Lactation Support and Promotion

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POLICY: LACTATION SUPPORT AND PROMOTION

POLICY SUMMARY/INTENT:

Lactation Support/Promotion

DEFINITIONS:

Baby Friendly Hospital Initiative (BFHI): The BFHI is a global initiative of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). It is implemented in the United States by Baby Friendly USA (BFUSA).

IBCLC: Internationally Board Certified Lactation Consultant.

Infant formula: expressed milk or human banked milk.

International code of marketing of breast milk substitutes: Employees of manufacturers or distributors of breast milk substitutes, bottles, nipples, and pacifiers will have no direct communication with pregnant women and mothers. The facility does not receive free gifts, non-scientific literature, materials, equipment, money, or support for breastfeeding education or events from manufacturers of breast milk substitutes, bottles, nipples, pacifiers, or other infant feeding equipment or coupons for the above items. Any educational materials distributed to breastfeeding mothers are free from messages that promote or advertise infant food or drinks other than breast milk.

Late preterm: An infant born later than thirty-six (36) weeks gestation but less than thirty-eight (38) weeks gestation.

LLL: La Leche League.

Preterm: An infant born at less than thirty-six (36) weeks gestation.

Skin to skin contact: Holding infant naked/or with only a diaper and unswaddled, belly down, directly against mother's bare chest.

Supplemental feeding method of choice: options include syringe, syringe and 5 french feeding tube, medicine cup for cup feeding, spoon for spoon feeding, or bottle teat for bottle feeding.

Supplementary feedings: Feedings provided in place of breastfeeding; this may include expressed or banked breast milk and/or breast milk substitutes/formula.

The Joint Commission: A private non-governmental agency that establishes guidelines for the operation of hospitals and other health care facilities, conducts accreditation programs and surveys, and encourages the attainment of high standards of institutional medical care in the United States. Member of The Joint Commission include representatives from the American Medical Association, American College of Physicians, American College of Surgeons, American Dental Association, and American Hospital Association.

United Nations Children's Fund (UNICEF): The United Nations Children's Fund is a United Nations Program headquartered in New York City that provides long-term humanitarian and developmental assistance to children and mothers in developing countries.

WIC: Women, Infant and Children.

World Health Organization (WHO): WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.

AFFECTED DEPARTMENTS/SERVICES:

Perinatal Services, Lactation Consultants, Nutritional Services, Clinical Information Systems (CIS), Operating Room (OR), Post Anesthesia Care Unit (PACU), Adventist Health Out-patient Perinatal Clinics

POLICY: COMPLIANCE – KEY ELEMENTS

A. **SPECIAL CONSIDERATIONS:** Strategy used to promote and support breastfeeding by lactation educators, consultants and licensed staff.

B. **PHILOSOPHY:**

1. Breast milk is the ideal food for infants and is the standard against which all commercially prepared breast milk substitutes are measured. The advantages of breastfeeding for the mother and infant are numerous and well supported by research. In support of the Healthy People 2010 breastfeeding initiative, the American Academy of Pediatrics Policy Statement on breastfeeding, and the Association of Women's Health, Obstetric and Neonatal Nurses' Position Statements on breastfeeding and The Nurse's Role in the Promotion of Breastfeeding, this organization is committed to ensuring that breastfeeding promotion and support is a priority for obstetrical staff. These organizations

recommend exclusive breast milk feedings for six (6) months, with continuance through the first year of life with addition of complementary foods at six (6) months. Nurses who care for women and infants in the prenatal and postpartum periods play a key role in providing education and support aimed at successful initiation and maintenance of breastfeeding. Additionally, physician will be educated to support the nutritional needs of the infant and support the mother's desire to breastfeed in a further effort to foster an environment that encourages breastfeeding.

2. The intent of this commitment is to encourage mothers regarding their attitudes and perceptions relating to her ability to breastfeed. Additionally, we recognize a mother's right to make informed decisions about her and her baby's care and will provide information to mothers that will assist them in making informed decisions. We recognize cultural beliefs and values may influence the choice to breastfeed; therefore culturally sensitive information will be integrated into all aspects of breastfeeding promotion.

3. The hospital, prenatal, and postnatal clinics will uphold the International Code of Marketing of Breast Milk Substitutes and will not promote the use of breast milk substitutes, nipples, or bottles.

4. The hospital will purchase all breast milk substitutes at fair market value and will receive no free supplies or educational materials from any breast milk substitute companies.

5. No pregnant women, mothers, or families are given marketing materials or samples or gift packs by the facility that consist of breast milk substitues, bottle, nipples, pacifiers, or other infant feeding equipment or coupons for the above items.

6. There may be certain instances, while not routine, that a woman should avoid breastfeeding. The woman will be encouraged to make this decision in consultation with her primary health care provider. Such situations include, but are not limited to:

    a. HIV infection.

    b. Illicit drug use.

    c. Active tuberculosis.

        i. **NOTE:** Until treatment is established with the need for medications contraindicated in breastfeeding, where the risk of morbidity outweighs the benefits of breastfeeding.

    d. Prescription medications.

        i. **NOTE:** While the vast majority of medications are safe to take during breastfeeding, it is important for breastfeeding women to discuss the use of herbal preparations, over-the-counter medications, and prescription drugs with a health care provider who has expertise in breastfeeding.

C. **STAFF TRAINING IN BREASTFEEDING EDUCATION AND SUPPORT:**

1. Perinatal Services will ensure that all Physicians, Registered Nurses (RNs), and IBCLCs who work in the Perinatal Services or prenatal clinic will receive the required number of training hours on the fifteen (15) lessons/topics that are specified by the Baby-Friendly Hospital Initiative and are inclusive of the WHO/UNICEF guidelines.All maternity staff will receive 20 hours of education in breastfeeding and lactation management. The curriculum for this training will cover the 15 sessions identified in the current version of the U.S. Baby-Friendly Guidelines and Evaluation Criteria and include 5 hours of supervised clinical experience. Health care providers with privileges for labor, delivery, maternity and nursery/newborn care will receive a minimum of 3 hours of breastfeeding management education pertinient to their role. At minimum, all health care providers will receive education on the benefits of exclusive breastfeeding, physiology of lactation, how their specific field of practice ipacts lactation, and how to find out about safe medications for use during lactation.

2. Upon completion of training, a designated training mentor, which may be a fellow RN, IBCLC, or Perinatal Services Director, will supervise, verify, and document the five (5) hours of supervised clinical experience of each staff member.

3. A designated healthcare professional (ex. a certified lactation consultant or trained R.N.) will be responsible for assessing needs, planning, implementing, evaluating, and periodically updating competency-based training in breastfeeding for all staff caring for mothers, infants, and/or children to ensure the standards of the Baby-Friendly Hospital Initiative are routinely being met.

4. Nurses coming in contact with mothers, infants, or children will receive standardized, evidence-based education and training on the support and management of lactation using the Birth and Beyond California Program for direct patient care staff. Training for new staff will be held within the first 6 months of hire. Staff education will be documented in the Employee Education file. An online course covering the basic knowledge base is required for all ancillary and clinic staff and approved training is held for physicians/providers. All training meets Baby-Friendly educational criteria. Lactation management will be included as part of orientation as well as included as part of ongoing training and competency evaluation for nurses and strongly encouraged for physicians and Certified Nurse Midwives.

5. New employees who have received training prior to employment will be exempt from this hospitals Baby Friendly Training requirements after they provide sufficient documentation of lactation management training in all of the required topics set forth by the Baby Friendly Hospital Initiative.

6. Staff Lactation Consultants and the Director of Perinatal Services will be responsible for ensuring that the aforementioned lactation education is implemented for all new employees.

7. The Baby Friendly 10 Steps will be communicated to all new hospital employees during general hospital orientation. All maternity staff and maternity care providers will be oriented to the policy upon arrival to the unit, during their clinical orientation to the floor (at least 8 weeks). New staff will read and sign off on the policy on HealthStream during their orientation to the unit.

D. **PRENATAL CLINIC PATIENT EDUCATION:**

1. The Adventist Health (AH) Outpatient Clinics which includes Perinatal Services will uphold the Baby Friendly Hospital Initiative's Steps 3 and 10 to "inform all pregnant women about the benefits and management of breastfeeding" and to "foster the establishment of breastfeeding support groups and refer mother to them on discharge".

2. The midwives, physicians, and nurses providing prenatal sercies at affiliated offices and/or clinics are responsible for educating pregnany women about breastfeeding.

3. Healthy Mothers Comprehensive Perinatal Services Provider (CPSP) program, Sweet Success, and lactation staff will provide prenatal and

postnatal education, counseling, and/or breastfeeding educational materials will be provided during each trimester or at the initial assessment and each subsequent trimester from when the mother enters the Healthy Beginnings program.

4. Discussion of breastfeeding takes place at the initial assessment of the trimester the mother enters the program as well as during the 3rd trimester childbirth preparation classes.

5. Mothers will be encouraged to utilize available breastfeeding resources, including classes, written materials and video presentations, as appropriate.

6. All pregnant women and their partners will be informed of and encouraged to attend a breastfeeding class during the prenatal period. Group classes will not contain education regarding bottles, formula, or other related items.

7. There is a schedule of topics to be discussed at each prenatal visit. The topics (see D7), which include all of the topics required in the U.S. Baby-Friendly guidelines and Evaluation Criteria, are listed in "Prenatal Breastfeeding Education Curriculum." Topics addressed in prenatal office/clinic visits and/or classes and educational materials will include but are not limited to:

    a. The benefits of breastfeeding for both the baby and mother.

    b. The recommendation of exclusive breastfeeding for the first six (6) months, as well as the continuation of breastfeeding after the introduction of appropriate complimentary foods, and throughout the first year of life.

    c. Labor management techniques to allow for non-pharmacological pain relief.

    d. Basic breastfeeding management, including proper positioning and latching techniques and recognition of feeding cues.

    e. Early initiation of breastfeeding.

    f. Early skin-to-skin contact.

    g. How to assure adequacy of milk supply, production, and release.

    h. How to maintain lactation even if separated from their infant.

    i. Hand expression of breast milk and use of pump if indicated.

    j. Twenty-four (24) hour rooming in and its relation to the importance of feeding on demand; infant led feeding.

    k. The importance of frequent feeding to ensure optimal milk production.

    l. Consistency of information with inpatient and outpatient information and seamless transition within prenatal, antepartum, and postpartum period.

    m. How to assess if infant is adequately nourished.

    n. Baby-led feeding and typical infant feeding behaviors.

    o. The couple care unit and the importance of rooming-in on a twenty-four (24) hour basis.

    p. The importance of skin to skin contact.

    q. Effective positioning and latch techniques.

    r. Psychosocial factors and socio-cultural barriers or constraints influencing the decision to breastfeed.

    s. Indications for supplementing breast milk.

    t. Reasons for contacting the healthcare professional.

    u. Individualized education when indicated on documented contraindications to breastfeeding and other medical conditions.

    v. Breastfeeding during the first day of life may take priority over other events such as infant bathing, pictures, and visitors.

        i. **NOTE:** Nursing staff will collaborate with the patient in scheduling these activities. This will be discussed during prenatal education classes and unit tours.

8. Instruction about formula feeding by bottle will be provided in the clinic on an individual basis as appropriate to:

    a. Women who explicitly states they are choosing not to breastfeed.

    b. When breastfeeding is contraindicated.

9. Required content for this counseling will be available for staff reference, and will be shared with the practitioners and staff. Physicians are encouraged to support breastfeeding.

10. Any educational materials distributed to pregnant women and breastfeeding mothers will be free from messages that promote or advertise infant food or drinks other than breast milk.

11. Feeding intention and education will be documented in the Electronic Medical Record (EMR) in the “Patient’s Data Profile (PDP)” under “Delivery Plans” and will be available for review.

12. Employees of manufacturers or distributors of breast milk substitutes, bottles, nipples, and pacifiers will have no direct communication with pregnant women and mothers at the AH Outpatient Perinatal Clinics.

13. No pregnant women, mothers, or families are given marketing materials or samples or gift packs by facility that consist of breaast milk substitutes, bottles, nipples, pacifiers, or other infant feeding equipment or coupons for the above items.

14. Mothers will be discharged with a breastfeeding support packet that contains the telephone number of the Hospital’s Breastfeeding

Lactation Consultant and they will be encouraged to call and schedule an appointment for breastfeeding support at their own discretion.

15. Our multidisciplinary team includes representations from the Kings County Department of Public Health, Fresno County Department of Public Health, WIC Program, Kings County Breastfeeding Coalition and the Adventist Health Breastfeeding Task Force.

16. Postpartum outpatient teaching will include:

    a. Education on the importance of exclusive breastfeeding for the first six (6) months. The information provided will be available in linguistically and culturally supportive services without ties to commercial interests.

    b. Signs and symptoms of breastfeeding problems including reasons for contacting the healthcare professional.

    c. The importance of continuing breastfeeding after the introduction of solid foods.

    d. Teaching and education resources promoting breastfeeding for each mother.

    e. Any materials or company logos that promote the use of commercial products known to interfere with breastfeeding such as formula or infant feeding bottles will not be used to teach breastfeeding.

    f. Referrals to visit services for breastfeeding support and follow-up. LLL, independent practitioners, local lactation consultants for breastfeeding support and follow-up.

    g. Additional resources may include a Resource List for all local breastfeeding support services in Fresno, Kings, and Tulare counties.

    h. Any breastfeeding concerns related to infant's ability to latch or effectively suckle at the breast will be communicated to the infant's healthcare provider after the referred visit is completed.

17. Discharge education will include contact information for the LLL, WIC Program, Kings County Health Department, Fresno County Health Department, Tulare County Health Department and the local IBCLC.

18. Mothers will also be encouraged to contact their healthcare provider for concerns or questions about breastfeeding.

E. **MOTHER/BABY SEPARATION:**

1. Mothers who are separated from their babies will be instructed in manual expression and/or electric pumping within four to six (4-6) hours after delivery. Manual expression is recommended for the first twelve (12) hours after delivery.

2. Mothers will be instructed to hand express or pump every two – three (2-3) hours x ten to fifteen (10-15) minutes or at least eight (8) times a day.

3. All breast milk will be labeled with an identification sticker including mother's name, medical record number, date of birth, and room number as well as, the date and time the milk was expressed.

4. Expressed breast milk will be logged into the breast milk refrigerator and signed out by an RN or IBCLC when used.

5. The patient will be educated on proper handling and storage techniques for breast milk through verbal instruction from the nursing staff and/or through written instruction which is located in Parent Handbook (A New Beginning) which states:

    a. Freshly expressed breast milk:

        i. May be left at room temperature for up to four (4) hours; room temperature no warmer than seventy-seven (77) degrees Fahrenheit (≤ 25 degrees celsius).

        ii. May be stored for up to four (4) days in the coldest part of refrigerator.

        iii. May be stored for up to six (6) months in the back of a freezer zero (0) degrees Fahrenheit (-18 degrees celsius) or colder.

            I. **NOTE:** Do **NOT** store breast milk in door of freezer.

    b. Frozen breast milk:

        i. Thawed breast milk that is unopened or unused can be stored in the refrigerator for twenty-four (24) hours.

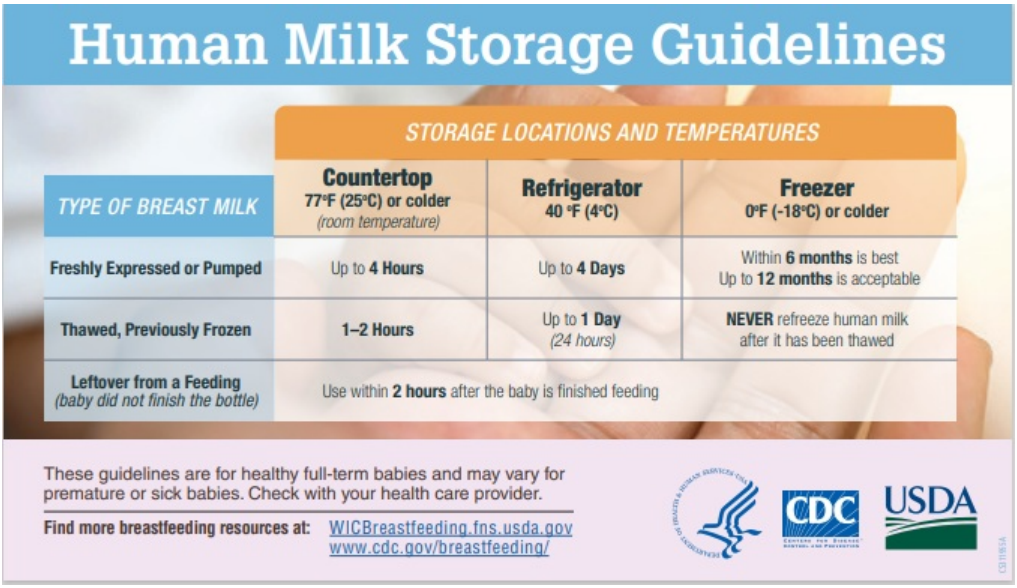
        ii. Do not refreeze breast milk.

        iii. Always chill freshly pumped breast milk in the refrigerator before adding to frozen or refrigerated breast milk.

        iv. Never microwave or boil breast milk.

            I. **NOTE:** Using a microwave could cause hotspots in the milk because it heats unevenly and could potentially burn the baby's mouth and throat and may alter the protein makeup of the breast milk and destroy the antibody composition of the milk.

        v. Thaw breast milk by running it under warm tap water or by placing it in a bowl of warm water to bring it to room temperature.



A. **INPATIENT BREASTFEEDING SUPPORT AND EDUCATION:**

1. Assuming that the baby and mother are stable, the mother and baby will be skin to skin immediately following birth. This includes the post-cesarean mother and baby as soon as mother is able to respond to her infant.

2. The baby will have access to breastfeed ad lib without restriction.

   a. The benefits of skin to skin care for mom and baby are well documented in current research and scientific literature. At Adventist Health skin to skin care will be implemented for all mothers and babies regardless of feeding choice immediately after vaginal delivery and as soon as mother is able to respond to her infant after cesarean delivery and remain there for at least 1 hour or until the first breastfeeding session has occurred, unless infant or mother are medically too unstable to tolerate.

   b. Adventist Health recognizes the importance of the first few hours after delivery as critically important for the establishment of bonding between mother and baby and has designated this period as a “Golden Hour”. Rooms with a “Golden Hour” placards on the door are recognized as being in this important period and will be disturbed minimally. Patients are oriented to this practice at Adventist Health during the hospital tour and/or during third (3rd) trimester prenatal visits.

   c. If infant/mother are medically too unstable for skin to skin care initially after birth, skin to skin should be implemented as soon as they are stabilized.

   d. Infants in Valley Children’s Neonatal Intensive Care Unit (NICU) should be placed skin to skin with their mother for at least one hour every shift (with provisions for Valley Children’s NICU equipment, lines, oxygen tubing, etc.)

   e. Staff will be available to support skin to skin care and initial breastfeeding. Baby led feeding will be encouraged by helping mother to recognize baby-led feeding cues.

   f. Routine newborn procedures such as bath, weight, vitamin K, and erythromycin administration should be delayed until initial breastfeeding and skin to skin care have been initiated.

   g. Skin to skin initiation and duration will be documented in the patient’s record.

      i. Vaginal deliveries: skin to skin initiation and duration will be documented under the patient’s delivery recovery section. Each subsequent skin to skin period should be documented in the infant’s ADL’s.

      ii. Cesarean deliveries: skin to skin initiation will be documented in the infant’s ADL’s with an Ad Hoc Note indicating beginning, duration of, and ending time of first skin to skin session. Each subsequent skin to skin period should be documented in the infant’s ADL’s.

   h. Mothers should breastfeed during the first hour following vaginal birth and cesarean section birth. The staff should assist the mother with breastfeeding and provide guidelines and support. Breastfeeding during the first day of life may take priority over other events such as infant bathing, and visitors. Nursing staff will collaborate with the patient in scheduling these activities. This will be discussed during prenatal education classes and unit tours.

   i. Frequency and duration of feedings at the breast should be infant-led and newborns should be breastfed whenever they show signs of hunger. Usually this is a minimum of eight to fifteen (8-15) times during a twenty-four (24) hours. Non-timed feedings and cue-based offerings will be the basis for mother-infant care.

   j. Mothers will be:

      i. Educated on the “supply and demand” principle of milk production and the importance of feeding frequency in relation to her milk supply.

      ii. Encouraged to breastfeed frequently in response to hunger cues. Mothers will be instructed and encouraged to watch the baby’s cues and breastfeed on both breasts each feeding and will be educated on importance of not limiting length of feeds.

      iii. Taught to recognize signs of effective breastfeeding such as a deep latch, rhythmic sucking and listening for her baby’s swallowing sounds, as well as appropriate infant output guidelines.

k. The staff and/or lactation specialist should discuss the importance of colostrum with the mother.

l. Postpartum instructions for the mother will include information about cluster feedings and should prepare her for growth spurts and other normal newborn breastfeeding patterns.

m. Nurses caring for mothers and infants will provide appropriate education using techniques such as one-to-one teaching, introduction to parenting guidebook, pamphlets and/or videotaped instruction. Teaching methods will be tailored to the age of the patient.

n. The perinatal nurse will respond to complaints of nipple soreness by assessing the source of the discomfort and assisting the mother in resolving the problem.

o. All breastfeeding mothers will be given instruction in hand expression of breast milk prior to discharge.

p. The staff nurse will educate the patient on various breastfeeding positions including but not limited to:

i. Baby led latch.

ii. Laid back breastfeeding position.

iii. Cross cradle hold.

iv. Football or clutch hold.

v. Side-lying position.

q. Every mother will also be instructed in recognizing signs and symptoms of a good latch including:

i. Baby's nose is across from mother's nipple; good infant positional alignment at breast with baby's torso in contact with mom's torso.

ii. Mother elicits and waits for a wide, gaping mouth before bringing baby to nipple.

iii. Nipple is pointed toward room of baby's mouth. Baby's lower chin and jaw are brought into breast first, and then baby's mouth is brought up and onto the breast.

iv. Baby's nose, cheeks and chin have light contact with breast, cheeks are rounded, and baby has smooth gliding jaw movement with occasional to intermittent swallows. Absence of pain with latch, cheek dimpling, puckering, and clicking noises.

r. Every staff nurse will perform a breastfeeding assessment at least once per shift. This will be documented in the baby's chart under LATCH score. Any additional comments related to the breastfeeding assessment will be recorded in the mother's EMR under Ad Hoc: Clinical Note. The assessment will include:

i. The mother's knowledge and ability of breastfeeding positions and good latching technique.

ii. Latch comfort.

iii. Audible and visual swallowing of the infant.

iv. Integrity of the nipple and areolar tissue.

v. Assistance required with helping the mother/baby dyad with latching at breast.

s. When a breastfeeding assessment identifies a dysfunction or the infant displays signs of inadequate intake, a lactation consult will be ordered.

t. Staff will educate mother on infant safety regarding holding/feeding infant only when awake; not alone if medicated and/or physically unable to do so.

B. **REASSESSMENT/CONTINUED FOLLOW UP:**

1. As mentioned in the Section C. (Staff Training in Breastfeeding Education and Support), staff nurses will perform a breastfeeding reassessment at least once every shift but more frequently if possible using the LATCH assessment tool.

2. Every mother will be instructed in recognizing feeding cues. When an assessment identifies a dysfunction or the infant displays signs of inadequate intake, a lactation consultation will be ordered. Signs and symptoms of maternal or infant feeding issues warranting referral to an IBCLC include:

a. Physician order.

b. Diabetic mom/unstable infant blood sugars.

c. Infant is preterm or late preterm gestation.

d. Infant is small for gestational age (SGA) or large for gestational age (LGA).

e. Maternal history of endocrine disorder(s).

f. Teen mother.

g. Infant weight loss greater than seven (7) percent.

h. Maternal history of inadequate milk supply.

i. Nipple trauma as evidenced by redness, cracks, blistering, bruising.

j. Mother/baby separation.

k. Formula supplementation.

l. Maternal history of breast surgery.

m. Sleepy baby greater than (>) twelve to twenty-four (12 - 24) hours of age with no documented sustained latch.

n. Jaundiced baby requiring phototherapy.

o. Electric pumping.

p. Parental request for formula.

q. Maternal history of prior poor breastfeeding experience.

r. Patient request.

C. **USE OF ASSISTED FEEDING DEVICES:**

1. In the event that a newborn has difficulty latching for greater than twelve (12) hours and assistance from a qualified nursing staff member does not result in a successful latch, the staff nurse will teach hand expression to the patient and seek assistance from another staff nurse. If the baby is still unable to latch, a lactation consultant should be contacted for a breastfeeding consult. If no lactation consultant is immediately available, the nurse should follow the Nipple Shield Pathway if she is considering using a nipple shield to assist with latch.

2. Breastfeeding with a nipple shield can be effective in helping to establish breastfeeding in the infant however it does carry risks which should be explained to the patient. If not used properly, a nipple shield may lead to:

   a. A decrease in a mother's milk production which can result in poor weight gain for her baby.

   b. A baby may show preference for the nipple shield and may initially refuse to latch without it when weaning from the shield is attempted.

   c. An increase in:

      i. Nipple trauma.

      ii. Engorgement.

      iii. Inhibition of let-down reflex.

      iv. Potential breast infection (mastitis) due to poor emptying of the breast.

3. Use of a nipple shield solely for sore nipples is not advised and should be decided upon only by an IBCLC or other trained lactation professional after a thorough latch assessment. Sore nipples are most often caused by improper positioning and latching of the infant at breast and the root cause of sore nipples should be identified and managed before a nipple shield is utilized.

4. Mothers should be cautioned of the risks associated with the use of a nipple shield by the staff nurse, as well as, the potential benefits of using a nipple shield.

D. **PRINCIPLES OF CARE: BASIC POSITIONING AND LATCH:**

1. All hospital staff who perform direct patient care to postpartum mothers and babies will have training in basic breastfeeding positioning and latch and should be able to identify:

   a. Flat nipples.

   b. Inverted nipples.

   c. Pseudo inverted nipples (nipples which appear inverted but evert with manual compression or are just dimpled in center).

2. If after the first hour of skin to skin contact the baby has not latched successfully to the breast via baby led latch, staff should attempt to provide assistance to mothers in basic positioning and asymmetric latching regardless of the presence of flat or inverted nipples. Use of asymmetric technique may help prevent sore nipples in the mother. Skin to skin contact should be maintained for at least the first hour after birth or until the first breastfeeding has occurred, in order to provide the infant with direct access to latching onto the breast as well as accomplishing other known benefits of skin to skin contact between mother and newborn.

3. Asymmetric latch technique will be taught as an effective means of achieving a deep latch at the breast, thereby minimizing and/or eliminating nipple discomfort related to breastfeeding:

   a. Ensure maternal hand is supporting infant's upper back and lower neck with infant's chest and torso having full contact with mother's torso; infant's head should have slight flexion (slight "sniffing" tilt).

   b. Place mother's nipple just above the infant's upper lip and gently tickle the infant's mouth, then pulling infant slightly away from breast, thereby eliciting a wide gaping mouth conducive to achieving a deep latch at breast.

   c. When infant opens mouth widely, lower jaw and lip should come in contact with breast first and infant's mouth and upper lip should quickly be brought up and onto the breast deeply. Approximately one-half (½) inch of areola both below and above the nipple should be in infant's mouth.

4. Nipple shield for mothers with flat or inverted nipples:

   a. Some mothers may need gentle manual eversion or positional changes to help evert the nipple to facilitate an effective latch. Trained staff should attempt to assist baby latching onto the breast by manually attempting to evert the nipple by having the mother gently roll the nipple between her thumb and index finger.

b. If manual eversion does not result in a successful latch, trained staff should:

   i. Provide education and demonstration on alternative nipple eversion methods such as:

      I. Lanolin latch assist.

      II. Bilateral pumping of the breasts for five to ten (5-10) minutes prior to breastfeeding attempt.

      III. Consider a nipple shield if above methods are unsuccessful.

   ii. Encourage continued skin to skin time to promote temperature stabilization, reduce infant's energy expenditure via thermoregulation, and allow infant unrestricted access to the breast.

   iii. Consider hand expression of colostrum during the first twelve (12) hours postpartum to entice infant to latch onto the breast, to provide breast stimulation, and to provide calories to infant via expressed breast milk.

   iv. Limit feeding interventions first twelve (12) hours of life unless medically indicated. Reinforce monitoring of hunger cues, positioning and latch techniques, and unrestricted access to the breast via skin to skin. Continue to attempt to breastfeed at least every one and one-half to three (1 ½ - 3) hours.

   v. If after the above mentioned steps were followed and a successful latch and breastfeeding session has not occurred, the staff nurse should request a colleague assess the breastfeeding session. If the colleague is also unsuccessful at helping the baby latch effectively, a nipple shield may be implemented.

c. Nipple shield considerations and education:

   i. Staff must provide patient education on the risks and benefits associated with the use of a nipple shield and obtain and document patient's verbal informed consent in the patient's electronic medical record using an "ad hoc" clinical note.

   ii. Nipple shield use must also be documented under the "LATCH" assessment tool.

   iii. The appropriate nipple shield size should be ensured through careful assessment of baby's mouth size and mother's nipple size.

   iv. It is important that any patient who is using a nipple shield to assist with breastfeeding have a consult with and be followed by a lactation consultant both as an inpatient and as an outpatient to ensure appropriate use and weaning from the shield as appropriate.

d. Method for using a nipple shield:

   i. When using a nipple shield the following instructions should be implemented:

      I. Fit the mother with the appropriate sized shield. The silicone nipple should be small enough for the infant to accommodate the entire nipple in its mouth yet large enough to accommodate the mother's entire nipple. Improper fitting will result in nipple trauma.

      II. Use proper hand hygiene prior to demonstrating the application of the shield on the mother's breast.

      III. Wash the nipple shield before and after each use with warm water and mild soap.

      IV. Provide verbal guidance or hands on demonstration as needed. Position the shield so that the cut out area, if present, is aligned with where baby's nose will touch the breast.

      V. Form the nipple shield so that it is almost inside out and fit the shield snugly onto the nipple so that the nipple is centered in the shield.

      VI. Smooth the shield over the nipple making sure the mother's nipple remains centered in the silicone nipple and that the silicone nipple accommodates the mother's entire nipple without pinching.

   ii. Assess for proper deep latch:

      I. The shaft of the nipple shield should not be visible when baby is latched.

      II. Ensure proper infant body alignment.

      III. Ensure baby's nose, cheeks and chin are lightly touching mother's breasts.

      IV. Infant should have good lower jaw movement, rounded cheeks with no visible cheek puckering and no clicking noises audible. Effective suck/swallowing movements should be seen.

e. Monitoring and follow up:

   i. A nipple shield is meant to be a transitional, temporary tool to help teach an infant to effectively breastfeed. Weaning from a nipple shield should begin as soon as possible.

   ii. If a patient is discharged home with a nipple shield in use, it is important that the patient be referred to an outpatient IBCLC and should have an outpatient appointment scheduled prior to being discharged home.

   iii. The mother should be educated on the importance of closely monitoring baby's intake and output during the time a nipple shield is in use to the risk of poor milk transfer with a nipple shield. The mother should be educated on proper intake and output based on the baby's age. Having a mother pump or hand express after feeds when a nipple shield is in use will help ensure adequate breast stimulation.

   iv. Documentation by the staff nurse should include date and time the use of a nipple shield was initiated as well as inclusion of the following:

I. Reason for nipple shield use.

II. Size of nipple shield.

III. LATCH assessment with nipple shield in use

IV. Referral/order for a lactation consult.

E. **SUPPLEMENTAL FEEDINGS:**

1. The American Academy of Pediatrics, The American College of Obstetricians and Gynecologists, American Academy of Family Physicians, Academy of Breastfeeding Medicine, World Health Organization, United Nations Children's Fund, and many other health organizations recommend exclusive breastfeeding for the first six (6) months of life. Exclusive breastfeeding is defined as an infant's consumption of human milk with no supplementation of any type (no water, no juice, no nonhuman milk, and no foods) except for vitamins, minerals and medications. Exclusive breastfeeding has been shown to provide improved protection against many diseases and to increase the likelihood of continued breastfeeding for at least the first year of life.

2. Breastfeeding infants will be given only breastmilk. Supplementary sterile or glucose water or artificial infant milk will not be given to breastfeeding infants unless specifically ordered by the physician for a medically indicated reason or per parent request. If a parent requests formula supplementation for a breastfed baby, the patient will be educated on the risks of unnecessary formula supplementation.

3. When supplementary feeding is necessary, goals are to feed the baby and to optimize maternal milk supply while determine the cause of poor feeding or inadequate milk transfer.

4. Pacifiers will not be given to breastfeeding infants without informing the mother of the risks and benefits of pacifiers as documented in the pacifier education paperwork in the patient breastfeeding bag. Documentation of education in patient's chart will be noted.

    a. For painful procedures pacifiers may be used with a physician order and approved glucose solution. They will be discarded after the procedure.

    b. When supplementation is medically indicated, a physician order will be obtained and will include the reason for supplementation, time of administration of the feeding, and this information will be ordered and documented in the infant's medical record. The use of bottles and artificial nipples will be avoided during supplemental feeds. Alternate feeding methods may be utilized to maintain mother-infant breastfeeding skills. These methods will be discussed with the mother and may include supplemental nursing system (SNS) via a syringe and 5fr. Feeding tube placed at the breast while the infant is breastfeeding, syringe/finger feeding, spoon feeding, or cup feeding. The reason for supplementation will be documented in infants' medical record by the nurse.

    c. Infant medical indications for supplementation include:

        i. Asymptomatic hypoglycemia verified by laboratory serum blood glucose measurement that is unresponsive to appropriate frequent breastfeeding. Symptomatic infants should be treated with intravenous (IV) glucose. Refer to Policy: Infant Hypoglycemia.

        ii. Clinical and laboratory evidence of significant dehydration.

        iii. Weight loss of greater than eight to ten (8-10) percent (%) accompanied by maternal delayed lactogenesis II (day 5 [120 hours] or later).

        iv. Delayed bowel movements or continued meconium stools on day five (5).

        v. Insufficient intake despite an adequate milk supply (poor milk transfer).

        vi. Hyperbilirubinemia.

        vii. "Neonatal" jaundice associated with starvation where breastmilk intake is poor despite appropriate intervention.

        viii. Breastmilk jaundice when levels reach 20-25 mg/dL in an otherwise thriving infant and where a diagnostic and/or therapeutic interruption of breastfeeding may be helpful

        ix. When macronutrient supplementation is indicated.

    d. Maternal factors indicating need for infant supplementation:

        i. Delayed lactogenesis II (day 5 or later) and inadequate intake by the infant.

        ii. Retained placenta (lactogenesis II will probably occur after the placental fragments are removed).

        iii. Sheehan's syndrome: postpartum hemorrhage followed by absence of lactogenesis II.

        iv. Primary glandular insufficiency: Primary lactation failure which occurs in less than 5% of women and is evidenced by:

            I. Poor breast growth during pregnancy.

            II. Minimal indication of lactogenesis stage II.

        v. Breast pathology or prior breast surgery resulting in poor milk production.

        vi. Intolerable pain during feedings unrelieved by interventions and consults with an IBCLC.

    e. Volume of supplemental feedings:

        i. Amounts of infant supplementation are dependent on:

            I. Assessment of the effectiveness of breastfeeding by a lactation professional.

            II. The age and weight of the newborn.

III. Current growth needs.

IV. Newborn readiness and satiation cues.

ii. According to the Academy of Breastfeeding Medicine and other sources, several studies have given ideas of intakes at the breast over time. The mean yield of colostrum for over the first twenty-four (24) hours after birth was 37.1 g with an average intake of 6 g per feeding and six feedings in the first twenty-four (24) hours. As there is no definitive research available, the amount of supplement given should reflect the normal amounts of colostrum available, the size of the infant's stomach (which changes over time) and the age and size of the infant.

iii. Based on the limited research available, suggested intakes for term healthy infants are listed in the table below although feeding should be by infant cue to satiation and tolerance as evidenced by the absence or of minimal emesis post feeding.

NEWBORN AGE	INTAKE
1st 24 hours of life	2-10 mL per feeding(avg. of 6 feeds in 24 hours)
24-48 hours	5-15 mL per feeding (8+feedings per 24 hrs.)
48-72 hours	15-30 mL per feeding (8-12 feedings per 24 hours)
72-96 hours	30-60 mL per feeding (8-12 feedings per 24 hours)

iv. The mother will be educated regarding the avoidance of artificial nipples and bottles as well as how to safely utilize the supplemental feeding device and administer the supplementation.

v. All staff that interacts with the mother-baby dyad should be aware of the risks of unnecessary supplementation and provide education to mothers regarding this. This education should be well documented in the mother's electronic medical record.

vi. Healthy newborns do not need supplemental feedings for poor feeding the first 24 hours of life, but babies who are too sick to allow breastfeeding are likely to require supplemental feedings.

vii. Infants born to diabetic mothers will be closely monitored during the first several hours after birth and if supplementation is necessary, will adhere to the Gestational Diabetic protocol.

F. **PROCEDURE FOR IMPLEMENTING SUPPLEMENTATION:** Once supplementation is determined to be appropriate:

1. Expressed breastmilk is the first choice for supplemental feedings unless otherwise indicated by physician order.

2. Hand expression should be considered as first choice method of milk expression during the first twelve to twenty-four (12 – 24) hours after birth as it may elicit larger volumes than a pump in the first few days and may increase overall milk supply. The nurse should demonstrate effective hand expression/breast compression to the patient and monitor the patient's effectiveness for at least the first few feedings to ensure good technique which promotes adequate infant intake.

3. If electric pumping is used as a method for obtaining expressed breastmilk, the mother should pump after each breastfeeding session for ten to fifteen (10 – 15) minutes bilaterally. If a mother is not breastfeeding and is pumping exclusively as a means of feeding her baby, she should pump a minimum of at least eight (8) times per twenty-four (24) hours. However, ten to twelve (10-12) times per twenty-four (24) hours is optimal.

4. If expressed breastmilk is unavailable or in insufficient amounts for required volume of supplementation, commercially prepared infant formula is an acceptable substitute. Protein hydrosylate formulas are preferable to standard artificial formulas as they avoid exposure to cow's milk proteins, reduce bilirubin levels more rapidly, and may convey the psychological message that the supplement is a temporary therapy, not a permanent inclusion of artificial feedings, however use of this formula will be at the discretion of the patient/pediatrician recommendation.

G. **PROCESS FOR SUPPORTING MOTHERS WHO FEED THEIR INFANTS BREASTMILK SUBSTITUTES**:

1. The Staff at Adventist Health supports safe and adequate nutrition for any infant, regardless of the feeding methods. For any infant in this facility that is being fed breastmilk substitutes, regardless of the reason, the mother or infant care provider will be taught by the nursing staff how to properly mix, handle, and store the breastmilk substitutes. The nurse performing the education will be responsible for requiring that the mother or care provider provide a return demonstration to ensure understanding of the information. The education will be documented in the mother's electronic medical record.

2. The process of the safe feeding of breastmilk substitutes is explained in the section below, titled "Safe Preparation and Administration of Breastmilk Substitutes".

3. In support of the International Code of Marketing of Breastmilk Substitutes, Adventist Health does not accept free or subsidized breastmilk substitutes, artificial nipples, or infant feeding bottles. All of these items are purchased at fair market value in accordance with the purchasing policy of Adventist Health to purchase any other product at Adventist Health.

4. Breastfeeding mothers who request breastmilk substitutes.

   a. If a breastfeeding mother requests that her infant be fed a breastmilk substitute, the staff nurse caring for the mother/infant dyad will explore the mother's questions and concerns about infant feeding and educate her regarding the possible negative consequences of feeding her infant a breastmilk substitute.

   b. This education will be documented in the mother's inpatient education document, nursing clinical note, and/or ad hoc section in the mother's electronic medical record. If the mother decides to feed her infant a breastmilk substitute after receiving education, her choice will be supported by the staff.

   c. Breastfeeding mothers who request artificial nipples and infant feeding bottles will receive education on the possible negative consequesnces regarding breastfeeding and this education will be documented.

H. **SAFE PREPARATION AND ADMINISTRATION OF BREASTMILK SUBSTITUTES**:

1. A current list of RNs who are qualified to perform this standardized function will be maintained in the Director of Perinatal Services office.

2. Nursing staff will be educated on the proper safe preparation and administration of breastmilk substitutes. In addition, the patient or family member will be educated using the printed WIC guide When You Feed Me Formula on proper formula feeding technique prior to discharge home. This education will be documented in the mother's electronic medical record.

3. Instruction will include:

    a. Infants two (2) months of age or younger should only be fed sterile, ready-to-feed formula or sterile liquid concentrate formula that has been reconstituted with water that has been boiled and cooled to room temperature.

    b. For infants older than two (2) months of age, if using powdered formula, measure the proper amount carefully using only the designated scoop provided in the formula can and sterilize the measuring scoop after each use in the same way bottles are sterilized-do not store scoop in formula container.

    c. Washing hands thoroughly with warm water and soap or using an alcohol based sanitizer to disinfect hands will prevent the spread of germs to the infant's formula.

    d. Clean and disinfect the surface or counter.

    e. Place equipment on a clean paper towel.

    f. Place water in bottle first. Water should be fresh, safe, previously sterilized, room temperature. Mothers will be taught to reconsitiute powdered infant formula using boiled water, cooled to no less than 158 degrees F/70 degrees C. The water should be cooled for no more than 30 minutes after boiling. After reconsituting the formula, the temperature of the formula should be checked before feeding the formula to the infant. Mothers will receive a printed handout with this information upon discharge.

    g. Place powdered formula in bottle next.

    h. Mix by shaking or swirling the bottle until completely incorporated.

    i. Prior to next use, re-usable bottles should be sterilized by:

        i. Boiling for 5 minutes, or

        ii. Washing on top rack of dishwasher.

            I. **NOTE:** Allow bottles to cool to room temperature before using.

4. Cue-based, paced feeding:

    a. Parents will be educated on observing for feeding cues including waking from a sleep state, licking/smacking lips, sucking on hands, bobbing head, and rooting.

    b. Parents will be educated on the importance of a paced feeding prior to discharge home. Points to be addressed include:

        i. Hold bottle horizontal so the gravitational flow is slow.

        ii. Place the bottle in the baby's mouth so lips flange over the base of the nipple.

        iii. If the baby shows any signs of stress allow baby to pause and take a break.

        iv. Burp about every one (1) ounce.

        v. Observe for signs of satiety (fullness) in the baby including open, relaxed hands, no rooting reflex, content and sleepy.

        vi. Never force baby to finish all the formula in the bottle.

        vii. Prior to discharge home the patient should be instructed to speak with her pediatrician about appropriate intake amounts for her baby once discharged home.

I. **ROOMING IN:**

1. Adventist Health maintains that infants, regardless of feeding preference, should remain at the mother's bedside both day and night beginning immediately after delivery for healthy newborns. The nurse should plan with the mother and family for periods of rest and sleep.

2. Healthy babies will be cared for at their mother's bedside including routine newborn procedures. This includes:

    a. Measurements.

    b. Baths.

    c. Weight checks.

    d. Hearing screens.

    e. Lab tests (unless placement of IV is necessary, baby will be taken to nursery).

3. Mother and family will be encouraged to assist with newborn care.

4. If a mother requests her newborn be taken to the nursery so the mother may rest alone, the nurse should gently explore the mother's request and remind the patient of the benefits to rooming in with her baby.

5. If after exploration of the mother's request for her baby to be taken to the nursery the mother still requests the baby to stay in the nursery at night, the infant should be brought to the mother to breastfeed when the baby displays hunger cues or at least every three hours. Patient teaching and professional recommendations regarding the benefits of rooming in should be documented in the mother's electronic medical

record.

6. Twenty-four (24) hour rooming in is the expected normal for mother/infant care at Adventist Health. If a newborn is removed from the mother's room at any time, time of removal, reason baby left mother's room, duration of separation, location of where infant was taken to, and time of infant's return to mother's room must be documented in infant's electronic medical record under an "Ad Hoc" clinical note.

7. The nurse should plan with the mother and family at least one to two (1-2) hours of undisturbed time, designated at Adventist Health as "Golden Hour" time, to be with and focus on her baby during the hospital stay.

8. If a breastfeeding mother is unable or refuses to feed her infant during the night, the infant will be fed in a manner that is consistent with preserving breastfeeding and reflects the skills and knowledge of the obstetrics/nursery staff in consultation with the infant's physician. The use of bottles or artificial nipples will be avoided unless medically indicated.

J. **DISCHARGE SUPPORT:**

1. At discharge, each breastfeeding mother will be given a breastfeeding bag that contains information on local breastfeeding support groups, outpatient lactation consultants contact information, and community resources for breastfeeding assistance. This bag should be reviewed with the patient prior to discharge by the staff RN responsible for discharge education.

   Postpartum discharge teaching will include:

   a. Education on the importance of exclusive breastfeeding for the first six (6) months. The information provided will be available in linguistically and culturally supportive services without ties to commercial interests.

   b. Signs and symptoms of breastfeeding problems including reasons for contacting the healthcare professional.

   c. The importance of continuing breastfeeding after the introduction of solid foods.

   d. Teaching and education resources promoting breastfeeding for each mother.

   e. Any materials or company logos that promote the use of commercial products known to interfere with breastfeeding such as formula or infant feeding bottles will not be used to teach breastfeeding.

   f. Referrals to visit services for breastfeeding support and follow-up. LLL, independent practitioners, local lactation consultants for breastfeeding support and follow-up.

   g. Additional resources may include a Resource List for all local breastfeeding support services in Fresno, Kings, and Tulare counties.

2. Discharge education will include contact information for the LLL, WIC Program, Kings County Health Department, Fresno County Health Department, Tulare County Health Department, and the local IBCLC.

3. Mothers will also be encouraged to contact their healthcare provider for concerns or questions about breastfeeding.

4. Mother will be educated on the American Academy of Pediatrics recommendations for newborn weight and jaundice check within two to three (2-3) days of discharge.

5. Opportunities for offering support, identifying early problems, and referring lactating mothers to appropriate resources will be provided.

   a. Nurses who are concerned about an infant's ability to latch on should inform the attending physician and refer the patient to an inpatient Internationally Board Certified Lactation Consultant (IBCLC) prior to discharge home. If an inpatient IBCLC is not available, the nurse should ensure that an outpatient lactation follow up appointment has been scheduled for the patient prior to the patient being discharged home.

   b. Physicians will be encouraged to support the mother's desire to breastfeed.

6. The lactation support team is a strategy used to promote and support breastfeeding mothers through formation of an interdisciplinary, culturally appropriate team. The team seeks advice from local experts and patients as necessary. This organization believes that concerned and interested individuals should join together to reduce institutional barriers to breastfeeding, such as mother-infant separation, fragmentation of care, and routine supplementation with formula. Additionally, the administration of this organization strongly supports breastfeeding/lactation support groups for mother and family.

7. Team membership includes Director of Perinatal Services, medical staff, nursing staff, inpatient lactation specialists, and nutritional services staff.

8. Lactation support team responsibilities:

   a. Implementing breastfeeding policies.

   b. Ensuring training/education for all obstetric staff.

   c. Providing ongoing education as needs are identified.

   d. Perform evaluation of breastfeeding program based on guidelines similar to Baby Friendly Hospital Initiative Guidelines and Criteria.

   e. Interdisciplinary team members should be aware of the International Code of Marketing of Breastmilk Substitutes.

ATTACHMENTS:
(REFERENCED BY THIS DOCUMENT)
OTHER DOCUMENTS:
(WHICH REFERENCE THIS DOCUMENT)
FEDERAL REGULATIONS:
ACCREDITATION:
CALIFORNIA:
HAWAII: **Not applicable**

OREGON:	**Not applicable**
WASHINGTON:	**Not applicable**

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ENTITY POLICY OWNER:	**Director, RN**

APPROVED BY:

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ADVENTIST HEALTH SYSTEM/WEST INDIVIDUAL:	**Not applicable**
ENTITY:	**(04/20/2021) Policy Review Committee, (05/13/2021) Quality Management Committee, (05/18/2021) Surgery Service Line, (05/20/2021) OB/Newborn Service Line, (05/20/2021) Outpatient Medicine Service Line, (06/01/2021) Medical Executive Committee, (06/01/2021) Patient Care Executive, (06/08/2021) Clinical Committee of the Community Board, (06/23/2021) Community Board**
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