



Providing Evidence-Based Care During the Golden Hour

The first 60 minutes after birth is a critical time for a woman and her newborn. It has been called the “Golden Hour” (Sharma, Sharma, & Shastri, 2017). This is a time of transition for a newborn, moving from the internal to the external uterine environment. The first hour of life requires the rapid adaptation of multiple newborn organ systems and includes pulmonary, circulatory, metabolic, and hemodynamic changes (Morton & Brodsky, 2016). The three key components of the Golden Hour consist of maternal–neonatal skin-to-skin contact, delayed cord clamping, and breastfeeding, all of which serve to improve mother–newborn bonding and neonatal adaptation (King & Pinger, 2014; Moore, Bergman, Anderson, & Medley, 2016). Skin-to-skin care must include the performance of newborn assessments with the newborn on his/her mother’s abdomen and the delay of non-urgent tasks for at least 60 minutes (Crenshaw, 2014). This particular Golden Hour intervention is especially critical, because it promotes neonatal thermoregulation, decreases newborn stress levels, improves mother–newborn attachment, and encourages breastfeeding (Phillips, 2013). This article explores the literature in support of the Golden Hour and describes an evidence-based protocol for the implementation of a Golden Hour in practice sites.

Abstract: The Golden Hour encompasses a set of evidence-based practices that contribute to the physiologic stabilization of the mother–newborn dyad after birth. Important elements of the Golden Hour include delayed cord clamping, skin-to-skin contact for at least an hour, the performance of newborn assessments on the maternal abdomen, delaying non-urgent tasks (e.g., bathing the newborn) for 60 minutes, and the early initiation of breastfeeding. The Golden Hour contributes to neonatal thermoregulation, decreased stress levels in a woman and her newborn, and improved mother–newborn bonding. Implementation of these actions is further associated with increased rates and duration of breastfeeding. This article explores the evidence supporting the Golden Hour and provides strategies for successfully implementing a Golden Hour protocol on a hospital-based labor and delivery unit. <http://dx.doi.org/10.1016/j.nwh.2017.10.011>

Keywords: breastfeeding | Golden Hour | newborn | postpartum | skin-to-skin



Jennifer L. Neczypor
Sharon L. Holley

Background

The theory of the Golden Hour originated with the work of Dr. R. Adams Cowley, a trauma researcher in the 1960s (University of Maryland Medical Center, 2017). He noted that the use of standardized emergency management protocols in the first hour after a traumatic event significantly improved health outcomes and reduced mortality (Sharma et al., 2017). This concept began to be accepted by other specialties, including maternity and pediatric care. References to a neonatal Golden Hour first appeared in the 1970s, when Michel Odent, a French obstetrician, posited that newborns instinctively seek out the maternal breast in the hour after birth (Odent, 1977). The contemporary conceptualization of the Golden Hour after birth includes three main elements: (a) direct, immediate skin-to-skin contact between a mother and her newborn, (b) delayed cord clamping, and (c) early initiation of breastfeeding, if medically appropriate and desired by the woman (Sharma et al., 2017; World Health Organization [WHO] & United Nations Children's Fund [UNICEF], 2009).

Together, these interventions prevent neonatal hypothermia and hypoglycemia and facilitate mother–newborn bonding (Sharma et al., 2017; WHO & UNICEF, 2009). Both the WHO and UNICEF's Baby-Friendly Hospital Initiative recommend that all healthy newborns, including those born via cesarean, experience immediate skin-to-skin contact with their mothers for at least an hour after birth (WHO & UNICEF, 2009). This recommendation coincides well with Healthy People 2020, which aims to improve well-being for women and infants through a broad set of strategies aimed at enhancing postpartum health behaviors, including breastfeeding initiation rates (U.S. Department of Health and Human Services, 2017).

The Golden Hour offers maternal health benefits as well. According to Lowson, Offer, Watson, McGuire, and Renfrew (2015), most mothers prefer to experience skin-to-skin contact after childbirth, and those who experience skin-to-skin contact experience less anxiety by Day 3 of the postpartum period and are more confident in their parenting abilities at discharge when compared with women who are separated from their newborns after birth. Moreover, the initiation of exclusive breastfeeding, which is facilitated by delayed cord clamping and prolonged skin-to-skin contact, promotes more immediate maternal health by contributing to more rapid uterine involution, decreased postpartum blood loss, and increased postpartum

weight loss (WHO & UNICEF, 2009). Continued breastfeeding offers further lifelong maternal health benefits such as longer intervals between pregnancies, which allows for maternal nutritional and energy replenishment, and reduced risk of breast, ovarian, and endometrial cancer (WHO & UNICEF, 2009). Despite these recognized health benefits, women who give birth in hospitals often do not have the opportunity to hold their newborns until after the neonate's bath and weight and pediatric evaluation are complete, thus disrupting the neonate's physiologic transition. Time constraints on the part of the staff and hospital policies that do not accommodate the Golden Hour can contribute to routines such as bulb suctioning on the perineum, immediate cord clamping, and taking the newborn from his/her mother to obtain the weight and bathe the newborn, all of which disrupt the normal bonding and latching processes (Koopman, Callaghan-Koru, Alaofin, Argani, & Farzin, 2016).

Golden Hour Protocol

A Golden Hour protocol emphasizes skin-to-skin contact, or the placing of the dried, unclothed newborn directly on his/her mother's chest and abdomen just after birth, before cutting the umbilical cord (Crenshaw, 2014). There is no routine bulb suctioning of the newborn's mouth. Instead, a dry blanket or towel is used to gently dry and stimulate the newborn and wipe away secretions from the mouth and nose (Crenshaw, 2014). After birth, delayed cord clamping is done by the maternity care provider to allow for the placental transfusion of blood to the newborn, which promotes improved transitional circulation and red blood cell volume, increased birth weight, and greater iron stores in infants at 6 months of age (American College of Nurse-Midwives, 2014). Simultaneously, delayed cord clamping decreases the need for neonatal blood transfusions and decreases risk of necrotizing enterocolitis, iron-deficiency anemia, and intraventricular hemorrhage (American College of Obstetricians & Gynecologists, 2017; Mercer, Erickson-Owens, Graves, & Haley, 2007).

Delayed cord clamping is not linked with an increased risk for maternal postpartum hemorrhage or blood loss after birth (American College of Obstetricians & Gynecologists, 2017). Although no standardized time limits currently define early versus delayed cord clamping, causing the exact amount of time given before cutting the cord to vary between individual providers and institutions, the WHO recommends clamping the cord 1 to 3 minutes after birth, the amount of time that is generally required for the cord to cease pulsating, whereas the American College of Nurse-Midwives suggests waiting at least 5 minutes for term newborns who are placed skin to skin, at least 2 minutes for term newborns positioned at or below the level of the placenta, and 30 to 60 seconds for preterm newborns (American College of Nurse-Midwives, 2014).

Jennifer L. Neczypor, MSN, CNM, FNP, is a new graduate who recently accepted a position as a certified nurse-midwife at Massachusetts General Hospital in Boston, MA. Sharon L. Holley, DNP, CNM, FACNM, is Chief of the Division of Midwifery at Baystate Medical Center in Springfield, MA. The authors report no conflicts of interest or relevant financial relationships. Address correspondence to: jennifer.lynn.neczypor@gmail.com.



The first hour of life requires the rapid adaptation of multiple newborn organ systems and includes pulmonary, circulatory, metabolic, and hemodynamic changes

All initial neonatal assessments should be performed with the newborn remaining on the mother's abdomen, maintaining skin-to-skin contact and facilitating delayed cord clamping (Crenshaw, 2014). Non-urgent tasks of care, such as weighing and bathing the newborn, should be postponed for at least an hour, thereby providing the woman and her newborn with 60 minutes of uninterrupted time for bonding, during which breastfeeding can be initiated (Phillips, 2013).

Conflicting opinions regarding the timing of cord clamping exist in the case of neonates born to women with HIV infection or hepatitis B. The WHO notes that, although some health professionals working with HIV-positive women advocate immediate cord clamping because of concerns about infected maternal blood transfusing to the neonate during

birth, recent WHO guidelines assert that the proven benefits of delayed cord clamping outweigh the theoretical risk of HIV transmission (WHO, 2013, 2014). These guidelines show that the additional 1 to 3 minutes of placental blood flow afforded by delayed cord clamping have not been shown to increase the risk of HIV transmission from mother to newborn and thus encourage delayed cord clamping as a best practice for mothers and newborns, except for those neonates in need of immediate resuscitation (WHO, 2013). After delayed cord clamping, neonates born to women with HIV or hepatitis B infection should be promptly bathed with gentle soap and warm water, thus removing contaminated body fluids and minimizing possible exposure to maternal blood, before being returned to their mothers for skin-to-skin care and, if the woman has hepatitis B but not HIV, the initiation of breastfeeding (Nelson, Jamieson, & Murphy, 2014).

Skin-to-skin contact increases the amount of time that newborns spend in the quiet alert state. Authors of a 2016 Cochrane Review report that early skin-to-skin contact initiated in the first 10 minutes of life improves the chances of successful breastfeeding and successful newborn transition to the outside world (Moore et al., 2016; Redshaw, Hennegan, & Kruske, 2014). A dose-dependent relationship appears to exist between skin-to-skin contact and breastfeeding. Newborns placed skin to skin

for 31 to 60 minutes or longer are more likely to be breastfeeding at 3 months postpartum than those who are held skin to skin for only 11 to 20 minutes (Biro, Yelland, & Brown, 2015). Long-term advantages of early skin-to-skin contact include increased rates of exclusive breastfeeding in the first 1 to 4 months of life, improved interactions between mother and infant, and reduced infant crying (Redshaw et al., 2014).

The prolonged skin-to-skin contact of the Golden Hour also assists in the physiologic stabilization of women and newborns. The practice reduces risk for neonatal hypoglycemia by raising glucose levels, regulates newborn temperature through the process of thermal synchrony (i.e., the woman's chest temperature increases to warm a cold neonate and decreases to cool a neonate who is too warm), stabilizes the newborn's respiratory rate and blood pressure, decreases levels of a newborn's stress hormones, and promotes neonatal brain development by activating the maturation of the amygdala (Phillips, 2013). Skin-to-skin contact likewise helps stabilize the woman's condition in the immediate postpartum period, because it promotes the release of oxytocin, the hormone responsible for maternal relaxation; breast milk letdown; and uterine contractions, the last of which are essential to uterine involution after birth (Crenshaw, 2014). Critically, women who experience skin-to-skin contact with their newborns have reduced postpartum bleeding and a decreased risk for postpartum hemorrhage,

as well as more rapid passing of the placenta compared with women who do not hold their newborns skin to skin (Moore et al., 2016). Increased oxytocin levels also promote maternal attachment to the newborn, which can improve mother-newborn bonding, lower a woman's plasma cortisol levels, and protect the neonate from the effects of sudden separation from the mother, a phenomenon noted to be similar to drug withdrawal (Biro et al., 2015; Moore et al., 2016; Redshaw et al., 2014).

A study of Australian women's immediate postpartum experiences identified eight variables that are associated with a greater likelihood of holding a newborn skin to skin during the Golden Hour (see Box 1; Biro et al., 2015). Although not all of these variables can be controlled by maternity nurses, it is important that nurses are able to identify those women who may be more at risk of not experiencing skin-to-skin contact, a crucial aspect of the Golden Hour. Nurses can encourage women to hold their newborns skin to skin for as long as

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desired in the immediate postpartum period and can focus on providing education on the benefits of this intervention to parents who are less likely to experience uninterrupted skin-to-skin contact with their newborns, such as primiparous women, women with higher-risk pregnancies, and women who experience surgical births (Biro et al., 2015).

Exclusion Criteria for the Golden Hour

Maternal

Specific maternal considerations that may render it necessary to postpone, modify, or forego the Golden Hour include extreme maternal exhaustion, recent opioid administration resulting in maternal sleepiness or altered level of consciousness, perineal lacerations in need of extensive repair, postpartum hemorrhage, and other maternal emergencies (Ferrarello & Hatfield, 2014; Mercer et al., 2007; Redshaw et al., 2014).

Newborn

Exclusion criteria for newborns include extreme preterm birth (i.e., defined as any birth occurring before 34 completed gestational weeks); neonatal respiratory distress; cyanosis; elevated infection risk as shown by a maternal temperature of 101 °F or greater; congenital anomalies that could result in cardiopulmonary problems; signs of perinatal depression such as decreased muscle tone, bradycardia, or apnea; and the birth of a non-vigorous neonate through meconium-stained amniotic fluid (American Academy of Pediatrics, 2009; Moore et al., 2016).

When neonatal resuscitation is required or any of the other specified conditions are present, a newborn should be resuscitated and fully evaluated by the pediatric team with the initial goal of stabilizing the neonate before attempting to initiate the Golden Hour protocol (American Academy of Pediatrics, 2009). Although the focus of this article is on the establishment of a Golden Hour for healthy term and late preterm neonates, it is worth noting that skin-to-skin contact, sometimes called *kangaroo mother care*, significantly reduces the mortality rate of small-for-gestational-age neonates weighing less than 2,000 g in low- and middle-income countries (Moore et al., 2016). The creation of a Golden Hour protocol for high-risk infants may thus be an intervention worthy of subsequent exploration after the widespread acceptance of the Golden Hour for low-risk newborns.

Implementing a Golden Hour Protocol

The process of protocol implementation begins with evaluating existing institutional policies and performing a review of the current literature. When updating or creating a protocol for the Golden Hour, the importance of all three major Golden Hour components—delayed cord clamping, immediate and prolonged skin-to-skin contact, and early initiation of

BOX 1

Variables Associated With Greater Likelihood of Skin-to-Skin Contact During the Golden Hour

1. Receiving midwifery care as opposed to physician care
2. Multiparity
3. Low-risk pregnancy status
4. Being married or partnered
5. Having completed secondary school
6. Experiencing a spontaneous vaginal birth
7. Accessing private rather than public health care
8. Giving birth to a newborn who does not require NICU admission

Source: Biro, Yelland, and Brown (2015).

breastfeeding—should be clearly noted. The protocol should also specify medical indications, such as maternal HIV-positive status, that render it necessary to forego certain aspects of the Golden Hour, such as delayed cord clamping and initiation of breastfeeding. If delayed cord clamping is not already part of a birthing unit policy, such a policy should be created with the support of the interprofessional group of stakeholders. The protocol should clarify when and in what capacity additional nursing support will be required in various circumstances, such as during a surgical birth, the repair of a severe vaginal laceration, or a postpartum hemorrhage.

If a mother is temporarily unable to participate in the Golden Hour because of a medical condition, the protocol should include the option of placing the newborn skin to skin on the father or partner's abdomen until the mother can take the newborn to continue with early breastfeeding and skin-to-skin contact. Protocols should also address additional staffing needs, logistical planning, and anesthesiology support to facilitate the Golden Hour after cesarean birth (Mercer et al., 2007). Postpartum care should be designed to reduce disruptions; for example, signs can be hung on the doors to women's rooms for those families that desire privacy. Women's gowns should be removed or opened to facilitate skin to skin contact and breastfeeding. A hospital-wide policy should be publicized that limits the number of visitors in the first hour after birth.

In-Service Training

After the approval of the Golden Hour protocol through the appropriate committees, in-service training sessions should take place for staff, nurses, physicians, and midwives. These sessions should include information on the new protocol, how to implement the Golden Hour, how to identify when additional assistance is required, and any pertinent information specific to the practice setting.

Conducting a Pilot Project

Before unit-wide implementation of a new protocol, a pilot project is a good option to evaluate what goes well and what needs improvement. A pilot project should involve only a select group of women, newborns, and staff members, and it can be used to smooth out problems in the implementation and to cultivate the support of stakeholders who may be particularly resistant to the new protocol. Although it is not reasonable to expect that all team members will be immediately enthusiastic about the changes, seeking out the assistance and input of those who are most averse to the new practice protocols during the pilot project could help facilitate an easier transition when the protocol is instituted unit wide.

Reaching Out to Stakeholders

When a birthing unit begins the process of implementing the routine practice of Golden Hour care, it is crucial to identify stakeholders who will need to be involved in the planning, creation, and revision of policies. The list of stakeholders should include maternity providers, labor and delivery nurses, pediatric and anesthesia staff, hospital administrators, information technology professionals, pharmacy, central supply, childbirth educators, doulas, birthing families, and visitors. The invitations for other stakeholders should be based on individual institutional requirements for workflow processes.

Overcoming Common Barriers to Implementation

Birth settings vary, but hospitals often have common barriers to implementing Golden Hour processes. Although maternity providers and nurses generally recognize the many maternal and neonatal health benefits of the Golden Hour, they may initially resist a new Golden Hour protocol, particularly if the protocol alters the customary workflow. For example, the Golden Hour can affect when a nurse obtains the newborn weight required to admit the neonate to the newborn nursery, thus affecting the release of the newborn's medications from the pharmacy (Koopman et al., 2016). This is why it is vital to address these valid concerns with a multidisciplinary team ahead of implementation and include pharmacy staff, charge nurses, and hospital administrators on the team during the protocol development process and the initiation of the pilot project. This will

facilitate problem-solving before wide-scale implementation. Preplanning for additional staffing needs and considering how to optimize workflows will contribute to more immediate success of the Golden Hour protocol (Mercer et al., 2007).

Other barriers identified in the literature include inadequate nursing staffing ratios, the perception that a neonate is safer under the warmer than on the mother's abdomen, habitual

Post a sign on the door to a woman's room that alerts visitors and staff that the Golden Hour is in progress

institutional and individual practices such as immediate cord clamping and prompt bathing of the newborn, and limited or no experience with initiating skin-to-skin contact in the operating room (Koopman et al., 2016). There may also be a general lack of knowledge on the part of staff and families regarding the importance of the Golden Hour. Overcoming this knowledge deficit requires the implementation of mandatory in-service education sessions for staff and anticipatory education for pregnant women and their family members.

Women who experience spontaneous vaginal birth participate in skin-to-skin contact more frequently than women who experience assisted vaginal birth and cesarean birth (Koopman et al., 2016). Logistical and medical complications associated with these latter two procedures, such as the limited size of the operating room and staff concerns regarding the neonate's well-being, may render it more difficult to implement early skin-to-skin contact and breastfeeding, but often this too can be resolved with planning and forethought (Koopman et al., 2016). For example, providing an extra nurse to participate in the cesarean birth would enable one nurse to attend to the needs of the newborn and allow the other to focus on helping the mother initiate skin-to-skin contact. Ensuring the support of anesthesiologists by providing them with a space at the protocol development table and including them in unit education initiatives is also key to instituting the Golden Hour after cesarean birth (Koopman et al., 2016).

Further obstacles to the Golden Hour involve a woman's desire for modesty, the desire of other family members to hold the newborn, and constant interruptions by staff and visitors (Ferrarello & Hatfield, 2014). New mothers often view interruptions by hospital staff and guests as exhausting, stressful, and detrimental to bonding with the newborn (Ferrarello & Hatfield, 2014). Staff should address a woman's privacy concerns by keeping curtains in front of hallway doors closed and covering a woman and her newborn with a clean dry sheet or gown while still facilitating skin-to-skin contact and breastfeeding. Staff



can also post a sign on the door to a woman's room that alerts visitors and staff that the Golden Hour is in progress (Ferrarello & Hatfield, 2014). Extended family and friends hoping to meet the newborn should receive anticipatory education prenatally and during the intrapartum period, informing them that the first hour after birth will be used to facilitate bonding between the mother, partner, and neonate and that this may affect their ability to enter the postpartum room during that time.

Women and their partners are more likely to support the Golden Hour when given anticipatory education during prenatal visits or childbirth education classes. This should include information about maternal fatigue and cultural expectations. Many women, especially those intending to breastfeed, desire early skin-to-skin contact (Ferrarello & Hatfield, 2014); however, it is worth noting that some women prefer to have their newborns bathed before they hold them (Mercer et al., 2007). These women may benefit from additional prenatal counseling and education on the importance of Golden Hour interventions; however, the woman should make the final choice. Discussions with a woman and her family in the intrapartum period will facilitate a clear understanding of what will happen immediately postpartum with regard to Golden Hour protocols, ensuring that there are no misunderstandings.

Financial Implications

Implementation Costs

Financial costs related to implementing a Golden Hour protocol will vary at each institution but will likely include items

such as policy updates, information technology support, and the creation of educational materials for mothers, families, hospital personnel, and the larger community. Other expenses may include advertising costs and spending associated with the execution of a pilot project. Time costs include planning meetings and training staff in person or via computer-based training. Information technology will need to be involved if there are any necessary changes to the electronic health record or if Web site development is required for public informational resources. Pharmacy systems may need to interact with supply and information technology to facilitate the dispensing of newborn medications such as vitamin K and antibiotic eye ointment in light of the new protocols. Anticipated overhead expenditures require discussions with hospital administrators to determine where the funds for initial startup will come from.

Population Impact

There are financial costs and gains associated with implementing the Golden Hour. These costs and gains affect individual and population health as well as health care systems. Cost savings and financial gains are related to improving the short- and long-term health outcomes for the newborn and are generated by the initiation of interventions done during the Golden Hour, such as early breastfeeding and immediate skin-to-skin contact, both of which promote long-term, exclusive breastfeeding (Lowson et al., 2015). In 2014, the global sales of breast milk substitutes totaled \$44.8 billion, and the per-person expenditure for breast milk substitute in high-income countries (total retail sales divided by the population of children ages 0–36

months, corrected for population growth) was approximately \$2,528 (Rollins et al., 2016). It is estimated that if 90% of families in the United States breastfed exclusively for 6 months, there would be an annual savings of \$13 billion related to direct and indirect costs and the ultimate economic impact of those costs. A British analysis of the economics of the Golden Hour showed that for every 1 pound (\$1.22 U.S.) invested in the promotion of early breastfeeding and skin-to-skin contact, between 4 and 13.82 pounds (\$4.87–\$16.81 U.S.) of cost-saving benefits are generated (Lowson et al., 2015). The Golden Hour therefore provides “substantial economic benefits compared to costs,” because implementation primarily involves inexpensive interventions involving maternal education and staff engagement (Lowson et al., 2015, para. 62). However, only 23% of infants in the United States are currently breastfeeding at 1 year of age, resulting in an estimated cost of \$17.4 billion (Bartick, 2013; Bartick & Reinhold, 2010; Lessen & Kavanagh, 2015)—a cost that can be reduced through the implementation of the Golden Hour.

A vital contributor to our project's success was ongoing open communication and dissemination of information provided by our physician–nurse dyad leadership team

Improved breastfeeding practices worldwide would also prevent 823,000 deaths a year in children younger than 5 years and 20,000 deaths per year in women due to breast cancer (Rollins et al., 2016). Encouraging breastfeeding in the first hour after birth may improve parental productivity in the workplace, because the long-term success of breastfeeding, which is more likely with early initiation of the act, means that parents do not have to take off as much time for early childhood illnesses such as otitis media, asthma, gastroenteritis, necrotizing enterocolitis, and atopic dermatitis, because the risk for these diseases is reduced in children who are breastfed (Bartick & Reinhold, 2010). Moreover, longer durations of breastfeeding diminish long-term risks for obesity, thus reducing financial burdens on insurance companies and taxpayers by decreasing the costs of care associated with chronic health conditions related to overweight and obesity (Bartick & Reinhold, 2010). Finally, breastfeeding for at least 6 months can decrease the devastating costs of premature infant death or sudden infant death syndrome, because 74% of the excess costs incurred in the United States by not breastfeeding are associated with premature death (Bartick & Reinhold, 2010). Naturally, the emotional costs of such tragedies cannot be estimated, and this lends poignant support to the need for Golden Hour protocols.

Quality Measures and Financial Gains

Insurance companies are now working with health care systems to improve managed care bundles, a process sometimes called value-based health care. These types of bundled sets for



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maternity care take into account the cost of providing maternity services, outcomes, and quality measures. Implementation of the Golden Hour as an evidence-based approach to providing newborn and postpartum care may have a positive impact on long-term cost savings for maternal and pediatric care. By implementing this low-cost set of interventions, there may be improvements with regard to newborn care, particularly as related to cost savings from decreased NICU admissions for neonatal necrotizing enterocolitis and gastroenteritis (Lowson et al., 2015).

With managed care bundles, if outcomes meet certain quality measures and costs of care are reduced, health care facilities may be able to spend less and retain more of the bundled payment, possibly improving their financial gains (Moriates, Arora, & Shah, 2015). Additionally, there are hidden financial benefits for quality measures such as increased maternal satisfaction, which affect reimbursements to facilities and to providers. Because most mothers report greater satisfaction with their birth experiences when they are able to hold their newborns sooner and for longer durations of time immediately after birth (Biro, Yelland, & Brown, 2015), as is stipulated by the Golden Hour, it can be inferred that such interventions will lead to financial gain for individual institutions (Redshaw et al., 2014). The larger health care system impact of the Golden Hour is the potential to keep overall health care costs down and therefore maintain lower insurance premiums—for example, through the potential reduction in rates of breast and ovarian cancer among women who breastfeed (Lowson et al., 2015) and through decreases in feelings of depression and anxiety self-reported by women who experience skin-to-skin contact with their newborns (Redshaw et al., 2014).

Conclusion

Implementing an evidence-based Golden Hour protocol can improve breastfeeding rates, decrease maternal and neonatal morbidity, and promote mother–newborn bonding, with minimal cost and probable financial gain for hospitals. Although not all stakeholders will initially support this practice change, education for staff and families can help overcome logistical and institutional barriers, as well as attitudes and habits, that do not facilitate the Golden Hour. Providing women and newborns with the benefits of immediate skin-to-skin contact, delayed cord clamping, and early initiation of breastfeeding can improve health outcomes, rendering it imperative for birthing units in hospitals to implement the Golden Hour in their practice settings. **NWH**



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It seems that barely a day goes by without a new drug being released—or perhaps recalled. How can you stay on top of it all?

Rx

Read “Rx,” a clinical practice column appearing three times a year in *Nursing for Women's Health*.

It covers the latest developments in prescription and over-the-counter pharmacotherapeutics—everything from the HPV vaccine to over-the-counter weight loss drugs, all to help you provide optimum care to your patients and to answer their questions.

