THE BABY FRIENDLY INITIATIVE

unicef UNITED KINGDOM

GUIDE TO THE UNICEF UK BABY FRIENDLY INITIATIVE NEONATAL STANDARDS

FOREWORD

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 births to overwhelmingly hospital births 50 years ago. Baby Friendly standards have already made a substantial impact within maternity services. This impact is now needed within 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 sense and 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 this 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 **UNICEF UK Guide to the Baby Friendly Initiative Neonatal Standards**. This guidance has been written for those tasked with implementing the Baby Friendly standards in their neonatal unit and is intended to provide a 'road map' for the journey towards Baby Friendly accreditation, including tips and ideas that may be helpful. It is intended to be read alongside the **Guide to the Baby Friendly Initiative Standards** which details the standards and assessment process.

BACKGROUND

The Baby Friendly Initiative is a global programme of UNICEF and the World Health Organization which aims to improve practice for infant feeding in health care settings. The Baby Friendly Initiative 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% of UK maternity units and 83% 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 babies, their mothers and families. For the first time, a decision was made to introduce bespoke standards for neonatal units. 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. Following on this, 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 neonatal standards were published with an audit tool to support 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 also developed consisting of interviews with managers, parents and staff of all disciplines and grades, as well as reviews of policies, guidance, materials for parents and mechanisms to support good practice. Units can 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

1. 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.

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 expertise and focus needed to support staff with the changes required. Depending on unit size and number of staff, the project lead will need some protected hours. This person will also need the experience to manage the project and command the respect of the staff. Their training requirements should be carefully considered, including the support needed to update clinical skills and knowledge, learn project management, educate staff and complete audits. Some of this can be provided by the maternity infant feeding coordinator. There are also courses provided by UNICEF UK and other organisations.

PROJECT CHAMPION

We suggest that a project champion be identified from the start. This is usually a senior member of staff who represents the project at senior management level and helps identify resources and offers support to the project lead and other team members. The project champion should be part of the senior management team (e.g. consultant neonatologist / paediatrician or head of nursing) and should be 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 also suggested that there be some forum for a senior group to oversee the implementation of the project. This group should be small enough to ensure that it is effective and should include key representatives who can steer the project in the right direction. 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, member of relevant allied profession e.g. dietician, speech and language therapist, psychologist or developmental care lead and a delegated representative of an active neonatal peer support group, if applicable. Simple terms of reference should be produced so the group's purpose is clear and agendas should be agreed and meeting notes recorded along with required actions so these can be followed up.

To some extent, project planning 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 with the involvement of the neonatal unit.

BUILDING A FIRM FOUNDATION

OVERVIEW

The purpose of a Stage 1 assessment is to ensure that all policies, systems and paperwork are in place in order to provide a solid platform for implementation of the project. It is important that you commit to completing all the Stage 1 paperwork as this lays the foundation for the project.

Please print or download the Stage 1 guidance and submission document and work your way through each section carefully. You can also make use of the sample documentation and other resources provided by Baby Friendly including:

- Sample infant feeding policies
- Curriculum guidance document
- Having meaningful conversations with mothers
- You and Your Baby: Supporting Love and Nurture on the Neonatal Unit leaflet
- Train the Trainer course and materials
- Embedding Baby Friendly Standards in Neonatal Care neonatal course and materials
- Audit tools and courses
- A Workbook for Neonatal Nurses

Once the form is completed, consider where the gaps are. This will help form the basis of your first action plan.

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MONITORING PROGRESS: AUDIT & 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.

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 to learn how to audit effectively.

It is important to assess the effectiveness of the training as soon as possible so that any weaknesses can be addressed before training the rest of the staff. Therefore, after the baseline audit, the second audit of staff should be carried out on those who have completed the training package.

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

When selecting mothers to 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.

STAGE 2

AN EDUCATED WORKFORCE

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Education of staff is key to ensuring that the standards are implemented and practice is 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 developing 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 and audit.

PLANNING THE TRAINING PROGRAMME

As you start to plan the training programme, you will need to consider various issues including:

- Commitment from managers to support the training, including allocation of preparation time and support for the training needs of the trainers.
- How staff are to be released to attend training, which requires agreement at the outset.
- Conducting a baseline audit of staff skills and knowledge using the Baby Friendly audit tool to identify strengths and weakness and inform what needs to be covered and in what depth.
- What the training needs are of medical staff.
- Sourcing and booking a suitable training venue (you may need to do this well in advance).
- How the training is to be delivered. This may depend on unit size, as larger units may be able to release 10 or more staff at a time for block training whereas smaller units may release smaller numbers. Some areas have combined basic training with midwifery colleagues and then provided additional training in bite-sized workshops and one-to-ones in clinical practice, whereas 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.
- What other (non-commercial) training and conferences may enhance that which 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.**
- Developing a system for keeping records of each staff member's completion of all parts of the training.
- Carrying out further audits of training to identify additional education needs and then amending the training programme as necessary.
- Auditing practice through face-to-face interviews with parents using the Baby Friendly audit tool and developing action plans to address any theory or practice gaps.

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PARENTS' EXPERIENCES OF CARE

OVERVIEW

The following section explains the three standards 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 long term.

We are looking for parents to be supported to understand that their relationship with their baby is crucial for their baby's wellbeing 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 wellbeing 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 / sick babies may have poor long-term health outcomes. Being separated from their baby at birth and faced with the possibility that their baby might not live can also result in some parents distancing themselves from their baby in order to protect their own emotional wellbeing. Staff therefore need to be gentle and sensitive in their approach and help parents to take small steps towards understanding the theory which 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 which address communication skills so that staff are enabled to feel confident to listen, tailor information and help parents' voices to be heard.
- Considering ways to revisit the key messages through the use of posters, leaflets and links to good quality information on websites. Because of the stress that parents are under, it is unlikely that they will be able to absorb much information in one go.
- Pointing out how baby responds to their parent's voice, touch and smell as a way of staff starting conversations and re-enforcing the key messages.
- Considering 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.


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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 the 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 basics functions, administer drugs, tube feed, etc. 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 Chicago hospital has a volunteer team who come in to cuddle babies if the parents can't be there. This has proven 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.
- Supporting 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. 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 incorporated into training and the culture change 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.
- Recording all contact as part of general care so that it is not forgotten and so that babies' experiences and responses can be mapped over time.


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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, etc. as appropriate.

The normal interactions between a parent and their baby can be severely restricted in a neonatal unit. Parents can feel 'on show' and there can be many barriers to getting close with their baby. 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 their 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 depending on background and culture.
- Recognising that staff with expertise in developmental care can offer much support. There are also excellent materials and courses that can help support staff to gain the necessary expertise.
- Written material, posters etc. which can help support conversations and information sharing.
- Supporting parents to recognise when baby needs time out; overstimulation can be just as distressing as none.
- Encouraging staff to listen, accept and respect parents' input about their baby's condition and needs. As parents get to know their baby they will be more attuned to their baby's individual needs and nuances.

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, resources and/or 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 to be aware of how to position the baby for safety and comfort.
- Educating all staff to support parent-led transfers for skin contact as and when the parents feel confident to do this.
- 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. Whilst 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 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. Educating parents and staff to invite the baby to draw in the teat rather than forcing it into the mouth and to pace the feed (including recognising baby's cues 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.
- For babies who may need additional support when establishing bottle feeding, implementing supportive measures such as elevated side-lying feeding with support from speech and language therapists should be considered.
- 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.


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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 acceptable 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 which prevents 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.


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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 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 implement the mechanism for supporting early expression.
- Auditing in order 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, 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.

CASE STUDY: SHEFFIELD TEACHING HOSPITALS

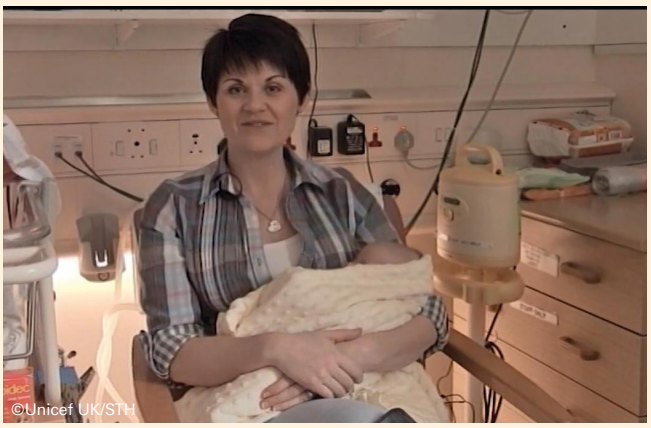
COLOSTRUM

In an example of neonatal and maternity services working collaboratively to provide excellent care, Sheffield Teaching Hospitals launched an initiative to develop a **colostrum pack** in order to support mothers to start expressing earlier and produce a well-established milk supply. Led by neonatal dietitian Shona Brennan and speech and language therapist Jane Shaw, this innovation was inspired from learnings taken from their Baby Friendly audit. Shona and Jane share:

"The idea originally came from a Baby Friendly audit. The results highlighted the need to support mothers to start expressing earlier, and it soon became obvious that we needed to work together as a whole hospital, to facilitate this."

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 parents would be able to see it fill up with valuable colostrum. This 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 with daughter Minnie on the neonatal unit, said: *"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 wellbeing was really phenomenal for me. Minnie is now a fully on-demand breastfed baby, so it's been a real success!"*



Emma with her daughter Minnie

5. Mothers learn how to express effectively by hand and pump (as appropriate to individual need) and learn 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 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 prompts in baby's records to remind staff to check that the mother knows how to hand express and to educate mother on pump use.
- Introducing and then using the Baby Friendly expressing assessment form for all mothers.
- Educating staff to be flexible in their approach to how mothers express their milk whilst 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 funnel sizes. 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 as opposed to expressing both breasts separately.
- 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 so as to help maximise the effectiveness of breastmilk. Once the gut has been primed with colostrum, breastmilk should be used fresh whenever possible.

CASE STUDY: ROYAL DEVON AND EXETER

INCREASING AVAILABILITY OF EXPRESSING EQUIPMENT

For the Royal Devon and Exeter NHS Foundation Trust, it was recognised that the frequency and effectiveness of mothers expressing was severely affected by the limited number of pumps available for mothers to use on the unit. Mothers described having to wait for several hours to use a pump or the expressing room, both which impeded their ability to pump effectively.

To overcome this, the Trust ensured that a **breast pump** was made available for every cot space and parent room and increased the number of electric pumps available for use at home. The senior management team described the availability of a breast pump for every mother as *'as important as having a ventilator.'*

This innovation ensures that every mother has access to a breast pump whenever needed and that they are able to pump next to their baby, thereby increasing frequency and effectiveness of expressing.

A mother and baby on the unit

6. Mothers are supported to express frequently to optimise supply, especially in first 2-3 weeks.

The first couple 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, as they are more likely to express frequently if given flexibility. 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 and 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. There also must 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 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. Provision 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 that 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 breastmilk 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.
- Ensuring all mothers have a formal assessment carried out at least four times in the first two weeks to ensure they are not experiencing problems. 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 how the mother is doing and talk through any challenges or obstacles they 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 if 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 the 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 whilst 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.
- 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 nurture to their baby. Helping them to understand that they can't spoil or overfeed their baby through too much breastfeeding is key.
- Ensuring 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 .

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

Experience suggests that lack of confidence often results in many mothers introducing infant formula 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 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 for breastmilk substitutes, bottles, teats or dummies.

All facilities working towards 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 is designed to protect parents from commercial influences at this most vulnerable time.

Steps towards making this happen could include:

- Having 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 infant formula.
- Putting into place systems for dealing with company representatives who come under the scope of the Code in order to protect parents and staff from marketing. It is important to ensure 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 and are given evidence-based information on the types and brands of infant formula.
- Ensuring that community-based staff enable parents to bottle feed safely.

You can read our Guide for Health Professionals to Working within the Code or visit First Steps Nutrition Trust for accurate and impartial infant formula information in the UK.

STANDARD 3: VALUE PARENTS AS PARTNERS IN CARE

Parents being 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 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 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 practices and routines to ensure parents can be with their baby whenever they wish.
- Considering the overall principle of 24 hour access and the message it conveys about parents' rights and responsibilities rather than becoming enmeshed in covering every eventuality. For example, denying parents access for 1-2 hours a day to allow for ward rounds conveys that the baby is primarily the staff's responsibility and parents are visitors who must fit in with the more important staff. The need to change this routine becomes obvious when staff appreciate the culture change required. However, denying parents access to their baby as a one-off because another baby in the room is ill and the staff are talking to / comforting them is reasonable and conveys common courtesy. Applying common sense while aiming for the overall principle of changing culture over time is required.
- Using the Baby Friendly audit tool to audit parents' experiences and identify barriers they have to being with their baby. Action planning and working jointly across disciplines to find solutions with innovative thinking is required, so encourage staff to think 'outside the box'.

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

It is not possible to address every barrier that parents face to being with their baby, however many can be alleviated with some time spent 'walking in the parents' shoes'.

Steps towards making this happen could include:

- Spending time on the unit observing what is going on and what parents 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, etc. Also consider siblings, food and drink and the physical environment on the unit. Start with the most pressing problems and consider what can be done.
- Considering where parents will be while on the unit. There needs to be a permanent space for parents, including comfortable chairs for all parent and places to leave 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 must feel equal to the staff in importance and relevance for the wellbeing 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, which will set the scene and make an equal relationship easier.
- Ensuring all staff in the baby's room introduce themselves, giving parents their attention as a priority, and recording when parents will be on the unit and planning their workload around this.
- Making sure that staff know parent's 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 wellbeing 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.

CASE STUDY: ROYAL DEVON AND EXETER

24-HOUR ACCESS

For the Royal Devon and Exeter neonatal unit, inconsistencies in managing parent attendance at ward rounds across different medical teams and unit areas resulted in parents feeling they had limited access to be with their baby. To combat this, the senior team arranged focus groups with staff to discuss and debate their current approach and find ways to prevent parents from feeling excluded.

The team considered a number of factors, including ensuring confidentiality, restricting professional numbers at ward rounds, and where and how rounds should be held and conducted. Parents were also able to feed directly into this through SNUG, a parent support group.

Changes resulting from these discussions included a limit on the number of professionals in attendance so as to minimise noise and not overwhelm parents, as well as ensuring sensitive information relating to the baby is discussed in an appropriate environment. Parents are also always informed of when rounds take place and are actively encouraged and welcome to attend and participate, and are not asked to leave at any time.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CASE STUDY: WRIGHTINGTON, WIGAN AND LEIGH

HELPING WITH COSTS

A 2013 survey by the charity Bliss identified the real costs of having a premature or sick baby on a neonatal unit. On top of the usual expenses, parents 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, including £32 on parking (Bliss, 2013).

Following conversations with children's ward support workers who said they always look after mothers by providing meals when their babies were readmitted, the Wrightington, Wigan and Leigh NHS Foundation Trust applied this approach to the neonatal unit and implemented a policy which provided meals free of charge for all mothers. All families were also provided with free parking for the duration of their stay if their baby was hospitalised for more than two weeks.

These policies allow parents to spend more time on the unit with their babies and reduce the need for parents to become reliant on hospital canteens or expensive franchises, as well as worrying about hospital parking charges.

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 cares 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 being in control.
- Developing a culture where staff could be encouraged to ask parent's 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 their baby 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.

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 Royal Devon and Exeter neonatal unit at any time they are unable to be with their baby. To facilitate this, cord-free telephones were installed on the unit, enabling staff to update parents from the cot side and to accurately describe the baby at the current time, helping parents who are unable to be on the ward to feel close with their baby.

SUPPORTING THE STAFF

Working on a neonatal unit is a complex and stressful job. Adopting a culture and routine that supports implementation of the Baby Friendly standards requires a fundamental shift in staff routines, attitudes and working environment. This needs to be considered when implementing the 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.
- Ensuring that communication with staff is as good as possible and using relevant meetings, handover periods, notice boards and e-mailings or newsletters to inform staff of changes and ideas. Experience has shown that staff rarely complain of being over-informed, but frequently of being under-informed.
- Having a forum for staff to discuss ideas and concerns. This could be via a moderated group that meets 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

Please review the below options 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 can 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.

CONTACT US

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

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:

STANDARD 2:

BREASTFEEDING AND BREASTMILK USE

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:

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13. **Support with positioning and attachment and recognising 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:

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