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Fragile Infant Forums for Implementation of IFCDC Standards, "The Mother-Baby Relationship: The Key Cornerstone of the IFCDC Standards"

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"Promotion of mother-baby relationships during the ICU stay requires advocacy, systems thinking, and support of the mother-baby bond for effective implementation of practices. This article will explore the importance of mother-baby bonding in ICUs and developing a conducive environment for the dyad."

Abstract:

Promotion of mother-baby relationships during the ICU stay requires advocacy, systems thinking, and support of the mother-baby bond for effective implementation of practices. This article will explore the importance of mother-baby bonding in ICUs and developing a conducive environment for the dyad.

Background

The Infant and Family Centered Developmental Care (IFCDC) Consensus Committee maintains that the baby's relationship with their primary caregiver, most often their mother, is critical to their early and long-term developmental processes (1). Positive mother-baby relationships play a role in a broad range of optimal developmental outcomes for babies, including social, emotional, and cognitive development, especially in those considered medically fragile and complex (2). However, at the most fundamental level, positive mother-baby relationships serve the purpose of meeting the babies' basic needs (3). Nonetheless, establishing the mother-baby relationship can be complicated for babies admitted to the intensive care unit (ICU) (4).

"The critical nature of the ICU environment can pose significant threats to establishing the mother-baby relationship (5). Upon admission to the ICU, the central focus is on the stabilization of the baby as they transition to extra-uterine life (6)."

The critical nature of the ICU environment can pose significant threats to establishing the mother-baby relationship (5). Upon admission to the ICU, the central focus is on the stabilization of the baby as they transition to extra-uterine life (6). During this initial transition, mother-baby separation is common as the primary care of the baby shifts to the healthcare team; however, this issue may persist through the duration of the baby's ICU stay (2). Moreover, the stress of having a baby in the ICU may challenge maternal role attainment and impede mother-baby bonding and attachment (7). As such, the healthcare team must recognize the non-normative nature of the ICU and its implication on the mother-baby relationship (6,7).

By Incorporating the principles of systems thinking, the healthcare team is well positioned to promote the essentialness of the mother and family to the overall health and development of the medically compromised baby (1,5). Supportive measures have been well established within the literature, and the healthcare team must remain current on evidence-based approaches to advocate for and promote the mother-baby relationship in the ICU (8). Several IFCDC Standards and Competencies provide guidelines for incorporating the mother and family in the care of the baby, underscoring the importance of promoting bonding and attachment (See Box 1). For example, one of the IFCDC Standards focuses on the recommendation of skin-to-skin contact (SSC) with intimate family members, prioritizing SSC with the mother (1).

Skin-to-skin contact (SSC) poses significant biological benefits for healthy, term babies and those of higher risk (9,10). Literature suggests that direct SSC influences cardiorespiratory outcomes and indicators for stress (cortisol) and attachment (oxytocin) (11);

Box 1.

Examples of the Integration of the Mother-Baby Relationship into the Developmental Care Standards for Infants in Intensive Care:

- **Systems Thinking, Standard 2:** The intensive care unit shall provide a professionally competent interprofessional collaborative practice team to support the baby, parent, and family's holistic physical, developmental, and psychosocial needs from birth through the transition of hospital discharge-to-home and assure continuity to follow-up care.
- ***Competency 2.1*:** Teams will demonstrate IFCDC through interaction, practice implementation, and documentation that they are baby, parent, and family-centered.
- **Positioning and Touch, Standard 4:** Babies in ICU settings shall experience human touch by family and caregivers.
    - ***Competency 4.1*:** A parent should be invited to participate with the primary caregiver to support the baby during potentially stressful caregiving and medical procedures. When parents are unavailable, a second caregiver should support the infant.
- **Sleep and Arousal, Standard 3:** The ICU shall encourage family presence at the baby's bedside and family participation in caring for their baby.
    - ***Competency 3.1*:** Policies and procedures in support of parent participation in routine care and sleep-promoting skin-to-skin holding shall be developed, implemented, monitored, and routinely evaluated.
- **Skin-to-Skin Contact, Standard 1:** Parents shall be encouraged and supported in early, frequent, and prolonged skin-to-skin contact (SSC) with their babies.
    - *Competency* 1.9**:** Parents shall be encouraged to have vocal and singing interactions with their baby during SSC to enhance parental-infant connections, reduce parental anxiety, increase newborn vocal/listening interactions, and improve the baby's autonomic stability**.**
- **Pain and Stress, Families, Standard 1:** The interprofessional team shall document increased parental/caregiver well-being and decreased emotional distress (WB/D) during the intensive care hospital (ICU) stay. Distress levels of the baby's siblings and extended family should also be considered.
    - ***Competency 1.1:*** Parents shall have unlimited opportunities to be with their babies and be encouraged to engage with them, including skin-to-skin interactions.
    - ***Competency 1.2*:** Education shall be provided to all parents on how to (a) recognize their baby's behavioral communications of pain and distress as well as signs of comfort and (b) support parents to use practical ways to comfort and soothe their baby safely.
- **Feeding, Standard 4:** Mothers shall be supported to be the primary feeders of their babies.
    - ***Competency 4.1*:** ICU professionals shall actively work with m/others to assist them in feeling confident and competent with feeding their babies.
    - ***Competency 4.2*:** Where relevant/necessary, bottle feeding shall be conducted by the m/other when she/he is present rather than by ICU professionals so that m/other is supported to be the expert. M/others or their designees shall be identified as the primary provider(s) of sustenance and nurturing.
    - ***Competency 4.3*:** Professionals shall support the parents' understanding of their baby's communicative behaviors while guiding and supporting the feeding experience.

these processes are specifically important for both preterm and medically compromised full-term babies (9). Furthermore, bonding interventions, such as SSC, have important implications for the mother and family, including reducing maternal stress and stimulating human milk production (11,12). Other support measures may include breastfeeding, baby positioning, touch, and maternal voice utilization to soothe the baby (See Box 1).

Despite the known benefits of supportive bonding interventions, disparities in care provision exist among diverse families in the ICU (13–15). Inequities in access to high-quality ICU care should be considered in racial/ethnic, socio-economic, and socially stigmatized identities (13,14). Evidence suggests historically marginalized families are less likely to receive supportive care measures in the ICU (14). For example, Black and Hispanic mothers with babies in the ICU were reported to experience higher rates of discrimination and disrespectful care when compared to their White counterparts (14,15). Similarly, in a study conducted by McGlothen et al. (2021), mothers with opioid use disorders reported feeling both stigmatized and unsupported in their efforts to engage in their baby's care. Bias, discrimination, and stigmatization may have detrimental implications on the provision of respectful care (16) and the support for mother and family engagement in

Box 2.

- Despite the known benefits of supportive bonding interventions, care provision disparities exist among diverse ICU families. Inequities in access to high-quality ICU care should be considered in the context of racial/ethnic, socio-economic, and socially stigmatized identities.
- Constraints on maternal engagement may impede supportive care practices that largely affect the baby's health, including SSC and breastfeeding.
- The healthcare team should be responsive to the ongoing needs of the mother-baby dyad as a unit and work to ensure that support for maternal engagement is at the forefront of the baby's care plan, empowering the mother and family in shared decision-making and making every effort to reduce mother-baby separation.

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Several studies continue to demonstrate that mothers are needed to help support babies' health and development (7). Specifically, maternal engagement in care helps medically compromised babies adapt to the chaotic environment of the ICU and supports physiological process development (6). Likewise, the enhancement of mother-baby bonding interventions offers an opportunity to support the mental health of the baby, the mother, and the family (17). Mothers' engagement in their babies' care must move from being considered an optional nicety to an essential part of the baby's care (18). Moreover, the healthcare team should be responsive to the ongoing needs of the mother-baby dyad as a unit and work to ensure that support for maternal engagement is at the forefront of the baby's care plan, empowering the mother and family in shared decision-making and making every effort to reduce mother-baby separation (19). Safeguarding the dynamic nature of the mother-baby relationship in the ICU is key to the long-term health and well-being of society's smallest, most important members.

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