INTERMITTENT SKIN-TO-SKIN CARE FOR NEONATES – GRACE CENTRE FOR NEWBORN INTENSIVE CARE

PRACTICE GUIDELINE ©

DOCUMENT SUMMARY/KEY POINTS

- Where possible daily skin-to-skin cuddles are offered to all parents whose infants are in the Grace Centre for Newborn Intensive Care
- The infant must be physiologically stable
- Skin-to-skin cuddles are supported for a minimum of a one hour period to enable the infant to regulate a normal sleep-wake transition
- The first skin-to-skin cuddle is documented in the infants progress notes
- Subsequent skin-to-skin cuddles are documented in the patient's notes including duration and tolerance.

Key Performance Indicator:

1. Every infant will have the opportunity for a skin-to-skin cuddle within the first 24 - 48 hours following admission providing they are physiologically stable and a parent is present
2. All parents are given an information brochure on the benefits of skin-to-skin cuddles either during an antenatal tour of the unit or on admission to the unit following birth

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st April 2023	**Review Period**: 3 years
Team Leader:	Clinical Nurse Consultant	**Area/Dept**: CHW GCNC

Date of Publishing: 14 March 2023 1:57 PM Date of Printing: 14 March 2023

CHANGE SUMMARY

- Amendment to guideline title to 'Intermittent Skin to Skin Care for Neonates-Grace Centre for Newborn Intensive care'
- Information on Single Standing (or cuddle) Transfer added
- Parent and staff information -links

READ ACKNOWLEDGEMENT

- All clinical staff in Grace Centre for Newborn Care (GCNIC) are required to read and acknowledge they understand the contents of this document.

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Background

Skin to skin contact is the process whereby an infant dressed only in a nappy is placed directly onto the bare chest of their mother or father and nursed in a prone, upright and flexed posture for a minimum period of one hour. Intermittent skin to skin care simply means that it is not carried out continuously, a method commonly practiced in modern, Westernised Neonatal intensive Care Units. If a prone position is not possible then a modified hold can be adapted with the infant held on their side positioned skin to skin with the parent/s chest. A cuddle differs to skin to skin contact as the baby and parent remain clothed or wrapped. The parent should be encouraged to hold their infant close to their chest in an upright position (as in skin to skin) This may be offered when the parent is uncomfortable with skin to skin or undressing the infant may disturb their calm state.

Documentation

- The first skin-to-skin cuddle undertaken in Grace Centre for Newborn Intensive Care is documented in the infant's progress notes.
- All subsequent skin-to-skin cuddles are also documented in the infant's progress notes. This documentation enables the targets to be identified and provides opportunities for benchmarking across NSW with other NICUs.

Objectives

Parent

- Helps foster parent/infant bonding and attachment through closeness.
- Reduces parental stress, anxiety and depression which is associated with separation from their infant, and concerns regarding their infants condition
- Provides positive interaction between parent and infant which contributes to maternal/paternal psychological and emotional wellbeing.
- Promotes parental confidence in handling their premature/unwell infant and helps them learn some of their early behavioural cues
- Creates a sense of parental empowerment by involving them in their infant's care.
- Helps promote lactation. Found to increase maternal oxytocin secretion, assisting with maternal relaxation and the 'milk ejection reflex'.

Infant

- Help to regulate infant cardio-respiratory rate as well as maximising oxygenation.
- Promotes temperature stability. With skin to skin contact heat is conducted from the parent to keep the infant warm.
- Reduced incidence of apnoea and bradycardia.
- Reduces number of crying episodes
- To help infant maintain an organised state which enhances a deeper and longer sleep cycle leading to improved neuro-behavioural outcomes.
- Provides an opportunity for the infant to practice early breast feeding skills, through nuzzling and non-nutritive sucking
- Helps colonize the infant with mother's skin bacteria to aid development of their own biome for ongoing immune protection
- Conserves energy and creates an environment to enhance infant growth and development
- Improves infants pain perception prior to and following a painful procedure
- Provides sensory stimulation and connection with parent through, touch, smell, taste, hearing and visual stimuli
- Is associated with improved breast feeding rates and shorter lengths of stay in hospital

Criteria

- Infant must be physiologically stable. This means they must be, able to rapidly recover baseline observations after handling during a procedure, and should have infrequent episodes of self-limiting bradycardia and apnoea.
- Infants of any weight, gestation, and medical condition can have skin-to-skin as long as they demonstrate physiological stability.
- Infants requiring respiratory support are also eligible for skin to skin contact as long as they are stable.(This includes infants receiving: mechanical ventilation, CPAP, midline CPAP and high flow oxygen therapy)
- If there is any doubt or concern about providing skin to skin contact/cuddles for an infant then refer to and discuss the individual case with the team leader and/or medical/surgical team. Consider if an alternative mode for skin to skin, like 'modified skin to skin care' is more suitable (Refer to page 8 of this document)
- Ascertain the parent/s are aware of the principles and benefits of skin to skin care/cuddles to reduce apprehension and promote this method of care as an ongoing treatment. Ensure they receive the admission booklet when their baby is first admitted.
- Follow infants own cues. The infant should preferably be in a wakeful state when transferred to avoid disruption of their sleep cycle.

Contraindications for Skin to Skin Care

- Unstable condition of the infant, as they are unlikely to tolerate the procedure and it may result in further deterioration.
- Infants in immediate post- operative state requiring ventilation and/or immobilisation (muscle relaxed).
- Infants requiring High Frequency Ventilation(HFV)
- Infants receiving Nitric Oxide therapy
- Infants in traction.
- Infants who have a silo for management of a gastroschisis.
- Presence of External Ventricular Drain (EVD) and Intracranial Pressure Monitoring (ICP)
- If there is any concern regarding the parents level of alertness or cognitive state

The benefits of skin to skin care for preterm and sick neonates are well renown therefore should be promoted where ever possible. This list is a guide only. Please consider the individual needs of each infant before skin to skin care is ruled out. Always check with experienced nursing and medical teams first.

Precautions

- Care MUST be taken with infants with arterial and central lines. All connections need be checked for security before the infant is removed from the cot for skin-to-skin and once the infant is moved into position onto parent/s chest. Continued monitoring of line placement during care should be carried out.
- Infants requiring respiratory support will need at least two (or when possible 3) nursing staff to assist with initialising this care. One nurse will be allocated to support respiratory equipment, one to support the lines and cables, and one to support the infant and secure placement on the parent's chest. Parents can be involved in this process providing they are given clear guidance and support.
- Caution needs to be taken with an infant who has any intravenous lines, intercostal catheters and external drains to ensure dislodgement does not occur during the care process.

Procedure

Parents - preparation

- Ensure parent/s are informed and aware of the principle of skin to skin contact/cuddles.
- Ensure parent can afford sufficient time for care, that is: at least one hour.
- Advise parent to be prepared. May need to use bathroom, express, and have a drink before commencing.
- If parent is not wearing a button up shirt or blouse, offer them a hospital gown to change into (with front open)
- Following a Caesarean Section the mother maybe in a wheelchair. Check her mobility, comfort levels and offer a supportive recliner chair.
- The parent must adhere to strict hand washing prior to handling their infant. Ensure they remove any rings, watches or accessories which may scratch or cause injury. Long sleeves should be rolled up above the elbows. Blankets can be used for warmth but must not hinder view of the infant.

Infant – preparation

- Ensure infant is physiologically stable. Vital signs and temperature should be within normal parameters.
- Any monitoring leads should be secure.
- Infant should be in a wakeful state.
- Dress the infant in a nappy only for skin to skin contact. A hat can be used if concerned about heat loss or infant is weighs less than 2500gram. For modified skin to skin where infant remains in a heated bed a hat may not be necessary.
- Ensure any IV lines are secure and leads are able to be moved close to recliner chair where cuddle will take place. Access to power supply must be attainable.
- If the infant is receiving oxygen therapy make sure the nasal prongs are secured firmly into place and tubing extends adequately for comfortable placement from crib to recliner chair.
- For ventilated infants consider suction of ETT prior to coming out for cuddling.
- Ensure taping of ETT is secure
- Ventilation or CPAP tubing may also need to be cleared of any water build up.
- Ensure that there is sufficient length or ventilation tubing for ease of infant transfer.
- There must always be sufficient staffing when considering skin to skin care with infants in NICU. Sufficient staffing ensures that transfer occurs safely and with minimal disturbance to the infant's state or wellbeing.

Method for bed to parent transfer

- Align recliner adjacent to or in close proximity as possible to infant's cot. Ensure there is enough access between the cot and chair for the assistance of other staff if required.
- All equipment should be positioned so accessible at all times, ie: Ventilator, IV pumps, feed pumps and monitors.
- Have privacy screen in place for comfort of parent if required.
- Have a blanket ready for infant transfer.
- All staff or helpers must wash hands as per hospital guidelines prior to handling the infant

Modes of transferring infants: Single Standing, Standing Assist, or Seated

Single standing:

- Also known as a cuddle transfer. It is performed primarily by the parent. This technique is thought to be less stressful on the infant due to minimal handling and manoeuvring and helps provide parental confidence in care giving
- It is preferable for infants with less attachments and in a relatively stable condition
- The parent stands at the cot side and uses a scooping technique by placing one hand under the infants head and the other under their back/ buttocks. While keeping their infant in a flexed posture the parent leans forward and places the infant directly onto their chest before moving back into adjacent recliner chair.
- The parent may need nursing support with monitoring leads or Intravenous lines if they are present.

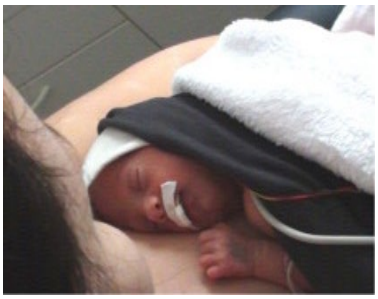
Standing assist:

- Standing transfer is often used with infants who have less attachments or who may be in a height adjusted open-care bed.
- The parent stands at the cot side. The nurse place's a blanket under the infant then picks up the infant, held in a flexed position in the blanket and places the infant prone onto parent's chest. The parent then moves to sit into the recliner chair with baby already secured and supported on their chest.

Seated:

- A sitting transfer maybe chosen for infant removal when many lines and tubing are present.
- Ideally three nurses are used to safely move the infant (contained in flexed position within a blanket or wrap) to the parent seated in a recliner chair.
- One nurse is allocated to move the infant, another to move and secure respiratory tubing and, the third nurse to manage intravenous lines and associated equipment.

- The infant should be placed prone in a flexed position with legs tucked in and head placed to one side in a neutral position between its mother's breasts or on father's chest. Hyper extension of the neck either back or forward should be avoided as it can occlude the infant's airway.
- Positioning of the infant can be modified if the placements of intravenous lines, drains or catheters are at risk of occlusion or dislodging.
- **Diagonal positioning may encourage interactions between the parent and baby. (See images below)**



- Cover infant with a warm blanket, leaving head free. Then secure parent's clothing around the infant (ie: do up gown or button shirt) alternatively cover with a warm blanket.
- If the infant is ventilated secure with tape to the parent/s shoulder or recliner chair to avoid the potential of disconnection.
- Continue to monitor infant throughout care.
- Ensure skin to skin care is recorded in infant's progress notes, including duration, level of tolerance, and the infant's vital signs.

Modified skin to skin care

Criteria for use

May be implemented when an infant's condition, is at risk of compromise by being removed from the bed or by using conventional methods of skin to skin care.

Preparation required

As per procedure outlined for conventional skin to skin care listed above.

Method

- Parent wears a buttoned up shirt or patient gown which ties at the front.
- Hand hygiene attended, with sleeves above elbow.
- Infant is in an alert wakeful state

- The infant is prepared as necessary, for example; suctioning of ETT and cares attended.
- The infant's bed is lowered or heightened to meet chest level of the parent who is seated on a stable chair or stool directly beside the bed. The cot side should be down on this side for ease of access.
- The infant is positioned close to the parent so that their skin is in direct contact with parent/s skin.
- Where possible, ensure the infant is facing the parent. This is to provide the benefit of smelling and touching their parent and may help them to visualize and orientate towards their parents voice.
- The parents arm is placed around the infant in cuddle like position, to offer support
- Warmth is able to be maintained from overhead and mattress heating, as well as warmth provided by parent/s skin.
- Keep infant in a flexed position if possible. May use swaddle while placed in position. Loosen once in close contact with parent and settled.
- Ensure the parent is comfortably seated.
- Document procedure in infants progress notes

Example of Modified Skin to skin with the mother seated at the cot side

Information for parents and staff for modified skin to skin can be found here: Modified skin to skin and hand-hugs

For step by step instructions on how to transfer a baby using the seated or standing skin to skin method – please click **here**.

Please note: Photographs used with permission of parent and staff

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