Reference/Standard:	**Number**: OBS.4.19	**Effective Date**: July 2012 **Revision Date**: 01/03/2013
Final Report: Maternal-Newborn Advisory Committee, Mother Baby Dyad Work Group, Ontario 2011	**Approval**: Maternal Child Committee	

STANDARD FOR SKIN TO SKIN CARE

Standard Statement:

Implement skin to skin care (SSC) following birth to optimize transition from fetal to neonatal life for the healthy term infant.

Policy/Procedure:	**Rationale:**
At pre-admission, explain to the mother and family expecting birth the best practice of skin to skin care following birth and obtain oral consent for it.	Explaining to the mother and family what routine care to expect after birth helps to close information gaps and decreases anxiety. Asking for the mother's consent emphasizes her important role in planning the care following birth. Mothers and families with different birth experiences have a chance to get familiar with a new care practice.
If the mother declines skin to skin care, respect her preferences for early neonatal care and bonding.	Respecting the mother's informed decision is best practice.
Following birth and cord cutting, dry the infant except hands thoroughly with a warm towel, apply warmed cap on the infant's head, put on diaper and immediately place in the prone position on the mother's abdomen or between breasts. Cover the infant and the mother with warmed blanket(s). Keep room temperature between 22-25^{o}C and ensure there are no drafts.	Minimize heat loss for the infant and mother in all aspects of care. Traces of amniotic fluid on the infant's hands work as sensory stimuli to move towards the breast of the mom (similar smells cue infant to move towards the nipple).
At the latest, skin to skin care should have been started 20 minutes after birth.	Given the described conditions, the mother has no problems to maintain her infant's body temperature.

Policy/Procedure:	**Rationale:**
Maintain skin to skin care of the infant and mother for the recommended duration of 1-2 hours. Treat the mother and infant as a unit. Perform all routine care, assessments and interventions during this time while keeping the infant and mother in skin to skin care. Avoid unnecessary interventions.	Benefits of skin to skin care are described for a minimum duration of one (1) hour. The extended direct physical contact reduces stress for the infant, promotes stabilization of the infant's body temperature, respiratory rate, heart rate, blood glucose levels. Promotes the infant state regulation, the initiation of breastfeeding and the infant's colonization with harmless bacteria from the mother. For the mother, skin to skin care promotes bonding and attachment and positively influences her ability to breastfeed.
Observe for movements towards breast like breast crawl, bobbing of head, rooting. Gently help the mother to support the infant into position which allows self-latching and suckling on breast.	In the first two (2) hours following birth, the healthy infant is alert and the infant's suckling reflex is intense. Skin to skin care stimulates the infant to search for the breast, self-latch and suckle. This increases the overall breastfeeding success.
Do not force the infant to the breast.	Suckling stimulates Oxytocin release in the mother which promotes bonding, decreases pain and stimulates uterine contractions which help to minimize maternal blood loss. Suckling stimulates as well the outpouring of different gastrointestinal hormones in the mother and infant which promote intestinal health.
When due to medical reasons immediate skin to skin care of the mother and infant cannot occur, attempt to initiate skin to skin care with other informed close support person such as the father. Place the infant in skin to skin care with the mother at the earliest possible time.	Skin to skin care with a close support person such as the father still provides many of the named benefits for the newborn. For fathers it is a great opportunity to bond with their baby. Skin to skin care contact with the mother provides the best stimulation for the infant to self-latch and start breastfeeding. Skin to skin care provides the mother with optimal conditions for bonding.
Encourage skin to skin throughout postpartum stay with the mother or support person.	Infant and mother/care givers continue to benefit from skin to skin care in the early postpartum days.

Policy/Procedure:	**Rationale:**
Caesarean section – skin to skin care will occur in the operating room with the mother if conditions allow. Exceptions would be a general anaesthetic or any objection from anaesthesia due to maternal instability. In this case, skin to skin can be carried out with designated support person or family member, i.e., father. The maternity nurse will assume responsibility of the infant until the mom is stable in PACU.	Accommodations for skin to skin in the operating room should be made to allow bonding and the same health benefits as a vaginal delivery.
Once in PACU, the support person or maternity nurse must stay with the baby.	The PACU nurse must remain 1:1 with the operative patient.
When the mother is being transferred to PACU, the maternity nurse will do a head to toe assessment, measurements, erythromycin and vitamin K. The infant will be placed back in skin to skin once the mother is stable in PACU. The support person and the bassinette will go to the PACU with the mother. Upon discharge from PACU, the mother is encouraged to hold her baby and arrive as a unit to the ward.	Treat the mother and infant as a unit.

Documentation:

Document the start and end time of skin to skin care and if breastfeeding occurred.

References:

1. Maternal-Newborn Advisory Committee, Mother Baby Dyad Working Group, Provincial Council for Maternal and Child Health (PCMCH) Ontario, Final report, 2011
2. Marshall Klaus Mother and Infant: Early Emotional Ties, Paediatrics 1998; 102; 1244- DOI: 10.1542/peds.102.5.SEI.1244
3. Goldstein Ferber S. and Makhoul I.R. The effect of Skin-to-Skin Contact (Kangaroo Care) Shortly After Birth on the Neurobehavioral Responses of the Term Newborn: A Randomized Controlled Trial, Pediatrics 2004; 113; 858
4. Riordan J. and K. Wambach K. Breastfeeding and Human Lactation , P 217 -218, 4th edition, 2010