ID: 83

TITLE: MOTHERS OF VERY PRETERM BORN INFANTS, EXPERIENCES IN HOSPITAL AND DURING POST-DISCHARGE INTERVENTION

AUTHORS: Martine Jeukens-Visser 1; Edith Raap 2; Monique Flierman 3; Frans Nollet 4; Katie Lee Weille 5.


CONTENT:

Motherhood begins unexpectedly when delivering a very preterm born (VPT) infant. Hospitalization and the discharge to-home are stressful experiences for mothers and make this transition into parenthood complicated. In the Netherlands, the ToP program, a strength-based responsive parenting intervention, is available for all VPT infants after hospital discharge. In 12 home-visits in the first year, parents are assisted in understanding their infants behavior and needs and how they can respond accordingly. The aim of this qualitative study is to gain deeper insight into how mothers of VPT infants experience the transition to motherhood as well as the support received during the ToP program.

Interpretative phenomenological analysis was applied to semi-structured interviews with two mothers of VPT infants who completed the ToP program. This idiosyncratic approach was chosen because it delves deeply into lived experience, producing nuanced insights into complex, subjective phenomena that may be experienced in widely varying ways. Mothers were purposively selected with different socio-economic backgrounds but with good abilities to reflect on their experiences. Mother 1 (M1) has a master’s degree and is employed and mother 2 (M2) is low educated, unemployed and chronically ill. Interview topics covered maternal experiences during hospitalization and the ToP program. The interviews were audiorecorded, transcribed and analyzed for superordinate and subordinate themes.

Four thematic domains were identified: 1) Balancing and precarity, including transitions in identity and regaining agency, 2) Social and discursive shaping of experiences, including socio-economic differences and the experiences of technology, 3) Attuned support and 4) Misattuned support. In the high-tech hospital environment and at home in the first year, both mothers struggle to develop a maternal self amidst invasive experiences. Help can be felt as deeply attuned or horribly misattuned. Support that helps mothers to regain agency and works within her own tolerance for input, is experienced as helpful. M1 feels educationally equal to professionals and gains agency by being informed but does not appreciate directive advice. M2 experiences developmental science as “pushing”, believing her infant will develop at his own pace but she values advice after seeing improvements herself.

Both mothers were overwhelmed by the unexpected birth and alienated environment, controlled by professionals and technology. In their long journey to achieve a secure maternal footing, they needed support attuned to their individual needs, beliefs and background. These interviews gave insights at both practical and more overarching levels about how to provide a more sensitive and attuned care during and after hospital discharge.

COI: none declared
ID: 203

TITLE: THERMAL INJURY IN NEWBORNS AND WITHIN THE FIRST 6 MONTHS OF LIFE

AUTHORS: Ashraf Mohammad zadeh1, Ahmad shah Farhat 2, Reza Saeidi 3

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CONTENT:

The skin is very thin and sensitive to burns in newborns. In this age group mortality rate is very high. Burns account for approximately 2 million injuries annually in the United States alone, of which 500,000 seek medical treatment and 100,000 require hospitalization. Approximately 50%, of burns occur in the pediatric population, with children younger than 5 years representing 17% of reported burn cases. Infants and children are a unique patient population that demonstrates increased susceptibility to death. Not only the young children have limited physiologic reserves, but their patterns of injury are very different from adults. Although thermal burns secondary to scale or flame are by far the most common etiologies in children and adults, injuries from chemical and electrical burns may be devastating and require early recognition and treatment.

The document of all infant burns admitted to Imam Reza hospital Mashhad Iran was retrospectively analyzed in one decade since 2001-2011.

Four hundred forty seven burns admitted to this ward for 10 years. Twenty five (6%) were in first 6 months of life. Three (12%) were newborn (first 28 days of life). Fifteen (60%) were female. Mean age in admission was 5.3±1.2 month (min 3 days, max 6 months). Mean percentile of burn was 23±15 percentile. Stay in hospital was 14±18 days. Mortality rate was 12%. Source of burns was hot water (tea,...)80% and fire 16%, and one case (4%) was a newborn that got burn in lower extremities due to malfunction of incubator.

Result of this study was the same as world. Hot water and fire were the most sources of burns. Female were injured more than male. Mortality rate was 12%.

COI: no
ID: 233

TITLE: DEVELOPING A TOOL TO DETECT INAPPROPRIATE PRESCRIBING IN NEONATES (TIP-N): AN INSIGHT FROM A RETROSPECTIVE PHARMACO-EPIDEMIOLOGICAL STUDY

AUTHORS: Asma Al-Turkait 1; Shalini Ojha 2; Imti Choonara 3; Lisa Szatkowski 4

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CONTENT:

Prescribing drugs to neonates is a complex process. To date, the availability of essential tools to detect inappropriate prescribing is sparse in the paediatric population especially in neonates.

Before proposing any tool to rationalise the prescribing of medicine in neonates, there is a need to establish crucial milestones that relates to the current drug use in neonates.

To achieve this, we aimed to identify the most commonly used drugs in neonatal units in the UK over the past 8 years (2010 to 2017).

A retrospective pharmaco-epidemiological study of a large prospectively collected database (The National Neonatal Research Database) was conducted.

This study was registered in clinicaltrials.gov (NCT03773289). Anonymised data was analysed to identify the most commonly used drugs across all gestational age groups.

The raw count of the drugs was reported as “n” which corresponds to the: number of neonates prescribed a particular drug at least once across the whole study period.

A total of 642,729 neonates included in the analysis (between 01 January 2010 to 31 December 2017). Benzylpenicillin and gentamicin were the most commonly used antibiotics. A summary of the results is tabulated below.

Benzylpenicillin and gentamicin were the most frequently prescribed antibiotics in accordance with national guidelines. Similarly Caffeine for apnoea in preterm neonates and vitamins for all neonates are recommended in guidelines.

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Most five commonly used drugs across different neonatal gestational age groups

COI: None declared
ID: 264
TITLE: LOOK AFTER YOURSELF AND YOUR COLLEAGUES – DEBRIEF! STEPS TO FORMALISE THE DEBRIEFING PROCESS ON THE NEONATAL INTENSIVE CARE UNIT
AUTHORS: Elke Reunis 1; Rashmi Mehta 2; Imogen Storey 3; Harsha Gowda 4
AFFILIATIONS: Neonatal Unit, Birmingham Heartlands Hospital, Birmingham, United Kingdom

CONTENT:

76% of doctors reported encountering difficult cases which have affected them either personally or professionally. Of these, the majority reported receiving little or no formal support following these cases (Harrison R, Lawton R, Stewart K, 2014). Research shows that debriefing aids recovery and promotes resilience (Harrison R, Wu A, 2017). So why are we not routinely debriefing in neonatology? We set out to change this on our Neonatal Intensive Care Unit (NICU). Our aim was to create an environment where regular debriefing occurs across the multidisciplinary team in our tertiary NICU.

Kotter’s 8-Step Change Model (Fig. 1) was used Oct 2018-March 2019.
1) Sense of urgency created by trainee request for debriefs and volume of challenging cases.
2) Coalition of interested trainees and consultants formed to lead change initiative.
3) Shared vision for regular debriefing established and implementation strategy devised.
4) Departmental qualitative survey of nurses and doctors conducted to identify individuals’ opinions regarding debriefing.
5) Teaching program delivered to illustrated importance of debriefing and approach to leading a hot debrief.
6) Book created to log debriefs happening.
7) Tailored departmental guideline designed, and daily team huddles introduced.
8) Survey results transformed into a motivational video, anonymously sharing the staff quotes with our department.

The survey results showed us that there was a real hunger for “regular debriefs as part of everyday practice.” They reported it “needs to become the norm,” and we need to “make it a set thing.” With this came the call to action for “more training,” to “educate staff to expect debriefs,” and design a “formal debriefing protocol” and “guideline.” Staff identified the need for a culture change with the “recognition of the importance” of debriefing, and the request for “the culture of debrief 2-4 hours post-event.”

These suggestions allowed us to remodel the culture around debriefing. We were able to produce robust guideline, detailing clinical and non-clinical events necessitating a debrief.

These changes are sustained by auditing debrief activities, incorporating regular debrief training, using feedback systems for debrief leaders, and sharing the motivational video of staff quotes.

Debriefing needs to “become the norm.” Our approach communicated this vision, empowered staff to ask for debriefs, and informed our design of clinical debriefing guidelines.

Regular multidisciplinary team hot and cold debriefs on our NICU have received positive feedback from the team and highlighted clinical and non-clinical events suitable for future simulation practice and training.

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Fig. 1: Kotter’s 8-Step Change Model (Kotter, 1996)

COI: None declared
ID: 332
TITLE: NEONATAL SKIN INJURIES: TOOLS TO ENHANCE ASSESSMENT AND MEASUREMENT
AUTHORS: August, Deanne 1; Hitchcock, Ian 2; Ray, Robin A 3; Kandasamy, Yoga 2, 3; New, Karen 4
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CONTENT:

Skin injuries are among the most common complications for hospitalised neonates. Younger neonates are more frequently injured due to minimal skin layers, which are additionally thinner with decreasing gestational age (0.9 preterm-1.2mm term). The current standard of skin injury assessment uses only the naked eye. Thus, neonatal skin injuries are increasingly difficult to quantify and assess for severity due to minimal tissue depth. While there are several neonatal skin risk assessment tools, these do not assist the bedside clinicians actual assessment of an injury (length or depth). Therefore, investigators of an epidemiologic study developed tool to enhance skin injury assessment and measurement.

Adult wound and neonatal literature was searched for key elements of skin assessment, injury assessment tools, injury measurement, and clinical image photography. Commercial wound cameras were compared for efficacy and cost efficiency for documentation and image collection of injuries against an iOS (operating system) application. Development of skin injury assessment tools considered skin colour changes, normal neonatal skin tones, injury size (often < 2cm), severity scales, injury locations, mechanical forces involved in injury aetiology and the descriptive language. Additionally, tool development considered cost, materials, feasibility and suitability for the neonatal clinical setting.

Commercial wound cameras were not more efficacious or cost efficient than the iOS application. The iOS application was more intuitive for clinicians. A metric graduated colour (MGC) tool, comprising of 15 colours, measuring 60 mm and displaying metric dimensions was developed along with a lanyard card tool depicting injury severity stages. The MGC tool offers a discernible reference for initial injury/wound bed assessment and comparison over time; while the lanyard card provides definitions and images of neonatal skin injuries related to mechanical force (pressure, friction, shear and/or stripping) to aid consistency in the description for documentation of injuries. Additionally, the MGC tool provides a focal point which enhances clinical photographs, and a measurement reference for both injury colour and size.

Initial evaluation of these tools showed promise in improving assessment and measurement of neonatal skin injuries, in conjunction with clinical photography. Formal evaluation is currently underway in a multicentre study. The adoption of these injury tools into neonatal care globally has the potential to allow for benchmarking of this hospital-acquired complication.

COI: Deanne August has a registered patent (2017904788) for the metric graduated colour (MGC) tool relating to assessment and measurement in human skin and tissue. Portions of this study were funded by the Mona Kendall Development Research Grant, The Townsville Hospital and Health Service Research Trust Fund, College of Medicine and Dentistry at James Cook University, the Graduate Research School of James Cook University and a Parker Healthcare and Australian College of Neonatal Nursing Research. The authors declare no other conflicts of interest.
ID: 558

TITLE: PARENTS AND CAREGIVERS PERCEPTIONS TO THE USE OF LIVE VIDEO RECORDING IN NEONATAL UNITS, A FOCUS GROUP STUDY

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CONTENT:

Live video recording is not routine in neonatal units. However, its use is beginning to appear as a tool to assist in diagnosis, monitoring or communication. The modalities of its implementation in neonatal care setting should take into account parents and caregivers perceptions. The objective was to study the perceptions associated with the use of video and sounds recordings in neonatal clinical practice in order to get information about acceptability, limits and constraints to be addressed.

Nine focus group interviews were conducted in four neonatal units involving 20 caregivers and 19 parents. The transcripts were analysed using the qualitative data analysis software, NVivo10. Data were triangulated using transcripts and field notes and analyzed using inductive, semantic thematic analysis.

Eight major themes emerged from the 4 caregivers focus groups : (i) impacts of video recording on caregivers behaviour (ii) impact of access to images for parents; (iii) forensic dimension; (iv) storage and protection of data; (v) compliance with the stated objectives in the use of data; (vi) value in the best interests of the child; (vii) ways of use (improvement of practices, teaching, research); (viii) technical aspect and feasibility. Five major themes emerged from the 5 parents focus groups: (i) value in the best interests of the child and to improve care; (ii) impact on parents, on their privacy and on potential benefits in case of separation; (iii) informed consent and compliance with the stated objectives in the use of data; (iv) concern about a possible disruptive effect for caregivers; (v) data protection. The forensic and technical aspects were not mentioned by the parents.

Despite differences in their perceptions parents and caregivers perceived video in care as useful and acceptable provided that measures are taken to ensure information, data protection, and to limit potential negative impacts for caregivers. The conditions pointed out by parents and caregivers for an acceptable use of video/sound recordings were not considered significant enough to prevent the use in clinical practice for the benefit of newborns.

COI: None declared
ID: 686

TITLE: DEVELOPMENTAL CARE QUALITY IMPROVEMENT - TOUCH A LIFE, IMPACT A LIFETIME

AUTHORS: Catherine Barraclough 1; Sarah Guest 2; Rani Jacob 3; Nazakat Merchant 4

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CONTENT:

Kangaroo care is recognised as an important part of family centred developmental care in the neonatal environment (NICE, 2010). Benefits have been widely researched and include reduction in mortality and improvements in cognitive and neurobehavioural outcomes (Akbari, 2018). Many quality frameworks in developmental care recommend families are supported to carry out kangaroo care regularly (Bliss, 2015). Despite this, rates of kangaroo care on our neonatal unit were found to be between 0 - 33%. Using a quality improvement model (QI) our aim was to increase participation of families in kangaroo care by 20% within 6 months.

A PDSA framework was used in order to structure an improvement plan and implement change. A developmental care multidisciplinary group was set up to propose drivers and change ideas. PDSA cycles completed were:

1. Developmental working group and ‘Coffee, cake and chat’ – Parent led mornings.
2. Education & empowerment cycle – Teaching on nursing study days, educational MDT grand rounds and kangaroo care champions.
3. Trial of a reclining chair to improve comfort for parents.

Rates of kangaroo care were recorded on a set day 2-3 times a month between December 2018 and March 2019. Data collected included gestational age of infant, location e.g ITU and other medical procedures occurring. Process changes were monitored using statistical process control charts.

All infants on the neonatal unit were included in the analysis unless deemed clinically unstable to have kangaroo care. Run chart shows percentage of kangaroo care carried out over 4 months. Following PDSA cycle 1, KC carried out increased from 10% to 40%. Further increased to 75% in the second PDSA cycle, however it did drop to 23%. Following 3rd PDSA cycle, percentages remained stable between 50-64%. Overall the median percentage of KC increased from 40% to 50% i.e. 25% increase from initial median. More of the infants on ITU (57%) or HDU (54%) participated in KC care compared to SCBU (37%). Infants in incubators participated in KC more than infants in cots (74% vs 24%). Feedback from parents informally through the parent groups was positive towards carrying out kangaroo care.

Utilising multidisciplinary working and structured quality improvement framework to plan and drive strategies for change; we have shown an improvement in delivering kangaroo care in our neonatal unit. Our next target is to ensure sustainability. Engagement with parents and staff is important in understanding barriers to kangaroo care and a survey is being carried out to understand this further.

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Kangaroo care QI driver diagram demonstrating change ideas and run chart of PDSA implementation.

COI: None declared
ID: 718

**TITLE:** PARENTS PRACTICES IN PREPARING MILK FORMULA

**AUTHORS:** Marta Stanonik 1; Renata Vettorazzi 2;

**AFFILIATIONS:** 1 University Clinic Golnik, Golnik, Slovenia
2 University of Ljubljana, Faculty of Health Sciences, Ljubljana, Slovenia;

**CONTENT:**

When using the powdered milk formula, parents must be careful to prepare it properly, ensuring the hygiene of bottles and teats. The powder is not sterile and may contain Cronobacter sakazakii, dangerous bacteria for infants. The purpose of the research was to determine parent’s awareness of the safe preparation of milk formula and importance of bottle and teat hygiene.

A descriptive quantitative research method was used, with structured questionnaire. The survey involved 263 parents who had a child up to two years old and use milk formula.

Although at the time of pregnancy mothers plan to exclusively breastfeed, many of them start to use milk formula shortly after childbirth. Most information on the safe preparation of milk formula parents got on internet and packaging labels. 1/3 of the parents prepare the feed in advance and store it in the refrigerator, despite the fact that this is not advice. Less attention is paid to the time of boiling and the temperature of the water at which the milk formula should be added according to the WHO guidelines. When preparing the milk concentration, most parents follow the manufacturer’s instructions. 3/4 of the parents discard the rest of the milk immediately. Feeding bottles and teats are usually washed with water and the detergent, or merely with water. Less than half of the parents wash their hands before preparing the feed and a weak third of them tidy the working surface.

The research showed that parents are often unaware of the importance of safe preparation of milk formula, and of hygienic handling of bottles and teats. They find preparing the formula separately each time they want to feed their baby too time-consuming, so they take various shortcuts. There is a great need that healthcare workers should educate parents on the proper preparation and handling of milk formulas.

**COI:** None declared
ID: 786
TITLE: AN AUDIT OF PRE-TERM INFANT POSITIONING IN THE NEONATAL INTENSIVE CARE SETTING
AUTHORS: Emma Poff 1; Anne Keane 2.
AFFILIATIONS: Physiotherapy Department, Our Lady of Lourdes Hospital, Drogheda, Co Louth, Ireland

CONTENT:

It is reported in the literature that physiological flexion is not achieved until 36 weeks gestation. In utero, the foetus is contained in midline with no gravitational pull. Pre-term infants in the neonatal intensive care (NICU) setting are working against the effects of gravity making it challenging to achieve midline and normal physiological flexion. Positioning these infants promotes autonomic stability, self-regulation and aids posture and movement as well as reducing muscle imbalance or movement disorders. The aim of this study was to observe pre-term infant positioning in the NICU and neonatal unit (NNU) in Our Lady of Lourdes Hospital and recognise potential areas for improvement.

An audit was carried out in the NICU and NNU in Our Lady of Lourdes Hospital Drogheda once a week for four weeks. This is a level 2 NNU. The audit day was randomly selected each week and NICU staff blinded as to day/time of audit. Two separate assessors reviewed each infant in the same position at the same time using the Infant Positioning Assessment Tool (IPAT). All pre-term infants born at<36 weeks gestation were included. An Excel record of resting infant position and their IPAT score was noted. The results were analysed and presented back to staff on the NICU/SCBU during an in-service training session. The IPAT was also made available in each ward. The audit was repeated following a one month period and results were recorded and analysed as per the initial audit.

68% of infants in the NICU/NNU met the inclusion criteria for the audit, this correlated as 52 infants. Gestational age was the only reason for infant exclusion. On initial audit, the average IPAT score was 7.8. A score of less than 9 indicates a need to reposition the infant. 58% of the infants assessed during the initial audit had an IPAT score below 9. On repeat audit, the average IPAT score was 9.9. 28% of infants assessed during the repeat audit had an IPAT score less than 9. Head, neck and prone positioning as well as infants positioned in prone were identified as key areas for improvement. These scores improved from averages of 0.5, 1.2 and 3.0 to 1.0, 1.9 and 9.0 respectively. Overall, the IPAT scores on repeat audit correlated as a 48% improvement in pre-term infant positioning.

On initial audit the average IPAT score indicated that recommended pre-term infant positioning standards were not being met. Following in-service training, the repeat audit showed significant improvement in average IPAT scores. In future continued monitoring of infant positioning is recommended in particular of head, neck and prone positioning. All staff entering the NNU environment should be educated on the best practice for infant positioning.

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Audit Results

COI: None declared
ID: 886  
TITLE: NURSES’ OPINIONS ON POSITIONING FOR NEONATAL LUMBAR PUNCTURE - LYING OR SITTING?  
AUTHORS: Alexandra Scrivens 1,2; Jessica Webster 2; Rhea Navani 3; Charlotte Bannink 4; Andrew Marshall 1; Charles C Roehr 1,2  
AFFILIATIONS: 1. Newborn Services, Oxford University Hospitals, Oxford, UK  
3. Monash University, Melbourne, Australia  
4. University of Tasmania, Hobart, Australia  

CONTENT:  
Neonatal lumbar punctures (LP) require skill in positioning the needle in the intervertebral space and also a skilled holder to keep the baby still during the procedure, a task often allocated to the nurse caring for the baby. As part of a study to determine the optimal position for neonatal LP, the sitting position was introduced as an alternative to the traditional lying position for lumbar punctures at a tertiary neonatal unit. Whilst data will soon be available comparing lying and sitting LP success rates, the opinions of nurses who regularly hold for LPs are very valuable in assessing infant comfort and ease of holding.  

Aim: To gauge the acceptability of the sitting position compared to the lying position to the nursing team. Nursing staff at a tertiary neonatal unit were surveyed, asking in which LP position do they feel that the baby is most comfortable? In which do they feel it is easier to hold the baby still? And which do they feel is most likely to result in a successful LP? Options were given as ‘definitely lying’, ‘probably lying’, ‘no preference’, ‘probably sitting’ or ‘definitely sitting’. Nurses were asked to consider these options for a 1 kg preterm baby, a 3.5kg term baby and a 5kg term baby.  

Of 72 ITU/HDU nurses, 34 responded to the survey (47%). Of these, 15(44%) had held a baby for a sitting LP, all had held for a lying LP. Results are summarised in figure 1. Participants felt that preterm infants tolerated LP best in the lying position (23/34 answered definitely/probably lying); whereas term infants, particularly larger infants, were more comfortable in the sitting position (19/33 answered probably/definitely sitting for a 5kg baby). Sitting was felt to be easier to hold in larger babies, yet it was easier to hold a smaller baby in a lying position. The chances of success were thought to be equal in both positions, with 39% expressing ‘no preference’ for all sizes of infant. Nurses who have held a baby for a sitting LP show confidence in the position and a stronger preference for the sitting position than those who have not held an infant in the sitting position.  

The nursing team feel that lying is more comfortable and better tolerated by smaller babies. The nurses show preference for the sitting position (for comfort and ease of holding) for term and larger babies. There is no clear preference for likelihood of success. Most nurses who have never held an infant in the sitting position indicated that, with appropriate training, they are willing to try and feel it may be more suitable in larger infants.  

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COI: None declared