

Abstracts Presented at the 8th Advanced Practice Neonatal Nurses Conference

Honolulu, Hawaii, April 27–30, 2011

These abstracts summarize poster presentations from the recent 8th National Advanced Practice Neonatal Nurses Conference in Honolulu, Hawaii. Cutting edge research and innovative programs were shared with colleagues from the U.S., Canada, and across the globe. Some abstracts have been edited for publication.

Dysphasia in Neonates Treated With Hypothermia Therapy

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Introduction: Hypoxic Ischemic Encephalopathy (HIE) is a significant cause of brain injury in neonates. The impact of HIE has varying degrees of neurodevelopmental sequelae including dysphagia.

Objective: To document that infants with moderate to severe HIE, who have received hypothermia treatment as standard of care, are at risk for dysphagia.

Methods: A retrospective chart review over a one year period of patients with HIE whom received hypothermia therapy was done. Modified Barium Swallow (MBS) studies were performed on this patient population. A comparison between abnormal and normal MBS study results were evaluated.

Results: There were a total of 32 patients in this chart review. Of the 32 patients, 23 had MBS studies done. Eighteen of 23 MBS were abnormal. This demonstrates a 78percent abnormal rate in MBS in infants post hypothermia therapy for treatment of HIE.

Conclusions: At this point, in the HIE population, using a specific feeding protocol as well as the inclusion of a MBS with speech therapy involvement, would be beneficial for optimum management of these high-risk infants.

Mandibular Distraction Osteogenesis in Pierre Robin Sequence Neonatal Data CHOC Children's

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Objective: To characterize the outcome of one institutes experience regarding the neonatal population with Pierre Robin Sequence (PRS).

Study Design: A two year retrospective review of the 9 neonates with PRS was performed.

Conclusions: Neonatal distraction of the mandible is a successful means of correction of upper airway obstruction due to micrognathia and retrodisplacement of the tongue and avoiding early tracheotomy and it's many accompanying morbidities.

There is opportunity for future research in optimizing nursing understanding of Pierre Robin Sequence in the neonate, the distraction process, with development of postsurgical checklist; Emergency Airway Bag; positioning in the distraction stage and immediately after removal of the distraction device to support infant's airway but also their abilities to suck and swallow, self-organization, calming, and proper muscular development.

Brain Cooling and ECLS for HIE and MAS

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This unusual case study demonstrates the use of two specialized treatment modalities for the NICU patient. Baby RG was found to be hypoxic and depressed at birth in the delivery room. Meconium was also noted upon delivery. The patient met criteria and was transported to our facility for a higher level of care as well as brain cooling therapy. As Baby RG was receiving brain cooling therapy, she continued to exhibit a declining respiratory status and met criteria for ECLS. The patient was placed on V-A ECMO while continuing on the protocol for brain cooling therapy. After 72 hours the brain cooling procedure was completed while the patient remained on ECLS support. She was then able to be weaned off ECMO with no obvious complications.

These therapies are highly specialized and fairly infrequent, yet this patient benefitted from simultaneous treatment by both. Knowing that the ECLS circuit had the functionality to warm the blood as well as cool it down, the question was posed: Could we perform total body cooling on this patient as well?

Advancing Neonatal Care and Academic-Clinical Relationships through a Unit-Based Journal Club: An Inviting, Kind, and Gentle Approach

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Our unit based journal club began with a motive to stimulate clinicians to think about current practice with questions from the bedside. "Why do we do things this way? Is our practice evidence-based?" In a professional environment that encourages use of evidence-based research to guide practice, we wondered if our clinicians were prepared to evaluate "the evidence". We hoped to expose and engage clinicians from every level to be able to critically evaluate research publications, articles, and products and apply results to unit practice. We needed expertise in research evaluation so we enlisted our colleagues in medicine and nursing to help.

Our topics are generated from staff suggestions and questions and are often timed around a new product evaluation, pending practice changes, or staff interest or concern. Exploration of topics often stimulates a unit project for practice evaluation and sometimes a change in practice. We offer food and CEU's for each journal club attendee. Topics have varied and include patient, parent, and clinician care topics. Each month, we take the opportunity to explain or teach a new concept or technique related to the research or literature. We have found many practice applications through our exploration of the evidence.

The ePortfolio Implementation Project

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The National Association of Neonatal Nurse Practitioners (NANNP) recently recommended professional portfolios as a means for NNPs to document learning, experience, and competency. This evidentiary collection should be updated regularly and reviewed as part of an evaluation process. The ePortfolio represents one method to address this recommendation.

Portfolios, including electronic formats (ePortfolios) are an evolving tool, and are utilized for curricular evaluation and demonstration of competencies (McCready, 2007). They typically represent varied evidence (artifacts) selected by the collector to showcase work and reflect on movement toward goals.

An ePortfolio template was recently developed at UCSF School of Nursing for the master's curriculum. This template addresses competencies and merges formative, summative, and reflective artifacts cohesively via an online learning system already in place. A pilot project is underway comparing two ePortfolio tools ("NPST" and "Mahara") which will address features such as customizability, ease of use and portability, and form recommendations for both student and faculty ePortfolio development.

References

McCready, T. (2007). Portfolios and the assessment of competence in nursing: A literature review. *International Journal of Nursing Studies, 44*, 143-151.

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The Effect of an 8-Week Massage Therapy Program on Perceived Stress, Absenteeism, and Turnover among NICU Nurses

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Neonatal Intensive Care Units are typically busy and stressful environments that can be intense, fast-paced, as well as chaotic. Without question, stress is an integral component in these units that stems from a variety of sources, including the highly technical environment, and the need for rapid decision-making. Continued exposure to these stressors can have a profound effect on the nurse's mental health, and lead to high levels of absenteeism, burnout, and depression. The purpose of this study was to determine whether an 8-week massage therapy program for NICU nurses would lead to a decrease in perceived occupational stress, absenteeism, and nurse turnover rates.

The design of the study was a one-group, pre-test, post-test design. During an 8-week period, massage therapists were available in the NICU setting to provide ten-minute chair massages for NICU nurses during their breaks. Pre- and post-intervention measures of perceived stress, absenteeism, and turnover rates were obtained. Seventy nurses participated in the study.

Statistically significant findings ($p < .05$) were obtained concerning perceived stress as well as NICU nurse turnover rates. However, no significant difference was noted in absenteeism. Based upon the results of this study, there is clearly a need for further research in this area.

Defining the Role of Comfort in Neonatal Nursing Care

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Background: Comfort care is the nursing process of providing comforting actions for a patient in order to provide physical ease and promote optimal health.

Purpose: To describe the meaning and process of comfort in the Newborn Intensive Care Unit (NICU).

Methods: A literature search was performed through CINAHL, Medline, PubMed, and the University of Utah Library catalog. Key words included "infant comfort", "infant soothing", "infant discomfort", "infant crying", "nurse" and "nursing". Searches were also

conducted using “neonatal nursing/methods AND pain therapy” as well as “neonatal nursing/methods AND nonpharmacologic”.

Results: Three main categories were identified in the literature related to comfort in the NICU: Nonpharmacologic pain management, developmental care, and comfort care at the end of life. A stepwise approach to identifying discomfort and providing comfort in the NICU is presented.

Conclusion: The temporal state of comfort may be obtained through the use of nonpharmacologic comfort measure to provide physical ease and freedom from pain. The long-term state of comfort can be obtained through the use of developmentally appropriate interventions to ‘strengthen’ the infant, preserve energy, and promote a nurturing environment. End-of-life care provides the ultimate challenge in comfort care to provide both physical ease for the infant and to strengthen the family through physical, emotional, social, cultural, and spiritual support.

Nurses’ Knowledge, Perceptions, and Beliefs about Kangaroo Care (KC) in a Level III All Referral Small Baby NICU

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Part of a larger, currently ongoing study that explores the factors influencing parental visitation and participation in Kangaroo Care (KC), this study investigated nurses’ core beliefs and knowledge about KC as well as perceived barriers to the KC process. Seventy nurses that were listed on the Small Baby Primary List were invited to participate in the study.

The study consisted of a one-time questionnaire that was developed by Engler, et al (2002) for the Kangaroo Care National Survey. Fifty-three percent of nurses responded. With regard to core beliefs, over 90 percent of respondents felt that KC increased the quality of care in the unit and is worth the teamwork required between nurses and parents. Additionally, most respondents’ current knowledge of the practice aligned with evidence-based research. However, findings from the “Barriers” items were mixed, with half of respondents citing advanced practice nurses’ and medical staff reluctance to allow KC as one of the significant barriers to KC. Other barriers included fear of arterial or venous line dislodgement and family reluctance to participate in KC.

Extremely Low Birth Weight and Very Low Birth Weight Infants Growth Velocity after Discharge from NICU

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Objectives: The purpose of this study was to compare the growth velocity of extremely low birth weight (ELBW) infants and very low birth weight (VLBW) infants following discharge from a Neonatal Intensive Care Unit.

Methods: A longitudinal comparison group design was used to establish 1) growth velocities of ELBW and VLBW infants at discharge, 2, 4, 6 and 12 months, and 2) differences in weight, length, and head circumference. Sixty ELBW and 60 VLBW infants were recruited.

Results: Graphic displays illustrate that growth velocity for weight, length, and head circumference was faster for ELBW infants than VLBW infants between 6 and 12 month assessment. The t-test indicates that VLBW infants weighed significantly more than ELBW infants except at discharge; the length was greater for the ELBW infant at each assessment period; and head circumference was greater for VLBW infants at each assessment period except discharge and 12 months.

Conclusions: Conclusions from this sample are that ELBW and VLBW infants have different growth velocities after discharge. Despite periods of accelerated growth for ELBW infants, catch-up growth to VLBW infants is not consistently evident.

What Has Changed in Meeting the Goals of Newborn Screening?

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This presentation will review the development of the Joint Committee on Infant Hearing position statements, examine legislation and health policy initiatives for universal hearing screening, and determine the changing nursing role in meeting the goals in the NICU.

The current goal is to screen all infants by one month of age, confirm hearing loss with audiologic examination by three months of age, and treat with comprehensive early intervention services before six months of age. Although hospital screenings have improved, there are changes in the position statement by the American Academy of Pediatrics that impact the NICU assessment. These updates are highlighted in this poster to rethink the NICU guidelines and improve hearing outcome.

Regional Newborn Intensive Care: Coping Strategies of Nurses

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Helping families grieve when a loved one dies is an inevitable and unavoidable aspect of professional nursing care. There is the expectation that nurses will be comforting, empathetic, and supportive with grieving families. Becoming overwhelmed with emotion, sadness, and grief is very likely for the nurse who becomes closely attached to a critically ill infant and family. NICU nurses develop relationships with infant’s families, celebrating milestones and recognizing the significance of parental grief as it relates to their critically ill or dying child. Thus, the nurses who work in RNICU (regional newborn intensive care unit) are in need of resources and successful coping strategies to manage their own grief when a patient dies. This qualitative study examines strategies that are utilized and the nurses’ perceptions of the adequacy of available institutional support. Nurses in a 53 bed Level III RNICU at a large academic health science center, which has magnet designation in the southeastern U.S., were surveyed to determine the current status of emotional support for nurses after an infant dies.

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A Quality Program Initiative to Provide Neonatal Feeding Enhancement in the NICU

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Background: There is wide practice-variability among the multidisciplinary feeding providers that are associated with delays in acquisition of feeding milestones.

Aim: We tested the impact of an interdisciplinary neonatal feeding team approach on an individualized feeding care plan by measuring staff and parent satisfaction.

Approach: Survey among feeding providers was conducted to identify variability in feeding practice. Guidelines were developed to target acquisition of feeding milestones. Focus groups were developed to enhance standardization of feeding practices. Feeding rounds are centered on: objective evidence, literature review and education, and research. Infants were monitored for compliance weekly. Repeat-survey was conducted to assess staff and parent satisfaction.

Results: At inception-survey (n=131 RN responders) suggested nursing education with feeding strategies (96 percent), parent education (81 percent), timely diagnosis (73 percent), and individualized-feeding-care plans (89 percent). Six-month survey (n=105 RN responders) found: feeding rounds helpful to them (74 percent) and patients (82 percent), increased parental empowerment (68 percent). Importantly, 68 percent achieved full oral feeding-milestone by 38 weeks corrected gestational age (vs only 43 percent pre-program baseline).

Conclusions: *Significantly*, this initiative contributed to the development of individualized feeding strategy and advanced knowledge base among feeding providers that resulted in 25 percent-increase in acquisition of feeding milestones.

Decreased Length of Stay Utilizing the COPE Program in Extremely Premature Infants in an All Referral NICU

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Background: The NICU at Nationwide Children's Hospital is an all referral unit. There is a dedicated pod for patients born at <27 weeks gestational age. Care is provided by a dedicated staff following a set of guidelines for the uniform care of the <27 week infant. COPE (Creating Opportunities for Parent Empowerment) was initiated in December, 2009 for all <27 week infants. The COPE program was developed as a tool for parents of premature infants in the NICU. It is designed to

encourage, educate, and empower parents to manage the difficulties of a NICU stay by using a holistic and interactive approach.

Objective: To analyze the potential impact on length of stay (LOS) in <27 week infants after the institution of the COPE program in the extremely premature infant in an all referral hospital.

Methods: We analyzed LOS in 69 consecutive surviving patients, 39 patients admitted between April 17, 2009 and November 11, 2009 (no COPE) and 30 admitted between November 24, 2009 and July 7, 2010 (COPE). Infants transferred to another facility and infants that died were excluded.

Results: The median gestational age did not differ ($p = .15$) between groups (no COPE 25 [intraquartile range 24–25] and COPE 25 [24–26]). The median birth weight did not differ ($p = .09$) between the groups (no COPE 675 [572–824] and COPE 717 [625–900]). The COPE group had a significantly decreased ($p < .001$) LOS (median for COPE group 114 [96–144] days, for no COPE 180 [114–215]).

Conclusions: These findings support the notion that empowering parents to take an active role in their premature infant's care from the day of admission substantially impacts LOS. Our results support the importance of active family-centered care.

Resuscitation of the Surgical Neonate

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The first minutes of a newborn's life are critical to the transition to the extrauterine environment. Management of these newborns in the first minutes to hours of their lives may have significant, life-long consequences. So much so that the "Golden Hour", a concept adopted from the trauma setting, is now utilized in neonatal resuscitation practices.

This poster will present a series of diagnosis-specific, evidence-based resuscitation guidelines developed to provide standardized, expert interventions aimed at promoting the best possible outcomes. Guidelines presented will include: Congenital diaphragmatic hernia, gastroschisis, omphalocele, sacrococcygeal teratoma, lung lesions, lymphatic malformations, myelomeningocele and cardiac defects.

Optimal care guidelines were developed based on our experience with a large surgical/neonatal patient population in our quaternary NICU and also our Special Delivery Unit, the first ever delivery unit within a Children's Hospital, dedicated to mothers carrying babies with diagnosed surgical and cardiac birth defects.

Through multi-disciplinary simulations and actual delivery experiences, we are able to ensure a highly-skilled, specialized team is ready to resuscitate each surgical neonate. By adopting a uniform approach, optimal management is achieved during the "Golden Hour" and beyond.

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Implementing Australian Resuscitation Council (ARC) Newborn Resuscitation Guidelines in a Level II Hospital

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Background: Australian Resuscitation Council (ARC) launched newborn resuscitation guidelines in February, 2006. Many hospitals encountered difficulties implementing these guidelines, particularly the perceived costs related to use of air rather than 100 percent oxygen. With redevelopment of their Child Birth Unit planned for 2010, Werribee Mercy Hospital (WMH) employed a neonatal educator in 2009 to project-manage the full implementation of ARC guidelines in a timely/cost effective manner.

Method: Review of resuscitation equipment/current practices within WMH, liaison with key stakeholders, and online survey of equipment/clinical practice in other Victorian hospitals.

Survey: 39 Victorian maternity hospitals of varying acuity contacted with 61 percent (24) response rate. There was 100 percent awareness of ARC guidelines—comments in the negative (to introduction of compressed air) related to cost.

Results: Rental of air cylinders, Y connectors to mix gases, purchase of 2 oximeters for “high risk” births and rationalization of required equipment, combined with regular staff updates and practical training sessions, led to full implementation by November, 2009.

Conclusions: Appointment of a project leader and economical use of available funds led to full implementation of ARC guidelines within 10 months. This process could easily be replicated in other clinical settings.

Achieving Reliable Scores Using the Finnegan Neonatal Scoring Tool

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Infants exposed *in utero* to drugs are at risk of developing Neonatal Abstinence Syndrome (NAS). NAS is a neonatal syndrome of drug withdrawal characterized by central nervous system hyperirritability, gastrointestinal disturbances, respiratory distress, and vague autonomic symptoms. Adverse outcomes for infants with NAS include seizures or death. At a Level III NICU, in a community non-profit magnet hospital, the number of infants treated for NAS increased 81 percent over the last 3 years. The Finnegan Neonatal Scoring Tool (FNST) is a semi-objective tool used to determine severity of withdrawal and treatment. The increase of NAS patients revealed inconsistencies in staff scoring the FNST. The goal of this project, led by the author, was to improve reliability among users. A literature search discovered an inter-rater reliability scoring program using the FNST. The initial education for staff using the scoring program's FNST guidelines was presented in a mandatory workshop. A task force of Super-Users was then trained in using the workshop guidelines. After the Super-Users achieved 100 percent inter-rater reliability, they coached every clinical nurse to

do the same. With this training, clinical staff achieved 100 percent reliability in only two months. Inter-rater reliability is being reassessed every six months to ensure sustained improvement.

Critical Airway Armamentarium: A Review of Alternative Methods to Securing a Patent Airway

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The complexity of neonatal nursing and medicine is ever growing, as well as the technology and equipment used to treat critically ill infants. This presentation focuses on the review of available equipment as well as the methods used to secure a patent airway in a neonatal critical airway situation. Equipment to be reviewed include but are not limited to the laryngeal mask airway (LMA), cricothyroidotomy, GlideScope, and Shikani devices. The objective of this presentation is to broaden the neonatal nurse practitioner's knowledge on available alternatives to the standard endotracheal tube (ETT) when utilization of routine equipment and processes are not effective in establishing an airway.

Inhaled Nitric Oxide Use in Extremely Premature Infants in an All-Referral NICU

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Background: The small baby pod is dedicated for the care of <27 week infants in our all-referral unit. The care is standardized and the use of inhaled nitric oxide (iNO) is not addressed.

Objective: To examine off-label iNO use in these patients.

Methods: Babies admitted from March 2005 to December 2010 had their charts reviewed, and a comparison (C) group of age and weight matched patients was identified.

Results: There was no difference between the iNO group (n = 74) and the comparison (C) group (n = 89) in terms of gestational age or birthweight. The average age of starting iNO was 26 ± 41 days and duration of iNO use was 22 ± 26 days. The iNO group (68 percent) had a lower (p<.05) survival rate than did the C group (84 percent). The incidence of severe IVH (iNO 35 percent; C 14 percent) was greater (p<.05) and the length of stay in survivors (iNO 199 ± 81; C 133 ± 50 days) was longer (p<.01) in the iNO group. There was no difference in the incidence of BPD between groups.

Conclusions: These data suggest that in infants born at <27 weeks, iNO is used in a highly variable manner in the sickest patients without obvious clinical benefit.

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Improving Best Practices for the Maintenance of Central Lines

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Central Line Associated Blood Stream Infections (CLABSIs) have led to an increase in hospital costs, patient mortality, and patient morbidity. Reduction in CLABSI's can be achieved through changes to the current nursing practice. The Center for Disease Control has not set a standard of practice for the maintenance of central lines in NICUs. Consequently, standards of practice vary widely between hospitals nationwide.

Question: What is the best evidence-based practice to maintain a central line in the NICU in order to reduce or eliminate CLABSIs?

Research: A summary of current research, focused on evidence-based central line care and maintenance practices, will be compiled and presented. Individual components from central line bundles will be scrutinized for the evidence-base.

Application of Research: As an example, the University of California Irvine Medical Center NICU's current policy and procedure for maintaining central lines, which helped reduce the CLABSI rate from 3.48 per 1,000 central line days to 1.48 per 1,000 central line days (with marked improvement in <1,000 g infants), will be displayed with accompanying statistics. Along with current research, a section will be dedicated to identifying the gaps in knowledge and potential areas for future research to help improve best practice.

Evaluating Developmental Care in the Neonatal Intensive Care Unit

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Developmentally supportive care and family-centered care are essential to the physical and psychological progress of the acutely ill infant in the neonatal intensive care unit. Developmentally supportive care integrates direct hands-on care, environmental factors, and caregiver and family interaction to ensure the most favorable outcomes, both short and long term, for each infant.

Many NICU's have developmental specialists whose function is to monitor and evaluate the developmental care delivered to each patient. In NICU's where there is no specialist or NIDCAP-trained individual to perform this function, nurses and other caregivers can provide this service successfully.

The NICU in which I work is a Level III. We do not employ a developmental specialist but we do have a developmental committee. The nurses and other committee members (physical, music, feeding therapists) conduct inservices and offer PowerPoint presentations on topics directly related to developmental care strategies. Rounds are conducted on both night and day shifts. We have a specific protocol, or tool, to follow in evaluating the infant's care and environment. The tool is the subject of this poster presentation. It evaluates the appropriate care interventions and modifications and the environmental factors that support growth and development. The tool is simple and can be implemented in any NICU, large or small, single-patient room or multi-bed setup. Each category evaluated by the tool can be enhanced or simplified according to the individual needs of the infant.

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