nidcap FEDERATION INTERNATIONAL
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Developmental
Observer

The Official Publication of the NIDCAP® Federation International

2025 | VOL 18 | NO. 1

> The path forward is rich with opportunities.
>
> *-Samantha Butler*

INSIDE

DOI:10.14434/DO.V18I1.40852

The Heidelise Als Lecture – 35th NIDCAP Trainers Meeting 2024

Shaped by Wisdom: Dr. Heidelise Als' Impact on My Professional Journey

Samantha Butler, PhD

DOI:10.14434/do.v18i1.40856

Dr. Heidelise Als was more than a mentor; she was a guiding force in shaping my career and fostering my personal growth. Her commitment to compassionate care continues to impact my approach to developmental care, along with engagement with life, family, and my professional career. Dr. Als shared her life experiences generously, weaving personal insights into her philosophy. Her support extended to fostering my professional growth and instilling faith in my potential, which remains a constant source of motivation. To me, she was family, always available with sage advice and encouragement.

I draw directly from the principles Dr. Als instilled in me. I strive to embody her philosophy that the care we provide effects outcomes and lifelong development. Her words, "It matters how we listen to the voice of and care for each newborn and each family. It matters how we care for one another and for ourselves," continue to inspire my approach. These words serve as a powerful reminder of the profound responsibility we hold as professionals in newborn care to deliver thoughtful, individualized attention during the earliest and most critical stages of a child's development.

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Dedication to Care

From the first moment I observed Dr. Als with an infant, I was struck by her profound compassion and keen insight into the experiences of newborns and their families. Her dedication to improving care for the most fragile patients deeply resonated with me. She demonstrated that even the smallest adjustments, rooted in respect and understanding, could create a transformation on the well-being of others.

Dr. Als' influence guides how I create environments that prioritize family-focused developmental practices. Dr. Als emphasized that every detail matters, not just in medicine but in every aspect of how we present ourselves. She reminded us that we are public figures and thus all interactions matter and deserve intention. Whether creating an environment to uplift others, preparing for an assessment, or organizing a meeting, attention to detail shapes how messages are received and how others feel within that space. She emphasized the power of projecting confidence, clarity, and empathy to rear connection and trust. This philosophy has extensively shaped my approach, driving me to approach interactions and decisions with thoughtfulness, ensuring that I reflect a sense of well-being, respect, and intentionality.

Philosophy and Mentorship

This deep commitment to care was also reflected in her approach to mentoring. Dr. Als embodied an extraordinary work ethic, dedicating countless hours to her mission and inspiring others with her drive and high expectations. Her approach to training was rigorous and comprehensive. Through the NIDCAP curriculum, she cultivated a philosophy of thoughtful engagement, observation, and practice, cultivating a community of clinicians dedicated to individualized developmental care. I feel a profound responsibility to honor and carry forward her vision. In my own NIDCAP training efforts, I strive to uphold her meaningful approach, providing structure and depth while also offering additional guidance to make the process accessible and encouraging for trainees. This sense of responsibility drives me to motivate others to see the insights she uncovered, publish meaningful research, and promote transformative care practices that improve outcomes for infants and families.

Dr. Als fostered a commitment to listening to, supporting, and inspiring others. Through her example, I advocate for the vital role we play in the lives of infants, their families, and others. I believe that as a professional in the field of neurodevelopment,

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Editorial

DOI:14434/do.v18i1.40855

A French Treat

This issue offers insights from the recent 35th NIDCAP Trainers Meeting, highlighting the exchange of knowledge that defines our global community. These meetings continue to grow in strength and scope, showcasing an outstanding diversity of information and experiences. The picturesque setting of Toulouse in the south of France provided a vibrant backdrop for the event, which also served as an invaluable opportunity for networking among delegates representing many countries.

In this issue, Samantha Butler shares the wisdom and legacy of Heidelise Als, taking us on her inspirational NIDCAP journey—a testament to vision and dedication. Deborah Buehler introduces us to an innovative perspective on the Synactive Theory, exploring its application across all areas of care.

The abstracts featured in this issue reflect the diversity and depth of the meeting. From groundbreaking research and new educational approaches to parent-led initiatives and strategies for expanding NIDCAP expertise. Additionally, we are delighted to include poster abstracts that highlight the incredible work of our NFI members.

For the first time, we have translated several articles from the original French, making their valuable content accessible to a broader audience. This new venture was made possible thanks to the generous assistance of Kiki Remont, and I extend my gratitude for her efforts. I would love to hear your thoughts on this new approach to fostering accessibility and understanding.

Thank you for your continued engagement and dedication to advancing the NIDCAP mission.

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Acknowledgments: External Reviewers 2024 – Samantha Butler, Marzieh Hasanpour, Kiki Remont.

Erratum: Vol 17, No 3, page 16. The image caption should read: Dr. Mohammad Heidarzadeh and Dr. Marzieh Hasanpour.

Cover image: Photograph used with permission of the mother in Shanghai

we hold a position of immense responsibility, to serve as the bridge between science, clinical care, compassion, and advocacy. Our role transcends the walls of hospitals and the pages of medical journals; we serve as the voices for those who cannot stand up for themselves. Advocacy in this context is not merely a choice, it is an ethical obligation. We are called to utilize our expertise, our voices, and our influence to ensure that our patients, their families, and our colleagues are recognized and prioritized. By doing so, we fulfill our moral duty to make a meaningful difference in the lives of those who rely on us most.

I see advocacy as a natural extension of compassion, whether we are caring for a newborn in the ICU, mentoring colleagues, or helping others navigate professional challenges. One of the most compelling reasons for our activism is the simple fact that hospitalized newborns cannot speak for themselves. Infants, particularly those undergoing surgical interventions, are in their most vulnerable state. When we advocate for newborns, we are addressing their immediate medical needs and nurturing the foundation of their future health and developmental outcomes. As is the motto of NIDCAP, we are the *voice of the newborn*, ensuring that every decision made respects individuality and promotes growth.

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Dr. Heidelise Als and Dr. Samantha Butler.

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Dr. Als created NIDCAP, which provided a way to observe and understand infant behavior, minimize stressful experiences, decrease the separation of infants from parents, and optimize development with consistent caregiving. The art of reading infant behavior, a skill Dr. Als pioneered and emphasized, provided an understanding of the infant's unique experiences and responses. By prioritizing observation, we collaborate with infants to enhance their development in a personalized way. I strive to motivate others in thoughtful interpretation of infant behavior, moving beyond surface-level solutions to connect with our patients, ensuring that every interaction is meaningful and tailored to a family's unique circumstances. This approach was especially crucial during my transition from newborn medicine to the world of cardiology, where infant behavior varies greatly, but the ability to read and respond to cues remains invaluable in providing effective care.

Dr. Als frequently reminded us of the meaningful influence of language in shaping perceptions and practices. She prioritized choosing words thoughtfully, because the language we use in policies, discussions, and everyday speaking reflects our values and priorities. This mindful use of language encourages us to affirm the roles of infants and families and avoid diminishing their significance. In my professional career, I am mindful of the power language holds and the impression it has on how we perceive relationships, responsibilities, and roles within the ICU. NIDCAP care involves creating a culture where the language used consistently respects and values families, team members, and the infants themselves, reinforcing a collaborative and compassionate approach to care.

Dr. Als' teachings went beyond advocating for infants and families and extended to highlighting the importance of nourishing all members of the team. This includes acknowledging the perspectives of professionals whose contributions are often overlooked. Therapists, environmental services staff, and other essential contributors are vital to creating a cohesive, nurturing environment. Their expertise elevates the care we provide and enriches discussions around standards of practice. I actively incorporate diverse perspectives, seeking out a multidisciplinary team that includes family members, various disciplines, and inpatient staff. I take great pride in our collaborative team, where we learn from and promote one another, cultivating an atmosphere of mutual respect and shared purpose.

Inspiration for Growth

Dr. Als was a positive energy in the field of newborn medicine. She supported engaging with the infant rather than simply offering treatment, at a time when the medical world often overlooked the individuality and humanity of newborns and failed to fully acknowledge the challenging path faced by the parents of an ill child. She moved us to strive for more. Her perseverance acknowledged that rousing change can be challenging. Her example continuously drives my commitment to carry forward her vision, ensuring that thoughtful, individualized care remains a priority, even when faced with barriers. Her work moves me to continue my efforts, knowing that this approach holds transformative potential.

"She supported engaging with the infant rather than simply offering treatment, at a time when the medical world often overlooked the individuality and humanity of newborns and failed to fully acknowledge the challenging path faced by the parents of an ill child."

She instilled the importance of continuous learning, reminding us that knowledge is ever evolving. Her dedication to education stimulates me to seek growth through research, collaboration, and reflection. This commitment ensures that care practices advance alongside new discoveries, improving how we care for newborns and their families.

Dr. Als placed great importance on reflective processing, urging us to thoughtfully consider every interaction. This approach shaped my connection between theory and practice to make intentional decisions. It also fostered a deeper understanding of how each moment fosters the emotional development of both the infant and their family, along with the professional course of myself and others.

Gratitude and Aspiration

Reflecting on my journey, I feel immense gratitude for Dr. Heidelise Als. Her guidance provided inspiration, motivation, and unwavering support. She demonstrated that true leadership is about accompanying others and her belief in me served as a guiding light in both my professional and personal life. By promoting collaboration, amplifying the perspectives of often overlooked professionals, emphasizing the importance of reading and responding to infant behaviors, focusing on the significance of every detail, and committing to lifelong learning, I strive to fulfill and advance Dr. Als' vision of thoughtful, intentional, and individualized care.

Carrying the Vision Forward: Inspiring the Future of Developmental Care

Together with the NIDCAP family and the NIDCAP Federation International, I am dedicated to ensuring that her profound impact on newborn care and developmental practices flourishes. Her legacy lives on in the countless lives she touched, reminding me daily of the difference one person can make in the world and that we can all do more.

The path forward is rich with opportunities to expand the transformative principles of NIDCAP. Future research must continue to evaluate the impact of NIDCAP on outcomes for infants and families, as well as quality improvement initiatives and feasibility studies in diverse healthcare settings. Disseminating knowledge through impactful publications and engaging presentations will ensure that these principles reach a wider audience, inspiring others to adopt and innovate upon Dr. Als' approach. Additionally, increasing accessibility to NIDCAP training is crucial. Efforts to create online resources, mentorship programs, and multidisciplinary collaborations can foster a global community of practitioners who are passionate about developmental care. By embracing continuous learning and reflection, and by championing advocacy and education, we can honor Dr. Als' legacy and inspire the next generation of caregivers to amplify her vision. Together, we can ensure that her teachings continue to transform lives, reminding all of us of the extraordinary power of compassion, intentionality, and individualized care.

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The Synactive Model: Individuals, Hospitals, and Systems

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DOI: 10.14434/do.v18i1.40899

Dr. Heidelise Als wrote …*intuitive parenting must become conscious parenting when the child's individuality portrays behaviors other than that which human expectation has prepared us for, in the thousands of years of evolution, to be good enough parents.*[1] Dr. Als understood that the greater an individual's medical, physical, cognitive, and/or social/emotional challenges, the less likely that person can accommodate to their social or physical environment. These challenges may elevate the risk of adverse health outcomes and developmental issues, highlighting the critical importance of providing tailored care that supports both the individual and their family. This understanding informs the design and implementation of personalized care for premature and at-risk infants and their families. Supportive care during hospitalization, as well as after discharge to home and community settings, promotes optimal well-being and positive outcomes.

Synactive Model of Behavioral Organization – Its Origins

In her work, Dr. Als drew from her personal parenting experiences as well as her clinical study of mother/infant relationships, including the study of infants with irritability and hypersensitivity. She saw the strength and importance of infant/mother connections from the very beginning of their relationships. This awareness became even clearer through her early graduate school training, her mentorship and collaboration with T. Berry Brazelton, MD, Director of the Child Development Unit at Children's Hospital, as well as her use, training in, and adaptation of the Brazelton Newborn Behavioral Assessment Scale. This is the foundation of the Synactive Model of Behavioral Organization and corresponding neurobehavioral observation and assessment tools, a caregiving intervention approach, and a training program.

Als and her Child Development Unit colleagues, Drs. Brazelton, Tronick and Lester, wrote the seminal paper "Toward a research instrument for the assessment of preterm infants' behavior" describing the *Synactive Model of Behavioral Organization*.[2] This developmental framework describes how humans' continuous, dynamic interactions with their environments influence their behavior and development. The term "Synactive" is from Greek and Latin origins meaning Together ("Syn"/Greek) and Action ("Active"/Latin). The "Together in Action" model was based on four principles of development: (1) Phylogenetic and Ontogenetic Adaptedness (species adapt to their environments and are influenced by their environments allowing for adaptation); (2) Continuous Organism-Environment Transaction (organisms continuously interact with their surroundings, adjusting behaviors based on feedback received); (3) Orthogenetic and Syncretic (organism's progressively develop as different abilities are integrated); and (4) Dual Antagonist Integration (a tension exists between environmental protection and exploration). Synthesizing these principles led to the theory that infants *actively* construct their own development within their physical and social environments and with the events that they experience. The Newborn Individualized Developmental Care and Assessment Program (NIDCAP)[3] was designed to identify these adaptation strategies and as an earliest intervention approach for preterm and at-risk infants. The NIDCAP approach combines includes an infant observation instrument, a caregiving intervention model, and a training program.

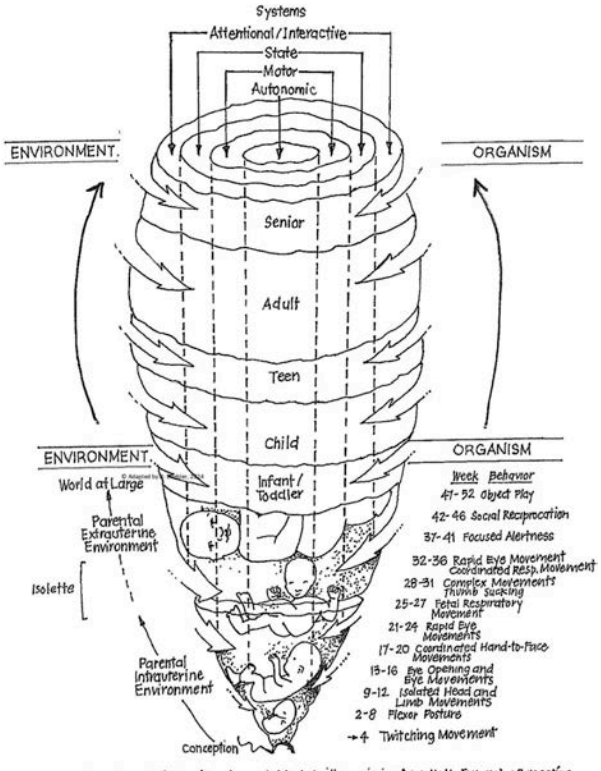
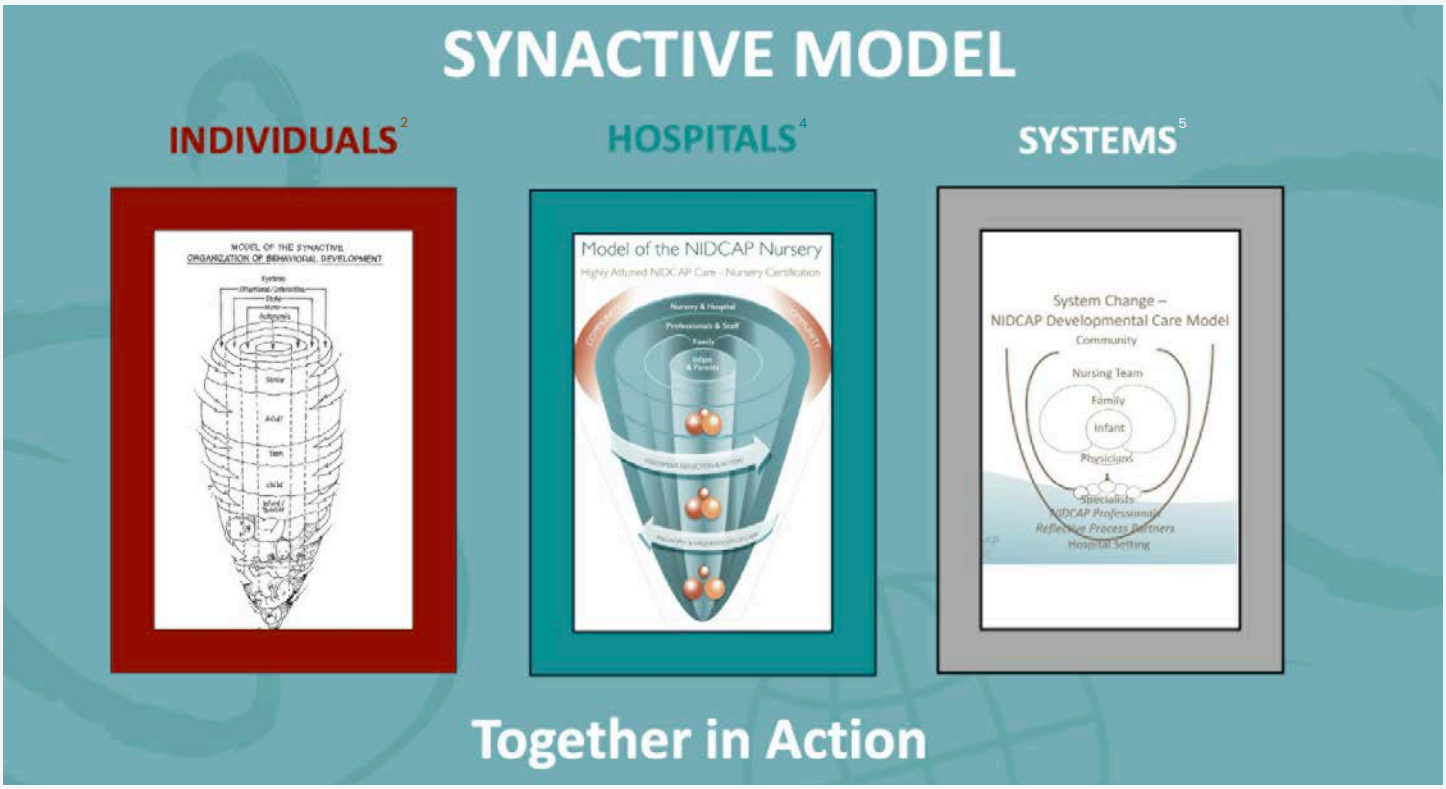


Fig.1. Model of the Synactive Theory of Development. Adapted with permission from Als H. Toward a Synactive Theory of development: promise for the assessment of infant individuality. Int Mental Health J 5 (1982), 229-243.

Adapted by Buehler, D. (2024).



Synactive Model of Organisms: Individuals, Hospitals, and Systems

In its broadest sense, the Synactive Model is applicable at many levels: the individual, the hospital (made of individuals, including premature and medically-at-risk infants), and the larger hospital and community system.

Individuals

Continuous dynamic interactions occur between individuals' various layered subsystems of functioning (autonomic, motor, state, and attentional/interactive) and with their physical and social environments. This is a lifespan process occurring as individuals learn and evolve. Early development sets the foundation for later development. Initially, development occurs within the womb, with its protections and entrainments, and later within the extrauterine environment. For infants born prematurely, this includes the intensive care setting, with all the demands and challenges this environment presents at this critical time. These factors influence their unfolding development. Premature and at-risk infants are actively shaping and being shaped by their environments. Appreciating that growth and change occur within the context of interactions with the environment, offers the opportunity to understand the influences on, and implications for, stability, health and development.

Development implies both growth and change, unfolding initially through the disruption of previously established ways of functioning. New accomplishments become integrated by systems, realigning and supporting one another in new, adaptive ways. Yet, for this realignment to occur, subsystem instability, disorganization, and de-synchrony may be experienced. Lack of stability in one or more subsystems may lead to disorganization to the other systems with consequences for the infants' efforts. The physical and social environment may thwart the subsystems' efforts to re-balance, and/or it may provide positive steadiness and support for this re-alignment. These efforts enhance the developmental strivings toward the next steps. As an example, an infant lying on a flat mattress may become flaccid with arms and legs extended, show breathing pauses, compromised color and unsettled sleep. When this infant is gently positioned into side lying with the face protected from lights and calm, steady hand swaddling containments for shoulders, arms and head, the infant may begin to show relaxation. Tone returns with tucked, flexed postures, hands rest by the mouth, breathing and color is regular and steady, and sleep becomes restful. Infants continuously adjust their behaviors based on the feedback received from their surroundings. Social and physical environmental support during periods of disorganization lead to subsystem rebalancing and steadiness. These adaptations provide positive behavioral support for the infants' emerging developmental agenda.

The Synactive Model of Behavioral Organization can be envisioned as a model of the developmental progression of individual human beings throughout their life span. Each person experiences continuous, dynamic interactions with their physical and social environments which may support their strivings or may hamper their efforts both influencing experience and perhaps outcomes.

The Synactive Model may be applied to NIDCAP's professionals and supporters. Every NIDCAP champion is a catalyst

for positive change for infants, families, healthcare professionals, hospitals, and systems. Inspiring, promoting, and guiding NIDCAP care are layers of the Synactive system's model. Individuals who serve as NIDCAP mentors and supporters evolve and change as do the systems of which they are members. It is critical to seek out education, mentorship, and emotional support to ensure continuous, dynamic environmental interactions and to positively influence behavior, well-being, development, and effectiveness in others.

Hospitals/Institutions

The Synactive Model can be extended beyond the individual to institutions such as hospitals which are created and maintained to serve many individuals. Each individual experiences their own autonomic, motor, state and attentional subsystem/environment interactions. In newborn and pediatric intensive and special care settings, infants, families, healthcare professionals, and the physical environment interact with one another. These interactions may be experienced as stabilizing and growth-promoting, or destabilizing, challenging and even, perhaps, detrimental. In the case of positive interaction among members of the system with common goals, the result may be a calmer more relaxed hospital unit; consistently steadier, healthier infants, ever more confident parents and families; and effective and satisfied healthcare professionals. Conversely, difficult experiences from members of the hospital system, and/or the environment itself, may negatively impact the others. The results may be infants with breathing irregularities, difficulty feeding and growing, parents who are exhausted, worried, and sad, healthcare team members who feel challenged by high acuity and limited staffing, and a unit that is bright, loud and chaotic. Any of these difficulties may lead to disruptions for the others. Incorporating steady nurturance by families and knowledgeable healthcare professionals, within a supportive physical and social environment, provides for smooth moment to moment interactions and care. The ripple effects of positive experiences and interactions create synchrony and balance in the system which optimally change experiences and outcomes. The model and resources of the NIDCAP Nursery Program[5] (add citation) describe this process of applying the Synactive Model to support optimal development and well-being.

Systems

The Synactive Model may also be considered for the larger communities that hospitals serve and where individuals live. Each of the layers: infants, families, hospital systems and entire communities are constantly evolving. They are interrelated and continually influence each other. The Synactive Model, in conjunction with the NIDCAP care it defines, has the extraordinary potential to change the course of lives and systems. NIDCAP has the potential to be adapted to other populations in healthcare, especially ones with patients and their families whose voices are not easily heard or needs understood (such as geriatric populations). Moment-to-moment positive experiences support stability, developmental strivings, and ultimately optimal health and well-being for individuals, systems, and communities. These experiences can impact generations to come.

The Synactive Model informs us that individuals (and the systems they are part of) are always changing. Als wrote *… each child actively shapes the adults and the environment around him or her, and that the adult, who becomes aware and has the emotional where-with-all to open earlier well-practiced ways, and see the child, becomes better for it.*[1] Each new layer of being and of functioning, whether it is a person or a system, is built on the one before. Cognitive flexibility is required to assess challenging situations and modify practices and policies to support change accordingly. Every interaction and decision require the strength, capacity and confidence to be reflective about seeing, being shaped by, and shaping interactions and environments to help to bring out the best in others. When this happens, infants and families, and those who care for them, have the best chance for optimal functioning and well-being.

References:

1. Als, H. (2007). Preparing to See and Seeing. Developmental Observer, 1(2), 3-4, p.3.
2. Als H, Lester BM, Tronick E, Brazelton TB: Toward a research instrument for the assessment of preterm infants' behavior (APIB). In Fitzgerald HE, Lester BM, Yogman MW (eds.), *Theory and Research in Behavioral Pediatrics, Vol. 1*. New York: Plenum, 35-63, 1982.
3. Als H (1999). Reading the premature infant. In Goldson E (ed.) Nurturing the Premature Infant: Developmental Interventions in the Neonatal Intensive Care Nursery. New York: Oxford University Press. 18-85.
4. Buehler, D., Kosta, S, Als, H. (March 2018). NIDCAP Federation International.
5. Vittner D, Butler S, Lawhon G, Buehler D. The newborn individualised developmental care and assessment program: A model of care for infants and families in hospital settings. *Acta Paediatr*. 2024 May 30. doi: 10.1111/apa.17300..

nidcap® FEDERATION INTERNATIONAL voice of the newborn

Mission

The NFI improves the future of all infants in hospitals and their families with individualized, developmental, family-centered, research-based NIDCAP care.

Adopted by the NFI Board, June 29, 2022

Vision

The NFI envisions a global society in which all hospitalized newborns and their families receive care in the evidence-based NIDCAP model. NIDCAP supports development, enhances strengths and minimizes stress for infants, family and staff who care for them. It is individualized and uses a relationship-based, family-integrated approach that yields measurable outcomes.

Adopted by the NFI Board, October 20, 2017

From Teaching to Coaching. Enhancing Communication with Parents in the Neonatal Unit Using Coaching Skills

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DOI:10.14434/do.v18i1.40857

Introduction

With the implementation of infant and family centred developmental care, healthcare professionals are called upon to support parents in becoming confident caregivers of their children in the neonatal units and upon discharge. Traditional teaching methods, even when gentle and respectful, often focus on instruction and hierarchy. Transitioning to a coaching approach, which has its foundation in active listening and person-centred theory can more effectively build parents' confidence and autonomy, leading to a stronger partnership between healthcare professionals and parents. Parents, with the healthcare professional's facilitation, will be able to find their own way of parenting and caring for their children rather than fitting in with professional expectations. This approach aligns with up-to-date research showing that communication with parents can have an impact on their wellbeing.

Aims

Develop a foundational educational programme to train healthcare professionals in fundamental coaching skills to:

- Communicate effectively with parents ensuring parents feel heard and treated with empathy.
- Promote a team-oriented dynamic between parents and healthcare professionals, fostering a strong partnership.
- Provide practical tools for navigating challenging situations, boosting healthcare professionals' confidence.

Method

The coaching education programme is built around three key coaching skills: active listening, open questioning, and how to share skills and knowledge with a coaching mindset.

A pilot programme was delivered in a three-hour session as part of a NIDCAP/FINE Masterclass delivered online on the 5th of July 2024. It was highly interactive to give participants the opportunity to practise the skills in a safe space. We explored the idea of shifting from teaching to coaching through discussion around two specific scenarios and identified three key coaching skills to practice. For each skill we discussed the concept, engaged in practical application, and concluded with a group discussion. Feedback collection from participants in the pilot is in progress. We sent a survey following the event to identify relevance and areas of improvement. This feedback will be used to shape the programme for a wider audience of healthcare professionals as part of a foundational Infant Family Centred Developmental Care (IFCDC) education curriculum appropriate for NIDCAP. The programme is collaboratively designed by healthcare professionals and parents and delivered by a certified coach with lived experience in NICU, actively volunteering in a level 3 hospital and working with healthcare professionals. A second parent with NICU experience will also contribute, ensuring diverse perspectives.

Results

Fifteen participants (parents, nurses, occupational therapists, physiotherapists, and researchers) all with experience of foundational education for IFCDC attended the pilot. This online Masterclass was highly interactive, and all participants were engaged and contributed greatly throughout the session. Preliminary feedback from the participants at the end of the session showed a high interest in the topic and a palpable need for training in coaching skills to enhance communication between healthcare professionals and parents. Participants supported moving to the next phase of the "From Teaching to Coaching" project.

Input from attendees at the pilot will help design questions to evaluate outcomes once the final format is in its trial phase.

Conclusion

This approach highlights the potential benefits of promoting coaching skills for parents and healthcare professionals in the neonatal unit by improving communication and fostering a stronger partnership. This is crucial for parents' and healthcare professionals' wellbeing and should enhance parents' confidence in caring for and bonding with their children, ultimately resulting in better outcomes for pre-term children and families.

Relevance to NIDCAP

Coaching skills could be part of the NIDCAP training skillset.

Using Social Network Analysis to Understand the Effect of Developmental Care Education

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DOI:10.14434/do.v18i1.40862

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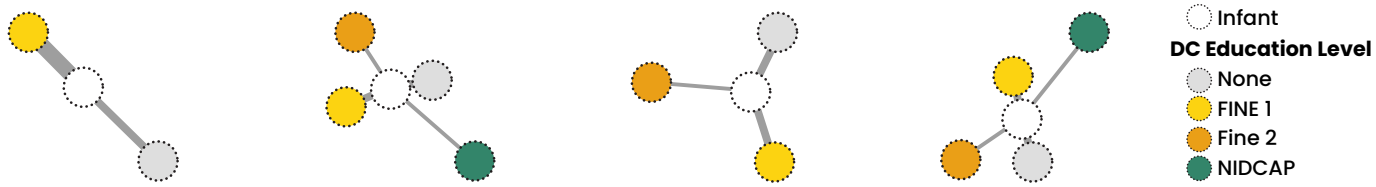

Figure 1: Examples of Social Network Analysis Density of education network for infants during their sNICU admission

Background

Developmental care (DC) is an important moderator against stressors in the newborn intensive care unit (NICU) for infants and their families. However, the impact of varying levels of developmental care education on infants and parents' experiences and outcomes remains unclear. Social network Analysis (SNA) is a methodology that provides researchers with valuable information to improve our understanding of complex relationships and offers better insights into where and how to intervene to improve outcomes.[1] We utilised this approach to evaluate the impact of the levels of developmental care education of neonatal nurses in the surgical NICU (sNICU).

Aim

To explore:

a) If exposure to nurses with differing levels of developmental care education influences parent perceptions of nurse support in the sNICU.

b) If caregiving by NICU nurses with differing levels of developmental care education influences infant behavioural and physiological responses.

c) What infant and nurse components in the sNICU influence nurse delivered caregiving.

Methods

A prospective observational cohort study explored associations between parents' perception of nurse support, nurses' perception of infant behaviour, and infants' responses during nurse-delivered caregiving (physiological and behavioural) with nurse DC education levels. Additional variables included in the analysis were caregiving duration, infant surgery type (group), infant severity of illness variables, and gestational age. Data were analysed through a multistep process of logistic regression and exploratory network analysis.

Results

Forty-five infants, parents and nurses participated in the study. Exposure to care by nurses with no DC education (n=22) increased infant heart rate during caregiving (OR: 5.09, 95% CI: -3.36, 13.56 p=0.67), increased the duration of caregiving minutes (p<0.001), and decreased parents' perception of emotional support (OR: -0.12, 95% CI: -0.23, -0.01, p=0.043). Increased infant severity of illness scoring (n-TISS) (OR 1.01, 95% CI:1.01, 1.04, p=0.040) and narcotic infusion was associated with non-significant longer duration of caregiving. Infants with congenital cardiac disease (CHD) received significantly shorter caregiving duration (OR: 0.58, 95% CI: 0.37, 0.01, p=0.002). Longer caregiving duration was associated with a higher behavioural stress score (OR: 2.10, 95% CI: 1.59, 2.59, p=<0.001).

We observed that the proportion of care provided by DC-educated nurses (density of DC education network) correlated with infant surgery group (Figure 1). Specifically, infants needing surgery for CHD received care from a greater number of DC educated nurses. (OR: 0.10, 95% CI: 0.49, 0.80, p=0.038). The density of the nurse network (proportion of repeat nurse assignments) was associated with gestational age and surgery group. Both preterm infants (OR: 0.13, 95% CI: 0.25, 0.71, p=0.06) and infants needing surgery for respiratory/oesophageal anomalies (OR: 0.11, 95% CI: 0.35, 0.61, p=0.021) received a higher proportion of repeat nurse assignments.

Conclusion

Using a novel analysis methodology, we have demonstrated a relationship between nurse DC education levels, nurse caregiving practices, infant physiological responses, and parent perceptions of caregiving in the sNICU. We identified several clinical care factors that influence the duration of caregiving, as well as infant characteristics that affect caregiving allocation. Providing neonatal nurses with DC education will help to ensure DC is embedded into everyday clinical care, supporting parent and infant outcomes within and beyond the hospital admission.

Relevance to NIDCAP

This research offers NIDCAP Trainers, NIDCAP Certified Professionals, and neonatal clinician's valuable insights into the complex relationships, social processes, and social structures that interact in the sNICU, and influence nurse delivered care.[1] It underscores the significance of developmental care education in highly technical settings.

Reference:

1. Parnell JM, Robinson JC. Social network analysis: Presenting an underused method for nursing research. Journal of Advanced Nursing. 2018;74(6):1310-8. https://doi.org/10.1111/jan.13541

The Transformative Power of Video Interaction Guidance in Alleviating the Disenfranchised Grief of Preterm Infants' Mothers

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Aims

Birth of a preterm infant is an unfortunate event and a critical situation for the family, which causes disenfranchised grief experiences in parents. Acute grief reactions occur when the parents realize that the newborn infant is not their ideal or fantasy child. Attention to this type of grief in parents and supporting them to interact with their infants is particularly important, specifically in mothers. Therefore, this study aimed to investigate the effect of applying video interaction guidance on disenfranchised grief severity in mothers with preterm newborn infants.

Method

The study used a quantitative interventional approach with a semi-experimental method. The sample consisted of seventy-two mothers with preterm infants in the newborn intensive care unit, with thirty-six mothers in both the control and intervention groups. Participants were selected using the convenience sampling method and allocated to the groups using block randomization. The intervention group underwent a video interaction guide intervention along with routine care for one week. The researcher recorded 5 to 10 minutes of natural mother-child interaction on the first, third, and fifth days of the intervention. Then, on the second, fourth, and sixth days, the researcher edited the videos to highlight the best moments, or "golden moments," of the mother-child interaction. On the third, fifth, and seventh days, the selected golden moments were shown to the mothers, who received positive feedback about their reactions and emotions. Meanwhile, mothers in the control group only received routine care. Both groups completed questionnaires for demographic information and prematurity grief before the intervention, immediately after, and one week later. The collected data was analyzed using SPSS version 25 and descriptive and inferential statistics such as the T-test, Chi-square, Fisher, Mann-Whitney, and Repeated Measures ANOVA.

Results/Findings

This study revealed that before the intervention, two control and intervention groups were homogenous regarding demographic characteristics and grief severity scores. The result of the paired t-test showed that the grief score in the intervention group decreased profoundly immediately and one week after the intervention. Furthermore, the independent t-test revealed that this difference between the two groups was statistically significant (P-value<0.001). Also, in the intervention group, there was a statistically significant difference between the three measures of grief severity using repeated measures ANOVA (P-value<0.001).

Conclusion

The findings of the current research highlight the significant impact of utilizing video interaction guidance in alleviating the

disenfranchised grief experienced by mothers of preterm infants. It underscores the crucial role of nurturing relationships between mothers and their infants for the Newborn Individualized Developmental Care and Assessment Program (NIDCAP) and infant- and family-centered developmental care. As a result, researchers recommended that healthcare providers in neonatal intensive care units consider incorporating video interaction guidance as an effective method to support mothers of preterm infants, leading to decreased feelings of grief and fostering secure interaction and attachment between mother and infant. This enhanced, secure attachment and increased emotional bonding can contribute to healthy infant brain development, reduced parental stress, and healthy family development.

Relevance to NIDCAP

Infant- and family-centered developmental care is a fundamental principle of the NIDCAP Care Model. In the NIDCAP Model, mothers play a crucial role in developing the attention-interaction system and fostering healthy infant brain development. It is important to recognize that mothers of preterm infants, while caring for their live infants, require substantial emotional and empathetic support as they grieve for the loss of their ideal and imagined child. Encouraging staff to utilize video interaction guidance in the NICU can significantly reduce the severity of mothers' grief and enhance mother-infant attachment.

Application of Observation Based Promotion of Oral Feeding Program in Very Low Birth Weight Infants: A Pilot Study

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DOI:10.14434/do.v18i1.40881

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Aims

To explore the effect of an observation-based promotion of an oral feeding program (OBPOF) on shortening the time to achieve full oral feeding for very low birth weight infants (VLBWI). OBPOF refers to the evaluation of an infant's capacity to adapt to feeding using a dropper. Upon successful adaptation, the subsequent step involves transitioning to feeding with a rubber nipple, during which the infant's adaptability should be closely observed before advancing to bottle feeding. Once the infant has successfully adapted, the final transition will occur towards breastfeeding.

Method

A prospective historical before and after control study design was used. Sixty-three very low birth weight infants (VLBWI) were included from the tertiary newborn intensive care unit (NICU) of Children's Hospital of Fudan University at Hainan from April 1, 2020, to November 30, 2021. The first stage (April 1, 2020, to November 30, 2020) was defined as the baseline stage (control group), followed by a four-month washout period (nurse training), and the second stage (April 1, 2021, to November 30, 2021) was defined as the intervention stage (experimental group). The OBPOF was applied in the experimental group (n = 29), and the traditional feeding program was used in the control group (n=34). The postmenstrual age (PMA) at the time of attaining full oral feeding was compared.

Results

During the implementation of OBPOF in the intervention group, the proportion of colostrum oral care increased significantly (100.0% vs 5.9%, $P < 0.001$), the proportion of routine use of pacifier before feeding increased significantly (100.0% vs 0%, $P < 0.001$), the proportion of oral stimulation increased significantly (100% vs 29.4%, $P < 0.001$), and the observation time before and after feeding also increased (8.6 ± 4.7 vs 0, $P < 0.001$). The PMA of achieving full oral feeding was designed as the primary outcome, which decreased from 36.1 ($\pm$ 1.0) w in experimental group to 35.0 ($\pm$ 0.7) w in the control group, $P < 0.001$. PMA of achieving full oral feeding was shortened by one week in the experimental group. Other indicators were not statistically significant.

Conclusion

The observation-based promotion of oral feeding program can shorten the time for VLBW infants to reach full oral feeding. It is recommended that nurses should use the observation based promotion of oral feeding program in VLBWs in NICUs.

Relevance to NIDCAP

Individualized observations are the main element of the NIDCAP program, and are performed before, during and after the activities of feeding. Professor Heidelise Als trained us how to do observations during caregiving. We combined these individualized observations in the promotion of oral feeding program and found that the very low birth weight infants achieved full oral feeding sooner, which promoted nursing care in our NICU.

The Impact of a Developmental Care Skin-To-Skin Quality Improvement Project as Part of our Process of Becoming A NIDCAP Certified Training Center

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DOI:10/14434/do.v18i1.40883

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Introduction

Trauma-informed developmental care (TIDC) is essential to premature infants and their families hospitalized in the newborn intensive care unit (NICU). The core measures in TIDC include five standards of care with skin-to-skin care (SSC) being central to their application.[1] SSC has multiple benefits for the infant and its family[2] but it also creates a sense of safety and security to foster the development of trust and attachment, all in alignment with TIDC principles.[1] This is why the World Health Organisation (WHO) now recommends the practice of a minimum of 8-12H of SSC per day in the NICU.[3] SSC is also considered to be the utmost co-regulation strategy to decrease stress and trauma as recommended by the Newborn Individualized Developmental Care Assessment Program (NIDCAP).[4-5] NIDCAP aims to prevent complications in NICU and to maintain the intimate connection between parent and infant through collaborative observations of behavioural cues, individualized care plans and follow-up by NIDCAP Professionals.[5]

Aims/Purpose

Our NICU is a 26 bed, open bay, level III unit in Montreal, within the French-speaking province of Quebec, located in a socio-economically challenged area of Montreal. About 50% of the patients are out born, sometimes from cities hundreds of miles away from Montreal, which limits parental presence. In the process of becoming a NIDCAP Training Center Unit and to foster parental presence and participation in care, we aimed to improve SSC session duration and frequency, as primary objectives for this project. However, as the training of our NIDCAP Professionals advanced, a secondary objective imposed itself. The goal was to determine the effect of being followed by a NIDCAP Professional in the context of the Advanced Practicum of NIDCAP Training and subsequent follow-up after their certification, on the duration of SSC.

Over the last three years, we developed a new SSC multi-disciplinary protocol, a SSC online training module, and SSC coaching sessions at the bedside for both parents and professionals. In addition, different tools to promote comfort and safety during SSC were purchased, such as zero gravity chairs, SSC wraps, as well as the use of leaflets and videos as parent resources.

Methods

To monitor the progress, we documented parental presence, duration and frequency of SSC sessions, transfer techniques and positioning during SSC with bi-annual audits. Those audits were developed and validated by a team of clinicians as part of our provincial community of neonatal nursing practice (CVP-Neon@t) and are used in many NICUs in Quebec. The audits are always attended over a three-day period that includes both week and weekend days.

Results/Findings

Over the span of three years, which included the COVID pandemic, our primary objectives were met. The duration of SSC sessions doubled, increasing gradually and continuously from an average of 89 to 164 minutes (P=0.025). The frequency of SSC sessions tripled by our second audit, from 29% to 100% (P=0.025) and was steadily maintained in the following audits. This meant that every time a parent was present, and the infant was eligible for SSC, SSC occurred.

This average duration of SSC increased to 258 minutes (P=0.025) when the infant was followed by a NIDCAP Professional within an advanced practicum. Some NIDCAP infants and their parents were having an average of 10 hours per day of SSC sessions.

Conclusion

Our small sample (N=87, average=15 patients/audit & NIDCAP N=7, average - 3.5 patients/audit) and non-statistically significant results are explained by the size of the NICU and we recently followed patients for the NIDCAP advanced practicum for a few months. Despite this small sample, we were able to demonstrate that this project not only improved SSC duration and frequency in our NICU but also that NIDCAP Professional follow-up almost doubled the duration of SSC sessions.

Relevance to NIDCAP

These findings are relevant to NIDCAP, as they support previous similar findings in France.[6] Since parent-infant attachment is at the heart of NIDCAP, the importance of SSC as an essential strategy to foster behavioral cue understanding, co-regulation, and the principle of zero-separation cannot be understated. This study demonstrates that we can maximize this strategy with NIDCAP advanced practicum follow-up.

References:

1. Coughlin M, DeWolfe T, Fuller K. Quality indicators for developmental care: a trauma informed conceptual model as an exemplar for change. In: Kenner C, McGrath J, editors. Developmental care of newborn and infants: A guide for health care professionals NANN - National Association of Neonatal Nurses. 3rd ed: Wolters Kluwer; p. 65-84.2003, ISBN/ISSN:9781975148393
2. Conde-Agudelo A, Diaz-Rossello JL. Kangaroo mother care to reduce morbidity and mortality in low birthweight infants. Cochrane Database Syst Rev. 2016, (8):CD002771. doi: 10.1002/14651858.CD002771.pub4.
3. Darmstadt GL, Kirkwood B, Gupta S, Darmstadt GL, Kirkwood B, Gupta S, et al. WHO Global Position Paper and Implementation Strategy on kangaroo mother care call for fundamental reorganisation of maternal infant care. *The Lancet.* 2023, 401(10390):1751-3. doi: 10.1016/S0140-6736(23)01000-0
4. Pierrat V, Mitha A. Contact peau-à-peau pour le nouveau-né prématuré ou de petit poids de naissance. In: Sizun J, Guillois B, Tscherning C, Kuhn P, Thiriez G, editors. Soisn de développement en période néonatale De la recherche à la pratique. Chapitre 13. 2e *Ed. ed: Lavoisier Médecine Sciences*; 2022, p. 90-6. ISBN : 978-2-257-20768-5
5. Als H. Theoretical persepective for developmentally supportive care. In: Kenner C, McGrath J, editors. Developmental care of newborn and infants: A guide for health care professionals NANN - National Association of Neonatal Nurses. 3rd ed: Wolters Kluwer; 2022, p. 35-64. ISBN/ISSN: 9781975148393
6. Pierrat V, Coquelin A, Cuttini M, Khoshnood B, Glorieux I, Claris O, et al. (2016). Translating Neurodevelopmental Care Policies Into Practice: The Experience of Neonatal ICUs in France-The EPIPAGE-2 Cohort Study. *Pediatr Crit Care Med.* 17(10):957-67. doi: 10.1097/PCC.0000000000000914

"This is the best ward round I have ever been a part of": Implementing Developmental Care Ward Rounds in a Tertiary Neonatal Unit in the UK.

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DOI:10.14434/do.v18i1.40885

Aims

The neonatal unit at University College London Hospital is the only NIDCAP Training Centre in the United Kingdom. We are committed to improving the collaboration between healthcare professionals and families. In 2023, we identified an opportunity for our multi-disciplinary team to work together to enhance this relationship by launching developmental care ward rounds.

Our quality improvement project (QIP) had three main aims:

1. Support parents as key nurturers
2. Provide individualised care plans for infants and their families
3. Ensure that staff feel valued as part of a wider interdisciplinary team

Methods

Key members of the neonatal team were identified as stakeholders for this project. These included an occupational therapist (NIDCAP trained), physiotherapist, speech and language therapist, psychotherapist, neonatal nurse and neonatal consultant with an interest in developmental care. The Plan-Do-Study-Act (PDSA) model was used in project planning and execution. A questionnaire was sent to parents asking them for their views and recommendations. Families were keen to participate and expressed a desire for an opportunity to share what they knew about their baby and to learn more about the different stages of their infant's development. Regular meetings were held to design a poster, parent leaflet and a bedside record sheet which includes an individualised care plan for the infant and family supported by the wider interdisciplinary team. The project was registered as a QIP within maternity services. To ensure a clear and efficient referral and selection process, a standard operating procedure (SOP) was developed and distributed to all staff. Additionally, regular bedside education and engagement sessions were held with all members of the neonatal team.

Results/ Findings

Our developmental care ward rounds were launched in August 2023 and have been running regularly for the past ten months. Two to three families are referred by staff and approached every alternate week. They are invited to participate and are supplied with information about what to expect during the ward round. This gives them time to prepare questions addressed to the interdisciplinary team. Around 40 families have been seen so far. Verbal feedback from families and staff involved has been very positive with some stating that it has been the best meeting they have ever had with professionals since they started their journey with us on the neonatal unit. A formal post-implementation questionnaire is currently being distributed to families and staff involved as part of a research project run by our chief research nurse intern.

Conclusion/Relevance to NIDCAP

Our developmental care ward rounds focus on providing individualised care to the infants and families on our neonatal unit. They offer parents the opportunity to demonstrate and enhance their role as lifelong nurturers as they lead on discussions and care plans for their baby. It has also helped NIDCAP Professionals identify which babies would benefit from a detailed observation. Each bedside record sheet emphasises the infant's unique behavioural communication and contains information on how to adapt their caregiving environment to make it more suitable to their needs. Moreover, this open communication helps build trusting relationships between health professionals and families. Staff involved have commented that it has helped advance their professional and personal growth and increased their job satisfaction. Our commitment to improve ensures that we continue to make a positive impact on families.

Developmental Observer

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ISSN: 2689-2650 (online)

All published items have a unique document identifier (DOI)

Education Sessions Improve Knowledge and Attitudes of Parents in a Newborn Intensive Care Unit within a Low-Income Country

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DOI:10.14434/do.v18i1.40888

Background

Parenthood can be overwhelming and anxiety generating for all parents including new ones. This is more pronounced for parents whose newborns are admitted to the newborn intensive care unit (NICU). In this environment, parents face complex information and are required to learn new skills to care for their infants, which can heighten their stress levels. Parental education in the NICU may help prepare parents for home transition, boosting their confidence and knowledge and reducing their stress.

Aim/Purpose

To evaluate the effectiveness of education sessions in enhancing knowledge and attitude among parents of infants admitted to the NICU of a tertiary care center in Lebanon.

Methods

Since August 2016, parent education sessions were held in the NICU as part of the unit's NIDCAP implementation process. Parents' readiness to care for their infants was assessed during their hospital stay and post-discharge. A parent education taskforce was formed to address parents' knowledge needs and readiness. The taskforce included a neonatologist, NIDCAP Professionals and NICU nurses. Baseline information was collected from ten NICU parents to identify topics of interest. Presentations were prepared on kangaroo care, breastfeeding, infant behavior cues and discharge process. Other topics were added later based on parents' feedback. Individual and group sessions were conducted, in person or online monthly and as needed. We took advantage of events' celebrations like Kangaroo Care Day, World Prematurity Day, and Breastfeeding Week. The sessions were interactive mostly when held in person. In January 2021, we began monitoring parental knowledge before and after each session.

The knowledge questionnaire included ten true/false questions about the topic of discussion. Open-ended questions were used to assess parents' needs, expectations and attitudes toward infant care.

Results

Over the last three years, 105 parents attended the sessions. The average knowledge score increased from 79% to 92%, reflecting a 16% improvement. Parents actively engaged in discussions, demonstrated keen interest in the content and acknowledged the sessions' significance for them. In the open-ended questions, parents reported that the educational sessions will change their misconceptions about breastfeeding and kangaroo care and equipped them with essential knowledge. One parent added *'I expect to have a wider knowledge regarding the "premature baby phase" in general and also to get ready emotionally and physically to take my baby home'* and another parent mentioned *'very valuable information to know about newborn care'*. Parents found the sessions particularly helpful when they addressed practical concerns such as storing breast milk, understanding their baby's behavior cues and post-discharge care.

Conclusion

Parent education sessions in the NICU play a pivotal role in nurturing a positive caregiving experience and promoting better health outcomes for both infants and parents. Overall, the knowledge gained from these sessions empowered parents, giving them a stronger sense of assurance in managing their caregiving responsibilities and preparing them more effectively for the transition home. Challenges remain in ensuring participation of all parents. Future directions include leveraging new technologies such as mobile applications. Additionally, involving former NICU parents to share their experience and perspectives during those sessions may be more welcoming.

Relevance to NIDCAP

Parental educational sessions align with the NIDCAP philosophy of promoting family-centered care and providing individualized support to parents, ensuring they are well prepared to care for their infants.

Analysis of Changes in Stress Perception Before and After FINE 2 Training

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DOI: 10.14434/do.v18i1.40891

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Aims

The FINE program (Family and Infant Neurodevelopmental Education) is a very useful tool to improve personal practice in the application of the developmental centered care model and NIDCAP.

In 2021, FINE 2 training started in Sant Joan de Déu Hospital in Barcelona. As part of this training, trainees were asked to answer a questionnaire on the practice of Developmental Care in their own centers. Included is the 'perception of a professional's stress when performing a series of infant care and procedures.

We aimed to analyze differences between the perception of the degree of self-stress by a group of professionals when performing usual procedures and care before and after their FINE 2 training.

Methods

Scores reported by the 22 trainees from one center for each item in their workbook were analyzed. The different variables have a rating scale between 1 and 5 with 1 being minimum stress and 5 being maximum stress. From September 2021 to June 2024, 22 students (15 neonatal nurses, 2 nurse assistants and 5 neonatologists) were trained in FINE 2 at our NIDCAP Center. Differences in average stress levels between both groups were compared using Student's t-test. Significance set at P <0.05.

Results

Average, standard deviation and statistical significance shown in bold of each item is shown in the table below.

Conclusion and Relevance for NIDCAP

Our aim was to make professionals more aware of and sensitive to the stress caused to newborns by most of the routine care. In particular, CPAP mask replacement and bottle milk feeding were the procedures in which statistically significant differences were observed in trainee's perception before and after FINE 2 training.

Procedure	Professional's stress before FINE 2	Professional's stress after FINE 2	n	p
Diaper change	3.27+/- 1.2	3.5 +/-1.1	22	0.25
Remove baby unwrapped from incubator	4 +/- 0.9	4.14+/- 0.8	21	0.37
Remove baby wrapped from incubator	3.3 +/- 0.9	3.3+/- 1	22	0.56
Weighing	3.3+/-1	3.1+/-0.8	21	0.71
Mouth aspiration	2.9+/-1.3	3.3+/-1.3	22	0.15
Peripheral intravenous access	3.6+/-0.9	3.8+/-0.8	21	0.16
Eye cleaning	2.1+/-1.4	2.7+/-1.4	22	0.11
CPAP mask placement	**3.3+/-0.8**	**4+/-0.8**	**21**	**0.002**
Nasogastric tube insertion	2.5+/-0.9	2.9+/-1.2	21	0.1
Bottle milk feeding	**1.5+/-0.6**	**2.2+/-1.1**	**21**	**0.01**
ROP screening	4.1+/-1	4.1+/-1	19	0.46
Thoracic or cardiac ultrasound	**2.3+/-0.9**	**2.7+/-1**	**19**	**0.08**

Exploring an Interdisciplinary Support Model for ROP Exams in the NICU

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DOI: 10.14434/do.v18i1.40893

Background

Retinopathy of prematurity (ROP) examinations frequently occur in the newborn intensive care unit (NICU). Ophthalmologists conduct these critical exams to screen, diagnose, and monitor the progression of ROP, with intervention required in severe cases. These exams can be highly stressful and potentially traumatic for critically ill infants and distressing for caregivers to witness. Effective management of the infants' stress and discomfort during these procedures is crucial for their overall development and recovery.

The author is part of an interdisciplinary team composed of ophthalmologists, developmental nurses, music therapists, child life specialists, and integrative care nurses. Over the past four years, this team has developed, tested, and refined a tiered support model aimed at providing non-pharmacologic intervention at every stage of the ROP exam: before, during and after. This model is grounded in five core measures of trauma-informed, age-appropriate care[1] and Als' synactive theory of infant development,[2] which emphasizes the importance of individualized and developmentally supportive care for preterm infants.

Aim

The aim is to highlight the theoretical framework and evidence base underpinning the model's design and implementation while providing a systematic overview of the model's development history and its application in a level IV NICU in the United States. It will also include a discussion of the practical challenges and solutions encountered during the implementation process.

Methods

The new model was initiated as a change in clinical practice. Previously, the ROP exam team consisted of an ophthalmologist, developmental nurse, and child life specialist, with support for the infant provided only during the examination due to time constraints and the volume of examinations. Recurring negative outcomes, such as increased stress responses and delayed recovery in infants, prompted a critical review of the process.

Through a comprehensive literature review, feedback from bedside staff, and the integration of personal experiences, a support model offering pre-, intra-, and post-exam interventions was developed. The pre-exam phase, provided by a music therapist, includes measures such as swaddling, providing positive touch, and soft singing or humming. During the exam, a child life specialist employs strategies such as gentle touch, non-nutritive sucking, and containment while maintaining a quiet environment. Post-exam care involves a holistic nurse providing comforting and grounding techniques. Families are incorporated into each phase of the process as much as they are comfortable.

After multiple iterations and testing, the final version was established as the new standard of care. The implementation process included staff education, protocol development, and ongoing evaluation to ensure adherence and effectiveness.

Results/Findings

Informal data collection, consisting of conversations with staff and discussions among the ROP team members indicated several positive outcomes. The new model resulted in increased family involvement and satisfaction, enhanced staff comfort and confidence during the exam process, and reduced negative clinical outcomes.

Conclusion

The development and implementation of this support model underscore several key insights related to the NIDCAP model:

- The importance of recognizing and responding to infants' behavioral cues, which is central to providing individualized, developmentally appropriate care.
- The impact of sensitive caregiving on clinical outcomes, demonstrate that non-pharmacological pain and stress management interventions can significantly reduce stress and improve recovery in preterm infants.
- The effective incorporation of families into the support process for stressful and painful procedures, highlights the role of parental involvement in promoting infant wellbeing.
- The benefits of interdisciplinary collaboration in navigating complex healthcare systems to minimize discomfort and agitation during procedures through non-pharmacological interventions.

Relevance to NIDCAP

This model serves as a promising framework that can be adapted and implemented in other NICUs to enhance the quality of care for vulnerable infants.

References:

1. Fuller K, DeWolfe T, Coughlin M. Trauma Informed Developmentally Supportive Care, *Developmental Observer*, 2022, 15(1), https://doi.org/10.14434/do.v15i1.33788
2. Als, H. (1982), Toward a synactive theory of development: Promise for the assessment and support of infant individuality. *Infant Ment. Health J.*, 3: 229-243. https://doi.org/10.1002/1097-0355(198224)3:4<229::AID-IMHJ2280030405>3.0.CO;2-H

Integrating Parent Lived Experience into Training Programmes for Healthcare Professionals

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DOI: 10.14434/do.v18i1.40894

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Introduction

Inviting parents to bring their lived experience to the education of neonatal healthcare professionals has proved to be both a revelation and an inspiration. Since 2017 we have been developing active roles for parents as part of the Family and Infant Neurodevelopmental Education (FINE) foundational education faculty. This began in Hungary and Romania with parents as organisers, co-coordinators and translators, but it soon became apparent that their lived experience and their passionate interest in improving service for children and families in neonatal units could be captured, extending their role to explore family experiences in a unique way. As they became familiar with the programme, they became very willing to take this on with confidence and we recognised the unique contribution their knowledge and experience brought to the validity of the training.
In the last year and a half, we have recruited and prepared parents for the UK faculty. Recruitment was through personal contacts and with the help of Bliss, a national charity that supports neonatal units. Our first recruits have brought a wealth of other professional skills to our team as well as their experience as parents.

Aims

- To bring lived experience into the training space
- To highlight the importance of communication with parents in the newborn intensive care unit (NICU)

Methods

- Parents who are not currently in the middle of the neonatal experience, who can participate and respond with knowledge and hindsight, are invited to be part of the faculty for foundational education programmes.
- They provide continuous insights during training days, help to shape the curriculum, and with experience and guidance lead some of the topics.
- They provide a space for discussion and reflection, and opportunity to ask questions in more intimate group workshops.
- The programme is semi-scripted so that the boundaries of discussion are contained.
- In recognition of the emotional energy that this work demands and the need to make it sustainable, professional psychological support is provided for parents who participate and, in addition, supervision and support from senior faculty is provided.

Results/Findings

- Through the participation of parents as faculty several aspects of the foundational education programme have been changed and improved, including the kind of language used and introduction of coaching techniques.
- Faculty report on the impact that parents' contributions have had on their way of teaching, how it has changed their perspective of their practice, and their perceptions of how the course has benefitted from the addition of this shared lived experience.
- Participants report that they highly value the powerful contribution of parents lived experience.
- Parents feel that by sharing their experience and the values of the FINE programme they have an impact on improving the care for preterm babies and therefore their future outcome. Furthermore, to be able to shape and improve the experience of parents on neonatal units gives the parent faculty members an enormous sense of fulfilment.

Conclusion

This approach highlights the benefits of drawing on lived experience. It enhances the value of foundational education particularly when this experience is also drawn on to shape the way training is delivered. Other ways in which this experience may be extended to help healthcare professionals gain skills in understanding and communicating with parents are being explored.

Relevance to NIDCAP

This approach could be integrated into the NIDCAP training programme to deepen the understanding of the training participants with regards to the lived experience of the parents and carers.

NIDCAP: Always a Journey

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DOI: 10.14434/do.v18i1.40895

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PADEICS-NIDCAP Group is formed by:

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Aim

To describe the collaboration between the Vall d'Hebron-Dr Trueta NIDCAP Training Center and the Catalan Health System (ICS) and how an expert advisory program was created to facilitate training across its six hospitals to improve outcomes for newborns and their families.

Methods and Results

YEAR 2016 – Start of collaboration.

The PADEICS-NIDCAP expert group was created. PADEICS is an expert advisory program promoted jointly with the healthcare medical director of the six hospitals of the ICS group (Catalan Institute of Health) within the public health system, that care for over 270 very low birth weight babies every year in Catalonia.

The group consists of representatives of the administration, medical and nursing leaders of the units, NIDCAP professionals, other professionals promoting Developmental Care and family representatives from the "SomPrematurs" association. The main objective was to implement a newborn care model guided by NIDCAP. This is organized through quarterly meetings, leadership teams in each unit and the setting of annual objectives. During the 2016-2017 period, two very important actions were carried out:

1. A working day between families and professionals. During this meeting, nine areas of work are agreed upon, which focus on both training and the application of the model.
2. NIDCAP Introductory 12-hour course, of theoretical and practical presentations and workshops. It is accredited in the Catalan health system. A total of 380 professionals from the six hospitals participated.

2018-2023 – NIDCAP Professional Training

- Certified NIDCAP professionals in all six hospitals.
- Intermediate training, with an in-person course of 25 hours conducted in small groups. The pace is slow, the turnover of professionals matches our training capacity.
- Incorporating FINE 2 into our training portfolio multiplies our training capacity.

2023 – Start of the family inclusion program.

The INclusion of FAmilies in Neonatology (INFA-Neo) program started in Girona, focusing on integrating families and providing individualized developmental care for high-risk babies, with a full-time NIDCAP nurse (Montse Reixach) and a part-time neonatologist (Angela Gregoraci).

2024 – More commitments from the administration.

- Commitment for 80% of professionals who work directly with babies and families to complete the FINE 2 training, in all care shifts.
- Commitment to have a full-time NIDCAP Professional position in all hospitals, responsible for training programs and implementing the care model.

Challenges

- The difficulty of administrators to authorize expenses that are not equipment or pharmacological treatments.
- The group does not include other hospitals that are not in the ICS group.
- The frequent turnover of healthcare professionals.

Strengths

- The participation in the PADEICS program and the commitment of the medical and nursing managers of the units, which are part of the PADEICS-NIDCAP group.
- Having a training model (NIDCAP, FINE) and implementation model (e.g. INFA-Neo)
- Collaboration with families and their associations (the president of SomPrematurs is part of the group).
- The collaboration with other NIDCAP Training Centers such as "Sant Joan de Déu" and "12 de Octubre".
- The unconditional support of our Senior NIDCAP Master Trainer, Graciela Basso and the NFI.

Conclusion / Relevance to NIDCAP

Collaboration with the administration is the way to consolidate the model in all ICS hospitals. Together with the Sant Joan de Deu group of hospitals, we provide care for over 70% of very premature babies in the Catalan health system. Our goal is to improve communication with the administration to establish NIDCAP as a standardized model across all units in Catalonia, and hopefully Spain.

Collaboration with the administration facilitates conducting research studies on the implementation of the model. This collaboration also supports initiatives aimed at improving training skills. We believe that sharing our experience with other regions of the state can serve as an example and an encouragement to promote similar programs.

NIDCAP Implementation in Neonatal Units and Breast Milk Feeding at Discharge: the EPIPAGE-2 Cohort Study

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DOI: 10.14434/do.v18i1.40896

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The impact of neurodevelopmental observations of preterm infants such as those offered in the NIDCAP program is still debated. By supporting oral feeding development, NIDCAP observations could enhance breast milk feeding at discharge of very preterm infants.

Aim

To describe breast milk feeding at discharge among very preterm infants according to the level of NIDCAP implementation in neonatal units.

Materials and Methods

Using the French national population-based EPIPAGE-2 cohort, implementation of NIDCAP in each of 11 NIDCAP neonatal units was defined as the proportion of very preterm infants (< 32 weeks' gestation) who had at least one NIDCAP observation during hospitalization. Breast milk feeding at discharge -partial, breast/bottle exclusive, and breast only exclusive- was evaluated after adjustment on maternal and neonatal characteristics, and unit policies to support lactating mothers.

Results

Among 569 very preterm infants included, 14% (78/569) had at least one observation during hospitalization. Implementation was defined as low in nine units and high in two units, with 7% (extremes: 0-13%) and 86% (75 and 100%) of infants having at least one observation, respectively. Breast milk feeding at discharge was reported in 55% of infants. In neonatal units with low NIDCAP implementation vs high, we observed 25%/6% of partial breast milk feeding at discharge, 16%/24% of breast/bottle exclusive, and 14%/28% of breast only exclusive. High NIDCAP implementation was associated with higher proportions of exclusive - only breast- breast milk feeding at discharge: adjusted odds ratio 4.72 (95% CI 2.79-7.99).

Conclusion/Relevance for NIDCAP

The level of NIDCAP implementation was associated with higher rates of breast milk feeding at discharge exclusively at breast. Investment of professionals and families in very preterm infants' observation could be an effective strategy to support exclusive breast milk feeding at discharge in this vulnerable population.

Partnering with the NICU Parent Leader

Reginato Cascamo, K

Courageous Steps; Gonzaga University, USA

DOI:10.14434/do.v18i1.40897

Aim

A Newborn Intensive Care Unit (NICU) Parent Leader collaborates globally with clinical leaders, health system organizations, governments and industry to advocate for credible healthcare quality improvement. NICU Parent Leaders are deeply aware of the perspectives of patients and families from their own experiences to improve healthcare quality, safety and patient experience. By modeling empathetic listening, discernment & interpretation of patient and parent stories and strengths-based communication, NICU Parent Leaders build consensus through multistakeholder representation.

Methods - Theory & Praxis Research

NICU Parent Leaders collaborate with organizations, communities and global societies in the following ways:

1. **Research Partnerships:** Ensure research aligns with the needs of those most impacted, integrates patient and partner perspectives in decisions, and includes diverse community partners to reflect marginalized viewpoints.
2. **Quality Improvement:** Enhances patient-centered care by systematically improving effectiveness, efficiency, safety, equity, and timeliness of healthcare services through data-driven evaluation and refinement of practices.
3. **Organizational Development:** Supports leadership development, process improvement, change management, employee engagement, and strategic planning to foster efficiency, adaptability, and sustained growth.
4. **Readiness Assessments:** Evaluates organizational preparedness for implementing changes, assessing infrastructure, staff skills, organizational culture, regulatory compliance, and impacts on patients and the community.
5. **Community Building:** Uses administrative and community organizing skills to enhance healthcare organizations' ability to engage patients and families by emphasizing trust, inclusivity, and meaningful contribution from diverse and underrepresented voices.
6. **Health Equity:** Promotes health equity by ensuring fair access to resources, eliminating disparities based on socioeconomic status, race, or ethnicity, and addressing social determinants of health to achieve optimal well-being for all.
7. **Event Planning, Conferences & Summits:** Hosts a spectrum of engagement events, including councils, panels, collaboratives, and workshops. These platforms facilitate collaboration among patients, family caregivers, and healthcare professionals, encouraging diverse perspectives to drive healthcare improvement.
8. **Board of Director Leadership:** Oversees governance, finances, executive leadership, risk management, and stakeholder relations to ensure effective and ethical operation of the organization.
9. **Educates Health Communities:** Delivers health education, assess community needs, provide resource referrals, advocate for health equity, and evaluate program effectiveness to enhance community health outcomes.

Theoretical Process Development (Results/Findings in Process)

Dr. Heidelise Als was a pioneering figure in the establishment of NIDCAP, introducing groundbreaking insights that revolutionized our understanding of infant development. Central to her contributions was The Synactive Theory of Infant Development, emphasizing the crucial role of a robust theoretical framework in clinical effectiveness. Dr. Als unraveled the sensory, cognitive, and social capacities of infants, highlighting their continuous interaction with the environment.

In a parallel manner, NICU parents navigate an unfamiliar environment with heightened vigilance, tasked with acquiring new skills. Dr. Als designed the Model of the NIDCAP Nursery to foster an environment of highly attuned care, supported by a community that envelops families, parents, and infants within the hospital setting.

Conclusion

This abstract proposes leveraging the Model of the NIDCAP Nursery in collaboration with NICU Parent Leaders to enhance healthcare quality, safety, and patient experience. As NICU Parent Leaders undergo personal and professional growth, including interdisciplinary collaboration and leadership skills development, they bring valuable insights and dedication to the organizational development of NICUs.

Relevance to NIDCAP

Effective NICU Parent Leaders have the transformative potential to apply the principles of the Model of the NIDCAP Nursery across multiple facets of the healthcare ecosystem. Through empathetic listening, discernment, and strengths-

based communication rooted in patient and parent narratives, they collaborate to enhance the well-being of infants, families, healthcare professionals, and hospital communities alike. By nurturing a reciprocal care approach, NICU Parent Leaders contribute to the restoration and improvement of healthcare systems that once supported them during their own critical journeys.

Investigating the Effect of Held Position During Kangaroo Care on Physiological Parameters of Premature Infants: A Randomised Controlled Trial

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DOI:10.14434/do.v18i1.40898

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Background

Kangaroo mother care (KMC) is an integral part of neonatal care, with its benefits to babies and families well documented. The position in which the parent holds her baby in KC, is mostly determined by maternal preference in the newborn intensive care unit (NICU). This study aimed to assess whether there is any differences to the babies cerebral oxygen levels, based on the two usual maternal positioning practiced in NICU at Cork University Maternity Hospital (CUMH) (30° or 60° incline position) and if either maternal position is more optimal for performing KMC.

Methods

Single centre cross-over randomised controlled trial in a tertiary newborn intensive care unit. Infants with a minimum corrected gestational age of 28 weeks and minimum 600 grams were included. Participants were randomly assigned to commence KMC, with their mother laying at either a 30° or 60° angle. The primary outcome measure was the median cerebral near-infrared spectroscopy (NIRS) values between the two positional angles. Near-Infrared Spectroscopy (NIRS) oxygen saturation monitoring was chosen as it provides non-invasive, real time, continuous, tissue specific measurements of cerebral oxygen saturation. NIRS monitoring can detect cerebral hypoxia, even when other monitors do not show signs of clinical deterioration.[1] Secondary outcomes were median infant peripheral saturations, median infant heart rates and numbers of significant bradycardia or desaturation episodes during KMC intervention. The results were analysed using the non-parametric Wilcoxon signed rank test.

Results

Twenty participants were included in the final analysis: median gestational age (GA) at birth was 28^{+1} weeks (range: 23^{+2} to 32^{+6} weeks) and median birth weight was 0.985kg (range: 0.620kg to 2kg). There were no statistically significant differences (p = 0.810) between the median NIRS values at 30° (median rSO2 = 67.5, IQR = 58.3 – 73.8) and 60° (median rSO2 = 68, IQR = 60.5 – 76). There were no statistically significant difference in the median peripheral saturations (p = 1), or median heart rates (p = 0.662) between infants held skin-to-skin at 30° or 60° positions.

Conclusion

Results indicate that maternal positioning at a 30° or 60° incline did not have a significant impact on cerebral oxygenation values in very preterm infants furthermore either position was associated with the infant's clinical stability. Evidence robustly supports implementation of KMC to improve outcomes for the infant and families.

Relevance for NIDCAP

As NIDCAP Professionals, when supporting the families in our care with KMC we have to ensure our recommendations are researched based and supporting the best possible outcomes for the infant.

Reference:

1. Vesoulis ZA, Sharp DP, Lalos N, Swofford DP, Chock VY. Cerebral Near-Infrared Spectroscopy Use in Neonates: Current Perspectives. *Research and Reports in Neonatology*. 2024;14:85-95. https://doi.org/10.2147/RRN.S408536

Behind the Scenes: Toulouse, France

Kaye Spence AM, MN, FACNN

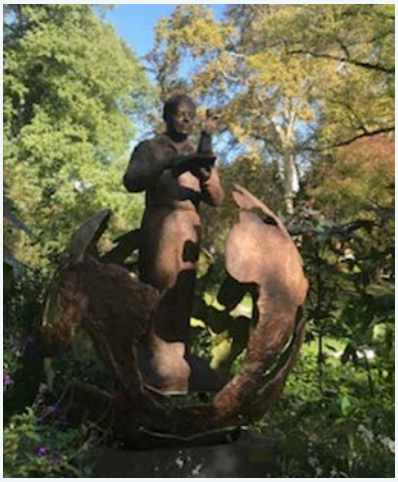
When I found out that the NIDCAP Trainers Meeting would be held in Toulouse, France, I was thrilled. This area of Europe has always fascinated me with its layers of history, beauty, and unmistakable ambiance. So uniquely, so unmistakably French. Arriving a few days before the meeting, I seized the opportunity to explore Toulouse which is famously known as 'La Ville Rose' for its rose-hued brick buildings. It is equally celebrated for its rich gastronomy. I was lucky to sample some of the delights.

Toulouse's storied past unfolded in its museums and churches. Once the Visigothic capital, later the County of Toulouse's heart, the city resisted 13th-century anti-heretic crusades tied to the Cathars. Its Parliament, established in 1420, governed Languedoc until the French Revolution. History came alive here, vividly preserved and powerfully resonant.

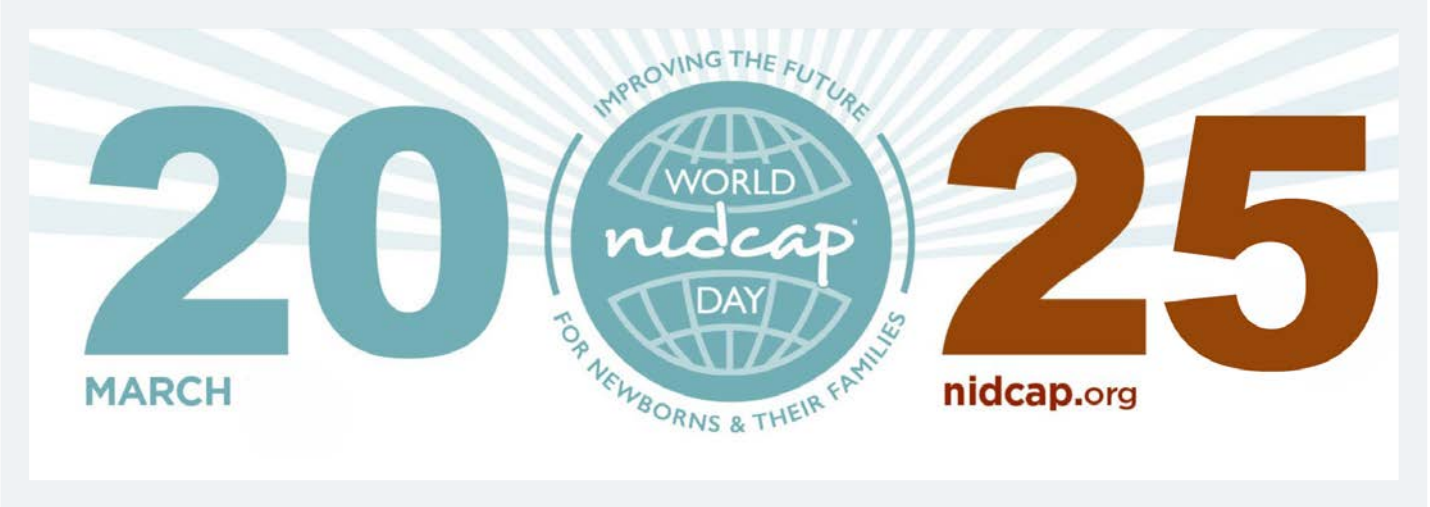
With every turn down its winding lanes, I found scenes worthy of a photograph, each capturing the city's timeless character. I was particularly struck by how well-preserved its historic buildings remain.

I walked over 15,000 steps exploring the riverside paths, churches, and museums. Everywhere I went, locals were warm and welcoming. One of the highlights of my visit was the Couvent des Jacobins. Walking through its chapels and cloisters, I felt transported to an era of devotion and defiance. The exhibition on the Cathars was particularly haunting—its vivid depictions of faith and persecution left me reflecting on the resilience of beliefs in the face of overwhelming odds.

As I prepared for the NIDCAP conference on *'Systems Integration at Local, Regional, and National Levels,'* I refllected on Toulouse's journey through history. From its origins as a regional medieval hub to its role as a cornerstone of the Occitanie region, and finally its integration into the broader map of France, Toulouse exemplifies the dynamic interplay between local character, regional collaboration, and national unity. It stands as a powerful metaphor for the potential of systems integration to honour individuality while fostering collective strength.



Meeting attendees



NIDCAP: Early Intervention Within a Nurturing Environment

One Day Conference

September 18, 2025
08:00-18:00 CET

Copenhagen
Denmark

Hybrid Conference

(in person and online)

Presented and hosted by the NIDCAP Federation International and NIDCAP Centers of Sweden and Denmark

NIDCAP Care in the Moment

Observing and learning

Image used with permission

Perspectives Mondiales des Soins de Développement - NIDCAP Francophones

Aurélie Guillou and Sandra Lescure, NIDCAP Trainers

L'association NIDCAP France a été créée en 2013 en tant que « French Chapter » autorisé par la NFI, sous l'impulsion du Pr Sizun et des membres du premier centre de formation NIDCAP français de Brest.

DOI :10.14434/DO.V18I1.40905

L'association NIDCAP France a été créée en 2013 en tant que "French Chapter" autorisé par la NFI, sous l'impulsion du Pr Sizun et des membres du premier centre de formation NIDCAP français de Brest.

L'association a pour but de coordonner et dynamiser la recherche, le développement et la diffusion du NIDCAP sur le territoire francophone. Elle soutient l'organisation des Journées NIDCAP Francophones, qui se déroulent chaque année dans une des unités françaises ou belges formées au NIDCAP. Un site internet et la création de comptes sur les réseaux sociaux (facebook, twitter) ont également été créés rapidement.

A partir de 2022, avec la formation de nouvelles formatrices NIDCAP belges et françaises, l'avenir de l'association NIDCAP France est discuté, afin de faciliter les échanges entre les centres de formation NIDCAP et de dynamiser le partage d'informations auprès du public francophone. Les statuts de l'association sont révisés et le nom NIDCAP France est modifié pour NIDCAP Francophone. Les sièges du conseil d'administration sont également ouverts aux représentants de parents (association SOS Préma).

Des professionnels de tous les centres de formation NIDCAP en France (Brest, Toulouse) et en Belgique (Bruxelles), mais également des représentants des futurs centres de formation NIDCAP (Valenciennes, Saint-Brieuc et Grenoble), des professionnels certifiés et adhérents à la NFI, sont élus membres du nouveau bureau ou présents au conseil d'administration en 2022.

Le bureau actuel de l'association NIDCAP Francophone est composé de:

Sandra Lescure, MD NIDCAP Trainer, Toulouse, présidente

Aurélie Guillou, RN, NIDCAP Trainer, Saint-Brieuc, co-présidente

Isabelle Olivard, RN, NIDCAP Professionnal and NBO Trainer, Brest, trésorière

Sylvie Minguy, RN, NIDCAP Trainer, Brest, co-trésorière

Céline Prout, RN, NIDCAP Trainer, Toulouse, secrétaire

Marie-Cécile Andro-Garçon, MD, NIDCAP Professionnal, Saint-Brieuc, co-secrétaire

L'association continue de soutenir les missions pour lesquelles elle a été créée il y a 12 ans, et réfléchit à de nouvelles perspectives, en se structurant. Elle a comme ambition de développer plusieurs commissions :

Commission pédagogique pour soutenir la formation et la diffusion du NIDCAP, en favorisant la coordination entre les différents centres de formation NIDCAP francophones afin de recueillir des indicateurs d'implantations des programmes de soins. Un des buts est de pouvoir partager entre formatrices du matériel-support de formation. Un autre est également de coordonner les formations au sein du territoire avec la présence de plusieurs centres de formation. L'association permet également aux formatrices de se soutenir mutuellement et de partager leurs expériences de formation. Enfin, pour l'année 2025, un des objectifs est d'organiser des Webinaires en français sur la thématique de l'observation, afin de soutenir les certifiés NIDCAP des différentes unités de néonatologie francophones.

Commission scientifique pour travailler avec les équipes organisatrices à l'élaboration du programme des Journées NIDCAP Francophones (JFN). L'autre objectif est également de dynamiser la recherche sur le NIDCAP. Actuellement cette commission travaille sous l'impulsion de Véronique Pierrat à l'évaluation de l'impact de l'implantation des programmes FINE 2 et CLE dans les différentes unités de soins.

Commission communication pour diffuser des informations fiables sur le NIDCAP, les Soins de Développement Centrés sur l'Enfant et sa Famille, en créant un nouveau site Web qui est en cours d'élaboration, l'initial ayant été fermé, qui permettra au public francophone d'avoir des informations locales sur la diffusion du NIDCAP en France et en Belgique, la traduction en français de certains articles importants ou la diffusion des informations apportées par la NFI. Ce site sera relié au site de la NFI. Cette commission réfléchit également à la présence de NIDCAP Francophone sur les réseaux sociaux pour pouvoir atteindre un plus large et plus jeune public.

Les membres de l'association se réunissent par Zoom de façon régulière et en fonction des missions et objectifs fixés. Depuis 2022, il y a eu environ quatre à cinq réunions par an. L'assemblée

générale se fait chaque année lors des Journées NIDCAP Francophone. Les membres du Comité d'Administration sont élus tous les trois ans. La prochaine élection aura lieu en 2025.

Lors des dernières journées NIDCAP Francophones en 2024, à Toulouse, il nous est apparu opportun de faire un état des lieux de l'implantation du NIDCAP en France et en Belgique. Un questionnaire a été envoyé à toutes les équipes formées au FINE 2 ou au NIDCAP (72 établissements de santé sollicités (63 français et 9 belges)/ taux de réponse à 69,4%), et les résultats préliminaires ont été présentés lors des journées. La perspective est de monitorer plus précisément l'implantation des SDCEF, du NIDCAP sur nos territoires francophones.

En France, il y a actuellement 20 unités de néonatologie (NICU) avec des certifiés NIDCAP dont certaines ont aussi des certifiés FINE. On compte également 32 autres unités avec des certifiés FINE 2. En Belgique, le NIDCAP est implanté dans 17 des 19 NICU. Dans les néonatologies sans soins intensifs, la moitié sont formées au programme CLE ou FINE 2.

Les Journées NIDCAP Francophones connaissent chaque année un franc succès. En 2024 étant donné l'organisation du 35ème Trainers Meeting sur Toulouse, il a été proposé d'y accoler les 12èmes JFN. Le but était de permettre aux certifiés NIDCAP/FINE ou CLE francophones de côtoyer les acteurs du NIDCAP du monde entier. Ainsi la dernière journée du Trainers Meeting était commune avec les JFN qui se sont poursuivies par une journée uniquement francophone, où les congressistes ont pu participer à plusieurs ateliers pour échanger sur leurs différentes pratiques. Ils ont pu également assister à la rubrique « Partage d'expériences » où chaque unité peut venir présenter les avancés dans son équipe concernant les soins de développement. La thématique était « Soutenir l'Implantation du NIDCAP dans les différentes unités de soins ». 150 personnes étaient présentes pour ces Journées Francophones. Jusqu'à présent, nous limitions la présence à 3 ou 4 personnes par unité de néonatologie afin de permettre des ateliers et des échanges entre participants. Ces journées sont également ponctuées d'une remise des diplômes des certifiés de l'année ainsi que d'une soirée dansante qui permet de partager dans la convivialité. Les prochaines JFN ont lieu à Montpellier les 25 et 26 septembre 2025 et ont pour thématique : "Construire une unité de néonatologie ne 2025 : architecture et bien-être soigné/soignant ".

En bas de gauche à droite: Frédérique Berne-Audeoud, Pédiatre, Formatrice NIDCAP en formation, Grenoble; Jacques Sizun, Professeur Emérite Université Toulouse, directeur retraité du Centre de formation NIDCAP de Toulouse; Sandra Lescure, Pédiatre, Formatrice NIDCAP et directrice du Centre de formation NIDCAP de Toulouse; Céline Prout, Infirmière Puéricultrice, Formatrice NIDCAP, Centre de formation NIDCAP de Toulouse; Nathalie Ratynski, Pédiatre, Formatrice NIDCAP retraitée, Centre de formation NIDCAP de Toulouse; Delphine Druart, Infirmière Puéricultrice, Formatrice NIDCAP et APIB, Centre de formation NIDCAP de Bruxelles

En haut de gauche à droite: Marie-Cécile Andro-Garçon, Pédiatre professionnelle NIDCAP, directrice du Centre de formation NIDCAP de Saint-Brieuc; Aurélie Guillou, Infirmière Puéricultrice, Formatrice NIDCAP, Centre de formation NIDCAP de Saint-Brieuc; Véronique Pierrat, Pédiatre professionnelle NIDCAP, chercheure INSERM équipe EPOPé-Inserm, Paris; Isabelle Glorieux, Pédiatre professionnelle NIDCAP, Toulouse; Sylvie Minguy, Infirmière Puéricultrice, Formatrice NIDCAP, Centre de formation NIDCAP de Brest; Peggy Laurant, Infirmière Puéricultrice, Formatrice NIDCAP, Centre de formation NIDCAP de Valenciennes; Juliette Barois, Pédiatre professionnelle NIDCAP, directrice du Centre de formation NIDCAP de Valenciennes; Inge Van Herreweghe, Pédiatre professionnelle NIDCAP, directrice du Centre de formation NIDCAP deBruxelles

En 2025, l'association NIDCAP Francophone souhaite s'ouvrir au Québec et se propose d'intégrer dans son Comité d'Administration Isabelle Milette qui est en cours de formation pour devenir formatrice NIDCAP à Montréal.

Global Perspective on Developmental Care - NIDCAP Francophone

Aurélie Guillou and Sandra Lescure, NIDCAP Trainers

Translated from the original French by Aurelie Guillou

The NIDCAP France Association was created in 2013 as a French Chapter authorized by the NIDCAP Federation International (NFI), under the leadership of Professor Jacques Sizun and members of the first French NIDCAP Training Center in Brest.

DOI: 10.14434/DO.V18I1.40904

The association aims to coordinate and energize NIDCAP research, development and dissemination in the French-speaking world. It supports the organization of a NIDCAP French-speaking meeting, held each year in one of the French or Belgian NIDCAP Training Centers. A website and social network accounts (Facebook, Twitter) have also been set up.

From 2022, with the training of new Belgian and French NIDCAP trainers, the future of the NIDCAP France Association is currently being discussed, to facilitate exchanges between NIDCAP training centers and boost information sharing with the French-speaking public. The associative statutes have been revised, and the name NIDCAP France changed to NIDCAP Francophone. Board seats have also been opened up to parents' representatives (SOS Préma association).

Professionals from all NIDCAP training centers in France (Brest, Toulouse) and Belgium (Brussels), as well as representatives of the new NIDCAP Training Centers (Valenciennes, Saint-Brieuc and Grenoble), NIDCAP certified professionals and NFI members, were elected to the new executive committee or the board of directors in 2022.

The current board of the NIDCAP Francophone Association is made up of:

Sandra Lescure, MD NIDCAP Trainer, Toulouse, President

Aurélie Guillou, RN, NIDCAP Trainer, Saint-Brieuc, Vice-President

Isabelle Olivard, RN, NIDCAP Professional and NBO Trainer, Brest, Treasurer

Sylvie Minguy, RN, NIDCAP Trainer, Brest, Co-Treasurer

Céline Prout, RN, NIDCAP Trainer, Toulouse, secretary

Marie-Cécile Andro-Garçon, MD, NIDCAP Professional, Saint-Brieuc, Co-Secretary

The association continues to support the missions which were created 12 years ago, and and is also bringing new perspectives to its restructuring plans. Its goals include the development of several commissions:

Pedagogical Commission to support NIDCAP training and dissemination, by promoting coordination between the various French-speaking NIDCAP training centers in order to collect indicators of the implementation of the program. One aim is to enable trainers to share training materials. Another is to coordinate training within the region, given the presence of several training centers. The association also enables trainers to support each other and share their training experiences. Finally, for the year 2025, one of the objectives is to organize Webinars in French on the theme of observation, in order to support NIDCAP Professionals from different French-speaking neonatology units.

Scientific Commission to work with the organizing teams to draw up the program for the NIDCAP French-speaking Meeting (JFN). Another objective is to boost NIDCAP research. This commission is currently working, under the direction of Véronique Pierrat, on assessing the impact of implementing the FINE 2 and CLE programs in the different care units.

Communication Commission to disseminate reliable information on NIDCAP, Infant and Family Centered Developmental Care, by creating a new website (currently under development, the initial one having been closed) which will provide the French-speaking public with local information on the spread of NIDCAP in France and Belgium, the translation into French of certain important articles or the dissemination of information provided by the NFI. This site will be linked to the NFI site. The committee is also considering the possibility of putting NIDCAP Francophone on social networks to reach a wider, younger audience.

The members of the association meet regularly via Zoom, according to their missions and objectives. Since 2022, there have been about four to five meetings each year. The ordinary annual general meeting is held each year during the NIDCAP French-speaking meeting. Board members are elected every three years. The next election will take place in 2025.

During the last NIDCAP French-speaking meeting in 2024, in Toulouse, it seemed appropriate to take stock of NIDCAP implementation in France and Belgium. A questionnaire was sent to all teams trained in FINE 2 or NIDCAP (72 health establishments were contacted (63 French and 9 Belgian) the response rate was 69.4%), and the preliminary results were presented at the meeting. The aim is to monitor the implementation of

IFCDC and NIDCAP in French-speaking units more closely.

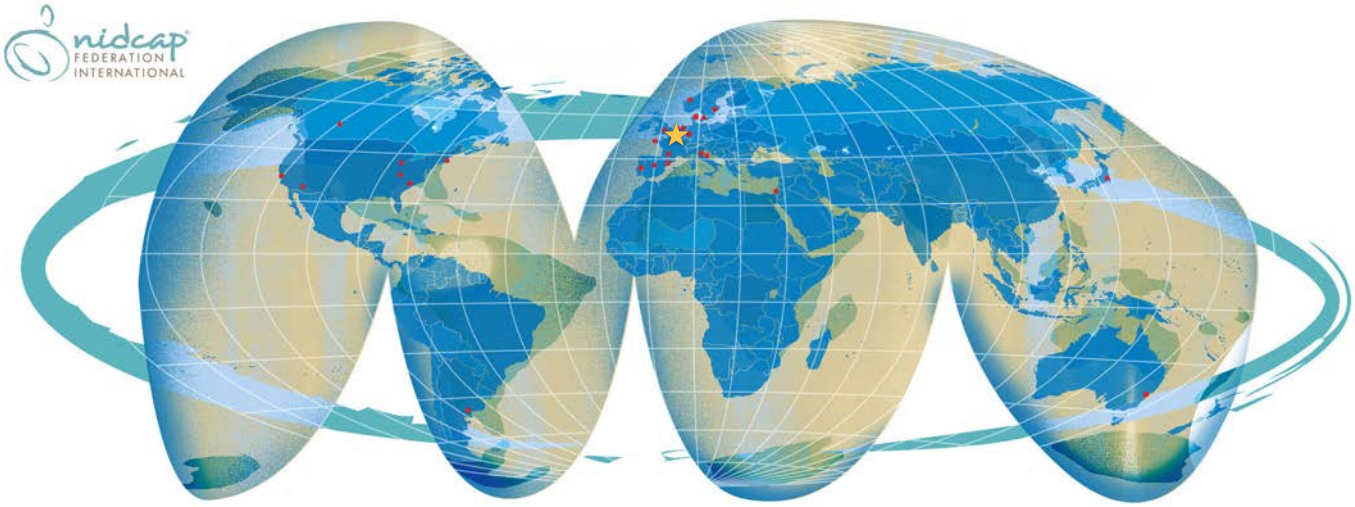
In France, there are currently 20 neonatal units (NICUs) with NIDCAP Professionals, some of whom also have FINE certification. In addition, there are 32 units with FINE 2 certification. In Belgium, NIDCAP is implemented in 17 of the 19 NICUs. In newborn units without intensive care, half are trained in the CLE or FINE 2 program.

The NIDCAP French-speaking meetings are a great success every year. In 2024, given that the 35th Trainers Meeting would be held in Toulouse, it was proposed that the 12th JFN should be held in conjunction with it. The aim was to enable French-speaking NIDCAP/FINE or CLE certifiers to rub shoulders with NIDCAP players from all over the world. As a result, the last day of the NTM was held in conjunction with the JFN, which continued with a day devoted exclusively to the French-speaking world, where delegates were able to take part in a number of workshops to share their different practices. They were also able to take part in the "Sharing experiences" section, where each unit could present the advances made by its team in developmental care. The theme was "Supporting the implementation of NIDCAP in different care units". One hundred and fifty people attended the NIDCAP French-speaking meeting. Until now, we have had limited attendance of three or four persons per neonatal unit, to enable workshops and exchanges between participants. These days are also punctuated by the presentation of diplomas to the year's recipients, and an evening dance to share in the conviviality. The next JFN will take place in Montpellier on September 25 and 26, 2025, with the theme: "Building a neonatology unit in 2025: architecture and well-being of caretakers".

In 2025, the NIDCAP Francophone Association plans to open up to Quebec, and proposes to integrate Isabelle Milette, who is currently training to become a NIDCAP trainer in Montreal, into its Board.

Bottom left to right: Frederique Berne-Audeoud, MD, NIDCAP Trainer in Training, Grenoble; Jacques Sizun, MD, Professor Emeritus University of Toulouse, Director retired of Toulouse NIDCAP Training Center; Sandra Lescure, MD, NIDCAP Trainer, Director of Toulouse NIDCAP Training Center; Céline Prout, RN, NIDCAP Trainer, Toulouse NIDCAP Training Center; Nathalie Ratynski, MD, NIDCAP Trainer retired, Toulouse NIDCAP Training Center; Delphine Druart, RN, NIDCAP and APIB Trainer, Brussels NIDCAP Training Center

Top left to right: Marie-Cécile Andro-Garçon, MD NIDCAP Professional, Director of Saint-Brieuc NIDCAP Training Center; Aurélie Guillou, RN, NIDCAP Trainer, Saint-Brieuc NIDCAP Training Center; Véronique Pierrat, MD, NIDCAP Professional, Researcher INSERM équipe EPOPé-Inserm, Paris; Isabelle Glorieux, MD, NIDCAP Professional, Toulouse; Sylvie Minguy, RN, NIDCAP Trainer, Brest NIDCAP Training Center; Peggy Laurant, RN, NIDCAP Trainer, Valenciennes NIDCAP Training Center; Juliette Barois, MD, NIDCAP Professional, Director of Valenciennes NIDCAP Training Center; Inge Van Herreweghe, MD, NIDCAP Professional, Director of Brussels NIDCAP Training Center



Valenciennes NIDCAP Training Center, France

So much progress made!

Juliette Guilliot, Head Pediatrician and Peggy Laurant, Pediatric Nurse and NIDCAP Trainer

DOI:10.14434/do.v18i1.40901

It all began in the city of Valenciennes, in the north of France. After the construction of a new hospital complex, which was completed before the Second World War, a new maternity ward was built in 1960. As a tribute to the principality of Monaco, which was a sponsor of the city of Valenciennes during the First World War, the ward was inaugurated in 1980 by the mother of Prince Rainier III and was named the "Monaco" maternity ward.

The neonatology department was located away from the maternity ward, with care rooms being large open spaces surrounded by bay windows, offering little space for parents. Dr. Catherine Zaoui, who was leading the unit at the time, was eager to explore other care practices and philosophies. A trip to Brest was organized to meet Drs. Nathalie Ratynski and Jacques Sizun, pioneers in introducing NIDCAP (Newborn Individualized Developmental Care and Assessment Program) in France. This marked the beginning of a significant transformation, but it had to be achieved within the existing architecture, which posed challenges due to much noise and light. Despite these limitations, the team's motivation was strong, and gradually, developmental care techniques were introduced, driven by a dynamic and caring team.

In February 2005, the neonatology department moved into new, purpose-built facilities designed to support the implementation of developmental care and NIDCAP. It was equipped with features such as centralized monitoring, parent-child rooms, reception lounges, a kitchenette, and accommodation for parents living far away. The care team, deeply invested in the project, began receiving training, starting with the certification of two pediatricians and two pediatric nurses under the guidance of Dr. Nathalie Ratynski from the Brest NIDCAP Training Center. The department was reorganized to align with this philosophy, introducing training on breastfeeding and establishing various working groups promoting breastfeeding, preparing parents for discharge, reducing noise disturbances, encouraging early interactions such as skin-to-skin contact, music, reading, and pain management, as well as a steering committee in collaboration with parents. Over several years, NIDCAP training continued, resulting in eight nurses and five pediatricians being certified.

Monaco Neonatal Hospital

A common room in the maternity ward

The Valenciennes NIDCAP Team

As part of the ongoing NIDCAP implementation, a dedicated coordinator position was created in 2011. The number of NIDCAP observations significantly increased. Two years later, the team committed to obtaining NIDCAP certification. At that time, only one service in France, the neonatology department at Brest University Hospital, was certified. In 2016, Valenciennes achieved this certification, recognizing the dedication and hard work of the entire team.

Efforts to promote breastfeeding also bore fruit, with the maternity and neonatology departments receiving the IHAB (Baby-Friendly Hospital Initiative) accreditation in 2011 and maintaining it through recertifications in 2015, 2019, and 2024. The department now has two lactation consultant positions (one in maternity and one in neonatology), a NIDCAP coordinator role in neonatology (with occasional support from other certified pediatric nurses or pediatricians), and a care coordinator role during weekdays.

Shortly after the NIDCAP certification, a local branch of the parent national association "SOS Préma" was established in the department. Mme Wallet, a volunteer mother from the association, regularly visits the department and organizes activities for families. Over the years, the department's layout has been continually reimagined. The parents' kitchen was completely renovated, double beds for parents were installed in three neonatal unit rooms, and the staff kitchen and service reception area were redecorated with the help of the "Bricos du Cœur" association.

In 2020, inspired by the national "First 1000 Days" project, the regional perinatal network (OREHANE) initiated a project, financially supported by the Hauts-de-France Regional Health Agency, to facilitate the implementation of developmental care in neonatal units by offering accessible training programs. This marked a pioneering experiment of such scale in France.

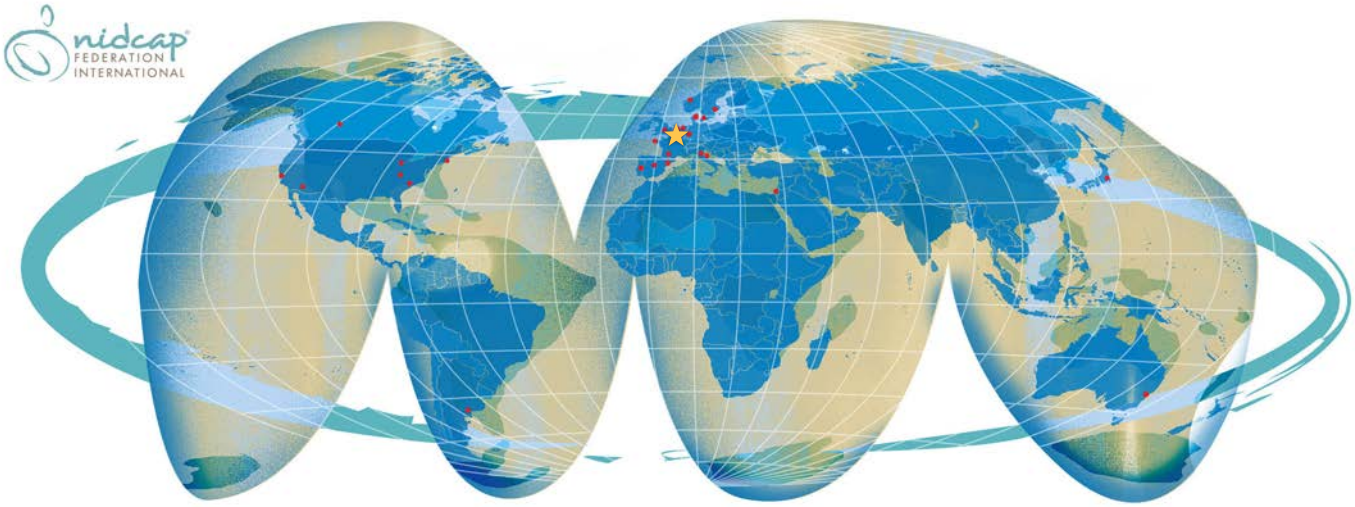
Peggy Laurant, a pediatric nurse from Valenciennes, began her NIDCAP trainer training in 2021, dedicating 50% of her time, supported by Valenciennes Hospital. The training was led by Delphine Druart from CHU Saint Pierre in Brussels, under the guidance of Agneta Kleberg and Deborah Buehler for the APIB (Assessment of Preterm Infants' Behavior). This ambitious training process expanded across the region, with Peggy Laurant conducting numerous developmental care initiation sessions, training 568 individuals from June 2021 to October 2024 (with additional sessions led by Stéphanie Giers, a certified NIDCAP professional from Roubaix Hospital, in 2024). As part of her NIDCAP trainer training, Peggy certified two neonatal nurses from Valenciennes.

In 2023, FINE 2 (Family and Infant Neurodevelopmental Education) training sessions began in Valenciennes before expanding regionally, with eight professionals certified in 2024 and 12 in training.

At the beginning of 2024, Peggy Laurant completed her NIDCAP Trainer certification and APIB Professional certification. The Valenciennes NIDCAP Training Center was then established, led by Dr. Sabine Réthoré (NIDCAP certified pediatrician) and co-led by Dr. Juliette Guilliot (head pediatrician, NIDCAP Professional) and Peggy Laurant as a NIDCAP Trainer.

The opening of the Valenciennes NIDCAP Training Center was the culmination of a long process, built on trust between leadership and department heads, but it also marked the beginning of a new chapter for the neonatology department in Valenciennes. To be continued...

English translation with assistance of AI and Kiki Remont.



Valenciennes NIDCAP Training Center, France

Tant de chemin parcouru!

Juliette Guilliot, pédiatre en chef et Peggy Laurant, infirmière pédiatrique et formatrice NIDCAP

DOI : 10.14434/do.v18i1.40913

C'est dans la ville de VALENCIENNES, dans le nord de la France que tout commence. Après la construction d'un Nouveau complexe hospitalier qui s'est achevé avant la seconde guerre mondiale, c'est en 1960 que la nouvelle maternité fut bâtie. En hommage à la principauté de MONACO, marraine de la ville de VALENCIENNES durant la première guerre mondiale, elle fut inaugurée en 1980 par la mère du prince Rainier III et devint alors la maternité "Monaco".

Le service de néonatologie était éloigné de la maternité, les salles de soin étaient de grands espaces ouverts entourés de baies vitrées, ne disposant que de peu de place pour les parents. Le Docteur Catherine Zaoui qui dirigeait alors l'unité était curieuse de découvrir d'autres pratiques et philosophie de soins. Un voyage à BREST était alors organisé, à la rencontre des Dr Nathalie Ratynski et Jacques Sizun, pionniers de l'implantation du NIDCAP en France. Le début d'un grand changement s'annonçait mais il a fallu faire avec les moyens que nous disposions c'est-à-dire cette architecture ! Avec beaucoup de bruit, de lumière…La motivation était bien présente et progressivement quelques techniques de soins de développement sont mises en place, menées par une équipe dynamique et bienveillante.

C'est en février 2005 que le service de néonatologie déménage dans de magnifiques locaux conçus dans l'objectif d'implantation des soins de développement et du NIDCAP avec des équipements adaptés comme un monitorage central, des chambres parents-enfants, des salons d'accueil, une tisanerie et une chambre pour des parents habitant loin. La

Hôpital néonatal de Monaco

formation de l'équipe soignante alors très investie dans le projet commence par la certification de 2 pédiatres et de 2 infirmières puéricultrices, formées par le docteur Nathalie Ratynski du centre de formation de Brest. L'aménagement du service est repensé dans cette philosophie, des formations sur l'allaitement maternel sont déployées et divers groupes de travail se mettent en place (Promotion de l 'allaitement maternel; accompagnement des parents vers la sortie ; lutte contre les nuisances sonores ; promotion des interactions précoces, du peau à peau, la musique, la lecture ; la prise en charge de la douleur…) ainsi que la mise en place d'un comité de pilotage en collaboration avec les parents. Les formations NIDCAP se poursuivent durant plusieurs années avec au total 8 infirmières et 5 pédiatres formés.

Une salle commune à la maternité

L'équipe NIDCAP de Valenciennes

Dans la continuité du projet d'implantation du NIDCAP dans le service, un poste de référent est créé en 2011. Le nombre d'observations augmente considérablement. Deux années plus tard, l'équipe s'engage dans la démarche de certification NIDCAP. Un seul service est alors certifié en France, le service de néonatologie du CHU de BREST. La certification est finalement obtenue par le service en 2016, récompensant alors le dynamisme et le travail de toute l'équipe.

Le travail sur l'allaitement maternel porte ses fruits et le service de maternité et de néonatologie obtient la Labellisation IHAB en 2011 et est depuis régulièrement recertifié en 2015, 2019 et 2024.

Le service dispose de 2 postes de consultantes en lactation en journée en semaine (1 en maternité, 1 en néonatologie), d'un poste de « référente NIDCAP » en journée en semaine en néonatologie (avec renfort occasionnel d'autres IPDE certifiées ou pédiatres certifiées) et d'un poste de « référente de soins » en journée en semaine.

Peu de temps après la certification NIDCAP, une antenne locale de l'association nationale « SOS Préma » est créée dans le service. Mme Wallet, maman bénévole de l'association, intervient régulièrement dans le service et organise des animations pour les familles. Durant toutes ces années, l'aménagement du service est toujours repensé. L'espace cuisine des parents est entièrement rénové, des lits doubles pour les parents sont installés dans trois chambres parentales dans l'unité de néonatologie. La cuisine du personnel et l'accueil du service sont également redécorés grâce à la participation de l'association des « Bricos du cœur ».

En 2020, sous l'impulsion du projet national des « 1000 premiers jours », un projet est élaboré par le réseau régional de périnatalité OREHANE avec le soutien financier de l'agence régionale de santé des Hauts de France. L'objectif était alors d'aider à l'implantation des soins de développement dans les unités néonatales en proposant des formations accessibles à tous. Il s'agit alors d'une première expérimentation d'une telle ampleur en France.

La formation de formateur NIDCAP de Peggy Laurant, infirmière puéricultrice de VALENCIENNES débute, grâce sa mise à disposition par le Centre Hospitalier de Valenciennes à hauteur de 50 % de son temps de travail. Cette formation commence en 2021, assurée par la formatrice Delphine Druart du CHU Saint Pierre de Bruxelles sous la guidance de Agneta Kleberg et de Déborah Buehler pour l'APIB. Un long et ambitieux processus de formation débute alors et se déploie dans la région avec de nombreuses sessions d'initiation aux soins de développement menées par Peggy Laurant permettant la formation de 568 personnes de juin 2021 à octobre 2024 (sessions également animées par Stéphanie Giers professionnelle certifiée NIDCAP du centre hospitalier de Roubaix en 2024). Dans le cadre de sa formation de formatrice NIDCAP, deux infirmières de néonatologie de Valenciennes sont certifiées par Peggy. Dans un second temps, les formations FINE 2 débutent en immersion à Valenciennes en 2023, avant de s'étendre à toute la région avec un total 8 professionnels formés en 2024 et 12 en cours de formation. (Cf carte régionale).

Début 2024, la formation de formatrice NIDCAP de Peggy Laurant et la formation APIB sont validées, le centre de formation NIDCAP de VALENCIENNES est alors créé, dirigé par le Docteur Réthoré Sabine (pédiatre certifiée NIDCAP) et co-dirigé par le Docteur Guilliot Juliette (pédiatre cheffe de service certifiée NIDCAP) et Peggy Laurant comme Formatrice NIDCAP.

L'ouverture du centre de formation est le résultat d'un long processus, d'une longue relation de confiance entre les directions et les chefs de Pôle… mais aussi le début d'une nouvelle histoire pour le service de néonatologie de Valenciennes. A suivre…

NIDCAP TRAINING CENTERS

AMERICAS

North America

CANADA

Edmonton NIDCAP Training Centre

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