1.0 PURPOSE AND INTENT:

1.1 To provide infants with skin to skin contact in the form of kangaroo care (KC) with their mother or father in a neonatal unit.
Note: For guidelines on skin to skin contact for newborns and their mothers in the immediate post-partum periods see HSC #80.275.353 or SBH #100.430.CH.001

1.2 To provide non-pharmacologic pain management for newborns during potentially painful procedures.

   Note: All recommendations are approximate guidelines only and practitioners must take into account individual patient characteristics and situation. Concerns regarding appropriate treatment must be discussed with the attending neonatologist.

2.0 PRACTICE OUTCOME:

2.1 To provide more consistent and appropriate thermoregulation to a newborn infant, especially a low birthweight or premature infant than is achieved in an intensive care bed or by traditional holding wrapped in blankets.

2.2 To improve neurodevelopment of the infant through stimulation of neuroprotective hormones, facilitation of breastfeeding and provision of cycled sleep.

3.0 DEFINITIONS:

3.1 Kangaroo Care / Skin to skin contact between a premature or ill infant and an adult where the infant’s chest is bare and is in direct contact with the adult’s bare chest in an upright position. The adult may be the infant’s mother, father or other individual on approval of the infant’s parent or guardian.

3.2 Respiratory Support: Includes endotracheal intubation and ventilation, tracheostomy, nasal continuous positive airway pressure (ncpap), and nasal trigger-pressure assist (TrPa).

4.0 GUIDELINES:

4.1 Decision made by bedside nurse. Consult charge nurse/ Clinical Resource Nurse or physician for assistance in decision-making as needed. For infants <1000 gram weight have discussion for approval from Attending Neonatologist.

   4.1.1 Assess infant’s needs for KC. If infant has recently been fed, plan to move them slowly in the KC position. Once in KC they will be less likely to reflux than in the bed. If infant is asleep, move them with minimal stimulation to avoid startling them. They will return to a better sleep shortly after moving into the KC position. Determine if there are any contraindications to the KC position such as gastroschisis, meningomyelocele or other surgical conditions or unstable invasive lines.

4.2 If an infant is experiencing discomfort or is unable to settle, consider KC as a means to provide pain relief and to encourage them to settle to a more productive sleep. For infants experiencing substance withdrawal, consider KC as a means to decrease their abstinence scores and to provide containment for them.

4.3 Assess ability of the parent to safely provide KC, particularly for recently post-partum mothers. Encourage parent to spend at least 2-4 hours per day providing KC for their infant to promote optimal
4.4 Record heart rate, respiratory rate, oxygen saturation and FiO₂ (if appropriate) before beginning and hourly during KC.

4.5 Dress the infant in a diaper and a hat and place on a flannel blanket. Wait up to 15 minutes for physiological adaptation to this handling. Adaptation is defined as all physiological parameters returning to baseline and staying there for 3 minutes. If adaptation has not occurred in 15 minutes, the infant is probably not stable enough to receive skin to skin that day.

4.6 To prepare parent have parent remove or open their blouse/shirt and place their infant in a head up position on their chest. Cover the infant with a blanket. Provide privacy at the parent’s request using screens or curtains.

4.7 If the infant has nasal prongs or any venous or arterial lines, ensure that all tubing and lines are secure on one side of the infant and supported during the transfer to the parent. For all infants requiring respiratory support (as defined above) follow the guidelines beginning below.

4.8 Facilitate a transfer of infant to parent that causes the least amount of stress to the baby. If the parent is physically able, the parent will stand up close to the bed and transfer the baby to their chest while still standing. The parent slowly sits down in the chair while maintaining the infant in skin-to-skin contact. The nurse manages the lines and wires to ensure a smooth transfer. For parents who are unable to transfer in this manner the nurse may bring the baby to the parent keeping the infant in containment wrapped in the blanket that will then be used as a covering. Ensure that the chair used does not have wheels. Provide privacy as much as possible or requested by parent.

4.9 Cover all exposed areas of the infant with a hat, socks and a blanket.

4.10 Positioned infant with head up. If infant is receiving cardiorespiratory and oximeter monitoring, continue these during skin to skin. Observe infant’s condition a minimum of every 10 minutes during skin to skin. Encourage skin to skin ideally for a minimum of 65 minutes if infant’s condition remains stable.

4.11 Provide KC for as long as tolerated by the infant and parent. Discontinue it if infant’s condition becomes unstable or infant shows signs of over-stimulation. Use it during procedures that may cause pain such as heel pokes or injections. If the parent falls asleep, assess the safety of the infant and wake the parent if the baby or the parent is not safely secured in order to prevent either one from falling from the chair.

4.12 Document infant’s vital signs and tolerance of KC following transfer back to the bed in the patient care record.

Infant Requiring Respiratory Support

4.13 Assess whether the infant is appropriate for KC. Discuss the following with the attending neonatologist and the team:

4.13.1 High frequency ventilation – requires a Respiratory Therapist to be present for the move to mom.
4.13.2 Infant requiring longer than 15 minutes to recover from care or handling – infant may not tolerate the move to mom.
4.13.3 Hypotension requiring inotropic support – if blood pressure continues to be labile, infant may not tolerate the move to mom.

4.14 Record infant’s baseline vital signs and ventilator parameters and auscultate chest to assess quality of respirations.

4.15 Before the transfer ensure stability and patency of the endotracheal tube or other respiratory support equipment. Ensure respiratory equipment is clear of excess water. Perform any necessary care and allow up to 15 minutes for infant to recover from procedure before proceeding. If the infant has not recovered in that time, they are not a candidate for KC.
4.16 For the transfer:
4.16.1 Assemble 2 assistants. In addition to the bedside nurse, one can be the second parent, the other should be a respiratory therapist if available. If not the third person should be a nurse.
4.16.2 Maintain respiratory support throughout the transfer process.
4.16.3 With support of a second person, place infant supine with a blanket under them. Assess for infant’s tolerance of handling evidenced by changes in oxygen saturation.
4.16.4 Have parent stand at the side of the bed while one staff member gathers all the infant’s lines on one side of the infant and a second staff member secure the ventilator tubing and a third responsible for the airway.
4.16.5 Have the parent lift the infant and blanket and place him/her prone on her chest in one movement.
4.16.6 Have parent or staff member secure the blanket across the infant’s back.
4.16.7 Move the parent backwards to the chair while supporting the lines and tubing.
4.16.8 Reposition the infant as needed and make sure that the infant is tucked in a slightly flexed position under the blanket. Assess the infant for respiratory and hemodynamic status and adjust oxygen settings as required, allowing the infant time to recover from the procedure.
4.16.9 Secure the ventilator tubing with velcro or tape so that no stress is placed on the endotracheal tube or to prevent upward pressure of the nasal interface on the nasal septum. (Waterproof tape may be too sticky and adhere too tightly to the tubing for later release). Ensure that the ventilator tubing is not in contact with the parent’s or infant’s skin but that drainage is away from the baby. Educate the parent to let the nurse know if the tubing moves out of position so it can be re-positioned.

4.17 Assess the baby 15 minutes after the move to KC and then continue monitoring and assessment as per routine for that infant and as required.

4.18 If the infant’s condition and oxygen requirements stabilize within 15 minutes, continue KC for up to 2-4 hours. If the infant’s oxygen requirements increase by more than 20% for longer than 15 minutes, return the infant to the bed.

4.19 Assess and drain ventilator tubing periodically.

4.20 To transfer infant back to the bed, begin by having one staff member assist the parent to move to the front edge of the chair with a second staff member managing the lines and tubing and a third to ensure stability of the airway.
   - Assist the parent to come to a standing position and place the infant in the bed.
   - Ensure all tubing and lines are secure and the infant is positioned in a developmentally appropriate manner.

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6.0 REFERENCES:


