Mother-Baby Dyad Care

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Mother-Baby Dyad (M-BD) Care

Overview

- Objectives
- Recommendations
- M-BD Practice Survey Highlights
- Implementation Toolkit

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M-BD Work Group Objectives

To:

- Identify the current state of mother-baby dyad care across the province
- Identify best practices in mother-baby dyad care
- Review best practices for maintaining mother-baby dyad care in the instance of potential or actual complications such as neonatal abstinence syndrome, jaundice, intravenous access required, etc.

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Objectives (continued)

To:

- Identify resources, skills and educational requirements to support mother-baby dyad care
- Recommend strategies to standardize best practice in mother-baby dyad care
- Identify a methodology for benchmarking Level II nursery admissions

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The M-BD Recommendations Support:

- National Guidelines for Family-Centred Maternity and Newborn Care
- World Health Organization (WHO) guidelines for Postpartum (PP) care of mother and newborn
- Excellent Care for All Act (Ontario 2010)
- Neonatal Resuscitation Program (NRP) guidelines
- Baby Friendly Hospital Initiative (BFI)
- Canadian Pediatric Society (CPS) guidelines
- Society of Obstetricians and Gynecologists of Canada (SOGC) guidelines

What has changed?

Historically, a newborn's survival was dependent upon close and continuous maternal contact.

Modern day hospital routines often disrupt the early maternal-infant relationship for the purpose of convenience and efficiency, and have never been validated.

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Special Care Nursery Admission Rates

- Wide variation in admission rates across Ontario, from 5% to >30%
- 42% of hospitals surveyed by PCMCH in 2009 reported rates greater than 25%

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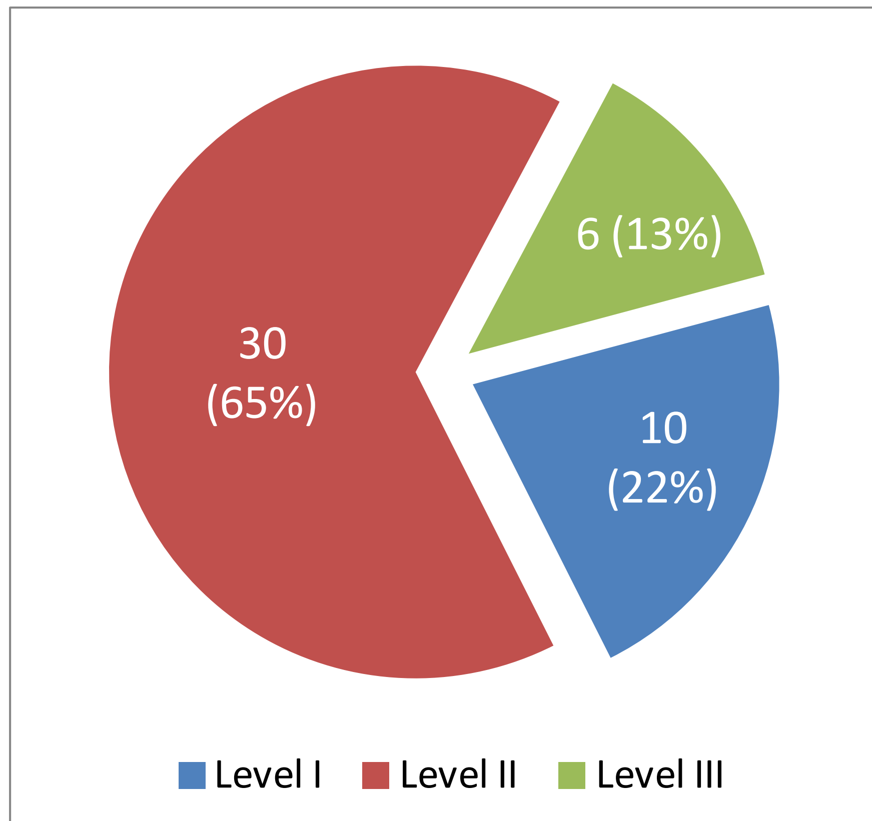
Mother-Baby Dyad Practice Survey

December 2011



Total participants*:

46

Hospital Sites

*Out of a total 108 sites that were surveyed

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Benefits of Mother-Baby Dyad Care

- Utilize skin-to-skin care (ssc) to reduce heat loss and promote thermoregulation
- Promote mother-infant attachment behaviours
- Increase breastfeeding success
- Decreased crying
- Fewer expressions of pain during procedures such as heel prick blood sampling
- Improved utilization of resources
- Provision of evidence-based care
- Enhanced family-centered care
- Increased patient satisfaction

Image used with permission from UNICEF Maharashtra, Prashant Gangal , "Initiation of Breastfeeding by Breast Crawl", 1st edition, 2007.

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Recommendation #1

Initiate continuous, uninterrupted skin-to-skin care (SSC) immediately post birth and continue for a minimum of 2 hours.

Encourage SSC throughout postpartum stay with mother and support person

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SSC Supports Physiologic Transition of the Healthy Newborn

- A mother's body warms up or cools down to moderate the temperature of her infant's body, preventing hypothermia
  - Hypothermia and cold stress lead to respiratory distress and hypoglycemia
- SSC regulates breathing
- SSC regulates blood glucose levels
- SSC increases success of initial breastfeeding

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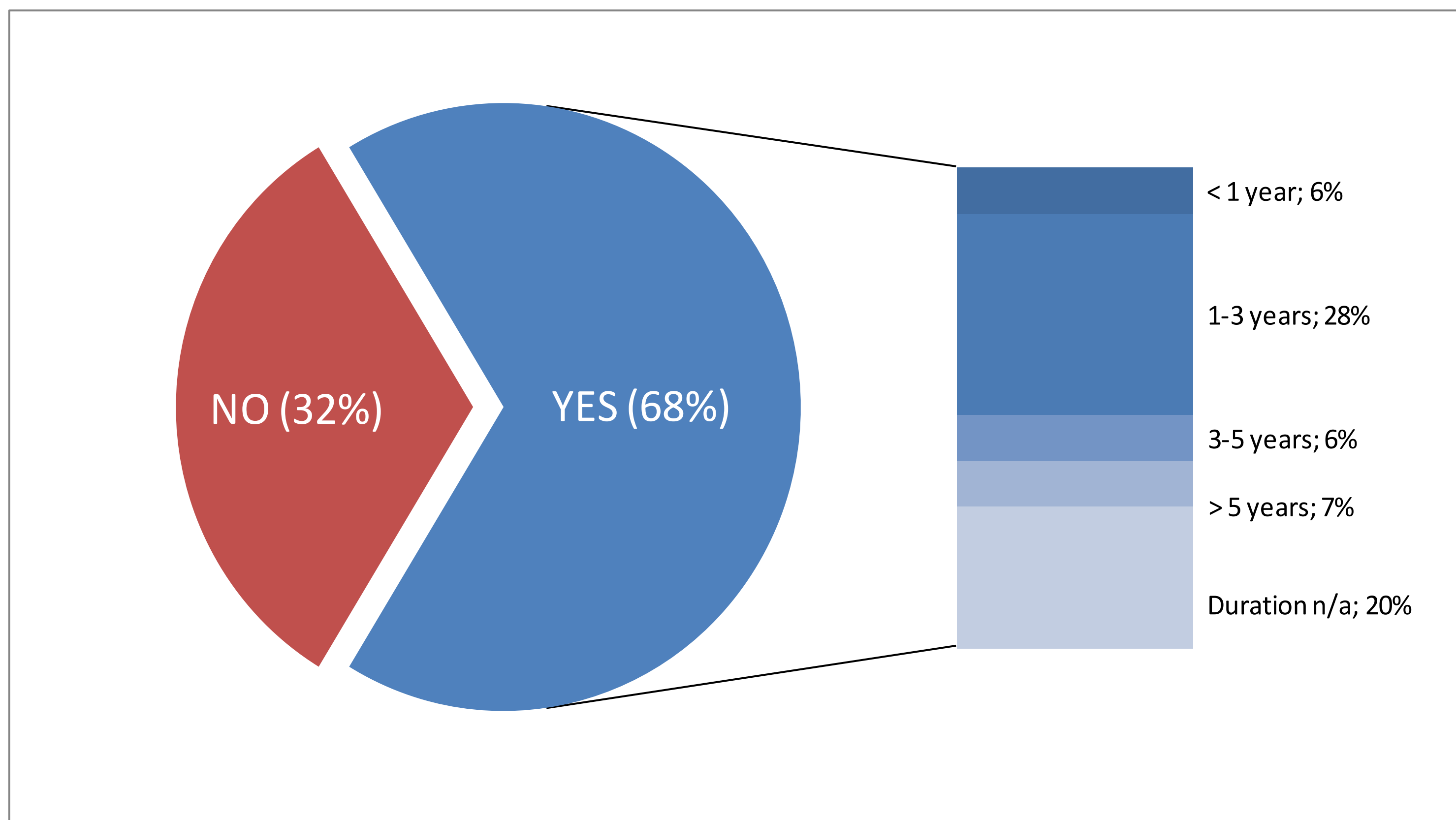
Mother-Baby Dyad Practice Survey (2011)

- Is continuous, uninterrupted skin-to-skin care practiced immediately after birth in your organization? (n=46)
- If YES, for how long has your organization practiced ssc? (n=31)



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Recommendation #2

Maintain skin-to-skin contact while doing assessments and interventions

Common interventions that can be conducted during skin-to-skin care:

- Physical assessment
- Vitamin K injection
- Erythromycin ointment application
- Oxygen
- Heel prick blood sample

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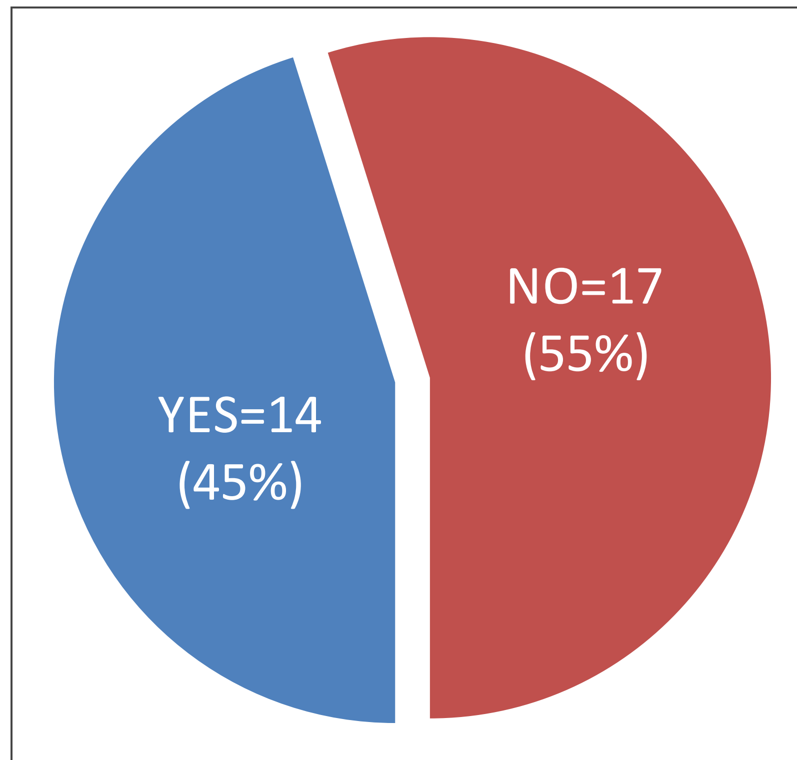
Mother-Baby Dyad Practice Survey (2011)

Is the ssc maintained during assessments (i.e. grunting, physical examination) and interventions such as administration of vitamin K injection, erythromycin ointment application, heel pricks etc (n=31)



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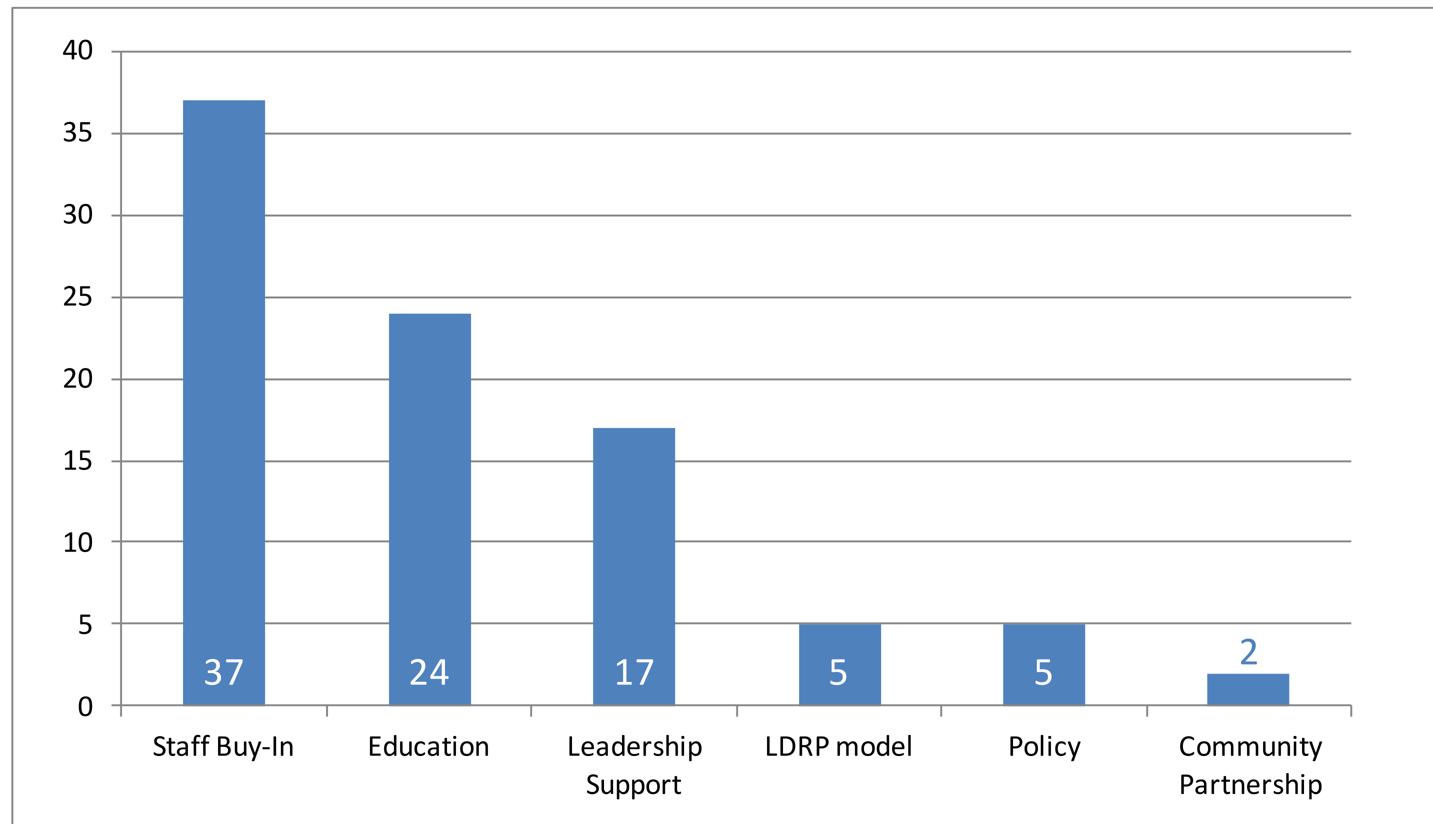
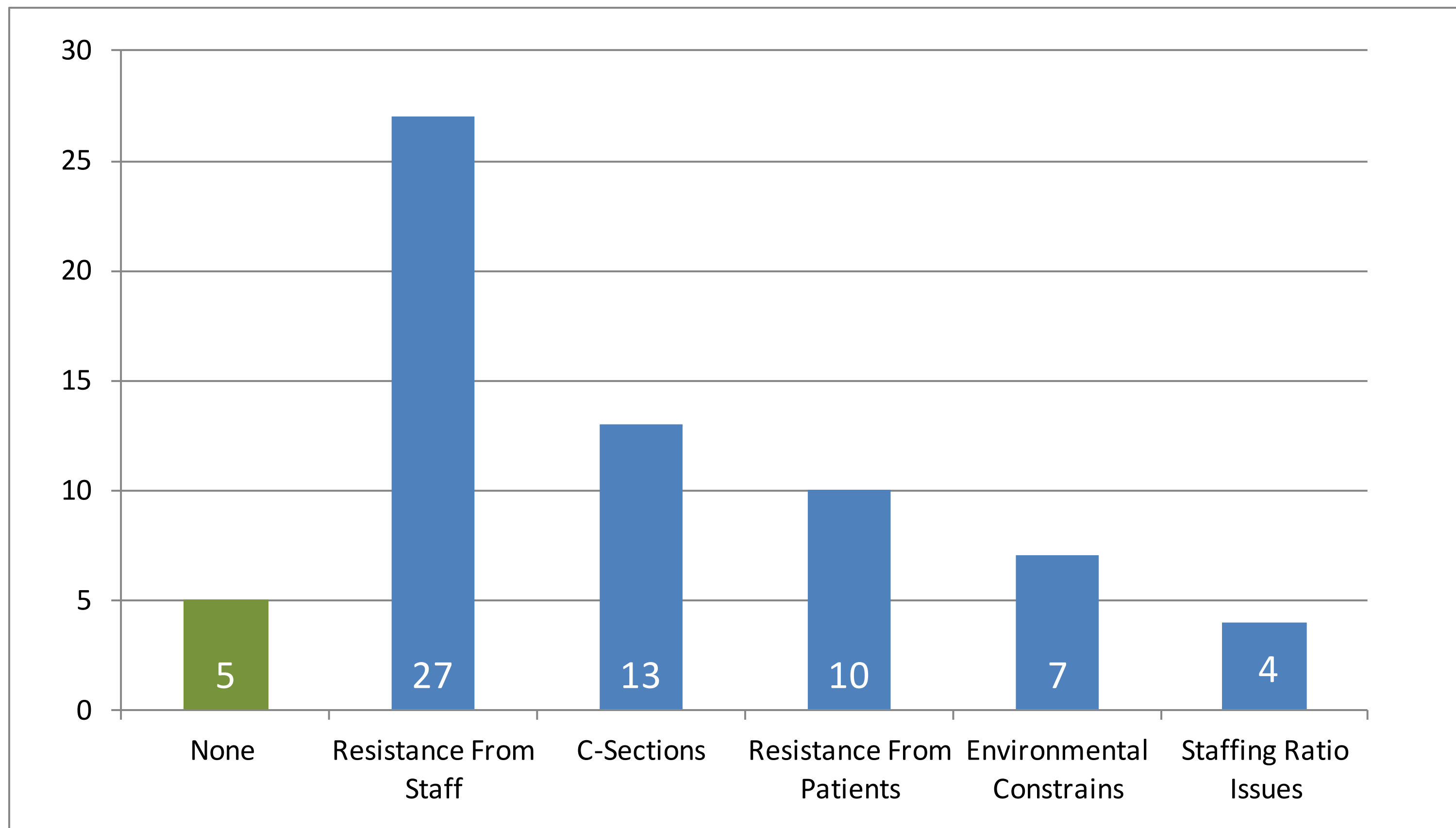
Mother-Baby Dyad Practice Survey (2011)

What are the **ENABLERS** within your organization that support the practice of ssc? (n=44)



Mother-Baby Dyad Practice Survey (2011)

What are the **BARRIERS** within your organization to practicing of SSC? (n=45)



Recommendation #3

Avoid unnecessary interventions, particularly those that may result in complications requiring transfer to the nursery i.e. routine suctioning.

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PCMCH: Admission Criteria for Level II Special Care Nurseries

This admission criteria document is developed to guide newborn admissions and the acceptance of retrotransfers at each of the three level II nursery designations.	
Notes:	
	1) Criteria are guidelines and individual clinical decisions are made with full consideration of the individual infant and the resources availble to meet the infant's needs.
	2) Retrotransfer admission criteria differ from regular admission criteria.
	3) Note: some maternal conditions require the care of a paediatrician but not necessarily admission to the nursery
	4) All infants less than 35 weeks+ 0 days or less than 2300 grams should be admitted to a level II nursery
II A	**Admission Criteria**
	Greater than 33 week s+ 6 days and 1800 grams
	Hypoglycaemia if IV therapy required
	Suspected sepsis if getting IV antibiotics
	Persistent temperature instability
	Suspected cardiac problems
	Neurological abnormalities
	Congenital abnormalities
	Respiratory distress
	Babies who have received Narcan
	cardiorespiratory monitoring
	O_2 therapy
	NGT feeding
	Observation for drug withdrawal
	Stabilization prior to transfer to a higher level unit
	Observation after retrotransfer from a higher level unit
	Newborns requiring a safe environment (CAS)
	Administer blood products
II A	**Retrotransfer Admission**
	Stable neonatal retrotransfers that are over 30 weeks + 6 days (corrected) gestation and not requiring assisted ventilation or advanced treatments or investigations. This would include infants with:
	Tolerance of full enteral feeding
	Chronic lung disease requiring low-flow oxygen therapy
	Stable apnea of prematurity
	Conditions requiring isolation
	Need for palliative care
II B	All treatment available in level II A and:
	Infants greater than 31 weeks 6 days and 1500 grams
	TPN
	Ventilation support for 12 to 48 hours
	CPAP
	Umbilical central lines
	PICC line maintenance
	Administration of blood products
II B	**Retrotransfer Admission**
	Stable neonatal retrotransfers that are over 29 weeks + 6 days gestation and over 1200 gramsnot requiring assisted ventilation or advanced treatments or investigations. This would include infants with:
	Tolerance of full or increasing enteral feeding
	Chronic lung disease requiring minimal or low-flow oxygen therapy including retortransfer CPAP
	Stable apnea of prematurity
	Evidence of stable or regressing retinopathy of prematurity (ROP)
	Need for palliative care
II C	All treatments available at Level II B and:
	Care of infants with a greater than 29 weeks + 6 daysgestational age and a weight of greater than or equal to 1200g who are ill with problems expected to resolve within a week
	Ventilation > 48 hours but expected to resolve within a week
	Access to PICC line insertion; PICC line maintenance
	When geographically required some centres may accept children of a lower gestational age and probable longer ventialtion
	Retrotransfer Admission
	Requests for retrotransfer should be reviewed on a case-by-case basis between the tertiary and receiving sites.

Will be posted online:

www.pcmch.on.ca/ClinicalPracticeGuidelines/MotherBabyDyadCare.aspx

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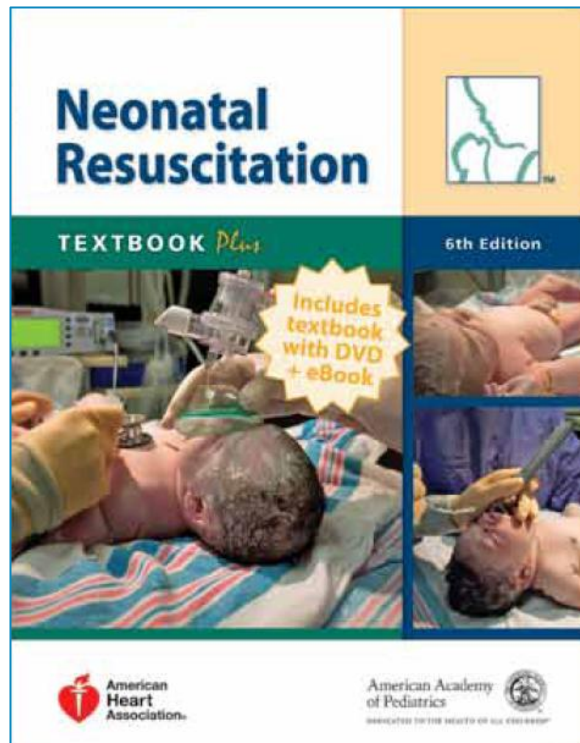
Recommendation #4



Manage transition using assessment skills recommended in the Neonatal Resuscitation Program (NRP) guidelines

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Recommendation #5

Bring the resources, expertise & equipment to the infant instead of the infant to the resources. Clinical therapies or treatments should be carried out at the bedside whenever possible.

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Recommendation #6

Incorporate delayed cord clamping for a minimum of 2 minutes after birth into day-to-day practice.

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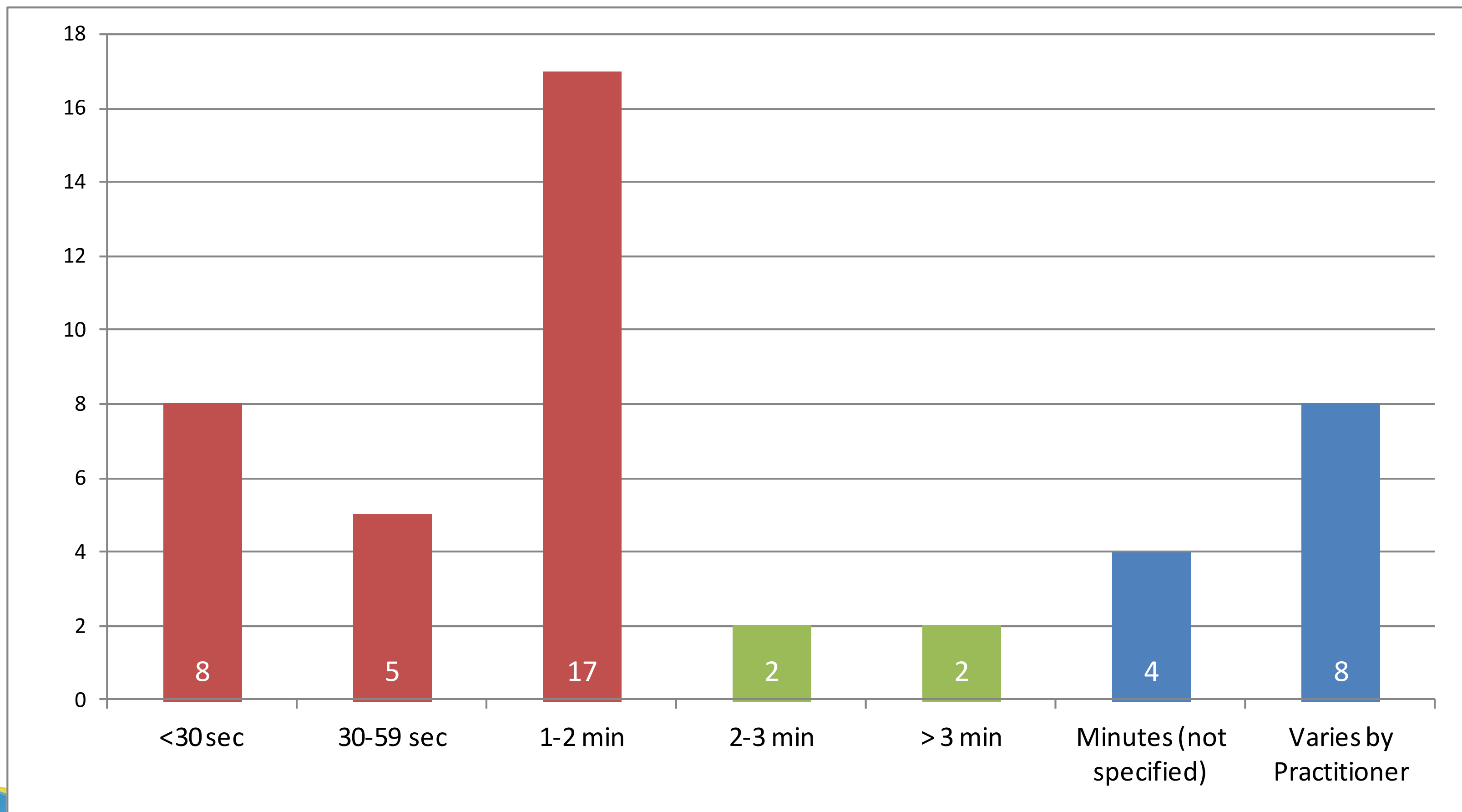
Mother-Baby Dyad Practice Survey (2011)

How long do you wait before clamping the umbilical cord? (n=46)



Recommendation #6 (continued)

Delayed cord clamping impacts practices relating to:

- Cord blood gas collection
- Cord blood stem cell collection

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Recommendation #7

Use of respite/observation nursery

(separate spaces in postpartum areas)

should be discouraged unless there are

maternal medical indications or for safety.

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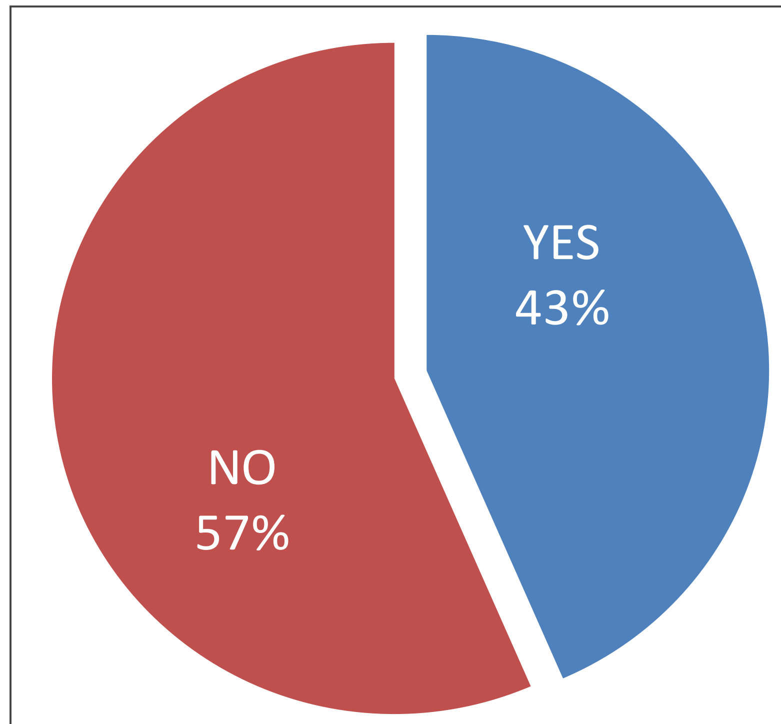
Mother-Baby Dyad Practice Survey (2011)

Do you have a space in the OBS unit where babies are moved for periods of observation and/or respite? (n=46)



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Recommendation # 8

Create therapeutic environments that support mother-baby dyad care.

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How much and what kind of support is recommended to facilitate best practice?

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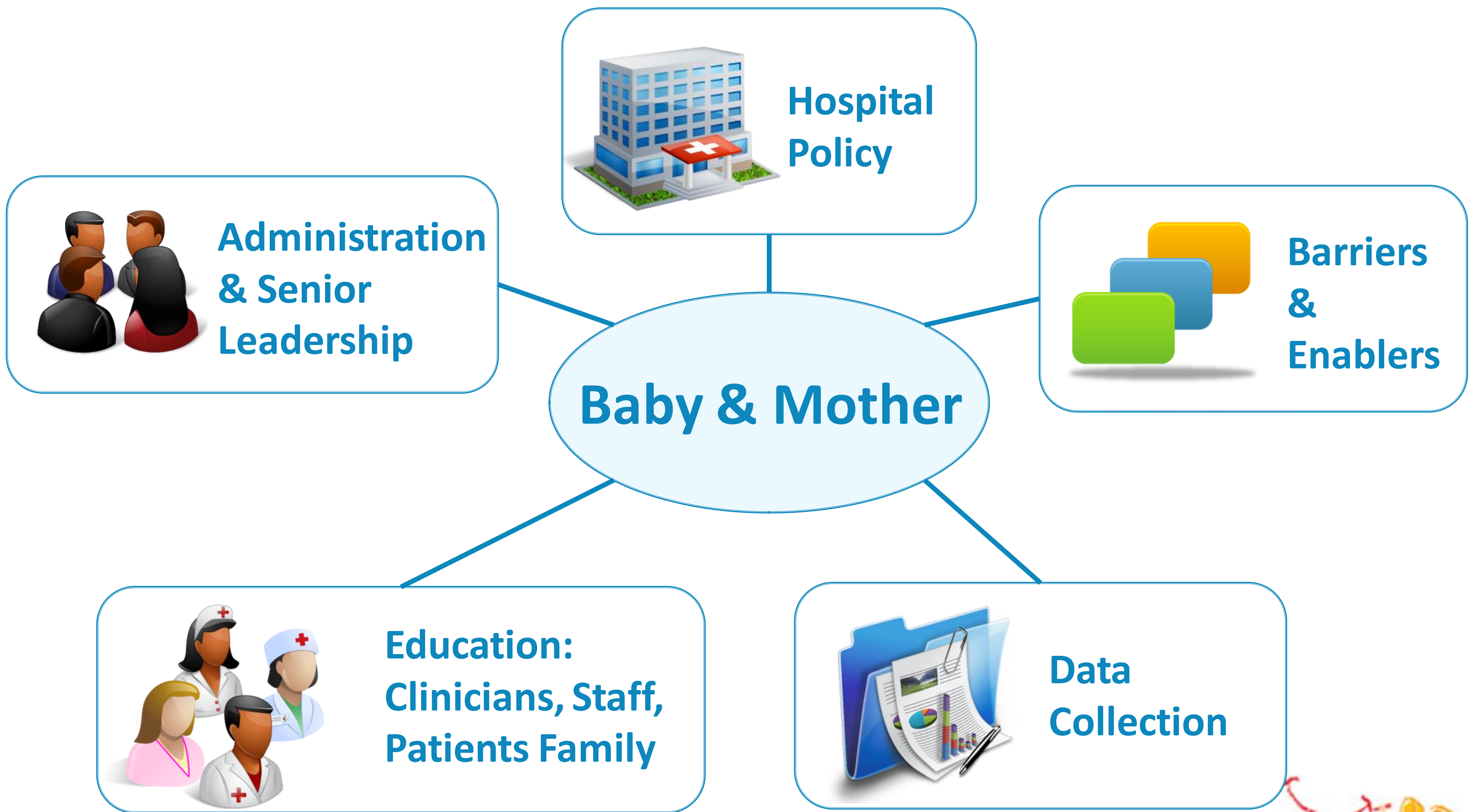
Components of M-BD Care



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Implementation

Toolkit for implementation of mother-baby dyad care

CONTENT:

1. Implementation guide
2. Teaching package consisting of:
   - Pretest
   - Slide deck
   - Video
3. Audit tool

http://www.pcmch.on.ca/ClinicalPracticeGuidelines/MotherBabyDyadCare.aspx

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Implementation

Monthly Teleconferences

Thursday, September 13th
2:00pm-3:00pm

Tuesday, October 2nd
2:00pm-3:00pm

Thursday, November 8th
2:00pm-3:00pm

Take home message

Practice changes that support keeping the mother and newborn together immediately after birth and during the postpartum period will have both short and long term benefits for the infant, the family and the system.

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Visit PCMCH online at: www.pcmch.on.ca
Or contact Anna Shynlova at anna.shynlova@pcmch.on.ca