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Perceived Barriers to Skin to Skin Care from Maternal and Nurse Perspectives

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ABSTRACT

PERCEIVED BARRIERS TO SKIN-TO-SKIN CARE FROM MATERNAL AND NURSE PERSPECTIVES

The purpose of this doctoral project is to provide foundational data for a skin-to-skin (STS) policy at a community hospital. Two surveys were used to determine the barriers to STS. One survey was given to the nurses electronically in the maternal/child department and the second survey was given to the mothers who delivered at the same hospital during Fall 2014. Following data collection, focus groups were formed. The groups consisted of volunteer nurses who reviewed the results of the surveys and developed preliminary data for a STS policy.

The three identified barriers to STS by both nurse and maternal surveys were visitors in room, family wanting to hold the baby, and mother's feeling/groggy/sleepy or sick. However, the nurses ranked these three barriers higher than did the mothers, indicating a difference in perspective. Nurses did, however, rate that the highest barrier (94% agreement) to STS was that mothers were not aware that STS is important. Nevertheless, 74% of mothers stated that they were aware of STS. Furthermore, 96% of mothers agreed that STS had benefits. Focus group recommendations were correlated with the steps of the Baby Friendly Hospital Initiative. It is hoped that increased understanding of barriers to implementing STS will lead to a rise in exclusive breastfeeding.

Rachel Alexandra Napoli
May 2015

**PERCEIVED BARRIERS TO SKIN-TO-SKIN CARE FROM
MATERNAL AND NURSE PERSPECTIVES**

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California State University, Northern Consortium

Doctor of Nursing Practice

School of Nursing

May 2015

APPROVED

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Perceived Barriers to Skin-to-Skin Care From

Maternal and Nurse Perspectives

BACKGROUND

In order to achieve optimal growth and development of the newborn, the World Health Organization (WHO) in its position statement recommended breastfeeding exclusively for the first 6 months of life (WHO, 2011). The American Academy of Pediatrics (AAP) endorsed the WHO's statement on breastfeeding and stated further that breastfeeding should continue beyond 6 months, preferably for 1 year or more (Eidelman et al., 2012). One of the foundational aspects of successful breastfeeding is early implementation of what is known as skin-to-skin (STS) between mother and baby (Moore, Anderson, & Bergman, 2009). STS care can be provided by the mother or father and requires the infant to be "worn against the parent's naked chest in such a fashion that the infant is held upright. The parent is then wrapped in a blanket to secure the infant against their chest" (Baby Friendly USA, 2013).

The origins of STS care come from research in Colombia where premature births were common and of those premature babies, only one in 10 survived due to the lack of incubators. Given this statistic, researchers developed a plan of care by which the mother served as the incubator. The infant was placed firmly to the mother's chest (baby's skin to mother's skin) and remained there day and night. This intervention resulted in an increased survival rate from 10% to 50% for these newborns (Kangaroo Mother Care, 2014; Moore, Anderson, Bergman, & Dowswell, 2012).

Purpose

The purpose of this doctoral project is to provide the foundational data for a STS policy at Madera Community Hospital (MCH). Early STS contact is closely linked to successful

initiation and sustained breastfeeding. This first foundational stage of policy development to increase the time mothers spend in STS contact with their newborns is necessary to improve the rates of breastfeeding. In the previous three quarters of MCH performance measurement reports, the percentage of mothers and newborns who received STS during the hospital stay was less than 50% (Aldrich, 2013). MCH has set a benchmark to have >90% of mother/baby couplets receive STS during their hospital stays. To successfully implement a policy to improve STS contact, a two-pronged approach will be utilized to identify perceived barriers.

- A survey to identify barriers to STS with new mothers delivering at MCH and a survey to identify barriers to STS on the part of the nursing staff at MCH caring for the mothers.
- Focus groups will then be completed after survey data have been collected to educate staff on survey results. The goal of the focus groups will be to develop foundational objectives for the STS policy through staff input.

The initial focus of this project will be to identify the obstacles that either prevent or discourage the practice of STS contact at MCH. After identifying the barriers, focus groups will then assist in the development of problem-solving techniques. The ultimate goal of improving breastfeeding rates of the mothers who deliver at MCH will continue to be a long-term goal in the development of the STS program.

Problem and Background

As of January 2013, the Centers for Medicare and Medicaid Services (CMS) required that all data from the core measures set by the Joint Commission be reported to CMS, and beginning in Fall of 2015, reimbursement for services will be tied to maintaining the standard (established by them) on those given core measures (The Joint Commission, 2013). The Joint Commission

has five core measures, one of them being exclusive breastfeeding (Perinatal Care [PC]-05).

Approximately 83% of the patient population at MCH utilizes Medi-Cal, Medicare, or Medicaid as their insurance providers. Therefore, the implementation of a successful breastfeeding program becomes significant in terms of hospital reimbursement.

Further regulations include a new mandate set by the Governor of California to require all hospitals that provide perinatal care to implement all 10 Steps of the WHO Baby Friendly Hospital Initiative (BFHI) or an alternative process by January 1, 2025 (de León, 2013-2014).

They are as follows:

- Have a written policy on breastfeeding (Step 1)
- Training all staff in skills to implement policy (Step 2)
- Inform mothers of the benefits to breastfeeding (Step 3)
- Help mothers initiate breastfeeding within the first hour of birth (Step 4)
- Show mothers how to breastfeed (Step 5)
- Give newborn no food or drink other than breast milk unless medically indicated (Step 6)
- Allow mothers and infants to remain together 24 hours a day (Step 7)
- Encourage breastfeeding on demand (Step 8)
- No artificial nipples or pacifiers (Step 9)
- Foster development and establishment of support groups (Step 10) (Baby Friendly USA, 2010).

Currently, the rate of exclusive breastfeeding upon discharge from MCH is 52% for mothers who at time of admission chose to breastfeed. In order to increase breastfeeding rates, a successful breastfeeding program needs to be established. STS has been so closely linked with

successful initiation and continued duration of breastfeeding that it is necessary to ensure that all mothers and newborns are participating in STS care while inpatients at MCH. As STS care is not a policy mandated within the mother/baby department, a key initial step in the implementation of a STS policy is the assessment of the perceived barriers to STS care. Again, as previously stated, the ultimate goal is to increase the practice of breastfeeding. The implementation of a STS policy has many other benefits, in addition to increasing the rate of breastfeeding; however, the focus of this project will be the link between STS and breastfeeding.

The decision to breastfeed is a multifactorial one generally made by the mother, at times with input from loved ones. The reasons that women choose to breastfeed are directly related to cost, benefits, and convenience. However, to continue and maintain breastfeeding rests ultimately on whether the mother feels that she can maintain the routine. Often the success is dependent on the amount of support from family, friends, and lactation providers to which the new mother has access (Meedya, Fahy, & Kable, 2010). Successful breastfeeding is a learned behavior in which education, modeling, support, and positive self-efficacy all play a role. There are many foundational steps that lead to a successful breastfeeding experience for the new mom. If not implemented, the breastfeeding experience could be compromised.

By providing support, education, and assistance with self-efficacy, the hope is that these newly delivered couplets are successful at breastfeeding. MCH is working to implement the WHO's ten steps to successful breastfeeding. Many of these steps involve education of mothers and staff members, with one critical step being "helping mothers initiate breastfeeding within the first hour of birth" (Baby Friendly USA, 2010, p. 11). This crucial first step of initiating breastfeeding within the first hour of birth is an essential component of a thorough STS policy.

The AAP (2012) recommended that the healthy infant be placed and remain in direct STS contact with the mother immediately after delivery until the first feeding is accomplished. The alert, healthy newborn is capable of latching onto the breast without assistance from mother or nurse within the first hour after birth. The healthy infant has a strong suck reflex within this first hour of birth, also known as the “golden hour,” or first stage of reactivity, and disruption in this critical time period can make it problematic for the infant to learn the sucking process, thereby inhibiting the initiation of breastfeeding (California Department of Public Health [CDPH], 2014).

Theoretical Framework

There are many aspects in the development of a comprehensive STS policy. Therefore, two theories will be proposed to help elucidate each of the main principles that form the basis of this project. The attachment theory by John Bowlby and Mary Ainsworth links the mother to STS and justifies the importance of STS. Secondly, Lewin’s change theory supports implementing change within the hospital.

Attachment Theory

The theoretical framework of Bowlby’s attachment theory was developed in the following three papers:

- **The Nature of the Child’s Tie to his Mother:** In this document Bowlby explains four theories that explain the infant’s tie to its mother.
 - “The child has a number of physiological needs which must be met, particularly for food and warmth” (Bowlby, 1958, p. 1).
 - “There is in infants an in-built need to relate themselves to a human breast, to suck it and possess it orally” (Bowlby, 1958, p. 1).

- “There is in infants an in-built need to be in touch with and to cling to a human being” (Bowlby, 1958, p. 1).
- “Infants resent their extrusion from the womb and seek to return there” (Bowlby, 1958, p. 1).
- **Separation Anxiety:** In this work, Bowlby refuted some of the claims proposed by Freud in regard to “maternal gratification being a danger in infancy” and made the claim that “A well-loved child is quite likely to protest separation from parents but will later develop more self-reliance” (Bretherton, 1992, p. 11).
- **Grief and mourning in infancy and early childhood.** In this paper, Bowlby explained that grief and mourning occur when the attachment needs are triggered but the attachment figure is unavailable; moreover, when alternates for the attachment figure are too regularly substituted, the result will be an inability to form deep relationships (Bowlby, 1960).

Mary Ainsworth worked with Bowlby to further develop attachment theory. In direct observation of mothers and infants in Uganda, she concluded that there are “distinct patterns of attachment that evolve between infants and their mothers in the opening years of life and that relationships are related to the responsiveness of the mother to the infant in the earliest months” (Arcus, 2014).

Further, Ainsworth developed a method to assess the security and attachment of a relationship known as the “Strange Situation Method.” In this study she developed three main attachment styles: secure, insecure avoidant, and insecure ambivalent. Through this research and subsequent attempts to validate her research, these attachment styles can only be attributed to the relationship that the infant has with the mother (McLeod, 2008).

- Secure attachment: These children “feel confident that the attachment figure (mother) will meet their needs” (McLeod, 2008, p. 1), feel comfortable in exploring environment, and will seek out their mother when anxious (Arcus, 2014; McLeod, 2008).
- Insecure avoidant attachment: These children do not seek contact with the mother when anxious and do not orient their environment to the mother as the securely attached child does. These children remain neutral of their mother physically and emotionally (McLeod, 2008).
- Insecure ambivalent/resistant attachment: Child does not develop feelings of security to the mother. The mother might have difficulty soothing the child and the child develops a disconnected bonding behavior in which the child feels reliant on the mother but then rejects the mother when contact occurs (McLeod, 2008).

Using Ainsworth’s work, Bowlby further refined his research through a trilogy of works on attachment theory. Bowlby found that organisms regulate instinctive behavior in distinct ways: from “fixed action patterns to complex subgoals” (Bretherton, 1992, p. 18). He further explained that organisms have the ability to adapt to a degree of environment changes if they do not deviate too far from an “organism’s environment of evolutionary adaptedness” (Bretherton, 1992, p. 19). “If the attachment figure (mother) has acknowledged the infant’s needs for comfort and protection while simultaneously respecting the infant’s need for independent exploration of the environment, the child is likely to develop an internal working model of self as valued and reliable” (Bretherton, 1992, p. 23). Furthermore, hormone research has also indicated that an important factor in facilitating the bonding relationship between mother and newborn is the release of oxytocin. Oxytocin is released through breastfeeding and STS (Norholt, 2010).

Not placing the newborn STS with the mother after birth can compromise breastfeeding because it causes a disruption in this innate and instinctual process. By ensuring the healthy, stable newborn is never separated from its mother, the opportunity for the newborn to exhibit feeding readiness is enhanced (CDPH, 2014).

The typical hospital environment does not always allow for this essential step in the recovery of the newborn, bonding with the mother, and facilitation of breastfeeding. The term *golden hour* was established because those initial minutes in the transition of a newborn from the womb to the outside world are the most critical for the mother/child relationship and when newborns are removed from their mothers, they can experience separation anxiety. Hospitals must, in turn, provide an *attachment environment* to establish the mother as the primary attachment figure (Kangaroo Mother Care, 2014; Moore et al., 2012).

Lewin's Theory of Change

Many barriers have been identified that prevent a woman from choosing to participate in STS and breastfeed her newborn. Some of those barriers can be attributed to nursing staff and hospital routines. Research has found that lack of personal knowledge of breastfeeding, lack of a designated breastfeeding expert, as well as rigid hospital routines can be barriers to successful breastfeeding (Lewinski, 1992). According to Lewin's theory of change, hospitals can work to implement the changes needed in order to increase STS and, in turn, breastfeeding rates. Lewin's theory of change consists of three steps:

1. Unfreezing
2. Change
3. Refreezing.

Unfreezing involves finding a method of making it possible to change routine. In order to do this, those affected by the change must believe the change is needed and those involved in making the change must motivate the team to change. The methods currently used must be “frozen” and the proposed change must seem necessary in order to successfully carry out the change. By way of the focus groups in this project, the team will be shown the data collected in the surveys and educated on why this change is necessary. The focus groups will provide the team input on the developing policy to better facilitate the change (Glenn, 2010).

In the *change* stage, the change is implemented. How the change is brought about depends on who implements the change. The AAP (2012) recommended the following to facilitate newborn transition and initial breastfeeding:

1. Newborns are placed STS.
2. Initial physical assessment of newborn is completed while newborn is STS with the mother.
3. All unnecessary procedures, such as bath, weight, and injections are deferred until after the first feeding.
4. Mom and baby are not separated during the recovery period.

The goal of the *refreezing* stage is to reestablish balance within the area of change. In the initial phases, support and encouragement must be provided to reinforce the change and to ease any resistance that may result (Glenn, 2010).

Conclusion

Utilization of the 10 steps to successful breastfeeding developed by the WHO, AAP recommendations, and utilizing Lewin’s change theory in developing STS policy will create and foster work environments that support breastfeeding. Mandates handed down from Joint

Commission, CMS, as well as the State of California to increase exclusive breastfeeding rates require hospitals to change policy in order to comply. Given the direct correlation of STS to successful, sustained breastfeeding, ensuring the implementation of a comprehensive STS policy within the hospital will provide one crucial piece to increasing breastfeeding rates.

REVIEW OF LITERATURE

The purpose of this project is to first identify the barriers to STS care and then to develop the foundational data for a STS policy. The review of the literature will focus on all background aspects supporting the purpose and methodology, including benefits of STS, benefits of breastfeeding, correlation of STS and breastfeeding, evidence of perceived barriers, and implementing change within the hospital.

Skin-to-Skin Benefits

STS has been shown to benefit preterm and full-term newborns, as well as parents. Nyqvist (2004) found that STS helps to maintain temperature stability, strengthen roles for parents, improves breathing patterns, and provides a stable place for baby. STS also aids mothers in starting and maintaining breastfeeding (Engler et. al., 2002).

STS care has been found to help maintain thermoregulation in the premature and full-term infant (Bohnhorst, Heyne, Peter, & Poets, 2001); decrease pain during invasive procedures (Akcan, Yigit, & Atic, 2009); and improve stabilization, including heart rate, respiratory rate, oxygenation status, and temperature control. Infants who receive STS cry less and have enhanced sleep patterns and improved scores of development. Mothers who participate in STS have greater bonding with their infants and less maternal anxiety (Bergh, Charpak, Ezeonodo, Udani, & van Rooyen, 2012).

Breastfeeding Benefits

In the AAP statement on breastfeeding and the use of human milk (2012), the authors published the health benefits of breastfeeding to the infant and the mother. The benefits of breastfeeding to the infant are the reduction of many disease processes:

Disease process	Reduced by (%)
Respiratory tract infection	74
Respiratory syncytial virus	74
GI tract infections	64
Necrotizing enterocolitis	58
SIDS	36
Celiac disease	52
Inflammatory bowel disease	31
Obesity	15-30
Diabetes	30
Childhood leukemia	20

Figure 1. American Academy of Pediatrics, 2012.

Breastfeeding benefits maternal health by decreasing postpartum blood loss, postpartum depression, rheumatoid arthritis, hypertension, hyperlipidemia, cardiovascular disease, diabetes, and reproductive cancers. Mothers who have gestational diabetes and also breastfeed have been less likely to convert to type II diabetes after pregnancy (AAP, 2012).

Skin-to-Skin and Breastfeeding

In addition to the physiological and emotional benefits associated with STS, it also has benefits for effective, successful, and continued duration of breastfeeding. A randomized control trial by Moore and Anderson (2007) found that early STS enhanced breastfeeding success during the early postpartum period. Ruxer et al. (2013) also concluded that STS immediately after birth has a positive correlation on exclusive breastfeeding at 4 weeks of age. Furthermore, Alex and MacLellan-Peters (2013) found that STS helped to reinforce mother's decision to breastfeed and further develop the mother-infant relationship. They also found that delaying the time after birth

that baby is placed STS delayed the first feeding and had a negative correlation on exclusive breastfeeding.

A randomized control trial (RCT) that evaluated breastfeeding, STS contact, and mother-infant interaction in the first 3 months of life found that STS facilitated the mother's ability to maintain breastfeeding. A large percentage of mothers stop breastfeeding by 3 months of age, but all mothers in this RCT who utilized STS were still breastfeeding at 3 months of age. Moreover, the study found that mothers utilizing STS while breastfeeding had more positive experiences with the feedings (Bigelow et al., 2014).

Self-efficacy is a term used when describing mothers who breastfeed. Bandura defined self-efficacy as "people's belief about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives" (Bandura, 1993 p. 118). Aghdas, Talat, and Sepideh (2014) conducted an RCT and found that STS is associated with an increase in mother's self-efficacy with breastfeeding; and as self-efficacy increased, the period of exclusive breastfeeding also increased.

Bowlby's attachment theory, discussed in chapter 2, is utilized to show how attachment is essential in facilitating breastfeeding. According to Bowlby's attachment theory, children are born programmed to form attachments to others. Caregivers respond to newborn behaviors. It is not food that determines the attachment but rather the care and responses the newborn receives. The primary attachment figure (mother) is critical in responding to those behaviors and, therefore, in establishing the attachment relationship. If that attachment relationship is not established, permanent developmental consequences can result (Bowlby, 1958).

Attachment theory suggests that after birth the natural next step of STS continues uninterrupted. The newborn's needs are met through STS and bonding is enhanced. Through

STS, the newborn is able to instinctively self-latch to the breast and breastfeeding outcomes are improved (Zauderer & Goldman, 2012).

Perceived Barriers to Skin-to-Skin

Given the documented benefits of STS, it would be assumed that STS would be implemented in all maternal-child healthcare settings. However, in a Centers for Disease Control (2013) report on breastfeeding, only 54.4% of mothers and newborns received STS care after a vaginal delivery and only 37.1% were in-room (keeping the newborn in a crib near the mother's bed instead of in a nursery during the hospital stay at least 23 hours per day (AskDrSears, 2015).

To ensure higher exclusive breastfeeding rates, California law requires that the BFHI, or an equivalent policy, be implemented in all hospitals by 2025 (de León, 2013-2014). The BFHI has 10 steps designed to "support breastfeeding and parent infant relationships" (UNICEF Baby-Friendly Initiative, 2000). STS and rooming-in are both criteria mandated within the 10 steps in the BFHI. The perceived barriers to implementing STS need to be understood in order to develop a standard protocol for STS on the mother-baby unit at the hospital.

Much of the difficulty in implementing STS exists in the inexperience among nurses and families. Further difficulties have arisen with the implementation of the electronic medical record system and frequent changes in staff workflow (Wallin, Rudberg, & Gunningberg, 2005). Additional barriers were newborn safety and nurse/physician reluctance to implement or participate in STS (Engler et al., 2002). Still other obstacles in determining readiness for a STS policy were lack of specific guidelines for STS, time management, peer pressure, and lack of physician support (Stikes & Barbier, 2013). When rooming-in is practiced, the mother can recognize early feeding cues and initiate STS, and successful breastfeeding is facilitated (Hansen et al., 2012).

Implementing Change in the Hospital Setting

With the requirement of a breastfeeding policy within all hospitals in California providing maternity care, many hospitals have been making changes. García-de-León-González, Oliver-Roig, Hernández-Martínez, Mercader-Rodríguez, and Muñoz-Soler (2011), found that there was no single model to achieve effective implementation of the BFHI and that a great deal of effort was needed in order to sustain change within the hospital setting.

Barriers identified from the perspective of the health care professional during implementation of BFHI included lack of breastfeeding knowledge, hospital practice routines requiring adaptation (García-de-León-González et al., 2011), personal attitudes toward breastfeeding, reluctance to promote breastfeeding, overuse of accessible formula, and resistance to change hospital routine (Hernández-Aguilar et al., 2014; Semenik, Childerhose, Lauzière, & Groleau, 2012). St. Fleur and McKeever (2014) found that in order to produce change, previous policies and procedures had to be examined to realign the current evidence with BFHI care practices. These authors also learned that nurses were reluctant to participate in STS due to concerns about hypothermia in the newborn. Through the implementation of STS, the nurses reported their experiences to other staff members, while also providing education and in-services that inspired change in others (McKeever & St. Fleur, 2012).

Barriers identified from the maternal perspective included lack of breastfeeding knowledge, traditional beliefs, previous birth experiences, prioritizing sleep over breastfeeding, as well as lack of breastfeeding support (Semenik et al., 2012). Henderson (2011) found that despite support from nurses, mothers still preferred to hold their babies in a more traditional swaddled cradle hold. Holding the baby in this manner allowed for others to be able to hold the baby. There was also a concern about modesty and wanting to be presentable to visitors.

Walsh, Pincombe, and Henderson (2011) recommended implementing BFHI based on maternity staff attitudes. These recommendations included hospitals sponsoring staff to become lactation consultants, providing BFHI education to all staff, increasing breastfeeding education within the community, and providing a policy and protocol template. Henderson (2011) proposed “clustering nursing care, allowing for uninterrupted periods of rest, limiting visitors or allowing for visiting hours to promote privacy and limiting time mom has to share the baby” (p. 7).

Utilizing Lewin’s change theory of unfreezing, change and refreezing will facilitate the implementation of the BFHI steps. All previous practices that did not promote STS and exclusive breastfeeding would need to be “unfrozen.” The unfreezing stage can cause a disruption in normal organizational processes and in order to facilitate this process Manchester et al. (2014) recommended having nurse backers of the change to help reinforce the practice. Change will be guided through new STS and breastfeeding policies and implementation of the BFHI steps. On-site support and continued reinforcement of the new policies will ensure that changes can be implemented and begin to solidify the refreezing process (Manchester et al., 2014). The importance of a thorough STS will become evident to the hospital staff through the implementation of this project.

Summary

The AAP has published a multitude of breastfeeding benefits for the newborn, mother, and society. The evidence has shown that STS benefits the newborn both physiologically and in helping initiate breastfeeding. STS also increases the duration of exclusive breastfeeding, facilitates bonding during feedings, and increases mother’s ability to successfully breastfeed (Aghdas et al., 2014).

The benefits of STS and its effects on breastfeeding are well established. UNICEF, CDC and the BFHI (2010) agree that the rates of STS are low and steps should be initiated to increase rates of breastfeeding. Although barriers have been identified that prevent early initiation of STS, they can be overcome with further education of mothers and staff and through policy change.

METHODOLOGY

The purpose of this project is to identify the barriers to STS care and then to develop the foundational data for a STS policy. This chapter will discuss the methodology, participants, criteria for inclusion or exclusion, surveys, and focus groups.

The methodology employed for this doctoral project was a needs assessment for determining barriers to STS. There were two surveys used to establish these barriers: one was given to the nurses in the OB department at MCH and the second was given to the mothers who had delivered at the same hospital. The nurse survey was administered electronically and e-mailed to all nurses in the mother/baby department. The 54 participating nurses could access the link from September 2014 through January 2015. The maternal survey was administered via paper and pencil and was distributed to postpartum mothers who delivered through the months of December 2014 and January 2015. Both surveys evaluated the perceived barriers to STS care from the perspective of each group. Upon completion of surveys and data analysis, semi-structured focus groups were scheduled. The participants of the focus groups were the OB nurses at MCH. The results of the survey were developed as talking points for the focus groups. The aim was to develop a plan to write and implement a STS care set for the mothers who deliver at the hospital. A STS care set will allow for recommendations for the ongoing development of a STS policy to be implemented within L&D, postpartum, and the nursery to increase STS rates.

Participants

There were three cohorts of participants from whom data were collected.

- Cohort 1 included all nurses (LVNs and RNs) currently employed at MCH (54 nurses were e-mailed the survey and 33 responded [61%]).

- Cohort 2 comprised newly delivered mothers on the postpartum unit at MCH. There were 26 surveys completed.
- Cohort 3 comprised MCH nurses who volunteered to participate in a semi-structured focus group. In all, there were four different focus groups. Two were scheduled so that nurses on the a.m. shift could participate and two were scheduled to allow for p.m. shift nurses to participate. All nurses were invited to participate in the focus groups. Nurses were informed of focus group meeting times by schedules posted in the department. A total of 15 nurses participated in the focus groups (10-day shift and 5-night shift).

Exclusion Criteria

There were no exclusion criteria for nurse participants. Exclusion criteria for mothers included those whose newborns were transferred to another facility, those who spoke a language other than English or Spanish, and those who stated they were unable to read.

Surveys

There were two surveys utilized in this study: one was given to the nurses and the other to newly delivered mothers. The surveys were adapted from a survey created by Ferrarello and Hatfield (2014).

Maternal Survey

The survey (see Appendix A) utilized for mother responses was an adapted tool that had been implemented in a previous study by Ferrarello and Hatfield (2014). Surveys were in written form. The original survey from Ferrarello and Hatfield was adapted for clarity and uniformity of all STS barrier questions. The surveys contained 29 questions. Fourteen of these questions were demographic in nature, including age of mother, ethnic group, number of children, and

experience with STS and breastfeeding. The remaining 15 questions were Likert-style questions that addressed knowledge and experience with STS. The survey took approximately five minutes to complete. These written surveys were assigned a random numeric code. The consent form explained that participation was entirely voluntary without any repercussions for nonparticipation. Mothers were able to submit their surveys anonymously to researcher or staff member, so that no identification was possible. To ensure confidentiality, all survey data compiled were saved to a password-protected computer accessible only to the researcher. No attempt was made to identify participants. All completed surveys were kept in a locked cabinet within a locked office accessible only to the researcher. All paper copies were destroyed upon the completion of the study. Data were collected from December 2014 to January 2015. One charge nurse in the department who spoke both English and Spanish distributed the surveys on her scheduled charge shift days. In the 2 months of data collection, surveys were given out during shifts and a total of 26 maternal surveys were completed (~16%).

Nurse Survey

The nurse survey (see Appendix B) was created from the adapted mother survey. Ferrarello and Hatfield were unable to provide a copy of the nurse survey they utilized. Ferrarello stated that the nurse survey used in their study (Ferrarello & Hatfield, 2014) included the number of years in practice, how long they have worked in mother/baby, and how they fed their own babies (D. Ferrarello, personal communication, March 18, 2014). Through the gathering of this information, the nurse survey was created and comprised similar questions and format, with changes in demographic information and the inclusion of questions on perceived maternal barriers to STS. Full discussion and results of the survey will be provided in chapter 4. The survey included 25 questions and was delivered in electronic format via Survey Monkey™

to each nurse's hospital e-mail address. Survey Monkey™ collected IP addresses to safeguard against duplication, and email addresses were not collected. Results were solely in aggregate form. To ensure confidentiality, data were secured in a confidential file on a password-protected computer accessible only to the researcher. No attempt was made to identify participants and no personal identifying data were collected. Data were collected via Survey Monkey™ from September 2014 until January 2015. Thirty four nurses completed the survey (63%).

Semi-Structured Focus Groups

The information obtained from the surveys was compiled for discussion in the four semi-structured focus groups with volunteer nurse participants. Through these individual focus groups for day shift and night shift nurses, the results of the surveys were shared and discussion points were developed regarding the steps needed to develop and implement a STS policy. The goal of the STS policy is to develop protocols for STS within L&D and postpartum units, and the low-risk (level 1) nursery. Focus groups were scheduled on February 8 and 10. Each day, a group was scheduled to meet during both the day and night shifts. A total of 15 nurses participated in the focus groups (10-day shift and 5-night shift).

Analysis

The results of the two surveys were calculated for trends and percentages and then compared with each other for correlations. The results of the data were provided to the nurses so they could then reply with recommendations for STS policy development. This will be discussed in more depth in chapter 4. A significant amount of attention in the focus groups was spent on overcoming the barriers identified from the nurse and maternal surveys.

The ultimate goal of the study was to collect evidence, recommendations, and data in order to have the foundational information necessary for a STS policy. Further information

obtained from surveys will be utilized in the ongoing development of the breastfeeding program and education of staff, patients, and families.

Human Subjects

There was no compensation to the subjects. The maternal subjects were patients who were receiving care at MCH. The study did not affect patient care because the nurses who volunteered to answer the survey did so on their own time and not during a scheduled shift. Focus group participants also volunteered on a day they were not scheduled to work.

Minimal risk existed for participants who may have experienced psychological stress when recalling a stressful situation while completing the survey. A volunteer social worker was made available to offer counsel in the event that a participant experienced psychological stress; however, these services were neither requested nor required. Internal Review Board (IRB) approval of this project was obtained through MCH and California State University, Fresno prior to implementation.

Summary

The purpose of this project is to develop the foundational data for a STS policy and to move forward in fulfilling the goals for Baby Friendly designation.

Through the literature review in chapter 2 and the data collected from the surveys and focus groups, a thorough assessment has been completed in order to make recommendations for a department policy for STS.

RESULTS

The purpose of this project is to identify the barriers to STS care and then to develop the foundational data for a STS policy. This chapter will present the results from both the maternal and nurse surveys and the focus groups. Following will be a discussion on the interpretation of those results. Incidental findings, limitations, and implications for future nursing practice will also be presented.

Results from the nurse survey will include demographics, information regarding the nurse's personal experience with STS and breastfeeding, and professional experience. The descriptive aspect of the survey results will then be presented in three categories:

- Nurse's perceived knowledge of STS and breastfeeding,
- Barriers to STS that prevent nurses from promoting STS
- Maternal barriers to STS identified by the nurses.

Nurse Survey

In total, 34 surveys were completed, representing 64% of the nurse population in the maternal/child department at MCH. At the time there were approximately 54 nurses, including Registered Nurses and Licensed Vocational Nurses in L&D and postpartum departments. The survey was sent to all 54 nurses. Table 1 presents the demographic information collected in the survey.

The ages of the nurse respondents varied widely, with the highest concentration in the 31-40 range (39%). The majority of the nurse respondents had fewer than 15 years' experience (80%), with the highest range (44%) being 6-10 years of experience in mother/baby. The majority of nurses held an associate's degree in nursing (58%). One-half of the respondents

identified themselves as Caucasian. In total, 70% of the nurse participants had children of their own, with the largest percentage of the nurses having two children (40%).

Regarding STS and breastfeeding, the nurses were evaluated according to their personal experience with STS contact with their own children, whether they breastfed any of their own children, and method used to feed their own children (see Table 2).

According to the nurse surveys, most had not done STS with their own children (45%), had never exclusively breastfed any of their children (52%), and of the nurses with children, most had utilized both breastfeeding and bottle feeding (45%). Additional information showed that of the nurses with children, only 18% had practiced breastfeeding exclusively.

Table 1.

Nurse Demographics

Variable	<i>f</i>	%
Age in years		
20-30	6	18
31-40	13	38
41-50	6	18
>50	9	26
Years working in mother/baby		
< 5	7	21
6-10	15	44
11-15	5	15
16-20	2	5
>25	5	15
Highest level of education		
Associate's degree	19	58
Bachelor's degree	12	36
Master's degree	2	6
Race		
Asian	7	23
African-American	3	10
Caucasian	15	50
Multiple races	5	17
How many children do you have?		
0		24
1		12
2		40
3		18
>4		6

Table 2.

Nurse's Personal Experience

Variable	<i>f</i>	%
Skin-to-skin		
Yes	11	33
No	15	45
N/A	7	21
Exclusive breastfeeding		
Yes	8	24
No	18	52
N/A	8	24
Method of feeding		
Only breast	6	18
Only bottle	4	12
Both	15	45
N/A	8	24

In evaluating the nurses' professional experience with breastfeeding and breastfeeding education, they were asked if they had completed breastfeeding continuing education (CE) courses and if they held any breastfeeding credentials, such as Certified Lactation Educator, Certified Lactation Counselor or International Board Certified Lactation Consultant. One-third (76%) of the respondents had no breastfeeding credentials and over half (56%) had never taken any breastfeeding CE courses (see Table 3).

Table 3.

Nurse's Professional Experience

Variable	<i>f</i>	%
Breastfeeding credentials		
Certified Lactation Educator	2	6
Certified Lactation Counselor	0	0
International Board Certified Lactation Consultant	6	18
I do not hold any breastfeeding credentials	26	76
Prior breastfeeding CEs before		
Yes	15	44
No	19	56

The descriptive aspect of the nurse survey utilized a Likert-type scale, such that 1 = Strongly disagree, 2 = Disagree, 3 = Agree, and 4 = Strongly agree. This scale was used to assess the nurse's perceived knowledge of STS and breastfeeding. The majority of the respondents agreed that STS has benefits (97%) and agreed that STS helps mom to breastfeed her newborn (94%). Most of the nurses (91%) still thought that the more STS mom does, the better she will breastfeed. The nurses also thought that moms needed to spend more time STS with their newborns (74%). The nurses felt more comfortable educating patients on STS (97%) than they did about breastfeeding (88%) (see Table 4).

Table 4.

Perceived Nurse's Knowledge of STS and Breastfeeding

Variable	Strongly		Strongly	
	disagree	Disagree	Agree	agree
I believe skin-to-skin care has benefits	3	0	9	88
I believe skin-to-skin care helps the mother to breastfeed	3	3	15	79
The longer a mother spends skin-to-skin with her newborn the better she will breastfeed	3	6	27	64
Right now our mothers spend enough time skin-to- skin with their newborns	18	56	26	0
I feel comfortable educating patients and families about skin-to-skin care	3	0	50	47
I feel comfortable educating patients and families about breastfeeding	6	6	44	44

The same scale was used to identify barriers to STS that affect how the nurses use or promote STS care (see Table 5). The nurses believed that the leading barrier to promoting STS was time management (15%). All of the nurse respondents disagreed with the notion that STS did not have benefits and that its benefits did not motivate them to dissuade STS.

Table 5.

Barriers to STS That Affect How the Nurses Use or Promote STS Care

Variable	Strongly		Strongly	
	disagree	Disagree	Agree	agree
I feel as a nurse skin-to-skin does not have benefits and this prevents me from using skin-to-skin with my patient.	82	18	0	0
I feel as a nurse my inexperience or lack of educating patient on skin-to-skin prevents me from using skin-to-skin with my patients.	53	38	9	0
I feel as a nurse my inexperience or lack of educating patient on breastfeeding prevents me from using skin-to-skin with my patients.	53	38	9	0
I feel as a nurse time management prevents me from using skin-to-skin with my patients.	33	52	15	0
I feel as a nurse using skin-to-skin interferes with required nursing tasks and prevents me from using skin-to-skin.	56	38	6	0

Again, using the Likert-type scale, the nurses indicated which barriers affected mothers participating in STS care (see Table 6). The majority of nurses felt that the primary barrier to mothers participating in STS was a lack of awareness of its importance (94%). All of the nurse respondents stated that they believed mothers would not refuse STS if offered.

Table 6.

Barriers Identified By Nurses That Affect Why Mothers Are Not Participating in STS Care

Variable	Strongly		Strongly	
	disagree	Disagree	Agree	agree
I feel visitors in the room prevent mothers from participating in skin-to-skin.	0	18	41	41
I feel that the mothers feeling groggy / sleepy/sick/(safety concern of holding baby) prevents them from participating in skin-to-skin.	3	15	62	20
I feel that mothers' not being aware that skin-to-skin is important prevents them from participating in skin-to-skin.	0	6	50	44
I feel that mother's concern about privacy or modesty prevents them from participating in skin-to-skin.	3	24	47	26
I feel that hospital personnel or hospital routines prevent mothers from participating in skin-to-skin.	3	47	41	9
I feel skin-to-skin being inconvenient prevents mothers from participating in skin-to-skin.	12	62	26	0
I feel that others wanting to hold the baby prevents mothers from participating in skin-to-skin.	3	12	35	50
I feel that the baby not being clean prevents mothers from participating in skin-to-skin.	6	53	32	9
I don't offer skin-to-skin to mothers because I believe they will refuse.	65	35	0	0

Maternal Survey

Results from the maternal survey included demographics and information regarding personal experience with STS and breastfeeding. The descriptive aspect of the survey results will be presented in two categories: (a) maternal experience with STS and breastfeeding and (b) maternal barriers to STS. In total, 26 surveys were completed, which represents 16% of the eligible postpartum mothers during the months of December 2014 and January 2015 (see Table 7).

The majority of mothers were between 21-25 years of age, had other children, and had, therefore, given birth before. A weak majority of the maternal respondents had only an elementary school education (42%), 81% had given birth before, and most had given birth vaginally (81%). The largest percentage of respondents identified themselves as Latino (92%). The survey was to be completed in the respondent's primary language of either English or Spanish, and the use of both languages was split 50/50. Most of the moms (92%) utilized Medi-Cal for insurance coverage.

Mothers were evaluated for plans for STS and breastfeeding and their experience in these areas (see Table 8). Almost all of the respondents were planning to breastfeed their newborns. Upon completion of the surveys (discharge day), 85% were still breastfeeding their babies. With 81% of mothers responding yes to having other children, the majority (50%) stated that they had never exclusively breastfed any of their children. Slightly more than half (56%) of the respondents had done STS with their other children.

Table 7.

Maternal Demographics

Variable	<i>f</i>	%
Age in years		
15-20	3	12
21-25	10	38
26-30	4	15
31-35	8	31
36-40	1	4
Have they given birth before		
Yes	21	81
No	5	19
How many children		
1		19
2		23
3		27
4		31
Highest level of education		
Elementary school	11	42
High school	10	38
Trade/technical	3	12
College degree	2	8
Graduate degree	0	0
Race		
Latino	24	92
Caucasian	1	4
Other	1	4
Method of Delivery		
Vaginal	21	81
C-section	5	19
Primary Language		
English	13	50
Spanish	13	50
Insurance Provider		
Medi-Cal	22	92
Private	8	0
No coverage	0	0

Table 8.

Personal Experience With STS and Breastfeeding

Variable	<i>f</i>	%
Were they planning to breastfeed?		
Yes	25	96
No	1	4
Were they breastfeeding currently?		
Yes	22	85
No	4	15
Did they do STS with any of their children?		
Yes	14	56
No	6	24
N/A	5	20
Did they exclusively breastfeed any of their children?		
Yes	9	35
No	13	50
N/A	4	15

The descriptive part of the maternal survey utilized a Likert-type scale, such that 1 = Strongly disagree, 2 = Disagree, 3 = Agree, and 4 = Strongly agree. This scale was used to assess their knowledge of STS and breastfeeding and barriers that affected their participation in STS.

Mothers agreed (96%) that there are benefits to STS, that STS helped them breastfeed (92%), and that they felt closer to their babies when doing STS (92%) (see Table 9).

Table 9.

Maternal Knowledge, Experience With STS and Breastfeeding

Variable	Strongly disagree	Disagree	Agree	Strongly agree
I spent enough time skin-to-skin with my baby after it was born	4	12	20	64
There are benefits to skin-to-skin?	0	4	19	77
Hospital staff encouraged me to be skin-to- skin with my baby	8	4	8	80
Did you feel that skin-to-skin helped you breastfeed?	0	8	23	69
Do you feel closer to your baby when doing skin-to-skin?	0	0	15	85
Hospital personnel taught me about skin-to- skin?	12	0	12	76

The same barriers presented to the nurses were given to the mothers to ascertain which ones they believed prevented them from participating in STS (see Table 10). The most commonly cited barrier was having visitors in the room (50%). Only 28% of the respondents agreed that STS is not important and 4% stated that they did not want to participate in STS.

Table 10.

Maternal Barriers to STS

Variable	Strongly disagree	Disagree	Agree	Strongly agree
Having visitors in the room prevented me from doing skin-to-skin with my baby	20	28	28	24
Feeling Groggy, Sleepy or Sick prevented me from doing skin-to-skin with my baby	40	16	40	4
I am not aware that skin-to-skin is important so I did not do it with my baby.	52	20	4	24
I feel exposed when doing skin-to-skin so this prevented me from doing skin-to-skin.	68	12	12	8
The hospital staff coming in and out of my room prevented me from doing skin-to-skin.	60	20	20	0
Doing skin-to-skin is not convenient so I did not do it.	77	15	4	4
Having friends or family that wanted to hold the baby prevented me from doing skin-to-skin	46	25	13	16
The baby not being clean made me not want to do skin-to-skin	76	8	8	8
I did not want to participate in skin-to-skin.	83	13	4	0

Incidental Findings

Two additional questions were asked of the mothers: (a) Would they like more education on STS? and (b) Would they like more education on breastfeeding (Figure 1)? The majority of the respondents declined further education about STS (76%) and breastfeeding (72%).

Figure 2. Do you want more education on ...?

Focus Groups

The structure for each session was to review the results of the surveys and then pose the following questions:

- Based on the information, how can we promote more STS in the postpartum department and the labor and delivery department?
- What policies would you put in place for a STS policy?

Focus groups were scheduled for February 8th and 10th. Each day, a group was scheduled to meet during both the day and night shifts. A total of 15 nurses participated in the

focus groups (10-day shift and 5-night shift). The recommendations listed below are the results of the combined focus groups and answers to the questions listed above. Included are suggestions for each department to promote STS and further STS policy recommendations.

Postpartum department:

- After each interaction with newborn, assessment, weight, vital signs etc, baby will always be returned to mother STS.
- Continued reassurance and encouragement to mother and family.
- Address concerns immediately, do not let mothers worry: For example, some mothers are concerned baby will not stay warm when doing STS. As nurses, we check baby's temperature and show mom the result to reassure her that the baby is maintaining a stable temperature.
- Ongoing breastfeeding and STS education.
- From an RN who is a lactation consultant (IBCLC): "just need to start at the beginning; if there are difficulties with breastfeeding, just put the baby STS."
- The posted visiting hours are from 2:00 p.m. – 4:00 p.m. and 6:00 p.m. – 8:00 p.m.; however, they are not enforced. Visiting hours need to be enforced. (Visiting hours do not include father or support person). By enforcing visiting hours we can allow mothers and newborns to spend most of the day together without interruptions in room (Prevent the barriers of visitors in room, family wanting to hold baby and potentially modesty issue by preventing traffic to room).
- No T-shirts or clothes on newborn first 24 hours and potentially until discharge.
- Move from the "Golden hour" to "Golden day" to do as much STS in first 24 hours.
- No pumping or artificial nipples in first 24 hours. Only baby to breast.

- When pediatrician does rounds on baby, after assessment is finished give baby back to moms STS or do assessment on the mother's abdomen.

Labor and delivery department:

- No visitors (except dad or support person) for first 2 hours after delivery.
- Baby stays on mom for first 2 hours or until first feeding is accomplished.
- Physician education to mom and family on STS when discussing process of delivery.

Other recommendations:

- CE courses on STS and breastfeeding for all nurses.
- Prenatal education courses for mothers and families scheduled alongside childbirth classes.

DISCUSSION

The present study aimed to explore the barriers to STS from maternal and nurse perspectives. The descriptive results show that nurses and postpartum mothers do not have a difference in opinions on the barriers to STS; however, there was a discrepancy in the rate that the barriers were identified. In particular, 94% of the nurses believed that mothers were not aware that STS is important, while 72% of the maternal respondents agreed that STS is important. Further discussion of each survey and focus groups are described below.

Nurse Survey

Demographics showed that 76% of the nurses had children of their own; however, of the nurses who had children, the majority did not have personal experience exclusively breastfeeding them (52%). In addition, for the nurses who had children, only 33% of them had done STS care with their own children. The maternal respondents had more experience doing STS than did the nurse respondents. Brodribb, Fallon, Jackson, and Hegney (2008) stated that nurses who had more than 26 weeks of personal experience breastfeeding their own children were more confident and knowledgeable educating their patients on breastfeeding. The majority of the nurse respondents at MCH had 6 to 15 years experience working in mother/baby and 56% of the nurse respondents had never taken any breastfeeding CE courses before.

Based on the results of the descriptive data evaluating the nurse's knowledge of STS and education, the majority believed that STS care has benefits (97%) and helps the mother to breastfeed (84%). Even though the evidence presented has shown that STS has benefits and helps the mother to breastfeed, there is still a small percentage of the nurses that disagreed with this evidence (6%). Based on the survey, 26% of the nurses believed that mothers spend enough time STS already; however, in the previous three quarter reports of MCH performance

measurement, the percentage of mothers and newborns who received STS during the hospital stay was less than 50% (Aldrich, 2013). MCH has set a benchmark to have >90% of mother/baby couplets receive STS during their hospital stays. Ninety-seven percent of nurses felt comfortable educating on STS; however, fewer felt comfortable educating on breastfeeding (88%). If the nurses were uncomfortable educating on breastfeeding, this might have made them hesitant to promote STS due to its correlation with effective breastfeeding. Brodribb et al. (2008) found that nurses who had more knowledge about breastfeeding were more confident and more effective educators to their patients about breastfeeding. Even though the BFHI allows for nurses without credentials to educate the mother on breastfeeding, step two of the BFHI does state that hospitals need to “train all health care staff in the skills necessary to implement the written breastfeeding policy” (United States Breastfeeding Committee, 2013, p. 25). With 76% of the nurses holding no breastfeeding credentials and 56% of respondents never having taken breastfeeding CE courses, there is still a need for breastfeeding education to the nurses. Since STS helps to promote breastfeeding initiation, the nurses need to feel comfortable providing education in both STS and breastfeeding.

The survey results evaluating what barriers to STS the nurses felt they had in promoting STS showed that the largest barrier was time management (15%). The percentages of barriers to STS from nurse perspective were very low, indicating that many nurses felt there were few barriers related to their jobs as nurses that should prevent them from promoting STS and those barriers identified could be easily managed.

In evaluating what maternal barriers to STS care the nurses identified, the nurses believed that the highest barriers to STS were mothers not aware that STS is important (94%), family

wanting to hold the baby (85%), visitors in room (82%), feeling groggy/sleepy/sick or safety concerns of holding baby (82%), and privacy or modesty (74%).

Maternal Survey

In comparing the results of the nurse survey to the maternal survey, the maternal demographics showed that 81% of mothers had given birth before and had two or more children. Only 35% of those mothers had exclusively breastfed any of their children and only 56% had done STS. These are higher percentages when compared to the nurses' responses, showing that the maternal respondents seemed to have more personal experience with STS and breastfeeding. The demographics also showed that a majority (42%) of the maternal respondents had only an elementary level education. Since low education levels are associated with low breastfeeding rates (Teka, Assefa, & Haileslassie, 2015), it is important for hospital staff to understand how much more breastfeeding education is needed due to lower education levels.

Maternal evaluation of knowledge and experience with STS showed that 84% of the mothers believed that they had spent enough time STS with their babies, indicating a need for educating mothers about the benefits of STS. Almost all of the mothers who responded (96%) believed that there are benefits to STS and 92% of them felt that it helped them breastfeed. With a large percentage of the mothers having this knowledge, implementing STS should be easier.

Based upon the maternal respondents, the highest barriers to STS were having visitors in the room (50%), feeling groggy/sleepy/sick or safety concerns of holding baby (44%), family wanting to hold the baby (29%), and not aware of importance of STS (28%). The largest discrepancy between the barriers identified by nurses and mothers was "not knowing that STS is important." The nurses rated this the top barrier for mothers not participating in STS (92%), while 74% of the mothers know STS is important and 96% stated that they wanted to participate

in STS and knew of its benefits. The other top barriers identified were the same for both mothers and nurses; however, the nurses felt that these barriers were more significant than did the mothers.

Further questions evaluated whether the mothers would like further education regarding STS and breastfeeding. Only 28% of the respondents wanted further education in breastfeeding and 24% wanted further education in STS. It is difficult to ascertain why such a large percentage of mothers declined further education. One reason could be the overall low level of education of the maternal respondents. These mothers might not have understood how much there is to learn about STS and breastfeeding, which makes it that much more important to provide further education about STS and breastfeeding.

Mothers indicated that they believed that STS made them feel more bonded to their babies and assisted them with breastfeeding. These findings support the attachment theory and give hospitals more reason to provide an environment that promotes attachment with mother and newborn (Moore et al., 2012).

Focus Groups

The discussion, comments, and recommendations gleaned from the nurses during the focus groups provide recommendations for further development of a STS policy within each department. These recommendations also coincide with the Ten Steps of the BFHI requirements (Baby friendly USA, 2010). These 10 steps or an equivalent policy must be implemented in each hospital that provides mother/baby care in California by 2025 (de León, K, 2013-2014). Each of the following recommendations has been correlated with the step in the BFHI to show its purpose and necessity in the policy:

- Schedule prenatal breastfeeding education courses for mothers and families alongside monthly childbirth classes (Step 2).
- No visitors (except dad or support person) for first 2 hours after delivery (step 4).
- Baby stays on mom for first 2 hours (Step 4).
- Physician education to mom and family on STS when discussing process of delivery (Step 3).
- Continued reassurance and encouragement to mother and family (Steps 3, 5, & 8).
- Ongoing breastfeeding and STS education (Steps 3, 5, & 8)
- No formula, pumping, or artificial nipples in first 24 hours. Only baby to breast, for mothers who choose to breastfeed with a healthy infant (Steps 6 & 9).
- Move from the “Golden hour” to “Golden day” and do as much STS in first 24 hours as possible (Step 7).
- Enforce the posted visiting hours (except dad or support person) from 2:00 p.m. – 4:00 p.m. and 6:00 p.m. – 8:00 p.m. (Step 7).

Through the focus groups, the nurses provided many comments and recommendations for implementing STS. The nurses were amenable to making changes and implementing these recommendations, which supports Lewin’s process of change, in that “unfreezing” old processes requires cooperation from the staff. In the change stage, the steps of the BFHI will need to be implemented; however, the staff identified during discussion in the focus groups many recommendations that fulfill these steps. These initial steps in Lewin’s process of change will allow for easier refreezing of the new policies (Glenn, 2010).

Through these recommendations and further development of a STS policy and breastfeeding policy, the hope is to increase exclusive breastfeeding rates. The Joint Commission

and the CMS advise that hospitals show an increase in exclusive breastfeeding rates to stay in compliance with the core measure. By implementing the 10 Steps to BFHI, the hospital comes in compliance with senate law #402 and helps to increase exclusive breastfeeding rates.

Limitations

The surveys and analyses are only descriptive of the population being studied and would be difficult to generalize to a larger population. In order to determine if the surveys would have external validity replication to different nurse and maternal populations would be required. The surveys do identify needs within the maternal/child population for education regarding STS and breastfeeding for nurses and mothers. As Ogden and Lo (2012) stated, there can be limitations in Likert-style questioning. Responses to these types of questions can be affected by mood, satisfaction, and health status (Ogden & Lo, 2012).

The maternal survey was adapted from a previous study conducted by Ferrarello & Hatfield (2014). The nurse survey was based on criteria from these same researchers (Ferrarello & Hatfield, 2014). The surveys were piloted in the current study and neither were evaluated for validity or reliability. The maternal respondents being only 16% of the eligible population during the months of December 2014 and January 2015 created the limitation of a small sample size. There was also the limitation of the lack of statistical analysis on the collected data, thus eliminating the ability to determine statistical significance.

Nurse Survey

The nurse surveys omitted a question regarding whether the nurses would, if possible, exclusively breastfeed their own children. Another limitation noted was the inconsistency of categories for ethnicity between the nurse and maternal surveys.

Maternal Survey

Upon reviewing the items in the maternal survey, a glaring omission was noted: “not applicable” (N/A) was missing in question 4: “Did you only breastfeed any of your other children (no formula)?” For those mothers who had just delivered their first babies, this was a necessary category. If the survey were implemented again, a suggestion is to change question 2 from “Were you planning to breastfeed this baby?” to “Were you planning to exclusively breastfeed this baby?” Through this simple change in wording, it could be ascertained whether the mom came into the hospital wanting to exclusively breastfeed. It was also suggested that question 3 read “Are you and your baby exclusively breastfeeding now?” instead of “Are you and your baby breastfeeding now?” These changes could indicate whether mothers who had expressed a desire to exclusively breastfeed were then able to continue to exclusively breastfeed through discharge from the hospital.

Implications for Nursing Practice

Based on the research regarding perceived barriers completed in chapter 2, it was identified that hospital routines or workflow, newborn safety, lack of education, lack of specific guidelines, and time management with nursing tasks inhibit STS and breastfeeding (Henderson, 2011). As this was a smaller study at a rural hospital, it is difficult to generalize to the larger population; however, studies like this one can be replicated in other hospitals that provide perinatal care in order to identify what specific barriers they might have in implementing STS and breastfeeding within their own departments. The barriers identified by the nurses and the mothers in each survey were similar but were rated less significant from the maternal perspective and through the recommendations given in the focus groups, these barriers could be alleviated.

Further research is needed to determine maternal breastfeeding knowledge. Since 76% of the respondent mothers declined further education on STS and 72% declined further education on breastfeeding, there is the potential to test maternal knowledge on STS and breastfeeding. Maternal knowledge of STS and breastfeeding could be tested and the results compared to those who declined or accepted further education in this area to evaluate how much knowledge they have.

Conclusion

There was a clear disconnect observed between the nurse and maternal respondents with regard to perceived barriers to STS and breastfeeding: the nurses believed that weak participation in STS and breastfeeding was due to ignorance, while the mothers were sufficiently aware of the benefits but felt hindered by various barriers, such as too many visitors in the room. Further research should be done to resolve this divide. Increased implementation of the BFHI steps could facilitate higher breastfeeding rates. By understanding potential barriers in the implementation of STS and providing a uniform education to mothers, families, and nurses, exclusive breastfeeding rates could rise.

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APPENDIX A: NURSE SURVEY**Consent Form**

Researcher: Rachel Napoli, MSN, RNC
Doctor of Nursing Practice Student
Doctorate of Nursing Practice, Northern California Consortium
rnapoli@csufresno.edu
559 278-8852

You are invited to participate in a study conducted by the researcher listed above. Through this research I hope to identify what the barriers are to implementing skin-to-skin care within the hospital setting. The rationale for identifying the barriers to skin-to-skin is to develop a policy for skin-to-skin care to increase the amount of time mothers and their newborns spend skin-to-skin. By increasing skin-to-skin the research shows that breastfeeding is more successful and lasts longer. By increasing exclusive breastfeeding the health and development of all newborns is increased.

You were selected as a participant in this study because you are a nurse within the mother/baby department at Madera Community Hospital.

If you volunteer to participate in this study, you will be asked to complete a survey that will take approximately 10 minutes and to participate in a focus group that will take place within the next month and take approximately 20 minutes. (Notices of scheduled focus groups will be posted within department) The emphasis of the focus groups will be to obtain recommendations for development of a department skin-to-skin policy. Since participation is voluntary, a participant can choose to not respond to the survey or exit the survey at any time prior to submission without fear of repercussions.

Potential benefits of your participation are:

- The information from this study may be used to develop a policy that will improve skin-to-skin care within the mother/baby department.
- Implementation of best practice models of care for mothers and their newborns.
- Improved patient outcomes
- Improved nursing satisfaction
- Improved breastfeeding rates

Confidentiality will be maintained at all times. Results will be solely in aggregate form. To ensure confidentiality, data will be secured in a confidential file on a password-protected computer only accessible to the investigator. No attempt will be made to identify participants. Survey Monkey™ will collect IP addresses to safeguard against duplication, email addresses will not be collected. No personal identifying data will be collected. The information will be used within the investigator's doctorate of nursing practice Project and potentially considered for publication in professional health care publications.

For your protection, this project has been reviewed and approved by Madera Community Hospital Institutional Review Board and California State University, Fresno Institutional Review Board. If you have any questions or concerns regarding your participation in this survey, please contact Rachel Napoli at 559 278-8852 or email at rnapoli@csufresno.edu.

Your participation in this survey is greatly appreciated. Thank you.
By completing this survey you are giving consent.

NURSE SURVEY:

Demographic Questions:

Have you taken CE's in breastfeeding before?

☐ Yes ☐ No

How many children do you have?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Have you breastfeed any of your other children?

☐ Yes ☐ No ☐ N/A

Have you exclusively breastfeed any of your other children?

☐ Yes ☐ No ☐ N/A

Did you do skin-to-skin with your children?

☐ Yes ☐ No ☐ N/A

With which racial or ethnic group do you most closely identify?

☐ Asian ☐ Latino ☐ African American ☐ Caucasian ☐ Middle-Eastern ☐ Other

What is the highest level of education that you completed? (Circle one)

Associates Bachelor's Master's Doctorate

Do you hold any of these breastfeeding credentials? (Circle one)

Certified Lactation Educator (CLE) Certified Lactation Counselor (CLC) IBCLC

Please circle your age group:

<20 21-25 26-30 31-35 36-40 41-45 46-50 51-55 >55

Please circle how many years have you worked in mother/baby?

<5 6-10 11-15 16-20 21-25 >25

Please respond to the following statement using a 4-point Likert scale in which**1 = Strongly Disagree 2 = Disagree****3 = Agree****4 = Strongly Agree**

1. I believe skin-to-skin care has benefits?

1 2 3 4

2. I believe skin-to-skin care helps the mother to breastfeed?

1 2 3 4

3. The longer a mother spends skin-to-skin with her newborn the better she will breastfeed?

1 2 3 4

4. Right now our mothers spend enough time skin-to-skin with their newborns?

1 2 3 4
 5. I feel comfortable educating patients and families about skin-to-skin care?

1 2 3 4
 6. I feel comfortable educating patients and families about breastfeeding?

1 2 3 4
 7. Identify how you feel these barriers affect MOTHERS participating in skin-to-skin?

- Visitors in the room

1 2 3 4

- Feeling Groggy / Sleepy / Sick (Safety Concern of holding baby)

1 2 3 4

- Not aware that it is important

1 2 3 4

- Concern about privacy / modesty

1 2 3 4

- Hospital personnel / Hospital routines (nurses?, wording)

1 2 3 4

- It was inconvenient

1 2 3 4

- Others wanted to hold the baby

1 2 3 4

- Baby was not clean

1 2 3 4

- I did not want to participate in skin-to-skin care

1 2 3 4

- Other: _____

8. Identify those barriers below that YOU feel affect how you use or promote skin-to-skin care with your patients?

- Skin-to-skin does not have benefits

1 2 3 4

- Inexperience or lack of educating patients on skin-to-skin

1 2 3 4

- Inexperience or lack of educating patients on breastfeeding

1 2 3 4

- Time Management

1 2 3 4

- Interferes with required nursing taSTS

1 2 3 4

- It is inconvenient

1 2 3 4

- Others wanted to hold the baby

1 2 3 4

- Other: _____

- Would you like more education on skin-to-skin?

☐ Yes ☐ No

- Would you like more education on breastfeeding?

☐ Yes ☐ No

Comments:

APPENDIX B: MATERNAL SURVEY**CONSENT FORM**

Researcher: Rachel Napoli, MSN, RNC, DNP(c)
Doctor of Nursing Practice Student
Doctorate of Nursing Practice, Northern California Consortium
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559 278-8852

You are invited to participate in a study conducted by the researcher listed above. I hope to identify what the barriers are to implementing skin-to-skin within the hospital setting. Skin-to-skin is the act of placing the baby (only in its diaper) on mom's bare chest. By identifying the barriers to skin-to-skin care a policy for skin-to-skin care can be developed to increase the amount of time mothers and their newborns spend skin-to-skin. By increasing skin-to-skin the research shows that breastfeeding is more successful and last longer. By increasing exclusive breastfeeding the health and development of all newborns is increased.

You were selected as a participant in this study because you recently delivered your baby at Madera Community Hospital.

If you volunteer to participate in this study, you will be asked to complete a survey that will take approximately 10 minutes to complete. Since participation is voluntary you are free to withdraw you consent and to discontinue participation at any time without penalty. Your decision to participant will not prejudice any future relations with Madera Community Hospital.

Potential benefits of your participation are:

- The information from this study may be used to develop a policy that will improve skin-to-skin care within the mother/baby department.**
- Implementation of best practice models of care for mothers and their newborns.**
- Improved patient outcomes**
- Improved nursing satisfaction**
- Improved breastfeeding rates**

Confidentiality will be maintained at all times. Results will be solely in aggregate form. All survey data will be aggregated onto the investigators personal computer and then locked in a file in the investigators office. To ensure confidentiality, data will be secured in a confidential file on a password-protected computer only accessible to the investigator. No attempt will be made to identify participants. Each survey will be assigned a random number for identification and no personal identifying data will be collected. The information will be used in my Doctorate of Nursing Practice Project and potentially considered for publication in professional health care publications.

For your protection, this project has been reviewed and approved by Madera Community Hospital Institutional Review Board and California State University, Fresno Institutional Review Board. If you have any questions or concerns regarding your participation in this survey, please contact Rachel Napoli at 559 278-8852 or email at rnapoli@csufresno.edu.

Your participation in this survey is greatly appreciated. Thank you.
By completing this survey and returning it to the investigator you are giving consent.

Skin-to-skin is the act of placing the baby (only in its diaper) on mom's bare chest.

SURVEY:

Demographic Questions:

1. Have you given birth before? ☐ Yes ☐ No
2. Were you planning to breastfeed this baby? ☐ Yes ☐ No
3. Are you and your baby breastfeeding now? ☐ Yes ☐ No
4. Did you only breastfeed any of your other children (No formula)? ☐ Yes ☐ No
5. Did you do skin-to-skin with your other children? ☐ Yes ☐ No ☐ N/A
6. Have you breastfeed any of your other children? ☐ Yes ☐ No ☐ N/A
7. Including this child how many children do you have? ☐ 1 ☐ 2 ☐ 3 ☐ 4+
8. How was your baby born? ☐ Vaginally ☐ C-Section
9. What insurance coverage do you have? ☐ Medi-Cal ☐ Private ☐ No Coverage

10. With which racial or ethnic group do you most closely identify? (Circle one)

Asian Latino African American Caucasian Middle-Eastern Other

11. What is the highest level of education that you completed? (Circle one)

Elementary School High School Trade/Technical School College Degree Graduate Degree

12. Please circle your age group:

15-20 21-25 26-30 31-35 36-40 41-45 46-50

Please respond to the following statements using by choosing 1-4 in which

1 = Strongly Disagree 2 = Disagree

3 = Agree

4 = Strongly Agree

9. I spent enough time skin-to-skin with my baby after it was born

1 2 3 4

10. There are benefits to skin-to-skin?

1 2 3 4

Skin-to-skin is the act of placing the baby (only in its diaper) on mom's bare chest.

Please respond to the following statements using by choosing 1-4 in which

1 = Strongly Disagree 2 = Disagree

3 = Agree

4 = Strongly Agree

11. Hospital staff encouraged me to be skin-to-skin with my baby?

1 2 3 4

12. Did you feel that skin-to-skin helped you breastfeed?

1 2 3 4

13. Do you feel closer to your baby when doing skin-to-skin?

1 2 3 4

14. Hospital personnel taught me about skin-to-skin?

1 2 3 4

15. Having visitors in the room prevented me from doing skin-to-skin with my baby

1 2 3 4

16. Feeling Groggy, Sleepy or Sick prevented me from doing skin-to-skin with my baby

1 2 3 4

17. I am not aware that skin-to-skin is important so I did not do it with my baby

1 2 3 4

18. I feel exposed when doing skin-to-skin so this prevented me from doing skin-to-skin

1 2 3 4

19. The hospital staff coming in and out of my room prevented me from doing skin-to-skin

1 2 3 4

Skin-to-skin is the act of placing the baby (only in its diaper) on mom's bare chest.

20. Doing skin-to-skin is not convenient so I did not do it.

1 2 3 4

21. Having friends or family that wanted to hold the baby prevented me from doing skin-to-skin

1 2 3 4

22. The baby not being clean made me not want to do skin-to-skin

1 2 3 4

23. I did not want to participate in skin-to-skin care

1 2 3 4

24. Other: _____

25. Would you like more education on skin-to-skin?

☐ Yes ☐ No

26. Would you like more education on breastfeeding?

☐ Yes ☐ No

Comments:

APPENDIX C: MATERNAL SURVEY (SPANISH)**Forma para Consentimiento Materno**

Investigador: Rachel Napoli, MSN, RNC, DNP(c)
Doctor of Nursing Practice Student
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Usted está invitada a participar en un estudio presentado por el investigador mencionado arriba. Esperamos identificar cuales son las barreras implementadas en el cuidado piel-a-piel en el hospital. Conociendo las barreras, podemos desarrollar una póliza para incrementar el tiempo de piel-a-piel entre mamá y su recién nacido/a. Cuando incrementamos el tiempo piel-con-piel, el estudio enseña que el tiempo y el éxito de amamantar mejora. Cuando mejoramos el tiempo amamantando a nuestros bebés exclusivamente, la salud y desarrollo de todos los recién nacidos es mejor.

Usted es seleccionada para participar en este estudio porque acaba de dar a luz a su bebe aquí en Madera Community Hospital.

Si usted acepta participar en este estudio voluntario, le daremos un cuestionario que durará aproximadamente 10 minutos para terminar. Este cuestionario es voluntario y tiene el derecho de terminar a la hora que pueda sin problema. Su decisión a participar en el estudio no afecta su relación o cuidado.

Beneficios de participar :

- La información del estudio ayudará a desarrollar una póliza en este departamento para mejorar el cuidado entre mamás y bebés usando piel-con-piel.
- Implementar el mejor modelo para cuidar mamás y bebés.
- Mejorar los resultados con los pacientes
- Mejorar la satisfacción con las enfermeras.
- Mejorar la cantidad de pacientes satisfechos que dan pecho

Su cuestionario será completamente confidencial. Los resultados serán agregados en una sola forma, y esta forma a la computadora personal del investigador donde será asegurada en una oficina privada. No hay manera de identificar las participantes. En cada cuestionario hay un número para identificar y no hay manera de identificación personal. La información se usa para un estudio llamado "Proyecto en Doctorado de Práctica en enfermería"

Para su protección, este proyecto está evaluado y aprobado por Madera Community Hospital Institutional Review Board y California State University, Fresno Institutional Review Board. Si usted tiene alguna pregunta o queja sobre su participación, por favor llamar a Rachel Napoli 559-278-8852 o correo electrónico rnapoli@csufresno.edu
Le agradecemos su participación. Gracias.

Esta forma se considera un consentimiento a participar en este estudio si completa el cuestionario y entrega al investigador.

CUESTIONARIO:

Piel-con-Piel es poner tu bebé sobre la piel en tu pecho sin ropa solo con pañal

Preguntas Demograficas:

1. ¿Haz dado a luz? ☐ Sí ☐ No
2. ¿Estabas planeando amamantar a tu bebé? ☐ Sí ☐ No
3. ¿Esta amamantando ahora? ☐ Sí ☐ No
4. ¿Has amamantado exclusivamente cualquiera de tus otros hijos?..... ☐ Sí ☐ No ☐ n/a
5. ¿Haz hecho piel-con-piel con cualquiera de sus otros hijos? ☐ Sí ☐ No ☐ n/a
6. ¿Has amamantado cualquiera de tus otros hijos? ☐ Sí ☐ No ☐ n/a
7. ¿Cuántos hijos tiene, incluyendo este hijo/a? ☐ 1 ☐ 2 ☐ 3 ☐ 4 or mas
8. ¿De que manera nació su bebe? ☐ Normal ☐ Cesarea
9. ¿Que tipo de aseguranza tiene? ☐ Medi-Cal ☐ Privada ☐ Nada
10. ¿Con qué grupo racial o étnico se identifica más estrechamente? (Circula uno)
 Asiatico Latina Africo Americano Europeo Medio Oriente Otro
11. ¿Cuál es el nivel más alto de educación que usted completó? (Circula uno)
 Primaria Secundaria Preparatoria Universidad Doctorado
12. Por favor marque su grupo de edad: (Circula uno)
 15-20 21-25 26-30 31-35 36-40 41-45 46-50

Por favor, responda a la siguientes frases mediante una escala en los que

1= Muy en Desacuerdo 2=Desacuerdo 3=Acuerdo 4=Muy de Acuerdo

1. Pasé bastante tiempo piel-con-piel con mi bebé después de dar a luz.

1 2 3 4

2. Hay beneficios con piel-con-piel

1 2 3 4

Piel-con-Piel es poner tu bebé sobre la piel en tu pecho sin ropa solo con pañal

Por favor, responda a la siguientes frases mediante una escala en los que

1= Muy en Desacuerdo

2=Desacuerdo

3=Acuerdo

4=Muy de Acuerdo

3. Las Enfermeras del hospital me animaron a estar piel-con-piel con mi bebé

1

2

3

4

4. Siento que estar piel-con-piel con mi bebé me ayudó a amamantar

1

2

3

4

5. Me siento más cerca de mi bebé cuando estamos piel-con-piel.

1

2

3

4

6. Las enfermeras del hospital me enseñaron sobre piel-con-piel

1

2

3

4

7. Tener visitas en mi cuarto fue un problema para estar piel-con-piel con mi bebé

1

2

3

4

8. Sentirme adormilada fue un problema para estar piel-con-piel con mi bebé

1

2

3

4

9. Yo no sabia que piel-con-piel era importante, entonces no estuve piel-con-piel

1

2

3

4

10. Me sentia con pena y fue un problema para estar piel-con-piel

1

2

3

4

11. El personal del hospital entraban y salian de mi cuarto, esto fue un problema para estar piel-con-piel

1

2

3

4

12. Estar piel-con-piel no es conveniente por eso no lo hice

1

2

3

4

Piel-con-Piel es poner tu bebé sobre la piel en tu pecho sin ropa solo con pañal

13. No quise estar piel-con-piel por que el bebé estaba sucio

1 2 3 4

14. Si el bebe no estaba limpio, esto me hizo no querer estar piel-con-piel

1 2 3 4

15. Yo no quise participar en el cuidado piel-con-piel

1 2 3 4

Otra razon: _____

¿Quieres mas información en piel-con-piel?

☐ Sí ☐ No

¿Quieres mas información sobre amamantar su bebé?

☐ Sí ☐ No

APPROVED

For the School of Nursing:

We, the undersigned, certify that the project of the following student meets the required standards of scholarship, format, and style of the university and the student's graduate degree program for the awarding of the doctor of nursing practice degree.

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