SAFE POSITIONING

During Skin-to-Skin and Breastfeeding

Robin A. Howe, MSN, RN, RNC-OB
Alejandra Pacheco, BSN, RN
Kristen Sapp, BSN, RN

Kaleidoscope, 2017
Safe Positioning

Background:

- What is Sudden Unexpected Postnatal Collapse
- Worldwide Incidence
- Causes are multi-factorial.
Contributing Risk Factors

- Maternal obesity or large breast-size
- Maternal distraction (phone, visitors, TV)
- Lack of parent education about positioning
- Co-sleeping/bed sharing
- Occluded airway (mouth/nose) neck bent
- Side-lying breastfeeding position
- Infant falls asleep after feeding; reduced arousal response
- Maternal exhaustion (long labor)
- Maternal medications (analgesia, sedatives)
- Decreased Nurse surveillance to promote bonding
- Head covered with blanket
- Prone position for SSC or breastfeeding
- Unsupervised breastfeeding
- Decreased response to asphyxiation position

(Luddington-Hoe & Morgan, 2014)
Trigger Incident

- April 2016, healthy infant born.
- Transitioned normally, at last assessment infant breastfeeding
- 17 minutes later, code initiated
- Infant resuscitated and transferred
- Mother’s comment
Annotated References

◦ Setting: France, 6 cases within first 2 hours, prone positioning during S2S. Talks about national committees recommending wireless pulse ox monitors, but does not cite those organizations. States greater surveillance required by staff.

◦ Setting: UK, 45 cases in 30 months, 24 related to positioning during breastfeeding or S2S. Recommends that guidelines for surveillance be developed: increased staff surveillance, stricter criteria for leaving infant alone with parent.

Feldman, 2013, AWHONN, 17(4), 337.
◦ Case study: 2 cases while breastfeeding (9 hrs and 45 hours): 1 died, 1 CP. Recommends increase surveillance by staff, increased parent education.

◦ Editorial that proposed increased observation by staff within 1st 2-3 hours, increased parent education will reduce these events.

◦ Case report of 2 incidences during breastfeeding, both saved by RN intervention. 1st in prone position, on the phone; 2nd in mother’s arm, also talking on phone. Both mothers oblivious to situation. Recommendations for increased surveillance, increased patient/parent education on positioning.

◦ Describes development and use of rapid newborn assessment tool. Identifies key teaching/checklist elements necessary for safe positioning during skin-to-skin and breastfeeding.

◦ Setting: Germany, 43 cases in 1 year. 9 within 1st 2 hours, 7 of which mom was awake, none monitored. Related to positioning (breastfeeding or prone against mother in S2S. Time interval between last evaluation before discovery 6-15 min. Although monitoring may have averted some events, it may interfere with mother-infant bonding in thousands of healthy neonates.
Risk factors/Causes

Literature from around the world cites multiple risk factors:

- Obesity
- Primiparous
- Maternal distractions
  - Fatigue
  - Lack of parent education
  - Poor positioning (mother or infant)
  - Infrequent surveillance
Parent Education

- Elements of Safe Positioning
- Handouts
- Checklists
Elements of Safe Positioning

- Skin-to Skin:
  - Infant body vertically aligned (spine to neck to head), lower extremities tucked
  - Neck straight, not bent
  - Head of infant at chest level, not into breast tissue
  - Head of infant turned to side, face fully visible
  - Color pink
  - Tone reflexive, not limp even when asleep
  - Easy respirations seen/heard

(Luddington-Hoe & Morgan, 2014)
Elements of Safe Positioning

- Breastfeeding:
  - Chest to chest
  - Neck straight, not bent, body-to-neck aligned
  - Full side profile visible at breast (unoccluded nares and mouth)
  - Color pink
  - Tone reflexive, not limp even when asleep
  - Easy respirations seen/heard

(Luddington-Hoe & Morgan, 2014)
Handouts & Checklists

- Developed parent education handouts and checklists that provide information based on optimal teaching timeframes

- Hand Outs
  - Antepartum
  - Early Intrapartum

- Checklists
  - Transition
  - Mother-Baby

Parent’s Guide to Safe Baby Positioning During Skin-to-Skin

Safe skin-to-skin positioning starts with placing the newborn upright onto Mom/Dad’s bare chest, baby’s tummy to adult’s chest.

Ensure infants head is turned to the side so that infant’s airway is open.

In this position, the infant’s color and breathing can be observed for signs of respiratory effort and perfusion.

Notify the nurse immediately if the infant’s color changes or appears to have difficulty breathing.

Is My Baby Okay Positioned Like This?

Respiratory Effort: Is infant breathing easily? Does the baby seem to be struggling to breathe or breathing too fast or too slow? Call the nurse immediately.

Activity: Is infant awake or asleep? Even a sleeping baby will respond to touch or movement. If the baby doesn’t respond, call the nurse immediately.

Perfusion/Color: Does the baby look “pink”? Any paleness, grey, blue or dusky color should be evaluated immediately. Call the nurse immediately.

Position: Baby should be positioned upright, head turned to the side, mouth and nose visible. Extremities should not be limp. If infant appears to be limp, call the nurse immediately.

(RAAP Assessment -E.K. Morgan, 2013)
“What information about skin-to-skin safe positioning was provided to you?”

- Pre-data
- Post-data

- "On my chest, cover with blanket"
- Don’t remember

- Patient info
- Checklist
- Verbal Instructions
“How do you know your baby is in the right position?”

Pre-data

- "my nurse told me"
- Vertical
- baby is calm

Post-data

- Breathing
- Activity
- Color
- Position

"my nurse told me"
“How comfortable do you feel using skin-to-skin?”
Safe Positioning for Newborn Infants

Kristen Sapp, BSN, RN
Alejandra Padilla, BSN, RN
Teaching Points

- Use exact wording for elements of safe positioning
- Use “Checklist”
- Demonstrate what positioning looks like
- Explain that a sleeping infant will not pull away from the breast/chest if airway is occluded
- If mother is sleepy or alone, infant must be returned to warmer/crib.
- If using warmer, apply temperature probe
Nurse Education

- Elements of Safe Positioning
- Use of a modified RAPP© Tool
- Optimal Parent Education Times
- Role Expectations
- Scripting
Teaching Points

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Nurse Expectations

L&D Nurse during labor:

✓ Provide pre-delivery education about elements of Safe Positioning

<table>
<thead>
<tr>
<th>Optimal education time points are:</th>
<th>Sub-optimal education time points:</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ Pre-registration (if scheduled)</td>
<td>▪ Immediately prior to pushing – conflicting task / objectives</td>
</tr>
<tr>
<td>❖ Inductions – after initiation of induction method</td>
<td>▪ Immediately after delivery – overcome with emotions</td>
</tr>
<tr>
<td>❖ Labor – following epidural</td>
<td></td>
</tr>
</tbody>
</table>

✓ Assess RAPP score every 15 minutes using paper assessment tool. Coordinate this assessment with Transition nurse evaluations.
Nurse Expectations

Infant Nurse (Birth to first 2 hours of Life)

- Place stable infant in vertical alignment on mother’s chest, face turned to side
- Ensure unobstructed ability to visualize infant’s face, color, respiratory effort, tone
- Instruct parents that if mother is sleepy/alone, infant **must** be returned to warmer/crib; if infant is returned to warmer, apply temperature probe and adjust warmer controls.
- Assess RAPP score every 15 min using paper tool (any RN at bedside)
- Document parent education in mother’s education screens
- Communication between caregivers is key.
Nurse Expectations

Mother-Baby (Postpartum) RN

- Assess parent understanding of safe positioning elements at every interaction
- Provide/reinforce parent education about safe positioning elements
- Reinforce that if mother is sleepy and alone, for infant’s safety, infant must be returned to crib.
- Reassess RAPP score every hour for first 4 hours postpartum using paper tool
- Document parent education activities in mother’s education screens
Modified RAPP Assessment Tool

- Utilized a modified version of Morgan’s RAPP© Assessment Tool
  - Focuses on
    - Respiratory Effort
    - Activity
    - Perfusion (Color)
    - Position/Tone
  - Documents RN Actions
  - Assessment Frequency
    - Transition
    - Postpartum

(Luddington-Hoe & Morgan, 2014)
How Often to Assess

**Pre-Data**
- Q <1 hr: 30%
- Q 1 hr: 35%
- Q >1 hr: 35%

**Post-Data**
- Q 1hr for first 4 hours: 50%
- Q >1 hr: 33%
- Q <1 hr: 17%
Pre-Data

What do you chart? - 20 responders
Post Data

What do you chart? - 6 responders
Breaking News – It Works!

- Between Sept 15 and November 15, there have been 3 documented “saves” as a result of this program.
  - 1. Grandmother
  - 2. L&D nurse
  - 3. MBU nurse

The Tipping Point: Specific parent education about elements of Safe Positioning coupled with increased surveillance.
References:

QUESTIONS?

Thank you!