

NICU SKIN TO SKIN CONTACT (KANGAROO CARE) GUIDELINES

I. PURPOSE

To provide guidelines for Skin to Skin Contact (STSC) in the NICU.

II. DEFINITION

STSC is when the infant dressed only in a diaper and a hat rests skin to skin against the parent's (or other person designated by parent) bare chest.

III. SKIN TO SKIN BENEFITS

- A. Stabilizes the infant's heart rate, allows for a more regular breathing pattern and a more stable oxygenation level.
- B. Promotes longer periods of sleep for the infant and increases deep sleep states.
- C. Improves weight gain
- D. Promotes brain development.
- E. Decreases time to transition to the breast
- F. Improves the mother's milk production.
- G. Promotes bonding and makes the parents feel that they are contributing to their child's needs/care.
- H. Decreases hospital stays.

IV. ELIGIBILITY CRITERIA

- A. Eligible Providers:
 - 1. Mother and father may provide skin to skin.
 - 2. Support person with maternal permission.
 - 3. Adoptive parents once "consent to adopt" signed and a copy is in the chart.
 - 4. Providers of skin to skin must be free of rashes, lesions or open areas of skin that could come in contact with baby during skin to skin session.
 - 5. Lactating mothers should be encouraged to practice skin to skin care and should pump before each skin to skin session
- B. Eligible Infants:
 - 1. Stable premature or term infant.
 - 2. No weight limitations.
 - 3. Respiratory status stable (NCPAP or intubated)
 - 4. PICC, Broviac, or UVC is permissible.
 - 5. UAC/PAL and Chest Tube require an MD/NNP order.
 - 6. Skin to skin may be done simultaneously with twins as long as neither

twin has a suspected or proven infection.

- C. Possible exemptions: most babies should be candidates. Discuss the infant's tolerance for skin to skin contact with primary medical team.
1. Infants during first 24 hours of mechanical ventilation.
 2. Infants having severe apnea, requiring more than tactile stimulation to recover.
 3. Infants receiving vasodilators, vasopressors, analgesic/sedatives via continuous IV infusion. Infants on low dopamine may be considered stable if frequent adjustments of the dosage are not required.
 4. Infants requiring increased ventilatory support such as increasing pressures, oxygen requirements, or reintubation.
 5. Phototherapy
 - a. Contraindicated if rapidly rising TsB, 2-3 banks of phototherapy are required, or TsB is nearing exchange level.
 - b. Skin-to-skin should be considered if TsB is stable and not rising rapidly. Biliblanket should be used during skin-to-skin. There should be no time limitation placed on skin-to-skin unless deemed necessary by infant's tolerance of skin-to-skin or per medical team discretion.

IV. ASSESSMENT

- A. Assess providers' readiness to practice skin to skin care:
1. Mutual planning should be done with the family to determine the frequency of practicing skin to skin. When an infant is first determined to be eligible, skin to skin may be initiated once per day, then increasingly more often depending on the baby's tolerance of the procedure (or continuing eligibility) and the parent's availability.
 2. Parents must verbalize understanding of the guideline and viewed skin to skin videos.
 3. Inform parent to set aside at least a 30 minute block of time for uninterrupted skin-to-skin.
 4. Inform parent that skin to skin can be terminated at parent's request or if infant shows persistent signs of distress such as respiratory distress, apnea, bradycardia or desaturation that does not resolve with usual interventions.
 5. Assess the type of transfer technique that should be performed –parent transfer or nurse transfer depending on the parent's ability to get in and out of the chair by themselves.
- B. Before transferring an intubated infant, assess vital signs, pain score, breath sounds. Check that the ETT is secured, the lines and cables are untangled and ventilator tubing for excess water.
- C. Assure that emergency equipment (bag, suction) will reach infant after transfer.

V. PROCEDURE

- A. Prior to touching infant, nurses must clean and warm hands.
- B. Provide Privacy.
- C. Position as follows:
 1. Providers of STSC must have clean, dry skin and will not wear any colognes, perfumes, oils or lotions, etc.
 2. Mother may remove or wear bra and open blouse as if to breastfeed. Bra should be removed if baby unable to make full contact with bra in place. Baby may get cold if not in full contact during skin-to-skin.
 3. Father opens shirt.
 4. Infant, wearing diaper and hat, is placed prone or sideways, vertically or angled across the chest.
 5. A warm blanket is placed over infant.
 6. Parents may close clothing over infant.
- D. Do not transfer infant immediately after bolus feed. Transfer prior to feed or 1 hour after. Infants may be fed during STSC.
- E. Transfer technique: Parent transfer versus nurse transfer depending of the parent's ability to get in and out of the chair by themselves. **Nurse transfer is the only technique that should be used when infant is intubated.**
- F. Start with 30-60 minutes, once daily and increase as tolerated.
- G. Infant monitoring:
 1. Infants receiving STSC will have continuous cardiorespiratory oximetry monitoring with the exception of an infant stable off oximeter (if it is not necessary to restart oximetry for STSC).
 2. Record temperature prior to and upon return to isolette. Monitor continuous skin temperature of infant < 1000 grams via electronic skin temperature reading on isolette.
 3. If the infant is intubated, monitor vital signs including temperature and pain score at 15 minutes post transfer and then every hour while infant is being held STSC.
- H. Document:
 1. Duration of STSC.
 2. Infant's tolerance of STSC.
 3. Vital signs and pain score for intubated infant.
 4. Problems encountered and action taken.
 5. Interdisciplinary patient-family education flow sheet.

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