

1. Introduction

The aim of this audit is to assess midwives' documentation of skin-to-skin contact (SSC) in the delivery suite and to compare existing practice to the evidence-based standards as outlined by NICE (2014) and local hospital policy (2010). This audit will also assess documentation of The Checklist for Newborn Infants in the first two hours of life as required by local policy (2015) *Safe Positioning of The Baby In The Postnatal Period*. It is hoped that by conducting this audit areas for improvement will be recognised, leading to a higher standard of care.

Early skin-to-skin contact (SSC) is the placing of the naked baby prone on the mother's bare chest at birth or soon afterwards (Moore et al., 2012). This early SSC is very important for the successful implementation of breastfeeding and has been shown to improve breastfeeding rates at one to four months after birth, to improve maternal attachment behaviour, regulate the neonates' temperature, and reduce infant crying (Moore et al., 2012). As most hospitals internationally implement The Ten Steps to Successful Breastfeeding (with Step 4 stating "Help mothers initiate breastfeeding within one hour of birth"), most babies will begin life skin-to-skin on their mother's chest (*Baby Friendly Hospital Initiative, Ireland, 2015*).

One rare but possible devastating effect of early SSC is the potential for an apparent life-threatening event (ALTE) Thompson et al., (2015). Another term used to describe ALTE's in the literature is Sudden Unexpected Postnatal Collapse (SUPC). Midwives play an important role in the prevention of these ALTE's, therefore completion of *The Checklist for Newborn Infants in The First 2 Hours of Life* is imperative.

2. Methods

A retrospective clinical audit was undertaken on 40 mother's notes who had given birth in a Maternity Unit between 18th January & 6th February 2016.

There is an abundance of literature on the importance of early SSC for premature infants and also initiation of early SSC in operating theatres post Caesarean Sections but this audit focussed solely on SSC for the healthy term infant immediately after a vaginal birth.

The notes of mothers whose babies required transfer to the Neonatal Unit were excluded.

Data sources utilised were patient records randomly selected on the postnatal wards. Anonymity was assured as no personal data was recorded.

A modified version of the BFHI audit tool was used as an audit measure.

A compliance benchmark of 90-100% against documentation policy was used as Standard 5 of *Practice standards for Midwives (NMBI, 2015)* states, "The documentation of the care you are giving must be carried out in a clear, objective, accurate and timely manner".

The local Clinical Directorate was informed of the audit and permission was obtained from the Clinical Midwife Manager.

3. Measuring Performance

Figure 1 outlines documentation of SSC.

100% (n=40) documented the date and time of birth accurately.

85% (n=34) documented SSC, 15% (n=6) had no documentation of SSC occurring at all.

57.5% (n=23) recorded initiation of SSC within 5 minutes of birth.

37.5% (n=15) had SSC for 60 minutes or more.

Only 15% (n=6) provided the reason for ending SSC if less than the 60 minutes recommended was adhered to.

Of the 25 that did not have the recommended 60 minutes only 8 (20%) recorded the duration of SSC, and only 6 (15%) recorded maternal request as being the rationale.

5% (n=2) had legitimate reasons for early SSC being unachievable, one mother required suturing of a 3rd degree tear in theatre and the other mother was transferred to theatre for a manual removal of placenta.

Figure 2 illustrates documentation of The Checklist for Newborn Infants.

At 30 minutes there was an 85% (n=35) documentation compliance this significantly reduced to 40% (n=16) at 120 minutes.

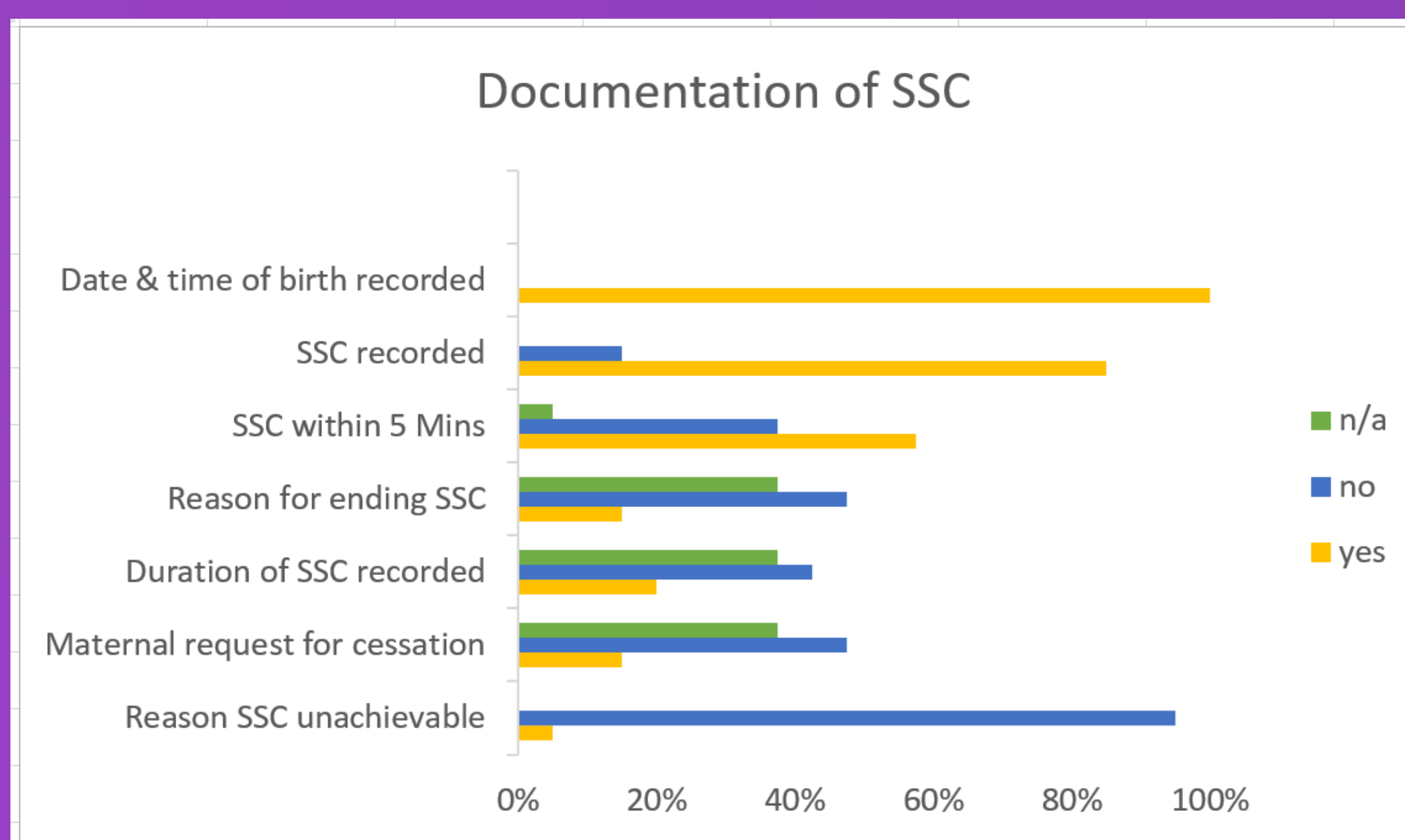


Fig 1

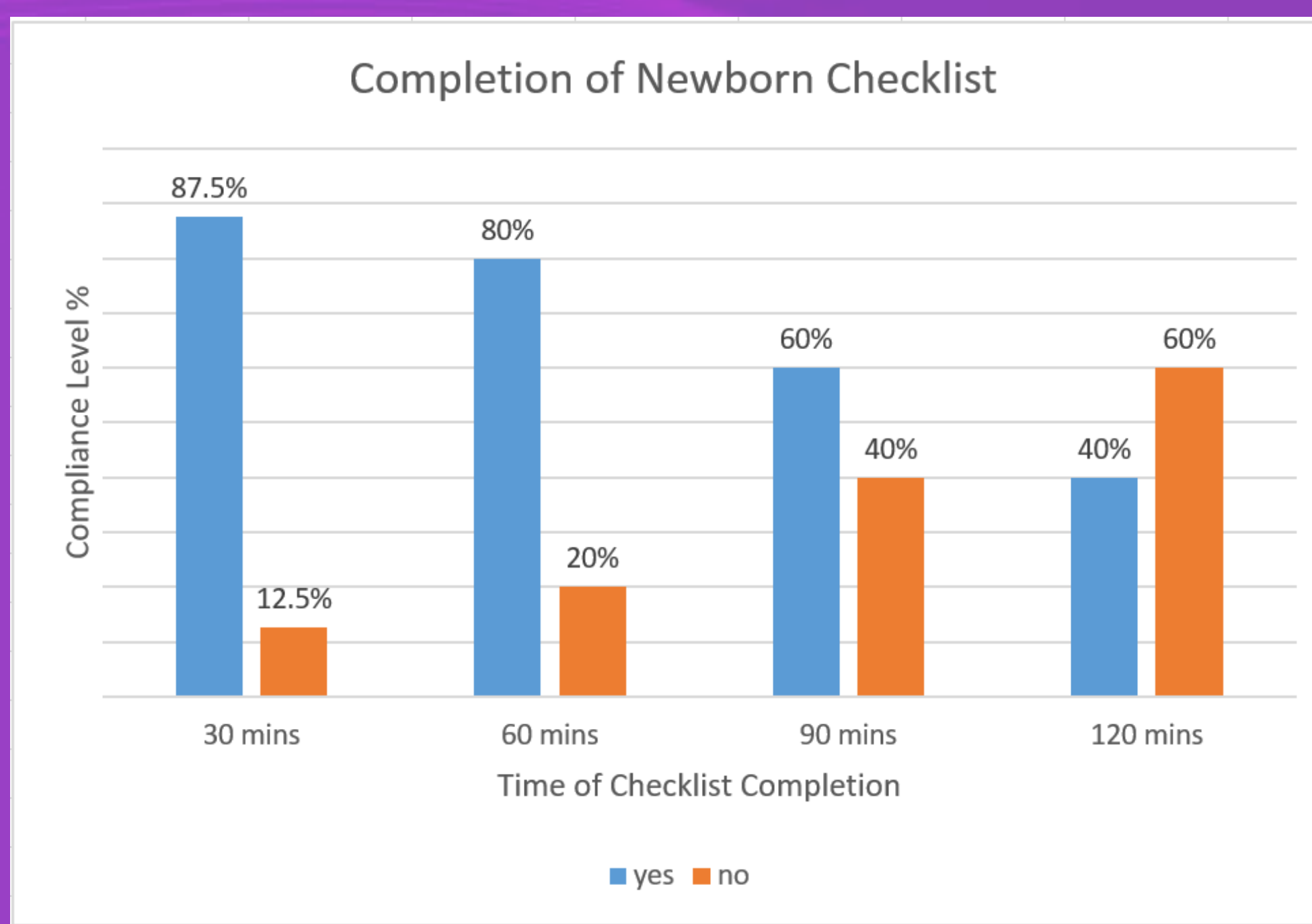


Fig 2

4. Practice Enhancement

The overall aim of this clinical audit is to use it as a quality improvement method. Unfortunately these audit findings do not score well when compared to the scoring system as outlined by Nursing and Midwifery Quality Care Metrics (HSE, 2015). Midwives in the clinical area need to be informed where documentation targets are not achieved, thereby encouraging them to improve practice. This poster will be used as a means of disseminating the findings to midwifery colleagues.

As stated by the HSE (2013) regular audit activity helps to create a culture of quality improvement in the clinical setting, therefore re-audit of this area would be beneficial. Also as new evidence comes on board literature critiquing, updating of policies and re-auditing will be required as outlined by HIQA (2011).

5. Conclusion

There is a plethora of literature outlining the benefits of early SSC therefore midwives need to avoid separating the mother and baby during the first "sacred" hour especially for routine postnatal procedures.

The National Maternity Strategy (Department of Health, 2016) sets out a vision of maternity services that is about safety, quality and choice and that places women very firmly at the centre of the service. Midwives can enhance maternal satisfaction levels by encouraging early SSC as Dabrowski (2007) describes how mothers engaging in SSC report a sense of being cocooned with their newborn. To ensure quality improvement, greater vigilance is required in the documentation of SSC but more importantly documentation of *The Checklist for Newborn Infants*.

It is hoped that this poster will highlight areas of shortcomings in the documentation of early SSC and the Infant Checklist, thereby improving documentation standards and resultant quality of care.

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