

Problem Statement

Trauma-informed care (TIC) in the neonatal intensive care unit (NICU) is not widely implemented, yet compelling evidence exists regarding adverse consequences of prolonged early experiences of toxic stress, bringing relevance for a trauma-informed approach to neonatal care.

Background

- ❖ Prolonged toxic stress and neonatal trauma can permanently and negatively alter long-term brain development and result in unfavorable impacts on the life course of both infant and family (D'Agata et al., 2017; Weber & Harrison, 2019; Wolke et al., 2019).
- ❖ Early adverse childhood experiences resulting from NICU hospitalization have garnered the attention of neonatal professionals, researchers, and policymakers in support of transformative change, yet there is a paucity of research related to TIC implementation in the NICU (Forkey et al., 2021).
- ❖ Trauma-informed care involves relational healthcare delivery aimed to mitigate stress using the buffering effect of parental attunement and coregulation while prioritizing collaborative and nurturing neonatal care (Forkey et al., 2021).
- ❖ The TIC approach is underpinned by robust development care theory which promotes a neuroprotective, healing environment for vulnerable infants and families (Coughlin, 2021). Many neonatal intensive care units profess to use a TIC approach; however, a significant gap in the translation of theory into practice exists. High levels of stress and burnout of NICU staff negatively influence advocacy for TIC and willingness to adopt necessary changes (Profit et al., 2014).
- ❖ TIC integration prioritizes the physical and emotional wellbeing of the infant-parent dyad, and the needs of staff who experience secondary trauma (Patel, 2011).

Research Questions

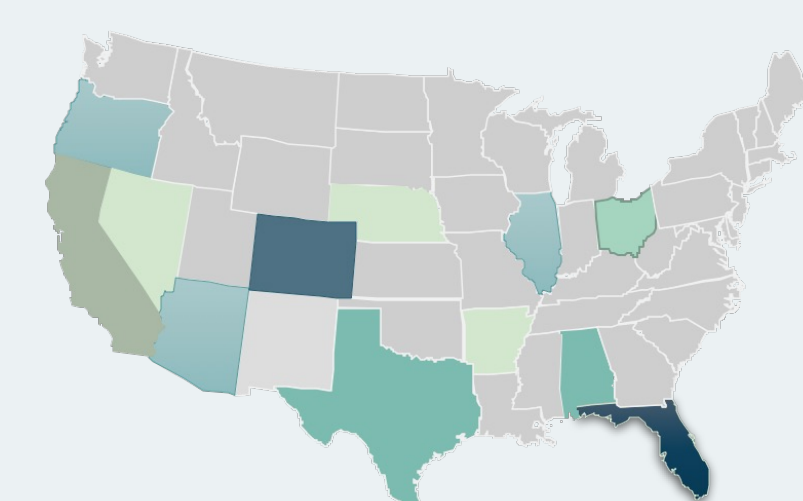
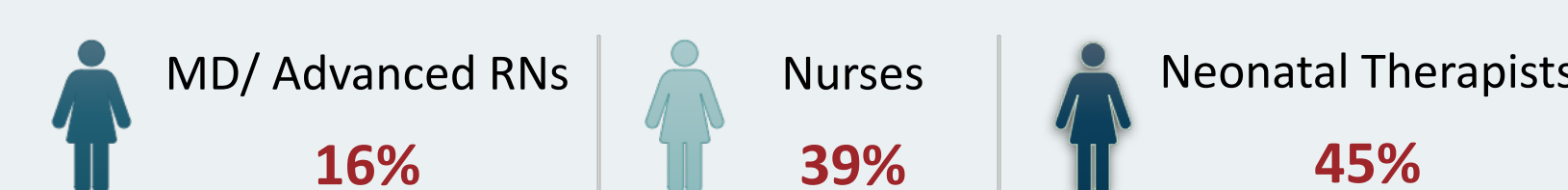
The overarching research aim was to identify the specific facilitatory and encumbering determinants of TIC implementation in NICU settings. This will help identify factors that influence TIC the adoption and integration into practice.

1. What is the perceived use and value of trauma-informed care principles within the participant's NICU setting?
2. What are perceived gaps in the delivery of trauma-informed care for infants and families in the NICU?
3. What personal factors are facilitators/barriers to implementation of trauma-informed care in the NICU?
4. What systemic factors are facilitators/barriers to implementation of trauma-informed care in the NICU?
5. What are Trauma-Informed Professionals' views on future research, policy and advocacy needs related to implementation of trauma-informed care practices in the NICU?

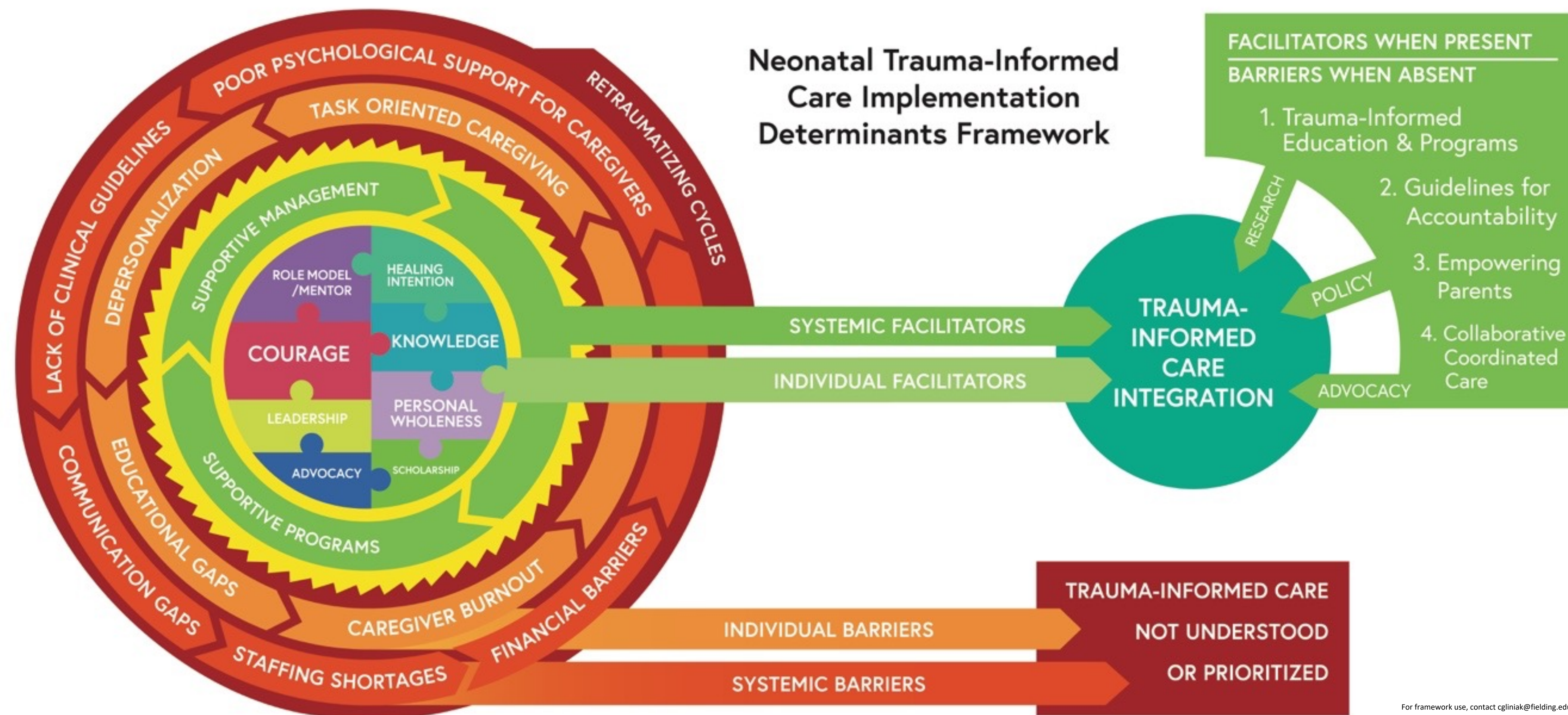
Methodology

- ❖ This study used a hermeneutic (interpretive) phenomenological research design to explore the lived experiences of neonatal professionals who champion trauma-informed care to uncover the "essence" of translating TIC theory into clinical practice (Neubauer et al., 2019).
- ❖ The neonatal health professionals in this study were active participants who helped co-create the data through mutual exploration and were viewed as content experts on trauma-informed care in the NICU (Carter & Little, 2007).
- ❖ Thirteen semi-structured interviews were conducted with multidisciplinary participants who were (a) English-speaking, (b) ages 25-70 years old, (c) veteran change agents, (d) had a minimum of 2 years of experience working in a NICU within the United States, and (e) had completed the Trauma Informed Professional (TIP) Certificate Program by Caring Essentials Collaborative, LLC.

Participant Demographics



19.36
Average Years of Experience in the TIP Cohort



Thematic Findings: (Architecture of the Framework)

There are three main architectural components in the framework: (a) a facilitatory cycle that leads to greater TIC integration, (b) an inhibitory cycle that contributes to retraumatization and a culture resistant to change, and (c) influential factors related to research, policy, and advocacy that when present are supportive and when absent are added barriers. The graphic represents the facilitatory cycles in green and the inhibitory elements in shades of red and orange. The two cycles have opposing forces resulting in a source of friction which is represented by a yellow jagged edge. When one cycle is consistently stronger, it will influence the trajectory of the TIC implementation process and ultimately dictate the overarching attitudes and practices within that individual NICU culture.

THEME 1:
Trauma-informed care fundamentals are NOT commonly practiced

There was an overwhelming consensus that TIC in the neonatal setting is poorly understood and often dismissed as nonessential to NICU care. Furthermore, results indicate that the tenets of TIC are not consistently practiced in the NICU, demonstrated by the multiple missteps and gaps witnessed by the participants.

"I don't really feel like, in these [neonatal] units, we've addressed trauma-informed care at all."

"I see a big gap in the way we speak to the families and the way we speak to each other...that is not trauma-informed care!"

THEME 2:
Individual & Systemic Facilitators

Individual Facilitators (represented as puzzle pieces): The eight attributes of a TIC champion were highly influential and contributed to recovery from burnout / secondary trauma, empowerment, and momentum towards their role as an agent of change.

"I was confident in my [TIC] knowledge. And that's why I was able to be courageous."

"I want to role model it [TIC] instead of trying to create change that's forced. We can show them, this is what the data is saying, and this is what the outcome will be if we keep following this pathway."

"You really have to get people to believe it and experience it. See the benefit... they won't want to do it any different."

Systemic Facilitators (includes the NICU team, hospital system, professional associations, etc.): Supportive stakeholders and TIC programming were identified as systemic facilitators. This includes NICU leaders that prioritize open communication and staff empowerment as well as advocacy for TIC education, funding, and evidence-based practices aimed to mitigate neonatal trauma.

THEME 3:
Individual & Systemic Barriers

Individual Barriers: Participants' lived experiences exposed four factors in the category of individual barriers to the implementation of TIC, including:

- caregiver burnout
- education gaps
- task-oriented caregiving
- depersonalization

"Nurses have their ABC, XYZ [tasks], and it's hard to get them to pause and rethink how they could do it better for the child or the baby, for the family."

"They don't really know what [TIC] means or how it applies"

Systemic Barriers: The data revealed five factors which were coded as systemic barriers including:

- staffing shortages
- poor psychological support
- a lack of clinical guidelines
- financial barriers
- communication gaps

"I think the big 'they' of the hospital system...think that it's fluffy"

"In terms of unit and even organizational [barriers], it comes down to staffing and resources."

THEME 4:
Future Determinants of Research Policy & Advocacy

The final theme was related to the impact of research, policy, and advocacy on TIC integration. These factors were supportive when present and barriers when absent. Four factors that emerged in the data were 1) TIC education and programs, 2) guidelines for accountability, 3) empowering parents, and 4) collaborative and coordinated care.

"Educating the staff, educating the nurses, educating the physicians, educating the respiratory therapists...educating everybody... Getting a baseline to even just recognize it [TIC]."

"There needs to be more, especially in the mental health area for our families. They focus so much on the baby, but the parents don't get what they need."

Guidelines for Accountability



Limitations

- ❖ TIC is not well defined; therefore, implementation is difficult to measure.
- ❖ This research adds to the body of evidence of why TIC theory is not translating into practice, but the results are not generalizable.
- ❖ There was a small sample size with administrators not represented.
- ❖ Participants were highly influenced by their TIP training.

Discussion/Conclusion

- ❖ Trauma-informed care in the NICU aims to apply neuroprotective developmental care to foster brain growth, infant-parent attachment, and future physical and social-emotional wellbeing of both infants and their parents (Sanders & Hall, 2018).
- ❖ This study unveiled the fact that NICU professionals value TIC and recognize its benefit for building therapeutic relationships, reducing stress and preventing retraumatization for infants and parents.
- ❖ This study revealed that TIC is often misunderstood, not commonly practiced, and not always considered a priority in the NICU.
- ❖ Gaps in the delivery of TIC that emerged, revolve around the need for safe, compassionate support for all families, regardless of trauma history, culture, or socioeconomic background.
- ❖ Participants emphasized how current NICU practices are insufficient in the way they support and engage parents by not involving them in team decisions, not actively including them in daily infant caregiving activities, use of judgmental communications, and making parents feel like visitors.
- ❖ In addition to the lack of TIC education, other individual barriers included caregiver burnout, depersonalization, and task-oriented caregiving.
- ❖ Systemic barriers that surfaced were poor psychological support for caregivers, communication gaps, staffing shortages, financial barriers, and lack of clinical guidelines.

Key Takeaways

★ Although the theoretical concepts of TIC are highly valued in the neonatal community, the translation of these principles into NICU practices is hindered by the lack of clear guidelines and consistent application.

★ By successfully uncovering barriers and facilitators of TIC implementation, this research enables individual caregivers and hospital systems to recognize their strengths and weaknesses and formulate a strategic plan to elevate trauma-informed care in their unique NICU settings.

★ To improve TIC integration, greater efforts in research, policy, and advocacy are needed in the areas of parent empowerment, TIC education and programs, development of guidelines for accountability, and more collaborative and coordinated care. This applies to both individual hospital systems as well as national policy makers.

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