Developing a Transition Nurse Team

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BACKGROUND

Low risk newborns and those severely ill are stabilized in Labor and Delivery and then find their place in either the Mother/Baby Unit or NICU easily. At-risk newborns and those with moderate illness are more problematic due to several factors, including:

- lack of clarity about newborns' needs
- variable medical/nursing treatment plans
- RN staffing
- the skill of RNs responsible for newborn care, and
- the over-arching drive to meet Family Centered and Baby Friendly standards.

These issues can lead to a failure to identify and prevent clinical problems, treat problems differently with variable outcomes, and inappropriately maintain couplet care or separate mothers and newborns.

Historically, our hospital used a Transition Nursery to manage all newborns who were at-risk for developing neonatal conditions such as hypoglycemia, hypothermia, respiratory distress, and possible sepsis. By its nature, this process caused maternal separation but was thought necessary for the proper care of the infant. With Baby Friendly designation in 2013, the emphasis shifted to keeping babies with mothers but also presented challenges for adequate care for at-risk newborns.

In the five years since Baby Friendly designation, we noted both an increase in admission to NICU for conditions that could have been managed at the bedside with more nursing intervention and a delay in treatment due to the drive to keep mothers and babies together. This prompted us to rethink the systems needed to manage at-risk infants. In addition to the needs of at-risk infants, the needs of antepartum mothers whose babies were likely to be admitted to NICU and the immediate lactation needs of mothers whose infants were admitted to NICU were also identified.

DESCRIPTION

After discussion among Nursing Leadership staff, it was determined that the plan for transition of at-risk newborns should be a person and not a place. Because the focus of both L&D and MBU nurses is primarily the mother, NICU nurses could most readily bring neonatal expertise to the care of at-risk newborns during transition. A steering committee with leadership and clinical nurses was formed to develop a program that would meet the needs of:

- at-risk newborns
- high-risk antepartum mothers whose babies would likely be admitted to NICU, and
- postpartum mothers with infants in NICU.

The Transition Nurse Team (TNT) steering committee included the Nurse Manager/Clinical Leader and clinical staff from NICU, L&D, MBU, and the Perinatal Clinical Nurse Specialist. We also identified Physician/NNP liaisons in the NICU and MBU to review medical protocols and act as provider champions.

The goals of the committee were to:

- identify the populations of newborns considered at-risk
- conceptualize the roles of RNs on the TNT, L&D, and MBU and develop a TNT role description
- review order sets and identify needed changes that would allow for more autonomous practice of the TNT
- identify needed electronic medical record enhancements to support the work of the TNT
- develop standard practices for managing the most common conditions of at-risk newborn
- develop operational processes needed by the TNT
- develop a staffing plan to provide TNT members from NICU staffing
- identify the educational needs of RNs within the TNT and on each of the three units, and
- recruit NICU RNs for the TNT role.

INTERVENTION

In this model, a group of NICU RNs will be developed to perform this resource role. One TN will be assigned to this role per shift in lieu of an assignment in NICU. The TN would not be counted in NICU staffing numbers. In the event that NICU staff would not allow for a dedicated TN, she/he would be on call to L&D as needed. Each TN would be assigned to this role 3-4 times/month.

The Transition Nurse Role

- Identify at-risk neonates in L&D and MBU based on maternal, fetal and birth histories.
- Monitor neonatal progress during and after transition.
- Round on neonates during hospitalization to assure STABLE status (Sugar, Temperature, Airway, Blood Pressure, and Emotional Support).
- Intervene with appropriate nursing interventions to manage neonatal status.
- Escalate care through appropriate medical channels to initiate required medical interventions.
- Actively assist mothers whose babies are NICU admissions with initial pumping within 1-2 hours and provide continuing support in collaboration with Lactation team.
- Identify and monitor the status of probable admissions to NICU in L&D and antepartum unit to facilitate communication with NICU CN and medical teams, begin parent orientation to NICU, and initiate lactation education.

EVALUATION

Transition Nurse Team Pilot Program

In order to determine the effectiveness of the Transition Nurse Team role, we will implement a four month pilot program from January through April, 2019. The goals of this pilot program are to evaluate the effect of the program on select patient outcomes, TNT interventions, NICU staffing, and RN satisfaction.

Transition Nurse Team Steering Committee
Roseanne Belser, BSN, RN (NICU); Dawn DiSalvo, DNP, NNP-BC, CLC (MBU); Monica DuPerry, BSN, RNC-OB (NICU); Carrie Hopkins, BSN, RNC-OB (L&D); Shelly Jacobs, ASN, RNC-NIC (NICU); Emily Kraus, BSN, RN (MBU); Jan Mackenzie, MSN, RNC-OB, C-EFM (L&D); Sandee Muir, BSN, RNC-NIC (NICU); Jennifer Pruitt, MSN, APRN, CNM (MBU); Candace Rouse, DNP, RNC, CNS-BC (Perinatal CNS); Alexis Speed, MSN, RNC-NIC (NICU); Elizabeth Talaga, MSN, APRN, RNC-NIC (NICU); Joanne Tanner, ASN, C-EFM (L&D); Donna Wilkerson, LPN (MBU); Yael Zaidel, BSN, RNC-MNN (L&D)