VENTILATED INFANT FOR KANGAROO PARENT CARE

This LOP is developed to guide safe clinical practice in Newborn Care Centre (NCC) at The Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this Local Operations Procedure (LOP).

INTRODUCTION
Kangaroo Parent Care, commonly known as Kangaroo Mother Care (KMC) or skin-to-skin care, is a vital part of nursing care for the newborn and caregiver. Benefits include decreased oxygen requirement, more stability in vital signs, temperature control, bonding and breastfeeding. For parents the benefits are increased milk supply, contraction of uterus post birth, bonding and psychological benefits.

1. AIM
- To ensure the safe provision of KMC for babies who are ventilated in the NCC.

Individual circumstances must be assessed including:
- parental choice
- accessibility of medical and nursing staff

Exclusion criteria:
- post-operative babies in the immediate post-operative period
- pre-operative gastroschisis
- infants with umbilical arterial lines
- infants who are clinically unstable

Potential exclusion criteria (to be discussed on ward rounds):
Consider modified versions of KMC or basic 'cuddles' for these infants
- infants with under water sealed chest drains
- infants in high percentages of humidity who have an unstable temperature
  NOTE: Humidity is **NOT** an automatic exclusion

2. PATIENT
- Neonates

3. STAFF
- Medical and nursing staff

4. EQUIPMENT
- Neopuff and mask
- Suction working and easily available (use extension tubing if needed)
- Suction catheters (short, 10Fr)
- Comfortable, stable chair
- Soft warm blanket, beanie (optional)
- Footstool (optional)
- Gown for parent (optional)
- Pillow (optional)
- Mirror for parent to easily view infant's face
- Resus trolley available
- Stethoscope
- 2.5cm Leukoplast

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VENTILATED INFANT FOR KANGAROO PARENT CARE cont'd

5. CLINICAL PRACTICE

Transferring out of crib to parent

1. Discuss with parent/s the benefits of KMC and establish an appropriate time. Ensure:
   - parent is not due to express breast milk
   - has drinking water available
   - a toilet visit is not required
   - can sit for a period of time to hold the infant for one hour minimum
   - wearing appropriate clothes (a hospital gown may be used)
2. Assess the infant's readiness for KMC.
3. Ensure that medical staff is aware and available for inadvertent events.
4. Gather equipment.
5. Prepare the infant:
   - Suction the ETT if needed.
   - Ensure ETT is secure - re-tape if needed.
   - Do a set of baseline observations including temperature.

NOTE:
- KMC is best conducted after cares (R1)
- Handle and transfer infant prior to feeding (R2)
- Apply a beanie hat

   - Position all lines on the side of the crib that the infant will come out (Picture 1). (R3)
   - Ensure the ventilator is accessible during KMC – position ventilator behind the parent. (R4)
   - Ensure the Neopuff tubing has adequate "stretching" length to use during the infant's transfer from crib to parent.
6. Auscultate chest for air-entry. Ensure that ventilation tubings has no tension or "drag" before and during transfer. If this is not possible Neopuff can be used for transfer (Picture 2).
7. RN assisting must monitor the infant's airway and tubings (Picture 3). Another assistant may be required if the infant has multiple lines. Infant may be transferred from the crib in a nest or wrapped loosely in linen. Remove linen post transfer.

Picture 1

Picture 2

Picture 3

VENTILATED INFANT FOR KANGAROO PARENT CARE cont'd

8. If the infant is not provided with security, use hands to provide a "nest" to secure the infant and contain the wire. (R5)
9. Gently transfer the infant from the crib to the parent's chest.
10. Monitor the infant's clinical status. Multiple moving steps may be required if infant becomes distressed.
11. Ensure parent's dignity during KMC. Consider use of a privacy screen.
12. Infant should be finally placed to prone position on parent's chest with head to one side (facing the ventilator tubing). Ensure tube stability by adopting one of two possible positioning of ventilation tubes (see Picture 4 & 6).
13. If using Neopuff for transfer re-attach ventilator. Auscultate chest, suction as necessary and assess ventilator values.
14. Use leukoplast tape to secure ETT and ventilator tubing onto parent's clothing, the chair or parent's skin (Picture 6).

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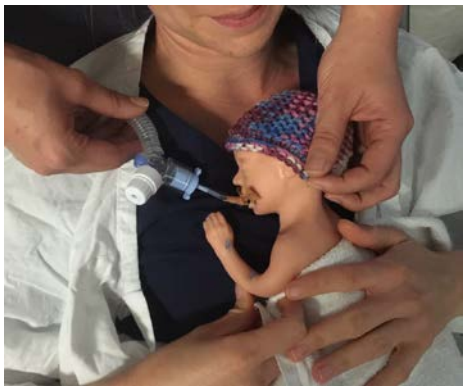
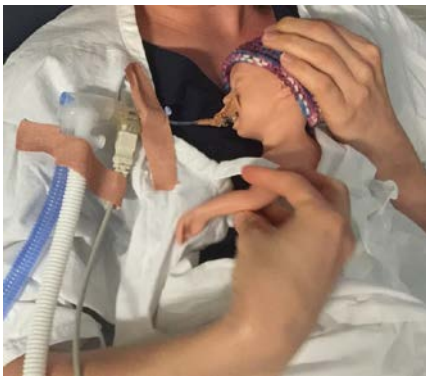
Picture 4



Picture 5



Picture 6

15. Ensure that the NGT is easily accessible for feeding.
16. Provide a footstool and pillow for parents to elevate their legs while in a reclining chair.
17. Encourage parent's hand to be positioned on the baby. Usually one hand over the head and one under the bottom with legs tucked up and under on parent's chest. (R6)
18. Provide a bunny rug or blanket on baby as necessary.
19. Ensure that the mirror and drinking water is accessible to parent.

NOTE: KMC should ideally be provided for <u>at least one hour per session</u>. There is no maximum time limit for kangaroo care. Frequency of KMC should be no more than twice per day.

<u>Transferring back to crib</u>

1. Auscultate and suction if necessary.
2. Undo taping to ventilator tubing and sit parent upright in their chair.
3. Transfer infant slowly, with assistance as needed, back into crib. Ensure airway stability at all times and use containment holding as before.
4. Auscultate chest and suction as needed after transfer.
5. Settle infant into nest, reattach and organise all wires/tubes/lines.
6. Encourage parents to contain infant until they settle.
7. Tidy and clean area. Document KMC given on observation chart.
8. Check temperature in one hour.

VENTILATED INFANT FOR KANGAROO PARENT CARE cont'd

6. DOCUMENTATION

- Integrated Clinical Notes
- Observation Chart

7. EDUCATIONAL NOTES

8. RELATED POLICIES/PROCEDURES/CLINICAL PRACTICE LOP

- Humidification – Dräger Isolette
- Guide to providing Kangaroo Mother Care

9. RISK RATING

- Medium

10. NATIONAL STANDARD

- Comprehensive Care

11. REFERENCES

- Als H., Gilkerson L. (1995) Developmentally supportive care in the neonatal intensive care unit. *Zero Three*. 15(1995) pp.1-10.
- Heimann K., Vaessen P., Peschgens T., (2010) Impact of skin-to-skin care, prone and supine positioning on cardiorespiratory parameters and thermoregulation in premature infants. *Neonatology*. *97(2010) pp.311-317*
- *Ludington-Hoe, S.M. (2013) Kangaroo Care as a Neonatal Therapy. Newborn and Infant Nursing Reviews. 13(2013) pp.73-75*
- Neu, M., Laudenslager, M.L., Robinson, J. (2009) Co-regulation in salivary cortisol during maternal holding of premature infants. *Biological Research Nursing* 10(2009) pp.226-240.

12. ABBREVIATIONS AND DEFINITIONS OF TERMS

KMC	Kangaroo Mother Care	IV	Intravenous
NCC	Newborn Care Centre	NGT	Nasogastric tube
ETT	Endotracheal tube		

13. RATIONALES

Rationale 1	when the baby is already disturbed but will be as comfortable as possible
Rationale 2	so as not to cause vomiting/aspiration of feed during transfer
Rationale 3	to avoid accidental disconnection of lines
Rationale 4	positioning ventilator tubing around the parent's neck reduces the slack/weight from it
Rationale 5	Contained holding is essential to minimise the stress of the movement as much as possible
Rationale 6	To keep the infant secure and in an optimal position

14. AUTHOR:

Primary	3rd Sept 2015	ACNE/CNS A. Ottaway
Revised	N/ A	N/A

REVISION & APPROVAL HISTORY

Approved Quality & Patient Care Committee 5/5/16

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