Australian College of Neonatal Nurses Inc.

PO Box 32 Camperdown NSW 1450
www.acnn.org.au ABN 62 075 234 048

Newsletter

March 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 May 2016

ACNN National Committee 2015 – 2016

Office-bearers

President	Karen Walker
Vice president	Karen New
Secretary	Shelley Reid
Treasurer	Neil Pulbrook

Committee members

Jennifer Dawson
Jane Roxburgh

Professional Officer

Karen New / Kim Psaila

NPCHN Associate Editor

Jann Foster

President's message

The national committee, branch and special interest group chairs have all been working incredibly hard over the last few months, and I would like to thank them all for the time they volunteer to our organisation. Without their enthusiasm and support we would not have such a successful organisation. Welcome to Dr Kim Psaila, our new Professional Officer, and Melissa Burnett, our Communication and Media Manager.

Let me highlight how we have spent our time. I might start with the annual conference. We engaged a professional conference organiser in an attempt to decrease some of our ever-increasing workload, and Nikki Abercrombie is working hard for us to make the 2016 conference a success. The venue, Rydges on Swanston in Melbourne, looks most pleasant and I hope you will all like the re-vamped program, with concurrent sessions and breakfast sessions. We need lots of abstracts so keep them coming before 31 March. The neonatal nurse excellence awards has just closed for nominations, and I would encourage you to nominate your peers for this next year. There is also the Mark New Award, established last year. We have had some great applications for the Parker Healthcare Scholarship and these are currently being reviewed.

The executive had a face to face meeting in Sydney in January, where among other items we worked on our strategic plan for the next few years. This is being finalised and will be on the website soon. We also had lengthy discussions on the very important issue of how we can have sustainable committees going into the future, with everyone being so incredibly time poor. We need to encourage new members to come onto the management team of our special interest groups, branches and the national committee and we discussed methods of support. This document has now been approved and will also be on the website in the members section, so please have a look. For those of you on Facebook, please like the ACNN Facebook page, where Melissa and Karen New (and occasionally me) keep you abreast of ACNN activities and interesting articles and information. We are finding this a great method of communication and will also be increasing our 'tweets' on Twitter – so also follow us at #ACNNInc to receive updates.

Its great to be able to tell you the good news of ACNN, but much more difficult for sad news and we were all very much saddened to hear of the tragic death of one of our members,

Cont. on page 2

From the President (cont.)

Melanie Robinson from the Bundaberg Hospital. Although I never knew her, she must have been very special from what her colleagues and friends have said.

I could keep writing about what we have all been up to, as we are truly an incredible organisation and there is so much to say. Please keep visiting the ACNN website for all the updates. I will finish now on just highlighting the fantastic Low Resource Special Interest Group fundraiser *Jazz it up for PNG*, which raised over $20,000, a fantastic achievement, and a great night. Congratulations to all involved in the organisation of this event.

So to finish, please keep recruiting new members (there will be a membership incentive announced in April, so for your chance to have your membership renewal paid or your conference fees – keep an eye out for the announcement via email, Facebook and Twitter) as through increasing our numbers, our professional body grows much stronger. Stay safe, happy and healthy and enjoy life.

Kind regards,

Karen Walker

NSW Clinical Nurse Consultant Column

Mary Lou Morritt

CNC Intensive Care
Sydney Children's Hospital, Randwick

As identified in a previous CNC Column, one of the many domains of practice of the NSW Neonatal CNC is Clinical Services, Planning and Management. This domain requires the CNC to show clinical leadership by taking primary responsibility for formal processes within strategic and operational planning for the clinical service in collaboration with key stakeholders. Consequently this involves the CNC identifying, managing and evaluating complex projects relating to significant practice change for neonatal services at a local or state level.

One such complex project currently underway across NSW is the implementation of the world's largest system-wide intensive care unit (ICU) clinical information system set to start in 2016. The electronic Record for Intensive Care (eRIC) Program* has been established to implement a statewide clinical information system across intensive care units (ICUs) and high dependency units (HDUs) in NSW. With a recent increase in funding eRIC will now be delivered state-wide to at least 986 adult, paediatric and neonatal intensive care and high dependency beds throughout NSW, i.e. 53 ICUs and HDUs.

eRIC will provide increased ability to monitor and manage critically ill patients and in so doing improve patient care and clinician satisfaction by providing sophisticated clinical decision support for clinicians as well as patient level, management level and state level reporting. Patients in adult, paediatric and neonatal ICUs will benefit from improved clinical efficacy – and, most importantly, enhanced safety – as supported by evidence that intensive care clinical information systems reduce adverse events and medication errors.[1,2]

Patient safety is at the core of all eRIC activities with key eRIC Program objectives including:

- Establish digital communication (electronic flow chart) in ICU/HDU
- Provide simultaneous access to multiple data and information sources at the point of care
- Interface to bedside devices
- Integrate with clinical, corporate and administrative systems at the point of care
- Enhance patient clinical management and review
- Link with electronic medication management
- Provide active decision support
- Automate monitoring, data capture and reporting
- Support quality improvement initiatives
- Facilitate large scale, multi-site clinical research.

Built for the specific and unique data collection, analysis and clinical documentation needs of intensive care services, the eRIC solution will give clinicians access to a comprehensive array of digital information and medications management at the point of care, while supporting improved information sharing across the continuum of care.

It has been a long journey originally funded by NSW Treasury in 2010. The program commenced its build phase mid-2014 with hundreds of ICU clinicians (including NICU), clinical stakeholders, information technology experts as well as the eRIC program team providing oversight and expertise, from development of the business case, selection of the technology supplier and design and build of the solution under the auspices of eHealth.

Strong clinical engagement has been a cornerstone of the program. Clinicians had a say in the design and build every step of the way, designing and configuring the clinical requirements over six sequential software build cycles. This engagement opportunity occurred through membership and participation on subject matter reference groups (SMERGs). The neonatal SMERG was responsible for providing specialist input, advice, recommendations and final signoff on design and build items. While the NICU SMERG comprised representation (nursing and

(previously ICCIS - Intensive Care Clinical Information System)

medical) from all NICUs in NSW and PSN, actual participation was disheartening with only a few NSW NICUs taking up the opportunity. The participation of those involved enabled real-time clinical reviews of the build progress through weekly WebEx meetings, clinical delegates attending onsite at eHealth headquarters where the program team are located, as well as ongoing user reviews of the solution in a test environment as it was being developed. As these cycles were completed, a remediation period focused on business process and workflow to improve the user experience and user interface. Usability testing is currently underway with end-user clinicians to assess human factors, clinician interaction and user-centred design. The lessons learned are being incorporated into system testing, training, and change and adoption activities.

The eRIC team continues to partner with local health districts (LHDs) on planning for implementation to establish a strong change management model that will optimise adoption of the system and maximise the benefits for patients and clinicians. The first go-live of eRIC, planned to take place at Blacktown Hospital's ICU in mid-2016, will draw on the experiences of Blacktown, St George, Children's Hospital at Westmead (CHW), Royal Prince Alfred and Orange Base Hospital ICUs, which have existing clinical information systems. The first go-live of a NICU environment is scheduled for CHW in the second half of 2016.

Clinician engagement and clinical leadership are key to the success of the eRIC program and as such clinicians need to be intimately involved. So what's the best way for you as neonatal clinicians to be engaged in the process? Clinicians need two primary things to get and stay engaged: first, simply the time to be involved, to be educated about the system and to be prepared to be constructive members of the leadership structures. Second, with the time to get educated and aware and make constructive contributions, they need to be empowered with decision-making authority and the responsibility that comes with that. This is very different to just having meetings, showing up and offering criticisms and complaints.

If neonatal clinicians are engaged and their leadership and contributions and welcomed, they will stay engaged. Health IT is not a one-time implementation and you are done – it is the new way of doing clinical care. It is transformative and disruptive and the frontline clinicians need to be available to be deeply involved at all phases and all levels.

If you have any questions regarding the project and its expected benefits to patients and clinicians, please contact any member of the NSW Neonatal CNC Network who will be happy to discuss aspects of the project with you.

Additionally the eRIC webpage is available to NSW Health staff through the ACI intranet. http://intranet.aci.health.nsw.gov.au/eRIC

References

1. Pageler NM, Longhurst CA, Wood M, Cornfield DN, Suermondt J, Sharek PJ, Franzon D. Use of electronic medical record-enhanced checklist and electronic dashboard to decrease CLABSIs. *Paediatrics* 2014; 133:3, e738-46.
2. Adams ES, Longhurst CA, Pageler N, Widen E, Franzen D, Cornfield DN. Computerised physician order entry with decision support decreases blood transfusions in children. *Paediatrics* 2011; 127:5, e1112-9.

Rural neonatal case study

David Blee

Even into the 21st century, two-thirds of Australian hospital services remain based in small rural communities and country towns, and 29 per cent of all Australian babies are born in rural and remote facilities. In 2010, 3,971 or just under 4 per cent of all New South Wales babies were born within the geographical areas served by the Western Local Health District, an area of some 250,000 square kms, from Goodooga on the Queensland border to the north, Bourke and Cobar to the west, and Cowra to the far south.[1,2] Rural birthing services in New South Wales operate within national and state-wide stratified levels of care, role delineations and perinatal and neonatal critical care referral networks that seek to support obstetric and midwifery staff while maximising maternal and neonatal safety.

This case study describes the management and care of a sick newborn baby in such a rural NSW facility and briefly highlights the inherent challenges and the collaboration required in maintaining a high level of neonatal clinical care in the immediate absence of neonatal specialists. In conclusion a reflective framework will operate from both an appreciative enquiry and a critical / improvement – opportunity paradigm.

The woman

The woman – henceforth referred to as Laura (pseudonym) – was a 24-year-old primigravida, married and living on a property 30 minutes' drive from the health care facility. Clinically Laura was Rh negative, GBS negative, rubella immune, with no significant past medical history excepting seasonal asthma. Antenatally Laura was under the private care of a GP obstetrician, but had also attended midwifery-led shared care clinics. A Jehovah's Witness, Laura had a clear Advanced Care Directive which included absolute refusal of human blood products even in the face of death.

Birth events

On a Saturday morning, at a gestation of 40 + 4 days, Laura

Cont. on page 4

Rural neonatal case study (cont.)

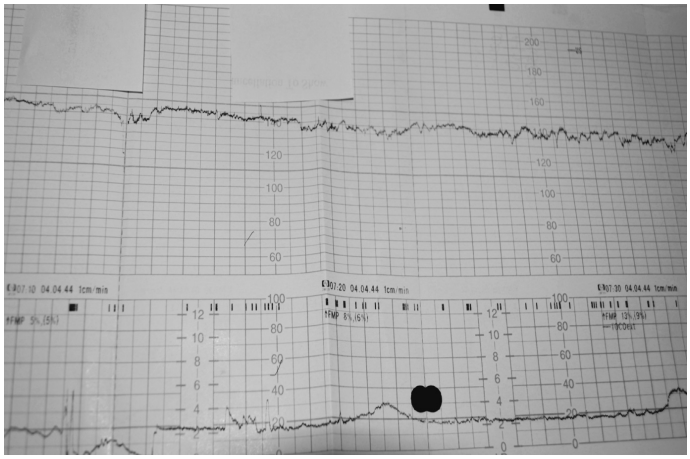
phoned into the maternity unit at 10am to report possible spontaneous rupture of membranes at around midnight that same morning. She described her liquor as clear, and stated that she had no contractions at that point. Laura elected at this stage to stay at home and await events. By 4.30pm that day Laura had not re-contacted the maternity unit. The on-duty midwife (there is only one midwife per shift) called her and after direct questioning elicited this information:

- She wasn't feeling great – and not sure why.
- The liquor on her pad had a greenish tinge.
- Fetal movements were reduced.

Laura was advised to attend maternity forthwith, and arrived at 6pm.

Maternal observations were: pulse 110 bpm, temperature 37.4°C, blood pressure 105/60. Objectively she was anxious, otherwise looking well. Abdominal palpation: Cephalic, long lie, no contractions palpated but generalised abdominal tenderness around umbilicus. The pad showed minimal liquor, green stained and malodorous and was Amnisure positive.

Cardiotocograph (CTG) was ominous (see de-identified section below) with little variability and shallow decelerations in an otherwise unstressed (no labour) fetus. The on-call GP obstetrician (GP Ob) was called in from home for immediate review and the on-call theatre staff alerted to a potential acute caesarean section.



On review the on-call GP Ob requested an acute caesarean section however some time was needed to explore the justification and potential ramifications to Laura and her husband including consent plus reviewing her Advanced Care Directive. The decision-to-delivery interval was 35 minutes, just 5 minutes over RANZCOG's Category 1 classification.[3] Intravenous antibiotics were given to Laura in transit to the operating theatre. Maternal blood loss from delivery was less than 500mls, but both an antifibrinoloytic agent (Tranexamic Acid) and ecbolic (Syntocinon infusion) were used judiciously.[4] Laura's placenta was delivered intact and appeared healthy and non-odorous. Placental swabs were taken for possible chorioamnionitis, cord blood was collected for blood gas analysis and neonatal group and DAT.

The baby

The baby – henceforth referred to as Ben (pseudonym) – was handed to the midwife for initial assessment and resuscitation.

Apgar scores were 8, 9 and 10, see Table 1. A light layer of thin green meconium was present in the creases and umbilicus. The infant was warmly wrapped and placed cheek-to-cheek with Laura.

Matched-pair cord gases were taken for analysis, but proved to be most likely from the same vessel. Venous results: pH 7.22, p02 11 mmHg, pCo2 68mmHg, base excess (BE) of 0.0 mmol with a lactate of 4.4mmols. Arterial results: pH 7.19, BE of 0.1mmols, lactate of 4.3.

Initial top-to-toe neonatal assessment revealed a post-dates appearance, well grown 3.650kg infant, handling well, afebrile and plethoric, post-ductal pulse oximetry recording saturations of 96 – 98%. Vit K and Hepatitis B vaccinations were administered with parental consent. Initial blood sugar at around one hour of age was 3.2mmols. Ben was nursed in an incubator for ease of observation, and at two hours of age developed mild (effortless) tachypnoea (RR of 65 – 70) and an oxygen requirement.

Warm, pink and sweet (and wash your hands!) – the essence of effective neonatal care

For those neonatal staff employed in tertiary units, it is perhaps worthwhile at this point to consider the limited resources both in relation to equipment and expertise available in this rural maternity unit – and many other birthing units as described in the introduction – and thus to make no apologies in referring to these, the absolute basics of neonatal care (or, as a Tongan colleague of mine once said, "More babies are saved every year by being kept warm by nurses with clean hands than by a neonatologist with all that HFOV stuff".

Over the next seven hours Ben continued to handle well. Maximum FiO_2 was .26, and oxygen therapy was discontinued by 4am. A few sleepy breastfeeding attempts were made. Blood sugars became problematic at 1.6 – 2.1 mmols and after expressing Laura with no initial success, permission was gained to offer infant formula via naso-gastric tube. This was effective in maintaining blood sugars initially but could not be maintained, with blood sugar levels falling again. In consultation with our referral neonatal paediatrician a sepsis work up was completed, intravenous antibiotics and intravenous fluids commenced (D10%W at 60mls/kg) and the decision made to 'watch and wait' before arranging retrieval.

Table 1: Apgar scores

Apgar	1 min	5 mins	10 mins
Heart rate	2	2	2
Breathing	2	2	2
Tone	2	2	2
Reflexes	1	2	2
Colour	1	1	2
Score	8	9	10

Table 2: Test results

Test	Day 1	Day 2	Day 5
Hb	221*	224	232
WCC	33.1	30.9	11.7
Platelets	54*	48	97
Hct	0.64	0.62	0.67
Left shift	No	No	No
Glucose	3.5	2.9	4.1
CRP	6		5
Cultures		Negative	Negative
ABO	B		
Rh	Positive		
Coombs	Negative		
SBR		82	
Conjugated bilirubin		10	
Sodium			140
Potassium			4
Chloride			107
Urea			<1.0
Bicarbonate			21
Placental Swab			Negative
Insulin Level			<30pmmol/L

**Maternal Hb was 134g/L, platelets of 236 at time of delivery*

Table 3: Appreciative inquiry reflection

What we did well	What we could have done better
Ai	**Critical Reflection**
Early recognition of fetal compromise	Persuaded Laura to attend maternity when SROM
Rapid acute 'out-of-hours' caesarean section	Earlier sepsis work-up
Acknowledged / planned for Laura's Advanced Care Directive	Earlier antibiotic cover
Anticipated neonatal compromise	Have experienced neonatal-midwife on call
Worked within role delineation and collaboratively	Visual link in real-time with referral centre (this is planned)
Collaborative, family centred care	
Drew upon medical and midwifery staff with sound neonatal experience	

Ben's investigations

Chest X-ray was clear with no evidence of congenital pneumonia or transient tachypnoea.

The interplay of polycythaemia and thrombocytopenia is of academic interest and of course, in Ben's case, of clinical concern. Alloimmune fetal-neonatal thrombocytopenia was unlikely, with no maternal antibodies detected. [5] Thrombocytopenia is commonly reported in neonatal bacterial and viral infections, is suggestive of increased platelet destruction and maligned clotting cascade and thus the potential for DIC.[5,6] Neonatal polycythemia (officially a haematocrit > 0.65) has been negatively correlated with platelet count and independently associated with SGA and chronic fetal stress.[7,8,9]

Maintaining the mother-child dad and disclosure

Ben was clinically well, intravenous fluids were titrated down as he became more eager at the breast, but clearly the initial blood results were of concern. After a period of shock and disbelief, Laura and her husband were allowing themselves to enjoy their son and he was rarely out of their arms, breast-feeding or enjoying skin to skin time. In conjunction with our referral neonatal paediatrician, both GP obstetricians, midwifery staff and Laura and her husband, an hour-by-hour, day-to-day approach was made, with full willingness to arrange for neonatal retrieval if at any point there was a suspicion of deterioration.

Ben was discharged home on day seven, fully breast-feeding, and well. He was recently (now aged two) causing noisy chaos with the antenatal shared care clinic toy-box as Laura and her husband are approaching parenthood once again.

Appreciative inquiry (Ai) with a critical gaze

While paradoxical, it seems sensible to adopt a review of Ben and Laura's care that celebrates what was done well, and reminds us of how we can do better; we look at our strengths through the lens of continuous improvement and a determination to deliver quality neonatal care.[10,11]

Stay at home in early labour to reduce intervention?

Place those terms into Google and you are greeted with 42,000,000 'hits', apparently mainly affirming this to be a good strategy. A good quality discourse analysis would no doubt suggest that such anti-hospital, anti-obstetrician, anti-hospital -midwife rhetoric is powerful, probably not without some justification, yet is problematic and often unhelpful. An educated, articulate and intelligent woman, Laura had a birth plan which included a latent phase spent at home; she admitted that even when persuaded to do so, she was reluctant to attend the local hospital for fear of intervention(s). The challenge of navigating in partnership [12] with the woman this copious volume of free-form opinion and rhetoric, quality versus poor quality evidence, theory and conjecture while remaining woman-centred is an ever-present challenge for midwives and obstetric staff.

Good-will, good skills and collaboration

Wherever possible rural women should have the option of birthing in their local communities. To a large extent good antenatal assessment will reveal those women with risk factors who might be safer to birth at a base or tertiary facility. Birth however is unpredictable, and thus small lower level facilities such as the one in this case study must be able to draw upon good clinical skills, experienced staff, decent equipment and a sound knowledge base in order for high quality neonatal care to be delivered whenever needed. Good-will, commitment and

Cont. on page 6

a shared sense of purpose from all staff revealed the density of social capital that is a hallmark of a small country town and – although not quantifiable – is a significant contributor to a positive outcome.

References

1. Western NSW Local Health Network. *Role Delineation of Services by Facilities*. Sydney, Australia: New South Wales Health; 2012.
2. Commonwealth of Australia. *National Maternity Services Capability Framework. www.health.gov.au/internet/main/publishing.nsf/content/FC3A10DCCCE8CC0BCA2/capab.pdf* (accessed January 2016).
3. Royal Australian and New Zealand College of Obstetricians and Gynaecologists. *Categorization of urgency for caesarean section. www.ranzcogg.com.au/* (accessed January 2016).
4. Halabler O. Perioperative management of Jehovah's Witness Patients in relation to their refusal of allogenic blood transfusion. *Network for the Advancement of Patient Blood Management, Haemostasis and Thrombosis.* 2015; 4(1892).
5. Espinoza JP, Caradeux J, Norwitz E, Illanes S. Fetal and Alloimmune Thrombocytopenia. *Obstetrics and Grnecology* 2013; 6(1).
6. Gunnink S. Neonatal thrombocytopenia: etiology, management and outcome. *Journal of Haematology and Oncology* 2014; 7(3).
7. Herrera E, Krause B, Ebensperger G, Reyes R, Casanallo P, Parra-Cordero M et al. The placental pursuit for an adequate oxidant balance between the mother and the fetus. *Frontiers in Pharmacology.* 2014; 5(149).
8. Arif SH, Ahmad L, Ali SM, Khan HM. Thrombocytopenia and bacterial sepsis in neonates. *Indian Journal of Haemotology and Blood Transfusion* 2012; 28(3).
9. Vlug RD, Lopriore E. Thrombocytopenia in neonates with polycythemia: Incidence and management. *Transfusion On-Line* 2014; DOI: abs/10.1586/17474086.2015 (accessed January 2016).
10. Bushe, GR. Appreciative Inquiry: Theory and Critique. In: *The Routledge Companion to Organizational Chance*, First ed. Oxford, UK: Routledge; 2011.
11. Rasche A, Scherer A. *Jurgen Habermas and Organization Studies - Contributions and Future Prospects.* Oxford: Oxford University Press; 2014.
12. Guilliland K, Pairman S. *The Midwifery Partnership: A Model for Practice.* Monograph Series, 95/1 ed. Wellington, New Zealand: Victoria University; 1994.

NSW Breastfeeding Column

Message from column editor Rachel Jones

We are aiming for a Family Centred Care theme for the breastfeeding column for 2016 and greatly encourage contributors from all over the country. We are linking this column with the Neo BFHI guidelines core document that was launched last year together with the educational materials and self appraisal kit.

We begin the year with a neonatal nurse's personal reflection highlighting the changes that have taken place over time and acknowledging the family's place in the neonatal unit. Trish retired from the lactation position at RPAH last year and received the ACNN excellence award for her contribution as a quiet achiever. She will be missed in this role but she helped build solid foundations for a culture of supporting mothers and their families with breastfeeding in the neonatal unit at Royal Prince Alfred Hospital, Sydney.

Please send all correspondence or further ideas for the column to Rachel Jones at rachel.jones3@sswahs.nsw.gov.au

Ch-Ch-Ch-Changes!

Memories of a neonatal nurse

Trish Mumford
Newborn Care, RPAH

I started working as a neonatal nurse 36 years ago now, in 1980 at King George V Hospital for Women and Babies (now known as RPA Women and Babies). Since that time, I have seen and worked with many changes and advancements. The care of the newborn baby is now directly aimed at their growth and development in order to achieve a better outcome beyond the short time they are cared for in the neonatal unit. This is the result of using evidence-based research in educating the health care team, as well as greater involvement by the parents.

These changes are being experienced across many neonatal units, to the extent that developmental care principles have become embedded within routine practice. Parents are encouraged to be part of the health care team managing the care and recovery of their baby.

Back in the early '80s, parents were not encouraged to be part of the care team within a neonatal unit which led to a feeling of diminished parental ownership of their baby. I remember that the parents were allowed to 'visit' only at restricted times. There was a lack of understanding of the importance of

parent-infant attachment or how it could be promoted in the restricted environment of the neonatal unit.

The neonatal unit culture has progressed a long way over time, with parents replacing the neonatal nurses' role where practical and safe. Parents are now encouraged to attend to their baby's basic needs such as nappy changing, weighing, bathing, managing gastric tube feeding and the most empowering of all – kangaroo care or skin to skin contact for both mum and dad. Neonatal nurses are moving towards practising as 'facilitators' rather than primary carers in a more family centred care model.

All of these changes have a direct impact on how parents manage their own difficult journey through the neonatal unit, emotionally and physically and hopefully we help them to regain a sense of empowerment and ownership. This transition is well supported by other members of the allied health team; social workers who have always had a role in the neonatal unit, as have physiotherapists, speech therapist and psychologists. These services, when available, can work together in a multi-disciplinary team approach.

The changes go beyond the support that was available for parents surrounding their baby's stay in the neonatal unit. The Newborn Family Support Team (NFST) in RPA Newborn Care is a specialty service aimed at getting babies home earlier than previously, by visiting after discharge for continued support by familiar staff and monitoring low flow oxygen and home-based gavage feeding by parents when this is required. It is a service that provides support for parents at home as soon as their baby is discharged, making that transition into their local Early Childhood Centre and the rest of the community less terrifying. Informing parents about this service early in their admission can provide a degree of relief especially when they have a very preterm or a sick baby or multiples.

For most of my years in the nursery, my experience involved working as a lactation consultant in the neonatal unit. The role was designed to offer support and assistance to mothers wishing to breastfeed. Providing breastmilk for their baby has become more challenging and demanding as we extend the boundaries with increased knowledge. We are learning more about the process of milk production and breastfeeding, both the physical and emotional aspects, in this group of often very high risk women. The emotional effect on a mother's milk production is significant, so counselling becomes a major part of the role. Who would think there was so much more to learn! There is a continual need to educate and support staff so they may in turn educate and support the parents. Keeping up to date with the latest research, problem solving, attending and presenting at conferences, networking with other neonatal units, attending online forums, contributing to newsletters and teaching material has all been part of my role as the lactation consultant in the neonatal unit. Parents are well informed and seek many answers and often have high levels of expectation which can be a major pressure on themselves and staff. Yes, demanding! We become their advocate so very frequently.

Change has occurred too within media and especially the arrival of social media having a place in everyday lives. A great promotion and focus on the benefits of breastmilk and breastfeeding is a positive step however it often brings enormous pressure and expectations for mothers to 'succeed and not fail' in this far from 'normal' situation!

For me, all these major changes since the '80s have been vital. We understood breastfeeding was important but did not have the full awareness or knowledge of the extent to which preterm and sick babies benefit from it and sometimes it is life-saving. In the mid '80s Dr Heather Jeffery and Dr Philip Beeby conducted research into starting enteric feeds with breast milk only at low a volume to help reduce the incidence of necrotising enterocolitis (NEC). Minimal enteric feeds began at 1ml every four hours and graded up as tolerated and the mother's supply allowed. This saw a reduction in the incidence of NEC in our unit and close to zero cases by 1990. Emphasising this life-saving effect of breastmilk instigated the development of the first specialty lactation position in the unit to support and educate mothers and staff. The service continues with a dedicated lactation consultant working with mothers every day.

We have continually challenged ourselves to find better ways to support the mothers, by helping to initiate and maintain breastfeeding or milk supply. Equipment and techniques have improved. We educate high risk women before they have their babies and stress the importance of good hygiene and clean equipment, safe storage and handling of breast milk. We understand better why some mothers may not be able to

NSW Breastfeeding Column cont.

produce enough milk and the best approach to optimise this, or what to do when they have too much.

My work as a lactation consultant in the neonatal unit has been incredibly rewarding with the highlight being involved with the establishment of the Donor Milk Program at RPA (established in 2005). This was initiated when a mother of a very preterm baby was unable to produce milk and the baby was at a high risk of NEC. This initiative was driven by Assoc. Professor Sandie Bredemeyer OAM and Professor Heather Jeffery with myself and Georgina Jandera taking part in the role of pasteurising the milk, a challenging and demanding process that required many anxious hours and troubleshooting to get it right and workable. We still have our program working today but are looking forward to the development of a state-based milk bank in the next few years.

Yes ... there have been many challenges and changes, and but all for the better.

FOR THOSE OF YOU ATTENDING PSANZ 2016

Things to Remember:

Bring a bottle of water (we don't have much water)

Don't forget a hat, sunglasses & sun cream

Remember a cardigan it's cold in the air con

Forget your jeans – average temperature in May is 22-28°C

Must-Dos

Make a day trip to magnetic Island and you must book a mini-moke and walk the forts (about a 3-hour round trip).

Get physical and walk or drive Castle Hill for amazing views

Take a casual walk along the Strand and reward yourself with a coffee at Juliettes or an ice cream from Gelatissimo.

Visit the Cotters Market, Flinders St – Sunday 08.30am -1.00pm

Talk a walk on the wild side at Billabong Sanctuary – 17km south of Townsville

Experience the Reef without getting wet at Reef HQ

A Cocktail or Two at Longboards on the Strand or Cactus Jack's Garden bar on Flinders Street.

Other Events

20 May 2016

Full Moon Down Under Party

Riverway Movie Night

Cowboys v Brisbane Broncos

21 May 2016

Burdekin Growers

Race Day

Home Hill Race course

23 - 29 May 2016

Townsville Fashion Festival

Various locations

Visit Townsville, Australia

townsvilleshines

thisisqueensland

For more information on events in Townsville

Townsvillenorthqueesnland.com.au/events