Safe Skin to Skin Guideline

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. 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.

Why is skin-to-skin contact important?

There is a growing body of evidence that skin-to-skin contact after the birth helps babies and their mothers in many ways.

- 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

What happens during skin-to-skin contact?

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.

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 mother has been given a lot of analgesia during labour baby may be drowsy and this process can take longer.

It is strongly recommended that mothers are not asked their feeding intention prior to delivery. Maternity staff should be proactive in the promotion and support of breastfeeding in the immediate postnatal period. On admission in labour the benefits of skin to skin

following delivery for mother and baby should be discussed as part of the care planning process. Parents should be actively encouraged to allow the baby at least one hour of uninterrupted skin to skin contact as part of the infants' adaptation to extra uterine life. If a baby requires non-urgent admission to the NNU, skin to skin should be carried out in accordance with the above guidelines. If a baby is admitted to NNU immediately after delivery, skin to skin should be initiated as soon as the baby's condition allows.

Unhurried skin to skin contact following birth

Every mother should be encouraged to have a prolonged period of skin to skin contact immediately following birth, or as soon as the condition of mother and baby allows.

During this time of skin to skin, babies' instinct to feed is heightened and the women should be offered the opportunity to encourage the baby to attach to the breast at this point. If the mother expresses a wish to give her baby formula milk it is important that the skin to skin contact is not interrupted and the woman should be encouraged to give the first formula feed while her baby remains in skin contact.(2)

The contact should last for at least one hour and not end until after the first feed unless the mother makes an informed choice to end skin to skin or either mother or baby requires acute medical attention.

If a mother requests her baby to be weighed this may be done immediately following delivery to prevent interruption of skin contact. The baby check can wait until skin to skin contact has ended naturally. Where appropriate and if maternal condition allows, skin to skin should take priority over 'non-urgent' procedures including perineal repair.

It is detrimental to the establishment of breastfeeding to end skin contact before the baby shows signs of readiness to feed. Mothers may be very tired or sedated after the birth and respiratory stability in new-borns can be sub optimal. It is vital that a vigilant supporter accompanies her during the contact. Birth partners are also encouraged to have skin to skin contact with the new baby.

Particular attention should be paid to drying babies carefully before keeping them warm in skin contact. This, together with an early feed, should be a priority for all babies but is essential for babies who are at risk if they become hypoglycaemic.

Safety of the baby is the responsibility of both family and staff.

Whether the baby is in skin contact with mother or father or in a cot, the parents or birth supporter will normally be expected to watch their baby during the first few hours. The midwife has a responsibility to explain to the parents and/or birth partner the guidelines

- If in skin to skin contact, mother and baby are supported in a position that ensures baby's airway is open and nostrils not occluded.

- How to recognise good colour and easy, regular breathing.
- How to call for emergency help if baby's colour or breathing become abnormal.
- Lighting in the room must be bright enough for the baby's colour and breathing to be easily observed.
- The baby should be covered with a dry warm towel, ensuring the baby does not get cold.

It is vital that the mother or father is capable of observing and assessing the baby, **or that parents are accompanied by a vigilant supporter during this early period. Mothers may be very tired or sedated after the birth and the baby's breathing may be irregular.**

The midwife has a responsibility to assess the parents' competence to observe their baby. If the midwife judges that parents are unable to observe their baby, or if parents feel unable to observe their baby, staff will make every effort to identify a staff member who will assist the parents in observing the baby who is in skin contact with mother during these early hours.

If parents are not able to observe their baby, and no supporter or staff member is available to help, the safest option is to place the baby in a cot at that time.

It is the responsibility of the midwife to document any episode of skin contact in the SWHMR notes and also any reasons why skin contact has not taken place.

Skin contact and perineal suturing

During perineal suturing skin to skin contact may be maintained if all the following conditions are present:

- The mother wishes it
- She is pain free and not using entonox
- Someone other than the mother and the person doing the suturing is available to observe the baby continuously during this time.

The observer must be instructed about good positioning, good colour and breathing patterns and when and how to call for help.

The ambient lighting must be sufficient to see the baby clearly.

If mother has had opiate analgesia within 2 hours prior to giving birth, a member of staff should be present to observe the baby who remains in skin contact with his mother during perineal suturing.

If the baby is breastfeeding there should be extra vigilance as it may be possible for the baby's position to become suboptimal while the mother is in lithotomy position.

If a mother and baby cannot maintain skin contact for any reason, the best alternative is skin contact between baby and father. Skin to skin contact with fathers has been shown to provide calming and warming effects and to elicit pre-feeding behaviour similar to skin contact with mothers (24).

If there has been a necessary interruption of skin to skin contact between mother and baby, it should be resumed as soon as possible.

Skin to Skin in Theatre:

Caesarean Section or Instrumental Delivery in Theatre should not interfere with skin to skin contact.

- In order to help women achieve skin to skin in theatre we will:
- Leave one arm out of the theatre gown to ease access.
- Place ECG leads on the woman's back, leaving the chest clear.
- Following delayed cord clamping, dry the baby thoroughly, apply a nappy and ID bands prior to skin to skin starting.
- Raise the woman's head slightly, so that they are not too flat. (The anaesthetist will help by placing another pillow under the woman's head or raising the head of the theatre table)
- The baby should be placed in a position that ensures its airway is open and nostrils are not occluded.
- Cover the baby with warm towels or blankets to keep them warm.

The midwife will explain to the parents / birth partner:

- How to recognise good colour and easy, regular breathing.
- How to help support the baby while the mother has only one free arm to hold it.
- How and who to call for help if they are concerned about the baby's breathing or colour. (This is of particular importance for when the midwife is out of the theatre checking and disposing of the placenta)
- How and who to call for help if the woman becomes nauseous or unwell and is unable to continue holding the baby.

Offer the partner skin to skin if the woman feels too unwell.

Facilitate continued skin to skin contact, during transfer from theatre table to postnatal bed and transfer from theatre to the recovery bay.

The Healthcare Safety investigation branch report and the key facts and learning from this report

HISB National Learning Report Neonatal collapse alongside skin-to-skin contact published August 2020

The HSIB maternity investigation programme report completed in March 2020 and then published on the 13th of August, explored sudden unexpected postnatal collapse (SUPC) at term in relation to skin to skin care. In their findings, the number of SUPC incidents 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), however these incidents may be avoided in the future and so learning is essential.

Learning observations include:

- Based on the evidence, a baby who is born apparently well, with good Apgar scores, can be safely laid skin-to-skin with the mother or parent and requires close observation in the first minutes after birth.
- Apgar scores must be attributed using close clinical observation of the baby. This can be achieved with the baby remaining in skin-to-skin contact.
- Vigilant observation of the mother and baby should continue, with prompt removal of the baby if the health of either gives concern.
- Mothers should be encouraged to be in a semi recumbent (half lying, half sitting) position to hold and feed their baby, ensuring the mother can see the baby's face.
- Care should be taken to ensure that the baby's position is such that their airway remains clear and does not become obstructed.
- Always listen to parents and respond immediately to any concerns raised.
- Medicines given to the mother should be considered when discussing skin-to-skin contact. Pain relief given to mothers can affect their ability to observe and care for their baby.

Additional risk factors should be considered. The level of risk for SUPC when a baby is in skin-to-skin contact can increase with, for example, increased maternal body mass index, antenatal use of opiate medication, sedation, and staff's focus on other tasks.

References

(2) UK Baby Friendly Initiative. Guide to the Baby Friendly Initiative Standards, 2012.

4) DeChateau P. The first hour after delivery. *Paediatrician* 1980; 9: 151–168.
(24) UNICEF UK. The evidence and rationale for the UNICEF UK Baby Friendly Initiative standards. UNICEF UK, 2013.

HISB National Learning Report Neonatal collapse alongside skin-to-skin contact published August 2020

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