit, but this varied depending on who I asked. Most patients on the unit were much older, and therefore the need for children to visit was minimal. My children had never gone longer than a weekend without mom being present, and we were now approaching 7 weeks with so many unknowns. I was told by the transplant team that there were "other ways" around the hospital's policy, but they varied based on the unit, the diagnosis, and the ages of the children.

I don't recall when, but at some point in my career, I crossed paths with one of the child life specialists at this hospital, and I was able to reach out to her through social media to begin a conversation about supporting my children for a visit. I felt very fortunate to know the role of child

life and to be able to advocate for a visit with my children. Still, there was fear that the transplant might not go well and that I would never have the opportunity to see my children again. On the day of my children's scheduled visit, the CCLS gave a quick overview of her role and began to develop rapport with each child. She shared her hospital contact information with my children and told them they were welcome to reach out to her at any time with questions, especially if they weren't comfortable asking mom or dad those questions.

The next time my kids visited was after my transplant and on a day child life wasn't in hospital. This visit required my entire family to meet in a lobby with my nurse present. There was no privacy, and I could see how uncomfortable my children were as I tried to explain the equipment that "traveled" with me in front of a room full of people. This was a very different experience from the bedside visit coordinated by our child life specialist. However, by this time I knew I was coming home, which decreased some of our anxiety. I am so grateful we were able to have child life support for my children to visit me during the time when we didn't know for sure that I'd be coming home.

As a CCLS, I now see the essential need for child life on adult units to support children in the meaningful ways that we are uniquely trained to impact. While I knew to ask child life for support with the visit my family and I so desperately

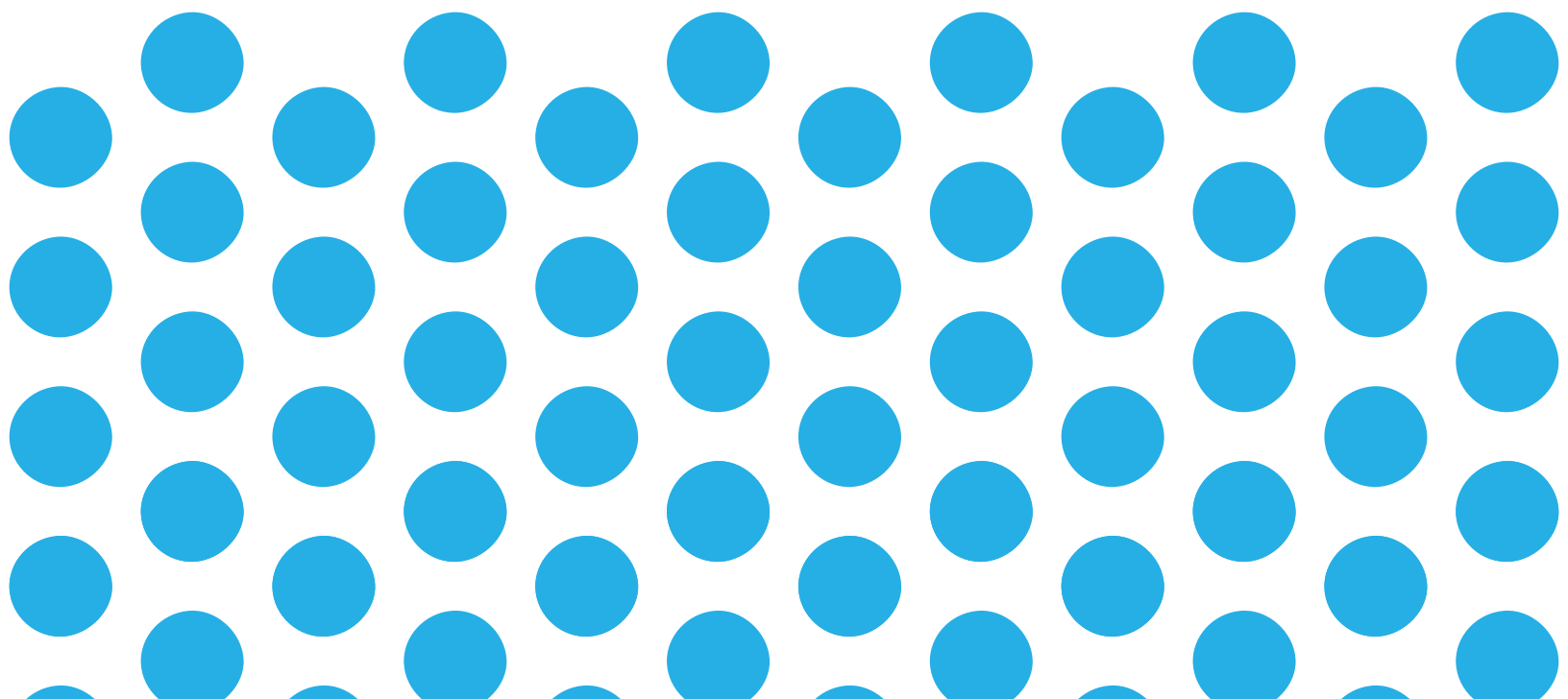
needed, I wondered how many other adults were unfamiliar with the role of a CCLS and didn't know this was possible. I wondered how many other adults on the unit were told the multiple and varying policies on children visiting. I should also note that I continued to encounter challenges despite my knowledge and advocacy. I wish every hospital, regardless of pediatric patient presence, had access to their own CCLS to support the needs of all their patients, not just those that fall under "pediatric" age requirements.

I am certain most children visiting a parent in an ICU or the hospital would benefit from age-appropriate interventions and education. I've worked professionally with so many children who weren't provided information before visiting a hospital, and many parents who were so overwhelmed that they didn't think to ask about what support was available for their children. Having someone uniquely trained to provide those supports, and to establish policies where visits include those needed supports, is something every hospital should have.

Looking back, I'm so grateful for the experience I had. First, I am glad that I knew what child life could do and was able to ask them to support my children in the ways they needed. My teenage children were able to spend time with me because of the presence of child life, and they were able

to hear from someone other than me what was happening and how they could be involved in my care. Second, I was grateful for having access to a CCLS who could step in to support my children when or if I couldn't, at a time when my non-CCLS husband was supporting their needs but very likely would have had a much tougher time ensuring their successful coping in those challenging moments.

I hope that this message is shared with all those hospitals without child life support designated for adult floors. Every hospital should consider where they are missing the most crucial needs of children and families and explore adding child life to their list of services for all patients, not just on pediatric units. Regardless of the patient's age, there is the likelihood of children and families needing psychosocial support within the medical setting, and family-centered care isn't possible without ensuring families have the support they need. Within the scariest of medical moments, CCLSs can provide what other specialties can't – a developmental focus on children, memory-making that involves every family member in meaningful ways, and ensuring families stay connected in the most challenging moments. One of my greatest memories from this time was being able to hug my children, and that was something that, even with my child life background, I almost missed out on



2024 DISTINGUISHED SERVICE AWARD WINNER:

Lucy Raab, MA, CCLS

Barbie Rudder, MA, CCLS, Child Life Manager,
Children's Mercy, Kansas City

"Amassed a body of work" perfectly describes Lucy Raab's over 25-year career as a dedicated child life specialist, advocate, and leader. Her passion for emotionally safe, patient- and family-centered care for all pediatric patients is well known. Before Emotional Safety was an official initiative, Lucy spent decades teaching and advocating for every patient to have the opportunity to do what she called "the Big Three:" normalize, mobilize, and socialize.

Lucy spent the first nine years of her career at Children's Mercy Kansas City intently focused on direct patient care, helping patients with rehabilitation, renal, and orthopedic diagnoses understand and cope with the hospital setting. She simultaneously served for eight of these years as the primary child life internship coordinator. Lucy started on her formal leadership path as a Child Life Supervisor for seven years before becoming the Assistant Director of Child Life at Children's Mercy in 2015, the role in which she currently serves. In this role, Lucy trains, educates, and coaches an ever-changing team of over 40 child life specialists and students.

Lucy has been a true leader in all positions in which she has served – from frontline care to formal leadership. She "talks the talk" and "walks



the walk” by weaving foundational child life principles and current evidence-based practices into her daily interventions and wide-reaching initiatives. For example, as one of five key leaders, Lucy was instrumental in deploying the Comfort Promise at Children’s Mercy, a bundle of four evidence-based strategies to reduce or eliminate pain caused by needle sticks and to help prevent long-term negative psychological effects of trauma during these painful needle procedures.

In 2021, Lucy received the Excellence in Leadership- Allied Health Award at Children’s Mercy, given annually to one Allied Health leader who embodies strong decision-making, sound communication skills, and the ability to manage and facilitate change. Awardees are nominated by colleagues and selected by other leaders, a true testament to how others value Lucy’s ability to achieve high levels of employee engagement and

establishing a core role for child life specialists as part of the ever-evolving behavioral health team and system at Children’s Mercy.

Lucy is honest, transparent, and accountable. Multidisciplinary coworkers often seek her out when they need something done efficiently and well. Staff members regularly take advantage of Lucy’s “open-door” policy, frequently popping in for support and guidance. Lucy is a role model to others, consistently demonstrating grace, patience, and integrity. She has a strong work ethic, takes a collaborative approach to problem-solving, and is persistent in doing what is right. Lucy holds herself accountable, is open and honest in her interactions with others, and has courageous conversations. At the same time, Lucy is empathetic and models trauma-informed care and psychologically safe practices, often saying things like “I totally understand where you are

“She is not only a cheerleader for the patients and families she serves, but also for the employees and students she leads daily. I consider myself lucky to be a witness to the incredible work that Lucy has accomplished throughout her career”

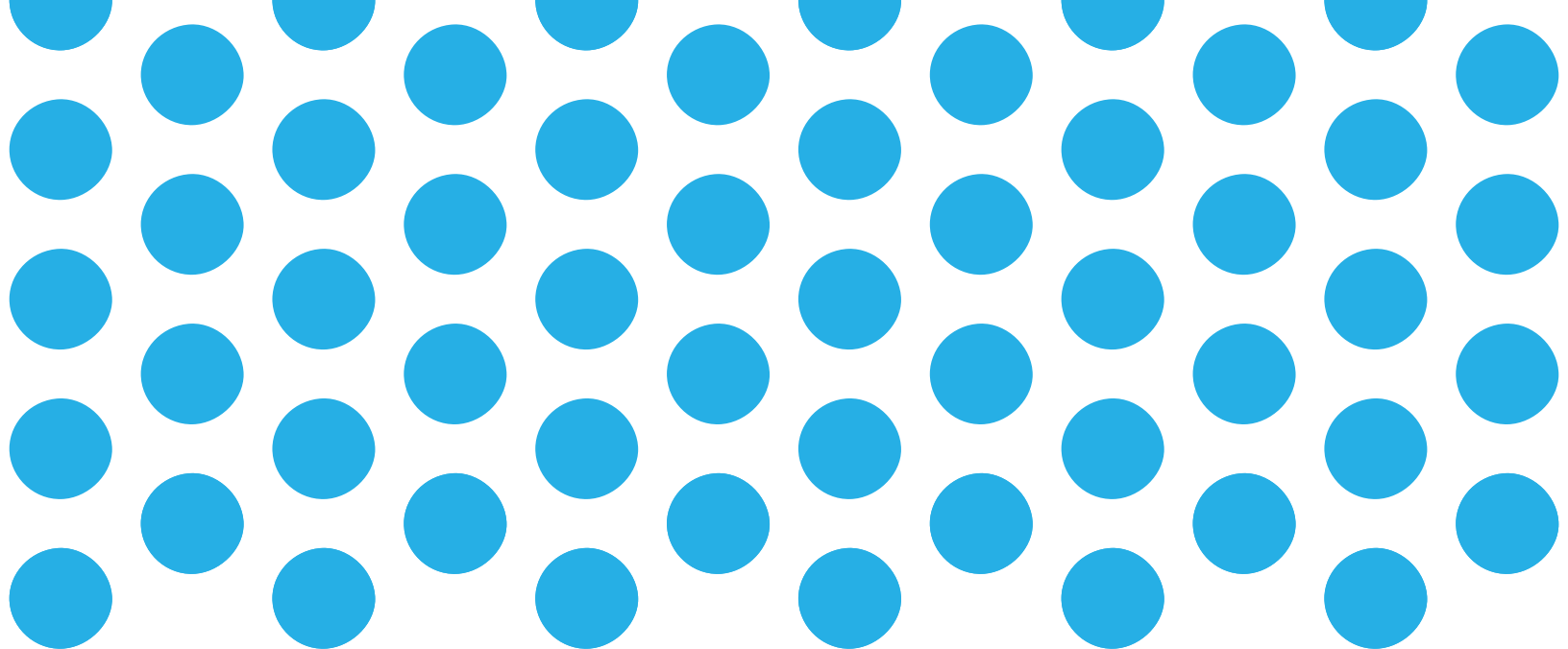
patient care outcomes that exceed the established benchmarks. An example of the work that led to Lucy receiving this award was how she translated vision to action in operationalizing ways for a large hospital system to incorporate all four Emotional Safety Pillars into large-scale, mass vaccination clinics, some of which were specifically designed for children with sensory needs and autism. Lucy collaborated with others of various disciplines, perspectives, and knowledge levels, helping them to see the vision of an emotionally safe vaccine environment and carry it to fruition.

With her inspirational leadership, Lucy continues to provide impactful interventions at the bedside. She brings her contagious laugh and play-focused, personalized interventions to children with the highest stress potentials and most challenging circumstances. In alignment with this work at the bedside, Lucy has been instrumental in

coming from” or “I can see why they might think that.” By listening with empathy, Lucy creates an inclusive environment that values different perspectives. She leverages the wisdom of others to make decisions and thus accomplish better, big-picture results.

Lucy is a visionary, a practical visionary. She is skilled at helping her team and coworkers see that being at their best helps the hospital be at its best, thereby allowing each patient and family to have the best possible experience. Lucy displays a daily commitment to shaping the culture in which she works. She has an ability to see the small picture right in front of her as well as the larger picture and goals and to motivate others to bring the two together.

Lucy’s legacy is evident in interactions with countless students and child life specialists who have benefited from her guidance, expertise, and



wisdom. One key legacy is Lucy's passion for play! Lucy will be the first to suggest play as a tool and often reminds others, "Play is our foundation." On any given day, you may find Lucy doing bedside crafts with loose parts, promoting health care play for a child with vaccine fears, encouraging a patient with behavioral health needs to play with shaving cream to cope during a procedure, or orchestrating an extravagant Taylor Swift-themed birthday party in a playroom. Lucy embraces and promotes the "magic" of play every day.

Lucy's influence in the realm of ethics in child life practice is also noteworthy. Lucy served as ACLP Ethics Committee Chair from 2016 to 2018. In 2018, Lucy graduated from the Bioethics Certificate Program at Children's Mercy – a challenging, international program. In 2019, Lucy presented an ACLP Webinar, Ethical Foundations in Child Life Practice, and in 2021, Lucy co-authored the book Making Ethical Decisions in Child Life Practice. Lucy turns practice into action, thereby leaving a legacy that will continue to impact the emotionally safe care of pediatric patients.

Lucy's contributions to the greater child life profession are numerous, and her resume abounds with examples of her impactful influence. To date, Lucy has served on nine ACLP committees

and served on the ACLP Board of Directors. Lucy began volunteering with ACLP more than 20 years ago with the Child Life Certifying Committee, now the Child Life Certification Commission (CLCC). She began as an item writer and reviewer, participated in exam assembly for many years, and later served as the CLCC Chair. Currently, Lucy serves as a member of the CLCC Appeals Committee.

Lucy is also an accomplished presenter who has shared her knowledge locally, regionally, and nationally, including presentations at multiple annual Child Life Conferences. Her presentations are varied in topic, including the psychosocial care of children, emotional safety, and best practices in providing comfort measures for pediatric patients. Lucy published an ACLP Bulletin article in 2020, "V is for Venipuncture: Child Life Empowering Parents to Be Partners at the Bedside." This publication centered around a quality improvement project and is a notable example of Lucy's drive to impact the care of pediatric patients on a broader scale.

Lucy has led a career full of distinguished service with no end in sight. Due to her influence, countless numbers of us will continue to empower patients and families to "normalize, mobilize, and socialize". And we will do so with a promise of comfort and the "magic" of play.



**Big passion.
Big capabilities.
Big energy.**

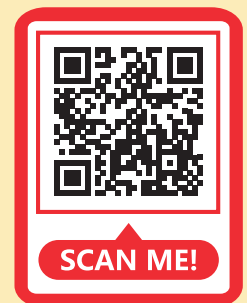
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2024 MARY BARKEY CLINICAL EXCELLENCE AWARD WINNER:

Julia Mendoza, BS, CCLS

Meghaan R. Nguyen, MSW, CCLS, Manager, Child Life and Expressive Therapies, Children's Memorial Hermann Hospital

A moment from childhood lies etched in Julia Mendoza's memory—a nurse's instruction to "choose a finger." Little did Julia know, the needle's poke, sudden and unwarned, would be imprinted in her mind, and a fear of needles would linger into adulthood. Years later, when Julia learned about the child life profession, that moment resurfaced, stark and potent, emphasizing the profound importance of empowering children with the knowledge to alleviate distress during medical procedures.

As a student, Julia saw the value of child life while bearing witness to the gaping disparity in care experienced by non-English speaking families during hospitalization. Her supervisors commented on the ease with which she was able to build trust and rapport with Spanish-speaking families due to a shared language and culture. These experiences motivated Julia to commit to serving Spanish-speaking families in her career. Driven by empathy and fueled by her past, Julia embarked on her journey as a Certified Child Life Specialist with her compass pointed toward a purpose: to be the advocate, the ally, and the voice for those who tread the same path she once feared.



For over 17 years, Julia has passionately served as a Certified Child Life Specialist at Children's Memorial Hermann Hospital in Houston, Texas. Julia began her career in the Neonatal Intensive Care Unit (NICU), where she worked closely with infants and their families. Drawing upon her expertise in Early Childhood Intervention (ECI), she quickly observed the long-term impact of providing infants with developmentally appropriate play experiences during hospitalization. She partnered with physicians to develop a standard for developmental care to optimize developmental trajectories. Julia's transition from the NICU to a pediatric unit further broadened her perspective on the significance of play across all age groups. Specifically, her creativity in loose parts play has emerged as a hallmark of her skill set, elevating her effectiveness in facilitating therapeutic interactions with patients. Recognizing its pivotal role, play is the foundation of her interventions and a cornerstone of her practice.

Then, for 10 years Julia was dedicated to working with patients and families on the dialysis unit. During that time, she found immense fulfillment in supporting the long-term needs of patients with chronic conditions, especially in witnessing their progression across various developmental milestones. With each new phase, distinct challenges prompted Julia to adapt both herself and her interventions to meet her patients precisely where they were in their journey. Julia states, "it has been a privilege getting to know them differently due to the long-term relationship. It allowed me to take my interventions to a deeper level as I had greater insight at what personally impacted each patient."

Furthermore, Julia has upheld her dedication to culturally sensitive care by ensuring that every aspect of unit programming, from interventions to decorations, embodied inclusivity and fostered a supportive environment for individuals from diverse cultural backgrounds. Multiple past patients and families have spoken about the emotional safety that Julia has provided them. Families have shared that her "persistence" and ability to "hold space" are some of the biggest influences that contributed to their positive coping throughout dialysis treatment.

In addition to her work with patients and families on the dialysis unit, Julia forged strong partnerships across the interdisciplinary team. Notably, through a collaboration with the unit's dietician, Julia led the development of a group program for patients and caregivers. Alongside her dietician colleague, Julia co-led intentional activities to address specialized nutrition and coping goals for children experiencing dialysis. Nurses and physicians have attested to the invaluable advantages they have gleaned from Julia's exemplary modeling, as it has enhanced their practice by equipping them with effective strategies to engage and communicate with patients.

As a Mexican American child life specialist, Julia acknowledges her minority status within both her department and the broader field, prompting her to explore the implications of her identity on her interactions within her team. Attending the inaugural Black, Indigenous, and People of Color (BIPOC) meeting hosted by the Association of Child Life Professionals (ACLP) proved to be a profound experience for Julia. It provided her with a sense of visibility and affirmation as she connected with fellow child life professionals of color. For the first time, Julia was able to fully process her past experiences, as well as gain the courage to explore what she could do differently.

Julia has always recognized the importance of providing care through a lens of diversity, equity, and inclusion (DEI). Yet, after the murder of George Floyd, she felt more urgency to connect with peers at the hospital and actively pursue equitable care for all. Through helping to create departmental DEI competencies and serving on the DEI committee, she has contributed to a new departmental framework that ensures child life services are in alignment with DEI values. Julia also represents child life in the hospital's Disparities of Health workgroup offering her expertise as a bilingual child life specialist to guide discussions and inform priorities alongside hospital leaders.

Although Julia did not have plans to leave her work on the dialysis unit, she could not ignore the passion she felt for directly supporting families in their own language. When a position opened within her child life team, Julia approached

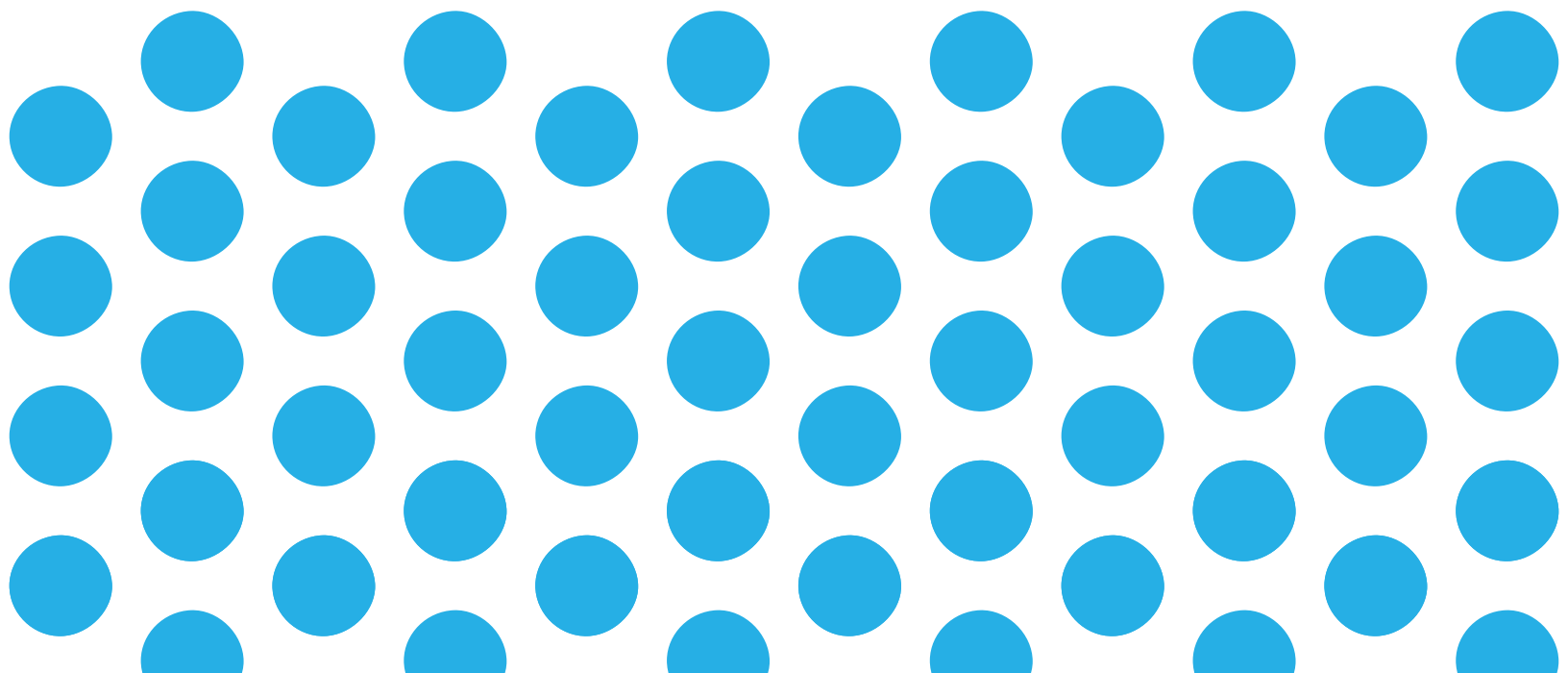
leadership with an innovative vision to restructure the position and directly address the needs of Spanish-speaking patients and families. Julia has now spent the last two years providing child life services to Spanish-speaking families across the pediatric hospital. She has embraced her newfound role and successfully built strong relationships spanning multiple units and devised streamlined processes, all culminating in the establishment of an integrated and valued position. Julia's initial aspiration to become a child life specialist dedicated to serving Spanish-speaking families evolved into a reality, filling her with a profound sense of purpose and pride.

Julia's commitment to fulfilling multiple roles within her department exemplifies her embodiment of the essence of teamwork. Staff members frequently turn to Julia as a source of support and inspiration, drawn to her collaborative approach of "let's work together and problem-solve" rather than her years of seniority. She serves as a reflective practice group facilitator where she values being able to process aloud the day-to-day practices of child life with peers. Julia has also served as a student coordinator for more than 15 years, influencing the clinical training of more than 40 students. She developed Children's Memorial Hermann's first practicum program, revamped their internship, and achieved ACLP internship accreditation on the first attempt

without any revisions. She has said, "I think of students like seedlings. We're here to pour the water to help them grow. It's hard being a student, so I want them to have someone who will both challenge and support them." Whether in her role as an unofficial staff mentor, reflective practice facilitator, or student coordinator, Julia views them all as symbiotic processes where she gains just as much as she pours in.

When asked about the source of her enduring passion for her work, Julia attributes it to her unwavering sense of curiosity. Reflecting on her journey, she shared, "we all go through waves of finding our identity, who we are and what role we want to play. Something about me, I'm always wanting to learn. When I find myself stagnant, I ask what I need to do to continue to grow—having peers to process with and the resiliency within me is important. There are going to be patients that impact you, some in hard ways. You must be able to sit with that. You can ride those waves if you allow space for those feelings, process with others, and continue to look for that spark that comes from curiosity."

Julia Mendoza's tireless dedication, unwavering passion, and exceptional commitment to delivering top-tier child life services have earned her the prestigious recognition of the ACLP's Mary Barkey Clinical Excellence Award.



GRIEF AND BEREAVEMENT SUPPORT

In One-Person Child Life Programs

Heather Gianatassio, MS, CCLS, GCCA-C, Adjunct Instructor,
Southern New Hampshire University



Grief and bereavement support can vary between settings. With one-person child life programs, support can be much more challenging. Below are two interviews that were conducted with two child life specialists. Each child life specialist works in a one-person hospital setting in different units. Both participants provided information about their hospitals and grief and bereavement support programs. Questions were tailored for the settings as well.

Jessica Lohre, MS, CCLS, Certified Child Life Specialist, Intensive Care Nursery, Thomas Jefferson University Hospital

Sarah Somers, MS, CCLS, CPST, Certified Child Life Specialist, Lutheran Children's Hospital

Q: Tell us about yourself and your role.

Sarah: I have been at Lutheran Children's Hospital in Fort Wayne, Indiana for the last 10 years. We are a children's hospital within an adult hospital. I cover inpatient, outpatient clinics, our ER, radiology, surgery and NICU.

Jessica: I'm a one-person program in a hospital that doesn't have a dedicated pediatrics unit, just an intensive care nursery, which is where I "live" so to speak. So, my home base is the ICN, but with frequent consults throughout the hospital to work with children of adult patients or the occasional pediatric patient in the ED prior to their transfer.

Q: What is it like to provide grief support in a one-person program or with limited resources?

Sarah: It can be difficult, and obviously the emotional side of being a one-person program can be difficult. You can't just "tap out" if you need a break or if you need somebody else to pick up that weight. I am lucky enough that our spiritual

care department works very closely with us and my nursing staff as well in some areas where I'm more prevalent. In the ER, it can be more difficult if they don't know me. It can be a lonely process and emotionally lonely as well.

As far as resources, I try to do the best I can with what I have and try to come up with different alternatives. We used to have Music Therapy, and so they would do the heartbeat recordings with the stethoscope. That resource has gone away because we don't have the technology. We've found other ways like using the doppler and things like that to be able to still give that to a family, which I think is really beneficial. Your standard handprints, footprints, things like that, we're still very much able to do and it's actually a good thing. We have a program that follows our families two years after the death of their child that I pretty much do as well.

Jessica: I'm lucky in that I'm able to order (within reason) most physical resources that I need; however, I'm limited in resources in the sense that there's no other child life specialist who is experienced in obtaining things like prints and molds and can be a second set of hands. Luckily in most cases, bedside nurses are willing to help, but then it's a lot of talking them through what's needed, which adds a layer to things, especially when trying to simultaneously provide emotional support if there's family in the room. Not necessarily a bad thing since I can always ask for

the nurses' help, but I do recall from my previous positions how nice it was to have a second set of "child life" hands for things like bereavements that require so much extra care and support. There's also the emotional toll of having limited coworkers who "get it", so when these tough cases arise, I feel limited in who I can lean on for support and to debrief with. Since I don't have a home base on these adult floors, there's limited opportunity to build a good relationship with the staff, with such frequent changeover and various consulting units.

Q: What kinds of activities do you offer when there is family beyond the parents and caregivers involved (siblings, other children, other adults) at the hospital at the time of death?

Jessica: I have the flexibility to order most supplies I'd like, as long as I can justify it. I do, however, have very limited storage, basically a drawer in my office if I'm being honest. Child life problems, right?. So, I stick with easy to store things like small playdoh cups, coloring printouts, crayons, fidgets, and an iPad. I keep those on hand for diversionary items, especially for if tough conversations are happening with me and/or with the team, or just a lot of "waiting around". I have a solid supply of children's books about death, dying, and grief that I'll send families home with "for later," since often times, the parent/caregiver/relative is going through their own raw emotions and reactions during these times. If memory making is desired and if I assess it to be appropriate, I invite the child(ren) of the patient who has died or is dying to take part in creating the prints and molds. I've seen this as a really therapeutic way for the children to be involved and around 90% of the time, children are very much willing to take part.

Sarah: It can be tough, but I think a lot of times it's just trying to engage them whatever way they want to be engaged, whether it be by going to the room, standing at the doorway. It's definitely taking that role of advocate, especially when we have those other caregivers or family members maybe don't want those younger people involved. Why don't we ask them and talk to them and see what their choice is in this? I think, a lot of times it



takes on more of the role of advocate and trying to help facilitate the conversation about their loved one who has died.

Q: What kind of support, if any, do you provide staff and vice versa? What do you think is missing?

Jessica: In terms of physical support, I try to be as helpful as possible without overstepping. The nurses I work with on the ICN can be a tad territorial of their assigned babies and families, but the more they see that I will often take my lead from them and that I work hard to honor and respect families' wishes, the better rapport and trust I have with the nurses. This also opens up a lot of opportunities for education so that over time, I've built enough trust to not always have to "take their lead" so to speak. This has been slow but steady growth in the year I've been here but lately I can tell more and more that we've been making great strides. I try to be a listening ear for staff as much as possible. Most of the nurses just like to have someone outside of nursing to complain to, anything from shift/staffing related to difficulties with families. I try my best to educate and validate simultaneously. During more difficult cases involving bereavements, I notice the nurses very much lean on each other for support which I love, but again, tough as a one person to find my groove here. I have a few nurses who I've been able to debrief with, as well as the social workers, so it's just been a matter of finding these alternative avenues when I've been used to having a child life team in the past. In terms of what's missing, I know the hospital has a peer support network for tough situations and losses but I'm not too familiar with it and I think it's mainly targeted to nurses and physicians. On the ICN specifically, I know our social workers are spread quite thin so I'd love if our unit had some sort of therapist/counselor dedicated to working with the parents in a purely therapeutic way. There's so many people on the ICN team who are all dedicated solely to the parent's baby/babies, that I worry they lack support that's just for them. I do the best I can within my own scope of practice and training, but I would love if we had someone who could provide

mental health support to these moms, dads, and guardians.

Sarah: I think it's interesting the way that our hospital is in that it is a teaching hospital. So we have nursing students, physician students, chaplain residents. We always have a lot of people getting an education within the building. I think, a lot of times, with our staff and the rotations, it makes it really hard to build a relationship with residents. So now, over the last few years, we have a staff chaplain. He has been super beneficial in trying to help us, but again, I think it's really hard to expect the people who have seen the trauma and done the work to then be the one to lead the debrief or lead the support of the other staff members. We try and there's always room for improvement, but I remember, early in my career, my manager told me it was my responsibility to be the cheerleader for the staff. I was like, where's my cheerleader? So, I think that expectation is put on a lot of specialists now especially with numbers decreasing and programs getting smaller. It's hard because that leaves us without any support, so, what do we do and how do we make that work?



BREAKING LANGUAGE BARRIERS

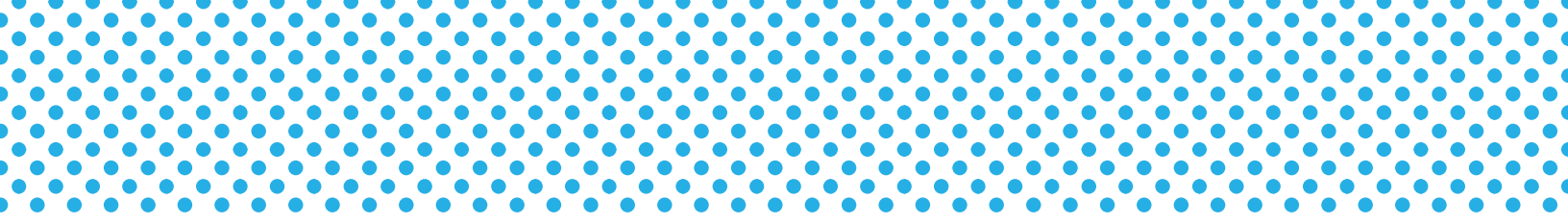
The Vital Role of Interpreters in Healthcare Settings

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As child life specialists, our role is to help patients and families understand the hospital setting. Through developmentally appropriate preparation and education, we explain diagnoses and procedures in a way that our patients and families understand. But what happens when it's not just the hospital setting that is unfamiliar to patients and families but our language? Using medical interpreters, we can communicate with our patients and families in a way that they can understand and ensure we are providing equitable care for all patients and families. This article briefly reviews the role of medical interpreters and how child life specialists can collaborate with them to better serve patients and families.

What makes a medical interpreter unique? On top of knowing another language, medical interpreters also take courses and training on medical terminology and anatomy. When I've worked on unusual surgical cases with our medical interpreters, they often spend time studying the procedure before interpreting for the physician and family so that they can prepare to interpret a wide variety of words and concepts. They learn the surgery and terms so they will understand what the doctors are saying. The role of a professional medical interpreter is to create a bridge between medical providers and our patients and families. They make sure that patients and families are hearing and understanding what the medical





staff is saying and that families have a voice with the medical team. Interpreters help create a safe space for families to share their worries and concerns, and they empower the patient and promote their participation by giving the patient and family an opportunity to actively participate in their care (Iftikhar, 2022; Krystallidou & Pype, 2018). A study found interpreters were associated with improved health outcomes for patients in the ICU (Duronjix et al, 2023). The use of medical interpreters is essential for patient- and family-centered care.

There are a couple of options for a professional medical interpreter, including a person who physically comes to the hospital or clinic room or an interpreter who supports via video chat or telephone. There are often connection issues with the video interpreters, and they have a limited view of the room, which can make interpreting for multiple people difficult. Similarly, a telephone interpreter helps provide language, but they can't see the staff or patient and family so they can't assess for confusion and misunderstanding in the same way as an in-person interpreter. However, using a professional medical interpreter to translate is preferred over using family members or friends for a variety of reasons. With family members or friends, there are concerns for conflict of interest, confidentiality, privacy, and the family member or friend's comfort with discussing hard topics or needing to be the bearer of bad news (Iftikhar, 2022). It is often an uncomfortable position for families to have to rely on this individual for interpretation as well as support.

At our institution, we have two Spanish-speaking medical interpreters on staff, and the hospital brings in other interpreters as needed. The interpreters at our hospital are very familiar with child life and are often a referral source for our child life team. Frequently, interpreters will work with a family throughout multiple visits and can be a helpful source of information for staff about the patient and family. For one chronic patient,

the interpreter was able to share with staff that the family understands some English and is working on learning more. This was helpful to know because the family will often stop during conversations and want to clarify the English word and its meaning. The interpreter's role works both ways, helping patients and families understand medical staff and helping medical staff to understand their patients and families better.

Interpreters are present through a variety of medical encounters and can recognize when a patient or family might benefit from additional child life support. When I first meet a family, the interpreter will often share with me the patient and family's past experiences that might be helpful for me to know. For example, when I was called by staff to come support a patient in ophthalmology clinic, the interpreter shared with me upon my arrival that the patient has a speech delay and communicates by pointing or taking his mother to what he wants. They also shared that the patient had left the clinic room multiple times already in the visit. When I was introducing myself to his family, I was able to pull toys out of my bag at the same time and block the door, allowing me to be proactive and provide distraction while also building trust. Connecting is harder when you don't speak the language, and the interpreter can help to make rapport building easier.

Interpreters also help hospital staff provide better care for their patients. A key part of our work as child life specialists is assessment and identifying if the patient understands what is happening. While I can read body language to know when a patient may be anxious, working with an interpreter is essential so I can understand their concerns and identify if there are misconceptions that need to be clarified. Interpreters also monitor the patient and the family during the visit to assess their level of understanding with what hospital staff are saying (Raymond, 2014). An interpreter can help assess how much English a child understands, which is

especially helpful if the child might be left alone during their admission or if we are talking about separating from family to go back to surgery with the OR nurses. Depending on what culture a family is from, I've also found that parents of patients with developmental disabilities may not know what information might be helpful to share about their child, and they benefit from assessment questions to learn more about a child's triggers and adaptive support needs. While I know the right questions to ask in my native language, the interpreter can ask these questions in a way that the family will understand best.

Interpreters can also provide insight into a patient and family's culture. When I was working with a patient and family from a country in South America, conversations were had among the team about whether it might be appropriate to introduce the facility dog to this patient. The interpreter was able to help the team understand that dogs are often wild and dangerous in the country this patient was from and why it might not be a good idea to expose them to our facility dogs since the plan was for this young patient to eventually return to his home country. The interpreter also shared with the larger care team that red was a sacred color in some South American cultures, so staff should be respectful of red clothing and potentially not remove red

bracelets prior to surgery if possible.

From my experience working with interpreters in a variety of settings in the hospital, I've begun to rely on their support and expertise. When I introduce myself to an interpreter, I'll often explain why I'm there and what kind of support I'll provide. I've found that there isn't an equivalent for child life specialist in many other languages, so I'll often use more common words like "hospital teacher" or person to help with distraction and make it easier for the interpreter to share what I'm saying. I will also ask if the interpreter is familiar with the family. It can be helpful to identify if the family understands any English and whether they can read or write. Reading and writing aren't as common in some other cultures, and handouts won't be helpful if the patient and family do not read in their native language. As child life specialists, we often emphasize to the team that the value in interdisciplinary care is that we all have different expertise that we bring to the table. As child life specialists, we bring our knowledge of child development and coping strategies. Interpreters are crucial too as they bring their expertise in the family's language and culture and are an essential part of providing patient and family-centered care in the hospital setting.



Tips for working with Interpreters

- Look at and speak directly to the patient or family, not the interpreter. The interpreter is a voice, you are interacting with and caring for the patient and family.
- Speak slowly and take breaks between short statements so that the interpreter has time to repeat what you are saying
- Give the interpreter time and space to share if they assess that the patient or family might not understand what is being discussed
- Watch for non-verbal communication such as facial expressions, gestures, and changes in tone.
- Avoid using family and friends as interpreters
- Plan for interactions to take longer and allow for that time for the interpreter to effectively help you communicate with your patients and families.

Adapted from Dibble (2019), Randall-David (1989) and Iftikhar (2022)

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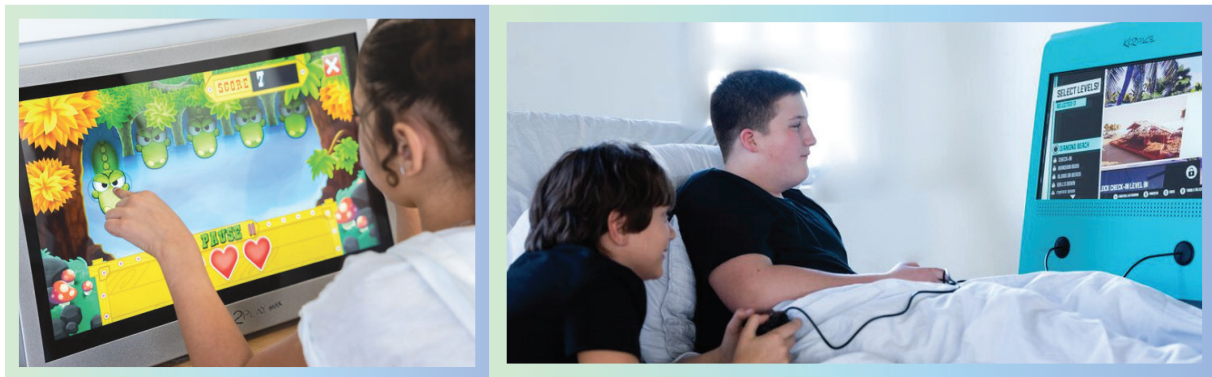
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