SUDDEN UNEXPECTED POSTNATAL COLLAPSE:

WHAT IT IS AND WAYS TO PREVENT."

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CA-AWHONN

February 2020

DISCLOSURES

- No commercial support or sponsorship was received for this presentation.
- No relevant financial or commercial conflicts related to this presentation.

OBJECTIVES

- Describe Sudden Unexpected Postnatal Collapse (SUPC) and identify the differences with Sudden Unexpected Infant Death (SUID).
- Identify methods to monitor babies during skin-to-skin contact
- Evaluate nursing interventions to prevent critical events.

WHAT IS SUDDEN UNEXPECTED POSTNATAL COLLAPSE?

- Depends on how it's defined…..

INCONSISTENT DEFINITIONS

- **SUPC** Sudden unexpected postnatal collapse
- **eSIDS** Early sudden infant death syndrome
- **ALTE** Apparent life-threatening event
- **SUDI** Sudden unexpected death in infancy
- **SUEND** Sudden unexpected early neonatal death
- **ENSUD** Early neonatal sudden unexpected death
- **ESUDI** Early sudden unexpected death in infancy

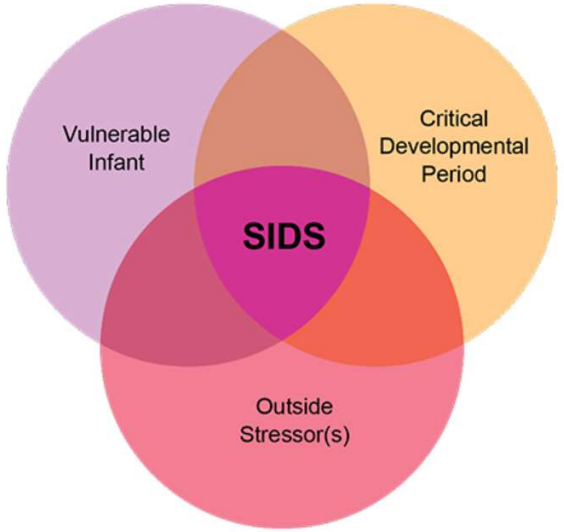
CASES REVIEWED

- ≥ 34 or 35 weeks or greater
- Apgar of 7 or 8 at 5 minutes
- Normal weight
- No congenital anomaly or other issues
- "Good condition"
- No evidence of resuscitation beyond suction of the airway
- Baby prone
- Breastfeeding

(Andres et al., 2011, Becher et al., 2012
Herlenius & Kuhn, 2013, Barbaglia et al., 2019)

SUPC ETIOLOGY

- SIDS Analogous Mechanisms & Risk Factors
  - SIDS: "triple risk" hypothesis underlying genetic or developmental predisposition
    - Infant vulnerability
    - Development
    - Environment
  - Case of death unknown
  - Deaths in 1st week often not included in SIDS databases



- No standard approach to investigation of events

(Herlenius & Kuhn, 2013, Becher et al., 2012, Lavezzi, Piscioli, Pusiol, 2017 NICHD, 2020)

SUDDEN UNEXPECTED INFANT DEATH

- Sudden unexpected infant death (SUID) is the death of an infant less than 1 year of age that occurs suddenly and unexpectedly, and whose cause of death is not immediately obvious before investigation.
- 3 types:
  - Sudden Infant Death Syndrome (SIDS)
  - Accidental Suffocation and Strangulation in Bed (ASSB)
  - Other Deaths from Unknown Causes

(CDC, 2018)

US TRENDS IN SUID

- Overall SUID Rates have declined:
  - 1990 =154.6/100,000
  - 2015 = 92.4/100,000

- "Back to Sleep" / "Safe Sleep" credited with decrease
- SIDS deaths have decreased 35.8% from 1999-2015
- No change in "unknown case" rates

(Erck Lambert, Parks & Shapiro-Mendoza, 2018, Bass, et al., 2018, Simpson, 2017)

ACCIDENTAL SUFFOCATION & STRANGULATION IN BED (ASSB) RATES

1999 to 2015 rates of ASSB increased by 183.8%

(Erck Lambert, Parks & Shapiro-Mendoza, 2018)

NEONATAL VS POST-NEONATAL

- CDC data--SUID 1995-2014 –
  - first hour, day, week, month of life
- Postnatal rates declined
- Newborn failed to decrease
- SUIDs attributed to unsafe sleep ↑ in both neonatal & postnatal periods.
- Neonatal: 29.2% occurred within the first 6 days life

(Bass et al., 2018)

SUDDEN UNEXPECTED POSTNATAL COLLAPSE

- Sudden unexpected postnatal collapse is the sudden collapse of an apparently healthy infant within the first days of postnatal life.
- Includes the following:
  - >35 weeks gestation
  - 10 minute Apgar of 8 or greater
  - Healthy with sudden unexpected collapse
  - Within the first week of life

(Herlenius & Kuhn, 2013)

TIMING OF SUPC

- 1/3 during the first 2 hours of life
- 1/3 between 2 and 24 hours of life
- 1/3 between 1 and 7 days of life

(Herlenius & Kuhn, 2013)

INCIDENCE

- Published reported cases vary
  - 2.6 to 133 cases/100,000
- Criteria varies:
  - Definition
  - Inclusion criteria
  - Exclusion criteria
- Cases may be underreported due to:
  - Cases of successful revival
  - Lack of standard definition

(Davanzo et al., 2015, Herlenius & Kuhn, 2013)

SUPC RATES IN THE US?

2.6 to 133 per 100,000 newborns =

91 to 4,634 possible cases in the US annually.

(Herlenius & Kuhn, 2013)

OUTCOMES

- Half of the infants die
  - No etiology found
- Half of the survivors have neurological sequelae including:
  - Cerebral Palsy
  - Hypoxic-ischemic encephalopathy (HIE)
    - Hypothermia treatment successful in some cases

(Pejovic & Herlenius, 2013; Herlenius & Kuhn, 2013, Echeverria-Palacio, 2019, Miyazawa et al., 2019)

IMPROVED DATA

International call for:

- Standardized definition of sudden unexpected postnatal collapse
- Standardized investigation criteria
- National Registry of these events
- Establish an official category in the International Classification of Diseases (ICD-10 code)

(Bass, et al., 2018, Herlenius, 2017)

COMMON DENOMINATORS—EXTRINSIC RISK FACTORS

One or more of the following was found in SUPC cases:

- Event occurred within 2 hours of birth
- Baby **PRONE** or side position on mother
- Baby head covered & not visible
- Mother supine
- Mother **primiparous**
- Maternal exhaustion and/or sedation
- Maternal overweight status (body mass index > 25kg/m^2)
- No direct staff observation during the initiation of **skin-to-skin & 1st breastfeeding**
- Parents alone with baby during first hours after birth
- Mother distracted with electronic device(s)

(Andres et al., 2011, Becher, Bhushan & Lyon, 2012, Pejovic & Herlenius, 2013, Herlenius & Kuhn, 2013, Poets et al., 2011, Bass, et al., 2018, Monnelly, & Becher, 2018)

SKIN-TO-SKIN CONTACT

- Recommended for all healthy term newborns due to physiologic and bonding benefits which include:
  - Regulation of newborn's temperature & prevention of hypothermia
  - Neonatal blood glucose regulation and prevention of hypoglycemia
  - Initiation and maintenance of exclusive breastfeeding and enhanced milk production
  - Enhance mother/infant relationship
- Skin-to-Skin contact should be done immediately after birth until the first feeding at the breast has been achieved.
- Healthy infants greater than 37 weeks and 0 days should be encouraged: frequent uninterrupted.

(AAP, 2017, AWHONN, 2016
Ludington-Hoe & Morgan, 2014)

"I did then,
what I knew how to do.
Now that I know better,
I do better."

MAYA ANGELOU

JOGNN

AWHONN PRACTICE BRIEF

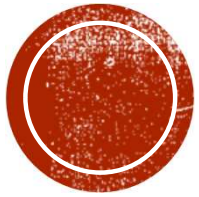
CrossMark

Immediate and Sustained Skin-to-Skin Contact for the Healthy Term Newborn After Birth: AWHONN Practice Brief Number 5

Stable healthy infants > 37 weeks of gestation should have trained professionals in attendance:

- First hour of life, at a minimum
- Until first breastfeeding is completed
- Skin-to-skin can be extended for 2-3 hours
- Delay "routine care"
- Benefits of breastfeeding noted in 20-minute breastfeeding sessions

(AWHONN, 2016)



WHAT DO WE KNOW?

RISK FACTORS

Babies

- Vulnerable during transition
- Prone position
- Against breast
- Head totally covered
- Mouth covered
- Nose covered
- Neck is bent
- First time breastfeeding attempt
- Unsupervised breastfeeding
- Side-lying breastfeeding

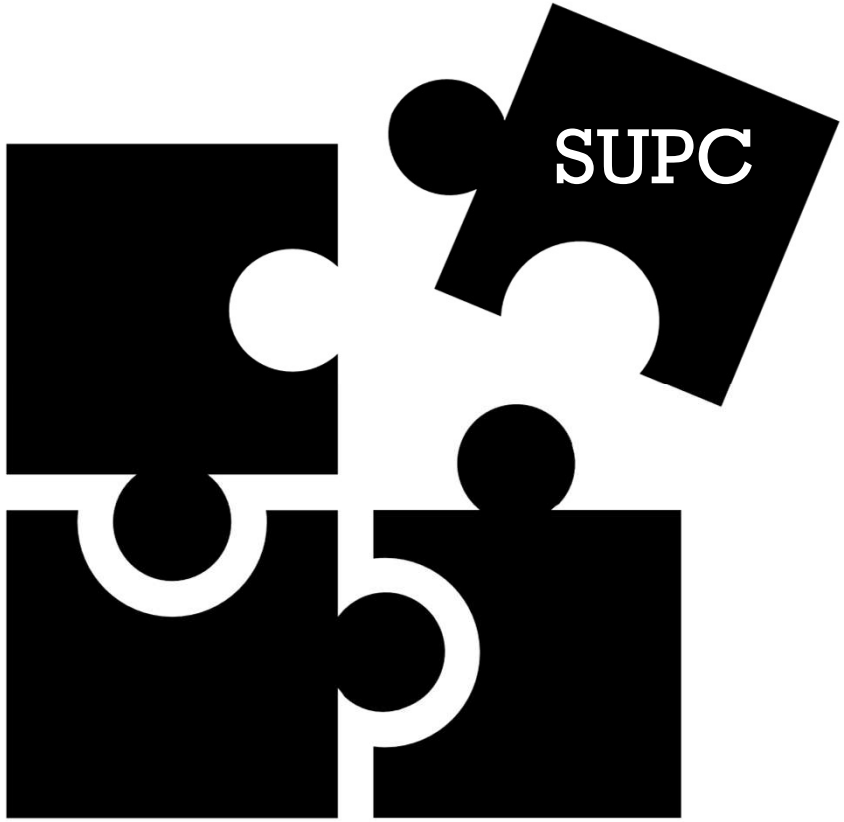
Mother

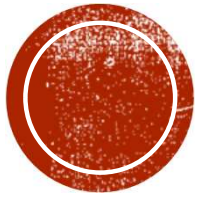
- Supine
- Primiparous
- Obese
- Left alone (no RN supervision)
- Lack of education/experience holding &/or what newborn should look like
- Tired or/& medicated (analgesia, sedated, or Magnesium Sulfate)
- Distracted (mobile devices - texting / social media, visitors, TV)
- Bedsharing

ANOTHER PIECE OF INFANT SAFETY

Highly associated with

SSC & breastfeeding





WHAT SHOULD WE DO?

RECOMMENDATIONS

1. Safe early skin-to-skin contact (SSC) in the delivery room.
2. Safe breastfeeding establishment in the first days of life.
3. Secure positioning of the infant during sleep.

(Herlenius & Kuhn, 2013)

ASSESSMENT OF SAFE SKIN-TO-SKIN CONTACT & SLEEP PRACTICES OF THE HEALTHY TERM NEWBORN

Criteria	Present Practice	Needed Change
Staff knowledge / evaluation		
Staff standardized education		
Staff standardized checklist		
Department policy & procedure		
Identified screening criteria		
Routine assessment parameters • Initial S-T-S in L&D • Continued S-T-S Mother/baby		
Education for new mothers/parents • Prenatal • Labor & Delivery • Mother/baby room posters • Discharge		

"MATERNITY NURSES' KNOWLEDGE ABOUT SUDDEN UNEXPECTED POSTNATAL COLLAPSE AND SAFE NEWBORN POSITIONING"

Maternity nurses' knowledge of SUPC was less than their knowledge of safe newborn positioning.

(Addison & Ludington-Hoe, 2019)

ALL NURSING STAFF…..

- Prenatal educators
- Labor, Delivery, Recovery, & Postpartum
- Should be trained in:
  - Assessing and recognizing problems in newborns
  - Assessing and assisting with breastfeeding

(AAP/ACOG, 2017)

NURSES ARE MORE LIKELY TO IMPLEMENT RECOMMENDATIONS INTO THEIR PRACTICE IF…..

- APPROPRIATE EDUCATION IS PROVIDED ON THE EVIDENCE BEHIND THE RECOMMENDATIONS.

(NANN, 2019)

PRIOR TO DELIVERY:

- Review mother's chart & identify antepartum SUPC risk factors.
  - Primiparous
  - Obesity
  - Education & experience regarding proper holding technique and what a newborn should look like
  - Sedation-narcotics or magnesium sulfate administration
  - Distractions in the room (devices & people)
- Risk factors = continuous monitoring with documentation every 5 minutes

(Ludington-Hoe & Morgan, 2015)

ASSESSMENT OF THE NEWBORN IN THE DELIVERY ROOM

- Healthy appearing newborn, stable & does not require further intervention.
- Immediate & sustained skin-to-skin contact with the mother.
- Newborn and mother, safely transported together from delivery to postpartum area, if transfer is indicated.

(AAP & ACOG 2017)

RECOMMENDATION #1:

Skin-to-Skin Care (SSC) in The Delivery Room

Continuous surveillance:

One caregiver focused on the baby during the first postnatal hours

- Always have a caregiver skilled in newborn assessment in the room (nurse, certified nurse midwife, physician)
- Position staff member to see mom & baby
- Reduce the risks of distractions (staff & mother)
- Assessment ongoing & continue throughout the recovery period
  - **Infant: breathing, activity, color, and tone**

AWHONN STAFFING GUIDELINES

AWHONN (2010):

- 2 nurses should be in attendance until the ***critical elements*** for both patients are met

  (1 nurse for the mother & 1 nurse for the baby).

- After the ***critical elements*** are met and when conditions of mother and baby are determined to be stable, 1 nurse can care for both the mother and the baby.

RECOMMENDATION #2
ESTABLISHMENT OF SAFE BREASTFEEDING

- Observe correct & safe positioning of infant
  - Tummy to tummy / chest to chest
  - Nose free
    - Uncovered by breast tissue
    - Uncovered by blanket
  - Head & neck aligned

TRANSITIONAL CARE

- After recovery, newborn should be carefully observed 2-24 hours after birth.
- Newborn should be monitored & recorded every 30 minutes until remain stable for 2 hours:
  - Temperature, heart rate, skin color, peripheral circulation, respiration, level of consciousness, tone, and activity
- Facilitate on-going contact between mother & newborn
  - (rooming-in: allows unrestricted contact and feeding)
- Mother should be assessed for impairment from fatigue & intrapartum medications.
- Move baby to separate sleep surface if mother is impaired.

(AAP/ACOG, 2017)

RECOMMENDATION #3

CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns

Lori Feldman-Winter, MD, MPH, FAAP, Jay P. Goldsmith, MD, FAAP, COMMITTEE ON FETUS AND NEWBORN, TASK FORCE ON SUDDEN INFANT DEATH SYNDROME

AAP, 2016

SECURE POSITIONING OF THE INFANT DURING SLEEP

- All newborn infants should be placed in supine position within the first few hours after birth is emphasized in the reports of SUPC and in organizational guidelines to reduce the risk of SIDS.

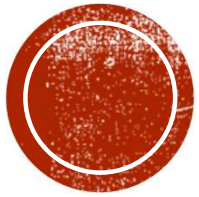
- Nurses need to **"model"** Safe Sleep behaviors and continuously educate parents to place the baby in the crib / bassinette on the back after feeding.

(AAP, 2011)

NANN:

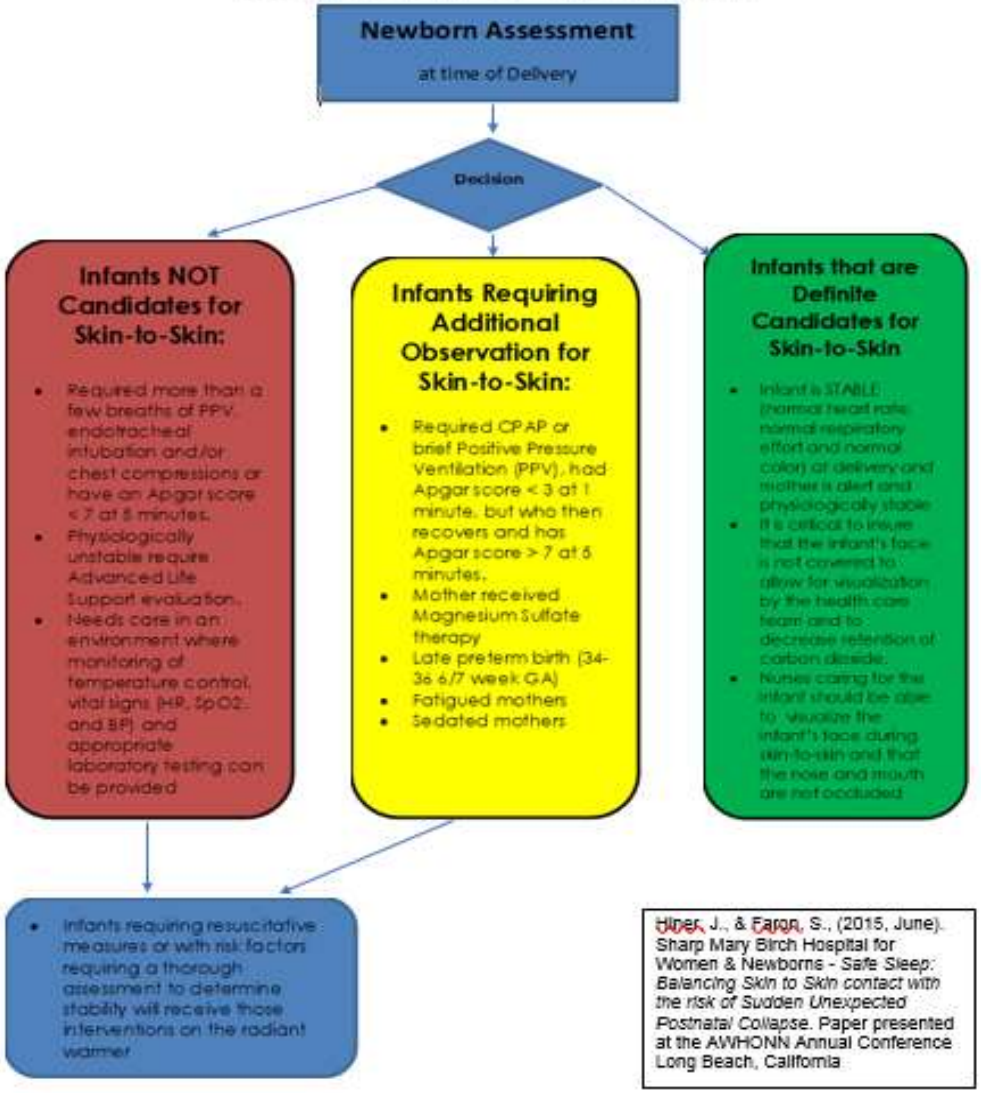
"When doing skin-to-skin care and breastfeeding with the infant in the delivery room, recovery room, or **mother/infant unit**, a nurse shall be available to monitor the mother-infant dyad, or **the infant will be monitored electronically**. An alert and awake family member that has been educated on the signs of infant distress can be used as an alternative to a healthcare provider."

NANN, 2019



TOOLS

Early Skin-to-Skin Algorithm



Hiner, J., & Faron, S., (2015, June). Sharp Mary Birch Hospital for Women & Newborns - *Safe Sleep: Balancing Skin to Skin contact with the risk of Sudden Unexpected Postnatal Collapse*. Paper presented at the AWHONN Annual Conference Long Beach, California

REVISED RAPPT™ INFANT ASSESSMENT SCORING TOOL

- RAPPT Components:
  - Respirations
  - Activity
  - Perfusion
  - Position
  - Tone

REVISED RAPPT™ INFANT ASSESSMENT SCORING TOOL

Sign	0	1	2
Respiratory	Apneic	Grunting / flaring/ retracting / irregular	No distress, easy regular breathing
Activity	No response	Whimpering, crying, hard crying &/or extremities moving	Quiet alert, sleeping, or breastfeeding, arms and legs at rest
Perfusion	Pale &/or dusky	Acrocyanosis	Visible parts pink
Position	Face into chest/ breast, and/or nares &/or mouth fully occluded, and not visible, and/ or neck fully extended or flexed	Partial head turn, nares or mouth partially occluded or partially visible; and/ or neck partially extended or flexed	Head turned to side; nares and mouth uncovered and visible when not feeding; neck midline, hands by neck
Tone	Flaccid, or no flexion of extremities	Partial flexion of extremities or vigorous motion	Full flexion of extremities, &/or slow, deliberate movements

Used with permission from Ludington-Hoe SM, Morgan, K. & Morrison-Wilford, B. (2015). Minimizing risk of newborn death: The Revised RAPPT Scoring System. The Learner's Manual for Kangaroo Care Certification . Cleveland, OH: United States Institute for Kangaroo Care

RAPPT™ SCORING & DOCUMENTATION

Continuous monitoring & documentation every 5 minutes for the first 2 hours of life.

- Score 0 or 1 in ANY field requires an intervention.
- Never accept score <2 in the **position** field.
- If two or more of the other fields score "0"-**STOP** skin-to-skin session.
- Document all interventions

(Ludington-Hoe & Morgan, 2015)

REVISED RAPPT™ INFANT ASSESSMENT SCORING TOOL

Time of Observation_____ **Time of SSC/BF _____**	Time:	Time:	Time:	Time:	Time:	Time:
Respiratory						
Activity						
Perfusion						
Position						
Tone						
***Total Score**						
RN Action was:						
Reposition head / neck						
Uncover nares / mouth						
Incline mother						
Continue SSC						
Stop SSC						
Move to radiant warmer/crib						
Call Neo/Peds						
Time SSC ends						
Duration of SSC						
RN initials						

Used with permission from Ludington-Hoe SM, Morgan, K. & Morrison-Wilford, B. (2015). Minimizing risk of newborn death: The Revised RAPPT Scoring System. The Learner's Manual for Kangaroo Care Certification . Cleveland, OH: United States Institute for Kangaroo Care

RAPPT™ SCORE CONSIDERATIONS

- Any interventions performed should be followed by 60 seconds of continuous monitoring to assess the newborn's response to the intervention.

- The lower the RAPPT™ score, the higher the risk of SUPC.

- Score of 10 = minimal risk, however, the newborn's condition & position can change quickly.

(Ludington-Hoe & Morgan, 2015)

POSTPARTUM RAPPT™ USE

Authors recommend RAPPT™ scoring should be conducted whenever the health professional enters the mother's room, no matter where the newborn is located:

- Bassinet
- Swaddled in someone's arms
- Snuggled up to a chest
- In skin-to-skin contact

1/3 of SUPC occurs in the first 24– 48 hours.

(Ludington-Hoe & Morgan, 2015)

QUALITY IMPROVEMENT APPROACH

- Healthcare System Wide project:
- Multidisciplinary team used a quality-improvement approach
- Driver—5 SUPC events in 17-months
- AIM: develop a bundled intervention to eliminate SUPC in the delivery room during skin-to-skin care.
- Intervention:
  - Standardized assessment tool (RAPP tool)
  - Measurement of oxygen saturation levels (at 10 minutes of age) baby's R hand
  - Prescribed responses to abnormal values
- Results: 5 cases/ 9143 births after 0/13,964 births

Paul, Johnson, Goldstein & Pearlman, 2019.

OBSERVATION CHECKLIST

Figure 1. Checklist for Newborn Infants in the First 2 Hours of Life, Particularly during Skin-to-Skin Contact.

Family Name_____ Name_____ Date of Birth_____ Hour of Birth_____:_____	Time after Birth				
Parameters to be Assessed or Events to be Registered	10 min[a]	30 min	60 min	90 min	120 min
1. Infant positioned with visible and unobstructed mouth and nose (Yes/No)					
2. Pink color (skin and/or mucous membranes) (Yes/No)					
3. Normal breathing (no retractions or grunting or flaring of the nares) (Yes/No)					
4. Normal respiratory rate: 30-60 breaths/min (Yes/No)					
5. Normal SpO_2: > 90% (if deemed necessary) (Yes/No)					
6. Subaxillary temperature at 60 and 120 minutes after birth (Normal range: 36.5°C-37.5°C)					
7. Mother never left alone with her infant (Yes/No)					
First breastfeeding attempt (time)					
Comments					

Used with permission from Dr Angela De Cunto: Figure 1. Checklist for Newborn Infants in the First 2 Hours of Life, Particularly during Skin-to-Skin Contact; from the article Making the First Days of Life Safer: Preventing Sudden Unexpected Postnatal Collapse while Promoting Breastfeeding

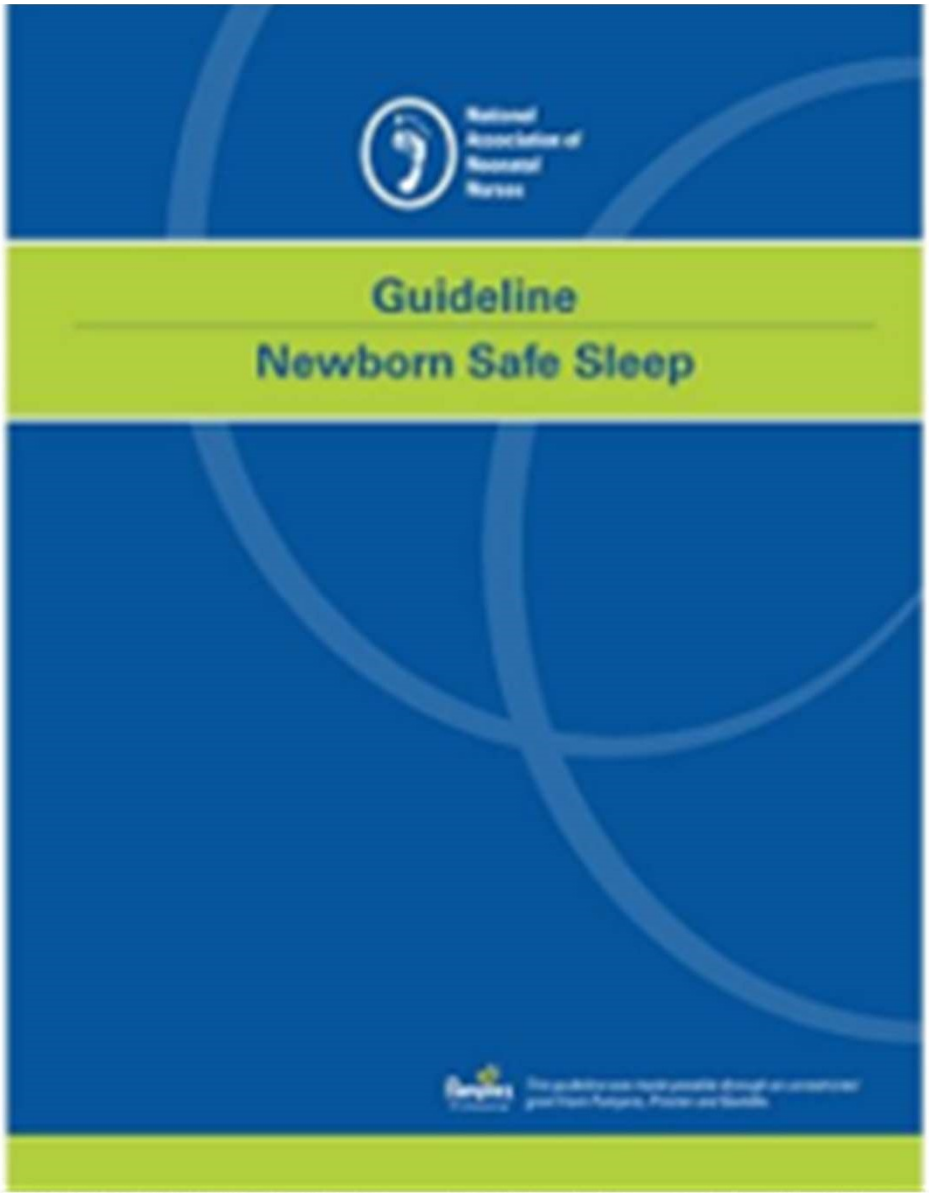
ADAPT TOOLS TO EMR

- Assessment criteria
- Action taken
  - Team approach:
    - IT
    - Staff nurses are key!
    - Healthcare providers: Obstetricians, Midwives, NP's, Pediatricians

BEDSIDE SAFE POSITIONING CHECKLIST

- ❑ Baby's face can be seen
- ❑ Baby's nose and mouth are uncovered
- ❑ Baby's head is in "sniffing" position
- ❑ Baby's head is turned to one side
- ❑ Baby's neck is straight / not bent
- ❑ Baby's shoulders are flat against mom
- ❑ Baby is chest to chest with mom
- ❑ Baby's legs are flexed
- ❑ Baby's back is covered with a blanket
- ❑ Mom is reclined (not flat)
- ❑ Mom is alert and awake

(Davanzo et al., 2015
Ludington-Hoe & Morgan, 2014)



NATIONAL ASSOCIATION OF NEONATAL NURSES 2019

NICHQ

NATIONAL INSTITUTE FOR CHILDREN'S HEALTH QUALITY

- National Action Partnership to Promote Safe Sleep Innovation and Improvement Network (NAPPSS-IIN)

  - Safety Bundles:
    - Save Sleep & Breastfeeding
      - Evidence Based Practices

NIH- NATIONAL INSTITUTE CHILD HEALTH & HUMAN DEVELOPMENT

RECOMMENDATIONS FOR HEALTH CARE PROFESSIONALS

- Prior to Delivery: Assess for RISK—
  - Primiparous
  - Obese
  - Education/experience holding &/or what newborn should look like
  - Tired or/& medicated
    - (analgesia, sedated, or Magnesium Sulfate)
  - Distracted
    - (mobile devices - texting / social media, visitors, TV)

RECOMMENDATIONS FOR HEALTH CARE PROFESSIONALS

First 2 Hours of Life:

- Do not leave mothers unattended, especially if primigravidas.
- Ensure (and verify) appropriate newborn positioning during skin-to-skin contact (SSC), with nose and mouth uncovered and head visible.
- The prone position is acceptable if the newborn is chest-to-chest (not over a breast, between breasts, or over the abdomen), with the head turned to one side, the neck straight, and mouth and nose uncovered and supervised.
- Avoid SSC when mothers have been given analgesics and/or appear tired unless staff can provide continuous monitoring of the mother-newborn dyad.
- First breastfeeding attempt should be supervised.

(Davanzo et al., 2015 Ludington-Hoe & Morgan, 2014)

RECOMMENDATIONS FOR HEALTH CARE PROFESSIONALS

After the First 2 Hours of Life:

- Bed sharing should be discouraged, if the mother is sleepy/sleeping and the mother-newborn dyad is unattended.
- Newborns found bed sharing with a sleepy/sleeping mother should be placed in the bedside bassinets.
- Teach "Safe Sleep." (& **model those behaviors**!)
- Prone position of the newborn should be accepted only during closely supervised SSC.
- Recurrent checks of the mother and the newborn are required and, if needed, the position of the newborn should be corrected.

(AAP, 2016, Davanzo et al., 2015)

STAFF EDUCATION

Pediatrics
May 2018, VOLUME 142 / ISSUE 1 MeetingAbstract
Section on Neonatal-Perinatal Medicine Program: Day 1

Sudden Unexpected Postnatal Collapse: Simulation Video, Literature Review and Educational Intervention

Matthew Pellerite, Bridget Wild, Nancy Rodriguez, Patrick Hughes, Monica Joseph-Griffin, Joseph R. Hageman

INNOVATIVE EDUCATIONAL PROGRAM

- Posters developed & displayed in the units SUPC- shift huddles to raise awareness
- "Pink & Positioned" (Documentation)
- Simulation Video developed
- Incorporated assessment & patient education into EMR
- Patient education video developed
- Grand Rounds
- Developed questionnaire for pre & post SUPC module education.

(Garofalo et al., 2018)

STAFF EDUCATION:

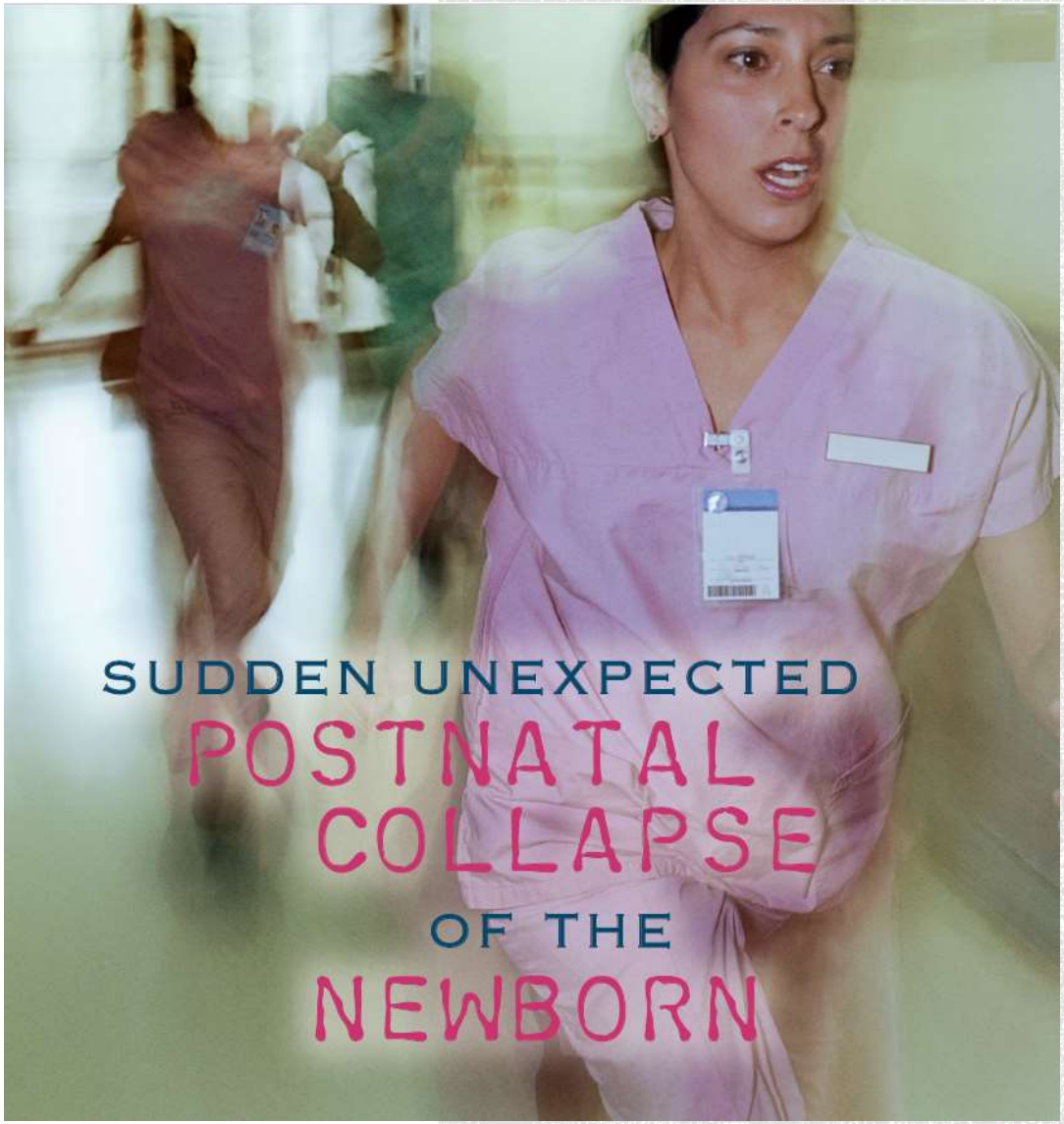
Read the article:

Ferrarello, D. & Carmichael, T. (2016). Sudden unexpected postnatal collapse of the newborn. *Nursing for Women's Health*, 20(3), 268-275.

LMS:

Post questions

Pictures/ corrective actions needed



Objectives

Upon completion of this activity, the learner will be able to:

1. Describe the categories and risk factors for sudden unexpected infant death.
2. Explain approaches to improve the effectiveness of nurses' conversations with parents about infant sleep and the safe sleep recommendations.
3. Outline key interventions nurse leaders can take to improve newborn safety on their units and develop a comprehensive safe sleep program for their organization.

Continuing Nursing Education (CNE) Credit

A total of 1.5 contact hours may be earned as CNE credit for reading "Nurses Leading Safe Infant Sleep Initiatives in the Hospital Setting" and for completing an online posttest and participant feedback form.

To take the test and complete the participant feedback form, please visit **http://learning.awhonn.org**. Certificates of completion will be issued on receipt of the completed participant feedback form and any processing fees.

Association of Women's Health, Obstetric and Neonatal Nurses is accredited with distinction as a pro-

Nurses Leading Safe Infant Sleep Initiatives in the Hospital Setting CNE

Sharon C. Hitchcock & Catherine Ruhl

ABSTRACT: Every day, 10 otherwise healthy infants die from sleep-related deaths in the United States. These deaths, termed *sudden unexpected infant death*, remain the leading cause of post-neonatal death in the United States despite known modifiable risk factors and prevention recommendations. In birthing hospitals, many parents report being given incorrect and sometimes no information about infant sleep safety, which creates immediate and long-term safety concerns. In this article, we provide an overview of sudden unexpected infant death, including sudden unexpected postnatal collapse, and the latest safe sleep recommendations from the American Academy of Pediatrics. We also offer practical guidelines for nurses—those working at

(APRIL - 2019) NURSING FOR WOMEN'S HEALTH, 23(2), 148 – 162.

RECOMMENDATIONS FOR MOTHERS

- During SSC, your baby's nose and mouth should be visible and uncovered at all times; the head should be turned to 1 side; the neck should be straight and not bent; and your baby should be chest-to-chest and not over a breast, between breasts, or over the abdomen.
- Focus on your baby. Avoid distractions, particularly the use of electronic devices such as smart phones, during SSC and breastfeeding sessions.
- The supine position (backs) is recommended when your baby is sleeping in the bassinet. (Safe Sleep)
- Do Not place your baby in the prone/side-lying position.
- The prone position (belly) is accepted only during SSC and if you are not feeling sleepy or tired.
- If you feel tired and/or sleepy, place your baby in his or her crib or call your nurse for assistance.
- Ask for help during all breastfeeding sessions.

(AAP, 2016; Davanzo et al., 2015)

LET'S REVIEW POSITIONING

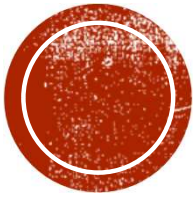
As you look at the following pictures, consider whether or not the position is safe or needs modification.

Consider using one of the tools we reviewed in this educational session.

STRATEGIES TO MINIMIZE SUPC RISK

1. Safe positioning education
   - Educate health care professionals
   - Educate the new mother (prenatal and in-hospital)
   - Educate family members / support persons
2. Posters &/or Checklists on room walls
3. "Model" the items on the checklist
4. Nursing staff need to KNOW the risk factors & vigilantly screen
   - Consider those who may not be a candidate for SSC or those who may need additional observation.
5. Develop a routine assessment parameters
6. Continuously monitor the mother-newborn dyad during SSC & breastfeeding in all postpartum settings.

(Ludington-Hoe & Morgan, 2014)



THANK YOU!

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