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Improving Clinical Outcomes by Evolving Mindset and Creating a Culture of Hope and Recovery

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The theories on underlying causes and treatment options for addiction and substance use have changed over the years. When addiction first began to be researched it was understood that addiction was a moral issue and choice. The cure was harsh punishment which was believed to be motivation to get the users to stop using. Tennessee was the first state to have criminal charges associated with substance use disorder in 2014. Additionally there are 18 other states that have deemed SUD during pregnancy child abuse. These types of punitive public policy create an environment that diminishes open communication for fear of punishment (Acquavita et al, 2018). It also forces pregnant women to evade care and truthful conversations that could get them treatment early in pregnancy because they are afraid of actions against themselves or their babies. This fear further complicates the ability for women with this disease to get the help they need before there is an impact on their unborn child. An environment of blame and punishment also increases the bias and judgment from the healthcare workers that care for women with SUD in pregnancy.

There are many bias to patients with SUD in pregnancy, as well as misconceptions on addiction and recovery. Many of these biases become evident at the bedside of the Labor/Delivery (L/D) and Neonatal Intensive Care Unit (NICU) units as care is provided for pregnant women with SUD and infants with NAS. Patients with SUD in pregnancy have complex emotional and mental issues that have likely led them to substance use and abuse. NICU nurses, when surveyed, have reported ethical tension and frustration when caring for infants with NAS. Some nurses have described how internally they blame mothers for not stopping the use of marijuana, heroin, or other drugs as they care for infants suffering with NAS (Tobin, 2018). The question resonates from healthcare providers: Why couldn't you just quit?

The literature supports the need for better education for both moms/parents of NAS infants, but also for the NICU nurses that are caring for the infants. (Tobin, 2018). NICU nurses are trained to care for the most fragile and critically ill infants, but have very little training on addiction or mental health. They are then put into an environment with person bias, and lack of knowledge on the disease of SUD and expected to provide bias free, non-judgmental care. Moms with SUD disorder come with very complex mental and emotional issues, and have no training on medical interventions or how their infant with NAS will act and behave.

What we know now is that addiction is a disease that changes the function and even the structure of the brain and needs to be treated as a disease. The physiologic response to the surge of dopamine that is experienced with the initial exposure to the abused substance is recorded by the memory as pleasurable. Repetitive use of the substance is seeking to have the pleasure again, but overtime that euphoric feeling is not felt because the Dopamine is used up. This leads to more cravings, which eventually leads

to addiction. While nurses have extensive training in being caring and compassionate during times of medical crisis and complication, they have little to no training on mental health or SUD. Where is the balance in supporting and caring for patients with SUD while also advocating and supporting the infant that are impacted by the SUD.

This is where the NAS taskforce stepped in and helped staff hear details of the NICU experience told from the patient's perspective. Past patients came back and talk to the NAS task force, and staff about their experience as a mom with SUD and a baby suffering from NAS. This was enlightening to the NICU nurses to understand from the patient's own experience how their behavior, attitudes and judgements can impact others. The patient stories illustrated firsthand the things RN's can do to support moms seeking recovery, as well as the things RN's can do that will foster internal feelings to use due to stress and judgement.

From that knowledge the focus became how to include the patients in the care of their NAS infants in the NICU, without them feeling isolated or judged. The goal is to prepare this mom to care for her infant at home, as well as to ensure that there is a safe environment for the infant to go to. Part of this plan to be more patient focused was the development of a family partnership agreement that stated how important it was for parents to be present at the bedside of NAS infants in the NICU. The agreement also covers expectations from the caregiver and what the caregiver should expect from staff. Rooming in was also implemented, when possible, to further foster that mother-infant unit early; and allow mothers to bond with their infants. These interventions created more shared time between the mother with SUD and the NICU nurse. This increased interaction began to change the relationships between nurses and patients with SUD. Everything up to this point was the beginning of a much larger conversation on how to follow current recommendations that focus on getting mom to care early, increasing access to treatment, and recovery support and eliminating things that deter women from seeking care early (Acquavita et al, 2018). Human connection and relationships have shown to be powerful in the road to recovery. The Women and Children's department have focused on improving relationships with providers and patients with SUD. Continued efforts will focus on maintaining a culture free of bias and judgement, and fostering a culture that believes in hope and recovery. We have come a long way in improving outcomes of NAS infants and their families, and there are many more exciting things still to come.

Title:

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References:

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Abstract Summary:

In healthcare, nurses/caregivers have personal bias that can impact the care of patients. How do healthcare workers overcome their bias to provide the best possible care? The journey to improve outcomes for NAS infants has to include not only the treatment of the patient, but education that involves parents/caregiver.

Content Outline:

- Nursing perception video
- Moral failure vs Disease
 - Ethics Councils
- Criminalization vs support
- Substance Use Disorder
 - Brain changes
 - Medication Assisted Treatment
- Evidence based practice literature review
 - Caregiver Education
 - Family Partnership Agreement
 - Nursing Education
 - Creating learning opportunities
 - Patient Stories
 - Community speakers
 - Continuing education
 - Standardizing Non-pharmacologic treatment
 - Swaddle bathing
 - Primary Care Nursing
 - Rooming-In with caregivers
 - Hospital volunteers
- Creating a culture of recovery
 - Recovery language
 - Peer Coaching in the NICU

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Author Summary: Aubrey has 8 years of experience working in Level III Neonatal Intensive Care Units and is very passionate about neonates. She obtained her certification in High Risk Neonatal Intensive Care from the NCC in 2015. She is currently the Neonatal Intensive Care Unit Educator for Northeast Georgia Medical Center. Aubrey is pursuing a degree in Master of Science with a major in Nursing Education.