## TV&W GUIDELINE FOR POSITIVE TOUCH ON THE NEONATAL UNIT

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<th>Presented to/on:</th>
<th>Thames Valley &amp; Wessex Neonatal ODN Governance Group 19 October 2017</th>
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<tbody>
<tr>
<td>Date of publication</td>
<td>February 2013</td>
</tr>
<tr>
<td>Last Reviewed</td>
<td>October 2017. Previously reviewed July 2016</td>
</tr>
<tr>
<td>Review date (Max 3 years)</td>
<td>October 2020</td>
</tr>
<tr>
<td>Authors</td>
<td>Thames Valley Neonatal ODN Quality Care Group</td>
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| Distribution | Thames Valley and Wessex Neonatal Clinical Forums  
Thames Valley and Wessex Neonatal Network website  
Thames Valley and Wessex Neonatal Network newsletter |
| Related documents | Positive touch references.  
Bond C (2000) Positive Touch; Winnicott Baby Unit Workshop, St Mary’s Hospital, Paddington. London.  
Griffin, T (2000) Introduction of a positive touch programme; the


**Kangaroo Care References.**


Kangaroo mother care: application in a high-tech environment. 


**Co bedding references.**


**Bibliography.**

FSID (2008) *Time to get back to sleep.* (sheet for parents) FSID, London


Email Info@lullabytrust.org.uk


[www.fsid.org.uk](http://www.fsid.org.uk) website with advice for parents and professionals. For co-bedding information follow the links - ‘looking after your baby’ - ‘ask the expert’ – ‘advice’.

### Implications of race, equality & other diversity duties for this document

This guideline must be implemented fairly and without prejudice whether on the grounds of race, gender, sexual orientation or religion.
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### Appendices

| Appendix 1 | Co-Bedding Multiples on the Neonatal Unit – A Parent’s Guide | 17 - 18 |
1.0 Aim of Guideline Framework

To provide a framework to ensure that all premature infants experience appropriate and optimal touch.

2.0 Scope of Guideline Framework

The guideline applies to all babies receiving care within Thames Valley and Wessex Neonatal ODN.

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3.0 Background information:

Touch is believed to build the foundation for the complex and intimate interchange between infant and their caregiver. As touch supplies the newly born infant with a beginning interpretation of the world and the relationships on which he comes to rely for survival.

Increasing awareness from researchers and clinicians suggests that touch is at the very foundation of infant experience and a major factor in formation of an infant – parent bond; However, babies cared for on a neonatal unit receive a large amount of touch that is not loving or tender. For example; procedural touch when being turned or medically examined. Or painful touch when siting intravenous lines or taking blood specimens.

The deliberate use of 'positive touch’ on the neonatal unit aims to give babies the experience of touch that is not for a clinical purpose, but given tenderly, lovingly and gently and that responds to and not ignores their behaviour. In addition, positive touch is felt to help the infant to settle and calm, encourages self–regulation and promotes neurological stability.

Positive touch encompasses a wide variety of techniques or methods, including the main three aspects listed below, which will be focused on in this guideline:
1. Still touch/ Comfort holding/ Cuddling
2. Skin to skin or Kangaroo care
3. Co-bedding of twins/ multiples

Infant massage will not be covered within this guideline, because the general consensus within the literature is that it is too stimulating for the sick or premature infants receiving care in the neonatal unit. Instead infants massage is something that babies and parents can be taught and gain great benefit from after discharge home.

4.0 Practice Guidelines

4.1 General Care

- Before any form of care giving activity involving the baby it is best to ‘introduce yourself’ to the baby, this means simply to give the baby warning that you are approaching. For example:
  - Speak softly to make your presence known.
  - Gently touch the area to be handled, using still touch, before proceeding to the task, i.e.
    o still touch of the arm/leg before venepuncture
    o touch face and mouth before oral suctioning
    o brief containment touch before turning baby over
- Positive touch, ideally, should be introduced as soon as the infant experiences negative touch, to offer some counterbalance to these experiences.
- The type of touch offered to each infant should be adapted according to the infant’s behavioural cues, physiological and medical condition.
- Consider the environment when offering any form of positive touch, all infants are likely to feel uncomfortable in a bright and loud environment, however, the extremely preterm or unwell infant may not be able to cope with being touched whilst also being bombarded with these stimuli. Try shading the infant’s eyes from light, using a hand or better still an incubator cover or cot canopy. Reduce noise levels near to the baby, perhaps by lowering alarm volumes, responding quickly to alarms and reducing unnecessary conversation with colleagues.

4.2 Still touch/ Comfort holding / Cuddling

- ‘Still touch’ is often holding a hand or a foot and talking gently to the infant, offering reassurance. This offers a minimal amount of touch, so is not too invasive for the extremely preterm or critically unwell baby and allows the baby to get used to being touched and to learn that touch can be a positive experience.
- Comfort holds are resting holds and are best offered to the infant when the carer has warmed their hands. The carer’s two hands can be used to gently ‘contain’ the infant, making them feel enclosed and secure. The infant’s head can be cupped with one hand and the other hand placed on or over the infant’s tummy, trunk or bottom. The hold is continued for as long as the infant’s condition allows, closely observing the infant’s behavioural cues and physiological condition throughout. These may be positive or negative.
- A cuddle – where the baby is cradled in a carer’s arms- is a ‘normal’ part of parenting, and something that parents should be encouraged and supported to do when the baby is well enough to tolerate this. The benefits of a cuddle are that the baby can be seen by the person
cuddling them, allowing an opportunity to interact with the baby. The baby can also be looked at and explored by touch, enabling a parent to get to know their baby more intimately.

- A cuddle can be given instead of kangaroo care for some babies who do not fit the criteria for kangaroo care – for example where there are newly sited umbilical lines.
- A cuddle can also be enjoyed if a parent is only visiting briefly and does not have time for a prolonged episode of kangaroo care.
- Evaluate results of positive touch, comfort holding and/or cuddling and document in care plan.

4.3 **Kangaroo Care/ Skin to Skin.**

- The concept of Kangaroo Care (KC) initiated in Columbia in 1979 after a shortage of incubators led to the practice of babies weighing less than 1.5kgs being nursed naked, except for a nappy, between their mothers breasts or on their fathers naked chests and enclosed by their parents clothes and/or a blanket. Thus, these babies were kept warm and soothed by their parents’ heartbeat. As the practice grew, so did evidence of the beneficial effects to both parents and babies. These included improved lactation and parental bonding for the parents, whilst improved oxygenation and deeper sleep states were recognised in some babies. These benefits are reported as increasing with duration of kangaroo care.
- Kangaroo care is still used in the neonatal units in developing countries as a cheap and safe method of keeping premature babies warm over many days or weeks. However in neonatal units with funding and facilities to provide incubators to for babies to be nursed in, kangaroo care is used as therapeutic intervention for the baby and its parents/carers.
- The risks of kangaroo care for infants include hyperthermia, hypoxaemia and accidental extubation of ventilated infants. These risks are found to be significantly reduced with experience. No risks to parents have been documented; however research suggests that some are discouraged by a lack of support and information, and a reluctance to discuss their feelings with nurses.

4.3.1 Each unit should have their own agreed exclusion criteria for Kangaroo Care. These would usually include; (relative- not absolute contraindications.)

- Extremely preterm infant in first 72 hours of life.
- Presence of umbilical catheters
- Muscle relaxed infants
- Significant breakdown of skin integrity/ extreme immaturity of skin
- Significant temperature instability
- HFOV/ high PIP/ on NO/ FiO2 >0.75%
- Baby deemed to be too unstable- i.e. multiple inotropes required.
- Parents’ unavailable or currently unsuitable (i.e. recent alcohol/ drug intake.)

4.3.2 Preparation

- Make available comfortable chair/ footstool/ soft blanket(s) /screen for privacy/ cushions for parent or baby if required.
Perform any necessary procedures that may otherwise require K C to be interrupted (ie blood tests/ passing feeding tube).

For the best skin to skin contact a baby should be dressed only in a nappy, however a baby will still enjoy KC wearing clothes.

Babies nursed in incubators or less than 2kg should wear a hat to start KC. This may be removed if the baby feels too warm. (Booties may be worn)

Ensure all lines and tubes are secure.

Ensure parents are comfortable in the seat provided/ have been to the toilet/ have a drink available/ have a book, telephone or other articles required close by.

4.3.3 Transfer

Always ask for help from colleagues when transferring babies receiving respiratory support or where you do not feel confident to move the baby alone.

Ensure that all lines/cables are not caught behind equipment and have enough length to enable the baby to be moved to the parent’s chair.

Identify the most vulnerable lines/tubes (i.e. et tube/ central line) for particular protection during transfer.

It is often safer and easier to disconnect nasal continuous positive airway pressure (CPAP) or endo tracheal (ET) tubes from the ventilator tubing during transfer- to stop pulling on or dislodgement of these tubes.

The baby may be transferred using one of two techniques;

The two person transfer

In its simplest form the parent sits in the chair next to the cot space and the baby is transferred to them by the unit staff.

The aim is to minimize the disturbance and/or distress to the baby during the transfer, which can be quite disruptive and stressful for the baby. This can be achieved by;

- Proceeding calmly and steadily
- Keeping the baby flexed and contained with boundaries, ideally so their hands are next to their face.
- Transferring the baby to the parent wrapped in the lining of its nest, and putting the baby against the staff member’s body, during the transfer between cot and parent.
- Small babies may be ‘sandwiched’ between the two hands of the person transferring them, so that as the baby is slowly moved into the upright position and onto the chest, the baby’s weight shifts between one hand and another.

The single person transfer

The parent stands at the bed side or foot, and with an open shirt bends at the waist and lifts the baby directly into contact with their chest. The baby is contained completely by the parent’s chest and hands, and the parent is then guided and assisted to sit down and then recline in a chair next to the cot side.

The technique appears to be less disruptive to the infant, than the two person transfer. However parents are often concerned about the ‘responsibility’ of transferring the baby ‘themselves’ and require much reassurance and support.

Settling the baby
• When the baby arrives at the parent give them supported containment and minimal stimulation, to enable them to adjust to the move.

• Parental hand placement can be used to offer additional boundaries, and well as skin contact and warmth.

• Place the infant upright in a prone position on the parent’s chest (between the Mother’s breasts, or either side of the Mother’s breasts for twins). The baby will be at an angle of about 60 degrees.

• Take care to position the baby so that their head and neck are in line, without their head being thrown backwards. This should ensure that their airway is not obstructed.

• If possible, position the baby’s face so that the parent is able to see it. This will facilitate interaction, bonding and the parent’s ability to react to the baby’s responses.

• Cover the baby’s body with a blanket, or get parents to button up open fronted clothing. It is important that the baby’s head can be seen.

• Lines or tubes may need supporting to prevent them putting tension on the baby’s skin or limbs. Avoid asking parents to hold lines or cables still for long periods of time, as this prevents parents from relaxing fully and can often be quite uncomfortable to do. Instead relocate equipment like ventilators or infusion pumps to prevent tension. Where this is not possible, use tape to secure tubing to the chair or parents clothing for the duration of KC.

• Special slings or ‘skin to skin clothing’ is now available, which parents may choose to use. These products are generally designed to have some elasticity that will enclose the baby and give parents more confidence that their baby is safe and secure. They also, generally offer more easy access to place the baby on the parent’s chest and it should be fine for parents to use these items.

• Transfer is probably the most stressful part of KC for the infant. So a long enough period of KC should be planned that the baby has time to recover from KC and still have time to enjoy skin to skin before being KC is ended.

4.3.4 During Kangaroo Care

• Continue with any monitoring that was in place before KC commenced. No additional monitoring is required.

• It may be expected for a baby’s vital signs to take 20-30 minutes to stabilise after transfer.

• A baby’s oxygen requirement may increase following transfer. This factor on its own should not be considered a reason to stop KC. Often the baby’s oxygen requirement will settle after 5-25 minutes to a level lower than ‘normal’.

• Research has found that babies generally have no problems maintaining their temperature during KC, due to heat transfer and insulation gained from their parent.

• Parent and infant should be disturbed as little as possible during KC. Only necessary nursing or medical care should be carried out.

• Ensure the parents remains comfortable, and that drinks and book/ phone are accessible, offer pillows to support arms or head. If they feel cold they can be given a blanket.

• Keep the parent informed about the baby’s status, if they know the baby is stable they will be able to relax and enjoy the process. If you need to leave the immediate area, inform the parent who will be available to help them.

• Parents can be offered a mirror, in order to help them to watch their baby’s face and behaviour.

• Babies who are deeply asleep should be undisturbed for as long as possible.
- Babies can be gravity fed using an oral or nasal feeding tube during KC.
- Babies who need a breast/ bottle/ cup feed during KC will need to change their position during the feed, but can continue with KC once their feed is complete.
- Monitor and document any signs of distress.
- KC may be discontinued if the baby shows signs of:
  - repeated or profound desaturation
  - repeated or profound bradycardia
  - repeated or profound apnoea
  - dislodgment or concern about dislodgement of ET tube
  - dislodgment or concern about dislodgement of venous access
  - behavioural cues indicate that the baby is not happy AND attempts to make the baby more comfortable have failed

4.3.5 Signs the baby may give that they are not happy:
- crying
- squirming/ wriggling and not settling
- going very pale/mottled
- glazing over in the face
- being very still and floppy
- vomiting/possetting
- physiological instability

4.3.6 Actions that can be taken to try and make a baby comfortable:
- reposition baby, especially if their chin has become pushed down onto their chest- closing down their airway
- ensure all lines and tubes are not pulling on baby’s skin or limbs
- check if baby has ‘slid down’ parent’s chest and become squashed or twisted
- encourage parent to talk soothingly to baby
- encourage parent to provide containment of baby’s body and head, using their hands
- feel if baby may be too hot or cold - add or remove a blanket accordingly

4.4 Co-bedding.

Co-bedding is when twins or multiple birth siblings are nursed in a single cot or incubator.

Multiples should be offered co-bedding as soon as they fulfil the criteria for good practice. Multiples have shared the same intrauterine environment for months and during this time have interacted together. It therefore seems logical after birth, to keep them together where they can continue to interact.

It may be reasonable to assume that these babies are born with a unique expectation of what is a normal environment after birth and that their transition to the outside world may be enhanced by continued close physical contact with each other.”
'It is important that we move towards a philosophy of care that carefully considers the attachment between multiples and their potential to support each other through the transition to extrauterine life.'

Reported benefits of co-bedding:
- Co-bedding is believed to promote physiological stability, co-regulation, growth and development.
- A study has shown a reduced level of apnoeas in co-bedded twins, due to skin-to-skin contact.
- Co-bedding has been shown to improve communication and decrease the number of staff involved with each individual twin.
- Co-bedding has been shown to enhance the physiologic recovery of preterm twins undergoing heel lance, but did not lead to lower pain scores.
- Nursing staff report parents seem happier when their babies are co-bedded.
- There has been no incidence of increased infection and no adverse clinical effects reported from co-bedding.

Reported challenges of co-bedding:
- more difficulty performing procedures and routine care
- increased potential for medical errors (feeds or drugs particularly)
- dislodgement of feeding tubes or monitoring leads by the co-bedded sibling
- if the babies are significantly different in size or weight the increased accidental suffocation increases
- parents may feel they are receiving the message that co-bedding is beneficial and safe in the home setting, when there is a lack of research in this area

4.4.1 Criteria for consideration of co-bedding
- Neither baby may require ventilator support (i.e. Ventilator or CPAP/ High flow/ Vapotherm. Low flow oxygen is acceptable.)
- Neither baby may have an arterial catheter in situ.
- Neither baby may have an umbilical line(s) (arterial or venous).
- Neither baby may be suspected or known to have sepsis.
- Both infants must be ‘stable’. (For example - one infant should not need so much intervention that the other twin is continually disturbed.)
- Neither baby should be requiring phototherapy.

4.4.2 Before implementing co-bedding
- Babies need to meet the criteria for co-bedding and be assessed before, and during the initiation of co-bedding.
- Parental preference to co-bed their babies is identified and documented in the care plan.
- Parents should be notified of the intention to begin co-bedding before it is initiated in practice. This gives parents the opportunity to reconfirm that they still consent to co-bedding.

4.4.3 Beginning co-bedding
• Check that each baby has two name bands on and that they are securely attached.

• Baby’s first names should be written on the name bands, not only twin I or II or A or B, to minimise the chance of misidentification.

• Monitors, iv lines and iv pumps, feed lines and syringe pumps should be positioned for each baby so that they are separate from the other babies. For example on different sides of the cot.

• As much as possible any wires/ lines for one baby should be positioned so that they do not come into contact/overlap with those belonging to the other baby(s).

• If either baby is using an apnoea monitor the abdominal sensor type of monitor must be obtained and used during co-bedding. There is a risk from the ‘apnoea mattress type’ monitor that the movement of one twin will incorrectly trigger the monitor of the other twin, indicating respiration that may not be present.

• Lines, cables and medical equipment is NOT labelled as belonging to a particular baby, because of the risk that labels are dislodged or incorrect.

• Jointly with parents choose the position in the cot that each baby will be nursed, ie left/right/middle. This will not be changed again whilst the babies are co-bedded. If parents know what position the babies were lying in utero, in relation to each other, then they may choose to position the babies in the same relative positions.

• If the babies are triplets some units will deliberately put the smallest triplet into the middle space, to assist with their heat retention.

• Label the head of the cot with the babies’ cot cards. For example, so that the baby chosen to be on the right of the cot, has their cot card above their head.

• All articles of personal hygiene must be clearly labelled and kept separately for each baby (i.e. mouth care water and paraffin oil/face and bottom bowls). Clean nappies and clean cotton wool can be shared.

• A spare cot must be set up so that if the babies need separating quickly a bed is instantly available.

4.4.4 Co-bedding in practice

• One nurse is allocated to all babies per shift but a team approach should be maintained.

• Identification of the babies is the joint responsibility of all nurses and doctors.

• At the beginning of each shift check that two name bands are attached to the baby and are secure.

• Careful checks must be made at the beginning of each shift to identify each baby and their own lines/cables, equipment. In particular staff must be confident which monitor belongs to which baby, so they can safely respond to any changes in the baby’s status.

• Consider clustering a baby’s care to avoid excessive disturbance to the other baby(s). However the priority should be to give individualised care, by responding to a baby’s behavioural cues.

• Record all care and recordings of one individual before moving onto the next baby.

• Staff should ensure strict hand washing between procedures and babies.

• Parents should use strict hand washing after contact with bodily fluids (i.e nappy care) and should use alcohol hand rub between handling of their different babies.

• Dress babies individually and cover together in the same blanket/bedding.
• Babies should be positioned close enough to able to touch/interact with each other - if being nested the babies would share one large nest. Do not put bedding barriers between the babies.
• Record babies’ individual temperatures regularly (4-6 hourly) and adjust clothing of each baby accordingly.
• Always position babies in the same place in the cot i.e. Twin A on right hand side and Twin B on left hand side.
• Babies can be placed side by side and positioned in accordance with positioning guidelines.
• The standard safe sleeping practices for prevention of cot death should still be applied. For example nursing babies supine, with ‘foot to feet’.
• Regularly assess the baby’s tolerance of co-bedding and document.
• Regularly assess to ensure the babies are still meeting the criteria for co-bedding.
• If either baby’s status changes and they no longer fulfil the criteria for co-bedding, the babies should be separated.

4.4.5 Preparing for discharge
• If parents wish to continue co-bedding after discharge, that should be at their own discretion and not actively promoted by staff, as there is limited research available about co-bedding at home.
  o Parents should be given the FSID recommendations for co-bedding at home, which include;
    ▪ All safe sleeping advice applies to babies who are co-bedded, the same as it applies to singletons.
    ▪ Babies can be placed side by side on their backs at the bottom of the cot in the foot to feet position.
    ▪ If parents want to give their babies more space by nursing them side by side across the width of the cot, the babies should be nursed in baby sleep sacs rather than blankets. This is because it is not possible to tightly tuck in the bed covers when babies are laid in this way, and there is a risk of loose covers being pulled over a baby’s heads.
    ▪ Moses baskets and small cribs are not suitable for co-bedding due to the risk of overheating.
    ▪ When babies are big enough to roll over they need to be separated into their own cots, so they cannot obstruct each other’s breathing.

4.5 Parents
• Assess the needs of the infant and his/her family considering their needs for support/privacy/readiness to learn about or begin positive touch.
• Explain the indications and rationale for positive touch to parents/carers and the benefits to themselves and their infant.
• Assist parents in identifying the most appropriate type of touch for their baby. If a baby is not well enough for a particular type of touch, explain to the parents why this is not currently beneficial. Wherever possible offer an alternative - i.e. comfort hold instead of cuddle - so that the parents do not feel rejected by or barred from contact with their baby.
- Encourage the parent/carer to talk gently to their infant and to observe their behaviour and condition throughout, supported by the nurse caring for their infant.
- Offer parents the Bliss booklets ‘Look at me, I’m talking to you’ and ‘Skin to skin with your baby’. Also show parents the Bliss posters illustrating comfort holding and kangaroo care or local displays of information.
- Where relevant, offer parents the leaflet ‘Co-bedding multiples on the neonatal unit’- see appendix 1 on page 17-18.
- In most instances KC should be limited to Mothers and Fathers.
- Ordinary hygiene and skin cleansing for parents is all that is necessary for parents to participate in positive touch.
- Parents with rashes or open skin lesions should abstain from KC.
- Some fathers are concerned about their baby resting on their chest during kangaroo care, if it is hairy. Reassure them that this should not cause a problem, but if they are still concerned the baby’s face can be protected using a small soft sheet, so that the baby’s body is still in direct contact with the father’s skin.
- Parent’s physical ability to carry out KC should be assessed. There may be a temporary incapacity due to parental intake of drugs or alcohol, meaning that parents would not be allowed to give KC on that occasion. For parents with ongoing incapacity, due for example to disability, staff should seek ways to facilitate safe KC, rather than deny parent and baby the benefits of KC.
- Parents will benefit from practical information relevant to positive touch. For example advice about wearing a top that opens at the front to allow easy access to the baby for KC. Or planning enough time for their visit, as KC should ideally be for as long as the baby will tolerate and this is frequently one or more hours.
- Parents should be reassured that help is always nearby if they are cuddling or having KC with their baby. Also, that if they feel the baby is compromised at any time, then the baby will be returned to bed.
- Document when and for how long a parent does KC/ cuddling for. This may be using the Bliss Kangaroo care record chart and stickers or another local method. This information is compared across units, so it is important that it is accurately recorded. Also record any concerns or preferences that the parents may have.
- To ensure parents have access to full and up to date advice on cot death prevention at discharge, offer all parents the ‘Time to get back to sleep advice card’ and The Lullaby Trust contact details; Telephone (general enquiries): 020 7802 3200, or email office@lullabytrust.org.uk This is particularly relevant if their babies have been co-bedded in the hospital setting.

4.6 Documentation

- All episodes of positive touch should be documented in the nursing record.
- Any concerns arising from positive touch should be clearly documented, including any action taken.
- If kangaroo care occurs during a shift this may need to be recorded in a designated place in unit paperwork- as many units are gathering this information for the ‘Badger’ data base.

4.7 Staff
• Staff should familiarise themselves with the positive touch guideline and seek further advice or clarification from the nurse in charge, or unit developmental care leads, if required.

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<td>Final for approval.</td>
<td>TVQCG</td>
<td>Neonatal Network Board approved.</td>
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<td>Reviewed Jul ’16 to Feb ’17-draft for comments sent to Fiona Lawson, Lead Nurse (Chair).</td>
<td>TV Neonatal ODN QCG</td>
<td>FL approved content in discussion with Kim Pease, Developmental Care Lead (UHS)</td>
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<td>Apr ’17</td>
<td>Presented to TV&amp;W Neonatal ODN Governance Group for approval.</td>
<td>TV Neonatal ODN QCG</td>
<td>Ratified 19 October 2017</td>
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Review Date: July 2020
Appendix 1

Co-Bedding Multiples on the Neonatal Unit

A Parent's Guide

What is co-bedding of multiples?

- Co-bedding means nursing your babies together in the same cot.
- Co-bedding seems sensible, as your babies have been very close to each other during your pregnancy.
- There are advantages to co-bedding but there are also some issues that you need to be aware of before co-bedding may begin. These will be discussed with you at the earliest opportunity.
- Not everyone wishes for their multiples to be co-bedded, if this is your wish please let the nursing staff know.

Is co-bedding useful?

- Co-bedding seems logical when you think that your babies have been closely together for several months in the womb.
- Cobedded babies tend to conserve their heat and maintain their body temperatures well.
- They also tend to gain weight quicker and have a shorter hospital stay.
- Babies seem to settle better when together and gain comfort from each other.
- The babies are less likely to have apnoeas (forget to breath) if premature, when nursed together.
- One nurse will be allocated to look after your babies, therefore there is less likelihood of confusion over treatments and medication.

Babies will not be able to be nursed together if they have a particular kind of intravenous line going into their umbilicus. These are often called a UAC or UVC. However, babies that do have these lines will not normally have them for longer than 10 days at which point co-bedding could then be considered.

How is it done?

- Co-bedding will be offered to all parents of multiples once the babies have stabilised. This will be a mutual decision between parents, nurses and doctors.
- Your babies are nursed next to each other in a cot. They will be no space between them and they will be covered in the same blanket, or in a nest if they need close observation.
- They are always nursed in the same place i.e. twin 1 on the right and twin 2 on the left. (It is helpful to know which position they were in the womb and consider copying that.)
- Co-bedding can be tried for short periods and then extended if the babies like it.
Your babies must always have two name bands on and their personal equipment (e.g. mouth care, toiletries and washing bowl will be kept labelled for them)

Possible disadvantages

- The babies may disturb each other or not like being in the same cot. This may be transient and they may get used to each other and then like it, if they do not, then they can be nursed separately.

- It is a bit more challenging to do care such as nappy changes with babies in the same cot.

If you wish to co-bed your babies please discuss this with a member of staff. Choosing to co-bed twins/triplets should always be a joint decision between you, (the babies' family) and the nurse and doctor. If you feel unsure about co-bedding it can be tried for a short period before a definite decision is made. Co-bedding is always a flexible arrangement, as your babies’ conditions may change.

Co-bedding at home

- If you are thinking about continuing to co-bed your babies at home, we suggest you seek advice from the Lullaby Trust about how to do it safely, whilst following the cot death prevention guidelines.

- Also talk to your local Health Visitor, as research looking at the safety of co-bedding has only looked at babies co-bedded in hospital not in their own homes.