

A Canadian perspective

Resting on the western edge of Canada, the city of Vancouver lies within 30 minutes of excellent mountain skiing to the north and one hour's drive of the US to the south. In the southern suburb lies the Children's and Women's Health Centre of British Columbia – a combined site facility which houses the provincial tertiary neonatal intensive care unit. This Level 3/4 care provider has an admission rate of 650 babies a year for NICU and is the end point of the care cascade. It supports level 2 and 3 units across British Columbia and the Yukon – a geographical area 2.5 times the size of the UK. Commonly infants and families reside a helicopter or plane journey away, with many communities isolated on the multiple islands off the coast or deep in the interior of the mountainous forested countryside.

Using similar equipment to UK NICUs, the team provides the full gamut of NICU therapies, plus ECMO when required. A 47-cot facility, the NICU houses two intensive care nurseries each with 12 spaces. Each nursery has a designated team of medical staff led by one of eight on-site neonatologists. This division of labour is repeated for the 150 nurses who work in teams of 12-15, led by a Clinical Nurse Leader (UK Sister equivalent), with each team taking responsibility for one NICU nursery and their graduates in the outer nurseries. Interestingly, each shift has the benefit of both a 'procedure' and a resuscitation nurse – who cover for breaks, attend resuscitations, take admissions, set up for procedures and accompany infants and families to investigations which occur

off the main NICU.

Operationally the application of staff is similar to the UK, with a 1:1 nurse to infant ratio for the paralysed ventilated infant and 1:2 for stable, ventilated infants. Concerns regarding the need for developmental care for continuing and convalescing infants have resulted in ratio aims of 1:2 staff ratio even for lower dependency infants. In common with many UK neonatal units, staffing shortages remain a constant problem, exacerbated by the unpredictability of admissions and high occupancy rates.

In addition to the regularly seen counterparts in UK nurseries, the BC Women's NICU ward rounds are

complemented by the input of additional professionals – some rarely seen in the UK, others completely new. Ward round reviews

British Columbia's Children's Hospital.

A family far from home – this baby was flown in from Victoria.



include contributions from the neonatal fellow, the neonatal nurse, the dietician (with Masters in Neonatal Nutrition – a rarity in the UK), the respiratory therapist (RT), the physiotherapist, occupational therapist and discharge co-ordinator. While the neonatal dietician aims to make everyone think nutrition, RTs collaboratively manage ventilation in all forms at the bedside, care for equipment and assist/perform ET suction. Feeding problems are the remit of the occupational therapist – there is no speech and language professional. Early return to level 2/3 units nearer to home is inherent in the team's philosophy and recognition of the challenges of care faced by parents so far from home underpins the approach of the discharge co-ordinator, not often a designated role on UK units, who is essential for the smooth transition to the home environment.

Facilities for parents are available in the hospital. As in the UK, parents near discharge are able to use parent sleep-in rooms on the unit. Additional accommodation is available at a nominal cost however, many opt to park their camper vans on-site – acceptable within this healthcare culture. Parents have internet access and are provided with an information pack. Multi-lingual web-based resources are planned to cover the diverse population needs. Although BC nurses are not children-qualified there is a clear emphasis on children and their needs, demonstrated by the establishment of playtimes – periods of supervised play in a family area for three hours, three times a week, to allow parents time to interact with their sick infant free from the pressure of managing the siblings.

It is clear that neonatal care in BC shares many traits with that in the UK – and the differences are worthy of examination and may enhance the UK neonatal knowledge landscape. British nurses are already a feature of the nursing team; undoubtedly many more will be tempted to join them.

Is your unit special?

Why not contribute to our focus on a unit feature?
Contact kate@infantgrapevine.co.uk