Australian College of Neonatal Nurses Inc.
PO Box 32 Camperdown NSW 1450
www.acnn.org.au ABN 62 075 234 048

Newsletter

September 2021

About the newsletter

This newsletter is the official communication of the Australian College of Neonatal Nurses to its members, produced quarterly in March, June, September and December. It presents information on a range of professional issues and clinical topics of interest to neonatal nurses. Any member of ACNN may contribute.

Articles should be submitted by email as Word documents. Any images should be in jpg format. Referencing style should follow the Vancouver style. All content will be edited to newsletter standard.

Editor: Shelley Reid. Proofreader: Jan Polverino.

Please send correspondence to the newsletter team at newsletter@acnn.org.au

Views expressed in this newsletter are not necessarily those held by the Australian College of Neonatal Nurses Inc.

Next deadline: 1 November 2021

ACNN National Executive 2021 – 2022

Office-bearers

President	Anndrea Flint
Vice president	Amy Curran
Secretary	Shelley Reid
Treasurer	Samantha Lannan

Ordinary Committee Members

Melissah Burnett
Nicol Franz
Kristin Hughes
Dr Linda Ng

Sarah Neale - Social Media

Professor Denise Harrison - Professional Officer

Executive Support Officer - Dr Karen New

From the president

Hi Everyone,

It seems like the year is just slipping away. Thank you to everyone who joined us for a fantastic 2 days on the virtual Annual Conference. During the Annual General Meeting the annual report was put forward, here are a few details:

1. Our governance activities are on track and all our policies and guidelines are currently up to date and published on the website.
2. There is an ongoing review of the strategic plan, twice a year adding items and ticking off items we have achieved.
3. Development of documents to support Branches and SIG in the form of how-to guides.
4. Creation of several partnerships and scoping the possibility of more to increase exposure for the college:
   - Finalising an MOU with the ACNP facilitated by the NNP SIG
   - Bronze Affiliation with the Australian College of Nursing, which offers benefits and exposure of our ACNN logo on their website
   - Continuing our excellent relationship with University of Tasmania

The college also supported:

1. Developing Australian Neonatal Nursing Care Outcomes: Neonatal Nursing Outcome Measures (NNOM) - Phase 1, by providing a research grant for this important work on understanding the needs and requirements for the neonatal workforce.
2. Membership promotion with May Madness
3. Working on a survey to make sure we are meeting the needs of the members and understand why members have left the college. Currently we have over 1000 members.
4. Quality process of continually reviewing and revising opportunities for Scholarships and Awards and the allocation of prize money.
5. Increased availability of educational opportunities for CPD points through virtual presentations

I would again like to acknowledge and thank Dr Linda Ng for

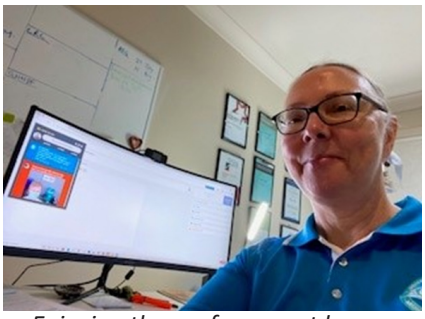
Cont. on page 2

From the President (cont.)

her work over the past 5 years in the role of the Professional Officer.

I look forward to working with a New Executive Committee this year and creating new opportunities for our members.

Anndrea Flint



Enjoying the conference at home

Low Resource Countries SIG

To help facilitate online training with colleagues in our neighbouring countries, the LRC SIG recently produced a video around the training that we had offered in-person. We hope that this video can be uploaded onto computers in country (in collaboration with some of our partner organisations such as Kokoda Track Foundation and Taking Paediatrics Abroad). Then we will be available online to also answer questions and facilitate their practice sessions – with equipment that we have sent up to them. Check out the video HERE.

Queensland Branch

The Queensland Branch successfully held our workshop at Logan Hospital on 26 June after having to postpone in February. This was an informative session attended by 30 delegates within COVID-safe restrictions. As nurses, we are talented at finding ways to cater for afternoon tea that keeps us COVID safe!

The topics included delayed cord clamping, managing hypoglycaemia, humidified high flow perspectives, Rapid Sequence Induction, and neonatal skin. We followed this with a dinner seminar attended by 21 delegates. Our guest speaker, Nicola Carlish – Exercise Physiologist, talked to us about the importance of exercise for mental wellbeing and we examined a case study presented by Anndrea Flint which certainly stimulated emotions and discussion. As neonatal nurses, we are often faced with extremely stressful circumstances at work and tend to prioritise our workplaces over our own health. It is important to explore debriefing and other strategies that can assist us with difficult cases and circumstances at work.

Our membership drive this year yielded 39 new or returning members, 6 more than last year! We would like to thank Amanda Bates and Stephanie Hall for recruiting members, each receiving $700 towards attendance at the National Conference in 2022 (being positive that face-to-face will happen in our 30th year!). Their recruits Amanda Cowan and Janine Douglas have won reimbursement of their membership. Welcome to the College!

The Branch is continuing to plan future face-to-face workshops with our next one to occur at Caboolture Hospital on November 6 (Save the Date). This workshop will take a bit of a different direction and look at neonatal abstinence syndrome, neonatal nursing workforce, admission rates, and qualified babies in the postnatal ward. Details to follow.

Celebrate your achievements! Scan the QR code to let us know if you have achieved a milestone in your neonatal nursing career. We would love to give you a big shout out!

NSW Neonatal Clinical Nurse Consultants Group

SOS – Save our Skin!

Emily Macnaught
Neonatal Clinical Nurse Consultant
NICU, Royal North Shore Hospital

In April 2020, clinicians in the NICU reported a perceived increase in extravasation injuries from infiltration of peripheral intravenous cannulas (PIVC). Skin injuries in critically ill and extremely premature neonates are at times unavoidable given the immaturity of their skin and the intensive care treatment required, however every effort should be made to minimise potential for harm. Extravasation injury secondary to PIVC infiltration is one of the most common iatrogenic injuries in neonates and is associated with long term morbidity including infection and scarring, particularly when located near joints.[1]

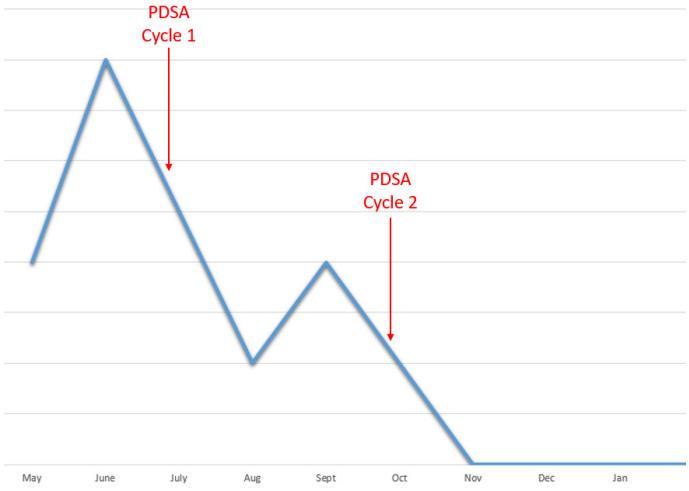
Potential drivers for an increase in extravasation injuries in the NICU were discussed and included: inconsistent taping methods to secure PIVCs, lack of a neonatal-specific PIVC policy or guideline, recent change in junior medical staff, turnover of nursing staff and lack of a robust scoring system for early detection of PIVC infiltration.

With the support of the NICU Skin Integrity Committee and Neonatal Education Team a clinical practice improvement (CPI) project commenced, with the aim to reduce the incidence of extravasation injuries secondary to PIVC infiltration in the NICU by 50% in 6 months with a stretch goal of 100%. Data were collected on all extravasation injuries related to PIVC infiltration for two months (May-June) using an 'extravasation injuries tracking tool' supported by a 'flowchart for management of extravasation injuries in the NICU'.

PDSA cycle 1 commenced in July. This included a literature review of best practice taping methods, a benchmarking audit of taping practices among all NICUs in NSW, removal of clear silicone tape for securing arm boards, improved clinical documentation of recording PIVC insertion in patient notes, finalisation of a PIVC management guideline for neonates (now published) and an education drive with in-services and practical skill sessions on the preferred PIVC taping method with emphasis on having both the cannula insertion and tip sites visible. Prospective auditing occurred for two months using the 'extravasation injuries tracking tool' following these initiatives (August-September).

PDSA cycle 2 occurred in October in which a second education drive focused on hourly documentation of the Neonatal Visual Infusion Phlebitis (NVIP) Score (a tool for assessing PIVC sites with modification for neonates) rather than the standard 'tick' indicating the site was checked and satisfactory, and a change in tape used for securing arm boards – changing from Leukoplast® Rigid to Leukoplast® Elastic – whilst maintaining the same method of taping. These initiatives were then implemented in the NICU, with a third two month period of prospective auditing from November-December, which was then extended a further two months until the end of February 2021.

Following the first PDSA cycle in July, the rate of extravasation injuries in the NICU reduced by 50% from six in May-June to three in August-September. The three injuries that did occur were more predictable e.g. a hyperosmolar infusion, an extremely premature infant (23 weeks gestation) with difficult venous access and multiple infusions. Following the second PDSA cycle in October and the implementation of the NVIP score, extravasation injuries further reduced to zero for the audit period November-December, and remained at zero when the audit period was extended until end February 2021.



Number of extravasation injuries

The 'SOS – Save Our Skin!' CPI project concluded in March 2021 after four months of zero extravasation injuries in the NICU. Reviewing current practice and products, benchmarking with peer NICUs, implementation of the NVIP Score and education on preferred taping method resulted in earlier detection of PIVC infiltration and prevention of tissue damage from extravasation, with a 50% reduction in extravasation injuries following the first education drive and a 100% reduction following the implementation of the NVIP score. Ongoing surveillance will continue with monthly review of ims+ and the Quality Audit Reporting System (QARS) PIVC insertion and management audit results to determine when targeted education should be revisited.

When concern around extravasations was initially brought to the NICU Skin Integrity Committee there was no immediate consideration to embark on a year-long CPI project! But now in retrospect it's great to be able to reflect on the process

Cont. on page 4

NSW Clinical Nurse Consultants group (cont.)

and see the impact fairly small changes can have on clinical practice. Nursing and medical staff in the NICU were receptive to all interventions and strategies as set out in the PDSA cycles, and the implementation of the NVIP score instead of a 'tick' was a surprisingly seamless transition. This reflects that practice change can be achieved with minimal resistance when supported by sound evidence and rationale as to why it will improve clinical practice. After all, neonatal nurses come to work every day to provide the best possible care we can and work together to achieve the best possible outcomes for babies and their families.

Acknowledgements: The NICU Skin Integrity Committee, the Neonatal Education Team, the NSW Neonatal CNC Network for sharing their unit practices and every nursing and medical clinician in the NICU as all were part of this practice change and resultant practice improvement.

Reference

Restieaux M, Maw A, Broadbent R, Jackson P, Barker D and Wheeler B (2013). Neonatal extravasation injury: prevention and management in Australia and New Zealand - a survey of current practice. *BMC Pediatrics* 13:34.

Education SIG

Council of International Neonatal Nurses (COINN)

Clinical A/Prof Karen Walker
President, COINN

Background

Every member of ACNN is a member of COINN, with the membership fees included in ACNN fees. For new members of ACNN, what does this mean and what actually is COINN?

COINN, an affiliate member of the International Council of Nurses (ICN), was founded by Professor Carole Kenner and was officially incorporated in 2005 to act as the global voice for neonatal nurses. COINN's mission is to advance neonatal nursing and health outcomes for newborns and their families, with a vision that all small and sick newborns receive high quality care by nurses who have neonatal nursing-specific education and skills. COINN has a major role working on global health policy, advocacy, education and competency development, building capacity and developing regional networks throughout the world for nurses who specialise in the care of newborn infants and their families.

The board of directors comprises representatives from 11 countries; neonatal nurse leaders working clinically, in academia and education, research, leadership and management. Three of the board are advanced practice Nurse Practitioners, the majority have Master's degrees, and 8 have PhDs. As leaders in neonatal nursing in their own country, they bring great expertise and passion to COINN. I have been President of COINN for the last 3 years.

Why is COINN important?

Approximately 2.5 million neonates die each year, which equates to 7000 dying each day – staggering statistics. What is also known is that the deaths of many babies the first 28 days of life could be prevented by quality care during childbirth and in the neonatal period. If you look at the 6 WHO regions, on average Africa has the highest mortality rates, but only 3 regions have an average below the Sustainable Development Goal (SDG) target of 12/1000 deaths. Australia, as you may know, has a neonatal death rate of 2.27/1000 but our closest neighbour, Papua New Guinea, which is only 15km from the tip of Australia, has nearly 10 times our mortality rate. These high mortality and morbidity rates and inequality within and between countries is what COINN and partners are working to improve.

Who do we work with?

In short, there are too many to write about in this short piece, so I will just mention our work with the World Health Organisation (WHO). COINN works with the WHO representing neonatal nurses on high level committees, developing policy documents and educational tools. COINN represents neonatal nurses as part of the Health Care Professional Association (HCPA) of the WHO Partnership for maternal, newborn and child and adolescent health (PMNCH). PMNCH is currently chaired by a former prime minister of New Zealand, Helen Clarke, and is the world's largest alliance for women's, children's, and adolescents' health (WCAH), bringing together over 1,000 partner organizations across 192 countries. Since its inception, PMNCH has worked to forge and strengthen partnerships and drive momentum towards the attainment of global targets for WCAH. On this committee are the CEO/Presidents or board representatives from the International Council of Nurses (ICN), the International Confederation of Midwives (ICM), the International Pediatric Association (IPA) and the International Federation of Gynaecology and Obstetrics (FIGO). I'm delighted to say that COINN has an executive role on both the HCPA committee and the new Knowledge and Translation working group. In collaboration with the WHO and multiple other stakeholders, we are also revising the Every Newborn Action Plan.

As I'm writing this on behalf of the Education SIG, I will concentrate on some of the education work COINN is doing. From a policy and education perspective, members of COINN participated in and contributed most recently to 2 WHO

documents. These were the framework developing Standards for Improving the Quality of Care for Small and Sick Newborns, and Human Resources for Health Strategies for low and middle income countries, both published last year. Both documents had a focus on education. Currently COINN is working with the WHO developing modules for a course for Level 2 units in low- and middle-income countries, focusing on Care of the Small and Sick Newborn. I'm grateful for the support in the development of the education modules from members of the ACNN Education SIG. This new course adds to the WHO Essential Newborn Care course, which is currently being revised (and that COINN has been part of a group reviewing). Another key publication from COINN is the International Neonatal Nursing Competency Framework, published in the Journal of Neonatal Nursing in 2019. These competencies are now being used as a framework for many courses and have been translated into Russian.

In many countries, nurses are not considered leaders, but as the largest component of health care workers, it is imperative that this view changes and that COINN, and ACNN, continue to advocate for this. ACNN has always had a strong relationship with COINN, the board and committees and I am delighted to share that Dr Karen New was the first Australian President of COINN. As the current President of COINN, I feel very privileged to sit on these global committees and advocate for neonatal nurses, and to continue and take forward the important work of COINN. Our new website https://www.coinnurses.org/ was launched this year, where you will find information about COINN and the work we, with many of our global partners, are involved in. We have an education committee, so if education is your passion, please join it and help drive global education.

It's taken many years for neonatal nurses to be globally recognised as pivotal in leadership roles, and we continually advocate for this. For the first time, an opinion/editorial written and signed by the president of ICN, ICN, IPA, FIGO and COINN has been accepted for publication in the British Medical Journal. I ask all nurses to stand up, be heard, our profession needs strong voices and we must lead education and be at every policy table.

Infant Feeding SIG

Feeding interval for babies ready to go home

Melissa Blake

Do all babies have to be put to 4 hourly feeds prior to discharge? In short – no!

Developmental care principles of assessing feeding readiness and developmental maturity should be applied to feeding practices on an individual basis for all gestational groups. Feedings must safe, developmentally appropriate, functional so infants can consume an adequate amount to grow, be nurturing and enjoyable.[1] Cue-based infant feeding has been found to facilitate oral feeding establishment and improve long-term premature infant outcomes.[2] It is important to remember that premature infants nearing discharge are still developmentally immature and careful assessment of their oral-feeding skills is required despite whatever prescribed feeding regimen is preferred.

Strict four-hourly feeding is largely an historical practice driven by U.S. paediatrician, Dr Benjamin Spock, who in the 1940s advocated for timed infant feedings, four-hourly schedules and formula supplementation for sore nipples.[3] Remnants of that era still exist today! For breastfed infants, whenever the infant is showing signs of feeding cues, regardless of the scheduled feeding times, the infant should be offered the breast. For late preterm infants, it is recommended to breastfeed at least 8 to 10 times over the 24 hours to ensure infants consume enough milk and mothers receive frequent breast stimulation.[4,5]

For formula-fed infants, the principles of cue-based feeding still apply. Bottle-fed premature infants may suck robustly despite poor oral regulation and swallowing coordination.[6] Pushing infants to '*finish the bottle'* should not be a feeding aim. Therefore, if the infant is feeding and growing well on 8 smaller feeds per day, 4-hourly feeding attainment is not necessary as a discharge criteria. For the premature infant who is nearing discharge, be mindful of potentially exacerbating reflux with larger volumes.

Be guided by the infant, and if showing signs of hunger, then feed!

References

1. Ludwig SM, Waitzman KA (2007). Changing feeding documentation to reflect infant-driven practice. *Newborn and Infant Reviews* 7:3, 144-160.

2. Shaker CS (2012). Feed me only when I'm cueing: moving away from a volume-driven culture in the NICU. *Neonatal Intensive Care* 25:3, 27-32.

3. Thulier D (2009). Breastfeeding in America: A history of influencing factors. *Journal of Human Lactation* 25:1, 85-94.

4. Meier P, Furman LM, Degenhardt M (2007). Increased lactation risk for late preterm infants and mothers: Evidence and management strategies to protect breastfeeding. *Journal of Midwifery & Women's Health* 52:, 579-587.

5. Meier P, Patel AL, Wright K, Engstrom JL (2013). Management of breastfeeding during and after the maternity hospitalization for late preterm infants. *Clinics in Perinatology* 40:4, 689-705.

6. Thoyre SM, Shaker CS, Pridham KF (2005). The Early Feeding Skills Assessment for Preterm Infants. *Neonatal Network* 24:3, 7-16.

Leadership SIG

Lyn Chapple

The Leadership SIG recently hosted two virtual workshops focusing on Communication and Conflict Competence. Julie Sorrell, a Nurse Researcher at North West Hospital and Health Service, has facilitated these sessions. Julie is passionate about leadership and its impact on nursing workforce and culture. Through an evidence-based practice culture she has developed and facilitated learning and activities that strengthen the ability of nurses, midwives, and allied health staff. Julie used her knowledge and experience when she developed the BOOST! Leadership Development Program, which has been implemented in Health Services across Queensland.

Julie highlighted the importance of communication, a skill that cannot be underestimated. Effective communication is vital to gain trust and inspire positive change. When communication is lacking, important information can be misinterpreted, causing relationships to suffer and, ultimately, create barriers that hinder progress. It is simply impossible to become a great leader without being a great communicator, and communication skills are required that go beyond just relaying information.

Conflict management is a skill that leaders must be able to employ when needed to help foster a productive working environment. The inability of a leader to deal with conflict not only leads to negative outcomes but may also undermine the credibility of the leader. Conflict management competence begins with leaders. It cannot be overstated that leaders who enhance their own skills and abilities set an example that has a significant impact on the rest of the workforce.

If you missed any these virtual sessions don't worry, they are now available through the ACNN website. Also, keep an eye out for future sessions being hosted by the Leadership SIG including Change Leadership / Change Management and Role Modelling.

If leadership is something you are passionate about and you would like to engage with like-minded clinicians, then I would encourage you to join the Leadership SIG committee.

Remember: *'Leadership is not a position or a title, it is action and example'*

Leadership in Neonatal Nursing

Alyson Smith

Neonatal nursing is often the unseen specialty, sitting somewhere between maternity services and paediatrics in many organisations. This has proved to be a frustrating part of my career as a manager in a level 5 Special Care Nursery. Making neonatal care and nursing more visible has improved organisational understanding of the role we play in maternity and paediatrics.

Hi, my name is Alyson Smith and I am a manager of a Special Care Nursery in a large regional hospital in Victoria. Like many other managers, this role was a 'learn as you go' situation, with many hurdles and brick walls along the way. Fifteen years on and I finally decided that perhaps it would be interesting to complete a Master in Healthcare Leadership.

I would recommend this step to any aspiring or current managers, especially in the neonatal field. Learning the theory and underpinnings of leadership is challenging but also rewarding. Managers manage but not all managers are leaders. Believe in the vision for the team/unit and bring others along on the journey.

My vision for our neonatal unit started way back in 1990 when I completed a Neonatal Intensive Care Nursing course in Melbourne. It was so different from Midwifery and the start of my journey to achieve something for the regional community I was to become a part of. Providing best practice, high quality neonatal care where more infants could stay closer to home and be given level 5 care in our unit became a reality in the early 2000s and has continued to improve and grow.

The support of the ACNN has been a part of this journey with many of my neonatal staff joining and receiving support through ongoing education and UTas tertiary enrolments. It is important to encourage neonatal staff to continue their learning, gaining tertiary qualifications. Increasing knowledge provides acknowledgement of how important this specialty has become.

Communication and collaboration between services and the medical team is an essential part of a healthy culture and team work. Moving forward into the future our service will be growing and the model of care is going to become more collaborative, with families becoming an integral part of our service. The plans for our new build will include an 8-bed parent neonatal unit with certain newborns cared for with their mother still an inpatient as well. This is an exciting move and one that I hope will filter into other neonatal units in Australia.

Neonatal Nurse Practitioner SIG

Addressing the challenges of bilious vomiting in retrieval

Jo Scott
Nurse Practitioner

Bilious vomiting (BV) in the newborn period is a surgical emergency. Admission to a surgical neonatal intensive care unit for investigation and assessment by a paediatric surgeon is recommended to exclude bowel obstruction, malrotation and other time-critical surgical pathologies.[1] In Victoria, most babies with BV are referred to the Pediatric Infant Perinatal Retrieval Emergency Retrieval (PIPER) service. While most babies with BV referred to PIPER are transferred by neonatal retrieval nurse (NTN) other options are also utilized. These include a retrieval doctor/nurse practitioner and NTN, or an Ambulance Victoria emergency paramedic team. PIPER neonatologists and other team members vary on how they assess risk for these babies. This in turn results in a variation in decisions regarding team configuration.

It is well recognised that not all cases of neonatal BV are associated with a time-critical risk of catastrophic bowel compromise. A previous study at the Royal Children's Hospital from July 2000 to February 2004 identified that 66 per cent of infants with BV had a surgical cause. A subsequent 8-year audit from February 2004 to February 2012 identified a 32 per cent incidence of surgical pathology, with 9.7 per cent of infants being diagnosed with malrotation, with or without volvulus.[2] To the best of our knowledge no study has described the incidence of deterioration during transfer or identified factors that could be used in a model to differentiate infants with time critical surgical pathologies who have the potential for significant deterioration enroute. This unpredictability in outcome for infants with BV coupled with the potential for deterioration whilst on retrieval presents a challenge to the retrieval service regarding team configuration.

Therefore, a study is needed to determine the risk and incidence of deterioration during retrieval and the clinical and other factors associated with such episodes. PIPER is currently planning to commence a study looking at these determinants, pending ethics approval. The information gained from this study will inform a decision support tool to improve logistical decision making and optimise patient outcomes by dispatching the most appropriately skilled team.

References

1. Mohinuddin S, Sakhuja P, Bermundo B, Ratnavel N, Kempley S, Ward H, Sinha A (2015). Outcomes of full-term infants with bilious vomiting observational study of a retrieved cohort. *Archives of Disease in Childhood* 100, 14-17. doi: 10.1136/archdischild-2013-305724

2. Moran MM, Gunn JK, Stewart M, Hunt RW (2013). Bilious vomiting in the neonate: An 8-year audit from a level 3 surgical centre. *PSANZ Congress Adelaide. J Pediatr Child Health* 49:Suppl 2, 10-58.

Neonatal Skin SIG

Neonatal Skin Assessment versus Risk Assessment

Dr Deanne August

The terms 'skin assessment' and 'risk assessment' are often used interchangeably and can be confusing. However, the assessment of skin or risk for injury are comprised of very different elements. A recent survey identified that 90 per cent of Australian and New Zealand Neonatal Units reported a head-to-toe skin assessment is completed on each neonate every 6 to 12 hours.[1] Yet, outside of a newborn assessment, the peer-reviewed literature is vague on the elements and process undertaken as part of a neonatal skin assessment. This has implications for neonatal nurses' knowledge of day-to-day skin assessments of hospitalised neonates, with many foundations of skin assessment based on adult wound care. Therefore, having a current understanding and confidence in the difference between the elements of skin assessment versus risk assessment is important.

A comprehensive skin assessment comprises visual examination and tactile elements such as palpation and pain assessment.[2,3] Other important elements include patient and injury history, which informs assessment related to aetiology and contributing risk factors.[2,4,5] Assessment requires a careful and detailed examination of the cutaneous layer, as differentiating skin abnormalities can be challenging due to the countless ways the skin can express disease.[6] For example, scaly skin in a newborn has a very different indication than dry or flaky skin in an adult, which for the newborn can express both icthyosis (inherited condition of abnormal keratinization) or normal post maturity desquamation.[6] Skin assessments should include observation of lesions, peeling (desquamation), injury, and colours, borders and configuration (shape and size). A skilled skin assessment can improve the ability to confirm injury aetiology and will lead to the selection of management decisions. Depending on the neonates' gestational age, there may be differences in appearance of the preterm and term neonate's skin. For example, preterm skin is described as gelatinous, shiny, appearing wet, and transparent with veins visible and this appearance will change in colour and texture

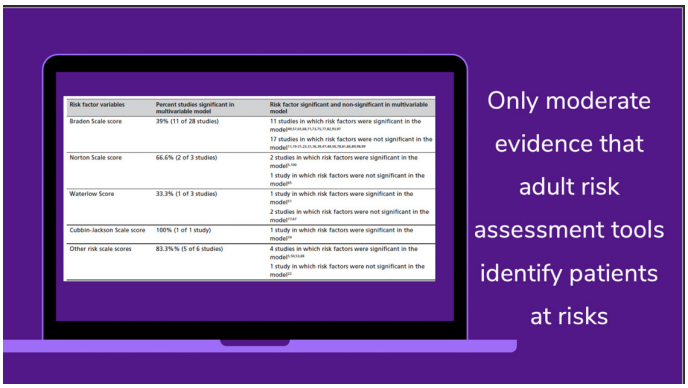
Cont. on page 8

NeoSkin SIG (cont.)

over the course of postnatal life.

A risk assessment for skin injury is a ranked list of risk factors, traits or symptoms associated with skin injuries, theoretically identifying the predisposition to injuries despite exact causal factors.[7,8] However, some of the risk factors within most established tools are inappropriate for neonates, such as ability to ambulate.[9] Ideally, risk assessment tools should be developed from epidemiologic data from the population of interest.[10,11] Yet, most neonatal validated tools are adapted from adult epidemiologic data, which may explain the common use of risk factors that reflect adult or paediatric risks, rather than neonatal risks.

While contemporary tools are being developed and validated,[12] current international guidelines emphasise that clinical education on skin assessment is of equal priority to undertaking a risk assessment.[13,14] Additionally, guidelines recommend specific education related to devices that prevent injuries and devices commonly related to injuries, and as devices are related to most neonatal injuries this is particularly important.[11] One of the latest guidelines states that there is minimal quality research investigating the effectiveness of formal risk assessment tools in identifying individuals at risk for injury.[13] Thus the importance on evidenced based and quality skin assessments rather than the risk assessments should not be undervalued.



Interested in skincare or want to know more?
Join the SIG for our Annual meeting on **Wednesday 24 November starting at 6:30pm (7:30 AEST), or visit** https://www.acnn.org.au/members-only-content/about-special-interest-groups/neo-skin-sig/ **for more information.**

References

1. Mishra U, Jani P, Maheshwari R, et al. Skincare practices in extremely premature infants: A survey of tertiary neonatal intensive care units from Australia and New Zealand. *J Paediatr Child Health.* Jun 18 2021. doi: 10.1111/jpc.15578.
2. Swanson T. Assessment In: Swanson T, Asimus M, McGuiness B, eds. *Wound management for the advanced practitioner.* Vol 1. Melbourne: IP Communications; 2014:e2070-2865.
3. LeBlanc K, Baranoski S. Skin tears: Best practices for care and prevention. *Nursing2014.* 2014;44(5):36-46.
4. Murphree RW. Impairments in skin integrity. *Nursing Clinics.* 2017;52(3):405-417.
5. Carville K. Skin Assessment. In: Carville K, ed. *Wound Care Manual.* Vol 7. Western Australia: Sivler Chain Nursing Assocaition; 2017:28-43.
6. Yan AC, Kim HJ, Honig PJ. Lesional Morphology and Assessment. In: Eichenfield LF, Frieden IJ, Mathes E, Zaenglein A, eds. *Neonatal and Infant Dermatology.* Vol 3. Kindle Edition ed. London: Elsevier Health Sciences; 2015:e2987-e3221.
7. Broom; M, Dunk; AM, Mohamed A-LE. Predicting Neonatal Skin Injury: The First Step to Reducing Skin Injuries in Neonates. *Health Services Insight.* 2019;12:1-10. doi: https://doi.org/10.1177/1178632919845630.
8. Webb P, Bain C. *Essential epidemiology: an introduction for students and health professionals.* Cambridge University Press; 2010.
9. Curley MAQ, Razmus IS, Roberts KE, Wypij D. Predicting pressure ulcer risk in pediatric patients: the Braden Q Scale. *Nursing research.* 2003;52(1):22-33. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med4&NEWS=N&AN=12552172.
10. August DL, Edmonds L, Brown DK, Murphy M, Kandasamy Y. Pressure injuries to the skin in a neonatal unit: Fact or fiction. *Journal of Neonatal Nursing.* 2014;20(3):129-137.
11. August DL, Kandasamy Y, Ray R, Lindsay D, New K. Fresh perspectives on hospital acquired neonatal skin injury prevalence from a multicentre study: length of stay, acuity and incomplete course of antenatal steroids. *Journal of Perinatal and Neonatal Nursing.* 2020.
12. Broom M, Burton W, Ehrlich L, Dunk A, Abdel-Latif M. Developing an Australian skin risk assessment and management tool for neonates. *Wound Practice & Research: Journal of the Australian Wound Management Association.* 2017;25(1):15.
13. European Pressure Ulcer Advisory Panel NPIAPaPPPIA. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. In: Guideline I, 3rd ed 2019.
14. Brandon D, Hill CM, Heimall L, et al. Neonatal Skin Care Evidence Based Guideline. 2018(4).

Research SIG

A/Professor Margo Pritchard
Perinatal Research Centre, Faculty of Medicine
Royal Brisbane and Women's Hospital, Qld

The last few months have been busy for the Research SIG on several fronts as reported below.

Funding of our first Research SIG Study titled: Developing Australian Neonatal Nursing Care Outcomes: Neonatal Nursing Outcome Measures (NNOM)

It is clear from our second workshop (2018) and from recent developments in midwifery care resulting from the Lancet Maternity Care Series (Renfrew M, 2014 et al. papers) that nursing *workforce issues impact delivery of optimal care* and that institutions and governments will respond to *systematic frameworks that measure nursing care and its impact on outcomes.* In this study we hope to further articulate our workforce's unique characteristics to ensure that we support the effective and economic use of resources to achieve better outcomes and experiences of care. To that end our study aims to systematically review high level evidence that supports our neonatal nursing care practices. The first step is to examine the Cochrane Library, and others, to determine available evidence to support specific neonatal nursing practices and how we might configure an associated outcome measure and make recommendations for research the gaps in our practice. We anticipate that this will provide a good return on investment, adding value and providing evidence that supports the justification of workforce development activity.

We would also like to gratefully acknowledge our thanks to ACNN for funding this study and lending invaluable advice and support.

Additionally, we were very privileged to have received and interviewed several highly skilled and passionate nursing candidates for the research nurse for this study and we would like to introduce the successful applicant (below). We look forward to working with Laura who will also keep members updated on our progress via the Newsletter.

We warmly welcome Laura Briguglio, the newly appointed research nurse to the NNOM Study

Laura is a Registered Nurse at The Centenary Hospital for Women and Children in Canberra. She currently works as the Clinical Audit Officer (NICUS) and as a clinical nurse in the NICU. In her role as Clinical Audit Officer, Laura collates all the data on babies who meet NICUS and ANZNN criteria, along with analysing data to support quality improvement and research projects, unit-specific reporting and data analysis within the unit. Laura is also a passionate neonatal nurse and works part-time as a senior RN in the unit. Laura is the ACT ACNN Branch secretary.

Laura has been involved in many research projects, of note is the Integration of Nurse Practitioners into Clinical Practice where the research team produced a published paper titled 'Nurse Practitioners Work: a Case Study'. Laura also supports many neonatal projects and initiatives including Neonatal Pain and Assessment Tools, Neonatal Nasal Injury Prevention, Supporting Early Kangaroo Care in the NICU and Reduction of Retinopathy of Prematurity in the NICU.

Laura has a particular interest in the integration of early Kangaroo Care in the NICU. Laura completed her Master of Neonatal Nursing in 2016 and her coursework major focussed on improving education of Kangaroo Care in the NICU for parents and staff. Laura is also passionate about clinical leadership, and strives to foster an environment of education, leadership and research into her clinical practice.

Laura applied for the Research Assistant position for the NNOM project to further diversify her knowledge and practice within neonatal nursing. Laura hopes to further her academic studies by participating in the NNOM project and working towards a PhD. As a life-long learner, Laura is motivated by research as it enables us to face challenges and work towards improvements by providing collaborative, evidenced based and excellent care for neonates and their families.

Research SIG Meetings and Research Presentations

These continue via Zoom the last Thursday of the month commencing at 7pm (EST). We have been delighted with the quality, robust discussion and enthusiasm that these presentations have received. We aim to offer a platform for all neonatal nurses ranging from novice to experienced researcher. The platform enables you to elicit peer type review and help with refining your presentation or just sharing your protocols or findings with your colleagues. In addition, we also invite other disciplines to help us increase our content and methodological knowledge base.

Our next presenter is September 23; Tracy Bjorkman Senior Research Fellow at UQ Centre for Clinical Research and School of Biomedical Sciences. Dr Bjorkman has a research portfolio in hypoxic brain injury in the newborn. Her specific interests are in Perinatal GABAa receptor development, GABA mediated excitotoxicity in the immature brain, seizures and injury following hypoxia, and neuroprotective therapies for newborn hypoxic-ischemic brain. Tracey will update us on some of her recent laboratory work and methodologies in this area.

Upcoming meetings

October 21, full committee meeting

November 18, presentation meeting – Phillipa Mann TBA

December 16, full committee meeting

Neonatal Nurse Excellence Award 2021

Dr Linda Ng
Professional Officer (past)

It gives me great pleasure to announce that Adjunct Assoc. Prof. Margaret Broom has been chosen as this year's recipient of the ACNN Neonatal Nurse Excellence Award. This award is given annually to a neonatal nurse that demonstrates exceptional contribution to neonatal nursing to neonatal nursing in one or more of the following areas: Clinical Practice, Education, and Clinical Research. It is a prestigious honour that serves to recognise the best of the best within our neonatal nurses.

In choosing the recipient, several things are considered, including leadership, and character. What set Marg Broom apart from other nominees was her ability to influence practice change in the unit and to influence other neonatal nurses to actively participate in quality improvement activities.

Please see the nomination that came from Julia Divall below.

Clinical research is at the heart of Adjunct Associate Professor Margaret Broom's significant contribution to Neonatal Nursing and exemplifies the ACNN standards. Margaret has over 30 years in the profession, with 20 years clinical experience and 10 years as a Neonatal Research Coordinator. Margaret is a triple certificate Registered Nurse and Midwife who also holds a Doctorate in Philosophy. She is the chair of the Australian College of Neonatal Nurses Research Special Interest Group (SIG), a member of the Perinatal Society of Australia and New Zealand on the Neonatal Nurse SIG and a member of the Council of International Neonatal Nurses.

Margaret goes above and beyond her duties as the Neonatal Research Nurse for the Centenary Hospital for Women and Children – in NICU and Special Care Nursery. She has organised and coordinated a variety of essential International and Australian based research projects and quality improvement activities. Margaret has led research over the last 10 years, she supervises and mentors post graduate students undertaking their Masters and Doctoral candidatures, including neonatal post-graduates. In 2017 Margaret led an experience co-design project to develop education and support for neonatal nurses in management strategies for the death of infants. She is also currently leading a project looking at the impact of social isolation on parental confidence at discharge.

Margaret has been highly active in research over an extended period. She has published over 20 research articles in journals that have significantly contributed to better outcomes for neonates by influencing practice change. A few examples include:

Heath J, Broom M, Shadbolt B, Todd D (2016). Ceasing CPAP a Standard Criteria (CICADA): Implementation improves neonatal outcomes. *Journal Pediatric Child Health* 52:3, 321-326.

This criteria has been used to improve neonatal outcomes and is now referred to worldwide to guide clinical practice.

Broom M, Dunk AM, Burton W, Mohamed AL (2019). Predicting neonatal skin injury: The first step to reducing skin injuries in neonates. *Health Service Insights*, 12, 1-10.

This neonatal skin risk assessment tool that is now being implemented globally.

Broom M, Wainwright L, Spence K, Harris DL, Van den Hoogen A (2020). Global neonatal nurses identify research priorities for improving neonatal outcome. *Journal of Neonatal Nursing* 27:2, 147-152.

This is the first article to outline neonatal nurse research priorities and further work is now being planned to facilitate research dissemination globally.

Margaret is professional and committed to improving the quality of neonatal health care and she performs well above and beyond her formal role as Neonatal Research Coordinator. Margaret engages in therapeutic and professional relationships. She supports and develops the profession, presenting at numerous national and international conferences and actively participates in the Neonatal professional colleges. Margaret actively reviews policy to ensure it is driven by contemporary evidence-based practice and research.

Margaret regularly influences practice change by running in-service education for clinical staff on the findings of research and evidence-based practice. By actively mentoring staff, Margaret has successfully supported and encouraged many other neonatal nurses to undertake research and to participate in quality improvement activities.

Margaret was instrumental in the establishment of the ACT Australian College of Neonatal Nurses. She focuses on continuous improvement of the profession and has significantly contributed to the body of research, the communication of findings from this research and importantly the overall capability of the profession.

Social Media Tributes from International Neonatal Nurses Day 2021

"A massive shout out to all the NICU and SCN nurses from Centenary Hospital for Women and Children in Woden, Canberra ACT. You are all amazing people. Our sons born at 24+1 weeks. 16/12/2017 a child to hold daily and a child who grew his wings too soon you guys need more appreciation, it's definitely not an easy job. We love you all! Michelle Lee your continued love and support will never be forgotten."
– Katrina

"Thank you to all of the neonatal nurses that go above and beyond every day and make a difference to so many patients and their families." – Ingrid

"Without this incredible human I don't believe my beautiful boy would be with us today almost 8 years later. (PProm at 17 weeks; born at 34 weeks). Forever grateful to Justine, my dear sister and the team at John Hunter NICU." – Kieran

"Bethany Westall thank you will just never seemed to be enough. Your care for my children and the support you have shown me goes above and beyond your duty. An amazing person. Also a huge thank you to Liverpool Hospital NICU and Campbelltown Special Care's amazing staff." – Tam

"A huge thank you to all the NICU nurses at Townsville University Hospital for looking after our Boy Ethan xx."
– Nicole

"They really really do and they don't get enough credit! I had the most amazing nurses at the Royal Hospital for Women during my sons 5.5 month NICU stay."
– Stacey

"A huge thank you to all the NICU and SCN nurses at Nepean Hospital for taking such amazing care of my son Edward born at 32+1 30/12/19. The care they gave him was outstanding. I wish I could show them how healthy, cheeky and funny he is now. You will always be in our hearts." – Meredith

"Thank you to all the incredible Neonatal Doctors and Nurses at RHW Randwick, who looked after our miracles born at 26 weeks. We will never ever forget the love and care shown to our babies. Thank you Renee Sherriff & Ruth Sinclair we are forever indebted to you both!"
– Nicole

"Thankyou to all the lovely NICU nurses, particularly those at KEMH and Fiona Stanley. Without the dedication of the staff many of us would not get to bring our babies home. Thankyou for all you do." – Angela

"Thank you to all the NICU Nurses at Mater Mother's Hospital and the Royal Brisbane and Women's Hospital! Our little one has been in the care of some lovely people so far! We wish we can do more! You deserve it." – New

"Alysha McEntee and all the nurses that looked after our Bella at King Eddies and SJOG Subi forever grateful."
– Verity

"Dear NICU & SCN Nurses, Thank you for caring and showing love to my son during his stay across two hospitals in the Western Sydney Health District. You cared so beautifully for Riley & taught my husband & I so much about how to look after our beautiful boy. You made the requirement to leave Riley for the care he needed so much more bearable; as we knew he was in such wonderful hands. We are forever grateful to the nurses in NICU & Gumnut Special Care Nursery; also to the doctors & birth unit/maternity ward staff at Westmead Hospital who cared so beautifully for our baby boy. Thank you so much." – Felicity

"Thank you to the wonderful NICU Nurses at Royal Hospital for Women! Complete admiration for the work they do and the quality of care provided to our daughter born at 27 weeks. The Nurses made a very difficult time much easier than it would have otherwise been without their kind words and support." – Belinda

"Salute to all the amazing NICU nurses of Westmead Hospital! We will never forget your kindness." – Cecille

"Thank you NICU and SCN Nurses and Doctors and also our social worker and all of the staff at NEPEAN hospital . They love and care for our twin boys Jackson and Jimmy . Jimmy is now our angel baby looking down on us. Thank you for looking after us. We will see you soon hopefully." – Rainbow

"Thank you sooo much to all the nurses at Liverpool and Campbelltown for taking care of our girl. Appreciate all your dedication." – Renee

"Thank you SJOG Subiaco NICU nurses – you are all amazing! A special mention to Lee and Lynette who were absolutely the best when our twins had a 33 day stay 4 years ago!" – Ace

"Thank you to the neonatal nurses at Royal North Shore Hospital! A debt we will never be able to repay, the care, compassion on such a scary journey, the team there in August 2018 – we love you forever for looking after my family and our now 3 yr old boy!"
– Stephanie

"Thank you to every single nurse at Westmead Hospital NICU, Liverpool Hospital NICU and Westmead Children's Grace ward who saved and looked after our baby and taught us so much. You are angels and we are so grateful."
– Tatjana

"Thank you! Really, truly thank you for everything you do 24/7. Westmead Hospital NICU nurses. So much respect for you!" – Christine

"My chats with Karen were a highlight of my daughters time in the RPA NICU! She's so clever, kind and such an asset to RPA." – Rebecca

"Saying thank you will NEVER, EVER be enough. We love you all so much and always will. Nepean Hospital NICU; 28.11.2002, home on 19.04.2003. Neamh Maree Tovey (23+4 weeks)."
– Jo

$1000 RAFFLE

Tickets are $5 each, 3 for $10 or 7 for $20.

Purchase online HERE

Drawn Saturday 6 November.

Proceeds from this raffle goes towards the work of the low resource countries special interest group - providing education and training (currently virtually) to health care providers caring for pregnant women, new mothers and their newborns.