Neonatal Special And Transitional Care

This is a reflective essay of an experience I had while caring for a high dependency baby on the ward. I will use Gibbs (1988) reflective model in writing the essay by describing an episode of care in regards to resuscitation of a baby in the presence of a parent. The reflective model will help me to describe the experience, evaluate, analyze and also help me develop a better approach in the future when the need arises. Resuscitation is a common emergency procedure which is normally done to save a neonate life or a patient. There are risk factors that might contribute to a baby being resuscitated which may include continuous desaturations, neonatal asphyxia, bradycardia, apneas and prematurity. Following NMC guidelines (2019) I will omit the use of names in order to maintain the privacy and confidentiality of the people involved in this experience.

Description

I cared for a prematured baby born at 26 weeks plus 3 days gestational via spontaneous vaginal delivery, initially admitted due respiratory distress syndrome and querying sepsis. The baby was given curosurf at birth in support of surfactant production to help the baby breathe normally . The baby was intubated and placed on a ventilator at birth and was extubated to continous positive airway pressure (CPAP) few days later, and then to vepothem. On my long day shift I cared for this baby who was now on vepothem flow of 5.0 and FiO2 at 22 %. On the ward rounds, after baby have been reviewed by the medical team, the plan was for baby to be on nasal prone oxygen and FiO2 at 0.02 % to start with. The oxygen was to be titrated according to baby's need. During the shift the baby had desaturated twice but self correcting. I did a blood gas after two hours which was good and the doctors advised me to continue with the plan. I handed over to the night staff to monitor and if by any chance the baby needs to be back on the vepothem she should do so as the doctor advised earlier. The next day I was on night duty and allocated to work with my mentor in the same room I worked the day before. Immediately the day staff started to hand over, the baby had a massive drop of his saturation to 54% and heart rate to 71. According to the day nurse the baby have been experiencing desaturations and bradycardia. We observed for a little while to see if the baby’s saturation will pick up to normal, my mentor increased his oxygen at a point but was of no avail. We realized the baby had collapsed so my mentor and the day nurse started to give inflation breaths. I was asked to pull the emergency button which I did and the team came in to help. In the process of the team resuscitating the baby, I noticed that mum was in the room standing there watching and crying. I immediately rushed to her as at this moment the team had taken over. I was not sure the time she came in the room and what she had witnessed. I offered her a chair and tissue and stayed with her. One of the doctors joined me to talk to mum but unfortunately for us mum had language barrier and had limited understanding of English. The doctor had to call one of our team members who was on her way home and can speak her language to interprete the situation to mum. The baby was intubated, stabilized and moved to the intensive care room. Mum was reassured by myself and the doctor, after a while she became calm and I took her to the room where her baby was after everything was settled. I hugged her and she said thank you very much.

Feelings

During the resuscitation of the baby, so many thoughts went through my mind.

When I was asked by the consultant to take baby off vepothem and rather use nasal prone the day before, I wondered why we couldn't wean him off vepothem flow of 4.5 Lpm before we take him off completely which I presume could have prevented him from collapsing. Furthermore, I also knew that lack of oxygen was not the only risk factor for the baby to collaspe. Factors such as low packed cell volume and necroting enterolitis could have contributed to the baby being unwell. Considering all these factors, I did not put any questions across since I knew the consultant made the decisions and had wealth of experience in the process. With that said, I was also glad baby was making progress from more input of respiratory support as nasal prone is a step down from the use of vepothem according to the unit guidelines. On noticing mum at the scene, I wished I had seen her earlier to divert her to the counseling room but it was too late, I then became nervous and did not really know what I was going to say to calm her down or make her understand the situation considering the language barrier. At this point I figured If there was an interpreter available at the unit it would have been a lot easier and saved us a ton of time in dealing with the situation. I felt helpless but I was glad the doctor joined me to assist mum in that difficult circumstance. After this experience, I noticed my senior colleagues had more experience and confidence in dealing with such cases , which made me realise I needed more training in dealing with parents whose baby have to undergo resuscitation. However, I was glad we fulfilled our objective and worked as a team.

Evaluation

In treating a collapsed baby, early intervention is the key to prevent serious illness, longterm concequences and mobidity. I was glad there was a team of medical professionals who collaborated and acted immediately at the time the baby collapsed. This shows the importance of having the right skill mix at a work place, according to Robb E et al (2011) a well structured orgainisation with the right workforce help improve patient care. I believe the mother maintaining her calmness although in distress helped the team to provide care without being distracted. I learnt that sometimes just being quiet and not suggesting any opinion to parent in distress is enough support they need. I was relieved when the baby was stabilized although I was not expecting reintubation, I knew it was the best option for the safety of the baby. I could see that the mother was more happy when her baby was stabilised. From experience working on the neonatal unit, I discovered that occassionaly prematured babies will deteroraite and have few health challanges on their journey to good health.

Analysis

Cardiopulmonary resuscitation is said to be a rapid medical intervention used to revive or save life (Heart Foundation 2018), however neonatal resuscitation is the intervention done to the dying baby immediately after birth in support of breathing and circulation, (Neonatal Resuscitation, 2006). This medical procedure should only be done to the unconscious and someone who is not breathing. Most babies especially prematured babies are given resuscitation at birth or once in their life to stabilize them (Lee A et al 2011). stated that 10 million out of 136 million birth are given some intervention in their first weeks of life. Parents with babies in NICU finds it challanging and very stressful and will need a lot of support during this time from health care providers. The presence of family members in health care settings during resuscitation is becoming common and acceptable in this modern age. This act is being

supported by the European resuscitation guidelines (Baskett e.g. al 2005) who encourages health care professionals to allow family members to be present during resuscitation of their loved ones. However, the practice is often discouraged based on the uncomfortable atmosphere and pressure it creates for health care personels to work freely (Boyd, 2000; Tsai, 2002; Kissoon, 2006; Walker, 2006) .

Furthermore, the demands and desires of the family to be present during CPR is ever increasing although there is an awareness that it might be positive or negative outcome (Mazer et al, 2006).

A qualitative study which was done by Sawyer A et al (2013) reveals that families who witnessed CPR of their baby's had positive impact, they were reassured and felt involved in their baby's care. Although few expressed having negative impact, this evidence cannot be generalized as the research was limited to one hospital. There have been three major concerns in literature regarding the presence of family during CPR. The first one is the performance of healthcare professionals being affected and also the routine being disrupted by family members (Meyers et al.2000). Secondly, families may be psychologically and emotionally affected by witnessing such an event (Crisci, 1994; Schilling, 1994; Fein et al., 2004) and thirdly the familes wished to have the choice to decide whether or not to be present during that difficult moment (Gulla et al., 2004).

A research by Saywer et al (2013) reveals that parents feel that they are able to provide comfort for their babys by touching them during CPR and the process helped them to come to terms in the event of a loss child. Furthermore, a research of fathers experience during CPR on their babies found that it had negative effect on them but they did not express regret at being present, (Harvey M. E and Pattison HM, 2012). They were rather undecided between supporting their partners or being at the bed side of their baby. In contrast, I could say the baby in my care mum was emotionally affected as she was in distress but supporting her gave her some comfort. It was also unfortunate the decision for mum to be present, in my experience was not made prior to as mum met the team performing CPR on her baby unexpectedly which can be negative effect on her. My unit provide parents with information about prematurity and CPR, I believe this information was communicated to mum.

Conclusion

Finally, it may be concluded that if I were to encouter a similar situation I would approach it similarly, but in a more professional manner such as briefing the mother about what to expect prior to entering the resuscitation area and responding realistically to any questions or concerns she may ask. Overall, I felt I could have assessed continually the emotional and physical status of the mother if I had undergone the speciific training required for a situation as such. Although it was the wish of the mother to witness her baby’s resuscitation, she experienced an emotional roller coaster during the process but because of my presence and application of knowledge I reassured and comforted her. I learned that a timely intervention could have a positive impact on the mother and her baby at the neonatal unit.

Action Plan

In the future, I aim to have exposure to similar scenarios so that I can develop my skills in order

to ensure the well-being of patients. From this event I have realised that learning never stops and I seek to enroll in a program that would train me on anticipating, managing and communicating with mothers witnessing their baby undergoing resuscitation. I will also read and familiarize myself on the unit guidelines on supporting parents during resuscitation. The training will not only help me provide effective care based on evidence but it will also equip me in supporting my team in a similar situation.