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Child life therapy
Burn patient management

Clinical guide

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Statewide Burn Injury Service

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Introduction

Paediatric health conditions and hospitalisation cause stress and anxiety for children and their families.

Child life therapy is an allied health profession that focuses on supporting, educating and empowering children and young people throughout their healthcare journey.

Child life therapists have a unique role in supporting children's needs through play, preparation and individualised refocusing strategies, to help build resilience and coping skills. They provide patient- and family-centred interventions throughout a patient's hospital stay, and they work as part of the multidisciplinary healthcare team.

This document outlines the integral role of child life therapists in supporting paediatric burns patients. Burns are acknowledged as a traumatic physical and emotional experience.[11] The complexity of care required during the traumatic nature of a burn injury highlights the need for a holistic multidisciplinary approach.[1]

This information may be relevant in other clinical contexts where there is high procedural occasions of service, or for procedures associated with significant pain or anxiety.

Role of a child life therapist

The role of a child life therapist is to assess, plan and implement individualised interventions for a child or young person. This involves:

- performing accurate and ongoing assessments of the children and the family's needs, to facilitate meaningful interventions and support
- equipping a child with appropriate and accurate information, increase coping, resilience and empowerment, and reduce pain, fear and anxiety
- providing procedural support, such as when dressings are changed
- offering and facilitating opportunities for a child to engage in play
- working using a family-centred practice approach (and encouraging others to do the same)
- keeping an accurate record of child life therapy interventions
- using documentation as a tool to advocate for children and their families
- continually adjust and improve practice based on current research.

Role in the multidisciplinary team

In a Paediatric Burns and Plastics Treatment Centre and/or connected inpatient ward, it is important that the child life therapist/s work in collaboration with the larger multidisciplinary team (MDT).

For paediatric burns patients, the team may include anaesthetists, surgeons, nurses, physiotherapists, social workers and other health professionals. Input from all stakeholders need to be considered when developing individualised procedural support plans. For example, input from anaesthetists and nursing staff is particularly important for child life therapy interventions, as it allows for safe and accurate pre-medications to be administered to support children through their procedures. This has a direct impact on the suitability of support strategies and techniques used in dressing change procedures.

Assessment

Goal: To perform accurate and ongoing assessments of children's and family's needs to inform meaningful interventions and support

In the burns context, appropriate initial and ongoing assessments of the child and family's needs is imperative to facilitating meaningful and effective interventions.[7]

Sources of information

The assessment process should be based on three sources: the child, the family and the healthcare team.[7]

Child

Observing a child's play behaviour within the clinic or ward can be an accurate source of information. It has been identified that play is the most accurate assessment tool, central to a child life therapist's work.[4]

The continuous nature of assessment is prevalent when working with the child – therapists observe what is effective and engaging for the child and what is not. Interventions are adjusted continually, both during preparation and the procedure itself.

The child's development, age and temperament are other indicators to inform appropriate intervention.

Family

First and foremost, establishing a supportive relationship with the family and child is imperative to obtaining accurate information for assessment and working with the family to achieve meaningful support.[7]

When conducting an initial assessment with families in the clinic or ward, a child life therapist should:

- introduce him/herself and the role
- seek information from the family and/or child about the child's interests
- ask about the child and family's coping to date (e.g. in previous dressing changes/or at home)
- observe behavioural responses from the family and collaborate with nursing staff about how the family is coping (looking to reassuring, educating and/or empowering them)
- seek family members' input/choice of preparation and procedural support, based on what they feel is suited to their child
- consider the family's culture and language.

Healthcare team

As each setting operates differently, it is important for child life therapists to seek out the best methods of collaboration, communication and information collection. Avenues may include:

- MDT meetings (to gain perspective and information from the practitioners involved with the patient)
- medical records
- speaking to nurses familiar with the child/family.

For paediatric burns patients, the following information may be sought to inform interventions:

- the burn type

- the position of the burn and total body surface area percentage
- the date of the injury (and thus type of treatment required, e.g. debridement)
- previous dressing changes/hospital experiences
- pre-medications.

Prioritisation

Prioritisation is a vital skill utilised every day when working to meet the needs of children and their families. This should be assessed in accordance to the prioritisation guidelines at the particular service.

High priority paediatric burns patients may include:

- a child who is experiencing his/her first dressing change since the injury, who is indicated as needing debridement
- a child or family who have previously experienced a challenging or traumatic dressing change
- a child who has previously had sedation but medication is being weaned/reduced
- a long-term patient experiencing first dressing change without a general anaesthetic.

Education and preparation

Goal: To empower and equip a child with appropriate and accurate information to increase coping, resilience and empowerment, and reduce pain, fear and anxiety

Through education and preparing a child or young person for healthcare interventions, child life therapists provide children with the knowledge, tools and strategies to assist them in coping and developing life skills. Education and preparation can help children to become more comfortable, confident and reassured about a particular procedure, re-introduction to baths/water play or re-integration into community/school.

It is vital that education and preparation is family centred and parents, carers and siblings are included as part of the process. This provides them awareness of what is happening and strategies to support their child's learning.

A variety of education techniques can be used, depending on the child's age, development and previous experiences – see Appendix 1.
This includes:

- medical play
- visual teaching tools
- verbal explanations.

Medical play

Medical play involves the use of real or pretend hospital and medical-related equipment in a playful context. Children have the opportunity to role play their hospital experience, using play medical kits and dolls.

The focus on medical play in a burns context is often to model dressing change procedures (removal and re-application), upcoming theatre experiences and grafting surgery. The play provides a valuable opportunity to talk about the sensations the child may feel or see during the procedure.

In an outpatient context it can be beneficial for a child to have medical play resources available, such as real bandages. The child can be encouraged to play out the medical experiences at home, and family members can be involved in education about the importance of play for coping, particularly for long-term patients.

Visual teaching tools

Visual teaching tools, such as a videos or photographs, can be a valuable tool for preparation. It is beneficial that videos and photos are specific to each burns context to support accuracy of information and expectations.

Visual tools can enhance engagement and reduce the risk of misconceptions.

Verbal explanations

The therapist may explain the procedure to the patient, but should be cautious about using only verbal explanations, as children will respond with imaginative or associative thinking. There is potential for misconceptions.

Using softened and developmentally appropriate language, the therapist may talk about:

- the reason for procedure
- positioning
- expected sensations and sensory experiences
- the sequence of events
- the duration
- choices that can be made (e.g. choice of coping tools)
- who will be in the room.

Additionally, therapists may consider sharing:

- the location of preparation
- timing
- family and nursing involvement
- post-procedural evaluation.[5]

Please note: not all children seek information to support coping, hence assessment on preference and suitability is advised prior to intervention

After education and in consultation with the patient, parents, carers and other healthcare team members, the child life therapist can prepare a procedure support plan to inform team's practice in future dressings/procedures (see following section).

Procedural support

Goal: To provide procedural support (for instance, during dressing changes or other treatment), to promote coping and reduce pain and fear

Child life therapists are specifically trained to assess and facilitate play and developmentally appropriate psychosocial support in the context of a hospital environment. Procedural support is often at the centre of a child life therapist's work in a burns context, as burns dressing changes are regarded as one of the most painful procedures, and likely to be recurring.[11] There are many factors that impact on a positive dressing change.

There are a range of strategies and non-pharmacological pain management techniques used on a regular basis, dependent on assessment findings. The continual cycle of assessment, intervention, and evaluation is pivotal in the effective use of non-pharmacological strategies. Therapists can consider the suitability of techniques on an individual basis from the categories; sensory, cognitive and behavioural. Table 1 provides an overview.

Additional tools and strategies are available – see resources such as *The Handbook of Child Life: A guide for pediatric psychosocial care*, *Everybody Stay Calm: How to support your young child through medical tests and procedures*.[13, 10]

Environment

The preference is for invasive procedures to occur in treatment rooms, with the bed and play rooms as safe areas for patients.

What a child sees as they walk into a treatment room can be very clinical. It is the role of the child life therapist to make treatment rooms patient friendly – this may include things such as:

- inviting images on the walls (points of interest when laying down)
- a selection of toys available to allow for choice but not to overstimulate
- quiet music or the ability to adjust room acoustics (noises associated with treatment).

Prepare the room in advance and have resources readily available. Advocate for nurses to do the same. Monitor the amount of people in the room at any one time, so it is not overwhelming and consider your position when working with a child (allowing them to make eye contact if developmentally appropriate and lowering yourself below the child's level when possible).

Comfort positioning

Comfort positioning helps allow children to feel safe and secure, rather than restrained or vulnerable. Comfort positioning during procedures can be adapted to suit the child/young person and the procedure[14].

The key principles of positioning for procedures are:

- the adult should provide positive assistance, not negative restraining
- upright positions promote sense of control and security
- the body/extremity is isolated, allowing for easy/safe access.[2]

Procedural Planning

As child life therapists, we can play an integral role in planning cohesive procedures for patients and their families. The process should be supported by facilitating communication between all stakeholders, including, the multi-disciplinary burns team, the patient and their family.

Effective communication is fundamental as we:

- Plan: Facilitating conversations about the patient, family and medical needs and how to support all these components successfully. This may include positioning requirements, a child's desire to be involved and the specific cares required.

- Prepare: Providing procedural preparation to the patient and/or set up a treatment room prior to a patient's entry, based on their interests. This may also involve advocating for nursing staff to set up resources prior to a procedure.

- Partnership: Including the family in these processes and conversations and allowing them to express their own expectations, needs and questions.

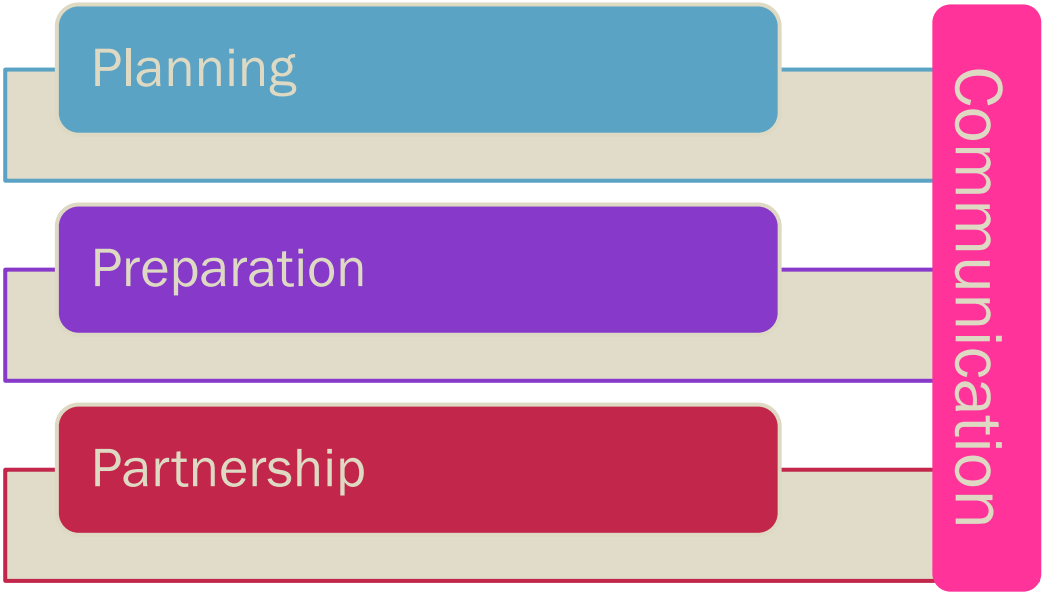

TABLE 1. OVERVIEW OF PROCEDURAL COPING STRATEGIES FOR PAEDIATRIC BURNS PATIENTS

<table>
<tr><td rowspan="4">SENSORY</td><td>Positioning</td><td colspan="3">See Comfort positioning (pp 189-192)</td></tr>
<tr><td>Soothing touch/massage</td><td colspan="3">Training courses available</td></tr>
<tr><td>Music</td><td colspan="3">- Quiet, steady music can create a calm environment
- Singing by parents or therapists can be familiar and soothing for infants/toddlers
- Preschoolers or school age children may choose a song/music
- Visual representations of music (accompanying books) can be used</td></tr>
<tr><td>Bubbles</td><td colspan="3">- Bubbles can be engaging for children of many ages (generally 0-8 years)
- Choosing when and where to use bubbles is important (bubbles should not be pointed at the child but in view of the child or grasping distance)
- Preschoolers or older children may want to blow the bubbles themselves
- Create games using the bubbles to increase their distractive qualities (e.g. counting, catching, songs and parent involvement)
- Bubbles can be utilised during the use of nitrous, as it allows children to fix their gaze on a calm sensory element rather than the ceiling when laying down</td></tr>
<tr><td>Food</td><td colspan="3">- If the child has fasted and the need for additional medications/gas has been eliminated, feeding can provide comfort. This is particularly helpful for infants and toddlers who are breast fed or bottle fed
- Food is often introduced during re-application of dressings when less movement is preferable. Be cautious not to introduce the food too early – collaborate with nursing staff about when they are ready to start re-dressing
- Involve parents in the discussion about food so it can be provided by family or staff</td></tr>
<tr><td rowspan="6">COGNITIVE</td><td>Refocusing/ distraction</td><td colspan="3">Scaffolded and active distraction is the most effective in re-focusing a child's thinking and thus minimising pain and/or anxiety.
Active distraction
• find-it books/games
• using an electronic tablet such as an iPad (scaffolded by therapist)
• storytelling/joke telling
• virtual reality
Passive distraction
• watching TV or a movie
• listening to music</td></tr>
<tr><td rowspan="4">Play</td><td>Infants</td><td colspan="2">- rattles
- reflective toys (when appropriate, depending on burn percentage and location)</td></tr>
<tr><td>Toddlers</td><td colspan="2">- cause-and-effect toys
- musical toys
- toys to hold and move
- bubbles
- books</td></tr>
<tr><td>Preschoolers</td><td colspan="2">- cause-and-effect toys
- musical toys
- construction (Duplo)
- bubbles
- books
- iPad (scaffolded by therapist)
- play dough
- toys of interest (e.g. dinosaurs, cars, construction, etc)</td></tr>
<tr><td>School age</td><td colspan="2">- electronic tablet such as an iPad
- virtual reality
- books
- Lego
- handheld problem-solving games, e.g. Rubik's cube</td></tr>
<tr><td>Guided imagery</td><td colspan="3">Requires training</td></tr>
<tr><td rowspan="2">BEHAVIOURAL</td><td>Relaxation techniques</td><td colspan="3">• Deep breathing (e.g. Peaceful Kids)*
• Stress ball
• Glitter wands/kaleidoscopes</td></tr>
<tr><td>Muscle relaxation</td><td colspan="3">• Can be guided by scaffolded conversation, focusing on the tightening or relaxing of muscles progressively
• Can be supported by stories intended to support muscle relaxation (e.g. Relax Kids)†</td></tr>
</table>

Source: Goldberger, Mohl, Thompson (2009)

* www.peacefulkids.com.au

† www.relaxkids.com

Developmental play

Goal: To offer and facilitate opportunities for a child to engage in play

Play helps children understand their world. It promotes learning, growth, development, relaxation and socialisation.

When a child is faced with a traumatic experience such as a burn injury, their usual routines are disrupted and they experience challenging emotions such as separation, pain and fear.

There are several benefits of play:

- Children can continue an aspect of their normal life when in hospital.
- Playing supports children to process new environments.
- Play can help children become more comfortable in unfamiliar surroundings and experiences of hospital, normalising the environment.
- Nurses and medical professionals who are playful in their interactions may be less threatening and more approachable.
- Through play, children can express their feelings and worries about treatments, reducing anxiety.
- Play provides an opportunity for children to make choices and retain a sense of control.[8]

When working with burns and plastics patients, therapists should be mindful of sensory play. While sensory play is an important component of play, there are often restrictions for burns patients. Speak with the nursing/medical team first.

Physiotherapy is a central part of a burns patient's care and rehabilitation, so it is valuable to collaborate with physiotherapists and/or occupational therapists. This will facilitate meaningful play opportunities for the child that will support physical recovery. Joint therapeutic sessions may support motivation and refocusing for the acute stage of stretches, splinting and additional physiotherapy cares.

Family-centred practice

Goal: To work using a family-centred practice approach (and encourage others to do the same)

Family-centred practice (FCP) is an approach for working with children and their families that promotes partnership between professionals and families and encourages the family's involvement when caring for their child.[6] In a FCP context, partnerships refer to relationships that are built on collaboration, valuing each other as equals and identifying individual strengths.[3]

The child life therapist has a unique role to facilitate involvement and empower families in the care of their child. The therapist may play a role as advocate for a family or provide support and play opportunities to siblings. The *Handbook of Child Life* has identified elements of practice.[13]

To support FCP, the therapist considers:

- **Environment –** how the environment is set up, or how people are positioned to allow the family to feel involved.
- **Cultural responsiveness –** cultural factors that may influence a parent's role, both with their child or when interacting with healthcare professionals. This also often impacts on the involvement/presence of extended family members and siblings.
- **Family strengths and priorities**
- **Prior knowledge –** what is the family's prior knowledge of developmentally appropriate responses to hospitalisation and pain?

In the burns context, the main roles of the child therapist include:

- empowering parents to have a role in supporting their child in a procedure, e.g. comfort positioning or play-based distraction methods
- including siblings in medical play
- facilitating communication between the family and healthcare team at times.

Regular communication is required so that both patient, family and staff needs are being met. These may include:

- daily meetings
- weekly meetings
- case conferences
- clinical meetings.

Required documentation

Goal: To keep an accurate record and use documentation as a tool to advocate for children and their families

Documentation of the clinical care provided allows child life therapists to leave 'footprints of their work.'[7] It is through documentation that a patient's records are kept and communicated on a daily basis within all disciplines across the healthcare environment. This is necessary to assess, plan and implement relevant interventions in meeting a patient's needs.

Each paediatric patient requires documentation to be undertaken by the relevant professional. This should be completed on the relevant electronic platform including assessment, planning, intervention and follow up.

Refer to *The Handbook of Child Life: A Guide for Pediatric Psychosocial Care* for additional tools and strategies.[13] Documentation protocols and templates are dependent on local site standards and preferences.

Documentation may involve the following:

- statistical record keeping of occasions of service
- written anecdotal evidence of clinical intervention in a child's medical notes (e.g. preparation, coping strategies etc.)
- a record of resources used for each patient to inform the plan for the next visit
- a procedural support plan/comfort care plan
- visual dynamic documentation of their play experiences.

When working in a MDT, documentation is key for ensuring consistency and team work. Additionally, as burns patients often require ongoing treatment, progression can be recorded and intervention can be adjusted or replicated to improve effectiveness.

Professional development

Goal: To continually adjust and improve practice based on current research

As child life therapy is a growing industry, it is imperative that therapists continually build on their professional knowledge and practice.

This helps to deliver the best possible care and maintain a strong foundation for the role of a child life therapist in the healthcare system. Professional learning can be made up of a number of experiences, such as attendance at conferences, workshops, membership of a journal club, in-services with colleagues and/or maintaining memberships of related associations.

Associations

- Association of Child Life Therapists Australia
- Association of Child Life Professionals (ACLP)
- Australian and New Zealand Burn Association
- Hospital Play Specialists Association of Aotearoa/New Zealand
- Association for the Wellbeing of Children in Healthcare

Journals

- Burns; Journal of the International Society for Burn Injuries
- Journal of Burn Care and Research
- Journal of Paediatric Health Care
- The Journal of Child Life

Occupational health and safety

Like other healthcare professionals, child life therapists must practice and promote occupational health and safety guidelines and practices, ensuring the promotion of patient care and recovery in a safe environment.

It is critical to implement safe work practices and attend mandatory training relevant to the patient and/or hospital environment. Be aware of procedures related to:

- infection control
- manual handling of patient and/or environment
- usage of age appropriate resources for patients
- use of equipment and/or resources to undertake the role.

Infection control

The child life therapist must be able to implement correct infection control procedures relevant to the patient's condition and hospital practices. General/universal infection control practices are fundamental to the role.

The practices include:

- knowledge and application of universal precautions (gloves, hand washing, protective clothing)
- knowledge and understanding of elements responsible for transmission of infection
- toy room protocols and procedures around cleaning, storage and access
- awareness of a patient's exclusions from group activities due to infection.

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Appendix 1. Assessment guide

Factors for assessment	Things to consider/determine	
	Hospital context	***Burns and Plastics Clinic***
Temperament	How does the patient typically present at home and in other contexts? • Activity level • Adaptability • Threshold of responsiveness, intensity of reaction • Mood • Distractibility • Attention span and persistence • Predictability • *Ideal: positive mood, predictable, easier to distract, more approachable, adaptable, less reactive to stimuli.* • State vs. trait anxiety	How is the patient presenting in the play context in the waiting area? • Activity level • What is the level of social engagement with children and staff? • How does the child respond to the administration of pre-medications? • Distractibility
Coping style	• Avoidant - Restricting their thoughts - Deny worries - Detach from stressful situation • Vigilant - Seeking out detailed information - Alertness to stressful stimuli - Focus on concrete, factual elements	This information can be gathered by discussions with older children themselves, or when speaking about any prior dressing changes with families of younger children. It may also be part of your ongoing assessment during the procedure as it develops.
Age	• Consider chronological age vs. developmental age. However, age is not a solely predictive factor.	• Consider chronological age vs. developmental age. This, combined with coping style, will help inform your decisions around educational intervention prior to procedures, and your selection of tools for the procedure.
Parental anxiety and distress	• Maternal anxiety • Paternal anxiety • Parental coping styles	• This can often be observed in the waiting area, and when parents interact with staff and yourself. It can also be valuable to collaborate with the social worker if they have meet with the family.
Family characteristics	• Parents marital status • Family size and composition • Socioeconomic status • Parental Involvement	• This information may come from nursing staff prior to families coming to the clinic, it may come from the social worker or from your own interactions with the family.
Illness	• Chronic vs. acute illness *(not always a predicting factor)* • Length of Hospitalisation	• Percentage of burn • First dressing? • Is debridement needed? • Is there removal or sutures, stitches or staples required? • Location of the burn • What pre-medication is the patient having?
Medical Experiences	• Exposure to Invasive procedures • Number of invasive procedures • Previous hospitalisations	• Has the child had any prior dressing changes? How did he/she respond? • Has the child had prior hospital experiences?

Source: Koller (2008), by Scott S (adapted for the burns context)