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Integrated family delivered care: Development of a staff education programme

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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.

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:

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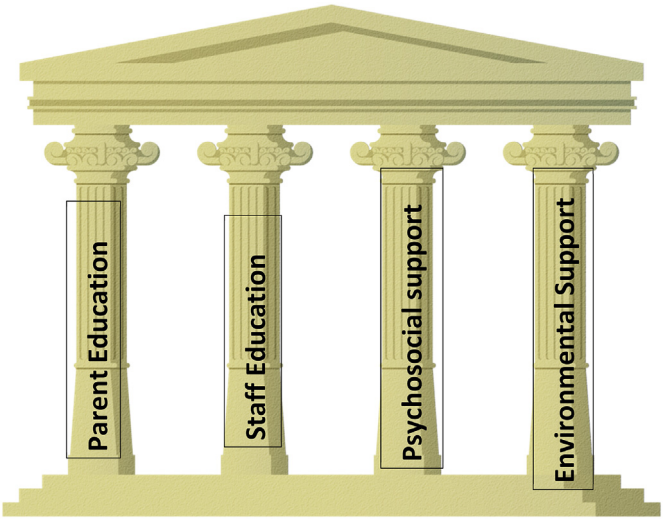

Fig. 1. Pillars of FIC.

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