## Mother-Baby Dyad Care Webinars (April 11, April 26, and August 9, 2012) 
### Questions & Answers

<table>
<thead>
<tr>
<th>Q 1</th>
<th>What is the best way to handle barriers when it comes to implementation of the skin-to-skin care (ssc) in the operating room (i.e. resistance from staff)? Do you have an example of ssc policy for the OR?</th>
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| A   | • If you have not implemented continuous, uninterrupted skin-to-skin care in your birthing unit yet, we recommend you begin with vaginal births first. As ssc becomes comfortable and natural for clinicians, then address the operating room. With the national C-section rates being close to 27%, becoming proficient with ssc for vaginal births first means close to 74% of newborns will benefit from ssc.  
When focusing on the C-section population, note that the Anesthesiologists will play an important role in the success of your implementation. Make sure to engage them early in order to ensure their support of the practice. The support person can provide ssc in the operating room if the mother is unable to do so. |

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<tr>
<th>Q 2</th>
<th>Will there be a cost for the Implementation Toolkit from the PCMCH to the institution that requests one?</th>
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<tr>
<td>A</td>
<td>No. The Implementation Toolkit is available free of charge on the PCMCH website. <a href="http://www.pcmch.on.ca/ClinicalPracticeGuidelines/MotherBabyDyadCare.aspx">www.pcmch.on.ca/ClinicalPracticeGuidelines/MotherBabyDyadCare.aspx</a></td>
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<th>Q 3</th>
<th>Can you comment on the strategies used to overcome some of the staff resistance factors in the hospitals that you surveyed?</th>
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| A   | The key strategies to use when implementing a successful change in practice include:  
• Ensuring early education for multidisciplinary staff. Informing and engaging all stakeholder groups, including physicians, midwives, anesthesiologists, nursing staff, educators, respiratory therapists, lactation consultants and volunteers, is important in order to mitigate potential barriers.  
• Developing front-line change champions. Focus on the most willing and engage them early on to demonstrate the benefits and to help drive change. As front line clinicians witness the benefits of ssc they will become more willing to embrace this practice change.  
• Involving those who are resistant in the process of implementation. Provide opportunities for them to observe other clinicians who can role model ssc. Create opportunities for discussion and problem solving regarding implementation challenges.  
It is important to realize that mother-baby dyad care does not require special equipment or supplies for implementation. It is simply a variation on the way we provide care that is not associated with extra cost. |

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<th>Q 4</th>
<th>Have these recommendations been reviewed with the Breastfeeding Work Group?</th>
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<td>A</td>
<td>The recommendations have not been formally reviewed by the Breastfeeding Work Group.however the evidence indicates that ssc has positive effect on early breastfeeding. Therefore, we do not anticipate any conflict with their recommendations.</td>
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<th>Q 5</th>
<th>How can we implement ssc while safely monitoring for Neonatal Abstinence Syndrome (NAS)? Can you name any reasons for not practicing ssc immediately post delivery with babies who may potentially go on to develop NAS?</th>
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<td>A</td>
<td>Skin to skin care is recommended for an infant at risk for NAS. The NAS Work Group Clinical Practice Guidelines recommend that the babies are transferred to a Special Care Nursery only when they require pharmacological intervention. For more information and to download a copy of the NAS Clinical Practice Guidelines, please visit us online at: <a href="http://www.pcmch.on.ca/ClinicalPracticeGuidelines/NeonatalAbstinenceSyndrome.aspx">www.pcmch.on.ca/ClinicalPracticeGuidelines/NeonatalAbstinenceSyndrome.aspx</a></td>
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<th>Q 6</th>
<th>Do you consider ssc on the postpartum unit an intervention or routine care? Can you comment on how</th>
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ssc fits with tucking the baby in bed with mom to support exclusive breastfeeding?

A We recommend ssc be part of routine care when the mother is awake. The Canadian Pediatric Society does not recommend bed-sharing for at least the first six months of child’s life.

Q 7 In rural hospitals physicians have a great deal of influence on practice. Has there been a strategy to get buy-in from physicians?

A Physicians represent a very important stakeholder group, particularly when it comes to certain recommendations such as delayed cord clamping. Early engagement in the change process is important when it comes to overcoming potential barriers in this group.

Q 8 Should the mom be getting up to use the bathroom in the first 2 hours postpartum? Can you comment on whether it is better to have the partner provide skin-to-skin for the baby or to do the physical assessment of the baby at the warmer during that time?

A SSC should not interfere with the mother getting up to the bathroom. Ideally, the partner should provide ssc while the mother is away. If the partner/support person is not available, you can use a warmer or bassinet.

We recommend maintaining ssc during physical assessments of the baby. This provides a great opportunity to introduce the baby to mom and dad, and to help build their confidence as parents. It is also an important teaching opportunity.

Q 9 What is your plan to assist the teams with difficult aspects of implementation if they are already achieving ssc for majority of births? Might there be a further work group?

A In follow up to the April webinars, PCMCH is considering local “train-the-trainer” session(s) in order to assist organizations with their implementation strategies. The webinar evaluation survey will include questions to help us assess whether or not these would be of value to providers. Such sessions could be customized – for example we could plan a session to help organizations that are advanced in their implementation in addition to sessions for those just getting started.

Q 10 Working with RNAO on safe sleep best practice guidelines, there was a lot of discussion around skin-to-skin with baby sleeping on mothers’ chest. This is a difficult issue; unfortunately there have been situations where there have been bad outcomes and even death with babies during skin-to-skin. What guidelines need to be in place to make this safe?

A There have been a few reports, and a term has been coined: sudden, unexpected post-natal collapse (SUPC). It is a rare case where a healthy term infant is found almost dead or dead in their mother’s arms. Each case is different. These deaths usually occur within the first 24 hours of the post partum period. We have to be careful not to let a few cases offset the benefits of skin-to-skin care.

One thing that is very important is to teach the parents to position the baby so that the airway is not obstructed and make sure that both mother and the staff check the positioning while the infant is skin-to-skin. Follow-up is important as mothers are often tired. After breastfeeding they feel relaxed and may get a little sleepy. We do not recommend co-bedding. If the mother is sleepy/sleeping the baby may be cared for skin-to-skin with an alternate person, such as a partner or grandparent, or alternatively placed in a bassinet.

Q 11 Are there any guidelines regarding potential changes in the staffing ratios, given the increased monitoring that may be required during skin-to-skin care?

A One would anticipate a decrease in admissions to the Special Care Nursery due to improved management of the post-natal transitional period. SCN resources may be re-directed to support mother-baby dyad care in the post-partum unit as needed. The SCN nurse can help to manage care requirements such as antibiotic administration in order to support mother and baby remaining together. Cross-training of staff is another option to facilitate having the right resources available to meet patient care needs wherever they occur.

Q 12 What if the mother is hypothermic post C-section?

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**A** Assess each situation based on the specific circumstances. Maternal hypothermia may limit the mother’s ability to warm her infant therefore skin-to-skin should be done by the other parent or family member in this situation.

**Q 13** We currently do not recover our c-section patients. Do you have any suggestions for implementing skin-to-skin care in this population in the recovery room?

**A** If you don’t recover the mother, explore other options that would allow the baby to stay with the mother. The baby may be taken care of by the recovery room nurse who is recovering the mother. Alternatively you can train perinatal or SCN staff to recover the mother in the recovery room. You may also consider using a support person to provide skin-to-skin care until mother is out of the recovery room.

**Q 14** During the initial newborn assessment, do you delay the weight until after the 2 hours of skin-to-skin care.

**A** Yes unless the weight is urgently required for treatment purposes. Most practitioners are happy to delay until after the 1st feeding. This would only be a problem if you must have an accurate baseline weight. In many cases it is not the parents who are eager to weigh the child, but the practitioner. Practitioner education will be important in modifying this practice.

**Q 15** What are your thoughts regarding post-partum depression prevention intervention?

**A** If the mother has a history of post-partum depression it is important to support her need to sleep at night. At the same time, the baby can still benefit from skin-skin care during waking hours.

**Q 16** Is everyone keeping the baby skin-to-skin during the first hours? Does the nurse sometimes take the baby to the warmer to wipe them down, wrap the baby and give them back to the mom?

**A** It depends on the normal practice of the provider/hospital and particularly of the nursing staff. We are recommending skin-to-skin care as an evidence-based best practice. As practitioners incorporate skin-to-skin into their routine care, they will dry and wrap the baby while on the mother.

**Q 17** Babies can receive skin-to-skin care from grandparents too, especially with a planned c-section, as there is lots of time for planning.

**A** Yes. This is consistent with the above recommendation regarding the use of a support person.

**Q 18** What are the advantages of delaying cord clamping for 2 minutes?

**A** Delayed cord clamping for 2 minutes results in a decreased risk of anemia and decreased risk of iron deficiency during the first 3 months after birth. In the preterm population, it was found to decrease the incidence of anemia, sepsis, and intraventricular hemorrhage.


**Q 19** What is the evidence for using ssc in the special care nursery for infants receiving C-PAP?

**A** The work of the Mother-Baby-Dyad Work Group focused on healthy infants in the period immediately after birth and postpartum. It did not include the infant receiving CPAP in the nursery. Perhaps the research for kangaroo care would be applicable to this.

**Q 20** Does the toolkit include details for implementation of ssc in the operating room in consideration of ORNAC standards?

**A** The toolkit provides a framework to guide implementation of ssc, however it does not contain specific actions for implementation. SSC in the operating room does not compromise existing operating room (OR) standards of care. If the mother is unable to provide ssc in the OR, her support person may provide ssc instead.

**Q 21** What kind of written material does PCMCH provide to support prenatal education?

**A** PCMCH has not developed prenatal educational materials re: ssc. Resources are available from within the community, for example Toronto Public Health recently launched a new campaign "Skin-to-Skin is the Healthiest Place to Begin", aimed at prenatal and postpartum women.

http://www.toronto.ca/health/breastfeeding/skin_to_skin.htm
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<th>Q 22</th>
<th>What are the benefits of ssc for infants after two weeks of age?</th>
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<td>A</td>
<td>Many of the benefits of ssc immediately after birth and in the early postpartum period continue for the weeks and months following birth, including: enhanced bonding and attachment, decreased infant crying, and increased breastfeeding success.</td>
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