

**Submitted by Santina Abbate
Endicott, New York**

Note: The name of the infant portrayed in this story has been changed to protect the confidentiality of the infant and family.

I still vividly recall my first few days in the Neonatal Intensive Care Unit. I was a new graduate, a fresh-faced Registered Nurse, ready to conquer the world. My desire to vanquish quickly vanished as I took my first steps onto the unit and surveyed my surroundings.

Alarms beeped and blared haphazardly while people scurried around, exuding an aura of importance and purpose. Individuals garbed in stark white coats were huddled together at a bedside with brows wrinkled and engaged in an apparently intellectual discourse. I captured blips of important conversations: "...the TPN was lowered to 5cc/hr...Dr. Witwell wants an ABG at 10 o'clock."

TPN? ABG? What could that possibly mean? Is everything an acronym around here? I felt like the lone duck in a gaggle of geese. As I pondered various modes of elopement, an older goose approached me.

"What is your name young lady?"

"Tina," I timidly quacked.

"I thought so. My name is Trudie and I will be your preceptor for the next twelve weeks. Chin up, young lady! This place isn't as scary as it seems."

I met baby Alex on the second day of my orientation. He was two hours old when we met, born during the night shift. He was small...freakishly small, tipping the scale at 430 grams. It seemed implausible for a baby weighing less than a pound to survive outside of the womb. He was a 23-weeker, born prematurely by nearly four months. His head was barely the size of a baseball and his body lacked the subcutaneous fat reminiscent of the chubby newborn. His eyes were fused shut and his skin was translucent. Baby Alex could fit into the palm of your hands.

I had never seen a baby that small up close and frankly, I could not stop staring. All of the technology that surrounded him...a ventilator, IV pumps, a radiant warmer catapulted me into an entranced state. These machines represented Alex's life support...a fighting chance at survival.

The hours passed quickly even though Alex was our only patient. His response to the ventilator was less than desirable. The doctors made numerous adjustments, slowly increasing the pressure necessary to expand his stiff, underdeveloped lungs. Blood work, paperwork, vital signs, IV fluids, suctioning...how will I ever make sense of it all?

Alex's parents came into the NICU around noon to visit their son for the first time. I wondered if *they* had ever seen a baby this small. They sat quietly at his bedside for quite some time and finally mom turned to me and asked, "Is he going to die?" I shot Trudie a panic-stricken look. I mentally fumbled, desperately trying to think of a response that was therapeutic enough...I drew a massive blank and began to perspire. Trudie interjected and simply stated, "Alex is very sick,

and we are trying everything within our power to help him live.” Trudie placed her hand gently on mom’s shoulder. She nodded and started to cry. A lump developed in my throat and I wanted to throw my arms around her and cry with her. I held back and scolded myself for being so emotional. Alex’s parents left shortly thereafter, leaving a trail of hopelessness and desperation behind them.

Twelve hours had passed and our shift was over. Alex was fourteen hours old and actually demonstrated signs of improvement. He finally responded to the vent as indicated by his blood work. A glimmer of hope sparkled for the first time. I sent Alex a mental message, “Hang in there, little man. I will see you tomorrow.”

The next day arrived and I marched into the NICU ready to face the challenges that loomed ahead. I walked into Alex’s room and went toward the back wall where he was stationed yesterday. He was not there. I approached a night shift nurse, “Where is Alex?” She smiled apologetically, “Alex died around 3am.”

It felt as if someone had forcibly kicked me in the chest. I hurried away and ran to the nearest bathroom. I sobbed uncontrollably. With all of the modern day medical ministrations we have readily available, Alex should still be alive! There was a knock at the door and it was Trudie. We held each other and cried for a long time.

Babies represent a beautiful futuristic hope. Some grow up to become influential pillars of our society and some die before they even have the chance. In a three-fold utopian dream, all babies would be healthy and robust, leading full lives, devoid of any pain or suffering. Reality, unfortunately, dictates a different story.

I embarked upon two startling realizations. First, it is okay to submit to your emotions and secondly, the nurse’s involvement within the family dynamic is far more considerable than I had ever imagined. As nurses, we embed ourselves within the fabric of a patient’s story. It is okay to thrust your heart and soul into your profession and there is no harm or shame in displaying natural emotions. I would imagine that suppression of these raw sentiments might progress into impairment for the long term. After all, we *are* humans caring for humans.

De Frain stated, in the early 90s, “The death of baby is like a stone cast into the stillness of a quiet pool; the concentric ripples of despair sweep out in all directions, affecting many, many people.” We will never forget baby Alex.

Back In Time
Submitted by Rhonda Argenbright
Winterville, NC

It is April of the year 2009. A neonatal nurse is working in a 50 bed Level 3 NICU with ground and air transport services. She is caring for 2 babies. One who was born at 26 weeks 3 days ago and is stable on a ventilator, receiving breastmilk nasogastrically every 6 hours along with TPN via a percutaneous line. His mother received antepartum steroids 2 days prior to delivery. The other baby was born at 29 weeks about 2 weeks ago and is being fed breastmilk nasogastrically

every 3 hours and receiving caffeine for apnea. His mother was Group B Strep positive and received antibiotic treatment. Each baby is in their own room with cyclic lighting and in a double sided isolette (with brightly illuminated temperature settings). Each baby is in a “snuggli” to promote flexion. One of the babies is doing kangaroo care with his mother as tolerated; a recliner chair is located at each bedside to promote this activity. There is a breast pump at the bedside of this baby which his mother uses after kangaroo care. This allows her to supervise her 5 year old as they visit together as they are staying at the Ronald McDonald House across the street. This mother also prefers to participate in medical rounds daily. The “vented” baby’s mother prefers to use a unit pump room for privacy reasons. Both mothers enjoy the weekly “Scrapbooking Class” held weekly and plan to attend today.

Later in the day this neonatal nurse is offered to participate in a unique experience. The “old NICU” which was built in 1978 is being demolished and there is a time capsule to be opened which was prepared by a neonatal nurse in 1984; 25 years ago! She is so excited as she has been a neonatal nurse for 3 years and just can’t imagine what neonatal life was before.

She opens the time capsule and here is what she reads: Hi, my name is Rhonda and I am the charge nurse today. I have been asked to write up a description of what neonatal nursing is about in 1984. We have come a long way! Our unit is 30 beds and we have 2 large rooms with babies squeezed into every available space. One room is for the intensive babies and the other for the intermediate care level babies. Most of the intensive care babies are in overbed warmers on ISC probes for visualization and quick access. Our older models are a little dangerous as you can turn the alarm off and it stays that way until you remember to turn it back on; this can result in babies overheating sometimes. Premies who are about 1250 grams will go in single walled isolettes when they are no longer on a ventilator. We also have these double walled isolettes nicknamed “bubbles” that smaller babies go into when they are over 1000 – 1200 grams. Babies are on ISC temp control mostly until they are greater than 1500 grams and not in the intensive care part of the unit.

We keep the lights on all the time so we can watch the babies. The nurses enjoy rock’n’roll music 24 hours a day. Our neonatologists bought us a nice radio a couple of years ago. We have no windows so you never know what the weather is like until you leave. Our parents sit in the adjustable nurses’ chairs when they visit in the intensive side and we have rockers in the intermediate care area. Parents, siblings, and grandparents are allowed to visit any time except during change of shift reports and during bedside medical rounds.

We have a lot of sick premies who require lots of chest tubes and stay on ventilators for very long periods of times (i.e. months). Respiratory distress syndrome (RDS) is the most common problem of premies we observe. Premies tend to have issues with apnea and we use the “bump” or the drug called Theophylline to treat them. The “bump” is an old CPAP machine with a glove on the end of the tubing. The Respiratory Therapist sets an amount and rate for inflation and the glove is positioned against the baby. Some babies are really rocking and still having apnea. We have premature babies who stay months who later developed the condition called bronchopulmonary dysplasia (BPD). These babies require high levels of oxygen, diuretics, and are very irritable. Some die from this condition.

Most of the babies who are in intensive care are getting continuous nasoduodenal feedings. As babies get more intermediate care they are switched to intermittent nasogastric feedings. We primarily use premature formulas manufactured by Ross or Mead Johnson. We have 2 electric breast pumps that we keep in the Parent Room but are rarely used. I don't think I have ever seen a baby actually breastfed in our unit.

Intravenous therapy is a big challenge for us. Sometimes in our small babies, born 28 weeks or greater, the docs will leave a UAC in for 28 days, but then we have to try to find veins and they just don't last. The babies are too small to have a central line put in by surgery. Thank goodness for transilluminators! You have to be careful with them because they can burn the baby.

The most common problems we see in babies are RDS, pneumothorax, necrotizing enterocolitis, spina bifida, BPD and other defects. We have outbreaks of NEC and sometimes we have to make one unit "NEC babies" and the other "clean babies". I have seen many babies die from this condition. I think one of the worst diagnoses is Group B Strep. These term babies come to the NICU with some mild respiratory distress and are dead in a few hours. Parents are devastated.

As a charge nurse, staffing can be a real challenge. We usually have a few 1:1 type patients and when there is a transport call I find a nurse to go with a RRT and NNP by ambulance to one of our 29 counties. I love it when nurses will take call for this job; it is extra money if they go out and they usually are not gone more than 6 hours. Most nurses on the intensive side take 2 babies and on the intermediate side a nurse usually has 3-4 babies. Usually a charge nurse takes one patient of lower acuity.

I love being a nurse in the NICU. I am the charge nurse on most days I work and then I do transports if I get called at home on my days off. I think I average about 100 working hours per pay period (2 weeks).

I wonder what neonatal nursing will look like in 25 years. More importantly I hope you love your babies and their families!

A Legacy of Caring and Compassion

Submitted by Kathy Brown, RN

Northport, AL

Neonatal Nursing is much more than a job. It is the essence of what we are. Long days working without eating, without a break; staying hours past the shift just to document. Working weekends and holidays, and sometimes even death can be a big part of the job.

I come from a time before Developmental Care, ECMO, heart transplants for newborns, surfactant replacement; when saving a baby at 27-28 weeks gestation was not a certainty.

We all wonder what becomes of these children that we care for and become so attached to. On a December evening some 20 odd years ago, we got the call from Labor and Delivery that the premie twins they had been watching were about to be born. Twin A arrived at 9:00 p.m. Twin B was born at 9:07 p.m. Both girls!

Their mom remembers that her family had gone home when the nurse came to check. She said, "You're about to give birth!" You never saw so many people and equipment in one room! Two of everything surrounded me. Taken immediately to the NICU, I didn't get a chance to really see my babies. The staff of the NICU was great. They explained everything and kept us well informed. To this day my husband remembers the first words he heard from the Neonatologist, "your babies are not doing good". It did take a while to get used to all the wires, tubes, and alarms. Having the girls on ventilators however, was very difficult for us.

The days went by slowly. At the end of January, Twin A (Jennifer) came home. We dressed Jenny in a soft pink preemie outfit for her trip home. It was hard to leave Amy (Twin B) behind. In February, Amy came home. She had lost down to two pounds and I remember how big her little pink outfit was on her.



Coordinator, I welcomed my new orientees. One of these young ladies seemed familiar. Her name was one I knew, but how? During the next few days I learned that this was one of those sweet twins I cared for all those years ago. What a shock!

I am so proud to have the opportunity to teach this young woman. I am equally proud to work along side her. Amy says she has always known that she wanted to be neonatal nurse. Their mom says that she finds it amazing that they both ended up in the very place where they both began.

I hope I made a difference in their lives. They have certainly made a difference in mine. Surely they will bring brighter tomorrows to other children.

I am thankful for my job and a career I can be proud of. And so I stay.

We had our family together again for the first time since December 10th. When our girls were small, they always wanted to put bandaids on everyone or wrap up an arm or leg. They loved to play "Nurse".

In 2006, as the Education



The Little Baby With a Wonder Bread Body and an E.T. Head
Erma Cooke, RN, MSN, NNP-BC
Camp Lejeune, NC

You know that you've been in this business of taking care of babies for a long time when you get an announcement that one of your preemies is getting married! One of my first and most memorable premature babies is Brian. When he was born during February 1985, he weighed just over 4 pounds. Now, he is more than 6 feet tall!

Brian was at 32 weeks gestation when he was born at the rural Georgia hospital where I worked. His mom was a smart cookie who had read up about newborns and their expected care. When she realized that she was in pre-term labor, she knew that things might get a little rocky. She told her husband, "This baby is coming. His lungs won't be developed. His eyes won't be developed."

When I spoke with her recently, Clara admitted she was scared. She did not have any steroids prenatally, no epidural and no sedation for delivery. She was considered too unstable for transport.

A pediatrician told her at the delivery that Brian was one sick little boy. But, at 4 pounds, 4 ounces, he told Clara her baby's size would work in his favor. Brian's lowest weight was 3 pounds, 5 ounces. He was transferred to the Level III nursery that first morning. He was 25 hours old when his first lung collapsed and 30 hours old when his second lung collapsed. Clara had read enough to know that the March of Dimes was working on "surfactant" therapy for babies, but the drug was not available to everyone yet.

I met Brian when I back-transferred him to our Level II nursery. He had already started to develop dolicocephaly. Brian's dad called him "E.T." because "he had ET's head on a loaf of Wonder Bread with all his ribs sticking out".

When Brian was 15 days old, he developed severe apnea and bradycardia events. We nurses would often sit by his bed and stimulate him. His mom remembers that Pam Kelly and I were at his bedside when he quit breathing and his heart rate was really low.

"Pam was rubbing his back so hard that her knuckles were turning white," she remembers. "Every time she stopped, Brian's heart rate would go back down. I had read that preemie babies would respond to their mothers and I thought if Erma and Pam ever gave up on him, I'd just hold him and he'd keep breathing." We finally got him on a ventilator and stabilized. He was anemic and required a transfusion.

Brian was discharged at 36 days of age. Clara brought him to the hospital on his first birthday to thank us for taking care of him during those dicey, early days. After that, she called the nursery every year on his birthday as well. I eventually moved on to another position, and we kept in touch. Clara gave me updates when Brian graduated college and when he got engaged. "Little" Brian is now a high school teacher.

Crooked Paths of a Neonatal Nurse
Submitted by Deborrah Furse, BSN, RNC
Clinical Manager NICU
Lawrenceville, GA 30045

My career as a Registered Nurse began in 1977 as a Labor and Delivery nurse, but was quickly drawn to the small “NICU” and began asking to float there to work. Pretty soon I made the transfer to the NICU and the rest is history, as they say. My greatest thrills were all night transports in an ambulance with the owner of the company telling ambulance stories to a wide eyed new graduate nurse.

I continued with my bedside career for many years, and was considered one of the “expert nurses”. I precepted for years, but my real love was those transports from before. To be a transport nurse I knew I had to have a BSN. So, I obtained my BSN while working full time and caring for my family! My last semester in the BSN program, I applied to NNP school. I couldn’t decide between that and becoming a transport nurse. As I have come to realize, sometimes big decisions are made for us when we are at a crossroads, and mine was made when I became pregnant with my third child in the last semester of the BSN program.

Shortly after my son was born, I began looking into other avenues for my career, and found a Nurse Manager position at a neighboring hospital in their Nursery that was going to become a Level II NICU. I needed a challenge, so I took the job. I spent 8 years feeling my way around the Leadership game. I made many mistakes, but had many successes as well. That was in 1991. Since that time, I have held NICU Director and Manager roles in 2 other facilities as well. Both were Level III NICU’s, and both had challenges for a new Leader. But, I love a challenge. After a lot of hard work, in 2006, my last unit won the Advance for Nurses “Nursing Team of the Year” award for the Southeastern United State. I felt a real sense of accomplishment.

I have always sought out new challenges. Some days I feel completely defeated, but I quickly think back to my early days in Neonatal Nursing at the bedside when I loved to care for the sickest and tiniest babies. Maybe I just love a good challenge?? It is really ok that our skill sets change as we grow in our careers. My skills as a bedside expert nurse are under the surface somewhere now, and there are many days I miss that. But, I have become skilled in helping nurses grow in their careers. I can help younger nurses learn to cope with the grief of dying babies, and I can support the older nurses who are caring for elderly parents at home and still come in with compassion and desire to help others. I have been in both those places and know from personal experience how that feels.

I think my crooked path took me where I am supposed to be.

**Submitted by Susan King, RNc, IBCLC
Staff Nurse, NICU
Davie, FL**

We were colleagues and we were friends.

Twenty five years ago things were a lot different. Not unlike today, the NICU was full of tiny patients with many challenging problems. We worked the long shifts, side by side, Registered Nurses, Respiratory Therapists, Nurse Practitioners, Neonatologists and others, preserving life and forging friendships that stood the test of time. Friendships that were cultivated through seemingly unending stress, exposing our strengths and weaknesses, yet, as comfortable as your favorite blanket.

Our unit was new, large and hollow. The soft classical music was not yet to play. Instead the popular top 40, mixed with laughter, loud voices and the beep-beep high pitched alarms of 25 level three occupants filled the air. The pressure driven ventilators puffed prescribed breaths to their tiny recipients with no regard to their stage of development or lung compliance. That magic liquid we now dribble down endotracheal tubes was something we could only dream of. Experts in identifying signs of pneumothoraces, we'd rush to the bedside offering all that we had to save lives. In the aftermath, babies would lay open on radiant warmers, chest tubes splayed out, attached to frumpy, bubbling evacuation devices offering help and hurt, both, at the same time. Neonatal pain, we were told, was virtually non-existent. Babies were thought not to perceive pain or at least they wouldn't remember early painful events. Nurses knew all along that babies felt pain, and today, thanks to dedicated and supported research, we can observe even the most subtle signs of pain in the tiniest and sickest patients and respond appropriately.

There were celebrations and there were tears, births mixed with bereavement, and hope lingering with uncertainty. Our own lives separate, yet intertwined, were connected at the bedside and at the barbecue. We embraced life and lost life, suffered broken promises and fulfilled dreams. We welcomed the formation of the National Association of Neonatal Nurses, our voice and path to the future. We became linked to nurses across the country at a time when computers and the internet was something beyond comprehension. Shortly thereafter, our small group, of colleagues and friends, organized the first local chapter of NANN. We called ourselves the South Florida Association of Neonatal Nurses, now the Southeast Florida Association of Neonatal Nurses.

Today, some of us are at the bedside and some are leading a new generation into the future of neonatal care. A few have opted to move on while others have since retired. There is one, my colleague and friend for 25 years, who blazed a trail to become a Neonatal Nurse Practitioner. Side by side we did what we loved, faced the challenges and embraced the future. Our lives separate yet intertwined, I bid farewell my friend.

A quarter of a century has passed, neonatal nursing has progressed, babies are afforded evidence based care, and it is an amazing time. I stand in awe of all the changes, still wanting more and better and think perhaps, there are barbecues in heaven.

Let's Celebrate 25 Years!
Submitted by Alison Mammone, RN
Akron Children's Hospital

As a nurse with 25 years of experience, I've seen many changes over the years, many with significant lifesaving results. Some are changes as technology advances, some are changes I've noted as I've worked in different areas of the country.

I was first introduced to neonates in the early 80's. I was in Virginia, working on an Infant's and Toddler's Unit. A portion of the unit was designated as the "NICU Stepdown". In retrospect, I find it very odd that sick infants were paired on the same unit as neonates! Of course, RSV and Rotavirus were not identified at that time. Good handwashing, and swinging glass doors to "The Stepdown" were our barriers of defense for the little ones! . I also learned about Hypoplastic Left Hearts. The Blaylock Taussig Shunt was the only surgical intervention being used, and that was palliative, at best.

By the late 80's, I was in Houston, Texas. I focused on more pediatric nursing. With some background in NICU Level 2, I often floated out to help in that area. I saw changes in the management of "feeders and growers", changes with new warmers and isolettes, introduction of new medications for infection, reflux, and apnea.

In the early to mid 90's, I worked in Pediatric Homecare. Many of the cases that I was initiating and supervising were coming out of the NICU's. More babies were living at earlier gestational ages, yet had ongoing conditions that needed homecare assistance. Surfactant had come into the picture, and saved more and more preemies and micro-preemies. I became proficient with the LTV home ventilators – which were so much better than the "Baby Birds"! I learned how to maximize the Homecare Medicaid programs, which were constantly changing to meet the high demands of our growing numbers of preemie and special needs children. By the mid 90's, monthly Synagis became a routine vaccine for the prevention of RSV in the premature babies, and homecare visits skyrocketed!

In the early 2000's, I moved from Texas to Ohio. I oriented into a Level 3 NICU, and saw some differences in the practice of care from the south to the north. One of the biggest differences, was that everything was done in the isolette – from intubation to ventilation to IV starts. In the south it's all warmers; in the north it's isolettes! . The orders and care seem more conservative in the north – not bad, just different. Developmental care, cue based feeds, Kangaroo care are now instrumental in neonatal care. New developments such as Cool caps, Vapotherm, , many types of ventilation, and advances in surgical procedures keep arising on the neonatal forefront. Ongoing education, even informally within the unit is essential!

What I learned in nursing school in 1983 about premature babies, is essentially obsolete! So many advances have changed the way we deliver care. At that time I was taught that "the age of viability is 24 weeks – and those babies usually don't survive." We have come so far in 25 years!

Twenty Five (Plus) Years and Counting.....

Terry O'Connor, NICU RN

This year I will be a neonatal nurse for 34 years. Every now and then I think back on how we used to do things....and I smile....

We took blood pressures with a Doppler. We had to push our cap forward to put the ear phones on our head. They did not have 1ml. heparin syringes to do an ABG; we had to make our own. Before the birth of the TCOM we did ABG's constantly. No stylets back then, so we kept the ETT's in the freezer. Babies stayed on ventilators for months. A 28 weeker I took care of in 1978 was on a vent for 97 days. There were no respiratory therapists in the NICU. You set up your own vent for your admission. You also took it apart and cleaned it as well. Vent tubing was very stiff and heavy. Ventilated babies were kept on their backs (a precursor to safe sleep☺) and their heads were kept straight. We would have the tubing coming from the top of the warmer and taped to a heat shield. Before double wall isolettes we used heat shields inside the isolette to avoid heat loss. Every isolette and Armstrong (remember those) had water put into them daily. The antibiotics used then were Pen & Kana; they were the Amp & Gent of today. If a baby had NEC the entire nursery were put on PO Vanco. On an extremely low birth weight baby we put saran wrap over the entire warmer. The only pumps we had were Harvard Pumps. We had to tape where the infusion began and where it would end. There were no pump feedings then. You sat by your baby and watched the entire feed go in by gravity. There were no indwelling feeding tubes so you put it in at feeding time and then took it out. 3 hours later you repeated the process. These were not the days of managed care; every supply that we used had a charge slip on it that we had to stamp with the addressograph. I can remember being in the Survanta study. I now cannot imagine life without it or Curosurf. Butterflies were our IV catheters. If a small baby had no breast milk, we would call down to the postpartum floor to see if a Mom had pumped any extra milk that we could use. We used 2 needle electrodes that went under the skin. It sounds so invasive now, but let me tell you, they stayed there for 2 weeks and worked. On the first day of life we now may go through 10 sets of leads. Technology comes with its price tag. What we do in neonatal nursing is priceless.

Yes, I have seen many things change, but what has not is the caring and the love we give to our smallest of patients. A neonatal nurse is in a world of its' own. I have been blessed and honored to belong to this world.

LOOKING BACK AND REMEMBERING

Submitted by Joyce Stein, RN, BSN

Brooklyn, MI



When reflecting on NANN's 25th Anniversary I am reminded of a journey I have taken these last 21 years with a NICU graduate, Jennifer, who has just celebrated her 21st birthday. Though she was not a premie, she highlighted a patient population that NICU's care for every day: the term infant. Jennifer's journey started as a term infant delivered at a local hospital 21 years ago.

She presented in those first several days of life with "apneic" episodes. Thinking she was septic the usual r/o sepsis protocol was done and it seemed pretty routine. But after those initial days in

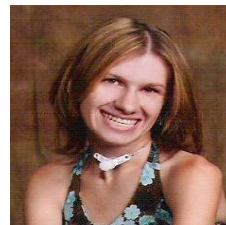
the nursery everything afterwards was far from routine. She continued with apneic episodes and started having feeding issues. She was transferred to our unit, the regional NICU. She would stay in our unit for the next 7 months. She would also be the “first” for many protocols that today are somewhat routine. She was diagnosed with “Ondine’s Curse”, today called Congenital Central Hypoventilation Syndrome (CCHS), and long segment Hirschsprungs Disease. Both are fairly rare diagnoses and even more rare to be together. She, to this day, is our most complex baby ever discharged from our NICU.

This was the 1980’s. Neonatal nursing was just beginning to emerge. She went home with a tracheostomy, ventilator, broviac, TPN, ileostomy and GT feedings. She was our first infant to be discharged home on a ventilator. She was also our first to have been discharged home on TPN. She originally went home with 24hr nursing care, another first.



She was the first complex NICU infant cared for by our local home nursing agency. Because she was going to be the first such complex infant for our local nursing agency, I was inspired to hire on to do some of her private duty nursing at home. Because of my experiences with her home care, the following year I created a Discharge Coordinator role for our NICU; another first. We have subsequently sent home numerous infants over the last 25 years with trachs, ventilators, TPN and GT feedings. All based on the “first” experiences we had with Jennifer. I have stayed in touch with Jennifer over these last 21 years.

Lessons learned from her care in the 1980’s, have helped shape many of our practices in our unit to this day. My personal practice of neonatal nursing was also shaped by lessons learned from her NICU stay and discharge needs. It only reinforces for me how special every baby is that we take care of every day and not knowing which baby will be our next baby of “firsts”. All of our efforts are like building blocks shaping our day to day practices and protocols. It is all about our experiences and taking those experiences and shaping our practice for the next generation.



**Submitted by Nancy Tella BSN RN, Staff Nurse II
The Children’s Hospital
Boston, MA**

I graduated from Boston College in 1981 full of excitement to start my nursing career. In 1981, most nurses had no true voice on the team; rather they just followed doctor’s orders. BC taught me that a nurse was a valued and respected member of the team, and I was eager to get to work.

My first job was in the NICU at a local city hospital. I soon learned that nursing there was based on an old school, paternalistic model where nurses had little say in the plan of care for their patients. The place certainly did not live up to the expectations that BC had set for me, and I moved on after only 3 months.

I interviewed with Susan Shaw, a dynamic, forward thinking woman who was then the Nurse Manager of the NICU at Children's Hospital Boston. Minutes into the interview, I knew I had found my professional and philosophical match. In her, I saw my nursing idealism personified, and knew I had found the place for me. The strong nursing identity she was creating within the NICU resonated with what I learned at BC.

Looking back on my career of 28 years, I have come to see my practice as a rich tapestry woven by the threads of my personal and professional experiences. The early years with Ms. Shaw instilled an unshakable sense of professional accountability and responsibility to advocate for patients and families. These values, along with strong clinical skills, are the foundation of my nursing practice.

Having had a daughter with complex cardiac disease has given my practice an invaluable depth, and these personal threads can never be separated from my clinical practice. Making difficult decisions and living through the heartache and introspection that came with her death has given me a deep level of understanding of parenting in the hospital and living with illness and grief that has been useful in caring for patients and families in the NICU.

Though the setting and the complexity of care provided in the NICU have changed immensely over the last 28 years, the cornerstones of my practice have remained the same. Seeing the difference that a strong nursing presence can make in the care of critically ill infants has heightened my commitment to the patients and families we treat, and has deepened my sense of responsibility to pass on these high expectations to my younger colleagues.

Nursing has developed in many ways over the last 28 years, and a strong nursing identity is now the rule rather than the exception at most hospitals. In our NICU, we continue to set the highest of standards in caring for our patients and families to ensure they receive the best and most comprehensive care possible. I have a tremendous amount of pride in my personal work, and in the care our entire team provides. I look forward to continuing to meet the challenges ahead in our ever evolving setting.



**1981 to 2009
28 Years of Nursing Practice**

**Submitted by Sandra Britto
Mother of a NICU Graduate**

My name is Sandra Britto. My daughter was born 4 weeks early almost 26 years ago.

Melissa Lynn Britto was born on May 26, 1983. She was born at 36 weeks gestation. Her original due date was June 23rd.

I had gone into Jordan Hospital on May 25th for a non-stress test, as my blood pressure seemed elevated and I was being monitored for Preeclampsia. After the test, my OB-GYN decided to perform an amniocentesis to determine if the baby's lungs were mature, but was only able to get bloody fluid. I later found out that the bloody fluid was because of placenta detachment. He determined that I would need to be delivered early and because Jordan Hospital was not equipped with a Neonatal unit, I was transported by ambulance to St. Margaret's Hospital for Women in Dorchester and after many various tests, the decision was made to deliver me via C-Section.

Melissa Lynn was born at 2:57pm on May 26th, weighing in at 3lbs. 12oz. She was 17½ inches long. She remained in the NIC unit for only 3 days and then was moved to the "Special Care Nursery" for the remainder of her stay which was only seven days. On June 2nd, when I was discharged, we were allowed by Dr. Kennedy at St. Margaret's Hospital to transport her by car directly to Jordan Hospital in Plymouth where she remained for another nine days. She left the hospital to go home on June 11th at a weight of 4lbs. 5½oz. It didn't take long for Melissa to gain and catch up to other babies of her age.

She just delivered her own son at 24 weeks at Tufts Medical Center, Boston and he is currently in the NICU there. He was 1lb 3oz at birth. His name is Jensen Caleb Grande.