Skin-to-Skin Contact on the Postpartum Unit to Improve Breastfeeding Rates After Hospital Discharge

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NUR 134A
Evidence-Based Practice Proposal
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INTRODUCTION & PROBLEM STATEMENT

Breastfeeding is the normative standard for infant nutrition and is recommended exclusively for the first six months by the World Health Organization (WHO), UNICEF, and the American Academy of Pediatrics (AAP). In the United States the problem is not that mothers fail to start, but that they stop early. Among infants born in 2022, 85.7% were ever breastfed, yet only 47.6% were exclusively breastfed at three months and 27.9% at six months. Roughly 60% of mothers stop earlier than they intended, and these losses concentrate among families already facing the greatest health disparities, making breastfeeding duration both a clinical and an equity concern.

The postpartum stay is brief but decisive. Milk supply is established and latch is learned during those few days, and in-hospital formula supplementation carries a threefold risk of cessation by day 60. Skin-to-skin contact (SSC) is the nursing intervention aimed most directly at this window, yet it is delivered inconsistently and only about one in five U.S. maternity facilities holds Baby-Friendly designation.

PURPOSE OF THE PROJECT

This evidence-based practice project evaluated whether SSC during the postpartum hospital stay improves breastfeeding after discharge in full-term neonates, and whether current practice should change. The team appraised six studies using the Johns Hopkins model, synthesized the findings by level and quality, and translated the result into a unit-level action plan. Because the shortfall in breastfeeding occurs after families return home, the outcome of interest was set beyond discharge rather than at hospital discharge alone.

P	Full-term neonates on a postpartum unit
I	Skin-to-skin contact during the postpartum hospital stay
C	No structured skin-to-skin contact (routine care)
O	Breastfeeding rates post hospitalization

SEARCH STRATEGY & APPRAISAL

Database: PubMed, including MEDLINE records.

Terms: "skin-to-skin contact," "mother-infant skin-to-skin contact," and "term infant" combined with "breastfeeding" and "exclusive breastfeeding" using AND, exact-phrase quotation marks, and truncation (breastfeed*).

Included: healthy infants 37 to 42 weeks, postpartum or maternity setting, breastfeeding outcomes, English, peer-reviewed, 2016 to 2026. **Excluded:** preterm or NICU infants, opinion pieces, editorials, narrative reviews.

312	20	6
records screened	full texts reviewed	studies appraised

Appraised with the Johns Hopkins Research Evidence Appraisal Tool; level and quality set by team consensus.

WHY SKIN-TO-SKIN WORKS

1. The unclothed newborn is placed prone on the mother's bare chest, uninterrupted.
2. Contact triggers maternal oxytocin release, which promotes milk ejection.
3. Maternal warmth and odor cue the newborn's rooting and sucking reflexes.
4. Earlier, more effective first feeds support continued breastfeeding after discharge.
5. Protecting the session from routine interruptions preserves the dose, since non-urgent newborn care was the most common reason contact ended early.
6. Sessions may run past 60 minutes whenever the mother and infant are able.

SUMMARY OF THE EVIDENCE

Six Appraised Studies by Level and Quality

Johns Hopkins levels of evidence, more than 5,000 mother-infant dyads across six countries

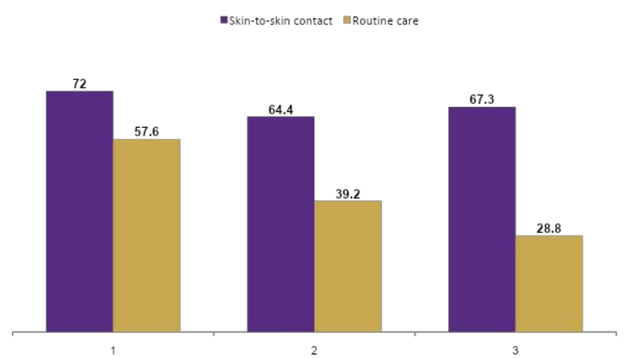
LEVEL	STUDY, DESIGN, AND SAMPLE	KEY RESULT	QUALITY
I	**Karimi et al. (2019)** Meta-analysis, 8 pooled RCTs, 1,104 dyads	OR 2.19 for exclusive breastfeeding (95% CI 1.66–2.89)	A
I	**Sharma (2016)** Randomized controlled trial, 200 neonates	72% vs 57.6% exclusive at 6 weeks (p = .04)	A
II	**Hung & Wu (2026)** Quasi-experimental, 50 dyads, 4 weeks	+9.2 adjusted days of exclusive breastfeeding	B
II	**Huang et al. (2022)** Quasi-experimental, 104 dyads, 60 vs 20 min	67.3% vs 28.8% first feed success; gains faded by discharge	B
III	**Giang et al. (2022)** Cross-sectional survey, 1,812 mothers	Dose-response: aOR 2.62 at 15–90 min, 5.98 above 90 min	B
III	**Chu et al. (2025)** Retrospective cohort, 2,205 dyads	64.4% vs 39.2% exclusive at discharge (p < .001)	C

Quality: A = high, B = good, C = low. No Level IV or Level V evidence met the inclusion criteria. All six studies favored SSC on at least one breastfeeding outcome and none found harm.

BREASTFEEDING OUTCOMES & DOSE RESPONSE

SSC Compared With Routine Care

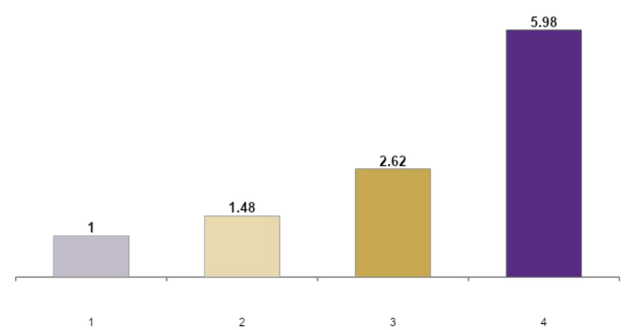
Percentage achieving each study's breastfeeding outcome



Pooled across eight randomized trials, infants receiving SSC were more than twice as likely to be exclusively breastfed (OR 2.19, p < .001), with low heterogeneity (I^2 = 16.2%).

Adjusted Odds by Duration of Contact

Giang et al. (2022), 1,812 mothers, adjusted analysis



Benefit appears only once contact passes a minimum duration, then strengthens. Only 18.8% of infants received more than 90 minutes with a completed first feed.

LIMITATIONS OF THE EVIDENCE

- Comparison condition was rarely a true absence of contact. Control groups in Huang et al. (2022) and Chu et al. (2025) received brief routine SSC, so those studies compared more contact with less rather than contact with none.
- Only three of the six studies followed infants beyond hospital discharge, so much of the evidence measures in-hospital breastfeeding rather than the post-hospitalization outcome named in the PICO question.
- Protocols varied widely, from a single 45 to 60 minute session at birth to daily sessions repeated across four weeks, which makes a single optimal dose difficult to identify.
- Blinding was not possible in any study, since mothers and nurses can see whether contact is occurring and mothers self-report feeding status, raising the risk of performance and detection bias.
- Two Level II studies used small, self-selected samples with unequal groups, and baseline breastfeeding intention differed substantially between groups in one of them.
- One Level III cohort was rated low quality for an unclear description of group assignment and the use of unvalidated outcome measures, so it is weighted cautiously.

CONCLUSION

Skin-to-skin contact is a no-cost nursing intervention with a measurable dose. Across six studies in six countries, more contact produced better breastfeeding outcomes, and brief contact of under 15 minutes performed no better than none at all. The body of evidence is good and consistent rather than strong, and follow-up beyond discharge remains limited, so the team recommends piloting a structured per-shift protocol on the postpartum unit and evaluating breastfeeding rates through the six-month well-child visit before spreading the change.

Bottom line: the evidence supports doing skin-to-skin longer and more often, not simply doing it at all.

SYNTHESIS OF FINDINGS

- All six studies pointed the same way. Across six countries and four research designs, every one favored skin-to-skin contact over no contact or very little, and none of them found harm.
- How much contact an infant received mattered more than whether contact happened at all.
- There appears to be a floor. Contact lasting under 15 minutes worked no better than none, and the strongest results showed up once contact ran past 90 minutes.
- The clearest results came from units where nurses guided the contact, with set expectations for positioning, monitoring, and feeding support.
- The pooled results varied little from one study to the next (I^2 = 16.2%), so the benefit was not tied to a single country or type of hospital.
- Taken together, this is good evidence with consistent results, which is enough to move forward carefully rather than to change practice outright.

RECOMMENDATION & INTERVENTIONS

Pilot the change — Good and consistent evidence plus low safety risk points to a pilot rather than a full practice change.

1. At least one uninterrupted 30 to 60 minute SSC session per shift for eligible dyads, extended whenever mother and infant are able.
2. Defer weights, measurements, and bathing until the session ends, the most common interruption identified.
3. Standardize nurse education on positioning, thermal protection, monitoring, and feeding support before launch.
4. Chart occurrence and duration in the existing newborn flowsheet; no new documentation system required.
5. Eligible dyads are healthy singletons at 37 weeks gestation or more with no contraindication to breastfeeding.
6. Coordinate with labor and delivery at handoff so that contact begun at birth continues on arrival to the unit.

IMPLEMENTATION & MEASURES

MONTHS 1–2	MONTHS 3–6	MONTHS 4–12
Protocol, approval, education, baseline data	Implementation with weekly chart audits	Follow-up to the 6-month well-child visit

- Clinical measure: exclusive breastfeeding at discharge and at each well-child visit through six months, compared with the unit's own baseline rate and the Healthy People 2030 target of 42.4%.
- Process measure: the share of eligible dyads who received at least one session per shift, taken from a weekly random chart audit.
- Sessions that were declined, interrupted, or delayed for medical reasons are charted separately so they are not counted as nursing noncompliance.
- The unit nurse educator or clinical nurse specialist leads the pilot, champion nurses on days and nights model it at the bedside, and the unit IBCLC builds the education module and competency checklist.
- Resources are limited to staff education time and IBCLC expertise. At Month 12 leadership revises, continues, or spreads the protocol.

BARRIERS & MITIGATION

BARRIER	EXISTING STRENGTH USED
Routine tasks interrupt contact	Formally resequence non-urgent newborn care to follow the session
SSC charted inconsistently, no baseline	Add occurrence and duration to the current flowsheet with weekly audit feedback
Staff may see it as added workload	Champion nurses on days and nights frame it as making current practice consistent
Mothers may decline or be fatigued	Offer later or by a support person; chart declines separately from staff performance
Breastfeeding is not tracked back to the unit after discharge	Pull feeding status from pediatric well-child visit documentation in the shared electronic health record

REFERENCES

Scan QR code
Full APA reference list, Johns Hopkins appraisal tools (Appendices G, H, and I), and supporting project documents.

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