Good morning, first I would like to Thank You for the opportunity to speak as a nurse who works at the bedside. I believe our input is critical to this issue.

My name is Maureen Keeley. I have been a full time nurse for 37 years. I have worked in adult ICUs and have been in the NICU for 25 years. I am here today because I feel strongly that NICUs and PICUs need their own separate acuity tool. These are not littles adults and needs from infancy through adolescents vary greatly.

I believe the MNA has covered many critical issues facing staff nurses in NICUs today and I was one of the people who participated in this process. can it use fine tuning? I am sure it can and I believe staff nurses should continue to be part of the process.

Ancillary personnel are necessary for us to do our jobs. It is impossible to concentrate on a sick patient when you have to worry about getting meds that should be stocked, having enough respiratory therapists to make changes and xray techs to do films. While you are caring for the patient and their family you shouldn't have to answer the phone and search for supplies.

25 years ago we barely saved babies born at 28 weeks, now we save 23 weekers. These advances have come with changes in the way these babies are cared for.

NICUs are unique in that most have teams, including nurses who physically leave the facility to pick up and transport these babies. transport can take 2-6 hours. What do you think happens to that transport nurses's assignment while she is gone? We generally have no notice and are expected to leave the building in 10 minutes. Sometimes this involves more than one baby and one team. We also leave the hospital to return babies to Level 2 nurses closer to home, this is done with just a nurse monitoring the baby.

Deliveries are sometimes planned but often are emergencies. We need to go to deliveries and take these babies on a moments notice. This can include one, two or even 3 babies. There is no ER or PACU to hold them till you are ready.

Basically it is always an unknown, a full term baby gone bad or a 23 weeker who doesn't breathe. All deliveries are basically a rescusitation.

We give these babies surfactant for their lungs and it can lead to pneumothoraces and pulmonary hemmorage. Their skin is 2 cells thick and fluids pour out of there bodies Constant weights,labs and fluid changes occur. Usually through a central line but not always. Imagine keeping multiple lines in a baby who weighs one pound and can lose a limb if an infiltrate is missed.

In the last 6-10 years it has been discovered that too much oxygen can damage their lungs and lead to ROP and possible blindness. We now have O2 sat ranges 87-95 if babies are in oxygen. Do you know how difficult it is to keep a baby in those ranges? They can have hundreds of high/low alarms a day. This includes babies with invasive or non-invasive ventilatory support.

Late preterm babies can be the sickest. meconium aspirations and pneumonias.

Now we cool babies who have had a neonatal asphyxia either in utero or at delivery. We can help salvage damage to their brains by cooling them. It requires temps every 5 minutes. Do you realize how quickly a 6-10 pound baby can be overcooled causing even more damage? This is one example where a patient needs 2 nurses for the first 8-12 hours.

Now place on top of this 2 grieving parents and extended family who are grieving. Their birth plan has gone wrong with little to no time to prepare and this is their brand new baby. Each baby is like having 3 patients at least initially.

My last example. Our society is dealing with a huge drug problem and we have not escaped this. These babies are the saddest. They cry and cry and cry till they are captured with narcotics. Even then they have the most sensitive nervous systems and can sieze. There family issues are another whole story.

One external issue is units that are 35 beds but only staff for 26 patients. Also, NICUs can have Level 2 nurseries but DPH will have to make that a priority if NICUs are looking to develop Level 2 beds.

I am sad that our profession has taken this turn to need a law to determine staffing rather than using nursing judgement, but if that is what it takes to keep our patients safe I support it fully.

I thank you again for your time and urge you to keep staff nurses involved in this process. personally I would be available for any assistance you may need.

The safety measures should also vary.

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Call for any questions or verifications. Thanks again