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Integrated family delivered care: Development of a staff education programme



Annie Aloysius*, Karen Platonos, Ann Theakstone-Owen, Aniko Deierl, Jayanta Banerjee

IFDC Core Group, Neonatal Unit, Imperial College Healthcare NHS Trust, Du Cane Road, London, W12 0HS, UK

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ABSTRACT

Neonatal staff education is critical to the successful implementation of Family Integrated Care (FIC) to support the shift in the focus of care giving for the baby to working with parents as part of the unit of care, treating them as equal and active members of the team in the care of the baby. Education should include an understanding of the parent experience to enable sensitive and effective communication required for partnership working. Effective staff education supports an understanding of the differences of FIC, what is required of staff, provides an opportunity to address hopes and fears and makes sure staff are up to date and confident in their clinical knowledge and skills to up-skill parents. Opportunities to educate staff can be hard to find with the challenges of staffing and acuity on a neonatal intensive care unit, this requires adaptability and innovative ideas to be successful.

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Introduction

The model of family integrated care described and evaluated by the FIC team in Mount Sinai Hospital (Toronto, Canada) has identified four key pillars to the programme (Fig. 1). The second of these is staff education and is critical to the successful adoption of this new model of care (Galarza-Winton et al., 2013). Implementation of FIC requires a shift in the focus of staff providing neonatal care from being the doers to being the educators or facilitators, supporting parents to do the cares. Parents are no longer visiting their baby but are actively involved as a member of the care team, participating to the best of their abilities. This is a paradigm shift in care giving and the staff would need to shift to partnership-working with parents, seeing them as equal partners in the baby's care rather than assuming most of the care of the babies and permitting the access between a baby and their parent. (see Table 1)

It requires an understanding of the neonatal parent experience and the barriers it can present to parenting and bonding, to enable nurses to communicate sensitively and effectively in this new teaching role. Communication needs to shift to enabling, listening to and acting on parents contributions. This represents a cultural

change for professionals working in the traditional family centred care model. Any change is always difficult as it can destabilise a controlled situation. Hence, it is not unusual for part of the team to be resistant to accepting such changes. It takes time, resilience and on-going education to slowly transform the attitude of the entire team.

The nursing role also has to extend to see the baby and their parents as a unit therefore caring not just for the baby but also for the family and considering their emotional and psychosocial needs. It is essential that nurses feel fully informed of the FIC model before implementation takes place and what it will mean in terms of their altered nursing role, including the opportunity to raise any concerns they have about this new model of care. At the end of this shift in care rather than a parent wishing they could take a nurse home with them at discharge from hospital they will feel enabled and confident to take their baby home due to the support and mentorship provided by nurses to become the main caregiver and advocate for their baby.

Staff need training in areas not always included in the mandatory professional development training. This shift in role for FIC also requires nurses to feel up to date and confident in the knowledge and skills that underpin their clinical practice so they can educate parents in the knowledge that they are teaching skills accurately and consistently. Our programme of nurse teaching therefore has three main aims:

* Corresponding author.

E-mail address: ifdc@nhs.net (A. Aloysius).

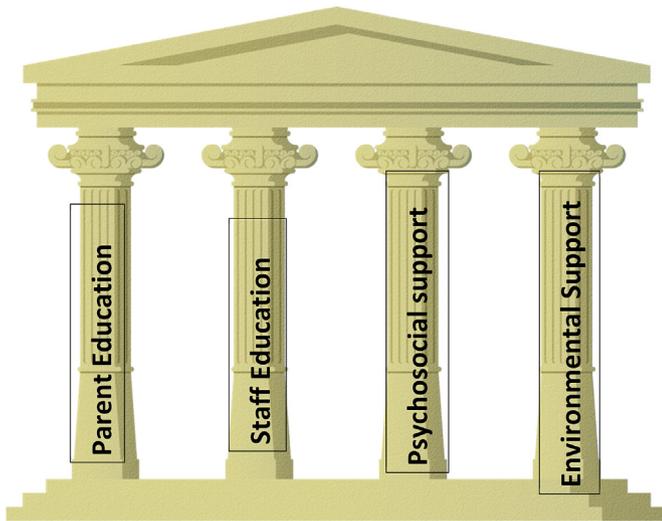


Fig. 1. Pillars of FIC.

Table 1
List of bite size modules currently running.

Module number	Title
1	A good beginning: supporting the baby-parent relationship through the neonatal journey
2	The Neonatal Care Journey
3	Integrated Family Delivered Care
4	Communication; the 6 h conversation
5	Expressing breast milk
6	Positioning and attachment
7	Transition from tube to breastfeeding
8	Supportive feeding
9	Breast milk fortifier
10	Introduction to developmental care
11	Developmental care- practical skills
12	Positioning to support breathing, development and for comfort
13	Positioning practical skills
14	Principles of skin-to-skin with practical
15	The stressful problem of pain
16	Routine Cares
17	Infection protection and control and neonatal screening
18	Physiology of Lung Development and Blood Gas Analysis
19	Practical Nursing Consideration in using CPAP/SIPAP as non-invasive ventilation
20	Discharge planning
21	Working with fathers
22	Supporting families at the end of life
23	Documentation

1. To familiarise nurses with the IFDC project, the background of FIC and what it will involve practically for them and the parents.
2. To consider the shift in the nursing role, addressing any concerns and providing support for the practical skills required to take on this new role in particular supporting them with understanding the parent experience and the communication skills required.
3. To provide a practical way to update nursing skills to ensure consistency of care

Staff education curriculum

One of our dedicated project co-ordinators and the medical leads for the project designed a 4-h training workshop for nursing

staff including:

- Introduction to the background of IFDC, current research into this model including outcomes
- Introduction to the Imperial IFDC project; including the recruitment process, paperwork, mobile parent app, parent education curriculum, parent competencies, roles and responsibilities and project outcomes to be collected.
- Addressing changes to the nursing role with an opportunity to discuss hopes and fears.
- Considering the patient experience; this included watching a video of the neonatal parent's experience with a chance to reflect on what being a parent on the NICU feels like and considering the importance and challenges and skills required for nurse parent communication.

An evaluation form was completed including a pre and post questionnaire about IFDC.

We trained 32 of our 39 nursing staff (82%) in this way during five sessions at our level 2 unit. The sessions were well evaluated and there was an upward shift in pre and post knowledge measures.

It is acknowledged nationally that there are staff shortages across nursing and specifically in neonatal care that can impact on the ability to provide high quality care and education particularly in neonatal intensive care. Facilitating the IFDC staff education sessions were more of a challenge for our level 3 unit due to these staffing pressures and the acuity of patients. Therefore a “bite size” 30 min session was designed that can be done opportunistically with staff on shift with the support of the education team to backfill clinical time. The content was a condensed version of the background to family delivered care with orientation to the IFDC project. It was recommended that all staff watch a neonatal patient experience film available online; the link was emailed to all staff and made available on the IFDC tablet computers. <http://www.neonatalbutterflyproject.org/>. This IFDC “bite size” session is now one of the mandatory nurse induction sessions for new starters.

This short session was also delivered at the senior nurses meeting with an opportunity to comment and ask questions. Medical staff were orientated to the project at senior staff meetings where regular project progress updates are also now given. All new doctors are made aware of the project during their mandatory induction.

Updating staff skills: bite size teaching

Keeping basic knowledge and skills in clinical practice up to date is a requirement of the nursing code of practice but can be a challenge in neonatal nursing where existing education sessions already use most of available non-clinical time. Much of this tends to be done online in short modules often in short break times during clinical shifts. This challenge had been recognised prior to the IFDC project and a network educational grant was obtained in 2013 to design a short duration package of training modules for delivery to small groups during clinical shifts. Each module has its own learning aims and lesson plan and a box containing a laminated flip chart presentation with any props and resources required in the training. The trainer can opportunistically pick up the box and deliver each module in 30 min with support from the nursing education team to backfill the clinical time. The model was made sustainable by training a range of nursing staff of varying grades to be trainers in certain modules. A one day train the trainer day was held with staff from all grades, considering the neonatal environment and team, different learning styles and teaching methods and

introducing them to the modules, a process of mentorship enabled staff to feel confident to deliver chosen modules.

The modules include 6 modules covering the mandatory requirements for the neonatal Unicef Baby Friendly Initiative curriculum. The “neonatal journey” and “communication skills” for nurses modules cover key information about the parent’s journey, models of neonatal care, considering the impact of the neonatal environment on bonding and relationship building and how we mitigate this and support parents. The communication module as well as considering the parent experience has the opportunity to role play communication skills, considering how parents may be feeling in the early hours after having a baby admitted to the NICU and how best to communicate. Within these modules there is also the opportunity to think about the language we use and how it may create difficult relationships; “my baby”, “when are you coming to visit” There is also a chance to consider how we label parents and that a parent who asks lots of questions is not a “difficult” parent but someone seeking information and control. These modules were felt to be very pertinent to family integrated care in considering the parent experience and communication skills. Two of the psychology modules also support and consider the parent experience and the importance of getting their neonatal journey off to a good start with another having a specific focus on supporting fathers. The package of bite size teaching has been expanded to include additional modules on IFDC and routine cares to support the project. It has become a successful format for nursing education and we now have 24 modules covering a wide range of topics and a format to easily add additional modules required.

Feedback from the staff education sessions; hopes and fears

There were many positive comments following the training sessions about the project and new model of care in terms of working life and the benefits to families and their care:

‘We will all work together: Improved continuity will lead to better outcomes; more team work! A chance to gain new skills and knowledge; To become confident with the model of care. I kind of like it; It’s exciting; I hope the visiting will stay as it is; Will be great to have siblings around all year; Grandparents are important; It will bring back better developmental care.’

The session with the senior nursing staff was successful in helping to address some nursing concerns about the new model of care:

‘Prior to the session ... at the band 7 meeting I had several pre-conceived ideas about IFDC. I had assumed that the concept of care was based on parents undertaking a commitment to spend at least eight hours with their baby as in the Mount Sinai model. I thought the project would be run rather like a transitional or intermediate care ward which would be self-contained and run by nursing and support staff. I had assumed that the focus would be on babies receiving low dependency care.

... I did not feel my role was undermined in any way, as Neonatal nurses we always encourage and support parents in hands on care and involvement with their babies, ...there was also a little anxiety about signing off a parent competencies. Prior to actually seeing the booklet, my experience of parent competencies had been at a highly skilled clinical level such as the changing of a tracheostomy tube and this was with the support of a specialist nurse, or with basic life support prior to discharge or rooming in.

After the session I realised that we are at the beginning of a

process and the competencies that the parents sign up for are very basic, and are just a way of formalising practices that should be happening in the unit. The session provided much greater clarity and cleared up any confusion. I feel I now have an understanding of the expectations of the IFDC team and can participate in assisting with the education and assessment of parent competencies. There is now a system, which indicates if a baby is signed up to the project which helps to manage expectations.

There seems to be a generalised positive feeling about the IFDC project, but in a busy tertiary level 3 we need to ensure that there is adequate communication to other hospitals when the babies are transferred back and out of the network to local hospitals that do not have this project in place.”

Along with the positive comments of course fears came to the surface as well and it is equally important to listen to these and discuss it with the nursing team: *‘Our communication will have to improve; People will use the excuse that they are too busy; the responsibility will fall on the co-ordinator; Will it reduce nursing ratios? What if parents can’t commit? Will parents become too empowered and become difficult? Will we be replaced by nursing associates? Some parents may cross professional boundaries, i.e. turning up oxygen or silencing alarms; It will create more difficult parents. It took me years to train as a nurse, Will parents think they will become one after only 2 weeks of training? Will it stress the parents who are unable to commit? Will it encourage mobile phone use? The idea of sharing charting scares me.’*

Nursing is a complex relationship of caring where we not only meet the medical and basic needs of a patient but need to treat them holistically caring for them as an individual with a range of needs to enable healing. This care is even more complex for the small sick baby where we are not just nursing them but their parents and their family. Jean Watson’s work has described in detail the theory of caring (Watson, 1979, 1985). Her principles of care help to underpin some of the key relationship principles that are important in shifting the nursing relationship and considering the communication required:

“Being with” – to be personally and emotionally present and available to accompany a parent through their neonatal journey

“Knowing” – to avoid assumptions and explore, ask and listen to a parent’s personal reality of having a baby on NICU

“Doing for” – to use teachable moments and anticipatory guidance to facilitate meaningful interactions and nurture the parent infant relationship

“Enabling” - to validate the parent baby relationship, helping them reconnect with their baby and make sense of things; e.g. what do you think your baby is trying to tell you?

“Maintaining belief” – to maintain a hopeful attitude believing in the capacity of a parent to rise above present circumstances and do the best they can for their baby.

In our unit’s, for many years before FIC, nurses worked along the ethos of family centred care (FCC) which means nurses supported parents to get to know their baby and be involved in their basic cares of nappy changes, mouth cares and skin to skin contact. Family integrated care means a shift in this role to move to be educators for the parents rather than providing the primary care for the infant, and involve parents in more of their infants cares to include tube feeding, giving medication and taking temperatures etc.

Some fears of this new model and shift in relationship are around undermining nursing roles, potentially replacing their

experience and expertise in care giving. Staff have been reassured that there is no intention to reduce nursing ratios or undermine the expertise and training required to be a nurse. This was also made clear to the management team, that this project is about quality improvement and under no circumstances would affect the recommended BAPM nurse patient ratio.

Specific concerns have been raised about the safety and responsibility of delegating care to parents under their supervision, getting them to do charting and some cares usually done by nurses. When drawn back to the Nursing and Midwifery Council (NMC) Code of professional standards and behaviour. It supports and advocates for this model of care ([Nursing Midwifery Council; McKean-Carter, 2017](#))

1. Prioritise people –treat people with kindness, respect and compassion working in partnership to deliver care effectively
 - 1.2. Listen to people and respond to their preferences and concerns. To achieve this you must
 - 1.2.1 work in partnership to make sure you deliver care effectively
 - 1.2.2 recognise and respect the contribution that people can make to their own health and wellbeing.
 - 1.2.3. encourage and empower people to share decisions about their treatment and care
 - 1.2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care.
2. Practice effectively; making sure it is within their scope of competence and they are adequately supervised and supported to provide safe care meeting the required standard. – 2.11 be accountable for your decisions to delegate tasks and duties to other people. To achieve this you must
 - 2.11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure they fully understand your instructions.
 - 2.11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care, and
 - 2.11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard.
3. Preserve safety
4. Promote professionalism and trust

The team in Mount Sinai Hospital, Toronto reported that they have found having competencies and clear boundaries and understanding about what parents can and cannot do accompanied by charting has meant less worries about parents doing things they shouldn't or were not able to. When the Mt Sinai FIC team discussed with the Hospital's legal team they thought rather than being a problem it was an improvement; we know parents do things but if it's documented and there are competencies built around their caregiving then we know they are safe to do it and it protects them and staff ([O'Brien, 2017](#))

The concerns about the perception of parents as 'difficult' is addressed and reflected on in the parent experience and communication bite size teaching. It remains a concern and illustrates the shift that has to occur in the nurse parent relationship to enable this model to be successful.

In our project model there is the premise and aspiration that this is our strategy for future care for the whole unit and not a temporary research project that you are either in or out. All parents can

access as much or as little of the project as they find helpful and possible; parent education sessions are open to all, they can do as many of the competencies as they wish, the app is free to download and available to all, they are given the opportunity to present their baby on the ward round if they wish etc. No family would feel penalised or that they received any less care being in the project or not. Participation depends on parental readiness and no family is pressurised to follow this care model. It is there to support and enable but we realise that personal and family circumstances are different for all in what they enable.

Summary

We are supporting nurses to make the cultural shift in their relationship with parents from co-dependence; parents watching nurses being experts in their babies care to independence with mutual trust and respect to enable partners as equal partners to gradually do as much as they can be supported to do for their baby's care.

To enable this to happen there needs to be a robust specifically tailored staff education programme to familiarise nurses with IFDC and what it involves for them and the parents. The shift in nursing role needs to be supported with opportunity to address and support any concerns and requirements for this new role. Nurses need regular skills updates to enable them to be confident and consistent in their nursing care which is part of their continuous professional development and revalidation process.

As we move through the project there is the need for further support of communication skills in the team to enable nurses to address the emotional and psychosocial needs of the family. One veteran father has helpfully reflected with us the need for more role play and opportunity for scenario practice to avoid miscommunication "*don't let the first time you do something be live*". He also reflected the need to be able when we do get it wrong to apologise for how it made others learn from what happened, then move on. We continue to learn together as a team how to improve the neonatal experience for staff and families.

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References

- Galarza-Winton, M.E., Dicky, T., O'Leary, L., Lee, S.K., O'Brien, K., 2013. Implementing family integrated care in the NICU. *Educating nurses. Adv. Neonatal Care* 13 (5), 335–340.
- McKean-Carter, R., 2017. *Clinical Governance Presentation at the FIC Bliss Study Day Birmingham*. Neonatal Nurses Association. Oct.
- Nursing Midwifery Council. The Code: Professional standards of practice and behaviour for nurses and midwives. www.nmc-uk.org
- O'Brien, K., 2017. What is family integrated care. In: *Presentation at Bliss FIC Study Day London*.
- Watson, J., 1979. *Nursing: the Philosophy and Science of Caring*. Little Brown, Boston.
- Watson, J., 1985. *Nursing: Human Science and Human Care*. Connecticut USA: Appleton-Century Crofts.