# South Central Neonatal Network Quality Care Group

*Working to provide a unified approach to excellence*

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## Guideline framework for kangaroo care

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<th><strong>Related documents</strong></th>
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<td>Nyqvist, K.H. et al (2010) Towards universal Kangaroo mother care; recommendations and report from the First European conference and</td>
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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.

1.0 Aim of Guideline Framework

To provide a framework to ensure that all babies whose condition allows, and parents have the opportunity for skin to skin contact in a safe and supported environment.

2.0 Scope of Guideline Framework

The guideline applies to all babies receiving kangaroo care within South Central and is a framework for use by all neonatal staff within South Central Care Unit.

North Network

Milton Keynes General Hospital, NHS Foundation Trust
Oxford University Hospitals NHS Trust, both John Radcliffe Hospital site & Horton site.
Buckinghamshire Healthcare NHS Trust, Stoke Mandeville site.
Royal Berkshire NHS Foundation Hospital
Heatherwood & Wexham Park Hospitals NHS Foundation Trust

South Network

Dorset County Hospital NHS Foundation Trust
Hampshire Hospitals NHS Foundation Trust, Basingstoke site & Winchester site
Poole Hospitals NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
Salisbury NHS Foundation Trust
IOW NHS Primary Trust, St Mary’s Hospital site
Portsmouth Hospitals NHS Trust
Western Sussex Hospitals NHS Trust, St Richard’s site.

3.0 Background information

3.1 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.

3.2 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.

3.3 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.

4.0 Practice guidelines

4.1 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 KC 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 or other articles required close by.

4.2 Transfer.
- Always ask for help from colleagues when transferring babies receiving CPAP or ventilation 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 (ie, et tube/central line) for particular protection during transfer.
- It is often safer and easier to disconnect nasal CPAP or ET tubes from the ventilator tubing during transfer - to stop pulling on or dislodgement of these tubes.
- Place the infant upright on the parent’s chest (between the Mother’s breast, 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.

- 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 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.
- 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.
  - dislodgement 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.

4.4 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.

4.5 Actions that can be taken to try and make a baby comfortable.
- reposition baby.
- 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.
4.6 Parents,

- In most instances KC should be limited to Mothers and Fathers.
- Ordinary hygiene and skin cleansing for parents is all that is necessary.
- Parents with rashes or open skin lesions should abstain from KC.
- Some Fathers are concerned about their baby resting on their chest 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 should be offered written information about KC. This may include showing them the Bliss KC posters, which provide a lot of information about KC and show photographs other parents doing KC. They will also benefit from practical information such as wearing a top that opens at the front to allow easy access to the baby 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 and 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 for, and record any concerns or preferences that they may have.