



CLINICAL PRACTICE GUIDELINE

Guideline coverage includes NICU KEMH, NICU PMH and NETS WA

Skin - to - Skin Holding

This document should be read in conjunction with the [Disclaimer](#)

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.

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 breast feeding 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 [here](#). 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:

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

Preparation for Skin-to-Skin

- Discuss with parents scheduling of STS cuddles see parent holding guideline re factors to consider in scheduling STS.
- 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.
- 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.

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 and should have the staff member readily available throughout the cuddle to provide assistance should complications arise e.g. dislodgment, blocked ETT.

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

Procedure**For Ventilated infants**

- Ensure the infant is dressed in a nappy only.
 - Ensure ETTs and IV cannulas are well secured.
- Position infant on his/her back on an open blanket in the cot/incubator, then swaddle in the blanket.
- Ensure the parent is comfortable in appropriate seating. Footstool is optional, depending on height of chair, parent's preference.
- 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.
- 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 blanket around the infant is loosened and may be removed **to allow as much skin-to-skin contact with the parent as possible**. The parent's shirt may be used as a cover. Additional covering may be necessary. Place a bonnet on the infant if necessary.
- 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.
- 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 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.

The FICare method is:

- Place recliner chair ready next to the cot.
- Preparation of the baby is the same as per Ventilated Baby.
- 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 babies' 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.

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 WNHS policies, procedures and guidelines

Neonatal Clinical Guideline – [Parenting in the Neonatal Unit Environment](#)

References

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