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Skin to Skin after Cesarean Birth

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Skin to skin contact between mother and infant for at least 1 hour following delivery is now recognized as preferred and optimal postpartum care for both vaginal and cesarean births. Ensuring skin to skin care is also a requirement for hospitals seeking Baby-Friendly designation. However, providing this care, especially post cesarean, can create challenges when practices need to change, especially after a surgical birth. This issue's RoundTable reports on changes and challenges from practitioners involved in different aspects of postpartum care in the operating room and their experience of instituting skin to skin care post cesarean.

Question 1: When did your hospital start to do this, and about what percentage of your healthy cesarean babies currently go skin to skin?

Shields: We started to implement skin to skin in the operating room (OR) in early 2012 at Tséhootsooí, a tribal hospital serving mostly Navajo, with about 500 births per year. At first only the nurses who were big proponents were putting the babies skin to skin and now all of our healthy babies get put skin to skin in the OR.

Madamangalam: The University of Oklahoma Health Sciences Center is a tertiary health care center, and we have 4200 to 4500 deliveries a year. There is an even mix of low and high risk deliveries. The hospital draws a patient population from all over the state as well as the surrounding states. Our hospital is well known for its level 3 neonatal intensive care unit, and this attracts a large high risk obstetric (OB) population. We started performing skin to skin contact in mid-2012 and, since then, the practice has gained strength. Currently, about 40% to 50% of babies are placed skin to skin. Although, when 1 of our certified nurse midwives is caring for the patient, it's closer to 85% to 90%. Recently, 1 of our OB residents declared she wanted skin to skin contact for all her cesarean sections (CS). I am sure our numbers will start to rise soon, as adoption by 1 resident recruits other residents by peer observation, and they find it is not as difficult or disruptive to the current established routine.

Barbero: We started the skin to skin after cesarean birth project at Madrid's Doce de Octubre Hospital in about 2007, performing the first ones with members of our hospital staff. We are a tertiary hospital that attends more than 500 000 people, with nearly 5000 births per year. These experiences allowed us to design a protocol and introduce skin to skin care for planned cesareans without serious maternal or fetal pathology. For 3 years now, we have offered skin to skin for all nonemergent cesarean births, and about 80% of them have been successfully executed.

Question 2: What type of reactions have you had among patients, since implementing skin to skin care post cesarean?

Shields: When a mom is planning on having a vaginal delivery and ends up with a cesarean, it can be devastating. Taking the baby away from mom while the surgery is finishing up and during recovery just adds to the devastation. Our moms have loved keeping their babies with them in the OR and recovery and having the opportunity to breastfeed right away even though they did not get the vaginal delivery they were hoping for. We have also noticed that when moms and babies are skin to skin in the OR and in recovery, they have less breastfeeding difficulties.

Barbero: Most of the patients are really pleased with this opportunity, which has turned cesarean section into a more humane way of giving birth, avoiding the mother-baby breakup; decreasing angst for mothers, babies, and companions; and easing the onset of breastfeeding after a cesarean birth.[1]

Madamangalam: Patients have welcomed it, though some have had doubts about the security of the baby on their chest. The hesitation was usually due to the fear of losing control of the baby and, in new mothers, a fear that they would somehow harm the baby. They have invariably been very glad that they were able to hold and support the baby after they went through with the skin to skin contact period.

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Question 3: How do you manage staffing around skin to skin in the OR?

Madamangalam: We are very happy that we have not had to make any staffing changes. We did invest a certain amount of time in nursing and physician education and then reinforced it with help and support in the OR. We have always had a circulator and a separate baby advocate in the OR. The baby advocate focuses on the baby exclusively and the circulator's only focus is the mother and the surgical process. In addition, the anesthesiologist monitors the mother constantly. Our nurse midwives are in the OR with their patients during the entire CS, and therefore we have someone that exclusively pays attention to enhancing this family experience at such times.

Shields: The nurse who was taking care of the mom on labor and delivery takes care of the baby in the OR and the circulator takes care of the mom. Once they move to the recovery room, the labor nurse continues to take care of the baby while the post-anesthesia care unit nurse takes care of mom. When they are done with recovery, mom and baby move back to postpartum where the nurse who was taking care of the baby takes care of them both. We also have "breastfeeding champions" throughout the hospital, including in the OR. These nurses have had breastfeeding training and can be an additional resource for the moms. Since the breastfeeding champions have had training, they understand the importance of keeping mom and baby skin to skin.

Barbero: The obstetrician, anesthesiologist, and neonatologist decide together on the suitability and safety of the mother and baby regarding skin to skin.[2] Once the patient is approved, the obstetrician informs and encourages the mother and her companion, and the midwife is responsible for preparing the partner and bringing them to the OR. After the birth, the midwife puts the baby on mother's chest and the neonatologist assesses the baby there.[3] The neonatologist remains in the OR for about 15 minutes, and then the neonatologist nurse is responsible for caring for the baby, ensuring continuation of skin to skin, and enabling breastfeeding initiation. When the cesarean section is finished, the mother, her baby, and her companion are taken to the postoperative care unit, where we have special places designed to ensure privacy and quiet. Before the mother is discharged, the neonatologist nurse checks on the baby's condition and on successful establishment and support of breastfeeding. If the mother cannot provide skin to skin care because of medical reasons, her companion is strongly encouraged to continue the process.

Question 4: What was the biggest barrier to skin to skin deliveries, and how did you overcome this?

Barbero: The unfamiliarity of the practitioners involved, which led to a "fear of the unknown," was the biggest barrier. The presence of a stranger in the OR, concern about providing good anesthetic care, which member of the staff should look after the neonate inside the OR area and the postoperative care unit . . . these were the main questions.[2] The solution was creating a detailed skin to skin after cesarean birth protocol with the collaboration of all the involved units, which were hard to coordinate due to the great number of staff implicated. This document describes all the stages of the process and the staff tasks. Also, we created an informational brochure for the patient and her family.

Madamangalam: Our division of obstetric anesthesiology consists of a group of physicians with a particular interest in OB. Initial hesitation was due to not realizing what skin to skin entailed in practice. We worried the baby would not be secure, which we soon realized was not the case. The mother took particular care to hold the baby securely and, if indeed she got tired or sleepy, was quick to ensure the baby was safe and voiced her concerns. In such cases, we asked the family member or support person either to give the baby added support or to hold the baby skin to skin themselves. Needless to say, all this needs coaching and planning. We were also concerned we might not be able to get to our monitors or the maternal airway if the clinical situation demanded it. We found that when the process was a planned event, we located all our monitors away from the maternal chest. Also, the person planning the skin to skin contact, usually the nurse midwife, was with us from the beginning of surgery to the end and helped the mother as well as the anesthesiologist by positioning the baby, ensuring the mother and baby were safe and secure, and monitoring mother and baby continuously. This assured anesthesiology and nursing that, if it became a medical necessity for us to intervene with the mother or her airway, the baby would be immediately moved over to the support person. Being aware of the satisfaction and gratification this simple process can give the family as a whole has helped our anesthesiologists adapt well to this process.

Our nursing staff found that skin to skin altered the rhythm of their established early routine with the baby and mother. Specifically, it delayed measurements, temperature recording, and documentation. With a little bit of reinforcement, education, and encouragement, the concept changed from this being an intrusion in the nursing routine to a great and desirable family experience. The nurses became advocates for

skin to skin and were able to adapt their routines with the baby on the maternal chest. It also helped that some of our labor and delivery nurses were the recipients of the skin to skin contact and became firm advocates! They propagate the phenomenon enormously.

Shields: Staff thought it would be too difficult and time consuming. We started by having a couple of nurses who were real big proponents of skin to skin do it and they were able to show the others that it wasn't difficult. Slowly, more and more nurses started to do skin to skin in the OR; now it is the standard. Other OR staff were concerned that the baby might "get in the way," but they soon saw this did not happen. We also did some role play with the staff so they knew what it would be like beforehand. They have enjoyed seeing the mom's joy and seeing the baby latch on unassisted. The nurse anesthetists are supportive, too, and frequently let everyone know what the baby is up to.

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Respondents

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