Team Name: Regional Obstetrical Team Team Lead: Regional Director-Acute Care Approved by: Executive Director-Mid	Reference Number: CLI.5810.PL.004 Program Area: Obstetrics Policy Section: General
Issue Date: April 13, 2018 Review Date: Revision Date:	Subject: Skin to Skin Contact Postpartum: Vaginal and Caesarean Section

POLICY SUBJECT:
Skin to Skin Contact Postpartum: Vaginal and Caesarean Section

PURPOSE:
To assist all healthy newborns in adapting to extra-uterine life, promoting bonding and early feeding practices.

BOARD POLICY REFERENCE:
Executive Limitation (EL-02) – Treatment of Clients
Executive Limitation (EL-01) – Global Executive Restraint and Risk Management

POLICY:
Skin-to-skin contact between mother and infant is recognized as preferred and optimal postpartum care for both vaginal and cesarean births.
Women whose birth is by cesarean (scheduled or unscheduled) who have regional anesthesia are offered skin to skin. The newborn can be skin to skin in the Operating Room, Post Anesthesia Care Unit and on the Birthing Unit. Optimal skin to skin bonding in the operating room starts within 5 minutes of delivery and is uninterrupted for at least 1 hour. If there is interruption in skin to skin prior to 1 hour, timing should start over.
The evidence based benefits of early skin to skin in the first hour of life include:

- Calms and relaxes both mother & newborn.
- Reduces the stress of birth.
- Assists newborn adaptation to extra-uterine life and promotes healthy neurological behaviors.
- Regulates newborn temperature, heart rate, respiratory status and blood glucose levels.

- Enables colonization of newborn's skin with mother's friendly bacteria thus providing protection against infection.
- Stimulates newborn feeding behavior and digestion (decreasing the risk for hypoglycemia).
- Stimulates the release of maternal hormones to support breastfeeding and mothering.
- Stimulates quicker placental expulsion which means less blood loss, less anemia and lower risk of postpartum hemorrhage.
- Reduces newborn pain associated with common procedures (i.e. phenylketonuria (PKU)/Heel lancing).
- Decreases postpartum depression and maternal anxiety.

DEFINITIONS:

Skin-to-skin contact: The practice of placing the healthy infant prone on the mother's bare chest in the immediate post birth period and throughout the postpartum hospitalization.

IMPORTANT POINTS TO CONSIDER:

- The practice of skin to skin care as a component of our Baby Friendly philosophy contributes positively to neonatal transition enhances attachment and promises long-term benefits to new families.
- Skin to skin should be encouraged with both parents on an ongoing basis throughout the entire postpartum stay. Parents should be encouraged to spend as much time as possible in skin to skin contact with their newborn throughout the postpartum stay. Baby Friendly Initiative recommends 12 hours daily of skin to skin.
- Each skin to skin session should be a minimum of 1 hour in duration to obtain maximum benefits.
- Mother's that fall asleep with the newborn skin to skin who do not have an alert partner with them shall have the newborn placed in the bassinet to ensure newborn safety.
- All mothers are educated about the benefits of ongoing skin to skin contact prior to discharge. Evidence based recommendations include skin to skin contact for a minimum of four hours daily until the newborn is three months old.
- Maternal temperature adjusts to ensure a proper temperature for the newborn. This does not happen paternally so if the newborn is skin to skin with the father (or other support person) for extended periods of time monitor the newborn's temperature.

PROCEDURE:

1. Discussion regarding skin to skin post delivery should take place prior to delivery, if able.
2. Skin to skin contact between mothers and their healthy newborn is encouraged by nurses, primary care providers and support staff (i.e. lab) after delivery and throughout the postpartum stay.
3. Skin to skin contact occurs immediately after birth unless medical conditions disallows it or the mother refuses, regardless of the feeding method, and should continue for at least 60 minutes or until the completion of the first feed

4. Assist the mother to a semi recline (45 degrees) or more in the upright position.
5. The newborn is placed prone vertically between the mother's breasts to maximize contact with the mother's skin surface and promote thermoregulation. The newborn's head is covered with a cap to prevent heat loss. A diaper is optional in this first skin to skin contact. Cover the newborn with a warm, dry blanket.
6. Ensure the baby's head is positioned so the nares are always visible in the sniffing position, the baby's color, perfusion and respirations remain stable and the baby does not slide off the mother's chest. Be especially vigilant if the baby is a late preterm or seems to have weak neck muscles.
7. The initial skin to skin contact should not be interrupted for the newborn assessment. Early assessment, Vitamin K and/or eye prophylaxis can be given without interrupting the skin to skin time.
8. Skin to skin contact is encouraged with all newborns, regardless of the chosen feeding method.
9. Observe and allow the newborn to transition through pre feeding behaviours, including hand to mouth movements, licking, drooling, rooting and moving towards the breast. If breastfeeding, allow the maternal/newborn dad to initiate breastfeeding independently. If requested, assistance may be given. If formula feeding, feed at this time.
10. Document skin to skin initiation and length of time on the newborn care map and the newborn feeding record. All subsequent skin to skin will be recorded on the newborn feeding record.
11. Skin to skin contact will be used when performing procedures that cause pain in the newborn, such as heel lancing, blood tests. Breastfeeding at this time will also decrease the sensation of pain for the newborn. Breastfeeding must consist of active nursing for a minimum of 5 minutes and skin to skin contact for a minimum of 10 - 15 minutes for them to be effective pain management strategies for the newborn.

PROCEDURE – CESAREAN SECTION:

1. Pre-op teaching is done informing the patients of the benefits of early skin to skin, how it is accomplished, and that mom and baby need to be in stable condition for it to occur. Teaching is done by Pre-Admit Clinic or Birthing Unit nurse.
2. In the operating room, the anesthesiologist will try to place the electrocardiogram (EKG) leads away from the maternal chest area and will try to place equipment so that mother has one or two arms free.
3. In the operating room, the surgeon will make sure the surgical drapes are placed with mother's chest exposed (top of drape below breasts).
4. When the baby is born, she/he is taken to the radiant warmer for assessment and stabilization.
5. A nurse from the Birthing Unit is in the operating room and assumes responsibility for baby for the entire time the newborn is in the operating room through to the transfer to Post Anesthesia Care Unit and the Birthing Unit.

6. The obstetrical nurse confirms with the anesthesiologist that mom is stable and it is appropriate to begin skin to skin while incision repair is occurring.
7. The anesthesiologist will adjust the bar supporting sterile drapes over mother's upper body (without compromising sterile surgical field) to make room for baby.
8. The Birthing Unit nurse places baby skin to skin on mother's chest, and both mother and baby are then covered with warm, dry blankets. The baby should be naked (wearing only a hat) against the mother's bare chest and covered thoroughly with warm blankets to prevent heat loss. Blanket and/or hat changes are made if cool or wet.
9. The Birthing Unit nurse visually monitors the baby while on the mother's chest until surgery is complete, being sure the baby's head is positioned so the nares are always visible in the sniffing position, the baby's color, perfusion and respirations remain stable and the baby does not slide off the mother's chest.
10. Baby should remain skin to skin with mom in operating room until mom is ready for transfer to Post Anesthesia Care Unit. The baby may be transported to the recovery room skin to skin with the mother during transport. The attendant nurse must pay close attention to ensure the safety of the infant during transport if the baby is being transported on the stretcher with the mom. Alternately, the baby shall be placed in the warmer or a bassinet for transport, following mom on stretcher to Post Anesthesia Care Unit. As soon as mom is in Post Anesthesia Care Unit, baby is again placed skin to skin on mom's chest.
11. The Birthing Unit nurse is responsible for all baby care requirements (i.e. vital signs, weight, medication administration) regardless of babies location (operating room, Post Anesthesia Care Unit , Birthing Unit), but is not required to stay in Post Anesthesia Care Unit if baby care is complete.
12. The Post Anesthesia Care Unit nurse provides mom's care and will call Birthing Unit nurse if baby becomes unstable, requires care, or if assistance is required for newborn feeding.
13. Documentation includes:
    - The Birthing Unit nurse will document initiation and length of skin to skin and breastfeeding time in the newborn chart.
    - The Post Anesthesia Care Unit nurse will document initiation and length of skin to skin and breastfeeding time on the Post Anesthesia Care Unit Record.

SUPPORTING DOCUMENTS

CLI.5810.PL.004.SD.01 Skin-To-Skin Contact Is For ALL Babies - Bilingual

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