Skin-to-Skin (Parent-to-Baby) Contact Guideline

Summary statement: How does the document support patient care?	Supporting safe skin-to-skin between parent and baby
Staff/stakeholders involved in development:	Midwives, Obstetricians, Paediatricians, Anaesthetists
Division:	Women and Children Health
Department:	Maternity & Neonatal Services
Responsible Person:	Chief of Service
Author:	Public Health Midwife & BFI Lead
For use by:	All midwifery, obstetric and paediatric staff
Purpose:	To provide clear evidence based guidance on facilitating skin-to-skin contact
This document supports:	HSIB National Learning Report Unicef Baby Friendly Initiative Auditable Standards
Key related documents:	**WSHFT Maternity Guidelines:** Newborn Feeding Guidance; Caesarean Birth Guidance; Neonatal Resuscitation Guidance
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If you require this document in another format such as Braille, large print, audio or another language please contact the Trusts Communications Team

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Version	Date	Author	Status	Comment
1.0	26/08/2020	Claire Parr	Archived	First version – new guideline
1.1	27/01/2021	Claire Parr	Live	Updated to reflect Resuscitation Council UK Guidance

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1.0 Aim

The aim of this is to provide guidance for midwifery, obstetric, anaesthetic and paediatric staff on how to offer safe skin-to-skin contact between a parent and the baby. To provide guidance on the benefits of skin-to-skin contact and how to facilitate this effectively to benefit both parent and baby.

2.0 Scope

- Midwives
- Obstetricians
- Paediatricians
- Anaesthetists

3.0 Responsibilities

Midwives, Paediatricians, Anaesthetists and Obstetricians are expected:

- To access, read, understand and follow this guidance.
- To use their professional judgement in the application of this guideline.

4.0 What is skin-to-skin contact

Skin-to-skin contact is usually referred to as the practice where a baby is dried and laid directly on their mother's bare chest after birth, both of them covered in a warm blanket and left for at least an hour or until after the first feed or for however long the parent wishes. Skin-to-skin contact can also take place any time a baby needs comforting or calming and to help boost a mother's milk supply. Skin-to-skin contact is also vital in neonatal units, where it is often known as 'kangaroo care', helping parents to bond with their baby, as well as supporting better physical and developmental outcomes for the baby.

5.0 Benefits of skin-to-skin contact

Skin-to-skin contact has physiological and psychological benefits for both the mother and baby. It is recommended by the World Health Organization (2019), National Institute for Health and Care Excellence (2017), Public Health England (2016) and Unicef UK (2016) and has become established practice in England, with most mothers having skin-to-skin contact with their babies after birth (NHS Digital, 2020).

There is a growing body of evidence that skin-to-skin contact after the birth helps babies and their mothers in many ways. Parents should be provided with information on skin-to-skin and how this will be supported alongside different modes of birth. Benefits include-

- Calms and relaxes both mother and baby.

- Regulates the baby's heart rate and breathing, helping them to better adapt to life outside the womb.
- Stimulates digestion and an interest in feeding.
- Regulates temperature.
- Enables colonisation of the baby's skin with the mother's friendly bacteria, thus providing protection against infection.
- Stimulates the release of hormones to support breastfeeding and mothering.

Additional benefits for babies in the neonatal unit

- Improves oxygen saturation.
- Reduces cortisol (stress) levels particularly following painful procedures.
- Encourages pre-feeding behaviour.
- Assists with growth.
- May reduce hospital stay.
- If the mother expresses following a period of skin-to-skin contact, her milk volume will improve and the milk expressed will contain the most up-to-date antibodies.

6.0 Fundamentals of Care

All mothers should have a period of uninterrupted skin-to skin contact with their baby after birth, at least until after the first feed and for as long as they wish.

In situations where the baby requires immediate paediatric review, once the baby is deemed able to return to its mother, skin-to-skin should be supported with minimal delay.

6.1 Antenatal Discussion

A discussion should take place alongside the feeding assessment in the antenatal period which describes the benefit of initiating a close relationship and feeding soon after the birth whilst in skin-to-skin contact. Parents-to-be should be offered Baby Matters classes or a one-to-one discussion with their midwife on responsive parenting. Parents should be informed that regardless of how the mother intends to feed her baby it is recommended that the first feed is given in skin-to-skin contact.

6.2 Immediately After Birth

On admission in labour confirm the parents' wishes for skin-to-skin contact immediately post birth. This should be documented in the birth plan/preference section of the antenatal notes, however if there is no record of this it is important to discuss the woman's preferences with her.

6.21 Normal Vaginal Birth and Instrumental Births including Optimal Cord Clamping

- When the baby is born it should be brought immediately to the mother's chest.
- The baby should be dried on its mother's chest but its hands left wet. This is because the smell of their wet hands helps the baby map its path to its mother's breast.
- The baby is likely to give a robust cry at this point.
- Ensure the baby's head is has turned to its side to allow for an unobstructed airway.
- The baby and the mother should be covered with a dry cloth/towel and a hat placed on the baby's head.

- The cord will be kept intact (unless the mother has chosen to opt out of optimal cord clamping) until it turns white or if the baby needs paediatric assessment at the resuscitaire.
- Babies at risk of resuscitation (those that cannot wait 30-60 seconds after birth) should have their cord clamped and cut and transferred to the resuscitaire for further assessment. The Resuscitation Council UK do not currently recommend milking the cord in those infants that require resuscitation. Vigorous term and preterm infants, who are not depressed at birth, should have optimal (delayed) cord clamping.
- Complete Apgar score assessments-
    - At 1 minute the baby's Apgar score should be assessed. This can be completed without interrupting skin-to-skin. The heart rate can be auscultated with a stethoscope through the baby's back. If there are any concerns, inform the mother that you advise to clamp and cut the cord and take the baby to the resuscitaire for a closer review (follow neonatal resuscitation guideline if required).
    - At 5 minutes assess the baby's Apgar score. Again this can be completed without interrupting skin-to-skin and only remove baby if there are any concerns, with informing the mother, and for a closer review on the resuscitaire.
    - At 10 minutes assess the baby's Apgar score. Again this can be completed without interrupting skin-to-skin and only remove baby if there are any concerns, with informing the mother, and for a closer review on the resuscitaire.
- Complete mother's observations as often as necessary. These can be completed without interrupting the mother and baby.
- See 9.0 for additional vigilance and safety measures.

6.22 Caesarean Birth including Optimal Cord Clamping

- ECG leads should be placed on the woman's back to ensure the woman's chest is clear.
- The woman's arm should be free from the surgical gown to help facilitate skin-to-skin.
- The anaesthetist and the Operating Department Practitioner will lower the drape at the appropriate time during surgery.
- When the obstetrician delivers the baby they will pass the baby to the midwife (who is wearing sterile gown and gloves) over the surgical drape. Avoid lifting the baby into the 'Lion King' pose.
    - This is unless the Caesarean is being carried out for suspected fetal compromise where it is likely that the baby will need to go to the resuscitaire for assessment prior to joining its mother.
    - However if the baby gives a robust cry the team should ensure that the baby goes to its mother without unnecessary delay.
- The cord will be kept intact (unless the mother has chosen to opt out of optimal cord clamping).
- Babies at risk of resuscitation (those that cannot wait 30-60 seconds after birth) should have their cord clamped and cut and transferred to the resuscitaire for further assessment. The Resuscitation Council UK do not currently recommend milking the cord in those infants that require resuscitation. Vigorous term and preterm infants, who are not depressed at birth, should have optimal (delayed) cord clamping. The midwife will support the baby to lie on its mother's chest.
- The baby should be dried on its mother's chest but its hands left wet. This is because the smell of their wet hands helps the baby map its path to its mother's breast.
- The baby is likely to give a robust cry at this point.

- Ensure the baby's head is has turned to its side to allow for an unobstructed airway.
- The baby and the mother should be covered with a warmed, dry cloth/towel and a hat placed on the baby's head.
- The obstetrician will wait at least 1 minute prior to clamping and cutting the cord. Either the cord will be clamped within the sterile field and the forceps will be passed carefully to the midwife or the obstetrician can double clamp the cord on the margin of the sterile drape, in which case the birth partner can cut the cord, with the midwife supporting the clamp on the baby's side. The midwife can then shorten the cord and will return the instrument to the surgical team observing the sterile area at all times.
- Shortening the cord and applying baby labels can be done without interrupting skin-to-skin.
- It is important that the midwife remains close and within the line of sight of the baby to ensure that she can hear concerns raised by the mother and so she can provide ongoing assessment of the baby whilst in skin-to-skin.
- Complete Apgar score assessments-
    - At 1 minute the baby's Apgar score should be assessed. This can be completed without interrupting skin-to-skin. The heart rate can be auscultated with a stethoscope through the baby's back. If there are any concerns, inform the mother that you advise to clamp and cut the cord and take the baby to the resuscitaire for a closer review (follow neonatal resuscitation guideline if required).
    - At 5 minutes assess the baby's Apgar score. Again this can be completed without interrupting skin-to-skin and only remove baby if there are any concerns, with informing the mother, and for a closer review on the resuscitaire.
    - At 10 minutes assess the baby's Apgar score. Again this can be completed without interrupting skin-to-skin and only remove baby if there are any concerns, with informing the mother, and for a closer review on the resuscitaire.
- Complete mother's observations as often as necessary. These can be completed without interrupting the mother and baby.
- See 9.0 for additional vigilance and safety measures.

6.23 Partners and Skin-to-Skin

It is important that wherever possible the mother is the primary parent that provides skin-to-skin contact with her baby due to the direct benefits on the baby's instinctive feeding behaviour and benefits to breastmilk supply as well as all the other known benefits (see section 5.0).

However if the mother is unable to provide skin-to-skin contact, or does not wish to following discussion, it is possible that the birth partner can undertake this in the initial post-birth period.

See 9.0 for additional vigilance and safety measures.

6.3 Instinctive Response of Mother and Baby to Skin-to-Skin

When a mother holds her baby in skin to skin contact after birth it initiates strong instinctive behaviours in both. The mother will experience a surge of maternal hormones and begin to smell, stroke and engage with her baby.

Babies' instincts after birth will drive them to follow a unique process, which if left uninterrupted will result in them having a first breastfeed. If they are enabled to familiarise themselves with their mother's breast and achieve self-attachment it is very likely that they will recall this at subsequent feeds, resulting in fewer breastfeeding problems.

After birth, babies who are placed skin-to-skin on their mother's chest will:

- Initially cry briefly – a very distinctive birth cry.
- Enter a stage of relaxation, where they display very little movement as they recover from the birth.
- Start to wake up, opening their eyes and showing some response to their mother's voice.
- Begin to move, initially little movements, perhaps of the arms, shoulders and head
- As these movements increase the baby will draw up their knees and appear to move or crawl towards the breast.
- Once they have found the breast, they will tend to rest for a little while (often this can be mistaken as the baby being not hungry or not wanting to feed).
- After a period of rest the baby will start to familiarise with the breast, perhaps by nuzzling, smelling and licking around the area. This familiarisation period can last for some time and is important so should not be rushed. Sometimes it is tempting to help baby to attach at this time but try to remain patient to allow them to work out how best to attach themselves.
- Finally baby will self-attach and begin to feed. It may be that mother and baby need a little help with positioning at this stage.
- Once baby has suckled for a period of time, they will come off the breast and often both mother and baby will fall asleep.
- If the baby falls asleep on the mother's chest and the mother also sleeps, she should not be left alone. If the midwife needs to leave the room and the partner is not around the baby should be placed in the cot. See 9.0 for Safety and Vigilance.

Most term healthy babies will follow this process, providing it is not interrupted by anything, for example taking the baby away to weigh, or the mother going for a shower.

Interrupting the process before the baby has completed this sequence, or trying to hurry them through the stages may lead to problems at subsequent breastfeeds. If the mother has been given a lot of analgesia during labour the baby may be drowsy and this process can take longer.

If the mother has chosen to bottle feed her baby this first feed should be offered in skin-to-skin contact too.

Weighing the baby should be carried out in the prone position and returned to the mother in skin-to-skin.

6.4 Documentation

All observations of the mother and baby should be documented in the usual way.

The time of commencing and finishing skin-to-skin should be documented in the Baby's Delivery Record.

Time of first feed should be documented in the Baby's Delivery Record.

6.5 Skin-to-Skin throughout the Postnatal Period

Skin-to-skin is an extremely beneficial tool for mothers to use throughout the postnatal period. The benefits of using skin-to-skin in the postnatal period in addition to those described above, are

- Establish and/or re-establish direct breastfeeding.
- Reinitiating the instinctive reflexes of the baby to feed (especially useful for sleepy babies or those reluctant to feed).
- Calming a fractious baby.
- Increasing breastmilk supply.

Safety should still be observed during this time (see 9.0).

7.0 Baby Friendly Initiative Standards

The Baby Friendly standards require that skin-to-skin contact is valued and supported in hospitals.

Maternity units are required to ensure that:

- All mothers have skin-to-skin contact with their baby after birth, at least until after the first feed and for as long as they wish.
- All mothers are encouraged to offer the first feed in skin contact when the baby shows signs of readiness to feed.
- Mothers and babies who are unable to have skin contact immediately after birth are encouraged to commence skin contact as soon as they are able, whenever or wherever that may be.

Neonatal units are required to ensure that:

- Parents have a conversation with an appropriate member of staff as soon as possible about the importance of touch, comfort and communication for their baby's health and development.
- Parents are actively encouraged to provide comfort and emotional support for their baby including prolonged skin contact, comforting touch and responsiveness to their baby's behavioural cues.
- Mothers receive care that supports the transition to breastfeeding, including the use of skin-to-skin contact to encourage instinctive feeding behaviour.

7.1 Audit

The Baby Friendly Initiative processes will audit compliance to these standards through audits carried out by interview of mothers and staff. These will be monitored through the Quality and Safety meeting where actions will be logged.

8.0 Safety Considerations

8.1 Staffing Considerations

The immediate post-birth period is a vulnerable time for mothers and babies and so, regardless of whether they are in skin-to-skin contact (or if the baby is in a cot), both mother and baby need to be closely observed in line with up-to-date Trust guidelines. Staff should have a conversation with the mother and her partner about recognising any changes in the baby's condition and how to alert staff immediately if they are concerned. If staff shortages make close observation and/or the ability of staff to be able to respond to parents' concerns immediately impossible, then the appropriate reporting mechanisms and actions should be put in place. The Escalation Guidance should be followed in these cases.

8.2 Sudden Unexpected Postnatal Collapse (SUPC)

The Healthcare Safety Investigation Branch (HSIB) summary of themes arising from HSIB maternity investigation programme report (March 2020) describes eight themes from the maternity investigations. Sudden unexpected postnatal collapse (SUPC) was identified as a theme for further exploration in order to highlight areas of system-wide learning. SUPC is a rare but potentially fatal event in otherwise healthy-appearing term (born after 37 completed weeks) newborn babies at birth. Between April 2018 and August 2019 HSIB completed 335 maternity investigations. Of these, 12 cases met the SUPC criteria (3.6%).

While there may have been other causative factors to why babies have collapsed, it is important to focus on how skin-to-skin contact may have contributed. In 6 of the 12 identified cases (1.8%), positioning of the baby to achieve skin-to-skin contact may have contributed to SUPC.

While the number of incidents found was small compared to the number of term babies who had skin-to-skin contact at birth (82% of 603,766 births in England 2018/19) (NHS Digital, 2019) these incidents may in future be avoided and so learning is essential.

9.0 Vigilance and Observation

Vigilance of the baby's well-being is a fundamental part of postnatal care immediately following and in the first few hours after birth. For this reason, normal observations of the baby's temperature, breathing, colour and tone should continue throughout the period of skin-to-skin contact in the same way as would occur if the baby were in a cot (this includes calculation of the Apgar score at 1, 5 and 10 minutes following birth). Care should always be taken to ensure that the baby is kept warm. Observations should also be made of the mother, with prompt removal of the baby if the health of either gives rise to concern.

Staff should have a conversation with the mother and her partner about the importance of recognising changes in the baby's colour or tone and the need to alert staff immediately if they are concerned. Women and their partner should be shown the normal and emergency call systems in case of concerns.

It is important to ensure that the baby cannot fall on to the floor or become trapped in bedding or by the mother's body. Mothers should be encouraged to be in a semi-recumbent position to hold and feed their baby. Particular care should be taken with the position of the baby, ensuring the head is supported so the infant's airway does not become obstructed

9.1 Mothers

- Observations of the mother's vital signs and level of consciousness should be continued throughout the period of skin-to-skin contact. Mothers may be very tired following birth and so may need constant support and supervision to observe changes in their baby's condition or to reposition their baby when needed.
- Many mothers can continue to hold their baby in skin-to-skin contact during perineal suturing, providing they have adequate pain relief. However, a mother who is in pain may not be able to hold her baby safely. Babies should not be in skin-to-skin contact with their mothers when they are receiving Entonox or other analgesics that impact consciousness.

The level of risk for SUPC when a baby is in skin-to-skin contact can increase with additional contributory factors, for example, maternal body mass index, antenatal use of opiate medication, sedation and staffs' focus on other tasks.

9.2 Babies

All babies should be routinely monitored whilst in skin-to-skin contact with mother or father. Observation to include:

- Checking that the baby's position is such that a clear airway is maintained– observe respiratory rate and chest movement. Listen for unusual breathing sounds or absence of noise from the baby.
- Colour – the baby should be assessed by looking at the whole of the baby's body as the limbs can often be discoloured first. Subtle changes to colour indicate changes in the baby's condition.
- Tone – the baby should have a good tone and not be limp or unresponsive.
- Temperature – ensure the baby is kept warm during skin contact.

Always listen to parents and respond immediately to any concerns raised.

9.3 Partners

Supervision of the baby and the baby's condition should remain a priority of staff. This should especially be considered if the mother has been transferred to theatre without her baby (due to requiring general anaesthetic or by choice). The Senior Midwife/ Coordinator will need to allocate a member of staff to support the partner with their baby. The same discussions around raising concerns should be made with the partner and ensure the partner has access to call bells should there be moments when a staff member is not present with them.

10.0 References

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