GUIDELINES:
Co-bedding multiples on NICU

Amendments

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Impact Assessment Carried Out By: Sue White
Comments on this document to: Sue White
Aim:

To ensure that co-bedding on the neonatal unit is implemented, when appropriate, in a safe manner in line with the evidence available.

Background:

Nursing twins or higher multiples in a single cot is known as co-bedding. Currently there is limited evidence available to support or refute implementation of the practice of co-bedding, in either the hospital environment or the community. Twins and triplets can be offered co-bedding as soon as they fulfil the criteria for good practice. Twins have shared the same intrauterine environment for months and during this time have interacted together. It therefore seems logical after birth, to keep them together where they can continue to interact.

Research on the benefits of co-bedding is limited; however, the published studies indicate that:

- The practice is not associated with certain poor outcomes, such as increased incidence of infection or increased number of apnoeic and bradycardiac episodes (LaMar 2006: Lutes & Altimer 2000).
- The practice is also associated with some benefits such as increased weight gain (Dellaporta 1998, Touch et al 2002).
- Other benefits may include supporting the interactive development that occurred in utero, increased parent-child attachment, improved parent-nurse communication and decreased hospital stay (Boyd 2001).

‘It may be reasonable to assume that these babies are born with a unique expectation of what is a normal environment after birth and that their transition to the outside world may be enhanced by continued close physical contact with each other.’(Buckinghamshire NHS Trust 2005)

The potential disadvantages of co-bedding in a hospital environment include:

- The risk of medication or treatment errors, the possibility of medical equipment becoming dislodged or the potential for injuring each other (Dellporta 1998).
- It has been suggested that infants who are co-bedded may maintain higher body temperatures than those that sleep separately: overheating is a known risk factor for Sudden Infant Death Syndrome (Nyquist 1998).
Once twins are both clinically, stable parents should be asked if they are intending to co-bed once they are at home: if they are, co-bedding should start as soon as possible, as the longer they are separated after birth may make it harder for them to settle once put together again.

**Criteria for co-bedding:**

- Both twins must be clinically stable
- Neither baby requires ventilator support. Low flow nasal canula oxygen is acceptable
- Have no invasive monitoring in situ, babies can have a cardio-respiratory and/or pulse oximetry monitoring in situ
- Infection free, no suspected sepsis
- No colonization with MRSA
- Neither baby requires phototherapy
- Similar sizes—not essential if using separate heat pads
- Separated if one becomes unstable
- Can have orogastric / nasogastric tube in place
- Dependant on weight and gestation babies can be co-bedded in either the Twin Cot, the Caleo (previously the Twincubator) or the Giraffe incubator

**Before commencing co-bedding:**

- Check that each baby is wearing two name bands at all times, clearly labelled with the infants first and second name, unit number and Twin1 or Twin2
- Parental preference whether to co-bed their babies is identified and documented in the care plan.
- All equipment and charts should be clearly labelled with the infants first and second name, unit number and twin1 or twin2.

**Commencing co-bedding:**

- Monitors, iv lines and iv pumps, feed lines and syringe pumps should be positioned for each baby so that they are separate from the other baby’s. For example on different sides of the cot.
- Jointly with parents, choose the position that each baby will be nursed in, i.e. left/right. This is not to be changed again whilst the babies are co-bedded.
- If parents know what position the babies were lying in utero, in relation to each other, then they may choose to position the babies in the same relative positions. Document preferred positioning in notes
- Label the head end of the cot with the babies’ cot cards in line with each baby.
- Nurse on apnoea monitor as per unit guideline
- Position so that they can freely reach their own and others sibling’s face
- A spare cot should be instantly available in case the babies need to be separated quickly.
- If co-bedding has not been started shortly after birth due to infants being unstable/sick/too preterm then it may take several hours for them to settle on the first occasion of co-bedding
• All equipment relating to personal hygiene must be clearly labelled and kept separately. Clean nappies and cotton wool can be shared.

Co-bedding in practice:

• Ideally one nurse should be allocated to both babies per shift but a team approach should be maintained
• At start of shift complete routine safety checks and ensure each baby has two name bands on and they are secure.
• Identify baby’s own lines, cables, equipment and monitors, so staff can respond to any changes to baby’s condition.
• Consider clustering care to avoid excessive disturbance to the other baby, whilst practising individualised care responding to baby’s own behavioural cues.
• Complete individual documentation, i.e. each baby should have their own records, DO NOT write “see other twin’s notes”.
• Strict hand washing as per unit guideline to be observed by staff and parents.
• Position babies so that they can freely touch and interact with their sibling. If being nested the two babies should share one large nest, do not put barriers between the babies.
• Cover together with the same blanket/bedding
• When beginning co-bedding temperature should be monitored 2 hourly in both infants until stable for 4 hours
• Position side by side in accordance with positioning guidelines.
• Safe sleep guidelines should be practised, e.g. supine and feet to foot.
• Regular assessment to determine that each baby still meets criteria for co-bedding should be undertaken. If either baby’s condition changes so that they no longer fulfil the criteria then separate immediately.

Information for parents on discharge:

• Parents should be given the “Safe Sleep” guide.
• Moses baskets and small cribs are NOT suitable for co-bedding due to the risk of overheating.
• When babies can roll over, they need to be separated into their own cots.
• The “safe sleep” guidelines apply to co-bedded babies as they do to singletons.
• Offer parents “Back to sleep” card and contact details for “Lullaby Trust”.

The research to date has been confined to healthy preterm population who have been cared for on the neonatal intensive units. Currently there appears to be insufficient researched evidence for nurses to encourage parents to co-bed their infants after discharge. Co-bedding of multiples following discharge is at the discretion of the parents. Prior to discharge it is important that parents are aware of the fact that there is limited research available on co-bedding.

Adapted from: South Central Neonatal Network Quality Care Group: Guideline framework for the Co-bedding of Twins or Triplets on The Neonatal Unit
References:

Boyd, S. 2001: ‘The way they were’ Multiple gestation infants and co bedding. Journal of Neonatal Nursing 7(3) 95-100

Buckinghamshire Hospital NHS Trust 2005: Co-bedding of twins and triplets, Neonatal Standards and Effective Practice. Stoke Mandeville Hospital, Aylesbury


DellaPorta, K. Aforismo, D. Bulter-OHara, M 1998: Co-bedding of twins in NICU Pediatric Nursing 24, 529-531


Lutes, L. & Altimer, L 2000: Co-bedding twins & higher order multiples. Central lines (16) 2, 10-13


Bibliography:

Liverpool co-bedding policy 2011, version 2
PREPARE COT OR INCUBATOR AND BOUNDARIES

ENSURE THAT BABIES MEET CRITERIA FOR CO-BEDDING AS PER GUIDELINE

POSITION “FEET TO FOOT” AND ENABLE BABIES TO TOUCH AND INTERACT

USE CANOPY IF INDICATED FOR GESTATIONAL AGE OR MEDICAL BENEFIT

USE SAME SHEET AND BLANKETS TO COVER BABIES

AT HEAD OF COT HAVE BABY ID LABELS IN LINE WITH CORRECT BABY
BABIES ONLY TO BE SEPERATED INTO INDIVIDUAL NESTS AND COVERS IF ONE OR BOTH ARE ON SEPERATE HEAT PADS

POSITION HEAT PAD MONITOR ON DRIP STAND ON CORRESPONDING SIDE OF COT. AT START OF CO-BEDDING, WITH OR WITHOUT HEAT PAD, CHECK TEMP 2 HOUURLY UNTIL STABLE, THEN 4 HOURS

ENSURE BABIES HAVE 2 NAMEBANDS ON AT ALL TIMES, NAME, HOSP NUMBER, TWIN ½

SEPARATE BABIES IF ONE BECOMES UNSTABLE OR NO LONGER MEETS CRITERIA

INFORMATION ON DISCHARGE:
- DO NOT USE MOSES BASKET OR SMALL CRIB
- FOLLOW “SAFE SLEEP” GUIDE
- SEPARATE WHEN ONE CAN ROLL OVER

CO-BEDDING AFTER DISCHARGE IS AT THE DISCRETION OF PARENTS- LIMITED RESEARCH AVAILABLE.