Australian College of Neonatal Nurses Inc.

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Newsletter

June 2016

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 as adopted by the journal *Neonatal, Paediatric and Child Health Nursing*. All content will be edited to newsletter standard.

Editor: Shelley Reid. The newsletter team for this issue comprised Jan Polverino, Nadine Griffiths, Amy Barker and Rachel Jones.

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 August 2016

ACNN National Committee 2015 – 2016

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President	Karen Walker
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Jennifer Dawson
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From the President

It's the middle of the year already and I just want to acknowledge how hard the members of the national committee, the branches and the special interest groups have all been working. I am privileged to work with such a team, and would like to emphasise to all our members that we are all passionate about neonatal nursing and ACNN. For many of you, you may not realise that all committee members are volunteers, who work in full-time positions external to ACNN – that is ACNN does not have a secretariat and this allows us to keep the membership fees low. The national executive meets monthly by teleconference to discuss overall items and we also meet separately each month for a teleconference regarding the conference. However in between times there are lots of other emails and calls. Every second month the national committee meeting involves all the chairs of the branches and SIGs, which has been most successful and is hopefully facilitating the dissemination of information more widely. We are continually working towards improved communication between committees and members.

Let me tell you some of our activities.

The new strategic plan is now up on the website. For those who have been involved in writing a strategic plan in your own units, you will know how time-consuming a procedure this is. This document outlines our strategic direction until 2020 with greater involvement of branches and SIGs.

As you are aware, ACNN withdrew as a partner in the NPCHN journal and we are now, in consultation with Dr Jann Foster, our associate editor, seeking new partnerships as the national committee believes in the importance of having a journal.

The sustainable committee document is one that we were passionate about writing and implementing, as unless we have new members volunteering to come onto the committees, ACNN will cease to exist. There was extensive discussion and consultation with the Branches and SIG committees, the Professional Officer and the Associate Editor. This document has been approved and is now available in the member's section of the website. Support to attend the ACNN conference will now be available for committee members who participate in the committees and achieve their KPIs. A small step, but we hope this will encourage more of our members to participate in our committees.

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From the President (cont.)

We are most excited that we have partnered with the University of Tasmania to offer scholarships to our members to undertake postgraduate training in neonatal intensive care. This is a first. We are trying our best to provide opportunities for our members and like anything new it has had teething problems around eligibility criteria which we are endeavouring to work through. I want to re-iterate that none of us have experience with what we are undertaking with UTAS and we are working as quickly as we can to resolve issues. In addition, we hope to expand the scholarships to undertake special care nursing courses.

We are delighted with the Facebook page which Melissa Burnett so efficiently keeps updating. It is impressive how many members (and non-members) actually look at it. ACNN has also supported the AMA and the ACN regarding their position statements regarding refugees. Please like the page if you haven't already done so. It's a great way to share information.

The conference committee is working to organise the conference in September, which as you will see from the website, has some excellent speakers. This year, we want to provide an opportunity for members to chair sessions, and I was delighted with the huge response.

The SIG committees are busy organising their meetings to be held on the Thursday prior to the conference.

We were gratified with the response when we asked for support for the NNE SIG and this special interest group will now continue.

I was invited to visit Canberra to attend one of their first scoping meetings to develop a branch. They are very keen to start an ACT Branch and this is exciting for ACNN and those who live in ACT.

All positions on the national committee will be vacant at the AGM in September and I would encourage all members to consider nominating for a position on a committee. It provides you with a unique opportunity to work with some incredible neonatal nurses. Please contact any of us on the national committee to ask about positions, we are happy to mentor and support. It is only through the support of the membership in taking these leadership positions that ACNN will continue.

Lastly I would like to thank those members who take the time to acknowledge the work that committee members are undertaking and those who offer constructive criticism and suggestions for improvement. While we really do appreciate receiving these, I would just like to ask before you hit "send" to please re-read the email. Email communication has caused so many problems in interpretation, with the lack of inflection and emotion. None of us are infallible and we are all extremely busy and sometimes emails might not be intended as they are sent. Once again, the national committee is really appreciative of all constructive suggestions and we encourage members to continue sending us their thoughts, ideas and feedback.

Enjoy each day and be kind to each other and to yourselves.

A/Prof Karen Walker

ACNN President

ACNN Queensland Branch

Queensland Branch April Dinner Meeting

13 April 2016

Redcliffe ACNN members volunteered to have the April Dinner Meeting; this in itself was exciting, enticing other professionals working in neonates to cross the bridge to join us by the seaside for an evening. The venue was the Belvedere Hotel, with a great menu and view catering to fifty-five attendees, a great response, the room was full of laughter and discussion. Members from as far as Toowoomba ventured to join us which was amazing.

The program listed three speakers, first Mark Davies who delivered very valuable information about the use of glucose gel, the evidence and outcomes. He did stress also the importance of continued auditing when implementing the use of the gel into management guidelines. Humour and wit were also part of the presentation and he made us laugh with photos and witty one-liners. A great presentation.

Tough act to follow but try I did. I went on to describe my experience over that last year, scoping and developing a neonatal nurse practitioner role in a regional centre. The presentation described how the role will span maternity services with follow-up capacity for families.

The third presentation given by Joanne Young was about Curosurf – why the change? Where has it come from? And what are the benefits? This was very advantageous with the change from Survanta to Curosurf recently. Joanne presented product and outcome data which was extremely interesting.

Overall the night was a great success, the concept of the Dinner Meeting is a fantastic idea and offers the opportunity for neonatal nurses to come together to enhance their professional knowledge and friendships.

Vale - Jo Kent Biggs

Jo was an exceptional neonatal nurse who had a huge heart and saw the good in most situations. I first met Jo almost 30 years ago when she bounced into Camperdown to take up a position in the Baxter Neonatal Intensive Care Unit at the Children's Hospital. She thought she would slowly slide into the team keeping a low profile. Alas no, she was spotted and her neonatal experience became known. From then on she was part of an experienced and dynamic team with friendships lasting a lifetime.

Jo had a vision which was underpinned by her passion for nursing and in particular neonatal nursing. She was a founding member of the Association of Neonatal Nurses of NSW and went on to become President of Australian Neonatal Nurses Association which eventually became the ACNN. She was proud of her accomplishments and was always the first to acknowledge and promote the accomplishments of others.

Jo was committed to her profession and was a champion for supporting new nurses taking them under her wing in an almost motherly fashion. She was very proud when they did well and demonstrated a commitment to their chosen specialty. This continued until just before her untimely death when she took students from Asia into her home with the same kindness and compassion. Jo demonstrated a commitment to mothers and babies and was a pioneer in setting up NETS, becoming Nurse Manager and leading that team of dedicated nurses. She saw a need for nurses to work in independent advanced practice and I hope the team will continue to develop to ensure her legacy.

Jo was always out for a challenge and took on and embraced the Manager role at the Perinatal Services Network to continue the work of her friend and colleague Professor David Henderson-Smart. More recently Jo worked at John Hunter Hospital taking on many varied and challenging roles; she was never going to retire but knew how to enjoy life. She loved Newcastle, her home and her dogs.

Jo was a friend over many years and we shared many good times. She had a passion for cricket and was part of the Children's Hospital brigade cheering on her favorites and Australia. We travelled together on journeys of search and discovery, sharing the highs as well as the lows. Jo's love of travel is evident and it was a pleasure to read her recent postings of her travels in Europe and Morocco with her travel buddies and friends Jane and Karen. She was so happy and had a knack of capturing the image of the characters she met along the way. Her cooking skills made me envious and she took pride in her abilities.

Jo will always be in the hearts of so many as she touched our lives in so many ways. She wore her heart on her sleeve and was not afraid to show her emotion. She will be remembered in the neonatal community as someone who made a difference and for the passion she spread in her daily life.

I will miss you dear friend and the catch-up we scheduled next month will have to wait for another time and place. Your legacy remains on the path you forged and the many nurses who will tread in your steps. Your untimely death has left a void in all who knew you.

Kaye Spence AM

NSW Clinical Nurse Consultant Column

Touch in the neonatal intensive care unit

Nadine Griffiths

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Have a heart that never hardens, and a temper that never tires, and a touch that never hurts. Charles Dickens

Touch is one of the first senses to develop *in utero* at approximately seven weeks gestation, laying the foundation for the later development of verbal communication, learning, regulation and social interaction.[1,2] Positive touch has emerged as an important modality for the facilitation of growth and development with strong evidence coming from studies of orphans in institutes where infants were deprived of normal sensory stimulation.[3]

The highly technological nature of the neonatal intensive care unit (NICU) has evolved to help infants survive prematurity and associated illnesses in the newborn period. It is well documented that the stress experienced by preterm infants in NICU is linked with adverse neurodevelopmental outcomes such as decreased brain size in the frontal and parietal regions, altered brain microstructure and functional connectivity, leading to altered neuro-behaviour at term equivalent.[4]

Historically, a number of policies in the NICU were intended to protect the preterm and unwell infant from the environment. Minimal handling policies were introduced to manage some of the negative responses to handling including apnoea, bradycardia, and variability in respiratory rate and blood pressure.[5] The policies were designed to allow the very preterm or medically fragile infant to receive necessary procedural touch only – that is, only touched when required for medical or nursing care.

A review of research undertaken in the 1980s regarding minimal touch policies found the difference in infant responses to touch and handling was often dependent upon the amount of information available to the caregiver.[6] One minimal touch study monitored the provision of care provided to newborn infants for four hours each day over the first five days of life. One group of infants had monitoring *in situ* (ECG, ABG, respiratory) that the nurse could view, the second group had the same monitoring in place with the addition of transcutaneous oxygen measurements with the nurses blinded to all recordings, the third group had the same monitoring in place as group two with the caregivers able to observe the recordings.[5,6] This research revealed an increase in hypoxemia associated with handling, which decreased when staff could see the effect the disturbance had on the infant (particularly associated with oxygenation) and the caregiver could modify their responses.[5] This research, highlighting the infant's sensitivity to handling, perhaps better represents an argument for cue based care practices rather than minimal handling policies.

In the NICUs of today specific models of care (individualised developmental care, family centred with parental involvement in care) and strategies (pain management practices, supportive holding, reduced noise and light) are aimed at modifying the care giving environment to buffer the NICU's stress-inducing effects. They decrease stress and have been demonstrated to improve the lived experience and outcomes for NICU patients and their families.[7] Procedural touch can avoid or reduce negative effects by being gentle, aware of the infant's needs and responsive to the infant's reactions. Care by parent provides a loving touch.

Preterm birth and the subsequent lack of tactile stimulation that the infant would have experienced in the womb has led to recommendations that infant massage as an intervention (after 32 weeks corrected age) may promote growth and development and moderate the influence of the extra-uterine environment for preterm infants.[8] To date, the majority of the research has been conducted in 'well' NICU populations using a range of therapeutic techniques, methodologies, study populations and clinical settings that has led to mixed findings.[1,8] A Cochrane Review described the benefit of infant massage to developmental outcomes as weak, with the research not warranting wider use of preterm infant massage.[8] The argument for further well conducted research on the use of infant massage in the NICU as a strategy to improve outcomes is to provide stronger evidence for benefit.

The practice of minimal handling while medically fragile and the introduction of infant massage by parents when appropriate led to what was described as the dichotomy of good touch (parent/carer led) and bad touch (minimal handling, procedural).[5] Establishing a balance between touch experiences that support the infant's development, while minimising adverse or stressful experiences, is recommended within a framework of developmentally supportive care. As clinicians we are faced with a number of questions: at what gestational age should touch be initiated? How much touch is enough? How much is too much or too little? How do we find the balance?

The answers lie with the infant themselves; they tell us in their responses to touch and handling. The challenge for

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NSW CNC Column (cont.)

neonatal nurses is how we promote touch experiences in a consistent, supportive and individualised manner. The positive touch program devised by Bond is a formal method of touch and interaction with infants.[9] The program involves the promotion of touch experiences during all interactions that are individualised and responsive to the infant's cues. The framework of positive touch incorporates a range of touch interactions including handling, holding and kangaroo care.

Positive touch aims to optimize care, making it gentle and responsive by fostering a dialogue between the infant and family.[9] Touch is adapted to the individual infant, acknowledging the infant's strengths and vulnerabilities with respect for parental involvement as a prerequisite. The positive touch approach works best if incorporated into the standard care of the infant, and done 'with', not done 'to' the infant. The infant's responses and cues are observed in such a way that the infant is teaching the caregiver what they are able to do and when they require support. The provision of positive touch in the neonatal clinical setting provides neonates with a consistent touch experience that responds to their cues and encourages self-regulation to promote neurological stability.

The goals of positive touch are to support parents in getting to know their baby while in the neonatal unit, to help parents understand their infant's behaviour and responses, and to improve the infant's experience in the neonatal unit by avoiding prolonged stress, tactile aversion and acute distress in order to promote long-term health and behavioural benefits.[9]

The positive touch experience from infant massage is underpinned by a technique known as the basic touch dialogue. The process consists of five steps that can be used for any touch interaction, from medical or nursing procedures to a loving parental connection.[10] The basic touch dialogue consists of preparation and observation, touch permission, being receptive, approach, and completion. This sequence is designed to place the infant at the centre of the interaction, recognising their behavioural state, respecting them as individuals and supporting their responses. Importantly it also suggests the interaction is completed at the infant's pace not at the caregiver's, highlighting that support may still be required beyond the completion of clinical tasks.

Parents are the key to practicing and implementing positive touch in the NICU. The experience for parents with an infant in the NICU is overwhelming, particularly in the acute period when parenting opportunities are more limited than later on.[12,13] Research suggests that providing opportunities for parents to be involved in handling and caring for their infant during hospitalisation increases parental feeling of self-confidence.[14] Positive touch and the basic touch dialogue provide a framework for parents to develop confidence when interacting with their infant in the NICU environment.

The intent of this article is to highlight the evolution of the use of touch in the NICU, describing how we have moved from minimal handling policies towards infant- and family-centred, developmentally supportive practices. As neonatal nurses you are encouraged to reflect on the application of touch for infants from both a personal and unit based perspective, exploring how you can improve and support therapeutic touch experiences for infants and their families.

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NSW Breastfeeding Column

Helen Mercieca and Gabrielle Kerslake

Grace Centre for Newborn Care
The Children's Hospital Westmead

We attended the Australian Breastfeeding Association's Seminars for Health Professionals - *Breastfeeding: Making Connections* at The Novotel Sydney. This year the ABA took on a new direction by focussing on information to attract more health professionals over the usual emphasis aimed primarily at their volunteers. We really appreciated and enjoyed this change as a large component related to breastfeeding in the NICU with an inspiring component on family focused care.

The first and main speaker of the day was Professor Shoo Lee from Mt Sinai Hospital in Canada. The lecture titled 'How breastmilk can prevent NEC' looked into the bioactive components of breastmilk and discussed latest research findings with interesting facts such as: Breast-fed babies consume up to two million stem cells a day. The stem cells are not digested by the body, in fact they remain whole and move to specific organs of the body for continued growth. Professor Lee highlighted the responsibility of the mother to colonize her baby with good bacteria at birth and revised the effects that modern birth intervention can have on this crucial process. Prof Lee discussed the harm caused by freezing and warming breastmilk, on the live components contained within it. He outlined that donor milk loses 60 per cent of its goodness with the process undertaken for safe distribution. I guess the old motto still stands that 'fresh is best'. The remainder of the talk looked at his research at reducing the incidence of NEC. He identified that Japan has the lowest incidence of NEC in the world, at 0.05 per cent. The reasons behind this are related to strategies such as skin to skin nursing, exclusive breastmilk feeding from less than 28 weeks gestation and 'aggressive feeding'. Aggressive feeding he defined as a technique of building up to full feeding straight away. There is no practice of checking gastric aspirates routinely. In a trial of this technique the incidence of NEC dropped from 8 per cent down to 1.5 per cent. Professor Lee also pointed out that Japan do not use any formula at all, only EBM or donor milk. The parents of these babies assume all the care and receive nursing guidance only.

The next speaker was Dr Kelly Dombroski, who added an interesting dimension to breastfeeding practise. As a doctor of human geography she has deeply researched and compared the breastfeeding beliefs and practices of Australian/New Zealand women to Chinese women. Dr Dombroski has explored the relationships of women's bodies in proportion to living. She discussed how traditional Chinese cultural beliefs can and do change the breastfeeding practice of Chinese women in comparison to Australian women who are more governed by a medical/scientific fact-based culture. This talk opened our minds to the need as professionals to respect and be mindful of cultural differences when supporting families of different racial groups.

Dr Susan Tawia, presented research from the EMBER project (Engaging Mother: Breastfeeding Experiences Recounted). This study looked at the impact that the Australian Breastfeeding Association's (ABA) service has on breastfeeding mother's experiences. Dr Tawia conducted a pilot study of ABA trainee's experience of breastfeeding to try and determine the 'positive deviance' with mothers who had more positive breastfeeding outcomes. The aim is to try and adopt some of these characteristics and behaviours to improve breastfeeding outcomes in the general population as a whole.

Birra Lee is a community breastfeeding mentor and he works within an Aboriginal Maternal and Child Health Service. He talked about how they worked to engage Aboriginal communities to improve breastfeeding rates and reduce some of the morbidity rates due to illness among Aboriginal people. An inspiring feature of this wonderful work is the 'deadly dads group' – deadly meaning 'awesome'. It is designed for dads only who attend an informal session where they are provided with a backpack of goodies and information to help them encourage and support their expectant partners to breastfeed.

Family centred care ... we think we have family centred care sorted and we practice family centred care but Professor Shoo Lee takes it to a new level … absolutely mind-blowing. In his final lecture for the day Professor Lee presented his latest work on setting up a neonatal nursery which works on a model of family initiated care … an extension of family centred care which places parents of babies requiring special care as the primary care givers. These parents assume most of the care for their baby, even taking part in medical rounds and administering oral medications. The aim is to give parents knowledge, confidence and control caring for their infant. Nursing and medical teams are purely there as advisors and teachers. Pilot studies have been conducted on family initiated care and the outcomes are extremely positive. Canada, New Zealand and Australia have a total of six hospitals who have partaken in a two-year trial of this family care model. Professor Shoo Lee will be presenting the final data and outcomes of the trial at the PSANZ Conference this year which will be very exciting to hear.

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My experience in Papua New Guinea, 6 to 13 May 2016

Caitlin Bice

If I was asked how to describe my eight days spent in Goroka, Papua New Guinea, I would struggle to find the words. It was stunning yet confronting, incredible yet upsetting and unbelievably rewarding yet challenging at the same time. Sitting at the entrance to the hospital at dawn with a candle in hand, taking in the stunningly harmonised singing of the local nursing students on International Nurses Day moved us all more than we could have imagined. Not only was this trip filled with teaching, giving and observing but also cultural experiences far beyond what you could experience in your average tour group. We were welcomed with warm and welcome arms and shown insights into how these people live and what they believe in.

Given the opportunity to be involved with and teach the Helping Babies Breathe training program, we were not just educating hospital staff and students as I had expected. One of the most rewarding days for me personally was when we visited a rural Mission and taught volunteer birth attendants, all of whom had been chosen by their own communities to attend and assist women in birth. With the help of a translator, they listened intensely and took in all that we had to say. Listening to their stories of neonatal and maternal death with no medical or nursing experience and common struggles such as no electricity for lighting or the need for gumboots to walk these women hours into Goroka if something were to happen was inconceivable and at times heart breaking. The strength of human character and will to live in circumstances that to us, from such a lucky and safe country, are beyond belief was truly an honour to witness and simply be a part of. Their resilience, which coincidentally was the theme of this year's International Nurses Day, was eye-opening and admirable to say the least.

Despite the critical importance of donating equipment to these types of low-resource communities, it also became more apparent that it is the imparting of knowledge and skills that can really enhance and assist these hospitals and populations. Knowledge brings with it infinitely better outcomes and is this not our aim when wanting to help low-resource countries?

The Papua New Guineans by nature listen intently to our advice and living by the graces of God, accept and appreciate every single word. Not surprisingly as well, the specifically chosen, desperately needed pieces of equipment that were so kindly donated were also accepted with open arms and a huge amount of gratitude.

There were so many things about this week spent in Goroka that I will take home with me and never forget. The beauty and grace of the Papua New Guinean people, the conditions in which they live in, the state of the hospital including the need for such simple resources and the importance of such a successful program such as Helping Babies Breathe. I have new attitudes towards our extreme use and subsequent waste of materials and resources, which to us are certainly not limited. I hope to visit Goroka again in the future and continue the incredible work that ACNN, Karen New and Gill Mibus are doing for this wonderful part of the world.

#ACNN2016

The ACNN National Conference will be held at Rydges on Swanston in Melbourne from 22–24 September 2016. You can enjoy Melbourne's 'four seasons in one day' and explore a city buzzing with theatre, exhibitions, concerts, festivals and sporting events. The ACNN conference will meet your continuing professional development (CPD) requirements with key content areas including; Respiratory, Neurology, Late preterm infants, Infant and family mental health, Ethics and leadership and Low resource and refugee settings.

Attending the conference will give you an opportunity to have fun with others who share a common interest, grow your professional network and making lifelong friends while embracing a chance to break away from the stress of everyday work.

Conference Highlights include:

- Special Interest Group Meetings
- ACNN National Executive Open Forum
- Annual General Meeting
- Two full conference days with invited speakers and high quality original abstracts
- Breakfast and concurrent sessions throughout each day
- Welcome Reception and Conference Dinner

For more information and to register your attendance visit: www.acnn.org.au/events

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For more CPD opportunities and to keep up to date with ACNN awards, events, resources and global news, visit and like: https://www.facebook.com/AustralianCollegeOfNeonatalNurses

twitter

At the National Conference in September we will officially be launching our Twitter activity. Find us at @ACNNInc and watch out for #ACNN2016