

Staffing Recommendation for Small Baby Units

A **small baby unit (SBU) or small baby program (SBP)** is best built around a **dedicated, core multidisciplinary team** that cares for infants ≤ 28 weeks' gestation (or < 1000 g) in a distinct area of the NICU, using standardized evidence-based guidelines to reduce practice variability and create a shared mental model.[\[1\]\[2\]\[3\]](#) The published literature on SBU staffing comes primarily from single-center quality improvement experiences rather than formal society guidelines, but several consistent themes emerge from successful programs.

Program Leadership and Governance - Successful SBP benefits from a defined leadership dyad or triad:

Medical Director(s) (Neonatologist): A dedicated neonatologist champion who leads guideline development, oversees clinical protocols, drives quality improvement, and ensures physician buy-in. This individual should have protected administrative time for the program.[\[3\]\[2\]](#)

Nursing Director/Manager: An experienced neonatal RN leader (BSN minimum, MSN preferred, neonatal certification preferred) who oversees nursing staffing, competency validation, and unit culture.[\[4\]](#)

Program Coordinator(s): A role (often filled by an advanced practice nurse, clinical nurse specialist, or dedicated coordinator) responsible for oversight of data collection, QI metrics, education scheduling, and interdisciplinary communication.[\[2\]\[5\]](#)

Core Interdisciplinary Team Composition - The hallmark of an SBU/SBP is a **consistent, dedicated team** — not just guidelines applied by rotating staff. The following disciplines should have members specifically assigned to the SBP who participate in ongoing education and process improvement:[\[1\]\[6\]\[2\]](#)

Neonatologists: A small, dedicated group of attending neonatologists who rotate through the SBU to maintain continuity and reduce practice variation. Ideally, the same 3–5 neonatologists cover the SBU rather than the entire neonatology division rotating through. AAP standards require 24/7 on-site privileged care providers with neonatal-specific training at Level III/IV NICUs.[\[3\]\[2\]\[4\]](#)

Neonatal Nurse Practitioners (NNP-BCs): Board-certified NNPs are ideal providers for this population, given their training in managing the full range of critically ill neonates including procedural competencies (intubation, umbilical catheterization, etc.). A subset of NNPs should be preferentially assigned to the SBU.[\[7\]](#)

Bedside RNs: A **dedicated nursing pool** is critical. Nurses assigned to the SBU should undergo specialized training in developmental care, minimal handling/stimulation protocols, and the unit's specific guidelines. Neonatal certification (RNC-NIC, C-ELBW) is preferred. Nurse-to-patient ratios for this population should be **1:1 for complex critical care** (unstable infants on ventilators, vasoactive infusions, etc.) and **1:2 for stable intensive care** infants. Higher nursing provision ratios in the first 24 hours of admission are independently associated with lower odds of mortality/morbidity.[\[4\]\[8\]\[9\]\[10\]](#)

Respiratory Therapists (RTs): Dedicated RTs with neonatal/pediatric certification should be assigned to the SBU and available 24/7. They participate in delivery room management, ventilator management, and weaning protocols. International data show low 24/7 availability of RTs in many NICUs, which represents a gap to address.[\[4\]\[8\]](#)

Registered Dietitian/Nutritionist: At least one RD with specialized neonatal nutrition training should have

dedicated SBU daily round participation, overseeing human milk/fortification protocols, and developing individualized feeding plans. AAP standards for Level IV NICUs call for a full-time NICU-dedicated dietitian.[\[4\]](#)

Pharmacist: A clinical pharmacist with neonatal expertise should participate in rounds and medication safety review. International surveys show pharmacist availability is inconsistent, but this role is important for dosing precision in extremely low birth weight infants.[\[8\]](#)

Social Worker: Dedicated social work support for family psychosocial needs, discharge planning, and resource coordination.[\[11\]](#)

Lactation Consultant (IBCLC): Given the emphasis on human milk for extremely preterm infants, a dedicated lactation specialist supports mothers in establishing and maintaining milk supply.[\[9\]](#)

Developmental Care Specialist / Occupational or Physical Therapist: Trained in NIDCAP or similar individualized developmental care frameworks, this role guides positioning, sensory environment management, and kangaroo care protocols.[\[12\]](#)[\[13\]](#)[\[2\]](#)

Strategies for Consistency and Continuity - Beyond assembling the team, these operational strategies are essential to building a shared mental model:

1. **Standardized evidence-based guidelines** covering the entire NICU course — antenatal counseling, delivery room management, golden hour, respiratory management, nutrition, infection prevention, neurodevelopmental care, and discharge planning. These guidelines reduce variability and serve as the foundation of the shared mental model.[\[6\]](#)[\[14\]](#)
2. **Dedicated physical space** - Successful SBUs care for these infants in a **separate geographic location** from the main NICU, reinforcing the distinct culture and protocols.[\[1\]](#)[\[2\]](#)
3. **Ongoing interdisciplinary education** — Regular team-based education sessions, simulation training, and case reviews ensure all disciplines maintain competency and alignment with the program's philosophy.[\[1\]](#)[\[2\]](#)[\[5\]](#)
4. **Quality improvement infrastructure** — Continuous data collection on **process** and **outcome metrics** with regular review by the team. This includes tracking compliance with guidelines and benchmarking outcomes against networks such as the Vermont Oxford Network (VON) and the California Perinatal Quality Care Collaborative (CPQCC).[\[3\]](#)[\[2\]](#)[\[6\]](#)
5. **Family-centered care integration** — Parents are considered part of the care team, with emphasis on kangaroo care, parental presence, and shared decision-making.[\[2\]](#)[\[15\]](#)

Important Caveats - It should be noted that a critical review of the SBU literature found that the evidence base is limited, consisting primarily of single-center before-and-after studies with potential confounding from concurrent QI initiatives. The core elements that drive improvement, evidence-based guidelines, standardized variability reduction, family-integrated care, and developmentally sensitive care, may improve outcomes for all premature infants regardless of whether a formal SBU structure exists, provided robust QI fundamentals are embedded in the unit culture.[\[16\]](#) The decision to create a distinct SBU versus implementing a SBP without a separate physical unit should be guided by local resources, volume, and institutional culture.

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There are several additional neonatal professional roles that are essential to a comprehensive SBP but are frequently underrepresented or absent from staffing plans, despite evidence supporting their impact.^[1]

1. Psychologist / NICU Mental Health Professional - is arguably the most overlooked role. Up to 40% of NICU parents experience significant mental health symptoms, double the rate of the general postpartum population.^[2] A recent systematic review and meta-analysis of 160 studies found that structured psychotherapy and emotional support interventions delivered by mental health practitioners (e.g., psychologists) demonstrated reducing parental anxiety, depression, stress, and trauma symptoms, even when

brief and targeted.^[2] Despite this, psychology consultation is available in only 4% of NICUs in the United States and United Kingdom.^[3] NICU mental health professionals should interact with all NICU parents, providing screening, psychoeducation, psychotherapy, and staff support.^[4] The Society of Critical Care Medicine recommends offering psychological support to ICU families.^[3]

2. Speech-Language Pathologist (SLP) - While occupational and physical therapists are commonly included in NICU staffing, SLPs are frequently absent or underutilized despite being essential for feeding and swallowing evaluation, a critical competency for ELBW infants. AAP standards for Level III and IV NICUs require on-site access to an SLP with neonatal expertise and dedicated NICU time.^[5] In practice, SLP services are initiated later (mean ~36 weeks postmenstrual age) and less frequently than OT/PT, yet they address unique interventions including oral sensory motor stimulation to support the transition to independent oral feeding.^{[6][7]}

3. Palliative Care Team - Despite the reality that a significant proportion of infants born at the lowest gestational ages will not survive or will face life-limiting conditions, **palliative care integration in the NICU remains inconsistent**. Palliative care extends well beyond end-of-life management as it offers proactive, holistic support addressing physical, emotional, spiritual, and social needs of the infant and family, and can be provided concurrently with life-prolonging treatment.^{[8][9]} Early integration of perinatal palliative care, ideally from the antenatal period, is associated with improved parental satisfaction, clearer goals of care, and reduced aggressive end-of-life interventions.^[9] ACOG recommends that a multidisciplinary palliative care team be identified with infrastructure to administer this care when indicated.^[10]

4. Pastoral Care / Chaplaincy - Parental stress in the NICU is inversely correlated with spiritual well-being, and spiritual needs differ by gender — mothers tend toward emotional and internal needs while fathers seek meaning and intellectual fulfillment.^[11] AAP standards require that personnel skilled in pastoral care be available as needed and represent multiple religious affiliations.^[5] The Society of Critical Care Medicine recommends offering spiritual support from a chaplain to ICU families.^[3] Despite these recommendations, chaplaincy is often treated as an afterthought rather than an integrated team member.

5. Dedicated Neonatal Therapists (OT/PT with Neonatal Certification) - While therapy services are commonly available in NICUs, therapists with dedicated NICU time and neonatal-specific certification is less common. AAP standards specify that Level III/IV NICUs should have OT and/or PT with dedicated time allocated to the NICU, covering six core practice domains: environment, family/psychosocial support, sensory system, neurobehavioral system, neuromotor/musculoskeletal systems, and oral feeding/swallowing.^[5] Neonatal therapy certification is preferred but not universally achieved.^[5]

6. Discharge Planning / Care Coordination - Formal care coordination roles, such as a nurse care coordinator, referral coordinator, or community health worker, are essential but often absent from SBU staffing models. Families transitioning from the NICU frequently experience fragmented care and limited psychosocial support.^[12] Successful programs (e.g., the Next Steps Program) employ dedicated coordinators, referral specialists, and even parent advisors to bridge the NICU-to-home transition.^[12] AAP standards require systems for discharge preparation including post discharge follow-up, developmental follow-up enrollment, and community resource linkage.^[5]

7. Clinical Pharmacist with Neonatal Expertise - International survey data show that 24/7 pharmacist availability in NICUs caring for infants <29 weeks is inconsistent across networks, despite the critical importance of precise dosing, drug interaction monitoring, and medication safety in extremely low birth weight infants.^[1]

8. Data/QI Analyst or Clinical Informaticist - Sustaining a small baby program requires continuous data collection, benchmarking, and process improvement. A dedicated data analyst or informaticist supports guideline compliance tracking, outcome benchmarking against networks like VON and CPQCC.[\[13\]](#)[\[14\]](#)[\[15\]](#)

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