The Distraction in Action Tool©: Feasibility and Usability in Clinical Settings

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Abstract

Purpose: Distraction is a relatively simple, evidence-based intervention to minimize child distress during medical procedures. Timely on-site interventions that instruct parents on distraction coaching are needed. The purpose of this study was to test the feasibility and usability of the Distraction in Action Tool© (DAT©), which 1) predicts child risk for distress with a needle stick and 2) provides individualized instructions for parents on how to be a distraction coach for their child in clinical settings.

Design and Methods: A mixed-methods descriptive design was used to test feasibility and usability of DAT in the Emergency Department and a Phlebotomy Lab at a large Midwest Academic Medical Center. Twenty parents of children ages 4–10 years requiring venipuncture and clinicians performing 13 of those procedures participated. Participants completed an evaluation and participated in a brief interview.

Results: The average age of the children was 6.8 years, and 80% of parent participants were mothers. Most parents reported the DAT was not difficult to use (84.2%), understandable (100%), and they had a positive experience (89.5%). Clinicians thought DAT was helpful (100%) and did not cause a meaningful delay in workflow (92%).

Conclusion: DAT can be used by parents and clinicians to assess their children's risk for procedure related distress and learn distraction techniques to help their children during needle stick procedures.

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Practice Implications: DAT for parents is being disseminated via social media and an open-access website. Further research is needed to disseminate and implement DAT in community healthcare settings.

Most young children experience a number of painful medical procedures, such as immunizations, as part of their routine health maintenance. Many children with health problems require additional painful procedures such as venipuncture and IV insertions related to diagnostic testing and disease treatment. Inadequate pain management related to needle sticks can create anxiety in the child, behavioral distress, and may have negative long-term consequences (Kennedy, Luhmann, & Zempsky, 2008; Taddio et al., 2012). Despite research to support interventions for acute procedure related pain in children, it remains undertreated (Stevens et al., 2011; Stinson, Yamada, Dickson, Lamba, & Stevens, 2008). Unreasonable failure to treat procedural pain may even be considered a breach in human rights and unethical (Czarnecki et al., 2011).

Distraction is a relatively simple and effective cognitive behavioral intervention for reducing pain and distress for young children undergoing painful procedures (Koller & Goldman, 2012; Stinson et al., 2008; Uman et al., 2013). Parents typically want to help their young child during medical procedures and many can be trained to be distraction coaches (Power, Liossi, & Franck, 2007). However, we found that about 15% of children do not respond to the distraction efforts of their parents, and display high levels of distress behavior during medical procedures (McCarthy et al., 2010a). These children may benefit from professional distraction coaching.

In children's hospitals, child life specialists may be on staff to meet the needs of children who are at risk for distress during procedures. However, child life specialist may not be available for every procedure. In these cases and in smaller community settings, it is often up to the parents or attending nurses to provide distraction coaching. Clinicians need tools to screen children for distress risk in order to help parents prepare to take an active role as distraction coaches or to have professional support arranged for the child.

Background

Our research team has carried out a series of studies aimed at decreasing the distress children experience during painful procedures by training parents to coach their children in the use of distraction. Our studies confirmed the effectiveness of parent provided distraction in decreasing child distress during an IV insertion (McCarthy et al., 2010b) and identified factors that predict risk for child distress (McCarthy et al., 2010b). Using the data from the 1116 children and their families in our studies and data mining methods, a web-based Distraction in Action Tool© (DAT©) prototype (formerly called the CPMD or C-PaD) was developed and tested (Hanrahan et al., 2012; McCarthy et al., 2014). The DAT identifies the risks for distress (DistrEstimate©) of a child undergoing an IV insertion when: 1) the parent is the distraction coach and 2) a trained professional is the distraction coach. It provides an evidencebased training video for parents on distraction coaching and suggests appropriate distraction strategies and instructions tailored to the individual child's characteristics.

This study describes transitioning the DAT from use in a controlled research setting to use in clinical practice. The purpose of this study was to pilot test the web-based DAT feasibility and usability in realworld clinical settings.

Methods

Design

A descriptive iterative design was used to pilot test the functionality and feasibility of the DAT. After the first five participants were enrolled, the research team reviewed the responses to decide if adjustments in the DAT interface and program were needed.

Setting

The University of Iowa Hospitals and Clinics Emergency Department (ED) and the University of Iowa Stead Family Children's Hospital Outpatient Phlebotomy Lab were used. Neither of these settings routinely has coverage from child life services and they are similar to the community settings that we are targeting for expansion of DAT usage.

Subjects

Twenty parents or guardians, their children, and the clinicians involved in the child's procedure were recruited. Children were between the ages of 4 and 10 and were in the ED or Phlebotomy Lab for an IV placement or blood draw. Because the prototype was already extensively validated in previous research and beta tested, we expected to be able to identify feasibility and usability problems with a small sample in the clinical setting.

Instruments

DAT—The web-based user interface for healthcare providers and parents was written using the software framework, Microsoft.NET, utilizing responsive design techniques. The interface is what the user sees and interacts with. A responsive design allows the user to access the program from both desktop and mobile devices. The supporting database (back end) for the user interface (front end) is a Microsoft SQL server.

A Web Service provides an automated communication layer between the user interface and the information generated from parent/ child responses and the decision engine guiding recommendations. The language and charts visible to users are tailored based on the returned responses. Both the user interface application and database reside in a secure, Protected Health Information (PHI) rated data center. Access to the clinician area of the interface is secured by role based permissions and credentials.

The web-based user interface and Web Services went through several levels of testing before being released. When the web development team was satisfied with the functionality of the user interface and Web Service, these applications were released to the research team for usability and acceptance testing. This testing process was repeated multiple times as developers implemented changes as a result of feedback from the research team. Once both developers and researchers were satisfied with the application performance, the pilot version

was released to a small group of end users new to the application for use in real-world conditions before final release of the application to the target user community.

The DAT can be accessed on any device when connected to the internet. After registering and logging in, the parent answers 16 questions and then hands the device to the child who answers 6 questions. If the child is not capable of reading or using the device independently, the parent or another adult can help to input the answers. The parent and child responses are used to generate a prediction or “DistrEstimate” of the child’s level of distress for the upcoming procedure. The prediction is displayed on two side by side meters showing the child’s likely distress 1) when the parent provides the distraction and 2) when a trained professional provides the distraction (see Fig. 1). Embedded in the DAT is a 3-minute teaching video (link to <https://uichildrens.org/healthlibrary/helping-your-child-during-medical-procedures>) that we used to successfully train parents to be effective distraction coaches for their child. Then tailored instructions for providing distraction are generated from an algorithm based on answers to the questions about characteristics of the parent and child. Finally, parents are provided with links to computer applications suggested for distraction.

Parent Evaluation Questions

After the child’s procedure, parents were asked 12 yes-no questions (see Table 1), one open text question (for comments or suggestions), and a parent rating of the child’s actual distress during the IV insertion on a 1–7 Likert scale, anchored with not at all distressed to extremely distressed. In a phone follow-up, within 48 h, parents were asked seven open ended questions about their experiences with the DAT:

- What is your previous experience with your child and painful procedures?
- Tell me about your experience with using the iPad during your child’s recent procedure.
- What did you like best about it?
- What worked well for you and your child?
- What was difficult about it?
- What did not work for you and your child?
- Do you have any comments or suggestions for improvement?

Clinician Evaluation Questions

Clinicians who performed the procedure were asked five yes-no questions (see Table 2), one open-text question, and a clinician rating of the child’s actual distress during the procedure (using the iPad and same scale as the parents, described above.). They were also asked to verbally answer seven open-ended questions about their experiences with DAT:

- Tell me about your experience with the study family that used the iPad during procedure you did
- What did you like best about it?

- What was difficult about it?
- Was DistrEstimate 1, prediction of child's distress behavior with parent distraction, helpful? If yes how? If no, why not, how could it be better?
- Was DistrEstimate 2, prediction of child's distress behavior with professional distraction helpful? If yes how? If no, why not, how could it be better?
- How could this intervention be best be implemented in community settings?
- Do you have any comments or suggestions for improvement?

Procedure

This study was approved by the Institutional Review Board. English speaking parents of children between the ages of 4 and 10 who required an IV insertion or blood draw in the Emergency Department or Phlebotomy Laboratory were invited to participate. The study was explained at staff meetings and clinicians gave verbal consent to participate if they were involved in a child's procedure. Parents were compensated with \$50 if they completed the phone interview a week after the procedure. Clinical areas were each compensated \$500 for participation. After giving consent, the parent was handed an Apple® iPad® mini 2 (iPad) with the DAT program activated. One parent and the child answered the predictive questions, the parent watched the distraction coaching video and then DistrEstimates were shown to the parent and clinicians with instructions to decide together who would be the distraction coach for the child. Individualized coaching instructions, including suggestions for age appropriate games and apps were displayed on the iPad. After the procedure, the parent and the clinician completed the evaluation questions on the iPad. Brief interviews with a research assistant (RA) to answer questions about the experience with the DAT took place at the convenience of the participants in person after the evaluation or within 48 h by phone. Interviews were audio recorded, transcribed by an RA, and managed using N-Vivo software.

Analysis

Mixed methods were used to evaluate the feasibility and functionality of the DAT. Descriptive statistics were used to analyze quantitative data. Quantitative data were entered by parents and clinicians on the iPad, housed on the university's secure web server then exported to a formatted file for analysis with Excel software. Parent and clinicians questions consist of dichotomous questions (yes/no), which are presented as frequencies. Pearson product moment correlation coefficient (r) was used to measure the strength of relationships between variables and predictions on scatterplots. The r values were interpreted as not related (< 0.30), weak ($0.30-0.49$), moderate ($0.50-0.69$) or strong (> 0.70).

Descriptive qualitative content analysis was applied to qualitative data from the parent and provider interviews. Inductive content analyses were used to identify trends in meaning. With inductive analysis, the process includes open coding of the interviews, followed by the creation of categories and finally a general description or abstraction of the general meaning of the information (Elo & Kyngas, 2008). Themes were identified by the first author (KH) and reviewed and refined with two additional authors (CK, BJM) until a consensus was formed.

Results

Twenty guardians of children having venipunctures participated including: 16 (80%) mothers, 2 fathers, 1 grandmother, 1 unspecified guardian. The children were 11 boys and 9 girls with a mean age of 6.8 years (range 4–10). Two enrollments were in the ED and 18 were in the phlebotomy lab. The majority of the procedures were venipuncture. Clinicians performing 13 of the 20 procedures participated. Participants' responses were examined after the first five enrollments. Although problems in functionality were not noted by participants, research assistants identified minor edits for clarity. These edits were made and the feasibility study continued.

Five of the 20 parents chose to provide distraction to their children during the procedure; 15 asked for a professional distraction coach. Nineteen of the parents completed the evaluation electronically on the iPad within a few minutes after the child's procedure was completed. All five of the parents who chose to provide distraction to their child answered the evaluation questions. Most of the parents had a positive experience with the DAT. Three indicated that using the DAT was difficult, but there were no explanations about that concern or how to make it easier. The only suggestion for improvement was to use a sliding scale for the questions instead of a yes/no format. Table 1 includes the specific questions and answers.

Five themes emerged from the parent interviews (see Table 3). The primary theme was that distraction works to decrease child distress with medical procedures. Although parents had differing stories (some good and some bad) about their child's experiences with procedures, most attributed their child's response (positive or negative) to past experiences. A few parents reported difficulty getting their child's attention and that their child was just "not distractible." Parents also noted that sometimes clinicians interfered with the distraction by engaging in other procedural or non-procedural talk. Some parents liked having a trained professional provide distraction, because it freed the parent up to provide other support for the child.

Table 2 shows the evaluation answers from clinicians who were involved in 13 of the medical procedures. Clinicians felt that both DistrEstimates were helpful (100%). There were no suggestions for improving the DAT.

Interviews with the clinicians who performed 13 of the procedures revealed five themes (see Table 4). They reported distraction works for most children, but that it depends on other factors such as characteristics of the parent or child and, similar to what parents said, the child's previous experiences with procedures. Clinicians stated that distraction can help to make the procedure go better with less distress, less restraint and with fewer attempts. They found value in viewing the DistEstimates and used it for clinical decision making. Many of the clinicians requested to have an iPad for their area, so that they could continue to use it for providing distraction. Finally, clinicians discussed how they adjusted workflow to include DAT, but that it did not cause meaningful delays.

Further validation of DAT was demonstrated by comparing the predicted DistrEstimate with parent and clinician report after the procedure. For parents who provided distraction coaching for their child, the DistrEstimate was strongly correlated with parent ($r = 0.85$) and

clinician ($r = 0.98$) report of child distress (see Fig. 2). For children who had a trained professional provide distraction, the DistrEstimate was moderately correlated with parent report ($r = 0.53$) and strongly correlated with clinician report ($r = 0.75$) of child distress (see Fig. 3). There was strong agreement between the parent and clinician ratings of child distress ($r = 0.93$). By comparison, parent's prediction before the procedure of their child's distress and parents and the clinician's report of child distress with distraction coaching were moderately correlated (0.68 and 0.63 respectively).

Discussion

This feasibility and usability study affirms that the web-based DAT can be used successfully by parents to assess their children's risk for procedure related distress and learn distraction techniques to help their children during needle stick procedures. Clinicians who were new to the DAT found it to be a useful tool that with minor adjustments to their workflow could be incorporated into clinical routine. Although not the primary purpose, this study provided further validation of the DistrEstimates for predicting child risk for distress in a clinical setting. DistrEstimates proved to be more highly correlated with parent and clinician reported distress than parent predictions. This finding highlights the importance of DAT for clinical decision making. Clinicians need valid tools for assessing risk and planning interventions. Having tools to support clinical decision making (such as DAT to determine a child's risk for distress) is even more important when resources are scarce and need to be allocated appropriately.

One parent and child in this study particularly struck our attention (shown as child 5 in Fig. 2). The child's distress risk scores were the highest in our sample on both DistrEstimates (80.9 parent and 77.7% trained professional), yet the parent chose to be the distraction coach. Notably, this parent was the only participant who commented that the DAT video and instructions were not helpful, the iPad games did not help provide distraction and that the DAT did not help the parent participate as much as desired in the child's care. This was the most negative assessment of the DAT among all participants. The clinician in this case reported the parent was not able to provide distraction and that the distraction was not helpful to the child. Despite the use of a topical anesthetic, both parent and clinician reported the highest level of child's distress (7 of 7) after the procedure. In the interview, the mom described the child's previous experiences as "there's a lot of screaming" and "I have to hold him down usually". Unfortunately, this pattern of high distress contributing to future distress is common and exactly why early interventions that include pharmacologics such as topical anesthetics and distraction are so important for procedures in young children. In cases like this, distraction by a professional is warranted. If parents understand and are comfortable with acting as the distraction coach, despite the predicted high distress, clinicians should make all attempts to provide the environment and back up support to enable success without interfering. If the child has a high predicted distress and there are no trained professional distraction coaches available, clinicians and the parent need to collaborate and create a plan to meet the child's needs as best as possible prior to initiating the procedure.

We experienced problems enrolling participants in the ED. Due to the unplanned nature of ED encounters our RA was often not there to consent parents. For this intervention to work,

clinicians at the point of care need to be ready to implement when opportunities present. Another limitation was the small sample size. The sample size was not adequate to examine the influence of the situation. Although the generalizability of the findings is limited, the sample was adequate for our purpose of testing usability and feasibility of the DAT in clinical settings and identifying opportunities for improvement. Further testing in other settings and situations is needed.

Implications

Use of DAT is expected to: decrease child pain, anxiety, and distress with painful procedures; increase parent participation and decision making; and increase awareness of individual child risk for distress in order to increase procedural success and appropriate allocation of resources. Parents and clinicians can use the DAT to identify children at high risk for distress with procedures and engage the parent in a conversation about how to handle the situation. Before using this tool, some orientation and training is recommended. To address this need, our team developed an open access website (<https://uichildrens.org/distraction-in-action>) to house the web-based DAT and resources related to distraction for parents and professionals.

Recognizing that trained professionals, such as child life specialists, are not available at all times or in every setting, our research team's first priority was to put the DAT in the hands of parents who want to help their child during procedures. The decision was made to develop DAT for parents as our first product for general use. In this version, because trained professionals may not be available, parents see only one DistrEstimate for predicted child distress when a parent provides distraction. Parents are encouraged to show the DistrEstimate to healthcare professionals and discuss options. The DAT for parents is currently being disseminated via our open-access website (link to <https://uichildrens.org/distraction-in-action>) and is being promoted via traditional and social media. Web analytics demonstrate over 641 unique page views, with the most traffic from google (30%).

Dissemination and implementation of evidence-based interventions like the DAT in healthcare systems is more challenging. An assessment of the culture, needs, opportunities and barriers is important for determining strategies. A planned approach is needed for sustainability. Further research is planned to determine how distraction and use of DAT can best be disseminated and implemented in community healthcare settings.

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Fig. 1.
The DistrEstimate displays the child's risk for distress behavior based on predictive models.

Fig. 2.
Parent distraction coaches: DistrEstimate vs parent and clinician report.

Fig. 3.
Trained distraction coaches: DistrEstimate vs parent and clinician report.

Table 1

Parent evaluation questions answered on iPad right after the procedure.

Parent evaluation questions	Yes	No
1. Did you understand the video about helping your child by using distraction?	19	0
2. Did you understand the instructions about helping your child by using distraction?	19	0
3. In general, did you understand the questions?	18	1
4. Did using distraction help your child today?	18	1
5. Did you find using the DAT to be a positive experience?	17	2
6. Do you think the prediction of your child's level of distress was accurate?	16	3
7. Was using the DAT difficult for you?	3	16
8. Do you have any comment or suggestions for improvement?	1	18
9. Did using the DAT and distraction help you to participate (as much as you wanted to) in your child's care?	4 ^a	1
10. Did the video help you to provide distraction for your child?	4 ^a	1
11. Did the instructions help you to provide distraction for your child?	4 ^a	1
12. Did the iPad games help you to provide distraction for your child?	4 ^a	1

One of the parent participants did not answer any of these questions.

^aAnswers reported for parents who chose to be the distraction coach for this procedure.

Table 2

Clinician evaluation questions answered on iPad right after the procedure.

Clinician evaluation questions	Yes	No
1. Do you think DistrEstimate 1, the prediction of the child's distress with parent distraction, was helpful?	13	0
2. Do you think DistrEstimate 2, the prediction of the child's distress with trained professional, was helpful?	13	0
3. Was the use of distraction helpful?	11	2
4. Did using the iPad cause a meaningful delay in workflow?	1	12
5. Do you have any suggestions for improvement or comments?	0	13
6. Was the parent able to provide distraction?	3 ^a	1

^a4 of the 5 parents who provided distraction to their children were evaluated by a Clinician participant.

Table 3

Themes from evaluation interviews and supporting comments by parents.

Theme	Comment
1. Distraction works!	... she was very distracted and very focused on making cupcakes on the iPad. And she actually was telling people when we got home that that's what she did. She didn't talk about getting her blood drawn, she talked about playing on the iPad.
2. Previous experiences are mixed and those experience matter.	I mean we've kinda been in and out of the hospital so he has had like the needle pricks and the blood work done and stuff. So ummm, he - we've never had an issue with any pain he pretty used to it I guess. Um, I think the main thing was just because he knew. He had experienced that before so he knew what was coming. I think that had a lot to do with it, the reason why the iPad and that was not working.
3. Some children were not distractible.	No, he really didn't like to play the iPad a lot but I don't know if it was the game or just the idea he knew he was going to get poked again.
4. Trained professionals freed the parent up.	... what worked well on that was me being able to hold him and be there for him like emotionally and having somebody else distract him ...
5. Clinicians may interfere with distraction	... if more than one people talk at the same time, the child is gonna try to grab the attention of one or two at the same time so it was better only one person talk at the same time instead of trying to get his attention.

Table 4

Themes from evaluation interviews and supporting comments by clinician.

Theme	Comment
1. Distraction works, but it depends	... the child barely knew what was going on. He felt the poke but other than that, he wasn't, his anxiety level was very low compared to, I've drawn him before. ...so I think parents do a good job distracting kids most of the times.
2. It helped to know risk for distress	I think we kind of predicted that the patient would be in distress so we were a little prepared going into it. Yeah, it looked like they were about the same so I think she would have been fine with whatever she was going to have.
3. Needle stick procedures go better with distraction	...that they were happy; that they weren't crying or upset. They were, you know, just interested in that and it just helped a lot to make the blood draw go smooth.
4. We want an iPad for providing distraction	So if we could get one of those it would be cool.
5. We can adjust the workflow to make it work.	I think things are running pretty smooth. You guys seem to have your stuff together as far as like our work flow goes. So it doesn't seem to interrupt it. We can take kids ahead of them if we're still waiting. So I think we're doing well with all of that. I don't think there's been any real problems.