

Abstracts from the 15th National Neonatal Nurses Conference and 18th National Mother Baby Nurses Conference Orlando FL, September 17–19, 2015

These abstracts represent a broad range of neonatal and perinatal issues. By sharing this information, we hope to increase awareness of research and innovative programs within the perinatal health care community, and support evidence-based nursing practice. Some abstracts have been edited for publication.

Disclosure

Unless otherwise noted, these presenters disclose no relevant financial interests or affiliations with any commercial interest.

The Use of Umbilical Cord Blood in the Detection of Neonatal Sepsis

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Sepsis is a significant source of neonatal mortality and morbidity therefore; rapid and accurate evaluation of neonatal sepsis is a critical step in the management of the newborn suspected of sepsis (Polin et al., 1981). Studies indicate that umbilical cord blood (UCB) is a safe and effective alternative to peripheral venous infant blood (PVIB) in sepsis evaluation. The purpose of this report is to provide evidence-based research on umbilical blood draws, as a method for UCB collection. Traditionally, complete blood counts (CBC's) and blood cultures (BC's) are drawn from a neonatal venous site. An exhaustive electronic literature search was performed to obtain evidence to answer the clinically pertinent query: In the neonate suspected of sepsis, how does drawing blood from the umbilical vein compared to usual neonatal venous draw, influence the need for policy and procedural change regarding the evaluation of sepsis? Contributions of this study include a synthesis of the evidence, evidence-based practice (EBP) model and a conceptual framework model. These contributions aid in the development of evidence-based interventions that can be easily implemented into the clinical practice. Examination of the literature concludes UCB is as predictive as PVIB in screening for sepsis.

Decreasing Unplanned Extubations in a Neonatal Intensive Care Unit

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Unplanned extubations (UEs) cause significant harm to ventilated patients. The University of Virginia's Neonatal Intensive Care Unit (NICU) experienced an increase in UEs in 2014 from 6.2/1000 ventilator days to 9.8/1000 ventilator days. This project was conducted at the University of Virginia Children's Hospital, in the 51-bed Level IIIc NICU.

The team utilized lean methodology to address the increase in UEs using the A3 tool. Direct observations were performed to evaluate variation in stabilization practices. 5S was used to address storage issues. Real-time problem solving at bedside huddles occurred after UE events.

Initial observations showed variations in stabilization of the endotracheal tube. The team created standard work for endotracheal tube stabilization, specifying all aspects of care including adhesive application and removal. After the implementation of situational awareness and development of standard work, there was a decrease in UEs to 2.3/1000 ventilator days. After each subsequent UE, a team huddle occurred, identifying root cause of each event. Standard work for stabilizing endotracheal tubes in neonates demonstrated a marked decrease in UE events in our NICU.

Reducing Unplanned Extubations in a Level IV Neonatal Intensive Care Unit

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Unplanned extubations (UE) of the neonate can cause or be associated with complications including acute cardiorespiratory decompensation, repeated intubations that increase the risk for airway trauma or subglottic stenosis and ventilator associated pneumonia. Unplanned extubation is defined as the removal of an endotracheal tube that is not intended by the medical team.

During 2014, there were a total of 45 UE (3.2 events per 100 ventilator days) in this Level IV Neonatal Intensive Care Unit (NICU). This has been an increase over the previous two years. Data was collected for each UE to determine process components that can have a large positive impact if better practices are focused on these areas.

An interdisciplinary team was formed to create a work flow diagram demonstrating how factors contributing to UE interact with one another and cumulatively contribute to UE. Primary and secondary key drivers were identified to achieve the aim to reduce UE by 30% to <2.3 events per 100 ventilator days. Strategies to alter the secondary drivers (process measures) were implemented. Data collection surrounding UE will continue to be collected in real time to evaluate the progress toward the stated goal.

Thrombocytopenia Among Small for Gestational Age Infants

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Thrombocytopenia is common among small for gestational age neonates but several aspects of this thrombocytopenia are unclear. Using nine years of multihospital records we studied SGA neonates with ≥ 2 platelet counts $<150,000/\mu\text{L}$ in their first week.

We found thrombocytopenia in 31% of SGA neonates vs. 10% of non-SGA matched-controls ($p < 0.0001$). One hundred-two of the 905 had a recognized cause of thrombocytopenia. This group had a 65% mortality rate. The remaining 803 did not have an obvious cause for their thrombocytopenia. We termed these the "thrombocytopenia of SGA". They had a mortality rate of 2% ($p < 0.0001$) and a nadir count on day 4 of $93,000/\mu\text{L}$ (90% CI; 88,600 - 95,500). By day 14, platelet counts were $\geq 150,000/\mu\text{L}$ in >half of the patients. Severely SGA neonates (<1st %) had lower counts and longer thrombocytopenia duration ($p < 0.001$). High nucleated red cell counts at birth correlated with low platelets ($p < 0.0001$). Platelet transfusions were given to 23% and counts typically >tripled.

We concluded that "thrombocytopenia of SGA" is a hyporegenerative condition of moderate severity and two weeks duration, associated with evidence of intrauterine hypoxia, not mechanistically related to preeclampsia, and associated with a low mortality rate.

What Happens to the Kidneys with a Hemodynamically Significant PDA: A Case Study

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Learning objectives: Explore the clinical symptoms associated with acute renal failure as a consequence of a patent ductus arteriosus (PDA)

This presentation focuses on a former 27 week female African American infant, who developed significant hyperkalemia (9.7mg/dl), hyponatremia (124), acidosis, elevated blood urea nitrogen (BUN), and creatinine due to renal blood flow reversal subsequent to a large 2.8mm PDA. This infant was stable on nasal continuous positive airway pressure (NCPAP) and on full feedings. The large PDA persisted but had recently shown a shift to a predominantly left to right flow with normal cardiac function. At a corrected age of 29 weeks 5 days, the infant had morning labs that were indicative of an acute change in clinical status which appeared to suggest acute renal failure. A sepsis rule out was initiated and the electrolyte panel was confirmed with an arterial stick. Abdominal ultrasound showed resistive indices as well as reversal of diastolic flow bilaterally and reversal of flow was also seen in the abdominal aorta. The infant was made NPO and corrective measures were made to reverse the renal failure and correct the acidosis.

Wolff-Parkinson-White Syndrome Presenting with Cardiopulmonary Arrest in Term Infant

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Wolff-Parkinson-White (WPW) syndrome is a congenital abnormality of the cardiac conduction system caused by the presence of an abnormal accessory electrical pathway between the atria and the ventricles. This can result in intermittent tachyarrhythmia such as supraventricular tachycardia (SVT). In rare occasions sudden death may also occur from atrial fibrillation with rapid ventricular conduction. Because of the paroxysmal nature of arrhythmias and the possible intermittent occurrence of pre-excitation, WPW may go undiagnosed in the immediate newborn period.

This poster presents the case of a two week old term male that is admitted to the ER in cardiopulmonary arrest secondary to undiagnosed SVT resulting in congestive heart failure. The symptoms and laboratory findings noted on admission to the ER as well as his clinical course are presented. Differential diagnoses are explored and ruled out as the diagnosis of WPW is uncovered in this mystery case presentation. The poster further educates the reader regarding Wolff-Parkinson-White syndrome and SVT. Symptoms, complications, treatment and outcomes are provided to the reader to allow them to strongly consider the diagnosis of WPW when an infant presents in SVT or even cardiopulmonary arrest with no other known history.

Implementation of Subcutaneous Treprostinil Therapy in a NICU

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Our institution implemented the use of Subcutaneous (SQ) Treprostinil for the management of Pulmonary Hypertension (PHTN) in neonates with Congenital Diaphragmatic Hernia (CDH). PHTN is a leading cause of death in CDH. Treprostinil has been used on younger children since 2011. Education was required regarding: drug adverse reactions, mechanism of action, stability, pharmacokinetics, dosage, and administration; preparation of the SQ site, placement of the SQ catheter, and priming of the special IV tubing including tubing changes; infusion management, site management and indications for site change. Education is challenging due to the infrequent use of this medication and administration equipment. Initial education was provided utilizing email with links to a PowerPoint presentation and video as well as "just-in-time" education at the bedside. Later education has been provided through a lecture with case studies of patients treated with SQ Treprostinil. Nursing management of this therapy has been key to providing a less invasive therapy to a subset of patients who's PHTN was slow to resolve.

Transcutaneous Bilirubin vs. Serum Bilirubin in Infants 1000–2000 Grams

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Background: Hyperbilirubinemia is a problem faced by 90% of low birth weight infants (1000g-2000g) between 27-31 6/7 weeks gestation. Bilirubin is primarily measured as total serum bilirubin (TsB), and is checked daily for the first week of life. Collection results in needle punctures, blood loss, inter-department coordination, and high costs. Transcutaneous bilirubin measurement (TcB) is a noninvasive, less expensive test. Our goal was to evaluate whether TcB measurement could replace TsB in determining phototherapy needs, while decreasing costs and reducing patient discomfort.

Methods and Materials: Sample size consisted of 100 LBW infants. Drager transcutaneous bilimeter was utilized. Forehead and sternum TcB's were measured concurrently with TsB draws. Run charts were used to evaluate the relationship between TsB and TcB values.

Results: Strong correlation between TcB (forehead) and TsB (R-value of 0.75). The R-Value for TcB (sternum) and TsB was less significant (R-value of 0.67).

Conclusion: TcB forehead measurements can be used to determine phototherapy needs. This allows phototherapy to be initiated 8-18 hours earlier and eliminates 10-15 needle punctures per baby.

The population studied represents a third of our patients per year, averaging 6 TsB samples each. Using TcB measurements results in savings of \$220,374 a year (\$378 per infant).

Decreasing Nasal Trauma Among Neonates on Nasal CPAP

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Objective: Non-invasive respiratory mechanisms are effective in providing respiratory support to neonates. However, widespread nasal CPAP use has left neonates with various degrees of nasal breakdown. This review critically evaluates the evidence to improve care and decrease iatrogenic complications of nasal trauma to neonates on NCPAP.

Search Method: Databases searched from 2003 to 2014 yielded 229 articles. Studies were evaluated for content related to neonatal skin breakdown and care strategies while on NCPAP. Nineteen articles were kept for critical review. The Johns Hopkins University Research Appraisal Tool was utilized to evaluate the strength and quality of each article.

Synthesis of Findings: Key interventions include: ability to choose the appropriate NCPAP interface device and size, use of hydrocolloid barrier on nasal skin, vigilance in focused assessments and monitoring, optimal developmental positioning and comfort measures, and alternating between nasal mask and nasal prongs to alter pressure points on the nares and nasal mucosa.

Conclusion: Prevention is key. Further studies are needed to identify preventive and therapeutic strategies aimed at preventing iatrogenic nasal trauma to neonates on NCPAP therapy. Identifying these strategies impact neonatal care by increasing noninvasive respiratory treatment success, and decreasing invasive mechanical ventilation complications like chronic lung disease and BPD.

Ash Leafs in the Wood's Light

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A mother brings her 'normal' newborn into the ER for tremors. She explains that her pregnancy went without a hitch and her baby boy is perfect. She cannot understand what possibly could be wrong and keeps repeating "Why does my baby keep shaking..."

Tuberous sclerosis complex (TSC) is an autosomal dominant disorder characterized by non-malignant tumors with multiple and variable organ involvement. "Tuber" or potato-like nodules of the disorder result from mutations in the TSC1 and/or TSC2 gene. Commonly affected organs include the skin, brain, kidneys, heart, and lungs. Infants presenting with unexplained seizures should be examined for hypopigmented, thumb or leaf-shaped cutaneous macules characteristic of TSC. The purpose of this educational poster presentation is to analyze a clinical case study of an infant presenting with "well-baby" seizures and utilize the study's relevance in identification of TSC in the NICU setting.

A Spoonful of Sugar: Nurse-Driven Pain Management Revisited

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Despite pain management being recognized in neonates in recent decades as an evidence-based standard of care to prevent immediate deleterious effects as well as long term sequelae, compliance to nurse-driven non-pharmacologic interventions (NDNPI) began to fluctuate to less than acceptable levels in our 49-bed, level III NICU. The Quality Improvement Facilitator, along with other Nurse Practice Committee members, first noticed variations in sucrose usage. A performance improvement project was created to monitor NDNPI (sucrose, pacifier & swaddling) surrounding procedures; both nurse-driven (heelstick, IV insertion etc.) and nurse-assisted (arterial stick, circumcision, etc.), as well as barriers.

Gaps in compliance with NDNPI were identified with pre-data averages; for example, heelsticks was 20-30%. Neonates with NDNPI were noted to have less frequent increases of pain scores and more rapid return to baseline.

A plan was made to increase nurse's awareness through education, direct feedback and proposed changes in workflow. The project goal was to increase compliance by at least 50%. Goal was achieved: sucrose and pacifier use increased to over 80%, swaddling over 45%, and a decrease in infants without adequate NDNPI. Committee members identified that basic nursing principles need periodic monitoring to ensure compliance of evidence-based, safe and compassionate care delivery.

Randomized Clinical Trial of High Dose Oral Sucrose to Decrease Pain Associated with Peripheral Intravenous Catheter Insertion in Preterm and Term Newborns

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Introduction/Purpose: Determine if 24% oral sucrose solution decreases pain associated with peripheral IV (PIV) insertion.

Study Population: Neonates requiring insertion of a PIV.

Study Design: Double-blind, randomized, placebo-controlled trial.

Intervention: Oral administration of 24% sucrose or placebo solution before PIV insertion.

Main Outcome Measures: Pain, heart rate, and oxygen saturation (SpO₂).

Methods: Oral 24% sucrose or placebo solution was administered two minutes prior to PIV insertion. Outcome measures were obtained prior to, during, and for 5 minutes after PIV insertion. Investigators and caregivers were blinded to group assignment. Data was analyzed with longitudinal analysis of repeated measures, with $p < 0.05$ for significance.

Results: A total of 36 neonates (24% sucrose $N = 20$; placebo $N = 16$) were studied. Pain scores significantly increased from 2.3 (± 1.5) to a maximum of 7.1 (± 3.8) at the time of catheter insertion, returning to baseline levels 8 minutes after PIV insertion ($p < .001$). No significant differences were found in pain, heart rate, or SpO₂ between sucrose and placebo groups ($p > 0.05$).

Conclusion: Administration of 24% oral sucrose solution did not significantly decrease pain associated with PIV catheter insertion compared to placebo solution in 36 neonates.

Implementation of Potentially Better Practices to Improve Admission Temperatures

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Introduction: Hypothermia in preterm infants, especially very low birth weight infants, may lead to increased morbidity and mortality. Environmental factors, such as delivery room temperature and air currents, are obstacles that may be overcome with modifiable nursing procedures.

Purpose: This was a quality improvement initiative in a 60-bed Level IV NICU to implement better nursing practices for increasing admission temperatures.

Methods: Baseline data of admission temperatures and current nursing practices was obtained via chart review over a three month period. New guidelines were developed, the entire NICU staff was in-serviced, and new equipment was purchased. Data collection was then obtained for all NICU admissions on 5 minute temperatures in the delivery room, room temperature, admission temperature, and nursing interventions.

Results: Acceptable temperatures were defined as 97.7F–99.3F. During the first five months after implementing staff education and new protocols, overall admission temperatures increased from 27% within acceptable range to an average of 78%. In the <1,500g population, they increased from 10% to an average of 77%.

Conclusions: Taking a 5 minute of life temperature in the delivery room drives the decision making process for nursing staff to implement set protocols for improving admission temperatures in the NICU.

Icy Infants QI Project: Very Low Birth Weight Infants and Admission Temperature

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Aim: Using the Model for Improvement, within one year we aim to admit all very low birth weight (VLBW) infants from the delivery room (DR) with an axillary temperature between 36.5 - 37.5 degrees Celsius.

Background: Hypothermia is associated with respiratory distress, hypoglycemia, sepsis, and intraventricular hemorrhage. These can cause morbidity and mortality in the VLBW infant.

Methods: Observation of admission temperatures in 2014 showed a need for improvement in the VLBW infant population. Fishbone and workflow diagrams were the QI tools used to create a bundle including primary drivers (1. Pre-warming DR and equipment, 2. Warming during delayed cord clamping, 3. Warming during resuscitation, 4. Warming during transport, and 5. Education). Sequential data collected includes gestational age, birth weight, and mode of delivery. Plan-Do-Study-Act (PDSA) cycles are performed to modify the process changes (secondary drivers).

Results: Admission temperature is plotted against time on a continuous annotated run chart. Six data points above the median were achieved following process changes, which shows improvement signal.

Discussion: Using QI tools and PDSA cycles, admission temperatures for VLBW infants have improved and can lead to better practices and outcomes.

Successful Use of the Vacuum Immobilizer for Brain MRI in Infants <6 Months of Age

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Background: Brain MRI is commonly used for the diagnosis of CNS injury & disease in infants. However, high quality scans require that infants remain motionless often necessitating the use of sedation. "Feed & swaddle" techniques with

the aid of the vacuum immobilizer successfully minimize the use of sedation in infants undergoing brain MRI in the NICU. Nonetheless, the use of this technique outside of the NICU is rare.

Objective: Compare the efficacy and safety of the infant immobilizer vs sedation for infants undergoing brain MRI beyond the NICU, in our tertiary care hospital.

Design/Methods: Retrospective chart review over a period of 21 months. We identified 68 infants who underwent brain MRI outside the NICU and collected the following: patient demographics, whether the study was completed, total scan & MRI suite time, body temp before & after the scan, and complications such as apnea, bradycardia, desaturations, and the need for supplemental oxygen. Data were analyzed using t-test, Pearson Chi-Square, or the Fisher's exact test.

Results: In tables and figures

Conclusions: The use of infant immobilizer for brain MRI in infants is effective and safe. Our study suggests that infant immobilizer should be incorporated into routine clinical practice for all infants.

Total Body Cooling for Hypoxic Ischemic Encephalopathy on Neonatal Transport

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Hypoxic ischemic encephalopathy occurs in 1-6/1000 live births and most are born outside a level III NICU. These infants require transport to a Level III NICU for total body cooling prior to 6 hours of life and ideally cooling should begin within 2-3 hours of life for optimal neurological outcome.

This poster will:

1. Reflect the criteria and optimal time frame for infants for total body cooling for hypoxic ischemic encephalopathy.
2. Outline the procedure for total body cooling on neonatal transport beginning at the referral hospital and continuing on transport to the Level III NICU center.
3. Cite the difference between active and passive cooling with advantages/disadvantages to both procedures.
4. Reflect research/data/outcomes collected on infants receiving total body cooling on neonatal transport, and those that did not receive total body cooling until admission to the Level III NICU.

Objective: The learner will be able to understand the rationale and procedure for total body cooling on neonatal transport.

Mothers Own Milk...A Nutritional Emergency

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Purpose

- Encourage use of Mothers Own Milk (MOM) in the NICU.
- Increase first feeding with MOM from 39.6% to 70%.
- Decrease first feeding with MOM from 7.3 to 4 hours.
- Increase discharge rate of MOM from 62.2% to 70%.

Background

- Increase the proportion of infants who are breastfed per Healthy People 2020.
- Human milk uniquely is superior for infants.

Target Population

- Breastfeeding mothers.
- Premature infants.

Target Audience

- Nurses working in Women's Services.

Implementation Steps to Achieve Goal

- First feed using MOM within 6 hrs.
- Within 3 hours of delivery - One hand expression.
- Within 6 hours of delivery - One pump session.
- Donor breast milk may be fed after 12 hours.

Nurse Interventions

- Encourage early pumping, skin-to-skin contact, data collection and documentation.
- Encourage mothers to have a balanced diet with plenty of fluids.

Outcomes 2014

- MOM used as first feeding increased from 39.6% to 65.2%.
- Infants fed with MOM within 6 hours of birth increased from 22% to 25.3%.
- Infants discharged on MOM increased from 62.2% to 80%

Breastmilk and Formula Prep Room Move from 4th to 6th Floor*Kathleen Castelloux, CRPhT**David Hunt, MBA*

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Background: The original design for breastmilk storage and preparation was on two separate floors. Mothers' Milk Depot (Breastmilk storage) located on 6th floor and Pharmacy preparing breastmilk on 4th floor.

In addition the process for handling unfortified breastmilk was the same as fortified breastmilk, resulting wasted movements, time and resources.

Combining these areas and streamlining our process, reduced travel time, decreased number of computer transactions and improved delivery cycle time. Among other changes, implementing nurse pick-up is 8% average eliminating waste (MUDA).

Program, Materials/Methodology: Evaluate process timeline, produce process mapping/value stream map (VSM), Count Steps/Motion, brain storming meetings using affinity diagram technique.

Impact or Results: From consolidating all on the same floor we eliminated waste from and allowed the prep techs to work at the top of their license.

The space previously used is now available for future pharmacy needs with technology (robots) to provide improvement.

Don't Leave it to Chance...Give Breastmilk a Second Glance*Kristina Shelton, BSN, RNC-NIC**Alice Summitt, RN*

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Background: From December 1, 2013-July 29, 2014 there were 74 Expressed Breast Milk (EBM) errors (wrong patient, wrong milk, wrong volume, expired) that were entered into Safety Tracker. Audits were conducted during the month of October and revealed that <5% of the RNs were following policy.

Purpose: The Purpose of our study was to decrease the number of errors related to Expressed Breast Milk, by 50%, by June 2015 in the NICU

Method: We recruited frontline staff in the NICU to perform audits for one month. We measured the percentage of RN's that were adhering to our current policy. At the time of our data collection, current policy required two staff members to verify Expressed Breast Milk at patient bedside for correct patient, correct additives, correct volume and correct date. We also reviewed Safety Tracker for the number of Expressed Breast Milk occurrences for the previous six months.

Results: After all of our pre data collection, we found that current policy decreased workflow for the RN, since it required two RN's to come to the patient's bedside and verify that the syringe of milk was for the correct patient, had the correct additives, contained the correct volume and was not past expiration. This policy was not being followed in its entirety due to the complexity of the process. After consulting with our hospitals IT department we were able to barcode our Expressed Breast Milk labels and add EBM verification to our electronic work list. This process allowed the RN to scan the patients armband and then scan the barcode on the Breast milk label. This process allowed the second verifier to become the scanning of the barcoded EBM label and the patient armband by the assigned patient RN. The RN is still required to do an independent check to ensure the patient is receiving the correct additives and that milk is not passed expiration date.

Conclusions: Patients receiving Expressed Breast Milk are at risk for inadvertent milk exposures. Our current policy was not being followed according to our audits conducted. We were able to change our "Breastmilk Storage & Handling" policy to increase staff workflow and provide a safety net for breast milk verification. We are continuing to follow data through Safety Tracker and since our go live date of December 9th 2014 we have only had two Expressed Breast Milk

occurrences to date. Both occurrences involved milk administered at wrong rate and milk administered through wrong route.

Implications for Nursing: Expressed Breast Milk is a bodily fluid that can transmit many communicable diseases. Any inadvertent EBM exposures put the patient at risk for transmission of HIV or Hepatitis B or C. Inadvertent milk exposures also subject the mother who provided the EBM and the exposed infant to having labs drawn (extra lab cost, painful procedure, blood loss) not to mention the anxiety that the exposed infants parents have to endure.

Initiating a Standardized Feeding Protocol to Improve Infant Outcomes

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Reducing the rate of neonatal deaths within the first year of life is one of the objectives for the morbidity and mortality topic of the Healthy People 2020 (healthypeople.gov). Infant nutrition plays a major role in the outcome of premature infants, especially the extremely low birth weight infants (ELBW). A challenge all healthcare providers encounter is providing adequate nutrition to the ELBW infant to decrease the risk of developing complications and long-term morbidity. Evidence in the literature shows the need for early enteral feedings, the use of human milk and a standardized feeding protocol. Implementing these items into practice as a guideline will increase and maximize optimal neonatal outcomes and increase survival rates with hopes of a decrease in the risk of neonatal morbidity (McCallie et al., 2011). An evidence based practice information session will be presented to Neonatologist and Neonatal Nurse practitioners in hopes of changing their views and practice when caring for the ELBW infant in their Neonatal Intensive Care Unit and incorporating the use of a standardized feeding protocol.

Evaluation of a Train the Trainer Program to Prepare Registered Nurses to Implement Cue Based Feedings for Hospitalized Premature Neonates in the NICU

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Problematic feeding issues in the preterm and high-risk infant contribute to increased length of stay and therefore increased hospital costs. Efficacious oral feeding in infants is an interactive developmental skill that requires the caregiver's ability to recognize and sensitively respond to behavioral cues demonstrated by the infant. Growing evidence supports moving away from the volume driven prescription to nipple-feeding progression and caregiving in response to infant cues or cue based feeding. This type of developmentally supportive care promotes successful and safe feeding experiences. The objective of this quality improvement project is to measure the effectiveness of a train the trainer program with respect to a cue based feeding protocol. This project encompasses three phases: 1) train the trainer; 2) train the staff; and 3) evaluation of effectiveness of the cue based feeding protocol training program. The trainers and staff were educated in a two-part course emphasizing evidence based practice in using cue based feeding, NANN's Guideline "Infant-Directed Oral Feeding for Premature and Critically Ill Hospitalized Infants", the SOFFI algorithm, and feeding documentation. Data collection is in progress to evaluate the effectiveness of the train the trainer program.

Very Low Birth Weight and Lactation: Decreasing Maternal and Environmental Barriers for Improved Infant Outcomes

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In the Neonatal Intensive Care Unit (NICU), advanced technology permits medical providers to perform care for infants who weigh three pounds or less. In the U.S., approximately one in nine births are preterm annually. Many of very low birth weight infants (VLBW) are at considerable risk for infection and feeding difficulties, afflicted with lifetime disabilities. Breast milk is superior as nourishment for premature infants evident by improved long and short-term outcomes during the neonatal period. Yet, in preterm deliveries, it is difficult establishing lactation, partly of early stage of breast development at parturition (birth). Significant reductions in morbidity associated to high doses of Mother's Own Milk (MOM) within the first 28 days post delivery, correlate with positive health outcomes.

Exorbitant financial costs tied to care for this fragile population proves difficult as premature-related morbidities translate to increased costs with prolonged hospitalization. In the current healthcare milieu, healthcare systems strive to maintain fiscal prudence, dispersing resources in a cost effective way.

Decreasing Length of Stay after Implementing a Cue-Based Nipple Feeding Program

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As part of a Quality Improvement change package for "Decreasing Length of Stay", A Cue-based Nipple feeding Program was implemented. The average gestational age at discharge decreased from 37+0 weeks to 36+1 weeks, for infants born at 27+0 weeks PMA, through 31+6 weeks PMA. This correlates to a reduction in the average length of stay for this group of 6 days. Feedings transitioned from being ordered by the doctor at 34 week's post menstrual age (PMA), to nurses assessing infants for nipple readiness, based on physiological maturity, beginning at 32 weeks PMA. Nurses were educated on Nipple Readiness, Infant Stress Cues and Quality of Nipple Feeding. Nurses, who were focused on volume completion for feedings transformed to supporting Infant driven feedings, by standardizing initiation of oral feedings based on readiness cues and stopping oral feedings based on stress cues. Additional outcomes noted included increased autonomy for nurses, earlier initiation of nipple feedings, decreased length of separation for families, and decreased expenses required for hospitalization.

The Effects of Oral Feeding Protocol on Oral Feeding of Premature Infants

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Many preterm infants have complex medical and developmental issues than can delay this transition. Interventions to support successful oral feeding need help for premature infants. This study was conducted to prove the effects of an oral feeding protocol, including oral stimulation, nonnutritive sucking, and oral support position.

The study group was composed of 90 premature infants (experimental group: 40, control group: 50, 32+0 ~ 33+6 postmenstrual age). The experimental group was provided with an oral feeding protocol once a day 10 mins before oral feeding until the success to independent oral feeding. The data collected was analyzed by SPSS 19.0, through *t*-test, χ^2 -test, & ANCOVA.

The results are as follows:

- The experimental group began independent oral feeding significantly faster than the control group.
- The experimental group had the earlier age at discharge than the control group.
- The experimental group had a shorter length of hospital stay than the control group.

Effectiveness of Oral Administration of Colostrum

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Background: Critically ill neonates are prone to nosocomial infections because of their immature immune system. Premature infants' mucosal lining of the mouth has a lymphoid tissue system that protects the neonatal respiratory and gastrointestinal tracts. These cells of the mucosal lining react to cytokines that are found in colostrum. The results of a literature search found that oral care with colostrum is safe, feasible and effective.

Program Description: An evidence-based practice project was initiated to incorporate swabbing of colostrum during oral care of premature infants.

Theoretical Framework: Watson's Theory of Human Caring was used to guide the practice.

Methods: The data collected during oral colostrum administration included vital signs, oxygen saturations and culture results.

Results: Of the 18 premature infants, 13 infants reached early full feedings at a mean of 8-9 days, therefore shortening the NICU length of stay. No infection was noted in the leukens or blood cultures of 16 out of the 18 infants. Infants had no signs or symptoms of feeding intolerances. All premature infants' vital signs and oxygen saturations were within normal limits when swabbing with colostrum during oral care.

Conclusion: Based on this evidence, it is recommended that oral colostrum be administered to critically ill neonates to help prevent nosocomial infections.

Give Sleep a Chance: A New Care Model to Decrease Sleep Interruptions in the NICU

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Background: Infant sleep, essential for brain development and physiologic stability, is often disrupted in the NICU. A new care model called "Give Sleep a Chance" was created to decrease interruptions. Our goal was to modify caregiving to promote sleep. Evaluation will include what caregiving episodes are initiated when infants are asleep and by whom.

Purpose: The purpose was to promote infant sleep.

Supporting Research Evidence: Our work was informed by a literature review for quality evidence. Evaluations examined sleep strategies in NICUs. We reviewed *Transformative Care in the NICU* by Mary Coughlin.

Practice Change Methods: Following baseline data collection, nursing education focused on sleep preservation. Teaching strategies included posters, emails, handouts, and shared messaging. Specific nursing interventions included caregiving contingent on infant cues.

Results: Successful implementation will be demonstrated by showing fewer disruptions to sleep. "Give Sleep a Chance" will be evaluated based on the results of our study and parent/caregiver feedback. The program will be monitored for unanticipated barriers.

Comparison to Research: Research has shown improved physiologic stability and improved weight with better sleep. Data collected before and after the practice change will be compared to evaluate how our NICU improves these parameters.

Care Program to Support the Sleep-Awakening Rhythm Formation in the Early Stage of Infancy

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The circadian rhythm becomes the base of the autonomous activity of the life and is formed by the age of four months. We could read the formation of the circadian rhythm as sleep-awakening rhythm.

Sleep-awakening rhythm is formed under the influence of the care environment such as light and the sound.

It may be said that it is connected in supporting the development of life, and it will support the sleep-awakening rhythm formation in the early stage of infancy.

Therefore, we developed an adjustment program of the daily living rhythm to support the formation of the sleep-awakening rhythm through the documents examination such as meta-analyses.

Objectives:

- Discuss an association between the formation of the circadian rhythm and the sleep-awakening rhythm.
- Describe an association between adjustment of the daily living rhythm and the sleep-awakening rhythm.
- Explain the methods used for adjustment of daily living rhythm in the early stage of infancy.

Parental Perceptions of Implementing Infant Safe Sleep Practices: A Descriptive-Comparative Study

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Creating a safe sleep environment for newborn infants is an important aspect of ensuring physical well-being and is vital in minimizing the risk of sudden infant death syndrome (American Academy of Pediatrics, 2011; Canadian Pediatric Society, 2004; Public Health Agency of Canada, 2010). Parental anxiety and lack of knowledge regarding safe newborn sleeping practices at home combined with inconsistent implementation of infant sleep practices in NICU have raised concerns for health care practitioners (Grazel, Phalen, & Polomono, 2010). In 2012, there was no policy in any NICU across Canada that ensured consistent progression of safe sleep practices from birth to discharge. In February 2013, a *Safe Sleeping Practices for Newborn Infants* policy was implemented at the Janeway Child Health Centre NICU in St. John's, Newfoundland. A descriptive-comparative study was undertaken to describe: (1) parental anxiety, knowledge, confidence, and application of newborn safe sleep practices following discharge from NICU; and (2) nurses' knowledge and implementation of safe sleep practices before discharge from NICU, prior to and following policy implementation. This presentation will focus on the findings related to parents' perceptions of newborn safe sleep practices. Knowledge from this study will be useful to better define this standard of care.

Implementation of a Safety Bundle and Education for Health Care Providers and Parents in the NICU to Increase Compliance of Safe Sleep Practices at Home

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Health care providers are the role models for parents as they prepare to be discharged home. Implementation of staff and parental education in the NICU along with transitioning to SSP (safe sleep practices) a couple of weeks prior to discharge influences the way parents position infants at home thus contributing to SIDS prevention.

We used discharge follow up calls to collect data and we found that although parents knew the recommendations only 53% of them were following SSP. We collaborated with nursing staff to educate, train and implement practice changes at the bedside. Mandatory SIDS education and the creation of a safety protocol bundle was completed. After implementation of this safety tool we have continued to follow up with families post discharge and found compliance at home to have increased to 75% for our first group post implementation (Post-I group) and to 86% (Post-II group). It has been over a year now and we have continued to sustain the compliance of Safe Sleep Practices at home for those patients discharged home from our NICU. We are now standardizing this practice to other areas of the hospital where infants are admitted within our stand alone pediatric facility.

Wrapping Your Arms Around Them: Establishing a Cuddler Program in a Special Care Nursery

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Neonatal abstinence is a growing diagnosis and concern across the country that has led to many challenges. Infants are monitored for withdrawal symptoms prior to being discharged in order to identify if treatment is needed. Of the infants that are exposed to drugs in utero 76% of them require pharmacologic therapy. In many hospitals across the country neonatal intensive care units are being used to treat and keep the infants. (Davidson & Schub, 2014). Some of the signs of withdrawal include irritability, crying, respiratory distress, and diarrhea. The duration of symptoms can be from 6 days to 8 weeks. Given the symptoms and length of stay, caring for this population causes stress on the nurses caring for the infants. There is little research done on nursing interventions done, however these infants require holistic planning in all aspects of their comfort and care (Nelson, 2013). As a result of this growing population, a cuddler program was developed

to help with nurse stress when caring for these infants. They are volunteer cuddlers that are trained and come into the unit to help hold and soothe these infants. This is a beginning program that will help provide holistic care to this growing population.

Interprofessional Healthcare Provider Education for Neonatal Abstinence Syndrome

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The rapidly increasing incidence of Neonatal Abstinence Syndrome (NAS) in the U.S. is a significant clinical issue as well as a national healthcare crisis. A need to address this issue was identified by the healthcare providers of a large, urban, not-for-profit, university-based, level IV perinatal center which did not have a standardized protocol in place. An evidence-based practice (EBP) change project was designed to implement a protocol to increase consistency in treatment for infants with NAS and provision of healthcare provider education to increase knowledge regarding NAS, as well as sensitivity to the signs and symptoms of withdrawal. It was intended to provide an organized, structured, systematic, and collaborative approach to assessment and treatment. 141 healthcare providers in the Neonatal Intensive Care and Mother/Baby units (54% of those eligible) participated, with 133 (94%) matched pretest/posttest available for comparison. Across the entire sample, posttest scores differed significantly from pretest scores ($t(132) = 3.69, p < 0.0002$). These results indicated meaningful knowledge gain through the EBP practice change project. This approach has the potential to improve consistency in assessment and treatment, ultimately decreasing hospital length of stay, thus improving outcomes as well as reducing hospitalization cost for infants with NAS.

Patterns of Disruptive Feeding Behaviors in Infants with Neonatal Abstinence Syndrome

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Introduction: Infants born to drug-addicted mothers are at high risk to develop Neonatal Abstinence Syndrome (NAS). There is a lack of research about infant behaviors that result in disrupted feeding. The purpose of this study was to describe the infant behaviors that disrupt feeding and identify opportunities for interventions to improve feeding success.

Methods: This was mixed methods study of 11 infants with NAS being treated with morphine.

Results: The behavior categories that resulted in disrupted feeding were fussing, resting, crying, and sleeping/sedated. Fussing disrupted feeding more frequently than any other behavior category, accounting for 42.2% of the feeding duration. Active infant feeding was documented only 24% of the feeding duration. Fussing was the behavior that bridged transitions to other disruptive feeding behaviors. The number of behavioral transitions during the feeding ranged from 6-149, with an average of 68.8.

Discussion/Conclusion: Results of this study suggest that infants with NAS have difficult feeding patterns that may be amenable to intervention. The frequent but short fussing behaviors may prove to be an optimal time for mother-initiated interventions to coax the infant back to feeding. Additional study is needed to evaluate the impact of maternal behaviors and environmental variables on infant behavioral transition.

The Effect of Developing a Small Baby Program on Outcomes in Extremely Preterm Infants Born at <27 Weeks Gestation

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Background: The care of extremely preterm infants can vary widely between practitioners and this variance in care could impact outcomes.

Objective: To determine if the implementation of standardized evidence based care for the extremely premature infant would improve survival and outcomes.

Patients and Methods: NICU staff volunteered to care for these infants regularly based on guidelines. Small Baby Guidelines (SBG) outline care from admission to discharge. Data were prospectively gathered on all infants cared for under the guidelines from 2005 to 2013.

Results: The mean survival rate was 82% and there was a significant increase in survival over time ($R = 0.82$, $p = 0.013$); increasing from 74% in 2005 to 88% in 2013. The mean length of stay for survivors was 115 ± 19 days. The mean rate of PDA ligation was $33 \pm 16\%$ and there was a significant annual decrease in PDA ligation rate ($R = 0.83$, $p = 0.006$). There was a trend toward an annual decrease in severe IVH rate ($R = 0.62$, $p = 0.07$). The mean proportion of patients discharged on supplemental oxygen was $74 \pm 16\%$.

Conclusion: Applying a unified approach to the care of the extremely premature infant in an all referral unit resulted in a substantial improvement in survival, which was sustained over time.

Interdisciplinary Collaboration for Improvements in Management of Tiny Babies: The Tiny Baby Project

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Situation Background: Current literature demonstrates a correlation between variations in practice and poor patient outcomes. We identified numerous inconsistencies in practice relating to patients less than 29 weeks gestation. With these patients in mind, efforts began to decrease practice variation with the end goal of a reduction in poor patient outcomes.

Approach: The following aim statement was developed: To provide a guideline for the care of our tiniest patients, who are at the highest risk for morbidity and mortality. By tailoring the care provided to a specific set of processes for these patients, the uniqueness of their needs is addressed.

Methods: Ideas were grouped by category and literature review was completed. The Plan, Study, Do, Act (PSDA) model was chosen to guide the process.

Results: Review of 2014 Vermont Oxford data for chronic lung disease, retinopathy of prematurity, intraventricular hemorrhage, and necrotizing enterocolitis indicate a decline in these morbidities. Our skin grading tool is in the process of validation and eventual publication.

Conclusion: The Tiny Baby Project was fueled by the hard work of the multidisciplinary team and the desire to see improved outcomes. While the evaluation of results remains in progress, the implementation of the protocol holds exciting possibilities for the futures of our tiniest patients.

Zero Healthcare-Associated Infections in First Year of Opening New Level-IV NICU at American Family Children's Hospital

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American Family Children's Hospital in Madison, WI had the unique opportunity to start a new level IV NICU. In preparation for this unit, the NICU nurse manager, clinical nurse specialist, and medical director saw a need to create a bundled approach to preventing health-care associated infections (HAIs). They took the opportunity to explore research articles, obtain the advice of the infection control and hospital quality departments, and gain the knowledge of staff with various NICU backgrounds. Using evidenced-based practice and potential best practice, they were able to create CLABSI, CAUTI, and VAP bundles. Due to the bundles and policies that were put into place, the AFCH NICU has been able to achieve zero HAIs for over a year. These bundles and policies require education of all NICU staff and hospital staff, education of families, visitor screening, supportive charting in the electronic medical record, and regular auditing.

When in Doubt, Pull Catheter Out: An Evidence-Based Approach to Prevention and Management of Peripheral Intravenous (PIV) Infiltration/Extravasation in Neonates

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Background: PIV Infiltration is common among neonates. However, if an infiltration/extravasation occurs, early recognition and proper, prompt treatment is important in minimizing morbidity.

Aim: To outline measures in proper maintenance of IV therapy in neonates. To improve identification and management of infiltration/extravasation in neonates.

Methods:

- Standardized IV assessment developed by K. Wilder et. al from Dallas Childrens Medical Center was adapted. The acronym ACT (Assess, Compare, Touch) was taught to the nursing staff in assessing their IV sites methodically and objectively.
- Protocol was developed. It includes preventative measures, lists of vesicants, dosage and administration of antidotes, grading scale, algorithm outlining the actions required in managing/treating the injury and wound care recommendation by our wound care nurse specialist.
- Staff education was provided.

Results: This initiative has led to improvement in clinical practice due to staff's increased awareness and knowledge of the risks associated with IV therapy.

Reduction in IV infiltration incidents and severity of injury lessened due to infants receiving proper treatment promptly.

The Use of Spiritual Coping Strategies by Parents After an Infant's/Child's ICU Death

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Purpose: To examine the relationship of spiritual and religious coping strategies to grief, mental health, and personal growth for mothers and fathers one (T1) and three months (T2) after their child's death.

Design: The sample consisted of 114 mothers and 51 fathers, 69 whose infant died in the Neonatal Intensive Care Unit and 55 whose child died in the Pediatric Intensive Care Unit.

Methods: Bereaved parents completed the Hogan Grief Reaction Checklist, Beck Depression Inventory II, Impact of Events Scale-Revised and Spiritual Coping Strategies questionnaires at T1 and T2.

Results: For bereaved parents, greater use of spiritual coping strategies was associated with less grief, depression and post-traumatic stress disorder (PTSD) at T1 and T2. Fathers' use of religious coping strategies was related to less grief, depression and PTSD at T1. Greater personal growth was related to use of spiritual coping for mothers and fathers at T1 and T2, and to fathers' use of religious coping at T2.

Conclusion: Spiritual coping strategies helped parents cope with their grief, maintain their mental health, and experience personal growth through 3 months after their child's death. Religious coping strategies were more helpful for fathers than mothers, with their influence significant only at 1 month post-death.

Optimizing Developmental Care for Neonates on Transport: The DCOT Project

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Background: A newly implemented infant restraint device, while reducing the risk for infant injury, led to transport clinicians observing and documenting subtle increases in stress behaviors in the preterm infants during transport. This issue led the team to reevaluate their current neurodevelopmental care practices for preterm infants on transport.

Purpose: The purpose of this quality improvement project is to assess the extent to which a proposed bundle of neurodevelopmental interventions can promote an infant's physiological stability during transport.

Methodology:

- The developmental specialist accompanied the transport team on transport to observe the challenges of providing a developmentally supportive environment for the preterm infant.
- Sources of stress were identified related to noise, vibration and light.
- Baseline measurements were documented for each of these identified sources of stress.
- The interdisciplinary team reviewed the literature to identify evidence-based practices that could be implemented to support the premature infant during transport.
- A bundle of potentially better neurodevelopmental practices was developed to support the infant during transport.

Impact:

- The DCOT bundle was developed to help modify the transport environment through the use of neuroprotective strategies to help minimize stress.

Objectives:

- The learner will be able to recognize existing stressors of the transport environment relating to noise, vibration and light.
- The learner will be able to identify interventions to promote physiologic stability during transport.

Responding to Obstetric Trauma with the Condition "O"

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Condition O is an alert at UPMC Mercy Hospital that indicates that there is an Obstetric (OB) trauma arriving in the emergency department. The responders are a multi-disciplinary team that collaborates between the Trauma, Obstetric, Anesthesia, Clinical Supervisors, and The Neonatal Intensive Care Units (NICU). The Trauma department initiates the Condition O and the Trauma, OB, Anesthesia, Clinical Supervisors and NICU departments respond, establishing attendants with skill to care for all aspects of the trauma state. UPMC Mercy provides 24 hour in-house attending level I Trauma Surgeons, Obstetricians as well as a Neonatologist in a Level III NICU.

Implications:

- The OB trauma patient is at risk for a mixture of adverse outcomes such as fractures, internal injuries, hemorrhage and death.
- The neonate is at risk for adverse consequences of the trauma, that the OB patient sustained such as complications of prematurity, fractures, internal injuries, hemorrhage and death.

NICU on the Big Screen: Showing a Unit Orientation Video at Admission to Decrease Parental Stress and Improve Satisfaction

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The neonatal intensive care unit (NICU) can be an overwhelming and unfamiliar environment for many parents and families. Prior to this process improvement project on a 52-bed Level II neonatal unit, family orientation to the unit was unstructured, inconsistent, and time-consuming. The goal of this project was to create a unit orientation video to be integrated into the hospital's video-on-demand system that would welcome families to the unit, provide consistency of information, and make the orientation process less time-consuming for staff. After the video was created and published on the hospital's video-on-demand system, the effectiveness of using this orientation video was measured by looking at patient satisfaction scores in three areas: how well nurses explained equipment/monitors, how well staff made families feel welcome, and consistency of information. In each of these areas, the mean percentile of patient satisfaction scores showed improvement in the two years after implementation of the orientation video compared to the two years prior to

implementation. When shown regularly, a unit orientation video can provide patients and families with a more consistent and thorough orientation to the hospital unit, thus improving satisfaction with care.

I Can See You! Decreasing Parental Anxiety and Stress with Webcam Technology

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The birth of a child is a joyous occasion, until that birth comes prematurely or the infant is born ill. The literature indicates that admission to a neonatal intensive care unit (NICU) impacts the parent's psychological, emotional and physical readiness for the birth of their child. Separation anxiety and stress can cause worry, guilt, and sadness.

Objectives for installing webcam technology:

- Decrease parental anxiety and stress
- Promote bonding for parents and extended family
- Increase family satisfaction

Through philanthropic funding and interdisciplinary planning the webcams were installed at each bedside in the NICU. Pre- and post-implementation surveys measured parental stress and anxiety using the Parental Stressor Scale: NICU. A portion of the scale, "relationship and parental role" was used to create the survey questions.

Findings: Quantitative and qualitative data indicates that webcam technology decreased anxiety and stress and increased parent/family satisfaction.

Future: Investigate further methodology to decrease parental stress and anxiety.

Objective: The learner will be able to describe how leveraging technology can decrease parental anxiety and stress in the Neonatal Intensive Care Unit.

'APP'lications in Neonatal Medicine

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Background: The popularity and daily use of smartphones continues to increase dramatically and their use is becoming more significant than ever within the medical community. Approximately 71% of US nurses use their smartphones at work. There is an estimated 40,000 medical applications (apps) now available for mobile device users and of those, 50% are targeted toward medical care providers.

Purpose: With smartphones becoming our primary source of information, this poster will explore the potential benefits and risks of app use in the neonatal intensive care unit (NICU). Additionally, how to assess an apps' credibility is reviewed. Finally, examples of apps that are useful in the NICU are briefly discussed.

Conclusion: Smartphones are becoming intertwined in all aspects of society with growing popularity and the development of medical apps has the potential to significantly impact how healthcare is delivered in the NICU. However, it is the responsibility of every healthcare provider to ensure that the apps used are credible, evidence-based, and protect patients' privacy.

Discharging the Complex Single Ventricle Patient: Measures Taken to Reduce Inter-stage Mortality

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The neonatal single-ventricle physiology patient requires special precautions and monitoring after discharge from the first palliative surgery. These babies are followed in a special home monitoring program, the Infant Single Ventricle Monitoring Program (ISVMP). Inclusion in this program allows for diligent home monitoring by experienced clinicians with an emphasis on learner education, involvement, and skill of primary caregivers which is essential to the infant's success during the inter-stage period.

Collaboration amongst the ISVMP front line clinicians and Cardiac Center Education Room staff has led to a more formal, structured discharge process for parents and primary caregivers of this fragile population. At the patient's bedside and during a series of private classes, parents and primary caregivers learn how to care for their newborn's complex medical

needs throughout their admission, using a checklist that is catered to specific patient characteristics. Necessary medical follow up in the inter-stage period is reviewed, including weekly phone calls from an ISVMP nurse practitioner and ISVMP communication with outside cardiologists. Since instituting the program and utilization of a standardized discharge checklist, mortality has decreased, communication between providers and family has improved, and family education and feelings of discharge preparedness have improved.

The Effect of Structured Discharge Education for Mothers Who Need Special Skill and Knowledge of Medical Devices in NICU

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Purpose: To evaluate the effect of a structured discharge education on maternal confidence and satisfaction, discharge delay, and re-hospitalization.

Method: This is a retrospective, before and after study. The education material was developed by researchers after validating from visiting nurses, pediatric nurse practitioners, experienced neonatal nurses, and literature review. It contains about special medical devices, e.g. pulse oximetry, oxygen delivery system, gavage or gastrostomy tube, tracheostomy cannular, and suction. The instruments used in this study were modified Maternal Confidence/Satisfaction Inventory and EMR review.

Results: Fifteen mothers in a traditional discharge education group before starting the structured education, forty five in experimental group were enrolled from January, 2013 to December, 2014. The infants' diagnoses can be classified into BPD, congenital anomaly, and hypoxic brain damage. There were significant effects on discharge delay ($p = .036$) and re-hospitalization(ER) ($p = .026$), but there were no significant differences in maternal confidence and satisfaction. However, Maternal satisfaction was conversely related to discharge delay ($p = .002$).

Conclusions: A structured discharge education may be effective in terms of preventing discharge delay and re-hospitalization. Further studies are recommended for evaluation of pre-post maternal caring ability.

Trauma-Informed Care: The Impact of the NICU Auditory Environment on Infants, Parents and Caregivers

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Introduction: Trauma-informed care is an emerging paradigm that acknowledges the environment as an important part of the hospital experience that has potentially long-lasting consequences. Neonatal nurses employed in a Level III private room unit questioned how the auditory environment is impacting the patients, families and staff.

Statement of Purpose: Using the foundational background of trauma-informed care, we seek to determine the impact of the auditory environment on premature neonates, their parents and nursing providers. Our goal is to collaborate with caregivers to decrease detrimental noise while providing a developmentally safe, healing environment.

Conclusion: Research has demonstrated that the auditory environment could be contributing to adverse outcomes for our patients, while contributing to the stress and anxiety of both parents and nurses. If is anticipated that through research and education, procedures and policies can be implemented that maintain safety as defined by regulatory agencies. Concurrently, we hope to make the NICU environment a place of calm and healing through minimizing auditory intrusions.

Impact of Kangaroo Care Intensive Course on Nurses' Knowledge and Confidence

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The problem was that in 2014 the practice of Kangaroo Care occurred in <20% of 996 NICUs in the U.S. and practice was inconsistent. Lack of knowledge and skill confidence contribute to minimal practice. Roger's Diffusion of Innovation Model guided the study.

Recently, 10 studies have identified a need for improving knowledge and skills of nurses to increase use of Kangaroo care. The purpose of the pretest-posttest quasi-experiment was to determine the effects of a 2.5 days course of kangaroo care evidence, skills, problem-solving and implementation approaches on nurses' knowledge and skills confidence level. 68 attendees were asked to complete a 36 items, content validity-based Likert Scale questionnaire (1 = strongly disagree to 5 = strongly agree) with 20 knowledge and 8 confidence items before and after the course. Descriptive statistics and paired *t*-test were conducted on 57 complete data sets. Nurses' characteristics varied and 18 knowledge and 5 confidence items significantly improved ($p < 0.01$, $R = 0.000-0.01$). Knowledge items about adequacy of KC practice and evidence-base of physicians' KC orders failed to change, as did 3 confidence items about managing KC in NICU and at birth, and initiating KC changes.

Objective: The participants will be able to understand how attendance at an intensive course can improve knowledge and skills confidence of practicing health professionals.

Safe Transfer to Kangaroo Mother Care for Vulnerable Preterm Infants: Keeping Mom and Baby Safe

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Kangaroo Mother Care (KMC) provides many benefits to both mothers and infants. Infants experience improved thermoregulation, oxygenation, breastfeeding, and brain growth; mothers achieve better milk supply, improved breastfeeding duration and exclusivity, and better mother-infant attachment, with recent reports suggesting KMC improves the mental health of mothers of low birth weight infants.

Unfortunately, there is often reticence from care provider teams to transfer into KMC those infants who could most benefit from it: vulnerable preterm infants who require extraneous life support equipment. There is empiric evidence that KMC reduces morbidity and mortality in low birthweight infants and that it is safe and effective for very low birthweight preterms; however, concerns regarding safe infant transfer sometimes result in avoidance or omission of KMC for this population. Recognizing the benefits and fears regarding KMC for vulnerable infants, nurses at a large central Canadian hospital began exploring the literature for assurance of its safety, and for strategies to safely accomplish transfer of these infants. The result is the creation of two protocols which guide providers to safely transfer vulnerable preterm infants into KMC. Family response to increased opportunity for KMC, and their perception of benefits they and their babies have experienced from it, will be shared.

Improving the Implementation of Kangaroo Care

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Darla Carter, RNC-OB

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Purpose: To develop a Kangaroo Care (KC) policy with competencies and staff education so that KC is practiced consistently and correctly therefore reducing risks to the infant i.e. decreased body temperature, respiratory collapse or falls.

Background: KC is a practice that helps infants adapt to extra uterine life, reduces stress in the mother and infant, and improves breastfeeding exclusivity. Nurses were promoting KC, but were apprehensive because of the perceived risks that occurred while in KC on the unit, only some of patients were kangarooing at birth.

Methods: A committee was formed. A policy with competencies was designed. The staff was then educated and observed teaching and assisting patients with KC. Simple statistic were used.

Results: After the entire staff was trained, we noted an increase in KC during the first hour of life. Nurses verbalized more confidence in practicing KC. Infants in KC the first hour of life increased.

Conclusion: Consistency in staff education in the practice of KC provided a notable increase in the in number of infants in KC.

Objective: Summarize the methods that can improve the implementation of KC.

Implementing Evidenced-Based Skin-to-Skin Contact to Increase Exclusive Breastfeeding at a Major Academic Medical Center

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As a nation, we fail to meet breastfeeding targets set by the WHO, CDC, and professional organizations. This poster reports a Quality Improvement initiative which translates evidence to promote exclusive breastfeeding.

Initially, a search of the evidence was conducted to identify best practices around the globe. Strong evidence supports the following: exclusive breastfeeding (EBF) within the first six months of life; establishment of early skin-to-skin (S2S) contact between mother and newborn as a means to achieve that goal; and uninterrupted S2S, up to the first breastfeeding. All are safe, effective, and low cost interventions which increase breastfeeding success and patient satisfaction. And still, the National Survey of Maternity Practices in Infant Nutrition and Care (mPINC) revealed only 72% of U.S. hospitals report S2S contact for at least 30 minutes after normal vaginal birth (CDC, 2013).

This Quality Improvement process supported adoption of the evidence, with the goal of increasing both uninterrupted S2S and exclusive breastfeeding. Policies have been changed, staff members have been educated, and an audit and feedback process has begun. A full year of data will be available for report at the time of the conference.

Objective: The learner will be able to understand how to employ strong evidence to improve outcomes.

Interprofessional Team Self-Efficacy Before and After TeamSTEPPS Training

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Team Strategies and Tools to Enhance Performance and Patient Safety, TeamSTEPPS, was designed to reduce errors, optimize patient outcomes, and maximize patient and staff satisfaction by improving communication within the health care team. TeamSTEPPS tools are not complex, and are readily understood by learners. The likelihood of actually using these strategies, however, is dependent upon an individual's self-confidence and willingness to speak up, often in very stressful situations, to influence the actions of colleagues on the interprofessional team.

Self-efficacy refers to an individual's confidence in his or her ability to perform a particular task or skill. Self-efficacy beliefs are determinants of motivation and action. Self-efficacy is a modifiable trait, and increased self-efficacy is generally predictive of increased success with regards to action and goal achievement.

To evaluate the impact of TeamSTEPPS training, the *Self-Efficacy for Interprofessional Experiential Learning* survey tool was used before and after an interprofessional workshop for Woman & Child Program staff in a tertiary care hospital.

Study results ($n = 515$) demonstrate a statistically significant increase in individuals' reported interprofessional team self-efficacy ($p = 0.00$) after the workshop, suggesting increased likelihood of effective communication among the interprofessional team after participation in this unique TeamSTEPPS training workshop.

Success Rates and Sample Quality Differences in Lumbar Punctures Performed by Physicians and Nurse Practitioners in the NICU

Danielle Whytal, MSN, NNP-BC

Kidz Medical Services

Boynton Beach, Florida

In recent years, the neonatal nurse practitioner (NNP) has become a key presence in the neonatal intensive care unit (NICU). Evidence suggests that NNPs are becoming an increasingly vital part of the healthcare team, both for their career long availability as providers of quality care, and for their expertise as leaders, researchers, and educators.

Lumbar puncture (LP) is a common procedure performed in the NICU. A LP is a procedure within the scope of practice of a physician or a neonatal nurse practitioner. The quality of the cerebrospinal fluid (CSF) sample collected can be crucial in formulating the plan of care. The purpose of this study is to compare success rates, as well as differences in the characteristics of CSF samples collected from LPs completed by NNPs or physicians in the NICU.

The Relationship Between Horizontal Violence and Healthy Work Environments in Women's and Children's Services

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Nurses play a significant role in patient safety. In order to contribute to a culture of safety, nurses need to practice in healthy work environments that are free from aggression and in which respect is demonstrated. Horizontal violence (HV) between nurses poses a threat healthy work environments. Behaviors such as intimidation, using threatening or abusive language, humiliating someone in front of others or refusing to help can lead to a breakdown in communication and collaboration thus affecting the well-being of patients and staff. This study will evaluate the relationship between HV and healthy work environments in order to understand how inappropriate behaviors affect the ability to establish empowering processes that may contribute to safety.

The setting for this study is a multi-hospital system in the southeastern United States. Data will be collected June-July 2015 using a demographic measure, the Horizontal Violence Scale, and the Healthy Work Environment Scale. Descriptive statistics will be used to analyze the data.

MRI Feed and Bundle

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Recent literature has shown multiple negative consequences of MRI with sedation in neonates. In developing workflows for our new NICU, we wanted to be consistent with best practices for our neonates. Prior to the Level IV NICU opening in May 2014, we wanted to decrease the number of infants being sedated for MRI in AFCH. The MRI Feed and Bundle approach was recognized as a new workflow, and prior to opening the new NICU this workflow was simulated with all members of the healthcare team. Several hours were spent during the simulation looking at: equipment education, patient transport to AFCH Imaging Pavilion, data transfer with wireless monitoring devices, physician workflow with order entry and collaboration with MRI staff, and nursing workflow process steps. The majority of the time the feed and bundle approach is successful and our neonates are not intubated/sedated for MRIs.

Obstetrical and Neonatal Collaborative Initiative for Delayed Cord Clamping in the Delivery of a Premature Infant

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When reviewing the literature the support of delayed cord clamping in the premature infant is evident. Delayed cord clamping in the premature population has shown to be beneficial in early hemodynamic stability. Both the American College of Obstetricians and Gynecologists as well as the Academy of Pediatrics recommend delayed cord clamping in the delivery of premature infants.

The Obstetrical and Neonatology divisions at UPMC Mercy collaborated to implement delayed cord clamping in the delivery of premature infants. After extensive review of the literature, an evidence based protocol was developed by members of both divisions and presented at their respective monthly quality meeting. Upon approval of the protocol, an instructional power point presentation was developed for the medical and nursing staffs for implementation of delayed cord clamping.

The objective of the educational tool was for the learner to be able to describe what patients were included in the protocol and the benefits and be able to demonstrate his or her responsibilities in delayed cord clamping in the delivery of a premature infant.

Is that Mother at Risk...of Falling?

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Nurses perform falls assessments on patients admitted to hospitals. The Morse Fall scale is commonly used. However the variables measured on this and other fall scales are not specific to the characteristics of women during the post-birth period. Thus the first question is, how adequate are the assessment parameters being used? Secondly when a new mother comes to the nursery to visit the infant, the nursery nurses usually have limited knowledge of the woman's conditions and whether she is at risk for falling and causing injury to herself, the infant or others. This presentation will share a collaborative evidence based project engage in by nursing students and RNs on a dedicated education unit to develop evidence based guidelines specific to this unique patient population and ways to communicate the potential risk for falling to all members of the healthcare team involved in the care of the new family.

Protecting Our Newborns: A Fall Prevention Initiative

JoAnn Lionarons, BSN, RNC-OB, C-EFM, CLC
Nancy Chevalier, BSN, CLC
Mary Vitale, BSN, CLC, C-EFM
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Patient falls are an NDNQI measure for 2015 and a Nursing Sensitive Indicator. Newborn falls continue to be an underreported event for hospitals, assumed to be due to parent's fear of being judged or shame. The risk to the newborn can be brain injury or even death. From the limited research available it is noted that approximately 600 to 1,600 in hospital newborn falls occur annually. A review of newborn fall cases from January 2013 through December 2014 on St. Peter's postpartum unit was also carried out. A task force of 2 staff RN's and the nurse manager of the unit met to strategize interventions to reduce our newborn fall rate to 0.

The team evaluated current practices and identified opportunities for improvement including: the initiation of purposeful hourly rounding utilizing the acronym N.I.C.E. which is specific to the mother-baby dyad, utilization of the NUROO infant carrier for safe skin to skin transport from labor and delivery to postpartum unit, the creation of a newborn safety contract for the purpose of review by the RN and signage by the parents on admission to postpartum unit and patient education signs hung in each patient room as reminder of infant safety.

Zero Mother Baby Falls 2020—Clinical Bedside Nurse-Led Change

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Advocate BroMenn Medical Center
Normal, Illinois

A 211 bed community hospital, averaging 125 babies delivered per month. The need to decrease falls for mothers, support persons and infants was identified with the goal of no falls by 2020. Shared governance groups made recommendations to formal leadership for clinical bedside nurse-led change. After evaluating fall data, the following measures were implemented to supplement falls precautions:

1. Falls contract specific to OB, printed and signed with admission consents then posted on white board.
2. Two staff assist, one an RN, patients to the bathroom first two times after delivery with desk staff aware.
3. Wheelchair outside patient rooms for the first two times.
4. All IV poles, cords on "nurse" side of the bed; labor support persons opposite bedside.
5. C-sections: Stool in OR for support person does not have wheels.
6. Poster showing baby swaddled in Halo® Sleep Sack, lying on back in empty crib stating "When I'm not being held, in my crib is where I belong".
7. Safe sleep education crib card including recommendation against co-sleeping.

The changes and education were driven by the bedside practicing nurse with positive and prompt buy in and a decrease in the number of falls is evident.

Neonates Discharged Home Dependent on Medical Technology

Valerie Toly, PhD, RN, CPNP
Amy Bieda, PhD, RN, PNP-BC, NNP-BC
Carol M. Musil, PhD, RN, FAAN
Rainbow Babies & Children's Hospital
Cleveland, Ohio

Statement of the Problem: While 20% of children discharged home from the hospital are dependent on medical technology (supplemental oxygen and feeding tubes), the percentage of neonates discharged home from Neonatal Transitional Care Units (NTCU) on technology is unknown. The purpose of this study was to describe the characteristics of neonates discharged home from NTCUs dependent on medical technology.

Literature Review: Approximately 450,000 babies per year are born preterm, and many continue to have complex healthcare needs at hospital discharge. Medical technology introduces another layer of complexity in the parents' care of the neonate, including frequent communication with healthcare providers and supply companies and specialized education about neonatal assessment and operation of technology.

Methodology: A retrospective chart review was performed of 71 technology-dependent infants discharged home over two years from a 44-bed Midwest NTCU. Study variables included type of technology used, gestational age, birth weight, hospital length-of-stay, hospital readmissions and emergency room visits one year post-discharge.

Data Analysis/Interpretation: Descriptive analyses (frequency, measures of central tendency, and dispersion of study variables) were performed. The most frequent technologies used post-discharge were supplemental oxygen (66%) and feeding tubes (46.5%). The mean hospital length-of-stay was 65 days. Post-discharge outcomes and implications will be described.

Baby Bucks: An Incentive-Based Nursing Program to Improve Engagement and Morale in the NICU

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Although widely used in job industries such as retail and food service, incentive programs for staff (financial or otherwise) are not common in the healthcare sector. A search of the literature reveals small pockets of research worldwide that have targeted primary care physicians offered financial incentives for improvements in patient outcomes, but no studies could be found that speak specifically to programs for nursing or in acute care settings. Baby Bucks is an incentive-based NICU nursing program which began in April 2015. The goals of the program are to improve staff morale and engagement, in turn enhancing the quality of care provided to NICU infants and their families. Potential additional goals of the program would be increased occurrence reporting, decreased sick leave and improved family satisfaction. Nurses receive and accumulate Baby Bucks for a variety of unit activities with the opportunity to redeem them throughout the year for gift cards or small prizes. Activities such as participating in committees, preceptoring students, reporting occurrences and having extended periods of time without sick leave will be rewarded, among other things. Funding for this program is expected to be approximately \$200/year to purchase the rewards and funds for the first year have been sought out and offered by the physicians and management of the NICU. The program will be evaluated after the first year using staff and family questionnaires, as well as unit statistics on committee involvement, occurrence reporting and sick leave.

Infusing the Theory of Human Caring into the Role of the Nurse Leader in Conjunction with our Studer Initiative

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In 2012 Einstein Healthcare Network launched a new initiative by partnering with the Studer group to increase both patient satisfaction scores and the employee satisfaction, we called our initiative Growth, Professionalism and Service (GPS). Prior to this, we had also achieved Caring Science Affiliate status, as a nurse leader and Caritas Coach I felt compelled to integrate the language of Human Caring and the Studer group best practices. Nurse Leader rounding seemed the most logical place to begin the integration. Studer coaches provided skills sessions and provided specific structure around the dynamic process of rounding on both patients and employees; it was here I found myself able to integrate the language of caring as I interacted with both my NICU families and my dedicated staff. Authentically spending time with the families of

my fragile patients was already part of my daily routine; however the idea of asking specific questions was something new. By focusing on a few key items at a time allowed this nurse leader to get a better understanding of what was most important to our families. I used this same type of guided approach when rounding on staff, to identify what was most important to them.

Our GPS journey did not always lend itself to a true integration with the Theory of Human caring, remaining truly focused on my role as a Caritas Coach , helped to light a path to finding the right words at the right times. Our journey continues and it through this journey that I believe we are making a difference in the lives of our patients and families and our staff. I continue to look at several indicators: patient satisfaction scores, employee satisfaction and RN engagement. There are still areas for improvement as well as new areas for exploration.

Car Seat Safety Checks with Premature and Low Weight Babies at Hospital Discharge

Tracey Waddell, RNC-NIC, BSN, CBC

Lino Chica, CPST

Winnie Palmer Hospital
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Many neonatal intensive care infants are not correctly fitted at hospital discharge for a car seat per the minimum criteria suggested by the manufacturer. Premature and low weight babies require special considerations when being transported home. Correctly positioned neonates minimize the risk of car crash fatalities. Many parents are unaware of car seat safety requirements or unprepared for the journey home. Some have received car seats as baby shower gifts inappropriate for their unexpected small infant, while others may have borrowed a car seat or intend to make use of an older sibling's car seat. Following an extensive literature search it was established that there was scant evidence to support safety checks in hospital discharged neonates. Collaboration between neonatal nurses and Certified Child Passenger Safety Technicians at infant discharge found that there were multiple safety issues which included babies too small for car seats or weight under minimum requirements, car seat harness fastened incorrectly, harness straps unable to be tightened sufficiently to secure the tiny infant correctly or harness height not below the infant's shoulder. Also found were expired car seats per the manufacturer, and missing or damaged parts. During the months of July through December 2014, safety checks uncovered 26% of car seats with safety concerns. Safety issues were resolved in 71% prior to discharge. Plans are to disseminate education to other areas where small infants are discharged and to apply for grant money to purchase car seats for neonates to support parents unable to afford approved car seats.

Baby Friendly...One Step at a Time Transforming an Urban Teaching Hospital Into a Baby-Friendly Hospital

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The University of Cincinnati Medical Center (UCMC) serves an area of high infant mortality rate and historically low breastfeeding rates. Breastfeeding is a critical component in the effort to reduce infant mortality. Using the Baby Friendly Hospital Initiative's 10 Steps to Successful Breastfeeding, UCMC has adopted practices to promote breastfeeding couplets. The learning objective is the implementation of Step 3 and Step 4 to lead to improvements in maternity care, breastfeeding initiation and achieving Baby Friendly designation. Infant feeding is correlated to long term health outcomes. Data indicates that breastfeeding reduces the incidence of respiratory infections, intestinal illnesses, asthma, allergies, childhood lymphomas, and Sudden Infant Death. Reduced risk for many of these is dose dependent. The 10 Steps to Successful Breastfeeding highlight evidence-based practices that can be implemented in any maternity settings to Protect, Promote, and Support breastfeeding. Major changes in practice, such as those necessary to provide evidence based practice to breastfeeding couplets, happen when patients, nurses, managers, and administrators together buy into the value of health outcomes associated with those changes. Facilitating focus groups of delivered mothers to better understand their needs and experiences coupled with ongoing data collection regarding breastfeeding initiation and duration will drive future improvement in breastfeeding interventions.

A Journey to Baby-Friendly Designation: One Department's Path to Staff Engagement and Empowerment

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NorthBay Medical Center
Fairfield, California

Breast milk offers the most complete form of nutrition for infants and its benefits for both baby and mom are well recognized. In alignment with the World Health Organization, Healthy People 2020, the American Academy of Pediatrics and The Joint Commission, the Women and Children Services in a community hospital embarked on a journey to obtain Baby Friendly Designation. This vision was supported by nursing and physician leadership and champions were identified early in the process. A very common challenge experienced when embarking on any significant practice change is how to engage and empower staff. By successfully engaging and empowering staff in the early stages of change, their increased buy-in had an important impact on implementing and sustaining the practice change. Understanding staff engagement and empowerment were the main barriers and the nursing leadership team diligently worked on ways to remove those barriers with efforts that worked to build on mutual respect, open communication, transparency and multidisciplinary teamwork. The path leading to Baby Friendly designation came with challenges, as well as individual and departmental growth and successes.

Adapting the Culture to Baby-Friendly Thermoregulation Evidence-Based Practice

Lynne Reiner, MSN, RNC-NIC, MNN, IBCLC
OSF Saint Francis Medical Center
Peoria, Illinois

Resistance to change is part of the culture in the medical field. This poster will describe the journey and progress of a traditional family birthing center adapting to accepted Baby-Friendly thermoregulation of the newborn practice. Included are the education, criteria, implemented changes and plans for further change, staff buy in, plans for research to increase acceptance of changes being made.

Educational strategies to impact the culture of belief of regional expectant parent populations will be included. Research outcomes and identified barriers will be discussed including what implementation strategies were used that may be replicated by other facilities on their journey to evidenced based practice or Baby-Friendly status.

Mother-to-Mother Peer Support Group for Breastfeeding Mothers

Emily Berghult, RN, BSN
SSM-St.Clare Health Center
Fenton, Missouri

The benefits of breastfeeding are obvious and true, but by not continuing education and support to new mothers after they leave the hospital we are doing them a disservice. Mothers often prematurely quit breastfeeding because of unrealistic expectations, or because of lack of support and encouragement. Many healthcare systems have exclusive breastfeeding as a core measure, which is enforced by Joint Commission. This puts an even bigger pressure on nurses to encourage breastfeeding. The United States government has exclusive breastfeeding as a goal in the Healthy People 2020 Objectives. By 2020 they would like to see 60.6% of infants breastfed for the first six months and 25.5% of infants to be exclusively breastfed for the first six months (*Healthy People 2020*, n.d.). The American College of Obstetricians and Gynecologists (ACOG) strongly supports breastfeeding for infants as the preferred feeding method for the first six months of life (ACOG, n.d.). A breastfeeding peer support group can be a beneficial form of promotion and encouragement for new mothers.

Using Best Practices, Nursing Education, and LEAN Daily Management to Improve Exclusive Breastfeeding

Jodie Bell, RNC-LRN, BSN, IBCLC
Marla Newmark, RN, BSN, IBCLC
Gwendolyn Cooper, RNC-LRN, BSN
Pamela Goeckeritz, RNC-LRN, BSN
Sarah Morrill, RN, BSN

Greater Baltimore Medical Center
Towson, Maryland

Background: Exclusive breastfeeding has many benefits for mother and baby. Supplementation with formula in the hospital negatively impacts breastfeeding success. At our hospital, almost half of our breastfeeding babies were given formula supplements.

Purpose: To improve exclusive breastfeeding in the hospital.

Methods: We had initiated several projects to improve exclusive breastfeeding, with variable success. In January 2014, we applied the LEAN Daily Management (LDM) process to exclusive breastfeeding and tracked reasons for formula supplements daily. We used the 5 Why problem solving tool to identify root causes and guide our action plans. We found that mothers were influenced by the advice of their care-givers and were unaware of the impact of supplements to breastfeeding success. In response, we educated all staff about the importance of exclusive breastfeeding.

Outcome: The exclusive breastfeeding rate improved from a mean of 57% in 2011 to a mean of 73% in 2014. (p 0.000)

Implications: Improving staff understanding of the importance of exclusive breastfeeding created a culture of support for breastfeeding. Daily monitoring through the LDM process enhanced problem solving, documented our progress, and increased staff engagement.

Improving Prenatal Breastfeeding Education

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University Hospitals MacDonald Women's Hospital
Cleveland, Ohio

Purpose: To develop a Prenatal Breastfeeding Education Curriculum and Process to meet the Baby-Friendly USA criteria for evaluation for Step 3 of the Ten Steps to Successful Breastfeeding: Inform all pregnant women about the benefits and management of Breastfeeding.

Background: Breastfeeding is the optimal method of infant feeding. The optimal time to make an informed decision regarding infant feeding is in the prenatal period. In June 2013, the documented rate of prenatal breastfeeding education in the five OB/GYN hospital-owned practice offices was 8.3%.

Methods: A Prenatal Breastfeeding Education Curriculum was developed. Using the Institute for Healthcare Improvement (IHI) Model for Improvement, a process for education and documentation of education was developed, tested, implemented and spread to the five OB/GYN practice offices.

Results: Documentation of Prenatal Breastfeeding Education is audited monthly by the Quality Improvement RN. Documentation of Prenatal Breastfeeding Education in the five OB/GYN practice offices improved from baseline 8.3% to 90% in March 2015.

Conclusions: A standardized curriculum and process for completion of Prenatal Breastfeeding Education had a substantial impact on the Prenatal Breastfeeding Education rate.

Standardization of Hypoglycemia Screening in the Newborn

Joanne Foresman, RNC, MSN
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St. Louis, Missouri

Caregivers at our facility raised the question whether it was a necessary practice to screen all newborns for hypoglycemia. This clinical query prompted leaders in our organization to examine the evidence and determine a need for modification in practice. Practice change led to standardization in definition of newborns at risk for hypoglycemia, thresholds for immediate treatment and provider notification, and necessary ongoing blood glucose monitoring. Evidence was reviewed, appraised and approved by a selected group of nurses and physicians. Tools for standardization included an orderset incorporated into the system's electronic healthcare record for easy accessibility to nurses, a standard definition for the at-risk newborn, a screening process developed around only those newborns deemed at-risk, an evidence-based feeding protocol and physician agreement on thresholds for treatment and ongoing monitoring. Each of these items was developed into a protocol which allows nurses to act immediately to treat low blood sugar in at-risk infants as well as continuation of monitoring once blood sugar has been corrected. From data collected, the authors conclude that hypoglycemia may be diagnosed and treated earlier, leading to a more efficient and effective use of resources at our facility to treat at-risk newborns.

Sensory Processing and Integration Deficits: Steps Towards Earlier Diagnosis and Treatment

Amy Manion, PhD, RN, CPNP
Felicia Kurkowski, BA
Rush University
Chicago, Illinois

When a child inability to process sensory input affects their daily lives healthcare professionals and parents should take notice. Studies estimate one in 20 children are affected by sensory issues and can have struggles with coordination, balance, focus, play, self-expression, organization, and motor skills (Sasson et al., 2009). Often these issues are not identified or misidentified (Pathways.org, 2010). However, evidence suggests therapy using a sensory integration (SI) approach may result in positive, developmental outcomes (May-Benson & Koomar, 2010).

This poster will review signs of typical sensory processing, explain steps to take if sensory issues are suspected, and continue the dialogue of co-morbidity.

In an effort to refer children to therapy earlier and understand the signs of sensory issues, 30 experienced pediatric therapists collaborated on a list of developmental sensory behaviors. The behaviors of a child with sensory issues are extremely varied, making them hard to detect and missing warning signs can often compromise progress towards functional goals. When healthcare professionals and parents know what to look for, it is easier to recognize these signs. This list of behaviors is an important step towards earlier identification and earlier therapy for children's sensory issues, which can help children reach their fullest potential.

Improving the Process for Delayed Bathing and the Impact on the Culture of Beliefs for the Impacted Units

Vicky Gronewold, RNC-MNN
Lynne Reiner, MSN, RNC-NIC, MNN, IBCLC
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Peoria, Illinois

Even with 40 weeks preparation time we all know the struggles of parents during admission when it comes to the newborn bath. This poster is intended to describe the recently updated improvement process identifying education, criteria, and process implementation for delayed bathing in a traditional nursery setting.

The process of improvement for delayed bathing can be adapted to any hospital environment and includes criteria and process implementation strategies to help with suggestions on which infants delayed bathing may be the best option for the baby.

Obesity in Pregnancy: Physical Activity Assessment Among Pregnant Women

Mary Beth McCloud, MSN, RNC-OB, BC, CNE
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Frostburg, Maryland

Objective: Overweight and obese pregnant women are increasing at an unprecedented rate. Exercise and weight management are key when attempting to limit the health issues and risks associated with an elevated BMI. This review allows learners to examine the relevance of instruments measuring exercise in the population of interest, including self-report and portable activity monitors.

Data Sources: A systematic literature review was conducted in CINAHL, PubMed, and Science Direct databases.

Study Selection: Peer reviewed studies that included pregnant women and instruments that assessed physical activity were included. Seven studies were included, but only five utilized a combination of self-report and objective measures.

Conclusion: There are a variety of instruments that can be utilized to assess the amount of exercise in the population of interest. It cannot be certain that either instrument is actually valid when assessing physical activity among pregnant women. The reliability of accelerometers has been well-established and was used as a method of concurrent validity in the majority of the studies included in this review. However, reliability is hard to establish in self-report questionnaires and studies are still needed to determine that actual reliability and validity of portable activity monitors in overweight and obese pregnant women.

The Heart of the Matter: Cardiopulmonary Resuscitation of the Pregnant Patient

Nellann Nipper, RNC NNP-BC

Jenn Young, RNC-OB

Heather Maus, RNC-OB

UPMC Hamot

Erie, Pennsylvania

ACLS-OB is offered in very few hospitals. To implement the guidelines of the AHA Maternal Modifications for ACLS, a three part program was designed as a Senior Professional Nurse Project to educate Labor and Delivery staff on the new AHA guidelines, review of the algorithms, decision making processes, development of a perimortem C-section tray for all L&D and ED crash carts, and adapting knowledge and response to our specific hospital equipment and environment. Adding Maternal Cardiac Arrest simulation drills for all L&D and NICU staff that were videotaped and debriefed provided real time emergency response, defined responder roles, standardized team communications and incorporation of the ACLS-OB maternal modifications.

The remarkable outcomes of this work were realized in a 35 week pregnant patient who presented in our ED after receiving 37 minutes of CPR enroute. The skills and teamwork of the ED, L&D and NICU, although unable to save the mother, resulted in the perimortem C-section delivery of an infant who at one year of age has no developmental or neurological deficits.

A Program for Caring for Women Using Opioids During Pregnancy in a Rural Community

Kara Platt, DNP, RN

Christine Savage, PhD, RN, CARN, FAAN

Deborah S. Finnell, DNS, PMHNP-BC, CARN-AP, FAAN

Western Maryland Health System

Cumberland, Maryland

Aims: The aims of this quality improvement project were to provide support for pregnant women using opioids through encouraging increased engagement in interdisciplinary and community services, and increasing mother's knowledge of addiction, self-care, and care for the infant.

Methods: The Prenatal to Postpartum: Collaborate, Assess, Refer, and Education (P2P CARE) program was implemented within an obstetric office in a rural mid-Atlantic state. The program provided case management and education to pregnant women using opioids during their prenatal appointments. Nine participants were followed throughout their pregnancy and post-partum period. Medical charts were reviewed, outcomes were compared to medical records from a retrospective group (n = 28) delivering a year prior to the intervention that were positive for opioids at time of delivery.

Results: Participants in the P2P CARE program had less opiate use by time of delivery, increased attendance at prenatal appointments and educational sessions, increased referrals and utilization of drug treatment participation, an increased rate of breastfeeding and infants born to P2P CARE participants had a decreased length of stay as compared to the analysis of the retrospective baseline group.

Conclusion: The addition of the P2P CARE program to an obstetric office improved outcomes for pregnant women using opioids and their infants.

Mercy Hospital Leans into Labor and Birth Improvements

Heather Thompson, RN, MSN, CENP

Tony Vago, MBA, MPA, ASQ

Ashley M. Bell, RN, MSN

Mercy Hospital St. Louis

St. Louis, Missouri

Mercy Hospital St. Louis is ranked among the top 20 hospitals in the nation related to birth volume and welcomes approximately 8600 babies annually. To keep up with growing demands, a new unit was built. In the months post move, the team recognized many of the workflows, as well as the culture, needed to change based on new demands. Through LEAN daily huddles and rapid improvement events, the Labor and Birth unit at Mercy Hospital St. Louis increased coworker engagement and patient satisfaction while seeing a 51% increase in on time induction start times and a 22% increase in on time starts for OR cases. The staff nurses and nursing leadership teams have continued to work together

and improve many processes while providing exceptional care in a dynamic healthcare environment. The key motive was to continuously improve and maximize value and quality for our mothers, babies and families.

Navigating Complex Change: Moving to Mother-Baby Care

Vicki Brockman, MSN, RN, NE-BC
Northwest Texas Healthcare System
Amarillo, Texas

As family centered care has become the expected standard, many facilities follow the mother-baby model, where care is provided to both mother and infant in the same room, by the same nurse. My facility practiced within the traditional model of nursing care with mother and baby in separate units, which was not evidence-based or financially sustainable. Once we made the decision to transition to the mother-baby couplet model, we utilized the Iowa Model of Evidence-Based Practice for Quality Improvement to guide the change process, as well as Lewin's change theory. A Failure Mode Effects Analysis (FMEA) was completed to proactively identify and correct any high risk processes. After implementing the mother-baby model, we experienced several positive outcomes:

36% increase in exclusive breast milk feeding rates at hospital discharge

- staff productivity consistently >100%
- 16% decrease in salary costs
- 2% increase in patient satisfaction (based on HCAHPS scores)
- 4.6% increase in delivery volumes.

This presentation will describe successes and challenges along the journey to couplet care and will show how the use of quality improvement tools, change theory and evidence-based practice models guided implementation of the new nursing model.

Developing the OB Stat Team

Heather Keller, MSN, RNC-NIC
Pat Newell-Helfant, MS, RNC, CPNP
Janice Miller, RNC-EFM, C-OB
St. Peter's Hospital
Albany, New York

While most U.S. births are uneventful, 1 to 2 percent of pregnancies are complicated by an obstetrical emergency. According to the Centers for Disease Control and Prevention (2013), about 650 women die each year in the United States as a result of pregnancy or delivery complications. Therefore, it is imperative that cross-functional multidisciplinary teams be created, along with equipment and support structures in place to manage this vulnerable patient population.

An evidence based policy and procedure was developed. Specified obstetric emergencies were identified including, but not limited to eclamptic seizures, hypertensive crisis, category 3 fetal heart tracing, hemorrhage, umbilical cord prolapse, and uterine rupture. The policy and procedure was brought to and approved by the OB quality improvement committee by interdisciplinary professionals. Education was disseminated in educational sessions, policy review, e-mail, memos, discussions at staff meetings and unit postings. Any team member can call an OB stat. Team activation occurs simultaneously through a centrally coordinated pager system. Additionally, there is a hospital-wide overhead page announced that includes the patient location.

Care Coordination Improving Communication on a High Risk Obstetrical Unit

Janice Buys, RNC, BSN, BSBA
Leslie Gostic, BSN, MSN, RNC-MNN, CBC
Diana Olasz, RNC
Magee Womens Hospital of UMPC
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Our poster summarizes the background of Care Coordination from our literature review and discusses the many advantages of including the entire care team along with the patient and their family in our plan of care.

We have listed and identified numerous goals and ground rules that were implemented on the unit in order to allow for an organized flow of patient rounding. Rounds are performed at the patient bedside with all members of the multidisciplinary team.

Our methods are described which include instructing patients on admission the time of daily rounds which allows the entire family to be present and collaborate on a plan of care. Strategic bedding and placement of patients has ensured that rounds are running smoothly and efficiently. We have measured and outlined the success of Care Coordination through the comparison of HCHAPS scores in nurse communication, staff responsiveness, and physician communication from pre-implementation to 6 months post implementation. This is all illustrated using a bar graph depicting the pre and post implementation scores. Care Coordination is well received from all members of the care team and is a highly effective model of care improving communication amongst providers and their patients and contributing to overall patient safety.

Bedside Nurse Developed and Facilitated Blitz: A Professional Development Shared Governance Project

Anne Saiter, RNC-MNN, BSN
Regina Ritter, RNC-MNN
Andrea Huber, RN, BSN
 Mercy Hospital-St. Louis
 St. Louis, Missouri

Purpose: The Mother Baby Professional Development Shared Governance Council at Mercy Hospital St. Louis developed and implemented a bedside nurse run blitz for education and competency verification of its coworkers.
Description: Mercy Hospital St. Louis is ranked among the top 20 in the nation related to birth volume. The hospital welcomes approximately 8,600 births annually. The Mother Baby Unit is comprised of 136 nurses and 18 support staff members. The Professional Development Shared Governance Council consists of 10 bedside nurses, a nurse clinician and nurse manager. The council provides education twice yearly based on a needs assessment from coworkers, quality management data, patient surveys, changes and updates in clinical practice, policies, and equipment. This educational blitz is held over multiple days and times to accommodate all coworkers. The council members develop presentations and competency verification methods, and also provide an opportunity for feedback through an evaluation.
Evaluation and Outcomes: Since the involvement of Shared Governance, the unit has been able to increase the attendance rate from 50% to 95%. This program, driven by bedside nurses, has helped increased coworker satisfaction levels, and given the nurses empowerment which has led to an overall more engaged unit.

Empowering Nurses to Utilize Teach-Back on a Postpartum Unit

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Research demonstrates that patients immediately lose 40 to 80% of medical information provided during discharge education. Nurses providing education on a postpartum unit have some unique challenges. These include short length of stay, increased number of visitors, and a decreased maternal capacity to process and understand basic health information during the taking in phase. Recognition of these issues within our institution led us to create a Teach-Back team on the Postpartum Unit. We explored problem areas, developed staff education and mentored staff in the Teach-Back process. A pre and post educational tool to measure nurse's knowledge base and confidence in utilization of Teach-Back on the postpartum unit was used and data collected. Data analysis showed that educational interventions improved the nurse's understanding of the Teach-Back process. It also empowered nurses to verify the patient and families understanding of education given, correct inaccurate information and reinforce knowledge and new home care skills. Findings specifically demonstrated the importance teach back has on preventing maternal or newborn readmissions and /or complications.

Keep Calm and Educate: Partnering with Perinatal Patients to Provide Education, Support, and Improve Outcomes

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"Partners in Pregnancy" was created to address the educational needs of women throughout pregnancy and in the postpartum period. Pregnant women were "partnered" with nurses from the inpatient obstetrical unit. The nurses

contacted the women on four occasions during the prenatal period. Information related to fetal development, required testing, the inpatient unit, what to expect during the labor process, pain management, breastfeeding, and postpartum follow-up were provided. The goal was to improve communication with patients, promote consistent prenatal care, and address patient questions and concerns related to the delivery process and postpartum period. The program was introduced utilizing the patients receiving prenatal care at the hospital-based obstetric office. The office provided prenatal records after the initial visit. A nurse from the inpatient unit was then assigned as a partner. The nurses were provided an outline of topics for each phone call based on gestational period. Throughout implementation the program was modified to meet goals. The poster depicts the goals, implementation, and outcomes at this point.

A Day in Her Shoes: An Interdepartmental Project to Enhance “RBC” Between Mother-Baby Unit and Labor & Delivery

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Eighty percent of serious medical errors involve miscommunication between caregivers during handoff. In recognition of this, and anecdotal reports or tension between L&D and Mother-Baby, our units created a program called, “A Day in Her Shoes.” This program, based on our care delivery framework of Relationship Based Care (RBC), was designed to enhance our working relationships.

Our Shared Governance (SG) teams came together to resolve interdepartmental concerns. We felt that we could better understand what our sister department’s day was like if we walked in her shoes.

The SG leaders worked together with participants from both day and night staff to allow nurses from each unit to spend a 12 hour shift in each other’s department.

The professionalism and positive interaction between staff members from each unit is exceptional. We feel confident that when a conflict arises we are able to “Speak Up” in a professional manner and resolve issues without dissatisfaction from either unit. The respect we give each other enhances the care we give to our patients! Our SG project continues to grow as other departments are utilizing this RBC approach to empower individuals to “Speak Up” and make positive changes to their working environment.

The Admit Nurse/Team Baby Model of Care

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The Baby-Friendly Initiative encourages hospitals to create protocols and standards to “protect, promote and support breastfeeding” (WHO, 2009). In the process of preparing for BF designation NYU Langone Medical Center created the role of “admit nurse” to assist keeping mothers and babies together in the LDR. The admit nurse is a designated staff RN that performs the following roles: initial infant assessment following a 1-2 hour period of “baby mooning,” supporting skin to skin contact, assisting and educating mothers on breastfeeding. We achieved Baby-Friendly designation in 2011. Recently, the admit nurse role has evolved further into the new “Team Baby.” To promote seamless care in the Baby Friendly Model, while emphasizing neonatal risk assessment, a collaboration of the admit nurse and L&D nurses has formed. The admit nurse/Team Baby model of care has been an innovative and effective method of providing high quality, evidence-based family centered nursing care in an academic medical center clinical practice setting. Implementing this admit nurse/Team Baby model can be done in any institution with no additional staff (FTE's) required.