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Addressing Bullying Behavior in Pediatric Patients Using a Clinical Practice Guideline

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This is to certify that the doctoral study by

Barnitta Moses

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2019

Abstract

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MS, University of Maryland, 2009

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Project Submitted in Partial Fulfillment

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Abstract

Childhood bullying can lead to adverse physical and mental health outcomes for both the victim and the bully. Risk factors for bullying can be related to gender, race, sexual preference, and having any type of disability. A pediatric primary care clinic in a large, metropolitan area, the focus for this project, did not have an evidenced-based clinical practice guideline (CPG) for providers to facilitate the management of children who presented with reported bullying. The project, guided by the Tanner's integrated model of clinical judgement, addressed the question whether a CPG would facilitate the early recognition and treatment of bullying in the pediatric clinical site. Using a literature search, a CPG was developed with evidence that included 6 recommendations ranging from clinical assessment and screening to advocacy. The CPG was then evaluated by 4 expert panelists using the AGREE II tool. Panelists included 2 pediatric medical doctors, 1 pediatric school nurse, and 1 mental health nurse practitioner. The panel evaluation results revealed a score of 81 out of a possible 100, where a score of 71 was the standard for acceptable results for the 6 recommendations. Results from the expert panel were used to modify the CPG, after which the guideline was presented to the panel for final approval. One final recommendation of the panel was to include a provision for referral and follow up for children identified with bullying. The finalized CPG was presented to the medical director of the pediatric clinic for implementation. The implications of the project for positive social change include decreased variations in clinical practice, early detection and intervention of bullying, improved effectiveness and quality of care, and decreased costly and preventable adverse events.

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Dedication

I dedicate this project to my husband, Mannie Moses, and my children, Jennifer, Jackson, and Janine Moses. Without them, none of this would have meaning. I thank my family for always being in my corner. I would be remiss if I did not also give honor to my Lord and Savior, Jesus Christ.

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Section 1: Nature of the Project

Introduction

Childhood bullying is intentional aggressive behavior repeated over time and involves an imbalance in power (Bellmore, 2016). Surveys conducted at schools across the country have indicated that 48% of children report bullying is a problem, 40% have reported that they witnessed the behavior, and at least 10% are bullied on a regular basis (Leff & Feudtner, 2017). Since 2005, when the federal government started to collect data on school bullying, incidence rates for bullying have continued to rise to 35% for traditional bullying and 15% for cyberbullying (Modecki, Minchin, Harbaugh, Guerra, & Runions, 2014; U.S. Department of Education, 2015). The various forms of childhood bullying are associated with increased risk of suicide, poor physical health, anxiety, poor school performance, and future development of delinquent and aggressive behavior (Wolke, Copeland, Angold, & Costello, 2013). Therefore, childhood bullying is a significant public health issue with broad implications (Centers for Disease Control and Prevention [CDC], 2017; Tsitsika et al., 2014; Waseem et al., 2016). But healthcare providers can offset bullying by screening for bullying behavior during well-child examinations and visits that involve changes in the child's behavior. There is a need to screen children at risk for bullying or those whose complaints may suggest that they are victims of bullying (McClowry et al., 2017). Early management and referral for mental health services has been shown to decrease long-term consequences (Stephens, Cook-Fasano, & Sibbuluca, 2018).

A private pediatric clinic was the site for this project study. The pediatric office was located in a large metropolitan area and has two pediatricians and one pediatric nurse practitioner in the practice. According to a pediatric doctor at the site, the patient population was a mix of state-insured and privately-insured patients with a ratio of 60/40, and the total number of school-aged patients between the ages of 5 and 18 was approximately 3,000. Section 1 will cover the problem statement, the purpose, the nature of the project, significance of the project, and a summary.

Problem Statement

Bullying can be either physical or verbal and can be associated with life-long consequences. Boys have a tendency to use physical bullying or intimidation, regardless of the gender of their victims (American Academy of Child and Adolescent Psychology [AACAP], 2016). Bullying by girls is more often verbal, usually with another girl as the target (AACAP, 2016). Social networking sites, online chat rooms, and e-mail are ways that children are bullied (AACAP, 2016). Control or domination of others is usually the driving force behind bullying, and victims are often victims of bullying themselves (AACAP, 2016).

Bullying is associated with long-lasting health consequences, including increased susceptibility to viral illnesses, impaired appetite, abdominal pain, and sleep disorders (Stavrou et al., 2017). Bullying is also a risk factor for suicide (Kodish et al., 2016), which is the third leading cause of death in youth between the ages of 10 and 24, resulting in roughly 4,600 lives lost each year (CDC, 2017). Life-long effects of bullying are associated with high costs (Wolke, Copeland, Angold, & Costello, 2013). For

example, child victims of bullying are 12% more likely to live in poverty as adults (Wolke et al., 2013). Additionally, truancy due to bullying costs schools an estimated $21,600 per year in funding, and treatment for depression and/or obesity can be upwards of $170/month (McCool, 2015). But bullying prevention is associated with approximately $1.4 million cost savings over the course of a single lifetime (Wolke & Lereya, 2015). Therefore, an intervention in the pediatric primary care setting for this project was necessary. Although numerous studies have shown the effects of bullying, bullying activity, and interventions in school systems, little research has shown the role of the healthcare providers in prevention of bullying and what to do once bullying has been identified.

The need to develop clinical practice guidelines for the primary care setting helped to facilitate early identification and intervention (CDC, 2017; Committee on Youth Violence Prevention, 2009). Pediatric primary care providers should take an active role in prevention of violence (American Academy of Pediatrics [AAP], 1999; Waseem, et al., 2016). Developing evidenced-based clinical practice guidelines to address bullying in the pediatric primary care setting advances the field of nursing practice. Clinical practice guidelines can be used to translate evidence into practice with the goal of improving patient outcomes and promoting social change.

Purpose Statement

The purpose of the evidence-based project was to develop clinical practice guidelines that will standardize and facilitate early identification, screening, and proper management of bullying behaviors in the pediatric primary care setting. The practice-

focused question for the project is: Will the development of a clinical practice guideline with a plan for screening of children help to facilitate early identification and proper management of bullying behaviors in the pediatric primary care setting? This project addressed a gap in evidenced-based guidelines to clinical practice in a pediatric primary care setting. It is essential to bridge this gap so that children will have improved outcomes regarding bullying. Screening processes and procedures in the primary care setting can help to facilitate early identification and management.

Clinical practice guidelines are necessary to facilitate proper referrals for bullied children to improve their future physical and emotional health (Dale, Russell, & Wolke, 2014). Clinical practice guidelines were originally developed to guide clinical decision-making as healthcare professionals struggled to remain current with the growing body of scientific literature (Czaja & Carson, 2015). Clinical practice guidelines are recommendations for clinicians about the care of patients with specific conditions. In this case, they were developed to address childhood bullying behaviors in pediatric primary care. These guidelines are meant to align with the Doctor of Nursing Practice (DNP) scope of practice, guided by eight principles outlines in the Walden University College of Health Sciences School of Nursing (2015) handbook:

- describing the appropriate care based on the best available scientific evidence using a broad consensus;
- reducing inappropriate variations seen in practice;
- providing a rational basis for referral;
- providing a focus for the use of continuing education;

- promoting efficient use of resources;
- providing a focus for quality control to include audits;
- highlighting gaps seen in the existing literature; and
- suggesting appropriate areas for future research.

The guidelines can be adapted to each patient as determined by the healthcare provider and can decrease variations in clinical practice from provider to provider and help to facilitate early detection and interventions (Dale et al., 2014). It is the hope that these guidelines will also improve the effectiveness and quality of care given to children and decrease costly and preventable adverse events (Kredo et al., 2016). New evidence and best practices need to be incorporated into healthcare in a timely and efficient manner to address concerns (Institute of Medicine, 2011). Schools have had guidelines and programs to address bullying behavior; however, there are currently no clear, evidenced-based guidelines in pediatric primary care.

Nature of the Doctoral Project

Evidence was organized and analyzed based on a review of the evidence and the effective methods for screening for bullying in the literature and appropriate for use in the development of the evidence-based practice guideline. To aid in the development of the evidence-based practice guideline, the review of guidelines research and appraisal by AGREE II Instrument was used as a framework (AGREE, 2017). This instrument assesses the methodological rigor and transparency in which a guideline is developed. A multidisciplinary group of four healthcare experts from academic and specialty areas was

also used, including two pediatricians, one pediatric nurse, and one mental health nurse practitioner.

Significance

The primary stakeholders for this project include pediatric health care providers at the practicum site. These clinicians were chosen because they may help to facilitate evidenced-based approaches to the health and well-being of all children (Bellmore, 2016, McClowry et al., 2017). Other stakeholders are parents, third-party payers, schools. These stakeholders may benefit from the management of bullying behavior within the primary care pediatric setting. Bullying impacts, the mortality and morbidity of children and may influence outcomes across their lifespan (Bellmore, 2016). But the early identification and management in the primary care setting will reduce the burden on school officials to manage this issue (Bellmore, 2016; Boyko, Wathan, & Kothan, 2017). Reduction of childhood bullying may reduce the financial impact of truancy associated with bullying (Boyko et al., 2017; Tsitsike, 2014). Insurance third party payers may also have a personal investment to encourage early intervention in the hopes of reducing costs of mental health and medical care across the lifespan (Bellmore, 2016).

Summary

Section 1 included a discussion of the public health issue of childhood bullying and the need for clinical practice guidelines in pediatric primary care. There are no evidenced-based clinical guidelines for primary care regarding bullying despite the guidelines for schools and emergency rooms. An important first step in bridging this gap in practice requires those with school children who are victims and/or perpetrators of

bullying to review and accept current evidenced-based clinical practice guidelines for bullying behavior. These guidelines can empower healthcare professionals to take an active role in the early identification and management of children who are victims and/or perpetrators of bullying in primary care pediatrics. Section 2 of the doctoral project includes a description and rationale on the model and theories used for the project, relevance to nursing practice and local background, the role of the DNP student, and the role of the project team in relationship to the project.

Section 2: Background and Context

Introduction

Childhood bullying continues to be a significant public health issue and has implications for future health costs and overall health for individuals, their families, and society (Dale et al., 2014). Bullying is the deliberate physical or psychological abuse with the goal to cause suffering in another person (Dale et al., 2014). The purpose of this project was to address bullying behavior in pediatric primary care through the development of clinical practice guidelines. The practice-focused question for this DNP project is: Will the development of evidenced-based clinical practice guidelines help to facilitate screening, early identification, and proper management of bullying behaviors in the pediatric primary care setting?

Concepts, Models, and Theories

For this project, Tanner's (2006) theory of clinical judgement was used to inform the doctoral project, constructed around the premise of critical and clinical thinking and the refinement of nursing to clinical judgement, evidence-based practice, patient-centered care, and leadership. This theory encourages nursing to learn from a variety of disciplines like cognitive science, psychology, and higher education (Tanner, 2006). Tanner's (2006) theory provides language to describe how nurses think and was easily applied to development of clinical practice guidelines because it provides an algorithm for management and referral for victims and perpetrators of bullying through clinical judgment and thinking. Tanner's model of clinical judgement has often been used when teaching nursing students in simulation practices and requires various types of knowledge

that is theoretical, generalizable, and related to many situations (Tanner, 2006). The process from the theory includes four aspects: noticing, interpreting, responding, and reflecting (see Figure 1).

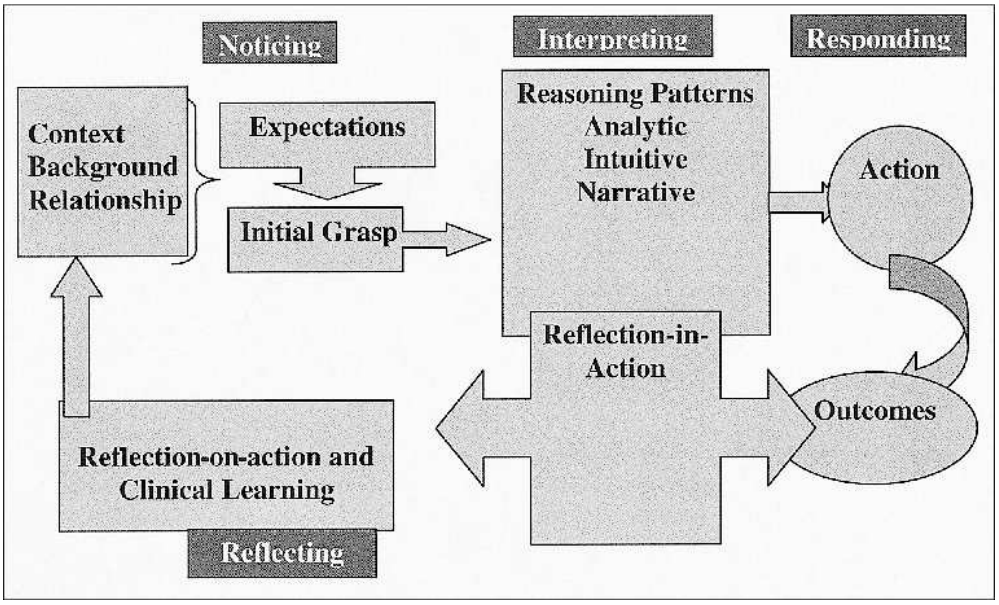

Figure 1. Tanner's integrative model of clinical judgement.

Relevance to Nursing Practice

Developing evidenced-based clinical practice guidelines to address bullying in the pediatric primary care setting advances the field of nursing practice because it decreases variations in clinical practice (Dale et al., 2014). The evidenced-based clinical practice guidelines facilitate early detection and intervention and improves the effectiveness and quality of care (Dale et al., 2014; Kredo et al., 2016). These evidenced-based clinical practice guidelines may decrease costly and preventable adverse events (Kredo et al., 2016). Some existing research in the area of childhood bullying are included in the next two sections.

Childhood Bullying and Suicide

Suicide is the third leading cause of death among U.S. youth and is responsible for the death of approximately 4, 000 adolescents per year (CDC, 2012; Kodish et al., 2016). About one-third of youth report involvement in bullying, and 10% of these youth have reported being victims (Kodish et al., 2016). Although the specific type of bullying is not always cited in studies, verbal harassment, physical aggression, and cyber bulling are related to increased suicide risk (Klomek, Marrocco, Kleinman, Schonfeld, & Gould, 2008; Kodish et al., 2016).

Bullying Prevention Programs and Screening

Due to the increase in suicidal ideation often related to bullying, many emergency rooms have become overwhelmed with psychiatric referrals for evaluation (Waseem et al., 2013). Because eemergency physicians often have to be the first responders in the health care system for bullying episodes, screening needs to happen quickly and efficiently to get these children into programs to assist them. It is also important to have tools to screen such as the Olweus Bully/Victim Questionnaire, the Peer Relations Questionnaire, and Personal Experiences Checklist (Kamppulainen, Rasanen, & Henttonen, 1999; Kodish et al., 2016; Rigby & Slee, 1991). Despite schools having many bullying programs in place, this problem continues to exist and there are still no clear guidelines for primary care. There is a need for schools, health services, and other organizations to organize their responses to bullying, and research is needed to appraise such interagency strategies and procedures (Dale et al., 2014).

Local Background and Context

Affecting about 13% of U.S. children, childhood bullying continues to be an expanding phenomenon (Tsitsika et al., 2014). Bullying varies by age group and country, but the commonality of the behavior is constant. With the significant role of technology, the emergence of cyber bullying is becoming the prevailing source of bullying (Tsitsika et al., 2014). Schools, health care providers, third-party payers, parents, and peers need to participate to find a way to reduce the incidence of this concerning public health problem. It is critical for pediatric providers to define their role and develop the necessary skills to address this threat effectively (AAP, 2009). Presently there are clinical guidelines for the emergency room and for schools have programs in place, but there are no clinical guidelines in place in primary care pediatrics (Dale et al., 2014). Evidence is still undeveloped for the role that primary care may play in determining the children involved in bullying and providing effective support (Dale et al., 2014). Evidence to inform policy, public health, and clinical guidelines is urgently required for health professionals to become more conscious of and equipped to confront the major risk to children's health.

Role of the DNP Student

The facility where the project took place was a busy pediatric clinic in Maryland. I am currently employed full-time as a pediatric nurse practitioner in the facility where the proposed project was implemented. I identified a number of children that were bullied; but, there are no standardized guidelines in this practice. The medical director also agrees to the lack of guidelines for pediatric primary care at this office. I provide primary care to pediatric patients from birth to age 21 years of age. As an employee of

this clinic, I had adequate access to the office to facilitate planning, development, and supervision of the proposed project with direct input from the expert panel. I had the following roles in the project:

Project Manager

- Identification of expert panel/advisory committee, contacted them via phone and/or email.
- Presented guideline to advisory committee to validate content using AGREE II instrument.
- Scored AGREE II instrument results from expert panel.
- Revised guidelines based on recommendations.
- Identified key stakeholders/end-users.
- Presented revised guideline to expert panel via email or hard copy and discussed to validate content and usability.
- Developed the final report.
- Distributed a final report to key stakeholders

Project Development

- Developed guidelines
- Revised clinical practice guidelines based on recommendations from panel

The motivation for this project was that I had a fair amount of children that reported that they are/were victims of bullying. Although schools have had guidelines in place for many years, the incidence of bullying continues to rise (Bellmore, 2016).

Advanced practice nurses have a responsibility to inform practice so that the mental health of these children is preserved once the incidence is resolved. I have seen them continue to suffer embarrassment, emotional problems, and many health problems as a result of these incidences and a passion to see this change is another purpose of this project.

Role of the Project Team

The project team consisted of the doctoral student as project manager and developer. There were four health care providers that served as the panel of experts: one pediatric nurse, two pediatricians, and one mental health nurse practitioner that reviewed guidelines for usability and validity using the AGREE tool. This group was contacted by email or direct phone prior to guideline review to ensure their participation. They were provided with the AGREE tool ahead of time to allow familiarity of the concepts included in the tool. The panel was given adequate time to review the completed guidelines and provide feedback to the author.

Summary

In Section 2, the doctoral project for addressing bullying behavior in pediatric primary care and development of clinical practice guidelines expounded on the framework that guided the DNP project. This project showed relevance to nursing practice, expounded on information on local background and context, and provided an explanation on the role of the DNP student and project team. The project will now expound on the connection to the gap in practice in section 3.

Section 3: Collection and Analysis of Evidence

Introduction

Pediatric providers have a significant role in the identification of children who are victims and/or perpetrators of bullying and a duty to refer them for proper services to decrease future psychological effects. Childhood bullying can be associated with increased risk of suicide, poor physical health, anxiety, poor school performance, and future development of delinquent and aggressive behavior (Wolke et al., 2013). Although the incidence of bullying varies by age and country, about 13% of children in the United States report some exposure to bullying behavior (Tsitsika et al., 2014). However, there are no clear guidelines for dealing with this public health problem in pediatric primary care (Dale et al., 2014). The purpose of this project was to encourage the early screen, identification, and management of victims and/or perpetrators of childhood bullying. Intended outcomes of the project include referral of children identified to the appropriate therapies and standardized the way childhood bullying was addressed in primary care pediatrics. Next, evidenced-based sources for the project was described and evidenced-based clinical practice guidelines were developed. The final area expanded on the analysis and synthesis of the data with integrity of the process of analysis.

Practice-Focused Question

This DNP project was intended to address the following practice-focused question: Will the development of a clinical practice guideline with a plan for screening of children help to facilitate early identification and proper management of bullying behaviors in the pediatric primary care setting? The practice-focused question and

purpose for the project was related to the incidence and prevalence of childhood bullying and the lack of evidenced-based clinical practice guidelines in primary care pediatrics. The office where this project was implemented reported increasing incidence of reports of bullying behavior across all patient age groups. I also noted an increase in the population of reports of bullying over that last 9 years with the last 2 years involving more cyber bullying cases (Hinduja & Patchin, 2018). Reports of suicide in schools due to bullying also increased the interest and need for clinical practice guidelines in this office, as none currently exist. Therefore, the DNP project was focused on the development of clinical practice guidelines to address bullying behavior in pediatric primary care, which may impact the rates of long-term effects from bullying (Wolke et al., 2013).

Sources of Evidence

The first source of evidence was from evidenced-based literature, which were summarized throughout Sections 1 and 2. The second source of evidence was the clinical guidelines previously developed for use in the emergency room for the early detection of bullying.

Published Literature

A comprehensive database search was completed electronically using PubMed, CINAHL Plus with Full Text, Ovid Nursing Journals Full Text, and Medline with Full Text to locate recommendations from peer-reviewed studies. I also searched Google scholar for possible articles. Search terms used were *childhood bullying, clinical practice guidelines, bullying and suicide, long-term effects of bullying, impact of bullying, cost of*

bullying, and *bullying behavior*. I used Boolean operators such as "or" and "and" to reduce the number of hits. Inclusion criteria were years of publication from 2014 to 2018 and English only with the exception of nursing model searches where the year was left blank.

Clinical Guidelines

To bridge the gap in practice contributing to the identified clinical practice problem, this project was focused on the development of evidenced-based clinical practice guidelines that can used in the primary care pediatric setting. Using a modified guideline from the emergency room, a guideline for primary care was developed. After the guideline was adapted, it was reviewed by the panel of experts and feedback was provided to me. The panel of experts evaluated the clinical practice guidelines for validity and usability using the AGREE II tool (Gene-Badia et al., 2016; Hoesing, 2016). A critical part of planning a program was to assure that the program goals and objectives were met. After the guideline was approved, I drafted the final product and prepared for implementation. Implementation is not a part of this DNP project but will be completed by the site. Because the guidelines were validated by the panel of experts, they can be used in the primary care setting (Gene-Badia et al., 2016; Hoesing, 2016).

I used the clinical practice guideline manual process:

- Developed evidence selection criteria:
- Description of system used for recording, tracking, organizing, and analyzing the evidence
- Outlined procedures used to assure evidence integrity

- Description of analysis procedures used to address practice-focused question
- Literature search
- Appraised the literature using Grading of Recommendations, Assessment, Development, and Evaluation (GRADE)
- Synthesized the evidence from literature
- Developed an evidenced-based clinical practice guidelines to address bullying in pediatric primary care.

Evidence Generated for Project

Participants. The participants for this project was the DNP student and the panel of experts that were responsible for reviewing the guidelines for usability and validity based on the AGREE II tool.

Procedures. The procedures of the proposed DNP project of addressing bullying behavior in the pediatric primary care setting began with obtaining a signed site agreement for permission for the project to be completed in the facility. The project team included the DNP student who acted as project manager and developer and the panel of experts which includes two pediatricians, one pediatric nurse, and one mental health nurse practitioner.

Protections. I adhered to the standards outlined in the Walden DNP Clinical Practice Guidelines Manual to reduce any prospective risks to human subjects partaking in the project. No data was collected from patients or patients' family members for this project type. Assurance that no sensitive material was disclosed. DNP projects adhering to the policies outlined in the DNP project manual meet the requirements for expedited

review by the Walden University IRB; therefore, I sought such a review upon final consent of the project proposal from the project chair and committee member. I used the site agreement of the project manual and was required to seek prior, written approval from the appropriate agency official where the proposed DNP project was executed. The DNP project was not implemented without final approval of the DNP project committee, and until such time Walden University IRB approval was received. Additionally, the Disclosure to Expert Panelist Form for Anonymous Questionnaires was administered and signed by each expert panelist before participation. The reviews of the panelists will remain anonymous and the facility name and exact location will not be disclosed.

Analysis and Synthesis

The clinical practice guideline was developed to create a standardized process for primary care providers to identify and manage instances of bullying behavior in the pediatric primary care setting. The AGREE II instrument was utilized to determine the effectiveness of the clinical practice guideline in meeting the criteria. This instrument was used to appraise the quality, usability, and thoroughness of the procedure used (AGREE Next Steps Consortium, 2017). The AGREE II instrument consisted of 23 items divided into six domains. Each item addressed the quality of each part of the clinical practice guidelines. It also contained two assessment sections that allowed the evaluator to offer final appraisal of the practice guideline (AGREE, 2017).

The AGREE II instrument was distributed to the panel members along with a copy of the clinical practice guidelines that was developed for the clinical site. The panel of experts provided their input in a printed copy of the AGREE II tool. I asked the panel

to place their results in a folder provided to them with the tool and the clinical practice guidelines and leave it at predesignated location at the clinical site. I collected the folders and individually collated the responses making adjustments to the clinical practice guidelines per the recommendations of the panel of experts.

Summary

Section 3 includes the doctoral proposal plan for collecting and analyzing the evidence with an identification for sources of the evidence, appropriate step by step description of how the evidence will be collected, attention to the specific participants, how the data will be measured, and ethical protection for the participants. Section 4 describes the process for developing the guidelines, will report on the findings, strengths, and implications that resulted from the analysis and synthesis along with the recommended solutions to address the gap-in-practice.

Section 4: Findings and Recommendations

Introduction

An evidenced-based bullying management guideline is lacking in the primary care pediatric clinic that was the focus for this project. This quality improvement project involves the development of a clinical practice guideline for its use in pediatric primary care. The purpose of this project was to provide this clinic with an evidenced-based bullying management guideline, so providers would have tools to guide their interventions and improve patient outcomes.

Findings and Implications

There are no published guidelines for management of bullying in pediatric primary care, so I used the recommendations of Connected Kids, the AAP (2009) primary care violence prevention protocol to develop these guidelines. Adherence to Connected Kids includes screening, counseling, appropriate and timely treatment, and referral for violence-related problems including bullying. The existing guideline for schools was also used to develop a guideline for pediatric primary care (see Albayrak, Vildiz, & Erol, 2015). In the developed recommendation, I encourage providers to use the Bullying Assessment Matrix, developed by the Bullying Prevention Advisory Group in New Zealand (Bullying Free NZ, 2019). This matrix can be used to assist providers' initial decision-making when bullying is reported. The tool can be used to assess the severity, frequency and impact of an incident, which allows the provider to develop an appropriate response using knowledge of the situation and make the appropriate follow-up and/or referral for additional resources.

The guideline in this project does not involve a particular validated bullying assessment tool; however, providers are encouraged to screen using the tool of their choice (see AAP, 2009; Kodish et al., 2016). A hierarchy of evidence for intervention studies adapted from the levels of evidence presented by the GRADE approach (Zhang, et al., 2017) was used to evaluate the strength of the evidence. The five levels of strength included in the hierarchy of evidence for intervention studies are as follows:

- Level 1: Systematic review and randomized control studies
- Level 2: Cohort studies
- Level 3: Case-centered studies
- Level 4: Case reports
- Level 5: Narrative review studies

The key recommendations that come from the literature review are provided in the following sections.

Disease/Condition

Childhood bullying is repeated intentional aggressive behavior that involves an imbalance in power (Bellmore, 2016). Childhood bullying is a significant public health issue (CDC, 2017; Tsitsika et al., 2014; Waseem et al., 2016), and bullying is a common experience for many children and adolescents. To help both victims of bullying and the bully, healthcare providers must take an active role in off-setting bullying by screening for bullying behavior during well-child examinations and visits that involve changes in the child's behavior.

Clinical Practice

Recommendation 1. Primary care is appropriate to identify and address bullying in children ages 6-18, as this is usually the first contact point (Dale et al., 2014). Primary care providers are encouraged to be trained to improve the evaluation of psychosocial risk factors in children to include childhood bullying (Dale et al., 2014) so they can identify bullying and provide the necessary care referrals. Providers are encouraged to develop a 5-7 item questionnaire from a validated tool to screen for bullying, which can be administered by the medical assistant to all patients ages 6-18 at well-child visits and any visit for emotional complaints. If bullying is reported, the provider should provide brief counseling to the patient and parent. This intervention should be documented in the patient record; based on a recommendation from one of the expert panel members, the diagnosis code for Adjustment disorder should be used. Providers should encourage the parent to communicate with teacher/administrative staff at the patient's school using the Bullying, Harassment or Intimidation Reporting Form. Providers should schedule a follow-up appointment to reassess the patient.

Recommendation 2. Pediatric providers are encouraged to become familiar with and to reference the Connected Kids: Safe, Strong, Secure primary care violence prevention protocol (AAP, 2009). Using this material, practices can integrate anticipatory guidance, screen for risk, and facilitate connections to community-based counseling and treatment resources. Providers may also use the Bullying Free NZ website as an assessment matrix to help guide care.

Recommendation 3. Providers need to have well-timed and appropriate treatment and/or referral for violence-related problems that are identified at any office visit (AAP, 2009; Abaza & Lu, 2017). Providers need to have a list of resources to include counseling and treatment centers in the community (AAP, 2009).

Advocacy

Recommendation 4. Providers should advocate for publicly supported community-based behavioral health services (Dale et al., 2014). Providers are encouraged to have on hand a list of preferred and/or known providers for mental health services

Recommendation 5. Providers should advocate for bullying awareness in schools by teachers, educational administrators, parents, and children. Providers should also be encouraged to follow an evidenced-based prevention program (Bellmore, 2016).

Recommendation 6. Providers should advocate for the inclusion of screening and prompts to screen, in electronic health records (AAP, 2009). Electronic medical records are required for use in all pediatric offices that participate in meaningful use and therefore will provide consistent documentation of all violence prevention education.

Education

Recommendation 7. Pediatric providers should strive to participate in continuing education opportunities through formal continuing education unit programs, web search for up-to-date community resources for children and adolescents, and elective courses, as required by state licensing agencies to remain current in recommendations for violence prevention.

Recommendation 8. Pediatric providers should advise patients and their parents of approaches to decrease emotional distress and to refer for counseling when appropriate (Abaza & Lu, 2017). Parents should be encouraged to openly communicate with their children about bullying. Providers need to encourage parents to take an active role in observing their children and encouraging involvement in positive school and community activities.

Research

Recommendation 9. Pediatric providers are encouraged to participate in practice-based research in the area of youth violence prevention (Abaza & Lu, 2017). Research is essential to the progression of medicine.

Recommendation 10. Providers are encouraged to advocate for legislation that mandates active local injury surveillance systems (AAP, 2018).

Intended Users

Intended users of the guideline include advanced practice nurses, registered nurses, physician assistants, pediatricians, and medical assistants working in a pediatric primary care clinic.

Outcomes

Expected outcomes of guideline implementation is to develop evidence-based, clinical practice guidelines for proper management of bullying behavior in the pediatric primary care setting, screening processes and procedures to facilitate early identification, and to develop procedures to facilitate early intervention and referrals.

Contribution of the Project Team

An expert panel was assembled for review of the final draft of the guideline. This panel included two pediatricians, a pediatric nurse, and a mental health nurse practitioner. The purpose of this project is to develop an evidenced-based bullying clinical practice guideline to be used in pediatric primary care clinics. The expert panel reviewed the clinical practice guidelines using the AGREE II tool. Domains 1 through 6 were reviewed and applied to the tool. Initial review of the guidelines. Under each domain all members of the team strongly agreed with the recommendations. Two members were unclear on the activities of the project team. I developed the guideline and used the members of the team as the expert panel. Once the role of the panel was explained, the panel members expressed full understanding. This project is fully supported by three members of the panel. One panel member wanted assurance that follow-up of those children identified as bullied would be done. One panel member wanted to be sure that the medical assistants would be fully involved and educated. This will occur during the dissemination of the project. The medical director and office manager of the pediatric clinic will review and support the guidelines prior to its implementation.

Table 1

Results of the AGREE Tool Provided by the Expert Panel

Domain	Expert 1	Expert 2	Expert 3	Expert 4
Domain 1				
Item 1	7	7	7	7
Item 2	7	7	7	7
Item 3	7	7	7	7
Domain 2				
Item 1	7	7	7	7
Item 2	7	7	7	7
Item 3	7	7	7	7
Domain 3				
Item 1	7	7	7	7
Item 2	7	7	7	7
Item 3	7	7	7	7
Item 4	7	7	7	7
Item 5	7	7	7	7
Item 6	7	7	7	7
Item 7	7	7	7	7
Item 8	7	7	7	7
Domain 4				
Item 1	7	7	7	7
Item 2	7	7	7	7
Item 3	7	7	7	7
Domain 5				
Item 1	7	7	7	7
Item 2	7	7	7	7
Item 3	7	7	7	7
Item 4	7	7	7	7
Domain 6				
Item 1	7	7	7	7
Item 2	7	7	7	7
Total	161	161	161	161

Note. Maximum possible score: 7(strongly agree) x 3 (items) x 4 (appraisers) = 81. Minimum possible score: 1 (strongly disagree) x 3(items) x 4 (appraisers) = 12. Results = 100%. Guidelines are considered high quality if they have domain scores greater than 70% (Brouwers, 2017).

Recommendations

I recommend that the clinic providers use the developed evidenced-based guideline to guide the management of children that meet the criteria for being bullied in the primary care pediatric setting. I recommend that the guideline move forward for approval by the governing bodies of the facility, that the providers and medical assistants be educated on its use, and that the results be monitored for 6-12 months to determine the effectiveness of the guideline. Prior to its use, staff will receive education with a recommended annual review to assess its continued use and understanding by staff. Education must address the need to overcome the long-term sequelae that can be associated with childhood bullying as evidenced by the literature. Additionally, members of the management should be included in the use of the guideline, and future self-confidence and ease amongst the guideline's users should be examined and assessed.

Guideline effectiveness should be measured at 3, 6, and 12 months after implementation for staff satisfaction, patient satisfaction with referral process through provider feedback, and future reports that bullying has resolved at subsequent follow-up visits. It is my hope that if successful, this guideline could be used across all clinics in the network.

Strengths and Limitations of the Project

The strengths of this project include the support of the medical director and management of the clinic where the project took place. The expert panel fully supports the created guideline and will be instrumental to its successful implementation. Provisions for financial support will be provided for education processes for

implementation by the facility. Full support will be provided by the medical director and eventually the director of community physicians group for implementation of this guideline. Limitations include no evidenced-based guideline in current use in the literature to serve as a guide to the planning and writing of this guideline.

All members of the expert panel fully supported this project using the AGREE II tool as a guide, after they were chosen. Expert panel, management, and medical director support were strengths of this project. Medical assistants also agreed that this is a worthy project and will serve the patients in the clinical setting.

Section 5: Dissemination Plan

Introduction

The plan for dissemination will begin with the introduction of the completed guideline to the providers currently working in the practice. This process will begin with a presentation on paper at a weekly provider meeting during the lunch hour where the office manager would be invited. The medical assistants would also be invited to attend for their enhanced knowledge on the subject of childhood bullying and what is being implemented as a practice to address this practice problem. Next, the guideline will be added to our practice/policy manual to be used as a reference. It is my hope that this could be incorporated into the anticipatory guidelines of our electronic medical record. To complete this, the guidelines would be presented to the forms committee of the governing institution. They could then be usable across the entire network.

This project could also be presented to other pediatric practices within the area during community physicians meetings, as this is problem that according to the literature most practices face. These guidelines could be adopted and amended for individual practices across the area if desired. In the future, these guidelines could be adopted for use by the AAP and the National Association of Pediatric Nurse Practitioners through a presentation at the national conference.

Analysis of Self

Through this process, I have learned about childhood bullying and the long lasting effects into adulthood that it could have on a person. I have also learned the evidenced-based process of writing clinical practice guidelines, which I have done for the first time

in my career. I learned that although childhood obesity has always been my passion, bullying has become even more so. Through talking about this subject with my patients and other medical providers, I learned that I have a passion for helping children to prevent the long-term effects of bullying. Through guidelines, patient outcomes can be improved.

This project has also caused me to self-reflect. For example, I have learned that I can be more patient than I once thought. I have also had to learn that there is always a more scholarly way to express my thoughts. I have gained self-confidence, knowledge, and comfort in expressing information on a topic. I have been asked to take a greater role in leadership in my current practice and have had a greater voice in the operation of the office. I believe that this project has given me that confidence to speak freely on a multitude of subjects related to pediatric care.

I hope that I will reach project completion in the next 2 months. I am sure there will be challenges to this process. Challenges that I have met so far are reflected in the project as mentioned. The general lack of evidenced-based guidelines is the major challenge. Another challenge will be getting providers to follow the proposed guidelines. Despite that fact that some form of bullying is in the media often, no formal guidelines have been developed. Being an active educator and continuing to discuss this worthy topic is a great way to overcome this challenge. I believe that continuing to discuss this topic often and reinforcing the use of the guideline within my practice will be the best way to address this practice problem.

Summary

Violence has become progressively evident in the lives of children in the United States. The rates of violence in the United States is the highest among the 26 affluent nations in the world, and it has one of the highest rates of homicide worldwide (AACAP, 2016). The use of evidenced-based clinical practice guidelines is recommended by large pediatric bodies such as the AAP, the CDC, the American Academy of Family Practitioners, and the AACAP; however, there are currently no evidenced-based guideline for use in the pediatric primary care clinics. But pediatric providers have an important role in the management of children who are victims and/or perpetrators of bullying and a duty to refer them for proper services to decrease effects related to increased risk of suicide, poor physical health, anxiety, poor school performance, and future aggressive behavior (Wolke et al., 2013). The use of an evidence-based clinical practice guideline for the management of childhood bullying in pediatric primary care can improve patient outcomes. This guideline will also improve the knowledge of pediatric providers and support staff on the importance of managing this threat to the health of children that can extend well into adulthood.

References

Abaza, W., & Lu, M. C. (2017, January 17). Protecting youth from bullying: The role of the pediatrician [Blog post]. Retrieved from https://www.stopbullying.gov

Albayrak, S., Zildiz, A., & Erol, S. (2016). Assessing the effect of school bullying prevention programs on reducing bullying. *Children and Youth Services Review, 6,* 1-8. doi:10.1016/j.childyouth.2016.02.005

American Academy of Child and Adolescent Psychology. (2016). Bullying. Retrieved from https://www.aacap.org/AACAP/Families_and_Youth/Facts for Families/FFF Guide/Bullying-080.aspx

American Academy of Pediatrics. (2009). Role of the pediatrician in youth violence prevention. *Pediatrics, 124*(1), 393-402. doi:10.1542/peds.2009-0943

AGREE Next Steps Consortium. (2017). The AGREE II Instrument [Electronic version]. Retrieved from http://www.agreetrust.org

Bellmore, A. (2016). Whose responsibility is it to stop bullying? *Policy Insights from Behavioral and Brain Sciences, 3*(1), 92-97. doi:10.1177/2372732215624218

Boyko, J. A., Wathen, C. N., & Kothari, A. (2017). Effectively engaging stakeholders and the public in developing violence prevention messages. *BMC Women's Health, 17*. doi:10.1186/s12905-017-0390-2Brouwers, A.D (2017). Failure and understanding within the entrepreneurial journalism. *Journal of Media Business Studies, 14*(3), 217-233. doi: 10.1080/16522354.2018.1445161

Bullying Free NZ (2019). Bullying assessment tool. Retrieved from

https://www.bullyingfree.nz/about-bullying-free-nz/

Centers for Disease Control and Prevention. (2017). Suicide among youth. Retrieved from https://www.cdc.gov/healthcommunication/toolstemplates/entertainment/tips/SuicideYouth.html

Czaja, M. T., & Carson, J. L. (2015). Improving clinical practice through the use of clinical practice guidelines. *ISBT Science Series, 10*, 73-78. doi:10.1111/voxs.12161

Dale, J., Russell, R., & Wolke, D. (2014). Intervening in primary care against childhood bullying: An increasingly pressing public health need. *Journal of The Royal Society of Medicine, 107*(6), 219-223. doi:10.1177/0141076814525071

Gené-Badia, J., Gallo, P., Caïs, J., Sánchez, E., Carrion C., . . Aymerich, M. (2016). *Gaceta Sanitaria, 30*(5), 345-351. doi: 10.1016/j.gaceta.2016.01.005

Hinduja, S., & Patchin, J. W. (2018). Cyberbullying fact sheet: Identification, prevention, and response. Retrieved from https://cyberbullying.org/Cyberbullying-Identification-Prevention-Response-2018.pdf

Hoesing, H. (2016). Clinical practice guidelines: Closing the gap between theory and practice. Retrieved from http://www.jointcommisioninternational.org

Kampulainen, K., Rasanen, E., & Henttonen, I. (1999). Children involved in bullying: Psychological disturbance and the persistence of the involvement. *Child Abuse and Neglect, 23*(12), 1253-1262. doi:10.1016/S0145-2134(99)00098-8

Klomek, A. B., Marrocco, F., Kleinman, M., Schonfeld, I. S., & Gould, M. S. (2008).

Peer victimization, depression and suicidality in adolescents. *Suicide and Life-Threatening Behavior, 38*(2), 166-180. doi:10.1521/suli.2008.38.2.166

Kodish, T., Herres, J., Shearer, A., Atte, T., Fein, J., & Diamond, G. (2016). Bullying, depression, and suicide risk in a pediatric primary care sample. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 37*(3), 241-246. doi.10.1027/0227-5910/a000378

Kredo, T., Bernhardsson, S., Machingaidze, S., Young, T., Louw, Q., Ochodo, E., & Grimmer, K. (2016). Guide to clinical practice guidelines: The current state of play. *International Journal for Quality in Health Care, 28*(1), 122-128. doi:10.1093/intqhc/mzv115

Leff, S., & Feudtner, C. (2017). Tackling bullying: Grounds for encouragement and sustained focus. *Pediatrics, 139*(6), e20170504. doi:10.1542/peds.2017-0504

McClowry, R. J., Miller, M. N., & Mills, G. D. (2017). What family physicians can do to combat bullying. *Journal of Family Practice, 66*(2), 82-89. doi:10.1016/s0300-7073(12)70023-3

Rigby, K., & Slee, P. T. (1991). Bullying among Australian children: Reported behavior and attitudes toward victims. *Journal of Social Psychology, 131*(5), 615-627. doi:10.1080/00224545

Stephens, M. M., Cook-Fasano, H. T., & Sibbaluca, K. (2018). Childhood bullying: Implications for physicians. *American Family Physician, 97*(3), 187-192. Retrieved from http://europepmc.org/abstract/med/29431974

Tanner, C. A. (2006). Thinking like a nurse: A research-based model of clinical

judgement in nursing. *Journal of Nursing Education, 45*(6), 204-211.

Tsitsika, A. K., Barlou, E., Andrie, E., Dimitropoulou, C., Tzavela, E. C., Janikian, M., & Tsolia, M. (2014). Bullying behaviors in children and adolescents: An ongoing story. *Frontiers in Public Health, 2*(7). doi:10.3389/fpubh.2014.00007

Walden University. (2015). Manual for clinical practice guideline development: Doctor of Nursing Practice. Retrieved from http://www.walden.edu

Waseem, M., Ryan, M., Foster, C. B., & Peterson, J. (2013). Assessment and management of bullied children in the emergency department. *Pediatric Emergency Care, 29*(3), 389-398. doi:10.1097/PEC.0b013e31828575d7

Wolke, D., Copeland, W. E., Angold, A., & Costello, E. J. (2013). Impact of bullying in childhood on adult health, wealth, crime, and social outcomes. *Psychological Science, 24*(10), 1958-1970. doi:10.1177/0956797613481608

Wolke, D., & Lereya, S. T. (2015). Long-term effects of bullying. *Archives of Disease in Childhood, 100*(9), 879-885. doi:10.1136/archdischild-2014-306667