Nursing Staff Issues and Baby-Friendly Practices: Changing a Culture based on History and Tradition

- Presenter: Jennifer Ustianov, MS BSN, RN, IBCLC
- Wednesday, March 16, 2016
- 11:00-12:00 CST

Please remember to mute your line (*6)!
Upcoming Wednesday Webinars

Webinars are held in collaboration with the Mississippi State Department of Health and are scheduled on Wednesdays from 11a-12p (CST)

ALL ARE WELCOME TO ATTEND! For log-in information, visit: www.CHAMPSbreastfeed.org/webinars

SCHEDULE

• April 6: The CHAMPS Community and the Baby Cafe Model
  Lucia Jenkins, RN, IBCLC, RLC; Kimarie Bugg, MSN, MPH, CLC; Danielle Lugrand, CLC

• May 18: Creating a Prenatal Education Plan

• June 22: Getting Hospital Leadership on Board
Upcoming: 4-hour Clinical Skills Trainings

• March 28th, Merit Health Woman’s Hospital

• April 7th, Baptist Memorial Hospital – North Mississippi

For more information, visit: CHAMPSbreastfeed.org/events1
Second Indian Country Breastfeeds Conference: Sustainability and Support

Date: May 9-10, 2016
Location: Albuquerque, NM

Topics Include:
• Sustainability
• The Baby-Friendly Hospital Initiative
• Breastfeeding and clinician support
• Historical trauma and breastfeeding
• Illicit drug use and breastfeeding

For more information, visit:
http://www.indiancountrybreastfeeds.org/events

OR

Email:
indiancountrybreastfeeds@gmail.com
Changing a Culture based on History and Tradition

Nurse Staffing Issues and Baby-Friendly Practices

Jennifer Ustianov MS BSN RN IBCLC
Senior Director, NICHQ
March 16, 2016

11:00 am – 12:00pm (CST)
No one likes a change except a baby with a wet diaper
Traditional Maternity Care

• Nurse/physician-centric practice
• Task focus
• Infants separated at birth or soon after
• Infants in nursery for long periods of time
Why Change?
No Separation at Birth

• Patient-centric practice
• Opportunity to breastfeeding early – usually in 1st hr. (Crenshaw, 2007)
• Thermal, respiratory and glucose stabilization in newborn promoted by S2S contact (Feldman, 2004)
• Separation increases risk formula supplementation
• Early breastfeeding has an impact on duration of breastfeeding (Dabrowski, 2007; Wlater et al., 2007)
Why Change?
Mother- Baby “Couplet” Care

- Patient-centric practice
- Continuity of care
- Skin to skin contact  (Moore et al., 2012)
  - Exclusive breastfeeding rates  (Bramson et al., 2010; Crenshaw, 2014; Rodgers, 2012)
  - Newborn admission to higher levels of care
  - Patient satisfaction scores  (Elliott-Carter and Harper, 2012; Waller-Wise, 2012)
- Mother/SO increased confidence and participant in care  (Waller-Wise, 2012)
- Cost effective  (Brockman, 2015)

“Couplet Care is designed to encourage family involvement in the baby’s care during the first few days of life” Lancaster General Hospital
Goals and Outcomes

- L&D RN and transition/baby RN work together providing evidence based care
- Improved continuity of care
- Decrease separation
- Cue based feeding
- Improved breastfeeding outcomes
- Decrease personnel providing instruction and education
- Handoffs more accurate & couplet specific
- Documentation of exceptions
- Parents increased confidence at discharge
Getting From Here To There
Starting With A Change Framework

Three Stages of Change

1. **Unfreeze** – identify the problem and the need for change
2. **Move/Transition** – staff involvement-planning and implementing the change
3. **Refreeze** – “making it stick” by reinforcing desired outcome

*Lewin’s Theory of Change (Lewin, 1951)*
Motivation for Change
Unfreeze Status Quo

• Baby Friendly
• Evidence
• Professional role in nurturing the mother-infant bond
• Family requests
• Desire to stay competitive in your community
Roger’s Adoption Curve

- Change is hard...and painful for some
- It takes time
- There is a tipping point

Desire to be a leader/champion

Requirement

Easy to use, simple
Staff Concerns and Challenges

- Patient ratios
- Assuming care for an additional population (newborn or mother)
- L&D RN caring for two patients in the busy, immediate postpartum
- Lack of confidence and competence
- Loss of identity, skill, “...this is what I love to do”
- Safety
- Space, privacy
What is Needed?

Move/Transition

• Strong Leaders who believe in the change
  • Nursing and Provider Leadership with support from administration

• Evidence-based care models → Policies and Procedures

• TIMELINE -- “Go-Live” date

• Multi-unit staff engagement, education and buy-in

• Provider engagement and buy-in

• Collaboration with OR, PACU

• Role re-defining

• Community education and marketing
What is Needed?
Move/Transition

• Guiding Team (membership may flux)
  • nursing, provider (OB, PEDS, Neo), respiratory, NICU, OR PACU, anesthesia, risk mgmt., pharmacy, ancillary staff, material mgmt., security, admitting department, IT, marketing/business office,

• Multidisciplinary staff input before, during and after
• Physical layout and set-up
• Coordination and collaboration with PACU
• TRIAL RUNS
• Expectations and accountability for practice
• Patient/family input and feedback
• Data to monitor early wins, progress and sustained success
• Connect the data to changes in practice
What is Needed?
Move/Transition

• Have a draw
• Have a friendly competition/contest
  ❖ % S2S for ≥ first hour
  • Between March 21’s 12-hr day shift and March 22’s 12-hr day shift
  • Between Saturday and Sunday (both days and nights)
• Most valuable “change agent of the week”
• Best story of the month on a chosen topic
• Best “idea to support breastfeeding” of the week
AWHONN Staffing Guidelines
AWHONN 2010 Guidelines for Professional Registered Nurse Staffing for Perinatal Unit

• Antepartum testing
• Obstetrical triage
• High risk conditions
• Women choosing minimal interventions during labor
• Coverage of high-alert medications
• Critical elements of care during postpartum recovery
• Lactation consultant coverage
• Minimal staffing and contingency planning
Staffing Guidelines and Recommendations

“Move/Transition”

Institute Of Medicine: *The Future of Nursing: Leading Change and Advancing Health*

Key Recommendations

1. Maximize the impact of perinatal nurses by ensuring they are practicing to the full extent of their education and training
2. Correctly match how nurses are educated and oriented to the roles and tasks they are expected to perform

...ensure that women’s health and newborn care in the US is consistent with the latest research regardless of the birth setting
Role of the Change Nurse

Move/Transition

Small Volume Perinatal Service
• Many need to take a patient assignment
• Manage hour to hour
• Supervisory tasks

Large Volume Perinatal Service
• Ideally no patient assignment
• Manage the hour to hour; mentor less experienced nurses
• Exception high census, short term such as baby nurse or OB triage
• Supervisory tasks
Models of Couplet Care

• L&D nurses
  - trained in newborn assessment (apgar, VS, general transition/appearance)
    • L&D RNs tag team and support each other at delivery
    • Baby nurse facilitates S2S, admits newborn, ID etc
    • initial NB assessment and VS documented
    • Transfer care to delivery nurse, as appropriate, provides care for remainder of stay in L&D
    • facilitate S2S, support first bf;
    • hand off mom and newborn care together

• Delivery support RN
  - attend all normal newborn vag and C/S deliveries,
    • assess and document care, VS and care in first q-2 hours of life
    • facilitate S2S
    • support first bf
    • hand off newborn care
Supporting Confidence and Competence

• Visit a local unit
• Shadowing
• Newborn Transition orders: outline parameters that require NB to be transferred for observation in nursery/NICU
• NBN RNs work directly with NICU to ensure transfer to mom as soon as infant has stabilized
Implementing Skin to Skin

• Education for nursing and providers
• Inform and educate mothers and families
• Simulation and testing
Design the Steps
Test it out

SKIN-TO-SKIN CONTACT (SSC) CARE PROCEDURE
SSC is for healthy, stable, term newborns >37 weeks gestation with low risk pregnancy/delivery and no evidence of respiratory compromise, meconium-stained amniotic fluid, hypotonia or weak cry at birth. In these incidences, SSC should be delayed and immediate pediatric assessment will take precedence.

1. Explain to laboring women about the concept of (SSC) and its benefits for mothers and newborns.

2. After delivery, immediately place infant on mothers abdomen. Dry and stimulate with warm towel and bulb suction as needed.

3. Remove wet towel and cover infants back with clean, warm blanket.

4. Assess infant vital signs if not doing so already and assign 1 minute APGAR.

5. Place head cap on infant and place ID bands on infant and mother per protocol.

6. Delay infant eye treatment, injections and measurements until after first feeding at breast or 1 hour.

7. Monitor infant’s skin temperature every 15 to 30 minutes to be certain that temperature remains within clinically acceptable range. Assign 5 minute APGAR.

8. Weigh infant and assess SpO2 at 15 minutes of life then return infant to SSC immediately. Notify pediatric resident if SGA or LGA and initiate glucose protocol if indicated.

9. Allow infant to spontaneously move toward the breast and latch onto a nipple. This may take up to 75 minutes but occurs in most infants.

10. Provide initial breastfeeding education to the mother.
Delaying the First Bath

Potential Benefits:
- Promotes transition to extra-uterine life
  - thermoregulation, blood glucose stabilization
- Early breastfeeding success,
- Benefits of vernix and amniotic fluid
- Promotes maternal-infant bonding

No documented benefit to preforming a bath within 2 hours of birth unless medically indicated
Practice Change Guided by Evidence

• Explored bonding at birth. First 60-90+ minutes after birth defined as a “sensitive period” for maternal-newborn bond.  
  (Klaus and Kennel 2004)

• 166% increase in hospital breastfeeding success after implementing a 12 hours delay in first bathing practices.  
  (Preer et al. 2013)

• *Newborn crawl and feeding cues are markedly reduced after bathing.*  (Varendi et al. 1998)

• “Wait for 8”  (AWHONN 2000 neonatal Skin Care Guidelines)
Process Implementation

• Educated multidisciplinary staff on delayed NB bathing
• Parent education: develop a script (EBP) on delayed bathing
• Bathing training/competency developed for NB bathing at bedside
• Small tests of change (Plan-Do-Study-Act)
• S2S after bath to ensure stable infant temp
Delaying the First Bath

Challenges

Change in Practice
• Move from task orientation to best practices
• Work flow – unsure when to get it done

Nurse Resistance
• Yuck factor
• One more task incorporated into postpartum care
• Universal precautions until bathed

Patient/Family Concerns
• Expectations around timing of bath
• Yuck factor especially the hair
Delaying the First Bath

Special Considerations

• No delay for newborns of mothers who are HIV and Hepatitis Viruses positive
• Handle all unborn babies with gloves
# NEWBORN ROOMING IN TRACKING CHART

##GOAL: Room in with mom >23 hours/day

THANK YOU for Supporting Our Practice Improvement

<table>
<thead>
<tr>
<th>Date</th>
<th>Time Separated</th>
<th>Reason</th>
<th>Time Returned</th>
<th>RN</th>
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Comments:
“Congratulations, it’s a boy!
Would you like to hold your baby now?
With safety in mind, we will work together to make sure he doesn’t leave your side.”
Mothers will say “NO”

- PLAN FOR THIS
- Staff to discuss this scenario
- Scripts for discussion reason, soothing techniques
- Role play
- Options to negotiate
  - Safe option to provide an hour break?
Newborn Assessment

Physical Exam

- **General appearance.** Physical activity, tone, posture, and level of consciousness
- **Skin.** Color, texture, nails, presence of rashes
- **Head and neck:**
  - Appearance: molding, cephalohematoma
  - Fontanels
  - Clavicles
- **Face.** eyes, ears, nose, cheeks.
- **Mouth.** palate, tongue, throat.
- **Lungs.** Breath sounds, breathing pattern.
- **Heart sounds and femoral (in the groin) pulses.**
- **Abdomen.** Presence of masses or hernias.
- **Genitals and anus.** For open passage of urine and stool
- **Arms and legs.** Movement and development.

Newborn Assessment

Physical Maturity (within 2 hours of life)

*Points -1 or -2 for extreme immaturity; 4 or 5 for postmaturity.*

- **Skin textures and appearance:** vernix, smooth, or peeling; lanugo
- **Plantar creases:** creases on the soles of the feet range from absent to covering the entire foot, depending on the maturity.
- **Breast:** The thickness and size of breast tissue and areola (the darkened ring around each nipple) are assessed.
- **Eyes and ears:** Eyes fused or open and amount of cartilage and stiffness of the ear tissue.
- **Genitals, male:** Presence of testes and appearance of scrotum, from smooth to wrinkled.
- **Genitals, female:** Appearance and size of the clitoris and the labia.
Newborn Assessment
Neuromuscular Maturity (by 24 hours)

*Six evaluations of the baby's neuromuscular system are done.*

- **Posture.** How does the baby hold his or her arms and legs.
- **Square window.** How far the baby's hands can be flexed toward the wrist.
- **Arm recoil.** How much the baby's arms "spring back" to a flexed position.
- **Popliteal angle.** How far the baby's knees extend.
- **Scarf sign.** How far the elbows can be moved across the baby's chest.
- **Heel to ear.** How close the baby's feet can be moved to the ears.
<table>
<thead>
<tr>
<th>Didactic instruction</th>
<th>8 Hours</th>
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<tbody>
<tr>
<td><strong>Newborn’s Care</strong></td>
<td><strong>Maternal Care</strong></td>
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<tr>
<td>Routine management of healthy newborns</td>
<td>Care of woman in postpartum period</td>
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<td>Assessment of the newborn</td>
<td>Postpartum assessment</td>
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<td>Circumcision</td>
<td>Hemorrhage</td>
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<td>Neonatal hyperbilirubinemia</td>
<td>Estimating blood loss</td>
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<td>Maternal infections</td>
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<td>Hypoglycemia in the newborn</td>
<td>Hypoglycemia management</td>
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<td>Passing meconium and urine</td>
<td>Transfusion guidelines</td>
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<td>Computer modules</td>
<td>5 Hours</td>
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<td><strong>Newborn assessment within 1 to 4 hours after birth</strong></td>
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<td>Normal postpartum physiologic maternal adaptations</td>
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<td>Physiologic and anatomic changes during the postpartum period</td>
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<td>Postpartum assessment after the recovery period</td>
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<td>Postpartum care of a woman post cesarean</td>
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<td>Postpartum complications</td>
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<td>Postpartum pain control and other self-care measures</td>
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<td>Postpartum psychological adjustments</td>
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<td>Specialty classes</td>
<td>8 to 16 Hours</td>
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<td>Bedside training</td>
<td>144 Hours</td>
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Measuring Success & Refreezing

**Measuring Success**
- Monthly, Quarterly Data
  - Exclusive Breastfeeding Rates
  - Staff and Provider Satisfaction
  - Patient Satisfaction
- Sharing data with everyone
- Financial Savings

**Refreezing**
- Policy
- Marketing
- Link practice to mission
- Practice accountability
- Addressing challenges constructively
Strategies for Implementing Practice Change

• Guiding Team/Committee
• Training
  • Research
  • Didactic education
  • Assessment/care classes
  • Nursing and providers provide the same message
• Engage and inclusion staff in change process (Moen and Core, 2012)
• MAKE IT FUN; Think Safety
• Set expectations and accountability for practice
• Provide opportunities to “grieve”
• Small TESTS OF CHANGE - PDSA
Mothers and babies form an inseparable biological and social unit, and... the health and nutrition of one cannot be divorced from the health and nutrition of the other.

*Global Strategy for Infant and Young Child Feeding*

THANK YOU