FANNP NEWS

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CALL FOR NOMINATIONS

FANNP Wants You!

This is an election year and positions are open for the Board of Directors for FANNP! The term of office is January 1, 2019 through December 31, 2020. All positions are a two-year commitment except for President-Elect. Responsibilities include attendance at Board of Director Meetings, participation at FANNP sponsored Symposium, and participation on established committees.

The Officer positions are:
President Elect: Fills in as President in their absence as designated, Chair of Bylaws Committee, succeeds to Presidency upon completion of term, and continues as Past-President following completion of Presidency term (4 year commitment).

Secretary: Keeps minutes of all meetings, gives notice of all meetings, keeps bylaws and

SEE "NOMINATIONS" on page 10

Improving Standard Practice for Perinatal Palliative Care: A Literature Review

Jennifer E. Humphries, MSN, RN, CRNP, NNP-BC

Abstract

Background and Purpose

The notion that perinatal palliative care is needed has slowly begun to evolve, but no model for a standard of care has been designed. The rising rate for survival of preterm infants and lethal congenital anomalies results in parents and health care providers being faced with complex end of life decisions for neonates. The purpose for this literature review is to determine if a standard model of care exists.

Review of the Literature

A review of current literature was conducted to identify and summarize current practice, evaluate effectiveness, and suggest a current model of care for perinatal palliative care. A systematic literature review yielded over 200 articles. After exclusions, 10 articles were used for the purpose of this review.

Evidence-based Strategies to Address a Gap in Literature

A major gap in care is the lack of consistency in the approach to perinatal palliative care. Health care providers often consult subspecialties such as hospice and pediatric palliative care for perinatal palliative care. This offers limited resources for the perinatal and neonatal clinical setting. Other gaps that contribute to the lack of standard care include: education, lack of communication, ethics, spiritual beliefs, and parental involvement.

Conclusions and Implications

Despite the awareness for the need of palliative perinatal care, there are no evidenced-based studies to indicate the best model of care. The articles reviewed identified similar barriers that lead to inconsistency in how health care providers approach the complex perinatal decision-making. Once the barriers are addressed further research should be done in order to create a model of care that would better accommodate this clinical setting.

Introduction

Over 1 million pregnancies result in fetal death and 19,000 infants in the neonatal period die every year in the United States (Cortezzo, Sanders, Brownell, & Moss, 2015). Some deaths are unexpected, but for those anticipated deaths, palliative care support is essential. Palliative

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Letter from the President

Hello FANNP Members!

As I begin my term as FANNP's president, I would like to share a quote from David Viscott's book of meditations, *Finding Your Strength in Difficult Times*: "The purpose of life is to discover your gift. The work of life is to develop it. The meaning of life is to give your gift away" (1993). In accordance with its mission of supporting and promoting advanced neonatal nursing practice, FANNP has been instrumental in the discovery and development of my personal and professional gifts. I first attended the National Neonatal Nurse Practitioner Symposium in 2010, as I was preparing for my NCC board examination. At the conference, I learned of the many opportunities for involvement and support that FANNP provides to its members and had many networking opportunities that led to my service as the FANNP newsletter editor from 2011-2015. I received an FANNP scholarship for my MSN and DNP degrees and had the opportunity to present at the conference in 2015, after the completion of my DNP program.

FANNP has invested greatly in my professional career and I look forward to this opportunity for reciprocity. Among others, I would like to thank past-president, Diana Morgan-Fuchs for her leadership and encouragement. I am absolutely humbled by this opportunity to continue to develop professionally, while serving FANNP as president.

In addition to its contribution to my professional career, I would be remiss if I did not take a moment to appreciate FANNP's rich history. One salient point about the organization is that for 29 years, FANNP has been operationalized solely by volunteers. Some of the original volunteers remain heavily involved in the organization. The impact that FANNP has had on generations of NNPs is inspiring. As a non-profit organization, the way that FANNP stewards their resources in order to remain effective and relevant would impress any CFO. I would like to thank the individuals who serve on the Board of Directors, that tirelessly volunteer their expertise, time and energy to provide opportunities for present and future NNPs.

How can FANNP assist you in discovering your gifts and achieving your highest success? Are you in need of scholarship support to pursue your graduate degree? I would like to encourage current and future students to consider applying for an FANNP scholarship (see FANNP.org for details and application). Perhaps you're an independent researcher or involved in research associated with your education and require a grant? FANNP has grant funds available!

Might you have an abstract or poster you would like to present at a national conference? Have you attended the annual symposium to prepare for your NCC board examination or renew your knowledge? Make plans to submit an abstract for a podium or poster presentation and attend FANNP's 29th National Neonatal Nurse Practitioner Symposium: Clinical Update and Review, October 16th-20th, 2018! Clearwater is gorgeous in October, and provides a perfect environment for learning, relaxing, and networking with new & existing friends and colleagues.

Would you enjoy the opportunity for complimentary, constructive editorial support and publication of an article in the newsletter? Are you involved in a professional organization to enrich your portfolio and career? FANNP provides all of these opportunities to discover, develop, and give your gifts away. Consider making 2018 the year that you establish and achieve new career goals. I am happy to mentor and assist in any way I can, so please do not hesitate to contact me for suggestions, questions, comments or concerns.

Tiffany Gwartney, DNP, ARNP, NNP-BC
President, FANNP

Food for Thought

Neonatal Abstinence Syndrome (NAS)

Submitted by Christa Smith, MSN, NNP-BC

In light of the current Opioid Epidemic, wherein prescription opioid sales in the United States has quadrupled since 1999 and death from opioid overdose has drastically increased (Paulozzi, Jones, Mack, and Rudd, 2011), a brief discussion on Neonatal Abstinence Syndrome (NAS) is warranted.

NAS is a group of symptoms that occur in a newborn exposed to addictive drugs while in utero. Symptoms of NAS depend on many factors, including the type of drug the mother used, how much of the drug she used, and duration of drug use.

Between the years 2004 and 2013, NAS has quadrupled and hospital length of stay increased significantly, resulting in a 7-fold increase in NICU stays related to NAS.

Infants at risk for NAS should be carefully monitored in the hospital for the development of withdrawal symptoms. Duration of hospital observation is variable and depends on a thorough assessment of maternal drug history. An infant born to a mother on a low-dose prescription opiate with a short half-life, such as hydrocodone, may be discharged if there are no withdrawal signs by age 3 days, whereas an infant born to a mother on an opiate with a prolonged half-life , such as methadone, should be followed for a minimum of 5-7 days.

The Finnegan scoring system is the most widely used method for assessing NAS, in both its original and modified forms. The Finnegan scale assesses 21 of the most common signs of NAS, and is scored on the basis of the severity of symptoms and pathological significance, which sometimes requires pharmacological treatment.

Primary treatment of neonatal symptoms due to substance exposure should be supportive since pharmacologic therapy can prolong hospitalization and exposes the infant to potentially unnecessary medications. However, pharmacotherapy for infants with more severe expression of NAS allows them to better feed, sleep, gain weight, and interact with caregivers. Opioids are currently considered the first-line therapy, with phenobarbital use as second-line and/or concomitant therapy.

According to Hamdan (2017),

> The limited available evidence from controlled trials of neonatal opioid withdrawal supports the use of oral morphine solution and methadone when pharmacologic treatment is indicated. Treatment with sublingual buprenorphine for NAS appears to be associated with a shorter duration of opioid therapy and hospitalization compared with oral methadone therapy. Studies comparing buprenorphine to morphine have shown shorter duration of treatment and shorter hospital stay in infants treated with buprenorphine. Both groups had similar rates of side effects.

The American Academy of Pediatrics (AAP), The American College of Obstetricians and Gynecologists (ACOG), and the Academy of Breastfeeding Medicine (ABM) all support breastfeeding among opioid-dependent women if no further contraindications to breastfeeding are observed, such as ongoing drug use or HIV infection. Higher calorie and more frequent small feedings are preferable for optimal growth of the NAS-affected infant. Careful monitoring of fluid intake and weight gain is of vital importance.

In utero drug exposure can also manifest adverse neurodevelopmental outcomes in children. Lower IQ scores have been reported with in utero exposure to methadone. According to Hamdan (2017),

> Speech, perceptual, and cognitive disturbances have been reported in toddlers who were exposed to opiates. In utero opioid exposure may have the potential to also affect gastrointestinal tract and the gut biome, which, in turn, may impair immunity and protection against pathogens, thereby affecting health over the long term. Death is rarely associated with withdrawal alone but occurs as a consequence of prematurity, infection, and severe perinatal asphyxia.

Although the long-term mortality rate is thought to be low, the risk for Sudden Infant Death Syndrome (SIDS) is significantly higher among opiate-exposed infants, with infants exposed to methadone having a 3.7-fold higher risk of SIDS in comparison with controls.

References:

Hamdan, A. (2017, Dec. 20). *Neonatal abstinence syndrome treatment and management.* Retrieved from https://emedicine.medscape.com/article/978763-overview

Paulozzi, L., Jones, C., Mack, K., and Rudd, R. (2011, Nov. 4). *Vital signs: overdoses of prescription opioid pain relievers-united states, 1999-2008.* Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w%20-%20fig2

Food for Thought is a quarterly addition to the FANNP Newsletter, where we discuss trending topics of importance in the Neonatal Intensive Care setting. We would love to hear what you and your colleagues are discussing currently in your work place, and greatly value your input. Please feel free to send any "trending topics" that you would like to hear more about to newsletter@fannp.org. In the ever-changing world of neonatology, remaining cognizant of current practices is of vital importance to furthering our education as providers!

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care in the neonatal population has been explored for decades, but only recently has the idea of implementing a standard of care practice emerged. Often women pregnant with complex fetal anomalies are provided consults with pediatric palliative care subspecialists, but not referred to perinatal palliative care specialists. Although pediatric palliative care can expand their assistance with medical and emotional support, the perinatal palliative care team has specific areas untouched by other subspecialists. They can provide support in creating a birth plan that accommodate the parent's wishes, improve communication, assist in comfort care, and coordinate services for hospice and bereavement (Kukora, Gollehon, & Laventhal, 2016).

Initiating perinatal palliative care can be challenging for healthcare providers, but ensuring consistency and offering a standard of care would benefit the family, infant, and healthcare providers (Tosello et al., 2015). Support and increased understanding is gained when palliative care is provided to families. With lack of support, families have feelings of helplessness, anger, and feel their child was not valued. There are positive effects of palliative care such as increased communication, parental involvement, and less resuscitation attempts and life sustaining procedures that prolong the inevitable (Cortezzo et al., 2015).

Literature Review

The purpose of the literature review was to examine the evidence concerning palliative care consults provided to women that are pregnant with a fetus diagnosed with a fatal anomaly. A great amount of data exists for palliative care in other aged population, but limited in the perinatal population. This review will incorporate barriers identified that prevent education, communication, and implementation of palliative care in the neonatal population that are born with fatal anomalies or diagnosed with fatal outcomes. Gaps are identified that support the need for improvement in creating policies and procedures in order to provide adequate palliative care in the neonatal population.

The literature review overall describes similar experiences among physicians, nurse practitioners, nurses, and parents. Some literature described the medical staff being confident that they offered adequate perinatal palliative consultation to parents (Korzeniewska-Eksterowicz et al., 2013). In contrast some findings in the literature revealed teams acknowledging the need for improvement in preparing families for end of life care during the perinatal period (Cortezzo, Sanders, Brownell, & Moss, 2015).

In regards to end of life decision making, parents have voiced concerns that their child suffers. Parents want to be more involved and share the decision making role and express that they are capable of handling a more active role in the palliative care phase. Physician's tend to focus mainly on preparing parents for the withdrawal of care instead of including the family in the end of life decision making due to the fear of placing too much responsibility on the parent (Cortezzo, Sanders, Brownell, & Moss, 2015). Despite the intention to protect parents the study has shown that parents appreciate full details because it helps them to face up to reality and helps them feel in control of the situation they face (de Vos et al., 2015).

In a pilot study, a survey was sent to parents that experienced the death of an infant by using a seven-point Likert scale. Twenty-three surveys were mailed with no reminders. Seven families responded and 5 were returned with undeliverable addresses. They were allowed to complete the survey by phone or on paper. Over half of the parents stated that their wishes were granted by the healthcare team and they did not feel alone. Close to three-fourths felt that they received emotional support from the healthcare team and most felt they were educated about bereavement services. All of the families left comments and voiced the importance of bereavement support, memory making, and follow up (Cortezzo, Sanders, Brownell, & Moss, 2015).

Barriers

Barriers to the delivery of adequate neonatal palliative care ranged from lack of communication, lack of opiate use due to fear of respiratory depression, and lack of education. Parents and providers often have different spiritual beliefs on how to approach end of life care. Parents felt as they were not included in making decisions for the end of life care (Martin, 2013).

Insufficient knowledge has been a major concern for personnel and families regarding implementation of end of life care (Peng et al., 2013). Barriers pointed out by nurses to list a few, were: difficult communication with physicians, few personnel members, conflicting opinions between family and personnel, lack of clear guidelines, and personnel's fear of legal action (Korzeniewska-Eksterowicz et al., 2013).

Intervention

Early intervention not only increases curative needs for the fetus and mother, but addresses needs of the whole family including psychological, spiritual, and social needs. It could aid in preparing for the infant's death and therefore assisting in coping (Balaguer, Martin-Ancel, Ortigoza-Escobar, Escribano, & Argemi, 2012). In a single center cohort study, patients were referred for outpatient perinatal palliative care performed by neonatologists. Although the outcomes for the neonates would not have changed, the patients were more likely to have a comfort plan implemented and have a shorter hospital stay prior to death. This was felt to be due to the parent's values and their wishes to expand their baby's life expectancy even if there were lethal conditions (Kukora et al., 2016).

There are two important implications with parental authority and what is in the best interest of the infant. First, it is crucial in perinatal palliative care to explore the parental values and beliefs especially for those infants diagnosed with lethal conditions. Second, if the palliative care team is not involved, a comfort care plan should be in place to manage pain,

agitation, and provide comfort for the infant (Kukora et al., 2016).

There is a need for health care providers to recognize and understand barriers in order to facilitate end-of-life care. The World Health Organization (WHO) provides support for the idea of end of life care in the neonatal population and supports a designed model of care that provides pain management to accomplish the best quality of life (Wright, Prasun, & Hilgenberg, 2011). One study discussed similar outcomes for infants that were deemed with poor prognosis whether perinatal palliative care was implemented or not. However, they were more likely to endure a shorter stay in the hospital until time of death and comfort care was likely to be provided (Kukora et al., 2016). In reviewing the literature there appears to be no evidenced based standard of care designed for the perinatal clinical setting, although it has gained much attention over the years.

Boundaries

Despite the awareness of the need for standard care for perinatal palliative care, barriers continue to exist. Hesitancy occurs with parents who do not desire limited life sustaining therapies, because they fear palliative care interferes with that goal. Parents need assurance that palliative care would not replace their desire, but support their wishes and provide support to the infant. In contrast for those parents wishing to not prolong the inevitable, the support from palliative care seemed to be beneficial. Hesitancy also occurs with providers not being comfortable to implement palliative care for those infants with potential for normal neurological development such as infant with a genetic disorder or syndrome. Some providers realize the outcome would not change for an infant with ominous anomalies and tend to not promote the idea of vigorous testing. This results in unknown diagnosis and therefore may exclude them from the benefits of the support provided opposed to the support received from parents who have an actual diagnosis (Kukora et al., 2016).

Effective communication between physicians and parents is found to be a barrier in perinatal palliative care. Physicians may approach parents with caution when preparing them for the decision to withdraw or withhold life-sustaining treatment, so as not to over-burden parents with too much responsibility. The study on parental interaction shows that parents want to be involved. They believe that having knowledge of information aids them in adapting and preparing for the decisions they must make for end of life care. Thus, having the right balance of communication between parents and the physician is the beginning of ensuring adequate preparation for the decision making stage. Unequal balance was demonstrated in the deliberating and final decision stages (de Vos et al., 2015).

Conclusion

The need for perinatal palliative care has increased over the years. It is not a new concept, yet progress has been slow. Using the example of adult and pediatric palliative care, evidence shows that palliative care improves quality of life and parental coping. A standard model of care has yet to be designed that focuses on the perinatal and neonatal population.

A good start to begin developing a standard model of care is to identify the limitations such as lack of education, different spiritual beliefs in end of life care, communication, and identifying the need to implement palliative care. Additionally, the goal is to provide methods of support to the families and allow them to become part of the decision making team. Education is needed for all team members including providers of care as well as the family. Embracing the importance of perinatal palliative care, overcoming barriers and establishing consistency in implementation in perinatal palliative care is imperative in order to improve overall standards of care in this population.

References

Balaguer, A., Martin-Ancel, A., Ortigoza-Escobar, D., Escribano, J., & Argemi, J. (2012). The model of Palliative Care in the perinatal setting: a review of the literature. BMC Pediatr, 12, 25. doi:10.1186/1471-2431-12-25

Cortezzo, D. E., Sanders, M. R., Brownell, E. A., & Moss, K. (2015). End-of-life care in the neonatal intensive care unit: experiences of staff and parents. Am J Perinatol, 32(8), 713-724. doi:10.1055/s-0034-1395475

de Vos, M. A., Bos, A. P., Plotz, F. B., van Heerde, M., de Graaff, B. M., Tates, K., . . . Willems, D. L. (2015). Talking with parents about end-of-life decisions for their children. Pediatrics, 135(2), e465-476. doi:10.1542/peds.2014-1903

Korzeniewska-Eksterowicz, A., Respondek-Liberska, M., Przyslo, L., Fendler, W., Mlynarski, W., & Gulczynska, E. (2013). Perinatal palliative care: barriers and attitudes of neonatologists and nurses in Poland. ScientificWorldJournal, 2013, 168060. doi:10.1155/2013/168060

Kukora, S., Gollehon, N., & Laventhal, N. (2016). Antenatal palliative care consultation: implications for decision-making and perinatal outcomes in a single-centre experience. Arch Dis Child Fetal Neonatal Ed. doi:10.1136/archdischild-2016-311027

Martin, M. (2013). Missed opportunities: a case study of barriers to the delivery of palliative care on neonatal intensive care units. Int J Palliat Nurs, 19(5), 251-256. doi:10.12968/ijpn.2013.19.5.251

Peng, N. H., Chen, C. H., Huang, L. C., Liu, H. L., Lee, M. C., & Sheng, C. C. (2013). The educational needs of neonatal nurses regarding neonatal palliative care. Nurse Educ Today, 33(12), 1506-1510. doi10.1016/j.nedt.2013.04.020

Tosello, B., Dany, L., Betremieux, P., Le Coz, P., Auquier, P., Gire, C., & Einaudi, M. A. (2015). Barriers in referring neonatal patients to perinatal palliative care: a French multicenter survey. PLoS One, 10(5), e0126861. doi10.1371/journal.pone.0126861

Wright, V., Prasun, M. A., & Hilgenberg, C. (2011). Why is end-of-life care delivery sporadic?: A quantitative look at the barriers to and facilitators of providing end-of-life care in the neonatal intensive care unit. Adv Neonatal Care, 11(1), 29-36. doi:10.1097/ANC.0b013e3182085642

**All Feature Articles are submitted to the FANNP Scholarship Committee by FANNP members seeking to further their education. This article was edited by the FANNP in conjunction with the student, and with the student's permission.

POCKET NOTEBOOK

Diane McNerney DNP, NNP-BC

Newborn Pneumonia: Etiology, Diagnostics, and Treatment

Pneumonia is a contributing factor in 10-25% of all deaths that occur in neonates younger than 30 days.

1. Prenatal Risk factors:
   - Unexplained preterm labor
   - Rupture of membranes before the onset of labor
   - Prolonged rupture of membranes
   - Maternal fever (>38°C/100.4°F)
   - Uterine tenderness
   - Foul-smelling amniotic fluid
   - Previous infant with neonatal infection
   - Non-reassuring fetal status
   - Fetal tachycardia
   - Meconium stained fluid
   - Recurrent maternal UTI
   - Infection of the maternal GU tract
2. Pathophysiology:
   - Early or late onset
   - Organisms acquired from the maternal genital tract or nosocomial
   - Bacteria are the principal pathogens for both types
   - Gram-positive cocci (e.g., groups A and B streptococci- GBS pneumonia)
   - Gram-negative bacilli (e.g., Escherichia coli, Klebsiella, and Proteus)
   - Additional pathogens include Pseudomonas, Citrobacter, Bacillus, and Serratia.
   - Noninfectious causes, such as aspiration of meconium, amniotic contents, food, blood, and other agents.
3. Late Onset Pneumonia
   - Respiratory pathogens (RSV, influenza, adenovirus, and others) may be transmitted shortly after birth, but infection by these organisms rarely apparent during the first 24 hours
4. Mechanism of Infection
   - Inflammatory pulmonary process
   - Abnormalities of airway patency, alveolar ventilation and perfusion
   - Altered gas exchange and cellular metabolism
5. Signs & Symptoms
   - Respiratory – Tachypnea, expiratory grunting, nasal flaring and retractions, airway secretions, adventitious breath sounds, cough, asymmetry of breath sounds and chest excursions, increased respiratory support
   - Cardiac – Tachycardia, hypo-perfusion, central cyanosis
   - Temperature instability
   - Skin – Rash, jaundice at birth
   - Glucose intolerance
   - Abdominal distention
   - Oliguria
6. Diagnostic Tests
   - Chest x-ray- alveoli may be atelectatic or hyper-expanded
   - CBC/CRP- increased inflammatory markers i.e.; platelets, band count, CRP
   - ABG- low Po2 elevated Pco2
   - Prenatal screening for infection
7. Treatment
   - Respiratory management- nasal O2, PPV, ventilation
   - Antibiotic coverage 7-10 days
   - Intrapartum Antibiotic Therapy- Reduces risk of neonatal infection but does not eliminate risk
   - Late Onset Infection:
     Vancomycin and Cefotaxime (MRSA)
     Ceftazidime (Pseudomonas)
     Erythromycin (Chlamydia)

References

Faix, R. F., (2007). Congenital Pneumonia. Retrieved from www.emedicine.medscape.com/article/978865

Gomella, T. L. (2013). Neonatology : Management, Procedures, On-Call Problems, Diseases, and Drugs, 7thEdition. McGraw Hill Medical/USA.

SPRING LEGISLATIVE UPDATE

Submitted by Ally Kayton, MSN, APRN, NNP-BC

Federal Legislation

According to the most recent data brief from the CDC and Prevention's National Center for Health Statistics, there were 63,632 drug overdose deaths in the U.S. in 2016. Using data from the National Vital Statistics System, researchers found that the age-adjusted rate of drug overdose deaths increased from 16.3 per 100,000 in 2015 to 19.9 per 100,000 in 2016. Additionally, the largest increases in drug overdose deaths from 2015 to 2016 occurred in adults aged 15 to 24 (28 percent), 25 to 34 (29 percent) and 35 to 44 (24 percent).

The District of Columbia, New Hampshire, Ohio, Pennsylvania and West Virginia had the highest drug overdose death rates in 2016. Additionally, researchers note "the pattern of drugs involved in drug overdose deaths has changed in recent years. The rate of drug overdose deaths involving synthetic opioids other than methadone (drugs such as fentanyl, fentanyl analogs and tramadol) doubled in a single year from 3.1 per 100,000 in 2015 to 6.2 in 2016."

American Medical Association (AMA) Resolution 214 Amendment and American Nurses Association (ANA) Response

The AMA adopted an amendment to its resolution 214 that urges the organization to create a strategy to oppose model legislation, and national and state level campaigns, that would allow non-physician practitioners to practice independent of doctor supervision. Resolution 214 asks that our American Medical Association convene an in-person meeting of relevant stakeholders to initiate a national strategy to address the APRN (Advanced Practice Registered Nurses) Compact.

The following statement is attributable to Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN, president of the American Nurses Association (ANA), in response to the American Medical Association's (AMA) amendment to Resolution 214.

"This divisive tactic will directly impact the nation's advanced practice registered nurses (APRNs), and perpetuate the dangerous and erroneous narrative that APRNs are trying to "act" as physicians and are unqualified to provide timely, effective and efficient care. APRNs practice advanced nursing, not medicine, in which they regularly consult, collaborate and refer as necessary to ensure that the patient receives appropriate diagnosis and treatment."

"AMA's Resolution 214 aims to perpetuate longstanding turf wars between some physicians and nurses, which foster unnecessary impediments to patients receiving quality health care services. ANA invites leaders of the AMA to work with us on measures that will increase access to care."

Enhanced Nurse Licensure Compact (eNLC)

The eNLC was implemented on Friday Jan. 19, 2018 with 29 member states. As of this date, nurses with eNLC multistate licenses may begin practicing in eNLC states. The eNLC allows for RNs and LPNs to have one multistate license, with the ability to practice in person or via telehealth in both their home state and other eNLC states. Licensing standards are aligned in eNLC states so that all nurses applying for a multistate license are required to meet the same standards, which include a federal and state criminal background check.

Telehealth nursing services allows that, in the event of a disaster, nurses from multiple states can easily respond to supply vital services. Additionally, many nurses, need to routinely cross state boundaries to provide the public with access to nursing services, and a multistate license facilitates this process.

Boards of Nursing (BONs) were the first health care provider regulatory bodies to develop a model for interstate practice with the original adoption of the NLC in 1997 and its implementation in 2000. While other health care provider regulatory bodies are just getting started in this process, the NLC has been operational and successful for more than 15 years.

Florida Legislation

Under a new proposed bill, women with low-risk pregnancies would not have to deliver at a hospital to receive an epidural or even to have a cesarean section delivery. A Florida House panel is in favor of the proposal, despite safety concerns raised by state hospitals. MaryLynn Magar (R), has proposed (HB 1099) as a way to lower health care costs while giving pregnant women more choices for delivery. Delivery options include home birth, hospital birth, and birthing center births. "Advanced" birth centers would be allowed to keep women up to 48 hours following vaginal deliveries and 72 hours following C-section deliveries, thus eliminating surgical and length of stay restrictions currently in place.

According to the Florida Hospital Association, the bill doesn't ensure adequate quality of care. However, the FHA has agreed to help improve the bill as it moves forward. There is also

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concern that, in turn, hospitals could have difficulty maintaining residency programs in obstetrics, and possibly even in pediatrics if less women choose hospital-based birth. Amy Mercado (D) has concerns regarding safety precautions of the proposed bill.

Important Bills to Follow

HB 1337/SB 1594 (2018) Updates Nurse Practice Act to conform to national standards. Defines the term "advanced practice registered nurse"; deletes the terms "advanced registered nurse practitioner" and "clinical nurse specialist"; provides for certain application requirements for nurses desiring to be licensed APRN; authorized the Board of Nursing to adopt rules; conforms provisions to changes made by act.

SB 434 (2018) Neonatal Abstinence Syndrome Pilot Project; Requires AHCA, in consultation with DCF, to establish pilot project to license facilities in Medicaid Region 8 to treat infants who suffer from neonatal abstinence syndrome in certain circumstances; requires DOH to contract with state university to study certain components of pilot project & establish baseline data for studies on neurodevelopmental outcomes of infants with neonatal abstinence syndrome.

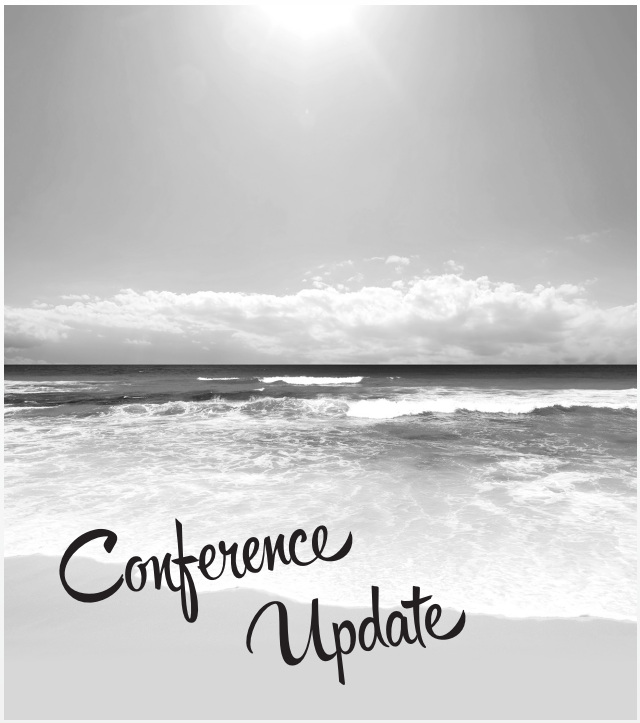
HB 973 (2018) Performance of Physician Assistants and Advanced Registered Nurse Practitioners; Authorizes physician assistant to sign, certify, stamp, verify, or endorse document that requires signature, certification, stamp, verification, or endorsement of physician; provides exception; authorizes advanced registered nurse practitioner to sign, certify, stamp, verify, or endorse document that requires signature, certification, stamp, verification, or endorsement of physician within framework of an established protocol & under supervision; provides exception. PASSES THE HOUSE.

HB 1099 (2018) Advanced Birth Centers; Provides for issuance, renewal, denial, & revocation of licenses to establish advanced birth center by AHCA; provides penalty for operating without a license; provides applicability of licensure requirements under pt. II of ch. 408, F.S., to advanced birth centers.

References

(2017, Nov. 11). American nurses association responds to resolution 214 amendment presented by the american medical association. Retrieved from http://www.nursingworld.org/FunctionalMenuCategories/MediaResources/PressReleases/ANA-Responds-to-AMA-Resolution-214-Amendment.html

Sexton, C. (2018, Jan. 16). Florida house panel backs plan for new birth options. Retrieved from http://www.dailycommercial.com/news/20180116/florida-house-panel-backs-plan-for-new-birth-options



Hi everyone! Your Conference Planning Committee is busily working on FANNP's 29th National Neonatal Nurse Practitioner Symposium: Clinical Update and Review to be held October 16-20, 2018 at the beautiful Sand Key Resort in Clearwater Beach, Florida. We are currently contacting speakers, arranging topics, planning parties, and everything else that goes into putting on our great conference. We hope to have an extra special Key Note Speaker this year, along with updates on many topics we face on a day to day basis, as well as those we might not see often, but still need to know. One thing we are working diligently on this year is closely examining the content of our Review Track, so that we may offer even more of the material necessary for the NCC exams. Hoping to see you all in October!

Mary Kraus, MSN, NNP-BC
Conference Committee Chair
Florida Association of Neonatal Nurse Practitioners

Save the Date!

FANNP's 29th National Neonatal Nurse Practitioner Symposium: Clinical Update and Review
October 16-20, 2018

FANNP Scholarship Eligibility
Check It Out

FANNP was founded to support the educational advancement of Neonatal Nurse Practitioners and remains committed to promoting education for NNPs.

Take advantage of this opportunity!

FANNP has scholarship money available for distribution to nurses and NNPs continuing their educational pursuits in the field of neonatal health care.

Scholarship Application
2018 Eligibility Guidelines

1. Applicants must be FANNP members.
   a. All voting members, student members and associate members are eligible.
   b. Priority for scholarship awards will be given to voting members, followed by student members and then associate members.
   c. Priority for scholarship awards will be based on length of membership and service to FANNP.
2. Applicants must be a licensed RN, ARNP, NNP or equivalent.
   a. Preference will be given to currently licensed NNPs working towards an advanced NNP degree.
3. Applicants must attend an educational program leading to a degree related to the health care field during the application period.
   a. The application period for the 2018 scholarship is September 15, 2017 to September 15, 2018 (i.e. to be eligible for a 2018 scholarship you must have attended classes sometime between September 15, 2017 and September 15, 2018).
   b. An applicant may receive a maximum of two scholarship awards for each degree sought.
4. Applicants will provide a short article, case study, practice pointer, evidenced-based practice update or literature review to be published in the FANNP Newsletter.

To obtain a scholarship application contact FANNP via email scholarships@fannp.org
COMPLETED applications must be postmarked by September 15 each year.

Calling for Research Proposals... FANNP Grants Available

Each year FANNP sets aside funds for the support of research projects. Applications for funding are reviewed by the Research Committee. The Research Committee makes recommendations to the Board of Directors on proposals received. Members of the Research Committee are appointed by the Board of Directors. The grant application period is rolling—there is no deadline for grant submission. Grants will be awarded within six weeks following submission, based on the Research committee and BOD decision.

Please visit www.fannp.org for more details.

Brag Board

Do you have a colleague, mentor, or student that you'd like to recognize for the Brag Board section of the newsletter? Or maybe you're the one doing some amazing work in the neonatal realm! Brag about it! Please email newsletter@fannp.org to share these accomplishments.

NEWSFLASH

Get the latest news and updates from FANNP at www.fannp.org.
In addition, don't forget to join us on Facebook and follow us on Twitter @FANNPorg!

NOMINATIONS from page 1

membership records, responsible for email blasts and Chair of Communication Committee.

Treasurer: Have charge and full knowledge of all Association funds, render statement of financial condition of the Association for all meetings, and Chairs the Finance Committee.

Additional Board of Director Positions:
At-Large Members (4): Serves on committees as assigned.

*Please see website for a complete description of these positions.

To be eligible to run as an Officer, you must be a current member who has served on the Board of Directors or any FANNP committee. To be eligible to run for an At-Large Member position, you must be a current member with an interest in continuing the mission of FANNP. Student members, Associate members and Retired members are ineligible.

Please consider running for one of these positions! We need your help to carry on!

Nominations are due by July 15, 2018. Send them to nominations@fannp.org. Ballots will be emailed to active members for voting by October 1, 2018. The newly elected candidates will be announced at the FANNP Symposium Annual Member Brunch.

Thank you,
Diana Morgan-Fuchs, NNP-BC
Past President, Chair: Nominations Committee

BRING IT ON ANSWERS Questions on page 12

1. **(A)**
Sensitivity =True Positive/(True Positive + False Negative) = 10/(10+0) = 100%
Sensitivity is the proportion of truly diseased persons in the screened population who are identified as diseased by the screening test.
Specificity = True Negative/(True Negative + False Positive) = 90/(90+10) = 90%
Specificity is the proportion of truly non-diseased persons who are so identified by the screening test.

2. **(A)** Acetylcholine is the active neurotransmitter for the parasympathetic nervous system. Stimulation of the sympathetic nervous system through the ganglionic chain releases norepinephrine and epinephrine, which act on the SA node, AV node, atria, and ventricles.

3. **(C)** The infant is at risk for low lung volumes and atelectasis if there is insufficient PEEP. Inadvertent PEEP can cause air trapping, and high PIP is associated with excessive tidal volumes.

FANNP's National Neonatal Nurse Practitioner Symposium: Clinical Update and Review, 2018

POSTER & PODIUM PRESENTATION CALL FOR SUBMISSIONS

SUBMISSION DEADLINE: June 15, 2018

FANNP is seeking abstracts for posters and podium presentations for the annual FANNP's National Neonatal Nurse Practitioner Symposium on October 16th-20th, 2018. The planning committee invites submissions by members and non-members and participation is open to health professionals whose specialty has a focus on the Neonatal Population (this includes but is not limited to NNPs, RNs, Clinical Nurse Specialists, & Neonatologists). We invite colleagues to share their expertise in one of the following categories:

- Original Research
- Innovations in Practice or Education
- Patient Safety
- Quality Improvement and Benchmarking Initiatives
- Case Studies

MORE INFORMATION IS AVAILABLE NOW AT FANNP.ORG

FANNP Newsletter Submission Calendar

Edition	Article Submission Deadline	Publish Date
March 2018	02/02/18	03/10/18
June 2018	05/04/18	06/09/18
September 2018	08/03/18	09/08/18
December 2018	11/02/18	12/08/18

In addition to the core components of the newsletter, we would love to hear what you have to say! Please send in anything you would like to see added to the newsletter, whether it is an interesting article, a hot topic in the neonatal world, or even a shout out regarding a fellow FANNP member who is doing awesome things! We want to hear from you! Please submit following the above guidelines to newsletter@fannp.org

EDUCATIONAL OFFERINGS

Contemporary Forums Neonatal Pharmacology
April 19-21, 2018
Philadelphia Sheraton Society Hill Hotel
Philadelphia, PA
www.contemporaryforums.com

Spring National Advanced Practice Neonatal Nurses Conference
May 4-6, 2018
Downtown Waterfront Marriot
Portland, OR
www.academyonline.org

Fall National Advanced Practice Neonatal Nurses Conference
Sept. 6-8, 2018
Hyatt Regency
New Orleans, LA
www.academyonline.org

6th Annual Fall Conference on Current Concepts in Neonatal Care
September 26-29, 2018
Balboa Bay Resort
Newport Beach, CA
www.symposiamedicus.org

2018 First Coast Neonatal Symposium
April 23-24, 2018
Hyatt Jacksonville Riverfront
Jacksonville, FL
www.neonatalsymposium.com

The 29th FANNP Neonatal Nurse Practitioners Symposium: Clinical Update and Review
October 16-20, 2018
Sheraton Sand Key Resort
Clearwater Beach, FL
www.fannp.org

NANN 34th Annual Conference
October 17-20, 2018
Anaheim Hilton
Anaheim, CA
www.nann.org

Hot Topics in Neonatology
December 2-5, 2018
Marriott Marquis
Washington, DC
www.hottopicsinneonatology.org

2019 Council of International Neonatal Nurses Conference
May 5-8, 2019
Auckland, New Zealand
www.coinnurses.org

The Kim Nolan Spirit Award

...In memory and honor of Kim Nolan

Do you know a special NNP? The Kim Nolan Spirit Award is given annually to a NNP who exemplifies Kim's exuberance and "can-do" attitude in service to profession, community, and/or family. To read more about Kim, and to nominate someone today, visit award@fannp.org! **Nominations due July 1, 2018.**

CLASSIFIEDS

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For information on Classified Advertising in the FANNP Newsletter, please refer to the guidelines and fees, which can be found at fannp.org under the Newsletters heading.

FANNP Dates to Remember

Event/Item	*Date/Deadline of Event/Item*
FANNP Grant	Ongoing
Poster Presentation Abstracts	June 15
Kim Nolan Spirit Award	July 1
FANNP Scholarship	September 15
National Neonatal Nurses Day	September 15
Annual National Neonatal Nurse Practitioner Symposium: Clinical Update and Review*	October 16-20, 2018
Nurse Practitioner Week*	November 11-17, 2018

**Dates change annually*

Bring it On...

Practice Questions to Prepare for the NNP Certification Exam

1. A newborn screening test is developed for a congenital metabolic disorder. Ten infants with the known metabolic disorder and 100 infants known not to have the metabolic disorder underwent the screening test. There were a total of 20 positive screening tests. All those with known metabolic disorder had a positive screening test. Which of the following statements is true?

A. Sensitivity was 100%
B. Specificity was 100%
C. Sensitivity was 90%

2. When levels of PEEP are inadequate, they can worsen lung disease due to:

A. Air trapping.
B. Excessive tidal volume.
C. Low lung volumes.

3. The active neurotransmitter for the parasympathetic/sympathetic nervous system is:

A. Acetylcholine.
B. Epinephrine.
C. Norepinephrine.

Answers on page 10

FANNP
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