Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 4991

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27 September 2018

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Kangawrap or Kangaroo Care and skin to skin.

You asked:
Could you send me your policy relating to the Kangawrap/kangaroo care and skin to skin please?

Trust response:

Please see the following policies.

- Maternity - Kangaroo Care on the Postnatal Unit guideline
- Maternity – Newborn feeding including excessive weight loss and reluctant feeder guideline
  - This guideline is currently under review
  - It is included because it also outlines the expectations relating to skin to skin contact

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Newborn Feeding including excessive weight loss and reluctant feeder

Target audience:	All maternity staff
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Document lead:	Infant Feeding Specialists
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Specialty:	Midwifery
Supersedes:	Newborn Feeding including Excessive Weight Loss and Hypoglycaemia Flow Chart; Version 3.6
Approved by:	Guideline Group **Date:** 9 July 2015
Ratified by:	Clinical Risk Management Group **Date:** 8 July 2015
Review date:	July 2018

Document History

Requirement for document:	To comply with national recommendations for good practice regarding newborn infant feeding.
Cross References (external):	1. Bell D. (2007) *Postnatal Weighing Baby guidelines.* Dartford and Gravesham NHS Trust. 2. Colson S. (2002) Womb to the World: A Metabolic Perspective. *Midwifery Today*. Issue 61.

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Associated Documents (internal):	Maidstone & Tunbridge Wells NHS Trust Intranet, Policies & Guidelines, Women's & Children's Database: • Maternity Training Strategy & Training Needs Analysis Matrix

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	First iteration of document	November 2009
2.0	Reviewed and amended by Jean Meadows	October 2011
3.0	Comprehensive review and update in preparation for Level 1 Baby Friendly Assessment.	May 2014 – July 2015
3.1	Minor amendment re numbering following publication	August 2015
3.2	Changes to: • Section 5.5.6 Bullet point 4 - typo correction • Appendix EIGHT Infant Feeding Assessment Tool – amended to improve both ease of use and data capture	November 2016
3.3	Further amendment to Appendix Eight Infant Feeding Assessment Tool. Margins corrected to improve quality of photocopying	November 2016
3.4	Update of Appendix 6 Reluctant Feeder Flow Chart to help	June 2017

	initiate breastfeeding for the term healthy newborn + minor formatting changes	
3.5	Numbering error so republished	June 2017
3.6	Updates to reflect recent changes: • Change in title • General formatting changes to improve staff accessibility to information • Removal of hypoglycaemia in Appendix 9 (now available as newly updated standalone documents) • Replacement of the term 'biological nurturing' with 'laid back position' • Clarity with terms such as baby-led feeding	September 2017
3.7	Removal of watermark	19 April 2018

Newborn Feeding including excessive weight loss and reluctant feeder

Contents

1.0 Introduction and Scope

1.1 Introduction

Maidstone and Tunbridge Wells NHS Trust Maternity Unit believes that breast feeding is the healthiest way for a woman to feed her baby, and recognises the important health benefits now known to exist for both the mother and her baby.

All mothers have the right to receive clear impartial information to enable them to make fully informed choices as to how they feed and care for their baby.

Healthcare staff will not discriminate against any woman in her chosen method of infant feeding and will fully support her when she has made that choice.

There has been significant reliable evidence produced over recent years to show that breastfeeding is a major contributor to public health and has an important role to play in reducing health inequalities; even in the industrialised countries of the world.

Below is a list of differences in health outcome associated with methods of infant feeding. The supporting studies can be found on the UNICEF Baby Friendly website www.unicef.org.uk/BabyFriendly/News-and-Research and have all been adjusted for social and economic variables. All were conducted in an industrialised setting.

Artificially-fed babies are at greater risk of:

- gastro-intestinal infection
- respiratory infections
- necrotising enterocolitis and late onset sepsis in preterm babies
- urinary tract infections
- ear infections
- allergic disease (eczema, asthma and wheezing)
- Type 1 and Type 2 diabetes
- obesity
- childhood leukaemia
- SIDS

While breastfed babies have a reduced risk of all the above and may have better:

- neurological development
- cholesterol levels
- blood pressure

Other studies of health and breastfeeding indicate improved rates of:

- cardiovascular disease in later life
- childhood cancers
- breastfeeding and HIV transmission
- breastfeeding and dental health

Women who breastfeed are at lower risk of:

- breast cancer
- ovarian and uterine cancer
- hip fractures and reduced bone density
- If mothers are adequately supported in their chosen method of feeding it has been shown to help prevent future problems and readmission to hospital

1.2 Aims:

- To ensure the health benefits of breastfeeding and potential health risks of formula feeding are discussed with all pregnant women so that they can make an informed choice about how they will feed their baby.
- To encourage healthcare staff to create/promote an environment where more women choose to breastfeed their babies; confident in the knowledge that they

will be given the support and information that will enable them to continue breastfeeding exclusively for six months - and then as part of their infant's diet to the end of the first year and beyond.

- To ensure that women who decide to artificially feed their baby are also given the support and information that will enable them to do this safely and in a way that responds to their baby's needs.

1.3 Scope:

- This guidance applies to all Maidstone and Tunbridge Wells NHS Trust (MTW) staff caring for mothers and their babies.
- A parent's guide to MTW's guidance regarding newborn feeding will be available to all pregnant women with the aim of ensuring that they understand the standard of information and care they can expect from Maidstone and Tunbridge Wells NHS Trust.

2.0 Definitions

Laid back position - is a breastfeeding position that refers to a range of semi-reclined maternal breastfeeding postures to aid innate feeding behaviours

Supplementary feeds - artificial formula given as an extra to breastmilk

Rooming-in - relates to the baby's cot being placed by the mother's bedside, with the mother being the prime care giver wherever possible

Hand expressing - the removal of mothers milk from the breast by hand

Expressed breast milk (EBM) – hand or pump

Baby-led feeding - Mothers are encouraged to recognise early feeding cues such as increased alertness or activity, rooting, hand-to-mouth movements, rather than waiting for baby to cry. There is no restriction placed on the frequency or length of feed. Babies can come off the breast of their own accord. Mothers can be encouraged to offer the second breast at each feed if the baby continues to show feeding cues / or mother would be more comfortable if the second breast is used

Responsive feeding - where the mother responds to her baby's feeding cues and feeds on demand

Infant Feeding Specialist (IFS) - MTW Trust Clinical Specialist in newborn feeding

CSW / MSW - Clinical Support Worker / Maternity Support Worker

3.0 Duties

- Routine antenatal group instruction on the preparation of artificial feeds should **not** be given; as evidence suggests that information given during the antenatal period is less well retained and may even serve to undermine confidence in breastfeeding.

- It is the midwife's responsibility to liaise with the medical staff (paediatrician, general practitioner) should any concerns arise about the baby's health.
- In order to avoid conflicting advice it is mandatory that all staff involved with the care of women adhere to this guideline. Any deviation must be justified and recorded in the mother's and baby's notes.
- Parents who have chosen to artificially feed their babies should be offered to be shown how to correctly prepare formula feeds:
    - This should be on a one to one basis during the **postnatal** period
    - The instruction must be documented in the postnatal notes
    - If parents decline this offer then the healthcare professional needs to ensure that the advice re making up bottles with water of 70° or more and making up one bottle at a time has been given and documented in the postnatal notes.
- No advertising of breastmilk substitutes, feeding bottles, teats or dummies is permissible in any part of MTW Trust. The display of manufacturers' logos on items such as calendars and stationery is also prohibited.
- No literature provided by infant formula manufacturers is permitted. A resource folder will be held by the Infant Feeding Specialist and NNU leads for staff to access away from the clinical area

4.0 Training / Competency Requirements

Professional competence

Registered midwives, nurses and medical staff caring for obstetric patients have a professional responsibility to maintain their competence.

Annual Newborn Feeding update

Maternity Mandatory training identifies the requirement for maternity staff to attend an annual Newborn Feeding update; addressing infant feeding. Refer to: Maidstone and Tunbridge Wells NHS Trust Training Strategy. Link is: http://twhqpulse01:85/QPulseDocumentService/Documents.svc/documents/Active/attachment?number=RWF-WC-OPG-MATERNITY-CG15

Infant Feeding Training

All those nursing and midwifery staff caring for nursing mothers and babies ~~will~~ receive additional Infant Feeding Training. Once current staff training has been completed, any new staff (including MSWs) then receives training within 6 months of joining the Trust. Learning records will be kept by Learning and Development in the AT Learning records. Students and paediatric staff are encouraged to attend.

5.0 Procedure for Newborn Feeding

5.1 Informing Pregnant Women of the Benefits and Management of Breastfeeding

- All pregnant women should be given the opportunity to discuss infant feeding on a one to one basis with a midwife. Such discussion should not solely be attempted during a group parentcraft class.
- One-to-one conversations should be tailored to the individual woman's needs. The aim should be to discuss issues surrounding breastfeeding relevant to each individual woman.
- All conversations should be documented.
- Safe night time feeding should also be discussed antenatally taking into consideration the NICE amendment to guideline CG 37.
- The availability of postnatal support groups should also be discussed with women to increase their confidence in their ability to successfully breastfeed.
- A woman whose baby may be at risk of hypoglycaemia should discuss Antenatal Colostrum Collection with the midwife and be advised to attend the clinic with the Infant Feeding Specialist.
- The physiological basis of breastfeeding should be clearly and simply explained to all pregnant women, together with good management practices, which have been proven to protect breastfeeding and reduce common problems. The aim should be to give women confidence in their ability to breastfeed.
- The mother will be given written information about the benefits and practicalities of effective feeding (Off to the Best Start). If available, the Best Beginnings DVD (Bump to Breastfeeding) should also be given to the mother - or she can be directed to the Best Beginnings website.
- Mothers may also be signposted to the UNICEF Baby Friendly Website where there is a wealth of up to date information for them. The link is: www.babyfriendly.org.uk The MTW Website also has useful infant feeding links and advice. The link is: www.mtw.nhs.uk/maternity/
- Parentcraft classes should reinforce the above.

5.1.1 Process for supporting women who are breastfeeding

- **All** mothers should be encouraged to hold their babies in a laid back (skin-to-skin contact) as soon as possible after delivery, in an unhurried environment until a successful first feed has been achieved, regardless of their feeding method. This will be documented on the SBAR tool for handover to the postnatal ward.
- Skin-to-skin contact should never be interrupted at staff's instigation to carry out routine procedures.
- All mothers should be encouraged to offer the first breastfeed as soon as baby is ready. If necessary mother should be transferred to post natal ward on a bed with baby skin-to-skin until first feed is achieved.
- All breastfeeding mothers should be offered further help with breastfeeding with early feeds. A health professional should be available to assist at all breastfeeds

during her hospital stay if a mother requires help. This will be documented in the mother's postnatal notes.

- Midwives should ensure that mothers are offered the necessary support to acquire the skills of positioning and attachment. They should be able to explain the necessary techniques to a mother, thereby helping her to acquire this skill for herself.
- All breastfeeding mothers should be offered instruction on hand expressing. Alternatively they should be signposted to the 'Bump to Breastfeeding DVD' or UNICEF website where a video clip explaining the process can be found. Community staff should ensure that mothers have received this teaching and be prepared to offer it at home if this is not the case.
- Staff should also ensure that the mother is aware of the value of hand expression, for example in the proactive treatment of engorgement to prevent the development of mastitis. This should be documented in the mother's postnatal notes.
- A feeding assessment will be performed on the postnatal ward prior to discharge. (See Infant Feeding Tool in APPENDIX EIGHT)
- 'How do I know that breastfeeding is going Well' leaflet should be given on discharge.
- Community Staff should remind breastfeeding mothers to access the 'Off to the Best Start' leaflet and/or 'Bump to Breastfeeding' DVD at home.
- An assessment of the mother's and baby's progress with breastfeeding will be undertaken at each visit as deemed necessary but at least on Day 5 and at discharge from community care. This will be documented in the handheld health record and baby's health record as appropriate (Red Book)
- As part of this assessment staff will ensure that breastfeeding mothers know:
    1. The signs which indicate that their baby is receiving sufficient milk and what to do if they suspect that this is not the case.
    2. How to recognise signs that breastfeeding is not progressing normally (e.g. sore nipples, breast inflammation).
    3. Why effective feeding is important and that mothers are confident with positioning and attaching their babies for breastfeeding.
    4. Staff should be able to explain the relevant techniques to a mother and provide the support necessary for her to acquire the skills for herself.
- Mothers whose babies are admitted to the NNU should be fully informed of the health benefits of breastfeeding. Any mother who still decides to formula feed should be asked to consider expressing in order to give their 'at risk' baby the opportunity to receive the health benefits of colostrum. They should not however be asked to breastfeed if they do not want to.
- Mothers who are separated from their babies should be encouraged to begin expressing as soon as possible after delivery and informed that early initiation of expressing colostrum has long term benefits for milk production.

- Mothers who are separated from their babies should be encouraged to express milk at least eight times in a 24-hour period and at least once at night. They should be shown how to express both by hand and pump.

5.1.2 Supporting Exclusive Breastfeeding

- No water or artificial feed should be given to a breastfed baby except in cases of clinical indication such as excessive weight loss, hypoglycaemia and **fully** informed parental choice.
- The decision to offer supplementary feeds based on a medical need should be made by an appropriately trained midwife or paediatrician
    - Parents should always be consulted if supplementary feeds are recommended and the reasons discussed with them in full.
    - Any supplements which are prescribed or recommended should be recorded in the postnatal notes along with the reason for supplementation.
    - If supplementation is required mothers should be asked to sign the relevant consent form (see APPENDIX FIVE).
- Parents who **request** supplementation, without medical indication, should be made aware of the possible health implications and the potential negative impact such action may have on breastfeeding
    - This is to enable them to make a fully informed choice.
    - The conversation should be documented. If supplementation is requested from ward stock parents should be asked to sign the relevant consent form (see APPENDIX FOUR)
- If baby is reluctant to feed refer to the Reluctant Feeder guidance (APPENDIX SIX)
- All mothers will be encouraged to breastfeed/breastmilk feed exclusively for the first six months and to continue to breastfeed/breastmilk feed for at least the first year of life. They should be informed that solid foods are not recommended for babies under six months (WHO recommendation)
- Breast milk substitutes must not be routinely supplied by health-care staff without a clinical indication.
- Breastfed babies are not to be fed using artificial teats.

  NOTE: - Formula company representatives will not visit staff in the clinical area; instead an opportunity for the company representative to meet with the Infant Feeding Specialist will be offered, away from the clinical areas.

5.1.3 Rooming In

- Mothers will normally assume primary responsibility for the care of their babies.

- Separation of mother and baby should only occur where the health of either mother or baby prevents the care being offered together.
- Babies should not be routinely separated from their mothers at night. Mothers recovering from Caesarean Section should be given appropriate care, but the policy of keeping mother and baby together should always apply.
- Information on the prevention of Sudden Infant Death should be given on discharge.

5.1.4 Responsive feeding

- Responsive feeding should be explained to mothers and encouraged for all babies unless clinically indicated. Hospital procedures should not interfere with this principle.
- Staff must ensure that mothers understand the nature of feeding cues and the importance of responding to them and that they have an awareness of normal feeding patterns, including cluster feeding and 'growth spurts'.
- Mothers should be informed that it is acceptable to wake their baby for feeding if their breasts become overfull. The importance of night time feeding for milk production should be explained to all mothers and ways to cope with the challenges of night-time feeding discussed.

5.1.5 Use of artificial teats, dummies and nipple shields

- Staff must **not** recommend the use of teats, dummies or nipple shields during the establishment of breastfeeding:
    - Parents wishing to use them should be advised of the possible detrimental effects such use may have on breastfeeding to enable them to make a fully informed choice.
    - The information given and the parents' decision should be recorded in the mother's postnatal notes.
- Nipple shields must not be recommended except in extreme circumstances and after discussion with the Infant Feeding Specialist. If utilised, nipple shields should only be used for a short period of time.

5.1.6 Encouraging ongoing community support for breastfeeding

- Breastfeeding support groups.
- MTW NHS Trust supports co-operation between health care professionals and voluntary support groups whilst recognising that health care facilities have their own responsibility to promote breastfeeding.
- Volunteer support in the way of trained 'Breast Buddies' will be welcome on the wards. They will have undergone a recognised training and the recruitment

process of MTW NHS Trust. The expectation is that they will adhere to this guidance at all times.

- Sources of national and local support should be identified and mothers given verbal and written information about these prior to transfer home from hospital.
- Breastfeeding support groups will be invited to contribute to further development of breastfeeding practices and policies through involvement of the Birth Voices forum meetings.

5.2 Process for supporting women who are artificially feeding

- **All** mothers should be encouraged to hold their babies in a laid back position (skin-to-skin contact) as soon as possible after delivery, in an unhurried environment until a successful first feed has been achieved, regardless of their feeding method. This will be documented in the mother's postnatal notes.
- Skin-to-skin contact should never be interrupted at staff's instigation to carry out routine procedures.
- The mother should be encouraged to give the first bottle herself in a skin to skin position.
- All mothers should be encouraged to offer the first feed as soon as baby is ready. If necessary mother should be transferred to postnatal ward on a bed with baby skin-to-skin until first bottle feed has been achieved.

The health professional's responsibilities to women who choose to artificially feed their babies are to:

- Ensure they have made an informed choice and are aware of the benefits of breastfeeding / breastmilk feeding.
- Document in the postnatal notes the feeding choice of the mother.
- Advise mother of the appropriate volume and frequency of feeds for age and weight of baby.
- Provide one -to-one education on the safe administration of artificial feeding including the correct preparation, sterilisation techniques and how to bottle feed.
- Parents will be encouraged to hold their baby close during a feed, making eye contact if possible.
- The baby should be encouraged to root for the teat by stimulating the upper lip with the bottle. The baby should be encouraged to 'take the teat' rather than the teat pushed into its mouth.
- Parents should be taught how to let the baby pace the feed, having breaks whenever it wants to. The baby should never be 'forced' to take a full feed if it has stopped sucking.
- Parents should be advised to limit who gives the feeds to their baby; especially in the early days when a baby is learning to get to know their parents.

- Community Midwives should check and reinforce learning following mothers transfer home.
- The mother will provide her own bottle feeding equipment for the baby.
- The mother will provide her own formula milk for her baby.
- Problems with bottle feeding are identified early and documented in the postnatal records, together with a management plan.
- Preparation of artificial feeds and bottle feeding should be supervised until parents are confident and competent; this should be documented in the mothers' postnatal notes.

5.3 Process to be followed if a problem with breast feeding is identified

When problems with breastfeeding arise staff must try to source the cause:

- The baby's mouth must be examined to exclude tongue-tie.
- A feed must be supervised from attachment to completion.
- Optimal positioning and attachment will be observed and adjustments advised as necessary.
- Every effort will be made to enable the mother to correctly latch the baby herself.
- Correct suck, swallow rhythms will be observed and explained to the mother to enable her to recognise effective feeding patterns.
- The babies output (wet and dirty nappies) should be monitored and recorded in the postnatal notes.
- For the sleepy baby reluctant to feed, please follow the Reluctant Feeders guideline (APPENDIX SIX)

5.4 Process to be followed if a problem with artificial feeding is identified:

- When problems with bottle feeding arise staff must try to establish the cause.
- The baby's mouth must be examined to exclude tongue-tie.
- A feed must be supervised and corrections made to techniques as appropriate to ensure optimal feeding.
- If the problem is the baby being too sleepy to feed, then the mother should be encouraged to nurse her baby skin-to-skin in a laid back position. Feeding cues should be explained to the mother and she should be advised to attempt to feed baby when he/she shows signs of wanting to feed.
- The babies output (wet and dirty nappies) should be monitored and recorded in the hand held notes.
- The baby's health and well being should be assessed and referral to a paediatrician if baby is unwell.

- If baby does not show signs of wanting to feed the mother should be encouraged to try smaller amounts more frequently.
- The baby should be assessed two hourly for well being until bottle feeding is established. This assessment should be documented in the notes. The baby should be referred to the paediatrician if unwell.
- Refer to the Reluctant Feeder Guidance (APPENDIX SIX) for more advice.

5.5 Process for weighing babies

5.5.1 Background

7% of birth weight is the physiological average weight loss of a breastfed baby on day 3 or 4 (just before a mother's milk 'comes in').

A weight loss of between 7% and 12% should be considered a warning sign that a baby is not receiving enough (but is not necessarily a sign that breastfeeding is not working and that artificial milk should be given).

Both breastfed babies and artificially fed babies should have regained their birth weight by around Day 14.

Weighing of babies can create anxiety for mothers and therefore mothers need to be well informed regarding the expectations of weight gain for their baby.

5.5.2 Routine weighing of babies

- As a minimum a baby must be weighed (naked) at birth, Day 5 and Day 10. Thereafter a healthy baby should be weighed (naked) no more than fortnightly.
- Where there have been issues identified with a baby's weight e.g. IUGR, Preterm, cleft lip and/or palate and/or feeding difficulties then weighing must be more frequent.
- The scales must be well-maintained, digital scales that are calibrated annually (NOTE: - At each use, staff are advised to check the spirit level at the rear of the scales).
- The weight must be recorded in metric i.e. grams on the neonatal sheet (in the Maternity Unit) and in the handheld maternal notes.

  All babies must be observed for signs of ineffective milk transfer i.e. abnormal patterns of wet and dirty nappies, lethargy, irritability, fever or exaggerated jaundice.

  However, weight loss is the only objective indicator of dehydration:

  1. Weight loss must be calculated as a percentage using the following formula:

     $$\frac{\text{Weight loss (g)}}{\text{Birth weight (g)}} \times 100 = \ldots\ldots \text{ weight loss \%}$$

  2. Where there is a weight loss of more than 10%, the Excessive Weight Loss guidance should be followed.

3. When babies are discharged from Midwifery care to care of the Health Visitors there must be a good handover regarding any feeding or weight loss issues.

5.5.3 Accepted Weight Loss

Weight loss in the neonate in the early few days of life is part of the normal process of adaptation to extra-uterine life when excess extra-cellular fluid is excreted. Conventional wisdom has been that this weight loss is likely to be up to 10% of birth weight. This suggestion was not evidence based and made at a time when management of breastfeeding was often flawed e.g. timed feeds, separation of mothers and babies.

Recent studies indicate that normal weight loss in the majority of babies is more in the region of 5-7% of birth weight however; a small group of babies may be vulnerable to greater loss (Dewey et al 2005, Macdonald 2002). Fewer than 5% of babies lose more than 10% of their weight at any stage; only 1 in 50 are 10% lighter than birth weight at 2 weeks, WHO-UK Growth Charts (2009). In the first week of life, weight loss greater than 7%, or which persists longer than 7 days, is a reliable sign of insufficient milk intake.

Between one week and three months, breastfed babies should gain weight at least as rapidly as their formula-fed counterparts (WHO/RCPCH, 2009).

5.5.4. Excessive weight loss occurs when:

Ineffective milk transfer to the baby occurs with poor positioning and attachment or infrequent feeds. This represents the most likely cause of the baby not receiving sufficient milk. Unless corrected, this problem will lead to an actual reduction in breast milk available to the baby.

This is due to the feedback inhibitor of lactation (FIL) – a chemical inhibitor of milk production present in breastmilk. As this builds up in volume in the breast due to poor milk transfer to the baby, future milk production is compromised (Neifert, 2004). The milk ejection (“letdown”) reflex may be delayed by factors such as stress and pain in the early period; resulting in the baby being unable to remove milk effectively again causing a build up of milk within the breast, which will ultimately result in suppression of lactation.

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5.5.5 Dehydration

Increasingly cases published in the literature describing the phenomenon of marked weight loss associated with raised sodium levels potentially indicating dehydration (hypernatraemia) and possibly marked jaundice; appear to indicate that this is an increasing problem. However, the incidence cited is low e.g. 7.1/10,000 breastfed babies (Oddie et al 2001) and there is no indication that this is increasing (Sachs and Oddie 2002).

Normal neonatal biochemistry blood values have proven difficult to quantify; however, it is likely that in excess of 150mmols when assessed together with a

clinical picture of weight loss in excess of 12%, diminished urine output and stooling and jaundice would indicate that the baby is at increased risk and a proactive management plan needs to be adopted (Macdonald et al 2002)

5.5.6 Breastfeeding management practices, which optimise milk production

- Skin to skin contact at birth; maintained until the baby has completed the first breastfeed.
- Help offered with a second breastfeed within eight hours of the birth to enable the mother to be taught the skills required for positioning and attachment and how to recognise effective feeding.
- Rooming-in enables a mother to learn to recognise the signs that her baby is hungry.
- All breastfeeding mothers must be given information about hand expressing and technique discussed and taught.
- Baby-led feeding - helping mothers to recognise early feeding cues such as increased alertness or activity, rooting, hand-to-mouth movements, rather than waiting for baby to cry. No restrictions on frequency or length of feeds. Babies can come off the breast of their own accord. Mothers can be encouraged to offer the second breast at each feed if the baby continues to show feeding cues/or mother would be more comfortable if the second breast is used.
- Offer the baby frequent opportunities to feed: skin-to-skin contact will encourage breastfeeding in the sleepy baby that's reluctant to feed and it helps the mother not to miss baby's feeding cues.
- Avoid offering food or drink other than breastmilk to the baby.
- Avoid teats, dummies during the establishment of breastfeeding.
- Occasionally nipple shields may be suggested, but should be used with careful consideration.

Feeding Assessment

- A formal feeding assessment will be undertaken prior to discharge from hospital, day 5 and prior to discharge from midwifery care (APPENDIX EIGHT)
- Deviations from the norm must be corrected and further weight checks instigated until a clear trend towards birth weight is demonstrated.
- A clear feeding handover must be clearly documented on the Health Visitor handover sheet and left in the Child Health Record (Red Book).

5.6 System for reporting babies readmitted to hospital with feeding problems during the first 28 days of life

- Readmissions into TWH hospital of babies under 28 days old will be monitored by the Infant feeding Specialist (IFS) who will access the Electronic Patient Records on the Patient Centre system, which records all Trust patient admissions and discharges. This will be done on a regular basis, but as a minimum once a

month (in practice this is usually daily when IFS on duty so that investigation can be as contemporaneous as possible).

- The IFS maintains an electronic database, which is regularly, but as a minimum monthly, updated with relevant case review information.
- All readmissions under 28 days identified with **only feeding problems with preventable causes** will be reported via the Trust e-reporting system (on the intranet) by the Infant Feeding Specialist. The e-report will also contain the details of the subsequent investigation and actions taken by the IFS. The Maternity Risk Manager receives this report and acknowledges that appropriate action has been taken by recording the electronic Risk Datix Database (together with the action/s and learning outcomes). Any on-going concerns will be highlighted and appropriately actioned via the Clinical Risk Management Group.
- Any appropriate learning is disseminated to staff via the quarterly Directorate Clinical Governance newsletter and Maternity Risk Monthly update; however, other methods may sometimes also be used e.g. specific targeted training with Paediatric staff.

6.0 Audit and Monitoring

Monitoring and Audit of this guideline will be identified with issues raised via Clinical Risk / Clinical Governance.

APPENDIX ONE

Process Requirements

1.0 Implementation and Awareness

1.1 Once approved this policy/procedural document will be published on the Trust intranet by the Maternity Compliance & Safety Co-ordinator.
1.2 On publication of any Maternity document, the Maternity Compliance & Safety Co-ordinator or Maternity secretary (as appropriate) will ensure that an email is sent to all Maternity staff and other stakeholders, as appropriate.
1.3 On receipt of notification that the document has been published, all managers should ensure that their staff members are aware of the new publications.

2.0 Review

2.1 It is essential that Trust Policy/procedural documents remain accurate and up to date; this policy/procedural document will be reviewed three years after approval, or sooner if there are changes in practice, new equipment, law, national and local standards that would require an urgent review of the policy/procedure. It is the responsibility of the Document Lead for this policy/procedure to ensure this review is undertaken in a timely manner.
2.2 The Document Lead should review the policy/procedure and, even when alterations have not been made, undertake the consultation process as detailed in **Section 5.5 Consultation** of MTW Policy and Procedure '*Production, Approval and Implementation of Policies and Procedures*'.

3.0 Archiving

3.1 The Trust Intranet retains all superseded files in an archive directory in order to maintain document history.

3.2 Old paper guideline copies pre-dating Datix (previous to Q-Pulse system) are stored at:

Chatham Archive & Storage document Co.
Anchor Wharf
Chatham
ME4 4TZ
Telephone: 01634 826665

APPENDIX TWO

CONSULTATION ON: Newborn Feeding including excessive weight loss and reluctant feeder

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Email: jean.meadows@nhs.net

By date: 2 February 2015 (all documents must undergo a minimum or two weeks consultation)

Name: *List key staff appropriate for the document under consultation.*	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Consultant Obstetricians	19/01/15		Y	Y
Consultant Paediatricians	19/01/15	July 2015	Y	Y
Consultant Midwife	19/01/15			
Head of Midwifery / Co-Clinical Director	19/01/15			
Maternity Matrons – Inpatient & Community	19/01/15			
Supervisors of Midwives	19/01/15			
Team leads	19/01/15			
Paediatric Matron	19/01/15		Y	Y
Neonatal Unit Managers	19/01/15			
Midwives	19/01/15			
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy and procedure development exercises.**

Title of policy or practice	Newborn Feeding including excessive weight loss and reluctant feeder
What are the aims of the policy or practice?	To ensure adequate support of mothers in their chosen method of feeding as this will help to prevent future problems and readmission to hospital
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	None applicable
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Gender identity	No
People of different ages	No Context of pregnant women and newborn infants
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language	No The Trust offers a translator service
People who have a physical or mental disability or care for people with disabilities	No
Women who are pregnant or on maternity leave	No
Sexual orientation (LGBT)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	None identified
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

APPENDIX FOUR

Maternal Request for Artificial Formula

Mother's Name: …….. . Hospital Number: ……

Date and Time of Birth: … / … / …… at ……. hrs

Gestation: …….. Birth Weight: ……

We understand that getting to know your new baby and feeding your baby may be daunting. We will support you in your chosen method of feeding. Offering skin-to-skin to your baby if he/she is unsettled is calming and reassuring for both of you. Before you decide to offer your baby a top-up of bottle milk you might like to consider the following:

- Offering artificial formula may lead to a reduced milk supply as your baby might be breastfeeding less.
- The protective effects of breast milk, such as ear infection, gastro enteritis, chest infection, allergies may be reduced when bottle milk is offered.
- If you decide to offer the formula by bottle, rather than syringe or cup, this may make attachment at the breast more difficult.

Before considering formula you should have been offered help with:

- Positioning and attachment to ensure a comfortable feed for you and your baby
- How to recognise feeding cues
- How to hand express colostrum and how to maintain your supply

If not, please ask the staff who will be happy to assist.

Supplement given by (please circle): cup bottle

Mother's Signature: ……. Date: … / … / ……

Health Professional Signature: ……. Date: … / … / ……

APPENDIX FIVE

Consent for Artificial Formula for Medical Reasons

Mother's Name: …….. . Hospital Number: ……

Date and Time of Birth: … / … / …… at ……. hrs

Gestation: …….. Birth Weight: ……

We as a Trust support you in your decision to breast feed your baby, but for the following reason we feel it is medically necessary to supplement your breastmilk with formula:

……

……

You should have been offered help with:

- Maintaining your milk supply by expressing, both by hand and pump, staff will be happy to help with teaching you these skills.
- If you need to increase your milk supply you will be offered help with:
    - Positioning and attachment.
    - Recognising effective attachment
    - Breast compression
    - Breast switching
    - Recognising feeding cues

If your baby requires supplementation we will help you to achieve this using your breastmilk to reduce the amount of formula given as soon as possible.

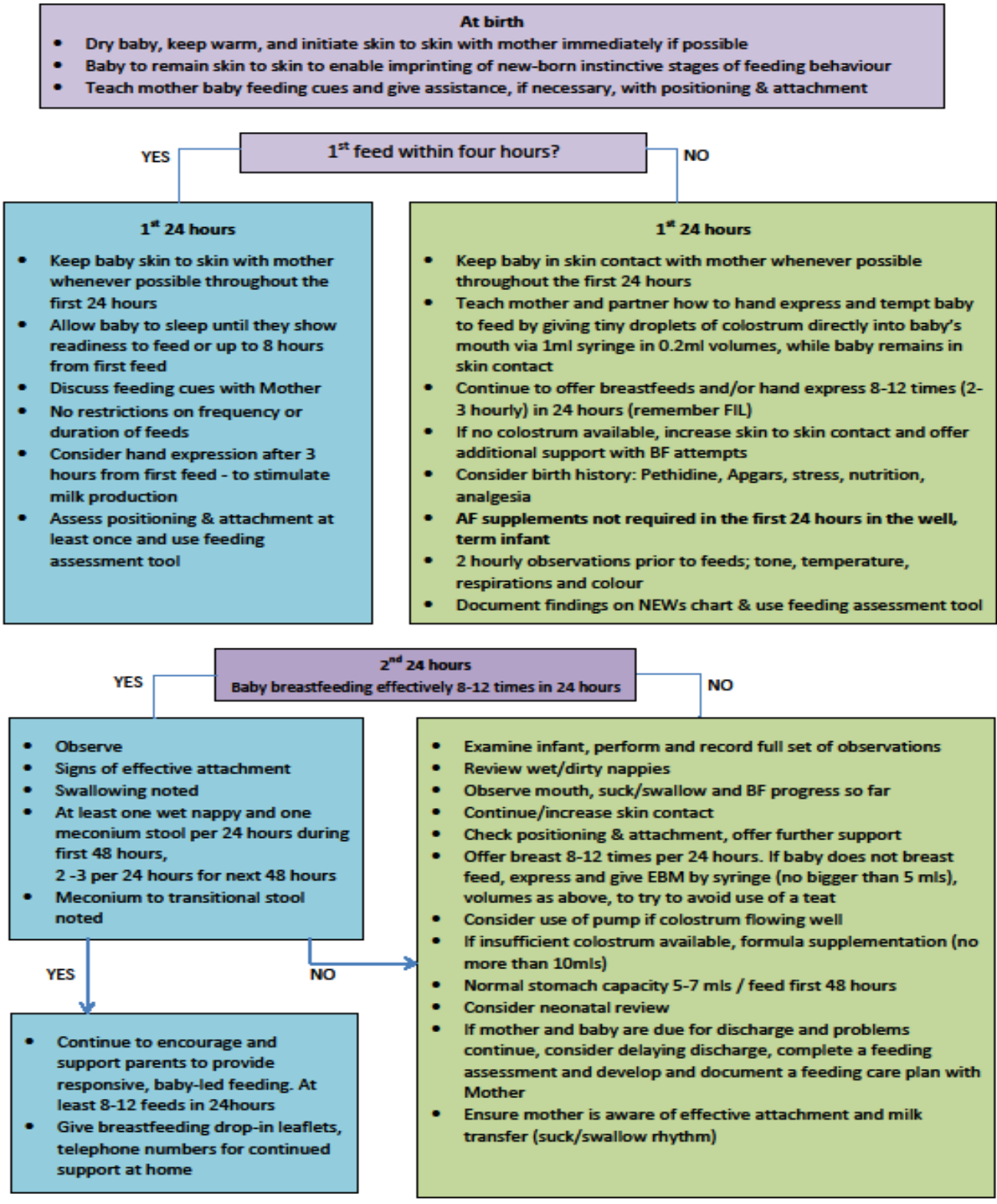
Supplement given by (please circle): syringe cup bottle NGT

Mother's Signature: …….. Date: … / … / ……

Health Professional Signature: …….. Date: … / … / ……

APPENDIXSIX

FLOWCHART TO HELP INITIATE BREASTFEEDING FOR THE TERM HEALTHY NEW BORN



FLOW CHART Excessive Weight Loss and Management APPENDIX SEVEN

Assessment of breastfeeding - at each postnatal visit, documented in post natal notes
Any abnormal finding triggers further action - Management Plan 1.

Weight- on Day five and at least once more prior to transfer to health visitor.
Weight loss of 8% or more triggers further action

Amount of weight loss	**Management plan indicated**
8-10% of birth weight	**1**
10-12% of birth weight	**1+2**
> 12% of birth weight	**1+2+3**

Management Plan	**Weight Loss**	**Management Details**
1.	8-10%	• Observe a full breastfeed-ensure effective positioning and attachment • Observe for effective sucking pattern • Ensure minimum 8 feeds in 24 hours • Skin contact to encourage breastfeeding • Observe output • Reweigh in 48hours.If weight increasing continue to monitor closely and provide support **If weight gain < 20gms/a day move to Management Plan 2**
2.	10-12 %	*Follow management plan 1, plus* If baby well : • Refer to breastfeeding drop-in clinic • Encourage switch feeding • Encourage breast compression during the feed • Express after each breastfeed & offer to baby by cup • Reweigh in 24-48 hours. **If weight < 20gms/a day or baby unwell/sleepy move to Management Plan 3**
3.	>12%	*Follow plan 1& 2 plus* • Refer to paediatrician for assessment of hypernatraemic dehydration. U&E's, Blood Glucose, FBC, CRP, SBR and Blood Gas • Serum Sodium < 150mmols/L and **baby well** follow management plan 1&2; check weight every 24 hours until weight gain. • Serum Sodium > 150mmols/L but **baby well** follow management plan 1&2 add EBM at 100ml/kg/day (formula may be needed if not enough EBM) • Serum sodium >150mmols/L and baby looks **unwell** start IV rehydration with 0.9% Saline in 10% Dextrose. Monitor Sodium every 12 hours. **Rehydrate gradually**

		aiming to reduce serum sodium by 5mmols/kg/day. Start milk feeds at 30/ml/kg/day increase gradually reducing IV fluids as tolerated

Infant Feeding Assessment Tool **APPENDIX EIGHT**

Assessment to be done at least once in hospital

Assessment in the Community at least on day 5 and discharge

A minimum of twice before baby is 10 days old or more frequently if action is required

Mothers Name: …… Hospital number: ……..

Date:	**Postnatal day:**	**Birth weight:**	Y	N	N A	Action Taken (if 'N')
OBSERVE – Positioning and Attachment (CHINS & CHAMPS)						
Close in to mum **H**ead free **I**n line **N**ose to nipple, **S**ustainable position		**C**hin touching breast **H**ave lower lip curled back **A**reola moustache **M**outh wide gape **P**ain Free **S**uck/swallow rhythm noted				
BABY						
Baby has had at least 8-12 feeds in 24 hours (at least 3-4 in first 24 hours)						
Has baby had skin to skin? Breast and formula fed babies						
Feeds between 5-40 minutes and comes off the breast spontaneously						
Has normal skin colour						
Is alert and waking for feeds						
Weight loss not more than 10% on day 5						
OUTPUT						
Wet nappies: Day **1-2** = 1-2 or more, Day **3-4** = 3-4 or more , Day **6+** = 6 or more, heavy **Stools / dirty nappies:** **Day 1-2** = meconium, **Day 3-4 =** changing, **Day 4+** = > 2 yellow, soft can be runny						
BREAST FEEDING						
Breasts and nipples comfortable/ Nipples same shape at the end of a feed as at start						
Have dummies / shields / formula / feeding cups been used? (if 'yes', circle & give reason for use in 'action taken' column)						
Hand Expressing skills taught						
Use of breast pump explained						
Tongue Tie referral made (if required)						

FORMULA FEEDING				
One to one feeding demonstration performed				
Responsive bottle feeding discussed and feed observed				
Signature: Print name: Grade:				

Kangaroo Care on the Postnatal Unit Guideline

Target audience:	All staff in the Maternity team
Main author:	Consultant Midwife (SG) **Contact details:** sarah.gregson@nhs.net
Other contributors:	None
Owner:	Consultant Midwife
Directorate:	Women's and Sexual Health
Specialty:	Maternity
Supersedes:	Kangaroo Care Guideline (2014); Version 1.0
Approved by:	Clinical Risk Management Group **Date:** 16 April 2018
Ratified by:	Clinical Risk Management Group **Date:** 9 May 2018
Review date:	May 2021

Document history

Requirement for document:	To ensure a positive impact on the lifelong health and wellbeing of the babies born in our Trust.
Cross references (external):	1. UNICEF / WHO Baby Friendly Initiative (2014). Available at: www.unicef.org.uk/BabyFriendly 2. Gregson S, Blacker J. (2011) Kangaroo care in preterm or low birth weight babies in a postnatal ward. *British Journal of Midwifery Vol 19 (9) 566-575.* 3. Conde-Aguldedo A, Belizan JM. (2003) Kangaroo mother care to reduce mortality and morbidity in low birth weight infants. *Cochrane database of systematic reviews.* Available at: www.cochrane.org/cochrane-reviews 4. Anderson GC et al. (2003) Early skin to skin contact for mothers and their healthy newborn infants. *Cochrane Database of Systematic Reviews (2): CD003519.* Available at: www.cochrane.org/cochrane-reviews 5. Colson S. (2014) Does the mother's position have a protective role to play during skin to skin contact? *Clinical Lactation Vol 5, Issue 2 41-47.* 6. Prio, E. et al. (2012) Breastfeeding after caesarean delivery: a systematic review and meta-analysis of world literature. American Journal of Clinical Nutrition. 95 (5), 1113-1135. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22456657 7. Zanardo, Z. et al. (2010) Elective cesarean delivery: does it have a negative effect on breastfeeding? *Birth. 37(4), 275-279*. 8. Cakmak, H. and Kuguoglu, S. (2007) Comparison of the breastfeeding patterns of mothers who delivered their babies per vagina and via cesarean section: an observational study using the LATCH breastfeeding charting system. *International Journal of Nursing Studies. 44 (7), 1128-1137.* 9. Rios, P. et al. (2008) Cesarean delivery as a barrier for breastfeeding initiation: the Puerto Rican experience. *Journal of Human Lactation*. *24 (3), 293-302.* 10. Gregson S and Meadows J. (2016) Skin to skin contact after elective caesarean: Investigating the effect of breastfeeding rates. *British Journal of Midwifery* Vol 24 No 1:18-25
Associated documents (internal):	• Kangaroo Care leaflet [RWF-OPLF-PWC89]

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	First iteration of this guidance	November 2014
2.0	Formatted into the Trust Template. Inclusion of:	February – May 2018

	• Training requirements • Safety information to be given to women prior to using either a KangaWrap or KangaWrapKardi • Specify Postnatal Unit in guideline title	

Kangaroo Care on the Postnatal Unit Guideline

Contents

	Archiving Arrangements
2	Consultation document
3	Equality Impact Assessment
4	The T.I.C.K.S. Rule for Safe Babywearing

1.0 Introduction and scope

This guideline applies to all babies receiving postnatal care at Maidstone and Tunbridge Wells NHS Trust. By facilitating Kangaroo Care (KC) at birth, and in the early neonatal period, we can have a profound impact on lifelong health and wellbeing of the babies born in our Trust [1]

Many studies, including a study at Pembury hospital in 2010, have shown that premature, low birth weight babies and babies of diabetic mothers who have Kangaroo Care have better weight gain and are more likely to stabilise more quickly and breastfeed successfully.[2-4]

Kangaroo care also has significant benefits for term babies. It helps with maternal bonding, babies are more likely to breastfeed successfully and it promotes healthy growth and development.

2.0 Definitions / glossary

Kangaroo Care' - involves placing a baby in direct skin to skin contact with their mother or father's chest.

All women who give birth at Maidstone and Tunbridge Wells NHS Trust should be encouraged to perform Kangaroo Care at birth for as much as possible during the first few days whilst the mother is awake; following this guideline.

The importance of KC must be discussed with the parents of all babies, not just breastfeeding babies. Bottle feeding babies also benefit from this experience.

KangaWrapKardi - no special equipment is needed to perform KC; however a KangaWrapKardi (a special cardigan) can be used whilst the mother is in bed to allow her to use both arms whilst holding the baby.

It should **never** be used when a woman is walking around as it has not been designed for that purpose and will not give enough support for the baby to be carried safely.

KangaWrap - for women who are mobile and want to walk around whilst doing Kangaroo Care, a KangaWrap can be used.

This is a specially designed baby wrap that assists with the correct positioning of the baby and allows the mother (or father) to walk around with both arms free.

Kangaroo Care leaflet - link is:

http://twhqpulse01:84/QPulseDocumentService/Documents.svc/documents/Active/attachment?number=RWF-OPLF-PWC89

NNU – Neonatal Unit

Postnatal Care - is received by the woman and her baby for 6-8 weeks following the birth.

3.0 Duties

It is the registered professional's responsibility to deliver care that is based on current evidence, always acting in the best interest of the woman and her baby.

4.0 Training / competency requirements

Registered nurses, midwives and medical staff caring for maternity patients have a professional responsibility to maintain their competence.

Community midwives should advise women about Kangaroo care from 28 weeks of pregnancy and ensure women are given the Kangaroo care leaflet or are directed to the relevant page of the maternity website. The maternal hand held notes also provide some information regarding the importance of skin to skin between mother and baby following birth.

Postnatal Care Planning (including Kangaroo Care) is the responsibility of the multidisciplinary team in all care settings, but is predominantly provided by midwives.

Student Midwives may provide postnatal care, under supervision.

Staff using KangaWraps must have received 'cascade training' for safe use (from the senior postnatal ward midwives).

Maternity staff supervising women using a KangaWrap or Kardi must have had training in safe use of the KangaWrap and Kardi, including application and awareness of any associated risks. Training is delivered by a member of staff who has already been deemed competent.

5.0 Procedure

5.1 Criteria for initiating Kangaroo Care at birth (all babies)

- Following delivery, the baby will be placed in a Biological Nurturing position on mother's chest.
- The woman should be advised to be in an upright or semi reclining position. Kangaroo care should not be performed with the mother lying completely flat as it is thought that this could lead to idiopathic sudden unexpected postnatal collapse. (5)
- Following cutting of the cord, the baby can be dried and weighed and given a nappy. It should then be given back to mother for more Kangaroo care. A KangaWrapKardi may be offered to women who are confined to bed (such as immediately after an operative birth) as it can be useful for keeping the baby warm and giving a sense of security for a woman whilst in bed to help facilitate this.
  - Staff must explain that this MUST NOT BE USED OUT OF BED.
    - Once a woman is able to mobilise she will be asked to return the KangaWrapKardi.
- This process will not be interrupted for routine medical procedures until the first feed has been successfully achieved. Measuring and Vitamin K administration can be performed whilst the baby is skin to skin.
- Skin to skin contact between mother and baby should be encouraged as much as possible (whilst mother is awake or being closely supervised by her partner / other).
- Once a woman is able to safely mobilise she may use a KangaWrap to perform Kangaroo Care, following the Risk Assessment below.

5.2 Risk Assessment for use of KangaWrap

- All women using a KangaWrap must be given an instruction leaflet and the Kangaroo care Information leaflet. Link to the Kangaroo Care leaflet is:

  http://twhqpulse01:84/QPulseDocumentService/Documents.svc/documents/Active/attachment?number=RWF-OPLF-PWC89
- Mother's condition must be assessed as 'stable' i.e.
  - Have walked to bathroom for shower with no ill effects
  - Observations within normal limits
  - Not receiving IV or IM opiate analgesia

5.2.1 Safety information to be discussed with woman prior to using KangaWrap:

To be discussed with woman prior to using KangaWrap using Information leaflet.

- Once mother's condition is stable she may walk around with baby in the KangaWrap, including visiting the restaurant or shop; but she should be discouraged from leaving the building.
- Mother and partner will be taught how to put the KangaWrap on safely by ward staff; this includes placing the baby in the KangaWrap whilst they are sitting down (until confident).
- The KangaWrap must ONLY be used for carrying babies in an upright position facing mother; so that the baby's face is visible at all times and its condition can be safely monitored. The Mnemonic '**TICKS**' is useful to explain the importance of safe positioning to parents when using the KangaWrap. See Appendix Four.

  Tight

  In view at all times

  Close enough to kiss

  Keep chin off chest

  Supported back

- Parents to be advised not to use the KangaWrap or perform Kangaroo care whilst asleep in line with current advice regarding co-sleeping from the Department of Health, to avoid the risk of the baby overheating and risk of 'cot death'.
- Kangaroo care should never be performed when lying flat as there have been isolated (rare) reports of babies 'collapsing' in this position. If lying down advise 2 pillows so the baby is positioned with a slight 'downward' slope, with head up.
- If the mother is a smoker explain the risks of passive smoking for her baby.
  - She should remove any outer clothing following smoking and before recommencing KC.
  - She should wash her hands following smoking.
  - There is no evidence to say how long after having a cigarette it is safe to be near a baby.
  - Parents should be encouraged to seek help to stop smoking. Please refer to Smoking Cessation for Maternity Women guideline. Link is:

    http://twhqpulse01:85/QPulseDocumentService/Documents.svc/documents/Active/attachment?number=RWF-WC-OPG-MAT-CG155

- Parents should be advised to refrain from using the KangaWrap in the kitchen or toilet areas of the hospital. Also to avoid having a hot drink whilst the baby is in the KangaWrap to avoid the danger of spillage on the baby.
- If baby needs to go to the NNU for IV antibiotics, the mum can take baby down in the wrap; however, **the baby's cot also needs to be wheeled down** as it may be required for the administration of the antibiotics and/or taking blood.
- Women must be advised that they must not sleep with baby in the KangaWrap.

5.2.2 Additional safety information to be discussed with woman prior to using KangaWrapKardi:

- Ensure woman understands that the KangaWrap Kardi is **NOT** suitable for carrying baby when walking around.
- Advice re co-sleeping, safe positioning of baby, avoidance of spillage of hot food or drinks and safe maternal positioning (as above) should be given.

5.3 Transitional Care Babies

Please refer to Transitional Care guideline. Link is:

http://twhqpulse01:85/QPulseDocumentService/Documents.svc/documents/Active/attachment?number=RWF-WC-OPG-MAT-CG151

- If it is known prior to delivery that baby will require Transitional Care then the benefits of Kangaroo should be discussed with the parents.
- The mother should be offered the use of a KangaWrapKardi and a KangaWrap whilst she is in hospital.
- Baby's condition should be monitored closely with their face visible at all times. Pre-feed observations of temperature, heart rate respirations and colour should be recorded on the Transitional Care feeding and observation chart.

5.4 Kangaroo Care in the Operating Theatre

A randomised controlled trial (Gregson and Meadows, 2016),[10] conducted at Tunbridge Wells Hospital, investigated the effect of immediate skin to skin contact in the operating theatre following a caesarean birth. Findings were that babies are more likely to breast feed successfully and that parents enjoyed and valued the experience. These findings are supported by a

Cochrane Review that also reported increased breastfeeding rates in babies at term who had Kangaroo care at birth.[4]

Babies born by Caesarean Section have different gut flora than babies born vaginally. Whilst the health implications of this are currently being researched, it is thought to be important that the baby is exposed to the mother's skin flora as soon as possible after birth to help the natural development of the baby's immune system.

In view of these findings, women having an elective caesarean (and where possible an emergency caesarean) are encouraged to perform Kangaroo Care in the operating theatre, providing there is no serious medical risk to the mother (e.g. anticipated excessive bleeding due to major placenta praevia).

Women should be advised to watch the 5 minute film 'Baby Friendly Caesarean Birth' which is available on the Trust website or YouTube. This film explains the benefits of immediate skin to skin in the operating theatre and also the benefits of delayed cord clamping. The link below may also be used to access the film:

https://youtu.be/fR-39ITbJOQ

On admission to hospital for an elective caesarean:

- Women will be offered the opportunity to wear a KangaWrapKardi under their operation gown so that they can experience immediate skin to skin contact with their baby as soon as it is born.
- The gown must be taped out of the way during insertion of the spinal anaesthesia so that there is no risk of contamination of the injection site.
- Once the spinal has been inserted, the KangaWrapKardi should be un-taped so the woman can lie down comfortably.
- The KangaWrapKardi is left untied. The ties should be placed so they do not become contaminated with blood.
- The woman should have 2 pillows under her head and shoulders to prevent her from lying completely flat, unless stated otherwise by the anaesthetist. If the woman is required to lay flat Kangaroo care should be discontinued.
- Women with increased BMI may have an Oxford pillow, or require 2 or more pillows to ensure they are not lying flat.
- If the mother feels unwell at any point then the baby may have to be removed from her chest and given to her partner or midwife.
- The baby must be closely observed by the midwife. He / she must not leave theatre unless another member of the team is happy to observe the baby in his / her absence. This must be recorded in the woman's notes.

- On completion of the operation, the baby can remain skin to skin whilst the woman is transferred to a bed.
- The woman should then be sat up and the KangaWrapKardi can be tied to give some support.
- The baby must be observed closely. If the woman is tired and needing to sleep, Kangaroo care should be discontinued unless supervised constantly by her partner or other person.
- The midwife must explain to the woman that the KangaWrapKardi is only suitable for use in bed or in a chair. It is not suitable or safe for mobilisation. Consider offering her a KangaWrap when she is mobile.

5.5 Infection control

After use, the KangaWraps and KangaWrapKardis should be sent to the hospital laundry for washing. The wrap must be placed in a clear plastic bag clearly labelled with **two** stickers stating:

- For the attention of Mark Wildish or Sue Mason.
- Please return to the Post Natal Ward, Level 3, Green Zone, Tunbridge Wells Hospital.

The bag should be sent to the laundry when there are 4 or more KangaWrapKardis requiring laundering.

6.0 Monitoring and Audit

If any issues are identified, then monitoring / audit will take place via Clinical Risk / Clinical Governance**.**

APPENDIX ONE

Process Requirements

4.0 Implementation and Awareness

4.1 Once approved this policy/procedural document will be published on the Trust intranet by the Maternity Compliance & Safety Co-ordinator.
4.2 On publication of any Maternity document, the Maternity Compliance & Safety Co-ordinator will ensure that an email is sent to all Maternity staff and other stakeholders, as appropriate.
4.3 On receipt of the publication notification, all managers should ensure that their staff members are aware of the new publications.

5.0 Review

5.1 It is essential that Trust Policy/procedural documents remain accurate and up to date; this policy/procedural document will be reviewed three years after approval, or sooner if there are changes in practice, new equipment, law, national and local standards that would require an urgent review of the policy/procedure. It is the responsibility of the Document Lead for this policy/procedure to ensure this review is undertaken in a timely manner.
5.2 The Document Lead should review the policy/procedure and, even when alterations have not been made, undertake the consultation process as detailed in **Section 5.5 Consultation** of MTW Policy and Procedure '*Production, Approval and Implementation of Policies and Procedures*'.

6.0 Archiving

3.1The Trust Intranet retains all superseded files in an archive directory in order to maintain document history.

3.2 Old paper guideline copies pre-dating Datix are stored at:
Chatham Archive & Storage document Co.
Anchor Wharf
Chatham
ME4 4TZ
Telephone: 01634 826665

APPENDIX TWO

CONSULTATION ON: Kangaroo Care on the Postnatal Unit Guideline

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Sarah Gregson, Consultant Midwife (email: sarah.gregson@nhs.net)

Job title:	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**

By date: 6 March 2018

Consultant Obstetricians	21/02/18			
Consultant Obstetric Anaesthetists	21/02/18			
Head and Deputy of Women's Services	21/02/18	21/03/18 (HoM)	Y	Y
Inpatient and Community Matrons	21/02/18			
All Staff leads	21/02/18			
Maternity staff	21/02/18			
All Team leads	21/02/18			
Maternity Risk Manager	21/02/18			
Community Midwives	21/02/18			
Audit Facilitator for Women's and Children's services	21/02/18	21/02/18	Y	Y
Clinical Skills Facilitators	21/02/18			
NNU Managers	21/03/18	27/02/18	Y	Y
The following staff have given consent for their name to appear in this guideline and its appendices: Sarah Gregson Mark Wildish Sue Mason				

APPENDIX THREE

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy and procedure development exercises.**

Title of policy or practice	Kangaroo Care on the Postnatal Unit Guideline
What are the aims of the policy or practice?	To ensure a positive impact on the lifelong health and wellbeing of the babies born in our Trust
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	**Yes** **See page 2**
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language	The Trust offers a translator service
People who have a physical or mental disability or care for people with disabilities	No
Women who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	YES
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

APPENDIX FOUR

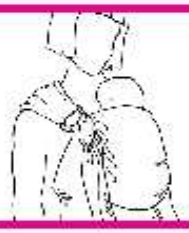
The T.I.C.K.S. Rule for Safe Babywearing

Keep your baby close and keep your baby safe.
When you're wearing a sling or carrier, don't forget the **T.I.C.K.S.**

- ✓ TIGHT
- ✓ IN VIEW AT ALL TIMES
- ✓ CLOSE ENOUGH TO KISS
- ✓ KEEP CHIN OFF THE CHEST
- ✓ SUPPORTED BACK

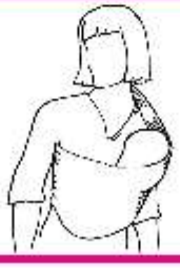
TIGHT – slings and carriers should be tight enough to hug your baby close to you as this will be most comfortable for you both. Any slack/loose fabric will allow your baby to slump down in the carrier which can hinder their breathing and pull on your back.

IN VIEW AT ALL TIMES – you should always be able to see your baby's face by simply glancing down. The fabric of a sling or carrier should not close around them so you have to open it to check on them. In a cradle position your baby should face upwards not be turned in towards your body.



CLOSE ENOUGH TO KISS – your baby's head should be as close to your chin as is comfortable. By tipping your head forward you should be able to kiss your baby on the head or forehead.

KEEP CHIN OFF THE CHEST – a baby should never be curled so their chin is forced onto their chest as this can restrict their breathing. Ensure there is always a space of at least a finger width under your baby's chin.



SUPPORTED BACK – in an upright carry a baby should be held comfortably close to the wearer so their back is supported in its natural position and their tummy and chest are against you. If a sling is too loose they can slump which can partially close their airway. (This can be tested by placing a hand on your baby's back and pressing gently - they should not uncurl or move closer to you.)
A baby in a cradle carry in a pouch or ring sling should be positioned carefully with their bottom in the deepest part so the sling does not fold them in half pressing their chin to their chest.