



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

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

*Please remember to mute your line (\*6)!*

# Upcoming Wednesday Webinars

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

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

## SCHEDULE

- April 6: *The CHAMPS Community and the Baby Cafe Model*  
Lucia Jenkins, RN, IBCLC, RLC; Kimarie Bugg, MSN, MPH, CLC; Danielle Lugrand, CLC
- May 18: *Creating a Prenatal Education Plan*
- June 22: *Getting Hospital Leadership on Board*

# Upcoming: 4-hour Clinical Skills Trainings

- March 28<sup>th</sup>, Merit Health Woman's Hospital
- April 7<sup>th</sup>, Baptist Memorial Hospital – North Mississippi

For more information, visit: [CHAMPSbreastfeed.org/events1](http://CHAMPSbreastfeed.org/events1)



# Second Indian Country Breastfeeds Conference: Sustainability and Support

Date: May 9-10, 2016

Location: Albuquerque, NM

Topics Include:

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

For more information, visit:

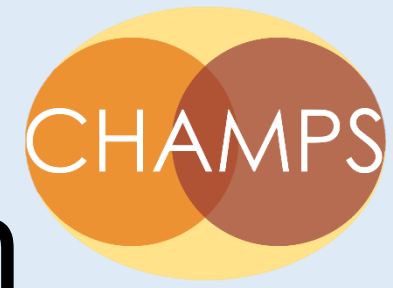
<http://www.indiancountrybreastfeeds.org/events>

OR

Email:

[indiancountrybreastfeeds@gmail.com](mailto:indiancountrybreastfeeds@gmail.com)

# Changing a Culture based on History and Tradition



## Nurse Staffing Issues and Baby-Friendly Practices

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

11:00 am – 12:00pm (CST)

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*No one likes a change  
except a baby with a wet diaper*

# Traditional Maternity Care

- Nurse/physician-centric practice
- Task focus
- Infants separated at birth or soon after
- Infants in nursery for long periods of time



# Why Change?

## No Separation at Birth



- Patient-centric practice
- Opportunity to breastfeeding early – usually in 1<sup>st</sup> hr. (Crenshaw, 2007)
- Thermal, respiratory and glucose stabilization in newborn promoted by S2S contact (Feldman, 2004)
- Separation increases risk formula supplementation
- Early breastfeeding has an impact on duration of breastfeeding (Dabrowski, 2007; Wlater et al., 2007)



# Why Change?

## Mother- Baby “Couplet” Care

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



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

# Goals and Outcomes



- L&D RN and transition/baby RN work together providing evidence based care
- Improved continuity of care
- Decrease separation
- Cue based feeding
- Improved breastfeeding outcomes
- Decrease personnel providing instruction and education
- Handoffs more accurate & couplet specific
- Documentation of exceptions
- Parents increased confidence at discharge

# Getting From Here To There



# Starting With A Change Framework

## Three Stages of Change

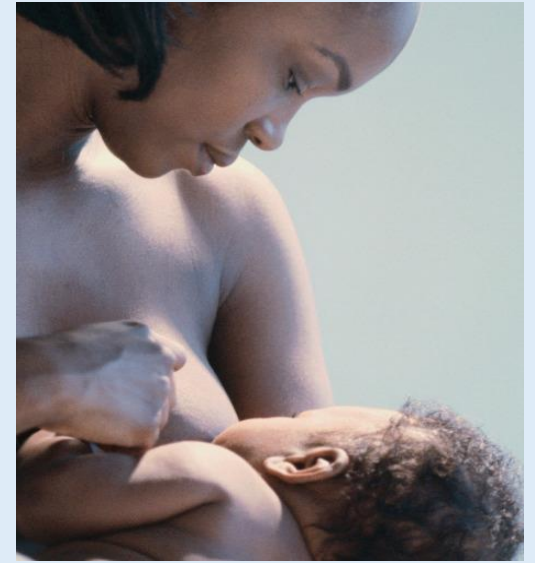
- 1. Unfreeze** – identify the problem and the need for change
- 2. Move/Transition** – staff involvement-planning and implementing the change
- 3. Refreeze** – “making it stick” by reinforcing desired outcome

*Lewin's Theory of Change (Lewin, 1951)*

# Motivation for Change

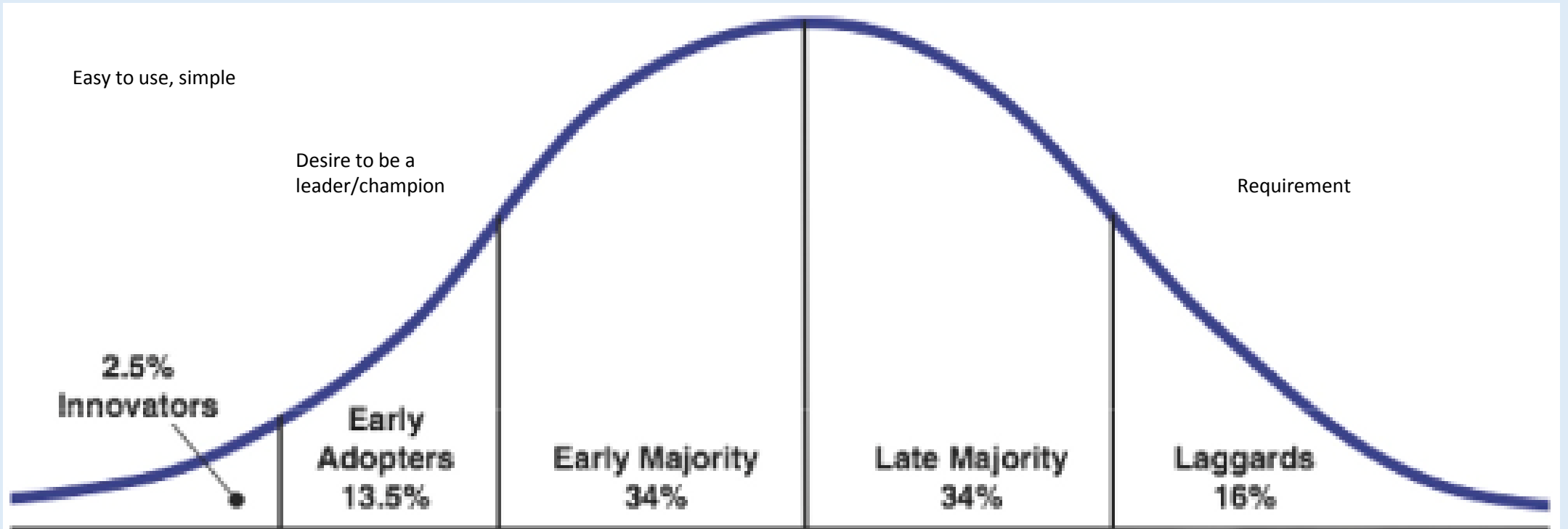
Unfreeze Status Quo

- Baby Friendly
- Evidence
- Professional role in nurturing the mother-infant bond
- Family requests
- Desire to stay competitive in your community



# Roger's Adoption Curve

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



# Staff Concerns and Challenges

Identify and Address

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



# What is Needed?

## Move/Transition

- Strong Leaders who believe in the change
  - Nursing and Provider Leadership with support from administration
- Evidence-based care models → Policies and Procedures
- TIMELINE -- “Go-Live” date
- Multi-unit staff engagement, education and buy-in
- Provider engagement and buy-in
- Collaboration with OR, PACU
- Role re-defining
- Community education and marketing





# What is Needed?

## Move/Transition

- Guiding Team (membership may flux)
  - nursing, provider (OB, PEDS, Neo), respiratory, NICU, OR PACU, anesthesia, risk mgmt., pharmacy, ancillary staff, material mgmt., security, admitting department, IT, marketing/business office,
- Multidisciplinary staff input before, during and after
- Physical layout and set-up
- Coordination and collaboration with PACU
- TRIAL RUNS
- Expectations and accountability for practice
- Patient/family input and feedback
- Data to monitor early wins, progress and sustained success
- Connect the data to changes in practice

# What is Needed?

## Move/Transition

# FUN

- Have a draw
- Have a friendly competition/contest
  - ❖ % S2S for  $\geq$  first hour
    - Between March 21's 12-hr day shift and March 22's 12-hr day shift
    - Between Saturday and Sunday (both days and nights)
- Most valuable “change agent of the week”
- Best story of the month on a chosen topic
- Best “idea to support breastfeeding” of the week

# AWHONN Staffing Guidelines

*AWHONN 2010 Guidelines for Professional Registered Nurse Staffing for Perinatal Unit*

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

# Staffing Guidelines and Recommendations

“Move/Transition”

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

Key Recommendations

1. Maximize the impact of perinatal nurses by ensuring they are practicing to the full extent of their education and training
  2. Correctly match how nurses are educated and oriented to the roles and tasks they are expected to perform
- ...ensure that women’s health and newborn care in the US is consistent with the latest research regardless of the birth setting

# Role of the Change Nurse

## Move/Transition

### **Small Volume Perinatal Service**

- Many need to take a patient assignment
- Manage hour to hour
- Supervisory tasks

### **Large Volume Perinatal Service**

- Ideally no patient assignment
- Manage the hour to hour; mentor less experienced nurses
- Exception high census, short term such as baby nurse or OB triage
- Supervisory tasks

# Models of Couplet Care

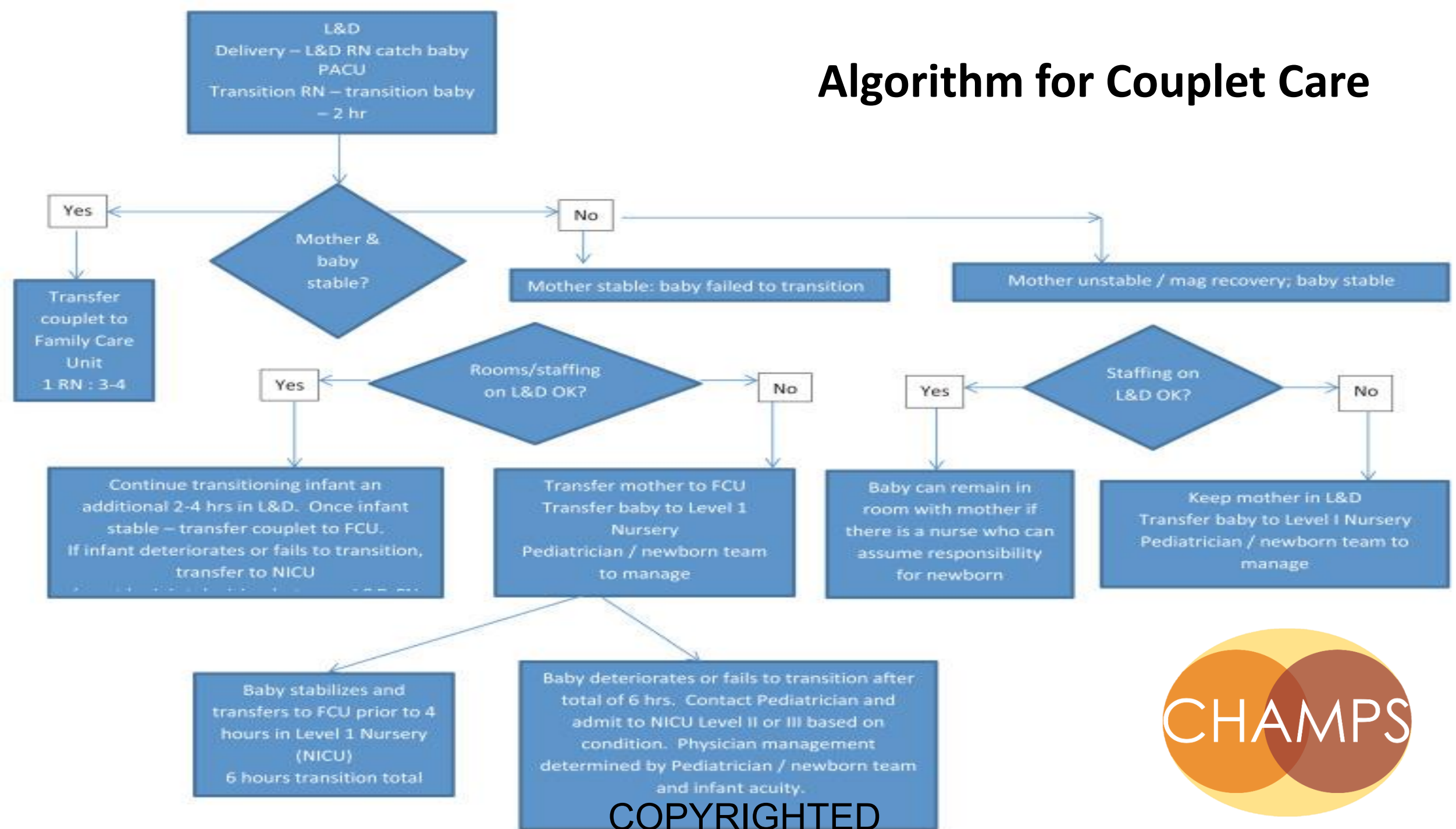


- L&D nurses
  - ❖ trained in newborn assessment (apgar, VS, general transition/appearance)
    - L&D RNs tag team and support each other at delivery
    - Baby nurse facilitates S2S, admits newborn, ID etc
    - initial NB assessment and VS documented
    - Transfer care to delivery nurse, as appropriate, provides care for remainder of stay in L&D
    - facilitate S2S, support first bf;
    - hand off mom and newborn care together
- Delivery support RN
  - ❖ attend all normal newborn vag and C/S deliveries,
    - assess and document care, VS and care in first q-2 hours of life
    - facilitate S2S
    - support first bf
    - hand off newborn care

# Supporting Confidence and Competence

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

# Algorithm for Couplet Care



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# Implementing Skin to Skin

- Education for nursing and providers
- Inform and educate mothers and families
- Simulation and testing

# Design the Steps

## Test it out

### SKIN-TO-SKIN CONTACT (SSC) CARE PROCEDURE

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

- 1.** Explain to laboring women about the concept of (SSC) and its benefits for mothers and newborns.
- 2.** After delivery, immediately place infant on mothers abdomen. Dry and stimulate with warm towel and bulb suction as needed.
- 3.** Remove wet towel and cover infants back with clean, warm blanket.
- 4.** Assess infant vital signs if not doing so already and assign 1 minute APGAR.
- 5.** Place head cap on infant and place ID bands on infant and mother per protocol.
- 6.** Delay infant eye treatment, injections and measurements until after first feeding at breast or 1 hour.
- 7.** Monitor infant's skin temperature every 15 to 30 minutes to be certain that temperature remains within clinically acceptable range. Assign 5 minute APGAR .
- 8.** Weigh infant and asses SpO2 at 15 minutes of life then return infant to SSC immediately. Notify pediatric resident if SGA or LGA and initiate glucose protocol if indicated.
- 9.** Allow infant to spontaneously move toward the breast and latch onto a nipple. This may take up to 75 minutes but occurs in most infants.
- 10.** Provide initial breastfeeding education to the mother.

# Delaying the First Bath



## Potential Benefits:

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

*No documented benefit to performing a bath  
Within 2 hours of birth unless medically indicated*

# Practice Change Guided by Evidence

- Explored bonding at birth. First 60-90+ minutes after birth defined as a “sensitive period” for maternal-newborn bond. *(Klaus and Kennel 2004)*
- 166% increase in hospital breastfeeding success after implementing a 12 hours delay in first bathing practices. *(Preer et al. 2013)*
- *Newborn crawl and feeding cues are markedly reduced after bathing. (Varendi et al. 1998)*
- *“Wait for 8” (AWHONN 2000 neonatal Skin Care Guidelines)*

# Process Implementation

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



# Delaying the First Bath

## Challenges

### Change in Practice

- Move from task orientation to best practices
- Work flow – unsure when to get it done

### Nurse Resistance

- Yuck factor
- One more task incorporated into postpartum care
- Universal precautions until bathed

### Patient/Family Concerns

- Expectations around timing of bath
- Yuck factor especially the hair



# Delaying the First Bath

## Special Considerations

- No delay for newborns of mothers who are HIV and Hepatitis Viruses positive
- Handle all unborn babies with gloves

**NEWBORN ROOMING IN  
TRACKING CHART**

Infant  
Patient Sticker

*This is a Test*

Date	Time Separated	Reason	Time Returned	RN

**Comments:**

**GOAL: Room in with mom >23 hours/day**  
THANK YOU for Supporting Our Practice Improvement

*This is a Test*



**“Congratulations, it’s a boy!  
Would you like to hold your baby now?  
With safety in mind, we will work together to  
make sure he doesn’t leave your side.”**

# Mothers will say “NO”



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

# Newborn Assessment

## Physical Exam

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



<http://www.aafp.org/afp/2002/0101/p61.html>

<http://www.aafp.org/afp/2002/0115/p265.html>

<http://www.duq.edu/academics/schools/nursing/newborn-assessment>

[http://www.utmb.edu/pedi\\_ed/CORE/Neonatology/page\\_11.htm](http://www.utmb.edu/pedi_ed/CORE/Neonatology/page_11.htm)

# Newborn Assessment

Physical Maturity (within 2 hours of life)

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

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

# Newborn Assessment

## Neuromuscular Maturity (by 24 hours)

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

- **Posture.** How does the baby hold his or her arms and legs.
- **Square window.** How far the baby's hands can be flexed toward the wrist.
- **Arm recoil.** How much the baby's arms "spring back" to a flexed position.
- **Popliteal angle.** How far the baby's knees extend.
- **Scarf sign.** How far the elbows can be moved across the baby's chest.
- **Heel to ear.** How close the baby's feet can be moved to the ears.

# Couplet Care - Staff Education Model

Didactic instruction	8 Hours	Newborn's Care	Maternal Care
		Routine management of healthy newborns	Care of woman in postpartum period
		Assessment of the newborn	Postpartum assessment
		Circumcision	Hemorrhage
		Neonatal hyperbilirubinemia	Estimating blood loss
		Maternal infections	Medications
		Hypoglycemia in the newborn	Hypoglycemia management
		Passing meconium and urine	Transfusion guidelines

## Newborn assessment within 1 to 4 hours after birth

Normal postpartum physiologic maternal adaptations

Physiologic and anatomic changes during the postpartum period

Postpartum assessment after the recovery period

Postpartum care of a woman post cesarean

Postpartum complications

Postpartum pain control and other self-care measures

Postpartum psychological adjustments

**Computer modules**

**5 Hours**

<b>Specialty classes</b>	<b>8 to 16 Hours</b>	<b>The STABLE program (postresuscitation/pretransport stabilization class)</b>
		Neonatal resuscitation program (NRP)
		The STABLE program (postresuscitation/pretransport stabilization class)
		Neonatal resuscitation program (NRP)
<b>Bedside training</b>	<b>144 Hours</b>	<b>Buddy system of newborn RN paired with postpartum RN for 12 shifts</b>



# Measuring Success

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

# & Refreezing

- Policy
- Marketing
- Link practice to mission
- Practice accountability
- Addressing challenges constructively

# Strategies for Implementing Practice Change

- Guiding Team/Committee
- Training
  - Research
  - Didactic education
  - Assessment/care classes
  - Nursing and providers provide the same message
- Engage and inclusion staff in change process (Moen and Core, 2012)
- MAKE IT FUN; Think Safety
- Set expectations and accountability for practice
- Provide opportunities to “grieve”
- Small TESTS OF CHANGE - PDSA



Mothers and babies form an inseparable biological and social unit, and... the health and nutrition of one cannot be divorced from the health and nutrition of the other.

*Global Strategy for Infant and Young Child Feeding*

**THANK YOU**