Skin to Skin Care

Procedure

目的
Skin-to-Skin Care is a developmental care practice intended to promote state regulation, physiological stability for the pre-term infant, lactation and parental – infant attachment. To optimize the benefits of skin to skin care, it is necessary for the nurse to teach or facilitate the parent to recognize and respond to behavioural cues of their infant while holding. It is important to recognize that not all infants will be receptive to skin to skin care at a given time, yet may become receptive with time.

政策声明
Skin to skin Care is the practice of holding a physiologically stable neonate in skin-to-skin contact with their parent/caregiver. The baby is clothed only in a diaper (a hat is optional). The baby is held in an upright position on the parent’s bare chest with ventral skin-to-skin contact between infant and parent. A blanket may be wrapped around the parent and neonate. The neonate may be nuzzled at the mother’s breast or may breastfeed actively. Particular attention must be given to maintain the head and neck in a neutral, midline position during Kangaroo Care. This care practice is important for both term and pre-term infants especially in the transition period after birth.

研究关于皮肤接触护肤的发现表明，这项实践：
1. 在母乳喂养中产生积极影响，包括增加奶量，延长喂养时间，增加频繁的起始，并提高独占性
2. 减少父母焦虑，促进更积极的父母互动，改善对早期父母依恋的满意度，并增强育儿信心
3. 维持和稳定宝宝的温度
4. 改善状态调节，更好的睡眠模式，减少哭闹，减少对镇痛剂的需求
5. 减少感染的发生
6. 可能促进体重增长
7. 有助于稳定呼吸速率（由于父母的持续呼吸模式）和心率，未改变氧饱和度，并可能减少婴儿的呼吸暂停和心动过缓
8. 通过使皮肤接触保持的直立位置，可能提高非通气患者的氧饱和度，慢性肺病的患者通过改善重力依赖的通气和灌注

适用性
All Covenant Health Neonatal Nursery Staff and physicians

Neonatal Policy & Procedures Manual

政策组: Developmental

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**Procedure**

The decision to initiate skin-to-skin holding is made by the bedside nurse (primary nurse) and the nurse in charge in consultation with the parents. Both ventilated and non-ventilated infants of any weight or gestation are eligible for skin to skin care.

Infants **NOT** eligible for skin to skin care include the following:

1. Infants with peripheral arterial lines, and chest tubes.
2. Current use of vasopressors or paralytic medications.

These conditions do not apply to infants in extremis, who are offered skin to skin care for comfort, family time, and as part of the process of withdrawal of life support treatments.

The length of the skin-to-skin period varies with the baby’s tolerance and weight. Parents need to be aware that if the infant falls asleep, a sleep period of **at least 60 minutes** is allowed before transfer to allow for a complete sleep cycle. Skin to skin care sessions are terminated if signs of distress persist or physiologic compromise. (eg. oxygen saturation less than 85 requiring an increase in oxygen of more than 20% greater than 10 minutes after transfer has been completed).

**Method**

Provide parents with information about skin-to-skin care including the purpose, benefits, risks, and procedure. Assess willingness of parents to participate.

1. **Before skin to skin care begins:**
   1.1. All care providers, including the parent, must perform hand hygiene
   1.2. Place recliner next to bedside and provide privacy. Dim lights.
   1.3. Ensure the endotracheal tube (ETT) is securely fastened.
   1.4. Remove the infant’s clothing except for the diaper.
   1.5. Secure all tubes and lines
   1.6. Place a receiving blanket under the infant. A hat is recommended for infants weighing less than 1 kg.
   1.7. Instruct parent to expose chest. A front opening shirt or cover gown can be worn.

2. A major factor affecting physiological stability during skin to skin care in ventilated infants is transfer technique. The parent standing transfer is preferred with ventilated infants if the parent is stable during the sitting and standing motion.

2.1 **Parent Standing Transfer**

   2.1.1 Assemble at least 2 staff members to assist the parent with the transfer
   2.1.2 One care provider moves all of the lines to one side of the infant ensuring that there is enough slack to allow for the movement of the infant to the parent.
   2.1.3 Another care provider dons gloves and ensures that the ventilator tubing is free from excess water to prevent inadvertent instillation during patient transfer. Ventilator tubing disconnects are avoided because loss of pressure can cause atelectasis.
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2.1.4 Have the parent stand at the side of the incubator / overhead warmer with the caregivers near the head of the bed. Ensure all intravenous lines and monitoring devices are gathered within the receiving blanket and are secured to move with the infant.

2.1.5 Have the parent lift the infant in the receiving blanket while another is responsible for moving the ventilator tubing with the patient.

2.1.6 Using a smooth, controlled movement, place the infant in a ventral, flexed, upright position on their bare chest between the breasts with the head above the nipple line and face to one-side.

2.1.7 Fold the infant’s blanket into fourths and place over the infant’s back from just below the infant’s ear to the feet, tucking the feet and legs in flexed position beneath the blanket. Secure infant with parents clothing or blanket.

2.1.8 Allow the infant to stabilize on the parent’s chest.

2.1.9 Caregivers hold lines and ventilator tubes securely so that they will not pull out of the patient with movement.

2.1.10 Move the parent backwards to the recliner and assist him/her to sit once the recliner is felt behind their legs.

2.1.11 Allow the infant to stabilize.

2.2 Nurse/baby transfer:

2.2.1 Have the parent sit in a recliner positioned next to the incubator / warmer.

2.2.2 Assemble at least 2 staff members to assist the parent with the transfer

2.2.3 One care provider will manage the infant, tubes, intravenous lines, and monitoring lines. The second care provider will don gloves and move the ventilator circuit and maintain ETT placement during transfer.

2.2.4 The transferring care provider “gathers” the infant in the receiving blanket, ensuring all intravenous lines and monitoring devices are secured to move with the infant.

2.2.5 The second care provider dons gloves and ensures that the ventilator tubing is free from excess water to prevent inadvertent instillation during patient transfer. Avoid ventilator tubing disconnects.

2.2.6 The transferring nurse moves the infant to a ventral, upright position on the parent’s chest using one smooth, controlled movement while the second provider moves the ventilator tubing and machine as necessary to prevent pulling.

2.2.7 Fold an infant's blanket into fourths and place over the infant’s back from just below the infant’s ear to the feet, tucking the feet and legs in flexed position beneath the blanket. Secure the infant with parents clothing or blanket

2.2.8 Allow the infant to stabilize on the parent’s chest.

2.3 After either transfer method:

2.3.1 Ensure infant position is chest-to-chest, upright, inclined at approximately 30° to 40° above horizontal, with legs and arms in a flexed position. Care is taken to position the head and neck in a slight sniffing position to prevent airway obstruction. If possible, position the face of the infant so that the parent can see the infant’s facial expression or give the parent a hand mirror to look at the infant.

2.3.2 Ensure all intravenous lines and monitoring devices remain securely attached and are functional.

2.3.3 Ensure the parent is seated comfortably and raise the chair’s footrest.
2.3.4 Infants back should be covered with four layers. Tuck the infant’s blanket around him/her and wrap the parent’s clothing over all to secure infant.

2.3.5 Drape the ventilation tubing over the parent’s shoulder, insuring that no traction is placed on the ventilator / patient interface, and tape the tubing securely to the parent’s shoulder and chair. Alternately, a restraint posey may also be used to secure the tubing.

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3. Remain available to the parent throughout skin-to-skin contact for support and assistance. This care practice may contribute to emotional release and the need for sharing by the parent. Be prepared for active listening and supportive counselling.

4. Allow for as much privacy for parent/infant dyad as possible during skin to skin care.

5. Rocking is not recommended initially because it provides too much stimulation.

6. Reverse the transfer method to return the infant to the warming environment.

7. Monitor temperature. In maternal skin to skin, infant may become too warm during the second or more hour of consecutive skin to skin. Check axilla temperature every 30 minutes after first hour. In paternal skin to skin, infants may become too warm after 30-45 minutes. Check axilla temperature after 30 minutes followed by every 15 minutes. Watch for signs and symptoms of hyperthermia.

8. Encourage mothers to pump after skin to skin care sessions because of the stimulating effect of this practice on milk production.

9. Document this care practice noting the following:
   8.1 Length of skin-to-skin contact
   8.2 Infant tolerance of skin-to-skin contact
   8.3 Infant’s behavioural state during skin-to-skin contact
   8.4 Temperature before and following skin-to-skin contact
   8.5 Cardio-respiratory status including oxygen saturation
   8.6 Parents comments about skin-to-skin contact
   8.7 Kardex individualized plan for skin to skin care established by the nurse and parent.

Definitions

- Sitting Transfer - Transfer of infant from a warming environment by staff to a parent sitting in a chair.
- Standing Transfer – Transfer of infant from a warming environment to standing parent. Parent sits with infant in arms.
- State Regulation – Appropriate and smooth transitions from one state to another without physiologic compromise behavioral agitation.

Related Documents

- Cue-Based Care
- Developmental Care
- Lighting
- Positioning
- Sound Recommendations
References


Revisions Kangaroo Care 2005
May 2016
Signing

Original signed

GAIL CAMERON
SENIOR DIRECTOR OPERATIONS
WOMEN'S & CHILD HEALTH
COVENANT HEALTH
GREY NUNS & MISERCORDIA HOSPITALS

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Original signed

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