

emotional SAFETY IN PEDIATRICS



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EXECUTIVE SUMMARY

We owe it to the future not to harm our children in their hearts, and minds while we cure their diseases and repair their broken bones.

- ASSOCIATION FOR THE CARE OF CHILDREN'S HEALTH

The intent of medical care is three-fold: the maintenance of health, relief from pain, and prevention of illness and injury. The ethical responsibility to “first, do no harm” extends beyond the body and into the minds of those seeking care (Hockenberry, et al 2021). However, “Damaging the emotional being can be an unintended consequence of healing the physical being. Children and adolescents can suffer for years as a result of this paradox” (Gordon & Paisley, 2018, p. 155). Providing emotionally safe medical care ensures such harm does not befall pediatric patients and their families.

Children and adults often feel frightened, confused, and overwhelmed by medical experiences. The National Child Traumatic Stress Network reported that up to 80% of children and their families experience some traumatic stress following medical treatment for life-threatening illnesses or injuries (Effects, 2018). Iatrogenic harm is known as the disease or symptoms that are a direct, albeit unintentional, consequence of medical care. The damage is not only brought on by the treatment but also by the actions or comments of healthcare professionals (HCPs). These negative reactions can have long lasting and far-reaching consequences, greatly impacting children’s physical and mental health (Landolt et al., 2009; Price et al., 2016; Zatzick et al., 2008).

Pediatric medical traumatic stress (PMTS)

refers to “a set of psychological and physiological responses of children and their families to pain, injury, serious illness, medical procedures, and invasive or frightening treatment experiences” (Medical trauma, 2018, para. 1). The symptoms of PMTS include intrusive thoughts, hypervigilance, and avoidance (Kassam-Adams & Butler, 2017; Kazak, A.E., 2006; Price et al., 2016; Medical trauma 2018). Though PMTS is not a diagnosis on its own, the traumatic stress symptoms associated are part of the diagnostic criteria for both posttraumatic stress disorder and acute-stress disorder (American Psychiatric Association, 2013). These reactions are known to negatively impact children’s daily functioning, adherence to medical treatment, and overall health-related quality of life (Kassam-Adams & Butler, 2017; Kazak, A.E., 2006; McCormick King et al., 2013; Price et al., 2016).

Childhood pain, anxiety, and poor coping have lifelong and costly consequences. Negative childhood experiences of medical pain and fear are significant predictors of pain, fear, and medical avoidance in adulthood (Pate et al., 1996). McMurtry et al. (2015) stated, “The emotional sequelae of unmanaged pain, most notably a fear of needles, can have a much longer lasting impact” (p. S7) and often originates from childhood experiences. Injection phobia leads to medication refusal, avoidance of preventative health, forgoing vaccinations, and delayed medical care (McMurtry

et al., 2015; Orenius et al., 2018; Wright et al., 2009). Avoiding preventative and life-saving medical care causes a significant economic burden (McMurtry et al., 2015). Just as negative medical experiences have a lasting impact, so do positive ones. Greater medical coping in adulthood is tied to positive medical coping in childhood. Similarly, when supportive measures are used for pain and fear in pediatric patients, they experience less pain and fear related to medical care as adults (Pate et al., 1996). Therefore, managing pain and providing developmentally and emotionally appropriate care in pediatrics paves the way for positive future healthcare encounters.


Pediatric healthcare professionals want what is best for their patients. However, barriers such as staffing logistics, institutional policies and practices, perceived and real time constraints, and inadequate staff training contribute to actions that may be harmful to children and families, and in turn, cause distress in medical team members. The result is that medical care delivery potentially creates lasting wounds for the patient and family, and for the HCP. Lee (2013) discussed the notion of guiding healthcare professionals to reduce suffering for patients and families, not just physically but emotionally. While experiencing distress when facing health issues is inevitable, the presence of “unnecessary anxiety” can be reduced by ameliorating the dysfunction in the delivery system (p. 1777). HCPs and the healthcare system can have a bidirectional impact on the culture of emotional safety.

The World Health Organization (n.d.) defined patient safety as the absence of preventable harm to a patient during the process of healthcare and reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. The acceptable minimum is based on collective notions derived from current knowledge and resources (World Health Organization, n.d.). To date, the level of emotional harm that pediatric patients are

expected to endure is far too high. In this paper, comprehensive details are shared regarding the impact and risks associated with emotional harm to pediatric patients in the healthcare setting, and to key mitigating strategies are outlined.

The Association of Child Life Professionals defines emotional safety (ES) as an intentional, interdisciplinary practice to promote resiliency, healing, and trust for pediatric patients and their families during medical experiences. The solution-focused practice includes proactively, comprehensively, and systematically addressing the developmental and emotional needs of pediatric patients. Emotional safety encompasses specialized strategies including atraumatic, patient and family-centered, trauma-informed, culture-centered, and developmentally appropriate care. These clinical components are woven throughout the four pillars of emotional safety: (a) screening and assessment; (b) intervention; (c) environment; and (d) education, training, and communication.. The supporting framework includes primary and sub-goals of each pillar. These key drivers were identified by researching evidenced-based practice, reviewing current best practice models, and incorporating input from content experts.

Each pillar in the emotional safety framework addresses a key area of focus. The first pillar, screening and assessment, addresses the implementation of a system that identifies patient and family perceptions, experiences, needs, and strengths. It also explores strategies for making the results accessible to all appropriate healthcare professionals, thus ensuring the implementation of interventions that prioritize, respect, and protect the emotional wellbeing of the patient and family during healthcare experiences. The second pillar, intervention, focuses on the commitment to a child’s comfort and understanding regarding medical encounters. It incorporates best practices, grounded in empirical evidence whenever possible, in each patient and family encounter. The third pillar, environment, uses evidenced-based practice to promote safe and reliable environments that minimize stress and promote emotional safety for patients, families, and healthcare professionals. The fourth pillar is staff

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education, training, and communication. The goal is to facilitate collaborative relationships and to develop helpful communication strategies among the interdisciplinary team, the patient, and their support systems. The goal includes educating teams about the implementation of emotionally safe standards of care, utilizing the patient and family voice, and advocating for them within the boundaries of the medical environment. This framework is a comprehensive guide to engaging in the practice of emotional safety in pediatrics.

Wherever physical safety is discussed, emotional safety should be addressed as well. They are two sides of the same coin and both deserve equal consideration. In 2020, the Association of Child Life Professionals conducted a national survey of healthcare professionals to gauge their thoughts on emotional safety. Of the 225 HCPs who responded, 95.95% stated they believe emotional safety is equally important to physical safety. However, Sokol-Hessner et al. (2015) asserted that the awareness and prevention of emotional harm is lagging that of physical harm by over twenty years. To date, the term “patient safety” is used to reference the physical safety of the patient and rarely, if ever, considers their emotional safety. The system needs to catch up with the values held by the front-line medical professionals. As the Institute of Medicine (2000) stated, “... it is simply not acceptable for patients to be harmed by the same health care system that is supposed to offer healing and comfort” (p. 3).

Healthcare professionals also suffer when emotional safety is not prioritized. Since its introduction over three decades ago, the term “moral distress” is increasingly used to describe the experience of healthcare professionals when they are routinely put into a position where they must comply with a process they believe is damaging. When they are placed in a systemic process that contradicts their belief in what is right, they can fall

into a crisis (Davis et al., 2018; Garros et al., 2015; Jameton, 1984). Two examples might be assisting in medical procedures where the child’s pain is not adequately controlled despite knowing there are accessible options available, or being asked to restrain a crying patient by lying them flat and holding them down during an examination when they could be held comfortably and safely by their caregivers instead. This incongruence of self leads to feelings of anger, frustration, powerlessness, and shame (Davis et al., 2018; Jameton, 1984). It can also lead to burnout (Burston & Tuckett, 2012), job dissatisfaction (Allen et al., 2013), and even to HCPs leaving the profession altogether. Rather than pathologizing moral distress in those who experience it, Tigard (2019) emphasized its value as it “...warns us of something significant being amiss and demanding systematic reform” (p. 602). The system can be changed when those within it bring to light the shortcomings and implement strategies for improvement.

It is imperative to adopt emotional safety as a core philosophy for medical delivery. Such practice will reduce patients’ medical trauma and distress and foster their trust, thus paving the way for positive healthcare encounters in the future and improving their health-related quality of life. Enhancing care by systemically adopting the ES framework will also result in a decrease of moral distress experienced by healthcare professionals. The emotional safety practice, and all four pillars therein, must be incorporated into the important quality and safety work being executed by medical institutions around the world. ☺

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EMOTIONAL SAFETY (ES) is defined as an intentional, interdisciplinary practice to promote resiliency, healing, and trust for pediatric patients and their families during medical experiences. In this paper, the term child refers to patients from birth through adolescence. Healthcare professionals (HCPs) are medical professionals who have specialized training and experience. This includes physicians, physician assistants, nurses, clinical assistants, medical technicians, specialists, and physical/occupational/speech/respiratory therapists. Psychosocial/spiritual professionals are those in the medical field who tend to the emotional, social, spiritual, and psychological needs of patients and families. They include child life specialists, clinical social workers, creative arts therapists, play therapists, chaplains, psychiatrists, and psychologists. Caregivers include the patient’s parents, guardians, or adults taking primary responsibility of caring for the child. Family is used to describe whoever the child defines as their support or family. Siblings include anyone the child considers a sibling, close relative, or friend.



EMOTIONAL SAFETY PILLAR #1: SCREENING & ASSESSMENT

Screening is the first step in assuring that the psychosocial risks and resiliencies of all families entering pediatric health care systems are detected early in the course of care.

- KAZAK ET AL., 2015B, P. 579

Patients and families bring more than their medical needs when they enter the healthcare system; they carry all their experiences, traumas, worries, beliefs, coping skills, and support systems as well. Therefore, it is important to understand who they are as individuals, as a unit, and as members of a community, to fully grasp the patient's and caregivers' strengths and needs. Assessments and screeners are valuable components to building individualized care plans that maximize resilience and minimize iatrogenic emotional wounds.

In the hope that pediatric patients and families experience a higher quality of life, healthcare professionals screen for psychosocial factors to identify and address potential risks, barriers, and strengths (Barrera et al., 2019; Kassam-Adams et

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al., 2013; Kazak, et al. 2015a; Staab et al. 2013). Assessments are used to guide the plan of care by identifying critical elements for ongoing support. When assessment systems are implemented, psychosocial factors can be determined early, and supportive interventions provided quickly. Comprehensive support is provided to build on patients' and families' strengths which benefits them within the medical institution and in their daily lives.

The National Child Traumatic Stress Network found that following a hospitalization for an illness or injury, 15%-25% of pediatric patients and their siblings experience persistent traumatic stress "that impair daily functioning and affect treatment adherence and recovery," which negatively impact quality of life (Effects, 2018, para. 2). Anxiety, temperament, exposure to invasive procedures, parental stress and support, trauma history, maladaptive coping strategies, and threat appraisal all inform how a child copes with their conditions and medical care (Kassam-Adams et al., 2013; Le Brocque et al., 2010; Staab et al., 2013). To reduce the emotional toll on pediatric patients, a proactive approach should be taken to assess their psychosocial risk factors and formulate a care plan.

Woolf et al. (2015) systematically reviewed 24 studies examining caregiver traumatic stress related to their child's hospitalization for a serious illness or injury. The results showed that within three months of the child's hospitalization, up to 63% of caregivers experienced acute stress disorder and up to 68% experienced posttraumatic stress disorder. In the studies explored, it was psychosocial factors, not medical ones, that predicted caregiver distress. Foundational psychosocial variables, such as a caregiver's social and psychological functioning, are highly linked to their acute stress reactions (Woolf et al., 2015). Factors including trait anxiety, family psychosocial risk and functioning, history of mental health issues, lack of financial resources, appraisal of the situation, and prior trauma all impact a caregiver's ability to cope with the medical stressors (Kazak et al., 2015b; Muscara et al., 2017; Woolf et al., 2015). Furthermore, a caregiver's emotional state is strongly tied to their child's understanding of the situation and reaction to it (Doupnik et al., 2017; Le Brocque et al., 2010; Morris et al., 2012; Nelson & Gold, 2012; Staab et al., 2013). Therefore, it would behoove medical and psychosocial teams to assess the caregiver's strengths and vulnerabilities, and to subsequently create an individualized plan to provide exemplary and sensitive care to the pediatric patient and family (Rodriguez-Rey et al., 2018).

A variety of tools are available that focus on psychosocial risk factors, acute stress, and traumatic stress. Guidelines are necessary to ensure that validated tools are used, that the resulting information is shared quickly and appropriately, and that evidence-based interventions are facilitated. Process standardization should include choosing which assessments and screeners to use, when they are implemented and by whom, establishing intervals for reassessment, determining who has access to the results, and determining what follow up interventions to provide (Kazak, et al., 2015b; Sint Nicolaas et al., 2017; Weiner et al., 2015). By selecting the most useful tools and standardizing the screening and assessment process, HCPs and psychosocial team members can maximize the patient and family's resiliency, ability to cope, and quality of life. ●

SUB-GOAL #1:

Ensure the appropriate screening and assessment tools are utilized to measure psychosocial risks and strengths.

The Substance Abuse and Mental Health Services Administration (2009) defined screening as a process for evaluating the possible presence of a particular problem, and assessment as a process for defining the nature of the problem, determining a diagnosis, and developing specific recommendations for addressing the concerns (Substance Abuse and Mental Health Services Administration, 2009, para. 6). Numerous determinants must be considered when assessing patient and family needs, and countless assessments and screeners exist to measure those factors. Deciding what to focus on and by which means can be daunting. The tools must meet the needs of the population, feasibly fit into the existing workflow, and have strong evidence supporting them. An evaluation of available pediatric assessment tools should be conducted to ensure the most helpful information is obtained and shared.

Considering which perspective to capture is an important step in instrument selection. As there can be a discrepancy between the HCP and caregiver ratings, using a hybrid model of clinical judgment and caregiver report can best describe the complexity of a family's problems that impact quality of life (Nofech-Mozes et al., 2020). Similarly, while caregiver input is particularly useful regarding family supports and functioning and the child's externalized display of distress, it may be less accurate when assessing the child's internalized emotional reactions to potentially traumatic situations. The caregiver's own response to these events and misunderstanding of the child's reactions can lead to a disconnect in the assessment of their coping. Therefore, the preference is to have the children self-report their experiences as well as to obtain caregiver input (Kassam-Adams et al., 2006; Kassam-Adams & Marsac, 2016; Le Brocque et al., 2010). Of note, while child report is preferred, some children

may not be able to accurately self-report, such as young children or those with developmental delays. Gaining insight from HCPs, caregivers, and children results in a deeper understanding of the patient's and family's needs.

The Patient Assessment Tool (PAT) relies on caregiver report and is designed to screen for psychosocial risk factors in pediatric patients and families (Kazak et al. 2015b). The PAT (and subsequent versions of it) is based on the public health framework, the Pediatric Psychosocial Preventative Health Model (PPPHM), which consists of universal, targeted, and clinical categories (Kazak, 2006; Kazak et al., 2018; Pai et al., 2008; Schepers et al., 2017). The PPPHM author conceptualizes psychosocial risk by placing families within these three tiers and suggesting depth of interventions based on those levels (Kazak, 2006). The PAT is a brief screener that takes the caregiver just 5-10 minutes to complete and can yield meaningful information. The domains covered are demographic characteristics, diagnosis, family structure and resources, social support, child knowledge of the diagnosis, school enrollment and placement, child, sibling and family problems, family beliefs, and stress responses (Kazak et al., 2015a). The PAT is used internationally and has been translated into a dozen languages, with English adaptations for multiple countries, and over 12,000 administrations (Kazak et al., 2015b; Pai et al., 2008). While it was originally created for families of pediatric oncology patients, the PAT has since been successfully modified for use with other diagnoses such as craniofacial conditions, sickle cell disease, inflammatory bowel disease, chronic headaches, and disorders/differences of sex development (Crerand et al., 2018; Ernst et al., 2018; Karlson et al., 2012; Pai et al., 2014; Reader et al., 2020; Woods & Ostrowski-Delahanty, 2017). The PAT is a widely used and studied tool that paints a systemic picture of a family's vulnerabilities and strengths, allowing for appropriate care plans to be created and for support to be maximized.

The Psychosocial Care Checklist (PCCL) (Barrera, 2015) is a 20-item tool designed for healthcare professionals' assessment. In it, HCPs identify psychosocial issues for pediatric oncology patients, their siblings, and caregivers.

The questions are centered around family coping, mood, behaviors, financial stressors, and support (Barrera, 2015). Because the PCCL relies on HCP input, combining it with caregiver report screeners such as the PAT, may provide a richer picture of patient and family needs. Exploring the larger context of needs can lead to personalized interventions that may positively impact quality of life (Barrera et al. 2016; Nofech-Mozes et al., 2019).

While some tools examine the broader needs of patients and families, others are intended to take a more focused approach to explore the impact of specific stressors and events, such as traumatic injury and medical trauma. Children who have experienced trauma are at risk of developing posttraumatic stress disorder (PTSD) and chronic pain (Nelson et al., 2012). Therefore, it is essential to have early identification tools to pinpoint which patients are at-risk (Kassam-Adams et al., 2015a; Kenardy et al., 2006; Nixon et al., 2010; Price et al., 2019; Staab et al., 2013). Yet many organizations do not have a standard for screening children for traumatic stress (Zatzick et al., 2011). Below are tools that address children's reactions to potentially traumatic events.

The various versions of the Acute Stress Checklist (ASC) measure acute stress symptoms following a traumatic event or injury (Kassam-Adams et al., 2006). The ASC-Kids self-report measure, written in English and Spanish (Cuestionario de Estrés Agudo-Niños [CEA-N]), is intended for use with children and adolescents ages 8-17 years (Kassam-Adams & Marsac, 2016). These screeners ask youth to identify their reactions during the event and their feelings and responses from the time it happened. The Acute Stress Checklists are useful with early identification of children in need of intentional, individualistic, trauma-informed care.

Another tool for assessing traumatic stress is the Child Traumatic Stress Questionnaire (CTSQ) (Kenardy et al., 2006). This is a 10-item, self-report screener used to identify children who are at risk for developing post-traumatic stress symptoms (PTSS) up to six months following the event (Kenardy et al., 2006). It is utilized for children ages seven-16 and is available in English, Arabic, and Croatian (Child trauma screening questionnaire,

2017). The CTSQ asks children to identify their thoughts and feelings about the traumatic event. Implementing this quick screener can aid in the prevention of PTSS by showing healthcare and psychosocial team members which patients need specialized care (Kenardy et al., 2006).

The Screening Tool for Early Predictors of PTSD (STEPP) is for traumatically injured pediatric patients. This instrument is intended for use with caregivers and children. It is used with children ages eight-17 and is implemented within one month of the injury. Children and caregivers are asked questions about their experiences during, and immediately following, the trauma. Caregivers are also asked about their child's baseline behavior or attention concerns. Physiological data that are tied to increased risk of PTSD are incorporated from the medical record, such as gender, age, pulse rate in the emergency department, and presence of an extremity fracture (Winston et al., 2003). One implementation study of the STEPP showed that over a 2.5-year time frame, 25% of the those who completed the tool had a positive screen for either the caregiver or the child. The standardization of the STEPP resulted in a significantly higher rate of psychology referrals for the patients and families than those in the control group (Price et al., 2019). Those who were at risk for negative psychological symptoms received early support that could mitigate the impact of the trauma.

Pediatric medical traumatic stress (PMTS) is a set of psychological and physiological responses to fear and pain caused by medical diagnosis and treatment (Kassam-Adams & Butler, 2017; Kazak et al., 2005). The National Child Traumatic Stress Network lists prevention and assessment as key components to combating PMTS. The Psychosocial Risk Assessment in Pediatrics (PRAP) (Staab et al., 2013) is a unique tool designed for that exact purpose. The PRAP has been integrated into standard practice by child life programs at many children's hospitals, as it focuses specifically on the factors that may impact the patient's ability to cope with the medical experience. Such information is helpful for child life specialists and others in the psychosocial care teams to prioritize which patients to see when volumes are high and time and resources are limited. The PRAP focuses on eight

variables that are explored through a combination of caregiver report and clinician assessment. The factors are communication, special needs, anxiety and coping with healthcare encounters, temperament, past healthcare experiences, caregiver stress, developmental impact on coping, and the invasiveness of the planned procedure or encounter (Staab et al., 2013). The PRAP has been validated on children as young as three-years-old, capturing the needs of a particularly vulnerable age group. A proactive approach can be taken when the team knows which patients are vulnerable to the negative emotional effects from medical experiences. Forming an individualized plan mitigates the risks of creating or exacerbating medical trauma while caring for pediatric patients.

It is known that youth with developmental disabilities are at a higher risk for experiencing negative emotional effects from medical experiences (Staab et al., 2013). Assessment tools should be used with these patients' unique needs in mind. Adaptive Care Plans (ACPs) take a patient and family-centered approach to assessing the patient's needs and communicating specific tactics to enhance coping (Jaffer, 2019; Liddle et al., 2018). The caregiver is asked for their assessment of the child's coping and reactions from past medical encounters, stressors and reactive behaviors, baseline temperament, sensory sensitivities, communication preferences, pain responses, and interests or motivators. They also provide their own suggestions for meeting each one of these needs through individualized interventions. As caregivers are the experts on their children, including them in the assessment process is key.

While there are a variety of assessment and screening tools available, there is no one tool that can capture the full spectrum of psychosocial risk. However, being able to articulate the emotional acuity of patients is critical to ensuring adequate psychosocial staffing and resource allocation to patients and families with the greatest need. Psychosocial and medical teams can work together to select the tools that best fit their needs. This collaboration leads to improved care in pediatrics. ●

SUB-GOAL #2:

Standardize the screening and assessment processes, including the plans for implementing, documenting, and reporting screener results, and for providing subsequent care.

“Pediatric illness and injury are among the most common potentially traumatic experiences for children and their families” (Marsac, et al., 2016, p. 70). Considering factors such as diagnosis or type of hospitalization can help drive what level of support families are offered. Using data to understand the unique risk factors of each population allows evidence-based decisions to be made regarding targeted versus generalized services. Such knowledge allows medical and psychosocial professionals to provide solutions to reduce or prevent the adverse psychological effects of medical care.

A significant number of caregivers develop chronic or delayed psychological symptoms as a result of their child being admitted to pediatric intensive care units (PICU) (Nelson & Gold, 2012; Rodriguez-Ray et al., 2018). PTSD rates in children following a PICU admission are reportedly between 5% and 28%, with post-traumatic symptoms being as high as 35% (Nelson & Gold, 2012) Colliva et al. (2020) studied PAT results of 300 families of pediatric patients with either acute lymphoblastic leukemia (ALL), epilepsy, or asthma. While the study showed that families of patients with ALL had greater overall psychosocial risk, each diagnosis yielded unique areas of patient and family-related problems. Caregivers of children with epilepsy reported concerns with the child’s high level of worry and sensitivity. These patients also showed higher instances of learning difficulties and developmental delays. Children with asthma were reported to be sadder and have more difficulty with

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attention than their counterparts with ALL. Youth with ALL exhibited a higher level of fear regarding hospital visits than those with asthma or epilepsy. Based on such data, psychosocial professionals can create guidelines regarding which populations would benefit from standardized assessments.

Screening is a useful communication tool that ensures the appropriate distribution of psychosocial resources, supporting the emotional safety of the patient and family (Di Battista, et.al., 2015) Desjardins et al. (2019) asserted that the active engagement of healthcare professionals is critically important to improving the implementation of psychosocial screenings. For example, HCP’s knowledge of PAT risk summaries helps secure appropriate psychosocial support early for families at risk (Nofech-Mozes et al., 2019; Schepers et al., 2017). Further, researchers have demonstrated that dissemination of PAT risk summaries with healthcare professionals can improve pediatric patients’ quality of life (Barrera et.al., 2013; Barerra et al., 2019). Standardizing which team members receive the screener data is a key step in ensuring that such improvements are made.

Leaning on specialized institutional staff who view patients and families through a psychosocial lens contributes to the facilitation of targeted interventions focused on emotional safety. When studying the PCCL, Barrera et al. (2016) found that social workers tend to have a greater psychosocial knowledge of patient and family issues over oncologists and nurses. This is unsurprising as it is the focus of their education and professional role. Similarly, child life specialists have specific training in psychosocial/emotional support, which has a positive impact on psychological and physiological outcomes (Boles et al., 2020). In one study of the PAT, the psychosocial team (i.e., child life, psychology, and social work) reviewed the scores of patients and families who were already receiving their support. The psychosocial team reported that the results matched their existing estimations of the families and did not offer much additional insight. However, their actions were influenced by the PAT scores as they monitored the families more closely and offered more individualized support (Kazak et al., 2011;

Schepers et al., 2017). Therefore, a strong model for implementation is to have other healthcare team members initiate the tools, then share the results with the psychosocial team for follow-up.

The timing of implementation is an important factor in providing relevant psychosocial care. Facilitators must understand the recommended time frame for each screener. Traumatic stress screeners are implemented soon after the potentially traumatic event (Kassam-Adams et al., 2015a). This ensures the interventions are provided before the acute trauma leads to an emotional sequela of on-going negative effects. The Commission on Cancer guidelines recommend screening at times of the highest distress, such as at the time of diagnosis, during the time of initial treatment discussions, and when transitioning off treatment (Kazak et al., 2015b). Proactive assessments, such as the PRAP, are useful when they are completed prior to the patient's medical encounter to ensure steps are made for planning and support (Staab et al., 2013).

Standardizing the reevaluation time frame is another important consideration. The Standards for Psychosocial Care in Pediatric Cancer recommend that "youth with cancer and their family members should routinely receive systematic assessments of their psychosocial health care needs" (Weiner et al., 2015, p. S422), showing the importance of reassessing over time. Reevaluating infants and children with congenital heart disease is also recommended (Wray et al., 2018). Pediatric transplant groups have long used screeners to assess various areas of risk in pediatric patients and families. Annuziati et al. (2010) asserted that it is important to assess risk factors related to transplantation success near the time of listing a patient for solid organ transplantation. However, routine screenings are not standard practice. The authors suggested that regular screening intervals may lead to early detection of deterioration while adjusting to life post-transplant, as well as create opportunities for follow up in patients with documented risk categories. The determination of reassessment intervals may need to be considered based on the risk category, such as people in the targeted diagnosis group of the PAT. It is crucial to understand the institutional

barriers for implementing assessments and screeners. When obstacles are understood, solutions can be explored and created. Getting healthcare professionals' buy-in regarding the usefulness of screeners and assessments can be one such barrier. Barrera (2015) examined HCPs' perceptions regarding the utility of two screening tools: the revised PAT and the PCCL. Nurses, oncologists, and social workers participated in the study. The instruments were used with families of a newly diagnosed pediatric cancer patient. For both instruments, the highest utility ratings came from nurses, the lowest were from social workers, and moderate ratings came from oncologists. It was postulated that social workers find the tools less helpful because their role demands they have a strong sense of the psychosocial needs of patients and families, while nurses' and physician's training and focus are elsewhere (Di Battista et al., 2015). While psychosocial team members who are already adept at conducting informal assessments on patients' and families' psychosocial risks may not see the benefit of completing a more formal assessment, there are a lot of benefits to capturing quantifiable data to demonstrate the emotional acuity of the patients for whom they care. In the data is used to communicate with the medical team and establish best practice for interventions and standardization of care. It is also helpful in ensuring staffing and resources are available to accurately meet the need as psychosocial risk and emotional acuity equate to more staff time and resources. Other barriers to implementing screening and assessment tools have been explored. In a presentation on early warning signs of psychosocial risks with pediatric oncology patients, Barrera (2015) shared other common barriers such as a lack of standardization, staffing, and time. In Price et al.'s (2019) study of the STEPP screener, one barrier was staff concern regarding asking patients and caregivers potentially sensitive and upsetting questions. It is possible that receiving further training in asking such questions could improve HCP comfort. Psychosocial risk screening and assessments can become a standard of care when the modalities are easy to use, endorsed by healthcare team members as integral to clinical

practice, and associated with improvements to care delivery.

By its nature, the healthcare system is problem-focused. Medical assessments are designed to examine chief complaints and explore dysfunction. That information is used by HCPs to identify a diagnosis and treatment plan. In contrast, focusing on a patient's strength makes a powerful, positive statement. A set of principles was created to ensure positive support is provided to patients and families. It is called CARE (choices, agenda, resilience, emotional support) (Lerwick, 2016). The principles include reframing the negative narrative by highlighting areas of resilience. During the evaluation process, strengths are discussed first, such as what the caregiver is most proud of with their child or in what areas the patient excels. Lerwick stated, "This may be the only time in the day the child hears about their positive qualities" (p. 148). In this model, questions are asked such as: "What was helpful when you sought out care for this previously?" Or, a question is reframed using more positive language, such as, "What would you like to be different?" versus "Tell me what's wrong" (Lerwick, 2016, p. 148).

To optimize the impact of screeners and assessments, organizational processes must be standardized. Clear expectations should be made regarding the implementation of these tools, documentation of the results, and facilitation of follow-up interventions. Specific results can be used for creating a care plan and for communicating needs to appropriate team members. Beyond diagnostic and planning uses, the information is impactful in a broader manner, as it is reviewed, analyzed, and leveraged to assess organizational needs. Examining the data collectively can help inform important operational and process improvements. Standardization of these processes enhance their impact on patient, family, and systemic levels. ●

SUB-GOAL #3:

Utilize technology for assessments and screeners.

Leveraging technology with the use of instruments creates an accessible and streamlined assessment and screening process. Although electronic medical records (EMR) systems were not originally designed with psychosocial needs in mind, the assessment and screener tools can be incorporated into these systems (Kazak, Schneider, et al., 2015b). Answers can be entered directly into the EMR, eliminating the extra step of moving information from the paper form. If the assessment tool or screener cannot be built into the EMR, a place for the results can be, increasing the ease of communication. When the EMR is utilized, information is shared efficiently among the necessary team members.

Recently, healthcare systems have employed tablet technology to facilitate, capture, and report medical and psychosocial screenings and assessments. User-friendly formats may reduce demand on personnel responsible for psychosocial care screening. However, healthcare team members must be properly trained and embrace the modality for it to be successful. The transmission of data from tablets can potentially simplify the screening process and expedite the facilitation of results into the patient's EMR (Kazak, et al., 2015b). Strategies should be developed together with team members to improve quick exchange of results in order to allocate support services in a timely manner. The electronic information can also be used to collect data to see trends more broadly, such as on the unit level, with specific age groups, or on a diagnostic level. This not only informs care for the patient but also impacts how units are staffed and patient loads are prioritized. ☺



EMOTIONAL SAFETY PILLAR #2: INTERVENTION

Ensuring that our profession does not cause preventable harm to our patients requires that we address emotional harms with the same rigor that we address physical harms.

- SOKOL-HESSNER ET AL., 2015, P. 552

When healthcare professionals (HCPs) engage in sensitive communication with patients and show empathy, there is a positive impact on the relationship, and even on health outcomes (Haley et al., 2017; Raja et al., 2015b). In pediatrics, communicating effectively and practicing empathy are dependent upon the ability to adapt one's approach to meet the child's developmental and emotional state. While feeling empathy and respect contribute to therapeutic relationships, those feelings must be translated into action in order to have the greatest impact. These individual considerations are key to providing emotionally safe, atraumatic medical care.

Communication strategies must be developmentally appropriate and tailored to fit the individual needs of the patient and family. Factors such as learning style, developmental level, sociocultural perspectives, and past experiences must be understood (Boles et al., 2020). Other considerations include the timing of communication and the emotional state of the patient and family (Gordon & Thomas, 2017). Additionally, it is crucial to deliver care in a manner that is sensitive and compassionate. A child's past experiences can result in either a feeling of ease, or fear, regarding medical interactions. How

they are cared for in subsequent encounters can then either heighten or reverse those feelings. Many interventions exist that can support a child's emotional wellbeing as they receive medical care.

Individualized and innovative approaches result in more successful outcomes during medical encounters. Proactive supportive measures should be explored and implemented for patients with developmental differences and sensory needs. Similarly, protective approaches must be used with children who have experienced physically and/or emotionally traumatic events. Providing exemplary care involves respecting and planning for patients' unique needs.

Medical procedures, especially those using needles, cause a great amount of pain and fear in children. Pain management is paramount to delivering high quality care. The use of topical anesthetics should be standard in pediatrics.

Protective approaches must be used with children who have experienced physically and/or emotionally traumatic events. Providing exemplary care involves respecting and planning for patients' unique needs.

Whenever possible, nonpharmacological tactics, such as deep breathing or distraction support, are a strong complement to pharmacological interventions. Many evidenced-based techniques address both the pain and anxiety associated with procedures and treatments and should be incorporated into all care plans.

Distress and angst are experienced when children are removed from their normal lives and are placed into the medical environment. Therefore, it is imperative to both health and coping that interventions can ease such discomfort be provided. Simple steps can be taken to make the medical environment more comfortable and conducive to healing. Items for comfort, normalization, and distraction should be provided regularly. It is also beneficial to engage services and professionals whose sole focus is to provide emotional support and outlets for hospitalized children. ●



SUB-GOAL #1:

Utilize developmentally appropriate and emotionally safe communication styles and tactics.

Best practice supports positive communication between pediatric patients and their healthcare professionals (Koller, 2017; Lerwick, 2016). “Careful consideration needs to be given to what sort of information children should receive, when it should be provided, and how it should be provided” (Jaaniste et al., 2007, p. 124). Effective communication of medical information is dependent upon HCPs’ comprehension of such intricacies (Perry et al., 2012). Klinzing and Klinzing (2018) asserted that when communicating with pediatric patients, the information ought to be adjusted to fit the “age, ability, and sensitivity of the child” (p. 139). Assessing the temperament and needs of the patient informs the plan, allowing the intervention to be appropriate for each patient (Carter et al., 2010; Koller, 2017; Kuttner, 2010; Sanchez Cristal et al., 2018). Information should be shared using concrete, simple terms to ensure understanding and decrease the opportunity for misunderstanding and fear (Boles et al., 2020; Guvenek-Cokol et al., 2016; Lerwick, 2016). Utilizing play and specially selected teaching materials also enhances the learning experience (Boles et al., 2020; Carter et al., 2010; Cejda et al., 2012; Grissom et al., 2016).

The Association of Child Life Professionals’ (2020) national survey of patient and family advisory councils found that of 105 respondents, 49.45% received life-changing news in a manner they found to be insensitive. In a busy medical

“The Association of Child Life Professionals national survey of patient and family advisory councils found that of 105 respondents, 49.45% received life-changing news in a manner they found to be insensitive.”

environment, the intentionality behind meaningful, sensitive communication is sometimes ignored in favor of speed and convenience for HCPs. Examples include families learning significant, life-changing information during handoffs or rounds, children overhearing frightening medical risks while consent is being reviewed, or caregivers and children hearing devastating news at the same time. These common situations can lead to pediatric medical traumatic stress and distrust in the healthcare team. Caregivers deserve to be told critical information privately, so they can have their emotional reactions and ask pertinent questions out of the child's presence. Then, a plan can be made to tell the patient (and siblings) in a developmentally appropriate way. In all these examples, the family should be given the option to have their personal support systems and psychosocial and spiritual professionals present. To provide a higher quality of care, it is imperative that communication plans are made prior to sharing important information (Gordon & Thomas, 2017).

Children can cope with potentially upsetting or frightening situations when they are given honest information in a developmentally appropriate and emotionally sensitive way (Boles et al., 2020; Guvenek-Cokol et al., 2016; Jaaniste et al., 2007; Koller, 2017; Perry et al., 2012). Comprehension and predictability decrease anxiety in the medical setting. Procedure preparation and diagnosis teaching are common interventions facilitated by child life specialists (Boles et al., 2020). When done appropriately, providing psychological preparation for medical procedures can reduce anxiety, increase cooperation, and lead to greater staff and caregiver satisfaction (Carter et al., 2010; Cejda et al., 2012; Grissom et al., 2016; Perry et al., 2012; Sanchez Cristal et al., 2018). With medical understanding comes a greater sense of autonomy and an increase in awareness and engagement (Asnani et al., 2016; Koller, 2017). While child life specialists receive specialized training in providing such education, it is imperative that all medical professionals give information to their pediatric

patients in a sensitive and developmentally appropriate manner.

To prevent healthcare-induced trauma and anxiety in pediatric patients, Lerwick (2016) created four treatment principles called the CARE process. CARE stands for choices, agenda, resilience, and emotional support. Children often feel a loss of autonomy and control when they receive medical treatment. They are unsure what is happening and why. In addition to the confusion, HCPs are physically holding and manipulating the child for medical procedures, adding to the feeling of helplessness. Caregivers also experience feelings of powerlessness as they are passive observers during such events. CARE was created to increase trust, communication, and empowerment for pediatric patients and their families.

The principles of CARE are simple and effective. Patients and families are empowered to have psychosocial control of their environment when they are offered realistic, appropriate choices. Additionally, explaining the treatment plan, including what is expected of the child and caregiver, reduces the fear of the unknown. Understanding the agenda for the appointment or visit creates "emotional and psychological safety for patients and families" (Lerwick, 2016, p. 147). In this process, resiliency and strengths are discussed, highlighting positive features and building rapport. HCPs are also encouraged to normalize and validate the feelings of their pediatric patients and families. When emotions are acknowledged without judgment, they feel understood and safe. Cultural considerations are also key to the CARE process. Lerwick stated that medical relationships must begin with "a respectful curiosity and an intentional invitation to understand differences and similarities" (p. 148). When deciding on a course of treatment, it is important for HCPs to understand the values of the patient and family so caution is taken to avoid implementation of interventions that could cause emotional distress. The quality of the interpersonal relationship between HCPs and pediatric patients can be improved using the CARE principles. ●

SUB-GOAL #2:

Implement individualized plans based on the developmental and emotional needs of the patient.

Atraumatic care is a philosophy of medical delivery that can positively impact children. In Wong's *Essentials of Pediatric Nursing*, atraumatic care is defined as "a provision of therapeutic care in settings, by personnel, and through the use of interventions that eliminate or minimize the psychologic and physical distress experienced by children and their families in the health care system" (Hockenberry & Wilson, 2021, p. 8). It includes pain management, patient- and family-centered care, developmental principles, and cultural considerations. Specific strategies include fostering the caregiver-child relationship, preparing the patient for any unfamiliar treatment or procedure, minimizing pain and bodily injury, providing opportunities for play, and returning control by giving the child choices. Healthcare institutions who prioritize atraumatic care create an environment that is more conducive to trust and healing, thus reducing the negative impact of treatment on all pediatric patients, ensuring that medical trauma is not created while providing care.

Pediatric patients with developmental delays such as autism spectrum disorder (ASD) can experience a myriad of barriers to having successful medical encounters. Medical team members and caregivers identify some of these to be the child's behaviors, non-compliance, communication, fears, sensory differences, environmental issues, and feeling disconnected to the HCPs (Bultas, 2012; Bultas et al., 2016; Johnson & Rodriguez, 2013; Venkat et al., 2012). HCPs report a lack of training and comfort regarding communicating with, and caring for,

Healthcare institutions who prioritize atraumatic care, create an environment that is more conducive with trust and healing thus reducing the negative impact of treatment on all pediatric patients, ensuring that medical trauma is not created while providing care.

patients who have an ASD diagnosis (Morris et al., 2019; Weil et al., 2010). Unsurprisingly then, caregivers express feeling a disconnect between what will make their child feel comfortable, and how prepared HCPs are to tailor their approach to meet their needs and to provide resources (Minnes & Steiner, 2009; Rhoades et al., 2007). With one in six children in the United States having some form of a developmental disability, it is imperative that professionals working with these pediatric patients facilitate care in an emotionally safe manner (CDC, 2022, May 11). Johnson and Rodriguez (2013) stated, "A better understanding of the function of an individual child's behavior during hospitalization could contribute to effective care planning and interventions for hospitalized children with ASD" (p. 131).

A tool was created that allows caregivers to quickly and easily share their child's unique concerns and needs with HCPs. As HCPs may not be familiar with the antecedents to challenging behaviors, communication with the caregiver is key. The Quick Tip Card (QTC) is a sticky note where caregivers write ten key pieces of information that will help guide the medical interaction (Bultas et al., 2016). The QTC has prompts that address the patient's communication, learning, sensory, and coping needs. Tailored interventions can then be facilitated to increase understanding, rapport, and cooperation during visits. A survey-design research study on the QTC yields promising results, showing high rates of acceptability from both HCPs and caregivers of children with ASD.

Another program specifically created to ameliorate pediatric, medical, traumatic stress and enhance coping for patients with developmental disabilities is called the Adaptive Care Plan (ACP) (Adaptive Care Program, n.d.; Adaptive Care Team, n.d.). Developed by child life specialists, ACPs were designed to enhance communication and cooperation during medical encounters. The caregiver is engaged in an assessment of the child's coping, preferences, and needs. With that information, a subsequent care plan is created and communicated to the medical and psychosocial teams (Liddle et al., 2018). Useful interventions are then implemented, such as reducing sensory stimulation by moving the patient directly into a

private exam room, facilitating tours of unfamiliar areas, guiding the care team to use preferred words and actions or to avoid triggering ones, having the child's favorite distraction available during a medical procedure, and using story boards to provide visual preparations for events.

Limited studies exist that examine the efficacy of ACPs and other individualized plans for pediatric patients with developmental disabilities. In one study, ACPs were not shown to have a greater positive effect on psychosocial outcomes for patients with developmental disabilities (Liddle & Sonnentag, 2020). However, other studies have found benefits to this and similar programs. When autism-specific care plans were used, the majority of caregivers reported they "definitely" improved their hospital experience (Broder-Fingert et al., 2016). Similarly, Balakas et al. (2015) and Whittling et al. (2018) showed that when these care plans are implemented, there are increases in caregiver satisfaction, staff attention, HCP comfort and understanding, and time management. Overall, caregivers reported believing their children's challenges were better addressed during medical encounters when adaptive care interventions were implemented.

Adolescent patients also have unique developmental needs as they straddle the worlds of pediatric and adult care. With an increase in autonomy, they shift from a passive to active role in their medical decisions and treatment plans (Koller, 2017). Teens are more likely to engage in risk-taking behaviors (CDC, 2020, October 27; Kim & White, 2018) and to have suboptimal medication adherence (McCormick King et al., 2013), which can potentially impact their health and quality of life. Due to these factors, it is important for HCPs to understand the developmental and psychosocial needs and vulnerabilities experienced by adolescent patients, and to communicate effectively with them.

"Health care professionals' communication skills with adolescents and young adults play a vital role in early identification of issues, provision of emotional support, effective illness management, and health education" (Kim & White, 2018, p. 198). A systemic literature review was conducted focusing on barriers to effective communication with adolescent patients. Developmentally

sensitive interpersonal communication practices for supporting this population were also explored. The information analyzed was put into three barrier and four recommendation domains. The themes surrounding youths' reluctance to fully engage with HCPs were concern for privacy and emotional safety and the need for inclusion and autonomy in care decisions. One recommended intervention is to inform youth about legal and professional privacy guidelines so they may feel more comfortable disclosing personal information. It is also suggested that HCPs take a humanistic communication approach in order to build rapport and encourage autonomy with the youth (Kim & White, 2018). When teens believe the HCP is authentic, non-judgmental, and trustworthy, they are more willing to discuss sensitive topics with their providers.

Approximately one in every four children in the United States will experience a traumatic event prior to the age of sixteen (Essential Elements, 2018). These traumatic events can be accidental injuries, natural disasters, abuse, violence, and medical trauma, to name a few. Additionally, each year in the United States, 9.2 million children under the age of 19 are treated in hospitals for unintentional injuries (CDC, 2019, October 10). It can be expected then that many pediatric patients have experienced potentially traumatic events; therefore, medical and psychosocial professionals in healthcare have a responsibility to provide trauma-informed care. The National Child Traumatic Stress Network explained that "by implementing trauma-informed integrated care practices, organizations can position themselves to have the greatest positive impact on the whole health of children, adolescents, families, and communities" (Essential Elements, 2018). Trauma-informed care (TIC) incorporates tactics that decrease distress, encourage positive coping, provide emotional support, share information, and offer anticipatory guidance for patients who have experienced trauma (Kassam-Adams et al., 2015a; Marsac et al., 2016). There are two domains for TIC in healthcare: universal trauma precautions and trauma-specific care (Raja et al., 2015a). With universal precautions, trauma-sensitive processes are always in place and do not require knowledge of the patient and family's trauma history. Practices

for universal precautions include offering choices to the patient to return control, providing an overview of what to expect during appointments and procedures, and having trauma resources available to everyone. Trauma-specific care is used when the provider is aware of the traumatic experience(s), thus an individualized plan is created, including engaging interdisciplinary support. In addition to being used with children with a trauma history, the trauma-specific approach should be taken when working with traumatically injured patients. Peritrauma factors must be examined, such as what the youth experienced at the time of the injury and the level of pain and fear they have experienced since (Kassam-Adams et al., 2015b). Such information is used to inform how medical procedures and conversations are carried out and what resources are provided (Gordon & Thomas, 2017). Special attention should be made to avoid retraumatizing these patients or creating new medical trauma. The Health Care Toolbox.org(n.d.) explained, “Trauma-informed practice can promote optimal health outcomes and reduce problematic psychological sequelae” (Health Care Toolbox para. 2). Marsac et al. (2016) stated, “Health care organizations with cultures marked by encouraging, compassionate, and emotionally supportive patient interactions, may be particularly well positioned to successfully implement trauma-informed care practices” (pp. 73-74). All healthcare organizations should exemplify such emotional safety cultures.

A model aimed at providing patient and family-centered, trauma-informed care is called D-E-F. (reduce distress, emotional support, and remember the family) (The D-E-F framework for trauma-informed care, n.d.). Medical providers are taught that the crucial first step in the assessment of physical health is A-B-C (airway, breathing, circulation). The second assessment should be to examine the emotional health through D-E-F (Marsac et al., 2016). While the techniques are applicable to providing atraumatic care in general, they are specifically created with the needs of traumatized patients in mind, including those with medical trauma. Managing the patient’s distress entails assessing and managing pain and fear. It also includes discovering if there are any grief or loss factors. HCPs are encouraged to evaluate what

emotional support the patient and family need and to explore ways to overcome barriers in mobilizing it. That feeds into the family considerations, which is where sibling and family member distress and needs are assessed, and resources are offered. The D-E-F guide was created with the understanding that “children’s traumatic stress responses to illness and injury can become persistent and problematic” and it is everyone’s responsibility to deliver care that halts that process (Health Care Toolbox para. 2) (The D-E-F framework for trauma-informed care, n.d.).

A detailed, integrative model was created to combat PMTS (Kazak, 2006). It is comprised of three phases of responses and interventions: peritrauma, acute medical care, and ongoing care or discharge from care (Price et al., 2016). The peritrauma phase addresses reactions and needs during and immediately following the potentially traumatic medical event, ensuring it does not cause persistent traumatic stress. It involves understanding what situations are stressful for the patient and providing support which shifts the negative subject experience. Interventions include providing anticipatory guidance to the patient and caregivers, administering pharmacologic aides, and engaging in TIC medical practice. Addressing staff compassion fatigue, burnout, and satisfaction are also included. The ongoing demands and challenges from the medical experience are addressed in the second phase of care. Key goals are to assess which factors may reduce or enhance traumatic stress responses and to screen for psychosocial concerns. The third phase addresses the long-term reactions separately from the acute event. Evidenced-based therapy interventions are facilitated, such as cognitive-behavioral and family therapy approaches (Kazak, 2006). This Integrative Trajectory Model of Pediatric Medical Traumatic Stress addresses potentially traumatic medical events, the subjective appraisals and responses, patient and family traumatic stress symptoms, and assessment and intervention (Price et al., 2016). ●

SUB-GOAL #3:

Offer full array of comfort measures for stressful, anxiety-provoking, or invasive procedures.

The Centers for Disease Control and Prevention (2019) reported that in 2018, 93.6% of U.S. children had contact with a healthcare provider. By the time a child is 18 years old, they have likely received at least sixteen vaccinations, some of which require multiple injections (Baudler, 2020). One study reviewed the medical charts of patients in 32 pediatric hospitals (Stevens et al., 2011). Of the 3,822 children included, 78.2% experienced at least one painful procedure in the previous 24-hour period, with a mean of 6.3 procedures per child. The associated pain and fear from such procedures can lead to pediatric medical traumatic stress and have life-long consequences, resulting in medical avoidance and decreased health-related quality of life (Nir et al., 2003; Wright et al., 2009). Wright et al. found that 22% of 177 adults questioned had a fear of needles. There was a strong association with past traumatic experiences within that group, with 20.5% admitting they had avoided medical care due to their needle fear.

Zelter et al. (2019) expounded upon numerous pharmacological and nonpharmacological treatments for pediatric pain. They explained that “pain is both a sensory and an emotional experience” (p. 469), thus taking a comprehensive approach is recommended. HCPs must facilitate interventions that are proven to decrease the patient’s anxiety and pain and to increase coping. Patients and families should know their options regarding comforting positions, distraction techniques, and analgesia. “Medical professionals should use all of the tools at their disposal to mitigate pain in children” (Short et al., 2017, p. 256). McMurtry et al. (2015) contended that it is necessary to engage in consideration and interventions for pain management in children enduring medical procedures in order to reduce or prevent “longer-term sequelae of unmitigated pain” (p. S6).

The American Academy of Pediatrics stated that “topical anesthetics should be available and used before obtaining blood samples whenever possible” (Sigrest et al., 2003, p. 1121). Such anesthetics are available in multiple forms with varying windows of effectiveness. Numbing sprays (Griffith et al., 2016) and needless lidocaine injectors (Ferayorni et al., 2012) offer quick-acting solutions, as does an external device that delivers cold and vibrating sensations to the skin (Moadad et al., 2016). While analgesic creams can take over an hour for maximum benefit, they are effective in reducing pain (Baxter et al., 2013; Foster et al., 2017; Kuttner, 2010; Zelter et al., 2019). Non-pharmacological pain management for infants includes using oral sucrose with nonnutritive sucking (Liu et al., 2017), breastfeeding (Harrison et al., 2016), and swaddling (Short et al., 2017) during procedures. Evidence also shows that “delivering maximum safe sedation at the time of initial procedures helps to prevent conditioned maladaptive responses to subsequent procedures” (Kazak et al., 2006, p. 349). HCPs can decide which methods are most appropriate, factoring in the condition of the patient, timing of the procedure, and resources available. Kuttner (2010) asserted, “Many hospitals now consider pain the fifth vital sign. However, for children in pain, it is number one” (p. 325).

Unfortunately, though pharmacological pain resources are at HCPs’ disposal, they are not always used with pediatric patients. Two studies examined beneficial techniques for intravenous catheter (IV) placement in Level 1 trauma emergency departments in pediatric hospitals. While the central focus was comfort positioning and psychological preparation, respectively, they both discovered that pain management was not a standard in care for children receiving IVs. Sparks et al. (2007) revealed that 64% percent of the children did not receive any anesthetic, while Sanchez, Cristal et al. (2018) discovered that patients who had child life support were significantly more likely to receive lidocaine than the group where child life support was not present. In the latter, it is hypothesized that the child life specialist’s advocacy resulted in greater use of the analgesic. Similarly, when a team investigated

pediatric procedural pain management in their multisite medical center, it was discovered that only 10% of pediatric inpatients received topical lidocaine (Rosenberg et al., 2016). Further, MacLean et al. (2007) conducted retrospective chart reviews of over 1,700 procedures performed in a standalone pediatric emergency department and found that “few to no patients” undergoing common procedures received pain management (p. 87). These procedures included venipuncture, IV placements, fingersticks, intramuscular or subcutaneous injections, urethral catheterization, and nasogastric tube placement. Pain management is a fundamental human right (Brennan et al., 2007) and must be a standard of care in pediatrics.

One health system identified the need to improve pain management and embarked on a successful quality improvement project that yielded positive results and lasting change. Rosenberg et al. (2016) focused their efforts on pediatric procedural pain management (PPPM). An interdisciplinary team was created including child life; inpatient and emergency medicine nursing; pediatric housestaff, and team members in pediatric hospital medicine; clinical pharmacy; patient experience; and nursing quality. A family consultant also participated in the team. The team worked with key stakeholders and identified champions to educate HCPs, role model, advocate, and create practice changes. Processes were adapted to minimize identified barriers, such as altering order sets in the electronic medical record to have preselected orders for topical lidocaine, reconfiguring automated dispensing cabinets, and partnering with the inpatient pharmacy team. The next step was to roll out comprehensive education and training based on best practice, encompassing pharmacological and nonpharmacological approaches and individualized procedural planning. Preprocedural planning was based on patient- and family-centered care, developmentally appropriate distraction, and environmental and behavioral interventions. Staff competencies were created to ensure standardization of knowledge. The project resulted in the implementation of multi-site educational and systemic change. In less

than 2 years, the use of topical lidocaine increased from just 10% to 36.5% and parent satisfaction rose as well. “Benefits of adequate PPPM include decreased child pain and anxiety, improved parent and staff satisfaction, and decrease in long-term risk of medical traumatic stress including needle phobia and health care avoidance” (p. 360).

The physical position patients are placed in during medical procedures greatly impacts their fear and coping. Sparks et al. (2007) described a familiar scene in which a child is held down flat on their back and restrained by several adults so a procedure can be completed. In their description, “A young child screams and thrashes” as the intravenous catheter is placed (p. 440). Other common holding practices include tightly wrapping children in sheets, or full body restraints, and strapping them to the bed or table, rendering them immobile. When one is forcibly laid flat there is an increased sense of fear and loss of control (Sparks et al., 2007, Stephens et al., 1999). In these situations, children are in such a state of fight or flight that they sweat, scream, vomit, or are utterly paralyzed with fear. Pediatric patients do not have to be traumatized for procedures to be physically safe.

A superior technique exists where pediatric patients can be held in a comforting and safe manner, thus allowing them to feel empowered instead of victimized. Positioning for comfort is the technique that allows the child to be upright and held by the caregiver in such a way that their mobility is restricted (Kuttner, 2010; Stephens et al., 1999). For infants, they are swaddled with the necessary extremity free while the caregiver holds them tightly, reducing their ability to squirm. This also allows the infant to be held and comforted by their trusted caregiver instead of being removed from their arms and placed supine on a bed or exam table. For older children, they sit on the caregiver’s lap, using the exam table or pram to stabilize the child’s body. This helps the child feel autonomous and supported, while reducing their ability to move around. Studies have shown that using comfort positioning results in greater caregiver satisfaction and lowered patient distress scores and anticipatory distress (Cavender et al., 2004; Dastgheyb et al., 2018; Sparks et al.,

2007; Stephens et al., 1999). One study revealed that nurses' comfort level varied with the upright positioning; however, their ability to start the IV was not significantly impacted (Sparks et al., 2007). Further nurse training and practice may increase their confidence in comfort positioning so that this technique can become standard. Romito et al. (2021) contend that using comfort positioning techniques "provide a viable and more humane alternative in most cases" (p. 2).

In addition to medication and comfort positioning, there are several other tactics designed to make medical procedures less traumatic. These techniques can be facilitated by HCPs, child life specialists, and caregivers. Koller and Goldman (2012) conducted a critical review of research on distraction techniques in pediatrics. Interactive electronic toys and games, including virtual reality goggles, resulted in reduced anxiety and pain. These activities require the child to focus and engage on something other than the potentially distressing stimuli. While some children are able to engage in games or activities during procedures, others may find it too tasking. Other studies highlight the effectiveness of passive distraction such as listening to music or watching television. Cognitive-behavioral distraction techniques such as controlled breathing and guided imagery also prove effective in reducing stress and pain. Patients should be offered developmentally appropriate deep breathing activities, such as blowing bubbles, using a pinwheel, or being coached on belly breathing. Lower pain is also reported when the patient's imagination is engaged with guided imagery. In this technique, the child listens to an audio recording or to someone in the room who uses a story or prompts, allowing the patient's imagination to distract them from the events taking place. With the gaps in research and limited studies isolating specific types of distraction, it is important to offer techniques that best fit the temperament and preference of the patients, and to engage the caregivers in the distraction (Koller & Goldman, 2012; Short et al., 2017).

Choices for pain and anxiety-reducing interventions must be provided. In doing so, patients and caregivers are empowered to work

collaboratively with the medical and psychosocial team to create an individualized care plan. Institutions can make their own initiatives or utilize already existing ones. The Children's Comfort Promise was born from the identified need to reduce distress with needle-related procedures (Friedrichsdorf et al., 2018). HCPs pledge to use four simple steps to increase their quality of care. The components are to first numb the skin, to allow infants to suck on sugar water or be breastfed during procedures, to use comfort positioning, and to engage the child in distraction (Children's Minnesota Comfort Promise, n.d.). The Children's Comfort Promise also recommends ensuring the child receives developmentally appropriate preparation prior to the procedure, to increase their understanding of the plan and their role in it.

To improve pain management in pediatrics, one organization's interdisciplinary team created standards in order to be considered an "Ouchless Place" (Schechter et al., 1997). To tout a medical institution as an "Ouchless Place," four components must be followed. First, protocols must be developed for post-op pain management and sedation regimens. If protocols are not being followed, team members are empowered to advocate for the patient by bringing it to the physician's attention. Second, pain assessment techniques are to be standardized. In the roll-out of this plan, an evidenced-based, self-report visual analogue scale was selected and added to the protocol. Pain was also included in the vital sign flowsheets to ensure it was captured regularly. The third piece is decreasing needle pain. Creating a standing order for topical anesthetic is suggested to improve workflow and decrease barriers. The use of the treatment room for procedures is also recommended over using the patient's room. The final aspect is to include the caregiver in every aspect of care, including procedure support. They are given a pamphlet that explains the aspects of the "Ouchless Place" and are encouraged to participate in creating a comfort plan individualized to their child.

The LEAPP™ program is a procedure-based plan created with process and quality improvement in mind (Botash et al., 2013). The mnemonic

stands for: listen, evaluate, anticipate, plan, and proceed, and it is centered around mindfully and intentionally planning for medical procedures. The first step of listening is taken once a provider knows a medical procedure is necessary. They speak with the nurse and child life specialist to gain an understanding on how the patient may cope and what would be helpful both physically and emotionally. Listening also encompasses hearing the concerns and needs of the caregiver and patient. Next, it is essential to evaluate and address the patient's current and anticipated pain and anxiety. Anticipation is a key proactive factor in this program's success. Coordinating care is crucial to ensure multiple procedures are not scheduled back-to-back. It is also used to gather the supplies needed and to prepare the treatment room (if it will be used). This is also when the child life specialist will prepare the patient and facilitate a conversation about coping. The information gathered is then used to form the plan. It is imperative that everyone knows their role in the procedure, including who will be the key person coaching and supporting the patient, so multiple people are not speaking at once. This will minimize confusion and stress in the moment. Finally, the care team can proceed with the procedure.

Another effective approach to medical procedures is called ONE VOICE (Wagers, n.d.). Each letter stands for a component of the ideal procedural environment. The individualized care plan consists of preparing the child for the procedure, creating a coping and distraction plan, and involving caregivers. It also advocated for the use of comfort positioning, identifying the one person who will speak to and coach the patient, and reducing the number of staff in the room. These techniques create a calmer, more cooperative procedural environment and ensures

the "child's needs are always at the center of the procedure experience" (Boles, 2013, p. 258).

The American Academy of Pediatrics recommends the use of a separate treatment room for patient assessment and medical procedures (Sigrest et al., 2003). The rationale being children become hypervigilant and unable to take refuge in their rooms when painful or frightening procedures take place in that space. With every staff member who enters the room, the child becomes anxious and focused on the possible threat. Children are also sensitive to the sounds of other patients screaming and crying in their rooms during procedures. Whether they are in private or shared rooms, the sounds of screaming carry, and children are unable to find reprieve from the fear (Deiner et al., 2017; Fanurik et al., 2000). Performing procedures in treatment rooms instead of in the patient's room is considered standard care in pediatrics; however, medical providers and nurses are not always keen to engage in this plan. In Fanurik et al.'s study (2000), barriers to using a treatment room included the time and effort of moving the patient, treatment rooms being used for general storage, thus rendering them inappropriate for patient use, and the need to have all the proper supplies readily available. In this study, nurses reported deciding factors for treatment room use to include the patient's age, room type (semiprivate, private, or intensive care), invasiveness of the procedure, and the availability of the treatment room. Concerningly, only a small number of nurses reported that it was important to consider the patient's or caregiver's preference when choosing the site for the procedure. Ultimately, treatment rooms must be set up to make procedures successful, and patients and caregivers should be given the option to use them. ●

SUB-GOAL #4:

Offer a full array of comfort measures during hospitalization.

Comfort menus give patients and families choices on which items or interventions are helpful, thus empowering them to use their preferences to tailor the medical experience. Comfort menus can be used to plan for medical procedures, appointments, or hospitalizations. Such plans include options for pharmacological pain interventions, education regarding the diagnosis and/or plan of care, comfort positioning, and distraction for procedures. Choices are also given regarding complementary services offering non-pharmacological support for pain and anxiety, recreational activities for distraction, and normalizing items to make the hospital more comfortable.

Zelter et al. (2019) suggested a myriad of nonpharmacological techniques to reduce pain, anxiety, and fear. Distraction, hypnosis, and guided imagery are offered as ways to shift a child's focus away from acute pain or distress. Similarly, biofeedback, relaxation therapies, controlled breathing, and progressive muscle relaxation are effective interventions. Integrative therapies are often used to compliment cognitive-behavioral approaches. Massage therapy is useful for chronic and myofascial pain in children. Acupuncture, which involves the placement of needles along the energy field of the body, is said to be "a feasible, popular part of pain management for children with chronic pain" (p. 484).

Schweitzer et al. (2004) performed a comprehensive literature survey to identify environmental barriers to creating a physically and psychologically safe environment. Consequently, several interventions are recommended to improve

the emotional impact of hospitalization on patients. Comfort items from home can create a sense of familiarity. When patients are offered arts and crafts, they report appreciating feeling control over their choices and the distraction of engaging in the activities. Other positive distractions to offer are toys, games, and virtual reality. Pleasant aromas reportedly have a positive impact on patients; therefore, aromatherapy and essential oils may be a simple addition to the medical environment where appropriate. With higher noise levels decreasing patient satisfaction, every effort must be made to reduce intrusive sounds. Tactics to reduce noise include lowering sounds from equipment, avoiding overhead paging, and offering music and headphones to patients and caregivers. These simple techniques and items can make a positive impact on patients and families.

Complementary medical professionals enhance the patient and family experience by offering a vast array of services and humanistic interventions. Boles et al. (2020) asserted, "Certified Child Life Specialists, as psychosocial healthcare professionals with focused training in child development, family systems, and evidenced-

Boles and colleagues (2020) assert "Certified Child Life Specialists, as psychosocial healthcare professionals with focused training in child development, family systems, and evidenced-based supportive interventions, are indispensable members of high-caliber healthcare teams."



based supportive interventions, are indispensable members of high-caliber healthcare teams” (p. 1). Social workers provide psychological support, resources, and education to patients and families receiving medical care and they advocate for “policies that reduce health disparities and improve access to healthcare...” (Health, n.d., p.2). Music, art, movement, and other creative art therapies are especially impactful for children who struggle or are unable to express themselves verbally (Zelter et al., 2019). By tapping into their creative, expressive core, these therapists unlock thoughts and feelings held deep within the child. Spiritual wellbeing is known to be a factor in human health and coping (Azarsa et al., 2015). Therefore, spiritual care professionals in the medical environment are a valuable asset for patients and families. “Psychosocial clinicians are experts in individual and systems interventions to reduce the distress of hospitalization” (Guvenek-Cokol et al., 2016, p. 695).

Additional support services can enhance the

medical experience and outcomes in pediatrics. The positive impact animals have on people is well documented, and the data on their positive role in medical environments are growing (Barker et al., 2010). Pet therapy is gaining popularity in hospitals for its role in reducing stress and pain in pediatric patients (Braun et al., 2009; Zelter et al., 2019). With a growing focus on gaming and technology, it is logical to incorporate them into the repertoire of activities offered to patients. Gaming and virtual reality are proving to be valuable tools in improving care for pediatric patients by offering distraction and escape (Koller & Goldman, 2012; Schweitzer et al., 2004). These benefits can be enhanced and broadened when a pediatrically-trained gaming and technology specialist partners with HCPs, including psychosocial supports such as child life and art therapy. There are numerous benefits to engaging complimentary, therapeutic support services in pediatric care. ☺



EMOTIONAL SAFETY PILLAR #3: ENVIRONMENT

Medical environments must “optimize physical, mental, emotional, and spiritual healing for the individual needs of patients from a variety of backgrounds and cultures...

- SCHWEITZER ET. AL, 2004, P. S-71

Entering a medical facility can feel daunting and frightening to anyone; this is especially true when it comes to children. It cannot be underestimated how much the environment impacts patients and families. Both the physical and cultural environments tell a tale to those who encounter the medical space. They can communicate an understanding and respect towards those who enter, or they can work against their needs, creating confusion and distress. To elicit feelings of trust and calm, organizations must turn to experts for input. By gathering information from evidenced-base design, patients, families, child life specialists, and other healthcare professionals, can ensure their environments are eliciting the positive responses desired.

An emotionally safe medical environment supports healing and human connectedness by understanding the unique needs of those served. In pediatrics, this means incorporating caregivers into the core team and honoring their expertise about their children. It entails creating space (both physically and metaphorically) for participation and engagement with those who are important in the

child’s life, including family members and friends. Exemplary care is achieved by creating a climate in which patients and families have meaningful opportunities to participate in everything from the design of the space, to creating a culture of patient and family emotional safety.

Creating a cultural shift takes everyone’s participation. Patients and families need to understand emotional safety (ES) options in order to advocate for their use. As a standard of care, front-line HCPs have the crucial role of incorporating emotional safety interventions into their daily practices and holding each other accountable. Healthcare leaders and executives must include the clinical components in policies and procedures, provide trainings to all team members, and include ES stories in quality and safety reporting. The value of ES and the promise of providing emotionally safe care should be highlighted by medical organizations, both internally with staff and externally to the community. Such measures ensure the philosophy and practice are understood and upheld, thus transforming the cultural environment. ●

SUB-GOAL #1:

Create spaces and wayfinding techniques utilizing the expertise of professionals, patients, and families.

Leveraging research on pediatric healthcare environments will aid in creating calm, engaging spaces. Historically, researchers examining the impact of the physical environment on patients' healing and wellbeing were mostly focused on adult settings. That lens has expanded over the past 20 years to include pediatrics (Weinberger et al., 2017). In that time, more organizations prioritized enhancing pediatric medical environments (Diener et al., 2017). In 2008, Sadler and Joseph synthesized over 200 studies examining how the physical environment impacts pediatric patients and their families, resulting in valuable insight. They demonstrated how environment influences "clinical, developmental, psychosocial and safety outcomes" (p. 2). They explored the positive impact of designing with light, sound, nature, privacy, distraction, and family needs in mind. When all of this is taken into account, the environment can work for patients and families. Warm lighting, soothing colors, and peaceful art depicting nature all have a calming effect, but special care should be taken to explore the specifics of what types are most beneficial (Schweitzer et al., 2004).

In addition to using research to make evidenced-based design decisions, drawing on the expertise of professionals is necessary. Certified child life specialists offer a unique perspective for designing pediatric spaces due to their education in child development and therapeutic play. With their specialized training, they see the environment through the eyes of children and therefore provide valuable feedback on design, décor, and developmental items (Weinberger et al., 2017). Cultural considerations must also be included in design therefore knowledgeable professionals should be consulted. Schweitzer et al. (2004) explored the ways culture can influence design, and vice versa. They explained that though there is little research on the topic of sacred geometry,

it is a belief system held by many cultures around the world. One example is the importance of orientation to the east in Islam. Another is the belief system some Native American's hold which attaches meaning to each of the four directions. Creating a diverse, welcoming environment is important. One study showed that healthcare team members found value in modeling diversity with artwork, informational displays, social media, food offerings, and special events (Vermeulen, 2020). When designing buildings and spaces, diverse perspectives and needs should be explored and incorporated.

When space is created for children, youth, and families, their insight must be included in the design process (Schweitzer et al., 2004). Many pediatric institutions have youth advisory councils that are comprised of adolescent patients and their siblings. It is also common practice for organizations to have family advisory councils for the parents and caregivers of pediatric patients. These patient family advisory councils ensure patient and family-centered principles are infused into medical organizations' policies, procedures, initiatives, and space design (Cunningham & Walton, 2016). Insight should also be gained from individuals in communities that are marginalized. For example, Ingrey (2018) explored the myriad of ways gender-exclusionary spatial designs negatively impact LGBTQ+ and gender-non-conforming youth. This discussion was furthered by Slater et al.'s (2018) inclusion of the impact of signage, language, binary gendered restrooms, and changing rooms on people with disabilities. Tapping all these valuable resources is paramount in enhancing space design in pediatrics (Johnson et al., 2010; McGee & Marshall-Baker, 2015; Norton-Westwood, 2012).

Easily and successfully navigating healthcare facilities is a basic, but often overlooked, aspect of building design. When wayfinding is considered only after the structure is built, the layout can cause challenges for people moving through the space, including stress, frustration, and time loss (Iftikhar et al., 2020). Ideally, environmental psychology and best practice will inform healthcare facility design (Devlin, 2014). Incorporating evidenced-based wayfinding

tactics into existing medical spaces is of vital importance (Sadler & Joseph 2008). To overcome language barriers, many institutions combine text with abstract symbols and colors to guide patients and visitors. Preference, understanding, and interpretation of such systems can depend on culture, language, gender, and level of education (Iftikhar et al., 2020; Leib et al., 2012) and therefore must be studied. Hashim et al. (2014) suggested testing signage with people from varying cultures and literacy ranges.

As technology advances, wayfinding options expand as well. Iftikhar et al. (2020) highlighted the need to synthesize multiple mediums for effective wayfinding. Devlin (2014) explored these options, including the use of virtual reality and smartphone applications. Sadler and Joseph (2008) suggested sending out wayfinding information or tools prior to the family's visit so they can familiarize themselves before entering the space. As many tactics depend on visual information, finding solutions for those who are visually impaired is also necessary. In order to create an environment that is simple to navigate, evidenced-based facility design should be applied, and patient and family feedback obtained. ●

SUB-GOAL #2:

Support health education, healing, and connectedness using physical and virtual environments.

The American Academy of Pediatrics recommends designating space for “play, entertainment, education, and other child life activities” and considers toys and developmental items to be “essential medical equipment” (Sigrest et al., 2003, p. 1120). Children learn and cope through play (Sadler & Joseph 2008). Play provides a safe opportunity for mastering experiences, expressing feelings, and connecting socially with others (Lambert et al., 2013). Offering playrooms, outdoor play spaces, and virtual play sessions, allows children, youth, and families to engage in beneficial recreational and therapeutic play, either individually or with others.

While the utilization of physical play spaces is ideal, it is not always option. Staffing deficits can result in the inability to open a play space, or the patient's isolation status or physical restrictions may keep them from leaving their room. Play spaces may also be closed due to health risks, such as an outbreak in the organization, an epidemic in the community, or a wide-spread pandemic. In these situations, creativity and technology should be engaged to meet the needs for socialization and recreational activity. Solutions offered must meet legal and privacy requirements, such as those posed through the Health Insurance Portability and Accountability Act (HIPAA). HIPAA-compliant programs exist where patients can play with each other through virtual playrooms. In these virtual playrooms, approved adults can moderate conversations and facilitate activities in which the children can

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participate. Group play can also be facilitated through closed-circuit broadcasting systems, such as with hospital-based television stations and studios (Romito et al., 2021).

Environmental considerations must include creating spaces that engage all abilities and needs. It is of vital importance that play spaces are available, accessible, and physically and emotionally safe (Sigrest et al., 2003; Weinberger et al., 2017). It is important that there are areas for those with specific developmental and sensory needs. Creating a sensory-friendly environment for children with developmental disabilities, sensory sensitivities, and autism spectrum disorder can help patients feel calm and be more cooperative during medical care (Breslin et al., 2020; Wood et al., 2019). This can be accomplished by designating space for sensory rooms where patients can self-regulate and relax, by providing portable sensory stations, and by teaching sensory-informed care to staff. Adolescent and young adult patients should have recreational spaces specifically designed with their needs and interests in mind as well. Having sensory-friendly and developmentally appropriate environments and play spaces is vital to meeting the unique needs of pediatric patients.

To provide optimal care for patients and families, caregiver needs must be identified and addressed. They have the important, and sometimes daunting, responsibility to make medical decisions in the best interest of their child. To best support them in this, resources must be available so they can understand and process medical information. Incorporating health libraries into design ensures that caregivers have the resources needed to improve health literacy (Schweitzer et al., 2004).

Incorporating family needs into space design encourages social connectedness (Schweitzer et al., 2004). Often, caregivers are balancing the responsibilities of work and family with caring for their sick or injured child. Amenities

such as accessible phone charging stations, concierge services, around-the-clock meal options, kitchenettes, and laundry facilities can improve the hospitalization experience. It is important to allocate space for caregiver sleep rooms, lactation rooms, and family-resource centers. Short-term child-care options within the hospital can reduce caregiver stressors as well. It is also necessary to create spaces for religious and spiritual reflection. Schweitzer et al. (2004) highlighted this important consideration as for some patients and families, “illness is not only a physical and emotional crisis, but a spiritual one as well” (p. S-72). By meeting these fundamental needs, caregivers and loved ones are able to be present and provide support to the patient.

Remaining connected to family and friends during a hospitalization provides children with a sense of security and normalcy (Norton-Westwood, 2012). Increasing a patient’s social interactions and opportunities for support are greatly beneficial (Sadler & Joseph 2008). Space must be created with the larger support system in mind. Having family spaces is important, as is inviting other children in the patient’s life to enjoy play areas. While visiting in person is optimal, there may be reasons why this is not possible and alternative options must be offered. Whether it be transportation issues, conflicting needs, or visitor restrictions, having support systems separated from the patient and family is detrimental. Technology can be implemented to remotely connect them when visiting in person is not possible. This sustains family and peer connectedness with the patient during hospitalizations. Virtual visits utilizing telepresence robots and video chat options can potentially decrease feelings of isolation for patients and families (Lambert et al., 2013). By engaging friends and family in the child’s medical experience their sphere of support is exponentially increased. ●

SUB-GOAL #3:

Create an environmental culture of emotional safety by including patient and family needs into practice, policies, and procedures.

Johnson and Rodriguez (2013) asserted, “Family-centered care principles are the foundation of care planning and interventions for hospitalized children” (p. 131). Cené et al.’s (2016) systematic review of articles on family-centered care in pediatrics highlighted positive outcomes such as “psychological function, quality of life, and symptom severity” along with improved satisfaction (p. 4). Therefore, caregivers must be included in healthcare organizations’ policies and procedures (Johnson et al., 2010). Examples include specifying their role in anesthesia induction, medical procedures, and resuscitations. Caregivers find benefit in having the choice to be present, and children often cope better when they have that support (Boles et al., 2020; Boudreaux et al., 2002). The language used in policies must be written in a way that differentiates caregivers from visitors, thus allowing for uninterrupted family presence at the bedside (Johnson et al., 2010).

The Joint Commission (n.d. 1) noted that effective communication is imperative for ensuring quality of care. It is essential to offer resources and support that aid the families’ abilities to access and understand information. Children of non-English speaking caregivers are at risk for health disparities due to communication barriers (Son 2018; Stephen & Zoucha, 2020). Appropriate resources must be available and utilized with these families. Policies are necessary to ensure certified medical interpreters are utilized over family members, friends, and untrained staff. Interpreter services should be offered in-person, over the phone, or virtually to accommodate the various needs.

To create consistency with care, standards and interventions for providing emotionally safe, atraumatic care should be incorporated into the organizational policies and procedures. Stress and pain management initiatives are sustainable only when they become engrained in the organization’s culture. Programs focusing on procedural pain and support have specific, evidenced-based tactics to follow. Those tactics should be included in policies for medical procedures and surgeries. For example, the expectations for the LEAPP™ program regarding preprocedural communication and planning are included in the organization’s policies (Botash et al., 2013). Institutions that follow the Children’s Comfort Promise adopt its key components into their policies and procedures for medical procedures and pain management. These steps include using numbing agents, providing sugar water or breastfeeding to infants, utilizing comfort positioning, and having child life provide distraction support (Friedrichsdorf et al., 2018). Incorporating successful tactics and programs aimed at the needs of patients with developmental disorders is also recommended (Johnson & Rodriguez, 2013). One such policy consideration is making it a standard of care to proactively speak to appropriate families about adaptive care plans prior to appointments for invasive procedures or surgeries. Another powerful tactic is to implement a trauma-informed care model, shifting the institutional culture from common to best practices. (Marsac et al., 2016). Incorporating emotional safety time-outs is also an effective way

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to ensure atraumatic care and address any moral distress staff may be experiencing (Garros et al., 2015). If anyone feels emotional harm is befalling the patient during a procedure or intervention, they should have the power to pause care so the plan can be reevaluated. Infusing these interventions into policies and procedures can have a transformative effect on the organizational culture.

Creating policies around safe spaces is one way to create the structure children need in order to feel safe. As hospitalized patients spend much of their time in their beds, it is important for them to be able to relax and recover while in their rooms. This can be difficult to do when they are worried something painful is going to happen to them whenever a staff member enters the room. By moving patients to a treatment room for invasive procedures, the hospital room can remain a safe place (Fanurik et al., 2000; Sigrest et al., 2003; Stephens et al., 1999). Similarly, for play and sensory environments to maintain their therapeutic value, they must be free from medical procedures. Weinberger et al. (2017) asserted, “Playrooms serve as a refuge for children, and while the absence of medical tests and procedures in playrooms sets the stage, playrooms can be more than shelter for medical interventions” they can offer space for children, youth and families to connect (Weinberger et al., 2017, p. 72). Play spaces can be optimal healing environments when children “have positive emotions, build coping skills and are free to be themselves” within them, therefore they must be safe from frightening events (Weinberger et al., 2017, p. 84). HCPs may believe it is easier to check an IV or peek under a

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bandage while the child is playing but doing so has the potential to destroy the air of safety and fun the playroom offers (not just for the child in question but for the others in the space as well). Patients deserve reprieve from the fear and pain they experience during medical care and creating a culture of protecting safe spaces can ensure they get the respite needed to heal. ●

SUB-GOAL #4:

Create an institutional, environmental culture supporting emotional safety congruent with the organizations’ high reliability initiatives, including behaviors, processes, and routines.

The science of high reliability is focused on reducing risks in professions that have a significant opportunity for causing harm to people. While it originated in such fields as aviation, air traffic control, and nuclear power it has since expanded into healthcare (High Reliability Training, n.d.). Wherever physical harm is discussed, emotional harm should be included in the conversation. Therefore, as healthcare leaders strive to make their environments high reliability organizations (HROs), they should include emotional safety measures into their plans. The Joint Commission suggested that organizations create a foundation that includes leadership committing to “zero harm goals” in order to mature towards becoming an HRO (High Reliability Training, n.d.). The Patient Safety Network stated, “HROs maintain a commitment to safety at all levels” and imparts the importance of establishing a culture of safety that is shared by team members, patients, and caregivers to ensure the commitment is not short-lived (Culture of Safety, 2019., para 1).

To create a cultural shift, it is also helpful to examine change-related tactics, interactions,

and theories as they relate to organizations. It is important to understand how change talks can be positive, allowing for team buy-in and implementation (Mikkola & Stormi, 2020). Institutions that have successfully adopted initiatives did so by integrating them into their missions, values, strategic plans, cultures, and daily practices (Botash et al., 2013; Marsac et al., 2016). Understanding how all of this translates into successful change is crucial to the longevity of initiatives and requires buy-in from key stakeholders. When Muskett (2013) conducted a comprehensive literature review examining trauma-informed care practices, it was revealed that systemic changes are dependent upon the support of senior leaders, clinical leaders, and nurses. Both top-down and bottom-up approaches must be utilized to make lasting change (Edwards et al., 2020). Therefore, there must be a common language and understanding of ES between patients, caregivers, front-line team members, middle management, and senior leaders alike. For ES tactics to create lasting change, everyone involved in creating the cultural environment must embrace ES as a core value. “Culture change takes time, perseverance, vision and responsibility” (Loscalzo et al., 2011, p. 457).

Learning from successes and mistakes is paramount in the quest for improvement. In order to prevent emotional safety errors from being repeated, they must be systematically identified and addressed in hospital quality improvement programs (Sokol-Hessner et al., 2015). Concerns, mistakes, and positive examples of ES should be included in existing organizational communication tools and reportable outcomes. Including them in safety huddles and calls, rounding, risk reporting and in caregiver feedback forums guarantees that the practice is engrained into the safety culture. Garros et al. (2015) encouraged a “culture of ethical questioning” where processes are created that foster authentic discussion of ethical concerns (p. 886). The Patient Safety Network stated, “In an HRO, everyone

is expected to share concerns with others and the organizational climate is such that all staff members are comfortable speaking up about potential safety problems” (High Reliability, 2019, para 6). Cases of preventable harm are “deserving of formal capture, classification, and action by the healthcare system” (Sokol-Hessner et al., 2015, p. 550). In addition to recording missteps, metric report cards can be established to assess, evaluate, and make contact improvements regrading ES and health equity. Leveraging input, research, and regulatory agencies’ resources ensures that best practice is incorporated into these key initiatives. Creating a culture where it is safe to express concerns or share missteps is key. This culture must extend to healthcare workers as well as to patients and families. Systems should be created where patients and families can give real-time feedback regarding their care and the environment (Cunningham & Walton, 2016). The Joint Commission shares tips and tools for incorporating “speak up” practices into healthcare for team members, patients, and caregivers alike (Joint Commission, n.d.).

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EMOTIONAL SAFETY PILLAR #4: EDUCATION, TRAINING, AND COMMUNICATION

It is important for medical providers to learn to mitigate psychological trauma in pediatric care. Left untreated, childhood trauma caused by healthcare-induced anxiety can cause significant mental health issues in a child's life.

- LERWICK, 2016, P. 144

Language becomes powerful when it is understood by a wider community. For “emotional safety” (ES) to be transformational, it must become a part of the healthcare lexicon. Team members at every level should possess an understanding of the concept, its importance, and their role in upholding it. Furthermore, patients and families deserve to be informed of ES and know how to advocate for that level of care for themselves and their loved ones.

It is essential to ensure ES is engrained into current healthcare standards. The first step to integrating it into the larger system is education. Future medical and psychosocial professionals must learn foundational information about the developmental and emotional needs of pediatric patients and their families. The American Academy of Pediatrics stated, “All healthcare professionals in a pediatric area should be familiar with the unique and changing physical and psychosocial needs of children.” (Sigrest et al., 2003, p. 1122). Team member education is also crucial upon hire, and incrementally throughout their careers, to ensure atraumatic care is being provided. For the information to be absorbed and used, effective teaching tactic, such as experiential learning opportunities, coaching, and real-time feedback, are key. Checklists can ensure standardization

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of the processes with visual ES cues to serve as reminders. By committing to initial and ongoing opportunities for education and conversation, ES values will be upheld and respected.

Emotional safety standards can be successful when both healthcare professionals and the public grasp their meaning so there is a shared assurance of its importance and use. Patients and families will understand that this type of care is to be expected during their medical encounters. With this knowledge, people will be able to create an emotionally safe medical environment and hold each other accountable. Collaborative communication and implementation strategies can then be formed which incorporate the voices of patients, families, and interdisciplinary teams. ●

SUB-GOAL #1:

Staff education and training.

The components of emotional safety must be taught early and often. Therefore, they should be included in school programs' curriculum, laying the foundation for future care. In doing so, weight will be added to the concept, thus moving it from a value that would be nice to uphold, to an expectation for everyone working in the medical field. Just as medical professionals learn a myriad of ways to keep patients physically safe, they must also learn how to keep them emotionally safe. Pediatric medical professionals receive rigorous education and training on the ways children's anatomy, illness, injury, and treatment differ from adults. Yet attention is not paid to the ways in which children understand and react to medical situations or life stressors. Without that foundational understanding, it becomes too easy for well-meaning professionals to assume the care they provide is not damaging their young patients when, in fact, it may be.

This misaligned comprehension is evident in a study by Botash et al. (2013). They examined healthcare professionals' varying appraisals of pediatric patients' pain and anxiety during medical procedures. In reviewing feedback following 50 procedures, 100% of the physicians surveyed agreed or strongly agreed that the patient's pain and anxiety were well controlled. In contrast, only 55% of caregivers and 60% of nurses, child life specialists, and independent observers believed the same. They were also asked how prepared the team was prior to beginning the procedure and their overall satisfaction with how it went. Nearly 72% of the physicians strongly agreed the procedure was successful compared to only 60% of caregivers and 52% of staff. If HCPs are uniformly taught children's developmental reactions and how to read their emotional cues, they will be able to uphold the value of providing emotionally safe care to pediatric patients.

For institutional practice to become the standard of care, everyone must learn the skills and understand the rationale behind them. Medical and

For institutional practice to become the standard of care, everyone must learn the skills and understand the rationale behind it. Medical and non-medical professionals alike need to be taught how to create an emotionally safe environment for patients and families.

non-medical professionals alike need to be taught how to create an emotionally safe environment for patients and families. Everyone should participate in these educational requirements. The screeners at the front door, environmental services team members, volunteers, people working in the cafeteria and gift shops, medical providers, and psychosocial team members must all be trained. As they join a healthcare organization, they should be told about the importance of ES, its clinical components, and concrete ways everyone in the healthcare system can contribute to its success. Further, re-educational intervals and opportunities should be established to maintain the practice and competencies completed for assurance of the skillset.

Teaching theory and research should be applied to any healthcare education plan created for staff. Several adult learning theories and models exist that can be applied to teaching medical professionals to maximize educational effectiveness (Lewis & Thompson, 2017; Loeng, 2018). Multiple theories impart the importance of the learner experiencing the information and attaching meaning and reflection to it (Lewis & Thompson, 2017). Therefore, teaching modalities should include experiential components with live feedback. Fischer et al. (2018) studied the efficacy of using high-fidelity simulator-based training of a cardiac procedure with medical students. Their findings showed the benefit of using simulation over a traditional lecture with informational slides presented. Another study that reviewed multiple teaching theories and models for use with physician assistant students concluded that

combining non-lecture-based tactics that allow for rich learning experiences and coaching are optimal (Lewis & Thompson, 2017). Objective structured clinical examinations (OSCEs) allow for the learner to move through clinical simulations and receive feedback on their performance (Harden et al., 1975). In the decades since its inception, OSCEs have become the gold standard for assessing clinical competency (Majumder et al., 2019; Patrício et al., 2009). OSCEs could provide opportunities for medical students and interns to practice ES responsiveness during clinical examination roleplays. In part, this was studied with successful outcomes when medical students used OSCEs to practice their newly learned trauma-informed care skills (Elisseou et al., 2019).

“Those that deliver healthcare should have awareness and training in how to treat children appropriately based on style of coping in hopes of decreasing levels of perceived trauma and healthcare induced anxiety” (Lerwick, 2016, p. 146). To engage in effective communication and support, pediatric professionals must learn how children emotionally and cognitively interpret information and events. Team members should learn about children’s development of conceptual abilities, the nuances of verbal and non-verbal communication, and implicit information gathered from the physical and social environments (Boles et al., 2020; Jaaniste et al., 2007). Care is enhanced when they understand common misconceptions and examples of triggering language versus honest but soft word choices (Stephens et al., 1999). Boles et al. (2020) asserted, “A pivotal apex in pediatric health care improvement is individually tailored, developmentally appropriate communication with children” (p. 15).

Trauma-informed care (TIC) is a concept widely used and implemented in various support settings, such as education, mental health, social service, and healthcare (Raja et al., 2015a). For TIC to be effective, healthcare professionals must be educated on multiple factors. Education should include the impact of trauma on development and health, recognizing emotional and behavioral manifestations of trauma and specific tactics for providing TIC (Marsac et al., 2016; Raja et al.,

2015a). It is important to explore the prevalence of trauma in both patients and staff, with medical professionals examining their own trauma history and responses as well (Raja et al., 2015a). While medical providers acknowledge the importance of TIC, many express the need for more specialized training and concrete, evidenced-based strategies (Kassam-Adams et al., 2015b; Yatchmenoff et al., 2017). The National Child Traumatic Stress Network, Health Care Toolbox, and the American Academy of Pediatrics have TIC teaching aides and resources aimed at educating healthcare professionals (Healthcare, 2018, The D-E-F framework for trauma-informed care, n.d.: Trauma-informed care, n.d.).

Marsac et al. (2016) recommended that healthcare organizations prioritize specialized training, “ensuring that trauma-informed practices are implemented by all individuals across the pediatric healthcare network” (p. 73).

LEAPP™ is a process and quality improvement program focused on medical procedures and implemented in a pediatric inpatient setting (Botash et al., 2013). LEAPP stands for listen, evaluate, anticipate, plan, and proceed. Each component addresses a step in procedural planning and execution with the aim of gaining valuable insight into the ways to decrease a patient’s stress and anxiety. To ensure its continued success, a comprehensive staff education plan was implemented. An online educational module was created for physicians, nurses, child life specialists, and students. The training was also added to new team member orientation for all surgical residents. Ongoing education was provided via training sessions for individual specialties and in nursing grand rounds. Various educational tools were utilized including the online module and video and printed teaching materials. A quiz was created to assess competency, and visual reminders of the program were made with a specialized LEAPP™ logo. These measures have helped with the successful implementation of this impactful program.

Pediatric procedural pain management (PPPM) is a key component to providing emotionally safe medical care. When one health system discovered that PPPM was not held as a standard

It is imperative that medical team members are educated about programs that specifically focus on increasing coping and cooperation during medical encounters for all children, especially those with developmental disabilities and sensory differences. (pg 37)

of care in their organization, an interdisciplinary team set out to create change (Rosenberg et al., 2016). Following a comprehensive needs assessment, which included gathering clinical expertise and input, a structured teaching system was created. They created educational and training opportunities based on best practice and actively worked to reduce barriers to quality of care. The information was focused on preprocedural planning, patient and family-centered care, pharmacological interventions, non-pharmacological skills, and awareness of standards. The team utilized a train-the-trainer approach, having nurses and child life specialists educate identified PPPM champions who, in turn, shared the knowledge with other HCPs. Staff competencies were assigned and completed by more than 90% of inpatient nurses and technicians. Visual cues and tools were provided to HCPs, such as badge buddies and acute pain management pocket cards. This system succeeded in drastically increasing the use of topical lidocaine, and nursing pain knowledge rose by 7% (Rosenberg et al., 2016).

It is imperative that medical team members are educated about programs that focus specifically on increasing coping and cooperation during medical encounters for all children, especially those with developmental disabilities and sensory differences. Johnson et al.'s (2010) pilot study yielded promising results when nurses participated in a two-hour training on preventing and managing challenging behaviors in pediatric patients with developmental disabilities. The nursing staff who completed the session reported having increased knowledge and decreased fear regarding caring for these patients. Extensive education should be provided regarding their unique needs and the programs created to support them.

Adaptive Care Plans (ACPs) are one such strategy aimed at supporting those who are particularly vulnerable to experiencing a sequelae of iatrogenic emotional harm—patients with developmental disabilities (Liddle et al., 2018). Staff education and training should encompass the need for this type of program, how to conduct adaptive care assessments, where the information is documented, and ways to facilitate the tactics to improve care. Ongoing training and testing for competency are also important. Visual cues with logos for the program can be placed in the medical chart and on the door of patients who have these individualized plans, triggering team members to pause and plan before proceeding.

Health disparities among people of color in the United States have been widely studied and acknowledged (Hall et al., 2015; Trent et al., 2019). The Centers for Disease Control and Prevention (2020c) explained that “some minorities experience a disproportionate burden of preventable disease, death, and disability compared to non-minorities” (CDC, 2020, para. 1). There is also a strong association between racial discrimination experienced in childhood or adolescence and poor physical and psychological outcomes (Cave et al., 2020). The attitudes and actions of HCPs are contributing factors in the health disparity problem (Blair et al., 2013; Hall et al., 2015). While explicit bias is more overt, implicit beliefs may exist outside of one’s awareness. However, it still influences behavior in a manner that may negatively impact the relationship between the healthcare professional and the patient and family and, in turn, the health-related quality of life. Blair et al. elucidated this dynamic by comparing the quality of the medical relationship with the degree of provider implicit bias. Clinicians with greater implicit bias rated lower in patient-centered care by Black patients compared to those who are White. With this knowledge, it is imperative that HCPs learn about bias, examine it in themselves, and implement tactics to improve care for their patients and families. ●

SUB-GOAL #2:

Establish communication methods to incorporate and standardize the emotional safety process.

Recognizing and discussing positive emotional safety moments helps to create the expectation that this level of care is the norm. When exemplary care is provided, sharing those stories offers concrete examples of successful interventions and of the feasibility of incorporating ES tactics into practice. When the mark is missed, or nearly missed, openly discussing those missteps creates a learning opportunity. Including these moments in daily safety conversations, such as safety huddle and rounding, will lead to a cultural shift that elevates ES as a core value.

Effective ways to guarantee that emotional safety components are engrained into clinical practice are using checklists and best-practice alerts. According to the Health Research and Educational Trust (2013), “Checklists used in the medical setting can promote process improvement and increase patient safety” (p. 3). As they are already widely used, ES standards should be added to current checklists, or new ES-focused lists can be created. This ensures that the expectations are communicated in a concise manner and that they become a standard of care. Commonly used checklists in healthcare include evidenced-based interventions aimed at reducing harm. Certain events can trigger best practice alerts, which guide team members to the appropriate checklist. These alerts should be created for many situations including pending surgeries or procedures, when there is an end-of-life situation, when the patient has a developmental disability or sensory needs, when there is a traumatically injured patient, and for sharing life changing news such as a new diagnosis. By including best practices for ES, institutions can exponentially improve their established culture of safety.

An impactful place where emotional safety tactics can be incorporated into safety checklists

is with medical procedures. As it is done with the LEAPP™ program, non-emergent preprocedural planning should include a checklist based on best practice with effective communication being at the center. This ensures that all the key players are notified about it in a timely manner so they can discuss the procedure, as well as the patient’s past experiences and needs, resulting in a comprehensive plan to minimize pain and anxiety (Botash et al., 2013). If the checklist is step one in procedure preparation, the medical team will have enough time to order the appropriate medications and organize necessary supplies. It also ensures there is time for the patient to receive developmentally appropriate and emotionally sensitive information regarding what is going to happen. Patient and caregiver questions can be answered, and a strong coping plan implemented. The checklist can include decisions around where the procedure will take place, who will be in the room, who will be the one person coaching the patient, what physical position the patient will be in, which medications are necessary, and what distraction is likely to be the most effective. In some emergent situations where time is of the essence, such steps may need to be omitted. However, there is often time to implement such tactics, even if it is at a more hurried pace. Mindfully and intentionally planning for a potentially traumatic medical experience helps the medical team, physicians, and caregivers be more aligned in their overall procedural satisfaction (Botash et al., 2013).

Checklists can also be used to guarantee team members are using trauma-informed care with traumatically injured patients and with children and families who have trauma history. Having a TIC checklist ensures that everyone pauses, communicates, and implements the best patient-centric care possible. A TIC checklist can include plans for trauma or acute stress assessment, medical procedures, sharing upsetting or life-changing news, pain and anxiety management, protection from or support with information in the media and on social media, and for psychosocial referrals (Gordon & Thomas, 2017). ●

SUB-GOAL #3:

Create internal and external-facing education and communication.

Educating the public on emotional safety standards has many benefits. When patients and families understand the tools and services available to help them, they can better advocate for the care they deserve. Many institutions share patient's rights and responsibilities directly with their patients and families. Pediatric-specific patient rights are also utilized, including one from the Society of Pediatric Nurses (Mott, 2014). These tools inform people of what they should expect from their providers and



medical institutions. Emotional safety standards can be incorporated into these educational opportunities, thus expanding understanding of the quality of care they can expect.

Emotional safety marketing tools can be deployed with two goals in mind: to educate patients and families on the initiative and to advertise this high standard of care as a differentiator from other medical institutions. Consumers are becoming savvier and more particular regarding their healthcare options. For example, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); has created a database where patients and families share their input and receive data on the perceived quality of care (HCAHPS, n.d). Families are also turning to social media for such consumer feedback. Creating logos and explanations to be shared in advertising and on social media can have a broad reach. As patient satisfaction is becoming a stronger variable in the selection of medical providers and organizations, including ES in marketing could guide a consumer to one institution over another.

Creating and advertising an Emotional safety Week is an interactive way to educate the public and medical staff alike. Healthcare leadership can use the opportunity to show they value and celebrate ES. An example of this tactic is The Beryl Institute, which encourages organizations to participate in Patient Experience Week as way to “celebrate accomplishments, reenergize efforts, and honor the people who impact patient experience everyday” (The Beryl Institute, n.d., para. 1). Similarly, child life professionals use Child Life Month to celebrate the field and to educate healthcare team members and the public on their services (King, 2020). Declaring an ES Week can be an engaging way to get the word out and highlight successes. ☺

“When patients and families understand the tools and services available to help them, they can better advocate for the care they deserve.”



CONCLUSION

Emotional harm is often invisible and therefore easily overlooked and dismissed. Emotional safety is as fundamentally important as physical safety. The short- and long-term implications of insensitive, developmentally inappropriate care are powerful and costly. The four pillars of emotional safety offer a guide for team members and healthcare leaders to be intentional in the ways they implement and use assessments and screeners, facilitate interventions, create physical and cultural environments, and educate, train, and communicate with staff and the public. When

healthcare professionals are properly trained and continuously encouraged to provide emotionally safe medical care, the impact is profound. The healthcare system can infinitely impact patients and families by recognizing, embracing, and upholding the value of emotional safety. ☺

“ Emotional harm is often invisible, therefore it is easily overlooked and dismissed. Emotional safety is as fundamentally important as physical safety.



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EMOTIONAL SAFETY FRAMEWORK





Emotional Safety Framework

Emotional safety is the intentional multidisciplinary practice to promote resiliency, healing, and trust for pediatric patients and their families during medical experiences.

<p>Screening and Assessment</p> <p>Goal: Implement a system that identifies patient and family perceptions, experiences, needs, and strengths, and is accessible to all appropriate healthcare staff for the implementation of interventions that prioritize, respect, and protect emotional well-being during the healthcare experience.</p> <ul style="list-style-type: none"> • Sub-Goal 1: Ensure the appropriate screening and assessment tools are utilized to measure psychosocial risks and strengths. • Sub-Goal 2: Standardize the assessment and screening processes, including the plans for implementing and documenting screener results and providing subsequent care. • Sub-Goal 3: Utilize technology during assessments. 	<p>Intervention</p> <p>Goal: Commit to a child’s comfort and understanding regarding medical encounters. Incorporate best practices grounded in empirical evidence when available in each patient/family encounter.</p> <ul style="list-style-type: none"> • Sub-Goal 1: Utilize developmentally appropriate and emotionally safe communication styles and tactics. • Sub-Goal 2: Implement individualized plans based on the developmental and emotional needs of the patient. • Sub-Goal 3: Offer full array of comfort measures for stressful, anxiety provoking or invasive procedures. • Sub-Goal 4: Offer a full array of comfort measures during hospitalization.
<p>Environment</p> <p>Goal: Using evidence-based practice, promote safe and reliable environments that minimize stress and promote emotional safety for patients, families, and staff.</p> <ul style="list-style-type: none"> • Sub-Goal 1: Create spaces and wayfinding techniques utilizing the expertise of professionals, patients, and families. • Sub-Goal 2: Support health education, healing, and connectedness using physical and virtual environments. • Sub-Goal 3: Create an environmental culture of emotional safety by including patient and family needs into practice, policies, and procedures. • Sub-Goal 4: Create an institutional, environmental culture supporting patient emotional safety congruent with the organizations’ high reliability initiatives, including behaviors, processes, and routines. 	<p>Staff Communication, Education, and Training</p> <p>Goal: Facilitate collaborative relationships and form helpful communication strategies among the interdisciplinary team, the patient, and their support systems. Educate teams about implementation of emotionally safe standards of care, utilize the patient and family voice, and advocate for the patient and family within the boundaries of the hospital environment.</p> <ul style="list-style-type: none"> • Sub-Goal 1: Staff education and training. • Sub-Goal 2: Establish communication methods to incorporate and standardize the emotional safety process. • Sub-Goal 3: Create internal- and external-facing education and communication.



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Screening and Assessment

Goal: Implement a system that identifies patient and family perceptions, experiences, needs, and strengths, and is accessible to all appropriate healthcare staff for the implementation of interventions that prioritize, respect, and protect emotional well-being during the healthcare experience.

Sub-Goal 1: Ensure the appropriate screening and assessment tools are utilized to measure psychosocial risks and strengths.

Tactics:

- Consider which perspective will be captured with the tool and who will answer the questions
- Decide which risk factors and strengths to target
- Inventory existing psychosocial assessment systems and review for current evidence-based practices
- Utilize a validated assessment tool to capture patient and family strengths and needs that are inclusive of marginalized communities to ensure equitable care for all

Sub-Goal 2: Standardize the assessment and screening processes. Including the plans for implementing and documenting screener results and providing subsequent care.

Tactics:

- Identify which populations to prioritize based on risk level (patient populations, units, diagnoses, family risk, etc.)
- Identify team members who will implement the tools, who/how to document results, and how to disseminate the information to the larger team
- Create a plan for timing of implementation and re-evaluation
- Examine and address institutional barriers to implementing assessment and screening processes

Sub-Goal 3: Utilize technology during assessments.

Tactics:

- Leverage technology to educate and invite parents and children to participate in initial assessments and screeners and to communicate the assessment in the EMR
- Utilize EMR to flag patients who exhibit vulnerability to emotional safety during healthcare experiences
- Utilize electronic records to house questionnaires and capture data
- Build reports to share measurable data



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Intervention

Goal: Commit to a child's comfort and understanding regarding medical encounters. Incorporate best practices grounded in empirical evidence when available in each patient/family encounter.

Sub-Goal 1: Utilize developmentally appropriate and emotionally safe communication styles and tactics.

Tactics:

- Utilize developmentally appropriate language and techniques
- Employ emotionally sensitive communication styles
- Create communication plans incorporating profession and personal supports
- Facilitate developmentally appropriate and emotionally sensitive patient education regarding diagnosis and treatment/care plans
- Incorporate teach back

Sub-Goal 2: Implement individualized plans based on the developmental and emotional needs of the patient.

Tactics:

- Ensure all children and families receive atraumatic care
- Develop treatment, coping and communication plans based on development differences (such as Adaptive Care Plans) to provide equitable care
- Identify and meet individual needs based on age and development, such as the unique needs of adolescents
- Provide trauma-informed care
- Utilize tactics to decrease the creation/enhancement of pediatric medical traumatic stress
- Engage patients and families in the care process

Sub-Goal 3: Offer a fully array of comfort measures for stressful, anxiety provoking of invasive procedures.

Tactics:

- Include a variety of pain management options as a standard of care
- Provide supportive measures to decrease anxiety and increase coping
- Promote procedure program/initiatives aimed at managing pain and anxiety



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Sub-Goal 4: Offer a full array of comfort measures during hospitalization.

Tactics:

- Include a variety of pain management options as a standard of care, including non-pharmacological choices
- Develop standardized comfort menu templates that can be adapted for each unit
- Offer choices of comfort, recreational, and therapeutic item
- Incorporate complementary services into care



Emotional Safety Framework

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Environment

Goal: Using evidence-based practice, promote safe and reliable environments that minimize stress and promote emotional safety for patients, families, and staff.

Sub-Goal 1: Create spaces and wayfinding techniques utilizing the expertise of professionals, patients, and families.

Tactics:

- Leverage research on healthcare environments (wayfinding, color theory, environmental psychology)
- Consider how environmental aspects are perceived differently by marginalized communities
- Involve patients, families, and child life in all aspects of environmental design and seek continuous feedback to maintain quality environments for diverse populations
- Enhance wayfinding to minimize stress in navigating the hospital by using visual cues, technology, etc.

Sub-Goal 2: Support health education, healing, and connectedness using physical and virtual environments.

Tactics:

- Create and advocate for spaces and environments that engage all abilities and situations (play, resource, sensory)
- Implement creative solutions for virtual environments/supports that sustain family and peer involvement and engagement
- Create family/community spaces
- Make resources for patients and families readily available (concierge, family resource center, guest services, etc.)



Emotional Safety Framework

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Sub-Goal 3: Create an environmental culture of emotional safety by including patient and family needs into practice, policies and procedures.

Tactics:

- Ensure all policies related to the physical environment support family involvement (visiting hours, meal availability, etc.)
- Implement safety practices that promote feelings of emotional safety and family-centered care
- Establish policies related to emotionally safe culture and family involvement
- Include language options and standards into policies and procedures
- Incorporate emotional safety interventions/processes into policies and practice, including standards for medical procedures and appointments, needs, and supports during hospitalizations, and communication considerations
- Implement emotional safety time outs
- Create policies and practices regarding expectations for physical space use, including treatment rooms and play spaces

Sub-Goal 4: Create an institutional, environmental culture supporting patient emotional safety congruent with the organizations' high reliability initiatives, including behaviors, processes, and routines.

Tactics:

- Incorporate emotional safety tactics into high reliability initiatives
- Explore and utilize evidence-based change-related techniques and theories when introducing new emotional safety initiatives
- Incorporate emotional harm moments into daily huddles, safety calls, and rounding
- Develop a reporting mechanism for complaints and grievances around emotional safety, including disparities in care addressing emotional safety
- Build outcome metrics for specific emotional safety interventions
- Develop solutions for reported incidents (family conference, multidisciplinary meeting, root cause analysis, specialty service consultation)
- Develop "Speak Up" practices and programs



Emotional Safety Framework

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Staff Communication, Education, & Training

Goal: Facilitate collaborative relationships and form helpful communication strategies among the interdisciplinary team, the patient, and their support systems. Education teams about implementation of emotionally safe standards of care, utilize the patient and family voice, and advocate for the patient and family within the boundaries of the hospital environment.

Sub-Goal 1: Staff education and training.

Tactics:

- Partner with school programs for healthcare providers to ensure emotional safety information is taught in the early career stages
- Incorporate emotional safety trainings into onboarding programs
- Provide ongoing learning opportunities and competencies
- Utilize evidence-based teaching theories and practices to guidance educational practices for healthcare providers and staff
- Educate all staff in the medical environment on pediatric-specific developmental and psychosocial needs, including special circumstances requiring extra care
- Train effective techniques for respectful, developmentally appropriate, and emotionally sensitive care and communication
- Educate healthcare professionals on effective tools and techniques for pain and anxiety management
- Include health disparities in ongoing conversations and implement plans to address them
- Provide trainings on explicit and implicit bias and their contribution to health disparities
- Encourage exploration of bias

Sub-Goal 2: Establish communication methods to incorporate and standardize the emotional safety process.

Tactics:

- Establish a norm of including emotional safety stories into healthcare professionals' conversations and practices
- Include emotional safety components into planning checklists for medical procedures, impactful conversations, and care planning
- Add emotional safety tactics/suggestions to best-practice alerts
- Utilize a variety of methods to establish a patient experience baseline (methods could include questionnaires, scores, phone calls, advisory councils, and other means to capture diverse perspectives)



Emotional Safety Framework

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Sub-Goal 3: Create internal- and external-facing education and communication.

Tactics:

- Educate the patients and families on their rights regarding receiving emotionally safe medical care within the organization
- Inform the public about the organizational commitment to providing emotionally safe medical care



AUTHORS



AUTHOR



JENAYA GORDON, MA, CCLS, NCC
Manager, Child Life Department
Children's Hospital Colorado
Aurora, CO

Jenaya Gordon is the manager of the Child Life Department at Children's Hospital Colorado and has been a part of that team since 2008. Her educational background includes a Bachelor of Arts degree in speech pathology/audiology with a minor in rehab psychology from the University of North Texas and a Master of Arts in counseling psychology from the University of Colorado. As a Certified Child Life Specialist, she has worked with children and families in the emergency department, pediatric intensive care unit, neurosurgery unit, and inpatient surgical/trauma unit. Jenaya also participates in research studies exploring various aspects of trauma-informed care. As a child and family therapist, she has provided support with grief, trauma, family conflict, and health-related struggles. Jenaya's publications and presentations address such topics as emotionally safe pediatric care, trauma-focused medical play, understanding and responding to children in crisis, trauma processing, and trauma-informed care. Additionally, Jenaya is a former board member of the Association of Child Life Professionals and continues to contribute her time as a committee member.

CONTRIBUTORS



ANNA AHRENS, MA, CCLS
Director, Transformation and Experience
Mary Bridge Children's Hospital and Health Network
Tacoma, WA

Anna is an innovative leader who is passionate about creating and delivering an exceptional pediatric experience for patients and families, and a positive and collaborative environment for staff, providers, and community partners. She leads the strategic direction and framework for Patient and Staff Experience, Family-Centered Care, Child Life Services, Complex Care, and Transformation initiatives at Mary Bridge Children's Hospital and Health Network, located in Tacoma, Washington. Anna holds a Master of Science in Human Development from Pacific Oaks College and a Bachelor of Arts in Child Development from North Dakota State University. She began her healthcare journey 22 years ago as a Certified Child Life Specialist.



SARA BARNETT, MBA, CCLS, CPXP

Manager, Volunteer Resources and Child Life

Riley Hospital for Children at Indiana University Health
Indianapolis, IN

Sara is the Manager of Child Life and Volunteer Resources for Riley Children’s Health in Indianapolis, IN. She also serves on the Patient Experience Team. With 35 years of experience in Child Life, she has enjoyed many roles supporting the profession locally and nationally. Her ACLP involvement includes being part of the initial CLCC Exam Development Committee and Item Writer, various ACLP committees as a member and chair, and also serving on the ACLP Board of Directors. Sara is honored to be part of developing and amplifying the Emotional Safety framework.



DOTTIE BARNHART, MS, CCLS

Child Life Specialist

Wonders & Worries and Children’s Memorial Hermann Hospital
Houston, TX

Dottie Barnhart became a CCLS after teaching general education and Spanish for five years in Houston, Austin and Morocco. She entered the child life world in 2009 as a Child Life Assistant at Dell Children’s Medical Center. After earning a Master’s degree in Family and Child Studies from Texas State University, Dottie has worked for four years at Children’s Memorial Hermann Hospital in Houston and is now also part of Wonders & Worries Houston staff.



CARLA BARRENTINE, MSW, CCLS

Director of Operations

Children's Hospital Colorado

Aurora, CO

Carla is the Director of Child Life of Operations at Children's Hospital Colorado where she oversees the Child Life Department, Creative Art Therapies Department, Spiritual Care Department, Seacrest Studios, The Zone, The Extended Reality Program and the Medical Dog Program. Carla began her career as an outpatient child life specialist for a few years and then she moved on to find her clinical passion of working with patients and families who have been impacted by a serious burn injury has been in leadership since 2004. Carla is a past president of the Association of Child Life Professionals (ACLP). Additionally, she chaired the ACLP's Patient and Family Experience Task force, which became an ACLP committee that she chaired for three years. In this role, she was a contributor to the Beryl Institute's white paper: What Patient Experience can Learn from Child Life Professionals; and she was one of the leaders for the ACLP Emotional Safety Summit.



HOLLY CLARK, MS, CTRS, CCLS

Executive Director

Pediatric Potential, Inc

Istanbul, Turkey

Ms. Holly Clark is dually certified as a Child Life Specialist and Therapeutic Recreation Specialist, and is a Co-Founder of Pediatric Potential. Holly served pediatric patients with hematology, oncology, and acute medical rehabilitation needs for over twelve years as a Certified Child Life Specialist. Amid her tenure as a clinician, she provided a variety of psychosocial care interventions, led community reintegration programs, implemented support groups, and cultivated external donor and partner relationships. Holly's global expertise spans from America, India, South East Asia, Africa and the Middle East. For the past ten years, she has dedicated her career to promoting culturally responsive psychosocial care, as a professional consultant, governing board member, researcher, guest lecturer and medical mission volunteer.



JANET NELMS CROSS, M.ED., CCLS, CPXP

Administrative Director, Patient and Family-Centered Care

Monroe Carell Jr. Children's Hospital at Vanderbilt

Nashville, TN

As Administrative Director of Patient- and Family-Centered Care at the Monroe Carell Jr. Children's Hospital at Vanderbilt, Janet is responsible for development, implementation, and evaluation of patient- and family-centered care initiatives as well as oversight of Child Life Services, Volunteer Services, Pastoral Care, Family Resource Center, Hospital School Program, Music Therapy, Art Therapy, Seacrest Studios, Facility Dog Program, Patient and Family Advisory Councils, Patient Experience, Patient Education and the Gift Shop. Janet obtained her Master of Education from Vanderbilt University and her Bachelor's degree from Mississippi State University. She is a certified Child Life Specialist through the Association of Child Life Professionals and a Certified Patient Experience Professional through the Patient Experience Institute. Janet was awarded the 2012 Distinguished Service Award from the Child Life Council, is the recipient of the 2011 Judy Koonce Family-Centered Care Award, and was named a finalist as a "Woman of Influence" by the Nashville Business Journal in 2012. Janet has served in multiple leadership roles for ACLP including President, Child Life Certifying Committee Chair, Local Conference Planning Committee Chair, Ethics Committee, Governance Task Force, Patient Experience Committee, Child Life Program Review Consultant, contributor of two chapters to Richard Thompson's Handbook of Child Life text book and contributor to the Beryl Institute White Paper "What Patient Experience Can Learn From Child Life Professionals". She is a member of the Beryl Institute's Pediatric Council, and Future of Human Experience 2030 Steering Team. She is also a member of the Nashville Ronald McDonald House Board of Directors and the Board of Directors for Cooper's Troopers, a foundation for the support of siblings of children with cancer. She served as the chair of the Professional Advisory Group for the Clinical Pastoral Education Program in Nashville, 2017 and 2018.



JENNI DAVIS, PHD C, CCLS, CTRS

Clinical Education Specialist – Patient and Family Centered Care
Phoenix Children’s Hospital
Phoenix, AZ

Jenni Davis is a dually certified child life specialist/recreational therapist with over 25 years of experience helping children and families cope with hospitalization. Jenni has worked at children’s hospitals in Texas, North Carolina, and Arizona; and helped activate Sidra Medicine, a women’s and children’s hospital, in Qatar. Jenni is currently the Clinical Education Specialist for Patient and Family-Centered Care at Phoenix Children’s Hospital. Jenni is a doctoral candidate in International Family and Community Studies at Clemson University. Jenni has a passion of ensuring that patients and families emotional safety needs are met in the hospital setting and beyond. Jenni has completed research on parenting in the Arab world, and her current research is evaluating the impact of child life services on staff coping



LORI GOTTHEIN, CCLS

Manager, Child Life and Creative Arts Therapies
Children’s Wisconsin
Milwaukee, WI

Manager of Child Life and Creative Arts Therapies at Children’s Wisconsin. Bachelor’s degree in Recreation Therapy; currently pursuing Master’s degree in Organizational Leadership and Administration. Trained as a CISM facilitator; received training in TIC.



CASSANDRA JAMES, MS, CCLS, CPXP

Manager, Family Support Services
Our Children’s House
Dallas, TX

Cassandra James is the manager of Family Support Services at Our Children’s House in Dallas, TX. She spent over 15 years as a child life specialist in the clinical setting. In her current role, she oversees the child life team, chaplain, interpreter, school services and volunteers. Cassandra also serves as an adjunct professor at the University of North Texas and Texas Women’s University. When not working, she enjoys spending time with family and crafting as a mode of self care.



MEG KELLETT, CCLS
Director of Pediatric Experience
Project Sunshine
New York, NY

Meg is the Director of Programs at Project Sunshine and leads their national initiatives, forging partnerships with medical facilities and nonprofits while coordinating volunteer efforts across the country. With over a decade of experience as a Certified Child Life Specialist, Meg's commitment to pediatric care transcends borders and inspires impactful change. Prior to her tenure at Project Sunshine, Meg established pediatric programs at Memorial Sloan Kettering's Patient Experience department and served as a lead Child Life Specialist at Cohen Children's Medical Center of NY on the Inpatient Surgical Unit. Her international experience at the Red Cross War Memorial Hospital in Rondebosch, South Africa, further enriches her diverse expertise, all of which she brings to Project Sunshine's programming.



STACEY KOENIG, MSM, CCLS
Senior Director, Patient and Family Support Services
Children's Mercy Kansas City
Kansas City, MO

Stacey is a dedicated professional with 30+ years of nonprofit experience improving the operations and culture of respected health systems. She is a national leader who effectively engages internal and external stakeholders to bring diverse perspectives and engagement to achieve organizational goals and streamline processes. She has a proven record of building programs that bring patient and family voice to the forefront that enhance relationships and produce successful outcomes across health systems. She has been part of the ACLP Board and currently serves as co-chair of the PFX committee.



JON LUONGO, MS, CCLS

Contract Administrator

Maimonides Medical Center/1199 SEIU

Brooklyn, NY

Jon has been a frontline Child Life Specialist since 2004 and is proud to volunteer with ACLP. An alumnus of Bank Street College of Education, he was an adjunct instructor in the Child Life Program there. He continues to deliver Child Life lectures periodically. In 2021 Jon began serving as a Union Organizer with 1199 SEIU at Maimonides Medical Center.



TONI MILLAR, MS, CCLS

Director of Program Innovation

Project Sunshine

New York, NY

Toni has been a CCLS for 25+ years. She has held clinical and leadership child life positions at two major children's hospitals, as well as multiple leadership roles with ACLP, including as President of the organization. Most recently, Toni has utilized her Child Life skills at a non-profit that provides supportive play to children and families facing medical challenges.



BRIANNE ORTIZ, MS, CCLS

Manager, Cherese Mari Lulhere Child Life Department

Children's Hospital of Orange County

Orange, CA

Brianne graduated with her master's degree in child life from the University of La Verne after completing her internship at CHOC in 2006. Following her internship, she joined CHOC as an associate and has been serving the organization for fifteen years. Brianne worked as a certified child life specialist in oncology, intensive care, and surgical services and then spent time as the department's first clinical educator. She moved into her current role as manager in 2017 and joined the ACLP's Patient and Family Experience Committee in 2019.



BARBARA ROMITO, MA, CCLS

Director, Child Life Program

The Bristol-Myers Squibb Children's Hospital at
Robert Wood Johnson University Hospital
New Brunswick, NJ

Barbara Romito, MA, CCLS, has served as the Director, Child Life Program at the Bristol-Myers Squibb Children's Hospital at Robert Wood Johnson University Hospital for the past 30 years. She oversees child life services and family centered care, developing innovative programs to enhance psychosocial care for children and families. She has lectured extensively to a variety of interdisciplinary groups and published research studies on psychosocial care of children and families. She received her MA in family studies from Montclair State University, has served on the boards of The Child Life Council, Child Life of Greater NY, and is currently the Association of Child Life Professionals' liaison to the American Academy of Pediatrics, Committee on Hospital Care. She is an adjunct instructor at Rutgers, Robert Wood Johnson Medical School, Department of Pediatrics.



NICOLE ROSBURG MS, CCLS

Manager – Child, Adolescent & Young Adult Life

MD Anderson Children's Cancer Hospital
Houston, TX

Nicole has been a certified child life specialist for 25 years and currently serves as the Associate Director of Child Life at The University of Texas MD Anderson Children's Cancer Hospital. She served as a Board Member for the Association of Child Life Professionals (ACLP) from 2008-2010 and has held a variety of committee leadership roles within ACLP through the Professional Resources, Public Policy and Evidence-Based practice Committees. She currently serves on the Patient and Family Experience Committee and the Leadership Development Task Force. She has a strong interest in pain management techniques, adaptive care planning, staffing metrics/ratios and team development, and is honored to have been able to contribute to the body of work around emotional safety.



KELLY WAGNER, MS, CCLS

Certified Child Life Specialist

Dell Children's Ascension

Austin, TX

Kelly has been a Certified Child Life Specialist for 10 years, primarily in the hematology/oncology setting. Kelly's passion for pediatric patient emotional safety stems from her own experience as the sibling of a hospitalized child. As a member of the Patient Experience Committee, Kelly aims to make emotional safety the every day language of her colleagues to improve the care pediatric patients and their families receive during healthcare experiences.



TRACI WOODS, BS, CCLS

Executive Director, Family Centered Care & Patient Experience

AdventHealth for Children

Orlando, FL

Traci Woods is a proud Certified Child Life Specialist with 28 years of healthcare experience. Currently serving as the Executive Director of Family Centered Care and Patient Experience for AdventHealth for Children and AdventHealth for Women. Focus is on leading initiatives to enhance quality of care and elevate experiences of patients, families and staff through process improvement and culture change.



ABOUT THE EMOTIONAL SAFETY INITIATIVE

Every child deserves emotionally safe care. Emotional Safety Initiative promotes resiliency, healing, and trust for pediatric patients and their families during all medical experiences. For too long, hospitals and medical institutions have prioritized physical health over mental or emotional needs, leading to potentially traumatic long-term effects. By incorporating evidence-based methods, open and age-appropriate communication with patients and families, reliable environments, and individualized intervention plans into all areas of pediatric care, we can minimize stress and foster a healthier lifelong relationship to the medical setting.

Learn more at www.emotional-safety.org

Gordon, J. (2021). Emotional Safety in Pediatrics [White paper]. Association of Child Life Professionals. https://emotional-safety.org/wp-content/uploads/2021/03/Emotional-Safety-Paper_DIGITAL-3.18.21.pdf.



ABOUT THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

Association of Child Life Professionals (ACLP) advances the field of child life by establishing and maintaining professional standards, enhancing the professional growth and development of members, and advancing the credibility of the child life profession by fostering research and promoting the standards of child life practice on a national and international level.

ACLP's vision includes the advancement of the emotional safety of all children, youth, and families impacted by healthcare and significant life experiences.

The Association represents trained professionals with expertise in helping infants, children, youth, and families cope with the stress and uncertainty of illness, injury, and treatment. ACLP is comprised of more than 5,500 individuals representing at least 600 organizations worldwide. Our members include Certified Child Life Specialists, child life assistants, university educators and students, hospital administrators and staff, school teachers, therapeutic recreation specialists, and professionals in related fields.

Learn more at www.childlife.org

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