

Neonatal Transport Nursing is an Interpretive Practice

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Abstract

In this paper, we offer a personal account of a neonatal transport nurse (TRN) and the interpretive nature of the TRN's work. Beginning at the start of a shift, the reader encounters the many ways in which the neonatal transport nurse interprets her surroundings, colleagues, patients, and circumstances, leading to how these factors are consciously and subconsciously engaged in the TRN's practice throughout a day's work.

Keywords

Hermeneutics, nursing, interpretive practice, neonatal nurse, transport, NICU

A common descriptor of the nursing profession is that it is a balance of art and science, and professionals within the field are guardians of the human experience at varying points along the health spectrum. To understand either of these fields demands an enormous amount of knowledge in contrasting areas. A common denominator can be found in interpretation.

Scientific interpretation is considered concrete, following universal rules, established truths and measured against standards. Artistic interpretation is dynamic and holistic, subject to an individual's lived experience, and freedom of expression. On its own, scientific interpretation is efficient and effective, but without the artful knowing of a patient, the care provided is incomplete. Nurses practice expertly within both arenas using interpretation as their guiding force.

One could think that the neonatal transport nurse (TRN) would be at a significant disadvantage

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in developing an interpretive practice beyond the scientific component. How could the nurse come to know a patient, hear their experience when they have none, understand the message beneath non-existent words and actions? Don't babies just eat, sleep, and have their diapers changed? Where does interpretation live in that? An easy misconception to hold, perhaps, and one that is put to rest by reviewing the interpretive practice of a TRN over the course of a twelve-hour day shift.

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It is an unintended advantage to any neonatal nurse's development of interpretive practice that neonates have immature and fragile immune systems; it requires that every shift begins with a one-minute hand to elbow scrub prior to entering the unit. This ritual, performed shift after shift, becomes a meditative moment, one to reflect on the day to come, to what patient might be received into care, and to get a sense of the unit's activity. The night shift is leaving and departing comments overheard shed light on what lies beyond the main doors. In those sixty seconds, an offering is made to the nurse: space and time to prepare for the patients and the work ahead. When tuned into this offering, the nurse in kind offers back a foundational minute of mindfulness. It is a moment that allows interpretive practice to come to the forefront.

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One of the three pagers clipped to the TRN's waistband alarms in a distinct pattern, and immediately communicates the potential of a transport within the catchment area of Southern Alberta. The transport team, comprised of physicians, registered nurses, and registered respiratory therapists (RRT's), convene in the transport office to patch into the incoming call. A quick glance out the window to the heavy thundershowers readies the TRN to the likely mode of ground transport, knowing that weather is a primary determinant in how quickly the team will be available to the referral centre. With luck, the neonate on the other end of the phone call is not in too severe of distress, or very far away, as air travel is unlikely in stormy weather.

The call is coming from Canmore, Alberta, a Level 1 delivery centre about one hour away from the tertiary care neonatal intensive care unit (NICU) at the Foothills Medical Centre in Calgary, Alberta. The TRN knows that the physicians and nurses at this site are not specialists in neonatal care, but have competency at providing immediate resuscitative measures for the newborn. While a comprehensive report is received over the speaker phone, the TRN is hearing a sense of urgency in the measured tone of the physician's voice and an underlying tremble while reviewing the infant's delivery. A true knot in the umbilical cord has resulted in a severely hypoxic and compromised baby at delivery.

Beyond the specifics of medical history and the interventions required for the newborn, the TRN has interpreted that a diligent physician is very concerned for the newborn, and that the request for immediate assistance is not a light one; the health care providers to this newborn are at the limits of their capabilities. This knowledge drives the decision to gather resources quickly and dispatch sooner than the typical allotted departure time.

All necessary standard equipment is packed, along with anticipated additional items possibly needed for a newborn with suspected Hypoxic-Ischemic Encephalopathy (HIE). En route to Canmore, the calculated particulars of critical newborn care are completed, and an entry plan of care is discussed with the transport RRT partner, knowing the plan will evolve based on what is encountered on arrival. In this preparation, having not yet laying eyes on the patient, the TRN is demonstrating interpretive practice through anticipation.

Anticipation, arrived at by piecing together bits of information, knowledge and experience into a potential whole, is one spoke on the wheel of interpretive practice. The complementing side of this wheel spoke is flexibility, as the TRN knows anticipation does not equate absolute truth. Being prepared yet adjustable to work in the moment, not the hypothetical moment, is what will ensure the best care is provided for the critically-ill newborn.

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On arrival to the referral site, the TRN sees at first look that the physical needs of the baby are being met; a cardio-respiratory monitor displays vital signs within normal limits, the warmer is at a low setting as required for babies with suspected HIE, and an IV is in situ infusing an appropriate solution at an appropriate rate. The presumed father looks disheartened and worried standing guard over his flaccid, motionless baby girl, and the mother, lying in a hospital bed, is being attended to by her own nurses. An older woman is at her side, likely grandmother to the infant as she shares the same curly tresses with the mother.

This immediate gathering of preliminary information in an unfamiliar environment with an unknown patient tells the TRN several things: the newborn has been in capable hands with the Canmore team, she has a family that is desperately worried for her, and she has been significantly compromised. The danger in these judgements is mistaking them for truths before verifying them. Interpretive practice is witnessed in the TRN's ability to use the judgements as an entry point of care, affirming or dismissing them, and then building from them.

During the TRN's assessment of the patient, discussion between the two health care teams flow back and forth, each piece of conversation building a more complete picture for both parties. Reassurance is given to the Canmore team that their skills were effective and appropriate. Small pieces of teaching are interjected when needed, knowing this is best received in moments of camaraderie rather than in condescension. Interpretive practice is implemented in relationship building, as the nurse knows a positive exchange will have impact on how the team is perceived, and could impact other newborns in the future.

The TRN considers the data collected on maternal and antenatal history and understands it for the basic information it conveys: the mother's gravida, para status (number of pregnancies, number of live births) is G1 P0, had regular prenatal care, and normal antenatal scans. What this data captures but does not convey is that a young, married couple have been joyously expecting their first child for the past 38 weeks; 38 weeks in which the mother has taken care of herself and her pregnancy, attuned to her baby so much so, that when no movement was felt overnight, she rushed into the local hospital for a check-up. It is interpretive practice that enables the TRN to appreciate what lies beyond the data to the human experience. It is in the observations of the

people surrounding this baby that the TRN has come to this understanding, knowing as well that similar data under different lived experiences will result in completely different families and how care will be best provided for them.

Through body language, the TRN sees that the father needs to be engaged in his baby's care, and involves him when appropriate. His eyes betray the strength he wants to show when asking why his daughter's abnormal movements are considered seizures. The subtle, abnormal movements astutely observed by the TRN and the quick response to draw up the appropriate medication demonstrates the impact proper interpretation of physical assessment can have on the necessary treatment of a patient.

While addressing the seizure activity of the baby and taking in the non-verbal communication of the family, the nurse is preparing for another form of interpretive practice: how to inform the parents of what to expect for their daughter. Translating the medical diagnosis, necessary interventions, and what the days ahead may hold, will be different for every patient and family. It is interpretive practice that enables the TRN to choose what language, tone, and pace of delivery to impart that information.

Having stabilised the newborn and readying for departure, the TRN prepares both mother and baby for their first hold. Interpretive practice is not required to know a mother wants to cradle her newborn, but it reminds the nurse that the emotions of a post-partum, new mother deserve gentle, honest handling. During this first hold, the nurse intuitively steps back, giving space to mother, father, and baby to be a family. Experience has proven that this precious, quick moment is more important than any further words. Separating the baby from her mother is unwelcomed but necessary, so the baby is safely and quickly transferred into the transport incubator.

Interpretive practice happens in small moments, unregistered, but real and impactful, nonetheless. The team is on site for a little over an hour; in this time, a critically-ill newborn has been stabilised, teaching needs of the referral site have been addressed, while maintaining a positive working relationship as an ambassador for the tertiary care NICU, and trust has been established with two new parents who are absorbing the shock of their baby born critically-ill. The TRN achieves this with deft capability and compassion, illustrating how neonatal transport nursing is an interpretive practice.

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On return to the NICU, hand over is completed and the newborn is no longer in the transport team's care. While reviewing the transport log, the TRN reflects on the trip: what was learned from this transport, this particular patient and family that can be carried forward to improve practice? What could have been done differently? What was done well? In this self-reflection, further evolution of interpretive practice is taking place, building off one experience, knowing it will further hone skills and knowledge for transports to come. As the TRN looks out the office window to a sunnier sky, the transport pager beeps, and preparation to care for the next baby is already underway.

