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Reduction of Surgical Site Infections After Cesarean

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Reduction of Surgical Site Infections After Cesarean

**Objective**
To decrease cesarean surgical site infection (SSI) rates to less than the National Health-care Safety Network (NHSN) mean. By decreasing SSI rates, secondary goals included improving the patient experience, decreasing readmissions, and promoting bonding between the mother and newborn.

**Design**
A review of the literature from the following was completed: the Collaborative Healthcare Associated Infection Network, the Surgical Care Improvement Project, and the Mayo Collaborative.

**Setting**
A regional birthing unit at which approximately 800 cesareans are performed per year.

**Participants**
All women who had cesarean births.

**Intervention/Measurements**
Thermoregulation, antibiotics administration (pre-op and timing), skin prep (pre-op and intra-op), operating room attire, operating room traffic, hair removal, closing trays, standardized incision care, standardized dressings, environmental cleaning processes, and improved team communication through briefing and debriefing.

**Results**
By implementing SSI bundles and evidence-based nursing practices, we saw a greater than 50% reduction in SSIs, which placed the facility rate at less than the NHSN mean.

**Conclusion/Implications for Nursing Practice**
The bedside nurse is able to directly affect outcomes related to SSI by providing evidence-based care and implementing standardized care practices.

Improving Breastfeeding Exclusivity by Initiating Skin-to-Skin Care Immediately After Cesarean

**Objective**
To increase breastfeeding exclusivity rates after cesarean by increasing skin-to-skin contact between mother and newborn immediately after birth.

**Design**
Retrospective chart review.

**Setting**
A 528-bed tertiary care, Baby-Friendly hospital in upstate New York with approximately 2,400 births annually, 800 via cesarean.

**Participants**
All women with scheduled and nonemergent cesareans for well infants, defined as >37 weeks gestation, that occurred between August 3, 2015 and December 31, 2015 (N = 173).

**Intervention/Measurements**
Nursing staff received inservice education on the following: benefits of skin-to-skin for mother and infant, the current process map, implementation of skin-to-skin immediately after operative birth, and parent education. Staff completed a decisional balance worksheet in a session mediated by a clinical psychologist. This worksheet was presented to leaders with the intent to remove systemic barriers. Lactation staffing was increased and repurposed as transition nurses to facilitate immediate skin-to-skin after cesarean. Data were abstracted from the electronic medical record.

**Results**
In 2015 before the project roll out, 31.7% of newborns (n = 247) were exclusively breastfed as compared to 42.8% after the project began. During the study period, 56.5% of infants who had skin-to-skin immediately after birth were exclusively breastfed. Of those infants who did not have skin-to-skin immediately after birth, only 35.1% were breastfed exclusively (p = .01).

**Conclusion/Implications for Nursing Practice**
Immediate skin-to-skin contact after birth as an intervention to improve breastfeeding exclusivity can be replicated in the operative delivery population.