BAYSTATE MEDICAL CENTER
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
CLINICAL PRACTICE STANDARD

2.2.14 Delayed Cord Clamping and Skin-To-Skin at Delivery in Newborns ≥ 36 Weeks – Vaginal Delivery

1.0 The purpose of this guideline is to promote both delayed cord clamping and skin to skin contact for uncomplicated term neonates. . Rationale for delayed cord clamping includes delivery of expected blood volume to the newborn for maintenance of blood pressure and cardiac function and facilitating adequate oxygenation to the baby while respirations are established. Rationale for skin-to-skin includes maintenance of newborn temperature, better cardio-respiratory and blood glucose stability, and increased breastfeeding success. Integrating both of these approaches will provide for more efficient care for both the mother and newborn.

2.0 The patient and her family should be informed prenatally and/or in labor that Wesson Women & Infants highly encourages immediate newborn care is skin-to-skin and delayed cord clamping in term uncomplicated vaginal deliveries. The rationale for this approach should be discussed and questions answered.

3.0 Preparation for delivery.

- 3.1 As in the preparation for all deliveries, the infant warmer should be on, in case it is needed for resuscitation.
- 3.2 Warm blankets for the newborn should be in the room.
- 3.3 Nursing staff should be prepared to assess and monitor the newborn in the mother's arms for a period of one hour.

4.0 At delivery. Refer to Flowchart for Overview.

- 4.1 The delivery attendant dries the newborn on dry towels at the perineum.
- 4.2 The delivery attendant briefly assesses the newborn (<10 seconds) to determine tone and presence of initial respiratory efforts.
- 4.3 If tone is good and there are spontaneous respirations:
  - 4.3.1 The newborn is placed skin-to-skin on the mother's chest, covered with a warm blanket by the nurse, and further dried and assessed by the nurse.
    - 4.3.1.1 If cord length does not allow placement on the mother's chest, the newborn is place on the mother's abdomen.
    - 4.3.1.2 If cord length does not allow placement on the mother, strip the cord several times then clamp and cut.
  - 4.3.2 Leave the cord intact until:
    - 4.3.2.1 Signs of spontaneous delivery of the placenta occur
    - 4.3.2.2 Or, cord looks pale, white and flat
  - 4.3.3 Clamp and cut the cord in the usual manner, leaving the newborn skin-to-skin.
    - 4.3.3.1 Newborn is left skin-to-skin for one hour.

2.2.14 Delayed Cord Clamping and Skin-To-Skin at Delivery in Newborns ≥ 36 Weeks – Vaginal Delivery

4.3.4 Cord blood may be obtained from major vessels in the placenta, if necessary.

4.4 If tone is poor, care should be based on the clinical situation:

4.4.1 If, based on the maternal and fetal evaluation prior to birth, there is an increased risk for fetal acidosis, and poor tone is noted at the time of delivery, milking the umbilical cord and then cutting it and resuscitation at the warming would be advisable.

4.4.2 If there has been reassuring fetal evaluation prior to delivery fetal acidosis is believed not likely:

4.4.3 Place newborn on clean pad at the perineum and dry

4.4.3.1 If newborn heart rate is ≥100:

4.4.3.1.1 Continue drying and provide stimulation. If tone improves and respirations established, place baby skin-to-skin, and follow 4.3.1, above.

4.4.3.1.2 If there remains poor tone or respirations or the newborn heart rate is less than 100:

4.4.3.1.3 Milk the cord several times

4.4.3.1.4 Recheck heart rate

4.4.3.1.5 If heart rate ≥100, follow 4.4.1.2. above

4.4.3.1.6 If heart rate < 100, clamp and cut cord, take baby to warmer, and continue with resuscitation.

5.0 The clinical status of mother or newborn may preclude skin-to-skin care and or delayed cord clamping. The judgment of the obstetrical and newborn teams will determine the most beneficial approach for each individual clinical situation.

Approved: Perinatal Committee Meeting-June 18, 2014

Daniel Grow, MD
Chairman, Department of Ob/Gyn

Andrew Healy, MD
Medical Director, Obstetrics