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Commentary

ChildKind: A global initiative to reduce pain in children

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Editor's note: This commentary was invited by the Editor on behalf of the Council of the Special Interest Group on Pain in Childhood, International Association for the Study of Pain, which has endorsed the ChildKind initiative. -CLvB

The ChildKind initiative is an evolving program designed to allow all children to benefit from the knowledge that has recently emerged about pain management. By offering technical support and ultimately a special designation to those institutions which have put in place specific policies known to be associated with pain reduction, the ChildKind initiative hopes to encourage the uniform application of this new knowledge. The object of this paper is to describe the origins of this project, its present status, and its plans for the future, and to encourage those who might be interested to participate in its development.

Background

Knowledge about pain in children has increased exponentially over the past 25 years and this new information has led to a dramatic shift in clinician attitudes and clinical care. Pain is now seen as an entity that demands treatment not only for compassionate reasons, but also because its undertreatment is associated with short- and long-term negative consequences. It is quite clear that with the uniform application of available technology we now have the ability to address the majority of traditional pain problems. The problem is, of course, that this does not always occur.

Although the situation has improved dramatically from a quarter century ago, a significant minority (at least 20% in studies in wealthier countries) of children still experience unnecessary pain while in hospital (Jacob & Puntillo, 2000; Ellis et al., 2002; Karling et al., 2002; Harrison et al., 2006; Taylor et al., 2008). The percentage is probably much higher in low- and middle-income countries (Forgeron et al., 2006). Research also suggests that there are both inter and intrahospital differences in the way specific pain problems are addressed. A study by Ammentorp et al. (2005) emphasizes the persistence of those inequities. Families were asked to list their most important goals for the hospitalization of their child and to report their level of satisfaction with meeting those goals. Pain management was second only to accurate diagnosis in importance to families, yet satisfaction with it was relatively low. As a result, issues around pain management demonstrated the largest gap between the importance of a problem to families and satisfaction with our response to it. In sum, pain remains a persistent problem for children in healthcare settings despite the exponential increase in our understanding of how to treat it.

Promoting change

A number of strategies have been attempted to alter the practice behavior of healthcare professionals regarding pain control in children. These include educational initiatives, guideline development, and quality audits. Unfortunately, multiple studies have suggested that although these techniques have some impact on practice behavior, in general, disconnected initiatives (random lectures on pain, availability of guidelines, occasional quality audits) typically do not yield sustained

change in the quality of pain management at a given institution (Lomas et al., 1989; Lomas et al., 1991; Davis et al., 1995; Davis et al., 1999; Pisacane, 2008; Zernikow et al., 2008).

It appears that unless concern about pain is perceived as a core institutional value and an essential element of care, initiatives by individuals, no matter how well meaning, will have only limited success. Interventions such as lectures and audits are more likely to impact on behavior if they fit into an institutional culture in which addressing pain is an expectation. In that way, appropriate pain management does not rely on the memory or good graces of any one practitioner but instead becomes part of the institutional fabric similar to issues of safety and confidentiality. For this to occur, first and foremost, providing comfort must be formally established by the administration as a priority. Inadequate pain management can then be viewed as out of context and should be seen as everyone's responsibility to remedy. All of the measures previously mentioned (education, guidelines, audit) will be subsequently seen in a different light.

A number of authors have written about building an institutional commitment to pain management and the Resource Center of the American Alliance of Cancer Pain Initiatives has developed a manual on how to do so (Gordon et al., 2000). Stevenson et al. (2006) have identified the key elements necessary to create a hospital-wide pain management plan. These include:

1. An interdisciplinary working group with administrative mandate for change
2. Institution-wide standards for pain assessment
3. Explicit policies and procedures regarding pain
4. Clearly defined accountability
5. Easily accessible information on pain treatment
6. Involvement of patients and families
7. Ongoing staff education
8. An ongoing audit process

The ChildKind initiative

Despite the potential of such an approach, few institutions have been able to fully implement it. Logistical and financial impediments often get in the way. The ChildKind initiative was developed to provide both motivation and guidance to child healthcare facilities interested in creating a system-wide approach to pain management. Institutions that meet certain rigorous criteria will be designated as *ChildKind Hospitals* and will receive an internationally sanctioned award that attests to their ongoing commitment to providing a uniform approach to pediatric pain management. It is our hope that such recognition will provide incentive for all institutions to overcome the barriers that prevent current knowledge regarding pediatric pain from being applied to every child.

The ChildKind initiative is modeled on the Baby Friendly Hospital Program, a WHO and UNICEF effort to encourage breastfeeding in hospitals. In this model, if institutions meet a list of specific criteria, they are awarded a *Baby Friendly Hospital* designation. This designation brings many potential benefits to institutions:

- Receipt of an international award is an achievement to celebrate within the institution.
- Public relations and marketing external to the institution will be facilitated.
- The process for obtaining this award can be seen as a quality improvement effort by the institution.
- Institutional revenue may be enhanced by attracting additional patients.

The institution will therefore benefit from *Baby Friendly* status as will infants in the community whose health will improve due to increased breastfeeding rates (Philipp et al., 2001). Currently over 15,000 institutions in 134 countries have been awarded *Baby Friendly* status.

The ChildKind initiative will encompass a similar model applied to pediatric pain prevention and relief. The program emerged from the International Association for the Study of Pain (IASP) Special Interest Group on Pain in Childhood. ChildKind has already been endorsed by major international health organizations including IASP, the Canadian Pain Society, the National Association of Pediatric Nurse Practitioners, the World Federation of Societies of Anaesthesiologists, the International Pharmaceutical Federation, the Royal College of Nursing, the Child Life Council, and the Canadian Nurses Association.

History of ChildKind

The board and membership of the IASP Special Interest Group on Pain in Childhood endorsed the concept of ChildKind at the 7th International Symposium on Pediatric Pain held in Vancouver, Canada in June 2006. With that endorsement, the organizing group received a grant from the Mayday Fund to support a consensus meeting to develop the core principles and philosophy of ChildKind. With the additional support of the Rockefeller Foundation and the Institute of International Education, the organizational meeting of ChildKind was held in Bellagio, Italy, at the Rockefeller Foundation Bellagio Study Center on November 4-8, 2008. At that meeting, 20 experts in pediatric pain representing 14 countries as well as the World Health Organization established the basic principles regarding pain management in children that would yield the criteria for ChildKind certification.

ChildKind principles

Those principles are now referred to as the Bellagio Declaration and are as follows:

1. There is a facility-wide, evidence-informed, written policy on pain assessment, prevention, and management.
2. There are comprehensive and on-going education and awareness programs for all staff, students/trainees, patients, and caregivers.
3. All children have pain assessed using an evidence-informed, developmentally appropriate process, and recorded in the patient record.
4. There are specific, evidence-informed protocols for pain prevention and management, including pharmacological, psychological, and physical methods.
5. There is a regular institutional self-monitoring program of ChildKind criteria which should review protocols, policies, and patient outcomes, with feedback to staff, within the framework of a continuous quality improvement.

The ChildKind organizing group felt that these core principles could be established at any institution, regardless of resource availability, assuming adequate commitment. The specific details of how these principles would be operationalized might vary depending on institution size, personnel, access to pharmaceuticals and precedent but as long as these efforts were evidence-informed, they would meet the standard for this award. Preliminary details of the criteria that were extracted from these principles are available at the ChildKind website (www.childkindinternational.org).

Operationalizing ChildKind

The organizational structure of ChildKind will ultimately depend on grant support and eventual endorsers but key elements have been agreed upon.

Interested institutions will submit a letter of intent to apply for ChildKind designation. That letter should include evidence of full administrative support, identification of a ChildKind "champion", and the results of a self-study which will be downloadable from the ChildKind website. This self-study will highlight institutional strengths and weaknesses. The ChildKind staff will review the letter of intent and subsequently a "designation package" will be sent to the champion. This will contain specific criteria necessary for accreditation as well as support materials including sample policies, protocols, audit strategies, and educational modules. The central office will provide ongoing technical assistance to institutions as they progress toward ChildKind certification, as this process is designed to be collaborative. Ultimately, a formal visit by a ChildKind team (local and/or international) will occur and if the institution is felt to meet the standard for designation, ChildKind status will be granted for 5 years after which time a review will again be necessary.

Going forward

As is evident from the previous description, the ChildKind project is clearly in its early stages and will require the creativity and nurturing of the pediatric pain community to achieve its full potential. A number of additional steps are currently being planned:

Creation of a Board of Directors. At this time, ChildKind continues to be developed by the small group of clinicians who initially conceived it. Creating a multidisciplinary board of directors will

bring additional perspective, resources, experience, and energy to the project.

Funding. Adequate funding is essential to the growth of ChildKind. A steady funding stream for the foreseeable future will allow for the recruitment of a small staff to handle inquiries, troubleshoot, maintain a website, collect and collate sample protocols and policies, and evaluate various educational modules to serve as templates for individual institutional initiatives.

Finalizing the process. The central office of ChildKind could exist within a healthcare facility such as a children's hospital, within a related non-profit organization such as IASP, or within a multilateral organization such as WHO or UNICEF. It remains to be decided who ultimately completes the evaluation. Possibilities include members of the ChildKind central staff, an international team of experts assembled by ChildKind, local or regional experts such as members of the regional IASP chapters, employees of international organizations such as WHO, or some combination developed on a case-by-case basis. Issues of language and cultural differences clearly are important and any eventual structure for ChildKind needs to be sensitive to them.

Additional endorsers. Although a number of organizations have already endorsed this initiative, the leadership of ChildKind is actively engaged in the process of securing additional endorsements which would further enhance the desirability of achieving ChildKind status.

Pilot sites. Even though many details of the process to achieve ChildKind accreditation are not definitive, a number of institutions have requested to participate as pilot sites. Of note, after a ChildKind workshop held in Ribeirão Preto, Brazil, in April 2010, the Brazilian Ministry of Health awarded a $74,000 CDN grant to researchers in Brazil to begin pursuing ChildKind standards in two pediatric health institutions. Such participation will benefit not only ChildKind, by helping us refine the process, but will also be instructive for the institutions, as it will provide a mechanism for self-analysis and a conduit to receive technical assistance. Pilot sites should represent the full gamut of child healthcare institutions (large and small, rich and poor, academic and community) so that unexpected barriers at all potential sites can be identified.

Summary

The ChildKind initiative is an attempt to improve the quality of pediatric pain management in hospitals by awarding special recognition to qualifying institutions. It is an alternative to other models which may be more punitive in nature and are often less successful at changing the inherent culture of the institution. ChildKind is modelled on the Baby Friendly program of WHO/UNICEF that has influenced institutional approaches to breastfeeding practices around the world.

At the present time, ChildKind's core principles have been established and it has garnered endorsements from leading international healthcare organizations. Much remains to be done in shaping and refining this program but it has already generated significant interest among practitioners and institutions. Individuals interested in being active participants in the development of this unique program are encouraged to write to us at childkind@me.com.

Visit the ChildKind website
www.childkindinternational.org

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