

Royal College of Occupational Therapists – Written evidence (PRT0067)

Occupational Therapy Neonatal Services

The Royal College of Occupational Therapists, Specialist Section for Children, Young People and Families, Neonatal Forum are pleased to have the opportunity to submit evidence to the House of Lords Preterm Birth Committee. The information contained in this submission primarily relates to the provision of neonatal and longer-term care and support.

Introduction:

Historically, neonatal care has been focussed on increasing survival rates of preterm and medically fragile infants. More infants are now surviving due to advances in medical care, but levels of disability remain high. The aim has shifted to a focus on the provision of care that achieves high quality outcomes. It is acknowledged that outcomes focussed around quality of life and functional abilities cannot be achieved by medical and nursing intervention alone. Known increased risks of language and cognition difficulties, attention and hyperactivity disorders, motor difficulties and mental health problems highlight the need for ultra-early intervention.

The Neonatal Intensive Care Services Review Group¹ found that as the effectiveness of neonatal care has become apparent, due to a number of factors such as increasing technical advancements, demand for this highly specialist care has grown. Intensive care is now offered to infants of significantly lower gestational age and birth-weight. Indeed, research has shown a 14% improvement in the survival rates of those born at 25-31 weeks' gestation from 1997 to 2011².

Neonatal occupational therapy has also commensurately evolved during this time to provide sensitive, individualised and family-centred

developmental interventions to support this increasingly complex clinical group. Linked with occupational therapy interventions in the days, weeks and months following preterm or high-risk term delivery, it is the presentation of these infants with subsequent developmental concerns which provides a strong impetus for occupational therapy prevention and early intervention.

A further emerging element that is relevant to neonatal occupational therapy is the impact of parental factors and subsequent involvement in child development. Developmentally supportive care interventions provided by occupational therapists in neonatal units, and early intervention/prevention models used in follow up, are embedded within a family-centred care approach. Understanding parental mental health outcomes following preterm birth is important due to the potentially negative effects on a child's health and development. Associated concerns relate to parental impairment in ability to recognise/respond to infant cues that have been shown to demonstrate an impact on development of synchronicity in interaction, the provision of fewer learning opportunities, an increase in child behaviour/emotional regulation issues, and an impact on language and cognitive development^{3,4}.

Occupational therapy is centred on promoting health and wellbeing through enabling engagement and participation in everyday occupations. It uses a framework which focuses on the relationship between the person, their environment and the occupations that they need or would like to do. Occupational therapists bring to the multidisciplinary neonatal team knowledge of infant neurobehavioural and neuromotor development and an understanding of the impact of the physical/sensory/psychosocial environment on infant development and family-centred care. When working with high-risk infants, occupational therapists promote optimal development of the child and work with families to support them to engage and participate in their role as parents/carers.

Neonatal occupational therapists have a lead role in working with the neonatal multidisciplinary team to promote a neuro-protective developmental care environment. Occupational Therapists provide therapeutic interventions to support infant occupations such as supporting both infants and parents in the provision of non-pharmacological pain management during painful and stressful caregiving procedures, positioning for optimal neurobehavioural regulation, enabling protected sleep, modulating the infant's individual environment to ensure that sensory input is aligned with developmental maturation, supportive regulation for positive feeding experiences, and provide specialist equipment where necessary. As the infant is discharged from the unit and grows older, ongoing intervention and/or guidance provide continued opportunities to support the development of infant occupations around self-care, learning and play. Through educating parents on strategies to support and engage their infant with appropriate sensory and motor experiences, occupational therapists can provide building blocks for developmental progression and parent–infant interaction.

Parents may also experience challenges with psychological adjustment and mental health issues which adversely affect parenting efficacy. Occupational Therapists facilitate support for neonates and their parents to develop successful psychological and practical coping strategies. Parent occupations are jointly identified which reflect the ongoing care needs e.g. containment holding, positive touch, skin to skin care, providing maternal scent and non-pharmacological pain management support. Psychosocial interventions are provided to parents to assist their adaptation to parenting their baby in an unanticipated environment and increase their self-efficacy. A focus is also provided on enabling parents to feel confident and competent in reading their infant's neurobehavioural cues and equipped with sensitive and contingent strategies to support their infant's development and regulation post discharge home.

In the UK, occupational therapists provide services to high-risk infants

across a range of neonatal services, including medical and surgical neonatal units (levels 1–3), transitional care units, maternity units, paediatric intensive care units (PICUs), paediatric cardiac intensive care units, acute paediatric inpatient wards and within early intervention services in the community.

The breadth of practice and degree of specialised care required in the neonatal unit require the occupational therapist to demonstrate advanced knowledge and skills in neonatal care to provide complex interventions to critically ill neonates and their families⁵. These include knowledge of emerging competencies in infant occupation, child development and medical knowledge, family- centred practice and developmental approaches⁵.

Royal College of Occupational Therapists Practice Guideline

In 2022 the second edition of the '*Occupational Therapy in Neonatal Services and Early Intervention Practice Guideline*' was published by the Royal College of Occupational Therapists⁶. This NICE and Royal College of Paediatrics and Child Health accredited evidence-based guideline aims to provide specific recommendations which describe the most appropriate care or action to be taken by occupational therapists working in neonatal services or early intervention. The recommendations aim to support the clinical reasoning of occupational therapists in regard to:

- Providing and promoting individualised care of high-risk infants and supporting their engagement with relevant occupations (e.g. sleeping, feeding, exploring).
- Working with individual families to negotiate their meaning of parenting and parent– infant co-occupations.
- Providing sensitive opportunities for parenting occupations to create more ordinary and positive experiences for parents and their infants within the neonatal unit.

The second edition of the guideline has provided 35 recommendations for clinical practice across 11 key domains of practice. These practice domains highlight the breadth and speciality of occupational therapy services for infants and parents in the neonatal unit and early intervention settings:

1. Occupation-based assessment
2. Developmentally supportive care
3. Pain management
4. Skin to skin (kangaroo) care
5. Touch
6. Postural Support
7. Infant feeding
8. Parent engagement
9. Parent support
10. Identifying developmental concerns
11. Early intervention

The specific recommendations are provided in the appendix to this document; the full guideline can be viewed at: <https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/neonatal-services>

Current contextual issues related to provision of neonatal occupational therapy services

1. Tensions for current workforce provision

NHS England commissioned the Neonatal Critical Care Review (NCCR)⁷ in 2018-19 to address the issues highlighted in the national maternity review and the Five Year Forward View for maternity care⁸. The RCOT Specialist Section for Children, Young People and Families, (Neonatal Forum) were involved in this project, which included the development of Occupational Therapy Staffing Recommendations for Neonatal Units which contributed evidence to the review⁹. Subsequently, the publications of the

British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK identifies that occupational therapy also has a key role in the delivery of neuro-developmental follow up and early intervention services to support the development of infant occupations around self-care, learning and play, and provides staffing specification standards¹⁰.

Historically, workforce funding to meet these staffing standards has been chronically insufficient. This meant that in many units no occupational therapy services were available. The implementation of the funding driven by the publication of the Ockenden Report in 2022/3 has resulted in a significant uplift in the number of occupational therapy posts in England. While the large majority of neonatal units across England now have access to at least part-time occupational therapy service provision, it does not yet meet the full complement identified in the BAPM standards in most instances. Equally, similar funding has been limited in Scotland, Wales or Northern Ireland with a result in significant gaps in occupational therapy provision remaining.

While RCOT has welcomed this investment in the neonatal occupational therapy workforce to better service infants and their families, this has resulted in a significant tension with recruitment and establishment of clinical staff in posts. Many posts have been filled by occupational therapists with robust experience in working with children in a range of settings, but no prior experience in the delivery of acute neonatal services. This has put a significant and ongoing demand on the Neonatal Network occupational therapy leads, and the Neonatal Forum members to provide a structured and cohesive approach to upskill these therapists to ensure the delivery of safe and effective practice.

2. Lack of a joined up approach with community early intervention services

While the NCCR and the Ockenden funding has enabled more consistent delivery of neonatal occupational therapy services while infant's are

admitted to a neonatal unit, there is a significant paucity of community based occupational therapy services who will accept referral of these infants on their discharge from hospital. As outlined previously, these infants can often present with a range of neurodevelopmental concerns that may have a significant impact on their participation in and performance of early play, social and school occupations. Early supportive gains supported and enabled to promote neurodevelopment can be lost without ongoing early intervention. This is further compounded by the loss for parents of ongoing access to specialist services that focus on optimising their infant's developmental outcome.

The reason for this lack of continuity appears to be two-fold. Firstly, it is as a basis of resource availability. Local services may acknowledge the relevance of an early referral to community occupational therapy for a high-risk infant following discharge from a neonatal unit but may not have capacity to accept the referral.

However, more concerningly is situations where a referral is attempted to be made and is rejected by a community service as a result of a lack of recognition of the ongoing needs of preterm and high-risk infants post-discharge from the neonatal unit. There can be a presumption that only the infants with the most significant co-morbidities (e.g. brain haemorrhage) warrant ongoing early intervention. This fails to encapsulate the range of potential adverse neurodevelopmental outcomes that may impact on infants born prematurely. For example:

- Extremely preterm infants (22–26 weeks gestation): serious cognitive impairment impacting on 40 per cent of ex-preterm infants in comparison with 1.3 per cent of controls; identification of cerebral palsy in 17 per cent of ex-preterm infants; impairments in motor planning, visuo-spatial, sensorimotor and attention functions^{11,12}.
- Very preterm infants (born before 33 weeks gestation): 32 per cent had a moderate cognitive impairment and 12 per cent had a severe cognitive impairment; overall disability (a variable composed of

neuromotor and neurosensory impairment) was identified as severe in 5 per cent of children, moderate in 9 per cent of children and mild in 25 per cent of children; parents of ex-preterm infants were twice as likely to report behavioural issues in their children compared with full-term controls in relation to increased activity/inattention, increased emotional lability and issues with peer relationships ^{13,14}.

- Moderate to late preterm infants (32–36 weeks gestation): increased incidence of autism spectrum disorders, neurosensory impairment, cognitive impairment and delayed social-emotional competence ^{15,16}.

Further, infants born at term who experience complications, such as post-asphyxia hypoxic ischaemic neonatal encephalopathy, also require ongoing developmental support and monitoring.

In both instances, this lack of a defined referral pathway for ex-preterm and high-risk infants into community early intervention services, can mean that a child may need to wait until they present with specific neurodevelopmental deficit (sensory, cognitive, motor, or social-emotional difficulties) at nursery school age, before they can access community children's occupational therapy services. This inevitably means that the key window of neuroplasticity to promote optimal neurodevelopmental outcomes is lost (up until 24 months of age), with a subsequent impact on their child, their family and their life-long participation and performance in meaningful daily occupations. As all early intervention services across the UK differ it creates inequity for families needing to access these services.

Summary

Neonatal Occupational Therapists provide specialist services to infants and their families on all levels of neonatal units and in other acute healthcare settings supporting infants' neurodevelopment and enhancing parenting confidence in caring for their infant and are an important member of the

multidisciplinary team. There has been considerable investment in neonatal OT services in England in the past 18 months, however, neonatal Occupational Therapists continue to be the least represented of the Allied Health Professions leading to inequity of access for infants and families. An area of ongoing concern for the Royal College of Occupational Therapists Neonatal OT Forum is the lack of joined up early intervention services for infants discharged from neonatal care. A high level of support is provided through the forum to all members to ensure a high standard of therapy is provided and reduce the inequity of access to services by working closely with the Operational Delivery Networks.

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APPENDIX: Recommendations from Practice Guideline

Guideline recommendations and evidence overview

The guideline recommendations are presented in eleven categories that loosely represent the stages of an infant’s journey through a neonatal admission and beyond.

The evidence from 138 studies used to develop the recommendations is summarised in the guideline document (Section 5), and in evidence tables (Practice guideline supplement). A total of 33% of the evidence from which the recommendations were developed was assessed as being high (Grade A), with 20% as moderate (Grade B) quality studies. A further 38% of the evidence was graded as low (C) and 9% as very low (D) quality. The overall grade of a recommendation is depicted in the guideline with a numerical, then alphabetical grade to reflect the strength of the recommendation and quality of the evidence (e.g. 1A – strong recommendation, high quality). Thirty-three of the 35 recommendations are graded as strong.

Occupation-based assessment

<p>1. It is recommended that occupational therapists safely and appropriately assess the neurobehavioural status of the high-risk infant, in order to plan/deliver developmentally supportive care.</p> <p>(Als et al 2003 [A]; Pineda et al 2020 [B]; El-Dib et al 2011 [C]; Allinson et al 2017 [D])</p> <p>[New evidence 2022]</p>	1A
<p>2. It is recommended that occupational therapists assess neurobehavioural and neurodevelopmental status to provide guidance and identify infants appropriate for developmental follow up following discharge.</p> <p>(Craciunoiu and Holsti et al 2017 [A]; Bartlett 2003 [C]; Sucharew et al 2012 [C]; Crowle et al 2015 [D]; Liu et al 2010 [D])</p> <p>[New evidence 2022]</p>	1A
<p>3. It is recommended that occupational therapists liaise with community teams and assess neurodevelopmental status for high-risk infants in the first two years of life to provide guidance and implement early intervention services where indicated.</p> <p>(Liu et al 2010 [D])</p>	1D

Developmentally supportive care

<p>4. It is recommended that developmentally supportive care principles are implemented for high-risk infants admitted to neonatal units to enhance short term health and developmental outcomes.</p> <p>(Als et al 2003 [A]; McAnulty et al 2009 [A]; Symington and Pinelli 2006 [A]; Legendre et al 2011 [B]; McAnulty et al 2010 [B]; Oostlander et al 2019 [B]; Soleimani et al 2020 [B]; Wallin and</p>	1 A
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<p>Eriksson 2009 [B])</p> <p>[New evidence 2022]</p>	
<p>1. It is recommended that occupational therapists promote an appropriate developmental environment, based on the infant's age and status and individual needs.</p> <p>(Pineda et al 2017 [A]; Symington and Pinelli 2006 [A]; Symington and Pinelli 2002 [A]; McAnulty et al 2010 [B])</p> <p>[New evidence 2022]</p>	1A

Pain management

<p>6. It is recommended that occupational therapists promote the use of non-pharmacological pain management strategies (e.g. skin-to-skin care, facilitated tucking etc) by all caregivers (parents and practitioners) for pain management during appropriate, planned, painful caregiving procedures.</p> <p>(Axelin et al 2006 [A]; Ferber and Makhoul 2008 [A]; Zargham-Boroujeni et al 2017 [A]; Johnston et al 2011 [A]; Hatfield et al 2019 [B]; Obeidat et al 2009 [B]; Cong et al 2012 [B]; Kostandy et al 2008 [C])</p> <p>[New recommendation 2022]</p>	1A
<p>7. It is recommended that occupational therapists support parent understanding and engagement in appropriate pain management strategies to enable them to provide sensitive support to their infants and promote parent self-efficacy.</p> <p>(Axelin et al (2006) [A]; Franck et al 2011 [A]; Franck et al 2012 [C]; Richardson et al 2020 [C])</p> <p>[New evidence 2022]</p>	1A

<p>8. It is recommended that occupational therapists work with the neonatal team to promote routine assessment of neonatal pain and identification of appropriate pain management strategies.</p> <p>(Gibbins et al 2015 [C]; Orovec et al 2019 [C])</p> <p>[New evidence 2022]</p>	1C
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Skin-to-skin (kangaroo) care

<p>9. It is recommended that occupational therapists collaborate with the neonatal team to facilitate parent engagement in skin-to-skin care for high-risk infants to promote pain management, physiological regulation and infant weight gain.</p> <p>(Luddington-Hoe et al 2004 [A]; Vittner et al 2018 [A]; Cunningham et al 2017 [A]; Boo and Jamli 2007 [A]; Cong et al 2019 [A]; Cho et al 2016 [B]; Head 2014 [B]; Bloch-Salisbury et al 2014 [C]; Carbasse et al 2013 [C]; Kostandy et al 2008 [C])</p> <p>[Amended statement and new evidence 2022]</p>	1A
<p>10. It is recommended that occupational therapists collaborate with the neonatal team to facilitate parent engagement in skin-to-skin care for high-risk infants to promote breastmilk feeding, parent wellbeing and parent self-efficacy.</p> <p>(Morelius et al 2015 [A]; Vittner et al 2018 [A]; Mu et al 2020 [A]; Gathwala et al 2008 [A]; Hake-Brooks and Anderson 2008 [A]; Cho et al 2016 [B]; Vittner et al 2019 [B]; Blomqvist et al 2013 [C])</p> <p>[Amended statement and new evidence 2022]</p>	1A

Touch

<p>11. It is recommended that occupational therapists facilitate the provision of positive touch and infant massage* by parents/primary caregivers to decrease infant stress and improve state and physiological regulation.</p> <p>(Asadollahi et al 2016 [B]; Baniasadi and Hosseini et al 2019 [C]; Kim et al 2017 [C]; Elsagh et al 2019 [D])</p> <p>[New recommendation 2022]</p>	1B
<p>12. It is recommended that occupational therapists facilitate the provision of positive touch and infant massage* by parents to decrease parent anxiety and promote parent mood and parent-infant relationship.</p> <p>(Shogi et al 2018 [B]; Lotfalipour et al 2019 [C]; Afand et al 2016 [C]; Kim et al 2017 [C])</p> <p>[New recommendation 2022]</p> <p>* NB: Please see information in section 5.5.1 of the full guideline regarding the requirement for specialist training/certification to facilitate parent-delivered infant massage with high-risk infants in the neonatal unit setting.</p>	1B

Postural Support

<p>13. It is recommended that occupational therapists collaborate with the neonatal team to facilitate individualised postural support recommendations for infants that promote infant motor outcomes, self-regulatory behaviours and prevent respiratory compromise.</p> <p>(Lai et al 2016 [A]; Santos et al 2017 [B]; Kochan et al 2018 [B]; Gouna et al 2013 [C]; Grenier et al 2003 [C]; Liaw et al 2012 [C]; Nakano et al 2010 [C])</p>	1C
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<p>[Statement amended and new evidence 2022]</p>	
<p>14. It is recommended that occupational therapists review the selection and use of neonatal postural support aids for their ability to promote infant motor outcomes, the development of infant postural control and self-regulatory behaviours.</p> <p>(Madlinger-Lewis et al 2015 [B]; Zarem et al 2013 [C])</p> <p>[Statement amended 2022]</p>	<p>1B</p>
<p>15. It is recommended that occupational therapists use a postural support assessment tool to support the education of the neonatal team and promote individualised positioning of high-risk infants in the neonatal unit.</p> <p>(Coughlin et al 2010 [D])</p> <p>[Statement amended 2022]</p>	<p>1D</p>

Infant feeding

<p>16. It is recommended that occupational therapists collaborate with the neonatal team to support parents in reading and responding to infant feeding readiness cues to promote the co-occupation of feeding in the neonatal unit and following transition to home.</p> <p>(Ross and Browne 2013 [B]; Brown and Pridham 2007 [C]; Caretto et al 2000 [C]; Mitha et al 2019 [C]; Maguire et al 2018 [C]; Swift and Scholten 2010 [C]; Ward et al 2000 [C]; Chrupcala et al 2015 [D]; Waitzman et al 2014 [D])</p>	<p>1C</p>
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[New evidence and statement amended 2022]	
<p>17. It is recommended that occupational therapists promote an appropriate environment in the neonatal unit to support parent/infant participation in early feeding experiences. Environmental support factors may include space, seating, privacy, sensory environment and NICU culture.</p> <p>(Flacking and Dykes 2013 [C]; Pickler et al 2013 [C])</p>	1C

Parent engagement

<p>18. It is recommended that occupational therapists work with parents of high-risk infants to support parenting roles and relationships, and to provide sensitive and appropriate parent engagement in the infant’s care in the neonatal unit.</p> <p>(Ding et al 2017 [A], Gibbs et al 2015 [A]; O’Brien et al 2018 [A]; Backe et al 2020 [C]; Dudek-Shriber 2004 [C]; Gibbs et al 2016 [C]; Pineda et al 2018 [C]; Gustafson et al 2018 [C]; Ganadaki and Magill-Evans 2003 [D]; Price and Miner 2009 [D]; Skene et al 2019 [D])</p> <p>[New evidence 2022]</p>	1A
<p>19. It is recommended that occupational therapists facilitate the development of co-occupations related to activities of daily living (including, but not limited to, feeding, bathing, nappy changing, dressing and play activities of daily living) with preterm and low-birthweight infants to ensure sensitive and appropriate caregiving and promote occupational performance of infants and parents.</p>	1C

<p>(Chiarello et al 2006 [C]; Kadlec et al 2005 [C]; Winston 2015 [D]) [Statement amended 2022]</p>	
<p>20. It is recommended that occupational therapists working with families of high-risk infants build a positive therapeutic collaboration with parents to enhance parental learning about their infant both during and following the transition to home.</p> <p>(Aydon et al 2018 [B]; Fucile et al 2020 [C]; Harrison et al 2007 [C]; Ingram et al 2016 [C]) [New evidence 2022]</p>	1B
<p>21. It is suggested that occupational therapists explore both traditional and innovative methods (e.g. video-conferencing) of supporting families post-discharge from the neonatal unit as a means of promoting parent confidence and competence in caring for their infant following the transition to home.</p> <p>(Gund et al 2013 [C])</p>	2C

Parent support

<p>22. It is recommended that occupational therapists support engagement in parenting occupations in the neonatal unit and following discharge (including, but not limited to, reading infant cues, guided participation in care, skin-to-skin, positive touch and holding) to promote decreased parent stress and positive improvements in parent–infant relationship and self-efficacy.</p> <p>(Evans et al 2014 [A]; Månsson et al 2019 [A]; Matricardi et al 2013 [B]; Melnyk et al 2006 [A]; Milgrom et al 2019 [A]; O’Brien et al 2018 [A]; Thomson et al 2020 [A]; White-Traut et al 2013 [A]; Zelkowitz et al 2011 [A]; Backe et al 2020 [C]; Nassaf et al 2020 [C]; Suarez et al 2018 [C])</p>	1A
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<p>[New evidence 2022]</p>	
<p>23. It is recommended that occupational therapists employ parent-focused interventions that incorporate parental attunement in order to reduce the psychosocial impact of delivering a high-risk infant, foster sensitive nurturing behaviour and promote the cognitive development of preterm infants.</p> <p>(Als et al 2003 [A]; Benzies et al 2013 [A]; Melnyk et al 2001 [A]; Nordhov et al 2010 [A]; Askary Kachoosangy et al 2020 [B]; Kraljevic and Warnock 2013 [B])</p> <p>[New evidence 2022]</p>	<p>1A</p>
<p>24. It is suggested that occupational therapists engage parents in brief activity-based interventions during their infant’s admission to the neonatal unit and that this can have a short-term effect in lowering parent anxiety.</p> <p>(Dur et al 2018 [B]; Mouradian et al 2013 [C])</p> <p>[New evidence 2022]</p>	<p>2B</p>
<p>25. It is recommended that occupational therapists consider the use of e-health interventions (e.g. web-based platforms, mobile apps, video-conferencing etc) to support parent engagement, particularly when parent presence may be interrupted.</p> <p>(Dol et al 2017 [A])</p> <p>[New recommendation 2022]</p>	<p>1A</p>

<p>26. It is recommended that occupational therapists employ the use of parent-focused psychosocial interventions to decrease parent stress and anxiety and promote parent coping, confidence and early parent-infant relationships.</p> <p>(Kasparian et al 2019 [A]; Gramszlo et al 2019 [B]; Petteys & Adoumie 2018 [B])</p> <p>[New recommendation 2022]</p>	1A
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Identifying developmental concerns

<p>27. It is recommended that occupational therapists should be involved in the screening and assessment of high-risk infants for problems related to cognitive performance and social interaction, to support the development of the infant's occupations, with referral to early intervention services as indicated.</p> <p>(Maitra et al 2014 [A]; Magill-Evans et al 2002 [C]; Pineda et al 2015 [C]; Sajaniemi et al 2001 [C])</p>	1A
<p>28. It is recommended that occupational therapists should be involved in the screening and assessment of high-risk infants for problems related to functional motor skills, to support the development of the infant's occupations, with referral to early intervention services as indicated.</p> <p>(Maitra et al 2014 [A]; Bigsby et al 2011 [B]; Watkins et al 2014 [C]; Fewell and Claussen 2000 [C])</p>	1A
<p>29. It is recommended that occupational therapists should be involved in the screening and assessment of high-risk infants for problems related to sensory processing difficulties, to support the</p>	1A

<p>development of the infant's occupations, with referral for early intervention services as indicated.</p> <p>(Broring et al 2017 [A]; Witt Mitchell et al 2015 [B]; Crozier et al 2016 [C])</p> <p>[New evidence 2022]</p>	
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Early intervention

<p>30. It is recommended that occupational therapists provide early developmental intervention programmes for preterm infants to promote improved cognitive performance through the preschool years.</p> <p>(Orton et al 2009 [A]; Spittle et al 2015 [A]; Spittle et al 2007 [A])</p>	1A
<p>31. It is recommended that occupational therapists provide home-based early intervention programmes for infants born <30 weeks' gestation in the first year of life as this may result in decreasing parent anxiety.</p> <p>(Spencer-Smith et al 2012 [A])</p>	1A
<p>32. It is recommended that occupational therapists facilitate individualised functional motor interventions for high-risk infants and young children to promote engagement in early occupations such as play, exploration and participating in personal care (activities of daily living).</p> <p>(Lekskulchai and Cole 2001 [A]; Hughes et al 2016 [A]; Duncan et al 2020 [B])</p> <p>[New evidence 2022]</p>	1A
<p>33. It is recommended that occupational therapists incorporate home routine/occupation-based approaches in early intervention programmes for children at risk for developmental delay as a</p>	1B

<p>means of promoting occupational performance.</p> <p>(Hwang et al 2013 [B])</p>	
<p>34. It is recommended that occupational therapists be routinely referred preterm infants with the following co-morbidities: septicaemia, extremely low birthweight (ELBW), chronic lung disease, periventricular leukomalacia (PVL) or intraventricular haemorrhage (IVH) (grade III–IV), for early intervention.</p> <p>(Hintz et al 2008 [C])</p>	1C
<p>35. It is recommended that occupational therapists working in early intervention settings with high-risk infants consider key elements when building a therapeutic collaboration with parents – promoting effective collaboration amongst multiagency providers, supporting family social/emotional needs in addition to infant developmental concerns, and consistency of service provision.</p> <p>(Ideishi et al 2010 [D])</p>	1D

27 March 2024