NIDCAP
Nursery Certification
Criterion Scales
(NNCCS)

Manual

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Mentoring caregivers. Changing hospitals. Improving the future for newborns and their families.

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Introduction

The NIDCAP Nursery Certification Program (NNCP) under the auspices of the NIDCAP Federation International (NFI) recognizes the excellence of a hospital nursery's commitment to and integration of the principles of the Newborn Individualized Developmental Care and Assessment Program (NIDCAP) for infants, families, and staff. Hospitals and their newborn nursery systems receive NIDCAP Nursery Certification when they demonstrate that they consistently promote best short and long term development of all infants and families in their care, and support their professionals and staff in accordance with the principle of assuring best personal and professional development towards relationship-based care implementation. NFI certified NIDCAP Nurseries provide a dynamic environment for the full integration of expert medical and nursing care securely embedded within the active pursuit of mutual respect, caring, nurturance of and collaboration with infants and families, and among all professionals and staff members.

Nurseries eligible to apply to the NFI for certification, must be part of a hospital system that, if in the USA, is licensed and accredited by the Joint Commission on the Accreditation of Healthcare Organizations, or if outside of the USA, meets the respective country's accreditation standards. Furthermore, nurseries eligible for certification must provide care to preterm infants under 1500 grams and/or under 30 weeks gestation either from birth on (NICU, Level III Nursery) or in a convalescent mode (Level II Nursery; step-down nursery), and/or provide care for full-term or near full-term infants who require intensive or specialized medical care to ensure their survival; and/or provide care for newborns cared for in a hospital setting for various reasons. Such nurseries must employ at least one full-time equivalent (FTE) NFI-certified NIDCAP Professional in good standing for the purpose of promoting individualized developmental care. Hospitals with multiple nursery settings may apply for certification for only one or for more than one of their nursery settings. Hospitals are encouraged to apply ultimately for certification for all the nurseries settings under their purview.

The NNCP utilizes the NIDCAP Nursery Certification Criterion Scales (NNCCS) as the key instrument to evaluate the quality of a nursery's developmental orientation and care implementation. The NNCCS are rating scales of many aspects of the environment, care implementation and philosophy that characterize a nursery, and that are assessed by an extensive nursery-self-assessment process followed by a two- to three-day site-visit, depending on the size and complexity of the nursery to be reviewed, conducted by an NFI-designated NNCP Site Review Team of three NIDCAP Professionals with complementary interdisciplinary backgrounds such as neonatology, nursing and one of the developmental disciplines. The Site Review Team members are trained and certified in the use of the NNCCS. The Team identifies and confirms a nursery system's strengths and, as indicated, provides guidance towards growth and further development in order that the nursery may achieve the ultimate goal of certification. During the site visit's first and/or second day the NNCP Site Review Team seeks to experience the path the families take from the hospital's entrance through the hospital to their infants' bedsides. The Team furthermore observes the overall as well as the specific aspects of the nursery environment, and meets with the hospital and nursery's administrative leadership, with representatives from across and within disciplines, and with parents and other family members, whose infants are currently cared for in the nursery. On the final day the NNCP Site Review Team meets off-site to discuss what each of the Team members learned in the course of the site visit in fleshing out the information gleaned from the application materials transmitted prior to the site visit. In review and discussion the team arrives at a preliminary overall assessment as to the nursery's level of NIDCAP implementation, which is subsequently further refined and integrated into an overall assessment and

results in the disposition as to the certification process, which is subsequently communicated in writing to the applicant site.

The NFI recognizes and validates nurseries that demonstrate understanding and integration of the NIDCAP model into the care for the infants and families they serve. Achievement of NIDCAP Nursery Certification demonstrates a consistently high level and quality of care implementation and overall functioning for infants, their families and the staff and professionals in the system. Such a level of achievement is to be commended and celebrated and serves as an inspiration for all other nurseries.

The NIDCAP Nursery Certification Criterion Scales (NNCCS)
The NNCCS Manual consists of 121 scales grouped into four major categories of a nursery's characteristics and functioning, as well as of four Category Summary Scales, and one Overall Nursery Summary Scale. The individual and the summary scales address the level of individualization, family-centeredness, and developmental support that a nursery provides for the infants and families in its care, as well as for the professionals and staff involved in delivering such care. Aspects of the nursery considered are the physical environment, the care for the infants, the care for the families, and the care for the professionals and staff members in the nursery, who in turn care for the infants and families. The individual scales thus are organized into the following four categories:

(1) Physical Environment of the Hospital and Nursery;
(2) Philosophy and Implementation of Care: Infant;
(3) Philosophy and Implementation of Care: Family; and
(4) Philosophy and Implementation of Care: Professionals and Staff.

The five-point rating scales of the NIDCAP Nursery Assessment Criterion Scales (NNCCS) assess a nursery's philosophy and implementation of care in reference to the NIDCAP (Newborn Individualized Developmental Care and Assessment Program) model. Each of the five score points on the NNCCS ratings represents a level or degree of NIDCAP implementation as follows:

(1) Traditional, conventional care;
(2) The beginning or a minimal degree or level of NIDCAP implementation;
(3) An inconsistent, variable or moderate degree or level of NIDCAP implementation;
(4) A consistent well-integrated level or degree of NIDCAP implementation; and
(5) A highly attuned, distinguished level or degree of NIDCAP implementation.
(NA) "Not applicable," is scored when an aspect of care does not apply to a specific nursery system.

Scores derived from the individual ratings within each of the four categories are utilized to describe and characterize an individual nursery in order to assess the nursery's level of developmental care implementation and integration, and its readiness to be certified as an individualized, developmentally supportive, family-centered NIDCAP Nursery.

Scoring of the NNCCS

On the final day of the site visit when the NNCP Site Review Team meets off-site to share what each of the Team members learned in the course of the site visit in view of the application materials already reviewed prior to the site visit, the Team members each score the five-point NIDCAP Nursery Certification Criterion Scales, based upon the site's self-assessment including the written materials submitted in advance, and the on-site observations. The scores derived during this process by each of the reviewers include *the Averaged Scale Scores by Category; and the Overall Hospital and Nursery Summary Score.*

The Site Review Team members score each of the items in the four categories of the NNCCS (Physical Environment of the Hospital and Nursery; Philosophy and Implementation of Care: Infant; Philosophy and Implementation of Care: Family; and Philosophy and Implementation of Care: Professionals and Staff). The reviewers then identify all two-or more-point score discrepancies among them. They resolve these discrepancies in discussion and reconsideration of evidence, and assign the respectively agreed upon scores to the items in question. Each of the Site Reviewers then calculates the Averaged Scale Score for each of the Categories (Sum of Scale Item Scores per Category/Number of Scales Scored within Category). From the three *Averaged Scale Scores by Category* the Team Leader forms the average score per Category and rounds to one digit after the decimal point, in order to arrive at the Category Summary Scale Score*.* The definitions provided in the NNCCS Manual for the Category Summary Scales present a general scaling per category from most traditional, schedule- and task-focused care to most individualized, developmental, relationship-based and family-focused care. From the four Team-Averaged Summary Scale Scores by Category the Overall Hospital and Nursery Summary Scale Score is derived by averaging the Team- Averaged Summary Scale Scores by Category (1) Physical Environment of the Hospital and Nursery; (2) Philosophy and Implementation of Care: Infant; (3) Philosophy and Implementation of Care: Family; and (4) Philosophy and Implementation of Care: Professionals and Staff and rounding to one digit after the decimal point. It must be noted that Category (1) Physical Environment of the Hospital and Nursery does not carry the same weight as the other three as it more often than the other three categories may be outside of the purview of the nursery itself.

Successful NIDCAP Nursery Certification requires Averaged Summary Scale Scores of four or five (≥ 3.5) on Scales (2), (3) and (4), i.e., pertaining to aspects of the philosophy and implementation of care for infants, families and nursery caregivers. The Averaged Summary Scale Score for Category (1) Physical Environment of the Hospital and Nursery may be lower than four (< 3.5) depending on the locus of control of the environment in a particular hospital. Nevertheless, for successful NIDCAP Nursery Certification, the Overall Hospital and Nursery Summary Scale Score must reach a score of four or five (≥ 3.5).

Special Considerations

The NNCCS is the key instrument to evaluate the quality of a nursery's developmental orientation and care implementation. The development of the NNCCS Manual is based on the authors' extensive knowledge and years of experience in working with hospital newborn nurseries both in the United States of America and internationally. The NFI is aware that some countries or cultures may not have developed some of the specific hospital organizational structures or procedures that are addressed in the NNCCS Manual, e.g., the formulation of a Mission Statement that integrates the principles of

NIDCAP and family-centered care; the creation of systems for policy development and review; the development of a Family Advisory Board for the nursery and Pediatric Services; or the establishment of systems for ongoing development and documentation of staff education. Some aspects may be a result of country and/or local regulations or cultural practices. In such circumstances and situations, where the control of change lies definitively outside of the purview of a nursery the review team scores the respective specific scales as "not applicable" (NA; i.e. an aspect of care does not apply to a specific nursery system). Such a score will not feature in the calculation of the Average Category Summary Scale Score and therewith will not feature in the Overall Hospital and Nursery Summary Scale Score. The NNCP Review Team may make recommendations in how to address the absence of such structures, systems, or procedures in the long run in its review's Feedback and Summary Letter.

Additional Uses of NNCCS

Aside from the NNCCS' primary use the NNCCS' goal also include training and mentoring; documentation of change in the course of a nursery's adoption of developmental care as framework of care delivery; documentation of the standard of care within a nursery; and examination of the relationship of environmental and caregiving parameters to infant, family, and staff functioning and satisfaction.

Note: The scales in the NNCCS Manual marked with an asterisk (*) were adapted from the NFI copyrighted instrument by Als H, Buehler D, Gilkerson, L and Smith, K. Profile of the Nursery Environment and of Care Components, Template Manual, Part I – Revised. Boston: Children's Hospital; 1990. Revised 1995, 2008, developed in the context of the National Collaborative Research Institute on Early Childhood Intervention (NCRI-ECI) (1989–1994), entitled "Family-Focused, Individualized Developmental Care for the Very Low Birthweight Infant," funded by the U. S. Department of Education Office of Special Education Programs (OSEP), Early Education Programs for Children with Disabilities (EEPCD), and directed by H. Als.

I. Physical Environment of the Hospital and Nursery

A. Accessibility of the Nursery from Outside of and from Within the Hospital

1. Access to Nursery from Outside of Hospital*

    (1) Access to the nursery from outside the hospital may be challenging. Public transportation to the hospital may be located several blocks or more away. The parking garage is difficult to locate; has few available spaces; and parking is very expensive. Identification of the hospital entrance is confusing; the entrance area is stark and/or dark; or overly starkly illuminated. Once inside the hospital numerous bare malodorous hallways with peeling paint, graffiti, haphazardly posted flyers and notices, lead in different directions. The few legible direction signs display technical abbreviations, and some appear outdated. Identification of the direction to the nursery is obscure. Once at the entrance of the nursery, rules for visitation spell out many prohibitions, and the entrance doors to the nursery are locked. Within the nursery, bare hallways are lined with notes taped to the walls, extra equipment, supplies, and used or discarded furniture.

    (2) Access to the nursery from outside the hospital is quite difficult. Public transportation may be available within one or two blocks of the hospital. The parking garage may be congested some of the times. There may be some financial subsidy for parent's parking. The hospital lobby may have an information desk with a computer or person; signs in the region's primary language direct visitors to the different areas of the hospital, including the nursery. Hallways throughout the hospital may appear clean and clinical. The entrance to the nursery may require nursery staff to open the locked door. The entryway may be clinical with notices on the walls describing rules and expectations for visitors. Some extra equipment and supplies may line the corridors of the nursery hallways. The paths that lead to family spaces and to the infants' bed spaces may be somewhat confusing.

    (3) Access to the nursery from outside the hospital is straightforward and welcoming. Some hospital-sponsored subsidy for public transportation and taxi fares is available for nursery family members upon application. Public transportation services are available within a block of the hospital. Parking rates are discounted for nursery families and the parking garage has a number of designated family parking spaces. The hospital entrance lobby has a reception desk staffed by a knowledgeable person, who greets families, supports them in securely storing coats, boots, and umbrellas and provides verbal explanations of the path to the nursery. Family members receive an attractive identification badge that identifies them as nursery families. Hallways are aesthetically designed and decorated and directions clearly marked in the region's two most prevalent languages likely to be used by the patient population. The path through the hospital is straightforward and readily followed. A well-marked wall plate opens the door leading to the nursery. Inside, a receptionist greets the family and directs them to their infant's caregiver. The nursery hallways are painted in warm soft colors and decorated with a thoughtfully chosen newborn infant appropriate theme. All signs are welcoming and tasteful. Families' paths to their infants are free of nursery supplies and equipment. The infant's nurse greets and welcomes the family.

(4) Access to the nursery from outside the hospital is inviting and the nursery is easy to find. Public transportation access is close to the front door of the hospital and fares are reduced for nursery families. Free valet parking is available to nursery families at the hospital entrance. The parking garage has a number of well-marked reserved spaces for nursery families; parking is free of charge throughout the infant's hospitalization. Hospital attendants assist persons who come to the hospital. A coat, boot, umbrella etc. check facility may be available in the entryway. Receptionists guide families to the nursery. Family members receive an attractive identification badge that identifies them as nursery families. The hospital path to the nursery is clearly marked, aesthetic, and easy to follow. Families use their identification badge to open the door into the nursery electronically; upon entrance a receptionist and a relaxing family lounge welcome them. The receptionist supports them to securely store any coats, boots, umbrellas, etc., and offers them a light snack, juice, tea, coffee or water. The washing area is comfortable, ergonomically well designed, and welcoming. The hallways leading to the family care spaces are attractively painted in warm soft colors and thoughtful artwork. The infant's nurse, informed by the receptionist of the family's arrival, greets the family.

(5) Access to the nursery from outside of the hospital is very inviting and the nursery is easy to find. Public transportation services are available to and from the entrance of the hospital. Free transit passes and/or taxi vouchers are available to all family members for the duration of the infant's hospitalization as well as for follow-up visits after discharge. Free valet parking is available 24 hours a day and seven days a week. Parking, with easy to locate reserved family parking spaces nearest to a door leading to the nursery, is free of charge for families throughout the infant's hospitalization and for all follow-up visits. Full assistance to the nursery is available. Knowledgeable, thoughtful receptionists within the entrance lobby of the hospital welcome families, direct them, and arrange for personal escorts as indicated. All pathways throughout the hospital and into the nursery are easy to follow with welcoming, well-designed tasteful signs in the region's languages. Near the nursery, relaxation and health services and facilities may be available (e.g., meditation, prayer, yoga, spa, massage, exercise and rest) for families and nursery staff. The family members' attractive identification badge serves to open the doors to the nursery. A greeter at the nursery entrance, familiar with each nursery family, receives and welcomes them. A concierge provides assistance with outerwear, bags, and doors; checks on nutritional needs of the family; and ensures that food and drink is available. The hand washing area is comfortable, ergonomically well designed, and welcoming. The greeter escorts the family to their infant. The infant's nurse, informed of the family's arrival, warmly greets the family. Each family's area within the nursery includes comfortable furniture for relaxation and sleep, a bathroom, and space for storage.

2. Location in Relation to Labor and Delivery Suites and Mothers' Postpartum Rooms*

(1) The Nursery is far away from the Labor and Delivery Suites, and the mother's postpartum room; or the mother is cared for at another hospital; or the mother has been discharged from the hospital, and she and the infant's father live a distance away from the hospital.

(2) The Nursery is located adjacent to the Labor and Delivery Suites; the mothers' postpartum room is in a separate location; or the mother has been discharged from the nursery, and she and/or the infant's father may stay overnight in a hospital-affiliated guesthouse.

(3) The Nursery, Labor and Delivery Suite and the mothers' postpartum room are in close proximity to each other; yet accessibility to the nursery for the postpartum mother is variable; or the mother has been discharged from the nursery, and she, the infant's father, and the infant, once stable, may stay together overnight within the hospital in a special facility or room for family-care prior to discharge.

(4) The Nursery, Labor and Delivery Suite and the mothers' postpartum room are in close proximity to each other on the same floor; transport (wheelchairs; moveable beds) for the postpartum mother are readily available and the mother may reach the infant's' bedside easily at any time; or the mother has been discharged and the parents may spend many hours a day, and occasionally a night, in the infant-family room. Duration of stay is dependent on staff variability.

(5) The Nursery, Labor and Delivery Suite and the mothers' postpartum room are in close proximity to each other and on the same floor. Rooming-in facilities within the nursery at the infant's bedside are available for mother, father, and infant. It is expected and supported that at least one of the parents lives in with the infant at all times. This meets with the nursery's expectations and is fully supported.

3. Transport to the Nursery from Outside the Hospital

(1) Volunteer paramedics or a member of the police meet the infant off-site, and drive the infant by police car or ambulance to the nearest hospital. Depending on circumstances the infant's mother may hold the infant in the police car or ambulance, while the police officer or paramedic delivers oxygen to the infant by bag and mask. Considerations focus exclusively on the infant's survival.

(2) A specialized transport team from the nearest newborn service is brought to the infant's local birth hospital by paramedics, who transfer the infant in the care of the transport team by ambulance to the nearest newborn nursery appropriate to the infant's condition. Considerations focus primarily on the infant's survival, and to some extent on the quality of survival.

(3) Paramedics and a specialized transport team collaboratively coordinate, with the aid of a specially developed emergency communication system, all steps of the infant's transfer from the birth hospital to the nearest Newborn Intensive Care Nursery (NICU) or other nursery as appropriate for the infant's condition. They inform and update the nursery of the infant's status, their progress, and the expected time of arrival, as they make their way to the hospital. Depending on the circumstances a member of the infant's family may be transported with the infant. Considerations focus foremost on the infant's survival; the infant's protection from loud sounds, and jarring movements; and the infant's and family member's comfort during the transport into the nursery.

(4) A specially trained transport team receives the infant and a family member; stabilizes and assures the infant's and family members' comfort; and accompanies them by a specially equipped NICU ambulance, helicopter or fixed-wing airplane, to the nearest nursery appropriate for the infant's condition. En route continued communication between the nursery and transport team ensures that staff and equipment are well prepared and the nursery team is ready to receive the infant and the member of the family. Consistent consideration is given to the infants survival; the quality of survival; protection from additional stressful experiences; and the assurance of the infant's and the family member's comfort.

(5) A specially trained transport team receives the infant and a family member; stabilizes and assures the infant's and family members' comfort; meets the infant's mother and invites her to hold her infant skin-to skin during the transport. Should the mother be well enough, the team beds the infant on the mother's chest and transports both, accompanied by an additional family member as indicated for support, on a safe, comfortable, and well-secured stretcher in an ambulance, helicopter, and/or fixed-wing airplane to the nearest nursery appropriate for the infant's condition. En route continued communication between nursery and transport team ensures that staff and equipment are well- prepared and the NICU team is ready to receive infant and mother as well as the support member of the family. Consistent consideration is given to the infant's survival; the quality of survival; protection from additional stressful experiences; and the assurance of the infant's, the mother's, and the family member's comfort.

B. Physical Environment of the Nursery

1. Overall Appearance*

   (1) The nursery has a clinical appearance; walls and floors are plain and institutional; windows are bare or have institutional blinds only; fluorescent lighting is prevalent.

   (2) The nursery is clinical in appearance, some attempt is made to make the nursery appear home-like, yet it is minimal: there may be an occasional picture or wall-hanging; there may be a patterned curtain; or an occasional personal item at a bed space; or a chair with a soft cushion.

   (3) The nursery has a moderately home-like appearance, while some aspects appear clinical: walls may be soft in color; some lighting may be indirect; the hallway leading to the nursery room may have pictures and home-like decor; there may be some individualization of the bed space, and an occasional home-like chair; overall, the area appears nevertheless quite clinical.

   (4) The nursery has a definite home-like appearance: Comfortable chairs are available to the parents; walls may have home-like wallpaper, borders, and pictures; curtains on the windows are home-like in decor; and lighting is indirect. Individualization of bed spaces is evident; a reclining bed-chair or parent-bed is available at each bedside; and the path to the infant from entrance to bed space is friendly and welcoming.

(5) The nursery has a definite home-like appearance in terms of furniture, color schemes and lighting. Furthermore, floors may be carpeted; home-like lamps with dimmer switches provide individualized lighting for each bed space; attractive plants are appealingly arranged and are well-tended; individualization of bed space is consistently evident; and furniture at the infant's bed space is comfortable for the parents and professional caregivers' restful caring and nurturing of the infant (reclining, two-parent bed-chair or bed; outgoing telephone lines; side tables or cupboards for personal items).

2. Physical Layout of Infant Care Areas*

(1) Space in the nursery is very crowded. Housekeeping and medical equipment storage areas, secretarial station and staff sitting spaces are part of the same space as the infants' care areas; and family spaces at the bedside are essentially absent.

(2) The location of infant care areas provides some separation of infants and their families from other unit activities: A treatment or triage area may be designated within the nursery space yet open into the care areas; equipment storage areas appear separate; secretarial station and staff lounges may be only partially separated from the care area and/or doors separating them may remain open; utility and conference rooms may connect directly to the infant care spaces; family space at bedside is minimal.

(3) The location of infant care areas from other activities provides considerable separation of infants and their families from interference by other unit activities: The staff lounge may be located very close to the infant care areas, etc. Family space at the bedside is available yet limited; doors to hallways may be consistently open.

(4) There is thorough separation of the infant care areas from other unit activities. Infants and their families are separate and protected from other unit activities: Family space at the infants' care areas is consistently available; furthermore there are separate parent rooms for the families at any time; the nursery has an adequate number of parent rooms; there are also adequate changing and storage areas for the families; equipment is stored away from infants and their families; treatment or triage rooms, secretarial stations, utility and conference rooms are separate, and afford infants and their families a peaceful environment in the nursery.

(5) Ample nursery space is available for infants and their families free of interference from other unit activities. Complete, comfortable and private rooming-in facilities, each with bath and shower, are available for each of the families in the individualized infant-family care rooms.

3. Density and Size of Bed Spaces*

(1) All infants are in very close proximity to one another. It is very difficult to fit a chair at any of the bedsides.

(2) The infants are in very close proximity to one another, although it is possible to fit a chair for the parent or caregiver at some of the bedside; or there is enough space at each of the infants' bedsides, yet all infants are cared for in one large, undivided room.

(3) There is enough bed space for the infants and their caregivers, a chair or recliner readily fits at each bedside, yet typically more than six infants are cared for in the same nursery room.

(4) There are four to six bed spaces in each of the larger nursery rooms; a large space is allotted to each infant and family; and each infant clearly has a distinct space and a recliner as well as a second chair that easily fits into each of the individual bed spaces.

(5) Each infant is cared for in a semi-private or private family room setting, with only one or two bed spaces in each of the spacious family care areas. There is ample space for each individual infant and family with full sitting and sleeping spaces.

4. Family Spaces

(1) Family spaces are available within the hospital, outside of the nursery itself. There may be some chairs in the nursery hallway. The hospital features a common cafeteria, payphones, and restrooms. Partners may stay with the infant's mother on the maternity ward during the mothers' admissions.

(2) Family spaces are available directly outside of the nursery itself. The areas may consist of waiting rooms where family members may gather and meet with friends. General hospital facilities may include restrooms and payphones near the nursery. Short and long stay lodging for parents may be arranged in a designated patient hotel or residential setting for families of hospitalized children.

(3) Family spaces are available within the nursery. They may consist of one or more family rooms within the nursery. These rooms may be available 24 hours a day, and include furniture that may convert to double beds for overnight parent stays on the nursery. Drink and food vending machines, telephones, and restrooms are available near the nursery entrance. Lodging for extended periods may be arranged in a designated patient hotel or residential setting for families of hospitalized children.

(4) Family spaces are amply available throughout the nursery. They may consist of: A comfortable family lounge to meet with other families; family rooms for parents to stay overnight; as well as restrooms, kitchen and telephones within the unit. The hospital has family Internet access and a family library and resource center. The nursery has a play space for siblings. Lodging for the duration of the infant's hospitalization may be arranged in a designated patient hotel or residential setting for families of hospitalized children.

(5) Family space is an integral part of the nursery design. Infants are cared for in comfortable, well-appointed individual family care rooms with furniture suitable for relaxing as well as sleeping, and a bathroom with tub and shower. Post-partum medical care of the mother is

delivered, as possible, within the family care room. A family lounge, common dining room, kitchen area, additional restrooms with showers, laundry facilities, library and resource room, and telephone and Internet access all exist within the nursery. A nursery concierge is available to all families to facilitate access to additional resources, including housing, home responsibilities, laundry, and childcare. Healthy foods and drinks are available for families at all times. Professionally staffed age appropriate spaces are available for family members. Access to daylight, a gym, green areas, psychological and spiritual guidance, a place of worship, and other resources are available within the hospital.

5. Areas for Breast Pumping and/or Feeding

(1) Opportunities for breastfeeding and breast pumping are very limited in the nursery. There is minimal environmental facilitation in terms of light, sound and traffic reduction; or in terms of space, or supportive equipment, or furniture and privacy.

(2) Opportunities for breastfeeding and breast pumping are provided with some environmental facilitation. At the bedside, a portable screen or curtain may be available at times to give the mother some privacy. The infant's nurse may have limited training and/or experience in supporting breastfeeding and pumping for preterm mothers.

(3) Opportunities for breastfeeding and breast pumping are provided in privacy within the nursery or in a room adjoining the nursery. A rocking chair or recliner is available for the breastfeeding/breast-pumping mother. Lighting in the immediate space may be somewhat dim. The room temperature may be comfortable for the feeding or pumping mother. Voices, alarms and other sounds may carry into the space of the breastfeeding or pumping mother. The infant's nurse or a specialist has training and some experience in supporting preterm mothers' breastfeeding and pumping. The nurse or specialist is usually available to assist mothers.

(4) Opportunities for breastfeeding and breast pumping are present within the relaxed space of the infant's care area and/or in rooms designated as private family rooms. Lighting and decor in these areas are soft, restful, and homelike. The mothers' nursing and pumping chairs are soft and comfortable, recline to accommodate a variety of restful positions, and include support of legs and feet. There are pillows and other aids available for comfort and positioning of infant and parent. Music, reading materials, or educational resources in support of breastfeeding may be available. The family room has a telephone or intercom for the mother to call for assistance as needed. Infant developmental specialists and lactation professionals are available, and are skilled and experienced in the support of breastfeeding and pumping with high-risk infants. Mothers are encouraged and acknowledged for their efforts to pump their milk and breastfeed their infants. Milk is stored reliably and is considered the best nutrition for the infant. Feeding schedules are arranged and adjusted to optimize successful breastfeeding. The staff offers gavage, cup, spoon or finger feeding when a mother is momentarily unavailable to breastfeed, or when an infant still requires additional support to feed successfully. Bottle-feeding is avoided in an effort to promote mothers' successful breastfeeding.

(5) Opportunities for breastfeeding and breast pumping are ever-present within the family's nursery area/room. Infants and their parents have continuous opportunity to be together for nurturance, nutrition, and relaxation. Skin to skin holding for prolonged periods is strongly supported. Mothers are encouraged to eat well and drink plenty of fluids. Meals and drinks are provided amply and at any time of day or night. The mothers' relaxation, breast care, and opportunity for regular periods of sound sleep are a high priority for the caregiving staff. The reclining chairs are soft and comfortable and accommodate a variety of restful positions, and include support of legs and feet. Soft pillows and other positional aids are available for comfort of the infant and the breast feeding/pumping mother. Primary nurses, supported by lactation consultants, are well trained, and receive ongoing education and support, to aid parents to be successful in and derive enjoyment from breast feeding. The nursery's goal for all parents is to attain 100% success in achieving exclusive breastfeeding by discharge.

6. Accessibility of Facilities and Services Supportive of Professionals*

(1) On-call rooms, laboratories, staff offices, pharmacy, staff changing rooms, lounges, and conference rooms are in separate and often distant areas of the hospital.

(2) One or two of the staff areas and/or support service areas are near the nursery space.

(3) Some of the support services and staff areas are near the nursery space.

(4) Most of the support services and staff areas are near the nursery space.

(5) Support services (e.g., laboratories and pharmacy) and staff areas, including conference rooms, on-call rooms, and staff lounges, are near the nursery space.

7. Private Staff Areas

(1) Private staff areas may consist of a small bathroom, water fountain, and a small crowded locker room serving as storage for staff belongings, as well as a staff changing space. All spaces are illuminated with bright fluorescent lighting, or are very dim. They are remote from the nursery. Food and drink availability is sparse; there is a vending machine outside the nursery; the cafeteria is in a different and remote building; cafeteria hours are limited, and food is of poor quality; choices are very limited.

(2) Private staff areas consist of a few bathrooms; a cluttered break room with used dishes and cups, and half-empty jars and bottles that are interspersed with supplies, personal belongings, and discarded equipment. The break room is artificially illuminated and may be consistently dim or is excessively bright and may consist of: A small wobbly table and few straight-backed mismatched chairs; a bulletin board with multiple old and new postings; an old-fashioned wall phone; haphazardly chosen and apparently randomly placed decorations on the wall; a water cooler; and coffee machine. A small changing room with

lockers may be near the nursery. The cafeteria is several floors away from the nursery yet in the same building.

(3) Private staff areas consist of a sufficient number of bathrooms and a break room where some used dishes and cups may stand interspersed with supplies, personal belongings, and discarded equipment. A window to the outside provides for some natural light, although artificial fluorescent lighting is the main light source. The break room's furnishings include: Perhaps some artwork hanging on the wall; a living plant may require tending; a small table, straight-backed chairs; a bulletin board with multiple postings; and a wall phone, computer, water cooler, and a coffee machine. A staff locker room with sufficient changing space is in the vicinity of the nursery. The cafeteria is located within the building and is readily reached. Vending machines may be located on the nursery's floor.

(4) Private staff areas consist of: An ample number of spacious, well-appointed bathrooms; an aesthetically-pleasing break room with walls painted in soothing colors; a kitchen that includes a sink with filtered cold and hot water, as well as a dishwasher, refrigerator, microwave oven, stove, and a buffet area, with tables and comfortable chairs; a sofa; well tended plants; windows with sky and scenery views; well chosen artwork, computers, modern telephones; appropriate lighting to compensate for nightshift and dim lights in the nursery; and appropriately large, well-appointed and secure storage areas for all break-room materials and personal belongings. The cafeteria is located near the nursery and there are opportunities to pre-order food to be ready for nursery staff at the beginning of their break.

(5) Private staff areas are restful, quiet, clean, well appointed, and protected from the activities of the unit. The entryway is off of a nursery staff hallway. A nursery staff aesthetics committee works with an interior designer to create the staff lounge spaces and maintain a supportive ambience for the staff. The comfortable staff lounge and suite within the larger nursery area houses several dining areas with attractive tables and chairs, sturdy attractive cabinets and drawers for china, glassware, and cutlery; rest and relaxation areas with reclining chairs, a sofa bed and/or comfortable couch; meditation, prayer, massage, and Jacuzzi/spa areas, office space with Internet access and private telephone spaces; and a living room with couch and recliner chairs, low tables, soft music, and calming art and reading materials. Ample bathrooms are tastefully decorated and attractively appointed. Locker and changing rooms have private showers. Rooms have fresh flowers and thriving plants. All rooms are individually temperature-controlled, regulated by the staff. High frequency treatment lights to prevent and treat Seasonal Affective Disorder (SAD) are offered free of charge to the staff. The dining spaces have continuously available nutritious food and drink; a nutritionist and chef plan and prepare the meals. A staff wellness coach or consultant is available to help promote staff health. There are views of the sky and gardens from the lounge windows. Soothing sounds, such as waterfall or fountain, are present in some areas while other areas are reserved for silence. The cafeteria is nearby and nutritious gourmet meals are available on site and to bring home at all times. There are concierge services for staff for the facilitation of daily living such as dry cleaning, car repair, car wash, shopping, and postal service. There is a hospital-based spa and fitness facility for relaxation and health services. There is priority parking and valet services for nursery staff.

8. Staff Work Areas

(1) Staff carries all equipment with them, including reference manuals, personal data assistants (PDA), pagers, and note pads etc, either in a knapsack or a belt pack. Small computer station surface areas may be available occasionally in the hallway or next to the infant's bedside, where staff members may briefly sit before another staff member requires access to the space. Or a designated staff work area is available within the care room, or in a hallway or room within or near the nursery. The area is crowded and haphazardly designed. Metal and/or hard plastic straight chairs stand at ergonomically challenging writing surfaces, which may be in disrepair. Precarious shelving overflows with too many books, manuals, paper files, binders etc. Flooring is in poor repair as are doors and filing cabinets; some drawers are off their hinges and partly open. Styrofoam cups, plastic bags, bottles, partially eaten food, outdoor clothing, sneakers, backpacks and plastic cutlery lay about and are piled up underneath surfaces. Metal trashcans are usually overflowing with discarded plastic, Styrofoam, and paper waste. Large computer monitors, some in working condition, may stand on countertops, cords dangling or draped across a loudly churning printer or fax machine. Overall the work area appears poorly organized and neglected. Or the staff work area may consist of a bare surface devoid of all supplies and equipment.

(2) Several designated staff workstations are available either inside the care rooms, in the hallways, or in a separate room off the nursery. The number of staff members exceeds the work areas available; this makes space a coveted commodity, and easily leads to staff tension and work flow delays. Computers and monitors are largely functional and occasionally serviced. Some chairs are adjustable in height to the counter areas, and provide ergonomically appropriate back support; most are ill suited and poorly designed. Filing cabinets, shelving, etc is sparse. Some materials are stored in the spaces below the work surfaces. Waste receptacles are emptied periodically. Recycling of paper and plastics is available in a remote area of the hospital.

(3) Staff work stations or areas are strategically located throughout the nursery, or in a central location depending on the design of the overall layout of the nursery. The number of work areas suffices for the number of staff members. Chairs and computer desks or surfaces are coordinated in height for ergonomic support. Filing cabinets, desk drawers, and shelving, while located at a distance from the computer work stations, are quite well maintained. Printers and fax machines, while loud, are positioned in relatively efficient spaces for staff access. Snack areas are separate from the workstations, though cups and bottles may be standing in the work areas. Recycling bins for paper and plastics are available in the vicinity of the workstations; emptying these bins, at a remote hospital recycling station, is left to individual staff initiative, which at times leads to staff tension and resistance to recycle.

(4) Staff work stations and areas are aesthetically appealing and strategically located throughout the nursery or in a central location depending on the design of the overall layout of the nursery. They are readily accessible and there are enough of them given the number of staff members. Each staff member furthermore has a designated drawer in a strategically located attractively integrated wall or island. Shelving and cabinet space is ample, well designed, attractive, and sturdy. Computer and writing surfaces are well

coordinated with corresponding chairs that are ergonomically designed, supportive, and readily adjustable to suit a variety of body sizes and shapes. Computer monitors have flat screens; computers are small, efficient, regularly updated, and well maintained by designated computer specialist. A knowledgeable and professional computer helpdesk service is readily available. Snack areas are attractive, well designed and stocked, and separate from the work areas. Recycling bins exist in the snack and the work areas and are emptied by specially designated hospital staff. Staff makes every effort to recycle.

(5) Staff work stations and areas are aesthetically very appealing, strategically located throughout the nursery or in a central location depending on the design of the overall layout of the nursery. Natural and/or recycled building and furniture materials of highest quality, finished with organic paints whenever possible, are the materials of choice. Work stations are readily accessible and sufficient in number given the number of staff. Each staff member, furthermore, has a personal designated drawer, shelf, and writing surface; sitting space is provided in a strategically located, attractively integrated staff work area, that is well-designed and attractive in color and layout, and ergonomically supportive. Shelving and cabinet space is ample, well designed, attractive, and sturdy. Attractive computer and writing surfaces are well coordinated with corresponding chairs, that are ergonomically well-designed, supportive, and readily adjustable to suit a variety of body sizes and shapes. Computer monitors are attractive flat screens; computers are small, efficient, and regularly updated. Computers are checked daily and well maintained by 24-hour on-call readily available, knowledgeable and friendly designated computer specialists. A knowledgeable professional computer helpdesk service is additionally readily available. Snack areas, separate from the work areas, are attractive, well designed and well stocked with nutritious organic foods and drinks. Attractive well-labeled recycling units are well integrated into the overall design of the snack and the work areas. They are emptied on a twice-daily basis by specially designated hospital staff. Staff makes every effort to recycle. All furniture and equipment is made of natural and/or recycled materials of highest quality, and is environmentally responsible. All paints, lacquers, waxes, papers and fabrics are organic, when feasible recycled, and thoroughly environmentally responsible.

C. Bedspace

1. Design of Bedspace*

(1) Medical equipment appears to interfere consistently with accessibility to all or most of the infants; chairs are seldom available at the bed spaces; excess equipment is stored around the bed spaces in the room.

(2) Medical equipment appears to interfere to some extent with accessibility to the infants; chairs are sometimes available at the bed spaces; some excess equipment may be stored around the bed spaces.

(3) Medical equipment sometimes interferes with accessibility to infants; chairs are available at most of the bed spaces; excess equipment is largely stored away from the bed spaces.

(4) Medical equipment is well arranged, accessibility to each of the infants is readily available; a comfortable chair, often a recliner, is available at each of the infants' bed spaces; excess equipment is stored away from the infants' bed spaces.

(5) Medical equipment is well integrated into the design of the infants' bed spaces. The room setting and furniture is family-like and semi-private or private.

2. Conduciveness for Family Participation*

(1) Space is very limited. The parents of only one infant at a time may be in the care room; space is too limited for the professional caregivers and parents to jointly care for the infants.

(2) Several chairs and/or places for parent-infant interaction are available in the nursery at large, yet the infants' care rooms are very limited in space. One or two parent rooms may be available for breastfeeding and for parent-infant interaction when the infant is well enough.

(3) Chairs and space are available at most of the infants' bed spaces. Bed spaces may be partitioned off within the nursery room. A parent room is available when the infant is well enough.

(4) A large, comfortable chair that reclines or a bed-chair is available next to most or all of the infants' bed spaces; more than one parent room is available. Overnight parent rooms are available for the families whose infants are well enough.

(5) The infants' care rooms are intimate, supportive, and home-like. A parent bed wide enough for both parents is part of each infant's bed space or each of the individual infant-family care rooms. There is enough space and privacy for the parents to sleep, stay overnight, and care for their infant's skin-to-skin. A private telephone is installed at each of the bed spaces for the families' personal use; smaller chairs and tables are available for young siblings. Each room has private bathroom facilities including tubs and showers for parents and other family members, who are living-in with their infant.

3. Family and Infant Space for Personal Belongings

(1) Families feel lost as to where to leave their outer garments, coats, boots, umbrella, briefcase, pocket book, etc. They learn quickly to bring as little as feasible. Everything else they must take along to their infant's bed space, while the nursery aims to keep the infants' care area and bed spaces free of family personal belongings.

(2) A hospital-wide secure storage space or visitor lockers for belongings are located in the hospital lobby or another area near the hospital entrance. These areas are designated for coats, outerwear, boots, and umbrellas. They require a deposit that is returned at pick-up

of the belongings. A small space may be available at some of the bedsides for storage of parent head and breastfeeding pillows; skin-to-skin holding shirts; a blanket; and/or for infants' personal belongings (special clothing the family may bring in for the infant, personal soft infant blankets, clothing, and bed sheets, stuffed animals, etc.). This space is very limited.

(3) A nursery-specific cost-free secure storage area and private lockers are located near the entrance to the nursery. They are designated for family and visitor belongings (coats, outerwear, boots, and umbrellas). Within the nursery some drawer or shelf space next to the infants' bed sides holds small family belongings and the infants' personal soft blankets, clothing, bed sheets, and stuffed animals.

(4) A nursery-specific cost-free secure storage area, with appropriately sized, spacious closets and/or private lockers holds family and visitor belongings (coats, outerwear, boots, and umbrellas). Each family may choose their designated storage space for the duration of their infant's hospitalization. Smaller personal belongings (briefcases, books, etc.) may be stored in a drawer within the family's private storage area. At the infants' bed spaces a designated drawer and/or cupboard holds the infants' personal clothes and private belongings as well as some of the family's smaller belongings.

(5) Storage space for family belongings within the nursery is ample, secure, well designed, and attractive. A specific spacious well designed walk-in closet facility; large enough to change one's clothing in private, is offered to and securely assigned to each family for the duration of their infant's hospitalization. A concierge is available 24 hours/day to receive and retrieve family belongings (coats, outerwear, umbrellas, bags etc.). Additionally, within each private family care room and/or next to every bed space, large well designed, attractive furniture and closet space for infant and family personal items is available.

D. Sensory Elements of the Bed Spaces

1. Light*

    (1) The infants' care occurs almost exclusively in an environment with bright fluorescent overhead light and/or bright daylight.

    (2) During rest periods, some infants are in somewhat muted light; a partial or thin blanket may cover some of the infants' incubators or beds, or a partial blind may be drawn at a window, though the care rooms are generally bright.

    (3) For periods, a number of infants are in semi-darkness; thick, large blankets or dense canopies shield a number of the incubators or cribs; some of the time the infants' eyes may be shielded from bright overhead light during alertness and/or when held; or the care rooms are largely maintained at semi-dark level.

(4) During sleep, most infants are in nearly complete darkness. During alert periods, and/or when infants are held, controlled indirect lighting provides an overall muted or semi-dark environment.

(5) Infants are in darkness during sleep and there are appropriately individualized levels of muted indirect light for alertness, and/or when an infant is held. Light adjustments are adapted to each individual infant's developmental progress towards increasing robustness and self-regulation. Individual bed space lighting with dimmer capacity is used throughout the care rooms. All lighting is indirect and is controllable by the parent as well as the staff.

2. Sound*

(1) Loud human voices and environmental sounds permeate the infant care areas at all times. These include: staff voices; frequent infant crying; overhead speaker systems; telephones and alarms ringing, sounds from the secretarial station; water rushing doors opening and closing; and equipment and supply sounds, etc.

(2) Loud human voice and environmental sounds occur in the infant care areas much of the time; fluctuations may occur between soft whispering and louder voices; radio, waste receptacles, and sink sounds clearly occur; as well as noises from the secretarial station, hallway, etc.

(3) Loud human voice and environmental sounds occur some of the time in infant care areas; at times human voices are held at soft levels; music may play at a low level; a sink may be used relatively quietly.

(4) Human voice and environmental sounds in the infant care areas are at a minimum. Very low levels of sound are present. There appears to be felt stripping on waste receptacles and drawers. Incubator portholes and cupboard doors are closed quietly; equipment is moved quietly. Ambient staff voices are very soft. Alarms are muted. Infant and families' proximity to faucets and sinks, x-ray screens, telephones, and staff movement is largely avoided.

(5) Sounds in the infant care areas are consistently very low. Wall materials are sound reducing and absorbing. Monitors and telephones ring very softly, and only as back up to visual and vibrating alarms. Staff voices are very quiet. Overall, the infant and family care areas are peaceful and quiet.

3. Activity*

(1) The nursery atmosphere is hectic; activity changes continuously; visitors, staff, technical and laboratory personnel hurry about; water runs,; doors open and close; and equipment moves in and out of the care areas.

(2) Activity levels are quite high, though at times they subside to lower intensities.

(3) Activity levels are moderately low. There appear to be efforts to move activity away from the infants' bed spaces and care areas, although this seems to be inconsistent.

(4) The nursery's atmosphere is largely calm and quiet; an exception may be an emergency situation, which nevertheless is managed in a contained fashion. Rounds and staff-to-staff communication occurs away from the bed sides and care areas.

(5) The nursery's atmosphere is consistently very calm, quiet, and soothing. Staff manages all situations including emergency situations calmly and quietly.

4. Visual Array Inside of the Incubators/Cribs*

(1) The walls of cribs and incubators continuously present a complex and dense array of visual stimuli. This may include numerous or intensely-patterned (e.g., black and white checkerboard) toys and mobiles, which are continuously within the infants' immediate visual fields; or the infants' visual spaces are filled with equipment and bedding; or the infants' visual fields are barren and essentially devoid of texture, form, and color.

(2) Many visual inputs continuously impinge upon most infants' immediate visual fields, be they equipment or toys, mobiles, etc.; or the infants' visual spaces are nearly devoid of all texture, form, and color.

(3) Several visual stimuli continuously are part of the infants' immediate visual field, whether infants are asleep or awake.

(4) Visual stimuli including the parents and/or professional caregivers' faces, present themselves when an infant becomes and/or is awake. They are muted or removed from an infant's visual field when the infant becomes drowsy, goes back to sleep, and/or becomes hyper-alert or upset.

(5) Differential visual stimuli, including the parents and/or professional caregivers' faces, are present, muted, and removed in support of an infant's state and self-regulatory robustness.

5. Olfactory Experience*

(1) Noxious odors are frequently present in all or most of the infants' immediate olfactory field, (e.g., alcohol wipes, hand-disinfectants, adhesive remover, cleaning fluids, recent painting, caregivers' perfumes, cooking odors; soiled clothing; rubber tubing, gloves, equipment and disposable staff gowns). Familial and comforting odors, such as the mothers' breast and body scents and/or the fathers' body scents, are absent.

(2) Noxious odors are periodically present in many of the infants' immediate olfactory fields; familial, comforting odors are available when the parents are near their infants.

(3) Noxious odors are infrequently present in the infants' immediate olfactory fields; familial, comforting odors are available when the parents hold their infants.

(4) Noxious odors are actively eliminated from the infants' immediate olfactory fields whenever possible. Familial, comforting olfactory environments are available for some of the time for many infants. When the infants are in their incubator or crib, they experience their mother's breast pad, or a blanket, cloth, or piece of clothing that their mother or father may have worn or held on their body. These olfactory objects are exchanged for fresh parent-scent-objects regularly should they become soiled.

(5) Noxious odors at all times are actively and reliably eliminated from all the infants' immediate olfactory fields. Consistently familial olfactory environments representative of the parents' body scents are present for most or all of the infants at all times.

6. Taste*

(1) Infants repeatedly experience exclusively noxious tastes including bitter, sour, and salty. These may be derived from: medications; inhalants; formulas, without and with additives; supplements and fats; staff hands and gloves; pacifiers; residual detergents and fabric softeners on blankets; clothing; paper gowns; disinfectants and soaps on staff hands and/or their own hands; plastic and rubber tubing; monitor wires; swallowing vomit; and others.

(2) Infants frequently experience noxious tastes such as described above. Pleasant tastes including sweet and umami, familial and comforting tastes, such as: the infant's vernix and amniotic fluid; the mothers' colostrums, breast milk; and the parents' skin tastes. These are experienced, at times briefly, by an occasional infant (when infants suck on or taste their own hands, and/or when the parents hold their infants).

(3) Infants at times experience noxious tastes such as described above, when they receive medications, inhalants, formula, with and without additives, supplements, and fats. Staff make efforts to eliminate staff hand, supply and equipment tastes, as well as laundry tastes. Pleasant sweet and umami tastes, familial and comforting tastes, such as the infant's vernix and amniotic fluid; the mothers' colostrum/breast milk; and the parents' skin tastes. These comforting tastes are encouraged at delivery and in the nursery, when the infants suck on or taste their own hands, and when the parents hold their infants.

(4) Infants experience noxious tastes such as described above, only rarely, and namely when they receive medications, inhalants, and formulas without and with additives, supplements, and fats. An effort is made to protect infants from tastes derived from staff hands, supplies and equipment as well as from laundry tastes. Familial, comforting tastes such as the infant's vernix and amniotic fluid as well as the taste of the mother's skin and breast are encouraged right after delivery. In the nursery active efforts are directed for the infants' to taste their mothers' colostrums and breast milk and the taste of their parents' skin, when held skin-to-skin by parents. Some efforts are directed to provide pleasant

tastes from breast pads, blankets, cloths, or pieces of clothing that the mothers or fathers have worn or held on their body, when the parents themselves are away from the infant. The infants may experience a pleasant sweet or umami taste, when they receive a drop of their mother's milk and/or sucrose in an effort to diminish pain experienced in the course of a procedure or event.

(5) Infants experience noxious tastes such as described above only when they receive medications, inhalants, formula without and with additives, supplements, and fats, for which better tasting alternatives are unavailable. Suitable, effective alternatives with less noxious tastes are chosen whenever available. Great efforts are directed to protect infants from all noxious tastes derived from staff hands, supplies and equipment as well as from laundry and soap residues. Familial, comforting tastes such as the infant's vernix and amniotic fluid as well as the taste of the mother's skin and breast are encouraged right after delivery and are continued and actively preserved in transfer to the nursery. In the nursery all efforts are consistently directed toward providing the infants, as much as possible, with the opportunity to taste their mothers' colostrum and breast milk, and to enjoy the taste of their parents' skin when held skin-to-skin. Consistent efforts are directed to provide pleasant tastes from breast pads, blankets, cloths, or pieces of clothing that the mothers and fathers have worn or held on their body, in the event that the parents themselves might be away from their infant for a brief period of time. The infants additionally experience the pleasant taste of an extra gift of their mother's milk and/or sucrose, should an infant be exposed to a painful procedure or event.

7. Touch*

(1) Harmful, irritating and/or injurious touch (e.g., with rough, abrasive, scratchy, sharp, hard, or sticky materials and/or chemical liquids), as well as abrupt, rough, quick, heavy, pressing movements and positions, constitute the range of touch the infants in the nursery may experience frequently. Agents of touch may include: electrodes, wires, IV-boards, probes, feeding tubes, lines, attachments of apparatus and equipment, tape, linen, mattresses, finger nails, chapped hands, Velcro, rubber, nylon thread, seams, fleece, polyester, foam, disposable diapers, and washcloths among others.

(2) Harmful, irritating and/or injurious touch as described above for most infants is at least periodically experienced. Occasionally some materials and substances used may be gentle and soothing to the infant's skin. Familiar comforting touch such as the parents' soft skin, soft natural sheepskin covered in soft pure cotton, velvet, and/or silk; such bedding and clothing rarely may be available and only to a few infants for brief periods, when the parents are with their infants.

(3) Harmful, irritating and/or injurious touch as described above, are infrequent infant experiences. Bedding and caregiving materials are typically supportive of the infants in weight and feel. Some materials and substances used are specially selected to be soft and soothing for the infants' skin. Staff makes efforts to provide gentle, smooth touch during caregiving procedures and interactions. The parents repeatedly provide the most consistent, familiar, and comforting touch experiences once they hold their infants.

(4) The staff makes active efforts to eliminate all harmful, irritating and/or injurious touch whenever possible. Familiar comforting touch such as the parents' soft skin, soft natural sheepskin covered in soft pure cotton, velvet, and/or silk; such bedding and clothing are provided much of the time for all, or at least most, of the infants by the families as well as by the staff. Infants reliably experience being held skin-to-skin and cradled in their parents' soft hands and arms. Caregivers make many efforts to provide soft cradling touch for the infants whenever they perform procedures and/or engage in care interactions. Bedding and caregiving materials are specially selected to be soothing, soft and pleasant in weight and feel.

(5) Harmful, irritating and/or injurious touch is actively eliminated and fully substituted by specially developed gentle and soft-to-the-touch electrodes, soft wires, small soft-cover IV-boards and probes, feeding tubes, lines, attachments of apparatus and equipment, and special infant skin protective tape. Only such infant-skin-soothing, protective and specially developed and/or adapted materials and agents are stocked and always available in the nursery. Active staff efforts are directed to continuously update and gather information about latest innovations in respect to skin protective and soothing materials. All infants frequently and reliably experience being held skin-to-skin and cradled in their parents' soft hands and arms. Caregivers consistently provide soft cradling touch for the infants when they perform procedures and/or engage in care interactions. Bedding and caregiving materials are consistently soothing and pleasing in weight and feel. The infant is always cradled and snuggled in soothing, relaxing positions that provide pleasantly assuring experiences. All materials and substances that are used are comforting and pleasant in touch, such as soft natural sheepskins covered in soft pure cotton, velvet, and/or silk, as well as soft pure cotton, velvet, and/or silk bedding and clothing. The infants' experience of nursery staff's touch during caregiving procedures is consistently gentle, smooth, well-paced and supportive of the infants' movements and overall well-being.

8. Nursery Temperature and Circulation Considerations*

(1) Air temperature and circulation in the nursery at large and around most or all of the infants' bed spaces, fluctuates greatly and reaches levels that often are too low and/or too high for the infants' well-being.

(2) Air temperature and circulation in the nursery at large, and around a number of the bed spaces, fluctuate repeatedly in a 24-hour day and the week, and repeatedly reach levels that are too low, and at times too high for the infants' well-being.

(3) Air temperature and circulation in the nursery at large and around a few of the bed spaces, at times fluctuate to some extent. Largely they remain fairly stable and within an acceptable range for the infants' well-being.

(4) Air temperature and circulation in the nursery at large, and around most of the bed spaces, are usually steady and at an appropriate level for the infants' well-being.

(5) Air temperature and circulation in the nursery at large, and around all the bed spaces, are reliably stable, consistent and at appropriate levels for the infants' well-being.

E. Category Summary Scale - Physical Environment of the Nursery and the Hospital

(1) The physical environment of the nursery and the hospital reflect traditional, task oriented care, with exclusive emphasis on a germfree setting constructed for the efficient delivery of specialty care and the comfort of the medical staff. Or the physical environment of the nursery and the hospital are outdated, very poorly maintained and disorganized.

(2) The physical environment of the nursery and the hospital reflect largely traditional, task oriented care, with emphasis on a germfree setting constructed for the efficient delivery of specialty care and the comfort of medical staff. Or the physical environment of the nursery and the hospital are largely outdated, with some more modern features such as functional patient elevators, yet in general the hospital relatively poorly maintained and somewhat disorganized.

(3) The physical environment of the nursery and the hospital reflect some traditional task orientation and starkness yet also show some aspects of appreciation of the importance of the infants and families served; some facilities indicate respect and care for the comfort of infants and families, and for the well-being of the staff.

(4) The physical environment of the nursery and the hospital reflect considerable appreciation of the importance of the infants and families served; many of the hospital facilities reflect respect and care for the comfort and wellbeing of infants and families, and the well-being of the staff.

(5) The physical environment of the nursery and the hospital consistently and thoroughly reflect appreciation of the importance of the infants and families served; all hospital facilities reflect deep respect and care for the dignity, comfort and wellbeing of infants and families, and the dignity, comfort and well-being of the staff.

II. Philosophy and Implementation of Care: Infant

A. Resources for Infant Support

1. Infant Holding

(1) Infants may receive inanimate supports, blankets, snuggle-ups, nests, etc. for sleep and wakeful periods. Medical procedures mainly occur in the infant's bed. Parents visit their infants after caregiving procedures and may hold their infant swaddled. Holding decisions are made by the staff on a case-by-case basis.

(2) Infants intermittently are given a finger or inanimate object to hold onto or suck, and may receive hand swaddling containments. Holding and caregiving facilitation decisions are made by the staff on a case-by-case basis.

(3) Parents may hold their infants skin-to-skin between caregiving procedures, mainly at the parents' insistence. Some staff members may facilitate skin-to-skin holding for some infants and parents. The infant must be placed into the incubator or bed for medical procedures. At times, two nursery caregivers may support an infant and each other during difficult medical and caregiving procedures. Holding and caregiving facilitation decisions are included in an overall nursery practice statement.

(4) Parents may hold their infants skin-to-skin based on the infant's cues and desires, and the parent's wishes. Most staff members facilitate and encourage skin-to-skin holding. Parents are treated as active and equal members of the caregiving team and are encouraged to support their infants during, following, and in-between medical and caregiving interactions. Staff readily follows nursery guidelines for skin-to-skin holding by the parent, as well as hand containment and cradling by parents and staff. These are considered the standard of care.

(5) Parents consistently and for prolonged periods, often 24 hours, hold their infants skin-to-skin based on the infant's cues and desires, and the parents' wishes. All nursery staff members facilitate such holding and care. Parents are supported in their skin-to-skin holding and caregiving with comfortable recliners, nourishment, privacy, and protection from extraneous nursery activities; they receive the staff's continuous thoughtful support. Parents are treated as active and equal members of the caregiving team and are actively encouraged to participate in medical and caregiving procedures by holding their infant skin-to-skin, or by supporting their infant with hand swaddling and cradling. Nursery policy and practice guidelines for skin-to-skin holding and hand swaddling are promoted as integral components of all nursery care.

2. Bedding and Clothing*

(1) Bedding and clothing that is utilized, is independent of the infants' individual preferences and expectations; most infants may lay naked on flat surfaces or wear only ill-sized and ill-fitted diaper; or most infants are very tightly swaddled.

(2) Bedding and clothing relate somewhat to some of the infants' preferences (e.g., the infants may be swaddled once cared for); however, swaddling may be quite tight and routinely applied; infants' diapers and clothing may be too large for them; some nesting and boundaries may be used, yet in a quite routine fashion.

(3) Bedding and clothing generally relate to the infants' preferences and expectations (e.g., the infants may wear hats and socks and have foot rolls), although it is unclear how these support the infants' organization. The parents and/or the professional caregivers may hold the infant at times for limited periods.

(4) Bedding and clothing are individualized (i.e., consistently related to the infants' preferences and expectations). This may include provision of options such: as water mattresses, sheepskins, boundaries, "nesting," clothing with soft one-piece suits, soft hats, gentle swaddling, appropriate bedding, and/or the parents' skin-to-skin holding of their infants for extended periods.

(5) Bedding and clothing is creatively individualized to suit each of the infants' preferences and expectations, This may include the provision of options such as buntings, hammocks, and small finger-like pacifiers with the opportunity to grasp; canopies, visors or tents to shield the infants' faces from light: and other individualized materials supportive of the infants, such as appropriately soft and small diapers, well-fitting, soft clothing, and soft cover blankets. The parents are included reliably as the infants' most well suited "beds"; they live-in fully with their infants.

3. Specific Supports for the Infant's Self-Regulation

(1) Provision of specific supports in facilitation of the infants' self-regulation such as: use of buntings and pacifiers; holding by the parents or the professional caregivers; facilitation by cradling, containment and gentle hand-swaddling; and opportunity to suckle on the parent's breast and/or a caregiver's finger, is completely absent.

(2) Provision of specific supports in facilitation of the infants' self-regulation is observed only occasionally and sporadically.

(3) Provision of specific supports in facilitation of the infants' self-regulation is intermittent and appears routinized. The parents and/or professional caregivers at times may provide more differentiated support.

(4) Provision of specific supports in facilitation of the infants' self-regulation is frequent and much of the time individualized. It may include holding, facilitation by cradling, soft hand and cloth-swaddling, caressing, and containment; opportunities to suck during and between procedures including gavage feedings; and holding on to the parent or a second caregiver's finger; and provision of bedding, nest-rolls, and/or buntings during care actions and procedures. The professional caregivers encourage and facilitate the parents' collaboration in aiding their infants' regulation.

(5) Provision of specific supports in facilitation of the infants' self-regulation is consistent, reliably individualized, and sensitively adapted to each infant's expectations and preferences. Parents facilitate and support their infants' regulation at all times; hold their infants skin-to-skin and support them for most of the 24 hour cycle; the professional caregivers support the parents' facilitation of the infants' self-regulation at all times; they consistently perform caregiving actions and procedures in collaboration with the parents, as the parent facilitates the infant; and they assure that the infants' regulation is well-supported by the parents and/or a second or third professional caregiver, as indicated given the nature of a particular procedure.

B. Caregiving Activities

1. Position, Movement and Tone*

   (1) The infants lay supine, prone, or on their side on flat, bare surfaces at rest and/or in the course of all care procedures. When caregivers or parents hold an infant, the infant's current strengths and competencies are the only facilitation available for the infant's position, movement and tone of trunk, arms, legs, and head.

   (2) When infants lay on their side, in prone or in supine, at rest and/or in the course of care-procedures, or when the caregiver or the parents hold the infant, they provide minimal support for the physiologically supportive alignment of the infant's head, trunk, and/or limbs; they make minimal or rare adjustments of the infant's shoulder and/or hip flexion, and they rarely support the infant's position, movement and tone of trunk, arms, legs, and head.

   (3) The infants intermittently receive individualized support for physiologically well-aligned positions and movements, and for well-modulated tone. The caregivers intermittently support the parents in facilitation of: their infants' trunks, arms, legs and head positions; their movement and tone whether the infants lay on the side, in prone or in supine within the incubator, crib or on another surface; rest and/or in the course of care procedures; and/or whether an infant is held by the parents or a caregiver.

   (4) The infants almost consistently receive individualized support for physiologically well-aligned positions and movement, and for well-modulated tone. The caregivers almost consistently support the parents in provision of facilitation of: their infants' trunk, arms, legs and head position; their movement and tone, whether the infants lay on the side, in prone or in supine within an incubator, crib or on another surface; rest, and/or in the course of most care procedures; and/or whether an infant is held by the parents or a caregiver.

   (5) The infants consistently receive highly sensitive, individualized support for physiologically well-aligned positions and movements, and for well-modulated tone. The caregivers consistently and sensitively support each of the infants and/or their parents in astute facilitation of: their infant's trunk, arms, legs and head position, their movement and tone, whether an infant may lay on the side, in prone, or in supine within the incubator, crib, or on another surface; rest, and/or in the course of all care procedures; and/or whether an infant is held by the parents or a caregiver.

2. Feeding (gavage/breast/bottle)*

   (1) The infants are fed on fixed schedules by routinized mechanically-implemented nutrition-delivery methods. The gavage feedings hang inside the incubator, or are delivered by automated mechanical pumps and flows into the infant at a pre-set rate. The infants remain in the same positions throughout and after the feedings; the caregivers are away from the infants' bedsides. When infants are fed by bottle, the bottles may be propped in

holders or are supported by bedding; or the caregivers may hold the infants at the back of the head or neck in partial sitting-position inside their incubators, in their cribs or on the caregivers' laps in profile or face-to-face. The caregivers may insert the bottle nipples repeatedly into the infants' mouths, in order to initiate the infants' sucking; they may rotate the nipple in the infants' mouths, and/or arouse the infants by jiggling and moving the infants' heads, arms and/or legs back and forth, tweaking the infants' feet, etc. Breastfeeding may be discouraged directly or indirectly. The nursery care rooms may be cold, loud and or very bright while the infants receive their feedings.

(2) The caregivers make a few arrangements prior to, during, and/or after feeding in terms of equipment, room temperature, lighting and sound, preparation as well as facilitation of the infants' states and positions and/or the caregivers' attentiveness, and emotional availability. The infants may be partially shielded from light and sound; the care rooms may be marginally warm enough; the caregivers' attention and emotion is attuned to the infants some of the time; some adjustments of the infants' positions may be observed. When fed by gavage or pump, onset, rate, and termination of food-flow typically are independent of the level of the infants' arousal or exhaustion. When bottle or breastfeeding, the infants' hands typically are actively excluded from the feeding process. The parents may be permitted to feed their infants yet only in the way prescribed by the caregivers.

(3) The caregivers make a number of arrangements prior to, during, and after feeding in terms of equipment, room lighting, sound and temperature, preparation as well as facilitation of the infants' states and positions. The caregivers' attentiveness and emotional availability intermittently may lack consistency or may be partially routinized. The infants' positions may be supported in advance of the feeding; however, the caregivers may provide little consistent support throughout or following feeding. The infants' hands may be freed, supported, and engaged in the feeding only partially. The parents may be encouraged to feed their infants, and breastfeeding in general may be valued to some degree.

(4) The caregivers make significant arrangements prior to, during, and after feeding in terms of equipment, room lighting, sound and temperature. The caregivers' attentiveness and emotional availability are quite consistent, as are preparation and facilitation of the infants' state, tone, movement and position. The infants' behavioral cues and states are largely well considered and supported; feeding occurs calmly and in an emotionally nurturing way; it is initiated once an infant indicates readiness. Timing and pacing of feeding are adjusted carefully to the infants' robustness and availability. The infants' hands are consistently engaged in holding on during the feeding. Pacifiers may be provided, if deemed supportive. The parents are encouraged and supported as the infants' appropriate providers of nourishment and nurturance. Breastfeeding is greatly valued and encouraged.

(5) The caregivers observe the infants closely for the infants' signals of awakening, emerging sensation of hunger, and early signs of requests for feeding. The caregivers coordinate feeding consistently with the infants' state cycles and/or facilitate the infants' development of such coordination. The care rooms are calm, warm, and muted in lighting. The infants are well-supported, held close, and snuggled securely and comfortably in the caregivers' or parents' arms, or rest against their chests. The infants' hands are supported

reliably to grasp as part of the pleasure and effectiveness of feeding. During feeding the caregivers or parents provide and assure at all times calm, gentle containment, security, and facilitation. The infants' cues, initiative, and energy determine the timing and pace of feeding, whether feeding occurs with the aid of a pump, gavage reservoir, or by breast. As indicated by the infants' cues, rests are built in. Pleasurable, satisfying, nurturing feeding experiences are the goal. After feeding, support continues in order to ensure the infants' well-maintained regulation and smooth transition back to sleep. Nuzzling and licking on their mothers' breast are actively encouraged and valued. Successful breastfeeding is the goal; bottle feeding is the mode of last resort and resorted to only should significant medical reasons preclude the mother from breast feeding. Cup, spoon, and finger-feeding are encouraged before bottle feeding becomes an option. The parents are considered the infants' most important providers of nutrition and nurturance.

3. Burping*

    (1) The infants receive repeated vigorous back patting or rubbing in the course of feeding, on an apparently fixed-interval schedule, regardless of the infants' cues. The infants may be held sitting upright, supported under the chin or the back of the head, with arms hanging or extended; or the infants are laid across the caregivers' laps for burping. Prevention of soiling of the shirts or blankets and use of a protective cloths or bibs may be an over-riding focus; or the infants may be tightly swaddled, with arms inside blankets, lifted upright and repeatedly patted on their backs. The infants may receive simultaneously considerable visual and auditory stimuli. The caregivers may appear distracted and preoccupied with other thoughts and activities most of the time.

    (2) Vigorous back patting or rubbing occurs repeatedly in the course of feeding, apparently little related to the infants' cues; tone and position supports are minimal, environmental stimulation is moderate most of the time, or at times very high, at other times more subdued. The caregivers may appear preoccupied with other issues much of the time, or focused largely on the adjustment of the bibs or protective cloths.

    (3) The infants receive a combination of moderate back patting and rubbing. Environmental stimulation may be muted. Burping actions may be timed partly in relation to the infants' burst-pause sucking pattern, and are performed relatively gently.

    (4) Burping, when indicated by the infants, is supported by gently moving an infant upright on the caregiver's chest or shoulder, perhaps by gentle up and down motion and/or walking. The parents are guided to always gently support their infants to burp when indicated by the infants' cues.

    (5) Burping is facilitated by gently and slowly moving an infant upright, nestled on the caregiver's shoulder, or against the chest. It is always performed very softly and slowly. The position changes are timed to the infants' cues, and relaxation is always the apparent aim. The parents are nurtured and supported as their infants' most important providers of feeding and burping.

4. Diaper Change and Skin Care*

(1) Diaper change and skin care always occur on a fixed schedule in an apparent routinized manner. The caregivers leave the bedside repeatedly to discard wet or soiled diapers, to fetch materials to clean the infants' skin, and again to fetch clean diapers. Adjustments of lighting, sound, and temperature; state preparation; and/or support to the infants' position, movement, and tone, if any, occurs independently of the infants' cues. Caregiver attentiveness and emotional availability, if any, are directed elsewhere. The infants fend for themselves in management of arousal, upset, and/or exhaustion, flaccidity, breathing difficulties, etc., which ensue during and after diaper change and skin care.

(2) Partial arrangements take place prior to, during, and after diaper changes and skin care in terms of equipment and room preparation, and/or in terms of the infants' state preparation, and support to the infants' position, tone and movements. Caregiver attentiveness and emotional availability at times are directed to the infants. The procedures may be performed while the infants lay on the side or in prone. The caregivers may support the infants' posture, tone and state incidentally, and/or briefly, before, during and after diaper changes and skin care.

(3) Effective arrangements take place prior to, during, and after diaper change and skin care in terms of state preparation, position, tone and movement support, lighting, temperature and activity. Caregiver attentiveness and emotional availability repeatedly are directed towards the infant. Whether diaper changes and skin care are performed while the infants lay on the side, in supine, or prone, facilitation typically is provided. The materials used are partially appropriately in size, texture, and shape and appear to be comfortable for the infants. The parents are encouraged to participate in or perform diaper changes and skin care.

(4) Significantly effective arrangements take place prior to, during, and after diaper changes and skin care in terms of equipment and room preparation, and in terms of state preparation, and position support. Caregiver attentiveness and emotional availability consistently focus on the infants. Diaper changes and skin care are accomplished while the infants are bedded in well-supported positions, be it in prone, on the side, or in supine. The parents are encouraged, and supported in participation in or independent performance of diaper changes and skin care. Support into flexion and aid towards self-regulation is provided before, during, and following diaper changes and skin care. The materials used are quite appropriate in size, texture, and shape to assure the infants' comfort.

(5) Individualized and highly infant-attuned arrangements take place prior to, during, and after diaper changes and skin care in terms of consistent equipment and room preparation, state preparation, and reliable support to the infants' position, movement, and tone. Caregiver attentiveness and emotional availability are continuously supportive and infant-focused. Diaper changes and skin care take place while the infants are bedded comfortably with effective support to flexion and self-regulation before, during, and following diaper change and skin care. The caregivers consistently assure calm, soothing atmosphere, and gently contain and support the infants. The materials used are soft, attractive, and appropriate in size, texture, and shape for the infants' comfort. The parents are valued as

the most appropriate persons to change their infants' diapers and provide skin care. The professional caregivers assist the parents as indicated.

5. Bathing*

(1) The infants fend for themselves before, during and after sponge, tub, or sink baths; the infants may lie on their backs naked or are held naked in a semi-upright position on a surface, when sponge-bathed or bathed in a tub or sink.

(2) Minimal preparation and facilitation occur prior to, during, and after bathing in terms of equipment, room temperature, sound and lighting, and in terms of state preparation, and support to the infants' positions, tone and movement. The caregivers' attentiveness and emotional availability are sporadically directed to the infants. The infants may be partially shielded from light and may receive some adjustment and/or sporadic facilitation of position, tone, and movement. The infants occasionally may receive support to maintain flexion during sponge, tub, or sink bath. The parents receive marginal encouragement to bath their infants.

(3) Moderate preparation and facilitation occur prior to, during, and after bathing in terms of equipment, room temperature, sound and lighting, and in terms of state preparation and support to the infants' position, tone and movement. Caregiver attentiveness and emotional availability are inconsistent and at times routinized. The infants may be shielded from light; the sound levels may be low and the room warm enough; the infants' position may be supported in advance of the bathing, however, the caregivers may provide little direct support throughout, or following bathing. Bathing may be individualized in frequency and timing; some flexor support may be given with partial immersion in water. The parents may be encouraged to participate in bathing their infants.

(4) Significant preparation and facilitation occur prior to, during and after bathing in terms of equipment, room temperature, sound and lighting, and in terms of state preparation, and support to the infants' position, tone and movement. Caregiver attentiveness and emotional availability are available to the infants almost consistently. The infants' behavioral cues and states are considered; bathing is performed calmly and gently. Bathing is initiated once the infants' state, position, tone, and movement are facilitated and ready. Pacifiers may be provided, if deemed supportive. Bathing is individualized in frequency and timing. Deep, warm water for immersion may be used. The infants may be lowered into their baths swaddled in blankets. The parents are considered their infants' best bathers.

(5) The infants receive well-implemented position support and containment prior to bathing. The room is calm, soothingly lit, and warm. During bathing the caregivers provide calm, gentle, human and blanket containments for the infants. After bathing, supportive containment continues in order to ensure smooth state and motor system transitions for the infants, as well as to ensure that the infants maintain self-regulation. Parents and infants may bathe together in the privacy of the family nursery suite. Bathing becomes a pleasurable family experience.

6. Protection of the Infants' Dignity and Privacy

(1) The infants' medical and social information is discussed in an open forum with little regard for the infants' privacy. Examinations, caregiving procedures and treatments proceed with little regard for the privacy and dignity of the infants' personhood and body.

(2) Curtains and screens are used intermittently and offer minimal visual and auditory privacy for the discussion of medical and social information. Examinations, caregiving procedures and treatments proceed with only occasional regard for the privacy and dignity of the infants' personhood and body.

(3) Curtains and screen partitions are used regularly and offer moderate protection for visual and auditory privacy for the discussion of medical and social information. Examinations, caregiving procedures and treatments proceed with moderate regard for the privacy and dignity of the infants' personhood and body.

(4) Semi-private family care rooms and effective partitions and/or thick curtains provide much opportunity for visual and auditory privacy for the discussion of medical and social information. Examinations, caregiving procedures and treatments proceed with considerable regard for the privacy and dignity of the infants' personhood and body.

(5) Given that family care rooms are private rooms, closed doors provide opportunity for consistent and complete visual and auditory privacy for the discussion of medical and social information. Examinations, caregiving procedures and treatments proceed with consistent regard for the privacy and dignity of the infants' personhood and body.

C. Caregiving In Support of the Infants' State Organization

1. Care Planning for the Infants

(1) Infants' care follows a routine nursery schedule and protocol.

(2) Infants' care follows a routine nursery schedule and protocol. Concern for infants' behavioral cues may be demonstrated during routine caregiving and procedures by provision of facilitation when indicated.

(3) Infants' care follows a routine nursery schedule that has some flexibility. Care may be initiated within a one hour period around the set schedule and concern for infants' cues is demonstrated during routine caregiving and procedures.

(4) Infants' care is based on the infants' individual cues (e.g., feeding or suctioning are initiated when infants demonstrate state changes, color changes, etc.), even if the cues may be subtle.

(5) Infants' care is based on the infants' developmental agenda and expectations. Optimal developmental supports are provided prior to and throughout administering medical

interventions. Whenever possible the infants' behavioral cues of stress are utilized to provide supportive care modifications with the goal to obviate the need for more invasive procedures (e.g., an infant in increasing respiratory distress may be given motor system support and containment to reduce stress and possibly prevent intubation). An infant with feeding difficulties may be fed on a demand schedule with environmental reduction of stimulation prior to and throughout the feeding.

2. Timing and Sequencing of Caregiving Interactions*

    (1) Care procedures and interactions are implemented on a fixed nursery schedule regardless of the infants' states and levels of organization; sleep is interrupted; caregiving interactions are interrupted in order to obtain necessary equipment (stethoscope, thermometer, diapers, etc.) or to rearrange space. The parents are excluded as possible facilitators of their infants.

    (2) Care procedures and interactions are implemented with some consideration of the infants' states and organization. An occasional arrangement is made for the scheduling of a procedure in consideration of an infant's sleep cycle. Basic equipment (stethoscope, thermometer, diapers, etc.) may be placed at the bedside prior to caregiving thus reducing interruptions during caregiving. Overall, a fixed nursery-based schedule is maintained. The parents feature minimally in structuring and facilitating care procedures for their infants.

    (3) Care procedures and interactions are at times individualized in terms of the infants' states and organization. Procedures are at times grouped into clusters and within a caregiving session sequenced to minimize stress; equipment and space are largely prepared prior to the onset of caregiving interactions. The parents are included to some extent in planning caregiving procedures and in facilitating their infants.

    (4) Care procedures and interactions are individualized and consistently implemented with consideration of the infants' states and organization. Caregiving interactions are timed to promote developmentally appropriate periods of uninterrupted sleep and of robust awakening. Procedures are clustered, to be individually supportive. The caregivers assess all interactions in order to determine appropriate timing and pacing. The parents are supported as their infants' most important regulators.

    (5) The infants' sleep-wake cycles, feeding robustness, and other emerging competencies are considered foremost when timing caregiving, including interventions of consultation specialties such as ophthalmology, neurology, ultrasound, X-ray, etc. The parents are valued as the infants' foremost regulators and facilitators in the course of all procedures. Enhancement of the infants' sense of pleasure and pride is an important goal.

3. Transition Facilitation*

    (1) Timing and pace of care components, procedures and interactions are performed solely with consideration of staff schedules. Staff preferences determine the level of room

lighting, sound and temperature. The infants are left to their own levels of competence for state and energy regulation, position, movement and tone maintenance, before during, and after care procedures, between components of care, and in efforts to return to restfulness. The infants are caught behind continuously in their effort to integrate the sequences of care and the tempo of implementation.

(2) Care procedures and interactions are at times performed with some preparation of room lighting, sound and temperature, preparation of the infants' state readiness and position, movement and tone, and assurance of the caregivers' attentiveness and emotional availability, in the implementation of care components, the shift from one component to the next, and the return to restfulness. The infants may be partially shielded from light, and the caregiver may be emotionally engaged some of the time; some adjustments of the infants' position, movement and tone, and the timing of care components are observed. The parents feature minimally in providing transition facilitation. The infants are caught behind repeatedly in the effort to integrate the sequences of care and the tempo of implementation.

(3) Care procedures and interactions are performed frequently with some preparation of room lighting, sound and temperature, preparation of the infants' state readiness, position, movement and tone, and the assurance of the caregivers' attentiveness and emotional availability, in the implementation of care components, the shift from one component to the next, and the return to restfulness. Care at times may be well-implemented and individualized; at other times the caregivers may rush the infants or leave it up to the infants in how to maintain regulation. The infants may be shielded from light; the sound levels may be kept minimal and the rooms may be warm; the infants' position, movement and tone may be supported in advance of care procedures and interactions; however, the caregivers may provide little direct support throughout, or following procedures and interactions; or some degree of facilitation may be given fairly consistently yet it may be removed before an infant is fully settled, restful, and comfortable. The parents may be encouraged to provide some facilitation. The infants may be caught behind at times in their efforts to integrate the sequences of care and the tempo of implementation.

(4) Preparations are made prior to, during and after care procedures and interactions in terms of room lighting, sound and temperature, in terms of supporting the infants' state readiness, positions, movements and tone, and in assurance of the caregivers' attentiveness and emotional availability. These preparations are consistently employed and are based on the infants' individual cues. Prior to necessary procedures and interactions the infants may be assisted in maintaining flexion, provided an opportunity for sucking, and shielded from interruptions and stress. Procedures are performed effectively and with continued support to the infants before, during and after each care component and in transition from one component to the next. Between and after procedures, reorganization is reliably facilitated, including support to flexion opportunities to hold on and to suck as indicated. Extraneous stimulation (e.g., stroking, talking, position shifts, etc.) are avoided and the infants are reliably supported to become well regulated; once calm, removal of one supportive aid at a time is attempted. Much time is taken to assure the infants' re-regulation. The parents are supported as the infants' important transition

facilitators. The infants keep up well most of the time in their efforts to integrate the sequences of care and the timing and flow of the largely well-supported implementation, and the return to relaxation and rest.

(5) The infants are consistently well-supported and well-regulated prior to, during and after all care procedures and interactions. The infants receive calm, gentle containment and facilitation. Individually appropriate levels of support continue throughout the day and night and successfully assure the infants' smooth and increasingly competent state maintenance and transitions, as well as the infants' increasingly well-maintained self regulation. The caregivers anticipate, plan for, and integrate smoothly, the assistance from additional caregivers, in order to assure consistently effective facilitation for the infants. The caregivers may choose to postpone to a more stable time, or modify more optional care components and adjust care components in their timing, sequencing, pacing, intensity and duration to the infants' levels of strengths and energy. The parents are valued and consistently included as the infants' most reliable and effective facilitators. The infants gain strengths and competence from each of the caregiving interaction sequences, the facilitation between components, and their return to rest and relaxation.

4. State Organization*

(1) Caregiving interventions are timed and performed with sole attention to staff schedules and preferences. The caregivers frequently and/or abruptly perform care actions on and/or interact with the infants, when the infants are sleeping or calmly awake. The caregivers always arouse and/or awaken infants suddenly and brusquely; and/or leave infants alone for prolonged periods when the infants are aroused, upset, crying, and/or calmly awake. The parents are relegated to the role of visitors and passive observers.

(2) The caregivers rarely pay attention to the infants' states when timing and performing caregiving interventions. The caregivers repeatedly may interrupt the infants' sleep or awake state. Such interruptions of sleep and alert states may be abrupt and occur with minimal facilitation. The parents are encouraged minimally as regulators of their infants' state organization.

(3) The caregivers pay significant yet at times somewhat inconsistent or partially individualized attention to the infants' state regulation. The infants are protected from disturbance when in deep sleep; when more awake, the infants receive some support for calm state regulation and facilitation during and after caregiving. Facilitation of transition back into sleep and/or enhancement of calm alertness may be occasionally observed. The parents are included to some extent in the facilitation of the infants' state.

(4) The caregivers consistently pay attention to the infants' state organization. The infants' deep sleep states and organization of sleep are supported by the maintenance of calm, predictable environments and schedules. The caregivers gently and consistently assist infants in most state transitions; in maintaining modulated calm states; and in returning to and achieving deep sleep. The parents are reliably and consistently encouraged and supported to participate in the facilitation of the infants' state regulation.

(5) The caregivers provide and support consistent, fully individualized attention and support to the infants' emerging and increasingly autonomous state regulation. The caregivers establish a reliable support pattern of gradual transition facilitation into and out of sleep. Steady sleep wake cycles, deep sleep achievement and maintenance, and enhancement of steady alertness receive consistent supports. All supports are carefully adjusted to the infants' increasing self-regulation. The parents are nurtured and valued as the infants' foremost state regulators.

5. Organization of Alertness by Use of Aspects of the Physical Environment*

(1) Intense light and sound consistently impinge upon the infants. Intense auditory and visual stimuli are provided at all times. The caregivers determine state interruptions, and/or perform caregiving actions based solely on caregivers' schedules and preferences. The infants' hyper- alertness or strained bare opening of the eyes are interpreted as availability for intensely animated adult interactions. The infants may be carried around and/or "shown off" for the benefit of the caregivers. The parents are relegated to the roles of visitors or passive observers.

(2) Minimal or sporadic protection from light and sound is provided in an apparent effort to facilitate the infants' alert states (e.g., light blankets may cover the incubators or room lights are reduced at times when the infants awaken). When infants attempt to open their eyes, the caregivers may comment on it, yet visual and auditory stimuli are provided inconsistently and regardless of the infants' alert states' regulation. The parents are minimally included in the facilitation of the infants' alert states.

(3) Moderate amounts of protection from light and sound are provided in apparent efforts to facilitate the infants' alertness. The infants' incubators may be fully covered with blankets or room lighting may be significantly reduced when infants attempt to come to an alert state. Some attempts are made to reduce sound levels around the infants' bedsides during alert periods. Occasional pleasing visual and/or auditory stimuli are provided when the infants are alert. The parents are encouraged at times to facilitate their infants' alert states with toys or other objects.

(4) Considerable protection from light and sound is consistently provided in order to facilitate the infants' alertness. The incubators may be well covered, room lighting consistently adjusted and/or the infants' eyes reliably shielded when out of the incubator; environmental sounds are kept to a minimum. Individually pleasing and supportive visual and auditory stimuli are provided as long as enjoyed by infants, and then removed when an infant begins to show the first signs of becoming tired or overwhelmed. The parents are consistently encouraged to support their infants' alert states.

(5) Consistent protection from light and sound is provided at all times in order to facilitate alertness. Visual and auditory stimuli that are individually pleasing and well-chosen by the parents, other family members or close friends are provided in an individually appropriate and well-timed fashion with the goal to support and enhance an infant's pleasurable alert

experiences and facilitate increasing autonomy and initiation of the alert experience. The parents are valued and fully supported as the most important nurturers of their infant's alert states.

6. Organization of Alertness by the Use of Aspects of Social Environment*

   (1) Timing, type, complexity and intensity of social interaction provided are based solely on the caregivers' schedules and preferences. Intense auditory and visual stimuli surround the infants at all times. The infants' hyper-alertness or strained bare opening of the eyes is interpreted as availability for intensely animated adult interactions. The caregivers move in closely to the infants' faces and speak loudly and/or intensely. The parents are actively excluded from social contact with their infants.

   (2) Timing, type, complexity and intensity of social interaction provided, repeatedly are based on the caregivers' schedules and preferences. Some consideration is given to the infants' transition to awaken and/or be awake, and/or calmly alert. The parents are minimally included in social contact, interaction with, and facilitation of their infants' alertness.

   (3) Timing, type, complexity and intensity of social interaction provided repeatedly are geared to support the infants' awakening and alert states and their maintenance and modulation. The caregivers' appropriately adapt softness and animation to the infants' level of robustness of awake and/or alert states. The parents are encouraged to enjoy, facilitate, and support the infants' awake and alert states.

   (4) Timing, type, complexity and intensity of social interactions provided are consistently adjusted to be supportive of the infants' alert states. The level of robustness and modulation of awake and alert states consistently is taken into account in all social interactions. The level and modulation of the robustness of awake and alert states during social interaction are supported consistently. Increased stability of the infants' transitions into alertness and its maintenance are the goal. The infants are protected from interruptions and intrusions, when in a quiet awake and/or alert state. Social interactions proceed in a softly modulated manner and support increasing reciprocity with the infants. The parents are consistently encouraged to enjoy, support, and facilitate the infants' alert states and social engagement.

   (5) Timing, type, complexity and intensity of social interaction provided are consistently highly individualized and supportive of the infants' increasingly robust and modulated alertness. The infants' initiation and timing of reciprocal social interactions are well-supported and enhanced consistently. Joyful, pleasurable interactions are assured by consistently individualized and modulated reciprocation, and enhancement of the infants' initiations. The parents are valued as the most important nurturers of the infants' alert states; they are assured that their faces and voices are the most important, increasingly familiar and reliable experiences for their infants' growing social and attentive interaction competence, differentiation and modulation.

7. Infant Observation

(1) Caregivers observe infants either while they simultaneously perform care or in response to alarms.

(2) Caregivers behaviorally observe infants while they simultaneously perform care, when they respond to alarms, and occasionally during infant rest periods.

(3) Caregivers behaviorally observe infants while they care for the infants, when the infants transition into sleep, and frequently during rest periods.

(4) Caregivers consistently observe infants behaviorally on a continuous basis and provide support when indicated.

(5) Caregivers continuously observe infants behaviorally and consistently provide appropriate supports, stabilize the infants and offer transition facilitation as indicated. Timing of care is based the infants' behavioral cues of readiness.

D. Assessment and Alleviation of Pain

1. Nursery Practice Regarding Infant Pain

(1) Staff believes that infants in the nursery hardly possess pain receptors and therefore have limited perception or experience of pain; and/or staff is uninformed of the importance and effect of pain and pain relief for infants in the nursery. Pain relief is addressed only informally.

(2) Staff believes that infants in the nursery may possess limited pain receptors and therefore experience limited pain only. Pain relieving medications and/or other means of pain reduction is used in extreme situations only (e.g., after significantly invasive surgery, or during terminal stages of illness).

(3) Staff believes that infants in the nursery possess pain receptors and experience pain and discomfort in a number of ways. Use of pain medications and/or other pain and discomfort alleviating means is to some extent individualized. Use of paralyzing agents, such as pancuronium bromide (Pavulon) or vercuronium bromide (Norcuron), is always accompanied by administration of pain relievers and/or sedatives, and is closely monitored. Changes in the environment and sensory facilitation are always performed along with such administrations.

(4) Staff believes and is well informed and knowledgeable of the fact that infants in the nursery possess pain receptors similar to those of older children and adults, and therefore that they intensely perceive pain and discomfort. Use of pain medications and/or other pain and discomfort alleviating means is largely individualized. Staff members are skilled in the recognition of a range of behavioral and physiological indices of pain. Good pain management is an expectation of appropriate care. Environmental changes and facilitative

supports are provided prior to, throughout, and following all caregiving in order to reduce discomfort and aid pain relief and management by medication. Paralyzing agents are only used after other means have failed. When they are used they are always accompanied by administration of pain relievers and/or sedatives, and are very closely monitored. The aim is to reduce the duration of use, by effective use of less extreme medications and behavioral means of pain relief and comfort.

(5) Staff is well educated and reliably keeps up to date in the field of infant pain receptors and experience. Staff is well aware that infants in the nursery possess a large number of widely distributed and highly sensitive pain receptors. Staff is very aware that infants perceive pain and discomfort acutely and intensely. Staff education in individualized use of pain medications and/or other means of pain and discomfort relief is current and a high nursery priority. All pain and discomfort management is individualized, closely monitored and reliably and frequently reassessed, and adapted in order to achieve best outcome. Creative environmental change and facilitative support and care adaptations, based on each individual infant's experience and expression of pain and discomfort, are provided reliably prior to, throughout, and following all caregiving interventions. Rest periods are equally closely monitored. A carefully developed comprehensive pain and discomfort plan or protocol is put in place for every infant on admission. It is carefully monitored, adapted, and updated, and addresses indication, initiation, monitoring, adaptation, reassessment and discontinuation of pain medication and sedation, as well of all other comfort measures deemed individually appropriate for each infant.

2. Comfort and Pain Relief Guidelines

(1) Caregivers rarely address infant's experiences of comfort and pain. Pain relief may be informally addressed.

(2) Caregivers inconsistently address infants' comfort and pain. The nursery may have guidelines for use of pain relief.

(3) Caregivers consistently address infants' comfort and pain; General guidelines for pain relief are present within the unit.

(4) Caregivers reliably address infants' comfort and pain. They are used frequently, increasingly with consistency, and they may be used individually based on each infant's need. General guidelines for pain relief are present and are always used.

(5) Caregivers consistently and formally address infants' comfort and pain. All assessments and implementation of measures taken are documented, monitored, and reflected in ongoing caregiving decisions. Guidelines about pain relief are present and used individually based on each infant's need.

3. Assessment of Acute and Chronic Pain

    (1) Caregivers rarely assess acute and/or chronic pain.

    (2) Some caregivers assess acute and/or chronic pain.

    (3) Most caregivers assess acute and/or chronic pain. Nursery policies, assessments, and protocols exist for evaluating chronic pain.

    (4) All caregivers assess acute as well as chronic pain. Nursery policies for the assessments and treatment of acute, as well as of chronic pain, exist; protocols exist and are consistently implemented for evaluation and treatment of pain.

    (5) All caregivers use well-defined assessments and protocols to evaluate and re-evaluate experiences of infants' acute and chronic pain. Nursery staff receives continuous training, evaluation and guidance for the awareness of painful and agitating procedures for infants. Families are supported to make these assessments as well.

4. Awareness of Painful / Agitating Procedures

    (1) Caregivers may at times be aware of the infants' experience of pain and agitation due to procedures.

    (2) Some caregivers are aware of the infants' experience of pain and agitation due to procedures.

    (3) Most caregivers are aware of the infants' experience of pain and agitation due to procedures. Nursery policies, assessments, and protocols exist also for the evaluation of infants' experience of pain, agitation and discomfort.

    (4) All caregivers are aware of the infants' experience of pain and agitation due to procedures. Nursery policies, assessments and protocols exist and are consistently implemented for evaluating the infants' experience of pain, agitation and discomfort.

    (5) All caregivers are continuously aware of the infants' experience of pain and agitation due to procedures. Nursery staff receives continuous training, evaluation and guidance for awareness of the infants' pain, agitation and discomfort experience. Communication of all painful and agitating procedures and events, with implications for care, are shared at all shift changes, from admission to discharge. Parents are supported as well in their awareness regarding pain, agitation, and discomfort due to procedures.

5. Non-Pharmacologic Means of Alleviation of Acute and Chronic Pain

    (1) Caregivers have limited awareness of or intervention strategies for the non-pharmacologic alleviation of acute and/or chronic pain.

(2) Some caregivers are aware of and may have limited intervention strategies available for the non-pharmacologic alleviation of acute and/or chronic pain.

(3) Most caregivers are aware of and have a number of intervention strategies available to alleviate acute and chronic pain non-pharmacologically. Behavioral caregiving facilitations are employed and are part of nursery policy.

(4) All caregivers are aware of the importance of and skilled in supporting infants for the non-pharmacological alleviation of acute and chronic pain. Nursery policies, assessments, and individualized intervention strategies are documented and are consistently implemented for the alleviation of all pain.

(5) All caregivers use well-defined documentation, assessments and protocols to evaluate and re-evaluate the non-pharmacological alleviation of acute and chronic pain for infants. Nursery staff receives continuous training, evaluation and guidance in the individualized awareness, assessment and implementation of non-pharmacological intervention strategies for the alleviation of pain. Communication of all interventions, and their effectiveness for alleviation of pain, are a mandatory component of report at shift change from admission to discharge. Parents are fully supported in their important role to also provide such interventions.

6. Assessment of the Effectiveness of Acute and Chronic Pain Management

(1) Caregivers have limited awareness of available assessments for the management of acute and chronic pain experienced by infants.

(2) Some caregivers are somewhat aware of, and may possess limited assessment skills for the effectiveness of the management of acute and chronic pain experienced by infants.

(3) Most caregivers are aware of and possess a number of assessment skills for the effectiveness of the management of acute and chronic pain experienced by infants. Assessments are employed and are part of nursery policy.

(4) All caregivers are aware of the importance of and possess assessment skills for the effectiveness of the management of acute and chronic pain experienced by infants. Effectiveness assessments are part of nursery policy and are consistently implemented for the alleviation of pain.

(5) All caregivers are highly skilled in the differentiated, individualized assessments of the effectiveness of the relief of acute and chronic pain experienced by infants. Nursery staff receives continuous training, evaluation and guidance for this skill. Communication of all assessments made are communicated and documented at each nursery shift change, from admission to discharge. Families are supported in their role to make such assessments as well.

7. Nursery Practice Regarding Weaning from Pharmacological Substances

(1) Caregivers discontinue narcotic or sedative medications abruptly; and/or infants' who experience even considerable withdrawal symptoms, may be treated with a pacifier and/or holding only.

(2) Caregivers discontinue narcotic or sedative medications abruptly; on nurses' requests for treatment of withdrawal symptoms, physicians may order sucrose, a pacifier and/or holding.

(3) Caregivers may discontinue narcotic or sedative medications gradually over a few days. Unit policies, assessments, and protocols exist for the evaluation and practice of weaning from pharmacologic substances.

(4) Caregivers may discontinue narcotic or sedative medications based on the individual infant's signs and situation. Unit policies, assessments, and protocols exist and are implemented for evaluating infants' comfort and providing support throughout the process of weaning from pharmacologic substances. Families are supported to make these assessments as well.

(5) Caregivers discontinue narcotic or sedative medications consistently based on the individual infant's situation and cues. All caregivers use well-defined assessments and protocols to evaluate and re-evaluate individual infants' weaning experience from pharmacologic substances. Nursery staff receives continuous training, evaluation and guidance for the awareness of infants' continuing signs of pharmacologic substance withdrawal, as well as of continuing pain and agitation. Families are supported reliably and consistently to make these assessments as well.

E. Nursery Documentation

1. Documentation

(1) Medical and nursing staffs write separate admission, progress, interim summary and overall summary and discharge notes and reports. They file them in separate charts, which are maintained in separate areas of the nursery, or in separate computer files.

(2) Medical and nursing staffs write separate admission, progress, interim summary and overall summary and discharge notes and reports. They file them in separate charts, which are maintained in the same area of the nursery or the same computer file.

(3) Medical and nursing staffs write separate admission, progress, interim summary and overall summary and discharge notes and reports. They file them in one and the same chart, located in one area of the nursery or in one computer file.

(4) Medical and nursing and all other professional staffs produce one integrated set of notes that contains all professional documentation (e.g., nursing, medical, respiratory therapy,

physical therapy, any consultations, etc.). Family contributions and observations are placed in the same permanent record. All professionals have equal and easy access to all progress notes as well as to pending information regarding specific tests and/or consultations.

(5) All professional and parent documentation is produced and available in one source and placed in a chart or on a computer. All professionals including the developmental team members, as well as the parents, have equal and easy access to all documentation that pertains to the infant.

2. Content and Format of Care Plans

(1) Only traditional medical and nursing goals are included in the care plan.

(2) Traditional medical and nursing goals predominate in the care plans. Developmental goals are uniform, generalized, and standardized.

(3) Individualized developmental goals supplement the predominantly medical and nursing goals. They are included in a separate section of the care plan and as separate goals from the medical and nursing goals.

(4) Individualized developmental goals are comprehensive and incorporated into all medical, and nursing goals, as well as other goals, such as family and social work goals, and are included in the care plan.

(5) Individualized developmental goals are comprehensive and incorporated into all medical, nursing and other goals, such as family and social work goals, and are fully included in the care plan. All care and intervention plans reflect the entire 24-hour period of the infants' days as well as the infants' continuously unfolding developmental competencies and agenda.

3. Creation and Revision of Developmental Care Plans

(1) Developmental care plans may be initiated only after maladaptive infant behavior patterns and otherwise difficult behaviors emerge. They may occur infrequently and if so, they are maintained separately from the medical and nursing care plans.

(2) Developmental care plans may be initiated after maladaptive infant behavior patterns and difficult behaviors emerge and/or in preparation of discharge. Plans are updated sporadically and maintained separately from medical and nursing care plans.

(3) Typically nurses initiate developmental care plans within the first few weeks after the infants' births. A developmental specialist and/or therapist also may create developmental care plans and update them on a relatively regular basis. These plans are considered part of the nursing care plans.

(4) Developmental care plans are initiated by the admitting interdisciplinary team and are an integral ingredient of the comprehensive medical/nursing care plans. The primary care team members, including the parents, review the plans daily and update them as indicated. The primary care team members discuss the plans at weekly multidisciplinary team meetings. Consultation by the infants' primary developmental specialists or NIDCAP Professionals is sought frequently, as indicated.

(5) Developmental care plans begin prenatally, should the mother be hospitalized before delivery. Otherwise, the triage team initiates such plans in the delivery room. They encompass delivery, immediate post-delivery care and admission to the nursery. They are updated and revised by the admissions teams and then the primary care teams who care for the infants and their parents. The parents and other immediate family caregivers actively contribute to and participate in the continued development and update of the comprehensive care plans. They are discussed and reviewed at all interdisciplinary team meetings and family meetings. Family input and suggestions are incorporated; parents are encouraged to formulate parts of their infants' care plans and update components as indicated.

4. Documentation of Infant Behavior

(1) Caregivers document medical events exclusively in their daily charting.

(2) Caregivers document infant behavior only in response to specific medical events (e.g., extubation, bottle-feeding, acute apneic episodes, etc).

(3) Caregivers document infant behavior in response to specific medical events and to daily caregiving interactions (e.g., vital sign assessment, diaper changes, etc). Formal NIDCAP observations and recommendations by the infants' developmental specialists or the nursery's NIDCAP Professionals are included in the chart, yet kept separate from daily documentation by nursing, medicine, and therapies.

(4) Caregivers and developmental specialists/NIDCAP Professionals document infant behavior jointly. These integrated descriptions of infant behavior are part of the daily charting for all infants.

(5) Caregivers document infant behavior comprehensively in response to direct caregiving, in the periods between these direct caregiving interactions and interventions, and in terms of behavior patterns observed over time. Parents are encouraged to document their observations of their infants' behavior. Observations by all members of the caregiving team are considered valuable and important. Developmental specialists/NIDCAP Professionals are integrated into the nursery and staff's functioning as valued collaborators, colleagues and mentors.

5. Planning Care for the Infant

   (1) Infant care exclusively follows a set nursery schedule and protocol.

   (2) Infant care largely follows a set nursery schedule and protocol. Care adjustments based on infants' behavioral cues may be demonstrated by some caregivers some of the time in the course of otherwise set implementation of caregiving sequences and procedures.

   (3) Infant care to some extent follows a set nursery schedule, yet has some flexibility in terms of timing and initiation of care, which may vary by approximately an hour, and are keyed to infants' cues of readiness. During most of the daily caregiving actions and during most procedures, caregivers take the infants' behavioral cues into account and adapt timing and implementation of their actions accordingly.

   (4) Infant care is based predominantly on the infants' individual behavioral cues. This is the case for the timing of daily care tasks and procedures, special procedures, as well as for the way most tasks and procedures are implemented (i.e., vital sign assessment, diaper change, bathing feeding, suctioning, mouth care, blood drawing, head ultrasounds and chest radiographs, line placements, facilitation of eye examinations, all specialty consultations, etc.). Infants' sleep is consistently protected. Autonomic stability and motor system integration are assured and modulation of state transitions are supported, including return to sleep upon conclusion of a sequence of interactive events. Infant cues are considered in decisions to administer or forego certain actions and procedures.

   (5) All infant care, including timing and implementation of care, is based at all times on each infant's individual cues and inferred developmental agenda. Continued detailed behavioral observations form the base for decision making and planning. All timing and implementation of care and interaction aim to reduce infants' stress responses and enhance infants' strengths and self-regulation behaviors and strategies. All infants are supported specifically in their own initiation of next steps in skill attainment, and growth of competence, in the various arenas of early development. Individualized developmental support consistently is provided prior to, during and after the administration of medical and other interventions, as well as prior to, during and after all care events. Furthermore, infant cues reliably are considered in all decisions to administer or forego actions and procedures.

F. Staffing

1. Nursing Assignments

   (1) Infant acuity, location, and continuity of care are rarely addressed when planning nursing assignments.

   (2) Infant acuity is addressed, though infant location and continuity of care are secondary considerations when planning and making nursing assignments.

(3) Infant acuity and location are considered important issues for planning and making nursing assignments.

(4) Infant acuity, location, and continuity of care are all considered when planning nursing assignments. Efforts are made to evaluate infants' location decisions proactively and to revise plans appropriately to ensure optimal provisions of care.

(5) Infant acuity and location are always addressed when planning and making nursing assignments. Primary teams are developed for clusters of infants, and care assignments are planned and made to assure maximal and optimal continuity of care.

2. Primary Care

(1) Infants' primary care team identifications, when and if identified at all, may take longer than a week after an infant's admission to the nursery. Caregiving assignments are inconsistent and infants and families experience multiple and ever-changing caregivers within a day and from day to day. Assignments are primarily driven by nursery-identified priorities; the individual requirements and preferences of infants and/or families may factor minimally if at all in staff scheduling. There may be very few established procedures for interdisciplinary care coordination.

(2) For a number of infants a primary caregiving team is identified within 72 hours of admission; infants may receive care from members of the identified care team only intermittently. Assignments are primarily driven by nursery-identified priorities; the individual requirements and preferences of infants and/or families are utilized quite inconsistently in staff scheduling. Interdisciplinary care coordination is inconsistent and parents are only rarely supported to participate in the care coordination process. Limited consideration is given to the infants' experiences and individualities in the planning and delivery of care.

(3) For all infants a primary caregiving team is identified within 48-72 hours. Many infants receive care for at least one shift every other day from a member of their identified care team. Nursery-identified priorities influence assignments yet the individual requirements and preferences of infants and/or families may be considered in staff scheduling. Efforts are made to enhance consistency of care and interdisciplinary care coordination. Parents may be identified as members of the caregiving team and are at times supported to participate in the care coordination process. Some consideration and discussion is given to the infants' experience and individuality in the planning and delivery of care.

(4) For all infants a primary caregiving team is identified reliably within 24 hours. The infants largely receive care from members of the identified care team. The individual requirements and preferences of infants and families are considered in staff scheduling. Consistency of care and interdisciplinary care coordination are nursery priorities. Parents are identified members of the caregiving team and are supported to participate in the care coordination process. Consideration is regularly given to the infants' experiences and their

individualities in the planning and delivery of care; written documentation of individualized family-centered developmental care plans underscore consistency.

(5) For all infants a primary caregiving team is clearly identified upon admission. A member of the identified care team consistently cares for the infant and family throughout the 24-hour cycle. Priority is given to the individual requirements and preferences of infants and families when staff is scheduled. Consistency of care and interdisciplinary care coordination are top nursery priorities and well established. Parents are identified as integral members of the caregiving team and are well supported to participate in all aspects of the care coordination process. Considerable priority is given to the infants' experiences and their individualities in the planning and delivery of care. Processes are established to develop written individualized family-centered developmental care plans and to support interdisciplinary implementation within all caregiving interactions. Continued efforts are made by incorporation of family feedback and communications to further the team process of excellent care coordination.

3. Staffing to Support Infants and Families

(1) Staff selection and ratios are decided by medical criteria such as an infant's physiological acuity only; planning for consistency of caregivers is lacking. Behavioral or socio-emotional requirements of infants and families are lacking from planning the amount and quality of caregiver time required. Processes for caregivers to increase their time for changing infant and family requirements are absent. Parents, when present are ignored as potential/active caregivers when staffing assignment decisions are made.

(2) Staff selection and ratios are decided by staff availability only and generally ignored in the nursery's operational systems plans and guidelines. A nurse is assigned to specific infants per shift, and there is little flexibility in the assignments to allow for staff members to assist one another when indicated. In general, staff covers for one another on breaks, yet have little knowledge concerning the infants under their peers' care. Care extenders or volunteer help are assigned to assist with non-clinical duties such as stocking of supplies, and paperwork. They rarely are involved in direct patient care under staff supervision, and are only infrequently permitted to attend to infants' requirements for calming and holding. Parents when present may provide limited aspects of infant care, yet their participation is not accounted or planned for in making assignments.

(3) Staff selection and ratios are decided by staffing plans that aim to assign consistent caregivers to each infant, yet nursery systems issues make this difficult to achieve. Some flexibility in staffing model and ratios provides for staff to step in when a nurse is not in a position to care for an infant, who signals a requirement for immediate care. Volunteers regularly provide calming and nurturing to infants, yet on their schedule and availability rather than on the families' anticipated involvement and wishes. Staffing ratios may be adjusted to accommodate planned time with parents such as discharge "training", and independent care-by-parent times.

(4) Staff selection and ratios are reliably decided by medical criteria, which dictate staffing ratios for licensed nurses; behavioral and socio-emotional requirements of infants and families are considered in the utilization of care extenders and volunteer help. The use of care extenders complements anticipated parent care. The nursing care model may be designed so that a staff team collaborated in the care of a number of infants, which assures that a staff member is readily available to attend to an infant when that infant signals a requirement for immediate care. Shift change reports and continued information are shared in such a way that the nurses in the team feel comfortable in their knowledge of all infants within their team's responsibility.

(5) Flexibility in nurse selection and staff ratios take into account the families comfort levels in providing care for their infants. The level of staff support is adjusted to each infant and families' requirements. The families' planned involvement and care for their infants is regularly reviewed and supported, and staffing is based on that plan. Care extenders and volunteers are recruited and trained to meet each infant's requirements and to be based on the families' plans. Care consistently provides flexibility so that those nurses, who are well familiar with respective infants and families, are available to meet the infants' and families' requirements and expectations.

G. Category Summary Scale - Philosophy and Implementation of Care: Infant

(1) All aspects of the philosophy and implementation of the infants' care are planned and performed according to protocols and are in keeping with fixed schedules. Only staff members may be in the presence of and interact with infants.

(2) Many aspects of the philosophy and implementation of the infants' care are planned and performed according to protocols, and are in keeping with largely fixed schedules. Staff members and, for specified periods, parents may be in the presence of and interact with infants.

(3) Some aspects of the philosophy and implementation of the infants' care are planned and performed according to protocols and may be performed on a relatively set schedule. Efforts are made to take into account the infants' individuality in planning some aspects of care. Parents and family members are welcome to visit the infant at set times during the day.

(4) Many aspects of the philosophy and implementation of the infants' care are planned and performed much of the time with consideration of the infants' stability and behavioral cues, as well as with consideration of the infants' overall development and the families' participation.

(5) All aspects of the philosophy and implementation of the infants' care are consistently performed with consideration of the infants' stability and behavioral cues as well as with consideration of the infants' overall development and the families' participation.

III. Philosophy and Implementation of Care: Family

A. Philosophy of the Nursery

1. Nursery Mission Statement Regarding Support of Families

(1) The nursery's mission statement does not address the parents' and families' role and participation in their infants' care. Nursery policies and evaluation criteria do not exist for staff competency with regard to family support, participation, and communication, nor for staff development related to the practice of family centered care. Family presence and participation is limited, and multiple restrictions are placed on when and how families may interact with their infants.

(2) The nursery's mission statement to some extent addresses the parents' and families' role and participation in their infants' care. Minimal nursery policy and evaluation criteria exist for staff competency with regard to family support, participation, and communication and for staff development related to the practice of family-centered care. Family-identified needs, priorities or concerns are addressed when requested by infants' parents. Staff inconsistently identify, address and support parent participation in care. In many instances, staff may take a directive role in interacting with parents around the care of their infants.

(3) The nursery's mission statement addresses the parents and families' roles and the value of parental participation in their infants' care. Nursery policy and staff performance evaluation criteria identify the importance of communication with and support to families. Inconsistency and variability in implementation of parental support and participation exist for staff competency, staff development activities, and processes for the identification of family centered priorities and concerns. The focus of the nursery is on alleviating parents' stress and on the requirements for instruction in how to best interact with and care for their infants.

(4) The nursery's mission statement clearly describes the importance of support for the parents' and other family members' roles, relationships, and participation with their infants and with the care team. Nursery policy and staff performance evaluation criteria exist for staff competency in support of the parents' roles; for interaction and relationship with their infants and the care team; and for staff development activities related to the practice of family centered care. The nursery has established mechanisms for the identification and support of family priorities and concerns. Staff may work with parents to develop goals related to their participation in their infants' care. Staff demonstrates behaviors that convey appreciation for and support of the parents' participation in the care of their infants and that draw on family strengths and priorities in supporting the parent-child relationship.

(5) The nursery's mission statement cohesively and clearly identifies an infant's parents as the primary caregivers of their infants. Parents are considered equal partners and essential members of the care team. Nursery policy and staff performance evaluation criteria effectively identify staff competencies and staff development in the delivery of family

centered care. Mechanisms for identification and support of family requirements, priorities and concerns are consistent and in place. Goals related to parents' participation in their infants' care are documented in an interdisciplinary plan of care. Staff consistently demonstrates behaviors that convey an appreciation for and support of parents as the best nurturers of their infants' behavior and overall development.

2. Respect for and Protection of the Dignity and Privacy of Families

    (1) The parents' medical and social information is discussed in an open forum and within easy earshot of casual listeners. Families' private lives and interactions, among one another, and with their professional caregivers, proceed quite publicly within view to anyone walking by or working in the general area.

    (2) Curtains and screens at times may be used to ostensibly offer visual and auditory protection of the privacy of discussion of medical and social information. At times communications and interactions proceed with some regard for the privacy and dignity of the family.

    (3) Curtains and screen partitions are used regularly and offer moderate visual and auditory protection for private discussion of medical and social information. Communications and interactions proceed with some regard for the privacy and dignity of the family.

    (4) Semi-private family care rooms with effective sound-absorbing partitions and/or thick curtains provide much opportunity for visual and auditory protection of the private discussion of medical and social information. Communications and interactions proceed with considerable regard for the privacy and dignity of the family.

    (5) Private family care rooms with sound-proof walls and closed doors consistently provide the opportunity for complete visual and auditory protection of private discussions of medical and social information. Examinations, caregiving procedures and treatments Communications and interactions proceed consistently with greatest regard for the privacy and dignity of the family.

3. Parents' Access to Care Information

    (1) Communication about infants' care is limited to nursing and medical professionals. Parents receive only minimal information.

    (2) Communication about infants' care is largely limited to nursing and medical professionals. Parents are informed of major changes in their infants' medical status.

    (3) Communication about infants' care is frequent and involves all members of the infants' care teams. The infants' primary nurses keep the parents informed of all clinical issues concerning their infants and in turn relay the parents' inputs to the larger care teams.

(4) Communication about infants' care is collaborative. Medical and nursing staff and the parents are integral members of all planning and decision making of the infants' care; they jointly contribute to the development of all care plans including the discharge plan.

(5) All communication about infants' care is collaborative. All medical and nursing staff and the parents are integral members of all planning and decision making of the infants' care; they jointly contribute to the development of all care plans including the discharge plan. The medical professionals are readily available to the families to discuss infants' status and next steps in care planning. The infants' primary care team nurses are available in person and/or by telephone on a 24-hour basis to communicate with the parents and discuss pending decisions and progress. Parents are informed of all care plans, tests and procedures, and are encouraged and invited to contribute to the decisions and implementation regarding timing and their availability to be there with their infants. Whenever possible parents' wishes and desires are respected and taken into account. In the case of emergency procedures, parents are contacted and informed by the primary physician and/or primary nurse as indicated, as soon as possible. Parents' questions are always answered fully and in understandable language. Staff has ample time to meet with and discuss all aspects of care with the parents.

4. Parent Participation in Care

(1) Professional caregivers perform all caregiving from the infants' admissions on through hospital discharge. Parents' access to the nursery is limited by the nursery's visitation policy, which may exclude parents during times of medical rounds and performance of medical procedures, as well as nursing shift changes and report times. Parents may visit their infants at the bedside while professional caregivers are interacting with and caring for their infants. Before discharge, parents may be instructed on how to care for their infants once at home.

(2) Professional caregivers perform most of the caregiving, from the infants' admissions on through hospital discharge. Parents may visit their infants for much of the day and night. Parents of stable infants may participate in caregiving, including such activities as diaper change and bottle and breastfeeding.

(3) The nursery has an open visitation policy for parents. Some professional caregivers may invite parents to participate in caregiving, from birth/admission through hospital discharge. Parents are an integral part of their infants' lives in the nursery and are welcome to be at their infants' bed space at all times. Siblings, if healthy, are invited to be at an infant's bedside during certain times. In the course of an infant's hospitalization, parents' are expected to become increasingly involved and competent in their infants' care, from holding their infants skin-to-skin to changing diapers and feeding their infants. By the end of the hospital stay, parents perform all caregiving interactions with their infants. Prior to discharge, parents may stay with their infants alone in a separate parent room within or close to the nursery to gain security in caring for their infants.

(4) Professional caregivers support parents to be the primary caregivers of their infants from birth/admission through hospital discharge. Family-centered, individualized developmentally supportive care is an integral part of the nursery's policy and expectation. The area around the infant is considered the family's bed space, and parents and siblings are welcome to be there at all times. Parents are guided in how to interpret and understand their infants' responses to caregiving interactions, procedures and the nursery environment. Parents are supported in their role as co-regulators of their infants during sleep and wakeful times as well as during procedures that may cause discomfort and pain.

(5) Parents are the primary caregivers of their infants from birth/admission through hospital discharge. Family-centered, individualized developmentally supportive care is consistently implemented for all families in the nursery. Professional caregivers perform medical and technical tasks in collaboration with parent facilitations of infant stability, relaxation, and comfort. The nursery's leadership team provides ongoing support, guidance, and training for the professional caregivers to effectively and consistently provide family-centered, individualized, developmentally supportive care. As appropriate, in the course of their infants' hospitalization, parents increasingly perform caregiving procedures (e.g., bathing, temperature taking, and diaper changing). Each infant's bed space is considered the family's area. Siblings are welcome at any time as long as they are healthy; they may stay overnight. Parents are expected to live in the nursery with their infants' throughout the infants' hospitalization.

B. Family Communication

1. Emotional Relationship among Staff, Parents, and other Family Members

(1) An authoritarian, hierarchical, and very formal relationship prevails among professional caregivers on the one hand and parents and other family members on the other. Professionals project authority and superiority; parents and other family members are beholden to the professional staff. Or professionals may be highly unpredictable, capricious, moody, and variable in their interactions and relationship with parents and other family members.

(2) A quite formal and largely authoritarian relationship prevails between staff and parents. A few professionals may have a warmer, more personal and respectful relationship with parents and family members, while some professionals may be unpredictable and quite variable in their interactions and relationship with parents and family members.

(3) A largely respectful and warm atmosphere and relationship exist among most staff, parents, and other family members. A few staff members insist on a more formal relationship yet are respectful; others may be at times overly familiar and take liberties with parents and family members' personal integrity and psychological boundaries. Parents, who are socially skilled, and/or similar in background to the staff, tend to have an easier time in the nursery. Families of more diverse backgrounds may experience suspicion, caution, and less support, trust and respect.

(4) An accountable, steady and mutually trusting, warm and respectful relationship prevails among staff, parents, and other family members. Parents and other family members with social, interactive, and/ or emotional challenges and/or with significant cultural differences in interaction are assisted by special intermediaries (e.g., social workers, psychologists, and/or language and cultural interpreters), in an effort to facilitate communication and a warm relationship. Professional staff makes efforts to meet such parents and family members in a respectful and supportive manner, and utilizes the special services for their own education and support.

(5) A fully accountable, mutually trusting, reliably warm, supportive and thoroughly respectful atmosphere prevails at all times among professionals, staff, parents and other family members. Parents largely become increasingly secure in sharing information, feelings, hopes and fears with staff. Staff, parents and families consider themselves important and trusted partners and collaborators in assuring the best developmental outcome for the infants, parents, and families. Continuous staff/professional education and psychological support as well as reflective process opportunities and mentoring are integral parts of the nursery, and encompass understanding, communication and relationship-building with parents and family members, especially those confronted with social, interactive, and/or emotional challenges and/or with significant cultural and religious differences. It is considered the staff and nursery's responsibility to avail themselves of special intermediaries (e.g., social workers, psychologists, and/or language and cultural interpreters, educators), in an effort to increase their awareness and knowledge, as well as strengthen their understanding and communication skill with such families. Formal educational opportunities reliably are available for staff to attend clerkships in psychology and psychiatry settings that focus on family support, as well as to experience formal exchange programs with other cultures and religions. Professional mentors are available to staff and families at any time and availing oneself of their support and education is considered an essential responsibility of all professionals and staff in the nursery. Staff and professionals as well as parents and families avail themselves readily of such mentors in order to increase the effectiveness in their mutual understanding and communication, and to strengthen their relationships on behalf of their infants and their own development.

2. Parents and Family Members' Role in their Hospitalized Infants' Lives

(1) Parents and other family members are considered sources of infection for the infants and intrusions into the effective work of nursery staff and professionals. They are therefore relegated to the role of spectators, and expected to relinquish their infant to the care of the professional, until such time that an infant is ready to be discharged, or may have died. They have the opportunity to see their infant through a window, door, or other viewing opening, at a fixed time, at most once a day, or perhaps only once a week. Or they may enter the nursery after having fully scrubbed and gowned, at a fixed time and day, and stand at the incubator or crib of their infant watching the infant for a few minutes, at most, up to one hour. At discharge they are notified to come and receive the infant, at an appointed time, at the entrance to the nursery. These rules are strictly enforced in written and verbal communication.

(2) Parents and family members are considered possible sources of infection and tolerated intrusions into the daily routines of the nursery. Strict visiting policies are enforced, which permit one or both parents' access to the nursery. They must scrub and don a gown, hat boots etc., and may stand or sit next to their infants' incubators or cribs for fixed times only (e.g., once a week for up to 2 or 3 hours, etc.). Close to discharge, they may hold their infants briefly, receive instructions and demonstrations in how to change the infants' diaper, and swaddle and feed their infants. Other family members may view the infants at appointed times only, through a glass window or door.

(3) Parents and family members are considered potential sources of infection, yet also a necessity in order to assure the eventual successful discharge of infants to their parents. Nursery policies control their presence. Even when written policies may state full inclusion of the parents into the nursery and visitation rights throughout 24 hours, practice may dictate that parents typically spend only three to four hours with their infants on most days, and/or time their visits to feedings and then leave again. Special daily events such as shift changes, daily medical rounds, and certain procedures are reasons the nursery gives to reliably discourage and/or forbid parents to be with their infants. Family members are more restricted in visiting times and durations than parents, and typically may only visit in the presence of one of the parents. There may be rules that restrict the number of persons at the bedside to two or maximally three. Strict rules regarding gowns, hand washing, etc. exist and are enforced. Most parents very quickly adapt to the functional rules of the nursery, regardless of the written policies and guidelines, which may be significantly more generous.

(4) Parents are considered integral partners in their infants' care and supported as the natural attachment figures and nurturers of their infants. They are encouraged to be with their infants at all times. Exceptions may be emergencies and on-site surgeries that may occur in their infants' vicinity. Parents are invited to be present during medical rounds in order to hear and participate in the discussions. They are encouraged to offer information and ask questions, as they wish. Other family members are invited to be with the parents at the infants' bedsides. Realistic space considerations may limit the duration of family members' visits and perhaps the number of simultaneously present persons. The parents are in charge of facilitating these decisions among family members.

(5) Parents are considered integral partners in their infants' care from labor and delivery on through admission to the nursery and throughout the infants' hospital stay. The mothers' own health considerations may present the only limiting factor early on for complete inclusion of both parents into the lives of their infants in the nursery. In such cases the mothers are well supported and their presence is facilitated to the best of the mothers' physical comfort and energy thresholds. Fathers and another family member, or close friend designated by the parents, may fill in for and take turns with the mother, and/or support mother and father in caring for the infant in the nursery. The nursery encourages each family to identify at least one such designated surrogate person, in order to facilitate a reliable close attachment and support network for each of the infants and the parents, in the hope that it will extend beyond the hospital discharge and into the home and community. These family support persons, be they grandparents, an aunt, or a friend may care for and hold an infant irrespective of the parents' presence. Depending on the

parents' wishes they may also hold the infant skin-to-skin and/or feed or breastfeed the infant, as is the norm in a number of cultures. All staff education, as well as written materials, support the belief that families belong, and are encouraged to be with their infants whenever possible. The infants' parents and/or family care group as well as the staff and professionals are well-supported in their roles, which include participation in rounds, shift change, and mutual communications.

3. Family – Staff Communication including Participation in Medical Rounds

(1) Professionals solicit, incorporate, and/or document feedback from one another and from invited specialist consultants. Parents receive cursory information, if any, until discharge when they receive a summary statement regarding their infant's status and a list of prescriptions and follow-up appointments. Professionals and staff attend to parents' questions and/or issues only when presented as formal complaints. Should parents be present in the nursery at all, they know that they must leave during medical rounds.

(2) A perfunctory optional process is in place to solicit, incorporate, and/or document feedback from families regarding their response to their infant's current care. Parents' comments and suggestions to individual staff members are variably shared with the care team as a whole. Informally, parents may ask and be asked for information about their infant and themselves. Parents may be asked to attend specially scheduled meetings, which typically are restricted to the communication of significantly grave news about the infant's condition or prognosis, or staff concerns about the parents' inappropriate behavior. Parents are expected to take the role as passive listeners. Should the parents ask questions these may be answered briefly. Should the parents be present in the nursery at all, during medical rounds they may be asked to leave, or their presence may be considered irrelevant, and they are ignored while rounds proceed.

(3) Efforts are made regularly to solicit, incorporate, and/or document feedback from families regarding their infant's response to care, decisions regarding tests to be performed and the planning of future care. Depending on individual staff members' sensitivity, parents may be asked by staff to describe their infant's progress and how they might be supported in their nursery experience. Parents may be present during medical rounds and nursing shift report; their insights might be asked for, for the benefit of the group of caregivers, yet their observations typically are of little consequence for the care plan. Any bedside journaling is considered to be informal and may be read or referenced inconsistently by staff. Specially scheduled meetings between the family and care team may be held with the purpose of: urging the family to comply with information previously communicated in a more casual manner; exploring unusual or worrisome behavior exhibited by the family; sharing a significant change in the care plan, or significant test results, and/or a change in prognosis for the worse. Parents' adaptation to the information communicated in the care meeting is monitored, and as deemed necessary, support for the parents from the social worker or psychologist may be recommended.

(4) A reliably practiced and well-integrated process is implemented, which supports the staff to solicit, incorporate, and document feedback from families regarding their infant's well-

being and response to care, as well as the families' own feelings and well-being, and the planning of next steps. Frequent meetings are held between the nursery staff and the parents to plan and participate in the care of their infants. At these meetings, including medical rounds, the families are invited to contribute their perspectives on their infants, the plan of care, and their own wishes in how to support their infants. Parents may report on their infants' behavior in their infants' medical chart. This information frequently is incorporated into the caregivers' approach to the infant. There are multiple opportunities for parents to share their impressions and experiences. All parents regardless of the frequency of their presence in the nursery, their language and/or culture, are strongly encouraged and supported to ask questions and give feedback.

(5) Mutual daily communication between staff and parents is a well-integrated and well supported feature of the nursery's culture and practice, regarding any aspects of the infants' care and progress or the families' feelings, concerns, wishes, and hopes or desire for information, support etc. All parent communication, be it spoken, written or evidenced behaviorally, is taken seriously, is respected and considered important and valuable in adapting care and interactions most sensitively, for the well-being of infant and family. Staff is well supported and guided in being actively attuned and reflective at all times in observation of, and interaction with parents and infants. Their professional attunement and sensitive openness and availability while actively processing the information they glean from all interactions, is valued in consideration of the best care for infant and family. From the infants' birth and admission onward, parents are supported in their collaboration and relationship with the professional staff in the nursery on behalf of their infants' best future. Staff takes seriously, and builds into all care planning and communication with other professionals concerned with the progress and care of the infants, any incidentally observed and received and/or formally encouraged observation and information families and/or infants may offer. All staff and family efforts are jointly engaged in supporting the infants' best progress. The nursery's communication matrix is anchored in the continuously growing and deepening, well-nurtured, mutual relationship of parents and professionals. They consider one another trusted partners. All nursery work is continually evaluated for increased opportunities for the collaboration of parents and staff. A professionally trained parent and family liaison person, as well as multiple reflective process consultants working with various groups of professionals, assist this process. Parents are considered integral partners in medical rounds and shift changes. Their incidental absence is considered a significant loss for the process. Parents and professionals regularly read and write in their infants' charts as a matter of course. Many opportunities exist and are fostered to support parents and professionals in this essential open communication and collaboration foundation of nursery care.

4. Tone of Nursery Communication

(1) The nursery's written materials and oral communications are off-handed, at times derogatory or demeaning, and/or exclusively clinical. Limited or no attention is paid to communicating with respect, sensitivity, and supportiveness of the dignity of infants and families served in the nursery. Medical terminology, nursery jargon, and technical abbreviations are used exclusively and/or predominantly in communication with infants

and families, and in written documentation. Signage is technical and/or exclusive, or predominantly expresses prohibitions and/or commands to be followed by families and staff (e.g., "Do not enter!"). Nursery staff refers to infants as "neonates," or "-weeker" (e.g., "32- weeker"), and/or by bed number/ location, disease process, and/or as kids, "it/they," or "my baby," etc.

(2) The nursery's written materials and oral communications, while largely clinical, are mostly respectful. Some of the staff typically pays attention to communicating with respect, sensitivity and supportiveness of the dignity of infants and families served in the nursery. Medical terminology, nursery jargon and technical abbreviations are used much of the time in communication with infants and families and in written documentation. Signage is often technical and/or largely expresses prohibitions and/or commands to be followed by families and staff. Nursery staff may at times refer to an infant as "neonate" or "-weeker" (e.g., "32-weeker"), kid, babe, and "my baby," etc.

(3) The nursery's written materials and oral communications are at times clinical. A number of staff communicates respectfully, supportively, and sensitively with infants and families. Communications repeatedly reflect nurturance and are culturally sensitive. Written documentation and family materials inconsistently reflect sensitivity to families. Some signage is technical, some more family-friendly. Signs express information neutrally and in declarative statement. (e. g. "Coats go in the Coat Closet"). A nursery staff workgroup may at times meet to address language sensitivity issues and implementation.

(4) The nursery's written materials and oral communications are supportively and sensitively phrased and reflect appropriate respect of the infants' and families' dignity. Nurturance and cultural sensitivity are reflected in most communications. Most signage, documents, and materials for families, are family supportive. Often parent input is sought to guide nursery staff in the understanding and implementation of communication sensitivity in the various media and channels pertinent to the nursery.

(5) The nursery's written materials and oral communications are consistently very supportive and sensitively phrased, and reflect deep respect for the infants' and families' dignity and integrity. Nurturance and cultural sensitivity are reflected in all communications. All signage, documents, and materials for families are family supportive. Parent input is sought reliably to guide nursery staff in the understanding, and implementation of communication sensitivity in the various media and channels pertinent to the nursery.

C. Family Support

1. Anticipatory Support around the Time of Delivery

(1) With labor onset and/or upon the mother's hospital admission to Labor and Delivery, families have limited or no access to staff and materials for information and support regarding the progress of the labor, the infant's birth, and the next steps planned for the care of infant and mother.

(2) With labor onset and/or upon the mother's hospital admission to Labor and Delivery, families have some access to staff and materials for information and support regarding the progress of the labor, the infant's birth, and the next steps planned for the care of infant and mother.

(3) With labor onset and/or upon the mother's hospital admission to Labor and Delivery, a staff person (designated by, and from among the Labor and Delivery staff, nursery staff, and/or antenatal staff, depending on the mother's prior care and expected labor outcome), ensures that family members are informed, supported, and kept up-to-date regarding the progress of labor, as well as the mother and fetus' well-being, infant's birth, and the next steps planned for the care of infant and mother.

(4) With labor onset and/or upon the mother's hospital admission to Labor and Delivery, a well-trained, emotionally attuned staff person familiar to and/or chosen by the family, (from among the Labor and Delivery staff, nursery staff, and/or antenatal staff, depending on the mother's prior care and expected labor outcome), ensures that family members are well-informed, sensitively supported, and up-to-date regarding the progress of the labor, the mother and fetus' well-being, the infant's birth, and the next steps planned for the care of infant and mother.

(5) With labor onset and/or upon the mother's hospital admission to Labor and Delivery, a well-trained, emotionally attuned staff person who may also be a NIDCAP Professional familiar to and/or chosen by the family (from among the Labor and Delivery staff, nursery staff, and/or antenatal staff, depending on the mother's prior care, personal desire, and expected labor outcome), will ensure that all family members are sensitively supported, well-informed and continuously up-to-date, regarding the progress of the labor, the mother and fetus' well-being, the infant's birth and the next steps planned for the care of infant and mother.

2. Developmental Support at the Time of Delivery

(1) Families are sent to the waiting room and are informed of the birth of the infant once the infant is stabilized and the mother is well-established in the recovery room or the recovery phase.

(2) Family members, waiting in the Labor and Delivery Suite's waiting areas receive multiple messages about the progress of labor from different professionals, paraprofessionals and/or clerk staff. Information received may conflict. The messengers' identity and official role are unknown to the family, unless the family specifically requests this information. On special request, and with special permission at the discretion of the obstetrician, the infant's father or another person, designated by the mother or the hospital, may attend the labor and birth as long as it proceeds without complications.

(3) The infant's father or another person designated by the mother is encouraged to attend the mother's labor and the infant's birth, unless the mother specifically request that she wishes to be alone. One person is designated from among the Labor and Delivery staff and/or antenatal staff, who ensure that the father or another significant person is

informed intermittently of the progress of labor and delivery and the birth of the infant.

(4) The infant's father and/or another person or persons designated by the mother are sensitively encouraged, and invited to attend the mother's labor and the infant's birth, and are supported during their attendance to the mother's labor and the infant's birth. Should the mother specifically have requested that she wishes to be alone, a specially trained professional labor support attendant will assist and attend to and support the mother during labor and the infant's delivery process and birth. Another specifically designated person from among the Labor and Delivery staff and/or antenatal staff ensures that the father and/or other significant person(s) are informed reliably of the progress of labor and delivery and the birth of the infant.

(5) The infant's father and/or another person or persons designated by the mother are invited, encouraged and well-supported throughout their attendance and support to the mother's labor and the infant's birth by a psychologically well-trained and sensitively attuned professional, who may be also a NIDCAP-Professional. Should the mother specifically request that she wishes to be alone, a specially trained professional labor attendant, who also maybe a NIDCAP Professional, will assist, attend to, and support the mother during labor and the infant's delivery process and birth. Another specifically designated, psychologically well-trained and sensitively attuned professional, who may be also a NIDCAP-Professional, from among the Labor and Delivery staff and/or antenatal staff, ensures that the father and/or other significant person(s) are informed reliably of the progress of labor and delivery and the birth of the infant.

3. Nursery Support Staff

(1) Nursery support staff members, including receptionists, administrative assistants, housekeeping staff, engineering staff and others are well trained and skilled in their specific work arena. The realization of the effect and importance of their actions, interactions and bearing, and the ways they execute their tasks, in relationship to the care and well-being of the infants and families in the nursery are left up to the sensitivity of individual support staff members.

(2) Nursery support staff, upon hire, receives a session or two of sensitivity orientation and training, regarding the effect and importance of their actions, interactions and their bearing, and the ways they execute their tasks, regarding the care and well-being of the infants and families in the nursery. After this orientation session, it is left up to the individual support staff member in how to interpret and integrate this information in their daily work. Follow-up and efforts at performance improvement occur only in the case of significant violation of appropriate behavior.

(3) Nursery support staff, upon hire, receives several educational sessions, at least one of which is an on-site mentoring session regarding sensitivity orientation and training on the effect and importance of their actions, interactions and bearing, and the ways they execute their tasks, in relationship to the care and well-being of the infants and families in the nursery. It is made clear that their performance in these areas is a formal expectation of

their work. After these initial orientation sessions, they receive official feedback regarding these areas of their work at least as part of their annual performance review. Efforts at performance improvement occur when performance is less than expected, and/or in the case of significant violation of appropriate behavior. Recurrences of significant violations become reasons for dismissal.

(4) Nursery support staff are informed in the course of the interview and hiring process that their actions, interactions and bearing, and the way they execute their tasks, are of great significance for the well-being of the families and infants. Once hired, they receive several introductory sessions and regularly scheduled on-site mentoring in sensitivity orientation and training, regarding the important effect they have on the care and well-being of the infants and families in the nursery. It is made clear that performance regarding these areas is a formal expectation of their work. The annual performance review process is an opportunity for special recognition and promotion of excellence in these areas. The goals include sensitive, respectful and forthcoming bearing, communications, and conduct of all support staff in the nursery with respect to infants and families' rights, dignity and individuality. Support staff are expected to be quiet and dignified around infants, parents and families at all times; helpful and forthcoming, yet very aware of their specific role and tasks. Guidance, emotional support and education, as well as sensitivity training, are provided regularly throughout the year. Support staff are valued members of the nursery team.

(5) Expectations regarding the effect and importance of support staff's actions, interactions and bearing, and the ways they execute their tasks in relationship to the care and well-being of the infants and families in the nursery, and the other staff, are an integral part of the job descriptions and hiring process for the respective positions. It is made clear to applicants that performance regarding these areas is a formal continued expectation of their work. The annual performance review process is an opportunity for special recognition and promotion of excellence in these areas. The goal is sensitive, respectful and forthcoming bearing, communications and conduct of all support staff in the nursery with respect to infants and families' rights, dignity and individuality, and with respect to the other professionals in the nursery. Several introductory sessions and regularly scheduled on-site mentoring and feedback sessions of sensitivity orientation and training are provided. Each support staff member forms a relationship with their assigned mentor from the developmental professional team. This person is their readily available resource for feedback and support. Their technical supervisors in the larger hospital system are well schooled in the special aspects and importance of these roles. The hospital takes pride that all support staff throughout the hospital is knowledgeable and schooled in their respective patient areas' special aspects and expectations. Hospital-wide support staff typically exceeds and excels the institutional and departmental expectations. Support staff in the nursery are expected to be at all times especially considerate, dignified, calm and quiet around infants, parents and families, and also around other staff and professionals; to be helpful and forthcoming, and simultaneously very aware of their specific roles. Guidance, emotional support and education, as well as sensitivity training, are provided regularly throughout the year. Opportunity for staff-initiated reflective and special problem solving is always available, and mentors and supervisors alike welcome requests for support and

education. Support staff members are highly valued, respected, acknowledged and celebrated members of the nursery team and the hospital community.

4. Parent Support Groups

(1) Efforts at establishment of a parent group are absent or sporadic at best. Goals, objectives and agenda, as well as group leaders, change frequently and/or postpone the process repeatedly.

(2) A parent group is offered on an at least monthly and perhaps weekly basis; it is typically more a conversation group than a meeting with a formal agenda. A parent or a nurse may open and close the meeting.

(3) A parent group is offered at least weekly. A parent and a staff member decide a topic for the week and post it. The meeting is open to current nursery families and staff. Tasty, nutritious snacks are provided by the nursery.

(4) A parent group is held weekly and is directed by a designated nursery staff member and one of the NIDCAP Professionals or a psychologist. Topics are jointly decided upon, and range from information sharing to emotional support and discussion hours. Both current nursery families and "graduate" nursery families may participate. Families are always welcome and encouraged to raise other issues, make suggestions for other and/or additional activities and express their desires for improvements in the nursery.

(5) A well-organized parent group is held weekly in a tastefully appointed room near or within the nursery. The room and furniture are comfortable, appealing, and supportive. A designated nursery staff team of a nurse and a neonatologist as well as one of the NIDCAP Professionals and/or a mental health professional, and a former and current parent as indicated, form the parent group organization team. At least the former nursery parent and the NIDCAP or mental health professional has formal training in group leadership skills. Topics are decided upon jointly. Thoughts and wishes are submitted to the team from parents and staff in the nursery, and may range from information sharing, to emotional support topics, follow-up topics, and discussion/conversation hours. Both current nursery families and "graduate" nursery families are invited and encouraged to participate. Families are encouraged and invited to raise issues, make suggestions for other and/or additional activities, and express their desires for choice of topics and improvements in the nursery.

5. Informal and Nursery-Sponsored Parent-to-Parent Support Opportunities

(1) Opportunities for parent-to-parent support arise informally, in chance meetings in the scrub area, coatroom, hallway, neighboring bed space, cafeteria, library, hospital-hotel and parent guesthouse.

(2) Opportunities for parent-to-parent support arise informally in places as mentioned above, in the designated parent lounge and/or parent dining room, and in the regularly scheduled parent group meetings.

(3) Opportunities for parent-to-parent support arise in the formal and informal parent support sessions led by professionals, and in special parent activities that the nursery sponsors, such as: scrap-booking, journaling, photo book construction, secure website updates of their infants' stories and progress, quilting, sewing and knitting circles, family gatherings, monthly infant achievement and milestone celebrations, and others.

(4) Opportunities for parent-to-parent support arise in the formal and informal parent support sessions led by professionals, and in the special parent activities that the nursery sponsors, such as: scrap-booking, journaling, photo book construction, secure website updates of their infants' stories and progress, quilting, sewing and knitting circles, family gatherings, monthly infant achievement and milestone celebrations, and others. Additionally the nursery and hospital sponsor a parent movie night and reading club, an annual or semiannual family reunion, a parent and family garden and plant activities, and others.

(5) Opportunities for parent-to-parent support arise from a rich number of ongoing formal and informal parent support sessions and activities, as listed above. Additionally there are breastfeeding classes; individualized smoking cessation services, supports and specialists; special father groups and group activities; festive regularly scheduled family afternoon tea and dinner events; nutrition, exercise and stress management events; spiritual and religious events; home improvement and repair gatherings (e.g., car beds, breast pumps, carriages and strollers, cribs, and high chairs, among others). There is a special family shop run by skilled staff for parents and other family members to repair, upgrade, renovate, and/or build from scratch infant furniture and equipment in preparation of the infants' home coming. Cooking and nutritious infant food selection and preparation classes and workshops are offered. Swimming, massage, sauna and other facilities have special parent and family hours and days. Activity and opportunity facilitators may be graduate parents, knowledgeable hospital volunteers, and/or skilled professionals, whom the hospital contracts or hires for the purpose of parent and family support and activities. Community Parent-to-Parent groups are invited to send representatives. There are a number of well-appointed comfortable public and private areas within and near the nursery, where parents may share ideas, learn about one another and the opportunities available, and gather for informal conversation, comfort, and support.

6. Inclusion of Siblings in the Nursery and in the Infant's and Family's Care

(1) Siblings are prohibited from entering the nursery setting.

(2) Siblings, above a certain age, may enter the nursery under the express supervision of a parent and a staff escort, and visit the infant on designated days and times and for specific limited durations. They must be screened in advance for any evidence of infection; must scrub, and wear a mask and gown; and/or may not touch the infant. Staff at any time may curtail the visit of a sibling.

(3) Siblings are included in various though often inconsistent ways depending on the respective staff on duty. They may only be included if the infant has been hospitalized long-term or is dying; participation may include brief holding, feeding, diaper changing, etc.; They must have passed a screen for any evidence of infection, and must scrub. Parents are responsible for the siblings' supervision, while the sibling is in the nursery. Staff at any time may suggest that the sibling's visit should be ended.

(4) Siblings are included consistently in visiting the infant when the family so chooses, as long as the sibling is free of any signs of infection. The sibling is shown how to scrub and is supported in participating in caring for the infant, as deemed appropriate by the parents and primary caregivers. Staff are facilitative and encouraging of the sibling's engagement with the infant, and praises the sibling for actions and support well done. Staff may support the sibling in an activity such as coloring, drawing a picture, and or writing a message for the infant. Staff encourage the siblings to come back to be with the infant again.

(5) Siblings are always welcome in the nursery and are encouraged to participate in caregiving, and to talk about the nursery, their baby, and themselves. There is special size-appropriate furniture and other supports for young siblings (e.g., sibling rocking chairs and recliners, foot stools, etc.). Designated staff are available to support siblings to feel comfortable in the nursery and in helping care for the infant. They are also available to support the sibling when the sibling has reached his or her limit of attention and endurance. They have supervised, well-organized special activities, and/or places for rest to which they may accompany the sibling. Should the sibling desire to stay closer to the parent there is a staff person designated to support the sibling, while the parent continues to care for and be with the infant.

7. Availability of Sibling Care Spaces

(1) Siblings may visit the infant only when one of the parents or a family member is available to supervise the sibling, once the sibling leaves the care area.

(2) A special area within the nursery or the nursery waiting room is furnished for child visitors and siblings, who must however be supervised at all times by a family member.

(3) A special area within the nursery or near the nursery area is attractively furnished for child visitors and siblings. Trained childcare staff is available at regularly scheduled times two or three times a week to support and supervise child visitors and siblings. The children must be free of any sign of infection, and must wash their hands. They must be signed in with their name, and date of birth, and the parent and/or parent-designated family member or friend's name and parent's signature, who is to receive the child at the end of the session. Only the parent or designated adult may retrieve the child at the appointed pick-up time.

(4) A special safe and secure area within the nursery or near the nursery area is attractively furnished for child visitors and siblings. Trained childcare staff is available at regularly

scheduled times, of at least two hour durations every day of the week, to support and supervise child visitors and siblings. There are nap and play facilities within the area, as well as well-chosen books and toys. The children must be free of any sign of infection, and must wash their hands. They must be signed in with their name, and date of birth, and the parent and/or parent-designated family member or friend's name and parent's signature, who is bringing the child and who is to receive the child at the end of the session. Only the parent or parent designated adult may retrieve the child at the appointed pick-up time.

(5) A special safe and secure area within the nursery or near the nursery area is attractively furnished for child visitors and siblings. Trained salaried childcare staff are available on a 24-hour basis every day of the week to support and supervise child visitors and siblings. Nap and play facilities exist within the area, as do well-chosen books and toys, and homework facilities exist for school age children. The children must be free of any sign of infection, and must wash their hands. Children with mild colds, etc., receive care in specialized child support areas, guarded against the spread of infection. Each child must be signed in with the child's name, date of birth, the name of the parent and/or parent or parent designated adult, and that person's signature and a contact telephone number. Only the parent or parent designated adult who is signed in may retrieve the child at the agreed upon pick-up time. In case of required time extension this is readily accomplished through nursery staff members, who communicate with the childcare facilitators. The trained child care facilitators are well supervised by a senior child life specialist or childhood educator, who is experienced and knowledgeable in staff training and supervision, as well as in crisis support for infants, children and adolescents. The childcare professionals have resources available for special referrals, consultations, continuing education, and emergency medical and mental health services for acute, unusual circumstances. The childcare facility is an integral well-supported component of the nursery.

8. Bereavement Support for Families at the Loss of their Fetus or Infant

(1) When a family loses an infant, or the infant is stillborn, the medical aspects such as death certificate, request for autopsy etc. are in place. The infant's body is removed from the delivery room or the nursery. The infant's body is considered the property of the medical system to decide with as they see fit. The mother receives postpartum medical care on the postpartum floor. The obstetrician and/or neonatologist may express their condolences. If the infant was admitted to the nursery prior to death the family receives a death certificate. The nursery lacks any bereavement services or supports for families of infants who die in the nursery. It is up to the family how they wish to proceed after the mother is discharged, or when the family leaves the hospital.

(2) There is a protocol in place when an infant is likely to die and/or a "do not resuscitate" (DNR) order has been decided upon. The parents are called in prior to the anticipated death, and are supported to be with the infant in a separate part of the nursery, reserved for death and dying. Should they wish the infant to receive their religious or culture's customary last rites, nursery staff calls on the hospital pastoral services such as a chaplain, rabbi, or mullah on-call service to provide such support, as available within the hospital.

The nursery staff is sensitive to the gravity of the situation and staff members monitor their voices and behavior to be appropriate to the situation. Once the infant has passed away, the infant is taken to autopsy; the parents receive the condolences of the staff and if available a photo of their infant or other memento such as a blanket. They receive the death certificate upon leaving the hospital. Should the family insist on a funeral, the infant's body is transferred, at the family's expense to a local funeral service or institute which, from that point forward, will handle the arrangements. The family may receive a list of counselors and/or support groups, in case they wish to avail themselves of any services. In the case of a perinatal death and or stillbirth, the infant's body is considered the property of the hospital, and removed from the labor and delivery floor. The mother is cared for on the partum floor and discharged when she is physically well enough.

(3) A structured network of anticipatory and follow-up support is in place surrounding the expectation of the death of a fetus or infant. Parents and other family members including siblings are invited to be with the infant in the last days or hours, throughout the fetus' or infant's final hours, and to remain with the fetus or infant for as long as they wish. A tastefully furnished private room or area is available for the family's leave-taking from the fetus or infant. Specially trained nursery and/or postpartum staff care for the parents and family members. Any religious ceremony the family wishes will be accommodated to the best of the available services. Community religious and spiritual support persons, on request of the family, will be included in the process. The family will have the option to decline an autopsy and to receive support with making funeral arrangements. They will receive information on counseling and be invited to avail themselves at any time of the nursery or perinatal bereavement support group that is part of the hospital services. Photographs of the fetus or infant, foot prints, blankets, stuffed animals, and any other mementos the family wishes, will be tasteful wrapped and presented in a special keepsake box. The death of one fetus or infant, in the situation of multiples, receives special support, in order to acknowledge the grieving and loss of one child while also supporting attachment and care of the other infant(s). Special counseling services and support staff are available to support families in such complex circumstances. Fetal death is treated as respectfully and seriously as infant death. A follow-up visit with the nursery bereavement specialist, the infant's nursing team and the obstetrician or neonatologist, who cared for the fetus or infant, is offered in six months, and a year after the death of a fetus or infant. The mother whose fetus or infant died, is cared for on a private antenatal or postpartum floor. Efforts are made to be sensitive to the mother's, father's and families' special grieving situation.

(4) A structured well thought-out network of services and trained staff assures support to parents, siblings and extended family in the event of anticipated and/or sudden death of a fetus, or an infant. The team functions as thoughtful and experienced advocates and supports for the family. An appropriate tastefully appointed space or room is set aside for the supportive process of accompanying the fetus or dying infant and the family. Cultural and religious services, ceremonies and special supports are welcome and integrated into the hospital setting. The family is assured of as much time as they wish to be with the fetus or infant in taking their leave. The family may choose from a number of special gowns and caps offered by the nursery for their infant, or they may bring a gown, suit and wrapping of their own choosing to dress the infant for this last journey. Siblings are encouraged and

well supported to hold the infant and to participate in the farewell. To facilitate the realization of the infant's parting, a thoughtfully decorated and lined keepsake box and/or album holding pictures and mementos of the family's choosing and/or those suggested by the support staff is part of the transition ritual. The staff will also take leave of the infant and provide comfort to the family. Upon the parents' desire staff may attend the funeral or service that the family may arrange. Opportunity for follow-up visit to the nursery or post-partum service and bereavement counselor, as well as meetings with the obstetrician, neonatologist and nurses who cared for the fetus or the infant, will be offered at least at three, six and twelve months. The postpartum or nursery bereavement counselor and/or the obstetrician, or neonatologist initiates a call at these times to the family. The family may avail themselves at any time of the bereavement services and counseling that the hospital has in place. Similarly comprehensive and specially adapted well-thought-out arrangements and supports are in place for the loss of one fetus or infant when another infant survives. The mother, whose fetus or infant died, is cared for in a section of a private postpartum floor specially set aside for mothers and families in such circumstances.

(5) A comprehensive, sensitive and well-resourced, in terms of cultural and religious practices and beliefs, network of services and a well trained staff assures support to parents, siblings and extended family in the event of an anticipated and/or sudden death of a fetus or an infant. The team members function as thoughtful and experienced advocates and supports for the family. An appropriate tastefully appointed private spacious room is set aside for the supportive process of accompanying the dying fetus or infant and the infant's family. Cultural and religious services, ceremonies and special supports are welcome and well-integrated into the hospital setting. The family is assured of as much time as they wish to hold, be with, and take leave of their fetus or infant. The parents and siblings are supported in bathing, dressing, wrapping and holding the fetus or infant. The family may choose from a number of special gowns and caps offered by the nursery for their infant, or they may bring a gown, suit, or wrapping of their own choosing to dress the infant for this last journey. Siblings are encouraged and well supported to participate in the farewell. To facilitate the realization of the infant's parting, a thoughtfully decorated and lined keepsake box and/or album holding pictures and mementos of the family's choosing and/or those suggested by the support staff, in cases where the family feels too overwhelmed to make choices, is part of the transition ritual. The staff will also take leave of the fetus or infant and provide comfort to the family. Staff may attend the funeral or service the family may arrange for, upon the parents' desire. Opportunity for follow-up visit to the postpartum service or nursery and the bereavement counselor at the postpartum or nursery, as well as meetings with the obstetrician, neonatologist, and the nurses, who cared for the mother and fetus or infant, will be offered at least at three, six and twelve months, and again at two years after the infant's or fetus' death. The counselor and/or the neonatologist or obstetrician depending on the relationship, may initiate a call at these times to the family. The family may avail themselves at any time of the bereavement services and counseling that the hospital has in place. All families are invited to the annual hospital, postpartum and/or nursery - sponsored memorial service for the infants and fetuses who have passed away in the past years. This service is festive and thoughtfully implemented. The names of the infants and fetuses who passed away in the preceding year are read aloud. Each family receives a memento in honor of the infant or fetus they lost. The hospital also maintains a special, calm and beautiful memorial garden,

where families and staff may come at any time to reflect and gain strengths in peaceful surroundings. Professional counseling and psychological support is available and encouraged whenever the family is ready to take advantage of such opportunities for healing. The mother, whose fetus or infant died, is cared for in a section of a private postpartum floor specially set aside for mothers and families in such circumstances. It is furnished tastefully with quiet sitting areas and private grieving spaces or a meditation grieving room. Specially trained staff supports the parents and families, and a counselor specialized in grieving processes supports the psychological well-being of the mother, father and other family members as indicated. One of the counselors is available 24 hours on the floor. All efforts by staff and professionals are made to be sensitive to each mother's and father's, and each family's special grieving situation.

D. Family Resources

1. Family Resource Library

   (1) Families who wish information regarding medical aspects, preterm care, or other pertinent topics must access community resources.

   (2) Families who wish information regarding medical aspects, preterm care, or other pertinent topics may access materials in a file drawer or on a shelf within the nursery. They must obtain permission. A staff member signs out the materials and requests that they be returned before the family leaves the nursery that day.

   (3) Families, who wish medical, preterm care, or other pertinent information, may access the family resource library in the nursery. It is well stocked and materials are easily identified and located. Several hours a week a librarian may be available to assist family members. A computer is also available with free access to the Internet.

   (4) Families, who wish medical, preterm care, or other pertinent information, may access the well-furnished, comfortable, and well-stocked family resource library, which is easily accessible from the nursery. It has a rich stock of up-to-date reading and audio-visual materials. Several computers with free Internet access are available for use by families at any time. A knowledgeable and forthcoming librarian, who is available daily and several evenings in the course of the week, staffs the library.

   (5) Families, who wish medical, preterm care, or other pertinent information, may access the well-furnished, comfortable, and well-stocked family resource library, which is easily accessible from the nursery. It has a rich stock of up-to-date reading and audio-visual materials. Infant and children's books for the infants in the nursery and for siblings are in stock also, as are a selection of high-quality trade books for adults. Several computers with free Internet access are available at all times for use by families. The library is staffed by knowledgeable and forthcoming librarians, who are available daily, as well as in the evening, and on the weekend. The library is open on a 24-hour basis. Copying and printing machines, free of cost, are well maintained. During library staff hours the staff also provides such services.

2. Financial Support for Maternity and Paternity Leaves; Childcare and Homemaker Support Services

   (1) Government and/or employer regulations for the mother and father's maternity/paternity leaves are the same as apply to the birth of a healthy fullterm child. Childcare or homemaker services for siblings at home or in the care of an elderly parent, while the infant is hospitalized in the nursery, and after discharge, are left up to the family's resources.

   (2) Government and/or employer regulations for the mother's and father's maternity/paternity leaves are the same as apply to the birth of a healthy fullterm child. Limited child care and homemaker services may be available, depending on the medical situation of the infant once discharged (e.g., an infant, who requires continued gavage feeding, suctioning, difficult to regulate oxygen, etc). may qualify for several hours/day or week of specialty care services.

   (3) Government and/or employer regulations for the mother and father's maternity/paternity leaves are adjusted to be more extensive in the case of the birth of a preterm-born child, who has documented special health care requirements that continue beyond discharge from the nursery. Childcare and homemaker services during and after hospitalization are available through various agencies and reimbursed on application and demonstration of special requirements.

   (4) Government and/or employer regulations for the mother and father's maternity/paternity leaves are adjusted to be more extensive in the case of the birth of a preterm-born child. Throughout the child's hospitalization the parents' salaries remain unchanged. Once the child is discharged from the hospital, maternity/paternity benefits apply and may be extended upon documentation of the child's vulnerability and a licensed health and development provider's recommendation for continued home parent care. In the case of the child's special health care needs, the pediatrician's or other medical specialist's recommendations suffice. While the infant is hospitalized and after discharge, the family's case or social worker assists the family with access to childcare and homemaker services (e.g., meal preparation, laundry, grocery shopping, respite care and transportation) that are supported on a sliding scale. The nursery provides staff and expertise to facilitate the application process in a proactive timely manner and follows through on appropriate implementation. The Continuing Care Department, or its equivalent at the care hospital, assures and follows up on the appropriateness of services.

   (5) Government and/or employer regulations for the mother and father's maternity/paternity leaves are adjusted to be generous in the case of the birth of a preterm-born child. Throughout the child's hospitalization and until the child is school age at least one of the parent's salaries remains the same as during prior employment, including the annual adjustments for cost of living increases. The second salary, or salary equivalent financial support, continues on a reduced level after the child reaches one year corrected age. In the case of a single mother her salary, or salary-equivalent financial support, continues at the original level, including annual adjustments for cost of living increases. Once the child is discharged from the hospital, and upon documentation of the child's continued unusual

vulnerability by a licensed health and development provider, and/or the child's continued special health care requirements by a pediatrician or other medical specialist, the family additionally qualifies for a significant monthly subsidy in order to facilitate the parent's opportunity to cover additional special costs associated with provision of optimal care. Additionally, while the infant is hospitalized and after discharge, childcare and homemaker services (e.g., meal preparation, laundry, grocery shopping, respite care, vacation coverage, and transportation supports) are available. The nursery provides staff and expertise to facilitate the application process for the services and benefits in a proactive timely manner and follows through on appropriate implementation. The Continuing Care Department or its equivalent at the care hospital assures and follows up on the seamless implementation of appropriate and comprehensive services and benefits.

3. Professional Mental Health and Psychological Support Services

(1) Professional counseling, psychological and/or psychiatric services for parents, siblings and/or other family members are rare, expensive, and typically difficult to obtain. It is left entirely up to the family to locate and pay for such services. A significant stigma is associated with the utilization of such services.

(2) Limited professional counseling, psychological and/or psychiatric services for parents, siblings and/or other family members are available in the community. They are typically very expensive. Only upon formal diagnosis of a mental health condition is reimbursement available from health insurance or other agencies. It is left up to the family to apply for such services, in which case the diagnosis must enter their record and has implications for future employment. Utilization of such services on private basis is typically kept strictly confidential.

(3) Professional counseling, psychological and/or psychiatric services for parents, siblings and/or other family members are available on a short term individual or group basis at the hospital and in the community. Most insurance carriers may reimburse a brief course. The nursery offers limited acute support services through a crisis counselor or social worker. Additional services must be obtained at personal cost in the community. The nursery offers suggestions to available resources. The stigma associated with more prolonged services in the community influences parents' considerations of making use of such services.

(4) Professional counseling, psychological and/or psychiatric services for parents, siblings and/or other family members are readily available on an individual or group basis at the hospital and in the community. They are reimbursed at close to, or the same rates as other health care services. The nursery offers acute and long-term support and formal psychological and psychiatric services through crisis counselors, social workers and/or psychologists and psychiatrists, well-trained and experienced in trauma and the experience of the birth of a preterm infant. The nursery is supportive of parents and families who wish to avail themselves of the existing services and/or of professional services in the community. The hospital and nursery mental health staff is available to assist with appropriate referrals and transitions. It is an expectation that a significant portion of nursery families will wish and/or are encouraged to receive such professional services.

(5) Professional counseling, psychological and/or psychiatric services for parents, siblings and/or other family members are readily available on an individual or group basis at the hospital and the community. They are reimbursed at the same or better rates compared to other health care services, and/or are fully financially supported by hospital resources. The nursery offers acute and long-term support and formal psychological and psychiatric services through crisis counselors, social workers and/or psychologists and psychiatrists, well-trained and experienced in trauma and the experience of the birth of a preterm infant. It is an expectation that all nursery parents and families avail themselves of such services. They are expected and required by hospital and government regulation for newborn intensive care nurseries. The nursery and hospital are equally supportive of parents and families who wish to avail themselves of alternative, approved mental health professionals' services in the community, especially if this facilitates their access to such services. Communities and the society at large expect and count on skilled mental health specialty services for families with early-born or otherwise at risk infants and children. The mental health and well-being of such and all other families is a high public priority. Much of the mental health work is anticipatory and preventive, and well-supported by the government, employers and taxpayer.

4. Resources for Families in High-Risk Social Circumstances

(1) Families at high risk socially (e.g., severe poverty, homelessness, untreated significant psychiatric illness, drug use, and/or violence) early on in their infant's nursery stay, lose custody of their child, and the child is placed in protective services. Depending on the severity of their condition, they may be barred from entering the nursery on their own. Rehabilitation if any is left up to community services, should they be available.

(2) Families at high risk socially (e.g., severe poverty, homelessness, untreated significant psychiatric illness, drug use and/or violence) are admitted to rehabilitation services. They are paired with a caseworker and/or social worker who may attempt to connect the parents to available community services. Depending on the parent's progress, the parent will be supported to visit the infant in the nursery. In cases of violence, a hospital security officer or other safety professional must accompany the parents. Should rehabilitation fail in the course of time of the infant's stay in the nursery, the infant is placed in protective services, and discharged to a medical or other foster home, depending on the infant's health issues. Any further rehabilitation for the parents is left up to community services, should they be available. Housing issues, in the absence of other issues, are attempted to be resolved with at least temporary housing or a shelter for homeless parents and infants; if these are successful and the parent is found capable of caring for the infant, the infant will be discharged to the parent.

(3) Families at high risk socially (e.g., severe poverty, homelessness, untreated significant psychiatric illness, drug use and/or violence) are connected on admission to social and rehabilitation services. They are paired with a nursery caseworker and/or social worker, who specialize in service and resource identification for high-risk infants and parents. Every effort will be directed to prevent ultimate separation of infant and parent. Depending on

the nature and severity of the challenges, extended family may be recruited, where available and willing to assist the parents, and take on temporary custody of the infant. Depending on the parent's progress, the parent will be supported to visit and be with the infant as much as possible and supported to learn parenting skills and gain motivation to rise above the current challenges. Should the infant leave the hospital to be in the custody of the parent, follow-up and support services will be assured, to monitor and support continued success, and/or revisit the necessity of removal of the infant from the care of the parent.

(4) Families at high risk socially (e.g., severe poverty, homelessness, untreated significant psychiatric illness, drug use and/or violence) are immediately connected on the prenatal service, or on admission to the nursery to social and rehabilitation services. They are immediately paired with a nursery caseworker and social worker, who specialize in service and resource identification for high-risk infants and parents. Every effort will be directed to recruit and put in place comprehensive services and resources to prevent ultimate separation of infant and parent. Depending on the nature and severity of the challenges, a parent-infant foster family will be identified, especially when the parents' own families feel overly challenged to come to the aid of the parents and their infant. The parent-infant foster family will immediately begin to support the young parent and/or couple in their rehabilitation and in the responsibilities in caring for their infant. Depending on the progress and success of these efforts, the infant will leave the hospital in the care of the parents and family foster parents, until such time that the parents may graduate to function well on their own as parents. Follow-up and support services will be assured, to assist with, support and monitor continued rehabilitation and ultimate success. Should the barriers be too significant, the family foster parents will assume full custody of the infant, and attempt to support the parents' continued education and rehabilitation. Only when these efforts fail may the parents temporarily lose visitation rights and/or permanent custody of their infant.

(5) Community, school, employment, and health care services are extensive in support of young persons reaching child bearing age, who are at high risk socially, and confronted with challenges such as severe poverty, homelessness, unidentified significant psychiatric illness, drug use and/or violence. To the degree that it is feasible, preventive and early rehabilitative services are instituted to assure the safety and healthy adolescent and adult development of persons such threatened. Voluntary self-admission to rehabilitation homes and services is supported, promoted, and consistently rewarded. Should a person in such circumstances nevertheless become pregnant, significant support and rehabilitative services, as well as caregiving supportive homes specially schooled in the development of adults at risk, are made available to accompany the person's pregnancy. On admission to the hospital such a person will be immediately connected with the prenatal services available to prepare for optimal delivery. On admission to the nursery of a preterm or otherwise medically at-risk infant the nursery's social and rehabilitation services will additionally be made available and coordinated with existing services. System failures and missed opportunities will be identified and all efforts will be coordinated and directed to support the young parents to become competent in raising their infant. They immediately receive the services and advocacy of a specially skilled and trained nursery case worker and social worker, who specializes in additional service and resource identification for high risk

infants and parents. All efforts will be directed to put in place a comprehensive network of long-term services and resources that will assure the successful discharge of the infant into the care of well-rehabilitated and competent parents. Depending on the nature and severity of the challenges, a parent-infant foster family will be identified. This foster family will also support the parents in their rehabilitation and in the responsibilities in caring for their infant. Depending on the progress and success of these efforts, the infant will leave the hospital to be in the care of the parents and family foster parents, until such time that they may graduate to function well on their own as parents. Comprehensive follow-up and support services will be assured, to assist with, and support and monitor continued rehabilitation and ultimate success. Should the barriers be too significant the foster parents will assume full custody of the infant and attempt to support the parents' continued rehabilitation. Only when these efforts fail may the parents lose visitation rights and/or permanent custody of their infant.

E. Admissions and Discharge Planning

1. Hospital Admission Plan

    (1)   The parent typically arrives at the hospital in labor. Delivery is for most families, their first experience and/or contact with the hospital.

    (2)   Prenatal education and support, which may include topics of high-risk deliveries, prematurity, and the nursery, may be available from early on in the pregnancy.

    (3)   Prenatal education and support is readily available for all families. Parents are supported to access classes and supports for high-risk deliveries and parent and infant care.

    (4)   Prenatal education and support is available to all families. Families with identified high risk maternal and infant factors are offered individualized opportunities for ongoing education and support. The perinatal, antenatal, and newborn teams coordinate their support for the families and with one another. Nursery caregiving team representatives may meet with the family and develop a family caregiving plan upon the mother's admission to the hospital, prior to her infant's delivery. The nursery caregiving team may arrange these meetings on a case-by-case basis; the team may consist of social worker, counselor, and appropriate medical care providers. These meetings may occur on the prepartum floor for the hospitalized mothers and within the nursery when the mothers are ambulant. Fathers and other family members are encouraged and invited to be part of the meetings.

    (5)   Prenatal education and support are universally available to all families. Every family receives a family care plan in advance of the infant's delivery. This plan is intended to reflect the family's unique situation, including medical, psychological, physical, and social concerns. The family's pre-existing sources of support (e.g., medical, social, etc.) together with the hospital's perinatal, antenatal, and neonatal teams, continuously coordinate their support to the families and with one another. Specific nursery caregiving team members, such as the case manager, primary nurse, neonatologist, or physician sub-specialist as appropriate, and the social worker may meet with the family and develop a family

caregiving plan upon the mother's admission to the hospital, prior to her infant's delivery. The family's situation, including the mother's medical situation, may determine the location of these meetings. Opportunities for parents to receive parent-to-parent support are readily available.

2. Transport to the Nursery

(1) The infant may be delivered outside of a hospital (e.g., home, car, etc.) and brought without the mother to the emergency room of the hospital. Or the infant is met off-site by county volunteer paramedics and driven/flown to the hospital.

(2) The infant is delivered at a community hospital and is moved by a regional or hospital transport team to the nursery. A perinatal hospital transport team transfers the infant to the nursery. Parents sign a consent, which contains the address and phone number of the hospital, releasing their infant to be transferred. The doctor may call to inform the family of the infant's condition upon arrival at the nursery.

(3) The infant is delivered at a community hospital and is transferred to the nursery appropriate to the infant's condition by an appropriately specialized transport team. This team provides the family with a packet of materials that may include photographs of the transfer hospital and nursery, a map with directions and travel times, lodging information, and hospital and nursery telephone numbers. A photograph of the infant is taken and given to the family. A transport team member calls the parents to update them of their infant's arrival and status upon arrival in the nursery. The attending doctor will follow-up with more specific information regarding the infant's medical condition and describe the plan for care.

(4) The infant is delivered at a community hospital and is transferred by a specialized transport team. The team may bring the parent(s) with them, including flying them with the infant and team. Emotional support, education, and supportive written materials are provided to the parents. Parents may include items such as blankets or stuffed animals to accompany their infant to the nursery. They are also given an item such as a stuffed animal to hold onto until they may bring it to their infant in the nursery. Continued education, with regular caregiving workshops, and emotional support is provided to hospital staff at outlying hospitals. Continued communication is available and provided to families and caregiving staff. The nursery transport team provides debriefings and updates of the infant's condition to the family and the community hospital's staff and physicians. Once the mother is well enough to be discharged, medical social workers may facilitate lodging for the family near the nursery.

(5) The infant is delivered at a community hospital and is escorted by a specialized transport team, with an internal transport facilitator/escort, to the family's bed space within the nursery. At no expense to the family, the infant's mother may be transferred and receive care with the infant at the new hospital. The infant may travel (e.g., ambulance, fixed wing airplane, helicopter) with the parent, while being held skin-to-skin. Ear protections and comfort are provided. The family's pathway assures privacy and efficiency, including an elevator that opens directly into the nursery. The infant and parent's transport experience

is safe, calm and smooth. Emotional support, reassurance and education are continually available to the family and the nursery caregiving team. The community hospital and nursery work together as an effective caregiving team, with ongoing and regular communications, in-services, and collaborations.

3. Family Involvement in the Discharge Plan

   (1) Families do not participate in the development of the discharge plan; minimal discharge teaching is provided; referrals are made based on staff identified infant and family needs; families are informed of plans at the time of discharge; a copy of the plan goes in the infant's chart and may or may not be given to the family.

   (2) Families have minimal input into and participate minimally in the discharge process. Care after discharge is discussed with families close to or at the time of discharge. Families do not participate in development of the plans but are informed of the nursery team's plans for their infants. Families may receive a hard copy of the plan devised for their infant.

   (3) Families have some input into and participate to some extent in the discharge process, though this may be inconsistent. Nursery staff develop discharge plans and parents have the opportunity to review and revise the plan prior to discharge.

   (4) Families are consistently involved in the discharge process. Ongoing assessments of a family's situation are performed by the nursery staff in collaboration with the family. Assessments include family identified, as well as staff identified, strengths, requirements, and resources. To the extent they choose, families participate in the development of written discharge plans, including determination of the types of referrals made, timing of referrals, and how/where initial contacts are made.

   (5) Family involvement in the discharge process, including discussions about discharge timing and resources, is a continuous process throughout the infants' hospitalizations. Families have opportunities to meet with individuals from referring agencies and when appropriate, to visit referral programs, prior to discharge. Families assist in identifying pre-discharge requirements in preparation for discharge. Families receive hard and/or electronic copies of the discharge plan and help to determine who else should receive copies of this plan.

4. Written Plans for Family Support at Discharge

   (1) The written discharge plan addresses the medical needs of the infant; no information on family strengths, needs, or concerns is included.

   (2) The written discharge plan mainly addresses infant medical needs; it may include family issues; family needs and resources may be identified but no procedures are put in place for family participation. Comprehensive planning for resources and family support occurs only for families involved with protective services or for families in extreme situations

(3) The written discharge plan includes, aside from the infant's medical needs, a description of the family's situation; staff has some knowledge of a range of basic family supports including social service agencies, homemaking services, community health agencies, early intervention programs, and financial assistance. The family's specific situation is discussed with each family and the family has the opportunity to review and revise the discharge plan before discharge.

(4) Comprehensive resource planning occurs for each family based on family identified, as well as staff identified needs, well before discharge; staff is knowledgeable about a comprehensive array of family support services including family resource programs, respite care, child care, parent-to-parent programs, early intervention programs, and family counseling.

(5) Comprehensive resource planning occurs for each family based on family identified, as well as staff identified needs, well before discharge; families additionally are provided with a supportive transition program of home visiting and telephone support during the first weeks at home. Well before discharge, the family reviews the care plan with the staff; the family is seen as a source of information and as an equal partner in the care and discharge planning for the infant. Comprehensive services are assured in support of infant and family upon and well beyond discharge.

F. Decision Making

1. Validation of Parent and Family Effectiveness and Competence

(1) The staff may actively and consistently discourages parents from participation in their infant's care.

(2) The staff may encourage parents to bring clothes, toys, and pictures; and assures parents that they will take excellent care of their infant, and the parents should concern themselves with their own well-being. Occasionally the staff guides the parents in performing a few perfunctory or quite simple daily caregiving tasks.

(3) The staff in general encourages and guides parents in interpreting their infant's behavioral cues as well as in performing daily caregiving tasks and interactions. The staff refers to and conceptualizes the infant as foremost the parents' child and their own role as the parent's professional partners and helpers.

(4) The staff consistently encourages, invites and engages the parents to share with the staff their own observations of their infant. The staff encourages and acknowledges the parents' great importance and contribution to the infant's physical and emotional well-being. Moreover the staff incorporates all parent-suggested effective methods of soothing and caring for the infant, into the infant's care plans and their own caregiving.

(5) From admission on, the parents are the respected, valued, celebrated and cherished active collaborators and partners of the primary professional caregivers. The parents provide vital

information and important understanding and feedback, and a unique emotional investment in their infant that is of critical importance for both their and the professional caregivers' interaction with and care of the infant.

2. Family Meetings with Primary Caregiving Team

    (1) Family meetings, if at all, are held on an impromptu basis.

    (2) Family meetings are held weekly without advance notice; they also may be cancelled without notice.

    (3) Family meetings are held weekly with advance notice to families. Efforts are made to assure that at least one parent may be present.

    (4) Family meetings are held as indicated, at least weekly, with advance discussion of time and notice given to the parents. There is a group leader, preferably the primary nurse, who facilitates the meeting and ensures that the family's situation, perspective, and concerns are discussed.

    (5) Family meetings are held regularly at a time that makes it feasible for both parents to be present; there is a group leader, preferably the primary nurse, who facilitates the meeting and ensures that the family's situation, perspective, and concerns are discussed; a designated person on the team then takes charge of assuring that the issues and topics discussed are attended to and resolved satisfactorily. This person reports back at the next family meeting and identifies continued and new issues, successes and new developments; families are encouraged to also initiate meetings as they see appropriate to ensure the best care and outcome of their infants and themselves.

3. Family Participation on Decision Making Councils and Committees

    (1) There are no family members on any of the hospital decision-making councils. Hospital staff performs all nursery and individual infant planning.

    (2) There are no family members on any of the hospital decision-making councils; yet, a systematic and regular effort is made to obtain nursery family input through surveys, focus groups and/or advisory council participation.

    (3) There are at least a few family members on hospital decision-making councils. A systematic and regular effort is made to obtain nursery family input through surveys, focus groups and advisory council participation.

    (4) Family members are well represented on hospital decision-making councils. There is a systematic effort to solicit and assure continued input from a wide-variety of family groups, including former and current nursery parents.

(5) Family members are an integral part of hospital decision-making councils and have opportunities for leadership positions on such councils. There are ongoing efforts to seek input and feedback from families, who have had infants in the nursery, and from professionals, who support nursery families in the community.

4. Family Advisory Board

(1) Nursery policy and care implementation is always determined by nursery professionals.

(2) Nursery policy and care implementation that pertains to the nurturance of infants and their families may receive occasional incidental input from family members, who have had an infant in the nursery, from special focus groups, and/or from hospital selected parents' opinions.

(3) Nursery policy and care implementation as it pertains to the nurturance of infants and their families may be determined by regularly solicited input from family members, who have had an infant in the NICU. Nurseries may have suggestion boxes, utilize family surveys, and/or solicit post discharge family feedback.

(4) Nursery policy and care implementation, as it pertains to the nurturance of infants and their families, is determined in collaboration with a Family Advisory Board. This Board is made up of volunteer family members who discuss with, and regularly consult to, the nursery regarding family situations and experiences in the NICU.

(5) Nursery policy and care implementation as it pertains to the nurturance of infants and their families is collaboratively determined by the mutual interaction of the Family Advisory Board Members who serve on the multidisciplinary NICU Board. Family members on this Board represent families, who have had infants cared for in this NICU, and represent cultural and language diversity. They receive financial remuneration to serve on the Board. The family members on the Board are committed to represent all families. The Board develops goals and a mission statement in support of the best care provided in the NICU. Representatives of the Board regularly participate in NICU staff meetings, medical and nursing education efforts, and various interviews to facilitate dissemination of the collaborative family-professional staff model.

5. Family Representatives on the Nursery Leadership Team

(1) The Leadership Team consists exclusively of nursery professionals.

(2) The Leadership Team consists exclusively of nursery professionals, who occasionally may solicit family consultation on selected topics and issues.

(3) The Leadership Team consists of nursery professionals, who regularly seek family consultation on specific nursery topics and issues.

(4) The Leadership Team consists of nursery professionals and at least one representative family member. The family member is encouraged to contribute family issues and concerns to the team for discussion.

(5) The Leadership Team may include at least two family members, who attend the Leadership Team meetings regularly, and actively contribute to nursery decisions and goals. They may suggest changes regarding family issues and concerns in the nursery. Family members actively contribute to the review of caregiving policies and procedures. They facilitate input to and from other unit councils and committees, and may attend the parent group meetings on a regular basis in order to be in touch with the current family concerns in the nursery. The family members of the Leadership Team are compensated for their time investment, and in their capacity as Leadership Team members they may become part-or full-time employees of the hospital.

G. Category Summary Scale - Philosophy and Implementation of Care: Family

(1) All aspects of the philosophy and implementation of care are solely patient-focused.

(2) Most aspects of the philosophy and implementation of care are patient-focused. Families are conceptualized as visitors, with limited and prescribed roles in their infants' care.

(3) A number of aspects of the philosophy and implementation of care are patient-focused. Concepts of family-centered and developmental care are paired with patient-focused care. Family presence and participation is prescribed and specified.

(4) The majority of aspects of the philosophy and implementation of care emphasize family-centered, individualized, developmental care. Family presence and participation are actively facilitated. Parents are supported in their role as their infant's primary caregiver. Other family members and/or close persons as defined by the parent(s) are supported in their care of the respective infant and family throughout the infant's hospitalization.

(5) Family-centered, individualized, developmental care is the primary focus of all aspects of the philosophy and implementation of care.

IV. Philosophy and Implementation of Care: Professional and Staff Members, Health Care System

A. Philosophy, Composition, Training and Support

1. Mission Statement and Individualized, Developmentally Supportive, Family-Centered Care

(1) The nursery has a mission statement that broadly describes their approach to care.

(2) The nursery has a mission statement that broadly describes the goal of developmentally supportive, family-centered care.

(3) The nursery has a mission statement that describes developmentally supportive, family-centered care, with a focus on individual ingredients of a developmental approach.

(1) The nursery has a mission statement that specifically addresses individualized, developmentally supportive, family-centered care in the nursery, including aspects of infant and family care, staff education, composition and support, and clinical management.

(2) The nursery has a mission statement which clearly, consistently, and thoroughly addresses individualized, developmentally supportive, family-centered care across all aspects of the nursery including the physical environment, direct infant care, family support in the nursery with transition at discharge, staffing including composition, training and support, and clinical management including policy, staff supervision, and medical and developmental documentation. Furthermore, staff continually expand and refine the mission statement and the respective policies to reflect deeper understandings of individualized, developmentally supportive, and family-centered care.

2. Consistency of Nurse and Medical Caregivers

(1) There is a tradition of assigning caregivers based on administrative decisions rather than on infant and family parameters. Nurses may be assigned to infants based on patient census; there are a high number of open nurse positions; the nursery utilizes traveling, agency, and float pool nurses. A high number of nurses work only part-time. Medical staff including the attending physicians serves for one or two week rotations.

(2) There is an effort to provide some consistency of caregivers for infants and families in the nursery at least in the main professions of nursing and neonatology.

(3) There is moderate consistency of nursing and medical caregivers for infants and families.

(4) There is considerable consistency of caregivers, including consistent use of primary nursing, and only a small percentage of part-time nurses, and of agency nurses. Nurse shift rotations are limited. Medical rotations extend over at least one-month periods.

(5) There is high consistency of caregivers. The caregiving teams reliably have the opportunity to become well familiar with and supportive of each infant and family. Continuity of caregivers is assured by elaborate assignment schedules that are maintained to assure such continuity.

3. Integration of Caregiving Team

(1) Each individual caregiver, from nursery staff to consultants, plan and provide care according to their own decisions. Coordination is absent.

(2) Caregivers attempt to collaborate in the way they provide care, yet recommendations formed collaboratively are incorporated and acted upon inconsistently. Consultants (e.g., physical and occupational therapists, and physician specialists) may work independently of the nursing and medical staff. Consultations do not include recommendations in how treatments may be incorporated into care.

(3) Caregivers collaborate in the way they provide care; recommendations formed collaboratively are often incorporated. Nursery staff arranges case consultations with specialists and consultants. Specialists and consultants coordinate their services with the caregiving team, including the family.

(4) Caregivers continuously attempt to collaborate in the way they provide care; every effort is made to incorporate collaboratively formed recommendations. Different disciplines are mutually supportive of each other's goals and care of infants and their families. Care is consistently planned, structured and implemented through the caregiving team. Most of the specialists and consultants are well-informed members of the nursery caregiving team and share the same developmental philosophy, and goals for the integration of care.

(5) Caregivers continuously make every effort to collaborate in the ways they provide care; every effort is made to incorporate collaboratively formed recommendations. Disciplines are always mutually supportive of each other's goals and care of the infants and their families. Care is consistently planned, structured and implemented through the caregiving team. All of the specialists and consultants are integral, well-respected, and well-informed members of the nursery caregiving team, and share the same developmental philosophy and goals for the comprehensive integration of all care.

4. Neonatologists

(1) Staff neonatologists conduct medical rounds and make key medical care decisions.

(2) Staff neonatologists conduct medical rounds, make key medical care decisions, and may be available for family meetings.

(3) Staff neonatologists conduct medical rounds, make key medical care decisions, may be available for family meetings, and provide ongoing education and support to medical and nursing staff as indicated.

(4) Staff neonatologists conduct medical rounds, make key medical care decisions, and may conduct and/or are readily available for family meetings. Furthermore they provide continuous education support to other disciplines in the nursery, as well as to the families as indicated.

(5) Staff neonatologists conduct medical rounds, make key medical care decisions, may conduct and/or are readily available for family meetings, and are integral members of the infants' developmental care teams. They are leaders in supporting infants and their

families, and are available to interdisciplinary staff at all times to provide education and discuss proactively professional topics as well as infant care and family support issues.

5. Nursing Hiring Policy

   (1) A very high percentage of the nursing staff consists of nurses who have minimal experience in the specialty area appropriate for the newborns cared for in the nursery.

   (2) A high percentage of the nursing staff consists of nurses who have minimal experience in the specialty area appropriate for the newborns cared for in the nursery.

   (3) A number of the nursing staff are nurses who have little prior experience in the specialty area appropriate for the newborns cared for in the nursery.

   (4) Only a small percentage of the nursing staff has little prior experience in the specialty area appropriate for the newborns cared for in the nursery.

   (5) Only nurses with prior experience appropriate to the newborns cared for in the nursery are hired. In addition nurses with prior NIDCAP training and experience are preferentially hired.

6. Orientation of New Nurses to the Nursery

   (1) Goals for the orientation period are not specified. New nurses are randomly assigned to work with a variety of different staff members.

   (2) Basic goals for the orientation period are specified. New nurses are randomly assigned to work with a variety of staff members with minimal regard for the continuity and/or the learning of the new nurse.

   (3) Detailed goals for the orientation period are specified. A core group of staff members are identified, who precept new nurses during their orientation. The orientation period is of a fixed length of time.

   (4) Detailed goals with criteria for meeting them are specified for the orientation period. New nurses work with one to two staff nurses who have received special training as preceptors. The new nurses' learning is assessed weekly and assignments are geared to meet their needs and are given priority within the unit. Orientation takes a minimum of a month and may be extended up to three months depending on the new nurse's progress and proficiency.

   (5) Detailed goals with criteria for meeting them are clearly and comprehensively specified. New nurses work with trained preceptors, learning needs are assessed and orientation extends for a period of one to three months. In addition, special courses and mentorship consultations and a differentiated salary exist for preceptors.

7. Nursing Mentorship Support

    (1) There is little guidance and support available for new nurses from experienced nurses.

    (2) There is some technical guidance and support available for new nurses from more experienced nurses.

    (3) There is technical guidance and clinical interactive support available for new and established nurses wishing advice and support from more experienced nurses.

    (4) There is consistent technical guidance and clinical interactive support available for new and established nurses from more experienced nurses. Assignment of an individual partner and mentorship is an option on request from a new or an established nurse.

    (5) There is ongoing technical guidance and clinical care and interaction support available for all nurses from more experienced nurses. Mentorship and partnership relationships are established for all nurses so that each nurse has a trusted partner and mentor with whom to discuss special questions and topics, and receive proactive guidance and support.

8. Staff Nurses

    (3) Staff nurses provide care independent and in isolation of other disciplines.

    (4) Only under extreme circumstances will staff nurses seek consultations from other disciplines and integrate the feedback received into their caregiving.

    (5) Staff nurses are integral members of the interdisciplinary caregiving team and integrate communication with and feedback from the other team members into their care plans and caregiving.

    (4) Staff nurses contribute actively to and are highly valued members of the interdisciplinary caregiving team; they implement and facilitate implementation of decided upon actions and interventions into the comprehensive developmental approaches to all care for all infants.

    (5) Staff nurses consistently integrate and implement collaboratively comprehensive, interdisciplinary developmental approaches into all aspects of infant and family care.

9. Therapists including Occupational, Physical, and Speech/ Language Therapists

    (1) The nursery professional team consists exclusively of physicians and nurses.

    (2) The nursery professional team may at times include therapists that have rotating assignments throughout the hospital including the nursery; their involvement in the nursery is infrequent and/or irregular or limited to a request for consultation in rare cases.

(3) The nursery professional team includes therapists that rotate throughout the hospital; they are available to the nursery on a regular basis and predetermined schedule. Therapists may have some knowledge of the principles of NIDCAP.

(4) The nursery professional team includes therapists with full-time nursery assignments; they are members of the nursery team, attend patient care rounds, and participate on developmental committees. They each are supported by at least one other therapist. All therapists are certified NIDCAP Professionals and may be APIB-introduced.

(5) The nursery professional team includes several therapists with full-time nursery assignments. The therapists attend daily patient care rounds, and participate on numerous developmental committees; they each are supported by at least one other therapist, and they are supervised and mentored by the nursery's educational and emotional support resources. All therapists are certified NIDCAP and APIB Professionals.

10. Respiratory Therapists

(1) Respiratory Therapists may not exist at all and/or their role is limited to assuring efficient and safe functioning of respiratory equipment.

(2) Respiratory care services are provided by a stable core of certified respiratory therapists, who occasionally attend patient care rounds.

(3) Respiratory care services are provided by a stable group of certified respiratory therapists, who attend patient care rounds on a daily basis and are aware of the goals of developmental care; respiratory therapists may be knowledgeable of NIDCAP principles.

(4) A consistent group of certified Respiratory Therapists certified in the specialty area appropriate for the newborns cared for in the nursery provide respiratory care to infants in the nursery; the therapist leaders are certified NIDCAP Professionals. They attend patient care rounds on a daily basis and function as integral members on the infants' primary care teams and the Developmental Team.

(5) The nursery's core group of Respiratory Therapists certified in the specialty area appropriate for the newborns cared for in the nursery is also certified NIDCAP and APIB Professionals; the therapists function as full members of the infants' primary care teams and the Developmental Team and they function as mentors for their peers across the disciplines.

11. Developmental Specialists

(1) Developmental Specialists, if they exist at all, may have training in education, psychology, or another mental health or education profession. Their guidance may be available from outside the hospital on a consultation basis.

(2) Developmental Specialists are available within the hospital for consultation; they are usually brought in on selected cases (e.g., infants with congenital anomalies, feeding difficulties, etc.; or parents with mental illness, etc.).

(3) Developmental Specialists are available within the nursery for limited consultation; they may be part-time members of the nursery team and they may have received NIDCAP orientation.

(4) Developmental Specialists are full-time members of the nursery team, are certified NIDCAP Professionals and participate in weekly developmental rounds.

(5) Developmental Specialists are certified NIDCAP and APIB Professionals and are integral, salaried members of the core nursery staff. They are called upon formally during rounds, and informally to support various interaction and care situations from admission to discharge, including transition planning; they are integral to the development of the nursery staff and culture.

12. NIDCAP Professionals

(1) Certified NIDCAP Professionals may be available as rare outside consultants to the nursery.

(2) A certified NIDCAP professional is on staff in the hospital and is available to consult to the nursery. This individual may be brought in on selected cases (e.g., extremely low weight preterm infants, infants with anomalies, neurologic conditions, feeding difficulties, etc., and/or families with particularly challenging situations).

(3) A NIDCAP Professional is on staff in the nursery and is available for consultation as indicated. This individual may mainly act as a clinical and educational resource for the nursery.

(4) Certified NIDCAP Professionals, full-time on staff in the nursery, are integral members of the multidisciplinary nursery team. They provide consultation in the nursery and participate in daily rounds and weekly developmental rounds. They are mutually supportive of and with one another and support all aspects of nursery and staff development.

(5) Certified NIDCAP Professionals, full-time on staff in the nursery, are integral members of the multidisciplinary nursery and the nursery's Developmental Team. They provide consultation, education and support in the nursery to all disciplines. They are called upon formally during rounds and informally for relationship and interaction as well as care issues as they arise. They address and support topics such as the enhancement of the admissions process, discharge planning, transition planning to community hospitals etc. They draw on the support from reflective process consultants from outside the nursery in order to maintain their own perspectives, mental health, and generosity in supporting the direct caregivers in the nursery.

13. NIDCAP Professional Team

   (1)   There is one professional on staff in the nursery who is a certified NIDCAP Professional.

   (2)   There are two or more professionals on staff in the nursery who are certified NIDCAP Professionals.

   (3)   There are several certified NIDCAP Professionals on staff in the nursery. Two or more disciplines (e.g., medicine, nursing, respiratory therapy, occupational, physical and speech therapies, neonatal nurse practice, and/or psychology) are represented. These professionals provide educational support, clinical expertise and support to families and staff. They may conduct formal NIDCAP observations upon request by staff for specific infants.

   (4)   There is a team of certified NIDCAP Professionals, in the nursery; they represent multiple disciplines including nursery leadership. This team provides support, clinical expertise, and educational opportunities for staff and families. Team members contribute to professional orientation and continuing education for new and experienced staff in the nursery. NIDCAP observations are regular integrated features for all infants in the nursery.

   (5)   There is a team of certified NIDCAP professionals who represent all key disciplines, in the nursery. This team takes part in the orientation process and the continuing education for new and experienced nursery staff members; the team provides continued NIDCAP observations of infants in the nursery; contributes to the individualized plans of care; consults as indicated with staff and families; collaborates with the other professionals in the nursery to optimize individualized care; participates in weekly developmental rounds; provides continued professional and family education; acts as a resource to other services within the hospital; and provides ongoing support to the development of clinical practice policies, procedures and guidelines with individualized developmentally supportive principles based in NIDCAP.

14. Psychologists

   (1)   Psychological support may be provided informally by peers and supervisors.

   (2)   Psychological support may be provided by hospital counselors, consulted when significant professional events occur in the nursery.

   (3)   Psychological support is provided by trained psychologists or psychiatrists, available for staff on an occasional usually crisis management basis.

   (4)   Psychological support is provided proactively for all staff by trained psychologists or psychiatrists within the nursery on a continuing regular basis. Participation is a requirement for all staff.

(5) Psychological support is provided proactively, regularly, and on a continuous basis by one or more nursery-affiliated psychologists and/or psychiatrists. Staff members receive additional opportunities for psychological support, when they desire and/or when events occur which present unusual challenges. Depending on the individual or group issues, psychologists and psychiatrists called upon are trained in specific areas, such as: clinical, cognitive, community, developmental, educational, engineering, health or medical, organizational, personnel, psychotherapy, and social psychological and psychiatric subspecialties.

15. Reflective Process Consultants

(1) Reflective process consultation may be provided informally by nursery peers or supervisors.

(2) Reflective process consultation may be facilitated by a specially-trained professional on a crisis management basis when significant professional events occur in the nursery.

(3) Reflective process consultation may be facilitated by a specially-trained professional on an occasional basis.

(4) Reflective process consultation may be facilitated by a specially-trained professional for individuals and/or teams within the nursery on a regular proactive basis.

(5) Reflective process consultations are regularly and proactively facilitated by a specially-trained professional. They are scheduled on a regular basis for multidisciplinary groups of staff and of leadership. Staff and/or leadership may request additional opportunities for reflective process consultation when an event presents special challenges to the staff and/or to the leadership, and which might profit from being addressed by a professionally guided and facilitated reflective process forum.

16. Social Workers

(1) Social workers are assigned at various times to various services throughout the entire hospital; they work independently from the other disciplines in their respective settings.

(2) Specific social workers are specifically assigned to the nursery, yet they work independently of the other disciplines.

(3) Specific social workers are assigned to a specific patient group in the nursery; they work with caregivers and families as requested.

(4) Social workers are assigned to a specific patient group and geographic area in the nursery; and are integral members of the specific caregiving teams in that area.

(5) Social workers are integral members of the caregiving teams for each infant in a specific area of the nursery; they are supportive of parents, have full knowledge of infant developmental and medical issues and family resources, and provide support to Nursery staff as well. They aim to be or may be certified NIDCAP Professionals.

17. Nutritionists

(1) Nutritionists may be available for consultation from outside the hospital. They may not have specific training or knowledge in preterm or high risk infant nutrition.

(2) Nutritionists are available for consultation from within the hospital; they have some basic knowledge of the nutrition issues of preterm and otherwise at risk newborn infants.

(3) Nutritionists with specific training in issues relating to the nutrition of preterm-born and otherwise at risk newborns are assigned at least part-time to the nursery.

(4) Nutritionists with specific training in issues relating to the nutrition of preterm-born and otherwise at risk newborns are assigned full-time to the nursery. They may attend daily or at least weekly patient care rounds, and assess the nutritional status of all infants. They may function as part of the caregiving team and their recommendations strive to take into account the infants' developmental aspects.

(5) Nutritionists are full-time members of the nursery staff and consistently participate in all aspects of care decisions as part of the multidisciplinary caregiving team; they strive to integrate their knowledge with that of their nursery colleagues on how to optimize all the infants' nutritional and developmental situations. They are certified NIDCAP Professionals.

18. Lactation Consultants

(1) Lactation consultants with training or knowledge in general infant feeding may not be available or only on special and rare occasions for consultation from outside the hospital, such as for an infant with significant oral/facial malformations etc.

(2) Lactation consultants with training or knowledge in general infant feeding and some experience in feeding special infant populations (e.g., preterm infants) are available for consultation from outside or within the hospital, on special requests signed for by the attending physician.

(3) Lactation consultants with specific training in issues related to lactation support of preterm-born and otherwise at risk newborns are assigned part time to the nursery, and available on call with delay of up to 24 hours.

(4) Lactation consultants with specific training in issues related to lactation support of preterm-born and otherwise at risk newborns are assigned fulltime to the nursery, and available on less than three hour notice. They attend weekly patient care rounds, and

assess and support the breastfeeding status of all infants. They may function as part of the care giving team and their recommendations take into account the infants' developmental aspects.

(5) Lactation consultants are certified NIDCAP Professionals, full time members of the nursery staff, and serve as parent partners in feeding. They are available on a 24-hour - seven day a week basis. They consistently participate in all aspects of care implementation and decision-making as part of a multidisciplinary care team. They integrate their specialist knowledge with that of their nursery colleagues in order to optimize from admission onward, proactively all infants' breastfeeding, nutrition and developmental progress and well-being.

19. Developmental Pediatricians

(1) Developmental pediatricians are available to families in the community after hospital discharge.

(2) Developmental pediatricians occasionally consult to the nursery caregiving team upon special request.

(3) Developmental pediatricians regularly consult to the nursery caregiving team upon request; they typically are in charge of the infant follow-up clinics.

(4) Developmental pediatricians regularly consult to the nursery caregiving team; they perform developmental assessments, plan interventions, participate in developmental rounds and care conferences, and provide continuity to the infant follow-up clinics.

(5) Developmental pediatricians are integral members of the nursery caregiving team; they provide clinical, educational, and caregiving support to the nursery staff and the community professionals. They perform developmental assessments, plan interventions, participate in developmental rounds and care conferences, and provide continuity to the community pediatricians, the community early intervention programs and services, and the infant follow-up clinics.

20. General Staff Awareness and Training in Infant, Family and Staff Development

(1) There is no, to very limited nursery staff interest in infant, family, and staff development, and training in these areas.

(2) Some nursery staff shows some interest in attending training in infant, family, and staff development.

(3) Many nursery staff members attend training and educational sessions as well as conferences on and off-site in infant, family, and staff development. There are occasional

opportunities for compensation of staff time and/or financial support, as well as continuing medical and nursing credits for attendance of such sessions.

(4) All nursery staff members attend training and educational sessions as well as conferences on and off-site in infant, family, and staff development, as well as in behavioral, developmental and environmental implications for care. There are frequent opportunities for compensation of staff time and/or financial support, as well as continuing medical and nursing credits for attendance of such sessions. Skills or competency labs in these areas, as well as a focus in expert knowledge and skill in the areas may carry opportunities for promotions and pay raise.

(5) All nursery staff members regularly attend training and educational sessions as well as conferences on and off-site in infant, family, and staff development. All nursery staff furthermore regularly attends behavioral, developmental, and environmental in-services and in-house conferences. These training sessions are considered to be integral to ongoing professional development. There are reliable opportunities for compensation of staff time and/or financial support, as well as continuing medical and nursing credits for attendance of such sessions. Skills or competency labs in these areas, as well as a focus in expert knowledge and skill in these areas, may carry opportunities for promotions and pay raise, as well as academic and leadership advancement.

21. Developmental Care Training of Caregivers

(1) Developmental care training is not available for nursery caregivers.

(2) An orientation to developmental care issues is available; this may include an introduction to the NIDCAP approach, although attendance at this orientation is optional.

(3) Developmental care training, including an introduction to the NIDCAP approach, is offered to all to nursery caregivers. Several caregivers may pursue more extensive training, usually on their own time outside of their staff time.

(4) Developmental care training, including an introduction to the NIDCAP approach, is required, and staff time is allocated for this initial training; several caregivers work towards NIDCAP certification, usually on their own time.

(5) Developmental care training is a continuous and an integral part of the nursery-offered and required education. Most staff members work towards and achieve NIDCAP certification. Monetary and time compensations are allocated for time spent involved in this training. The nursery maintains a standing relationship and contract with a certified NIDCAP Trainer, in order to upgrade and maintain the nursery staff's expertise. Caregiving staff continuously strives to develop more supportive caregiving strategies. There are frequent in-services and materials offered to address continued developmental care issues in the nursery.

22. Orientation of House Officers and New Medical Staff

(1) House officers and new medical staff members may not receive any orientation prior to their rotation in the nursery.

(2) House officers and new medical staff members receive a brief perfunctory orientation by an available staff nurse prior to their rotation in the nursery.

(3) House officers and new medical staff members reliably receive an orientation by an assigned nurse and/or physician prior to their rotation in the nursery.

(4) House officers and new medical staff members receive a thorough orientation by the nurse manager, clinical nurse specialist, and a designated senior physician prior to their rotation in the nursery. The orientation includes introductions to the family, primary caregivers, and members of the developmental team.

(5) House officers and new medical staff members receive a thorough orientation by their assigned preceptors and designated nursery caregiving team members, prior to their rotation in the nursery. The orientation includes introductions to the family, primary caregivers, and members of the developmental team. Special consideration is given to assurance of consistency of care for all infants and families. New medical staff have an assigned mentor to consult with on a regular basis throughout their rotation in the nursery.

23. Orientation of Clinical and Support Nursery Staff

(1) Orientation of all nursery staff in the nursery is not required by the hospital.

(2) Orientation of all nursery staff in the nursery is available and required by the hospital. Nursery specific information, written materials as well as resource individuals are available for new staff within each of their professions.

(3) Orientation of all nursery staff in the nursery is available and required by the hospital. Nursery specific information, written materials, including a guide or manual of protocols and job-specific tasks and skills, as well as a resource individual are available for new staff within their profession. A nursery-specific didactic presentation is offered additionally.

(4) Orientation of all nursery staff in the nursery is available and required by the hospital. Nursery specific information and written materials, resource individuals for mentoring new staff within profession, the discipline's manager, as well as a psychologist and/or reflective process consultant are available to all new staff. Each new staff member is partnered with a more senior experienced member of the nursery team in their respective discipline, in order to assist with day-to-day problem solving, adaptation and skill and professional growth.

(5) Orientation of all nursery staff in the nursery is available and required by the hospital. Nursery specific information, written and audio-visual materials, resource individuals and

mentors from within the new staff person's profession are available. The discipline's manager, a psychologist and/or psychiatrist, and a reflective process consultant are available to the new staff member on a proactive and continuous basis. Each new staff member is partnered with a more senior experienced member of the nursery team in their respective discipline, in order to assist with day-to-day problem solving, adaptation and skill and professional growth. All efforts are directed to make the new staff member's transition and team integration a success.

24. Care Team Composition

(1) The care team consists of a series of nurses and neonatologists depending on current assignment. The nurse and neonatology professionals may have access to physical, occupational, speech, and other therapists or specialists, who may provide consultation when they are available to the nursery. A conventionally scheduled nursing and neonatology approach to care is used.

(2) The care team consists of a variably predictable group of nurses and neonatologists, depending on assignment and staff shortage. The nurse and neonatology professionals may have access to physical, occupational, speech, and other therapists or specialists, who may provide consultation during the time they are regularly assigned to the nursery. A largely conventionally scheduled nursing and neonatology approach to care is the rule. Developmental specialists and other therapists, who receive occasional referrals, may attend weekly rounds.

(3) The care team is multidisciplinary and consists of primary and associate nurses, medical staff, infant development specialists and consultants upon request, such as occupational, physical, speech therapists. The infant developmental specialist is likely to be a certified NIDCAP Professional, and/or may have NIDCAP knowledge.

(4) The care team is interdisciplinary and consists of primary and associate nurses, medical staff, a certified NIDCAP Professional in the role of infant development specialist with a minimum of least one full time or two part time NIDCAP Professionals, which together equal one full-time equivalent position (FTE) for every 25 nursery beds; physical and occupational therapists, respiratory therapists, a developmental neonatologist and a nursery graduate parent. All nursery staff has received introductory NIDCAP training.

(5) The care team is interdisciplinary, coordinated and supported by certified NIDCAP Professionals who serve as infant development specialists with a minimum of two full time NIDCAP Professionals or two to four part-time NIDCAP Professionals with one FTE for every 25 beds, and consists of parents, primary and associate nurses, medical staff, clinical nurse specialists, neonatal nurse practitioners, physical, occupational, and respiratory therapists, social workers, and lactation consultants. All nursery staff members are certified NIDCAP Professionals. The infant developmental specialists additionally are certified APIB Professionals and receive continuing developmental care education and mentorship by their certifying NIDCAP Trainer.

25. Staff Job descriptions

(1) Staff job descriptions do not require licensure in the individual's profession.

(2) Staff job descriptions require licensure in the pediatric specialty for the individual's profession.

(3) Staff job descriptions include the requirement for licensure in the pediatric specialty for the individual's profession, as well as developmental care competencies determined by the nursery.

(4) Staff job descriptions include requirement for licensure in the pediatric specialty for the individual's profession, as well as developmental care competencies determined by the nursery, which includes NIDCAP orientation.

(5) Staff job descriptions include the requirement for licensure in the pediatric specialty, as well as developmental care competencies determined by the nursery, which include NIDCAP Professional certification.

26. Continuing Education

(1) Professional staff seeks continuing education on their own time and expense. Continuing education may be optional for certain professionals.

(2) Professional staff are infrequently offered continuing education opportunities, and may use vacation time accrued for participation. Continuing education is a requirement for continued licensure for most professionals.

(3) Professional staff are offered continuing education opportunities and may use hospital funds and/or scholarship funds dedicated for participation. Continuing education is a requirement for continued licensure for all professionals.

(4) Professional staff are supported, with time and expenses, to make use of continuing education opportunities. All staff receives education days on an annual basis, which are designated for required educational opportunities, and pertain to their practice area. Continuing education is a requirement for continued licensure for all professionals.

(5) Professional staff are continuously supported, with time and financial resources to make use of continuing education opportunities. The concepts of life-long learning and education are a key philosophical ingredient of the nursery and the hospital. Staff members contribute to learning within their setting by sharing educational ideas with fellow staff members. Continuing education is an opportunity and a requirement for continued licensure for all professionals.

B. Management

1. Systems Management

   (1) There are poorly identified and defined lines of communication among the various persons coming together in the hospital-setting, from the patient and parent/family level to the nursery's management and top administrative levels.

   (2) There are limited lines of communication among the various levels of persons coming together in the hospital-setting, from the patient and parent/family level to the nursery's management and to top administrative levels.

   (3) There are well-defined lines of communication, that are established through formal processes, among the various levels of persons coming together in the hospital-setting, from the patient and parent/family level to the nursery's management, and to the top administrative levels.

   (4) There is an open and effective communication system in place among the various levels of persons coming together in the hospital-setting, from the patient and parent/family level to the nursery's management, and to the top administrative levels. Information is shared on a regular, formal and informal, effective basis.

   (5) There is an open and very effective communication system in place and mutual support systems for communication among the various levels of persons coming together in the hospital-setting, from the patient and parent/family level to the nursery's management, and to top administrative levels. There is constant sharing of information among all levels and in all areas; this helps support an open-door-policy and a mutually supportive atmosphere throughout the hospital.

2. Policy Development

   (1) There is neither a written hospital nor a nursery policy in place to govern the hospital or the nursery's functioning. Or, while there may be an overall hospital policy, the nursery does not have its own policy and is governed by the overall hospital policy only. There are no checks, consequences or remedies in place for adherence to the existing policies. The policies that exist may be quite outdated.

   (2) There is a team of nursery leadership professionals who are in charge of the development, monitoring adherence to and periodic review of nursery policies. The policies are developed to be in alignment with professionals' employment contracts, and the hospital administration's priorities. They typically result from crisis, failure, wrong-doing, and/or other adverse situations.

   (3) There is a team of representatives from the nursery's leadership and staff who collaboratively develop, monitor adherence to, intermittently review, and revise the nursery's policies. Occasionally a graduate family may be asked for input regarding specific

aspects of a nursery policy. Policy development occasionally results from a crisis, failure, wrong-doing, and/or other adverse situation.

(4) There is a team of representatives from the nursery's leadership, staff, developmental professionals and graduate nursery families, who collaboratively develop, monitor adherence to, review, and revise the nursery's policies. Physicians and/or nurses are the key team leaders for most policies. Families are the primary team leaders on policies concerning infant comfort, family care giving, and family decision making concerning specified optional aspects of care implementation (e.g., circumcision decisions). Most policies are developed proactively and anticipatorily in order to assure successful and effective functioning.

(5) There is a team with representatives from all staff levels including the nursery's leadership, staff, developmental professionals, graduate nursery families, and support and ancillary personnel (e.g., housekeeping and clerical staff) who collaboratively develop, monitor adherence to, review, and revise policy development and revisions. Prior to policy adoption all team members have an opportunity to obtain their peers' input and suggestions. A democratic consensus process is strived for and must be reached before policies are put into action. Professional facilitators and process consultants, whose role it is to facilitate the process for optimal democratic consensus and unanimous adoption, may be called upon in difficult situations. Policies consistently include developmental considerations. All policies are developed proactively and anticipatorily in order to assure successful and effective functioning. In the event of a crisis, failure, wrong-doing, and/or other adverse situations, proactive processes for a full review, fact-finding, as well as formulation and safeguards for preventive future actions and policies are in place.

C. Resources

1. Support Services for Professional Caregivers

(1) Professional caregivers seek support services independently outside the nursery and work setting.

(2) Professional caregivers may receive a support services resource directory from the hospital's employee health department. Obtaining of support services is up to each individual.

(3) Professional caregivers have access to hospital support services; a certain number of visits per year may be allocated. There may be some opportunities for professionally guided debriefing of nursery events.

(4) Professional caregivers are supported to make use of hospital support services, outside of their work time. There are professionally guided opportunities for debriefing of nursery events on an ongoing, regular basis.

(5) Professional caregivers have unit psychology, psychiatry, and/or counseling services available, which may be accessed during paid time. Ongoing respite, group counseling and/or professionally guided debriefing of stressful events occur in the nursery. Other resources, available on a regular basis, include: massage therapy, break times with yoga, exercise therapy, and/or nutritional support.

2. Location for Support Services for Professional Staff

(1) Support services for professional staff are absent or are located at various distances from the hospital.

(2) Support services for professional staff are located within the hospital neighborhood, campus, and/or walking distance of the main hospital building.

(3) Support services for professional staff are located within the main hospital building for treatment of acute crises, and may be located nearby for ongoing treatment and support.

(4) Support services for professional staff are located within the same building as the nursery for treatment of acute crises, and may be nearby for ongoing treatment and support.

(5) Support services for professional staff are within the nursery proper, very nearby and/or off-site for issues of privacy. Staff may choose their provider. All time off for such services is compensated financially.

3. Staff Advocacy Programs

(1) Nursery staff may bring concerns, issues and grievances to their department supervisor. Responsiveness is typically low. Repercussions may include punitive actions towards the person bringing the grievance.

(2) There exists a tiered communication channel to discuss concerns, issues and grievances. First step of communication is with the most immediate supervisor and/or senior person of the shift or rotation. Once their advice is obtained, the next step for, as yet unresolved issues, is the department supervisor, nursing, medical or other service director of the nursery. Only significantly grave grievances are typically addressed satisfactorily. Lesser topics may be considered nuisances.

(3) Nursery staff have information on and access to well-defined, confidential communication channels for concerns, issues and grievances. These channels involve various levels of authority, corresponding to the level of the concern to be addressed. Each of the incumbents at the various levels is skilled in recommending and bringing about resolutions at their level, and/or referring to the next higher instance as appropriate. A response and/or resolution will be offered as available. An advocacy program within the hospital exists for issues that remain unsatisfactorily treated or resolved.

(4) Nursery staff have information on and access to a clear, well-defined, confidential system of communication channels for concerns, issues and grievances. These channels involve various levels of well-defined authority that correspond to the level of the concern to be addressed. Each of the incumbents at the various levels is skilled in recommending and bringing about resolutions at their level, and/or referring to the next higher instance as appropriate. A response with an appropriate action plan is offered in a timely fashion. An effective confidential hospital guidance and advocacy program is easily accessed by nursery staff. Mediators are provided by the hospital. Seeking of counsel, mediation and/or correction of inappropriate situations is considered professionally mature and is welcome by the leadership of most disciplines

(5) Nursery staff have information on, access to, and encouragement for taking advantage of a system of clear, well-defined, confidential communication channels for concerns, issues and grievances. These channels involve various levels of well-defined authority, which correspond to the level of the concern to be addressed. Each of the incumbents at the various levels is skilled in recommending and bringing about resolutions at their level, and/or referring to the next higher instance as appropriate. A response with an appropriate action plan is reliably offered in a timely fashion. An effective confidential hospital guidance and advocacy program is easily accessed by nursery staff. Mediators are provided by the hospital. Seeking of counsel, mediation and/or correction of inappropriate situations is considered professionally mature and is welcome by the leadership of all disciplines and the overall hospital leadership. Independent advocacy programs and mediators are available to advise staff at any level. For time-sensitive issues there is a 24-hour quick response team and system in place for every service and discipline, as indicated. It is considered professionally responsible to bring concerns, issues, and grievances at all levels to the attention of the appropriate leadership persons or teams. Services and representation of all employees is guaranteed. There is a policy of privacy protection, non-retribution, and/or reward for proactive problem solving when concerns are brought forward.

4. Support among Nursery Caregivers

(1) Nursery staff feels little trust and support from their co-workers. Staff members work in isolation from one another and seldom seek peer assistance.

(2) Nursery staff feels some trust and support from their co-workers. Concrete actions and expressions of support are performed readily when solicited.

(3) Nursery staff feels trusted and supported by their co-workers. Concrete actions and expressions of support are exchanged readily. Staff members regularly cover their peers' assignments to assure that everyone has the opportunity for a work break.

(4) Nursery staff feels great mutual trust and support from their co-workers. Expressions of support are readily exchanged without solicitation. An atmosphere of mutual support and respect exists in the nursery as evidenced by effective team work when performing infant

caregiving procedures; sharing in the development of care plan; and regularly offering assistance.

(5) Nursery staff feels solid mutual trust and support from their co-workers. Effective problem solving and team work are the rule for all aspects of their care.

D. Transition Systems

1. Transfer and Discharge Plans

(1) Written transfer and discharge plans solely address infants' medical circumstances.

(2) Written transfer and discharge plans address infants' medical circumstances, and may contain a brief description of an infant's current developmental status, should there be significant developmental concerns. Referrals to developmental services may be suggested at the time of transfer and/or are made at the time of discharge for infants with diagnosed severe disabilities.

(3) Written transfer and discharge plans typically include at least a brief description of an infant's current developmental status. Recommendations for caregiving may include environmental adaptations, suggestions for routine caregiving, and availability and preferences for social interaction; referrals for developmental services as indicated may be suggested and/or are initiated from within the discharging nursery.

(4) Written transfer and discharge plans are comprehensive regarding all infants' developmental status. Descriptions of infants' neurobehavioral organization, individualized caregiving recommendations, family participation in the care of the infant, resource and referral information, including purpose and type of referrals, all are typically well-specified, depending on the complexity of the transferred or discharged infant's situation

(5) Written transfer and discharge plans contain detailed individualized developmental care and family service plans, which will have been developed with parent, family, and staff support and input, and will have been approved by the parents. Such plans are utilized, reviewed and updated by the receiving team either at the transfer hospital or in the community (e.g., the Early Intervention Program, home services and therapy agencies, visiting nursing program, and/or the receiving pediatrician and specialists, who will provide care for the infant after discharge home).

2. Links between Newborn and Transfer Hospitals

(1) Transfers once decided upon by the medical care provider, are initiated and coordinated by any staff member as available.

(2) A designated small group of staff members who, in addition to having other duties are also in charge of transfers. The patient census in the nursery plays a major role in the decision of transfer initiations.

(3) A designated small group of specially trained staff members, who also have several other duties, are in charge of arranging transfers. An infant's medical issues, nursery census, and parents' desires to have their infant closer to home are the determining factor in transfer decisions.

(4) A designated small group of specially trained staff members have as their sole responsibility the assurance of smooth transitions for infants and families between the nursery and the transfer site. These staff members review the medical issues of infant and parent as indicated; the concerns of the family and staff; and the availability of beds at the receiving site. They facilitate communication between the primary care teams of the two settings and the family. These individuals arrange for the family to visit the transfer site well in advance of reaching the final decision, which is always reached collaboratively.

(5) A designated small group of specially trained staff members have as their sole responsibility the assurance of smooth transitions for infants and families, and for the staff at both sites, from the nursery and the transfer site. These staff members review the medical and developmental situation of infant and parents as indicated; explore the concerns of the family and the staff; and review the availability of beds and of transportation and other facilities (e.g., living-in with their infant, etc) for the family, at the receiving site. They facilitate communication between the primary care teams of the two settings and the family. These individuals arrange for the family to visit the transfer site and staff well in advance of reaching the final decision, which is always reached collaboratively with the family. Parents are involved in the decision of accompanying their child in the course of the transfer and/or of providing skin-to-skin holding in the course of the transfer. All efforts are directed at assuring a smooth and successful transfer for infant, family and staff. The transfer team facilitates communication among all concerned, and has resources available to assist in problem solving as indicated.

3. Links between the Nursery and Primary Health Care Providers in the Community

(1) There is no contact at all between the nursery and the receiving community provider throughout or following an infant's nursery stay.

(2) A copy of the infant's discharge summary is sent to the community provider upon the infant's discharge, if requested by the infant's parents.

(3) The community provider's office is contacted by telephone or email by the discharging nursery physician shortly before an infant's discharge, and a copy of the discharge summary is sent to the community provider's office upon the infant's discharge. Should a family not have decided upon a community provider, the discharging provider suggests a community provider to the family, contacts that provider's office, and forwards a discharge summary.

(4) The community provider, whom the family has selected for their infant's care upon discharge, visits the infant and family towards the end of the infant's nursery stay. The nursery physician may have contacted the community provider prior to the visit; communicated key medical and developmental issues regarding the infant; and may invite the community provider to make suggestions regarding the development of the discharge plan, and in terms of coordination of medical and developmental follow-up for the infant.

(5) The community provider, whom the family has selected for their infant's care upon discharge and met well in advance of their infant's discharge, visits the infant and family towards the end of the infant's nursery stay. The nursery physician has contacted the community provider prior to the visit; communicated key medical and developmental issues regarding the infant and family; and has invited the community provider to make suggestions regarding the development of the discharge plan and in terms of coordination of medical and developmental follow-up for the infant, once discharged. The community provider in turn provides written documentation and information to the hospital-based follow-up team prior to each follow-up visit; the follow-up team reliably provides detailed feedback regarding their assessment of and recommendations for the infant; and consults with the community provider before medication and procedure changes are ordered, and/or further referrals are made.

4. Links between the Nursery and Community Agencies including Nursing (Visiting Nurses Association, Public Health Nurses, Private and Public Home Health Agency Nurses), Therapies (Respiratory, Occupational, Physical, Speech and Language), and other Specialty Services.

(1) Upon discharge from the nursery, infants and parents are rarely if ever referred to community agencies. Services may be rare; if they exist at all they are very difficult to identify, access and qualify for.

(2) Upon discharge from the nursery, infants and parents may be referred to one or another community agency. It is up to the parents to confirm the availability of the service to which they have been referred. Services typically are difficult to identify and access. Only rarely may a child actually qualify for the recommended service.

(3) Prior to discharge, infants and parents are referred to appropriate specific community agencies and/or therapies; the services an infant and family have been referred to are accessible, and the infant qualifies for the service.

(4) Prior to discharge, infants and parents are referred to appropriate specific community agencies and/or therapies; a representative from the agency or service visits the infant and family in the nursery prior to discharge in order to meet the parents and the infant's primary caregiving team, and learn about the specific expectations and individuality of infant and family. This is deemed helpful by the agency or service in order to assure appropriate specialty service and care delivery.

(5) Well before discharge, infants and parents are referred to appropriate specific community agencies and/or therapies that are expected to be helpful for the infant and family upon discharge. The community agencies choose representatives who are deemed most appropriate to meet and assess the infant and family in the course of a series of visits to the nursery prior to discharge, in order to develop an individualized family service plan with the family and the staff. They meet the parents, other family members, the infant, and the infant's primary caregiving team, and they may participate in rounds when the infant's discharge plans are discussed. In collaboration with the parents and the infant's primary team they formulate the discharge plan and make the appropriate referrals, upon which they then act.

5. Links between the Nursery and Respite Services

(1) Families have limited or no access to respite services.

(2) Families may be referred to very limited respite services after discharge.

(3) Families may be referred to respite service agencies prior to discharge, so that the initial family interview will have been completed by time the time the infant is discharged, and respite services may be initiated as soon as the infant comes home.

(4) Families reliably are referred to respite service agencies well before the infant's discharge; respite services are readily available and affordable. The initial family interview will have been accomplished well before the infant's discharge and respite services are ready to go upon the infant's discharge home.

(5) Families reliably are referred to respite service agencies well before the infant's discharge; respite services are readily available, generous and affordable. The initial family interview will have been well accomplished prior to discharge; the respite service providers selected by the family visit the nursery to meet the infant and family, meet with the infants' primary caregiving team regarding caregiving, and provide input in discharge planning. Respite services are in place and ready to go upon the infant's discharge home.

6. Referrals from the Nursery to Community Early Intervention Services

(1) Upon discharge from the nursery, infants and parents are rarely, if ever referred to community Early Intervention Services. Services may be rare; if they exist at all they are very difficult to identify, access and qualify for. Most referrals to community Early Intervention Program's are left up to the family's pediatrician or other health care provider after discharge.

(2) Prior to hospital discharge referrals to Early Intervention Programs are made only for those infants at overwhelming environmental risk or with severe, well-documented developmental disabilities.

(3) Prior to hospital discharge referrals to Early Intervention Programs are considered and in some cases initiated for infants and families with a range of identified significant environmental risks and/or a range of diagnosed developmental disabilities. The nursery staff is knowledgeable of the specific qualifying criteria for Early Intervention in the State.

(4) Well before hospital discharge referrals to Early Intervention Programs are made for infants and families with a wide range of environmental, developmental and medical issues, and/or at risk for the development of such issues. The nursery staff is well-versed in and knowledgeable of the specific qualifying criteria for public and private Early Intervention Services available. The nursery has an up-to-date roster of the key agencies' identified contact persons. From within the nursery specified and specifically trained professionals (e.g., discharge planners, social workers, nurses, or case managers) will establish contact with the most appropriate agency's contact person, given the infant's and family's situation. The contact person, or a person designated by the program, will visit with the infant and family as well as with the referral-initiating nursery professional and the primary care team in the nursery, in order to develop the best transfer process to initiate appropriate comprehensive services. The nursery has a process in place to update the nursery's knowledge of and information regarding programs.

(5) Well before hospital discharge referrals to Early Intervention Programs are made for infants and families with a wide range of environmental, developmental and medical issues, and/or at risk for the development of such issues. The nursery staff is well-versed in and knowledgeable of the specific qualifying criteria for public and private Early Intervention Services available. The nursery has a continuously up-dated roster of the key agencies' identified contact persons. From within the nursery specified and specifically trained professionals (e.g., discharge planners, social workers, nurses, or case managers) will establish contact with the most appropriate agency's contact person, given the infant's and family's situation. The contact person or a person designated by the program will visit with the infant and family as well as with the referral-initiating nursery professional and the primary care team in the nursery in order to develop the best transfer process to initiate appropriate comprehensive services. The nursery has a process in place to update the nursery's knowledge of and information regarding programs. Referrals to Early Intervention Programs are made for infants with a wide range of established developmental and medical issues, and for infants and families at risk for such issues. Early Intervention Program representatives regularly make rounds in the Nursery, consult with staff and meet families, who are referred well before discharge. In-service training sessions are provided by the hospital for Early Intervention teams and by the Early Intervention teams for nursery staff. Families are invited and encouraged to visit programs considered appropriate for their infant and observe them in action, before they agree to a particular program, and well before their infant is discharged from the nursery.

7. Links between the Nursery and Infant Follow-Up Services

(1) Neither hospital-nor community-based infant follow-up services are available for infants, who have been cared for in the nursery.

(2) Hospital-based and/or community health-clinic-based infant follow-up services are available only for a very small, narrowly defined population of infants, who have been cared for in the nursery. The data obtained almost exclusively serve research and health statistic purposes. The cost to attend the infant follow-up services must be carried by the family.

(3) Hospital- and/or community health-clinic-based infant follow-up services are available for a defined population of infants at greatest risk for long-term sequelae, and for research and health statistic purposes. In the event of identification of a heretofore undiagnosed situation, the infant follow-up service will make an effort to connect the infant and family to appropriate services.

(4) Multidisciplinary hospital- and community health-clinic-based infant follow-up services are available for all infants, who have been cared for in the newborn nursery and for their families. The follow-up clinic visits are free of charge, and evaluate the child comprehensively at regular intervals, at least until age three years of age. The evaluations are utilized to update the services the child qualifies for and should receive. Parents as well as primary care providers receive detailed reports that specify the child's current status and identify issues that should be addressed.

(5) Multidisciplinary hospital- and community health-clinic-based infant follow-up services are available for all infants, who have been cared for in the newborn nursery and for their families. The follow-up clinic visits are free of charge, and evaluate the child comprehensively at regular intervals, at least until age six years of age. The evaluations are utilized to update the services the child qualifies for and should receive. Parents as well as primary care providers receive detailed reports that specify the child's current status and identify issues that should be addressed. Appointments are scheduled with each family in order to assure that it is feasible for the family to bring the infant for follow-up. All costs connected with transportation, child care for other children, meals for the day of the visit, etc., are paid for in advance or reimbursed, depending on the family's preference. Identification of educational opportunities for the child is considered as important as those of more medical aspects. Support and education around parenting and around the parents' other family members' emotional and physical well-being are also considered under the purview and responsibility of the follow-up program, which is connected to a comprehensive rich network of services. Parents as well as primary care providers receive detailed reports that specify the child's and family's current status, identify issues that should be addressed, and make specific recommendations in how best to go about addressing them. Trained facilitators and advocates are available through the follow-up program that assists families in implementing the recommendations made.

E. Category Summary Scale - Philosophy and Implementation of Care: Professional and Staff

(1) All aspects of the philosophy and implementation of care reflect an authoritarian and hierarchical, discipline-specific, and regulation-oriented conceptualization and treatment of professionals and staff members.

(2) A number of aspects of the philosophy and implementation of care reflect an authoritarian and hierarchical, discipline-specific, and regulation-oriented conceptualization and treatment of professionals and staff members, who are mainly expected to perform their prescribed tasks efficiently. A few areas of professional and staff members' work expect aspects of collaboration and consideration of the families' perception of the staff and the professionals in the institution

(3) A few aspects of the philosophy and implementation of care reflect some authoritarian and hierarchical, discipline-specific, and regulation-oriented conceptualization and treatment of professionals and staff members, who are expected to perform their prescribed tasks efficiently and effectively. A number of areas of professional and staff members' work expect aspects of and skill in interdisciplinary collaboration and in consideration of families' perception of and infants and families' response to the staff and the professionals in the institution.

(4) Many areas of professional and staff members' work presuppose skill in interdisciplinary collaboration and in consideration of infant and family as active partners in their care. Staff members' professional and personal growth is an area of priority and importance in the institution.

(5) All areas of professional and staff members' work presuppose skill in continued and effective interdisciplinary collaboration and in consideration of infant and family as active equal partners in their care. Staff members' professional and personal growth is an area of greatest priority and importance in the institution.

V. Overall Hospital and Nursery Summary Scale Score

(1) Overall, the hospital and nursery strive to provide medical and nursing care that meets the standards of safe care. Limited or no attention is paid to family-centered, individualized, developmental support and care for infants and their families.

(2) Overall, the hospital and nursery largely provide current, commonly accepted, evidence-based, medical and nursing care practices. Some attention is paid to aspects of family-centered, individualized, developmental support and care for infants and families.

(3) Overall, the hospital and nursery reliably provide current, evidence-based medical and nursing care. This includes efforts towards the implementation of basic aspects of family-focused, individualized, developmental care for infants and families.

(4) Overall, the hospital and nursery strive to promote good health outcomes as well as good short and long term development of all infants and families in their care. The integration of high medical and nursing care standards is embedded within the active pursuit of mutual respect, care and nurturance of and collaboration with all infants and families, as well as among all professionals and staff members.

(5) Overall, the hospital and nursery consistently promote and realize best short and long term health and developmental outcomes of all infants and families in their care. The dynamic full integration of expert medical and nursing care is securely embedded within the mission and active pursuit of mutual respect, caring, nurturance of and collaboration with infants and families, and among professionals and staff members.