THAMES VALLEY & WESSEX NEONATAL OPERATIONAL DELIVERY NETWORK

Guideline for Co-bedding twins/triplets in the neonatal unit	
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Related documents / References	Badiee Z, Nassiri Z, Armanian A. Co-bedding of twin premature infants: calming effects on pain responses. Pediatric Neonatology. 2014 Aug;55(4):262-8. doi: 10.1016/j.pedneo.2013.11.008. Epub 2014 Mar 30. PMID: 24694748. Brunse A, Peng Y, Li Y, Lykkesfeldt J, Sangild PT. Co-bedding of Preterm Newborn Pigs Reduces Necrotizing Enterocolitis Incidence Independent of Vital Functions and Cortisol Levels. Front Pediatrics. 2021 Apr 1; 9:636638. doi: 10.3389/fped.2021.636638. PMID: 33869114; PMCID: PMC8049114. Campbell-Yeo ML, Johnston CC, Joseph KS, Feeley N, Chambers CT, Barrington KJ, Walker CD. Co-bedding between preterm twins attenuates stress response after heel lance: results of a randomized trial. Clin J Pain. 2014 Jul;30(7):598-604. doi: 10.1097/AJP.0000000000000015. PMID: 24300226. Hayward KM, Johnston CC, Campbell-Yeo ML, Price SL, Houk SL, Whyte RK, White SD, Caddell KE. Effect of co-bedding twins on coregulation, infant state, and twin safety. J Obstetric Gynaecology Neonatal Nursing. 2015 Mar-Apr;44(2):193-202. doi: 10.1111/1552-6909.12557. Epub 2015 Feb 24. PMID: 25712585. Lai NM, Foong SC, Foong WC, Tan K. (2016) Co-bedding in neonatal nursery for promoting growth and neurodevelopment in stable preterm twins. Cochrane Database Systematic Review. Apr 14;4(4)

	Mandana Kashaki1, Mina Salimi2, Somayeh Jafari2, Elahe Norouzi3*, Majid Karoubi4, Nasrin Khalesi5 (2022) The Effect of Co-bedding Premature Multiple-birth Infants on Growth and Physiological Stability: A randomized clinical trial. Journal of Kerman University of Medical Sciences. Vol. 29, No. 5, 2022, 446-451 Mann P, Schmied V, Psaila K, Foster J. (2023) Integrative Review of Co-bedding of Infant Twins. J Obstetric Gynaecology Neonatal Nursing. 2023 Mar;52(2):128-138. doi: 10.1016/j.jogn.2022.12.004. Epub 2023 Jan 23. PMID: 36702163. Salimi, M. Jafari, S. Bordbar, A. Kashaki, M. Saboute, M. (2021) The Effect of Co-Bedding Premature Twin or Multiple Birth Infants on their Growth, Physiological Stability, and Short-Term Prognosis in NICU 2021). Pakistan Journal of Medical and Health Sciences 15(8):2346-2349 Twins and multiples | The Lullaby Trustfleet.
Implications of race, equality & other diversity duties for this document	This guideline must be implemented fairly and without prejudice whether on the grounds of race, gender, sexual orientation or religion. *This guideline has been adopted by kind permission from the North Wales guideline

Version Control

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Co-bedding twins/triplets in the neonatal unit Guideline

Contents

1.0 Aim of Guideline....4
2.0 Scope of Guidelines....4
3.0 Definitions....4
4.0 Guideline Framework....4
5.0 Appendices....8
Appendix 1....9

1.0 Aim of Guideline

To ensure that when appropriate, co-bedding on the neonatal unit is implemented, in a safe manner in line with the current evidence-based practice, particularly Family Integrated Care (FiCare) and Developmental Care.

2.0 Scope of Guidelines

The guideline applies to all neonates who are born in neonatal units and maternity units covered by Thames Valley & Wessex Neonatal ODN. This includes the following hospitals:

Thames Valley		
Trust	Hospital	Designation
Oxford University Hospitals NHS Foundation Trust	- John Radcliffe Hospital, Oxford	NICU
Buckinghamshire Healthcare NHS Trust	- Stoke Mandeville Hospital, Aylesbury	LNU
Frimley Health NHS Foundation Trust	- Wexham Park Hospital, Slough	LNU
Milton Keynes University Hospital NHS Foundation Trust	- Milton Keynes General Hospital	LNU
Royal Berkshire NHS Foundation Trust	- Reading	LNU

Wessex		
Trust	Hospital	Designation
University Hospital Southampton NHS Foundation Trust	- Princess Anne Hospital	NICU
Portsmouth Hospitals University NHS Trust	- Queen Alexandra Hospital	NICU
Dorset County Hospital NHS Foundation Trust	- Dorset County Hospital, Dorchester	SCU
Hampshire Hospitals NHS Foundation Trust	- Basingstoke and North Hampshire Hospital	SCU (Temporary designation)
Hampshire Hospitals NHS Foundation Trust	- Royal Hampshire County Hospital, Winchester	SCU (Temporary designation)
Isle of Wight NHS Trust	- St Mary's Hospital	SCU
University Hospitals Dorset NHS Foundation Trust	- Poole Hospital	LNU
Salisbury NHS Foundation Trust	- Salisbury District Hospital	LNU
University Hospitals Sussex NHS Foundation Trust	- St Richard's Hospital, Chichester	SCU

3.0 Definitions

Co-bedding means twins, triplets or other multiples share the same sleep surface for any sleep period.[1] Co-bedding has been widely accepted practice as part of developmental care in Neonatal Units, a measure aimed at reducing stress in babies and improving neonatal development. There is growing evidence available to support the implementation of the practice of co-bedding in the hospital environment.

4.0 Guideline Framework

Twins, triplets and multiples can be offered co-bedding as soon as they fulfil the criteria. Twins have shared the same intrauterine environment for months and during this time have interacted together. It therefore seems logical after birth, to keep them together where they can continue to interact.

[1] Twinstrust.org / www.lullabytrust.org.uk

Research into co-bedding of twins or multiples is limited and the findings have limitations. Findings, therefore must be evaluated and cannot fully advise current practice in Neonatal Units, however, the published studies indicate that:

- The practice is not associated with differences in increased incidence of infection or increased number of apnoeic, heart rate or oxygen saturation (LaMar 2014: Lai et al 2016; Mann. P, et al. 2023).
- The practice is also associated with benefits such as increased weight gain (Lai et al, 2016, Mann. P, et al. 2023; Kashaki, M. et al. 2022)
- Other benefits may include supporting the interactive development that occurred in utero, increased parent-child attachment, improved parent-nurse communication and decreased hospital stay (Boyd 2001).
- Co-bedding promotes self-regulation and sleep and decreases crying without apparent increased risk (Hayward, K.M. et al. 2015)
- Co-bedded infants had better synchronisation of sleep-wake states (Mann. P, et al. 2023; Hamadneh, S. et al 2016)
- Benefits found for procedural pain relief and recovery after heel lance (heel prick) among co-bedded infants (Mann. P, et al. 2023) (Badiee, Z. et al 2014) (Brunse, A., et al 2021) (Campbell-Yea, M-L. 2014)
- No evidence of harm related to co-bedding twin infants (Mann. P, et al. 2023)
- Co-bedded twins seemed to spend more time in quiet sleep state (Lai, NM. 2012)

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

- Improved weight gain
- Procedural pain relief
- Decreased apnoea rates
- Improved physiological stability and thermoregulation
- Shorter length of hospital stay
- Improved staff and parent satisfaction with care
- Synchronous feed and sleep patterns
- Improved bonding between babies

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

- The risk of medication or treatment errors
- The risk for feeding errors
- The potential for drug errors
- the possibility of medical equipment becoming dislodged or the potential for injuring each other.
- It has been suggested that infants who are co-bedded may maintain higher body temperatures than those that sleep separately: overheating is a known risk factor for sudden infant death syndrome.
- Task of completing cares can be more challenging for parents
- Message being perceived by parents that co-bedding is safe in the home setting

Criteria for co-bedding:

- **ALL** babies must be clinically stable
- Neither baby requires ventilator support. Low flow nasal canula oxygen is acceptable
- Have no invasive monitoring in situ, babies can have a cardio-respiratory and/or pulse oximetry monitoring in situ
- Neither baby requires use of 'hot cot' or humidicribs/incubators for temperature management
- Infection free, no suspected sepsis
- No colonization with MRSA
- Neither baby requires phototherapy
- Separated if one becomes unstable

Babies can have orogastric / nasogastric tube in place.

Before commencing co-bedding:
- Parental preference whether to co-bed their babies is identified and documented in the care plan.
- All siblings to meet the criteria for co-bedding.

Staff:
- Monitors, iv lines and iv pumps, feed lines and syringe pumps should be positioned for each baby so that they are separate from the other babies. For example, on different sides of the cot.
- Choose the position with parents, that each baby will be nursed in, i.e. left/right. If parents know what position the babies were lying in utero, in relation to each other, then they may choose to position the babies in the same relative positions. This is not to be changed again whilst the babies are co-bedded.
- Document preferred positioning in notes.
- Label the head end of the cot with the babies' cot cards in line with each baby.
- Place cot cards on correct side of infant, checking that cot card is also labelled with 'twin1', 'twin2'.
- All equipment and charts should be clearly labelled with the infants first and second name, unit number and twin1 or twin2, for example, monitors, feeding tubes etc.
- Check that each baby is wearing two name bands, always, clearly labelled with the infants first and second name, unit number and Twin1 or Twin.
- Nurse on apnoea monitor as per unit guideline.
- Position babies, so that they can freely reach their own and others sibling's face.
- A spare cot should be instantly available in case the babies need to be separated quickly.
- If co-bedding has not been started shortly after birth due to infants being unstable/sick/too preterm then it may take several hours for them to settle on the first occasion of co-bedding.
- All equipment relating to personal hygiene must be clearly labelled and kept separately. Clean nappies and cotton wool can be shared.
- Ideally one nurse should be allocated to both babies per shift, but a team approach should be maintained.
- At start of shift complete routine safety checks and ensure each baby has two name bands on and they are secure.
- Identify baby's own lines, cables, equipment and monitors, so staff can respond to any changes to baby's condition.
- Complete individual documentation, i.e. each baby should have their own records, **DO NOT** write "see other twin's notes".
- Strict hand washing as per unit guideline to be observed by staff and parents.
- Position babies so that they can freely touch and interact with their sibling. **If being nested the two babies should share one large nest, do not put barriers between the babies.**
- Cover together with the same blanket/ bedding.
- When beginning co-bedding, babies temperature should be monitored 2 hourly, in both infants until stable for 4 hours.
- Position side by side in accordance with positioning guidelines.
- Safe sleep guidelines should be practised, e.g. supine and feet to foot.
- Regular assessment to determine that each baby still meets criteria for co-bedding should be undertaken. If either baby's condition changes so that they no longer fulfil the criteria then separate immediately.

Parents:
- Discussion to take place with parents regarding their plan for sleeping arrangements at home to ensure that there is ample time in preparation for home.

- If parents are not planning on co-bedding the twins at home, cease co-bedding at least 48 hours prior to discharge home

Information for parents on discharge:
If parents choose to co-bed their babies when they go home, they should be made aware of the following:
- Neonatal staff **cannot** advise on co-bedding when the babies are discharged home from the neonatal unit, and the decision to co-bed babies when they go home is their choice.
- Parents should be given the 'Safe Sleep' information/ guide.
- The principles of 'Safe Sleep' guidelines apply to co-bedded babies, as they do for singletons.
- Moses baskets and small cribs are NOT suitable for co-bedding due to the risk of overheating.
- When a baby can roll over, they need to be separated into their own cots.

5.0 Appendices

TT Safer Sleeping factsheet

Neonatal Generic email: england.tv-w-neonatalnetwork@nhs.net
Neonatal Website: *https://neonatalnetworkssoutheast.nhs.uk/*

Appendix 1