The first quarter of 2014 has been very busy. There have been some major strides accomplished throughout the State in the first quarter of this year. Rep. Cary Pigman, R-Sebring, has had the courage to champion for nurse practitioners across the state despite severe opposition from his physician colleagues.

The Senate panel voted on SB 1352 to allow nurse practitioners to have prescription authority, but not practice independently. This bill allows highly trained nurses more authority, but not the independence they truly need. This bill narrowly passed at its first committee with a 5 to 4 vote. SB 1352 would allow specialized nurses with graduate degrees to prescribe controlled substances and institutionalize patients with mental health issues. The Health Policy Committee approved the bill with a razor-thin 5 to 4 vote with Republicans and Democrats on both sides of the issue.

A separate proposal in the House, HB 7071, would allow nurse practitioners to practice without a supervising physician. HB 7071 is an even tougher sell in the Senate, where members have strong ties to the Florida Medical Association (FMA) who adamantly oppose these measures. Rep. Denise Grimsley, R-Sebring, states that the changes in SB 1352 are needed to address Florida's physician shortage and implement changes that virtually every other state has already adopted. “We are the last state in the nation to pass this legislation,” she said. Other Senators disagree with Grimsley's belief that expanding the scope of practice for highly trained nurses is the best way to address Florida's health care workforce issues. “Physicians have attended medical school and received the training needed to perform certain duties that nurses have not”, said Sen. Eleanor

**Back to Sleep Recommendations for Convalescing Patients in the Neonatal Intensive Care Unit**

*Stacy A. Stanford*

*Stony Brook University*

**Abstract**

**Objective:** The purpose of this literature review is to provide evidenced-based research to assist in creating a hospital policy for transitioning healthy, premature infants, to the supine sleeping position prior to discharge, in adherence with American Academy of Pediatrics (AAP) recommendations.

**Method:** A literature search was performed obtaining peer-reviewed articles from PubMed, Cumulative Index to Nursing (CINAHL), Ovid and Cochrane databases.

**Results:** After reviewing the literature available with regard to this topic, there is little research available to assist in determining how or when the healthy, preterm infant convalescing in the NICU should be transitioned to the supine position for sleeping.

**Conclusion:** In review of this literature, it is the opinion of the author that we move forward in the development of a “Safe Sleep/Sudden Infant Death Syndrome Prevention” protocol.

**Key Words:** sudden infant death syndrome, premature infant, supine positioning, prone positioning, neonatal intensive care and sleep position.

**Introduction**

As defined by the American Academy of Pediatrics (AAP), “sudden infant death syndrome (SIDS) is characterized as the sudden death of an infant younger than 1 year of age that remains unexplained even after a complete autopsy, a death scene investigation, and a thorough review of clinical history are conducted” (2005). In the
Hello FANNP members,

With the ending of spring and the beginning of summer comes graduation. It is during this season that new neonatal nurse practitioners complete their education and start the voyage of making a significant contribution to the field of neonatal nursing. Graduation is not the only time for us to consider how we contribute to our profession. In fact, now is the best time for YOU to consider how you have made a difference in the lives of the critically ill infants and families you have cared for.

It is also the time for YOU to consider how you might move past your comfort zone and make new and challenging professional goals. As these goals evolve, it is important to remember that FANNP is here to assist in this transition. Whether you are a new NNP or a “seasoned” practitioner, this is the time to consider how to move forward in your career and best meet the needs of your patients. These goals may include furthering your education, beginning a quality improvement or research project, or increasing your knowledge regarding caring for critically ill infants. FANNP is dedicated to facilitating NNPs in attaining their professional goals. We offer scholarships for those interested in furthering their education, research grants to assist NNPs with research goals and for those interested in the legislative aspect of neonatal nursing, we can help involve you in this endeavor. We also offer the opportunity to showcase your hard work by sharing your case studies, research or quality improvement projects at the annual FANNP conference or in the FANNP newsletter. Of course we are best known for delivering a top-notch quality conference to facilitate learning in both the novice and expert neonatal nurse practitioner.

As FANNP celebrates its 25th anniversary, we honor those who came before us and contributed to this wonderful organization and to the NNP profession in general. If not for them, our profession would not have evolved to its current state and the benefits we currently enjoy would not be available. Of course, these individuals are also responsible for our incredibly successful annual conference. This conference has assisted hundreds of brand new NNPs in passing their NCC examination, progressing into successful practicing NNPs, and has provided educational opportunities for practicing NNPs to assist them in providing excellent care to their patients.

This year’s conference will commemorate our 25th anniversary and continue to honor our legacy by providing the same excellent review course for novice NNPs. However, remember this conference is not just for new NNPs but for those of us who are more “seasoned” in our profession. Even those of you that have been practicing as long as I have (over 20 years) will come away from this conference with a renewed spirit and an increased knowledge of neonatology because of the nationally known and expert speakers. I never cease to be amazed that even after all the years I have worked in the NICU, I continue to obtain an exceptional educational experience in the advanced track of the conference. Don’t miss the opportunity to attend this year’s FANNP National Neonatal Nurse Practitioner Symposium: Clinical Update and Review on October 14-18, 2014, at the beautiful Sheraton Sand Key Resort in Clearwater, Florida. Join us in learning, having a wonderful time, networking and of course celebrating our 25th anniversary!

Please do not hesitate to contact me for suggestions, questions, comments or concerns.

Leslie Parker, PhD, NNP-BC
President, FANNP
late 1980’s, the prone sleeping position was recognized as a modifiable potential risk factor for SIDS (AAP, 1992). In 1992, the AAP implemented formal recommendations for placing full-term infants in the supine sleeping position to reduce the incidence of SIDS (AAP, 1992). Two years later, when the “Back to Sleep” public health campaign was launched, 70% of infants in the United States were commonly placed in a prone position for sleep (AAP, 2000). Since the campaign, and promotion of a supine sleeping position, the incidence of SIDS has declined by 53% (AAP, 2011).

In 2000, the AAP reinforced the “Back to Sleep” message identifying additional risk factors for SIDS including soft sleeping surfaces, loose bedding, soft objects in the sleeping environment, overheating, maternal smoking, bed-sharing in certain situations, preterm birth, and low birth weight. The AAP released an updated policy statement in 2005, stating that the side-sleeping position increases the risk for SIDS significantly, and should be avoided (AAP, 2005).

In 2008, the AAP announced the recommendation that premature infants be transitioned to the supine sleeping position at 32 weeks postmenstrual age in order for the infants to become accustomed to this position prior to discharge (AAP, 2008). The AAP also recommended that healthcare professionals should be more vigilant in endorsing and modeling recommendations for SIDS prevention prior to discharge of an infant from Neonatal Intensive Care Unit (NICU).

### Methods

#### Population

The target population is healthy, sleeping, premature neonates, hospitalized in the Neonatal Intensive Care Unit (NICU).

#### Procedure

Inclusion criteria for the review included quantitative or qualitative studies from peer-reviewed journals and contained (1) specifically discussed hospitalized neonates in the NICU and (2) actively transitioning the term and/or premature infant to the supine sleeping position.

The methodology used for this integrative review was inclusion and exclusion criteria, literature search and retrieval process, data abstraction process, and quality and strength of evidence evaluation. The purpose of this review was to assist healthcare providers in evaluating the available research, as well as identifying any gaps in the literature that warrant further research.

### Literature Search

The following keywords used in various combinations included sudden infant death syndrome, premature infant, supine positioning, prone positioning, neonatal intensive care and sleep position, which yielded 33 articles. The databases searched included PubMed, Cumulative Index to Nursing and Allied Health (CINAHL), Ovid, and the Cochrane library, using the Stony Brook Health Sciences Library. The search was limited to literature published after 2003. Statement articles published by the AAP were reviewed as well. Reference lists for each article were reviewed to obtain relevant articles.

### Analysis

Four articles met the inclusion criteria, out of thirty-three identified and reviewed. Table 1 summarizes the four articles that met the inclusion criteria for this literature review, and includes the author’s name, purpose of the study, design, sampling characteristics and size, along with the author’s findings and any limitations to the study. Four articles were prospective survey designs (Aris et al., 2006, Rao et al, 2007, Grazel et al., 2010, & Dattani et al., 2011).

Aris et al., (2006) conducted a survey in two phases exploring the NICU nurse’s knowledge and practice in the NICU to determine the best sleep position for term and preterm infants, as well as determining instructions provided to parents at discharge regarding sleep positioning. Of 514 questionnaires distributed, 252 nurses completed the questionnaire producing a 49% response rate. Nurse respondents identified the prone position as the best general sleep position for preterm infants (65%), followed by either prone or side-lying positioning (12%), during NICU hospitalization (Aris et al., 2006).

Determining the infant’s readiness for a supine sleeping position at the time of discharge varied among the nurses polled. Most respondents reported preterm infants were ready for supine sleeping position at any time (29%), when close to discharge (13%), when maintaining thermoregulation in an open bassinet (25%), between 34-36 weeks postmenstrual age (PMA) (15%), after 37 weeks PMA (13%), and when the infant’s respiratory status was stable (6%) (Aris et al., 2006).

Full term infants in the NICU were positioned in different sleep positions including supine (40%), side or supine.  

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SLEEP from page 3

(30%), all positions (18%), side (8%), prone or side (3%) and prone (1%). Reported nursing rationale for placing full term infants in the prone position included reflux (45%), upper airway anomalies (40%), respiratory distress (29%), inconsolability (29%) and to promote infant comfort (17%) (Aris et al., 2006).

At the time of discharge, 52% of the nurses instructed parents to place their infant in the supine sleeping position, while the most common non-supine sleep positions recommended were either supine or side-lying (38%), and exclusive side-lying positioning (9%) (Aris et al., 2006).

The authors indicated that nearly 95% of nurses described a non-supine sleep position as optimal for hospitalized full-term and preterm infants, stating that these sleep positions provide physiologic benefits during the acute stage of their illness (Aris et al., 2006). Aris et al. (2006), stated these rationales have the potential to be generalized and misused in well, convalescing infants, in whom the supine position is the safest option. The Aris et al. (2006) study concluded that nurses provided inconsistent discharge teaching related to safe sleep practices, and in some cases were in direct conflict with the national “Back to Sleep” recommendations.

Grazel et al. (2010), completed a prospective survey to examine and describe NICU nurse’s knowledge of SIDS risk-reduction measures, modeling safe infant sleep interventions prior to discharge, and providing parental education in SIDS reduction. A survey consisting of 14 questions was distributed to 1080 nurses in 19 NICUs with 430 (40%) NICU nurses completing the questionnaire. Grazel et al. (2010) determined the majority of nurses (85%), identified the AAP SIDS risk-reduction strategies for safe sleeping. In addition, the study revealed nurses frequently position healthy preterm infants supine for sleep either when weaned to an open crib (50%), at 34 weeks PMA or greater (48%), one week prior to discharge (16%), wait one to two days before discharge (15%), or never (6%) (Grazel et al., 2010). Preterm infants were placed in a side-lying or prone position secondary to the nurse’s fear of aspiration (29%), to promote infant comfort (28%), and infant safety (20%).

Another finding identified 57% of nurses placed discharge-ready preterm infants in the supine-only sleep position, whereas 67% of respondents placed term infants exclusively supine for sleep (Grazel et al., 2010). The authors concluded that the participating NICU nurses were able to identify most of the recommended SIDS risk-reduction strategies, but there are inconsistencies assimilating these strategies into NICU clinical practice (Grazel et al., 2010).

Rao, May, Hannam, Rafferty & Greenough (2006) conducted a study in the United Kingdom to determine evidence-based recommendations regarding optimal sleep positions for premature infants prior to and following discharge; and measure any subjective changes from responses recorded in a previous survey, completed in 2001-2002. There were 182 (80%) NICUs that responded to the questionnaire.

The authors reported 151 (83%) of the responders instituted supine-only sleep positioning beginning at least 1 or 2 weeks prior to discharge; 78 (43%) transitioned the infant to supine-only sleep positioning at a pre-specified time prior to discharge, 36 (20%) placed infants supine for sleeping when the infant matured beyond requiring apnea monitoring, and 36 (20%) placed the infants supine for sleeping when the infant was transitioned into a bassinette (Rao et al., 2006). In comparing the responses of the two surveys, Rao et al. extrapolated that more NICUs transitioned infants to a supine sleeping position 1-2 weeks prior to discharge, and fewer recommended the side-lying sleeping position following discharge (Rao et al., 2006). Unfortunately, fewer NICUs were found to be discouraging parents from placing their infants in a prone sleeping position following discharge. The authors identified many inconsistencies between facilities in terms of practicing in a manner that is congruent with AAP’s Back to Sleep recommendations.

The purpose of the fourth survey study reviewed was to assess the effectiveness of a national campaign entitled, “Time to get back to sleep”, comparing the fore mentioned 2006 survey (Dattani, Bhat, Rafferty, Hannam, & Greenough, 2011). Two hundred and seventeen United Kingdom NICUs were invited to participate in the study, with a 90% response rate. The authors determined there was no significant difference in the number of NICUs that recommended supine sleeping beginning at 1-2 weeks prior to discharge (78% versus 83%) (Dattani et al., 2011). Dattani et al. (2011) identified that all units recommended supine sleeping following discharge. A smaller number of NICUs recommended side-sleeping after discharge (8% versus 17%), and a greater number of units discouraged prone positioning for sleeping (62% versus 38%). In conclusion, the authors discovered that the majority of NICUs are providing appropriate recommendations regarding safe sleep practices following discharge from the hospital.

Discussion

After an extensive review of the literature, there has been minimal research conducted to assist in determining how and when the healthy preterm infant convalescing in the NICU should be transitioned to a supine sleeping position. A major limitation of this review is that only subjective, or survey driven research has been conducted to determine what positions infants are placed in during sleep. Further studies utilizing observational data collection would most likely yield more enlightening results.
and optimal outcomes. An obvious knowledge deficit has been identified in terms of what gestational age or physiologic criteria should be utilized in determining when to place convalescing NICU infants in the supine sleeping position. This was discovered in the survey studies demonstrating a wide variability between nursing practice in transitioning the infant supine prior to discharge (Grazel et al., 2010, & Aris et al., 2006). Further research is needed in this area to identify the safety and efficacy of this practice. Without additional research specific to this area of practice, clinicians may remain reluctant to change their practice, parents may continue to receive inadequate information with regard to optimal sleep habits, and the incidence of Sudden Infant Death Syndrome (SIDS) may continue to escalate.

However, it is well known that “infants born prematurely have an increased risk of SIDS, and the association between prone sleep position and SIDS among low-birth weight infants is equal to, or perhaps stronger than, the association among those born term” (AAP, 2011). Additionally, it is well documented that placing infants in the supine sleeping position following discharge corresponds with a large reduction in the incidence of SIDS (AAP, 2000). Therefore, it is imperative that healthcare providers offer consistent and accurate information regarding an optimal and safe sleep environment prior to discharge in compliance with the current AAP policy statement on SIDS reduction (Table 2).

Conclusion

Facility-specific policies play an important role in consistent practice from hospital to hospital and in compliance with the recommendations of governing bodies such as the AAP. Raydo and coworkers (2000) found that in facilities that implemented written policies for infant sleeping positions, 98% of nurses reported placing infants in the supine position for sleeping. In nurseries that lacked policies or protocols for sleeping positions, only 28% of nurses reported placing infants in the supine position for sleep.

According to McMullen, Lipke & LeMura (2009), without a clear understanding of AAP guidelines and supporting hospital policies, nurses may convey conflicting information that can confuse parents as to when, or even if, they should place their infant supine for sleep. It is the author’s intention to develop and implement a policy or protocol to ensure that supine sleeping and other safe sleep practices are modeled for parents, prior to their infant’s discharge from the hospital (Table 3). Ideally, all NICU health care providers will be invited to participate in a questionnaire regarding infant sleeping positions to determine any knowledge deficits in terms of safe sleep positions, and evaluate the information they provide to parents prior to discharge. (Table 4). Following data collection and evaluation, an education program for nurses and parents will be developed. The “Safe Sleep/Sudden Infant Death Syndrome Prevention Protocol” will then be implemented and assimilated into NICU nursing practice. An additional survey will be conducted approximately six months following the implementation of the protocol to evaluate efficacy and consistency of practice. Subsequent action will be taken for necessary revisions to the protocol and education reinforcement.

In conclusion, the NICU poses a particularly challenging environment in which to teach parents about SIDS risk reduction. However, it is imperative that nurses serve as role models and educators that promote SIDS risk reduction guidelines in order to improve quality of care and decrease the incidence of SIDS in this high-risk group of infants. An initiative for safe sleep requires minimal financial resources and the benefits far outweigh the alternative outcomes.

References


**Legislative from page 1**

Sobel, the Hollywood Democrat who voted against the bill. “We need to conquer the widespread use of controlled substances, not to expand them,” Sobel said. The business community, including the Florida Chamber of Commerce and Associated Industries of Florida, is supporting the efforts to give highly trained nurses more authority, but the powerful FMA, representing physicians, is opposed.

In response, the ARNP independent practice bill HB7071 was trimmed down and rolled into an “omnibus” bill, HB 7113. So what is an omnibus bill? It is a proposed law that covers a number of diverse or unrelated topics. Derived from Latin, omnibus means “for everything.” An omnibus bill is a single document that is accepted in a single vote by a legislature, but packages together several measures into one, or combines diverse subjects. So what does this omnibus bill mean for Florida APRNs? The new bill removes CRNAs from the independence issue. It keeps the joint committee but removes the Surgeon General and adds a pharmacist to the committee dynamics. It charges this committee to develop an “exclusionary” formula. This formulary will list medications under controlled substances that NPs may not prescribe. The bill retains our title as ARNP, but adds a new category called “INP” for Independent Nurse Practitioner. To be an INP, one must have 2000 hours of post-graduate experience from any state in the country. One must also have a graduate course in pharmacology and maintain national certification. It allows INPs to sign in scenarios of initiating the Baker Act or a death certificate. It also allows psychiatric NPs to release or discharge a Baker Act patient. It is tied to the Trauma Center bill, Tele-health bill and other bills of high importance to the Senate. This strategy is what is known as an omnibus bill.

**HISTORIC DEVELOPMENTS**

Fireworks were flying in Tallahassee on April 25th, a historical day for NPs in Florida. The Florida House of Representatives passed CS/HB 7113 to address the current and projected health care workforce shortage in Florida. The bill expands the scope of practice for ARNPs by authorizing them to prescribe controlled substances under a supervising physician’s protocol. More importantly, the bill allows certified NPs that meet certain criteria, to register as INPs and practice without physician supervision. INPs may also prescribe controlled substances autonomously, subject to an exclusionary formulary. “We have a striking shortage of primary care providers in Florida that is only going to worsen with time. Florida is the most restrictive state in America when it comes to allowing highly qualified nurse practitioners to practice to the full extent of their education and training. I believe the new authorities granted to certain INPs under this bill will enhance access to good primary care for Florida residents,” continued Representative Cary Pignman (R-Avon Park), Vice Chair of the House Select Committee on Health Care Workforce Innovation.

“Current law requires an NP to establish a supervisory relationship with a physician, even if that physician is not collaborating with the NP and simply signs charts at the end of the month. Often this supervisory relationship requires the NP to pay a significant fee to the physician, with this additional cost being absorbed into the overall health care system. Florida residents do not benefit from this increased expenditure,” continued Vice Chair Pignman. “The House Select Committee on Health Care Workforce Innovation was charged with investigating health care practitioner workforce needs and exploring policy options for meeting those needs. For nearly five months, the Select Committee studied the problems in Florida and heard from health care industry experts on possible solutions. The Committee developed a comprehensive set of proposals which take significant steps to address the health care workforce shortage in Florida,” said Representative Jose Oliva (R-Miami Lakes), Chair of the House Select Committee on Health Care Workforce Innovation. The bill also allows NPs to see patients via telehealth services. The final vote on the bill was 74 to 42 with bipartisan support.

**And the story continues…**

The 2014 legislative session ended May 2nd. The last few hours were spent with many bills passing back and forth between the House and Senate. One of those bills was HB 7113. Initially Senator Hays unfortunately introduced an amendment to strip the ARNP language from HB 7113. The Senate approved this amendment on voice-vote and sent it back to the House. The House would not concede and did not accept the bill as amended. Several attempts were made to negotiate a deal. With regret HB 7113 ultimately did not pass the Senate. Florida’s citizens will again be faced with shortages of providers to meet their health care needs.

Although things did not go as desired, we can be very proud about this year’s session. In past sessions, DEA language was not on the calendar to be heard in any committee in the House or Senate. This year, not only was DEA language heard in both the House and Senate, but also the House passed an entire independent practice bill. The Senate also heard a bill in committee by Sen. Grimsley that would recognize NPs as providers in DEA statutes, and allow psychiatric NPs to release a Baker Act patient. It did not move past its first committee, but again this was historic.

Florida Association of Nurse Practitioners (FLANP) lobbyist Chris Floyd was successful in adding ARNPs
back into tele-health language in the Senate. Although the bill did not pass, we did have a strong show of support from many Senate members.

We are analyzing all the amendments and especially the Transitional Living bill. This bill grants NPs the ability to admit, discharge and manage patients in a transitional living facility.

**NON-LEGISLATIVE WINS FOR FLORIDA**

Although the legislative session fell short of our greatest expectations, we are still working on non-legislative ways to improve practice in Florida. This especially includes helping to revise current rules governing practice. Those final rules are due to be released soon and we anticipate that these rule changes will make practice easier for NPs.

In addition to the rule changes, two NPs were appointed to Medical Care Advisory Board sub-committees. Cynthia Alceus, MSN, ARNP, FNP was appointed to the HIV/AIDS subcommittee and Sherry Rowe, DNP, FNP was appointed to the Children Including Safeguards and Performance committee.

These NPs join Stan Whittaker, our board’s Chair at the Medical Care Advisory Committee in making sure NPs have a place at the state’s governing table. We need to remember; if we are not at the table we will be on the menu!

As we review all the new legislative changes, we will be sure to update you on anything pertinent to our practice.

Congratulations to the State of Connecticut as they became the 18th State to have full practice authority for NPs. When signed, SB 36 offers patients full and direct access to the quality care NPs provide. The bill now heads to the Governor’s desk where it is expected to be signed into law. Congratulations Connecticut NPs!

Florida continues to have a heavy workload. So, let’s get to work! If you have not called or emailed regarding how Florida is disconnected in terms of creating solutions for our stagnant health care problems, then you must get moving! Florida elections for all House of Representatives members and many Senators will occur this November. You work diligently in your practice for others every day. It is time to work for yourself and for your profession in assisting to get HB 7113 passed in the Senate. Write the Senators today because time is ticking away.

We are still waiting for an update on the House of Representatives bill HR 1281, Newborn Screening Saves Lives Reauthorization Act. This bill mirrors the Senate bill and was introduced by Rep. Lucille Roybal-Allard of California. To date, there are 113 sponsors for HR 1281. This is an excellent opportunity to contact your Representative to co-sponsor this bill. You can follow the bill’s progress at the following URL: [https://www.govtrack.us/congress/bills/113/hr1281](https://www.govtrack.us/congress/bills/113/hr1281)

**New CE Requirements for RNs in Florida**

RN are required to complete 24 hours of appropriate continuing education (CE) during each renewal period, including two hours relating to prevention of medical errors. In addition to these 24 hours of general CE, each RN must complete two hours of domestic violence CE every third renewal for a total of 26 hours. For initial licensure, RNs must complete one hour of HIV/AIDS CE (one time requirement), and a two-hour course relating to prevention of medical errors.

Beginning with the biennium ending in 2015, each licensee shall complete a two-hour course on the laws and rules that govern the practice of nursing in Florida. This will be part of the total 24 hours that are required each biennium.

**Changes to ARNP license renewal process in Florida**

There have been changes to the license renewal process and continuing education process with your next renewal. You MUST have your CEUs populated in CE Broker in order to complete your renewal. If you have not met the proper CEU requirements, the system will indicate that you are deficient and are unable to renew your license. Visit [www.CEAtRenewal.com](http://www.CEAtRenewal.com) to review your CEU documentation and verify that you have all completed CEUs recorded. There is an option for manually entering CEUs into the system. You are not required to purchase CE Broker and can just access through the basic service. You are responsible for making sure you have renewed the required CEUs.

Remember to send your protocols to the Board of Nursing when you renew your license or have a change to your protocol. Florida Statute 464.012 states the following:

“An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol that is filed with the board upon biennial license renewal and within 30 days after entering into a supervisory relationship with a physician or changes to the protocol. The board shall review the protocol to ensure compliance with applicable regulatory standards for protocols.”

We encourage membership with the Florida Association of Nurse Practitioners ([www.flanp.org](http://www.flanp.org)). Our continued support provides the salary for attorney and lobbyist, Chris Floyd, and allows him to continue to advocate on our behalf.

- Ally Kayton, RN, MSN, APRN-BC
FANNP is seeking abstracts for posters and podium presentations for the annual FANNP National Neonatal Nurse Practitioner Symposium on October 13th-17th, 2015. The planning committee invites submissions from members as well as non-members. 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

PODIUM & POSTER PRESENTATION PEER REVIEW PROCESS
A panel of experts will choose the four best-developed abstracts for a podium presentation. These will be selected on the basis of overall quality, originality and appropriateness to NNP practice. Preference will be given to research with complete data available. Podium presentations are 10 minutes with 3 minutes for questions. *Podium presenters will receive a $75 honorarium. All other conference expenses are the responsibility of the podium or poster presenter.

POSTER PRESENTATION
Abstracts not chosen for podium presentation will be considered for poster presentation. Detailed instructions for the poster presentation will be provided to the primary author at the time of the notification of abstract acceptance.

SUBMISSION REQUIREMENTS
Abstracts must be submitted electronically. Abstracts should be no longer than 500 words, in 12-point font, with up to 2 additional bibliography pages. The content should be presented in the form of a structured abstract:

- Purpose
- Subjects
- Design
- Methods
- Results
- Limitations
- Implications for Practice

A signed conflict of interest statement & CV (required for CE credits) must be submitted with the abstract. See the attached checklist for complete details. Abstracts that do not follow the submission guidelines will not be reviewed. Abstracts previously presented in other arenas are acceptable for submission.

NOTE: Include the submission checklist with the abstract.

SUBMISSION DEADLINE: June 1st, 2015
NOTIFICATION OF ACCEPTANCE: July 1st, 2015

CONFERENCE EXPENSES: All presenters chosen for the podium and poster presentation are responsible for conference registration fees, travel and all other expenses. Podium presenters will receive a $75 honorarium.
Harmony™ Chromosomal Prenatal Test

A. Definition
- As recommended by the American Congress of Obstetricians and Gynecologists (ACOG), all pregnant women should be offered prenatal testing for chromosomal abnormalities.
- An estimated 60-70% of women are prenatally screened for Trisomy 21.

B. Technology
- Advanced technology has been developed to utilize DNA analysis to identify and count cell-free DNA fragments in maternal blood. Upon analysis, maternal blood for cell-free DNA fragments identify any potential aneuploid (trisomy) chromosomes, and compare the results to what would be expected from that of a euploid chromosome.
- The DNA analysis is capable of determining, with enhanced sensitivity and specificity, whether a fetal trisomy may be present.
- Cell-free DNA (cfDNA) fragments are short fragments of DNA found in the blood. During pregnancy, there are cell-free DNA fragments from both the mother and fetus in maternal circulation. It is possible to analyze cell-free DNA to detect common fetal trisomies such as Down syndrome (trisomy 21), Edwards syndrome (trisomy 18), and Patau syndrome (trisomy 13).

C. Testing Schedule
- Screening can be done at in the first trimester after 10 weeks gestation through the third trimester.
- The screen is not reliable if utilized with a multiple gestation pregnancy.
- After 12 weeks gestation a nuchal translucency scan can be done together with the Harmony screen to rule out trisomy 21.

D. Trisomies
1. Down syndrome and Trisomy 21
   - Extra copy of chromosome 21.
   - Down syndrome is the most frequently occurring genetic trisomy.
   - The majority of infants with Down syndrome are born to women under the age of 35.
   - On average, Down syndrome occurs in one out of every 700 newborns.

2. Edwards syndrome and Trisomy 18
   - Trisomy 18 is an extra copy of chromosome 18.
   - Trisomy 18 causes Edwards syndrome and is associated with a high rate of miscarriage.
   - Infants born with Edwards syndrome may have various medical conditions and a shortened lifespan.
   - It is estimated that Edwards syndrome is present in approximately one out of every 5,000 newborns.

3. Patau syndrome and Trisomy 13
   - Trisomy 13 is an extra copy of chromosome 13.
   - Trisomy 13, also called Patau syndrome, is associated with a high rate of miscarriage.
   - Infants born with trisomy 13 usually have severe congenital heart defects and other medical conditions.
   - Survival beyond the first year is rare.
   - It is estimated that trisomy 13 is present in approximately one out of every 16,000 newborns.

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

Each year on December 31st, at least 10% of the available monies in the FANNP general operating budget are put in a scholarship fund.

FANNP is proud to be able to award scholarships to nurses and NNPs continuing their educational pursuits in the field of neonatal health care.

Five scholarships were awarded in 2013 to Teresa Ashley, BSN, NNPS from University of Alabama, Melissa Cole, MSN from East Carolina University, Lorri Logan, BSN, NNPS from University of Alabama, and Tiffany Gwartney, MSN, DNPS from Vanderbilt University.

FANNP would like to be able to award more scholarships in 2014, but we can only award scholarships if we receive applications.

Are You or Is Someone You Know Eligible for a 2014 FANNP Scholarship?

FANNP members who attend an educational program leading to a degree related to the health care field between September 15, 2013 and September 15, 2014 are eligible for a 2014 scholarship.

FANNP Scholarship Eligibility Criteria:
1. Scholarship applicants must be FANNP members.
2. All members, student members and associate members are eligible.
3. Priority for scholarship award will be given to members, followed by student members and then associate members.
4. Priority for scholarship award will be based on length of membership and service to FANNP.
5. Scholarship applicants must be a licensed RN, ARNP, NNP or equivalent.
6. Preference will be given to currently licensed certificate NNPs working towards a NNP degree.
7. Scholarship applicants must attend an educational program leading to a degree related to the health care field during the application period.
8. Preference will be given to those working towards a degree in Neonatal health care.
9. The application period for the 2014 scholarship is September 15, 2013 to September 15, 2014. (i.e. To be eligible for a 2014 scholarship you must have attended classes sometime between September 15, 2013 and September 15, 2014.)
10. An applicant may receive a maximum of two scholarship awards for each degree sought.

Applicants are asked to include a 3-5 page submission for publication in the FANNP newsletter as part of the application process. The submission can be an original article, a paper you submitted for coursework, a case study, best practice clinical update or a literature review.

The completed scholarship application packet must be postmarked by September 15, 2014.

For questions, more information or to obtain an application please contact FANNP via email at: scholarships@fannp.org.
As a family-owned and operated specialty service for the neonatal health care industry, Linkous & Associates has specialized in the recruitment and placement of NNPs nationwide for over 20 years. LinkousRecruiting.com.

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2014 Classified Advertising in the FANNP Newsletter

Acceptance of Advertising
■ Classified ads only
■ Link on website for direct submission
■ All advertisements are subject to review and approval by the Editor

Ad Options
■ May run ad in one newsletter or all year- 4 total newsletters, December, March, June, and September issues

Cost
■ $50.00/ad each newsletter or $150.00 for all 4 newsletters. No cash discounts.
■ Payment must be received in full prior to the scheduled close date for the quarterly issue.
■ Payments can be made though the PayPal link on the FANNP website

Format
■ The classified ad section of the newsletter: will be limited to 1 page only with approximately 30 ads per page
■ Ads will be processed on a first come first serve basis

Closing Dates for Space and Advertising Materials is as Follows
■ September, 2014-ads must be received by August 8, 2014, and paid in full
■ December 2014-ads must be received by November 14, 2014, and paid in full
■ March, 2015-ads must be received by February 13, 2015, and paid in full
■ June, 2015-ads must be received by May 8, 2015, and paid in full

FANNP BOD

BRING IT ON ANSWERS
from page 12

Answer is A;
Cleft lip and palate are frequently associated although they are embryologically distinct disorders. Cleft lip occurs when the maxillary process does not emerge with the medial nasal elevation on one or both sides. Cleft palate occurs when the lateral palatine processes fail to meet and fuse with each other, the nasal septum, or the primary palate. Rates of recurrence risks indicate that genetic factors are frequently involved. Environmental factors also appear to contribute in some way, thus indicating a multifactorial mode of inheritance. Maternal medications in the first trimester, especially benzodiazepines, phenytoin, opiates, penicillin, salicylates, cortisone, and high doses of vitamin A have all been associated with clefts.

Answer is B;
S1 is the sound resulting from closure of the mitral and tricuspid valves after atria systole. S1 is the beginning of ventricular systole. S2 is the sound created by closure of the aortic and pulmonary valves, which marks the end of systole and the beginning of ventricular diastole.

Answer is B;
In the newborn population, the most frequent cause of SIADH is asphyxia, with signs including low serum osmolality; low serum potassium, chloride and calcium; high urinary sodium in the presence of severe hyponatremia; decreased free water clearance; and elevated urine specific gravity.
Bring it On...

Practice Questions to Prepare for the NNP Certification Exam

1. Which of the following is a true statement:
   A. Cleft lip and cleft palate are embryologically distinct disorders
   B. Cleft palate occurs more frequently in males
   C. Cleft palate repair can be done at about 3 months of life

2. There are four individual heart sounds (S1, S2, S3, S4). S3 and S4 are not generally heard in the neonate. Which statement best describes the cause of the sounds identified as S1 and S2?
   A. S1 is the result of the closure of the mitral and tricuspid valves after atrial systole; S2 is the result of closure of the aortic and pulmonary valves
   B. S1 is the result of closure of the mitral and tricuspid valves at the end of atrial diastole; S2 is the result of closure of the aortic and pulmonary valves at the end of systole
   C. S1 is the result of closure of the aortic and pulmonary valves after atrial systole; S2 is the closure of the mitral and tricuspid valves at the beginning of ventricular diastole

3. The most frequent cause of syndrome of inappropriate secretion of antidiuretic hormone (SIADH) is:
   A. Prematurity
   B. Asphyxia
   C. Intraventricular hemorrhage

Answers on page 11