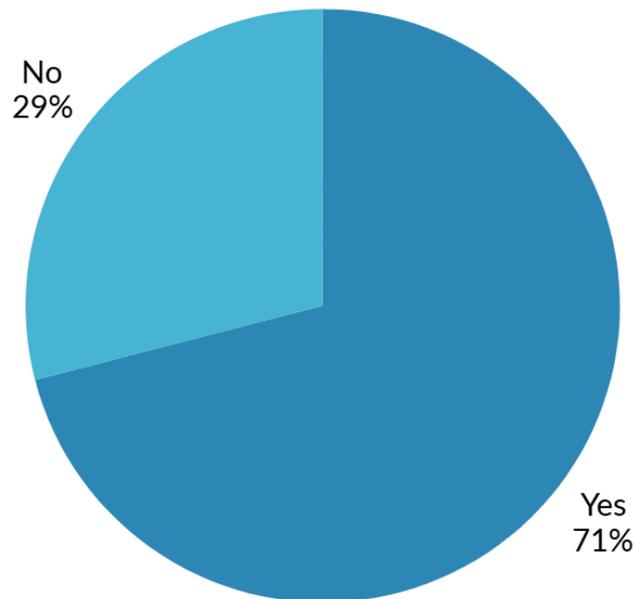


## FCC Taskforce Monthly Polls & Responses

To submit questions for future polls or to share information addressing past polls, please email us at [familycenteredcaredtaskforce@gmail.com](mailto:familycenteredcaredtaskforce@gmail.com)

**October 2025: Help us support NICUs working toward welcoming gestational siblings at the bedside.**

**If an infant in your unit is one of multiples and their sibling(s) is not/ are not inpatient, does your NICU welcome the sibling(s) at the bedside with parents/primary caregivers?**



**If yes, please share your unit's guidelines/policies around gestational sibling presence; if no, please share your unit's barriers to welcoming gestational siblings:**

- ❖ Sibling more than 2 years are welcome with their parents - Ideally we suggest to take an appointment with nurse the first time for a formal welcome. We organize welcome time for sibling with doll, incubator... The unit psychologists can take care for the whole family if necessary. A volunteer can take care of sibling 3 days a week, in the unit, when parents need for 1 or 2 hours.
- ❖ It depends on what time of year it is. If the hospital has flu/rsv restrictions, and there are older siblings at home or if there is known illness at home, the multiple(s) will not be allowed back. **If the other sibling is the only one at home and parents are well, they are typically welcomed back.**
- ❖ We follow our sibling visiting guidelines which **allow siblings to visit if immunizations are up to date and they are free from infectious symptoms. We usually have a cot they can use while parents are visiting.**

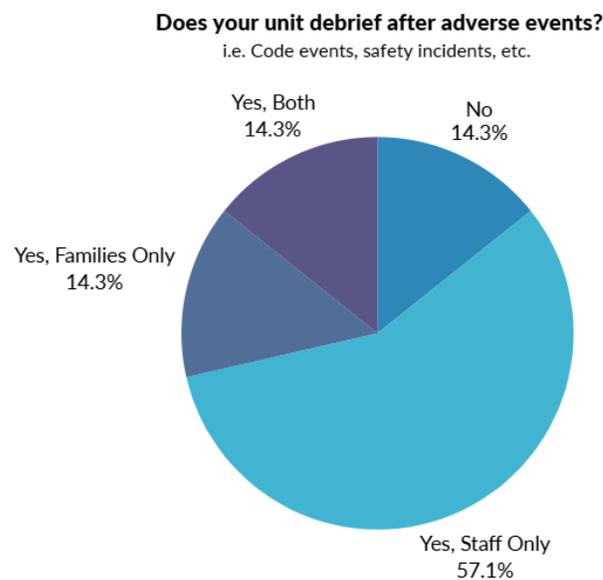
- ❖ They are **admitted as "Co patients"**
- ❖ Infection control doesn't allow it.
- ❖ Gestational siblings may be present during visiting hours only, 8a-8p. Gestational siblings are not permitted to stay overnight with parents/primary caregivers in the room.
- ❖ Our NICU visitation policy does not allow for siblings.
- ❖ Up to age 6 months (mother must be breastfeeding)
- ❖  **multiples are always allowed with a crib placed at their bedside. No restrictions.** For older, non-multiple siblings they must be <2 years with proof of vaccination.
- ❖ When a multiple sibling is discharged home, **the parents are allowed to bring him/her back when visiting while waiting for the discharge of the sibling multiple. An open crib is kept in the room so the parent can put the sibling down while performing cares and feedings with the sibling that is still inpatient.** To that note, older non-gestational siblings are not allowed to visit if under the age of 16.
- ❖  **Multiples w/discharged siblings can visit with parents if they do not have an older sibling at home.** If they have older siblings we don't allow them to visit due to possibility of communicable diseases, particularly in school-aged children.
- ❖ No siblings under the age of 3 are allowed. During flu season, no one under 18
- ❖  **Parents can bring the birth multiple siblings when they "visit" the infant in the unit. We provide a separate crib for the sibling to sleep.** We have private room setup in the NICU.
- ❖ Honestly, I am not sure. I think it is just so far out of the box for us that people are overwhelmed when I've brought it up.  **I would love to find out how to make this happen in our NICU, it is definitely one of my top FCC goals!**
- ❖  **The sibling can come to the unit for the first six months of life,** but we do not offer our equipment for the non-admitted infant. Also, our units' sibling visitation hours are between 2 pm and 8 pm.
- ❖  **We allow twin of baby if discharge first to continue promoting breastfeeding/bonding.** Other siblings would need to be 2 years and above with proof of up-to-date vaccines.
- ❖ No children are welcome in the NICU since COVID.
- ❖ Families can bring the sibling, they stay in the family room outside the NICU and a family member needs to stay with the baby. infection prevention and legal team prevents us to welcome siblings in the NICU. Nurses are not allowed to assume responsibility of a baby that is not a patient in our NICU
- ❖  **They are welcome at all times, they are able to use our bassinette** and the parents provide all that is needed for the baby and they are responsible for all that baby's care.
- ❖ Fever and cough free, not in the beds with the inpatient twin, can secure Child Life for sibling support during part of stay to allow parents to focus on inpatient
- ❖ Inflexibility. Abiding by a strict "no siblings under 18" policy for "infection prevention"
- ❖ of course must be healthy.  **we provide crib** but family provides everything else (milk, diapers). They must never be left alone.
- ❖ We allow all siblings (definition: those who live in the same household as the patient- may be cousin etc.) at the bedside for short visits. If the sibling is a toddler and very active we ask for them to limit the time in the ICU rooms to 20-30 minutes, but if the child

is quiet (sibling pack-coloring pages/books provided) we do not limit. The only exception is during "respiratory season" generally November through Feb/March we do not allow any children under 3 at the bedside unless exterminating circumstances exist and approval from Manager/Director/MD Director.

- ❖ **No restrictions on gestational sibling present. A rolling crib is provided as a safe sleep surface.** Unit staff cannot provide any assistance to the family with the gestational sibling.
- ❖ **Our twin rooms are built with a connected parent room. The post-partum and non-NICU baby dyad are cared for in this connected room during their own inpatient stays. When the non-NICU dyad is discharged, they can continue to stay in this connected room for the duration of the NICU baby's stay.**
- ❖ We do not have a written policy but **siblings both gestational or otherwise are invited on to the unit and can stay with the parents at all times. We recognise the family unit.**
- ❖ We welcome siblings unless they are ill.
- ❖ Sibling can be with parent but we do not provide items for sibling, such as bed, food, diapers etc..
- ❖ Not allowed because the other baby is okay; To prevent [healthy] baby from getting sick too
- ❖ If one is discharged before the other, don't allow the discharged one to come back cuz of risk for infection

**September 2025:** We asked you to share what you love about the FCC Taskforce and where we can improve. Responses are linked [here](#).

**August 2025:** Help us support NICUs working toward implementing staff and family debriefs after adverse events.



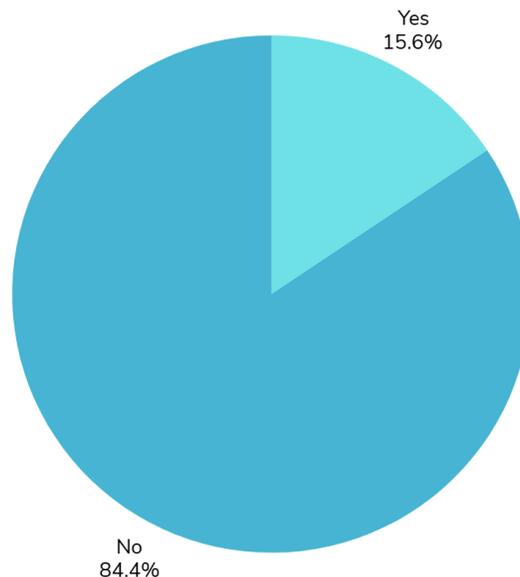
**If yes, does your unit use a script or tool for staff and family debriefs?**

- ❖ Yes, it is a template
- ❖ Yes there is a script with topics as well as time for open discussion
- ❖ The physician/practitioner usually calls the family to inform what happened and current status
- ❖ We have 'hot debrief' within the shift of the event and 'cold debrief' within a week of the event

**July 2025: Help us support NICUs working toward improving parental engagement by sharing your unit's experience with use of technology to supplement family communication.**

**Does your unit use any apps for parent communication/text updates to supplement family communication?**

5 responded 'Yes' / 27 responded 'No'



**If yes, what App Platform do you use?**

- ❖ Yomingo in the past but was not well received, it was only educational
- ❖ Only our social workers and psychologist have the capability to text the families
- ❖ Mychart via EPIC
- ❖ Angel Eye Platform

**If you are a NICU staff member, do you prefer using apps for parent communication/text updates to improve (not replace) in-person or phone conversations? Why or why not?**

- ❖ In person and phone calls because when you face the parents you can read their emotions and when you call them they feel loved and cared for
- ❖ Yes it's less costly
- ❖ Yes
- ❖ I'd love to consider it as I hesitate to call parents at home - don't want to risk waking them up from much needed sleep or initiate panic with receiving a call from the hospital

- ❖ I would like to have the option to connect with parents by text if they were interested
- ❖ Yes, the App we use allows staff to send pictures (EPIC EHR/MyChart)
- ❖ Would be great to supplement but without adding additional workload on the staff
- ❖ Yes. It provides parents with nice updates in a way that they can easily receive non-critical information. It helps keep them informed, updated, and connected to their baby and their plan of care
- ❖ I would rather use in-person conversations
- ❖ Yes, I hope it will help parents feel connected
- ❖ Not using
- ❖ Yes i think it's the perfect way to have families feel connected to their baby and the nurse
- ❖ As a rehab team, we would want the opportunity to text to give updates or help schedule appointments for education
- ❖ No; phone calls are more personable and professional. I think a one-way text communication is appropriate in which the team member they have the question for can respond when able
- ❖ I think having an app would be a great addition. Sometimes the information is too much to process in one go. Also basic information about the terms used or common concerns would be helpful for families to have access to always
- ❖ It's helpful to share resources for parents to refer to after our in-person discussions
- ❖ In person and phone conversations because when you are in person the individual feels involved
- ❖ Parents have enjoyed receiving discharge information through the app- they can access it repeatedly and watch on their own time
- ❖ I think there are opportunities for both platforms

**If you have had a child in the NICU, do you prefer using apps for staff communication/text updates to improve (not replace) in-person or phone conversations? Why or why not?**

- ❖ In person and phone calls and WhatsApp
- ❖ Yes, because the is directly sent to the person
- ❖ Yes
- ❖ Yes, I would have loved it if there was something available back then. Anything to keep me connected to him and his progress would have been amazing!
- ❖ In-person
- ❖ I don't prefer text updates which may lead to misunderstandings
- ❖ Not sure
- ❖ An app would save time and quick phone calls
- ❖ Yes - this would be a helpful supplement to live conversations IF the responses were timely

**June 2025: Tell us about your unit's experience with a paid Family Partner position!**

**If your unit has a paid Family Partner position, how much does it compensate?**

- ❖ \$24-\$25 per hour (CA)
- ❖ \$20-\$25 per hour (MI)
- ❖ \$46 per hour (MA)
- ❖ \$43 per hour (NY)
- ❖ \$20 per hour plus benefits (CA)

**How many hours per week does your paid Family Partner work?**

- ❖ 20-30 hours/week
- ❖ 32 hours/week
- ❖ 20 hours/week
- ❖ 20 hours/week
- ❖ 20 hours/week

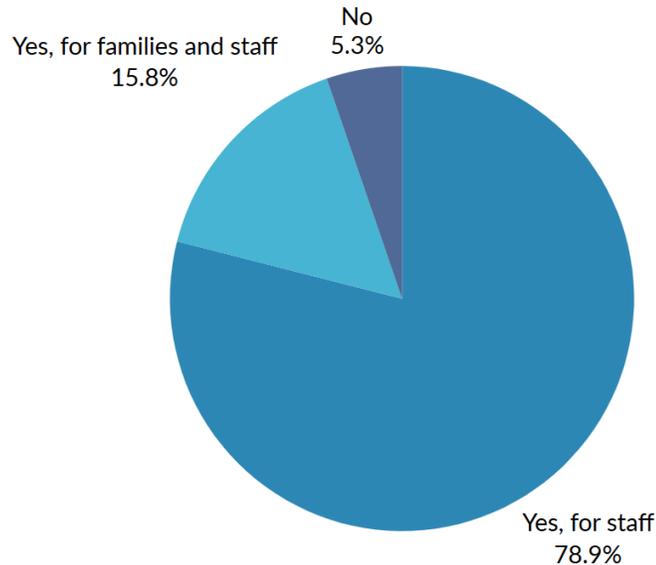
**What cost center does your paid Family Position fall under?**

- ❖ NICU
- ❖ Hospital foundation grant
- ❖ Nursing
- ❖ Philanthropy
- ❖ NICU

**May 2025: Tell us about your NICU's protocol & guidelines around fingernails!**

**Does your unit have a protocol & guidelines for fingernail length, artificial nails, and nail polish?**

15 responded 'Yes, for staff' / 3 responded 'Yes for families and staff' / 1 responded 'No'



**Can you share more about your unit's policy and guidelines?**

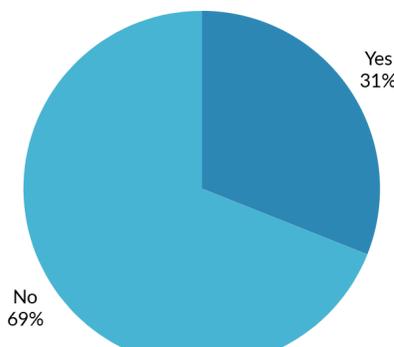
- ❖ It is a guideline from infection control which does not allow nail polish or artificial nails. It requests short, clean fingernails.
- ❖ Nothing on nails except polish that is not chipped. No artificial nails, wraps, gels, shellac, etc. Must be 1/4 inch or shorter.
- ❖ No artificial nails, no chipped polish, no more than 1/4" past fingertip.
- ❖ No nail polish, no artificial nails, no gel.
- ❖ No artificial nails. Leaders just sent an email to reinforce this but stated they prefer no nail polish and further stated they can't enforce no nail polish because it isn't stated in the policy.
- ❖ Nothing artificial on nails, no chipped nail polish. Handwashing for 3 min before work or before visiting baby (staff & parents wash).
- ❖ Our hospital utilizes the following as our guideline:

- ❖ Illinois Department Of Public Health, TITLE 77: The policy for infection control in the obstetric and neonatal departments shall include, but not be limited to, the following: Health personnel shall:
  - Show evidence of prior rubella infection or rubella vaccination and comply with the health assessment and immunization requirements of Section 250.450 (Personnel Health Requirements). Health care personnel in obstetric and neonatal services shall comply with any additional requirements for health and immunizations, pursuant to the hospital's policies and procedures for infection control in the obstetric department;
  - Wash hands to the elbows with an antiseptic agent using a procedure developed and posted by the infection control committee before entering the nursery at the beginning of a shift, and before handling infants for the first time. Hands shall be washed before and after touching each infant and after touching any object. Fingernails shall be kept short. Artificial fingernails or anything other than clear polish is not acceptable;
  - Remove all rings, watches and bracelets before hand washing and entering the nursery.
- ❖ No nails longer than 1/4 inch, no chipped polish, no artificial or gel build up. Bare below the elbows.
- ❖ No artificial nails. Unchipped nail polish is allowed. Policy is not well enforced by nursing leadership.
- ❖ No artificial or gel polish. No chips. Fingertip length.
- ❖ No powder gel no acrylic per infection control.
- ❖ All nurses should cut their nails short, without nail polish and perform handwashing upon entering the unit and every before and after touching the baby and other moments of hand washing guidelines.
- ❖ No artificial nails or nail polish allowed and short nails.
- ❖ Nails must be short, unseen while looking at the palm. No false nails or fingernail policy, even clear polish.
- ❖ No artificial nails, including gel/dip polish. Regular polish only as long as it's unchipped. Fingernails must not be more than 1/4" in length.
- ❖ Staff are not able to wear artificial nails, nail polish may not be chipped, nails can be at most a quarter inch long. In our family policies, we state in information that families sign that if they have on artificial nails, they must wear gloves. This is not enforced.
- ❖ [Fingernail Policy - Hunt Regional Hospital](#)

**April 2025: Tell us about your unit's experience with Couplet Care!**

**\*\*\*Couplet Care is a model where mothers and babies are cared for together in the same room with considerations for the interdependent needs of the mother and infant, and where gestational siblings are welcomed at the bedside.**

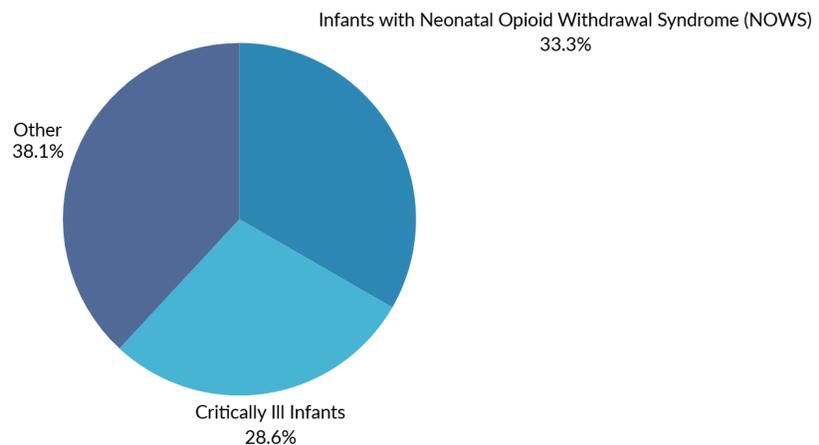
**Does your NICU utilize a Couplet Care model?**  
Of 29 respondents, 9 answered 'Yes' while 20 answered 'No'



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**If yes, what kinds of patients does your Couplet Care model serve?**

Of 29 respondents, 9 answered 'Yes' while 20 answered 'No'



**Other:**

- ❖ It is important to also look at what criteria there is for the mother; for a critically ill mother the couplet care needs to be located at the adult ICU or the maternity unit. When the infant is in need of neonatal intensive care, hopefully the mother's care can be tailored and located at the infant's bedside. Care for both patients is organized in the unit responsible for the patient with the most complex medical needs.
- ❖ Any preterm/term infant 30wks and above not requiring mechanical ventilation at the time of admission (but can be requiring CPAP and are not moved if later require ventilation). Excludes HIE, PPHN, CDH. Specific maternal criteria exist as well due to location off of the postpartum floor.
- ❖ All our infants stay with their mothers
- ❖ All babies are eligible, moms have to be off mag for 8 hours, have their recovery completed (2 hrs), and not be requiring IV antihypertensives. We are a level II progressing to level III this fall and have many questions about what this will look like with higher acuity babies!
- ❖ All neonates admitted to NICU

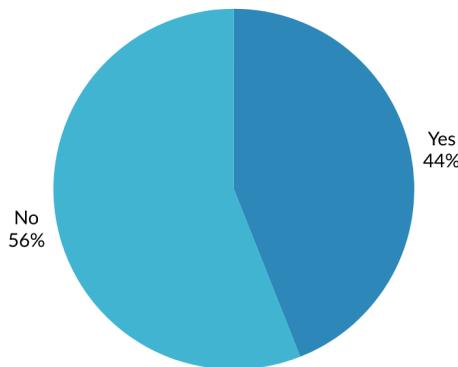
**If your unit utilizes a Couplet Care model, can you tell us how staff are cross-trained?**

- ❖ To a limited extent. There are different teams caring for the mother and the baby. They collaborate but have separate responsibilities. All teams need to know first aid for both patients and to have routines for getting the right team to be alerted in emergency situations (like different sets of alarm systems for the two patients). They are also trained to be able to help each other with delegated tasks.
- ❖ There are separate teams responsible for the care of the mother and the infant respectively. Staff is trained for first aid emergencies of both patients and alarm systems are known and practiced to alert the needed competencies as soon as possible. Staff is also trained to be able to help each other with delegated tasks. For example maternity nurses and midwives can take a blood glucose and monitor clinical parameters of a newborn. NICU staff can give oral analgesic to a mother, remove a drip that is finished and empty a urinary bag. Usually it is the nursing staff that is crossed trained for delegation tasks like this and not the doctors. All working with mothers and newborns should have team training in first aid measures for both patients.
- ❖ Couplet care located in the NICU and mom is staffed by postpartum mother/baby RN and baby staffed by NICU RN. Available to assist as needed but not specifically cross trained.
- ❖ Maternity has Couplet Care model. NICU does not.
- ❖ NICU nurses on hire are aware that they will cross train to take care of well moms with their baby/babies. Depending on the severity of the infant then a L&D nurse may care for the mom. If the mom is on Mag or too ill for a NICU nurse to care for a L&D nurse will care for the mom on LDRP and the NICU nurse will care for her baby there. We have central monitoring and are on 2 different floors but the monitors can be seen on both floors.
- ❖ Our unit is only 3 years old and most of our team worked in post-partum previously. This made our transition easy at first as the team needed to learn a few NICU skills, but already had the PP skills. As we have hired additional experienced Level III RN's, we are not requiring them to learn PP as they will be precepting our current team as we progress to Level III. We have created a Level II/PP team of RN's that will take low acuity babies and all PP moms. As the educator, I manage their NICU training and work closely with our OB educators who manage the PP training and continuing education. These RN's get their PP training by spending several weeks working in OB, then completing all ongoing education assigned by that department. They are similar to a little float team!

- ❖ Once our team is solid in Level III skills, we may revisit upskilling our Level III RN's to care for PP patients.
- ❖ NICU Staff in turn take care of them.
- ❖ It is challenging - only space for couplet care is on the Mother-Baby floor outside of NICU. There was cross training but more often now our Eat Sleep Console intervention is delivered in the Newborn nursery and if complications beyond ~5 days they need to move up to the NICU.
- ❖ Most of the time L&D staff take care of mother and NICU staff take care of admitted neonates in the same room. All NICU staff are trained in taking care of postpartum mothers also.
- ❖ Interdisciplinary training, in services skills fair

**March 2025:**

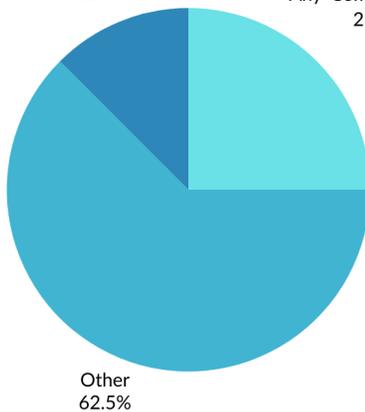
**Does your NICU have a Continuity Attending Program?**  
Of 25 respondents, 11 answered 'Yes' while 14 answered 'No'



**What patients does your unit assign a Continuity Attending to?**

Any Baby Under a Specific Gestational Age  
12.5%

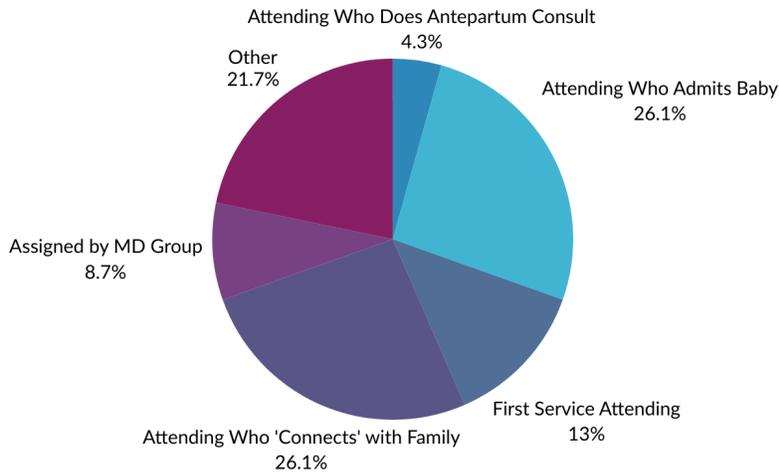
Any 'Complex' Baby  
25%



**Other:**

- All inpatient newborns
- Infants with BPD
- There are no set guidelines, but generally it is complex and/or extremely preterm patients though not all complex and/or extremely preterm infants end up with a continuity attending.
- At request of a social worker who feels family would benefit
- LOS > 14 days; multiple sub-speciality teams involved
- We have 3 NICU areas: ICU (up to 7 babies), Tower (6 intermediate babies), CCN (Continuing Care NICU: 6-7 babies). Doc #1 follows ICU babies for 7 day stretch. Doc #2 follows Tower and CCN babies for 5 day stretch. Both docs and one NNP will cover all other babies in Main NICU; usu intermediate babies.

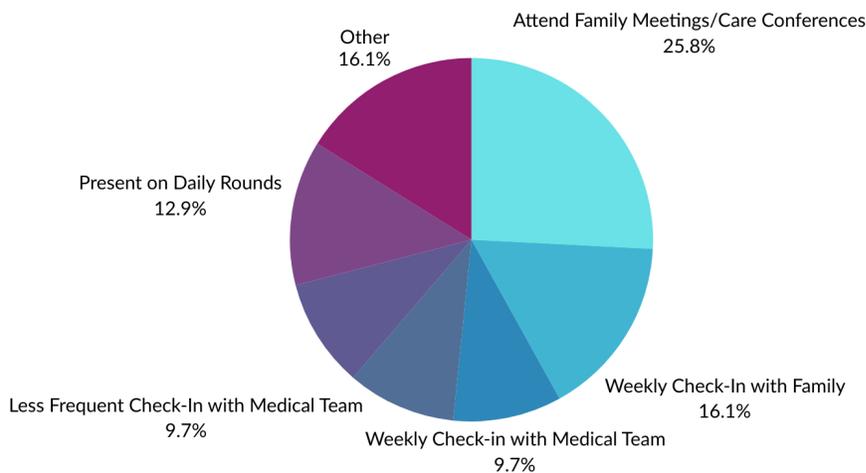
**How does your unit assign a Continuity Attending Program?**



**Other:**

- There are no set guidelines and it is often the attending who connects with the family that takes on this role. There are times when an attending on service and/or another member of the care team recommends that a patient have a continuity attending.
- Can also be identified/requested by family
- Based on expertise in area of infants' main condition
- Assigned by NICU areas

**What is the expectation of the Continuity Attending?**



**Other:**

- There are not set guidelines, but when a patient does have a continuity attending, they generally check in weekly and join for family meetings
- We are private group so in unit each week and when on shift we see the baby; at least 2-3 times per week
- <30 weeks and complex patients have a detailed meeting at around 7-10 days, then regularly as required and at 36-37 weeks
- Patient assigned to a team; each team has 3 attendings that rotate every 1-3 weeks; family stays with the same team and has those 3 attendings as their primary

**February 2025: How does your NICU maintain energy and enthusiasm around FCC training and retraining in the face of staff turnover?**

**Responses:**

- ❖ Our team has a strong desire to learn best practices; however, things really fall apart when they don't have designated and paid time to engage in learning. Trying to complete training modules between care times is problematic for many reasons.

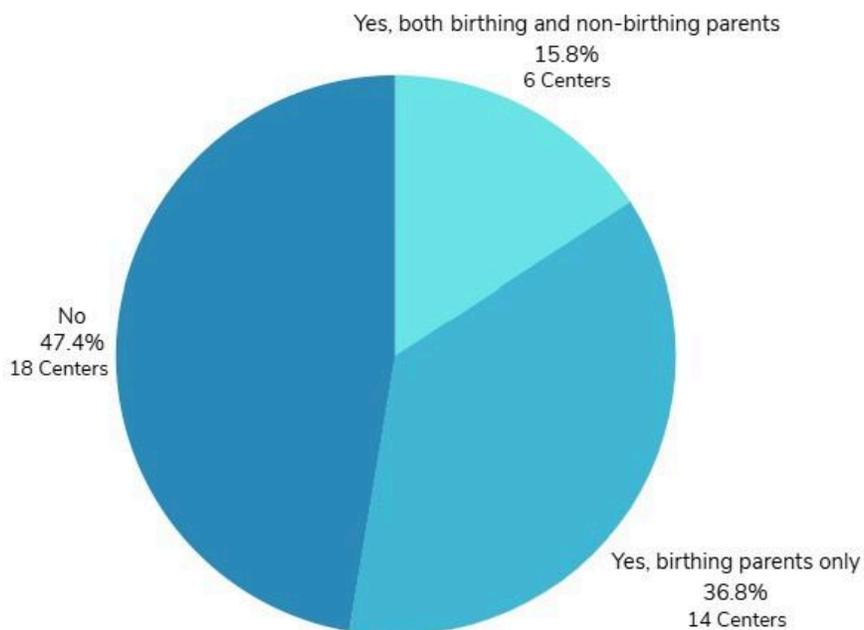
- ❖ I can't say we do a great job of this. We try to highlight our most important education stations at an "Ed Fair" where completing the stations gives you a ticket to a drawing for something like a Starbucks gift card or other not too expensive but fun to get item.
- ❖ Create a checklist of all FCC related training and education and ask the staff ( include new staff) to complete it every year during professional development day.

**Tips:**

- ❖ Provide paid time for training, if possible
- ❖ Create incentives for training
  - If all training is done by deadline, nursing staff wins a catered lunch
  - Nursing staff earns raffle tickets when training is complete to win gift cards, coffee, etc. Drawings should take place each week or each month (depending on unit goals) to maintain momentum
- ❖ Identity FCC Champions who can mentor new staff in this area
- ❖ Utilize this [FCC Training Checklist](#) for staff orientation

**January 2025: Help us understand your unit's practices around mental health screening for NICU families!**

Does your unit screen NICU families for perinatal mood disorders and anxiety disorders?  
(ex. PMAD Ex Edinburgh Scale)



**November & December 2024: Help us support NICUs who are struggling to find resources to create patient/family satisfaction surveys by sharing your unit's best practices! Please share when and how your NICU measures patient/family satisfaction.**

**Responses:**

- ❖ We give a survey out the day before discharge. Parents fill it out anonymously and seal it in an envelope. All surveys are reviewed 1-3 months later by the Medical Director.

- ❖ Press Ganey surveys emailed to families after discharge; we use standard NICU Press Ganey Questions.
- ❖ We provide a parent survey before discharge. Parents place completed form in a mailbox. Results are shared with leadership and staff once a month.
- ❖ Empathic-N
- ❖ All small babies' families are given a family satisfaction survey at their 'graduation' out of the small baby unit. Families are also contacted post-discharge via text, email, and phone to complete a Press Ganey survey of their NICU experience.
- ❖ Standard Press Ganey survey for NICU is sent electronically to parents after discharge, we do not do any other surveys at this time.
- ❖ We use the Empathic-N

**Please share survey questions sent to parents & family caregivers in your unit.**

[Click here](#) to access a database of patient/family satisfaction surveys used by FCC Taskforce members.

**October 2024: If you are a neonatal therapist with an active role in Family-Centered Care in your NICU, please share how you were able to get involved/be included.**

**Responses:**

- ❖ We have a family-centered care and developmental care group that meets to facilitate FCC
- ❖ My nurse manager and nurse educator chose a family-centered care program that had neonatal therapy (PT/OT/SLP) integrated, therefore, ensuring we are involved in the care. We have always been invited to rounds, and bedside family rounds, to be involved in all of our patients' care.
- ❖ I was able to work on implementation of the Discharge Preparation Transition Planning Guidelines by partnering with the NPA and other non-profits who are providing open access resources and complementary services to our families.

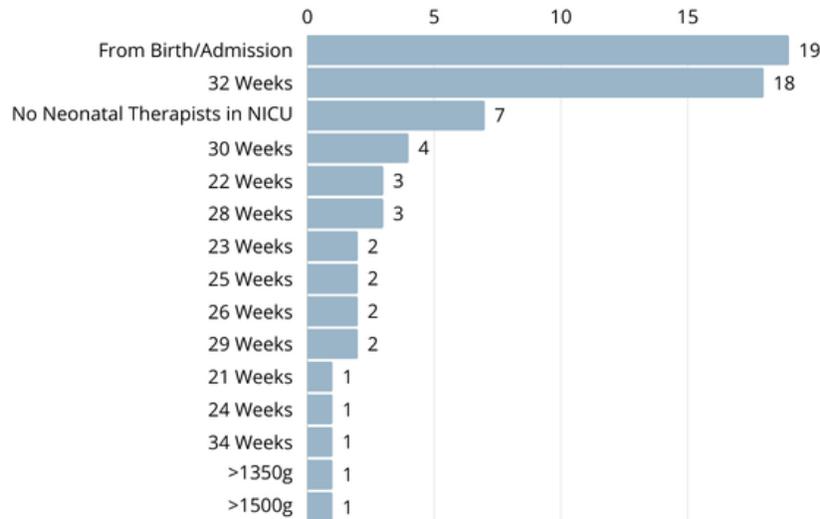
**Do you have any advice for neonatal therapists experiencing pushback around their presence in the NICU?**

**Responses:**

- ❖ Continue to attend meetings, ask to attend others, be seen and when able, be heard
- ❖ Buy in; give lectures and educate staff
- ❖ Utilize your evidence to show the important role that you play in the unit, and more importantly in the care of your babies and their families
- ❖ Relationships are so important. I focused on developing strong, positive relationships, working and providing value where staff felt it was most needed, before tip toeing into programmatic change. If we are feeling pushback, I wonder if we need to relook at where to start. It is a challenging and continuous journey, but a journey worth traveling.

**September 2024: At what corrected gestational age/birth weight do neonatal therapists engage with infants in your unit?**

**Responses:**



**Those who answered 'From Birth/Admission Regardless of CGA/Weight' said:**

- For parent education and procedural support
- Immediately for a second set of hands and positioning
- Immediately to participate in two-person cares!
- To engage with families in the first week of life and introduce the therapist role
- To offer neuroprotective four hands care

**Those who answered 'Dependent on Type of Therapy' said:**

- 28 weeks for PT/OT, 33 weeks for SLP
- 25 weeks for OT/29 weeks for SLP
- 28-29 weeks for positioning/30 weeks for positive touch
- From birth/on admission for OT/31-32 weeks for SLP
- From birth/on admission for OT/32 weeks for PT/34 weeks for SLP

**Neonatal Therapy Cheat Sheet:**

- OT = Occupational Therapy  
Focus: Developmental care, sensory processing
- PT = Physical Therapy  
Focus: Positioning, infant massage, motor skill development
- SLP = Speech-Language Pathology  
Focus: Feeding, communication

**August 2024: Does your NICU allow doula presence to support NICU families?**

**Responses:** Of the 17 centers who responded, **35% (6) allow doula presence** while **65% (11) do not.**

***If yes, please elaborate on how your NICU utilizes doula support for NICU families. If no, please share while your NICU does not utilize doula support for NICU families***

- ❖ It didn't come to our attention and would like to explore the benefits
- ❖ It's not available, it has never been discussed
- ❖ It is allowed but not practiced in my NICU, doulas are primarily seen in L&D
- ❖ It has not been proposed to have doula support in the NICU
- ❖ I'm not sure that we've been asked to allow a doula in the NICU, but our visitor policy is limited currently to parents
- ❖ Our unit would not stop a doula who a family has invited onto the unit, but we are not initiating doula support and would not allow a doula who is not employed by the hospital and in a specific role to be on the unit attending to patient families
- ❖ I don't see this often in the actual NICU but our visitor policy would allow a doula to be placed on the visitor list after the infant is born for specific private room units. I also see doulas at deliveries. We do have doula limitations in our resuscitation room/area which an infant can be in for 4-48 hours after birth.
- ❖ I don't know that it is NOT allowed. It has never come up that I am aware of. I will follow up with our management.
- ❖ It is a parent initiative, meaning parents have a doula, mostly pre/during/post labor. It is not seen in my NICU, we would not, however, resist the presence of a doula
- ❖ Parents have never asked for this; they have doula support for labor but have not asked for it in mother baby unit or NICU
- ❖ We welcome any support people that the family requests participate in training within the parameters of Covid19 policy around bedside visitors (which is ever-changing)
- ❖ Most doulas in this hospital are for postpartum and birth only
- ❖ I'm not sure? I don't think it's not allowed, but I don't recall seeing any...
- ❖ I am a parent advocate, doula support should be a part of every family's birthing experience. They are essential for birthing peoples' and families' safety and wellbeing. Their role fills a gap in care; they provide advocacy and support for parents when others are focused on the infant. As more and more state Medicaid programs explore providing doula care during pregnancy and delivery, it is essential that NICUs create inclusive policies that welcome doulas as part of the NICU family's care team - just as they should be welcomed in any other unit of the hospital.
- ❖ The allow a 'visitor' and some use that as doula support!
- ❖ We are just starting to use doulas in our LD, so hopefully we will start to use them in NICU also

**July 2024: Does your unit educate paid and/or volunteer Family Partners on implicit bias, emotional support, and/or how to navigate challenging situations?** Education could be in the form of online modules, written materials, etc.

**Responses:**

**We have a Parent Partner Team who completes education within the team, supported by other Parent Partners and a social worker.**

- ❖ Yes! We offer bias training, DEI education, education around pronoun usage, and crisis intervention tools. Our education happens both at onboarding as well as continuously throughout our PFAC meetings. Our initial training covers the following:
  - Hospital Compliance - privacy, hand hygiene, isolation precautions, other hospital volunteer logistics
  - DEI - identifying and managing biases, how our own circumstances change how we show up
  - Tips on Communication
  - Family-Centered Care Basics
  - Trauma-Informed Care basics

Throughout the year (goal being 4x) we pick a topic and find supporting videos or articles and share with our council and then discuss all together. We find articles and videos from Courageous Parents Network, Beryl, IPFCC, etc.

- ❖ We have a Parent Partner team who completes education supported by other Parent Partners and a social worker.
- ❖ Because so many of our Family Connection Program roles are virtual and we really want to respect people's time as busy parents, we didn't want them to have to do all the stuff that pertained to on-site work. We settled on HIPAA and ICARE training and wanted an Unconscious Bias piece but didn't find anything that seemed to be the right fit that was aimed at volunteers, was virtual, and could be accomplished in an hour... so we created our own. We worked with our DEI consultant who is also a grateful GCH mom as well as our Office of Equity and Inclusion to create training. It is now taught by a Learning Specialist from the Office of Equity and Inclusion (who is also a former GCH Child Life Specialist). It is offered bi-monthly and we request our volunteers complete the training within their first 6 months of onboarding. The first part educates on the science of bias and how we all have bias, how to recognize bias and what to do when we encounter it. The second half puts that science to practice with 4 scenarios that peer mentors might experience:
  - A peer mentor who is gay is supporting a family who makes a remark showing a bias against a gay nurse.
  - A family overhears a staff member commenting that they don't understand why a family that they perceive as in the country illegally gets all the care that other families receive.
  - A peer mentor who identifies as atheist is supporting a family who very openly has faith as a big part of their life.
  - A peer mentor supporting a parent of color who shares that they feel like they have to work twice as hard to earn half the respect from medical teams.We talk about recognizing these scenarios, possible techniques to try and handle them, and hopefully make clear that they don't have to "solve" these issues but rather it's a huge help to bring them to staff attention so we can study them internally with the goal of improving care. I think this Unconscious Bias/Authentic Advocacy training has been well received by not only our volunteers, but staff as well. There

are talks of replicating the concept of this training for other volunteers across the medical center. As for how to provide emotional support/navigate challenging situations without formal specialized training... We touch on that in our Buddy Program training, specifically the [Canadian Premature Babies Foundation training](#).

**June 2024: For those who have successfully implemented FCC practices (NICU-specific FCC Committee, NICU-specific Family Partnership Council, Paid Family Partner position(s), parental mental health support, unlimited caregiver access, etc.), how did you obtain buy-in from senior leadership and administration?**

**Responses:**

- ❖ Partnering with the Patient Experience Office and showing improvements in the Press Ganey/HCAP scores over a 12 month period to show the importance of FCC in the NICU can help with buy-in. Senior leaders were briefed on the progress of the FCC program and positive outcomes/improvement in parent satisfaction several times a year in different meetings.
- ❖ Repeated discussion about its importance
- ❖ Multi prong:
  - Start of NIDCAP
  - Neurodevelopmental committee work
  - Addition of family educators
  - Efforts of our quality leader through QI
  - Sharing FCC Taskforce webinars and emails
- ❖ Related to VON work and the All Care is Brain Care initiative
- ❖ We have had mixed results. Protocols come about via a shared governance Developmental Care Committee in our magnet hospital. They gather data and evidence for interventions and the admin backs those up. But that is in regard to very basic practices like parent presence, or doing a kangaroo-a-thon once a year. We tried to implement an early relational health intervention that required real investment, and solid data on the efficacy of the intervention, plus external funding for the program for two years allowed us to pilot the program to see if it saved the hospital money. Due to staff turnover and the pandemic, we were not able to deliver and study the intervention in the time frame of two years, so the program was discontinued.
- ❖ Starting with things that did not cost any money and were easy to implement such as changing the limited visiting hours, allowing parents in rounds, and allowing moms the ability to pump at the bedside.
- ❖ I would say a unique FCC program that we developed was a discharge coordinator navigator role to ensure better education on post-discharge home care needs for baby(ies). That decreased our discharge care failure rate over the span of a decade. We have a parent readiness assessment, a pathway to home, and post discharge follow-up phone calls to discuss issues that caregivers may be having several days post-discharge.
- ❖ Our unit has had unlimited caregiver access for decades. I feel our unit has had excellent FCC practices for many years. There is always room for improvement. We

have had a paid Family Partner for 9 years. Prior to that, we had Family Partners on the unit, but it was inconsistent. One change made to make the support more consistent is when the hospital gave the Family Partner an office at the hospital and required regular office hours so the staff could rely on that support for families. From there, the position really took off. The Family Partner worked at the hospital but was paid by a local non-profit. There were limited resources, but the community provided support for programs. One of the first supports for NICU families were the NICU dinners. Local stores, restaurants, and businesses donated to make this happen. Another project in the beginning was the 'Pictures of Hope'. A local photographer donated her time and talent to create beautiful portraits of former NICU patients holding a picture of themselves at birth. Families are able to see that their fragile babies could grow and heal. The Family Partner has been able to create many more supports for our NICU families and is on several committees to provide a parent perspective where decisions are made. 5 years ago, the hospital created a position for the Family Partner, which secured this support for families. In those years, we now have a NICU Parent Advisory Team with the Family Partner, former parents, and staff. We also have a FICare team of doctors, nurses, leadership, the Family Partner, and members of the diversity, equity, and inclusion team. Many wonderful things are happening in our NICU! I think the key to obtaining buy-in from leadership was consistency and seeing how effective the position was in supporting NICU families.

**May 2024: Does your unit allow unrestricted access to family caregivers?**

**Responses:** Of the 75 centers who responded, **76% (57) allow unrestricted access** while **24% (18) do not.**

***If not, what restrictions are in place?***

- ❖ If parents are present already, we do not ask them to leave at shift change, however if they are not already in the unit, parents cannot come in for an hour in the morning and an hour at night [during shift changes]. Banded caregivers can stay without restrictions, however any additional visitors have to leave at 8pm once hospital visiting hours end.
- ❖ Parents excluded during invasive procedures.
- ❖ No access during change of shift.
- ❖ Closed for 30 minutes at change of shift.
- ❖ Visitation allowed 22hr/day. Closed for one hour at nurse change in shift. Only 2 [allowed] at the bedside at a time and one must be a banded caregiver.
- ❖ It is not policy, but the staff (medical and nursing) will not allow parents to be at bedside for an admission or for a sterile procedure (including line change) - despite much effort in stopping them from doing this.
- ❖ No access during change of shift (6:30-7:30 am/pm).
- ❖ [No access] only when sterile procedures are occurring in one of our large bay-type rooms where part of the room is closed.

- ❖ Primary caregivers may stay at the bedside during line changes, PICC insertions, etc. but may not come and go during these times. In other words, if parents are there at the start, they can stay, but no one else may enter once the procedure starts
- ❖ 2x shift change closing of unit for 1 hour - UGG.
- ❖ Parents are only visitors allowed right now. Must step out during nursing change of shift or when rounding on other patients.
- ❖ Visitation allowed 22 hours per day. Closed for 1 hour during each shift change. Two at the bedside at one time. Designated list of 4 visitors who can come without parents; all other visitors must be accompanied by parent.
- ❖ No access during shift change twice a day. No sleeping, food, or drink allowed.
- ❖ Mothers are not allowed to be in the NICU for the first 24 hours of life if they are on magnesium.
- ❖ 1. Change of shift twice a day (7am/pm); this does not affect parents if they are already at the bedside, it only affects parents if they are entering the NICU at that time.  
2. During rounds; half of NICU is closed to parents on Mondays from 1-2:30pm and the other half is closed Wednesdays from 1-2:30pm.
- ❖ Banded individuals must be at the bedside before shift change or wait until after change of shift [for access]. We do not kick out for shift change but staff must concentrate on report and not be addressing individuals during that 30-45min. We also encourage no phone calls during shift change (12hr shifts).
- ❖ Parents allowed 23 hours/day; must step out for one hour while fluids are changed. Only 4 visitors allowed on the visitation list that can change monthly, but they can only visit 8am-10pm.
- ❖ Parents and designee (usually grandparents) allowed 24/7 but have to step out at 7am and 7pm for nursing change of shift. Other visitors allowed 9am-9pm.

**April 2024:** Family Partners, your feedback is crucial! Some of our Taskforce members are considering adopting the **TrackMyMilk app** to their centers, **which shares pumping volume information to the Electronic Health Record (EPIC) after parents input data.** This app, unlike others, integrates into EPIC, reducing the need for constant queries about mother's own milk supply. Your insights will greatly help in making these important decisions!

#### **Responses:**

#### ***How would you have felt about using this app to track your (or your partner's) milk production?***

- ❖ I'm not a fan of using an app to track milk production. It only helps moms who have good milk production - for moms who don't or who feel a need to increase their milk production, it's added pressure and a constant reminder of what's not working.
- ❖ As an underproducer, this would have been very detrimental to my mental health. I felt judged by the nurses that I wasn't making enough milk and having the numbers staring me in the face every day would have made me feel very upset. The positive would be a record of how much milk my child had in storage. Sometimes milk was misplaced so this would help alert the staff to keep looking.
- ❖ Felt good.

- ❖ I did use an app to track milk production. On one hand, it was motivating to see how my production slowly increased when my little one was in the NICU. I was initially not producing much, so I wouldn't have been able to tell the difference without tracking. However, with my second baby, I had to stop tracking as I overanalyzed every pump. I was producing more than enough milk but would worry if I produced less in one pump.
- ❖ Mixed feelings. Initially I think it would be added pressure and possibly a space where I might feel even more of a failure. However, if it were set up to encourage and reinforce for any submission, I can see it being a motivator.
- ❖ I think for people struggling with milk production it might add to their guilt/stress of not being able to produce. But it's a great tool for those who want to use it to understand and see their production. I used one and it helped me learn patterns.
- ❖ This would be wonderful and motivating.
- ❖ I would have loved an app to keep track of this. I kept a journal while in the NICU with the times and amounts pumped, an app would have been so convenient to have accessible vs. carrying around a notebook and pen.
- ❖ I would like that parents would know when we were getting close to needing milk.
- ❖ Yes; if offered in a gentle way and after discussion about the importance of a human milk diet.
- ❖ Helpful. You have so much going on that I think it would be very helpful.
- ❖ I would have loved it.
- ❖ I loved having an app track breastfeeding with my youngest (no apps existed for preemies) - I think it would have helped me to see how much I was providing, I remember keeping a manual milk journal. I think it could be hard though if staff is not trained in trauma informed communication and could have devastating consequences for parents who aren't able to produce, don't produce much, or don't want to. Having CLEAR training in communication with parents would be critical if this is utilized.

***How would you have felt about receiving MyChart messages about your TrackMyMilk volumes daily on the first 0-5 days in the NICU, then weekly during your infant's hospitalization?***

- ❖ If it's purely informational to share how much supplement is being added to the mom's breastmilk to arrive at total milk intake - sure.
- ❖ It would need to be an opt-in.
- ❖ It [would be] useful.
- ❖ It would have been upsetting for me to receive these messages. I had a very difficult beginning to our breastfeeding journey. I think receiving messages in these early days without also having the right supports in place would have been detrimental to my mental health.
- ❖ I don't think it would be particularly helpful to receive alerts, but if it was information that could be searched I think it would be nice.
- ❖ Pressured. Especially during the first 5 days. If there was an opt-in, then fine but not for everyone.
- ❖ This might be overwhelming and provide too much pressure on me.

- ❖ The first five days I feel as though this would be overwhelming. There is so much going on in those first few days with your baby and trying to get a grasp on the situation as a parent, I feel the daily reminders would be an added stressor. Maybe every other day?
- ❖ I would be fine with it. It would be nice if it was a feature you can elect to turn off if it stresses you.
- ❖ I would be okay... it should have an easy option to dismiss the alert; or hospital staff can update in terms of loss.
- ❖ I would have loved it.
- ❖ I probably wouldn't remember or even pay attention to the messages. Those first several days tend to be a blur.
- ❖ It should be optional to receive messages. To me: No messages please. Enough pressure on mom already.
- ❖ I would have loved that!

***How would you have felt about seeing a week's pumped daily volumes in your baby's notes/provider's progress notes/lactation notes?***

- ❖ Initially it may be helpful - but at some point it will become a stress point. Only relevant for moms who do not have enough.
- ❖ I think this would be dependent on how the mom feels about their volumes. If it's not as high as needed can definitely be demotivating.
- ❖ Yes, [it would be] useful.
- ❖ Unless this tracking came alongside support for pumping moms, this would not have been helpful to me.
- ❖ I think it would be fine.
- ❖ So much pressure. Judged on the amount, questioning myself is it enough or not. Guilt at not enough. But again for those comfortable with it, great. But the language used can't be negative.
- ❖ I think this would be nice for me to be able to track.
- ❖ This would be fine.
- ❖ I think it helps the medical staff know what the supply is and come up with a plan to help increase the supply or stretch the supply out.
- ❖ Fine as long as a discussion is had about the importance of every drop and a true acknowledgement of how much milk a baby needs (size of stomach).
- ❖ Yes.
- ❖ [Would have] loved it.
- ❖ As long as it isn't used or communicated as goals to reach because that could put unneeded pressure on the pumping parent. I really liked tracking things and logging things - but I would not make it required, more of a way to see how it's going, maybe the data would help identify early issues like blocked ducts, etc. It just can't be used or communicated in a way that creates a negative experience for the parents.
- ❖ I would have felt great, because it keeps everybody accountable, me as a breastfeeding mom and the nurse or lactation specialist that is in charge of dispensing the milk to my baby. Also the tracking would be great as long as:
  - There were no issues 'losing' milk

- There were no issues labeling the milk
- There were no issues dispensing the milk
- There was no other debate about feeding formula to my baby

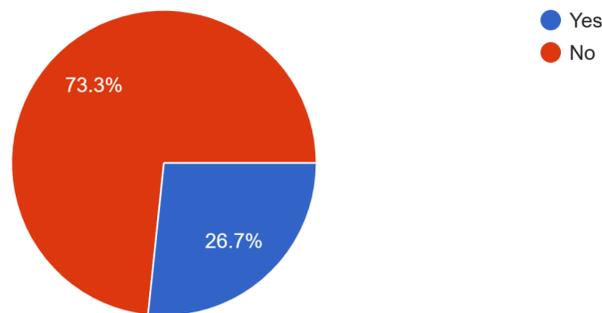
I.e. as long as staff were properly trained to do the whole breastfeeding cycle properly, without a glitch.

- ❖ That would have been helpful and brought down trends to my attention sooner.

**March 2024: Help us understand how your unit includes Family Partners in charting and meetings with families!** We want to know if Family Partners (i.e. former NICU parents who are paid or unpaid and who are assisting in current activities on the unit) are able to use electronic medical records (EMR) to document updates on the current NICU families they are supporting as well as in meetings attended with families with healthcare providers, social workers, etc.

Does your unit include Family Partner in charting?

30 responses



### Responses:

#### ***If yes, what kinds of things are they documenting?***

- ❖ Who they talked with and follow up needed
- ❖ We chart notes when we do supportive check-ins, care conferences, education, etc. We chart discharge planning tasks as appropriate.
- ❖ There is a separate record used by our Parent Support Program to document encounters.
- ❖ Family interactions, referrals/connection to social work, other support-related information
- ❖ Conversations with families
- ❖ Parents on staff chart (this was introduced as a 'pilot' of the practice about five years ago), documenting communication with families (in person, over the phone, written) that included support or education. This includes types of support offered and any significant information that was shared (e.g. family circumstances relevant to helping the current NICU family, discussions about feelings or values) and what the staff member did (e.g. validated feelings, encouraged asking questions with the medical staff, invited to support events, etc.). Volunteer parents do not have access to EMR.

- ❖ Parent contact, number of minutes in room, support given (invited to scrapbooking, invited to NICU dinner, gave information about benefits of Kangaroo Care, reading, oral care, step-down unit, or if served as a supportive presence).
- ❖ There is a general plan to begin creating notes for family interactions and concerns, but these are on hold to consider HIPAA implications.

***If yes, how is that data being used or measured?***

- ❖ Team awareness
- ❖ I don't believe it is
- ❖ The data is solely used by our parent-to-parent support program
- ❖ We use it to demonstrate the value of the family support role, how it differs from social work, and how many touch points and supports families have during a NICU stay
- ❖ Anyone with access to EMR can read what is charted, and social workers have indicated they read detailed charting done by family partners.
- ❖ Number of minutes [spent with families]
- ❖ Currently not used or measured in any meaningful way, although we do have the ability to aggregate the number of patients seen using an intervention tracker in the chart as a metric

**February 2024:** Typically, centers ask NICU parents to wait 1-1.5 years after discharge to join a Family Advisory Council. Considering this, **how long should a family who had a neonatal loss journey wait when they are eager to join?**

**Responses:**

- ❖ Depends on the family, but our rule of thumb is 12 months
- ❖ Whenever they feel ready
- ❖ 1 year
- ❖ For as long as THEY are not ready to resume exposure to a clinical environment
- ❖ I think this is such a case-by-case basis. Bereaved parents may want to start working on meaning-making soon after their child dies. I think it would be important to have a meeting with them and discuss the impact of being back in the hospital and what to do if they have an emotional reaction. I could see asking them to wait at least a few months - [giving them] a chance to experience grief reactions [that may] become more intense and frequent (which can happen months after). Maybe take a break from [in-person] meetings, move to providing feedback online, etc. and maybe have a check-in with the chair of the FAC on a regular basis. The goal would be to make sure they are protected from retraumatization and to know what to do if they find themselves impacted or triggered during or after meetings.
- ❖ Speaking as a bereaved parent, and knowing that each parent's grief journey looks different, this is a tricky question. At Hand to Hold, we typically encourage peer mentors and Family Support Specialists to wait up to two years before applying. This allows them to get beyond the one-two year milestones that can often be the most difficult. If they are at risk of prolonged or complicated grief, this also allows more time to identify and address these risk factors. While I have come across parents who donate items to the

NICU early on in memory of their child, and who are eager to give back in other ways, it can sometimes catch them off guard when they are back in the hospital and they realize they are not quite ready to go back into that environment, and that they may need a little more time to heal. Equally, it can be incredibly healing to start paying it forward immediately, and some parents demonstrate more resilience than others.

- ❖ It's different for each family. Some families can join one year after their loss.
- ❖ They should be allowed to join whenever they're ready - no gatekeeping!
- ❖ 2-4 years
- ❖ 2 years
- ❖ As soon as they feel ready, and feel like it will help them in their healing.
- ❖ I had a NICU loss and I just can't imagine a family being 'eager to join' an FAC. There is a lot of processing and healing that needs to take place after a NICU journey, especially when there is a loss. Having said that, sometimes that processing and healing takes place in sharing that story and serving other NICU families which causes me to ask: Why do we wait a year? Perhaps it would be better to consider the individual and their reasons for joining the FAC. It could be a very healing experience for them.
- ❖ Minimum 2 years
- ❖ 1.5 years
- ❖ I myself am a NICU parent who had twins that were born at 34 weeks. I was very unprepared after a life-threatening C-Section and my twins going to the NICU. They did very well in the NICU, despite a COVID setback, and went home stable and healthy a few weeks later. I personally do not have the same journey experience as someone who has gone through losing their child and cannot attest to how I might feel afterwards in regards to wanting to be a part of a Family Advisory Council. However, knowing the circumstances are different for parents who have had a neonatal loss journey, I can only give my best assumption as to why they may be eager to do so and how long to wait to allow them to. There is a possibility part of their healing process is to join the Family Advisory Council and help advocate for others who may go through a neonatal loss journey. I also understand that it can cause a lot of negative emotions and triggering memories to be a part of something related to their loss too soon. The time recommended of 1-1.5 years could be a good recommendation for parents wanting to join the council and return to support when they have had a successful discharge and time to recover and bond with their baby/babies. Considering these are two very different NICU experiences, my opinion would be that very different neonatal journeys (comparing neonatal loss with successful discharge) would probably need different recommended wait periods to join the Family Advisory Council, for some it may help them heal, for others it may be may take longer than the 1-1.5 years.
- ❖ I had a 24-weeker who survived, but I have had multiple pregnancy losses and work for a local nonprofit called [HAND: Helping After Neonatal Death](#). Our bereaved families can volunteer at any time, but they can only volunteer for parent-facing roles starting 1 year after their loss. It is very triggering to volunteer in the area in which your trauma is based, so we encourage eager volunteers to check in with seasoned volunteers regularly to see if they're getting burned out. If they are, then we scale back their workload or have them wait a bit longer before they volunteer again.

- ❖ We have found it varies from one family to another. Generally, groups wait 1 year, but then again, this may not be enough for some, and some are ready quicker. Then it depends on the "task" parents want to do. Many do not want to come back to the hospital but can help in several ways. Others teach palliative care courses with us, while others come to the unit. We have documented this in an article [here](#).

**January 2024: N/A**

**December 2023: N/A**

**November 2023:** Please provide your unit's guidelines around **recruiting Family Partners**. How does your unit recruit Family Partners for FAC/FPCs (Family Advisory Councils/Family Partnership Councils), FCC Leadership, Peer to Peer Support, and QI work?

**Responses:**

- ❖ We have a flier that helps explain the NICU Family Advisory Council and how parents can become involved. These can be passed out in-patient or at developmental follow up visits.
- ❖ We recruit past parents/families that have been in our NICU. Usually our Social Workers, Child Life Specialist, nurses, and even doctors will give names/make suggestions. We have also collected contact information from interested families and kept it until the right fit comes along.
- ❖ Fliers are given at discharge and parents can register virtually through a link.
- ❖ Our unit has a Family-Centered Care Team with three paid Family Support Specialists (FSS), a Director, and a Family Education Specialist that work in close unison with NICU Leadership to create entities like Family Staff Advisory Councils. Collectively, we put together our Family Staff Advisory Council earlier this year by reaching out to graduate NICU parents and NICU staff to elicit interest in forming our FSAC. This was done via email, by announcements at NICU staff meetings, etc. Our FSSs are in touch with many NICU families even after their babies graduate from our NICU and that connection was very important for us to recruit families to the Council.
- ❖ Information about the PFAC is in some NICU materials given to families and it is on our website.
- ❖ Sometimes, a family who brings an issue to our Patient Relations Team does so because they are passionate about making positive change. Sometimes a family can see past the issue(s) that bothered them and are open to using their experience to create positive changes in other areas, and are thus interested in joining a Council or Committee. We get recommendations from word of mouth from staff or other families. We've also created this form for families to read about engagement opportunities and let us know if they are interested. This form is on our hospital website and I like that it enables anyone to self-refer. Our Public Relations team is spotlighting this effort soon and I'm excited to see it (hopefully) bring in more interested Family Partners.  
<https://www.urmc.rochester.edu/childrens-hospital/quality/patient-family-experience.aspx>

**October 2023:** The Family-Centered Care Taskforce is collecting information on variation of practice for skin-to-skin holding across NICUs. What **restrictions** around skin-to-skin holding does your center currently have?

1. When babies have umbilical lines - (n=15) **60% of centers who responded have this restriction**
2. When babies have chest tubes - (n=16) **64% of centers who responded have this restriction**
3. When babies are on Oscillators - (n=19) **76% of centers who responded have this restriction**
4. When babies are on Jet Ventilators - (n=8) **44% of centers who responded have this restriction**
5. When babies are on Mechanical Ventilator support - (n=5) **20% of centers who responded have this restriction**
6. When babies are on pressor support - (n=8) **32% of centers who responded have this restriction**
7. When the baby's head is kept midline - (n=12) **48% of centers who responded have this restriction**
8. When babies are below a certain Gestation Age (GA) - (n=2) **8% of centers who responded have this restriction**

**Other restrictions noted:**

- ❖ Nurse/RT/provider comfort level (having guidelines & training in place can eliminate this issue)
- ❖ IVH precautions
- ❖ When babies have arterial lines

**Guidelines provided:**

**Inclusion Criteria**

1. Gestational age:
  - a. Greater than or equal to 28 weeks or greater then or equal to 1000 grams: begin KC after initial assessment and stabilization
  - b. For 24-28 weeks or less then 1000 grams after 72 hours of life
  - c. Under 24 weeks, regardless of weight after 7 days of life
2. Lines:
  - a. Venous catheters that are well secured: tunneled ( e.g. Broviac) or non-tunneled (e.g. PICC)
  - b. Umbilical venous catheter at the nurse's discretion

**Exclusion Criteria**

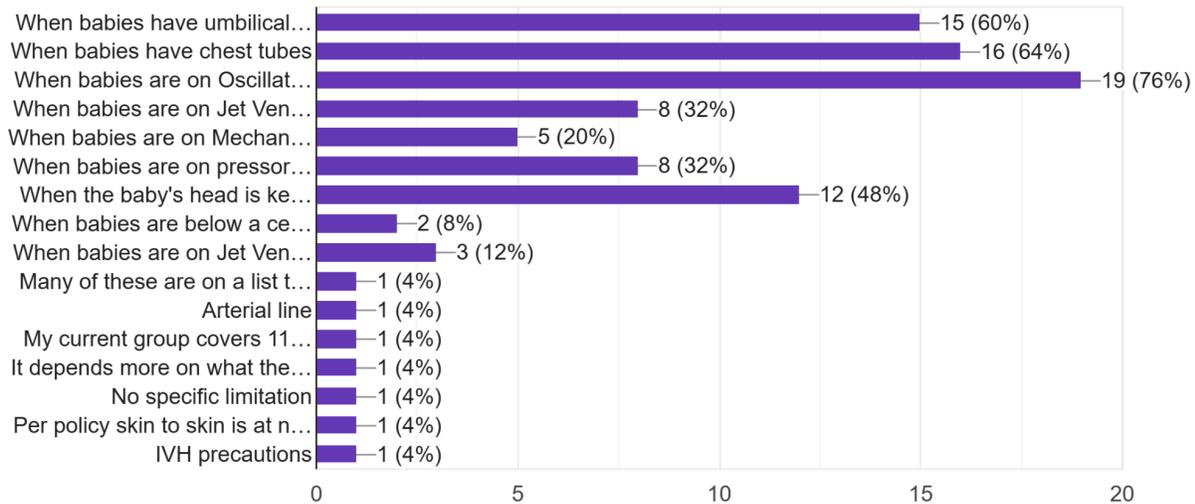
1. Infants who are not medically stable of who have had an acute or sudden deterioration in condition within the past 24 hours.
2. Persistent pulmonary hypertension/need for inhaled nitric oxide

3. Radial arterial catheter/umbilical arterial catheter
4. Chest tube in place
5. Open abdominal, spinal or surgical defects
6. Hyperbilirubinemia when at high risk for an exchange

For infants unable to participate in KC nursing staff will demonstrate appropriate tactile stimulation for parents to facilitate bonding. Instruct parents on Hand hugs holding.

What restrictions around skin-to-skin holding does your center currently have?

25 responses



**Check out results from a July 2025 survey on holding with UVCs & UACs by Jonathan Swanson, MD, MSc, MBA:**

Survey by:

**Jonathan Swanson, MD, MSc, MBA**

*Director, Division of Neonatology*

*Chief Quality Officer for Children's Services, UVA Health Children's*

**Questions:**

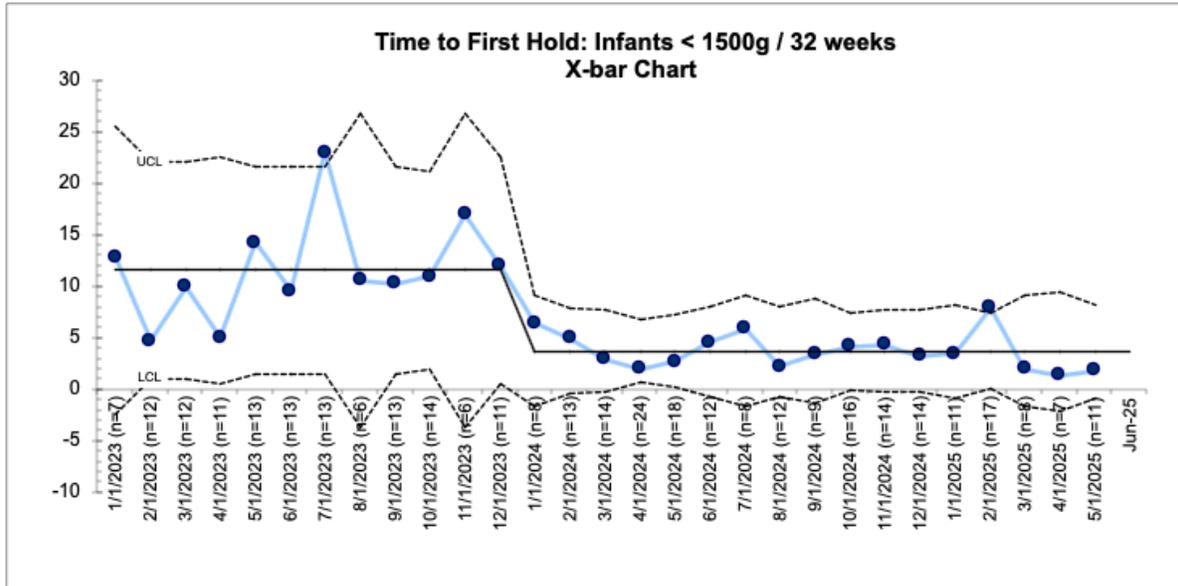
1. Do you allow caregivers to hold infants with a UVC in place?
2. Do you allow caregivers to hold with a UAC in place?
3. Any caveats/restrictions if you said "yes" above?

**Results:**

**Of 36 respondents, nearly all hold with UVCs (94%) and the vast majority hold with UACs (72%)** Many have caveats with low-lying lines and with clinical stability (didn't note clinical stability as that will always be the case).

Location	Hold UVC?	Hold UAC?	Caveats
UIC	Yes	No	Holding only allowed by more experienced/developmentally aware nurses
Miller Children's	Yes	Yes	
St Lukes, ID	Yes	No	Not with low UVC
Norton Children's	Yes	Yes	See attached run chart
El Paso	Yes	No*	*UACs with exception
HPHMG, HI	No	No	*Hold with extreme exception
St. George, UT	Yes	Yes	Typically a team-based discussion
Oschner	Yes	Yes	
Penn St	Yes	Yes	Deferred if lines are not sutured
St. Vincent, MT	Yes	Yes	
Arkansas Children's	Yes	Yes	
Baylor	Yes	Yes	
Peyton Manning	Yes	Yes	
St. Louis Children's	Yes	Yes	RN must assist
Vanderbilt	Yes	Yes	Not with low-lying
Salem Health	Yes	Yes	Hold side-lying so RNs have easy access and visualization
Stanford	Yes	Yes	
Holy Cross, MD	Yes	No	
Sharp Mary Birch	Yes	Yes	Not with low-lying
Pittsburgh	Yes	Yes*	Not with low-lying; *Team discussion; See Attached Criteria
Brigham & Womens	Yes	Yes	
Tucson	Yes	No	
Wake Forest	Yes	No	
Endeavor Health, IL	No	No	
OHSU	Yes	Yes	
MercyOne, IA	Yes	No	
CH King's Daughters	Yes	Yes	
Michigan	Yes	Yes	
USF/Tampa	Yes	Yes	
Bronson Children's	Yes	Yes	
Driscoll Children's	Yes	No	
John Muir	Yes	Yes	
Coxhealth	Yes	Yes	See attached criteria
Mississippi	Yes	Yes	
Alabama	Yes	Yes	Nurse to remain in the room
Nebraska	Yes	Yes	

Louisville Run Chart:



Pittsburgh Criteria:

Category	Respiratory Parameters	Cardiac Parameters	Other Parameters
Less Critical	<ul style="list-style-type: none"> <li>RA/LFNC</li> <li>NPV/bCPAP</li> <li>Weaning on support</li> </ul>	<ul style="list-style-type: none"> <li>No active cardiovascular problems</li> </ul>	<ul style="list-style-type: none"> <li>PICC, UVC</li> </ul>
Critical-Stable	<ul style="list-style-type: none"> <li>PIP ≤ 35</li> <li>PEEP ≤ 10</li> <li>FiO<sub>2</sub> &lt; 0.9</li> <li>Oscillation</li> <li>New intubation &lt;24 hrs</li> <li>Use of Nitric Oxide &gt;24 hrs</li> <li>No significant escalation of support</li> </ul>	<ul style="list-style-type: none"> <li>No significant escalation of cardiovascular support</li> </ul>	<ul style="list-style-type: none"> <li>Tenuous IV access</li> <li>Lines: low lying UVC, UAC</li> <li>Chest tubes</li> <li>Cooling</li> <li>Sepsis/NEC in past 48 hrs</li> <li>&gt; 27 0/7 wk GA</li> <li>22-27 0/7 after 72 HOL</li> <li>Humidified bed</li> </ul>
Critical-Unstable	<ul style="list-style-type: none"> <li>PIP &gt; 35</li> <li>PEEP &gt; 10</li> <li>New initiation of nitric oxide</li> <li>FiO<sub>2</sub> &gt; 0.9</li> <li>O<sub>2</sub> saturation &lt; 88% or &gt; 10% outside of acceptable range for patient</li> <li>Intubated with a <u>CRITICAL AIRWAY</u></li> </ul>	<ul style="list-style-type: none"> <li>Escalating cardiovascular support</li> </ul>	<ul style="list-style-type: none"> <li>Medications: pressors, versed drip</li> <li>Continuous EEG</li> <li>Communicable skin lesions on chest/breast</li> <li>Rapidly rising TsB requiring 2-3 banks of phototherapy or near exchange level</li> <li>GA 22-27 0/7 weeks under 72 hrs old</li> </ul>
<p><b>GREEN: OK to Kangaroo      YELLOW: Discuss with medical team      RED: HOLD on Kangaroo</b></p>			

**September 2023:** Centers in our Small Groups shared their barriers to forming a Family-Centered Care Committee; **lack of staff time was identified as a top barrier.** Of the

FCC Taskforce's 600+ members, some of you have a well-established FCC Committee. **Please share your insights on overcoming the 'lack of staff time' barrier.**

**Responses:**

- ❖ The FCC team in our unit at Santa Clara Valley Medical Center NICU consisting of a Director, 3 Family Support Specialists and a Family Education specialist is invited to most weekly NICU meetings such as Clinical Rounds, Multi- Disciplinary Rounds, Family Conferences, Division meetings etc . This allows NICU staff to hear updates from NICU families during weekly staff meetings on a regular basis.
- ❖ 1. Recruit passionate staff by reaching out directly instead of group email recruit and sharing how good they were with that family.  
2. Get leadership buy in by sharing family stories.  
3. Leadership provides admin time for staff to participate to the meeting.  
4. Instead of having a large committee form small subcommittees and let staff own their project which provides flexibility in their meeting attendance.  
5. Chair check in by text or personal email ( if they are ok) regularly about their subcommittees work. We get quick responses by this way.  
6. Staff education about why we do what we do, helps us to get their buy-in so they don't say they don't have time to guide the families.
- ❖ Training for staff on how important it is. I think they think there is a lack of time because they do not understand that if part of the routine really does not take up a lot of time but may actually give them some time back.
- ❖ Referencing that family-centered care actually benefits staff - can save time in the long run and creates joy in practice; getting leadership buy-in that trickles down; having meetings be organized, engaging, and valuable; demonstrating outcomes/wins/"products"; and messaging that FCC is simply "the right thing to do."
- ❖ Our FCC met every 3rd month in person for 2 hours. A parent was identified as chair, co-chair & secretary. Staff facilitators had minimal responsibilities. FCC guidelines were created to provide structure & set expectations. My hospital eventually hired a part-time parent advisor who helped manage the logistics for selecting & onboarding new FCC parents which also reduced NICU staff time commitments.