East of England Neonatal ODN
(Hosted by Cambridge University Hospitals)

6. Infant and Family Centred Developmental Care Toolkit: Positioning & Handling

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For use in: EoE Neonatal Units
Guidance specific to the care of neonatal patients.

Used by: This guideline is intended for all healthcare professionals and staff working within the neonatal unit. The principles outlined should also be shared with parents, supporting a collaborative approach to caring for premature or unwell infants.

Key Words: Therapeutic positioning, Handling, motor and sensory development, Neuroprotection, Family-centred care, Skin-to-skin (Kangaroo Care), Individualised developmental care.

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Therapeutic Positioning

Introduction

Providing optimal therapeutic positioning is a core component of developmentally supportive care. Optimal therapeutic positioning should provide the infant with an experience that is safe, supportive and dynamic[33]. It is the responsibility of all neonatal staff involved in an infant's care and should be considered from delivery. All infants should receive care that provides them individualised positioning support and comfort[3].

Partnering with Families

There is overwhelming evidence which supports the understanding that parents' presence on the Neonatal unit and partnership in the care of their baby is an essential component of delivering quality developmental care and improving developmental outcomes for infants.[1,3] Parents should be educated, coached and mentored on the principles of positioning their baby, including using the 5 step dialogue (Appendix 2) and how to individualise the positioning for their baby. Please refer to EoE Neonatal ODN Partnering with families

Background

The in-utero environment provides the perfect foundation for the development of the musculoskeletal and sensory systems. In utero, the walls of a mother's tummy supports and provides containment for the developing infant. This environment facilitates the development of flexion of the trunk and limbs and provides reactionary forces in response to foetal movements which helps to develop muscle strength and coordination[8]. However, the preterm infant has low muscle tone and an immature sensory system due to missing much of this development that occurs in utero. Premature infants left with no support or boundaries, who are unable to provide and maintain their own flexed postures to achieve body alignment, are at risk of cranial misshaping, torticollis, and poor sleep[14] as well as imbalances of their musculoskeletal and sensory systems.

It is important to recognise that supportive therapeutic positioning plays a vital role in preserving an infant's musculoskeletal integrity and supporting the developing motor system. It also has a positive influence on the developing behavioural and regulatory systems[20], which plays an important role in facilitating development[20]. Providing developmentally supportive positioning in the neonatal unit is not only essential for optimum musculoskeletal development[15] it also influences physiologic function and stability, thermal regulation, bone density, neuro behavioural organisation and sleep facilitation, calmness and comfort, skin integrity, optimal growth and brain development [1,2]. Providing appropriate postural support in the neonatal period is also essential for optimising respiratory function[16], sensory development and neurodevelopmental outcomes[9 10]. It should be noted that every position the

infant experiences influences the multiple developing systems. Preterm infants should be exposed to a variety of positions, changed regularly, to enrich their sensorimotor experiences and prevent the development of fixed postural patterns[14] and movement preferences.

Babies born below 30 weeks gestation

In the extremely preterm infant, the current recommendation is to have the head in a midline position to reduce the incidence of intraventricular haemorrhage[34]. For all babies born 30 weeks gestation or below during their first 72 hours of life please refer to the East of England Neonatal ODN guideline on Strategies to reduce incidence of IVH and promote neuroprotection in the infant below 31 weeks.

Benefits of individualised developmentally supportive positioning

- Facilitates development of bone density[22,18]
- Promotes midline orientation and development of self-regulatory behaviours[18]
- Reduces stress and promotes feeling of security and physiological stability[1,18]
- Promotes sleep[20,18]
- Aids digestion[18]
- Promotes skin integrity[20]
- Promotes musculoskeletal development[18]
- Reduces risk of intraventricular haemorrhage[18]
- Reduces energy expenditure[1]
- Better weight gain and improved growth[1]
- Reduced risk of unplanned extubation[18]
- Supports development of sensory systems (tactile, proprioception & vestibular)[51]
- Promote better respiratory function[9]

Clinical Implications of poor positioning

If the appropriate therapeutic positioning is not provided during an infant's stay on the neonatal unit, the infant is at increased risk of:

- Muscle imbalances[1,9]
- Abnormal movement patterns being reinforced[9]
- Joint contractures[9]
- Head turn preferences and abnormal head shape[38,45]
- Pressure areas[9]
- Increased stress and limited self-regulation ability[5]
- Physiological instability[5]
- Poor thermoregulation
- Increased stress which can have an impact on brain development
- impact on longer term developmental outcomes
- impact on sensory development[51]

Core principles of developmentally supportive positioning[17,18,19]

- Promote and support comfort and regulation
- Promote flexion of trunk and limbs
- Promote midline symmetry and alignment
- Promote 360º containment
- Promote and support developing posture and movements

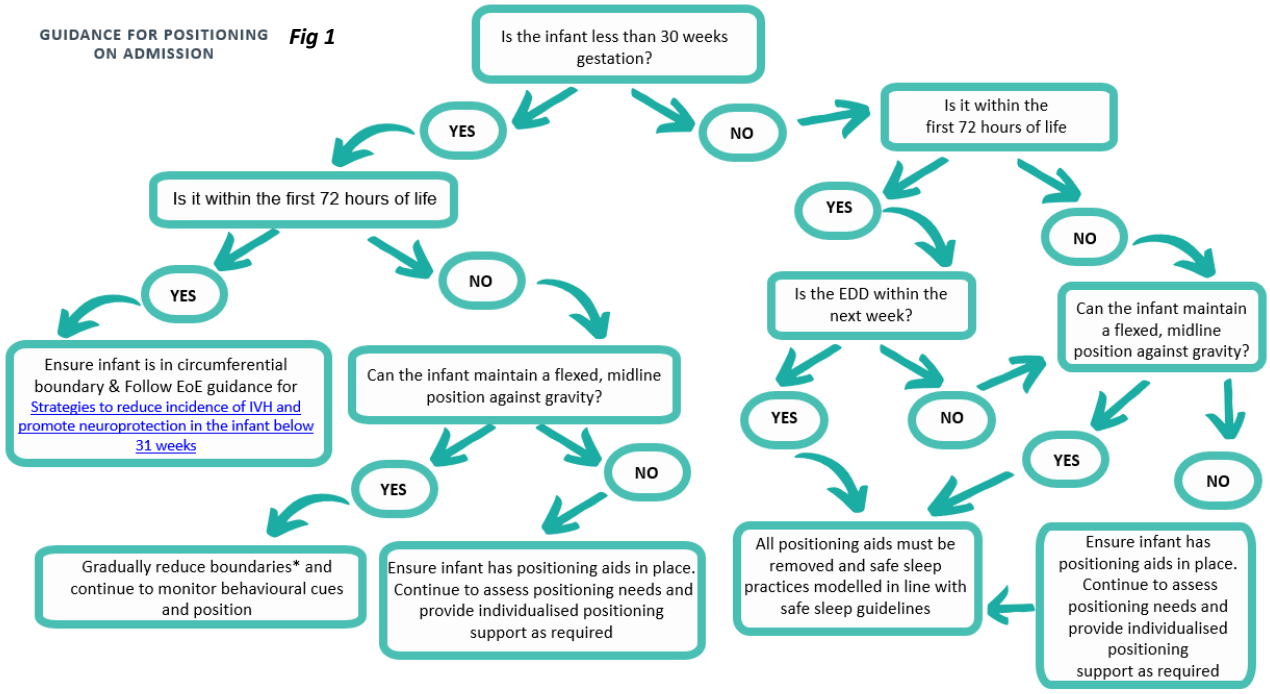
General recommendations for developmentally supportive positioning
Positioning of the infant is important; however, safety needs must always be prioritised above positioning needs.
Premature infants on a neonatal unit should be positioned to support musculoskeletal, physiological and behavioural stability[3]. Providing support using a boundary can reduce the abrupt movements that increase the stress in the infant, and it can facilitate age-specific postures and movements[19]. Using a boundary facilitates a flexed and adducted posture, promotes midline and supports normal movement patterns[19]. The boundary is most effective when it is close enough to promote flexion but also promote the infant's developing movements[20].
Infants of term age should be starting to explore and move against gravity. However, they may still require ongoing support with positioning. Consider a referral to your unit therapist for support with this.
Developmentally supportive positioning can be achieved with different positioning aids for example; commercially available nests, handmade nests, swaddling, or positioning of different types of physical boundaries around the infant[23]. Refer to appendix 4 'Positioning equipment that you might find on a neonatal unit' for a summary of different positioning equipment that is available.
There are advantages and disadvantages to each position so baby should be assessed individually to decide on best position according to their medical needs, infant's preferences and behavioural cues.
Change position regularly and provide a balance of different positions over each 24-hour period[11].
Vary the direction that the head is facing, including right, left and midline position to minimise skull deformity[20].
Use a recognised positioning tool to evaluate the infant's position (see Appendix 1)
Use a recognised pain assessment to record an infant's pain. Refer also to EoE Pain Management Guideline
Record baby's body, head position and any positioning aids on nursing chart to ensure balance of positions over each 24 hour period.

The timings of position changes should be individualised and linked to baby's sleep/wake cycle and behavioural state.
Check infant's pressure areas, on a change of position, to note any changes in skin integrity. Follow your unit protocol as appropriate. Refer also to EoE skin integrity guideline
General recommendations for developmentally supportive positioning continued
Containment is not restraint. The boundary should be supportive not restrictive, the infant must be able to move within the boundary [20].
If a baby does not tolerate a position – try an in arms position with parents or try for shorter periods of time.
Continue to monitor infant and behavioural cues and adapt positioning as required. Sole use of positioning products does not guarantee appropriate individualised positioning[36]. Refer to Developmental Care toolkit: Infant Behaviour
Implementing safe sleep prior to discharge is important[7] (refer to section preparing for discharge).
The infant should be used to sleeping on their back (following safe sleep practices) on a firm flat mattress before they go home and parents should be familiar with this practice and understand the reasons behind safe sleep practices.
If a baby has a specific medical need requiring deviation from safe sleep practices their management should be agreed by the medical lead.
Educate staff & Parents about positioning principles and how to use any positioning aids correctly.
Please consider a referral to you unit therapist for support with positioning any baby but particularly with those babies with complex positioning needs.

Positioning on Admission

For all babies born 30 weeks gestation or below during their first 72 hours of life please refer to the East of England Neonatal ODN guideline on Strategies to reduce incidence of IVH and promote neuroprotection in the infant below 31 weeks. This guideline outlines current accepted practices to reduce the risk of IVH in preterm babies at increased risk of intraventricular haemorrhage.

On Page 6 is a guide (Fig 1) to positioning an infant on admission[24], if you require further support or guidance please seek the support of your unit Physiotherapist or Occupational Therapist.



Graphic adapted from NWNODN Positioning & Handling Guideline with permission [24]

**See reduction of boundaries section*

IMPORTANT – Positioning aids must ONLY be used on the neonatal unit with infants who are on physiological monitoring. They are NOT to be used by infants who are no longer being monitored.
Choice of position and any additional supports used should be individualised to the baby .

Supine (lying on back)

Advantages	Disadvantages
Reduces the risk of SIDS (sudden infant death syndrome). Infant must be placed in supine position if no longer monitored as per safe sleep guidelines in preparation for discharge home.[6 7]	Increases energy expenditure[14]
Easier access for medical care and observation	Work of breathing is increased
Easier visual exploration by infant	Reflux is more likely to occur
If infant head is in midline position this can help to contribute to better head moulding.	Effect of gravity makes it difficult to achieve developmentally supportive position.
Able to see abdomen, easier to observe baby	Promotes atypical extensor patterns[20]
	Associated with increased stress & awake behaviours[35]

	Midline head position is challenging to maintain.

Baby in utero[30]

Baby in supine position

Recommendations for supine position
Use a high sided circumferential nest providing appropriate containment either side of the body, head and feet.
Support head in the midline with a high sided nest (i.e. chin in line with sternum). Avoid lateral extension, where head falls towards shoulders (use gel pillow, fluidised head positioner or head scroll to help support a midline position as appropriate).
Shoulders should be softly rounded and assisted with support, to maintain a flexed position towards the chest. A positioning support can be used if required, to assist the shoulder position.
Hands should be supported forward to each other to encourage and allow for hand/mouth/face co-ordination.
The hips need to be aligned in a flexed position, where they are drawn towards the abdomen. Avoid hip abduction (frogged position).
Ankles and feet should be softly flexed with plantar surface contact in neutral position on the boundary sheet/towel.
The infant should be well supported but with enough room to spontaneously move within the boundary.

Side lying (lateral position)

Advantages	**Disadvantages**
Encourages flexion and discourages hip external rotation and 'W' arm position	Can encourage neck extension if support provided behind head.
Promotes self-regulation	Infant at risk of asymmetry and head flattening as weight bearing on side of head.

May be used to encourage flexion and adduction, counteracts external rotation of limbs	
Reduces severity of reflux[13]	
Facilitates midline orientation of the head and extremities	
Easiest for infant to make themselves comfortable	
Improved sleep compared to supine[20]	

Baby in utero[30]

Baby in side lying position

Recommendations for side lying position
The hips and knees should be flexed towards the tummy and tucked within boundary.
The infant should have enough room to move within the supports.
Arms should be forward to midline or face and shoulders comfortably flexed.
The infant's back should be well supported to maintain a flexed symmetrical side-lying posture.
The infant's neck should be in a neutral position or slightly flexed position.
Make sure you alternate sides, so the baby is positioned in both the left and right side at some point during each 24 hours.

Prone (Lying on tummy)

Advantages	Disadvantages
Facilitates flexion[14]	Access for medical care is more difficult
Facilitates the development of head control	Infant may self-extubate
Facilitates self regulation[35]	Some infants cannot tolerate prone
Decreased energy expenditure[14]	At risk of shoulder adduction and internal rotation contractures[9]
Improved oxygenation[20,28]	Prolonged time in this position may contribute to abnormal head moulding[9]
Lowers intracranial pressure[14]	
Lower respiratory rate (than in supine)[14]	
Promotes quiet sleep[35]	
Significantly reduces the severity of gastroesophageal reflux[20]	
Heat loss is minimised	
Promotes infant comfort[35]	

Baby in utero[30]

Baby in prone position

This position **should not be used** with:

- infants at risk of IVH please refer to the East of England Neonatal ODN guideline on Strategies to reduce incidence of IVH and promote neuroprotection in the infant below 31 weeks
- infants who are not monitored

Recommendations for prone position
Ensure monitoring is in place
Use a prone positioner, folded sheet/muslin or similar support to encourage shoulder and hip flexion.
The infant's hips, knees and shoulders should be flexed in a neutral position.
The arms should be flexed and near the head/face.
The head should be turned to one side and the hand on the face side should be near the mouth.
Circumferential boundary should be in place for further support and containment
This position should not be used for infants close to discharge, who should be placed on their backs to sleep, according to safe sleep advice[7]

Positioning in relation to head shaping

The incidence of positional skull deformities such as dolichocephaly (also know as scaphocephaly) is high in the preterm population[38]. This bilateral flattening of the skull occurs because of consistent pressure from weight bearing on the side of the head. Essential medical care required to support preterm infants can often limit the positioning options required to minimise musculoskeletal complications[38]. If the infant's head is consistently positioned to the side, this can also lead to head turn preference and plagiocephaly[20]. This may contribute to longer term challenges in developing midline control and developmental delay[39]. Early intervention of an individualised positioning program can minimise potential deformities[38,45]. Skull shaping continues after discharge from the neonatal unit and can be influenced by positioning and play strategies at home[20], therefore referral to ongoing therapy services following discharge may be appropriate.

Recommendations to promote head shaping
Aim to keep the head in midline or in less than 30° from midline (if baby is ventilated or on CPAP ensure tubing is adequately supported. Infant may require support from head scroll* or fluidised positioner.
In the extremely preterm infant, the current recommendation is to have the head in a midline position to reduce the incidence of intraventricular haemorrhage[34] Refer also to Strategies to reduce incidence of IVH and promote neuroprotection in the infant below 31 weeks
Consider the environment, as this can have also impact on head position[39,45]. For example, if a cot is always facing the same way by a window, parent always approaches infant from the same side etc
With babies who do not have active movement of their head against gravity, consider use of a positioner or head scroll to aid positioning of the head.
Referral to the neonatal Occupational Therapist and Physiotherapist on the unit can support with early intervention positioning programs as an individualised positioning program may be required.

Example of head support in midline position with head scroll

- Head Scroll - sheet folded and rolled either side to provide support to encourage a midline position of head.

Picture credit NWNODN guideline reproduced with permission

Supportive sitting

Term infant position

Parent holding infant

Infant in baby chair

For an infant who is term age or a premature infant who is now stronger and more alert and approaching term age, it may be developmentally appropriate to start to spend time in a supportive sitting position when awake and supervised. A supportive sitting position can be achieved in arms with parents or by using a baby chair. A supported sitting position provides the infant with the opportunity to observe their surroundings and to be in a different position. The infant should not be left in this position for long periods. Some reclining baby seats also have vibration and music settings. Care should be taken not to provide too much stimulation for the infant. The infant's behavioural cues should be monitored and position and/or stimulation changed appropriately.

Recommendations for supportive seating
Infant should be fully supported – if in arms with parent you may decide to swaddle to provide extra support.
Hips should be in the middle of the seat (to promote a straight trunk position)
Rolls may be used either side to provide support at shoulders and promote midline head and upper limb position if required
Infant should be monitored appropriately.

Older Infants

Infants who are term age or older and still on the neonatal unit may continue to benefit from provision of positioning equipment especially if you have identified an ongoing need for example head turn preference, low muscle tone etc. They may benefit from referral to the unit Occupational Therapist or Physiotherapist for assessment and provision of positioning advice and an individualised program.

Reduction of boundary

Recommendations for reduction of boundary
When an infant is ready for the positioning supports to be removed this should be done gradually so that the infant can get used to having less support.
It may be appropriate to use rolls either side of the infant instead of a nest
Consider if the infant still requires a head support.
Parents should be informed and involved with any discussion to reduce/remove positioning. They should be provided with information on the difference between positioning on the unit and at home, reiterating the importance of the safer sleep advice. Refer also to EoE Neonatal ODN Partnering with families

Removing Supportive Positioning in preparation for discharge

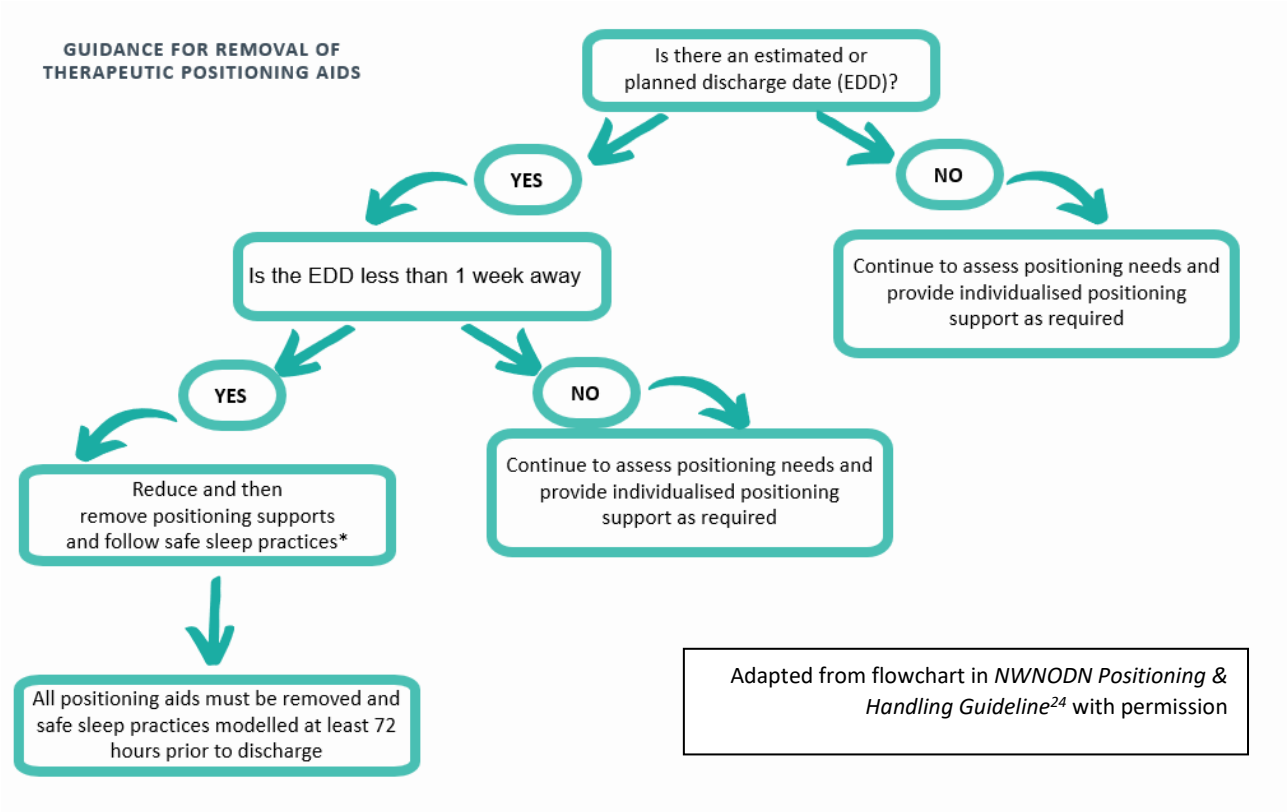
It is important to consider the following when thinking about removing positioning supports:

- Ability to maintain physiological stability
- Ability of infant to turn their head from side to side
- Ability of the infant to curl up on their own, bring hands to face etc.
- Ability to control behavioural states
- Feeding type & ability of infant

Things to consider when removing supportive positioning
Gestation & Development In practice, a baby's gestation will guide us to look and assess the positioning equipment but the decision to remove should always be based on the baby's competency/ development alongside discharge plans. Your unit therapist will be able to help guide with this.
Development of posture & muscle tone A baby starts to develop stronger muscle tone into flexion moving towards term age - remember to continue to evaluate positioning support provided and adjust/remove positioning supports appropriately.
Partnership with Parents Parents should be informed about supportive positioning on the neonatal unit and then involved in the decision making process on when to remove. They should be provided with information on the difference between positioning on the unit and at home, reiterating the importance of the safer sleep advice. Refer also to EoE Neonatal ODN Partnering with families.
Individualised Remember all positioning needs are individualised so some infants may need equipment for longer. This should only follow assessment and directed by a therapist if possible. Safe sleep advice prior to discharge should still be followed (see below).
Safer Sleep Advice Following safe sleep advice has been shown to reduce the rate of SIDS[7] (sudden infant death syndrome). The basics of safe sleep advice is to sleep the baby in their

own, clear, flat, firm separate sleep space in the same room as the parent[7]. Premature and low birth weight infants are particularly vulnerable to SIDS[7] so modelling and provision of safe sleep advice to parents is an essential part of discharge planning. It is good practice that the baby has time (ideally 1 week) sleeping on their back and safe sleep behaviours being modelled prior to discharge[6].
Refer also to flow chart (Fig 2) on guidance for removal of positioning supports (page 13)

Fig 2 Flow chart for guidance for removal of therapeutic positioning aids:



***Safe Sleep Practices**

The safest place for a baby to sleep is in their own clear, flat, firm separate sleep space (e.g. a cot or moses basket) in the same room as the parent. Follow safe sleep practices as per lullaby trust guidelines

Car seats

- Car seats are designed to keep babies safe while travelling, but they are not designed to be a main sleeping place, so they are not suitable for sleeping for long periods[7].
- A car seat should be used for transport only, not as an alternative to cots, highchairs or pushchair[7].
- Positioning aids should not be used in car seats[7].
- Further information on car seats is available from BLISS HERE
- Useful to signpost parents to In Car Safety Centre for specialist advice (www.incarsafetycentre.co.uk)

Positioning in Special circumstances / surgical considerations /complex babies

It is acknowledged that there are sometimes medical reasons why an infant may have some exceptions to routine positioning recommendations either for surgical, respiratory or medical needs etc.

If positioning is challenging or deviants from routine universal care, ensure you refer to your unit therapists for specialist individualised positioning and developmental care advice.

Developmentally Supportive Movement and Handling

Introduction

Frequent insensitive handling and touch can be a cause of stress and be detrimental to an infant's sleep leading to decreased weight gain, poor state regulation, increased stress and adverse effects on brain development[37]. Where possible stressful handling should be minimalised[37] to reduce unnecessary stress.

Evidence supports that skin-to-skin contact with parents is the preferred neuroprotective environment and position to support an infant. Skin to skin should be encouraged whenever possible[3].

Recommendations for supportive movement and handling
Handling of an infant should be performed only as needed.
Always consider the environment before handling infant to minimise sensory overload.
Always use the 5-step dialogue to approach infant (refer to appendix 2)
Infants should be handled using slow, gentle, and controlled movements, with their limbs maintained in a flexed and supported position. In the case of medically fragile infants, 2-person technique may be indicated to ensure optimal support and stability[1].
Moving and stabilising an infant using 2-person care with one person handling the behavioral and physiological stability of the infant. Whenever possible a parent should be part of the 2-person care.
The position of limbs and body are relevant for comfort, providing a midline, flexed and contained position supports comfort and regulation.
Pace care activities according to infant's behavioural responses/cues. This may include pausing and providing extra support if necessary. (refer to Developmental Care Toolkit: Infant Behaviour)
Promote a well-positioned head – this will determine the rest of the baby's body position
Where possible use a supported side lying position for transfer of an infant. The side lying position promotes flexion and midline. It can minimise disorganised movements and support the infant's efforts at self-regulation. In summary, provide hand hug, containment and roll gently onto side then transfer.
Expose only areas that need to be touched and keep other areas wrapped
Support self-regulation eg providing a finger to grasp, comfort hold, cupping feet, support hands to midline etc.
Provide swaddling when bathing and weighing (see below)
Allow alcohol gel to 'dry' before handling infants.
Educate staff and Parents about handling principles

Side lying nappy change

Changing an infant's nappy in the side lying position can:

- Maintain best flexed position for the infant.
- It can encourage the infant to bring their hands to their mouth and supports their comfort and regulation
- No change in blood pressure or intracranial pressure by lifting hips
- Light dimmer and easier to control
- Able to see baby and talk with them
- Able to clean effectively

Recommendations for side lying nappy change
Refer to this VIDEO for more information
Use 2-person care when possible
Use appropriate size nappy to promote developmentally supportive hip position

Swaddling

Swaddling or wrapping of an infant is the practice of wrapping them in a fabric cloth e.g. muslin, encouraging a flexed position with hands to midline. Wrapping an infant is known to have beneficial effects on preterm infants by supporting physiological stability, self-regulation and reducing behavioural stress signs[20].

Bathing and weighing can both be stressful experiences for an infant[40,43]. Wrapping a baby for such activities can provide a more developmentally supportive experience by supporting the infant's physiological stability and behavioural organisation[20].

Benefits of wrapped weighing & Bathing[42]

- Reduced physiological stress
- Reduced visceral activity, such as hiccupping
- Supports self-regulatory behaviours
- Improved motor organization
- Reduced general energy expenditure

General Recommendations for swaddling/wrapping
Promote midline position with hands
The infant should be wrapped cosily but not too tightly.
Refer also to lullaby trust guidelines on swaddling for advice following discharge
Wrapping can be used for weighing and bathing occupations to support the infant to feel safe and secure
Wrapped Bathing First baths should be no longer than 5-8 minutes[43]. For specific information on steps for wrapped bathing please refer to page 17-19 HERE[46]

Wrapped Weighing For specific information on steps for Wrapped Weighing please refer to page 20-22 HERE[46]
Always observe behavioural cues and adjust handling appropriately

Positive Touch

Touch is our first sensory system to develop in the womb[47,49] and it affects every area of our life. Our tactile system protects us against danger, it provides us with emotional memory, it helps us feel calm and loved and it helps us explore the world. Preterm neonates are more sensitive to pain/stress than infants born at full term and display a lower threshold to touch and more pronounced reflex responses to touch, compared to full-term infants. With repeated touch, this lower threshold declines further due to excitability of sensory neurons in the spinal cord.[52]

Premature and sick infants therefore may experience stress and pain not only from essential medical procedures but from necessary handling and daily cares. Health care professionals should be mindful of the impact touch and handling and adjust approaches to prevent unnecessary stress and pain.

Equally, infants should experience positive touch to support their physical and emotional development. Providing positive touch experience is an important role for parents and enables them communicate love and reassurance to their baby[49]. Parents should be encouraged to observe their infant's individual behaviour and in return respond to their needs.

All infants are born with the ability to communicate, by observing an infant's behaviours parents and staff can learn what kind of touch to use and when it is appropriate, safe and pleasurable for the infant. Refer to Developmental Care Toolkit: Infant Behaviour

Sick and preterm infants do not always tolerate handling and can respond in a variety of negative ways. This can be daunting for a parent, and they can be very anxious about handling their baby. The development of parent-infant relationships in the NICU is complex, both will benefit from the support and encouragement to progress from touching to holding their baby when this is possible.

Positive touch experiences should be promoted on a neonatal unit to counteract the unpleasant touch that infants can regularly receive on the neonatal unit[5]and to promote parental attachment and bonding.

Examples of positive touch

- Skin to skin
- Connection without touch

- Still touch/Comfort holding
- Facilitated tucking
- Positive oral experiences e.g breast feeding, non-nutritive sucking
- Neonatal massage
- Cuddles

5 Step Dialogue

The 5 Step dialogue is a framework for caregivers to interact with infants to ensure they are being approached and supported effectively[32] (refer to appendix 2).

Recommendations for positive touch
Every interaction with every infant should use the 5 Step dialogue technique (refer to appendix 2)
Observe how the infant handles during interventions and modify according to their response Refer to Developmental Care Toolkit: infant Behaviour
It is important to help parents to identify the type of touch that their infant likes and encourage them to become the primary provider of touch
Rub your hands together before touching to ensure they are warm

Skin to skin (Kangaroo Care)

Skin to skin is recognised as the optimal neuroprotective environment and the best strategy to restore some of the sensory discontinuity associated with preterm birth.[1,3]

The benefits of skin to skin are well documented [3] and further practical guidance can be found in the EoE skin to skin guideline (Developmental Care Toolkit: Skin to Skin).

Connection without touch

There may be times that the infant may be very ill and will not respond to touch in a good way. During these times it is important that any handling is sensitively attuned to the individual baby to avoid stress and deterioration in the infant's vital signs.

It is also important to communicate this to parents and show them ways of non-touch comforting.

Recommendations for connection without touch
Having their hands placed near the infant so they can sense and smell their parent talking calmly to the infant – watching carefully for his/her cues.
Pacing the interaction of voice/talking/singing/reading to the individual baby.

Comfort Holding

Comfort holding can also be referred to as hand hugs, cradle holding, containment holding or still touch. It is a developmentally sensitive non-pharmacological comfort measure that can both reduce the stress from procedural pain and calm an unsettled infant[44]
A still resting hand can promote a sense of calm and settle an infant. The infant can recognise where they are being touched and this supports their efforts to regulate themselves.

Recommendations for comfort holding
Infants usually prefer firm still holding as it makes them feel secure
If infant is not able to tolerate a hand hug, offer a finger to grasp.
Hand hug – rest one hand on the head and one on
A beanbag positioning aid (for example Zaky hug, Bertie or Freddy frog) may be used to provide some still touch when parent is not present. Follow your unit guidelines for use
Encourage parent to wear the positioning comfort aid inside their top prior to using with the infant so that it takes on their scent.

picture of comfort holding

picture of finger hold

Facilitated Tucking
Facilitated tucking is when the infant is supported with containment of the infant's arms and legs in a flexed, midline position close to the trunk[44]. It can be used to provide comfort for many different procedures for example, lumbar puncture, suction, heel prick etc.

Facilitated tucking has been proven to decrease pain scores in infants needing medical interventions such as blood sampling, NGT insertions, venflon / cannulation insertion and cares[44]

Recommendations for facilitated tucking
Facilitated tucking should be provided for a few minutes before and after the procedure[44].
It should also provide containment and comfort to the infant throughout the duration of the procedure.

A figure 8 sheet may be used for lumbar puncture: The baby is wrapped in a sheet or muslin, using a figure of 8 and held still throughout the lumbar puncture. The baby should be more comforted by the security of the wrapped figure of 8*. Neonatal staff should seek support or training to support them to implement this.

***Example of facilitated tucking for lumbar puncture using figure 8 sheet.**

Facilitated tucking using hands

Positive oral experiences

Refer to the EoE oral feeding guideline

Infant Massage

Infant massage has been used in neonatal intensive care units with benefit for various positive outcomes such as weight gain, reduced length of stay at hospital and postnatal complications. It has been shown to have positive benefits for both the infant and the parent[50].

Refer to EoE Infant Massage guideline

Benchmarking

1. Positioning audit should be completed 3 times a year using a recognised positioning audit tool for example the IPAT (Appendix 1)
2. Have you shared results of your positioning audit with the unit?
3. 100% infants are positioned in a good position (for example using IPAT in midline, flexed & contained position with an IPAT score of 10-12)

References:		
Acknowledgements to:		NWNODN Positioning & Handling Guideline
		Yorkshire and Humber Neonatal ODN Infant and Family Centred Care & positioning and handling guidelines
		EMODN positioning and handling guideline
		EoE Neonatal ODN Developmental Guideline Working Party.
1	Altimier, L & Phillips, R (2016)	The Neonatal Integrative Developmental Care Model: Advanced Clinical Applications of the Seven Core Measures for Neuroprotective Family-Centered Developmental Care. Newborn and Infant Nursing Reviews 16, 230-244. (PDF) The Neonatal Integrative Developmental Care Model: Advanced Clinical Applications of the Seven Core Measures for Neuroprotective Family-Centered Developmental Care
2	Hunter, J. (2010)	Therapeutic positioning: neuro-motor development and beyond. In C. Kenner & J. M. McGrath (Eds.), Developmental care of newborns & infants: A guide for healthcare professionals (2nd ed., pp. 285-312). National Association of Neonatal Nurses
3	European Standards of care for newborn health	Infant & Family Centered Developmental Care Infant- & family-centred developmental care - ESCNH - European Standards of Care for Newborn Health
4	Griffiths N, Spence K, Loughran-Fowlds A et al. (2019)	Individualised developmental care for babies and parents in the NICU: Evidence-based best practice guideline recommendations. Early Hum Dev 2019;139:104840
5	Warren I & Bond C (2010)	A Guide to Infant Development in the Newborn Nursery (5th Edition) Winnacott Infant Unit.
6	Michael H. Goodstein, et al (2021)	COMMITTEE ON FETUS AND NEWBORN, TASK FORCE ON SUDDEN INFANT DEATH SYNDROME, Transition to a Safe Home Sleep Environment for the NICU Patient. *Pediatrics* July 2021; 148 (1): e2021052046. 10.1542/peds.2021-052046

7	Lullaby trust (2025)	www.lullabytrust.org.uk Safer sleep overview | The Lullaby Trust
8	Sweeney, J, et al (2010)	Neonatal Physical Therapy. Part II: Practice Frameworks and Evidence-Based Practice Guidelines. *Pediatric physical therapy* Vol 22 page 2-16
9	Prescott MG et al. (2024)	Infant positioning for promoting development and preventing morbidity in preterm infants. Cochrane Database Syst Rev. (2024) 5;12(12): CD016029.pdf
10	Hunter A (2015)	The use of clinical audit in successfully implementing a change of clinical practice in developmental positioning. *Infant Vol:11 issue 5* https://www.infantjournal.co.uk/pdf/inf_065_udi.pdf
11	Vaivre-Douret, L et al. (2004)	Effect of positioning on the incidence of abnormalities of muscle tone in low-risk, preterm infants. *European Journal of Paediatric Neurology*, Volume 8, Issue 1, 21 – 34.
12	Arlene Spilker et al (2016)	The effectiveness of a standardised positioning tool and bedside education on the developmental positioning proficiency of NICU nurses, *Intensive and Critical Care Nursing*, Vol 35, p 10-15.
13	Ewer AK, James ME, Tobin JM. (1999)	Prone and left lateral positioning reduce gastro-oesophageal reflux in preterm infants. Arch dis child fetal neonatal ed. 1999;81(3):F201-5
14	Picheansathian, W et al (2009)	Positioning of preterm infants for optimal physiological development: A systematic review. *JBL Library systematic reviews,* 7 (7), 224-259
15	Hummel, P. and Fortado, D. (2005)	Impacting Infant Head Shapes. Advances in Neonatal Care. Vol. 5(6), pp. 329-340
16	Hough, J., Trojman, A., Schibler, A. (2016).	Effect of time and body position on ventilation in premature infants. Pediatric Research 80(4), 499-504. https://dx.doi.org/10.1038/pr.2016.116
17	Bowden. V. R., Greenberg, C.S. and Donaldson, N.E. (2000)	Developmental Care of the Newborn. Online Journal of Clinical Innovations. Vol. 3(7), pp.1-77 cited in [18]

18	APCP (2020)	Guidance for Good Practice for Physiotherapists working in Neonatal Care Guidance for Good Practice for Physiotherapists Working in Neonatal Care (2020) | Association of Paediatric Chartered Physiotherapists
19	Ferrari, F et al (2007)	Posture and movement in healthy preterm infants in supine position in and outside the nest. Archives of Disease in Childhood; Fetal and Neonatal Edition. Vol. 92, pp. 386-390.
20	Kenner C., and McGrath J.M. (2023)	Developmental Care of Newborns and Infants; A Guide for Health Professionals (3rd Ed) St Louis Elsevier
21	Sweeney, Jane K.; Gutierrez, Teresa (2002)	Musculoskeletal Implications of Preterm Infant Positioning in the NICU. The Journal of Perinatal & Neonatal Nursing 16(1):p 58-70, June 2002.
22	Chinoy A, Mughal MZ, Padidela R. (2019)	Metabolic bone disease of prematurity: causes, recognition, prevention, treatment and long-term consequences. Arch Dis Child Fetal Neonatal Ed;104(5):F560-F566.
23	Symington A, Pinelli J. (2006)	Developmental care for promoting development and preventing morbidity in preterm infants. Cochrane Database Syst Rev. Apr 19;2006(2):CD001814.
24	NWNODN (2023)	NWNODN Positioning & Handling Guideline Positioning-and-Handling-Guideline-2023-Final-1.pdf
25	Coughlin, Mary et al (2010)	Reliability and Effectiveness of an Infant Positioning Assessment Tool to Standardize Developmentally Supportive Positioning Practices in the Neonatal Intensive Care Unit. *Newborn and Infant Nursing Reviews* 10(2):104-106.
26	Adams J (2024)	Yorkshire & Humber Neonatal ODN Supportive positioning guideline
27	Cater H et al (2024)	EMNODN Positioning & Handling Guideline
28	Rivas-Fernandez M, et al (2016)	Infant position in neonates receiving mechanical ventilation. Cochrane Database Syst Rev 7;11 CD003668
29	Sweeney, J et al. (2020)	Infant and Family centred Developmental Care – Recommendations for best practice for positioning and touch. Report of the First

		Consensus Conference on Standards, Competencies and Best Practices for Infant and Family-Centered Developmental Care in the Intensive Care Unit NICU Recommended Standards | University of Notre Dame
30	Hayat TTA et al (2011)	Optimization and initial experience of a multisection balanced steady-state free precession cine sequence for the assessment of fetal behaviour in utero. American Journal of Neuroradiology. 32 (2) 331-338
31	Ferrari F, Bertoncelli N, Gallo C, et al (2007)	Posture and movement in healthy preterm infants in supine position in and outside the nest. Archives of Disease in Childhood - Fetal and Neonatal Edition;92:F386-F390
32	Bond, C (2003)	Positive Touch and massage in the neonatal unit: a British approach. Vol 7 (6) 477-486 Seminars in neonatology.
33	Browne JV, Jaeger CB, Kenner C (2020)	Gravens Consensus Committee on Infant and Family Centered Developmental Care. Executive summary: standards, competencies, and recommended best practices for infant- and family-centered developmental care in the intensive care unit. J Perinatol. 2020 Sep;40(Suppl 1):5-10
34	Romantsik O et al (2017)	Head midline position for preventing the occurrence or extension of germinal matrix-intraventricular haemorrhage in preterm infants. *Cochrane Database of Systemic Reviews.* 7(7):CD01236
35	Skelton H et al (2023)	Systemic Review of the effects of positioning on nonautonomic Outcomes in Preterm Infants. *J Obstet Gynecol Neonatal Nurs*. 2023 Jan;52(1):9-20
36	Merenstein G & Gardner S (2002)	Handbook of Neonatal Intensive Care. 5th Edition. Mosby
37	Weber A & Harrison T, M (2019)	Reducing toxic stress in the NICU and improving outcomes. *Nurs Outlook*; 67(2): 169–189
38	Danner-Bowman, K & Cardin, A (2015)	Core Measure 3: Positioning & Handling – A Look at Preventing Positional Plagiocephaly. *Newborn and Infant Nursing Reviews*; vol 15 (3) p111-113

39	Rohde JF, et al (2021)	Association of Positional Plagiocephaly and Developmental Delay Within a Primary Care Network. *J Dev Behav Pediatr.* 2021 Feb-Mar 01;42(2):128-134. Association of positional plagiocephaly and developmental delay within a primary care network
40	Brooks M & Currie G (2022)	Swaddle Bathing: Improving the experience for preterm infants. *Infant.* 18(4) 148-51
41	Vicente-Perez S, et al. (2023)	Physiological responses and behavioural organization of very low birth weight infants during swaddled versus traditional weighing. *Nurs Open*;10(10):6896-6902
42	Neu M & Browne JV. (1997)	Infant physiologic and behavioral organization during swaddled versus unswaddled weighing. *J Perinatol.* May-Jun;17(3):193-8.
43	Quraishy K et al (2013)	A protocol for swaddled bathing in the neonatal intensive care unit. *Newborn & Infant Nursing reviews.* 13. 48-50
44	Cignacco E et al (2010)	Facilitated tucking as a non-pharmacological intervention for neonatal pain relief: is it clinically feasible? *Acta Paediatr.* Dec;99(12):1763-5
45	Dunsirn, S., Smyser, C., Liao, S., Inder, T., Pineda, R. (2015).	Heading in the Right Direction: Understanding Head Turn Preference in the Premature Infant. American Journal of Occupational Therapy, Vol. 69,
46	All Wrapped up (2023)	Yorkshire & Humber Neonatal ODN. Version 1
47	Rolland Souza AS et al (2019)	The impact of maternal touch of the abdomen on cardiotocography fetal patterns. *Brain Behav.* Aug;9(8)
48	Bergman, N.J.(2014)	The neuroscience of birth – and the case for Zero Separation', Curationis 37(2), Art. #1440, 4 page. http://dx.doi. org/10.4102/curationis. v37i2.1440
49	La Rosa VL et al (2024)	Affective Touch in Preterm Infant Development: Neurobiological Mechanisms and Implications for Child-Caregiver Attachment and Neonatal Care. Children (Basel). 20;11(11):1407.
50	Mrljak R et al (2022)	Effects of Infant Massage: A Systematic Review. Int J Environ Res Public Health. 24;19(11):6378.
51	Prescott MG et al (2024)	Vestibular stimulation for promoting development and preventing morbidity in

		preterm infants. Cochrane Database Syst Rev. 2024 Sep 5;9(9):CD016072. doi: 10.1002/14651858.CD016072. PMID: 39234929; PMCID: PMC11392060.
52	Grunau RE (2013)	Neonatal pain in very preterm infants: long-term effects on brain, neurodevelopment and pain reactivity. Rambam Maimonides Med J. 2013 Oct 29;4(4):e0025. doi: 10.5041/RMMJ.10132. PMID: 24228168; PMCID: PMC3820298
53	Sensory Beginnings (2025)	SEB-The-Power-of-Touch-A5-AW.pdf accessed 21/07/2025

Appendix 1

The Infant Positioning Assessment Tool (IPAT) is a validated and reliable tool used to evaluate the posture of premature infants. A downloadable IPAT audit tool[25] template can be found HERE

Infant Positioning Assessment Tool (IPAT)

Background

Developmentally supportive positioning in premature and critically-ill infants is one of the seven core measures for family-centered developmental care detailed in the Philip's Neonatal Integrative Developmental Care (NIDC) Model.[1,2] (Philips HealthTech, Cambridge, MA). Positioning infants in the NICU is a neuromotor developmental intervention used to minimize positional deformities and to improve muscle tone, postural alignment, movement patterns, and ultimately developmental milestones.[3] Developmentally supportive positioning positively influences physiologic function and stability, sensory development, neurobehavioral organization, skin integrity, thermoregulation, bone density, sleep facilitation, optimal growth, brain development, and neonatal developmental outcomes.[1-5] The core measure 'Positioning & Handling' incorporates the Infant Positioning Assessment Tool (IPAT), which was developed with three goals for use:

1. as a reference and educational tool for teaching,
2. as an evaluation instrument, and
3. as a method of standardizing best positioning practices of premature infants in the neonatal intensive care unit.[4]

Introduction

The IPAT is a validated and reliable easy-to-use pictorial tool used to evaluate posture of premature infants in six areas of the body (head, neck, shoulders, hands, hips/pelvis, and knees/ankles/feet), with cumulative scores ranging from **0 – 12**. A two-point scoring system is used on each area of the body with a score of **2** for ideal therapeutic positioning, **1** for acceptable positioning, and **0** for unacceptable positioning. Any asymmetrical positioning of the arms or legs is scored a **1** (a full score of **2** is never granted). According to the IPAT, a full score of **12** is indicative of ideal positioning, scores of **9** to **11** are acceptable as it accommodates for asymmetry of positioning often needed when technology interfaces (infants with various venous or arterial access needs, drains, surgical sites, etc.) are present, and scores of **8** or lower indicate a need for positioning support that offers containment, promotes flexion and ensures proper body alignment.[4,5,6] Routine utilization of a validated & reliable positioning assessment tool provides appropriate positioning and encourages accountability.

How to use the tool (A, B, Cs)

A) Utilize the IPAT prior to engaging in caregiving interactions to identify infant movements that may benefit from developmentally supportive positioning, as well as ensure that the infant is repositioned appropriately to promote self-regulation, musculoskeletal development, sleep, comfort, sensory system development, and growth. Spontaneous movement is a natural phenomenon for infants; however, in the absence of therapeutic positioning supports, these spontaneous movements may leave the infant 'stranded' in a suboptimal position.

B) Assess and score the infant utilizing the IPAT in each of the six body-part areas.

1. Score a **2** for an ideal therapeutic position
2. Score a **1** for acceptable alternative positioning
   - Score any asymmetrical positioning of the arms or legs
3. Score a **0** for unacceptable positioning.
4. Total the cumulative score.
5. Once this baseline information/IPAT score is assimilated by the clinician, s/he is ready to provide consistent developmentally supportive positioning.

C) Positioning in the NICU simulates the flexed/contained/midline posture of the infant in utero; external supports provide a temporary substitute for the immature infant's diminished internal motor control. Provide premature infants with positioning aids and boundaries to help them maintain optimal tone and position, remain either in a quiet, restful sleep or a relaxed, comfortable wakefulness. Consistency in positioning for the infant can promote strong neuronal connections. Positioning aids provide greater ease-of-use and consistency among caregivers.

References

1. Altimier, L. & Phillips, R. (2016). The Neonatal Integrative Developmental Care Model: Advanced Clinical Applications of the Seven Core Measures for Neuroprotective Family-Centered Developmental Care. *Newborn and Infant Nursing Reviews: NAINR*, 16(4), 230 – 244. http://dx.doi.org/10.1053/j.nainr.2016.09.030
2. Altimier, L. & Phillips, R. (2013). The Neonatal Integrative Developmental Care Model: Seven Neuroprotective Core Measures for Family-Centered Developmental Care. *Newborn and Infant Nursing Reviews: NAINR*, 13(1), 9 – 22. http://dx.doi.org/10.1053/j.nainr.2012.12.002
3. Hunter, J., Lee, A., & Altimier, L. (2015). Neonatal Intensive Care Unit. Occupational Therapy for Children and Adolescents. St. Louis: Elsevier. 2015. p. 595-635.7
4. Coughlin, M., Lohman, MB., & Gibbins, S. (2010). Reliability and effectiveness of an infant positioning assessment tool to standardize developmentally supportive positioning practices in the neonatal intensive care unit. *Newborn and Infant Nursing Reviews: NAINR.*, 10(2), 104–106.
5. Jevanson, E. (2013). One-to-One Bedside Nurse Education as a Means to Improve Positioning Consistency. *Newborn and Infant Nursing Reviews: NAINR*, 13(1), 27-30. http://dx.doi.org/10.1053/j.nainr.2012.12.004
6. Spilker, A. & Hill, C. (2016). The effectiveness of a standardized positioning tool and bedside education on the developmental positioning proficiency of NICU nurses. *Intensive and Critical Care Nursing*., 35, 10-5. http://dx.doi.org/10.1016/j.iccn.2016.01.004
7. Altimier, L. & Phillips, R. (2018). Neuroprotective Care of Extremely Preterm Infants in the First 72 Hours after Birth. *Critical Care Nursing Clinics of North America*. doi:10.1016/j.cnc.2018.07.010
8. Liu, W., Laudert, S., Perkins, B., MacMillan-York, E., Martin, S, Graviens, S. (2007). The development of potentially better practices to support the neurodevelopment of infants in the NICU. *Journal of Perinatology*. 2007;27(Suppl): S48-S74.
9. Lockridge, T. (2007). Neonatal Neuroprotection: Bringing Best Practice to the Bedside in the NICU. *MCN, the American journal of maternal child nursing*.

Appendix 1 continued

IPAT Tool Page 2

Infant Positioning Assessment Tool (IPAT)

Patient's name: _____ Birth gestational age/corrected gestational age: _____

Clinician's name: _____ Date/time of assessment: _____

Infant position: ☐ Supine ☐ Side-lying ☐ Prone

Indicator	0	1	2	Score
Head	 Head rotated laterally (L or R) > 45° from midline	 Head rotated laterally (L or R) 30 - 45° from midline	 Head aligned (L or R) 0 - 30° from midline	
Neck	 Neck in hyperextension or hyperflexion	 Neck neutral	 Neck neutral, aligned, head slightly flexed forward 10°	
Shoulders	 Shoulders retracted	 Shoulders aligned, flat to surface	 Shoulders rounded forward towards midline	
Hands	 Hands away from body	 Hands touching torso	 Hands touching face	
Hips/pelvis	 Hips/pelvis abducted, externally rotated	 Hips/pelvis aligned but extended	 Hips/pelvis aligned and softly flexed	
Knees/ ankles/feet	 Knees extended, ankles and feet externally rotated	 Knees, ankles, feet aligned but extended	 Knees, ankles, feet aligned and softly flexed	
12 = ideal cumulative score. 9 – 11 = acceptable cumulative score. ≤ 8 = need for repositioning.			Total cumulative score	

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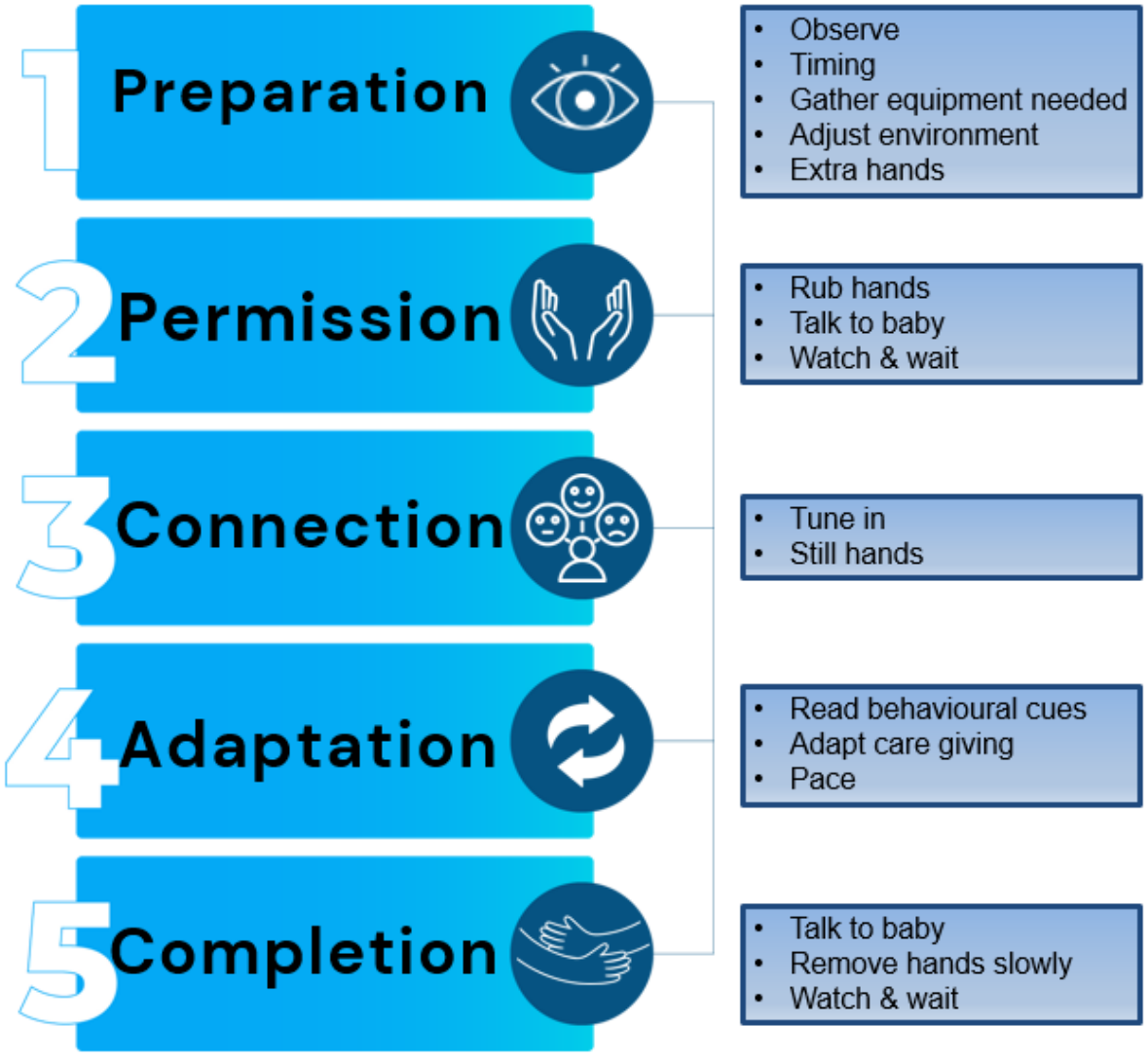
Appendix 2

- Principles are observe first, talk, touch then move
- Video on 5 step dialogue can be viewed HERE



Appendix 3

Useful Resources

	Credit	
How to make a nest	produced by West Midlands Children's Network	
How to make a nest	Produced by NeoSims	Tips for Making a Nest
Position changes within a boundary		Positioning on Vimeo

Appendix 4 Positioning Equipment you may find on the Neonatal Unit.

Please note this list has been produced to save time when researching positioning products, it is not an exclusive list of suppliers and you must consult manufacturers guidelines and your own infection control processes prior to use. The EoE neonatal ODN do not specifically endorse any of these products. This information is for you to arrange a demonstration of products if required and select those appropriate for your unit.

Recommendations if using positioning equipment
Consult your unit therapists for support with positioning equipment
All staff will require training with using any positioning equipment, please liase with your unit therapists to support with this.
Please make sure that the size of the equipment is appropriate for the size of the infant.
Humidity and temperature may need monitoring more closely when using positioning equipment.
Positioning equipment is only for hospital use.
Positioning equipment should only be used with infants that are monitored.

Positioning Equipment you may find on the Neonatal Unit.		
ITEM CATEGORY	**Company Name / Website**	**Product(s)**
Head Positioners May be used to promote head moulding, midline position support	Dandlelion Medical Home - Dandle•LION Medical And also Pressure Care Management Ltd www.pressurecaremanagement.co.uk	 Fluidised positioner *This can also be used as a prone positioner*
	Delta Medical International Developmental Care | DeltaNeo Range | Delta Medical	Gel Supports 
	Dandlelion Medical Home - Dandle•LION Medical	 Gel positioner

Nests	Cuski www.cuski.com	 Claire's clinical nest non-collapsible
	Dandlelion Medical Home - Dandle•LION Medical	 Flo form/fluidised positioners positioners
	Pressurecare management	Fluidised positioner
	Dandlelion Medical Home - Dandle•LION Medical	 Dandle Roo2
	Sleep Angel Products - SleepAngel Medical Bedding with a Filter	 Neonatal positioners
Boundary		
	Hospital sheets and towels can make an adequate nest. It is preferable to fold towels rather than to roll	For information on how to make a nest insert link
	Dandlelion Medical Home - Dandle•LION Medical	 Cozy cub

	Inspiration Healthcare Bendy Bumper - Inspiration Healthcare	 Bendy Bumper
	Delta Medical International Developmental Care | DeltaNeo Range | Delta Medical	 Positioning Boundary
	Cuski www.cuski.com	 Bertie positioning aid
Prone Positioner	Dandlelion Medical Home - Dandle•LION Medical	 Dandy Prone Pad
	Conceptnatal Positioning conceptnatal - Prone positioning cushion	 Birdy Prone positioner cushion
	Inspiration Healthcare Prone Plus - Inspiration Healthcare	 Prone Plus

Positioning Bundle	Repton Medical Support & Positioning. Repton Medical	 Snuggle up positioning aid
Other Aids	The Zaky The Zaky HUG® – The Zaky - Official Website and Store	 The Zaky Hug®
	Inspiration Healthcare Frederick T Frog - Inspiration Healthcare	 Frederick T Frog
	Delta Medical International Developmental Care | DeltaNeo Range | Delta Medical	 Positioning Butterfly
Wraps / Swaddles	Cuski www.cuski.com	 Neonatal cuddle wrap

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