An enhanced dynamic and interactive mentored educational program to teach NIDCAP principles in the critical care setting

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Introduction: Clinical and basic science evidence support early intervention as being protective of the developing brain of hospitalized infants. This support can also be stabilizing and nurturing for families as they encounter the healthcare environment. The purpose of this project is to disseminate the most current developmental practices to rehabilitation professionals working in the critical care environment of infants. The project will address consistency of care and standardize the provision of assessment, treatment and support to infants and families.

Objective: Conference participants will learn an enhanced method to tailor NIDCAP instruction to individual healthcare professionals.

Approach: A structured training model (ADDIE) was used by a NIDCAP professional (KF) to guide and individualize learning in a mentored peer-to-peer training environment. Non-NIDCAP trained therapists (PT/OT/ST trainees) were given pre-mentoring, interim, and post-mentoring surveys to assess perceptions and gaps of knowledge in NIDCAP principles. Trainees (n=9) completed interim and post-mentoring surveys of the mentor based on the principles of reflective supervision. Survey results were used throughout the intervention period to improve implementation. Knowledge gaps were discussed with each trainee to facilitate an individualized approach to learning. The NIDCAP evaluation form was used to identify coping vs worrisome infant behaviors and how those behaviors would affect the trainee's interactions with the baby, family and staff. Once permission was obtained from staff to observe an episode of care, the mentor and trainee participated in a series of 3 bedside observational assessments led and facilitated by the mentor. Sessions included an interactive discussion between mentor and trainee regarding assessment of the physical environment while providing real-time descriptions of infant behaviors related to staff interactions and impact of the environment. At least one of the observation sessions occurred with the infant's family present. NIDCAP training materials were used to guide and structure the peer-to-peer discussion. Learners were guided in the use of a structured format (AMSAS – Autonomic/Motor/State/Attention/Self-regulation) to formulate a NIDCAP evaluation and goals.

Conclusions: Utilizing a structured training model that includes peer-to-peer interactions at the bedside with ongoing bi-directional mentor-trainee feedback has the potential to improve parent-infant development within a critical care setting by accelerating adoption of NIDCAP principles. This mentored instructional approach may also increase healthy working relationships and create new champions for family-centered developmental care.

References:

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