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A juxtaposition of birth and surgery: Providing skin-to-skin contact in the operating theatre and recovery

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ABSTRACT

Objective: to provide insight into the facilitators and barriers of providing skin-to-skin contact in the operating theatre and recovery.
Design: ethnographic study utilising video recordings, field notes, focus groups and interviews.
Setting: a metropolitan public hospital in Sydney, Australia.
Participants: 21 low-risk mothers having a repeat caesarean section, 26 support people, >125 staff members involved in their care and 43 staff members involved in focus groups/interviews.
Data collection and analysis: collecting video footage and field notes for up two hours post caesarean section births, interviews at six weeks post partum and staff focus groups/interviews. Data was entered into NVivo10 and analysed using critical ethnographic techniques.
Findings: providing skin-to-skin contact in the operating theatre and recovery presents unique challenges due to the 'juxtaposition' of providing social and emotional care in an intrinsically medicalised setting. Staff members suggest that skin-to-skin contact in this environment can be improved by increasing staff and parent knowledge, writing and implementing a policy, addressing staffing issues, improving staff communication, addressing time constraints, adjusting the placement of equipment in the environment and making small changes to the way equipment is utilised.
Conclusions and implications for practice: our findings show that skin-to-skin contact can be successfully implemented in the operating theatre and recovery room with staff members input into adjustments to existing care.

Introduction

Skin-to-skin contact (SSC) is where a naked baby, sometimes with a nappy on, is placed directly onto the bare chest of his or her mother or father (UNICEF, 2011). Immediate and continuous SSC between the mother and newborn is recommended as long as the mother is alert and responsive (World Health Organization & UNICEF, 2009a; Baby Friendly Health Initiative, 2012). SSC between the mother and newborn is ideal because it is biologically normal and promotes the well-being of the mother and newborn (Bergman, 2014). A Cochrane review provided evidence that SSC promotes a longer duration of breast feeding, helps keep newborns physiologically stable and potentially improves the maternal and infant early relationship (Moore et al., 2012). A recent review provided some evidence that SSC immediately or soon after a caesarean section promotes newborn physiological stability, breast feeding and emotional well-being and reduces maternal pain and anxiety (Stevens et al., 2014).

Even though immediate SSC can be safely provided after a caesarean section, there are barriers that need to be overcome (Stevens et al., 2014). In Australia, a policy directive called 'Breastfeeding in NSW: Promotion, Protection and Support' (NSW

Abbreviations: SSC, Skin-to-skin contact; OT, Operating theatre; WHO, World Health Organization; FG, Focus group

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Department of Health, 2011), states that all NSW hospitals need to comply with the Baby Friendly Health Initiative by June 2016, which includes uninterrupted immediate SSC following birth for a least one hour, if the mother is alert and responsive (World Health Organization & UNICEF, 2009b; Baby Friendly Health Initiative, 2012). These policy imperatives have informed this study. This paper will focus specifically on the organisational and environmental barriers influencing SSC after a caesarean section.

Methodology and methods

Study design

The aim of this study was to determine the facilitators and barriers of providing immediate skin-to-skin contact (SSC) in the operating theatre (OT), to observe variability in the interactions between the mother and support people with the newborn, and to discover what contact women want with their newborn during this time. An ethnographic research methodology was chosen because it allows the researcher to gain an in-depth understanding of human interaction and culture (Cluett and Bluff, 2006; Neuwirth et al., 2012). This methodology informed fieldwork and the gathering of exceptionally rich data to support the comprehensive analysis of both the environment and interactions between health professionals and women in the OT and recovery.

Study setting

This study was conducted at a large metropolitan hospital in Sydney, Australia, with approximately 3700 births per year, of which approximately 35% are caesarean sections. This hospital is working towards Baby Friendly accreditation status. Human Research Ethics Committee (HREC) approval was received from the hospital: Study no. 13/47-HREC/13/…/102 as well as. University: Study no. H10482 and all participants provided informed consent.

Standard midwifery care for elective caesarean sections, at this facility, included allocating a birth unit midwife to look after the newborn in the OT and then transfer care to a postnatal ward midwife who would facilitate SSC in recovery. Alternatively, some women had access to a caseload midwife who provided continuity of midwifery care. This model enabled the midwife to look after the newborn in both the OT and recovery.

Table 2
Focus groups and interviews.

	In depth individual interviews	Focus groups participants	Experience in years
Midwives (2x in-services)		19	6 months–33 years
• Midwives		5	8 months–3 years
• Student midwives			
Midwifery managers	2		16–20 years
Midwifery consultant	1	1	25 years
Operating theatre/Recovery nurses (2x in-services)		5	9 months–10 years
Nursing Manager	1		20 years
Anaesthetists	3		11–26 years
Neonatologists/ Paediatrician	3		16–20 years
Obstetricians	3		3–36 years
TOTAL	13	30 (4x in-services)	6 months–36 years

Participants and recruitment

A total of 314 people were recruited for the research at the hospital. This number included 35 women, 26 support people, 210 staff members for OT cases (see Table 1) and 43 staff members for focus groups (FG) and interviews (see Table 2). Staff members were recruited at in-services or on the day of the caesarean section, interview or FG. Of the 210 staff members recruited for OT cases around 125 were actual participants. The exact numbers are unknown because names were not gathered on the day of the caesarean section if staff stated that they had previously consented at in-services. To be a participant, the women had to be planning a caesarean following a previous caesarean section, have no complications that would impact the birth, be between 18 and 40 years of age, have a singleton pregnancy and plan to breast feed. Of the 35 women who were recruited through the antenatal clinic, 21 remained participants. Three women declined to participate after discussing the research with their partner, four women withdrew due to complications, three were transferred to a less acute hospital, two had their babies early and two cases could not be attended by the researcher. Recruitment methods are detailed in another publication under review.

Data collection

This research involved collecting baseline information from

Table 1
Staff recruitment for theatre cases.

Participants	Overall totals		Recruitment related to in-services			Recruitment on the day		
	Staff consented	Staff participating in the research	Number of in-services	Staff consented at in-services	Staff participating in the research	Staff consented on the day	Staff declined to participate	Staff declined to be filmed
• Hospital midwife	68	32	9	45	9	23	0	3
• Caseload midwife	5	2	1	5	2	0		0
• Student midwife	4	4	- with Hospital	2	2	2		0
Total midwives	77	8	10	52	13	25	0	3
Obstetricians	25	25	1	0	NA	25	0	5
Paediatricians/ Neonatologists	7	6	- with Obstetricians	1	0	6	0	3
Anaesthetists	17	17	1	0	NA	17	1	4
Nurses – operating theatre and recovery	74	> 29*	6	45	Unknown*	29	1	4
Unknown area of work	10	10	0	0	NA	10	0	0
TOTAL	210	> 125	28	98	13	112	2	19

* No exact numbers – names were not gathered if staff stated they had previously consented at the in-services.