POLICY AND PROCEDURE

Title:	Skin-to-Skin Contact for Newborns	Number:	IWK – 1745 NSH – MC-NB-001
Sponsor:	Director Women's and Newborn Health, IWK Health Senior Director Maternal Child Health, NSH	Page:	1 of 16
Approved by:	IWK Policy and Practice NSH VP, Integrated Health Sciences, Primary Health Care Population Health	Approval Date: Effective Date: Approval Date: Effective Date:	October 10, 2023 November 2, 2023 TBD
Applies to:	IWK Health Staff and Health Care Providers NSH Staff and Health Care Providers in Maternal/Newborn Health		

Contents

PURPOSE

The purpose of this policy is to promote and support mothers and gestational parents and infant togetherness through the evidence-based practice of Skin-to-Skin Contact (SSC).

IWK Health and Nova Scotia Health (NSH) support the goals of Kangaroo Mother Care (KMC) in the Neonatal Intensive Care Units (NICU), and at this time do not practice this care exactly as it pertains to its standard definition. Therefore, SSC will be the term used for all care areas.

POLICY STATEMENTS

1. All Health Care Providers (HCP) within the hospital and community supporting families during the prenatal, intrapartum and postpartum periods, must:

    1.1. Provide information to parents about the importance of immediate and uninterrupted SSC, encouraging discussion along the continuum of care.

    1.2. Promote and support the newborn being placed in SSC with their mother and gestational parent immediately following birth regardless of method of birth (vaginal or cesarean section) unless the mother and gestational parent or infant are medically unstable, or safety is an issue.

        1.2.1. SSC must take place for at least one to two hours, until completion of the first feed, or as long as the mother and gestational parent wishes including on transfer to a different care area.

            1.2.1.1. Follow Operating Room Nurses Association Canada (ORNAC) standards for patients giving birth in the operating room.

        1.2.2. Routine assessments of the infant and mother and gestational parent must be completed without interrupting SSC.

        1.2.3. HCPs must document information about initial SSC on the permanent record. Include that SSC:

            1.2.3.1. Was immediate (within 5 minutes).

            1.2.3.2. Was uninterrupted in duration.

            1.2.3.3. Did not occur or if interrupted, had an identified medical reason or request by the mother and gestational parent based on their informed decision.

    1.3. Family and infant togetherness must be supported during the newborn period and

beyond.

1.3.1. Together Practice must be supported for preterm infants equal or greater than 32 weeks gestational age.

2. The newborn must only be removed when the mother and gestational parent or newborn is medically unstable and/or safety is an issue OR if requested by the mother and gestational parent based on their informed decision. SSC must begin/recommence as soon as medical status permits.

3. When the mother and gestational parent is unable to provide SSC secondary to medical issues or safety, the support person, if available, must be offered the opportunity to provide SSC until the mother and gestational parent is able and when safely possible.

3.1. A support person from the same home environment is optimal.

ROLES AND RESPONSIBILITIES

HCP are responsible to:

- Be knowledgeable about the importance of SSC and provide education to families that promotes and supports SSC.
- Support SSC immediately following birth.
- Ensure safety of the newborn.
- Obtain vital signs and observe the infant (temperature, breathing, color and tone) and mother and gestational parent as per standard practice in all care areas without interrupting SSC.
- Support SSC for painful procedures in addition to other supportive practices. For example, blood work, injections, tube insertions and removal or change of tape or adhesive.
- Use the approved IWK/NSH falls prevention tool (see relevant Fall Policy) to assess the mother and gestational parent's ability to safely provide SSC during mother and gestational parent's movement between stretcher, bed or wheelchair.
- Facilitate immediate and uninterrupted SSC in stable preterm infants equal to or greater than 32 weeks gestational age for up to two hours. Assessment of stability and ongoing observation should be coordinated with the neonatal team.

Managers are responsible to:

- Identify Staff and HCP training needs and provide support for education related to SSC, which includes expectations of Staff and HCPs in relation to this policy.

- Implement process to audit SSC practices immediately following birth (in different care team areas) at a minimum annually; Take corrective actions as needed. **Data** collected to include whether SSC is:

    - Immediate (within 5 minutes) and duration of uninterrupted SSC.
    - Delayed – include length of delay and identify medical reason why or if requested by the mother and gestational parent based on their informed decision.
    - Discontinued – identify medical reason why or if requested by the mother and gestational parent based on their informed decision.
    - Not at all (none) – identify medical reason or if requested by the mother and gestational parent based on their informed decision.

IWK and NSH Leadership are responsible to:

- Support development and implementation processes for this IWK/NSH SSC Policy.

PRINCIPLES AND VALUES

Centering the mother and gestational parent with the newborn supports physiologic transition of the newborn following birth. Maintaining togetherness as much as is possible offers positive support to relationship in the immediate postpartum period. These skin-to-skin care practices are upheld in accordance with the principles and values of:

- Baby-Friendly Initiative Implementation Guidelines
- The Children's Comfort Promise
- People Centered Care

PROCEDURE – IMMEDIATE AND UNINTERRUPTED SSC FOLLOWING BIRTH

HCPs are responsible to:

1. Support SSC immediately following birth by:
    1.1. Assisting the mother and gestational parent to place the newborn prone on their chest with the ventral surface of infant's body in direct contact with mother and gestational parent.
        1.1.1. In the event of a gestational carrier, discuss with the patient and intended family the plan for SSC following birth.
    1.2. Drying newborn's back and head.
    1.3. Covering mother and gestational parent and baby with a warm, dry blanket while supporting practices that reduce the risk of infant overheating.
    1.4. Documenting reason if not possible immediately after birth, and reuniting parent-infant dyad in SSC as soon as possible.

2. Prioritize safety of the newborn by:
    2.1. Ensuring the newborn can spontaneously lift their head **at all times** to facilitate optimal breathing and attachment to breast and chest.
    2.2. Visually checking newborn's breathing and color when checking vital signs as per protocol.
    2.3. Ensuring the newborn's nose and mouth are visible **at all times.**
    2.4. Supporting SSC when mother and gestational parent drowsy/asleep by having a support person or nurse present to observe.
        2.4.1. Move the infant to a safe sleep surface if the support person or nurse is not available for ongoing observation.
    2.5. Asking the support person to firmly hold the newborn's buttocks or thigh to avoid slipping, when in SSC with the mother and gestational parent in the operating room.
    2.6. Raising mother's and gestational parent's head of bed gradually and slowly to a comfortable safe position following transfer from operating room.
    2.7. Ensuring family understands how to maintain safety of the infant in SSC.
3. Obtain vital signs and observe the infant (temperature, breathing, color and tone) and mother and gestational parent as per standard practice in all care areas without interrupting SSC and:
    3.1. Delay all routine measurements that necessitate the newborn being removed from SSC (such as weight and assessment for developmental dysplasia of the newborn's hips) until completion of the first feed and completion of the first two hours of SSC.
    3.2. Delay routine medications for at least two hours of SSC or until completion of the first feeding.
    3.3. Ensure newborn medications are administered with newborn in SSC including breast and chest feeding for any painful procedures to support pain management.
4. Use the approved IWK/NSH falls prevention tool (see relevant Fall Policies), to assess and support the mother's and gestational parent's ability to safely provide SSC during mother's and gestational parent's movement between stretcher, bed, or wheelchair.
    4.1. The HCP ensures the newborn is positioned vertically on the mother's and gestational parent's chest; the parent crosses their arms around the newborn to hold securely.
        4.1.1. Additional safety measures as needed based on related Falls Prevention Policy.
            4.1.1.1. As necessary, place the newborn in SSC with the support person, if available, covered with a dry blanket, while the mother and gestational parent is transferred.
            4.1.1.2. As soon as the mother and gestational parent is settled, the support person reunites the infant in SSC with the mother and gestational parent with assistance from the HCPs.

5. Be knowledgeable about the importance of SSC and provide education to families that promotes and supports SSC by:

    5.1. Sharing approved resources and key messages (written and verbal) to families about SSC at all points of care. (See Appendix B)

PROCEDURE – ONGOING SSC

HCPs are responsible to:

1. Promote ongoing SSC for infants of all gestational ages.

    1.1. In preterm infants SSC is recommended for 8-24 hours per day.

    1.2. Recommend SSC sessions be longer than one hour, as this allows the infant to experience at least one sleep cycle.

        1.2.1. If a session cannot be longer than one hour, any amount of SSC is preferred.

2. Be partners in care with the parent(s) and discuss family and infant readiness for SSC:

    2.1. Provide parent(s) with the evidence-based benefits of SSC for their infant and themselves. (Appendix B)

    2.2. Confirm with parents their readiness to provide SSC with their infant.

    2.3. Assess individual infant readiness to be transferred into SSC.

        2.3.1. When an infant is unable to engage in SSC, develop an ongoing plan to reassess readiness.

            2.3.1.1. When concerns arise surrounding SSC and safety of the infant and the direct care providers cannot come to a consensus, initiate a team huddle including the most responsible health care provider to collaboratively g

            2.3.1.2.

            2.3.1.3. ive consideration to the benefits and risks and long-term care goals for the infant.

                i. All efforts should be made to facilitate parental requests for SSC at end of life. Initiate team huddle to address any health care provider concerns.

            2.3.1.4. Document these discussions and plans in the infant's permanent health record.

    2.4. Assess individual parental readiness to hold infant in SSC.

        2.4.1. Consider parent's psychological, physical, and emotional well being.

    2.5. Prepare the parent doing SSC.

        2.5.1. Coordinate timing for SSC.

2.5.2. Ensure parent is physically comfortable, and able to reposition throughout SSC.

2.5.3. Ensure parent knows how to reach out for support as needed.

2.5.4. Review the options for SSC transfer: HCP to parent or parent-led transfer.

2.5.4.1. Review parent-led transfer as necessary.

2.6. Gather equipment.

2.6.1. Pillows, glass of water, gown/tube top, blanket from warmer, chair.

2.7. Prepare the infant.

2.7.1. Consider if diaper change needed.

2.7.2. Place hat on infant if desirable.

2.7.3. For infants requiring increased medical support:

2.7.3.1. Auscultate the chest and suction airway if necessary.

2.7.3.2. Ensure that electronic monitoring leads and pulse oximeter cables are without tension to reach the patient.

2.7.3.3. Ensure resuscitation equipment (neopuff/manual resuscitator) is within reach of the infant.

3. Support transfer of infant into SSC

3.1. Assist the parent to place the newborn prone on their chest with the ventral surface of infant's body in direct contact with mother and gestational parent.

3.2. Cover parent and baby with a blanket

3.3. Prioritize safety of the newborn by:

3.3.1. Ensuring the newborn can spontaneously lift their head **at all times** to facilitate optimal breathing and attachment to breast and chest.

3.3.2. Visually checking newborn's breathing and color when checking vital signs as per protocol.

3.3.3. Ensuring the newborn's nose and mouth are visible **at all times.**

3.3.4. Supporting SSC when parent drowsy/asleep by having a support person or nurse present to observe (falls prevention).

3.3.4.1. Move the infant to a safe sleep surface if the support person or nurse is not available for ongoing observation.

3.4. Obtain vital signs and observe the infant (temperature, breathing, color and tone) and mother and gestational parent as per standard practice in all care areas.

3.5. Use the approved IWK/NSH falls prevention tool (see relevant Fall Policies), to assess and support the mother's and gestational parent's ability to safely provide SSC during mother's and gestational parent's movement between stretcher, bed, or wheelchair.

3.6. Be knowledgeable about the importance of SSC and provide education to families that promotes and supports SSC by:

3.6.1. Sharing approved resources and key messages (written and verbal) to families about SSC at all points of care. (See Appendix B)

3.7. For infants on respiratory support:

3.7.1. Check that T-piece and mask are on.

3.7.2. Confirm appropriate placement and security of endotracheal tube (ETT), nasogastric/orogastric tube, peripheral intravenous, umbilical artery catheterization, umbilical vein catheterization, peripheral intravenous central catheter lines, as needed.

3.7.3. Disconnect the ETT suction prior to transfer and reconnect post transfer.

3.7.4. Facilitate parent-led transfer when appropriate.

3.7.4.1. 1-2 Registered Nurses (RN)s will assist parent if infant on Continuous Positive Airway Pressure (CPAP) therapy or non-invasive positive pressure ventilation (NIPPV). Clinical status may require Respiratory Therapist (RT) presence.

3.7.4.2. 2 RN(s) or 1RN and 1 RT will assist parent if infant intubated and parent-led transfer not appropriate.

3.7.4.3. Ensure parent is standing close to infant's bedside.

3.7.4.4. Parent places hands under infant and brings infant close to parent's chest.

3.7.5. If infant is intubated, RT provides stability for ETT and guides ventilation tubing.

3.7.6. RN guides intravenous (IV) tubing, umbilical/PICC lines and monitoring cables.

3.7.7. RN or RT guides parent away from infant's bedside and aides them into the chair.

3.7.7.1. Position feeding tube to be accessible during SSC.

3.7.8. Ensure infant is in a flexed position with neck and head aligned to provide a clear airway and their back is covered with a warm blanket.

3.7.9. Secure lines and ventilator tubing to parent's clothing.

3.7.10. Explain importance of maintaining ETT position to parent.

3.7.11. Provide parent with instructions for how to contact staff if concerns arise.

3.7.11.1. Ensure call bell is within reach of parent.

3.7.12. Ensure infant is placed on a monitor by a HCP or continually visualized by an alert adult.

REFERENCES

Legislative Acts/References

Accreditation Canada. Retrieved from https://www.accreditation.ca

Bartick, M., Stehel, E.K., Calhoun, S.L., Feldman-Winter, L., Zimmerman, D., Noble, L., Rosen-Carole, C. & Kair, L.R. 2021. Academy of Breastfeeding Medicine Position Statement and Guideline: Infant Feeding and Lactation-Related Language and Gender. *Breastfeeding Medicine* 16(8). DOI: 10.1089/bfm.2021.29188.abm. Academy of Breastfeeding Medicine Position Statement and Guideline: Infant Feeding and Lactation-Related Language and Gender (bfmed.org)

Brimdyr, K., Stevens, J., Svensson, K., Blair, A., Turner-Maffei, C., Grady, J., Bastarache, L., Al Alfy, A., Crenshaw, J.T., Giugliani, E.R.J., Ewald, U., Haider, R., Jonas, W., Kagawa, M., Lilliesköld, S., Maastrup, R., Sinclair, R., Swift, E., Takahashi, Y. & Cadwell K. (2023). Skin-to-skin contact after birth: Developing a research and practice guideline. Acta Paediatr. Aug;112(8):1633-1643. doi: 10.1111/apa.16842. Epub 2023 May 24. PMID: 37166443.

CPS Position Statement. (Reaffirmed 2020). *The Baby-Friendly Initiative: Protecting, Promoting and Supporting Breastfeeding.* Retrieved from: http://www.cps.ca/documents/position/baby-friendly-initiative-breastfeeding

Deys, L., Wilson, P.V. & Meedya, D.S. (2021). What are women's experiences of immediate skin-to-skin contact at caesarean section birth? An integrative literature review. Midwifery. Oct;101:103063. doi: 10.1016/j.midw.2021.103063. Epub 2021 Jun 10. PMID: 34157585.

El Sehmawy A.A., Younes Abd, Elaziz S., Elwahed, R.M.A. &Elsheikh, A.A. (2023). Skin-to-skin contact and its effect on mothers' postpartum psychological distress and their full-term neonate in Egypt. *J Trop Pediatr*. Apr 5;69(3):fmad020. doi: 10.1093/tropej/fmad020. PMID: 37203231.

Johnston, C., Campbell-Yeo, M., Disher, T., Benoit, B., Fernandes, A., Streiner, D., Inglis, D., & Zee, R. (2017). Skin-to-Skin care for procedural pain in neonates. *Cochrane Database Systematic Review*, Issue 2).Art. No.: CD008435,. DOI:10.1002/14651858.CD008435.pub3.

Kangaroo mother care: a transformative innovation in health care. Global position paper. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO.

Maastrup, R., Weis, J., Engsig, A., Johannsen, K. & Zoffmann, V. (2017). 'Now she has become my daughter': parents' early experiences of skin-to-skin contact with extremely preterm infants. *Scand J Caring Sci; 2018; 32; 545-553.* doi:10.1111/scs.12478

Minot, K, Kramer, K., Butler, C., Foster, M., Gregory, C., Haynes, K., Lagon, C., Mason, A., Wynn, S., Rogers, E. & Leibowitz, M. (2021). Increasing Early Skin-to-Skin in Extremely Low Birth Weight Infants. Neonatal Network 40(4) 242-250. http:// dx.doi.org/10.1891/11-T-749

Nation H, Sanlorenzo L, Lebar K., & Brandon D. (2021). A Quality Improvement Project to Increase Frequency of Skin-to-Skin Contact for Extreme Low-Birth-Weight Infants in the Neonatal Intensive Care Unit. *The Journal of Perinatal & Neonatal Nursing* *35*(3) 247-257. DOI: 10.1097/JPN0000000000000556

Neugebauer C., Wonjung O., McCarty M. & Mastergeorge A. (2021). Mother-Infant Dyadic Synchrony in the NICU Context. *Advances in Neonatal Care 22* (2) 170-179. DOI: 10.1097/ANC.0000000000000855.

Operating Room Nurses Association of Canada. (2023). *The Operating Room Nurses Association of Canada (ORNAC) Standards, Guidelines, and Position Statements for Perioperative Registered Nurses* (16th Ed), Section 3(9), 272-287. https://www.ornac.ca/en/standards

Pérez-Jiménez, J. M., Luque-Oliveros, M., Gonzalez-Perez, D., Rivera-Sequeiros, A., & Rodriguez Blanco, C. (2023). Does immediate skin-to- skin contact at caesarean sections promote uterine contraction and recovery of the maternal blood haemoglobin levels? A randomized clinical trial. *Nursing Open*, *10*, 649–657. https://doi.org/10.1002/nop2.1331

Province of Nova Scotia. Breastfeeding Basics (2023). https://www.nshealth.ca/sites/nshealth.ca/files/patientinformation/05003.pdf

Province of Nova Scotia. Loving Care Birth to 6 Months (2023). https://www.nshealth.ca/sites/nshealth.ca/files/patientinformation/09045.pdf

Province of Nova Scotia. (2019). *Provincial Infant Feeding Policy Posters.* Retrieved from: https://rcp.nshealth.ca/breastfeeding

Tomlinson, C., Haiek, L.(2023) Breastfeeding and human milk in the NICU: From birth to discharge. Canadian Paediatric Society position statement. Breastfeeding and human milk in the NICU: From birth to discharge | Canadian Paediatric Society (cps.ca)

Ulmer-Yaniv, A.; Yirmiya, K.; Peleg, I.; Zagoory-Sharon, O.; Feldman, R. Developmental Cascades Link Maternal–Newborn Skin-to-Skin Contact with Young Adults' Psychological Symptoms, Oxytocin, and Immunity; Charting Mechanisms of Developmental Continuity from Birth to Adulthood. Biology **2023**, 12, 847. https:// doi.org/10.3390/biology12060847

Widström A-M., Brimdyr K., Svensson K., Cadwell K. & Nissen E. (2020). A plausible pathway of imprinted behaviors: Skin-to-skin actions of the newborn immediately after birth follow the order of fetal development and intrauterine training of movements. *Medical Hypotheses* 134. doi.org/10.1016/j.mehy.2019.109432.

Widström A-M., Brimdyr, K., Svensson, K., Cadwel, K. & Nissen, E. (2019). Skin-to-skin contact the first hour after birth, underlying implications and clinical practice. *Acta Paediatrica* 108, 1192-1204. DOI:10.1111/apa.14754.

WHO/UNICEF (2018). Implementation Guidance. Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services: The revised Baby-Friendly Hospital Initiative. Geneva: WHO. Retrieved from https://breastfeedingcanada.ca/en/baby-friendly-initiative/

WHO/UNICEF (2022). WHO recommendations for care of the preterm or low birth weight infant. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO.

RELATED DOCUMENTS –

Policies

IWK Health Policy 1115 NSHA MC-GA-001 Infant Feeding

IWK Health Policy 80.46 Neonatal Glucose Monitoring and Treatment of Neonatal Hypoglycemia

IWK Health Policy 50005 Comfort Promise—Comfort Positioning Guidelines

IWK Health Policy 1012 Falls Prevention and Injury Reduction

IWK Health Policy 1700 Oral Sucrose Administration for Minor Procedural Pain Management in Infants Less than or Equal to 12 Months of Age

NSHA CL-SM-010 Fall & Injury Prevention

IWK Health Policy 8664 Neuroprotective, Developmentally Supportive Care Guidelines

IWK Health Policy 4563 Phototherapy Management of Newborn Hyperbilirubinemia

Procedures

IWK High Risk Protocol for Preventing an Unplanned Extubation (UPE)

Forms

IWKNEWAS Newborn Assessment
IWKNECA Initial Assessment & Plan of Care Newborn Women's and Newborn Health Program
IWKADFL Admission Flow Sheet NICU
IWKINTR NICU Flow Sheet
Reproductive Care (RCP) Partagram (cannot find but was in initial policy)

Brochures

IWK/NSHA A Parent's Guide to SSC: What you can do to support your baby

NICU Voyage to Home

Appendices

Appendix A: Definitions

Appendix A: Definitions

Defined term	Definition text
Comfort Promise	Includes four best practice measures to help prevent and treat pain during medical procedures. SSC is part of comfort positioning measures. Comfort Promise – Comfort Positioning Guidelines
Gestational Carrier	A woman who carries and delivers a child for a couple or individual. Also called a surrogate. (Note: surrogate denotes genetic link while gestational carrier does not have any biological connection to child).
Gestational Parent	The individual who will carry the pregnancy and give birth.
Health Care Providers	Includes all IWK and NSH employees working within hospital and communities who support families during the prenatal, intrapartum and postpartum periods.
Low birth weight infant	Term to describe infants who are born weighing less than 2500 grams.
Kangaroo Mother Care	An intervention involving skin-to-skin contact to care for premature or low birth weight infants,
Together Practice	The provision of two hours of uninterrupted SSC for stable preterm infants born at or greater than 32 weeks gestation following birth.
Newborn	A child recently born.
Newborn Period	The neonatal period is the first four weeks of a child's life.
Parent-led transfer	In consultation with the infant's nurse/team, parent initiates transfer of their infant from the infant's sleep space to the parent's chest.
Preterm Infant	Infant born alive before 37 weeks of pregnancy are completed. Subcategories of preterm birth based on gestational age are defined as follows: Extremely Preterm (less than 28 weeks) Very Preterm (28 to less than 32 weeks) Moderate to late preterm (32 to 37 weeks)
Skin-to-Skin	When a mother and gestational parent(s) holds baby dressed only in a diaper on their bare chest, maximizing skin contact between the ventral surfaces of the two. It may also be provided by a support person identified by the mother and gestational parent when circumstances prevent them from being able to provide it.
Support Person	Person identified by the mother and gestational parent.
Term Infant	In infant born between 37 and 42 completed weeks.

Appendix B – Educational Supports

Approved resources and key messages (written and verbal) are to be shared with families about Skin-to-Skin Contact at all points of care. These messages include and are not limited to:

a. The importance of immediate and uninterrupted SSC for at least the first two hours, until completion of the first feed *or* as long as the parent desires. (See A Parent's Guide to Skin-to-Skin Contact Brochure)

b. 9 Stages of the Newborn. https://www.sciencedirect.com/science/article/pii/S0306987719310230

c. Infant cues and responsive parenting (Loving Care Birth to 6 Months)

d. Positions that facilitate eye contact between the parent and infant to support recognition of infant cues.

SSC maximizes physiological and psychological outcomes for both the mother and gestational parent and infant including optimal infant stability and infant attachment, as well as stimulation of feeding behavior.

a. Optimal thermoregulation of the newborn is supported through immediate uninterrupted SSC following birth and ongoing.

b. SSC is important

    i. For preterm infants, as it:

        1. promotes and improves state modulation
        2. enhances an in-line stabilized posture
        3. extends quiet sleep periods and quiet alert periods
        4. provides an opportunity for non-nutritive sucking
        5. enhances physiological stability and improves weight gain

    ii. For mother and gestational parent, as it supports:

        1. Less postpartum psychological burden
        2. Reduced anxiety and depression in initial postpartum period
        3. A positive birth experience, especially for those with caesarean section
        4. Decreases the duration of third stage of labor
        5. When undergoing caesarean section:

            a. Greater uterine contraction
            b. Higher maternal plasma hemoglobin at discharge
            c. Less maternal pain and comfort

c. SSC provides the family with the opportunity to recognize and respond to their infants' behavioral cues, thus becoming aware of their infants' individuality. This promotes earlier attachment and an increased sense of confidence in caring for their infant.

d. SSC promotes breast and chest feeding by increasing milk volume and enhancing the duration of lactation.

2. SSC is an effective non-pharmacological strategy for infant pain management.

    a. SSC **and** baby latched at the breast is the optimal non-pharmacological strategy for minor painful procedures in the neonatal period.

    b. All staff and HCPs will center care on the dyad to support procedures that can be done safely in SSC.

POLICIES BEING REPLACED

(Please List)

VERSION HISTORY

Major Revisions (e.g. Standard 4 year review)	Minor Revisions (e.g. spelling correction, wording changes, etc.)
[To be completed by the Policy Office]	