



Back transport of infants to community hospitals: 12 years' experience of an intervention to prepare parents for their infants' transfer from neonatal intensive care to community hospital

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Abstract Effective regionalized neonatal intensive care includes back transport of stable infants to community hospitals. This transition can be pleasant or frightening for the family, and psychological preparation is critical. The aim of this study was to evaluate an intervention performed in collaboration with the neonatal intensive care unit (NICU) and community hospitals (CH) in the northern health care region of Sweden. Questionnaires were sent to families who had an infant transported from NICU to CH and discharged to home over three periods from 1994 to 2007. Families rated information about the CH more accurate, reception at the CH better, and their preparation for the transition better when they were contacted by the CH during their stay at the NICU. Both NICU and CH staff have a responsibility to facilitate back transport by promoting communication between families and staff at the hospital to which they are to be transported.

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Introduction

Over the last few decades, perinatal care has become more regionalized, with increasing rates of survival and stability for extremely preterm infants (<28 weeks' gestation/<1000 g) (Yu and Doyle,

2004; Fellman et al., 2009). For optimal use of neonatal intensive care unit (NICU) resources and to prevent overcrowded departments, transportation of stable infants to their community hospital (CH) for further care is both necessary (Jung and Bose, 1983; Croop and Kenner, 1990; Socialstyrelsen, 2004) and cost-effective (Bose et al., 1985; Phibbs and Mortensen, 1992). Nevertheless, the transition from NICU to the CH can be frightening and troublesome for the parents. Parents of a premature

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infant in NICU care can experience an emotional roller-coaster ride, ranging from initial anxiety and fear provoked by having a premature baby who needs intensive care, to feelings of comfort and safety that can come from gradual acquaintance with the staff, technical apparatus, and procedures that provide some predictability in their otherwise chaotic everyday lives (Hawthorne and Killen, 2006). The parents learn that a stable environment is important for their infant's growth and development. When the time comes for transport back to the CH, this perceived interruption of their infant's care and safety can trigger renewed feelings of anxiety and fear in the parents, despite their infant's improved condition. The parents may be sceptical of the new department and the new staff, who know neither the infant nor the family (Kolotylo et al., 1991; Hall, 2001, 2005; Chaboyer et al., 2005). The experience of back transport varies among parents, and well prepared parents seem to experience the transport and the new department better than those who are not well prepared (Kuhnly and Freston, 1993; Slattery et al., 1998; Rowe and Jones, 2008). The NICU staff, with their knowledge of the infant's condition, may view the back transport as a positive step, but if the family is not well prepared for the transition, staff may encounter the parents' feelings of dissatisfaction and lack of confidence (Bouve et al., 1999; Rowe and Jones, 2008).

Although some studies touch on how and when to prepare the family for their forthcoming transition to the CH, few studies focus on implementing routines for psychological preparation, and none focus on routines developed in collaboration between the NICU and the CH. The aim of this study is to evaluate an intervention created in collaboration with the NICU Department in Umeå and the CHs in Northern Sweden for the psychological preparation of families before back transport of their infant from NICU to CH.

Method

Population, reception area, and the northern health care region of Sweden

Sweden is divided into five regions for health and medical care, including at least one university hospital with a level III NICU. The northern health and medical care region in Sweden comprises four counties in an area of 225 464 km² with a population (as of December 2007) of 878 581 people; this is approximately half the area of Sweden but less than 10% of the total Swedish population (Official Statistics of Sweden, 2008). The northern

health and medical care region has seven community hospitals with pediatric/neonatal wards and one level III NICU located at the Umeå University Hospital in Umeå. Perinatal care of all infants under 28 weeks' gestation is centralized to Umeå. Annually, the northern region averages 8500 live births and the NICU in Umeå averages 340 annual admissions, of which approximately 30 are infants under 28 weeks' gestation.

Participants

All families registered with a CH whose infant was either born at or transported to the University Hospital in Umeå for specialized neonatal care, afterwards transported to the CH for further neonatal care, and then discharged to home were included. The periods of recruitment were the years 1994, 1997–2003, and 2006–2007. Families discharged directly from the NICU to their homes or whose infant had deceased were excluded.

The families' names and addresses were collected from the Department of Pediatrics at Umeå University Hospital and checked against the national register. In total, 647 families were identified that met the study criteria: 54 families for 1994, 533 families for the period 1997–2003, and 60 families for the period 2006–2007.

Design and procedure

The study had four major events: 1) baseline investigation – questionnaire sent to families cared for at the NICU and at the CHs during 1994; 2) construction and implementation of a model for preparing families for the transition from NICU to their CH; 3) follow-up with a modified questionnaire after the implementation of the model with families cared for at the NICU and the CHs during the period 1997–2003; and 4) long-term follow-up with the modified questionnaire sent to families cared for at the NICU and the CHs during the period 2006–2007.

This design resulted in three study groups: Group A (1994), Group B (1997–2003), and Group C (2006–2007). For Groups A and C, the questionnaire, along with an information letter and a prepaid envelope, was sent by post to their homes, while for Group B the questionnaires, information letters, and prepaid envelopes were given to the families at discharge, with the request that they answer the questionnaires at home.

All questionnaires for Groups A and C were issued with a control number that could be linked to the family in order to avoid sending reminders to those who had already replied. Questionnaires in Groups A

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