




AGOSTO 16 2019  
REUNIÓN CANGURO CONGRESO NACIONAL NEONATOLOGIA

- RED SUR RUTH LOPEZ
  - SAN RAFAEL GLORIA SANCHEZ
  - CLINICA LA MUJER HENRY SANCHEZ
  - FMC ADRIANA MONTEALEGRE
- 

# CONCLUSIONES O PUNTOS RELEVANTES

- DEMORA AUTORIZACIÓN EPS
- INCREMENTO EN REINGRESOS DHT HIPERNATREMICA E ICTERICIA
- PAPAS PARTICIPES DEL CUIDADO Y APERTURA DE 24 HORAS (NO SALGAN EN ENTREGA DE TURNO POR EJEMPLO)
- POCA CLARIDAD EN EXCLUSIONES
- DESDE SALA DE PARTOS
- MAS PARTICIPACIÓN PADRES
- RED DE APOYO ENTRE PADRES
- DIVERGENCIAS EN PESO DE EGRESO

The background is a light blue gradient with several realistic water droplets of various sizes scattered across the surface. The droplets have highlights and shadows, giving them a three-dimensional appearance. The text is centered in the middle of the image.

# **PROGRAMA CANGURO INTRAHOSPITALARIO**

# VENTAJAS CUIDADO CANGURO

- ❖ REDUCE MORTALIDAD (HASTA 40% EN MENORES 2000 GM)
- ❖ MEJORA TERMOREGULACIÓN, RESPIRACIÓN, OXIGENACIÓN Y SAT O2
- ❖ REDUCE APNEA Y BRADICARDIA
- ❖ ACELERA GANANCIA DE PESO
- ❖ MEJORÍA REGULACIÓN AUTONÓMICA VS INCUBADORAS/LÁMPARAS CALOR RADIANTE

- ❖ MENOS DOLOR, HIPOTERMIA Y MEJOR CRECIMIENTO INCLUSO CON 4 HRS/ DIA
- ❖ BENEFICIOS PADRES (MÁS CONFIANZA, MENOS ANSIEDAD, MENOS DEPRESIÓN POST PARTO)
- ❖ MEJORA TASAS DE LACTANCIA MATERNA
- ❖ DISMINUYE TASAS DE INFECCIÓN



**Cochrane**  
**Library**

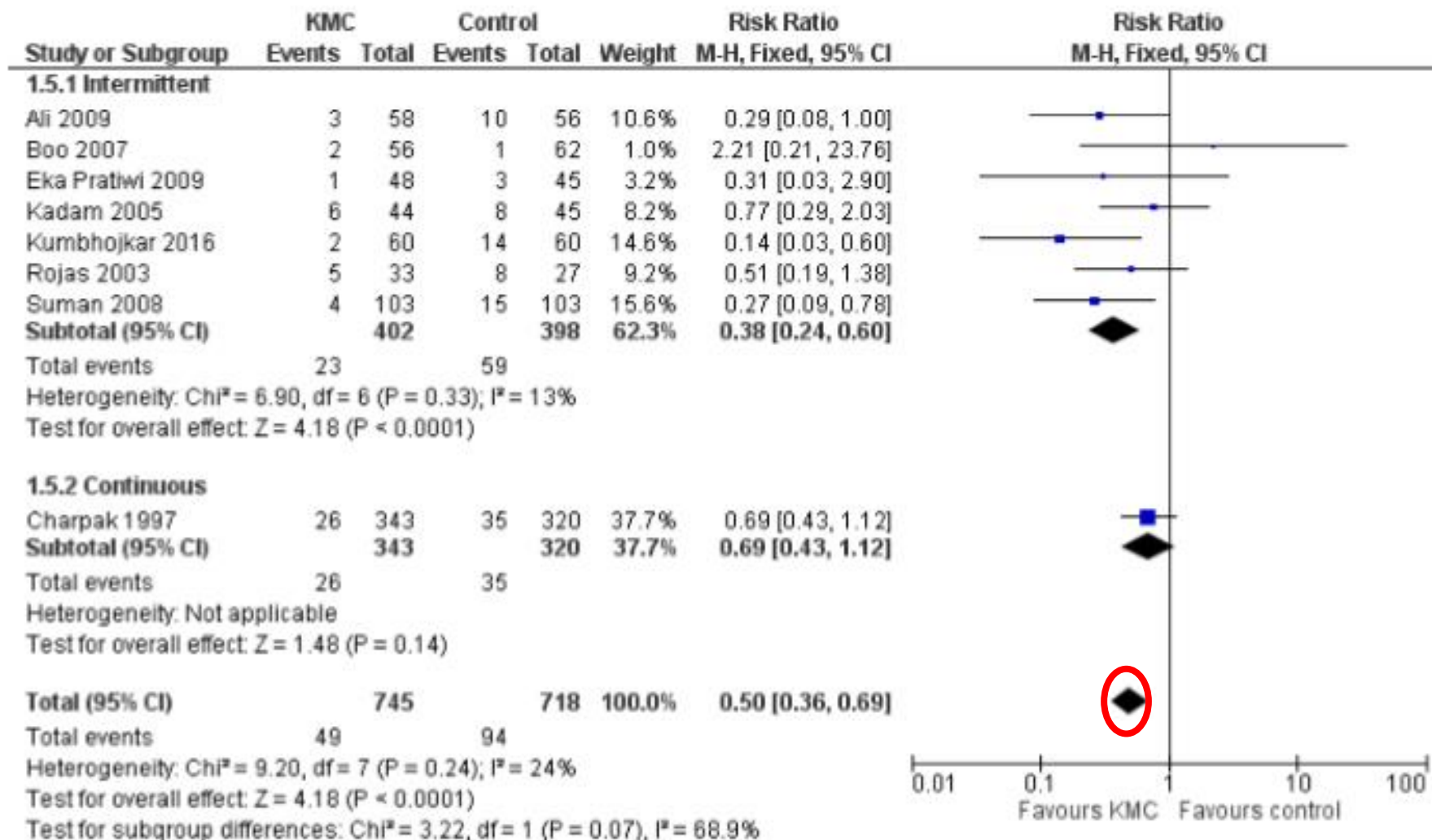
Cochrane Database of Systematic Reviews

## **Kangaroo mother care to reduce morbidity and mortality in low birthweight infants (Review)**

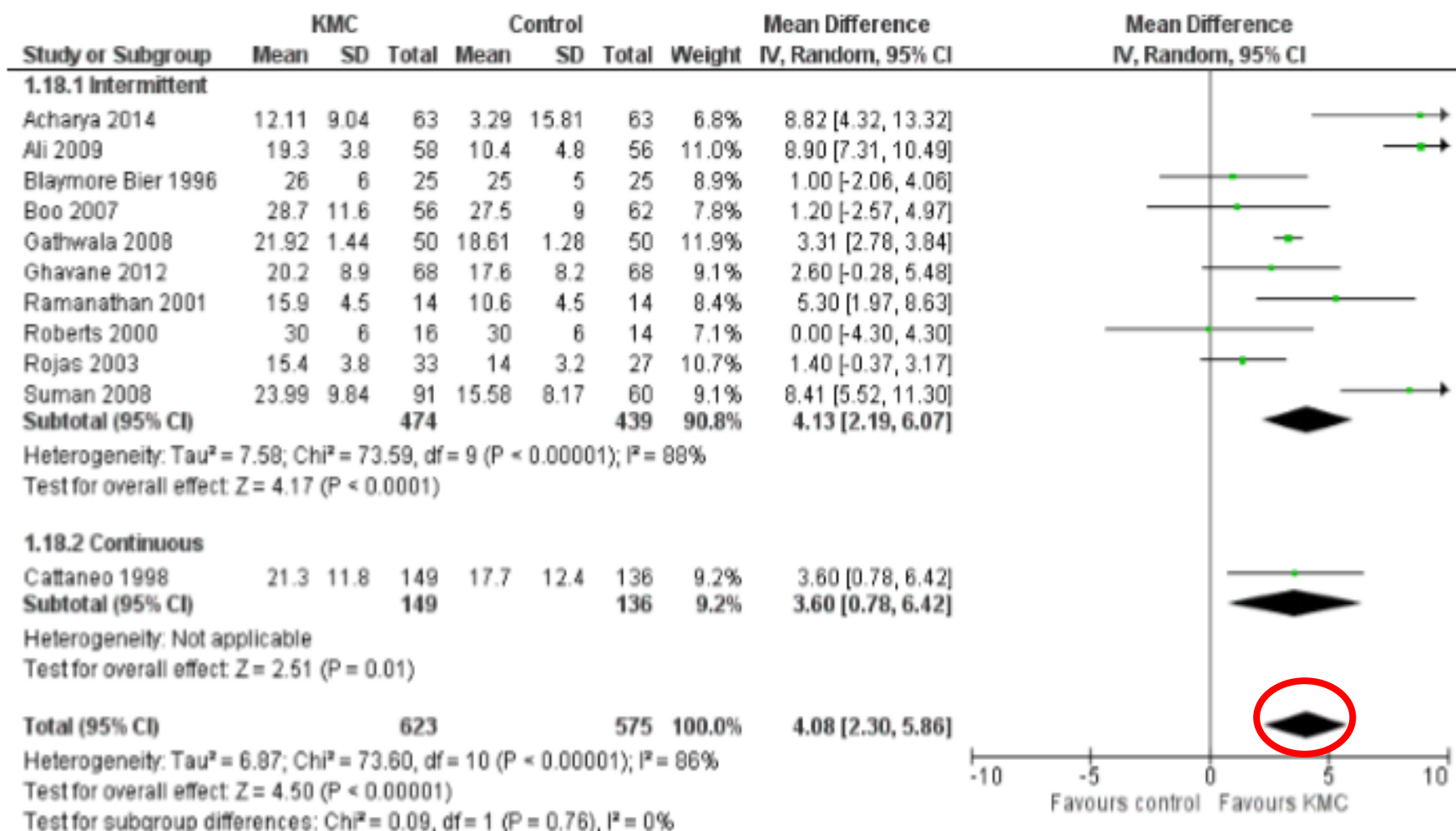
Conde-Agudelo A, Díaz-Rossello JL



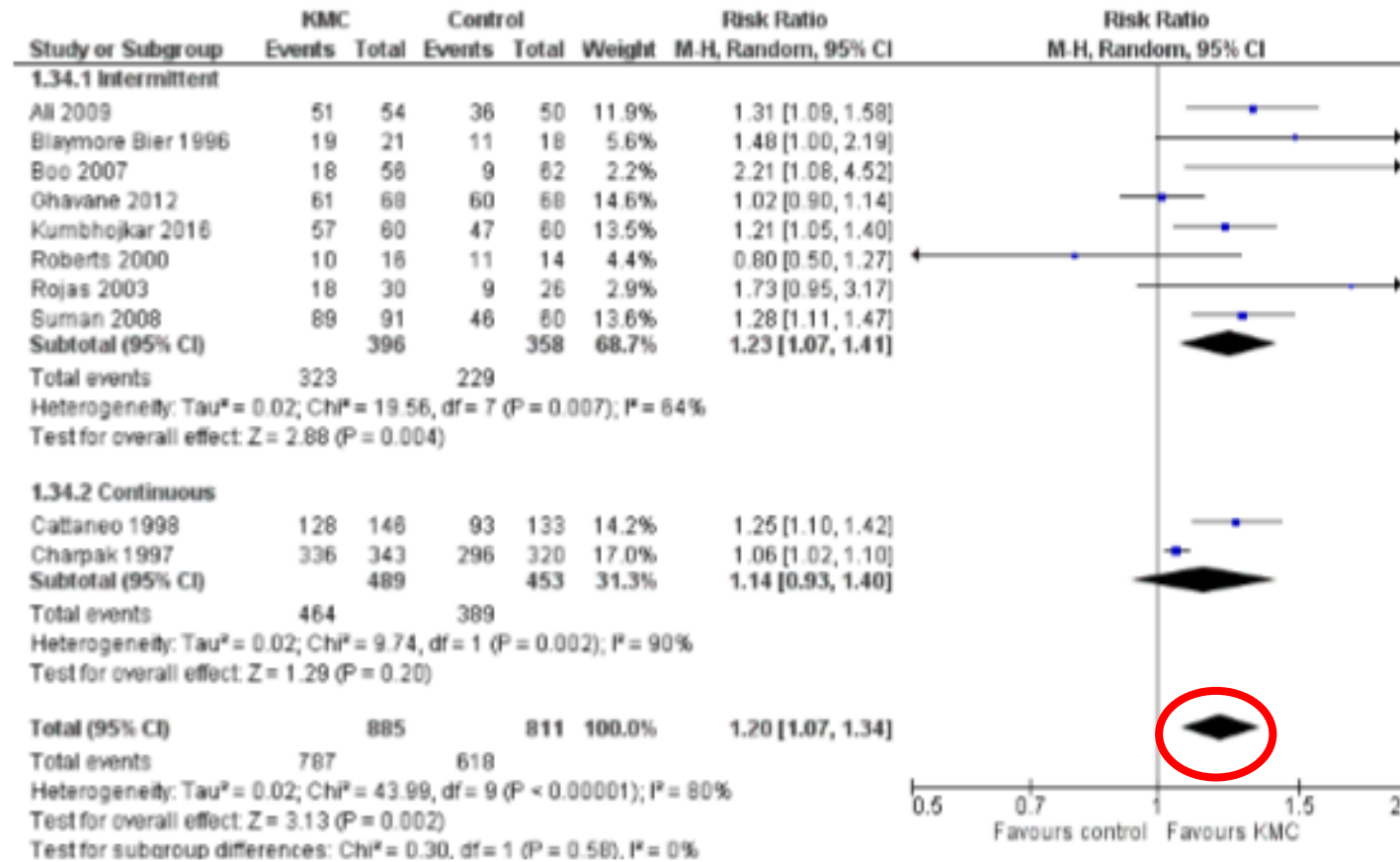
**Figure 4. Forest plot of comparison: I Kangaroo mother care versus conventional neonatal care, outcome: I.2 Severe infection/sepsis at latest follow-up - stabilized infants.**



**Figure 5. Forest plot of comparison: I Kangaroo mother care versus conventional neonatal care, outcome: I.10 Weight gain at latest follow-up (g/d) - stabilized infants.**



**Figure 6. Forest plot of comparison: I Kangaroo mother care versus conventional neonatal care, outcome: 1.34 Any breastfeeding at discharge or at 40 to 41 weeks' postmenstrual age - stabilized infants.**







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## Journal of Pediatric Nursing



# The Impact of Kangaroo Care on Premature Infant **Weight Gain**

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### ABSTRACT

**Background:** Preterm births occur among 11.4% of all live infant births. Without steady weight gain, premature infants may experience lengthy hospitalizations, neurodevelopmental deficits and hospital readmissions, which can increase the financial burden on the health care system and their families. The total U.S. health-related costs linked to preterm infant deliveries are estimated at \$4.33 billion. Kangaroo care is a feasible practice that can improve preterm infant weight gain. However, this intervention is utilized less often throughout the U.S. due to numerous barriers including a lack of consistent protocols, inadequate knowledge, and decreased level of confidence in demonstrating the proper kangarooing technique. An integrative review was conducted to evaluate the impact of kangaroo care on premature infant weight gain in order to educate nurses about its efficacy among pre-term infants.

**Data Sources:** A literature search was conducted using CINAHL, PubMed, Cochrane Reviews, ClinicalKey and Google Scholar. Large volume searches were restricted using appropriate filters and limiters.

**Conclusions:** Most of the evaluated studies determined that weight gain was greater among the kangarooing premature infants. Kangaroo care is a low-tech low-cost modality that can facilitate improved preterm infant weight gain even in low-resource settings. Despite its current efficacy, kangaroo care is not widely utilized due to several barriers including an absence of standardized protocols and a lack of knowledge about its benefits. Kangaroo care can become a widespread formalized practice after nurses and parents learn about the technique and its numerous benefits for premature infants, including its association with improved weight gain.

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## The effect of kangaroo ward care in comparison with "intermediate intensive care" on the growth velocity in preterm infant with birth weight <1100 g: randomized control trial.

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### Abstract

Kangaroo mother care (KMC) reduces neonatal mortality, neonatal sepsis and improves growth outcome in preterm infants. In this study, we compared the efficacy of "baby care in kangaroo ward (KWC)" with "baby care in intermediate intensive care (IIC)" in stable preterm infants (birth weight <1100 g) for improving the growth velocity till term corrected age. One hundred and forty-one infants were randomized to KWC (n = 71) or IIC (n = 70) once the infant reached a weight of 1150 g. Infants in the KWC group were shifted to the KWC immediately after randomization and those in the IIC group were given care in the IIC till they attained a weight of 1250 g and then shifted to the KWC. The average weight gains as well as weight, length, and head circumference at term corrected age were comparable in both the groups. There was significant reduction in IIC stay post randomization and increase in weight gain before discharge in the KWC group. There was a significant increase in incidence of apnea in the IIC group.

**CONCLUSION:** Early KWC is equally efficacious as IIC in improving the growth outcomes of stable preterm (birth weight <1100 g) infants at term gestational age.

**CLINICAL TRIAL REGISTRATION:** Clinical trial registry of India CTRI/2014/05/004625 **WHAT IS KNOWN:** • Kangaroo mother care (KMC) reduces neonatal mortality, neonatal sepsis and improves growth outcome in VLBW infants. **What is new:** • Baby care by mother can be given safely in kangaroo ward from a weight of 1150 g in stable preterm infants without any adverse effects.



## Kangaroo care was as effective as sucrose for painful procedures for babies in the neonatal intensive care unit

### STUDY DESIGN

**Design:** Single-centre, randomised clinical trial.

**Allocation:** Block randomisation to kangaroo care (KC) alone, KC and sucrose or sucrose alone using computerised off-site system.

**Blinding:** All research and clinical staff except the study research nurse were blinded to if placebo (sterile water) or 24% sucrose was given. It was not possible to blind KC. The neurodevelopmental assessments were conducted blind to group assignment.

### STUDY QUESTION

**Setting:** Single tertiary neonatal centre in Eastern Canada.

**Patients:** Infants born less than 37 weeks within 7 days of birth who were clinically stable enough to receive KC from their mothers. Exclusion criteria were infants with congenital anomalies, infants requiring surgery or those on sedation or analgesia.

**Interventions and comparisons:** KC 15 min before a procedure with sucrose; or KC 15 min before a procedure with placebo (sterile water); or sucrose only 2 min prior to the procedure. The procedures were three medically indicated heel lances.

**Outcomes:** The primary study outcome was biobehavioural pain response. This was measured using the Premature Infant Pain Profile (PIPP) scored at 30, 60, 90 and 120s after heel lance. Secondary outcomes

included the Neurobehavioral Assessment of the Preterm Infant (NAPI).

**Follow-up period:** Infants had up to three neurodevelopmental assessments at 32, 36 and 38 weeks.

**Patient follow-up:** Of the 242 infants randomised, four discontinued the intervention.

### MAIN RESULTS

PIPP is scored using seven indicators, with a score of 0–6 indicating no to mild pain; 7–12 indicating moderate pain; and >12 severe pain; a difference of 2 points being considered clinically meaningful. NAPI is scored 0–100 with higher scores indicating better performance. The peak mean PIPP scores were highest 30s after the heel lance across all the groups, decreasing over time. The mean difference (95% CI) is narrow, suggesting the minimally significant 2 points are excluded in this study. There was no observed clinical difference between the PIPP scores or neurodevelopment measured using the NAPI at 32 and 36 weeks' corrected gestation. The authors state NAPI scores were consistent with normative data in this population (see table 1).

No statistically significant differences were noted in the need for rescue sucrose or incidence of adverse effects such as apnoea, bradycardia or desaturations.

### CONCLUSION

This study has shown that KC is as effective in reducing pain as 24% sucrose for repeated painful procedures during neonatal intensive care unit (NICU) admission, but equivalence could not be clearly demonstrated. Additionally, there is no added benefit to combining KC with 24% sucrose. KC should be considered as an alternative to sucrose.



**Actualización de los Lineamientos  
Técnicos para la implementación  
de Programas Madre Canguro en Colombia,  
con énfasis en la nutrición  
del neonato prematuro  
o de bajo peso al nacer**



LINEAMIENTOS  
2017

# CÚANDO INICIARLO?

- DESDE **SALA DE PARTOS** SI EL PREMATURO **NO** REQUIERE MANIOBRAS DE REANIMACIÓN, HACER CONTACTO PIEL A PIEL EN POST PARTO INMEDIATO. **BAJO SUPERVISIÓN** DE PEDIATRA O ENFERMERÍA DE SALA PARTOS.
- INICIAR LA POSICIÓN CANGURO A PARTIR DEL MOMENTO EN QUE EL NIÑO **ESTÉ ESTABLE** SIN VARIACIONES EN SATURACIÓN DE OXÍGENO, FRECUENCIA CARDÍACA, FRECUENCIA RESPIRATORIA DURANTE LA MANIPULACIÓN DEL NIÑO Y QUE EXISTA DISPONIBILIDAD DE LA MAMÁ O MIEMBRO DE LA FAMILIA.
- EN LA ACTUALIDAD, **NO** EXISTE EVIDENCIA SÓLIDA A FAVOR DE LA POSICIÓN CANGURO EN RECIÉN NACIDOS CRÍTICOS E INESTABLES, SIN EMBARGO SE HAN INICIADO EN PAÍSES NÓRDICOS NUEVOS ESTUDIOS SOBRE EL CONTACTO PIEL A PIEL INMEDIATO DESPUÉS DE NACER, CON EL FIN DE ESTABILIZAR EL NIÑO INMADURO EN UN AMBIENTE CON MENOS ESTRÉS.



# REQUISITOS

## CRITERIOS DE ESTABILIDAD PARA INICIARLO:

- FC Y FR ESTABLE DURANTE LAS MANIPULACIONES (LAS MANIPULACIONES NO PROVOCAN LA CAÍDA EN LA SATURACIÓN DE OXÍGENO O VARIACIONES SIGNIFICATIVAS EN LOS SIGNOS VITALES).
- EL RECIÉN NACIDO HA SUPERADO CUALQUIER PATOLOGÍA CRÍTICA COMO INFECCIONES.

## CRITERIOS DE SELECCIÓN Y REQUISITOS PARA LA MADRE O CUIDADOR:

- AUSENCIA DE ENFERMEDADES INFECTO-CONTAGIOSAS, CUTÁNEAS Y/O HIPERTERMIA. - -CAPACIDAD FÍSICA Y MENTAL PARA MANEJAR EL NIÑO EN MMC.
- ACEPTAR VOLUNTARIAMENTE SU PARTICIPACIÓN EN EL ENTRENAMIENTO.

# CÚANTO TIEMPO?

- EN LA ETAPA INICIAL DE LA ADAPTACIÓN A PROGRAMA MADRE CANGURO EN LA UCIN EN NIÑOS FRÁGILES RECIENTEMENTE ESTABILIZADOS SE ACONSEJA COLOCAR AL NIÑO SOBRE EL PECHO DE LA MADRE DE FORMA INTERMITENTE, PERÍODOS MÍNIMO DE 2 HORAS Y SE ALTERNA CON INCUBADORA.
- SE BUSCA QUE SEA 24 HORAS





# CONDICIONES PARA LOGRAR EL EXITO

- UNIDADES PUERTAS ABIERTAS 24 HORAS A PADRES
- PROTOCOLOS ESCRITOS “LINEAMIENTOS Y REQUISITOS PARA IMPLEMENTACIÓN DE PMC” (CUMPLE DIRECTRICES DE RESOLUCIÓN 0412 DEL 2000 DE MIN PROTECCIÓN SOCIAL).
- CRITERIO MÉDICO PARA ESCOGER MOMENTO DE INICIAR MMC (SEGÚN EXPERIENCIA Y EVIDENCIA CIENTÍFICA)
- COMPROMISO Y CONVENCIMIENTO DE TODO EL EQUIPO

# LISTA DE CHEQUEO PARA CASA

## ADAPTACIÓN CANGURO EXITOSA:

- AUMENTO DE PESO AL MENOS 2 DÍAS CONSECUTIVOS, (EXCEPTO PRIMEROS 10 DÍAS DE VIDA)
- BUENA COORDINACIÓN SUCCIÓN-DEGLUCIÓN-RESPIRACIÓN.
- EL RECIÉN NACIDO HA TERMINADO TRATAMIENTO MÉDICO, SI LO HABÍA.
- SI REQUIERE O<sub>2</sub>, SER MENOR A 0,5 LIT X MIN
- CUENTA CON UN PMC AMBULATORIO EN CAPACIDAD DE RECIBIRLO Y BRINDARLE UN SEGUIMIENTO ADECUADO

## ADAPTACIÓN CANGURO INTRAHOSPITALARIA EXITOSA:

- LA MADRE HA ADQUIRIDO TÉCNICAS DE LACTANCIA Y EXTRACCIÓN DE LECHE.
- EXISTE UN COMPROMISO Y CAPACIDAD FAMILIAR DE ASISTIR A LOS CONTROLES DEL SEGUIMIENTO AMBULATORIO EN EL PMC.
- LA MADRE O EL CUIDADOR ESTÁN EN CAPACIDAD FÍSICA Y MENTAL DE CUIDAR A SU HIJO Y SE SIENTE CAPAZ DE CUIDAR A SU HIJO BAJO EL MMC EN CASA.

- QUÉ MAS NUEVO HAY EN EL HORIZONTE?





# MMC A PACIENTES CRÍTICOS

- ES STANDARD DE CUIDADO EL MMC A PREMATUROS ESTABLES
- NO ASÍ DE PREMATUROS CRÍTICOS O VENTILADOS.
- SE PLANTEA REALIZARLO A ESTOS PACIENTES.



-Mother Care in Hospitalized Low Birth-Weight Infants on Respiratory Support. A Feasibility and Safety Study  
Shridevi Bisanalli et al. Advances in Neonatal Care. 2019. DOI: 10.1097/ANC.0000000000000666  
in Neonatal Care 2019. Bisanalli S et al KMC in Hospitalized LBW Infants on Respiratory Support  
-Advances in Neonatal. Liza Cooper et al , Vol. 14, No. 6, pp. 410-423

# BARRERAS A MMC EN PTES VENTILADOS

- AUSENCIA DE CRITERIOS PARA SELECCIÓN DE LOS CANDIDATOS
- TEMOR A EXTUBACIONES ACCIDENTALES
- TEMOR DE ESTRESAR AL NEONATO
- AUMENTO TIEMPO DE ENFERMERÍA PARA LOGRAR LA TRANSFERENCIA DEL NEONATO (SOBRECARGA DE TRABAJO), RELACIÓN INADECUADA ENFERMERA/PACIENTE.
- TEMOR DE HIPOTERMIA
- TEMOR DE ENFERMERÍA A SER CULPADOS SI ALGO SALE MAL, ESPECIALMENTE SIN POLÍTICAS ESCRITAS DE PRÁCTICA DE MMC EN PACIENTES VENTILADOS.
- POTENCIAL DIFICULTAD EN MONITORIZAR AL NEONATO DURANTE MMC.

# MMC EN PTES VENTILADOS

- ESTUDIO PILOTO INDIA:
    - 15 PACIENTES CPAP Y 5 EN SIMV.
    - PODÍAN TENER CATÉTERES UMBILICALES.
- “ SE PUEDE HACER Y ES SEGURO”.
- NO EFECTOS 2RIOS.

TABLE 2. Comparison of Variables Before, During, and After KMC

Parameters	Before KMC	During KMC	After KMC	P Value
Temperature, °C	36.7 ± 0.10	36.7 ± 0.06	36.7 ± 0.07	.55
Heart rate, beats/min	147.3 ± 11.5	150.8 ± 11.0 <sup>a</sup>	147.3 ± 11.1 <sup>b</sup>	.04
Respiratory rate, breaths/min	60.5 ± 4.1	60.6 ± 3.9	59.7 ± 3.8 <sup>b</sup>	.07
Saturations, %	94.35 ± 0.98	93.4 ± 1.5	94.7 ± 1.2 <sup>b</sup>	.42
FIO <sub>2</sub>	30.6 ± 8.1	31.8 ± 8.1 <sup>a</sup>	30.7 ± 8.0 <sup>b</sup>	.03

Abbreviation: KMC, kangaroo mother care.

<sup>a</sup>P < .05 between before KMC and during KMC.

<sup>b</sup>P < .05 between during KMC and after KMC.



# Skin-to-skin care in preterm infants receiving respiratory support does not lead to physiological instability

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Accepted 1 December 2016

#### ABSTRACT

**Objective** Providing skin-to-skin care (SSC) to preterm infants is standard practice in many neonatal intensive care units. There are conflicting reports on the stability of oxygen saturation (SpO<sub>2</sub>) during SSC, which may create a barrier to a wider implementation of SSC to infants receiving respiratory support. Regional cerebral oxygenation (rcO<sub>2</sub>) measured using near-infrared spectroscopy can serve as a surrogate parameter for cerebral oxygen delivery and consumption. We hypothesised that rcO<sub>2</sub> during SSC would be similar to standard care in preterm infants receiving respiratory support.

**Design** Prospective observational non-inferiority study.

**Setting** Single tertiary perinatal centre in Australia.

**Patients** Forty preterm infants (median (IQR) of 27.6 (26.0–28.9) weeks' gestation) receiving respiratory support were studied on day 8 (5–18).

**Interventions** Ninety minutes of SSC, with infants in incubators acting as their own control. Parents and caregivers were blinded to the measurements.

**Main outcome measures** Mean difference in rcO<sub>2</sub> between SSC and incubator care; as well as heart rate (HR), SpO<sub>2</sub>, fraction of inspired oxygen (FiO<sub>2</sub>) and temperature, were compared using a paired t-test.

**Results** rcO<sub>2</sub> was similar during SSC (mean (SD) 74.9 (6.5)%) compared with incubator care (74.7 (6.1)%, mean difference (95% CI) 0.2 (–0.8 to 1.1)%, p=0.71). No clinically important differences in HR, SpO<sub>2</sub>, FiO<sub>2</sub> or temperature were observed in the whole cohort and by mode of respiratory support (endotracheal tube mechanical ventilation, continuous positive airway pressure and high-flow nasal cannulae).

**Conclusions** Cerebral oxygenation and other physiological measurements in ventilated preterm infants did not differ between SSC and incubator care.

**Trial registration number** 12615000959572.

#### What is already known on this topic?

- ▶ There are conflicting reports on the stability of oxygen saturation (SpO<sub>2</sub>) during skin-to-skin care, which may be a barrier for implementation in very preterm infants.
- ▶ Both excessive and insufficient oxygen supply to the brain might contribute to morbidity and mortality in preterm infants.
- ▶ Regional cerebral oxygenation (rcO<sub>2</sub>) measured non-invasively using near-infrared spectroscopy (NIRS) can serve as a surrogate parameter for brain oxygen supply and consumption.

#### What this study adds?

- ▶ rcO<sub>2</sub> during skin-to-skin care is stable and the intervention is non-inferior compared with incubator care for very preterm infants receiving respiratory support.
- ▶ There was no difference in physiological parameters by mode of respiratory support or oxygen requirements.
- ▶ Extremely preterm and very low birthweight infants are not more vulnerable to physiological instability during skin-to-skin care.

mortality, severe infection and length of hospital stay compared with standard care.<sup>7–9</sup> Moreover, SSC in newborns immediately after birth stabilises cardiorespiratory adaptation<sup>7</sup> and decreases duration of infant crying.<sup>8</sup>

Short-term studies of the physiological impact on preterm infants during SSC are conflicting. More

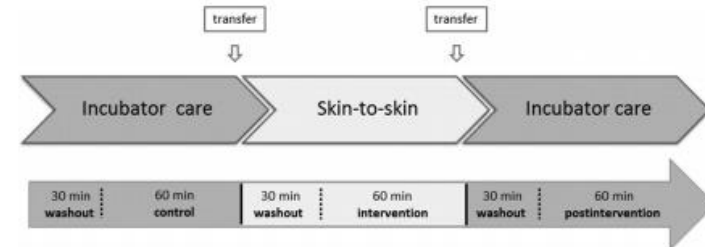


Figure 1 Graphical presentation of the study design with its different study periods.

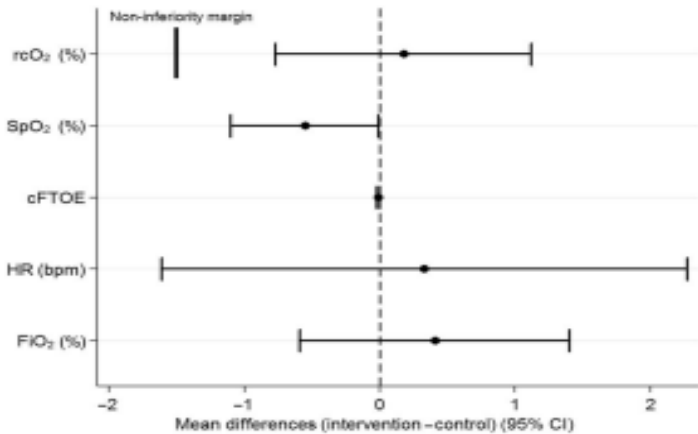
F2

Lorenz L, et al. Arch Dis Child Fetal Neonatal Ed 2017;0:F1–F6. doi:10.1136/archdischild-2016-311752



Figure 2 Preterm infants during skin-to-skin care with the near-infrared spectroscopy sensor placed on the right temporoparietal area of the scalp fixed by a firm fitting hat.

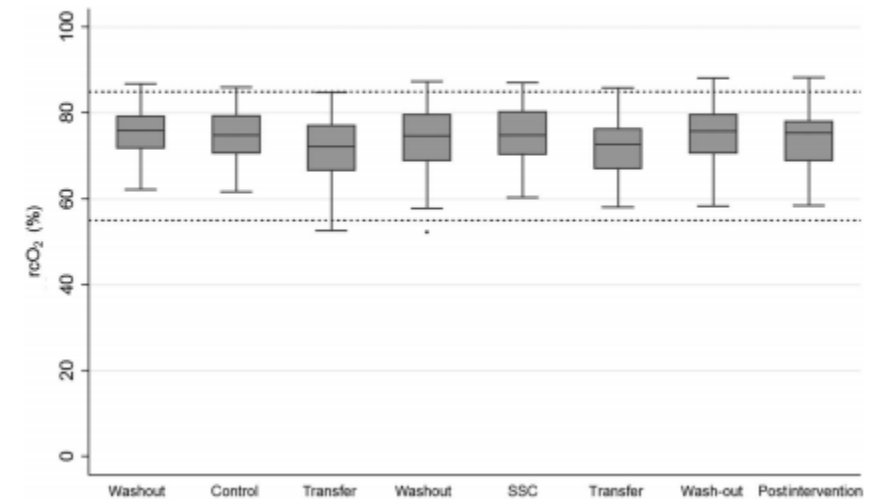
# NO DIFERENCIAS EN OXIGENACION REGIONAL CEREBRAL



**Figure 3** Absolute mean differences (95% CI) in regional cerebral oxygenation (rcO<sub>2</sub>), oxygen saturations (SpO<sub>2</sub>), heart rate (HR), fraction of inspired oxygen (FIO<sub>2</sub>) and cerebral fractional tissue oxygen extraction (cFTOE) between skin-to-skin care and incubator care.

Original article

**Figure 4** Box plots showing regional cerebral oxygenation (rcO<sub>2</sub>) over different study periods. The dotted lines are the normal ranges of rcO<sub>2</sub>.





# ABC DE MANEJO

**TABLE 2**

*Safe Protocol for Kangaroo Care With Mechanically Ventilated Infants (KC-Vent)*

Kangaroo Care is skin-to-skin contact between a preterm infant and a parent, usually mother, chest-to-chest in an upright prone position. The infant is clad in a diaper and has a receiving blanket covering the infant's back. The optimal chair for experiencing kangaroo care is a recliner. Mechanically ventilated infants are intubated or receiving nasal CPAP or oropharyngeal CPAP via a ventilator. The physician will be contacted for approval to kangaroo the infant and confirmation of infant's hemodynamic stability.

**Prior to transfer**

1. Record infant's baseline ventilator parameters (SIMV/IMV, PIP, PEEP, FiO<sub>2</sub>) and hemodynamic (HR, RR, SaO<sub>2</sub>) and thermal values (axillary temperature). These measures should be carefully monitored during KC-Vent to ascertain the infant's tolerance of this intervention.
2. With support of a second person, place the infant in supine position. Note any significant changes in the infant or mechanical ventilator requirements.
3. Auscultate the infant's chest for quality of breath sounds, suction the endotracheal tube, and change the infant's diaper as necessary.
4. Suction infant if necessary and drain the vent circuit of condensation. The water condensed in the ventilator tubing will be drained to decrease resistance and maintain flow (Bhutani & Abbasi, 1992).
5. Assess infant's response to the above actions. Wait up to 15 minutes to allow for physiological adaptation to the above ministrations. Adaptation is defined as all physiological parameters returning to baseline and staying there for 3 minutes. *If adaptation has not occurred in 15 minutes, the infant is probably not stable enough to receive KC-Vent on that day.*
6. Place a receiving blanket, folded in fourths, underneath the infant (or in the bed but easily accessible to the mother) so mother picks up her infant by placing her hands underneath the blanket and moving infant and blanket simultaneously.
7. Position and prepare the chair to be used.

Ludington-Hoe, S. M., Ferreira, C., Swinth, J., & Ceccardi, J. J. (2003). *Safe Criteria and Procedure for Kangaroo Care With Intubated Preterm Infants*. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 32(5), 579–588.  
doi:10.1177/0884217503257618

# ABC DE MANEJO

## Transfer From Incubator to KC-Vent

1. Have two or three staff members assist the mother in the transfer of the infant.
2. Have mother stand at the side of the incubator/warmer while one staff member gathers all the infant's lines on one side of the infant.
3. A second staff member is responsible for transferring and securing the ventilator tubing. (A third staff member may be needed to assist the mother.)
4. Disconnect the ventilator tubing from the ETT and have mother lift her infant and place prone on her chest in one movement.
5. Reconnect the ventilator tubing, and have mother or staff member quickly secure the receiving blanket across the infant's back (if not already placed when mother picks up her infant as instructed in step 6 above).
6. Disconnect the ventilator tubing and move mother backwards to recliner/chair, assisting her in sitting once she feels the recliner against her calf. Reconnect ventilator tubing to ETT.
7. Raise the footrest and reposition the infant, as needed, and make sure the infant is tucked in a slightly flexed or comfortable position underneath the blanket. If infant is in fully flexed position, monitor for respiratory compromise and reflux.
8. Drape the ETT circuit securely over the mother's shoulder (be sure adequate circuit tubing length has been provided).
9. Change the setting on the incubator/warmer to air control and set it at 33.0°C for duration of KC-Vent.
10. Monitor the infant's condition every 10 minutes during KC-Vent. Allow KC-Vent for a *minimum* of 1 full hour if infant's condition remains stable.

## Transfer From KC-Vent Back to the Incubator

1. Have one staff member assist the mother in moving to the front edge of the chair, a second staff member handle the lines, and a third staff member disconnect the ventilator tubing.
2. Assist the mother to a standing position, reconnect the ventilator tubing, and give the infant several ventilator breaths.
3. Disconnect the ventilator tubing and replace the infant in the incubator/warming table in one movement.
4. Reconnect the ventilator tubing and make sure all ventilator tubing is stabilized and all lines are placed securely within the incubator/warming table.
5. Document infant's participation in and tolerance of KC-Vent.

Bhutani, V., & Abbasi, S. (1992). Evaluation of pulmonary function in the neonate. In Polin & Fox (Eds.), *Fetal and neonatal physiology* (Vol. 2, pp. 853-871). Philadelphia: W B Saunders.

Ludington-Hoe, S. M., Ferreira, C., Swinth, J., & Ceccardi, J. J. (2003). *Safe Criteria and Procedure for Kangaroo Care With Intubated Preterm Infants*. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 32(5), 579–588.  
doi:10.1177/0884217503257618

# APARENTE FALACIA VS PRÓXIMAS REALIDADES.

- CONTACTO PIEL A PIEL A PREMATUROS 1 HORA EN PARTOS PRE TRASLADO A UCIN.
- GRUPO DE ANGELA KRIBS, COLONIA (ALEMANIA)
- 88 RN. PREMATUROS **25-32** SEMANAS
- EN CPAP, 1 HORA PIEL A PIEL, CON 3 PERSONAS VIGILANTES (NEONATÓLOGO Y ENFERMERA) VS CONTACTO VISUAL 5 MINS.
- “ MEJORA LA INTERACCIÓN MADRE/HIJO A LOS 6 MESES Y REDUCE RIESGO DE DEPRESIÓN MATERNA POST PARTO TEMPRANA Y DE ALTERACIONES EN EL VÍNCULO, **SIN AUMENTAR LAS COMPLICACIONES** PROPIAS DE LA PREMATUREZ”



# EXCLUSIONES ANTIGUAS CANGURO SAN LUIS



MADRE CANGURO  
I-UCIN-076

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Fecha: 12-07-13  
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## Criterios de exclusión:

- Ventilación mecánica.
- Oxigenoterapia con Fio2 mayor de 40%.
- Catéteres Umbilicales
- Tubos torácicos
- Infusiones de medicamentos inotrópicos o transfusiones.
- Inestabilidad hemodinámica y/o metabólica.
- Patología infecciosa que requiera aislamiento.
- Padres con lesiones o infecciones cutáneas



ALGUNAS DE ESTAS  
CONTRAINDICACIONES  
YA  
SON MITOS Y SE HAN  
ELIMINADO DEL  
PROTOCOLO.

























# MENSAJE FINAL



- LUCHEMOS POR LOGRAR UNA REAL APLICACIÓN SIN BARRERAS AL MÉTODO MADRE CANGURO INTRAHOSPITALARIO, REDUCIENDO LAS EXCLUSIONES O CONTRAINDICACIONES AL MISMO, CON EL OBJETIVO DE LOGRAR DESDE MÁS TEMPRANO SUS BENEFICIOS
- LUCHEMOS POR UNIDADES REALMENTE ABIERTAS 24 HORAS.