

Relevance to NIDCAP

Individualized observations are the main element of the NIDCAP program, and are performed before, during and after the activities of feeding. Professor Heidelise Als trained us

how to do observations during caregiving. We combined these individualized observations in the promotion of oral feeding program and found that the very low birth weight infants achieved full oral feeding sooner, which promoted nursing care in our NICU.

The Impact of a Developmental Care Skin-To-Skin Quality Improvement Project as Part of our Process of Becoming A NIDCAP Certified Training Center

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Introduction

Trauma-informed developmental care (TIDC) is essential to premature infants and their families hospitalized in the newborn intensive care unit (NICU). The core measures in TIDC include five standards of care with skin-to-skin care (SSC) being central to their application.¹ SSC has multiple benefits for the infant and its family² but it also creates a sense of safety and security to foster the development of trust and attachment, all in alignment with TIDC principles.¹ This is why the World Health Organisation (WHO) now recommends the practice of a minimum of 8-12H of SSC per day in the NICU.³ SSC is also considered to be the utmost co-regulation strategy to decrease stress and trauma as recommended by the Newborn Individualized Developmental Care Assessment Program (NIDCAP).⁴⁻⁵ NIDCAP aims to prevent complications in NICU and to maintain the intimate connection between parent and infant through collaborative observations of behavioural cues, individualized care plans and follow-up by NIDCAP Professionals.⁵

Aims/Purpose

Our NICU is a 26 bed, open bay, level III unit in Montreal, within the French-speaking province of Quebec, located in a socio-economically challenged area of Montreal. About 50% of the patients are out born, sometimes from cities hundreds of miles away from Montreal, which limits parental presence. In the process of becoming a NIDCAP Training Center Unit and to foster parental presence and participation in care, we aimed to improve SSC session duration and frequency, as primary objectives for this project. However, as the training of our NIDCAP Professionals advanced, a secondary objective imposed itself. The goal was to determine the effect of being followed by a NIDCAP Professional in the context of the

Advanced Practicum of NIDCAP Training and subsequent follow-up after their certification, on the duration of SSC.

Over the last three years, we developed a new SSC multi-disciplinary protocol, a SSC online training module, and SSC coaching sessions at the bedside for both parents and professionals. In addition, different tools to promote comfort and safety during SSC were purchased, such as zero gravity chairs, SSC wraps, as well as the use of leaflets and videos as parent resources.

Methods

To monitor the progress, we documented parental presence, duration and frequency of SSC sessions, transfer techniques and positioning during SSC with bi-annual audits. Those audits were developed and validated by a team of clinicians as part of our provincial community of neonatal nursing practice (CVP-Neon@t) and are used in many NICUs in Quebec. The audits are always attended over a three-day period that includes both week and weekend days.

Results/Findings

Over the span of three years, which included the COVID pandemic, our primary objectives were met. The duration of SSC sessions doubled, increasing gradually and continuously from an average of 89 to 164 minutes ($P=0.025$). The frequency of SSC sessions tripled by our second audit, from 29% to 100% ($P=0.025$) and was steadily maintained in the following audits. This meant that every time a parent was present, and the infant was eligible for SSC, SSC occurred.

This average duration of SSC increased to 258 minutes ($P=0.025$) when the infant was followed by a NIDCAP Professional within an advanced practicum. Some NIDCAP infants and their parents were having an average of 10 hours per day of SSC sessions.

Conclusion

Our small sample (N=87, average=15 patients/audit & NIDCAP N=7, average - 3.5 patients/audit) and non-statistically significant results are explained by the size of the NICU and we recently followed patients for the NIDCAP advanced practicum for a few months. Despite this small sample, we were able to demonstrate that this project not only improved SSC duration and frequency in our NICU but also that NIDCAP Professional follow-up almost doubled the duration of SSC sessions.

Relevance to NIDCAP

These findings are relevant to NIDCAP, as they support previous similar findings in France.⁶ Since parent-infant attachment is at the heart of NIDCAP, the importance of SSC as an essential strategy to foster behavioral cue understanding, co-regulation, and the principle of zero-separation cannot be understated. This study demonstrates that we can maximize this strategy with NIDCAP advanced practicum follow-up.

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"This is the best ward round I have ever been a part of": Implementing Developmental Care Ward Rounds in a Tertiary Neonatal Unit in the UK.

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Aims

The neonatal unit at University College London Hospital is the only NIDCAP Training Centre in the United Kingdom. We are committed to improving the collaboration between healthcare professionals and families. In 2023, we identified an opportunity for our multi-disciplinary team to work together to enhance this relationship by launching developmental care ward rounds.

Our quality improvement project (QIP) had three main aims:

1. Support parents as key nurturers
2. Provide individualised care plans for infants and their families
3. Ensure that staff feel valued as part of a wider interdisciplinary team

Methods

Key members of the neonatal team were identified as stakeholders for this project. These included an occupational thera-

pist (NIDCAP trained), physiotherapist, speech and language therapist, psychotherapist, neonatal nurse and neonatal consultant with an interest in developmental care. The Plan-Do-Study-Act (PDSA) model was used in project planning and execution. A questionnaire was sent to parents asking them for their views and recommendations. Families were keen to participate and expressed a desire for an opportunity to share what they knew about their baby and to learn more about the different stages of their infant's development. Regular meetings were held to design a poster, parent leaflet and a bedside record sheet which includes an individualised care plan for the infant and family supported by the wider interdisciplinary team. The project was registered as a QIP within maternity services. To ensure a clear and efficient referral and selection process, a standard operating procedure (SOP) was developed and distributed to all staff. Additionally, regular bedside education and engagement sessions were held with all members of the neonatal team.