GUIDELINE

Skin to Skin Holding

Scope (Staff):	Nursing and Medical Staff
Scope (Area):	NICU KEMH, NICU PCH, NETS WA

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this disclaimer

Aim

To facilitate and promote skin to skin holding for infants and their parents within the neonatal units.

Risk

Reduced time and contact between the infant and parent, this may affect parent infant bonding.

Background

Skin- to- skin (STS) holding (also known as Kangaroo Care) is the method of holding an infant between the mother's breasts or against the father's chest. The infant is dressed in a nappy only.

Also refer to Parenting in the Neonatal Unit guideline.

Benefits to the Infant in Being Held Skin- to- Skin

Published articles in the medical and nursing literature report the benefits of STS for both premature and full-term infants as well as the parents. Even very small infants and infants on ventilators have shown:

- Improved breathing, heart rate and oxygenation
- Stable temperature
- Better growth. Shorter time in hospital
- More comfortable awake time

- More deep sleep time
- Less crying at six months old
- Improved mental and movement development at one year old

Parents Experience

- Facilitation of parent-infant attachment
- Increased milk production
- Greater breastfeeding success
- A positive effect on parenting i.e. reduction in stress and depression and increased confidence

Risks to the Infant during STS

Infants are usually very stable during STS. Maintaining a stable airway and environment is very important for the experience to be beneficial to all. Therefore, the timing of STS and positioning of the equipment and infant during the move is paramount.

Who can receive Skin-to-Skin?

The criteria for parents holding their infant's is available in the Parenting in the NICU guideline. If the infant is suitable to be held by a parent, then skin-to-skin can be considered after reviewing the exclusion criteria for skin-to-skin (see below).

If an infant is suitable to hold but not suitable for skin-to-skin, then the infant can be held in the parent's arms.

Exclusion criteria for skin-to-skin are:

- Unstable infants should not be moved for parent-infant holding without consent of the consultant neonatologist and medical availability.
- Surgical infants within 48 hours of major surgery, especially, if still ventilated.
- Infants with chest and/or abdominal lesions, (gastroschisis) /wounds/drains/ vacuum dressing/new stomas.
- Infants with an arterial umbilical line, without medical consent.
- Medically unstable infants i.e. muscle relaxed, continuous inotrope infusions, high frequency oscillatory ventilation/nitric oxide (unless consented by consultant).
- Parents with unexplained/contagious skin rashes.

These exclusions may be waved in consideration of a high likelihood of demise.

Preparation for Skin-to-Skin Considerations

- Discuss with parents scheduling of STS cuddles, referring to parent holding in Parenting in the NICU the guideline re factors to consider in scheduling STS. Consider that STS Cuddles may be for extended periods and more than once a day when planning.
- STS cuddles should be of at least 60 minutes duration to allow time for the infant to adjust to their new position and to allow the parent time to relax and interact with their infant.
    - **NOTE:** Parent circumstances may impact the duration of STS. Facilitating and promoting STS is to take precedence over the duration.
- Can continue for as long as the infant is stable, not needing interventions other than feeds and the parent is comfortable.
- Advise the parents to come prepared (had food, drink, toilet break, camera etc.) and to wear clothing that opens down the front to maximize skin-to-skin contact with the infant. Mothers may wish to remove their bras entirely or wear a front closure bra that can be opened and moved aside.
- A quiet, calm environment is preferable.
- Consider cultural need for privacy – privacy screens may be needed.

High back chairs or recliner chairs with arm supports are to be utilised for cuddles.

Procedure

For Ventilated infants when parent is seated

- Ensure the infant is dressed in a nappy only.
    - Ensure ETTs and IV cannulas are well secured.
- Position infant on his/her back in the cot/incubator. A pouch may be used to move the infant in
- Infants receiving mechanical ventilation should have their chest auscultated immediately prior to being moved for parent-infant holding to ensure that ETT suction is not required
- Safety: Ensure Medical staff, Coordinator /Float are on the floor and aware of planned move
- Ensure the parent is comfortable in appropriate seating. Footstool is optional, depending on height of chair, parent's preference. NB: ensure brakes are on.
- Conventional Ventilation: One nurse will support the infant on transfer from the cot/incubator while another nurse supports the ventilator tubing and ETT position. The nurse will slowly lift the infant to a vertical position and bring to the parent's chest in the prone position. Ensure the infant has enough support to maintain neutral head alignment (not over-extended neck) and flexed limbs.

- Jet Ventilation: One extra nurse to handle and secure the “Wobble Box”.
- The nurse responsible for the ventilator tubing maintains the connection to the ventilator and ETT position.
- The parent should be seated comfortably, usually in a reclining position.
- The nurse secures the ventilator tubing, avoiding obstructing the parent's view of their infant.
- Other equipment is checked, connected and secured (e.g. Feeding pumps).
- The parent's shirt may be used as a cover. Additional covering may be necessary. Place a bonnet on the infant if necessary.
- A staff member must be readily available throughout the cuddle to provide assistance should complications arise e.g. dislodgment, blocked ETT
- When returning to the cot two nurses will assist with the move. One looking after the infant and one responsible for the securing of the ventilator tubing and ETT position.
- Infant chest auscultated immediately to ensure ETT placement and that suction is not required.
- Document on MR489/491 the date of parent-infant hold.
- For infants who are receiving long term ventilation they can be discussed with the CNC to allow the parents to be taught the FICare method of picking up their baby.

For Ventilated infants – The FiCare Method

- Ensure the infant is dressed in a nappy only.
    - Ensure ETTs and IV cannulas are well secured.
- Position infant on his/her back in the cot/incubator. A pouch may be used to move the infant in.
- Infants receiving mechanical ventilation should have their chest auscultated immediately prior to being moved for parent-infant holding to ensure that ETT suction is not required
- Safety Ensure Medical staff, Coordinator /Float are on the floor and aware of planned move
- Conventional Ventilation: The parent stands as close as possible to the open incubator door with open top clothing.
- The parent slowly lifts infant placing the infant vertically and prone on their chest whilst a nurse supports the ventilator tubing and ETT position. Nurse. ensure the infant has enough support to maintain neutral head alignment (not over-extended neck) and flexed limbs.

- Jet Ventilation: One extra nurse to handle and secure the “Wobble Box”
- The nurse responsible for the ventilator tubing maintains the connection to the ventilator and ETT position.
- The parent chair is brought up behind the parent by another staff member for them to sit slowly down on and slide back onto back rest. NB: ensure brakes are on.
- The chair is slowly reclined to a comfortable position for parent
- The nurse secures the ventilator tubing, avoiding obstructing the parent's view of their infant.
- Other equipment is checked, connected and secured (e.g. Feeding pumps).
- The parent's shirt may be used as a cover. Additional covering may be necessary. Place a bonnet on the infant, if necessary.
- A staff member must be readily available throughout the cuddle to provide assistance should complications arise e.g. dislodgment, blocked ETT
- When returning to the cot - parent chair slowly moved upright with two nurses will assist with the move. One responsible for the securing of the ventilator tubing and ETT position. The other assisting the parent and moving the chair
- The parent slowly stands up beside the incubator and gently lowers the infant into the incubator in the supine position. The second nurse will remove the chair
- Infant chest auscultated immediately to ensure ETT placement and that suction is not required
- Document on MR489/491 the date of parent-infant hold.
- For infants who are receiving long term ventilation they can be discussed with the CNC to allow the parents to be taught the FICare method of picking up their baby.

For Ventilated infants – surgical infants

Skin to skin is not possible for many surgical infants.

Discuss with team at clinical round

- when skin to skin is likely to be feasible
- Consider if pain relief for transfer is appropriate
- More clinical staff may have to assist with transfer comfortably
- Infant may not be able to be prone but maintain some skin to skin contact in alternate position

For CPAP infants

The infant may be transferred to the parent's chest as above or if the parent has been trained in the 'FICare Method' then they may take the baby out with the assistance of a single nurse.

Parents of stable infants should be encouraged to use the FiCare method as soon as possible

NB: Nurse must always be present for this procedure

The FICare method is:

- Place recliner chair ready next to the cot, ensure brakes are on.
- Ensure the infant is dressed in a nappy only.
    - Ensure IV cannulas are well secured.
- Place a blue 'strappit' around the tubes of the CPAP anchoring them to the 'ponytail' of the CPAP hat.
- When the nurse, parent and the baby is ready, the parent leans their body as close as they can to the baby, (this is easier to do in an open cot, if the baby is still in an incubator, then the parent should get as close they can to the open incubator door).
- The parent supports the baby by putting one hand underneath their baby's bottom, the other underneath their head.
- The nurse helping will support their CPAP/HHF tubing, monitoring cables and any IV lines.
- The parent gently and slowly lifts the baby up until you can snuggle them close to their chest, ideally in an upright position between their breasts.
- The parent takes a step backwards towards the chair and sits down, with the guidance of the nurse.

For infants on HHF, PBF and self-ventilating

- Once taught parents are able to take babies out as they feel most comfortable. The 'FICare Method' is recommended as it promotes parental involvement in caring for their infant, requires the minimal amount of nursing intervention.
- NB: Nurse must always be present for this procedure

Exceptional Circumstances

In exceptional circumstances, parents who are unable to visit due to illness or social circumstances for an extended period of time, may elect a grand-parent or significant other, in order to temporarily facilitate the skin- to- skin process.

Related CAHS internal policies, procedures and guidelines

Neonatology Clinical Guideline

- Parenting in the Neonatal Unit Environment

References

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