Neonatal Nurses College of Aotearoa (NNCA)

NEW ZEALAND NURSES ORGANISATION
TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

Neonatal Nurses College Aotearoa
New Zealand Nurses Organisation

SPECIAL EDITION

COINN 2019
Enriched Family – Enhanced Care
5-8 May 2019, Auckland, New Zealand

Neonatal Nurses College of Aotearoa (NNCA) Newsletter 2019

Table of Contents

NEW ZEALAND NURSES ORGANISATION
TŌPŪTANGA TAPUHI
KAITIAKI O AOTEAROA

Ngā Tapuhi Whare Kohanga o Aotearoa
Neonatal Nurses College Aotearoa
New Zealand Nurses Organisation

COINN 2019
Enriched Family – Enhanced Care
5-8 May 2019, Auckland, New Zealand

Like

Welcome— from the Editor

Rose Batchelor

Hi There!

Well this edition of the newsletter is BIG! HUGE even! So get a glass of wine, sit back and prepare yourself for an entertaining read.

This edition is dedicated to our international conference, being held in May, and highlights neonatal care “kiwi” style. NICU’s and SCBU’s from all over New Zealand give a glimpse into “What is happening” locally. A massive thank you to all that have given up their time to put together some highlights which showcase their neonatal care.

A big thank you also to the COINN Local Organising Committee who have been hard at work putting together an amazing program for us and promises of a wonderful evening out “Gatsby” style. We look forward to welcoming some great speakers, as well as a number of international guests, and am sure their time spent in Aotearoa will be remembered for a long time.

On a more serious note—following a highly successful One Day Symposium at the end of last year (Thank you Waikato!) I need you to mark a date in your diary for later in the year. The Managers Forum and the Neonatal Nurse Practitioner (Specialist) forum will be held on Thursday 17th October at Wellington Hospital. The AGM will be held on that day also—so please mark this date in your diaries and ensure you make the appropriate preparations to get there. More information will be forthcoming.

So, as they say “without further ado” please enjoy this bumper issue of the newsletter and I look forward to seeing as many of you as possible at the COINN conference on Sunday, Monday, Tuesday and Wednesday May 5th to the 8th!

Bye for now
Rose

COINN 2019
Enriched Family – Enhanced Care
5-8 May 2019, Auckland, New Zealand

Report from the Chair

Gina Beecroft

Our new year is now well underway and with it some exciting opportunities for us to look forward to and celebrate.

At a workplace level, this year we can look forward to seeing some traction into the work that was conducted last year when we saw recognition at a ministerial level of our ongoing national issues with overcrowding and overcapacity. This resulted in the Ministry of Health (MoH) calling for a review of Neonatal Care. The now completed review was coordinated by the Newborn Clinical Network and conducted by an external independent evaluation and research specialist company. The findings are in the process of being presented to the National General Manager Planning and Funding and the CEO DHB Group. After which there will be a wider discussion and dissemination of information and eventual MoH national release of Review findings.

Alongside this the National Neonatal Service Specifications have also been under review. This has been long overdue and the service specifications should reflect some of the changes now seen in neonatal care with the recognition and inclusion of some changes in classifications of care, for instance transitional care. The timing of the two large pieces of work together are fortuitous as they are interlinked and needed to be looked at together. Both pieces of work have resource and funding implications and both hopefully will help prompt some changes and improvements for us and the babies and families we provide care for.

At a personal and professional level and from the college perspective we have much to look forward to. In particular our long awaited, long planned for, long worked for, and long prepared for COINN conference in Auckland in May.

At a personal and professional level and from the college perspective we have much to look forward to. In particular our long awaited, long planned for, long worked for, and long prepared for COINN conference in Auckland in May.

It is hard to believe it is finally here. Significant energy and expenditure have gone into preparing for the conference to help ensure its success and ensure we get as many NNCA members to be able to attend as possible. This was done by offering as much financial assistance as possible, to as many people as possible, to help offset the expense of attending an international conference. This is a once in a lifetime opportunity for many of us to attend an international conference.

Thank you so much to the COINN local organizing committee (LOC) for their tireless work to make this conference a reality. Thank you also to all the past LOC's of National Conferences for hosting financially successful conferences that have enabled us as a college to have financial reserves to be able to invest back in membership and therefore be able to offer scholarships to attend COINN. Thank you to the team who many, many years ago dreamed that we could hold an international conference in NZ and paved the way for our successful bid to host. Also thank you to our Australian colleagues in the Australian College of Neonatal Nurses (ACNN) for supporting us by foregoing their own conference so that their membership could attend our conference

Now it is time to enjoy the fruits of all the hard work, enthusiasm and vision. Here's to COINN 2019, we are very much looking forward to our membership and international colleagues reaping the benefit of this in May. See you there.

Ngā mihi Gina

Introducing your NNCA Executive Committee 2019

Where do your executive committee come from??

Helen—Waikato

Tracey—Christchurch

Rose—Rotorua

Fiona—Wellington

Juliet—Dunedin

Barbara— Whanganui

Ros—Auckland

Gina—Christchurch

And Kate is our Professional Leader from New Zealand Nurses Organisation!

Ngā Tapuhi Whare Kohanga o Aotearoa
Neonatal Nurses College Aotearoa
New Zealand Nurses Organisation

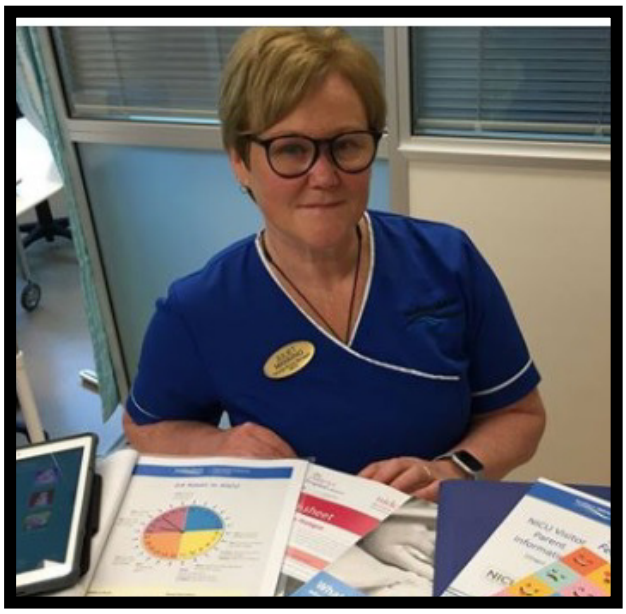
Ngā Tapuhi Whare Kohanga o Aotearoa
Neonatal Nurses College Aotearoa
New Zealand Nurses Organisation

Profiling New Executive Committee Member Juliet Manning

Charge Nurse Manager of NICU in Dunedin, NZ. I have worked in a range of settings in New Zealand, Australia and the United Kingdom. The majority of my nursing has been in Neonatal Intensive Care. I have undertaken a range of postgraduate and post-registration education and development and held a variety of positions as a Registered Nurse including Clinical Coordinator, Nurse Educator and management roles.

My involvement with NNCA dates back to NZANN days as a committee member working towards College approval. Prior to joining the NNCA Committee I became involved with the NNCA Special Interest Group developing guidelines for periviable infants. I'm on the NZNO Board of Directors, finishing my term in September 2019. I've completed a governance training program and developed skills to support organisational sustainability. I'm also a Trustee for NERF which involves governance of the Trust funds, ensuring the intent of Trust Deed is honoured, as well as reviewing applications for the various funds administered by NERF.

My current CNM role has an emphasis on supporting the effective running of NICU through financial planning, performance and activity; workforce management; quality and risk management; evidence-based practice and professional development planning for nursing staff – all with a focus on patient safety, workforce development and contemporary clinical care for babies and whanau.



Welcome

Juliet!

IMPORTANT!

SAVE THE DATE!!

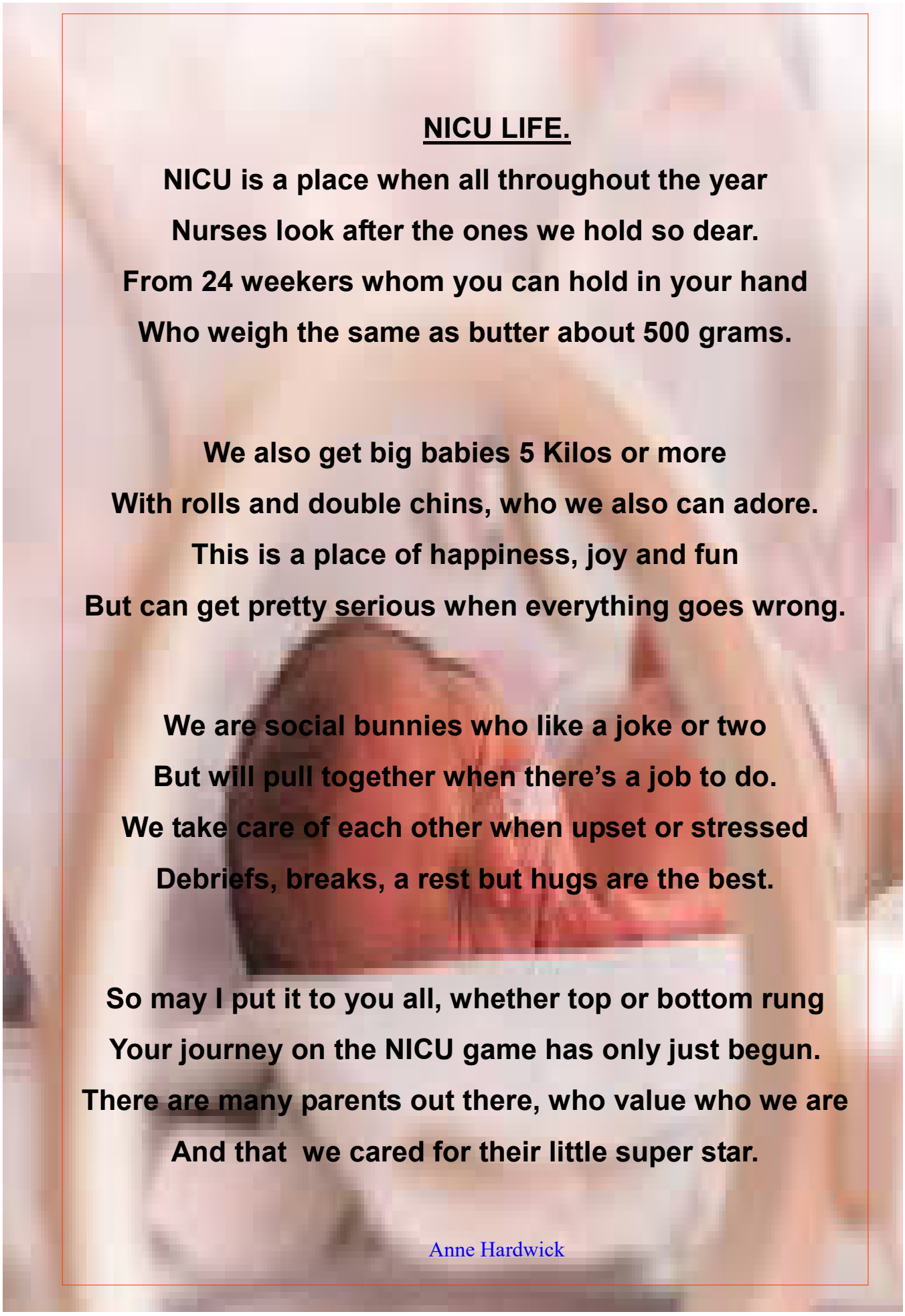
Thursday October 17th 2019

Neonatal Nurse Manager's Forum

Neonatal Nurse Practitioner's Forum

WELLINGTON

More information to come...



NICU LIFE.

NICU is a place when all throughout the year
Nurses look after the ones we hold so dear.
From 24 weekers whom you can hold in your hand
Who weigh the same as butter about 500 grams.

We also get big babies 5 Kilos or more
With rolls and double chins, who we also can adore.
This is a place of happiness, joy and fun
But can get pretty serious when everything goes wrong.

We are social bunnies who like a joke or two
But will pull together when there's a job to do.
We take care of each other when upset or stressed
Debriefs, breaks, a rest but hugs are the best.

So may I put it to you all, whether top or bottom rung
Your journey on the NICU game has only just begun.
There are many parents out there, who value who we are
And that we cared for their little super star.

Anne Hardwick

COINN 2019

Enriched Family – Enhanced Care

5-8 May 2019, Auckland, New Zealand

AUCKLAND | NEW ZEALAND 2019

www.coinn2019.com



NEW ZEALAND NURSES ORGANISATION

Neonatal Nurses College Aotearoa

COINN Council of International Neonatal Nurses

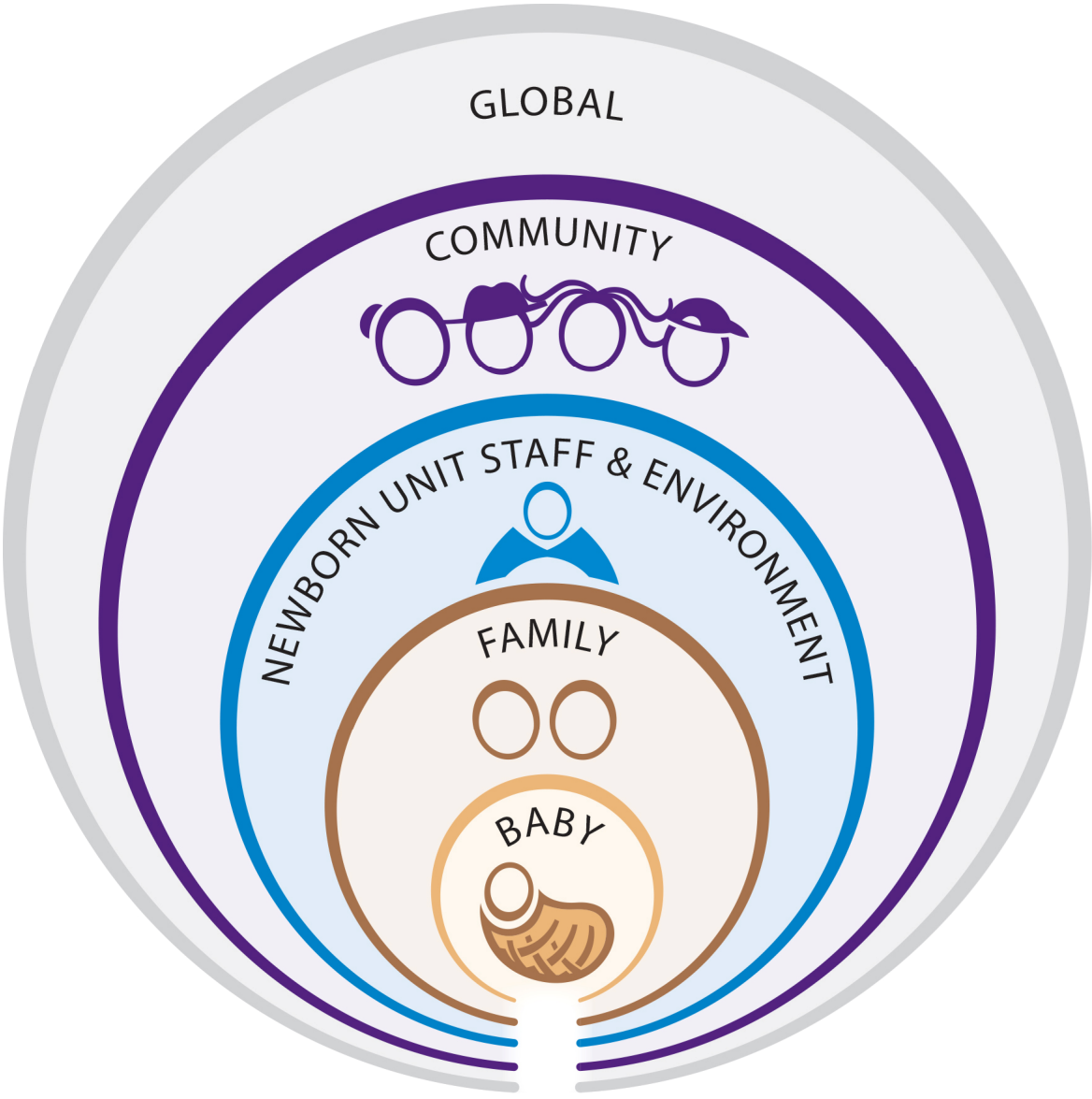
100% PURE NEW ZEALAND

COINN 2019
Enriched Family – Enhanced Care
5-8 May 2019, Auckland, New Zealand

Enriched Family-Enhanced Care

Globally, the family unit is fundamental in the optimal care of babies; providing growth, strength, resilience and unity.

COINN 2019, New Zealand, offers an opportunity to celebrate and recognise the importance and contribution of families in the care of preterm and sick babies in newborn units globally, in a range of cultural and social contexts.



http://www.coinn2019.com/

Profiling Dr Heidelise Als

Dr. Heidelise Als is a researcher and clinician who has focused her life research on the behavioural organisation of the newborn infant, especially the preterm and high risk infant. From neurobehavioral and neurophysiological studies, it is clear that the preterm infant at school age emerges as significantly more at risk for attention deficit disorder, lower IQ, difficulties in social-emotional functioning and self-regulation, and will have increased need for specialised school services.

These differences may be attributable at least in part to the difference in sensory experience of the immature nervous system when cared for outside the uterus before term.

Dr. Als is the author of the APIB (Assessment of Preterm Infants' Behaviour) and the originator of the Newborn Individualised Developmental Care and Assessment Program (NIDCAP), an individualised, behaviourally-based developmental care model, developed help mitigate the impact of the altered environment these infants find themselves in. Her Synactive Theory of Infant Development provides a framework for understanding the behaviour of premature infants.

NIDCAP and APIB were developed for the education and training of staff and the support of parents in reading the infant's behavioural cues in order to implement individualized developmental care collaboratively with the infants needs.

Dr Als is the founder and President of the NIDCAP Federation International, a non-profit organization which provides national and international training for advanced professionals in the field of NICU developmental care implementation.

"The goal of my work is to increase knowledge and understanding of all human development, to improve the lives of the most vulnerable newborn populations and their families, and to assure that the opportunities they have allow them to fulfil their potentials to lead fulfilling lives. My research and clinical observations have convinced me that all human beings have rich inner lives that must be supported to unfold and thrive or will be thwarted diminished by the care, opportunities and environments they encounter. Every human being continuously attempts to be the best they can be, no matter how their current actions express themselves. This humbles me as clinician and researcher; I believe in the human condition and its unlimited capacity for transformation. This conviction carries my work and continues to characterize my personal and professional journey." Als.

Toward a Synactive Theory of Development: Promise for the Assessment and Support of Infant Individuality
Article (PDF Available) *in* Infant Mental Health Journal 3(4):229 - 243 · December 1982

Continued...

COINN 2019
Enriched Family – Enhanced Care
5-8 May 2019, Auckland, New Zealand

Dr Heidelise Als

Monday 6th May 0900

Protecting the preterm brain – family and staff collaboration

Wednesday 8th May 1240

NIDCAP, The Voice of the Newborn – Responsibility and Opportunity

New Zealand Newborn Clinical Network

The Newborn Clinical Network is a multidisciplinary group established in 2013 to provide clinical leadership in the development and maintenance of a nation-wide, clinical service for newborns. It is tasked with supporting clinicians working across primary, secondary and tertiary services to deliver high quality, cost effective and integrated newborn treatment programmes for babies and their whanau.

The network consists of medical and nursing leaders from across New Zealand from all levels of care. It formulates consensus statements with other organisations, monitors and audits services to inform continuous quality improvement, and liaises with the Ministry of Health regarding the neonatal workforce and unit capacity issues.

The network links with the Australian and New Zealand Neonatal Network (ANZNN), Maternal Foetal Medicine (MFM) network, Maternity Quality and Safety Committees, Midwifery /NZ College of Midwives (NZCOM), Well Child/Tamariki Ora and has a representative from the Neonatal Nurses College Aotearoa (NNCA).

Ideally the network would include;

- Neonatal Paediatricians from the 6 level 3 units
- Paediatricians with an interest in neonatal care from level 2 units
- ANZNN L3 and L2 representative
- Nurse managers
- Nurse Practitioner/ Clinical Nurse Specialist advanced neonatal practice
- Neonatal transport nurse co-ordinator
- Neonatal nurse education
- Neonatal discharge facilitator
- Level 2 nurse representative
- NNCA representative

Other specialist groups may be co-opted including;

- Midwifery representatives
- Obstetric and MFM specialists
- University / research representative
- Well child Providers
- Maori and Pacific health providers
- Allied Health
  - Dietetics
  - Pharmacy
  - Neonatal Social workers
  - Neonatal Physiotherapist/ developmental therapists
- Community interest/support groups
- Consumers

Continued...

Continued...

The network hold teleconferences bi-monthly and an annual face-to face meeting. Sub-committees are formed to generate recommendations and guidelines that are then ratified by the network before being circulated and published on their website. https://www.starship.org.nz/for-health-professionals/new-zealand-child-and-youth-clinical-networks/newborn-clinical-network

Some of the topics completed include practice recommendations for treatment of hypoglycaemia with dextrose gel, oxygen saturations targets, a consensus statements for the treatment of neonatal encephalopathy and retinopathy screening.

The latest practice recommendation newly published is for Neonatal Subgaleal Haemorrhage.
https://www.starship.org.nz/media/575544/neonatal-subgaleal-haemorrhage-oct-2018.pdf

Topics are sourced from network members looking for a collective best practice guidelines, challenging clinical incidents that may have occurred and quality improvements that have been brought to the attention of the group. Currently the network is looking at recommendations around Congenital Diaphragmatic Hernia and red eye reflex assessment. New topics include routine follow up of preterm infants and the management of neonatal hypernatraemia.

One of the largest current projects is the development of a national transdisciplinary consensus document, to provide equitable care for mothers and babies at 23 to 24+6 weeks gestation. Divided into antenatal, intrapartum and care of the extreme preterm, a working party for each section was formed including obstetric and consumer representation. Each group is working towards forming a national agreement over the management, care and support required for these fragile infants and their whanau. It is hoped to be completed this year.

Alongside the clinical challenges of neonatal care are the managerial and logistical issues. The network is working in conjunction with the Ministry of Health currently to review Service Specifications. It also looks at safe staffing, neonatal nurse training, capacity numbers and the movement of infants from unit to unit.

Paula Dellabarca
Neonatal Nurse Practitioner
Wellington NICU

NNCA representative on the NCRG

What's happening in your back yard??

Neonatal Intensive Care and Special Care Units from around New Zealand share local news...

Haere mai and welcome to our place here in the SCBU Nelson. Our 10 cot unit has been getting busier each year with over 200 admissions and an average length of stay of around 8 days. We service a fairly large area and work closely with our sister unit at Wairau hospital and our regional tertiary centre in Wellington. Luckily we have a small 2 bed roomed cottage available for out of town parents and whanau to stay in when they have a baby in our unit.

New happenings in recent times.

Minimally Invasive Surfactant Therapy (MIST) - In the last year we started using MIST to treat neonates with severe RDS, using a narrow gauge catheter to administer surfactant without the need for full intubation and ventilation. This has huge benefits for the neonate and their whanau in avoiding a transfer to Wellington, in addition to less separation and time in hospital. There is also a significant cost saving for NMH as Life Flight retrieval services are not required.

Family Integrated Care (FIC) - For many years family-centred care has been our philosophy in SCBU. However, there is growing evidence both nationally and internationally showing the benefits of a shift to a more shared care arrangement with the parents as the primary caregivers working in partnership alongside the health professionals. We are looking at our SCBU culture and rethinking how we can further work with parents to plan and deliver care. We work hard to accommodate all parents on the unit and have been donated more breast pumps and recliner chairs to fully equip each room. Exciting times!

Simulation Training for Neonatal/Paediatric staff - In partnership with Starship and the Douglas Starship Simulation Program, NMH have embarked on developing our own program and two staff have attended the training in Auckland. The Auckland team are coming to Nelson for two days in March to stage one paediatric and one neonatal crisis event and assist with developing the skills of debriefing after. This in itself will be extremely helpful and then later further staff will attend the Auckland workshop with the aim of maintaining a local team of experienced trainers who can continue to offer

Continued...

NELSON
CONTINUED

This in itself will be extremely helpful and then later further staff will attend the Auckland workshop with the aim of maintaining a local team of experienced trainers who can continue to offer simulation training here.

Finally, we are very excited about the forthcoming COINN conference and thanks to NMH, NZNO, NNCA and fundraising, have managed to fund five of our team to attend. We look forward to them sharing the learning and innovations on their return.

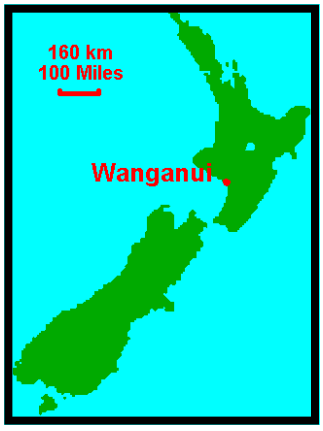
Maree Arps, Neonatal Nurse Educator & Jan Kirk Acting CNM

Whanganui SCBU is a 4 cot unit (cared for by 1 RN) with a neonate admission criteria of 32 week gestation and 1500 grams - plus we stabilize other gestations with CPAP and / or ventilation, as required. These babies are flown to our tertiary centre at Wellington Hospital. Our average yearly admission is 150 babies.

Our SCBU was lucky to receive a large donation from the Countdown Kids appeal at the end 2018. It was decided that rather than spend the funds on medical equipment , we would use the money to provide some extras for our families and babies.

We have purchased an extra breast pump, cosy cot and are trialing new breast feeding chairs that are also comfortable for mother and baby to enjoy skin to skin.

Additional purchases include merino blankets for babies to use while in the unit and then take home with them, as many of our families struggle to be able to afford wool blankets and clothing for their babies.



Barbara Hammond

The Neonatal service recently officially launched the Neonatal Men's Shed.

Background as to why we have a shed.
The birth of a premature or unwell baby results in the need for a neonatal admission, a period of stay and separation from the family. This ushers a period of time of uncertainty and stress for parents. As a service we want to continue to work and build upon our partnership in care with our parents and their wider whanau, to reduce their stress and to support them on this journey so that they feel included and empowered in their baby's care and decision making and confident parents by the time they leave the NICU with their baby/babies.

Family integrated care is a model of care that the Christchurch NICU launched earlier this year and over the past year we have been working away on a number of initiatives to enhance and promote this model of care. One pillar of this care is that of Psychosocial support. One focus within this working group is to be able to support fathers more through the neonatal stay.

Through my own personal Masters research on father's experiences and the limited internationally published research on the impacts of a NICU journey for a father, a few projects have already been undertaken. The Men's shed being one such project , a dedicated space for providing resources for fathers . The availability of written information was a theme shared by a number of fathers interviewed . One father told me that "as staff we should never fear bombarding him with information as he wanted to know everything" another talked about " the information we give as being too much initially but to be able to access when the time was right would be great"

So with that in mind the group explored the opportunity to define a dedicated place for information for fathers and to source relevant resources that they could read at their leisure.

Courtesy of Nell Wilson one of our neonatal ward receptionists whom coaxed her talented husband Craig in his spare time to craft us this wonderful shed we are now fortunate to have this housed within our neonatal parent lounge.

Debbie O'Donaghue

I first developed an interest in the idea for Books for Babies in our unit a few years ago when doing my PG Cert. I had to put together a proposal and as neurodevelopmental care has always been a passion of mine, the idea of Books for Babies arose.
Initially my idea was that every baby in the unit would receive a new book to keep, along with information on reading to your baby.

I lobbied a few likely places, either getting no reply or a rejection.
I then contacted Storytime book foundation who were and are very willing and able partners.

Unfortunately there are not enough resources for every baby to get a book pack so this is done discretionally, based on gestation and need.
Along with this the Storytime foundation provided a wee library (built by Men in Sheds , Tauranga, and painted by a local artist) they also provided some initial book stock.

This has been added to by myself and donations.

Parents are encouraged to read books to their babies while in our unit.
The packs given out contain one Hairy McLarey Board book and one soft book.
Information is given to the parents re the first 1000 days, attachment , bonding and growing our babies brains.

Parents have embraced our book packs and little library well, It has become very successful and my aim is to have every baby in the unit receiving a book to go home with and encouraging families to enrol their babies at the local library and/or give their whanau a library card as a gift.

Brenda Pearce

WELLINGTON

A new initiative for Wellington NICU is basket weaving. A group of nurses are learning how to weave baskets from harakeke (flax) for the babies that pass away in the unit. The initiative came about as the current system was struggling to meet the needs of our patients. Firstly there were not enough baskets to allow for single use baskets and secondly the re use system was culturally insensitive to Maori patients as well as other cultures within our patient demographic.

Many of our families/whanau prefer to take their babies home with them straight from the unit, bypassing the mortuary. Therefore we like to offer parents a basket to carry their baby out of the unit in, to provide privacy for the deceased baby as they leave the unit. Our current system means we rely solely on Sands (not for profit organisation who support parents through loss of a baby/child) to provide the baskets we supply to families. Sadly the number of baskets available do not meet the number of baskets required. The solution seemed simple, we need more baskets.

Unfortunately there was no money in the budget for baskets. Without a budget we had to get inventive and the idea came about that nurses could learn to weave baskets for the unit. Various conversations amongst colleagues led to the utilisation of the concept of the wahakura (safe sleeping device made from harakeke). We made contact with a few people that weave wahakura and enquired about making something similar for angel babies. Thankfully some lovely weavers in the Kapiti Coast offered their time and skill to us free of charge. We were able to secure a school hall as a venue, also free of charge.

Once we had weavers and a venue, we needed to gauge interest from staff. It seemed a huge ask to see if anyone was interested in learning a new skill for the benefit of the unit, which had to be done in their own time (unpaid) and their own money (small koha to go to the weavers) as well as their own travel expenses as the weaving workshop would be located on the Kapiti Coast. However never underestimate the care, compassion and dedication of nurses. There were over 40 nurses interested (a third of nursing staff) in attending the course, we were able to accommodate 20 of them on the first workshop.

The harakeke was harvested by one of the nurses and the weavers prior to the workshop. The workshop had to be split into two days. The first day of the workshop we learnt how to prepare the harakeke for weaving. The second day will be weaving the baskets.

Continued...

WELLINGTON

CONTINUED

There is a lot of work involved in preparing the harakeke (six hour day) and we all came away with sore hands and an appreciation for weavers and the work they do and produce.

Sore hands aside, the day provided staff the opportunity to interact with each other outside of work whilst learning a new skill that would ultimately benefit the unit. The weaving process is therapeutic and a lot of dedication and time has gone into it.

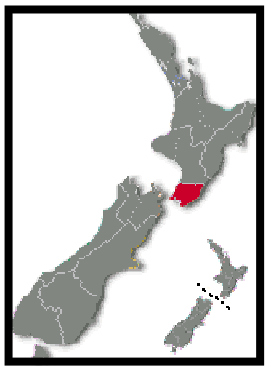
There is also an element of healing involved for the nurses that end up caring for the babies that will need these baskets.

When the babies are placed in these baskets, there will be a card attached with further instructions for use (must be buried/returned to mother earth) as well as a small note to let the families know the dedication, care and compassion that went into making these baskets. The second workshop day will take place in April.

Hayley Dent

2019 started off with our busiest month for admission in 2 years, now it has calmed down slightly we can look forward to some more positive changes. Over the next year in Hutt Valley SCBU we are continuing to build on our close working relationship with the maternity team and through a joint business care are hoping to finalise funding for a much needed blood gas machine to share between the wards.

We are trialing new height adjustable bassinets to replace our old ones and one of our nurses is continuing to work on updating our developmental care work and fundraise for some new equipment for this. We have successfully transitioned to a trendcare handover and from a medical side our doctors have stopped attending elective sections, freeing up a lot more time to spend on the ward and we have finalised a new sepsis guideline to ensure standardised approach to care.



Rebecca Abbotts

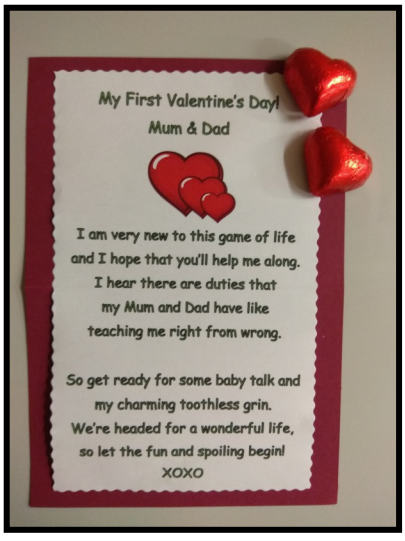
It is the small things that count when giving compassionate Care in SCBU
The vision of our DHB is to support our communities to be healthy and thriving. Our CARE values underpin everything we do guiding our behaviours and decisions. The acronym of CARE stands for compassion, all-one-team, responsive and excellence. Our CARE values are important to us and we see this as a foundation for delivering a really great service to our babies and families.

In SCBU we focus on providing compassionate nursing care that includes the whole family, especially ensuring the mothers feel supported and special. One way we can do this is by providing Mothercraft rooms for the mothers to stay in.

Tauranga SCBU was purpose built 10 years ago as part of the new extension of Tauranga hospital with the nurses having a large role in the design.

The Mothercraft rooms are situated within the unit allowing mothers the opportunity to be close to their babies and having both privacy and immediate contact with staff if needed.

Night time is a unique time to connect with mothers who are often awake feeding their babies. Mothers are offered fluffy milos or porridge (to promote lactation) and an opportunity to discuss issues they might not want to talk about during the day.
Special days are celebrated by handmade cards, poems, chocolates and special treats. Valentine's Day, mother's day, St Patrick 's Day, Easter, Christmas and father's day all deserve recognition!



Night time is a unique time to connect with mothers who are often awake feeding their babies. Mothers are offered fluffy milos or porridge (to promote lactation) and an opportunity to discuss issues they might not want to talk about during the day.

Special days are celebrated by handmade cards, poems, chocolates and special treats. Valentine's Day, mother's day, St Patrick 's Day, Easter, Christmas and father's day all deserve recognition!

TAURANGA

CONTINUED

One mother wrote: "*The nurses in SCBU are dedicated and passionate about caring for us and our babies. On Valentine's Day we got a card with beautiful heart felt words, which made me cry. I loved being pampered and made fluffy hot chocolate in the middle of the night, as well as being told I was doing a good job. All those little things meant a lot to me. I especially loved being able to use the Mothercraft room where I stayed with my baby and cared for her as if we were already home. The amazing part though, was a nurse was just outside the door ready to support, help and give advice if needed.*"

Sometimes SCBU staff meet families in the community who have had a baby in SCBU. Women will often ask about the night nurses who made them fluffy milos and who took the time to make pretty name cards and do hand / foot prints for their babies. Those lasting memories of the "extra little things we do as nurses, appear to outweigh the "not so nice" treatment interventions families often experience when their babies are in SCBU. When the unit is frantic with many babies and few nurses, managing to just do the essential things is a challenge.

However when we can, taking the time to make a mother and her family feel special and cared for is important and rewarding. It is the small things we do that count when providing compassionate care to families.

Marion Wordsworth

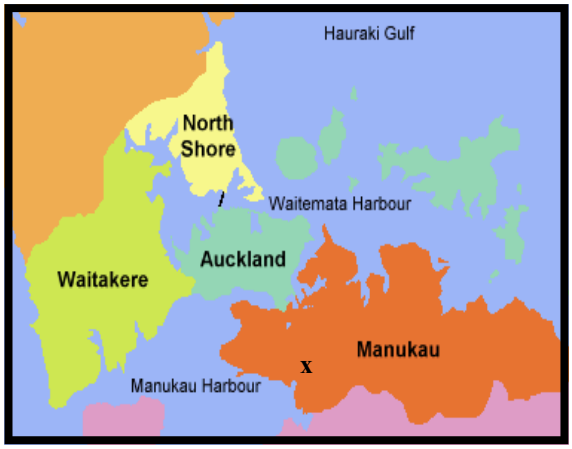
Tauranga SCBU is a 12 bed unit (including 3 HDU bed spaces). There are approximately 350 admissions each year from 2500 births.

On average there are 8 babies with 2 nurses on each shift. The team consists of 15 nurses and 1 CNC and have access to a lactation consultant.

SCBU is positioned in-between theatres and delivery suite and is on the same floor at the postnatal ward.

The tertiary referring centre is Waikato Hospital.

Over 800 babies are admitted each year to Kidz First Neonatal Care (KFNC) at Middlemore Hospital, representing approximately 10% of the annual birth population for the Counties Health Region.



KFNC provides full tertiary services for newborn babies, including advanced ventilation and care of extremely preterm infants (from 23 weeks or 450 g) and those with complex health needs.

Admissions to KFNC are usually unexpected and result from complications around the time of birth, serious illness after birth or because of unplanned preterm birth. The sickest and smallest babies admitted to KFNC may spend up to 4 months in hospital.

Babble team

A new approach to communication with parents is needed

Until recently in KFNC information was provided to parents via printed pamphlets, including a black and white introductory booklet, and regular verbal updates at the bedside from the nurses and medical teams. We were aware that the current printed information available in our unit is often not read.

Possible factors include lack of visual appeal, pamphlets being lost or not available, and low literacy or having English as a second language. In our conversations with parents they have remarked the printed information is “boring because it is in black and white print and only words." Staff also appear reluctant to use our brochures, possible for fear of providing too much information to families at once. For example, when referring to the Welcome Booklet, one nurse said "I don't want to overwhelm them with all this information at once".

Nevertheless, written material and visual aids are important as research has shown that only about a third of verbal information provided by health professionals is retained. This may be even worse when parents are under stress.

For health information transfer to be effective, it needs to be delivered in a format that is relevant to patients’ culture, generation, socioeconomic context, and in language that they understand. It also needs to be available when parents need it. For example, one parent explained when she held her baby skin to skin, "I was bored and wanted to know something about my baby. The nurse was busy so I got my phone out and tried to find some information about the neonatal unit. It would be really good to have information for parents in an app.”

Continued...

MIDDLEMORE

CONTINUED

Counties Manukau birthing population is unique

The Counties Manukau maternity population is one of the most ethnically diverse and socially deprived birth populations in New Zealand. Nearly 50% of mothers are Maori or Pacific, and approximately 25% are of Indian or South East Asian origin. Approximately 40% percent of mothers are in the lowest socioeconomic quintile. Further, mothers are often young, with the majority being less than 23 years of age. This presents unique challenges in terms of health information and support.

Despite this, most mothers have a smart phone, and for many who cannot afford a home computer, the phone is their primary communication tool. In recognition of this fact, Counties Manukau now provides free WIFI for patients and families. Our culture is changing with phone apps rapidly becoming a primary means of information gathering and communication, and printed material is fast becoming culturally foreign to younger generations. Health services have been slow to embrace these changes.

BABBLE: An Innovative Solution for Parent Education and Support

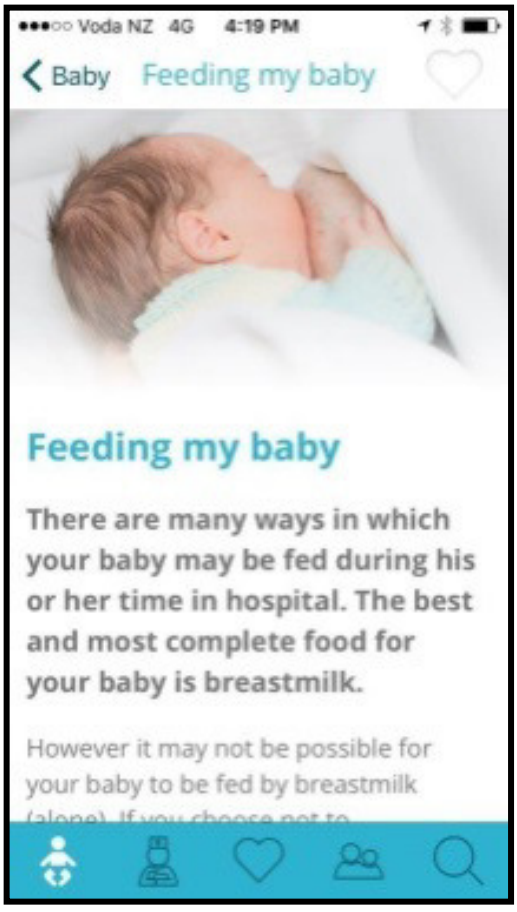
We proposed introducing the BABBLE phone platform to deliver culturally and locally appropriate information for parents of babies admitted to KFNC. BABBLE is an information platform, specifically designed for neonatal units that can be used on smart phones or tablets by parents and whanau to inform them of care provided to their baby. The primary goal of BABBLE is to assist, empower, and support parents.

BABBLE was created by paediatrician Dr Nathalie de Vries at Palmerston North Hospital. Her team of doctors and nurses interviewed parents to understand what information they needed and the best ways that the information could be delivered.

A smartphone app was overwhelmingly support by parents. She partnered with a local Palmerston North software company to create a unique platform called BABBLE that was launched on 18th May 2016.

Recognising that each region may have different patient needs, the platform has been designed so that information can be tailored to each unit.

We set up a local version of BABBLE that will contain information about our neonatal unit, including information about staff and ward rounds, routine checks and tests, equipment, gestational expectations, advice for dads, problems and diseases, feeding advice, medications given to baby and preparation for going home.



Example of screenshot

Continued...

MIDDLEMORE

CONTINUED

This is presented in a visually appealing manner, with wide use of info-graphics, pictures and bullet points. Parents are able to download the free app at the bedside using free hospital WIFI. BABBLE will centralise the information currently provided to parents from multiple sources and will be tailored for local needs. When fully implemented, users will be able to select their own language.

BABBLE also allows parents to record the journey of the baby in a special diary function, including photos and journal entries. Importantly, this personal information will only be stored on the parents' phone and not retained centrally, thus preserving privacy. However, we plan to invite parents to share their stories and we will curate a public gallery of journals for other parents to read. Storytelling is an important way for parents to receive and give support, enabling connection and a sense of shared experience. Telling one's story is also a key way of dealing with stress.

BABBLE also includes an analytics function to provide information on how often the app is being used and how often pages are viewed. It can also be used to seek feedback from parents about the value of the app and the content that they find most useful, and the service provided by the neonatal unit.

Potential Impact of BABBLE on patients and staff

A key benefit of BABBLE is that all key information for parents will be provided in one place and will be available to them at any stage during their baby's admission and on discharge. Mothers will be able to become fully informed about the neonatal unit from their hospital bed. Parents will be able to digest information at their own pace, reading pages as needed at different stages of the baby's admission or as issues arise. Another advantage of using a mobile platform is that whanau who may be involved in a baby's care, can also access the information.

Staff will use the app in their discussions with parents to reinforce understanding of their baby's care and the processes in the neonatal unit. BABBLE will act as a visual reminder for staff to cover important topics and to improve the consistency of information provided. All members of the care team (lactation, social work, physiotherapy, nursing, doctors) will be able to refer to relevant sections, reinforcing use of the app. BABBLE pages can be easily updated, so that parents have immediate access to the latest approaches to care.

Project Structure

A working group led by Chris Mckinlay, the KFNC Developmental Care Team and Nurse Educator (Julie l'Anson) have developed the material for the BABBLE platform. Parent representatives will be sought to participate in the working group, with representation from Maori and Pacific Peoples. The version of BABBLE that is already operating at Palmerston North Hospital will be used as the basic structure for the Counties content. KFNC working group have worked collaboratively with Dr de Vries, Palmerston North Hospital to share resources and costs in developing the app. Babble app has now completed and is available for Apple and Android devices.

Julie l'Anson

The Hawkes Bay Region sits on the East coast of the North Island of New Zealand. The Hawke's Bay district stretches from the north of the Mahia Peninsula to just south of Porangahau. In the west the district is bounded by the Ruahine, Huiarau and Ahimanawa ranges and the Pacific Ocean is to the east.

Hawke's Bay District Health Board (HBDHB) serves a population of 155,000 people approximately 80% of which reside in Napier or Hastings, the two most urban areas located within 20 kilometres of one another. Smaller communities such as Wairoa and Waipukuarau have populations of around 4,000 with the remaining population residing in the more rural and remote locations.

Hawkes Bay Fallen Soldiers' Memorial Hospital is the main public health facility in the region and includes the regional Special Care Baby Unit.

The HBDHB provides a special care baby nursery (Level 2+) and is a linked to the Neonatal Intensive Care Unit in Wellington. The Unit has twelve resourced neonatal cots including two cots for high dependency care and admits approximately 300-350 neonates annually. This is on average of 15% of all babies born in Hawke's Bay. The number of births in the Hawke's Bay region has gradually declined over the last ten years however there is a trend of increasing rates of premature and low birth weight babies. The demographics of young maternal age and socioeconomic deprivation has also led to an increased demand for neonatal services.

Challenges with the high number of the of late-preterm admissions also impacts on overall occupancy with "bed-blocking" common. When a cot is not available, a baby will be transferred to another hospital often geographically far from home. This can mean mothers and babies are separated at a time of high stress and anxiety.

The neonatal transition model of was introduced in 2018 was a way to manage high occupancy and decrease the length of stay. The overall purpose was to support mothers to room-in with their baby for their entire stay and empower mothers to care for their baby with support.

The youngest baby to start this pathway was 33 + 4 weeks and discharged 17 days later. Mother and baby were never separated and length of stay was reduced by at least 7 days.

Unfortunately lack of space in the unit impedes the growth of this model of care but the benefits of transitional care are undeniable.

Continued...

HAWKES BAY

CONTINUED

Training and recruitment are also highlighted as critical components of future planning – particularly due to the ageing workforce of our nurses. We have committed to recruit new graduates and support non-experienced nurses into our workforce. To support this the Wellington Neonatal exchange programme was established in 2014 funded from the Oliver Smales Trust. As part of this program nurses are able to attend two days in Wellington hospital, comprising of a study day with lectures followed by a second full day for observation in the NICU.

With help from the Freemasons we were able to purchase a Sim NewB and regular simulations are now an important factor in growing competencies so nurses are confident to "expect the unexpected'.

Future direction will be to developed nurse specialist and practitioner roles.

Michelle Robertson

COINN 2019
Enriched Family – Enhanced Care
5-8 May 2019, Auckland, New Zealand

MR DIAMOND is a sub – study of the DIAMOND trial. DIAMOND stands for *DI*fferent *A*pproaches to *MO*derate - & late-preterm *N*utrition: *D*eterminants of feed tolerance, body composition and development.

It aims to investigate the impact of different feeding strategies currently used in NZ, on feed tolerance, body composition and gut microbial composition in moderate to late preterm infants.

Eligible participants are babies 32+0 - 35+6 weeks gestation, whose mothers' intend to breastfeed, admitted to a neonatal unit, requiring IV insertion and domicile in an Auckland DHB.

There are 3 independent variable or factors and the babies randomized to receive or not receive each of the three factors:

- D10% vs Amino acid solution (P100)
- Supplemental milk vs wait for breastmilk
- Taste/smell vs standard protocol

MR DIAMOND aims to determine the effects of different feeding strategies being tested in the DIAMOND trial on specific aspects of brain maturation as measured by MRI.

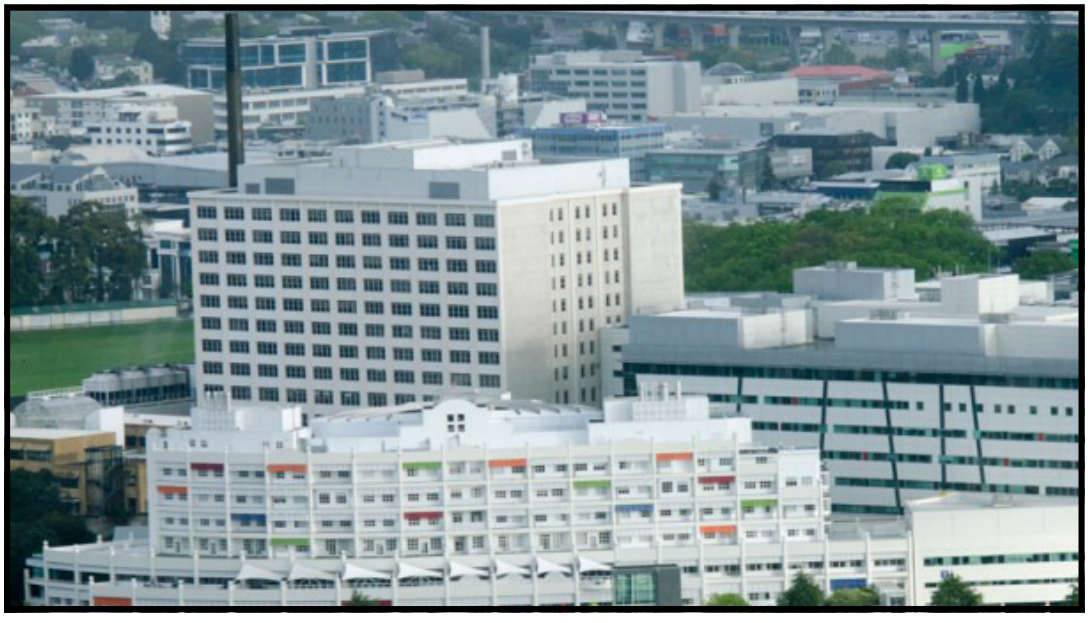
HYPOTHESIS: interventions in DIAMOND will be associated with distinct brain MRI signatures.

PRIMARY OUTCOME

1. P100 vs dextrose will result in enhanced cortical maturation
2. Formula vs breast milk will alter white matter maturation
3. Exposure to taste and smell of milk will enhance thalamus maturation

SECONDARY OUTCOME

Accurate grading of brain injury



Continued...

AUCKLAND

CONTINUED

The consent for MR DIAMOND is optional from the DIAMOND study. We have begun recruitment to the MR DIAMOND.

Study size of 96 babies, 12 per condition, 48 per comparison group

We aim to complete our first scan early April.

The study aims to perform 2 MRIs on eligible babies - one as soon as clinically stable after birth and one at term-corrected age.

The scan is approximately 45mins in duration and takes place at CAMRI in Auckland Univesity. This is accessed via a tunnel on level 3 which connects Auckland hospital to Auckland University.

The first scan will be done on in-patients; several of the term-corrected age scans will be after the babies have gone home.

We have MRI compatible equipment.

The ScanPod incubator will be strapped on a standard patient bed.

The babypac 100 will be used for infants on CPAP.

The Tesla M3 monitor has two wireless modules. One for Spo3 and pulse rate. The other for ECG monitoring.

A temperature probe is connected to a monitor in CAMRI to monitor the infant's temperature during the scan.

A transwarmer gel will be used for thermoregulation. A small built in trigger is broken to activate the gel inside and provides up to 2 hours of warmth.

The infant will be placed on a vacuum mattress to aid with patient positioning.

Precielle Joy Monje

It all POINTS in the right direction.

P.O.I.N.T.S. of Care: Nursing Education the Samoan Story

What's your nurse to baby ratio in your neonatal unit? 1:1, 1:2 in Level 3. Perhaps 1:4 or 1:5 in Level 2. How would you manage 1:9 or maybe 1:19? And how about your occupancy levels? Many of our units are running well over 100% capacity, now try perhaps 200%. This is the working reality for some nurses working in the developing countries.

We have just returned from Samoa after being invited to provide a neonatal nurses training programme called P.O.I.N.T.S. of Care for a group of nursing staff working in Tupua Tamasese Meaole (TTM) Hospital Apia. It was here we really discovered what challenging work environments really are. We went to provide nurses with the knowledge and skills around the core aspects of neonatal care, and for every lesson we gave we received a lesson in return. Talk about school the teachers!

As a college one of NNCA's objectives is to provide educational opportunities for neonatal nurses and promote neonatal nursing and standards both nationally and internationally. We are also committed to actively participating in United Nations (UN) Sustainable Development Goal (SDG) goal number 3.2: Reduction in infant mortality rates. We believe a skilled nursing workforce and nursing education is one way to contribute and nursing staff working with babies, are one of the most valuable assets to the promoting the health of babies and their families and contributing to the development and delivery of the best possible healthcare.

This is also a view held by Samoa. In line with this several years ago NNCA in partnership with the Pacific Regional Development Unit (PDU) and with the support of TTM Hospital trialled, developed and piloted a specialist education programme, called Neonatal P.O.I.N.T.S. of Care. Several local champions were then trained as credentialled trainers in the programme so they could continue training their own workforce. In addition, a core of New Zealand Nurses were also trained to be credentialled trainers.

The imprint of the staff who had been previously trained in P.O.I.N.T.S. is evident in practice. Watching these staff in practice, their skills, knowledge, confidence and competence is heartening and you can see the value in the programme. You could also see the mentoring and staff development they had achieved. However all though several of the P.O.I.N.T.S trained staff are still working in the Neonatal Unit, there is simply not enough of them for the neonatal unit now and they currently don't have the capacity to upskill the large volume of nurses required. TTM hospital recognised this and wanted to train and upskill more staff and provide more cover and expertise for their neonatal unit. Hence the invitation to return to provide more training, something we felt very honoured to be asked, and privileged to be able to do.

Continued overleaf.

P.O.I.N.T.S. of Care: Nursing Education the Samoan Story

Continued

The P.O.I.N.T.S programme is designed to provide neonatal nurses with the specific knowledge and skill set to manage the premature and complex unwell infant. It covers the key POINTS (or aspects) of neonatal care, Pain management, Oxygen management, Infection prevention and control, Nutritional support and management, Temperature management and Supportive care, providing the foundation for the practical management of infants in the neonatal unit. This is what we delivered over the course of a week to 13 very enthusiast nurses along with neonatal resuscitation and CPAP training.

The hunger for knowledge was phenomenal, and staff just wanted to learn so they could do a "better job and provide better care and make it better for the babies". This hunger for improvement was only exceeded by the hunger for the 3 mandatory meals that must be provided on training days! Morning tea, lunch and afternoon tea and all of the same size. This was our first lesson learnt. "You must feed the body if you are going to feed the mind" and "This is the Pacific way" as one of the girls gleefully told us. She laughingly informed us as long as she was fed, we would have her undivided attention and attendance! The humour and hospitality afforded us was incredible, and there was much laughter on our training days.

The sacrifice to attend the training was also amazing both at hospital level and individual staff level. Hospital resources were stretched the to be able to release 13 nursing staff for a full week training, but the hospital felt it was invaluable training for their staff and wanted as many as possible to benefit. In addition, some of our students would even go and work a full afternoon shift or night shift after full day training to try and decrease the burden on the areas where they knew they were going to be short staffed because of the training. Next day they would arrive bright and early and eager for a further days training. There stamina surpassed ours!

The joy to learn was quite infectious. We had several very animated staff one morning following our CPAP training day, as several had gone onto work afternoon and night shift! They had to utilise their new found skills and knowledge and put two infants onto CPAP something they had never done before. They were delighted with themselves and what they had been able to achieve as were their class mates.

The Apia Neonatal Unit has 9 beds but we saw it stretch up to 19 in the time we were there. Frequently there is just one nurse in NICU for this number (something they are trying to address). The staff have to deal with small and very sick (down to 27/40) and large and very sick and everything in-between! They have provision to provide Bubble CPAP to 3 infants, and have a number of incubators and radiant warmers, but all may not be fully functional at all times as they have only one technician for the hospital. There are no breast pumps, but all the baby's we saw received fresh breast milk, with all the mothers hand expressing 2-3hrly day and night to deliver milk for their baby's feeds. Mothers provided a lot of hands on care, and a lot of the things we take for granted to be able to deliver care aren't readily available.

Continued overleaf...

P.O.I.N.T.S. of Care: Nursing Education the Samoan Story

Continued

However, these factors do not stop the very capable and dedicated staff from striving to improve care and care is always delivered with a smile and love. We learnt the true meaning of resourcefulness and tenacity and humanity and humour and how these will to get you through an incredibly busy day, when your workload doubles in a shift! So, although we went to deliver training and have imparted some valuable skills and knowledge on neonatal care it has been a reciprocal teaching and learning process and our experience in TTM Hospital taught us much also.

Like us Samoa is experiencing challenging times in neonatal care with overcapacity and workforce issues and not enough staff for capacity. They also recognize neonatal care is a specialist area and requires specialist staff with specialist training. They are committed to improving care and trying to reduce infant mortality rates and are investing in the education of their nursing staff as one of the strategies toward this.

We would like to thank TTM Hospital and staff and all our brilliant trainees for their hospitality and dedication and the opportunity they gave us to work together. Also, our respective NZ and Samoan liaison links Villy and Robyn for helping make this trip possible and so successful.

Fa'afetai Gina Beecroft and Anne Jackson

COINN 2019
Enriched Family – Enhanced Care
5-8 May 2019, Auckland, New Zealand

Cool Topics in Neonatology

Cool Topics Conference Melbourne (The Royal Women's Hospital) November 2018

Mary Fahey, Associate Charge Nurse NICU Dunedin

This conference was held on Thursday 22 and Friday 23 November 2018

I was fortunate to receive sponsorship from NNCA to attend this conference, held on the 22nd and 23 of November and I was accompanied by Pip Martin CNE. We found that the sessions were topical, well-presented and all relevant to our practice, being mostly focussed on care and treatment of the premature infant. We have chosen a selection of the sessions most relevant to neonatal nursing practice to report back on.

Postnatal Steroids for BPD: What's new?

The first session delivered by Brett Manley introduced the topic of Bronchopulmonary Dysplasia and discussed the pros and cons of corticosteroid treatment for this condition which still appears to be a prominent contributor to adverse outcomes for infants born extremely preterm and for which there are few effective therapies.

He described the technique of mixing Budesonide with surfactant for intratracheal administration and delivery to the distal airways. The results which have been achieved in clinical trials so far are promising, with the aim of the treatment being to maximise local anti-inflammatory effects in the preterm lungs while minimising systemic adverse effects. This work which warrants further investigation has led to the design and implementation of the international, multicentre PLUSS trial of intratracheal Budesonide mixed with Curosurf.

The study is ongoing however it is hoped that it will demonstrate that, used as an early prophylactic treatment, the risk of steroid use can be minimised and the benefits enhanced in order to improve long term outcomes, without short term adverse effects, in this population group.

Human Milk Banks (HMB) – Regulation and Social Responsibility

Professor Karen Simmer from King Edward Memorial Hospital in Perth, gave an excellent presentation on human milk banking. It focussed on a slightly different area of interest around the practice of using donated breast milk but the content of the presentation raised issues pertinent to us all.

The first HMB in Australia was established 12 years ago with the aim of promoting breast feeding and avoiding artificial formula use for infants born less than 32 weeks gestation. Since the establishment of the HMB service there has never been a shortage of willing donors however this year (2018) the concept of imported human milk and the potential need for it, has been mooted and is being seriously considered in Australia. This would be a commercial enterprise, regulated as Human Milk Formula and available for purchase - but its use has been explored without engagement of the community or promotion of the benefits of breastfeeding and importing the product would appear to create a significant burden for Australia's health service.

Continued overleaf

Cool Topics Conference Melbourne (The Royal Women's Hospital) November 2018

Continued...

Professor Simmer highlighted the ethical dilemmas associated with this practice, including the possible risks to the health of the most vulnerable Australian infants and also the potential that the practice might exploit vulnerable mothers?

Evidence of benefit and also absence of harm needs to be established and the prioritising of the need of the donor's own infant for its mother's breast milk needs to be ensured, especially if donations are imported from countries where mothers are paid to donate breast milk. Breast milk, which the World Health Organisation (WHO) considers to be human tissue, requires a governmental approach around ethical and effective processes to ensure the safety, quality and efficacy of its use both nationally and internationally.

The commercial attractiveness of the concept of imported Human Milk Formula was pointed out by Prof Simmer and also she emphasized the need to manage this situation in a way that is safe, ethical, effective and sustainable, while exercising social responsibility at all times. Milk should not be taken away from the donor's baby and more ways to promote public health initiatives to draw attention to the health advantages of breast feeding after premature birth need to be explored. This should happen alongside support measures to assist breastfeeding.

To summarise the speaker reinforced the important role of donated breast milk in premature nurseries and supported its role as part of a preterm lactation support service. However she saw weak and conflicted evidence only, in support of a commercially available human milk product - in a climate where the current availability of milk donations is adequate and the costs to establish a commercial product could be high, alongside the need for further regulation, legislation and meticulous quality control.

A Review of Melatonin and its Role in Neurodevelopment during the Perinatal Period

This session was given by Professor Nikki Robertson from the University College in London and was a discussion of potential uses for melatonin in the NICU. Melatonin is excreted from the pineal gland and she described it as nature's most diverse signal, having been used in Chinese medicine for many years. The fact that it may play a part in neuroprotection has led to consideration of its potential usefulness in neonatal medicine.

Newborn infants have no discernible melatonin levels and most babies take 2 – 3 months post birth to achieve adult levels of melatonin secretion. Levels rise after a traumatic brain injury and questions have been asked about the role of melatonin alongside cooling for HIE and whether this could result in a time-critical mopping up of free radicals. In this situation melatonin is also thought to have a role in potentially mobilising endogenous stem cells and assisting in neural repair. Further research is required but melatonin has so far proved to be safe in clinical trials and to have been associated with reduced oxidative markers, though the optimal dose and the timing of administration remain unclear.

Continued overleaf...

Cool Topics Conference Melbourne (The Royal Women's Hospital) November 2018

Continued...

Newborn Resuscitation – some new thoughts?

Research to date mainly carried out on animal models has offered new thoughts around commonly accepted practices. Dr Peter Davis, Eoin O'Currain and Associate Professor Graeme Polglase described 3 different areas which are currently being researched. Dr Davis spoke about the practice of sustained inflations in neonatal resuscitations and looked at the research underpinning this. The practice worked well on animal models who were intubated and sedated however in newborns, particularly preterm newborns, there now appears to be no benefit for mortality, BPD or air leak and low quality evidence of a decreased need for mechanical ventilation. Further research is required however, before there can be any advice to deviate from the ILCOR guidelines.

Eoin O'Currain described his PhD research around evaluation of a respiratory function monitor to teach mask ventilation of the newborn. He stated that face-mask leak during newborn resuscitation is a common occurrence and can impede effective ventilation. The aim of the study was to determine whether a respiratory function monitor could reduce mask leak and included health professionals enrolled in a formal, structured newborn training course as participants. He concluded the use of the monitor reduced leaks during face-mask ventilation and allowed operators to see how effective their technique was.

Dr Graeme Polglase spoke on the practice of clamping the umbilical cord prior to resuscitation of the newborn, which is consistent with the ILCOR guidelines, and presented some research to support resuscitating with the cord still attached although most studies as yet have been done on animal models.

Dr Polglase presented evidence to show that delaying the clamping of the umbilical cord until after respirations have been established in babies requiring respiratory support could have marked beneficial effects and that the effects on cardiovascular function and physiological adaptation were present for at least 30 minutes after birth in some studies.

Delaying cord clamping for resuscitation, potentially results in maintenance of cardiac output until pulmonary blood flow increases, continued gas exchange until lungs aerate and pulmonary blood flow stabilises, and some degree of placental transfusion. There are logistical considerations particularly during a caesarean section delivery which need further discussion and there is no indication at present that research indicates that the current ILCOR guidelines warrant changing.

This is an area for watching and waiting however.

Continued overleaf...

Cool Topics Conference Melbourne (The Royal Women's Hospital) November 2018

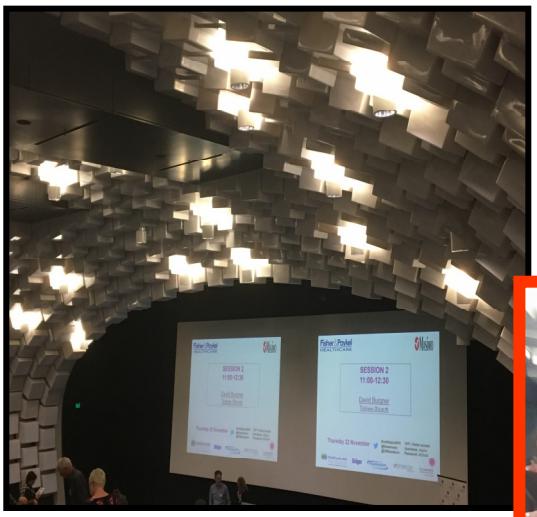
Continued...

Neonatal Hypoglycaemia

Dr Chris McKinlay discussed transitional hypoglycaemia posing the question is it actually a problem or are we just treating numbers? Impaired metabolic transition is a common problem in late preterm and term infants. There is evidence to suggest that neonatal hypoglycaemia impairs specific neurocognitive skills that only become evident at later ages. Rapid correction or over correcting may be harmful with the suggestion to target stability rather than just getting the blood sugar up rapidly.

The Cool Topics Conference was held in the impressive Copland Theatre, Melbourne University and was well attended by delegates from Australasia and many from the UK and Europe. The first day in particular was extremely well attended and the lecture theatre appeared to be full. The sessions generated lively discussion and interest as delegates pondered the extent of current research around neonatal treatments and what the future might look like in terms of practice changes.

My grateful thanks go to the NNCA for granting me a scholarship to allow me to attend this gathering.



Research...

Time to achieve desired fraction of inspired oxygen using a T-piece ventilator during resuscitation of preterm infants at birth

Dekker, J. et al.
Resuscitation , Volume 136 , 100 - 104

Abstract

Aim

To determine the time between adjustment of FiO_2 at the oxygen blender and the desired FiO_2 reaching the preterm infant during respiratory support at birth.

Methods

This observational study was performed using a Neopuff™ T-piece Resuscitator attached to either a test lung (during initial bench tests) or a face mask during the stabilization of infants at birth. FiO_2 was titrated following resuscitation guidelines. The duration for the desired FiO_2 to reach either the test lung or face mask was recorded, both with and without leakage. A respiratory function monitor was used to record FiO_2 and amount of leak.

Results

In bench tests, the median (IQR) time taken to achieve a desired FiO_2 was 34.2 (21.8–69.1) s. This duration was positively associated with the desired FiO_2 difference, the direction of titration (upwards) and the occurrence of no leak (R^2 0.863, F 65.016, $p < 0.001$). During stabilization of infants (median (IQR) gestational age 29^{+0} (28^{+2}–30^{+0}) weeks, birthweight 1290 (1240–1488) g), the duration (19.0 (0.0–57.0) s) required to reach a desired $FiO_2$was less, but still evident. In 27/55 (49%) titrations, the desired FiO_2 was not achieved before the FiO_2 levels were again changed.

Conclusion

There is a clear delay before a desired FiO_2 is achieved at the distal end of the T-piece resuscitator. This delay is clinically relevant as this delay could easily lead to over- and under titration of oxygen, which might result in an increased risk for both hypoxia and hyperoxia.

NNCA Professional Development Grant

Approx Amount Available: Up to $6000.

The *maximum* scholarship will be $1000 per person at the discretion of the NNCA Executive Committee.

Eligibility: Applicants must be a full member of NNCA for 12 months.

Criteria: **Courses, seminars, conferences or projects** relating to neonatal nursing. Priority will be given to nurses embarking on research or writing for a peer reviewed journal.

Applications must be received on the correct application forms.

Applicants receiving funding from NNCA will be expected to contribute to the Newsletter or the annual Conference.

Application dates:

April 30

July 31

Sept 30

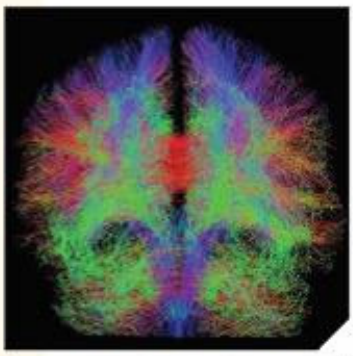
Application forms can be found on the NNCA website for funding opportunities.

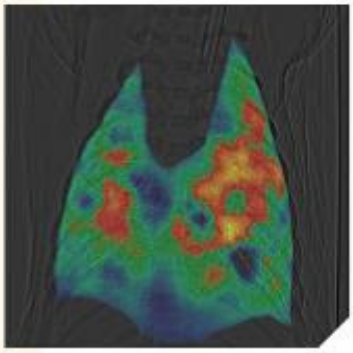
Send applications to –

Scholarships & Grants - NNCA Administrator
NZNO National Office
Level 3, Willbank Court,
57 Willis Street
PO Box 2128,
Wellington 6140
Fax: 04 382 9993
E-mail: Rosanne.Grillo@nzno.org.nz

THE ROYAL WOMEN'S HOSPITAL PRESENTS

COOL TOPICS IN NEONATOLOGY 2019





SAVE THE DATE

THURSDAY 14 AND FRIDAY 15 NOVEMBER

INTERNATIONAL SPEAKERS:

Professor Roger Soll
University of Vermont, USA

Professor Neena Modi
Imperial College, London

Professor Richard Polin
Columbia University, USA

THURSDAY 14 AND FRIDAY 15 NOVEMBER 2019

INFORMATION ON HOW TO REGISTER YOUR INTEREST TO FOLLOW

cooltopics@thewomens.org.au

the women's
the royal women's hospital
victoria australia

FINAL 22 February 2019

Sector update re the Safe Staffing Accord

1. Representatives of the New Zealand Nurses Organisation (NZNO), district health boards (DHBs) and the Ministry of Health signed an Accord on 30 July 2018 committing the parties to there being sufficient nurses and midwives in our public hospitals to ensure both their own and their patients' safety.

Agreed Commitments

2. The accord commits the Parties to the following:

a. to explore options for providing employment and training for all New Zealand nursing and midwifery graduates and report to the Minister of Health by the end of November 2018

b. to develop any accountability mechanisms that the Parties believe are necessary (over and above those already agreed) to ensure DHBs implement the additional staffing needs identified by CCDM within the agreed timeframe (June 2021) and report to the Minister of Health by the end of February 2019

c. to develop a strategy for the retention of the existing nursing and midwifery workforce and the re-employment of those who have left the workforce, and report to the Minister of Health by the end of May 2019.

Progress to date

3. Work is progressing on parts B and C of the Accord commitments, and an update to the Minister on part B is nearing completion.
4. We realise the importance of CCDM to ensuring DHBs are in a position to implementing the additional staffing needs identified.
5. We note many DHBs have already recruited into the CCDM co-ordinator and Trend-Care coordinator roles – indicating a serious commitment to implementation.
6. Beginning in February 2019, HealthCERT will be piloting an audit of CCDM as part of the certification process.
7. We are currently sending out our analysis of feedback received from Directors of Nursing, Nurse Executives of NZ, and nurse educators in surveys last year. This feedback informed our advice to the Minister on new graduate employment and continues to inform our work. We are awaiting the last of the NETP/NESP evaluations to come in from remaining DHBs.
9. In regards to the funding for immediate staffing relief, we understand DHBs have commenced recruitment of nurses and midwives. We anticipate we may be in a better position to update you on these recruitment numbers in the next update.
10. The Group is also focusing on Part C of the Accord commitments. First steps have included digging deeper into data on workforce entry and exit patterns, and the literature on factors influencing nurses' decisions to stay or leave, existing retention strategies, and lessons learned. This will help us to focus on priority actions.
11. The Accord signatories will be meeting with the Minister on 11 March to discuss progress.
12. Please also feel free to distribute this update widely and we will be posting this to our Safe Staffing Accord section on the Ministry's website.
13. We are keen to keep everyone informed on our progress and are always happy to receive contributions from people. If you do want to share your thinking, please feel free to email our office at chiefnurse@moh.govt.nz.

FOR THE NEWSLETTER…

- Use **Word Format** please.
- Up to 500 words.
- Arial Size 12 font
- Pictures tell a 1000 words
- Does NOT have to be academic writing—just great reading!
- Each submission gives you **One entry for a prize** !!
- Send your work to Rosanne at Rosanne.Grillo@nzno.org.nz

Just Do It!!