



<b>CLINICAL GUIDELINE</b>	
<b>Parenting in the Neonatal Unit</b>	
<b>Scope (Staff):</b>	Nursing and Medical Staff
<b>Scope (Area):</b>	NICU KEMH, NICU PCH, NETS WA

**This document should be read in conjunction with this [DISCLAIMER](#)**

**Contents**

Background..... 2

Family Integrated Care..... 2

Admission ..... 2

Parent Involvement in Infant Care..... 3

Cuddling/Holding the Infant..... 4

Parent Involvement in Infant Feeding..... 5

Parent Involvement in Decision Making ..... 6

Parent Education ..... 7

Appendix: Guide for parents introducing their baby on the ward round ..... 8

## Background

The quality and nature of parent-infant relationships influence the infant's development, identity and the formation of subsequent attachments. Parents separated from their infants through admission face several challenges in developing relationships with their infant as they deal with obstacles presented by their infant's condition, the environment of the neonatal nursery and disruptions to their own processes in preparing for their parenting role.

Those working with infants' and their families hold a privileged position, exerting influence and guiding parents' earliest interactions with their infant; they have a responsibility to keep informed of the factors influencing the parenting role and to utilise evidence based interventions to promote infant development. The delivery of care and support to infants and families should foster the development of these significant relationships, particularly for families at risk including parents of preterm and sick infants, infants with congenital abnormalities, and families with limited socioeconomic resources.

## Family Integrated Care

Family Integrated Care (FICare) is a model of care for infants and their families practised at WNHS. In FICare parents are supported to be integrated with the NICU health team in the care of their infants. The FICare model provides the structure for parent-centred care in WNHS.

The goal of FICare is to facilitate the partnership and collaboration between parents and the NICU health team so that parents are providing active care for their infant.

This is achieved by:

- 1) Parents are invited to be partners with the NICU health team in their infant's care on admission to the NICU or neonatal nursery.
- 2) Parents are supported to participate. This support is multidimensional and includes the health care team, social work department, psychological medicine and graduate parents.
- 3) Parents are taught care giving activities by the bedside nurses and can participate in providing care for their infants.
- 4) Parents can attend ward rounds and participate in decisions on ward rounds.
- 5) Parents are provided with education.

Preliminary research suggests that infants admitted to the NICU and cared for under the FICare model grow faster and have less stress, spend fewer days in the NICU, and are less likely to be readmitted to hospital after discharge, compared to infants cared for primarily by staff.

## Admission

- When one or both parents are present on their infant's admission to the NICU, staff caring for the infant should acknowledge their presence, introduce themselves, congratulate the parents on the birth of their child. When the situation allows, provide a simple explanation of infant's current condition and care including equipment and monitoring, the visiting guidelines, and availability of parent facilities.
- If both parents are unable to visit the NICU within the first few hours of admission, the medical/nursing staff caring for the infant should telephone parent/s or visit the mother to provide information regarding the infant's condition and care. Visiting the mothers is possible for infants at KEMH whose mothers who are also inpatients at KEMH.

- A photograph of the infant should be provided to the parents - provision of an infant photograph has been demonstrated to have a significant positive effect on maternal-infant bonding.
- Determine the mother's chosen method of infant feeding and document this in progress notes and on the neonatal history sheet.
- Determine whether the infant has been named, and whenever possible, call the infant by his/her given name to reinforce their identity. Refer to the infant by the correct sex pronoun (he/she).
- Encourage and assist parents to touch their infant (in a manner that is appropriate to the infant's gestation and condition) in the hours and days following admission - such contact has been shown to impact significantly on later maternal-infant interaction.
- Sensitivity to the loss of a baby in a multiple birth situation. Ensure this information is handed over shift to shift so that parents are not asked where the other infant is and the tear drop sticker is prominently displayed.

### **Parental Involvement in Infant Care**

Parents should be encouraged to become familiar with and be taught to participate in infant's care as appropriate to the infant's condition and the parents' readiness to contribute to care. In the first few days after admission, some parents may be fearful for the outcome for their infant and avoid contact and interaction. All parents need support and encouragement during this time of crisis.

- If parents have not made contact with the unit by midday each day, the nursing staff members are to contact the parents to give them an update on the infant's progress. At this time, inform the parents of the plan for the day, so they can decide the best time to visit and contribute to cares.

When parents attend the unit, discuss developmentally appropriate interaction, explaining the infant's capacity to tolerate and respond to different types of stimuli. The paediatric physiotherapist will be involved as appropriate to assist parents in identifying their infant's positive and negative responses to interaction such as positive behavioral responses or less tolerant behaviors' such as colour changes and deterioration in vital signs.

The degree of parent-infant contact will be guided by the infant's medical condition, tolerance of handling and parental readiness to participate in parent-infant contact.

### **Medically Unstable Infants (Muscle-Relaxed / Inotropes / First 24 Hours Post Major Surgery)**

Promote active participation in infant care and facilitate parent-infant interaction by providing opportunities for provision of care and interaction, providing constructive feedback and support and promoting parental independence in providing care. Practical methods to achieve this:

- Parents can be guided in providing gentle, non-stimulating touch such as placing a hand on the infant's head or over a limb, or by placing a finger in the palm of the infant's hand.
- Parents should be encouraged to talk/sing/read to their infant.
- If gentle touch is tolerated, parents can be instructed in providing mouth care, and can assist with hygiene needs such as nappy changing. They can also be taught to apply coconut oil if it is prescribed.
- Medically unstable infants should not be moved for parent-infant holding without consent of the consultant neonatologist.

- Involve parents in decision making (see below).

### **Infants Receiving Assisted Ventilation (Mechanical Ventilation, CPAP)**

Promote active participation in infant care and facilitate parent-infant interaction by providing opportunities for provision of care and interaction, providing constructive feedback and support and promoting parental independence in providing care. Practical methods to achieve this:

- Parents can be taught to provide care and developmentally appropriate interaction such as assisting with hygiene needs, mouth care, hold the tube during gavage tube feeds (put link in here) and apply coconut oil.
- Parents can be taught to calm the restless infant through appropriate touch, talking, singing, reading providing periods of eye contact with the infant.
- Liaise with parents to schedule parental involvement in infants cares to co-ordinate daily cuddles.
- Involve parents in decision making (see below).

### **Medically Stable Infants Nursed In Incubators / Radiant Warmers / Cots**

Promote active participation in infant care and facilitate parent-infant interaction by providing opportunities for provision of care and interaction, providing constructive feedback and support and promoting parental independence in providing care. Practical methods of achieving this may include:

- Continue to involve parents in hygiene needs, mouth care, holding syringe tube during gavage tube feeds (link here), applying coconut oil
- Liaise with parents to schedule the infant's cares and feeds for times when they are available to participate.
- Encourage parental responsibility for infant bathing and/or selection of clothing. The first bath of infant should be performed with the parents.
- Liaise with parents to schedule time for holding and cuddling their infant.
- Teach parents of suitable infants to perform IGT feeds (teaching package available in the nurseries).
- Involve parents in decision making ([see below](#))
- For infants that do not require continuous monitoring and/or infusions, consult medical staff to determine whether infants may spend time away from neonatal nursery with their parents (e.g. Parent lounge/room, day leave) and liaise with parents to schedule time for this.

## **Cuddling/Holding the Infant**

### **Which infants can be held by their parents?**

- Parent cuddling/holding/skin- to- skin of their infant does need to take into account the medical condition of their infant.

**Exclusion criteria** to being held by the parents are few. They are listed here:

- Considered too medically unstable by consultant neonatologist. Eg muscle relaxed infant, Chest drains/abdominal drains in situ.
- Within 48 hours of major surgery.
- Umbilical lines that are considered to be not securely enough fastened by senior nursing and medical staff. A securely fastened umbilical line is not an exclusion criteria for an infant to be held in its parent's arms.

### **Infants who are stable enough to tolerate routine weighing:**

- The infant may be held by the parent on a daily basis (regardless of whether the infant is nursed in an incubator, radiant warmer or open cot or receiving respiratory support).
- Infants who are in an open cot and receiving respiratory support such as those who have been transitioned to HHF from CPAP or who have been stable on CPAP for more than 1 week may be held more than once a day.
- Infants who are in an open cot and not requiring respiratory support can be held at their parent's discretion.

### **What types of cuddles/holds are available?**

- Parents can hold their infants in their arms
- Or skin- to- skin (kangaroo care) hold. Please refer to the link to guide decision to offer skin to skin, criteria for skin to skin holds and process for skin to skin. The guideline on [skin- to- skin](#) holding should be read in conjunction with this section.

### **How to schedule a cuddle/hold/skin to skin**

- Liaise with the parents for when they are available and what type of hold do they want.
- Review number of infants out for cuddles at the same time, staff meal breaks and other procedures taking place within the nursery.
- Schedule time for cuddle/hold and alert the coordinator.
- Prior to refusing a parent a cuddle/hold liaise with senior nursing staff to ensure that all options to allow the cuddle have been explored.

### **How long is the cuddle/hold/skin to skin to go for?**

- Unless the infant shows signs of intolerance of such handling, cuddles should be of at least 20 minutes duration to allow time for the infant to adjust to their new position and for the parent to relax and interact with their infant. Skin- to- skin holds are recommended to be longer. Please refer to [skin-to- skin](#) guideline.
  - There is no maximum time limit. The time an infant is out for cuddles should be determined by the parents.
  - In exceptional circumstances nurses may ask the hold to end.
- Infants receiving mechanical ventilation should have their chest auscultated prior to being moved for parent-infant holding to ensure that ETT suction is not required. These infants should also have their chest auscultated on returning to the incubator/cot.
- For infants receiving assisted ventilation, two nurses, (one of which is to be deemed competent in coordinating ventilated weighs) should be involved in the transfer of the infant from their bed to their parent's arms.
- Infants receiving assisted ventilation should have a staff member readily available throughout their cuddle to provide assistance should complications arise e.g. Adverse responses, disconnected ventilator tubing, blocked/dislodged ETT.

### **Parental Involvement in Infant Feeding**

The infant's first feed is a significant event for many parents. Mothers that choose to breastfeed their infant should be provided with the support and encouragement required to establish lactation and breastfeeding. Breast pumps, breast milk storage facilities, and instructions on expressing, breast milk storage and establishment of breastfeeding should be readily available to mothers.

Mothers should be consulted for consent for formula milk and/or pacifiers/dummies to be used. Their decision should be adhered to and documented clearly in the observation chart and progress notes.

Feeding schedules may be adjusted to accommodate times that are convenient for parents.

Instruction in formula preparation and sterilisation of feeding equipment should be offered to all parents that choose to artificially feed their infants beyond discharge. Parents need to have selected formula to be used at home prior to instruction.

## Parental Involvement in Decision Making

As a result of admission to a NICU, parents may have feelings of helplessness and be unsure of their role. Even though health professionals are directing the care of the infant, parents can assist in decision-making regarding some aspects of their infant's care. This role expanding as the infant's condition stabilises and the family nears discharge from the neonatal unit.

The Neonatal Team play a pivotal role in supporting the parents and involving them in decision-making. The following practical strategies are useful in promoting parental participation in decision making:

- Regularly provide information regarding the infant's medical problems, care and treatment in simple language so parents can understand their infant's condition.
- Invite parents to be present and involved during medical ward rounds.
  - Nursing staff to ask parents if they want to introduce their baby to the ward round and note this on the communication board and in the handover tab on iSoft.
  - Nursing staff to teach and assist parents with presenting on the ward round by using the ward round guide ([Appendix 1](#)).
  - On the ward round:
    - Introduce ward round members to parents.
    - Parents who wish to present their baby do so.
    - Any comments parents wish to make, or ask questions, or raise concerns from parents.
    - Further information from medical and nursing staff presented.
    - Discuss with all members of round, including parents to make plans for the baby.
    - Summarize discussion and confirm plans verbally and in the medical record.
- Provide anticipatory guidance throughout the infant's period of hospitalisation so that parents can prepare for and contribute to the likely progression of events in their infant's care e.g. Discuss the need for interventions and treatments ahead of time - provide option of being present, giving of permission for non-urgent treatments such as top-up blood transfusions.
- Facilitate participation in decisions regarding timing of care and feeds.

## Parental Education

- There are parent education sessions throughout the week.
- Encourage parents to attend the teaching sessions.
- The parent education schedule for the week at KEMH is available on the noticeboard in the parent lounge.
  - The topics and presenters will vary each week.

### Related CAHS internal policies, procedures and guidelines

[Skin- to- Skin Holding](#)

### References and related external legislation, policies, and guidelines


1. [www.familyintegratedcare.com](http://www.familyintegratedcare.com)
2. O'Brien K, Bracht M, Macdonell K, et al. A pilot cohort analytic study of Family Integrated Care in a Canadian neonatal intensive care unit. *BMC Pregnancy and Childbirth*. 2013;13(Suppl 1):S12. doi:10.1186/1471-2393-13-S1-S12.
3. Kenner C, McGrath JM, eds. *Developmental Care of Newborns and Infants: A Guide for Health Professionals*. St. Louis, MO: Mosby; 2010.
4. Mares S, Newman L, Warren B. *Clinical Skills in Infant Mental Health: the first three years*. 2nd Ed., ACER Press, 2012.
5. Reynolds LC, Duncan MM, Smith GC, Mathur, Neil AJ, Inder T, Pineda RG. Parental presence and holding in the neonatal intensive care unit and associations with early neurobehavior. *Journal of Perinatology* (2013) 33, 636–641
6. Smith VC; Steelfisher GK; Salhi C; Shen LY. Coping With the Neonatal Intensive Care Unit Experience. Parents' Strategies and Views of Staff Support. *The Journal of perinatal & neonatal nursing*. Volume 26(4), 2012 p.343–352
7. Turnage-Carrier C. Developmental support. In: Walden M, Verklan T, eds. *Core Curriculum for Neonatal Nursing*. 4th ed. Philadelphia: WB Saunders; 2010:208-232.

### Useful resources (including related forms)

Department of Health WA [Safe Infant Sleeping Policy](#)



This document can be made available in alternative formats on request for a person with a disability.

File Path:			
Document Owner:	Neonatology		
Reviewer / Team:	Neonatal Coordinating Group		
Date First Issued:	July 2006	Last Reviewed:	19 <sup>th</sup> November 2019
Amendment Dates:		Next Review Date:	19 <sup>th</sup> November 2022
Approved by:	Neonatal Coordinating Group	Date:	26 <sup>th</sup> November 2019
Endorsed by:	Neonatal Coordinating Group	Date:	26 <sup>th</sup> November 2019
Standards Applicable:	NSQHS Standards: 		
<b>Printed or personally saved electronic copies of this document are considered uncontrolled</b>			



## Appendix 1: Guide for Parents introducing their baby on the ward round

Note this is a guide only. Parents may wish to choose which aspects of the guide they will speak about on the ward round. To begin with parents may choose to introduce themselves and state their baby's name. As parents gain confidence with the ward round they may speak about more items in this guide. It is not expected that parents will speak about every issue listed in the guide below. They should be guided by staff to speak about what is important to them.

### Introduction:

Hello my name is.....

My baby is.....

He/She was born at..... weeks and..... days weighing .....

He/She is now..... days old, which is ..... weeks and .....days.

The most recent weight is ..... I last held him/her.....

### Overall condition :

I think they are: - doing well / not as good as usual / getting better etc

Recently..... happened to them

I am concerned about .....

I have questions about.....

I am happy about.....

### Current supports (modify as needed for the baby):

My baby is needing Ventilation/CPAP/HHF /breathing for themselves

Ward round to add in details about respiratory support

My baby is not feeding / tube fed x hourly / starting to learn to suck / receives x milk type +/- level x

Tolerating / not tolerating feeds / Vomits or spills

On phototherapy / Recently stopped phototherapy

### Medical and nursing Ward round members to add in details:

About iv fluids/TPN/

Medications IV and oral

Recent blood test results and investigations

Other aspects as needed

**Discussion takes place with parents and staff members on the ward round regarding plans for the baby.**

**Write this plan on communication board for everyone to access**