

# Family Education

# Disclosure

There is *no conflict of interest* with any financial organization regarding the material discussed in this presentation.

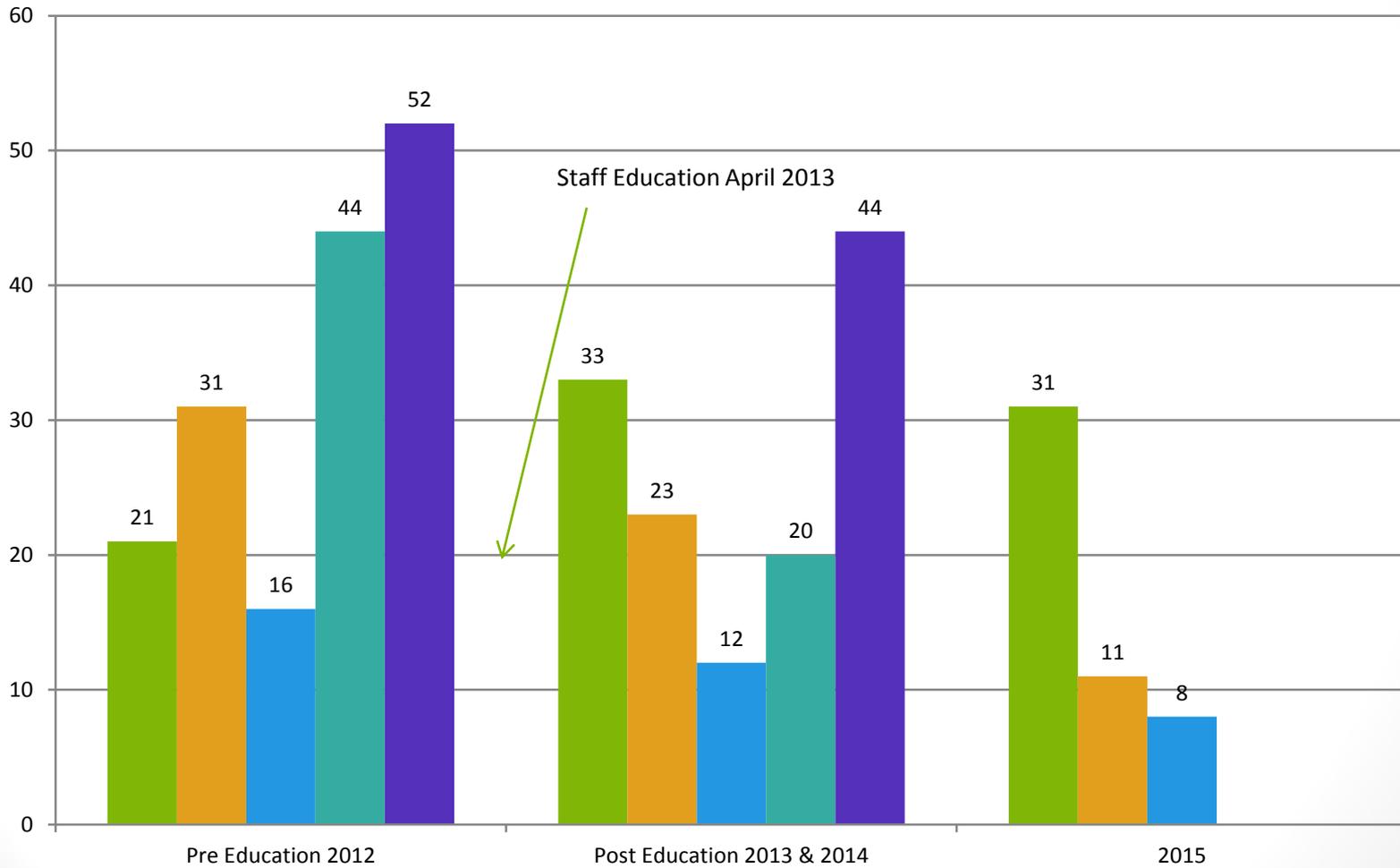
# Speakers

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# BEMC Trends



# “It’s all about that B.A.S.E”

Lisa Jaacks, MD

Desert West OB/GYN

# BASE

Build Trust & Establish Rapport

Ask Questions

Set the Expectation

Educate

# B: Build Rapport/Establish Trust

- Difference Between Addiction & Dependence
- Barriers: Nursing & Mothers
- Benefits
- Ways to Build Rapport/Trust

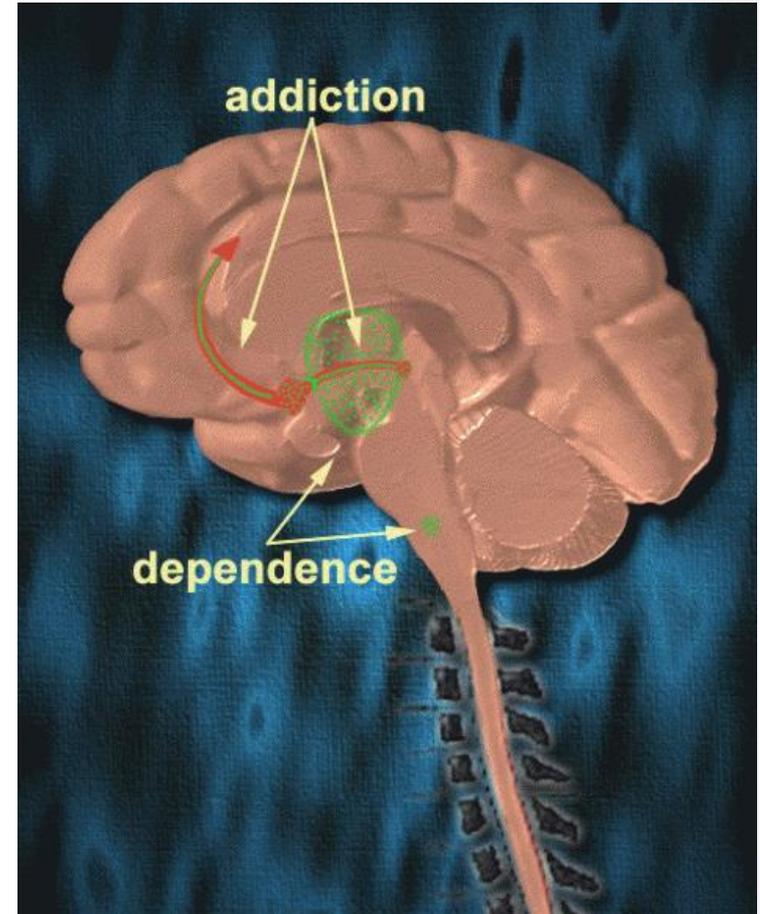
# Ultimate Goal

“Provide supportive care to baby, mother and extended family in a non-judgmental manner”



# Drug Dependence

- **Thalamus & Brainstem**
- Normal function only in presence of drug
- Physical disturbance during abstinence
- Babies are born “**passively dependent**”



# Research Study – Nursing

- Frasier, et al study (2007)
- Nurse's Experiences – NAS babies
- Qualitative Study - Interviews
- Four (4) Separate Nursery/NICUs
- Thirty-Two (32) Nurses
- Australia

# Nurse's Perspective

- Babies “time consuming” & high acuity
- Parents not available emotional/physical
- Concern re: safety after discharge
- Lack of consistent nursing caregivers
- Sub-optimal environment
- Lack of training in substance abuse
- Lack of training in gathering information

# Research Study - Mothers

- Cleveland & Bonugli (2014)
- Fifteen Mothers – NAS
- Mother's Experience
  - LOS 14 to 270 (Average 52 days)
  - Adopted Family (1) Foster (1) HX Adoption (7)
  - Developmental Delays (4)
- Qualitative Study - Interviews
- Large Urban City – Southwestern USA
- Small sample size – Limitation

# Demographics

- Hispanic
- Age Range – 22 to 40 years
- Employed (3)
- School
  - <HS Diploma (8) HS Diploma (4) College (3)
- Marital Status
  - Single (10) Married (3) Divorced (1) Widow (1)

# Drug Use/Mental Health/Abuse

- Age 14 or 15
- Older family member or boyfriend
- 14/15 Heroin & 1/15 Cocaine
- 13/15 Mental Health History
  - Bipolar, Depression, Anxiety, ADD, Low self-esteem
- Personal Violence
  - Childhood, Intimate partner, Physical/Sexual abuse

# Mother's Perspective

- “Guilt and shame” witnessing withdrawal
- Helpless when unable to provide comfort
- Concerns over inconsistent scoring
- “Feel Judged” and Vulnerable
- Nurses don't understand addiction

# Mother's Comments

I think they knew a lot about what the baby goes through as far as withdrawal and withdrawing....Okay, you know that this mother used. (But), why was she using? You don't know that"

“I felt . . . I did bad. I hurt him...If it wasn't for my drug use, my stupidity, he wouldn't be going through this... I needed to be there because he needed my help... He's a baby. He doesn't understand, so I had to be there. I put him in that situation. And I . . . myself . . . had to help him . . . nobody else but me”.

# Parallel Perceptions

## Mother

- Don't feel welcome
- Guilt & Shame
- Helpless (Coping)
- Judged

## Nurse

- Parents don't visit
- Emotional unavailable
- DC Concerns (SBS)
- DCS Referral

“Care for parents and baby often occurs parallel rather than as a partnership”

# Baby may be motivator for change!

Oei, J., Abdel-Latif, M., Craig, F., Kee, A., Austin, M., Lui, K. (2009). Short-term outcomes of mothers and newborn infants with comorbid psychiatric disorders and drug dependency. *Australian and New Zealand Journal of Psychiatry*, 43, 323-331

Fenton, M., Keyes, K., Geier, T., Greenstein, E., Skodol, A., Krueger, B., Grant, B., Hasin, D. (2011). Psychiatric comorbidity and the persistence of drug use disorders in the United States. *Addiction* doi:10.1111/j.1360-0443.2011.03638.x

# Benefits of Rapport/Trust

- When mothers realize they aren't being judged by nurses, they feel more at ease
- Through self-reflection, nurses may improve their perception of substance-addicted women, thus minimizing judgmental behaviors



How do we establish rapport?

“I’m a toilet paper salesman”

Ken Weise  
Future Husband

# Building Rapport & Trust

- Sit down – make eye contact
- Welcoming body language
- Be attentive/present
- Avoid the temptation to interrupt
- Restate “key points”
- Don’t dominate the conversation

# A: Ask Questions

- Active Listening
- Comprehensive History
- **VARK** learning preferences

# Active Listening

- Welcoming body language
- **Take notes**
- Listen attentively
- Avoid interrupting
- Avoid criticizing
- Use “**open-ended questions**”
- Restate “key points”

# Comprehensive History

- Identify poly-substance abuse and concomitant infections
- Reliability of the patient to accurately self-report
- Influenced by discomfort, inexperience, or interviewer bias



“I’m not comfortable  
talking about addiction”

Shari Weise, RN  
(the old me 😊)

# Patient X

- Gravida 3 – Para 0
- 28 1/7 week Gestational Age
- “Drug Seeking Behavior”
- Complaining of pain – opiates
- Wants to delivery baby “today”

Who did we send in to  
interview Patient X?



What did she find?

# Learning

- Dynamic & Continuous
- Information is absorbed, processed, and retained
- Predominate senses = Determine preferred learning style

# Neil Fleming

## Learning Preferences

Visual

Auditory

Read/Write

Kinesthetic



# Auditory Learners

- Lecture
- Discussion



Care Conferences

Bedside “verbal teaching”

# Read/Write Learners

- Textbooks
- Manuals
- Handouts



# Kinesthetic Learners

- Physically touch or manipulate object
- Real-life examples
- Under 25 years



Videos/TV +

Are we limited to  
one preference?

No...multi-modal

# Does Drug Abuse Affect Learning?

Tramullas, M., Martinez, C., Hurle, M. (2008). Chronic administration of heroin to mice produces up-regulation of brain apoptosis-related proteins and impairs spatial learning and memory. *Neuropharmacology*, 54. 640-652.

Battistella, S. Constantinou, N., Morgan, C., Davis, P., O’Ryan, D., Curran, H. (2012). Semantic priming and verbal learning in current opiate users, ex-users and non-user controls human psychopharmacology *Human Psychopharmacology Clinical Expert* 2012; 27: 499–506. Published online in Wiley Online Library (wileyonlinelibrary.com) DOI: 10.1002/hup.2255

# S: Set the Expectation

- Be upfront about expectations for their infant's hospital stay
- Can be written & signed agreement

# Family Care Agreement

## Newborns in Withdrawal in the NICU: *Care Agreement for Family Members*

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All newborns need consistent, loving care. But a newborn in withdrawal is particularly sensitive and needs particularly sensitive care. This handout explains what you and your family members can do to help provide this care in the NICU. Please read it and sign on the bottom to show you understand the information and agree to help us provide excellent care to your baby.

**Please visit often — but help us keep things calm.** Your baby will feel comforted by your quiet presence at the bedside. **If you can commit to coming to the hospital at a regular time, please share this schedule with the NICU staff.** This helps the medical team plan and provide care.

While you're here in the NICU, please do these things to help your baby:

- **Get centered.** Since babies in withdrawal can be jittery and fussy, it helps if you're calm. Take deep breaths and try to radiate comfort and security.
- **Talk before touch.** Use a soft, calm voice to greet your baby before you touch him or her.
- **Turn it down.** Help create a soothing environment by keeping the lights low — and music and voices soft.
- **Stick to a schedule.** Establish a routine of feedings, diaper changes, and so on.
- **Respond calmly and immediately to your baby.** It's easier to soothe a baby who's just starting to fuss, rather than one who has escalated into a full-blown upset.
- **Be gentle and firm.** When you hold your baby, use firm pressure — your baby will find this reassuring and soothing. Encourage your baby's hand-to-mouth sucking or use of a pacifier ("binky").
- **Hold your baby skin-to-skin.** Holding your baby closely, with your bare chests touching, can relax both of you.



To help your baby recover as quickly as possible, please follow these guidelines in the NICU.

- **When you put your baby back down in the crib, position your baby's body** on its side, tucked slightly into a C-position with the legs tilted up at the hip. Use firm, gentle pressure to place and hold your baby in this C-shaped curl. The weight of your hand and your baby's own body can help with relaxation.
- **Swaddle your baby.** Your baby's caregivers can show you how to do this with a blanket. Swaddling helps newborns feel safe and in control of their bodies.
- **Keep movements slow and rhythmic.** When you're holding your baby, try swaying in figure-eight pattern, following the line of head-to-toe.

To help my baby rest and recover,

I \_\_\_\_\_, agree to follow the guidelines described in this handout.

# Parent Involvement

- Parents have a special role: they are the one “constant” and give love and care only a parent can provide
- Can observe behaviors and report concerns to nurses and medical team
- Provide comfort-this is one of the most important part of their baby’s care

# E: Educate

- Causes of NAS
- Symptoms & Diagnosis
- Treatment
- Cue recognition
- “Sensitive care”
- Soothing techniques
- Breastfeeding
- Discharge Planning

# Educate: Causes

- Intrauterine exposure to certain substances during pregnancy-infant becomes *passively dependent*
- Symptoms occur after infant is born and no longer “supplied” with substance
- Discuss medications that can cause the withdrawal
- Not all babies are affected/factors

# Educate: Diagnosis

- Testing
- Symptoms
- Abstinence
- Scoring tools



# Educate: Symptoms

- Irritability, cry, difficult to soothe
- Sleep issues, trouble settling, excessive yawning
- Unusual stiffness, startling
- Trembling, twitching, shaking, jittery
- Feeding difficulties (weak or frantic suck)
- Diarrhea, vomiting and poor weight gain
- Breathing difficulties: tachypnea or apnea
- Sweating
- Sneezing or stuffy nose
- Skin problems: from rubbing or loose stools

# Educate: Scoring Tools

SYSTEMS	SIGNS AND SYMPTOMS	SCORE	AM						PM						DAILY WT.		
			2	4	6	8	10	12	2	4	6	8	10	12			
CENTRAL NERVOUS SYSTEM DISTURBANCES	High Pitched Cry	2															
	Continuous High Pitched Cry	3															
	Sleeps < 1 Hour After Feeding	3															
	Sleeps < 2 Hours After Feeding	2															
	Hyperactive Moro Reflex	2															
	Markedly Hyperactive Moro Reflex	3															
	Mild Tremors Disturbed	2															
	Moderate Severe Tremors Disturbed	3															
	Mild Tremors Undisturbed	1															
	Moderate Severe Tremors Undisturbed	2															
	Increased Muscle Tone	2															
	Excoriation (specify area): _____	1															
	Myoclonic Jerks	3															
	Generalized Convulsions	3															
METABOLIC VASOMOTOR/ RESPIRATORY DISTURBANCES	Sweating	1															
	Fever < 101 <sup>o</sup> F (39.3 <sup>o</sup> C)	1															
	Fever > 101 <sup>o</sup> F (39.3 <sup>o</sup> C)	2															
	Frequent Yawning (> 3-4 times/interval)	1															
	Mottling	1															
	Nasal Stuffiness	1															
	Sneezing (> 3-4 times/interval)	1															
	Nasal Flaring	2															
	Respiratory Rate > 60/min	1															
	Respiration Rate > 60/min with Retractions	2															
GASTROINTESTINAL DISTURBANCES	Excessive Sucking	1															
	Poor Feeding	2															
	Regurgitation	2															
	Projectile Vomiting	3															
	Loose Stools	2															
	Watery Stools	3															
SUMMARY	<b>TOTAL SCORE</b>																
	<b>SCORER'S INITIALS</b>																
	<b>STATUS OF THERAPY</b>																

Adapted from Finnegan L. Neonatal abstinence syndrome: assessment and pharmacotherapy. Neonatal Therapy: An update, F.F. Rubaltelli and B. Granti, editors. Elsevier Science Publishers B.V. (Biomedical Division). 1986: 122-146

# Educate: Treatment

- Monitoring
- Medication
- “Sensitive Care”



# Educate: Medications



# Educate: “Sensitive Care”

- Closeness
- Quiet, calm, consistency
- Patience & attention
- Comfort positions & pressures



# Educate: Identify/Respond to Cues

**Notes**

CUES that my baby is...  
.....

**Calm:** \_\_\_\_\_  
\_\_\_\_\_

**Upset:** \_\_\_\_\_  
\_\_\_\_\_

**Hungry:** \_\_\_\_\_  
\_\_\_\_\_

**OTHER THINGS I notice about my baby:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TO RELAX AND COMFORT MY BABY, I can:**  
\_\_\_\_\_  
\_\_\_\_\_

**IF I FEEL FRUSTRATED OR OVERWHELMED,  
I can call:** \_\_\_\_\_  
\_\_\_\_\_

**MY BABY'S DOCTOR:** \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

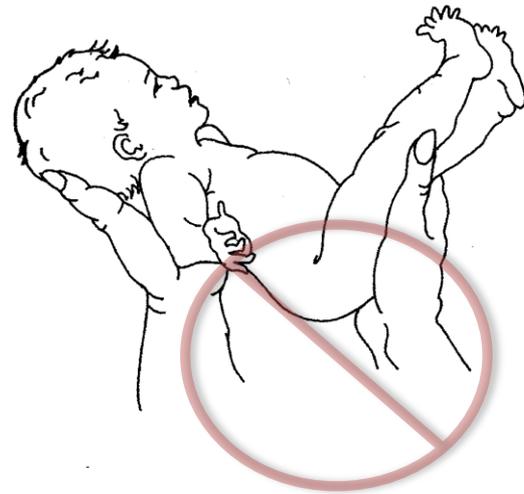
# Educate: Handling

- Therapeutic handling can be KEY to reducing irritability, continuous crying, and frantic/out of control arms & legs
- Methods used in facility in Washington state that specifically cares for drug-exposed babies

# Handling: Swaddling



# Handling: C-Position



Chin down, legs up, arms forward with back rounded forward

# Handling: Vertical Rock

- Frantic, hard to calm infants
- “C” hold, two inches from your body and facing away from you
- Slow and rhythmic
- Up and down
- Infants typically calm after 3 or 4 up and down movements and can then be returned close to your body and held snugly while you sway from side to side



# Handling: C-Position Facing Out



- When human closeness and sight of human face are too stressful
- Turn baby away from your body, curl into a C position
- Also good for babies with increased tone: you can use your own body as a brace to prevent their tendency to arch backward

# Handling: Clapping



- While swaying back and forth, you may add clapping to help the baby relax
- Cup your hand and clap slowly and rhythmically on the baby's bottom
- Try clapping to the beat of your heart...you should feel the baby relax

\*\*NOTE: This may be over-stimulating for hypersensitive babies\*\*

# Handling: C-Position in Bed



# Alternative Therapies



# Educate: Breastfeeding

- Generally safe and encouraged if mother is in drug treatment (methadone/buprenorphine) but must adhere to regimen and not use any non-prescribed drugs
- Facility policy
- Benefits
- Offer emotional support
- Weaning

# Discharge Planning

- Mother's substance abuse management
- Ongoing needs assessments (infant & family)
- Comprehensive, family focused services across care continuum
- NICP, AzEIP, other community resources

# Discharge Planning

Am I ready to take my baby home?	
In the hospital	<input type="checkbox"/> My baby is gaining weight.
	<input type="checkbox"/> I respond to my baby's needs and care for my baby in a safe and gentle way.
	<input type="checkbox"/> I know the signs that my baby is hungry and can feed him or her safely.
	<input type="checkbox"/> I feel a healthy bond with my baby.
	<input type="checkbox"/> I know the everyday duties of a parent.
	<input type="checkbox"/> I can give my baby's medication or treatment correctly, if needed.
At home	<input type="checkbox"/> I have someone who can help and support me.
	<input type="checkbox"/> My baby has a crib and safe place to sleep.
	<input type="checkbox"/> My baby will have a smoke-free home and car.
	<input type="checkbox"/> I have a safe place in my home to store my baby's medication, if needed.
Follow up plans	<input type="checkbox"/> I will take my baby for check-ups with the doctor or midwife.
	<input type="checkbox"/> I know how to safely travel with my baby. I have a car seat for my baby.
	<input type="checkbox"/> I agree to a home visit(s) by a Public Health Nurse.
	<input type="checkbox"/> I will share information about my health and my baby's health with the health care team.
	<input type="checkbox"/> I know what warning signs to watch for and who to call for help. For example, I know how to get help if my baby gets sick.

- Independent
- What to expect at home
- Strategies for coping/caring for infant at home

\*\*Hamilton Health Sciences

# Educate: At Home

- Infant will likely remain sensitive at home
- Ability to identify cues
- Slowly introduce more stimulation based on infant cues/readiness for interaction
- Discuss how long to anticipate symptoms

# Educate: At Home

- What to do if they are overwhelmed
- Have a “go to” person for support
- Safety monitor
- Counseling or support groups
- Self care
- When to call doctor
- Keep all appointments

# Summary

- **Build Rapport:** Although, challenging families to care for, they are still a family! Our priority is to educate them to be the best parents they can be. Consider self-reflection. Know your attitude towards drug-dependent mothers. Be non-judgmental and give them the tools they need for success.
- **Ask Questions:** Do staff feel comfortable talking about addiction? Will you consider education on how to care for the drug-addicted mother?
- **Set Expectations:** Do you have a caregiver agreement?
- **Educate:** What is your current education for families? Do you have handouts? How will your discharge planning process change?

# Any Questions?



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