

A Quality Improvement Initiative to Screen for Bullying in Pediatric Orthopedic Outpatient Clinics

Leslie A. Hoover, MS, RN, FNP-C; Jessica B. Holstine, MBOE, LSSBB; Jayme Williamson, MBA, RN; Julie B. Samora, MD, PhD, MPH

ABSTRACT

Background: Bullying annually affects 20%–25% of middle- and high-school children. Persistent bullying can lead to feelings of isolation, rejection, and despair and trigger depression and anxiety. In addition, pediatric patients have presented to outpatient orthopedic clinics with injuries consistent with physical bullying. Due to the high prevalence and negative ramifications of bullying, we developed a quality improvement (QI) initiative to screen for these behaviors. We aimed to increase the screening for bullying in pediatric orthopedic outpatient clinics from 0% to 60% by the end of 2020 and sustain these levels for 6 months. **Methods:** Using the Institute for Healthcare Improvement Model for Improvement QI methodology, including Plan-Do-Study-Act cycles, we developed a four-question yes/no screening tool that asked patients (ages 5–18) and parents/guardians about bullying experiences in the preceding 3 months. To increase screening rates, we trained staff, integrated the screening form into the electronic medical record, initiated interscreener competitions, and shared unblinded data with screeners. **Results:** The bullying screen rate of pediatric orthopedic patients increased from 0% to a process mean of 80%. In just over 1 year during the COVID-19 pandemic, clinics screened nearly 8,000 patients for bullying. Two percent of patients reported bullying in the prior 3 months. We offered patients who reported bullying literature and referrals to social work and/or behavioral health. **Conclusions:** Implementing a QI initiative to provide universal bullying screening and increase bullying awareness in outpatient pediatric orthopedic clinics is feasible and sustainable. (*Pediatr Qual Saf* 2023;8:e677; doi: 10.1097/pq9.000000000000677; Published online August 7, 2023.)

INTRODUCTION

Bullying annually affects 20%–25% of middle- and high-school students.^{1,2} Individuals with perceived differences, such as those with chronic illnesses or orthopedic conditions, are at higher risk for being bullied.^{3,4} Bullied children are likelier to have adverse health and psychosocial problems, such as depression, anxiety, poor general health, and suicidal ideation.^{2,5,6} Bullying experienced as a child or teen can

lead to long-term personal and economic consequences in adulthood.^{7,8} Despite awareness of the broad impact, bullying prevalence has not significantly decreased.¹

Healthcare professionals should identify children at risk for bullying to avoid long-term physical and mental health consequences. Bullied children and adolescents are at least two times more likely to have psychosomatic complaints, such as backache, headache, and abdominal pain, and 30% more likely to be injured than nonbullied peers.^{5,9,10} Although professional organizations and experts contend that pediatricians and primary care providers have an essential role in screening and identifying bullying,^{11–15} many primary care providers do not routinely screen for bullying,^{16–18} which may be due to the lack of validated and easily implemented screening instruments.^{18–20} Other screening barriers include the provider's lack of self-efficacy and negative attitudes regarding the importance of screening.¹⁶ To increase early bullying detection, nonprimary care providers have implemented opportunistic screening for bullying exposure in children with disabilities or injuries.²¹ Thus, screening for bullying in a pediatric orthopedic setting may be a logical opportunity.



From the Nationwide Children's Hospital, Center for Clinical Excellence, Columbus, Ohio.

*Corresponding author. Address: Leslie Hoover, MS, RN, FNP-C, 1924 Red Oak Lane, Lino Lakes, MN 55038
Email: lhoover11@yahoo.com
PH: 612-813-8172; Fax: 612-813-8710

Copyright © 2023 the Author(s). Published by Wolters Kluwer Health, Inc. This is an open-access article distributed under the terms of the Creative Commons Attribution-Non Commercial-No Derivatives License 4.0 (CCBY-NC-ND), where it is permissible to download and share the work provided it is properly cited. The work cannot be changed in any way or used commercially without permission from the journal.

To cite: Hoover LA, Holstine JB, Williamson J, Samora JB. A Quality Improvement Initiative to Screen for Bullying in Pediatric Orthopedic Outpatient Clinics. *Pediatr Qual Saf* 2023;8:e677.

Received for publication November 16, 2022; Accepted July 6, 2023.

Published online August 7, 2023

DOI: 10.1097/pq9.000000000000677

This project aimed to increase the screening for bullying in outpatient pediatric orthopedic clinics in patients 5–18 years from 0% to 60% by the end of 2020 and sustain this level for 6 months. An additional goal of this project was to raise bullying awareness and prompt intervention when a positive screening response was detected.

METHODS

The Department of Orthopedics has more than 36,000 annual outpatient encounters completed by 12 orthopedic surgeons and 11 advanced practice providers at eight locations as part of one large, urban academic center. On average, providers encounter 15–60 patients per day ranging in age from newborn to 18+ years. Patient visits occur every 10–15 minutes, but a patient may be in the clinic for an hour or more.

During each patient visit, clinic staff register patients, and orthopedic technicians or athletic trainers place them in rooms. Before provider evaluation and management, radiology technicians may take radiographs of patients. Patients may see an orthopedic technician again after the provider evaluation for durable medical equipment or immobilization needs. Finally, patients interact with a nurse or athletic trainer for education and discharge. Clinic staff may also consult a social worker or psychologist by phone during or up to several days after the encounter.

Members from orthopedics—nurses, advanced practice providers, technicians, surgeons, and clinic management—and members from behavioral health, school health, social work, and a Quality Improvement (QI) specialist collaborated to create a multidisciplinary QI team. Using an affinity diagram, the team identified several key drivers, including the need for an efficient, evidenced-based bullying screening tool, clinic resources to provide screening, and support for patients with positive screens (Fig. 1). As a QI initiative, this project was exempt from IRB approval.

After an extensive literature review, the team agreed to use the Centers for Disease Control and Prevention’s (CDC) widely accepted definition of bullying: “Any unwanted aggressive behavior(s) by another youth or group of youths, who are not siblings or current dating partners, that involves an observed or perceived power imbalance, and is repeated multiple times or is highly likely to be repeated. Bullying may inflict harm or distress on the targeted youth, including physical, psychological, social, or educational harm.”²² The widespread prevalence and detrimental consequences of bullying made this project a vital undertaking despite the scope being outside the primary functions of orthopedic care.^{1,2,5–8} However, because our patients have reported injuries from being deliberately pushed or tripped at school, orthopedic providers and clinic leaders readily supported the project, provided clinic flow, and visit times remained the same.

Bullying Screening for Pediatric Orthopedic Patients

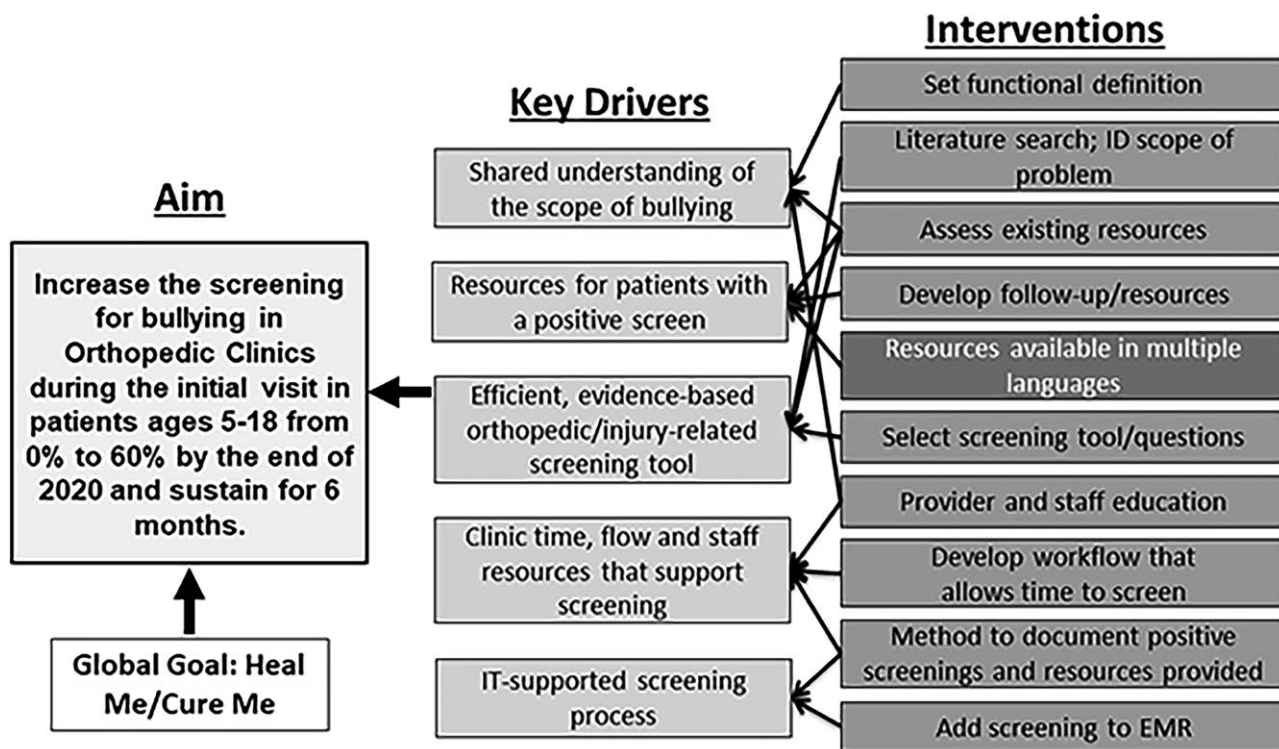


Fig. 1. Key driver diagram for bullying screening for pediatric orthopedic patients.

Orthopedic clinic providers saw patients weekly for fracture or wound management; however, only patients between 5 and 18 years old, had a new orthopedic problem, and had not been screened within the past year were screened. The reason for the visit (eg, injury or chronic condition) was not a consideration. Previously available screening tools were lengthy and not validated for all ages. Using the CDC’s definition as a framework and the American Academy of Pediatrics’ guidelines *Connected Kids: Clinical Guide*²³ and *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*,²⁴ key team members from multiple specialties developed a four-question yes/no screening tool (Table 1). Questions inquired about bullying experiences in the previous 3 months to focus resources and support on bullied patients rather than capturing patients’ entire bullying histories. Patients and parents/guardians could decline the screening, and their orthopedic visit would continue as before instituting the bullying screening. For all patients and parents/guardians who consented to screening, the screening occurred with the patient and parent/guardian in the room.

The QI team created a process map to determine when to screen patients. We considered whether patients could complete the screening before or during their visit or if clinic staff should help complete the screening. Due to varying patient ages, reading levels, and the need for interpreters, we determined that clinic staff should screen patients verbally during the visit. Since patients were already asked about hospital-wide standard safety questions and social determinants of health when roomed, adding the bullying screening to this process was logical.

The first Plan-Do-Study-Act (PDSA) began with two providers asking screening questions and completing a paper screening form for several weeks. As a result,

team members adjusted questions and created a script for a short yet consistent introduction to bullying screening. After standardizing the script, staff personnel who roomed patients took on the screener role. Three separate clinics launched screenings in September 2020, and all clinics were screening patients for bullying by December 2020. Each clinic had a designated launch day when project team members held a brief, in-person meeting to review expectations before starting the clinic. Screeners independently determined if patients were appropriate to screen based on age and visit type. Staff submitted completed paper screening forms weekly to the team’s QI specialist for data aggregation and analysis. Initial screening percentages were low, and the team needed greater engagement from the screeners. We initiated a gift card competition from November 2020 until March 2021 to maximize screening. Project leaders awarded \$20–\$25 gift cards to the two screeners who screened the highest percentage of eligible patients every 2 weeks. Sharing unblinded data with the screeners about their screening percentages with their colleagues also increased the number of patients screened.

Once the paper version of the screening tool was deemed appropriate, IT experts built the questions as a specialty form within the electronic medical record (EMR) to enable easy use, improve data collection and analysis, and allow users to view previous responses. The test of change cycles identified that screeners had difficulty remembering to perform the screening without the paper forms as a visual reminder. As a result, IT personnel added a best practice advisory (BPA) in the EMR to alert screeners of patients who met the screening criteria. This advisory helped to capture all eligible patients by prompting screeners to complete the specialty form.

If a patient had a positive screen, the clinic staff notified the clinic nurse. The nurse discussed the resources available with the family and patient, and together with clinic provider input, they determined what would be most beneficial. Intervention handouts included: *10 Tips to Teach Your Kids to Combat Bullying*, *Bullying: Info for Parents*, and *Bullying: It’s Not OK*.^{25–27} The nurse, in conjunction with the clinic provider, referred patients to social work or behavioral health when appropriate. Clinic nurses documented handouts and referrals they provided, initially on the paper screening tool and then in the EMR.

The project’s outcome measure was the percentage of bullying screenings completed by eligible patients. We used a statistical process control p-chart to track biweekly and monthly progress. Since this process did not previously exist, the baseline was 0%, and we implemented multiple interventions and tracked over time to the target percentage of 60%. Process measures included the percentages of resources provided and referrals made for patients. Qualitative measurements included patient and family feedback. In addition, screeners, providers, and clinic management monitored the impact on clinic flow

Table 1. Four-question Bullying Screening Tool

	Question	Answer/Intervention
1	Patient: In the past 3 mo, have you been in any pushing or shoving fights with a kid who does not live with you?	<input type="checkbox"/> No <input type="checkbox"/> Yes—Provide Bullying Helping Hand AND Bullying: It’s Not Okay
2	Patient: In the past 3 mo, have you been afraid of being hurt by any other kids?	<input type="checkbox"/> No <input type="checkbox"/> Yes—Provide Bullying Helping Hand AND Bullying: It’s Not Okay
3	Patient: In the past 3 mo, have you been bullied in person or online by any kids who do not live with you?	<input type="checkbox"/> No <input type="checkbox"/> Yes—Provide Bullying Helping Hand AND Bullying: It’s Not Okay
4	Parent: In the past 3 mo, do you believe your child has been picked on by another child outside of your home? RN/PROVIDER: Would patient benefit from a referral for bullying (related to being upset or injured by a bully?)	<input type="checkbox"/> No <input type="checkbox"/> Yes—Provide 10 Tips to Combat Bullying, Bullying Helping Hand AND Bullying: It’s Not Okay <input type="checkbox"/> No <input type="checkbox"/> Yes—Social Work (for help reporting an injury or finding additional support) AND/OR Behavioral Health (for coping with emotional and social impacts)

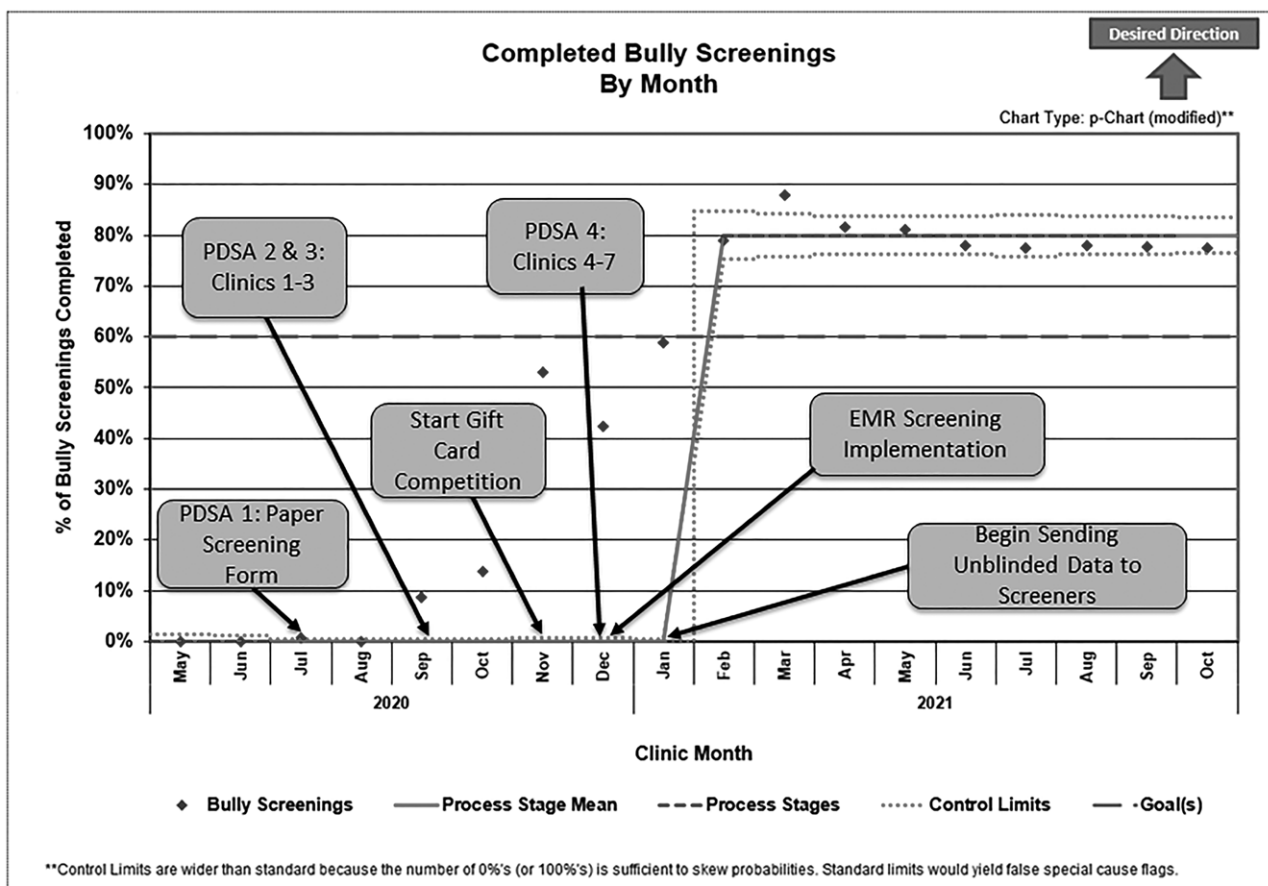
and visit times with verbal check-ins throughout the project. The volume of patients seen in clinics and the length of time to complete clinics remained consistent throughout the project.

The three interventions that increased the screening rate were the gift card competition, the transition from paper-based screening to the electronic specialty form with BPA reminder, and sending of comparison data to screeners. After implementing the gift card competition, we detected a large increase in screening rates compared to the prior month. Eliminating paper screening and creating the EMR specialty form and BPA increased screening rates since they removed the screener’s need to determine patient eligibility. Sending comparison data to screeners likely increased perceived friendly competition among screeners. In addition, we privately approached individuals with low screening volume or with large percentages of patients who declined screening to discuss their concerns and limitations. Finally, we retrained two screeners who recorded the patient/family’s “no” response to bullying as “declines screening.”

RESULTS

Between July 2020 and October 2021, the orthopedic clinic staff screened 7,939 patients for bullying. The initial monthly screening rate for three clinics was 8.7%, which increased to 52.9% after initiating the gift card competition in November 2020. During PDSA 4, with the rollout to four clinics and electronic screening implementation, the capture rate of eligible patients declined to 42.2%. In February 2021, clinics screened 78.8% of eligible patients and did not institute any further interventions. Following high screening volumes, the process mean shifted to 80% in October 2021 (Fig. 2).

As of October 2021, 2% of patients and families reported bullying experiences in the previous 3 months. These reports came from patients/families who responded positively to any one question (Table 2). Not quite half of those who reported bullying received handout resources, while fewer requested or agreed to referrals to behavioral health or social work. Fifty-six percent of patients screened were male, with a 2.25% positivity rate. Elementary school-aged children had higher positivity rates than



Screenings	0	0	6	0	80	131	287	185	357	503	706	841	828	809	662	800	811	933
Patient Opportunities	100	150	776	826	922	957	542	438	608	638	803	1030	1020	1038	855	1027	1042	1205

Fig. 2. P-chart of completed bullying screenings by month.

Table 2. Patients Reporting Bullying Experiences

Month	No. Positive Screenings (Answered “Yes” to any Question)	Total No. Encounters
2020		
July	1	776
August	0	826
September	8	922
October	8	957
November	13	542
December	7	438
2021		
January	5	608
February	11	638
March	17	803
April	10	1,030
May	27	1,021
June	19	1,038
July	7	855
August	6	1,027
September	9	1,042
October	13	1,205
Grand total	161	13,728

Table 3. Positive Screenings by Age

Age	Positive Screenings	Percent
5–6	5	1.16
6–7	15	2.95
7–8	17	3.05
8–9	18	3.38
9–10	19	3.05
10–11	22	3.17
11–12	12	1.66
12–13	18	2.33
13–14	13	1.63
14–15	15	1.97
15–16	4	0.66
16–17	1	0.24
17–18	2	0.53

middle- or high-school children (Table 3). Racial groups with greater than 100 positive responses were not statistically different in positive screening rates. Qualitative outcomes included parents or guardians learning about online bullying or learning for the first time that their child was bullied. Staff recorded responses such as “Mother found out at this appointment that [child] was pushed down at school” and “Mom had no idea of bullying.”

DISCUSSION

Using QI methodology, a multidisciplinary team implemented a new screening process for bullying in pediatric orthopedic clinics at a large tertiary children’s hospital. Bullying is highly prevalent and may have short- and long-term negative implications. Despite school districts implementing antibullying programs across the United States over the past several decades, bullying has remained at 20%–25% nationally.^{1,28} Healthcare providers and school personnel have been unable to identify young children at risk for adverse sequelae before developing pronounced symptomatology.¹⁷ This secondary prevention QI project raised awareness about bullying by uniformly screening patients and parents/guardians during an orthopedic outpatient clinic visit and connecting families to resources in a time-sensitive manner.

We found an overall 2% rate (161 positive responses/7,939 surveyed) of bullying experiences in the preceding 3 months for orthopedic patients ages 5–18, below national averages.^{1,2} In contrast, Carrillo et al. reported that bullying among pediatric orthopedic patients was 39%.³ Different analysis timeframes and study designs can explain the reasons for this discrepancy. Our QI study evaluated bullying three months before the clinic visit in children ages 5–18, whereas many national averages are annual rates for children ages 12–18. The Carrillo et al. study surveyed patients over 5 months, resulting in fewer participants (N = 198 compared to N = 7,939) and a smaller age range (10–17). In this study, patients completed paper-based questionnaires, including the Child Adolescent Bullying Scale-9 questionnaire and questions about demographics, orthopedic devices, and attitudes toward orthopedic devices. Parents also completed a paper-based questionnaire covering multiple topics. Patients and families who experienced bullying may be more likely to complete longer questionnaires and opt-in to a study than patients/families who did not perceive bullying.

Clinic staff in our QI project asked all patients and families presenting with a new orthopedic problem that had not been screened in the past year four bullying screening questions during the rooming process. Patients/families had the option to decline or opt-out. Staff asked questions verbally in the presence of parents, guardians, caregivers, and/or siblings. Children may be less likely to report bullying in the presence of others. Screening patients using an opt-out process in a format that was not anonymous may have resulted in overall lower rates of reporting. Since staff administered screenings, the data captured depended on their comfort with screening and their ability to ask questions and document responses. Finally, clinic nurses documented that they provided handouts to less than half of the patients with positive screens. This number may be low because clinic staff did not notify clinic nurses of positive screens, nurses did not document they provided handouts, or patients declined handouts. Additional staff and nurse training could increase screening rates, increase positive responses, and ensure additional families accessed resources.

Prior studies have found that older children and males are less likely to report bullying, with middle- and high-school children demonstrating lower positivity rates than elementary-aged children.¹ In our study, genders with positive screens were not statistically different ($P = 0.110$). However, different age groups were statistically different in positive screenings: 5 to <11 and 15 + ($P < 0.001$, 95% CI: 1.76–3.07) and between age groups 11 to <15 and 15 + ($P < 0.001$, 95% CI: 0.85–2.03) (Table 3). Children in the 5 to <11 age group reported the highest rates of bullying, followed by the 11 to <15 age group and 15+ age group. This finding may be because older children are less likely to report bullying.^{1,28} The rates of bullying among racial groups with large numbers of screenings

were not statistically significant ($P = 0.056$). Given that many patients presenting to the orthopedic clinic have injuries, orthopedic patients may be more likely to have experienced physical bullying than other types. However, we did not find this to be the case, as rates of physical bullying (eg, pushing/shoving fights; 0.9%) were similar to other types of bullying asked in our screening.

Since professional organizations and bullying researchers recommend pediatric healthcare providers ask children starting at age six about bullying rather than use a lengthy form,^{13,24,29} we developed a short four-question screening tool. We used the CDCs definition of bullying and revised it several times. However, we did not test for reliability or validity. Further testing and development of the screening tool in future PDSA cycles could improve positive capture rates and demonstrate a local prevalence more consistent with nationally observed bullying averages.

Although our institution supports and encourages QI initiatives, similar resources may not be available at other institutions. Patients and families where English or Spanish was not the primary language did not receive written resources. Attempts to create resources in languages other than English and Spanish were initially cost-prohibitive. This QI project was also implemented during COVID-19, when many children may have attended school virtually or had limited to no extracurricular activities, reducing possible interactions with other children. Indeed, some clinic staff and patient families questioned the relevance of bullying screening during this time. In response, we provided education about online bullying, which accounts for 15.7% of bullying nationally.¹ One question addressed in-person and online bullying; therefore, we could not determine if COVID-19 contributed to overall bullying rates or types of bullying experienced. Since screenings are ongoing, examining bullying experiences during subsequent years could provide comparison data.

CONCLUDING SUMMARY

Implementing a QI initiative to provide universal bullying screening and increase bullying awareness in outpatient pediatric orthopedic clinics is feasible and sustainable. This QI project resulted in nearly 8,000 screenings in just over one year. This project answered a national call for healthcare professionals and community members to combat bullying by asking about bullying. Since clinic staff universally applied this brief screening tool, it did not negatively impact clinic flow or result in the self-selection of positive individuals. Clinic staff provided patients with positive screens with literature and appropriate referrals. Bullying screening continues in our pediatric orthopedic clinics to raise awareness of bullying and connect families to resources.

ACKNOWLEDGEMENTS

The authors express their gratitude to Courtney Bishop, PA-C, Roxanne Demarest, PA-C, Kathy Fisher, RN,

Melissa Brown, Terry Hennessy, and the numerous advanced practice providers, nurses, orthopedic technicians, and athletic trainers who implemented this project—additional appreciation to Dr. Melody Davis and Dr. Beth Reichard for their contributions to this manuscript. The project sponsor/senior author contributed to the gift card competition.

DISCLOSURE

The authors have no financial interest to declare in relation to the content of this article.

REFERENCES

- Basile KC, Clayton HB, DeGue S, et al. Interpersonal violence victimization among high school students—youth risk behavior survey, United States 2019. *MMWR Suppl.* 2020;69:28–37. 10.15585/mmwr.su6901a4.
- Hamm MP, Newton AS, Chisholm A, et al. Prevalence and effect of cyberbullying on children and young people: a scoping review of social media studies. *JAMA Pediatr.* 2015;169:770–777. 10.1001/jamapediatrics.2015.0944.
- Carrillo LA, Sabatini CS, Brar RK, et al. The prevalence of bullying among pediatric orthopaedic patients. *J Pediatr Orthop.* 2021;41:463–466. 10.1097/BPO.0000000000001911.
- Blake JJ, Lund EM, Zhou Q, et al. National prevalence rates of bully victimization among students with disabilities in the United States. *Sch Psychol Q.* 2012;27:210–222. 10.1037/spq0000008.
- Moore SE, Norman RE, Suetani S, et al. Consequences of bullying victimization in childhood and adolescence: a systematic review and meta-analysis. *World J Psychiatry.* 2017;7:60–76. 10.5498/wjp.v7.i1.60.
- Hutson E. Integrative review of qualitative research on the emotional experience of bullying victimization in youth. *J Sch Nurs.* 2018;34:51–59. 10.1177/1059840517740192.
- Arseneault L. The long-term impact of bullying victimization on mental health. *World Psychiatry.* 2017;16:27–28. 10.1002/wps.20399.
- Jadambaa A, Brain D, Pacella R, et al. The economic cost of child and adolescent bullying in Australia. *J Am Acad Child Adolesc Psychiatry.* 2021;60:367–376. 10.1016/j.jaac.2020.05.010.
- Gini G, Pozzoli T. Bullied children and psychosomatic problems: a meta-analysis. *Pediatrics.* 2013;132:720–729. 10.1542/peds.2013-0614.
- Nansel TR, Overpeck M, Pilla RS, et al. Bullying behaviors among US youth: prevalence and association with psychosocial adjustment. *JAMA.* 2001;285:2094–2100. 10.1001/jama.285.16.2094.
- Lyznicki JM, McCaffree MA, Robinowitz CB. Childhood bullying: Implications for physicians. *Am Fam Physician.* 2004;70:1723–1728.
- Hickner J. It's time to screen for bullying. *J Fam Pract.* 2017;66:66.
- Committee on Injury, Violence, and Poison Prevention. Policy statement—role of the pediatrician in youth violence prevention. *Pediatrics.* 2009;124:393–402.
- Stephens MM, Cook-Fasano HT, Sibbaluca K. Childhood bullying: Implications for physicians. *Am Fam Physician.* 2018;97:187–192.
- McClowry RJ, Miller MN, Mills GD. What family physicians can do to combat bullying. *J Fam Pract.* 2017;66:82–89.
- Hutson E, Melnyk B, Hensley V, et al. Childhood bullying: Screening and intervening practices of pediatric primary care providers. *J Pediatr Health Care.* 2019;33:e39–e45. 10.1016/j.pedhc.2019.07.003.
- Vessey JA, DiFazio RL, Strout TD. Youth bullying: a review of the science and call to action. *Nurs Outlook.* 2013;61:337–345. 10.1016/j.outlook.2013.04.011.
- DiFazio RL, Strout TD, Vessey JA, et al. Item generation and content validity of the child-adolescent bullying scale. *Nursing Res.* 2018;67:294–304. 10.1097/NNR.0000000000000283.
- Hamburger M, Basile KC, Vivolo AM. *Measuring bullying victimization, perpetration, and bystander experiences: A compendium of assessment tools.* National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention; 2011.

20. Vessey J, Strout TD, DiFazio RL, et al. Measuring the youth bullying experience: a systematic review of the psychometric properties of available instruments. *J Sch Health*. 2014;84:819–843.
21. Seltzer M, Menoch M, Chen C. Opportunistic screening for exposure to bullying in the pediatric emergency department. *Glob Pediatr Health*. 2017;4: 2333794X17714377
22. Gladden RM, Vivolo-Kantor AM, Hamburger ME, Lumpkin CD. *Bullying surveillance among youths: Uniform definitions for public health and recommended data elements, version 1.0*. National Center for Injury Prevention and Control; 2014.
23. American Academy of Pediatrics. *Connected Kids: Safe, Strong, Secure Clinical Guide*. Spivak H, Sege R, Flanigan , E, et al. eds. American Academy of Pediatrics; 2006.
24. Hagan J, Shaw J, Duncan P. eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents [pocket guide]*. 4th ed. American Academy of Pediatrics; 2017.
25. Nationwide Children’s Hospital. *Bullying: Information for parents*. [Nationwide Children’s Hospital Web Site]; 2020. Available at: <https://www.nationwidechildrens.org/family-resources-education/health-wellness-and-safety-resources/helping-hands>. Accessed August 26, 2020.
26. American Academy of Pediatrics. *Bullying: It’s not OK*. [American Academy of Pediatrics Web site]; 2018. Available at: <https://patiented.solutions.aap.org>. Accessed July 14, 2020.
27. Nationwide Children’s Hospital. *10 tips to teach your kids how to combat bullying*. [Handout]. Nationwide Children’s Hospital; 2017.
28. Wang K, Chen Y, Zhang J, Oudekerk B. *Indicators of school crime and safety: 2019*. NCES 2020-063/NCJ 254485. National Center for Education Statistics; 2020.
29. Hensley V. Childhood bullying: a review and implications for health care professionals. *Nurs Clin North Am*. 2013;48:203–213. 10.1016/j.cnur.2013.01.014.