GUIDANCE FOR NEONATAL UNITS
It gives me great pleasure to welcome this new guidance, which I commend to every neonatal service. Indeed I believe that it is not fanciful to say that the Baby Friendly Initiative is one of the most important developments in the care of newborn babies and their parents since the move from predominantly home birth to overwhelmingly hospital births 50 years ago. Baby Friendly standards have already made a substantial impact within maternity services. This impact is now needed in neonatal units.

Separation of parents and babies gives rise to all sorts of problems. Being in a neonatal unit creates physical barriers to touch, smell and breastfeeding, and creates difficulties in establishing and fostering a loving and responsive parent-child relationship.

Some of the problems lie in an antiquated approach to the physical design of neonatal units. While in paediatrics single parent-child rooms are the norm, neonatal care seems stuck resolutely in the 20th century with barn-like communal intensive care areas, and special care rooms that parody Nightingale wards. None of this makes any sense, and all of it can be done differently. But the rest of the problem lies in the unquestioned customs and traditions in neonatal care.

So how to make things better? This is where the Baby Friendly Initiative can make a huge difference to babies and their families. Even where the physical environment may not facilitate a more Baby Friendly approach, a great deal can be done with some radical re-thinking about the roles of professionals and parents, and imaginative ways of working. In the guidance there are some great examples of new ideas that break free from the assumptions of the past. To be truly Baby Friendly recognises that close and loving relationships are for all babies, whether breast or formula fed, and whether they are in special or intensive care.

This guidance will help every neonatal service to gain Baby Friendly accreditation. At least as important, it should also help neonatal facilities to sustain the cultural changes in the delivery of care that underpin the Baby Friendly standards.

Please, don’t ask ‘should we do it?’ Just do it. Be Baby Friendly.

Martin Ward Platt,
Consultant Neonatal Paediatrician,
Newcastle upon Tyne
INTRODUCTION

Welcome to the Baby Friendly Initiative guidance for neonatal units. It has been written for those tasked with implementing the Baby Friendly standards in their neonatal unit. It is intended to provide a ‘road map’ for the journey towards Baby Friendly accreditation, as well as tips and ideas that may be helpful. It is intended to be read alongside the Guide to the Baby Friendly Initiative standards, which explains the standards and assessment process in detail. bit.ly/1QI3G5L

BACKGROUND

The Baby Friendly Initiative is a global programme of Unicef and the World Health Organisation introduced to improve practice for infant feeding in health care settings. It was introduced into the UK in 1994 and has been very successful in changing routine care for mothers and babies. At the time of writing 89 per cent of UK maternity units and 83 per cent of health visiting services are actively engaged with the programme.

In 2012 the Baby Friendly Initiative started a major review, which resulted in the standards being expanded to cover holistic care for all mothers, babies and their families. At this time, a decision was made to introduce bespoke standards for neonatal units for the very first time. Up until this point neonatal units had been included as part of the maternity unit standards but only in a limited way by concentrating on the care of mothers currently on the postnatal ward with a baby on the neonatal unit. Nevertheless, the Baby Friendly Initiative had still succeeded in greatly improving care on neonatal units especially around skin to skin contact, expressing breastmilk and breastfeeding. It was felt that an expanded set of evidence-based standards which encompassed the holistic care of families related to building close relationships, feeding and supporting parents to be partners in care, could have the potential to transform neonatal units and greatly improve outcomes for these most vulnerable babies. Therefore, an expert group was convened, an evidence review completed and neonatal standards developed.

After extensive consultation and piloting, the standards were published along with an audit tool to support neonatal units to internally audit the standards. This audit tool uses interviews with clinical staff and parents to allow trained staff to map progress over time. An external assessment tool was then developed which consists of interviews with managers, staff of all disciplines and grades and parents, as well as reviews of policies, guidance, materials for parents and mechanisms to support good practice. Units can now apply for Stage 1, 2 and 3 accreditation.
OVERVIEW OF THE STANDARDS

STAGE 1: BUILDING A FIRM FOUNDATION

1. Have written policies and guidelines to support the standards.
2. Plan an education programme that will allow staff to implement the standards according to their role.
3. Have processes for implementing, auditing and evaluating the standards.
4. Ensure that there is no promotion of breastmilk substitutes, bottles, teats or dummies in any part of the facility or by any of the staff.

STAGE 2: AN EDUCATED WORKFORCE

Educate staff to implement the standards according to their role and the service provided.

STAGE 3: PARENTS’ EXPERIENCES OF NEONATAL UNITS

1. Support parents to have a close and loving relationship with their baby.
2. Enable babies to receive breastmilk and to breastfeed when possible.
3. Value parents as partners in care.

If you are not familiar with the standards or how the Baby Friendly assessment procedure works visit our website, babyfriendly.org.uk, where this is explained.

GETTING STARTED

The very first piece of work required is deciding how the project is going to be led and what roles staff are going to take. This is a major change management project and so it is important to consider available resources carefully.

PROJECT LEAD

It is common for there to be an infant feeding coordinator employed by the maternity unit who takes a lead on Baby Friendly. While this person can bring a wealth of knowledge and experience to the project and be crucial to its success, experience has shown that it is also very beneficial to have a project lead based in the neonatal unit. This brings the necessary expertise and the focus required to support staff with the changes required. This person will require some protected hours (depending on the size of the unit and number of staff employed) and the experience to manage the project and command the respect of the staff. Their own training needs should be carefully considered, including support needed to update clinical skills and knowledge and to learn project management, educating staff and audit. Some of this can be provided by the maternity infant feeding coordinator and there are also courses provided by Unicef UK and other organisations. For details, visit unicef.org.uk/BabyFriendly/Health-Professionals/Training/
**PROJECT CHAMPION**

We suggest that a project champion be identified from the very start. A project champion is usually a senior member of staff who represents the project at senior management level. This person also helps identify resources and offers support to the project lead and other team members. This person should be part of the senior management team (for example consultant neonatologist/paediatrician, head of nursing) and willing to offer their experience and influence to take the project forward. Although the project champion is not expected to have a ‘hands-on’ role they should be kept regularly informed about progress made and be fully conversant with what is required of the unit as the standards are implemented.

**PROJECT STRATEGY GROUP**

It is suggested that there be a forum for a senior group to oversee the implementation of the project. The group should be small enough to ensure that it is effective and should include key representatives who will be able to steer the project in the right direction. Actual membership will depend on the size and complexity of the unit, but representatives could include the unit lead, senior clinical staff member, neonatologist, project lead, maternity infant feeding lead, a member of a relevant allied profession such as a dietician, speech and language therapist, psychologist or developmental care lead and, if there is an active neonatal peer support group, a delegated representative. Simple terms of reference for the group should be produced so that the purpose of the group is clear. Agenda setting should be agreed and notes of meetings recorded along with any required actions so that these can be followed up at subsequent meetings.

To some extent, how the project is planned will depend on what has happened in your neonatal unit so far with regards to Baby Friendly. In almost all hospitals in the UK, the maternity unit has made some progress towards Baby Friendly accreditation and the neonatal unit has been involved with this.
The purpose of a Stage 1 assessment is to ensure that all your policies, systems and paperwork are in place in order to provide a solid platform for implementation of the project. It is very important that you commit to completing all the Stage 1 paperwork as this lays the foundation for the project.

If your maternity unit has undergone a Stage 1 assessment, then the maternity infant lead will be able to assist with this work. If your maternity unit has achieved a Stage 1 or above then you don’t need to submit the neonatal Stage 1 documentation for a formal assessment. However, it is still important to take this process seriously.

Print off or download the Stage 1 guidance and submission document and work your way through each section carefully. unicef.org.uk/BabyFriendly/Health-Professionals/going-baby-friendly/stage-1-a-firm-foundation

Make use of the sample documentation and other resources provided by Baby Friendly, including:

- **Sample infant feeding policies**
  unicef.org.uk/BabyFriendly/Resources/Guidance-for-Health-Professionals/Writing-policies-and-guidelines/Sample-infant-feeding-policies

- **Curriculum guidance document**
  unicef.org.uk/BabyFriendly/Resources/Guidance-for-Health-Professionals/Writing-policies-and-guidelines/Guidance-on-writing-a-curriculum

- **Having meaningful conversations with mothers**
  unicef.org.uk/BabyFriendly/Resources/Guidance-for-Health-Professionals/Forms-and-checklists/New-guidance-for-antenatal-and-postnatal-conversations

- **You and your baby: supporting love and nurture on the neonatal unit**
  unicef.org.uk/BabyFriendly/Resources/Resources-for-parents/You-and-your-baby-Supporting-love-and-nurture-on-the-neonatal-unit

- **Train the trainer course and materials**
  unicef.org.uk/BabyFriendly/Health-Professionals/Training/Train-the-trainer

- **Neonatal course (Embedding Baby Friendly standards in the neonatal unit)**
  unicef.org.uk/BabyFriendly/Health-Professionals/Training/Neonatal-course

- **Audit tools and courses**
  unicef.org.uk/BabyFriendly/Health-Professionals/Training/Audit-Workshop

- **A workbook for neonatal nurses**
  unicef.org.uk/BabyFriendly/Resources/Training-resources/A-workbook-for-neonatal-nurses

Once the form is completed, consider where the gaps are and these will then form the basis of your first action plan.

**MONITORING PROGRESS: AUDIT AND EVALUATION**

Monitoring how well the standards are being implemented is an ongoing process. The Baby Friendly neonatal audit tool has been designed to help keep you informed as to how well you are doing and when it is appropriate to book external assessments. unicef.org.uk/BabyFriendly/Resources/Guidance-for-Health-Professionals/Audit/Audit-tools-to-monitor-breastfeeding-support

We strongly recommend that a baseline audit of all the standards is carried out as soon as possible. This will allow you to identify the areas that are already working well and the areas where there is work to do. It will also allow you to map the progress that is being made to improve care right from the start. This is important as it provides evidence of improvements in outcomes for all the work and investment that is taking place.

The Baby Friendly audit tool is designed to be used by clinicians with knowledge and skills in the Baby Friendly standards. One day workshops are provided to support the auditors learn how to audit effectively: unicef.org.uk/BabyFriendly/Health-Professionals/Training/Audit-Workshop
After the baseline audit, the second audit of staff should be carried out on the staff who have completed the training package. This is because it is important to assess the effectiveness of the training as soon as possible so that any weaknesses identified can be addressed before training the rest of the staff.

As more staff attend training, practice in the unit should begin to change. Therefore, when enough staff have been trained to affect care, further audits of practice can begin. The Baby Friendly audit tool (mother interview) will provide an insight into the care parents have experienced.

When selecting mothers for interview it is important to select parents at different stages of their journey through the neonatal unit, as well as mothers whose babies have been discharged home. This is because perceptions change over time. We also suggest that interviews start with mothers whose baby is at least 30 weeks corrected age, as this will allow enough care to have been provided to make the form relevant.
Education of staff is key to ensuring that standards are implemented and practice improved. Good quality training which engages and inspires participants can exert a profound influence over the culture within a unit. Time is required to plan training that is interesting, relevant and fun. You also need to ensure that key learning outcomes are met and participants have an opportunity to discuss, question and unpick issues which will affect their day to day working environment. The Baby Friendly Initiative has developed guidelines for development of a training curriculum with an outline of key topics which need to be covered.

There are also a number of courses to help staff responsible for leading on:

- **Training:** [unicef.org.uk/BabyFriendly/Health-Professionals/Training/Train-the-trainer](unicef.org.uk/BabyFriendly/Health-Professionals/Training/Train-the-trainer)
- **Audit:** [unicef.org.uk/BabyFriendly/Health-Professionals/Training/Audit-Workshop](unicef.org.uk/BabyFriendly/Health-Professionals/Training/Audit-Workshop)

### PLANNING THE TRAINING PROGRAMME

- There needs to be a commitment from managers to support the training, including the allocation of preparation time and support for the training needs of the trainers.
- How staff are to be released to attend training requires agreement at the outset.
- A baseline audit of staff skills and knowledge using the Baby Friendly audit tool will identify their strengths and weakness and so inform what needs to be covered and in what depth.
- Consider the training needs of medical staff.
- Source and book a suitable training venue (you may need to do this well in advance).
- Consider how the training is to be delivered. This may depend on the size of the unit as larger units may be able to release 10 or more staff at a time for block training whereas smaller units may only release small numbers. Some areas have combined basic training with midwifery colleagues and then provided additional training in small bite sized workshops and one-to-ones in clinical practice, while others have run the entire training as a series of small workshops based within the practice area. Regularly updated workbooks, e-learning and other innovative approaches can further support formal training.
- Look at other (non-commercial) training and conferences which may enhance what is provided locally. (For more information, see [Unicef UK’s Guide for health professionals to working within the International Code of Marketing of Breastmilk Substitutes at unicef.uk/code](unicef.uk/code)).
- Develop a system for keeping records of each staff member’s completion of all parts of the training.
- Carry out further audits of training to identify additional education needs and then amend the training programme as necessary.
- Audit practice through face to face interviews with parents using the Baby Friendly audit tool and develop action plans to address any theory or practice gaps.
STAGE 3

PARENTS’ EXPERIENCE OF CARE

The following section explains the three standards in stage 3 in detail, including what they mean for practice and what the Baby Friendly assessment team will be looking for at assessment.

STANDARD 1: SUPPORT PARENTS TO HAVE A CLOSE AND LOVING RELATIONSHIP WITH THEIR BABY

1. Parents understand why close and loving relationships are important now and in the longer term.

We are looking for parents to be supported to understand that their relationship with their baby is crucial for their baby’s well-being and development both now and in the longer term. The goal is to empower parents to feel that they are a vital part of their baby’s care rather than a visitor who is less important to their baby’s well-being than the staff carrying out the majority of care. We are also looking for parents to understand in simple terms the general principles of the science that underpins this standard, thereby preparing them to nurture their baby now and in the future in a loving and responsive way.

It is recognised that great sensitivity is required with this standard, as some very preterm or sick babies may have poor long term health outcomes. Also being separated from their baby at birth and faced with the possibility that their baby might not live can result in some parents distancing themselves from their baby in order to protect their own emotional well-being. Staff therefore need to be gentle and sensitive in their approach and help parents to take small steps towards understanding the theory that then leads to gradually applying this to their own situation in a way that is right for them and their family.

Steps towards making this happen could include:

- Providing good quality training to enable everyone on the neonatal unit to understand the basic neuroscience that underpins this standard, including considering the different challenges faced by a preterm baby growing inside an incubator as opposed to their mother’s womb.
- Training programmes should also address communication skills so that staff are enabled to feel confident to listen, tailor information and help parents’ voices to be heard.
- Because of the stress that parents are under it is unlikely that they will be able to absorb much information in one go. Consider ways to revisit the key messages through the use of posters, leaflets and links to good quality information on websites.
- Staff can point out how baby responds to their parent’s voice, touch, smell as a way of starting conversations and re-enforcing the key messages.
- Don’t forget the longer term. This information is not just important while a baby is very ill, but also as they grow stronger and once they leave the unit and throughout their childhood and into adulthood.
2. In the absence of parents, baby’s needs for comfort and emotional support are met by an individual selected by the parents or by a staff member.

Babies thrive when they are in close contact with their main carer (for very young babies this is most often their mother, but fathers also have an important role). Parents are therefore the most appropriate people to provide comfort and contact and should be encouraged to do so as much as possible.

However, parents may not be able to be in the unit at all times because of work and other family commitments, and it is important that the needs of the baby for care and comfort continue to be met. Consider what would happen under normal circumstances if a baby was at home. It is unlikely that they would be left alone for long periods without contact. Sadly, because of pressure of work within busy neonatal units, staff can find it easier to carry out basic functions, administer drugs, tube feed and so on without providing touch, communication or comfort.

We would like to see comfort and emotional support as second only to survival in the priority it is given on a neonatal unit, so that babies are not left for hours without human contact.

Steps towards making this happen could include:

- Supporting parents to select other family members to provide this care in their absence.
- Looking at other schemes to help parents and staff provide this care to babies. For example, a hospital in Chicago has a team of volunteers who come in to the hospital to cuddle babies if their parents can’t be there and this has proved to be very successful. All substitute carers are screened for infection control and there is no evidence that babies are at increased risk from this practice. For more information, see: http://stanfordmedicine.org/communitynews/2014spring/cuddler.html
- Supporting the nurses to feel comfortable taking on this role. Our experience is that nurses worry that they will be seen as not working hard enough if they are simply talking to and cuddling a baby and they also worry that they will be considered as taking on a parental role. Supporting nurses and other staff to feel confident that this is part of their role needs to be part of training and then the work to change culture over time. Both parents and staff also need to be supported to understand that this is in the very best interests of babies and not an optional extra.
- All contact should be recorded as part of general care so that it is not forgotten and babies’ experiences and responses can be mapped over time.

3. Parents and staff are enabled to recognise baby’s behavioural cues and tolerance for stimulus, and parents are supported to build close relationships via touch, talking, comforting and so on, as appropriate.

The normal interactions between a parent and their baby can be severely restricted in a neonatal unit where parents feel on show and where there are so many barriers to getting close. Behavioural cues in preterm and sick babies are also different and more subtle than in a well baby. Understanding these cues and feeling able to interact with your baby is therefore a vital part of offering appropriate close and loving care.

Steps towards making this happen could include:

- Including behavioural cues in staff training and making sure that all parents are supported to understand their baby’s cues.
- Providing screens, books and other tools as aids for parents. It can be difficult to talk and comfort in an open plan public environment and it is also harder for some parents than others depending on background and culture.
- Staff with expertise in developmental care can offer much support. There are also excellent materials and courses that can help support staff gain the necessary expertise.
- Written material, posters and so on can help support conversations and information sharing.
- Parents may need help to recognise when their baby needs time out as overstimulation can be just as distressing as none.
- As parents get to know their baby they will be more attuned to their baby’s individual needs and nuances. Staff should be encouraged to listen, accept and respect parents’ input about their baby’s condition and needs.
4. Prolonged, frequent skin to skin contact is encouraged for all babies. Skin contact is prevented only for acceptable clinical reasons and not because of lack of staff training or resources.

Skin contact needs to be recognised as a part of essential care, not as a desirable ‘add on’ if there is time and resources and staff availability.

Steps towards making this happen could include:

- Educating all staff to be confident to assist with the transfer of the baby from the incubator and be aware of how to position the baby for safety and comfort.
- Making sure that the chairs provided are comfortable enough to allow skin contact for prolonged periods.
- Recording both the occurrence and duration of all skin contact.
- Supporting parents to become confident in recognising their baby’s behavioural cues so that they can take a lead on initiating skin contact.
- Ensuring that skin contact is not viewed as only important in a high dependency environment, but is encouraged for parents and babies throughout the neonatal stay and beyond.

5. Parents and staff who are bottle feeding are supported to do this responsively, recognising the baby’s cues and need for comfort and closeness during feeding.

Feeding is a key time for babies to be close to their carers and to receive comfort and communication. In a neonatal unit, feeds are often seen as a clinical intervention with the objective being to make the baby swallow a prescribed amount of milk. While it is recognised that nutritional intake needs to be carefully regulated and monitored, it is important that babies also experience feeding as a safe and pleasurable experience where their needs for closeness and comfort are also met.

Steps towards making this happen could include:

- Helping babies to learn to coordinate their suck, swallow and breathing as they bottle feed in a gentle supportive way. The teat provides a very strong stimulus for baby to suck and hyper-stimulation caused by rubbing the teat against the baby’s palate can be distressing for a baby. Educating parents and staff to invite the baby to draw in the teat rather than forcing the teat into the mouth and to pace the feed, including recognising the baby’s cues that they want to stop, will make feeding less stressful.
- Encouraging staff and parents to finish feeds by nasogastric tube rather than force feeding babies. It is better that babies take a smaller amount and experience feeding as pleasurable, than be forced to take a larger amount which causes them stress and could lead to feeding problems later on.
- Supporting both staff and parents to feed babies close in a semi upright position with plenty of eye contact, so that they feel safe and comforted. Preterm babies have limited core stability so the common practice of holding them away with support only behind their shoulders is stressful for them.
- Encouraging eye contact and gently talking to and reassuring baby throughout the feed so that signs of distress or cues that baby has taken enough are responded to.
- Supporting staff to feel confident with responsive bottle feeding. Staff may sometimes feel that holding babies close is inappropriate for them as it makes feeding less of a clinical intervention and they may look as if they are taking time out. Supporting them to understand why this is important for the baby is therefore vital. Nurses are also important role models for parents.
- Ensuring that all parents are supported to learn how to make up bottle feeds correctly and what milk to use prior to going home with their baby.
STANDARD 2: ENABLE BABIES TO RECEIVE BREASTMILK AND TO BREASTFEED WHEN POSSIBLE

1. A discussion with parents takes place about the value of breastmilk as early as possible.

Breastmilk is vitally important for preterm and sick babies and it is extremely important that all parents who have, or are likely to have, a preterm or sick baby understand this. Many parents who may have never considered breastfeeding will be open to providing breastmilk when they understand its value to their preterm baby.

Steps towards making this happen could include:

- Developing a mechanism with the maternity services to ensure that the neonatal unit is alerted to every pregnant woman who may have a preterm or sick baby so that a conversation about breastmilk and expressing can be arranged.
- Having a conversation with parents about breastmilk and expressing as part of the admissions procedure for every baby admitted to the unit.
- Having written information to leave with parents after the conversation to help them recall and consider the information.
- Ensuring that the key staff responsible for conducting these conversations have the information and communication skills to do this effectively.

2. Mother’s own breastmilk is always the first choice of feed (except for a small number of clinical indications, for example HIV infection or a mother undergoing chemotherapy).

Mother’s own breastmilk, and particularly her colostrum, will bring the greatest benefits to her baby.

Steps towards making this happen could include:

- Ensuring that all staff understand the value of colostrum for priming and protecting the very immature ‘gut’ of preterm and vulnerable babies.
- Labelling and numbering colostrum collections so that it is used in the order that it is expressed. Colostrum contains a number of concentrated properties which provide a protective coating to the lining of the gut preventing bacterial transfer. Some studies suggest that colostrum should be used in order of expression as evidence suggests that it changes to meet babies’ requirements in the early hours and days after birth.

3. Mothers are enabled to express milk as soon as possible, ideally within the first two hours.

The earlier a mother begins to express her breastmilk the better her long-term production will be.

Steps towards making this happen could include:

- Developing a mechanism whereby neonatal staff and midwifery colleagues on the delivery suite are reminded to support and record this.
- Introducing colostrum packs (ready-made packs containing all equipment and information to support hand expressing of colostrum) to help staff to implement the mechanism for supporting early expression.
- Auditing to monitor what percentage of mothers express within two hours and set targets and timelines for improvements when these are required.
4. Breastmilk is used for mouth care and tempting the baby to feed.

The anti-bacterial properties of breastmilk combined with the sweet familiar taste (babies appear to recognise their own mothers’ milk) provides comfort to babies, stimulates enzyme release and is an excellent way to keep baby’s mouth clean. Even when baby is not tolerating feeds using breastmilk for mouth care is valuable and staff should be encouraged to use this in preference to other mouth care solutions.

Steps towards making this happen could include:

- Educating staff and parents to the value of using breastmilk for mouth care.
- Showing parents how to do this and providing them with the necessary equipment.

5. Mothers learn how to express effectively by hand and pump (as appropriate to individual need) and how to store milk.

Hand expressing is a useful skill for all breastfeeding mothers as it requires little equipment and can be used at any time. It is particularly useful for expressing colostrum as the small amounts can easily be collected in a syringe ready to be stored or used immediately. Mothers also need to be enabled to use the available breast pumps and therefore need instruction on how to do this, with follow up to ensure effectiveness.

Steps towards making this happen could include:

- Liaising with the maternity unit to ensure that all mothers are shown how to hand express as soon as possible after birth.
- Developing a prompt in the baby’s records to remind staff to check that the mother knows how to hand express and to educate her on the use of the pumps.
- Introducing and then using the Baby Friendly expressing assessment form for all mothers: http://bit.ly/1TWUmLy
- Educating staff to be flexible in their approach to how mothers express their milk, while employing strategies that are known to increase milk production and yield such as combining hand and pump expression, massage and double pumping.
- Suggesting mothers try hand expressing at the beginning and end of an expression with a pump. Touch is important for production of the milk-making hormone prolactin, so this can be helpful.
- Ensuring that hospital grade breast pumps are always available as these are the most efficient.
- Increasing the availability of different sizes of funnel. Too large a funnel will result in decreased milk expression and too small will cause damage to the nipple and breast.
- Promoting double pumping as this can be more efficient in gaining larger volumes in a shorter period of time than expressing both breasts separately.

CASE STUDY: SHEFFIELD TEACHING HOSPITALS

COLOSTRUM PACKS

The development and introduction of a colostrum pack was an example of neonatal and maternity services working together to support families. Shona Brennan, a neonatal dietitian who coordinated the initiative along with speech and language therapist Jane Shaw, says: “The idea originally came from a Baby Friendly audit. The results highlighted the need to support mothers to start expressing earlier. It soon became obvious that we needed to work together as a whole hospital to facilitate this.”

As well as getting mums started on expressing, the colostrum pack is designed to support mothers to get their milk supply really well established. Parents were central in the design of the pack, in fact it was a mother’s idea to use a syringe rather than a bottle, so that mums could see their syringes filling up with valuable colostrum. The colostrum is used as soon as possible, wherever the baby is on the neonatal unit, whether for mouth care, or to start feeds for the baby.

Emma, pictured below, whose daughter Minnie was on the neonatal unit, says: “It didn’t feel overwhelming to express milk, as the syringe was so small. It felt like the one thing I could do for Minnie while she was in intensive care. To contribute towards her well-being was really phenomenal for me. Minnie is now a fully on-demand breastfed baby, so it’s been a real success!”
UNICEF UK BABY FRIENDLY INITIATIVE: GUIDANCE FOR NEONATAL UNITS

Providing mothers with storage containers and labels and ensuring that there is a system whereby milk is labelled to enable it to be used in order of expression in order to help maximise the effectiveness of breastmilk. Once the gut has been primed with colostrum, breastmilk should be used fresh whenever possible.

6. Mothers are supported to express frequently, especially in the first two to three weeks, to optimise supply.

The first couple of weeks after birth are crucial for optimising future milk supply. It is recognised that the more a baby feeds in those first couple of weeks the better the milk supply will be in the future. Mimicking what a mother and baby would do if they were together is therefore the best way to support expression.

Steps towards making this happen could include:

- Encouraging mothers to express between eight and 10 times (minimum) in 24-hours including once at night.
- Educating mothers not to leave a gap of longer than five hours between expressions. However, mothers do not need to express to a strict three hourly regime, they are more likely to express frequently if given flexibility in their regime. Cluster expressions, whereby a mother may express twice or three times in a four-hour period, followed by a gap of four to five hours, may work best for some.
- Providing mothers with their own expression log so they can record expressions. It is the responsibility of the staff to check the logs and discuss expressing with mothers so they can monitor and support progress.

7. Mothers have access to adequate, effective expressing equipment to use on the unit and at home.

There should be easy access to pumps on the unit, including a choice of funnel size and there has to be an effective breast pump loan scheme that the unit takes some responsibility for. It is not acceptable for the unit to simply refer mothers to a third party provider of breast pumps and then never check the quality of the service provided.

Steps towards making this happen could include:

- Ensuring that hospital grade pumps are provided in all units with a range of funnel sizes available.
- Auditing the current system for provision of breast pumps to use at home. This can be carried out by asking mothers if they have always had a pump available and if the pump used is effective enough for expressing breastmilk for a preterm or sick baby.
- Planning to develop an effective breast pump loan system if the current arrangements are inadequate.

Planning of electric pumps for use at home that are of a high quality and can provide a double pumping feature should be considered in order to continue to support effective expressing when the mother is unable to be resident on the neonatal unit. If a third party is used to provide this service, audit should be undertaken to ensure effective support and equipment is provided.
8. A formal review of expressing takes place a minimum of four times in the first two weeks and there is access to further help with expressing if milk supplies are inadequate or less than 750mls by day 10.

It is important that mothers have the support that they need to maximise the amount of breastmilk they are able to express for their baby. The first two weeks are crucial for priming the breasts and so it is essential that mothers are not just left to manage their expressing alone during this period. Further support should be provided to the mother if her milk supply is not increasing sufficiently during this time. Evidence suggests that approximately 750mls or more by day 10 is an indicator of an ongoing milk supply. Individual circumstances such as extreme prematurity, changing condition of the baby and maternal condition could all affect the ability of the mother to express effectively. Sensitive communication should be employed to discuss this with mothers. Support to encourage any breast milk for the baby is essential. Steps towards making this happen could include:

- Using the Baby Friendly Initiative sample expressing assessment form, which can be adapted for individual hospital use: [http://bit.ly/1TWUmLy](http://bit.ly/1TWUmLy)
- Ensuring that all mothers have a formal assessment carried out at least four times in the first two weeks to ensure that they are not experiencing problems. These assessments should be recorded and remain with the mother.

9. Expressing is frequently checked, on an informal basis, after the first two weeks.

Although there may be no need to continue to check technique formally once the mother has mastered the technique of expressing, it is important to check in on how she is doing and talk through any challenges or obstacles she may have encountered. Long term expressing is a relentless task and ongoing empathy, praise and genuine interest will go a long way to support mothers to continue.

Steps towards making this happen could include:

- Having reminders in the records so that staff remember to raise the topic with mothers.
- Encouraging mothers to maintain an expressing log which is regularly checked by staff.
- Encouraging mothers to seek help if they are experiencing difficulties or their milk supply is reducing.

10. The unit has an environment conducive to expressing.

Neonatal units often offer little privacy and it can be daunting for mothers to have to express their breastmilk in places where they don’t feel safe. Providing comfortable private space is therefore essential.

Steps towards making this happen could include:

- Encouraging mothers to express near their baby by providing curtains or screens and adequate chairs to allow privacy and comfort.
- Ensuring that the room provided for mothers to express is comfortable and pleasant enough to spend significant amounts of time in.

11. Skin contact is used to induce instinctive feeding behaviours.

Skin to skin contact has many emotional and physiological benefits for parents and babies. When mothers and babies spend lots of time together in this way with baby’s head close to mother’s breast, instinctive pre-feeding behaviours are encouraged. Enabling baby to root, lick and familiarise themselves with their mother’s breast provides the perfect introduction to breastfeeding and should be seen by staff as important to the transition to breastfeeding.

Steps towards making this happen could include:

- Educating staff to understand the value of skin contact for encouraging breastfeeding.
- Providing privacy and an unhurried environment for mothers as they learn to breastfeed.

12. Mothers can be close to their baby in order to respond to feeding cues.

Long before a baby is ready to feed, mothers can be taught how to recognise their baby’s early feeding and pre-feeding cues such as rooting, tongue movement, turning towards the breast, opening eyes, putting hands to mouth. As the baby becomes more developmentally mature these cues will become more evident and provide the basis for responsive feeding.

Steps towards making this happen could include:

- Educating staff to be alert to these cues so they can help parents tune into their baby.
- Providing education for parents including written material so that they are aware of the importance of feeding cues.
13. Support with positioning and attachment and recognising effective feeding.

Mothers can be supported with the principles of positioning long before the baby is ready to feed. As baby becomes more developmentally mature they will go through a process where they may appear to attach to the breast and suckle but their co-ordination may be poor. Over time they will begin to co-ordinate their suck/swallow/breathe patterns to enable some transfer of milk. Steps towards making this happen could include:

- Educating staff and parents in how to recognise effective positioning and attachment, while ensuring awareness that this can be a slow process and so patience is needed. Staff need to be especially vigilant to ensure realistic parental expectations regarding the pace at which their baby learns to breastfeed.

14. Additional support is provided to help with expressing and feeding challenges when needed, including specialist help when required.

It is important that mothers are able to access additional skilled support when faced with challenges, including creating a plan of care as appropriate to need, which staff are then supported to implement. Steps towards making this happen could include:

- Identifying staff with a particular interest in infant feeding and enabling these staff to access extra training to gain skills in supporting mothers.
- Working with the maternity infant feeding lead to develop a system whereby mothers with particular challenges are referred to their team.
- Monitoring referrals to the specialist staff – particularly numbers referred and reasons for referrals. The aim should be to ensure that mothers with particular challenges are supported and that staff are coping with the day to day care of most mothers without over referral to the specialist staff.

15. Mothers are prepared for going home.

Parents need to feel safe and confident about feeding their baby when they go home and so preparation for this needs to be built into feeding plans. Steps towards making this happen could include:

- Involving parents as partners in care from the beginning with the nurse’s role being as much about being a teacher or enabler as that of a clinician.

16. Information about how to access support with feeding in the community is provided.

Experience suggests that lack of confidence often results in many mothers introducing formula milk and stopping breastfeeding soon after discharge home. Often the pressure on space within neonatal units results in babies being discharged home before breastfeeding has become fully established. It is important that mothers are as prepared as possible for going home breastfeeding and that they have support to continue breastfeeding once they are at home. Steps towards making this happen could include:

- Supporting parents to become responsive to their baby’s feeding and behavioural cues rather than sticking with a rigid regime as the time for discharge draws near.
- Giving all parents the opportunity to room in with their baby for as long as needed and to take full responsibility for their baby’s care.
- Supporting mothers to understand that, although nutrition remains a key priority, they can also breastfeed responsively as a means of offering comfort and nurturing to their baby. Helping them to understand that they can’t spoil or overfeed their baby through too much breastfeeding.
- Ensuring that parents understand that their baby needs a minimum of eight feeds in 24-hours, but that more is better. Many mothers will also need to continue expressing after discharge home.

- Supporting staff and parents to understand that continued breastfeeding is important. It provides nutrition and protection from infections which can save babies from being readmitted to hospital, thus saving considerable financial cost to the health service and emotional cost to the family.
- Training for all staff who support parents after discharge on how to support continued breastfeeding effectively.
- Referring mothers and babies who are making the transition to breastfeeding to the infant feeding lead within the hospital/unit so that a plan of care can be developed. This should include details of where they can continue to get follow up help and support after discharge.
- Ensuring that all mothers have both written and verbal information about where to access help and support once they are discharged home.
- Fostering support groups and peer support for parents with a baby who has been cared for on a neonatal unit.
17. There is no advertising of breastmilk substitutes, bottles, teats or dummies.

All facilities working to Baby Friendly standards are required to adhere to the International Code of Marketing of Breastmilk Substitutes (the Code). This standard does not restrict the provision of accurate and impartial information about formula feeding but rather is designed to protect parents from commercial influences at this most vulnerable time.

Steps towards making this happen could include:

- Staff education, including for medical staff, on the principles of the Code and what this means for their practice, including where to access unbiased, evidence based information on formula milks.
- Systems in place for dealing with representatives from companies that come under the scope of the Code, in order to protect parents and staff from marketing.
- Ensuring that parents who are formula feeding their baby are given clear written instructions and shown how to make up a feed safely before they leave hospital. They also require evidence based information on the types and brands of formula milks.
- Ensure that community-based staff enable parents to bottle feed safely.

For more information see the Health Professional’s Guide to working within the Code at unicef.uk/code.

For accurate and impartial information on formula milks in the UK please see the First Steps Nutrition Trust report Infant Milks in the UK at firststepsnutrition.org/newpages/Infant_Milks/infant_milks.html.
STANDARD 3: VALUE PARENTS AS PARTNERS IN CARE

Having parents as true partners in care requires a significant culture shift for most neonatal units in the UK. Ultimately we are aiming for parents to be seen as the primary care givers, with clinical staff providing specialised care while acting as teachers and supporters to parents as they learn to care for and take responsibility for their baby.

1. There is a policy of 24-hour access; staff routines and practices do not interfere with this.

With the exception of neonatal units, it is expected and accepted in the UK that parents are the key carers and advocates for their children. Refusing parents access to their child in the absence of safeguarding issues would be considered totally unacceptable in almost all other circumstances. Legislation supports the concept that children in hospital should have a parent or parent substitute with them at all times and on paediatric wards it would be expected that parents remain with their child throughout the hospital stay. Extending this philosophy to neonatal units is therefore considered pivotal to the concept of parents as partners in care.

Steps towards making this happen could include:

- Creating a policy or mission statement that articulates 24-hour access as the philosophy of the unit and then communicating this to staff and parents.
- Identifying when access is denied to fit in with routines, practices and procedures other than emergencies and agreeing alternative working practices and routines to ensure that parents can be with their baby.

- Considering the overall principle of 24-hour access and the message it conveys about parents’ rights and responsibilities, rather than becoming enmeshed in too much detailed planning to cover every eventuality. As an example, denying parents access to their baby for one or two hours every day to allow a ward round to take place conveys the message that the baby is primarily the staff’s responsibility and the parents are visitors who must fit in with the more powerful and important staff. The need to change this routine becomes obvious when staff appreciate the change in culture required. However, denying parents access to their baby as a one off because another baby in the room is very ill and the staff are talking to and comforting their parents is perfectly reasonable and conveys nothing except common courtesy. Applying common sense while aiming for the overall principle of changing culture over time is required.
- Auditing parents’ experiences to identify the barriers they have to being with their baby, using the Baby Friendly audit tool, then action planning and joint working across disciplines to help find solutions. Innovative thinking will sometimes be required, so give staff time and encouragement to think ‘outside the box’.

2. Measures are taken to ensure that practical difficulties do not prevent parents being with their baby.

It is, of course, not possible to address every barrier that parents face to being with their baby, however many can be alleviated with a bit of thought and time spent ‘walking in the parents’ shoes’. Steps towards making this happen could include:

- Spending time on the unit simply observing what is going on and what the parents actually do when they are on the unit in order to spot where care and facilities could be improved.
Gathering small groups of parents and asking them to discuss their experiences on a practical level. Ask them about their daily routines and what would help make life easier. Consider transport, including fares, car parking fees and so on. Also consider siblings, food and drink and the physical environment on the unit. Then start with the most pressing problems and consider what can be done to help.

Considering where parents will actually be while they are on the unit. There needs to be a permanent space for the parents, including comfortable chairs for every parent and places for them to leave their belongings, otherwise they will always feel like visitors and many will worry that they are in the way.

3. Parents are welcomed on the unit and treated with dignity, respect and equality.

For parents to be partners in care they have to feel equal to the staff in importance and relevance for the well-being of their baby.

Steps towards making this happen could include:

- Communication training for staff, perhaps using the principles of transactional analysis in a simple form. Communication plays a huge part in achieving a sense of equality. ‘Parental style’ offers of care and concern for parents, no matter how well meaning, can rob them of a sense of confidence and equality. Conversely, too much deference can leave them feeling unsafe and out of their depth. Power and control are nuanced issues and staff need a framework in which to consider them and how best to build productive relationships.
- Assuming parents are responsible for their child from the beginning will set the scene and make an equal relationship easier.
- Ensure that all the staff in the baby’s room introduce themselves, give parents their attention as a priority, record when parents will be on the unit and plan their workload around this.
- Make sure that staff know parents’ names. Calling parents mum and dad can feel patronising within a professional relationship.

4. Parents are respected as primarily responsible for their child. Their opinion is sought and they are involved in decision making.

Babies on a neonatal unit are highly dependent on both the clinical team and their parents. Information sharing and joint decision making, with the most relevant person taking the lead depending on the situation, is therefore desirable. For example, the consultant neonatologist or paediatrician is the most appropriate person to lead on complex clinical issues, whereas specialist staff will lead on their specialism. Parents will lead on the general well-being of their baby, gradually taking more of a lead as their baby’s condition improves. All interested parties working together to discuss issues and arrive at consensual decisions will deliver the best outcome for the baby.
Steps towards making this happen could include:

- Having mechanisms in place to keep everyone fully informed at all times. This may include access to records, providing a notice board for parents and providing time for staff to update parents and parents to update staff.
- Involving parents in all discussions about their baby and educating them so that they understand the treatment and care that is being suggested.
- Creating a staff/parent journal where day to day changes and messages can be recorded. This can be a memento for parents to take home after discharge.
- Auditing parents’ experiences over time. Asking parents if they feel more like a parent or like a visitor can be revealing.

5. Parents are enabled to carry out as much of the care as possible.

As a general rule, there is no one who is more concerned about their baby’s care than the parents. Yet their capabilities in carrying out that care are often seriously under-estimated, with staff concerned that they will not be able to manage even quite simple tasks.

Steps towards making this happen could include:

- Thinking beyond basic nappy changing, bathing and feeding to consider what parents could be supported to achieve in terms of competence to care for their baby. Quite a lot of nursing care can be taught to parents, with staff acting as teachers and supporters to enable this to happen.
- Encouraging parents to take the lead as their competence and confidence grows. Experience has shown that parents often feel that they are ‘allowed’ to carry out specific care only with permission and that this is dependent on which staff member is caring for their baby. Changing this culture so that parents take responsibility for care does much to encourage their sense of being a parent and in control.
- Developing a culture where staff could be encouraged to ask parents’ permission to carry out procedures (apart from emergency situations) is an excellent way of shifting the power balance in favour of parents.

6. Parents are encouraged to comfort and support their baby during procedures.

In most paediatric settings, parents would be expected and encouraged to be with their child if a painful or distressing procedure was taking place. Their role would be to comfort and reassure as much as possible. In neonatal units there can be an attitude that parents need to be shielded from distress or that they will be in the way. Changing this could do much to support a culture that recognises the parents’ role and the humanity of a baby undergoing a painful and frightening experience.

CASE STUDY: WRIGHTINGTON, WIGAN AND LEIGH

HELPING WITH COSTS

A survey by the charity Bliss in 2013 identified the real costs of having a premature or sick baby in a neonatal unit. On top of all the usual costs parents have to face daily travel costs to hospital, hospital parking and food and drink. This can be worked out on average as an extra £282 a week (Bliss, 2013). Wrightington Wigan and Leigh NHS Foundation Trust now provide meals free of charge for all mothers who have babies on the neonatal unit. This occurred following a conversation with support workers from the children’s ward who said that they always looked after the breastfeeding mothers by giving them meals when their babies were readmitted. They decided to apply this to the neonatal unit; they enlisted the help of their Matron and catering agreed to provide the meals. This allows mothers to spend more time on the unit with their babies and also reduces the need for parents to become reliant on the hospital canteen or expensive franchises. Food is provided for all mothers regardless of their method of feeding. From the same survey by Bliss, having to pay for parking worked out on average as an extra £32 a week. Families at Wrightington Wigan and Leigh NHS Foundation Trust receive free parking if their baby is hospitalised for more than two weeks for the duration of their stay.

The article ends here.
Steps towards making this happen could include:

- Educating staff to take a child rights approach to care. This means putting the baby at the heart of the care and always considering what is best for them. Encouraging staff to imagine what it would feel like to be the baby can help with this.
- Educating staff to assume that parents will be with their baby during treatment as a general philosophy of care and the default approach.
- Considering how this is managed in paediatric settings to help overcome practical difficulties.
- Remembering that this is a general principle, not a rigidly applied dogma. Situations vary and parents are individuals who may or may not be able to cope at any given time.

**CASE STUDY: ROYAL DEVON AND EXETER**

**UPDATING PARENTS WHEN THEY’RE NOT ON THE WARD**

Parents are encouraged to phone the unit at any time they are unable to be with their baby. Cord free telephones were installed enabling staff to update parents from the cot side when they call. This also enables staff to accurately describe the baby at the current time which can help parents who are unable to be on the ward to feel close to their baby.

**SUPPORTING THE STAFF**

Working on a neonatal unit is a complex and stressful job. Adopting a culture and routines that support implementation of the Baby Friendly standards requires a fundamental shift in staff routines, attitudes and working environment, and this needs to be considered when implementing changes.

Steps towards making this happen could include:

- Helping staff to see their role as one of teaching and supporting as well as of clinical care, including taking time to discuss the implications of this.
- Making sure that communication with staff is as good as it possibly can be. Using relevant meetings, handover periods, notice boards and e-mailings or newsletters to inform staff of changes and ideas are all important. Experience has shown that staff rarely complain of being over-informed, but frequently of being under-informed.
- Having a forum for staff to discuss their ideas and concerns. This could be via a moderated group that meet face to face or via email or a social media group.
- Creating a safe space for staff to interact and reflect. If the clinical areas are ‘owned’ by the parents, with staff acting as their supporters and mentors, then staff need places where they can be with colleagues other than the clinical areas.
- Creating a formal mechanism for staff to receive feedback and support with their individual progress towards implementing the standards.
- Recognising that some parents can be challenging in their behaviour and attitudes and providing supportive mechanisms to help develop appropriate coping strategies and solutions to challenges.
PLANNING YOUR ASSESSMENTS

There are a number of options available to you when considering when and how you apply to have your service assessed.

Option 1
You can work through the entire assessment pathway, completing a formal Stage 1 assessment followed by separate Stage 2 and 3 assessments when your internal audit results demonstrate that the service provided meets the Baby Friendly standards.

Option 2
You complete a formal Stage 1 followed by a combined Stage 2 and 3 assessment when your internal audit results demonstrate that the service provided meets the Baby Friendly standards.

Option 3
If you are confident that you have already begun to implement the standards and are working collaboratively with a maternity service that is on the Baby Friendly pathway, you may wish to complete the Stage 1 application as an internal exercise (rather than have it formally assessed) to help you develop your action plan. You could then apply for separate or combined Stage 2 and 3 assessments when audit results demonstrate readiness or to fit into a timescale already determined by your maternity unit partners.

If you have any queries regarding the best option for your service please contact the Baby Friendly office (bfi@unicef.org.uk).
### Appendix

**Neonatal Stage 3 Checklist**

**Information will be taken from:**

- Interviews with managers and staff of all grades
- Mothers with babies who are over 30 weeks corrected age. Mothers with a baby on the unit and after discharge home will be interviewed. At least 40 per cent of interviews should be with mothers whose baby has been discharged.
- Review of policies and guidelines
- Observations on the unit

**Standard 1: Close and Loving Relationships**

1. All staff trained to understand the importance of close and loving relationships for the baby and family both now and in the longer term.

   - Standard met? □ Fully □ Partly □ Not met
   - Notes:

2. Parents understand why close and loving relationships are important now and in the longer term (Note: sensitivity is required re long term outcomes for some of these babies, therefore parents should be supported to understand the underlying science as a general principle which is then applied to individual circumstances as applicable).

   - Standard met? □ Fully □ Partly □ Not met
   - Notes:

3. In the absence of parents, baby’s needs for comfort and emotional support are met by an individual selected by the parents or by a staff member. Contact is recorded as part of general care. (The principle is that babies are not left for hours without human contact and this is seen as an important part of a nurse’s role. Good infection control is taught to everyone.).

   - Standard met? □ Fully □ Partly □ Not met
   - Notes:

4. Parents and staff are enabled to recognise baby’s behavioural cues and tolerance for stimulus and parents are supported to build close relationships via touch, talking, comforting etc. as appropriate.

   - Standard met? □ Fully □ Partly □ Not met
   - Notes:

5. Prolonged, frequent skin to skin contact is encouraged for all babies.

   - Standard met? □ Fully □ Partly □ Not met
   - Notes:

6. Skin contact is prevented only for acceptable clinical reasons and not because of lack of staff training or resources.

   - Standard met? □ Fully □ Partly □ Not met
   - Notes:

7. Parents and staff who are bottle feeding are supported to do this responsively, recognising their baby’s cues and need for comfort and closeness during feeding.

   - Standard met? □ Fully □ Partly □ Not met
   - Notes:
1. A discussion with parents takes place about the value of breastmilk as early as possible (during the antenatal period if possible and with particular emphasis on the benefits to the preterm baby).

   Standard met?  □ Fully  □ Partly  □ Not met

   Notes:

2. Mother’s own breastmilk is the first choice of feed (except for a small number of acceptable clinical indications).

   Standard met?  □ Fully  □ Partly  □ Not met

   Notes:

3. Mothers are enabled to express milk as soon as possible – ideally within the first two hours.

   Standard met?  □ Fully  □ Partly  □ Not met

   Notes:

4. Breastmilk is used for mouth care and tempting the baby to feed.

   Standard met?  □ Fully  □ Partly  □ Not met

   Notes:

5. Mothers learn how to express effectively by hand and pump as appropriate to individual need and how to store milk.

   Standard met?  □ Fully  □ Partly  □ Not met

   Notes:

6. Mothers are supported to express frequently especially in first two to three weeks to optimise supply.

   Standard met?  □ Fully  □ Partly  □ Not met

   Notes:

7. Mothers have access to adequate, effective expressing equipment to use on the unit and at home. (Note: There should be easy access to pumps on the unit, including a choice of funnel size and there has to be an effective breast pump loan scheme that the unit takes some responsibility for. The unit cannot simply refer mothers to a third party and never check the quality of the service provided).

   Standard met?  □ Fully  □ Partly  □ Not met

   Notes:

8. A formal review of expressing takes place at least four times in the first two weeks and there is access to further help with expressing if milk supplies are inadequate or less than 750mls by day 10.

   Standard met?  □ Fully  □ Partly  □ Not met

   Notes:

9. Expressing is frequently checked informally after the first two weeks.

   Standard met?  □ Fully  □ Partly  □ Not met

   Notes:

10. The unit has an environment conducive to expressing.

    Standard met?  □ Fully  □ Partly  □ Not met

    Notes:

11. Skin contact is used to induce instinctive feeding behaviours.

    Standard met?  □ Fully  □ Partly  □ Not met

    Notes:

12. Mothers can be close to their baby in order to respond to feeding cues.

    Standard met?  □ Fully  □ Partly  □ Not met

    Notes:

   (continues on next page)
13. Support with positioning and attachment and recognizing effective feeding is provided.

Standard met?  ☐ Fully  ☐ Partly  ☐ Not met
Notes:

14. Additional support is provided to help with expressing and feeding challenges when needed, including specialist help (e.g. referred to infant feeding lead if needed).

Standard met?  ☐ Fully  ☐ Partly  ☐ Not met
Notes:

15. Mothers are prepared for going home (e.g. staying overnight and modified responsive feeding). Mothers confirm that they felt prepared for discharge.

Standard met?  ☐ Fully  ☐ Partly  ☐ Not met
Notes:

16. Information about how to access support with feeding in the community is provided.

Standard met?  ☐ Fully  ☐ Partly  ☐ Not met
Notes:

17. There is no advertising of breastmilk substitutes, bottles, teats or dummies.

Standard met?  ☐ Fully  ☐ Partly  ☐ Not met
Notes:

STANDARD 3:

PARENTS AS PARTNERS IN CARE

1. There is a policy of 24-hour access and staff routines and practices do not interfere with this.

Standard met?  ☐ Fully  ☐ Partly  ☐ Not met
Notes:

2. Measures have been taken to ensure that practical difficulties do not prevent parents being with their baby (consider transport, including car parking fees, siblings, food and drink. The physical environment on the unit is important. It needs to be a permanent place for the parents to actually be, including comfortable chairs for every parent, places for parents to leave their belongings, and so on).

Standard met?  ☐ Fully  ☐ Partly  ☐ Not met
Notes:

3. Parents are welcomed on the unit and treated with dignity, respect and equality. Staff introduce themselves, give parents their attention as a priority, record when parents will be on the unit and plan their workload around this.

Standard met?  ☐ Fully  ☐ Partly  ☐ Not met
Notes:

4. Parents are respected as primarily responsible for their child. Their opinion is sought and they are involved in decision making. To enable this, mechanisms are in place to keep them fully informed at all times. This may include access to notes, message boards, daily journal, and so on. (Parents may be asked if they feel like a mum/dad or like a visitor).

Standard met?  ☐ Fully  ☐ Partly  ☐ Not met
Notes:

5. Parents are enabled to carry out as much of the care as possible. They are supported to be the first choice of carer rather than ‘allowed’ to carry out limited care by staff.

Standard met?  ☐ Fully  ☐ Partly  ☐ Not met
Notes:

6. Parents are encouraged to comfort and support their baby during procedures.

Standard met?  ☐ Fully  ☐ Partly  ☐ Not met
Notes: