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A Meta-ethnography

Skin-to-Skin Holding From the Caregiver's Perspective

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ABSTRACT

Background: Although the benefits of skin-to-skin care (SSC) are well documented in the literature, practices in the clinical setting remain inconsistent. Although nurses' reported knowledge about SSC has improved, confusion still exists regarding safety and appropriateness. Existing qualitative literature primarily focuses on parents' experiences; yet it is crucial to describe the essence of professional caregivers' experiences to enhance facilitation and implementation of SSC. Most studies surrounding the caregiver's perspective and SSC have focused on barriers that impede implementation or examined the experience from the organizational perspective and general group experiences rather than individual personal experiences with SSC.

Purpose: This meta-ethnography integrated the findings from several discrete studies into a salient interpretative perspective, creating a relevant understanding of the process of SSC as a means of enhancing facilitation and implementation of SSC with hospitalized infants.

Methods: An ethnographic meta-synthesis of qualitative literature was completed.

Results: As a result of this synthesis, the caregivers' experiences were separated into themes to articulate the phenomena juxtaposed from the 8 original studies that influence facilitation of SSC for the parent–infant dyad. Qualitative data analysis uncovered 4 overarching themes: (1) varying thresholds of getting started; (2) defining adequate resources; (3) navigating the demands and complexity of the infant; and (4) balancing parental readiness with infant needs.

Implications for Practice: This ethnographic meta-synthesis confirms nurses have good intentions in supporting SSC practices, yet struggle to meet competing demands in their daily practice.

Implications for Research: Innovative and practical translations of SSC are needed to normalize SSC as the daily standard for premature infants.

Key Words: ethnography, kangaroo mother care, meta-synthesis, premature infants, qualitative, skin-to-skin care

Skin-to-skin care (SSC) is the holding of a diaper-clad infant on the parent's bare chest. A warmed blanket is often placed over the infant to maintain body temperature while the infant is held. Holding can be for minutes to hours, but should last as long as it is physiologically supportive to both the infant and the parent. However, SSC for less than 30 minutes has not yielded physiologic benefits for preterm infants possibly because of the time needed for infants to adapt to position changes with enough recovery time.[1-3] Neu and colleagues[4] reported that the recovery time for the infant's physiologic stability was within 15 minutes. The effects of SSC on parents and infants are well documented in the literature. Immediate and long-term benefits include physiologic stability for infants during and after SSC.[3,5-10] Other benefits to the infant include more stable thermoregulation and weight gain.[3,11,12] Improved brain development, as well as better motor and mental development, is also documented findings for infants held in SSC.[3,13,14]

Parents also benefit from SSC including reduced maternal stress and decreased postpartum depression.[15,16] There also appears to be benefits with SSC with regard to parent–infant bonding; SSC has been found to enhance the developing relationship; mothers report feelings of closeness; increased maternal confidence; improved breastfeeding success; as well as reduced stress levels.[17-22] Skin-to-skin care is an effective strategy nurses may use to enhance the parent–infant relationship. The majority of literature related to the nurse's experience is quantitative,

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examining nurses' attitudes, barriers to implementing SSC, and nurses' knowledge of SSC.[23-26] Fewer studies have provided a qualitative understanding of this practice from the nurse's perspective.

Although there are benefits for both infants and parents; the newborn intensive care unit (NICU) is a technology-driven environment where nurses have many tasks to accomplish throughout the day. Within the NICU, SSC needs to be considered a process rather than a task and demands a modified sensory environment with decreased lighting, sounds, and activity. This modified environment enhances the parents' experience and allows the parent–infant dyad to relax and spend quality time together. Skin-to-skin care supports the infant and parent to develop reciprocity or coregulation through interaction. It is essential that parents have a calm, soothing atmosphere while holding their infant to support bonding and reciprocity to occur, ensuring the experience is positive for both participants.[27] Nurses often attend to the demands of the environment at the infant's bedside and are aware of how the atmosphere influences SSC experiences for both parents and infants, making them the ideal health professional to facilitate the process.

Overall, qualitative literature on the subject of SSC primarily focuses on the parents' experiences. Often the purpose of these inquiries has been to increase understanding of the multifaceted advantages of SSC on maternal attachment and confidence.[20] Participants in these studies have identified communication and information provided by the nurse as strongly influencing their experiences while participating in SSC with their infant.[16] Skin-to-skin care can also help fathers of preterm infants gain confidence in their parental role, coping with the unexpected stress of preterm birth and extended hospitalizations.[28]

Although the benefits of SSC for parents, as well as infants, are well documented in the literature, the practice of SSC remains inconsistent.[23,24] Ludington-Hoe documents that adoption of SSC by nurses in the United States continues to be slow despite strong evidence that support its use.[29] Nurses report that although knowledge about SSC has improved, confusion still exists among them with regard to safety and appropriate use of SSC.[25] In addition, nurses have reported that the support from leadership, education on SSC, and adequate staffing levels are all factors that influence their decision to facilitate SSC.[23,30] The aim of this meta-synthesis is to describe the essence of healthcare providers' experiences in facilitating SSC, with the overall goal of increasing understanding of the process, thus enhancing the facilitation and implementation of SSC.

This synthesis of the literature adds to the discourse regarding the meaning of caregivers' experiences in facilitating SSC by blending the findings of several individual qualitative studies. The purpose of this meta-synthesis is to integrate the findings from several discrete studies into a more salient interpretative perspective that will lead to more targeted understanding that can be used to support implementation and facilitation of skin-to-skin holding experiences for critically ill or hospitalized infants.

What This Study Adds

- Description of 4 key themes that influence the caregiver's facilitation of SSC.
- Deeper understanding of the caregiver's experiences with SSC, highlighting the complexity of SSC experiences as nurses and health professionals navigate competing demands, which influence when or if SSC is initiated.
- Identifies knowledge practice gaps with regard to SSC.

METHODS

Noblit and Hare's[31] method for meta-ethnography has been used by many nursing scholars to combine the findings of multiple qualitative studies, translating or "juxtaposing" the findings, to create a figurative meaning of the identified themes resulting in a new understanding of the caregiver's experiences when facilitating SSC with parents and their hospitalized infants. This method was selected because it maintains the richness, essence, and integrity of the original studies while integrating the context into a newly defined whole. These interpretive findings serve as units of analysis. Table 1 outlines the methodological process. For the meta-ethnography, a constant comparative procedure grounded in the hermeneutic process was used with analysis. Data were extrapolated from the individual studies themselves and were examined in relation to each other, which brought forth 4 overarching themes elicited by metaphors. This synthesis generated a new understanding of the caregiver's experiences when facilitating SSC. Table 2 identifies overarching metaphors

TABLE 1. Meta-ethnography Method[a]

Phase 1	Identify a topic
Phase 2	Deciding what is relevant to initial topic
Phase 3	Reading the studies
Phase 4	Determining how studies are related
Phase 5	Translating the studies into one another
Phase 6	Synthesizing translations
Phase 7	Expressing the synthesis

[a]*This method is adapted from Noblit and Hare.*[31]

TABLE 2. Individual Study Metaphors as Related to Overarching Themes

Study	*A Fork in the Road:* Varying Thresholds of Getting Started	*Spectrum of Possibilities:* Defining Adequate Resources	*Continuing to Grapple:* Navigating Demands/Complexity of the Infant	*Dancing the Waltz:* Balancing Parental Readiness With Infant Needs
Wallin et al[32]	"Considerable attention was devoted to preparing information … focusing on developing unit-based guidelines" for KMC	"Perceptions about contextual conditions" manager influenced adequate staffing resources and demonstrated respect for nursing	"You notice it both in infants & on the monitors. The monitors don't alarm, the oxygen is reduced and the baby does well"	"wide perception that care procedures changed and parents and infants well being was enhanced"
Chia et al[24]	Education was essential for staff knowledge and skill to facilitate SSC	"All respondents expressed strong frustration with increased workload & low staffing levels" making SSC difficult	"Condition of the infant area of concern, with consensus that infant's tolerance level was deciding factor to encourage parent to practice" SSC	"Understanding kangaroo care"… "explaining what it actually means and how they can go about doing it"
de Hollanda Parisi et al[33]	"Decision making and awareness of process of healthcare team" was pivotal to successful implementation	"Need for adequate physical space, chairs etc" "When adequate resources and staff available advantages of SSC obvious"		"The mother is more of a partner of ours than of the medical team"
Lee et al[34]	"Lack of adequate staff education about importance of" SSC…"not all staff believed in benefits of SSC"	"Creative opportunities to increase motivation for staff" participation. "Physician and leadership support critical"	Impression of "infants' clinical stability" was variable, thus influenced SSC practices	"increasing maternal motivation for STSC can be difficult in light of cultural traditions"
Gontijo et al[35]	Ministry of Health defined proposal for implementation. "Importance of method of newborn care"	Lack of "institutional support" most hindering to SSC constraints with physical space limitations	Lack of "institutional support" most hindering to SSC constraints with physical space limitations	"We can help facilitate this bond between mother and baby, decrease anguish that his is a terror"
Kymre and Bondas[36]	Realizing urgency in transferring and limited valuable time for "being with" infant before death		"Dignity for the dying newborn was raised as challenging in regard to simultaneous urgency of the situation"	Persuaded parents to hold their dying newborn skin to skin; "common experience …was that parents were thankful for being helped to cross threshold of getting close to child they were about to lose"
Kymre and Bondas[37]	"Shared experience of changing focus in the history of NICU care." "Initiating SSC as soon and much as possible"	Nurses perceived SSC as responsibility, "giving up SSC by transferring back to incubator was seen as failure in nursing care"	"The sicker the newborn, the more important SSC is" Signs of wellness and harmony are motivating for SSC	"Encouraging parents to dare to hold their newborn skin to skin"
Ferrarello and Hatfield[38]	"All nurses indicated SSC was important" yet "would involve complete change in the way we do care" for staff	Logistics of not enough time to complete all that needs to be done within shift. "There's so much to do. Where can you fit it in?"	Many visitors in mother's room considered barrier. Wanting to share infant with visitors inhibited SSC	SSC removes barriers between mother and infant enhancing interactions and promotes calm

Abbreviations: KMC, kangaroo mother care; SSC, skin-to-skin contact; STSC, skin to skin care.

that were extrapolated as specific phrases, ideas, and concepts that were extrapolated from each individual study. Table 2 also provides an audit trail to enhance the credibility of the analysis. Synthesizing the translations through this method of analysis creates a new product, which serves as something more than the individuality of its parts.

SAMPLE

A cross-disciplinary review of the literature was completed using CINAHL, PsycInfo, PubMed, and the Cochrane Library as well as Scopus Databases. Anthropological and humanities literature as well as the sociological abstracts was also searched. The key words for the searches included the following: *kangaroo care, kangaroo mother care, skin-to-skin holding, neonatal intensive care, qualitative, grounded theory, phenomenology, mixed methods, nursing care, nursing knowledge, nursing attitudes, premature, systematic reviews, meta-analysis, and meta-synthesis*. Inclusion criteria included qualitative studies that identified the caregiver's perspective when facilitating skin-to-skin holding experiences. There were no quantifiers on the type of qualitative design used for inclusion of the studies. Peer review articles in English were utilized to integrate knowledge on SSC into this ethnography. The final sample was selected to maximize heterogeneity in terms of the healthcare provider's experiences and perceptions in facilitating SSC. Of the 62 articles that were read and screened for eligibility, 8 met the inclusion criteria and were included in this synthesis. Eleven studies did not pertain to skin-to-skin holding with infants; 28 studies focused on parental perspectives; 4 articles were duplicates; and, the remaining 11 articles did not attend to staff experiences or used quantitative methodologies.

In a meta-synthesis, each of the research studies is examined both as a unit and as part of the whole. Table 3 identifies demographic characteristics of study participants. Many of the qualitative study reports did not identify extensive, distinct characteristics of the individual study participants. There were 343 participants overall within the 8 qualitative studies. Five of the studies were published from the nursing discipline, whereas the remaining 3 were published from the discipline of medicine, yet these studies primarily utilized nurses as participants. One article utilized multidisciplinary participants from nursing, lactation, occupational therapy, physical therapy, dieticians, and physicians. Many of the studies utilized either convenience or purposive sampling with thematic analysis methods. See Table 4 for explicit methodological characteristics of the sample.

FINDINGS

Below is a summary of overarching themes related to the various aspects of this meta-ethnography. An elucidation of key metaphors that correspond to the overarching themes emerged from the individual studies and contributed to the synthesis. A metaphor is used as a figure of speech to highlight an implied comparison for a word or phrase that is ordinarily used with other meaning. Metaphors are often exaggerated expressions that elicit a profound statement. Individual study metaphors and participant quotations that contributed to the reciprocal translation of this synthesis are highlighted. Sample memos and examples are meant to demonstrate the constant comparative method encompassed within the hermeneutic process, to analyze and articulate the caregiver's experiences. Most studies

TABLE 3. Demographic Characteristics of the Participants of Individual Studies Included in Metasynthesis

Study	Discipline	Sex	Country	Age, y Mean (Range)	Practicing RN, y
Wallin et al[32]	Nursing	Not specified	Sweden	39 (23-63)	Range, 1-37; mean, 15
Chia et al[24]	Nursing	Female	Australia	39.7 (25-56)	Range, not specified; mean, 9.9
de Hollanda Parisi et al[32]	Medicine	Not specified	Brazil	Not specified	Not specified
Lee et al[34]	Medicine	Not specified	United States	Not specified	Not specified
Gontijo et al[35]	Medicine	Not specified	Brazil	Not specified	Not specified
Kymre and Bondas[36]	Nursing	Female	Sweden Denmark Norway	Not specified	Swedish RN, 3-24; median, 13 Danish RN, 7-22; median, 12 Norwegian RN, 4-22; median, 11
Kymre and Bondas[37]	Nursing	Female	Sweden Denmark Norway	Not specified	Swedish RN, 3-24; median, 13 Danish RN, 7-22; median, 12 Norwegian RN, 4-22; median, 11
Ferrarello and Hatfield[38]	Nursing	Not specified	United States	Not specified	Not specified

TABLE 4. Methodological Characteristics of Individual Studies Included in Metasynthesis

Study	Sample Size	Setting	Sampling	Qualitative Research Design	Data Collection	Data Analysis
Wallin et al[32]	45	(4) NICUs	Convenience	Descriptive qualitative	Focus group interviews, Morgan and Krueger, 1998	Transcript-based analysis
Chia et al[24]	4	(1) NICU	16 self-identified then randomized sample	Mixed methods, descriptive qualitative	Interviews	Thematic analysis
de Hollanda Parisi et al[33]	5	(1) NICU	Not specified	Exploratory descriptive qualitative	Semistructured interviews	Narrative, categories and core themes
Lee et al[34]	128	(11) NICUs	Not specified	Descriptive qualitative	Focus groups	Thematic analysis Atlas Ti Software
Gontijo et al[35]	135	(10) Maternity hospitals	Purposive	Grounded theory, Strauss and Corbin, 1990	Semistructured interviews, observations	Structural analysis of narration
Kymre and Bondas[36]	18	(3) NICUs	Purposive	Phenomenology, Dahlberg, Dahlberg, and Nystrom, 2008	Interviews	Essence, identify constituents to create meanings of new whole
Kymre and Bondas[37]	18	(3) NICUs	Purposive	Not specified Phenomenology, Dahlberg, Dahlberg, and Nystrom, 2008	Interviews	Essence, identify constituents to create meanings of new whole
Ferrarello and Hatfield[38]	8	(1) Postpartum	Purposive	Mixed methods, descriptive qualitative	Focus group interviews	Thematic analysis

Total participants: 343.

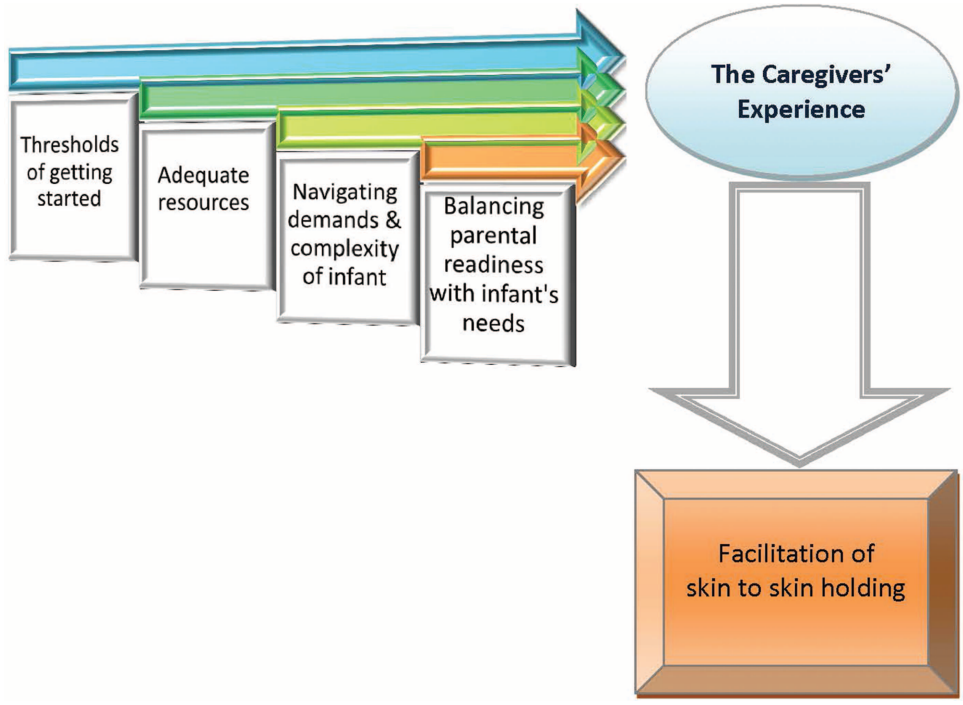
surrounding the caregiver's perspective and SSC have focused on barriers impeding implementation or examined the experience from the organizational perspective and general group experiences, rather than individual personal experiences with SSC. In contrast, a few studies have attended to the unique perspectives of the individual nurse, which provided a rich cadre of experiences to explain the phenomenon of facilitating SSC.

The reciprocal translations necessary in this metasynthesis yielded 4 metaphors that were further defined by the identified overarching themes: (1) *a fork in the road*: varying thresholds of getting started; (2) *spectrum of possibilities*: defining adequate resources; (3) *continuing to grapple*: navigating the demands or complexity of the infant; and (4) *dancing the waltz*: balancing parental readiness with the infant's needs. These themes comprise the health professional's experience and influence the facilitation of SSC. As illustrated in Figure 1, caregivers' perceptions and experiences are separated into 4 categories to articulate the phenomena juxtaposed from the 8 original studies that influence facilitation of SSC for the parent–infant dyad. Following is an in-depth description of each metaphor with the corresponding theme that emerged from the meta-synthesis.

A Fork in the Road: Varying Thresholds of Getting Started

The metaphor of *a fork in the road* emerged through the synthesis as described with the first overarching theme of the *varying thresholds of getting started*, as evidenced with the premise that despite the theoretical knowledge about humane care that includes SSC, the practice of SSC was not fully incorporated into clinical settings.[35] The Ministry of Health in Brazil

FIGURE 1



Overarching themes of caregiver's experiences in facilitating skin-to-skin holding.

developed a proposal for implementation of SSC to help uncover the gaps between knowledge and application because of inconsistent practices of SSC within the NICU.[35]

In one study from Scandinavia; SSC has been fully integrated into the nurse's role. Participants describe this change as stemming from a NICU cultural practice shift when they began using NIDCAP (Newborn Individualized Developmental Care and Assessment Program). These strategies incorporate infant development into the healthcare process and views parental attachment as a priority within traditional medical care of the infant.[36,37] The nurses' self-awareness of these changed attitudes described a completely different path to reaching a higher threshold of SSC implementation than found in other studies in the synthesis. These nurses perceived the approach to caring for an infant to be defined as individualized developmentally supportive care intertwined with empowering parenting as their utmost responsibility and priority. Supporting the infant's experiences was considered a central component of the nurses' daily work, which included SSC. This cohort articulated "initiating SSC as soon and as much as possible" and described it as a critical threshold to achieve harmonic SSC, which enhanced the nurses' functioning.[37 (p.4)] Another participant from the Kymre and Bondas study stated "the sicker the newborn is, the more important it is to get started to have SSC."[37(p.4)] If the infant was dying or decisions were made to stop life-supporting treatments, the nurses in this study perceived "urgency in transferring, and limited, valuable time for being with" was expressed as the notion of "should" with a participant stating, "the newborn 'should' have the opportunity to be with (their) parents before passing away."[36(p.671)] In contrast, another study with postpartum nurses in the United States identified that although "all nurses indicated SSC was important," practicing SSC on a regular basis "would involve complete change in the way we do care" and respondents focused on perceived barriers to implementation of SSC, which was not a part of their daily nursing practice.[38(p.58)]

Many studies identified education or training as essential to providing staff with knowledge and skills to facilitate SSC. Considerable attention was devoted to preparing information for colleagues focused on developing appropriate guidelines and unit protocols for SSC. "We know staff is going to need support because it (SSC) hasn't always been an expectation and it hasn't always been positively promoted."[34(p.81)] The theme of staff buy-in, motivation, and interdepartmental communication also influenced the perception of, or if and when, SSC was utilized. However, despite the perceived need for knowledge about SSC, the priority within that study was in regard to how the staff were supported "through role-plays we

captured a lot of situations that were difficult to express" to help diffuse the perceived burden or negativity associated with SSC.[32(p.65)]

In many of the studies, there were nurses who expressed positive personal emotions when implementing SSC.[24,32,36,37]

For example, "respondents said they were knowledgeable about the use of KC (SSC) and expressed a sense of excitement and enthusiasm about facilitating SSC"[24(p.24)]; thus, these mixed findings contribute to the overarching theme of varying thresholds of getting started with SSC.

Spectrum of Possibilities: Defining Adequate Resources

The metaphor of the spectrum of possibilities corresponding with the theme of defining adequate resources was pervasive throughout all the studies. Chia and colleagues documented "all respondents expressed a strong sense of frustration with increased workloads and low staffing levels, making it difficult for them to find time to facilitate KC (SSC) effectively."[24(p.24)] An organization's leadership was described as pivotal to success for implementing SSC, with the nursing manager influencing adequate staffing levels and respect for nursing.[32] One respondent from Wallin and colleagues stated: "We have a good nurse manager … she trusts us and supports us in what we are doing. It is important that you have someone trustworthy to talk things over with"; yet others within the same study stated, "KMC had not been prioritized because of heavy workloads and many ongoing projects."[32(p.69)]

A participant from another study identified the lack of adequate staffing resources, which was portrayed as a challenge to facilitate SSC, "We are kind of stumbling a little bit because of our lack of manpower to … move forward with a lot of our things. I think the intent (for SSC) and will is there, just we require more staff members."[34(p.81)]

A few studies identified inadequate resources limiting physical space as constraints associated with inadequate institutional support hindering SSC.[33-35] When there were adequate infrastructures and sufficient human resources within a nursery as well as ample physical space for chairs, the staff acknowledged the advantages of SSC are obvious.[33]

> *Besides material resources, there is still the human resources factor that is a limiter for the execution of the healthcare proposal (SSC), we have few professionals to supervise the actions provided to the mother-child binomial adequately, especially on weekends when we work with a reduced staff, and still have the managerial activities that take up a large share of our time.*[33(p.578)]

The logistics of not enough time to complete all that needs to be done within a shift were expressed as "there's so much to do where do you fit it all in."[38(p.58)] The postpartum nurses participating in this study were focused on the multitude of tasks that need to be done with new mothers and infants such as hearing screenings, as well as environmental and dietary considerations.[38] These nurse respondents perceived SSC as one more task.

Yet, nurse participants from the Scandinavian studies articulated a very different perspective.[36,37] If SSC was not practiced, it was perceived as unacceptable. One participant described, "Giving up SSC by transferring an uncomfortable newborn back into the incubator was seen as failure in nursing care and could possibly make the parents more anxious."[37(p.5)]

Thus, adequate resources were considered in the context of balancing challenges of shared responsibilities within themselves as nurses, as well as with what the parents brought to the interaction and how the nurse perceived what they, as expert nurse, would need to do to facilitate SSC. For these Scandinavian nurses, it was the personal resource of emotional competence found within themselves to attend to the complexity and challenge these sick infants required rather than physical resources as expressed in the findings of other studies.

Continuing to Grapple: Navigating the Demands and Complexity of the Infant

The metaphor of *continuing to grapple* elicited by the overarching theme of *navigating the demands and complexity of the infant* was threaded throughout all of the studies in the synthesis. The professional caregivers needs to trust their interpretation of the infant's physiologic complexity and whether they feel comfortable with their perceptions of the infant's condition. The Scandinavian nurses stated, "I have seen them (infants) get more stable and since studies have found the brain develops better, I understand the importance."[37(p.5)] The condition of the infant was an area of concern and consensus among the nurses who responded within the study conducted by Kymre and Bondas in Scandinavia.[37] The infant's physiologic status and tolerance of care interactions often dictated whether SSC was encouraged with parents or not. The respondents' were also concerned with dislodging infusion lines and equipment when transferring an infant for SSC, yet also stated asking a second staff nurse for assistance was helpful.[24] A respondent commented that "kangaroo care supported the physiological and behavioral status of the infant, keeping the infant warm, maintained the infant's heart and respiration rate and promoted sleep."[24(p.24)]

There was general agreement that infants needed to be clinically stable to be eligible for SSC, yet there was also recognition that there was significant

variability and sometimes disagreement over the definition of clinical stability among providers.[24,34] Another factor that posed a barrier to SSC was the type of technology and equipment being used to care for the infant, which meant that at times, extra assistance by additional personnel was needed. Some of the participants were focused on the infant's experience attempting to navigate the complexity of the care needs as illustrated by the comment, "Because he was very ill, I am uncertain of what he was sensing. I think it depends on the various physical condition and medications. If they are conscious or in a doze, (asleep) but I believe the skin to skin contact is good for the newborn."[36(p.672)]

Another participant from the same study stated "dignity of the dying newborn was raised as challenging in regard to the simultaneous urgency of the situation."[36(p.672)]

The nurse participants felt a responsibility to get the infant onto the mother's chest before the infant's death to preserve the infant's dignity, yet the challenge of the simultaneous demands of urgency paired with the complexity of the critically ill infant to facilitate SSC within this critical window was difficult for the caregiver.

Dancing the Waltz: Balancing Parental Readiness With the Infant's Needs

The overarching theme of balancing parental readiness with the infant's needs was first identified by Kymre and Bondas in their phenomenological study of the facilitation of SSC with premature infants that were dying.[37] Many nurses consider it important to be sensitive to the parent's perspective and not impose on parents to feel guilty for not being continuously present in the NICU.[24,34,36,37] Some parents decline a nurse's suggestion to hold SSC and need to be encouraged or persuaded to stay with their infant. The participants in Kymre and Bondas' study felt a responsibility to talk with parents about the efficacy of SSC:

> *Sometimes we persuade parents to hold their baby skin to skin, especially the smallest, who they don't dare to touch. We cannot push too hard, but we may sometimes be impatient in getting started with SSC. This outcome is normally good, though we have to go step by step to get there.*[37(p.5)]

Supporting parents in the delicate dance of beginning the parenting process was expressed as follows:

> *The mother is more like a partner of ours than the medical team, surely this doesn't mean all the doctors. The impression I have is that the doctors give the orders and we have to accomplish it, when everybody should actually be inserted in the situation. It is necessary to decide together the best form and the best moment to perform the technique, (SSC) as to not do it carelessly.*[33(p.578)]

In another study, a participant, identified that it is important to carefully approach parents when broaching SSC, "We cannot push them too hard. The very first SSC is sometimes a threshold to cope with, especially if the infant is critically ill". One nurse said, "I will not push them if they won't, but I always try to persuade them to hold the child close."[36(p.673)] Skin-to-skin care should be a mutually cohesive experience for both the parent and the infant supporting their developing relationship. It is imperative to consider the infant's needs as well as parental readiness when facilitating SSC. Parental support in the form of SSC education was illuminated by one respondent:

> *It's a parent education thing too … explaining to them what it actually means and how they can go about doing it and how often and how long it does actually take … you need to explain to parents what to wear.*[24(p.25)]

Increasing maternal motivation can be difficult for nurses to navigate in light of diverse cultural traditions and language barriers; one participant reflected, "I've often found that sometimes the nurses think the mother is understanding everything and when I try and get into some detail with them, she doesn't even understand enough English to really know what I'm talking about."[34(p.82)]

Lee and colleagues highlighted that the participants within their study felt the use of interpreters or staff who speak the same language as the parent may influence parents' participation with SSC. Clinical practice was an important source of feedback in how staff interacted with families, "wide perceptions that care procedures (SSC) changed and parents and infants well being was enhanced," which gave the staff incentive to strive for further improvement and increased facilitation of SSC.[32(p.65)] To clarify, the participant's perception was that the infants' and parents' well-being was enhanced when they participated in SSC practices, which then further drove the participant's desire to facilitate SSC.[32]

CLINICAL IMPLICATIONS

The results of this meta-synthesis provide implications for clinical practice, highlighting the complexity of SSC experienced by nurses and health professionals as they navigate the competing demands in the NICU, which influence when or if SSC is initiated. Nurses and health professionals at the bedside need to plan accordingly, using critical thinking skills for various components of how best to support

and facilitate SSC. It is not only the physical resources of comfortable reclining chairs or adequate staffing that influence SSC practices but also the nurse's emotional competence and wherewithal to prioritize caregiving tasks that also affect the process.

A priority of most healthcare professionals is for safe implementation of SSC to ensure a positive experience for the parent and infant. Examining the findings within this meta-synthesis also provides an opportunity for professional caregivers to enhance their awareness through reflection about their own practices of SSC. This new understanding may augment an increased understanding of the caregiver's experiences to encourage SSC implementation on a regular basis.

LIMITATIONS

A limitation of this study is in generalizing findings, given the vastly different practice approaches to healthcare from various countries such as Scandinavia and the United States. Another consideration is noted with the lack of identified demographic characteristics of the participants in several of the studies, which warrants generalizing the findings with caution. Six of the 8 studies identified the staff as working in the NICU, yet the authors did not differentiate the acuity of the infants as primarily preterm or very preterm within the NICU setting. Further research is needed to better understand the phenomenon of nurses' experiences when facilitating SSC to increase participation for all hospitalized infants and their families.

CONCLUSIONS

This meta-synthesis provides insight that many nurses have good intentions in supporting SSC practices, yet struggle to meet the multiple demands of daily practice of SSC. Education for staff nurses and health professionals as well as parents is essential to create positive SSC experiences in this critical window of development for young infants. Clearly, a paradigm shift or culture change is necessary to provide individualized developmentally supportive care practices, focusing on the infant's developmental trajectory. The overall human experience must be seen as pivotal to collaborative care practices of nonseparation between the parent and infant and thus, essentially integrated to enhance implementation of SSC practices. The 4 key themes identified and articulated within this ethnography that influence caregivers' experiences to facilitate SSC: varying thresholds to getting started, defining adequate resources, navigating the complexity of the infant and balancing parental readiness provide an increased awareness to enhance the professional caregiver's understanding of the complexity of SSC practices.

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Summary of Recommendations for Practice and Research

What we know:	• Despite the plethora of evidence to support SSC, practices remain inconsistent. • This study reinforces that nurses have good intentions to facilitate SSC, yet struggle to meet the multiple demands of daily practice. • Skin-to-skin care is the recommended method of care for the parent–infant dyad. • Although education on SSC knowledge is necessary, organizations that have undergone a paradigm shift in care, such as NIDCAP, are more successful in implementing SSC.
What needs to be studied:	• Core factors that contribute to inconsistent practices of SSC. • Innovative and practical translations of this evidence-based practice strategy, to enhance the parent-infant dyad, normalizing SSC as the standard of daily practice. • Practical applications that support nonseparation of the mother–infant dyad.
What we can do today:	• Enhance the critical thinking skills of the healthcare team to facilitate their ability to plan accordingly, as they navigate the complexities of how best to implement SSC. • Acknowledge the complexity of delivering SSC holding and provide opportunities for teams to work together to support each other in greater implementation of this practice. • Provide strategies such as reflection that highlight the professional caregiver's experiences and intentions to practice SSC, yet struggle to implement on a daily basis.

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