

**PROVIDING BREASTFEEDING SUPPORT:
MODEL HOSPITAL POLICY
RECOMMENDATIONS**

**June 2005
THIRD EDITION**



INLAND EMPIRE BREASTFEEDING COALITION

&

INLAND COUNTIES REGIONAL PERINATAL PROGRAM

PROVIDING BREASTFEEDING SUPPORT: MODEL HOSPITAL POLICY RECOMMENDATIONS

**June 2005
Third Edition**

ADAPTED FROM:

ST. JOSEPH MEDICAL CENTER
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WELLSTART INTERNATIONAL
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Dedicated to all mothers and the health care professionals who support them

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INTRODUCTION

There is overwhelming scientific evidence that breastmilk is the optimal food for infants. Numerous professional organizations actively encourage breastfeeding, including the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American College of Nurse-Midwives, the American Hospital Association, the Association of Women's Health, Obstetric and Neonatal Nurses and the American Dietetic Association.

This document was originally compiled by a local coalition as an exercise in the development of breastfeeding policies based on scientific data. Results are shared to assist and support hospital systems in their effort to replicate this process and better support breastfeeding. Because most babies are born in the hospital, there is a clear opportunity for hospital personnel to affect the initiation of breastfeeding. The education and support of breastfeeding mother/infant pairs will increase the duration of this health enhancing, cost saving, practice.

These model hospital policy recommendations are intended for use as a framework that should be molded to fit each particular setting. Implementation should be consistent with existing regulations, and should be done, through a review of the literature, by local committees who will implement the resulting policies. These recommendations apply to normal, healthy, full-term infants and are not intended to apply to the specific needs of high-risk infants.

There are few maternal conditions that preclude infant breastfeeding; examples include HIV positive serology and chemical dependency. Active protection of each mother's milk supply is recommended for conditions that are temporary such as maternal separation and chemotherapy.

We welcome your feedback and suggestions and wish you well in your efforts to offer the best support for mothers and infants.

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**RECOMMENDATIONS FOR SUCCESSFUL DEVELOPMENT
AND
IMPLEMENTATION OF HOSPITAL POLICIES ON BREASTFEEDING**

1. Create an interdisciplinary team to review and strengthen breastfeeding policies. This team should include members who:
 - a. support breastfeeding
 - b. understand the breastfeeding process
 - c. represent the cultures of the community they serve.
2. Revise hospital breastfeeding policies as they come up for review.
3. Review the literature prior to making recommendations to the hospital policy committee.
4. Recognize that these policy recommendations are intended as a guide and should be adapted to fit your hospital's needs. The Inland Empire Breastfeeding Coalition has made broad recommendations that may not fit every situation.
5. Implementation of new or revised policies should be accompanied by staff education, patient education materials, and ongoing support, and reinforcement of, the new policies.

Inland Empire Breastfeeding Coalition

SUMMARY OF MODEL HOSPITAL POLICY RECOMMENDATIONS

PURPOSE: These policy recommendations are designed to give basic information and guidance to perinatal professionals who wish to revise policies that affect the breastfeeding mother. Rationale and references are included as education for those unfamiliar with current breastfeeding recommendations. When no reference is available, the interventions recommended are considered to be best practice as determined by consensus of the Inland Empire Breastfeeding Coalition.

Policy #1: Hospitals should promote and support breastfeeding.

Policy #2: Nurses, certified nurse midwives, physicians and other health professionals with expertise regarding the benefits and management of breastfeeding should educate pregnant and postpartum women when the opportunity for education exists, for example, during prenatal classes, in clinical settings, and at discharge teaching.

Policy #3: The hospital will encourage medical staff to perform a breast exam on all pregnant women and provide anticipatory guidance for conditions that could affect breastfeeding. Breastfeeding mothers will have an assessment of the breast prior to discharge and will receive anticipatory guidance regarding conditions that might affect breastfeeding.

Policy #4: Hospital perinatal staff should support the mother's choice to breastfeed and encourage exclusive breastfeeding for the first 6 months.

Policy #5: Nurses, certified nurse midwives, and physicians should encourage new mothers to hold their newborns skin to skin during the first two hours following birth and as much as possible thereafter, unless contraindicated.

Policy #6: Mothers and infants should be assessed for effective breastfeeding. Mothers should be offered instruction in breastfeeding as indicated.

Policy #7: Artificial nipples and pacifiers should be discouraged for healthy, breastfeeding infants.

Policy #8: Sterile water, glucose water, and artificial milk should not be given to a breastfeeding infant without the mother's informed consent and/or physician's specific order.

Policy #9: Mothers and infants should be encouraged to remain together during the hospital stay.

Policy #10: At discharge, mothers should be given information regarding community resources for breastfeeding support.

EXPANDED HOSPITAL POLICY #1

Hospitals should promote and support breastfeeding.

INTERVENTION/MANAGEMENT	RATIONALE
<p>1.1 Form an interdisciplinary, culturally appropriate team comprised of hospital staff including; administrators, medical staff, nursing staff, perinatal health educators, lactation specialist/consultants, and registered dietitians. Team members should join together to reduce institutional barriers to breastfeeding, such as mother-infant separation, fragmentation of care and routine supplementation. This team will be responsible for</p> <p>1.1.1 developing, implementing, and monitoring hospital policies and practices.</p> <p>1.1.2 ensuring ongoing education for all staff.</p> <p>1.1.3 performing an evaluation based on guidelines similar to the <i>Baby-Friendly Hospital Initiative Self Appraisal Tool</i>.²</p> <p>1.1.4 assuring support for pregnant and breastfeeding patients and hospital staff.</p>	<p>1.1 A multidisciplinary task force can bring a variety of perspectives. 4,8,9,10,19,20</p> <p>1.1.3 Ongoing evaluation will assist the team in program implementation and planning. 2,6,7,12</p> <p>1.1.4 Information from local experts and patients using the services will often be helpful.</p>
<p>1.2 Team members should review the <i>International Code of Marketing Breastmilk Substitutes</i>.</p>	<p>1.2 International concern exists regarding the marketing practices of artificial infant milk manufacturers. Accepting educational grants, teaching materials, gratuities, and gifts from artificial infant milk companies may indirectly endorse artificial infant milk. 1,24,25,26</p>

INTERVENTION/MANAGEMENT	RATIONALE
<p>1.3 The team should designate a member to be responsible for assessing needs, planning and monitoring interventions, implementing, and updating competency-based training in breastfeeding for all staff caring for mothers, infants, and/or children.</p>	<p>1.3 Ongoing training is essential to maintain staff competency. The level of competency required and/or needed should be based on staff functions, responsibilities, and previously acquired training, and should include documentation that essential competencies have been mastered.^{3,5,11,13,21,22,23}</p>
<p>1.4 All hospital departments serving mothers, infants, and/or children should have written breastfeeding policies that are routinely communicated to all health care staff, beginning with hospital orientation.</p>	<p>1.4 Ongoing reinforcement of policies is essential to maintain competence.^{17,20}</p>
<p>1.5 Nurses coming in contact with mothers, infants or children should receive standardized education and training on the support and management of lactation. Lactation management should be included as part of orientation and included as part of ongoing training and competency evaluation for both nurses and physicians.</p>	<p>1.5 Training will assist nurses in using common terms and standard recommendations.</p> <p>Mothers are often confused and frustrated when receiving varying advice. Eighteen hours of education (15 didactic, 3 clinical) is the minimum amount of lactation training recommended by the World Health Organization (WHO).^{5,11,12}</p>
<p>1.6 Hospitals should demonstrate support for breastfeeding by fostering the formation of breastfeeding support groups.</p> <p>1.6.1 Hospital administration should provide space and/or cover operational costs to support local community lactation support groups or hospital-based breastfeeding support groups.</p>	<p>1.6. Ongoing peer support groups lead to increased success and increased duration of breastfeeding.^{15,16,18,23} (note policy #10).</p>

INTERVENTION/MANAGEMENT	RATIONALE
<p>1.7 Hospitals, as employers, should demonstrate support for breastfeeding employees by providing education and assistance to pregnant and lactating staff. Employers should provide a clean, comfortable break space and time to express milk for hospital staff who are breastfeeding mothers and should consider offering</p> <p>1.7.1 electric breast pumps for hospital staff use.</p> <p>1.7.2 extended maternity or paternity leave.</p> <p>1.7.3 on-site child-care for breastfeeding infants of hospital staff.</p> <p>1.7.4 private space and time for the mother to nurse her baby during breaks.</p>	<p>1.7 Workplace environments that support breastfeeding facilitate continuation of breastfeeding.^{20,21,23,25}</p> <p>1.7.4 California state law requires employers to provide a private space other than a toilet stall and a reasonable amount of unpaid time (if it is not concurrent with usual break time) for breastfeeding mothers to express milk.¹⁴</p>

POLICY #1

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EXPANDED HOSPITAL POLICY #2

Nurses, certified nurse midwives, physicians and other health professionals with expertise regarding the benefits and management of breastfeeding should educate pregnant and postpartum women when the opportunity for education exists, for example, during prenatal classes, in clinical settings, and at discharge teaching.

INTERVENTION/MANAGEMENT	RATIONALE
<p>2.1 Pregnant and postpartum women should be provided information prior to birth, following birth, and before discharge regarding the benefits and management of breastfeeding and the risks associated with artificial feeding. This information should include how to maintain lactation when separated from their infants. Classes and teaching materials should be selected which consider the woman's cultural background, education and preferred language.</p>	<p>2.1 Knowledge and support improve the breastfeeding experience. Most women make their decision about breastfeeding prior to delivery. 2,6,7,8,9,10,15,20,21,23</p>
<p>2.2 Education should be provided using a combination of techniques such as one-to-one teaching, group classes, pamphlets and/or video taped instruction. Hospitals should work with prenatal providers to inform and encourage pregnant women and their partners to attend available breastfeeding classes during the prenatal period.</p>	<p>2.2 Consistency of information provides a similar frame of reference. The mother can refer to educational materials during and after her hospital stay to reinforce learning. 12,16,19,24</p>
<p>2.3 Classes, pamphlets and videos should reflect the cultural background, education, and language of the population being served.</p>	<p>2.3 Understanding the cultural and socioeconomic context of infant feeding practices is necessary to provide clients with relevant education. 5,21</p>

INTERVENTION/MANAGEMENT	RATIONALE
2.4 Materials that promote the use of commercial products known to interfere with breastfeeding should not be used to teach breastfeeding.	2.4 All materials used for breastfeeding promotion and education should be produced by companies whose interests are not in conflict with the promotion of breastfeeding. ²⁰
2.5 Teaching methods should be tailored to the age of the client.	2.5 Teens may prefer alternative learning opportunities such as field trips, games and videos when appropriate. ⁴
2.6 Regardless of feeding choice, discharge teaching should include the benefits of keeping the baby in close physical proximity. As part of the continuum of care, mothers should be provided discharge education on sleeping with their infants.	2.6 When mothers and babies are in close proximity, mothers are able to identify their infants' hunger cues and readiness to feed. ^{2,4,15,16,19,20} The American Academy of Pediatrics (AAP) guidelines regarding parents sleeping with their infants should be followed. ³
2.7 Physicians should be encouraged to support breastfeeding enthusiastically, according to the recommendation of the American Academy of Pediatrics, and should educate patients based on AAP guidelines.	2.7 Physicians can influence their patients' health behavior choices during the perinatal period. ^{22,23} Many professional organizations actively encourage breastfeeding including the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, American College of Nurse-Midwives, the American Hospital Association, the Association of Women's Health, Obstetric and Neonatal Nurses and the American Dietetic Association. ¹
2.8 Mothers should be instructed in a method of hand expression of breastmilk. Instruction should be offered to all mothers regardless of feeding choice, prior to hospital discharge.	2.8 Breastfeeding women may have unexpected separations from their newborns. Hand expression is the easiest way to empower new mothers to manage normal breastfeeding emergencies. Hand expression may produce more milk due to the breast massage and skin contact. ¹⁷ Non breastfeeding mothers may require relief from engorgement.

INTERVENTION/MANAGEMENT	RATIONALE
<p>2.9 The breastfeeding mother should be instructed in the correct use of a hospital grade electric breast pump by an experienced perinatal caregiver when the infant consistently demonstrates inadequate suckling or when prolonged separation of the mother and infant is expected because of prematurity or illness. The mother should be given the opportunity to pump as soon after birth as medically feasible.</p>	<p>2.9 Feeding the infant expressed milk validates the mother's efforts and provides health benefits to the baby.^{11,13,15}</p> <p>2.9.1 The electric pumping system is time-saving for the mother. Piston electric pumps attempt to imitate the suckling cycle of the infant.^{11,13,15,18}</p> <p>2.9.2 Breast stimulation and breast emptying are necessary to initiate and maintain lactation.⁹</p> <p>2.9.3 Following a protocol for pumping helps maintain consistency of technique and information between care providers.</p>
<p>2.10 Discharge planning for breastfeeding mothers who are likely to be separated from their infants should include methods of expressing breastmilk including hand expression and/or pumping. A support person should be included in the teaching process.</p>	<p>2.10 Emphasize the importance of regular breast expression in maintaining lactation. Pumping frequency and length guidelines are based on the method of expression, taking into account baby's age and mother's ability to maintain enough volume to support her infant's needs. If her supply begins to decrease, increased frequency and duration of pumping may increase production. Mothers who have support are likely to sustain pumping for a longer period of time.^{14,17,18,20}</p>

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EXPANDED HOSPITAL POLICY #3

The hospital will encourage medical staff to perform a thorough breast exam on all pregnant women and to provide anticipatory guidance for conditions that could affect breastfeeding. Breastfeeding mothers will have an assessment of the breast prior to discharge and will receive anticipatory guidance regarding conditions that might affect breastfeeding.

INTERVENTION/MANAGEMENT	RATIONALE
<p>3.1 The perinatal caregiver should examine the breast to assess</p> <ul style="list-style-type: none"> • previous breast surgery. • nipple protractility. • progressive breast enlargement during pregnancy. • breast pathology. • skin condition. • lesions (herpes, yeast, etc). <p style="padding-left: 40px;">This assessment should be documented in the patient chart.</p>	<p>3.1 Perinatal caregivers should identify and document mother’s breast abnormalities prior to birth and postpartum, and provide appropriate anticipatory guidance and resources.^{1,2,3,4,5,6}</p>
<p>3.2 Both a visual and palpation exam needs to be performed by the primary caregiver(s).</p>	<p>3.2 A thorough breast exam is imperative to ensure successful breastfeeding and will enable the clinician to help the mother avoid or circumvent problems that may otherwise interfere with breastfeeding.³</p>

POLICY # 3

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EXPANDED HOSPITAL POLICY #4

Hospital perinatal staff should support the mother's choice to breastfeed and encourage exclusive breastfeeding for the first 6 months.

INTERVENTION/MANAGEMENT	RATIONALE
<p>4.1 During the hospital stay, an atmosphere that supports exclusive breastfeeding should be encouraged and supported. Interventions may include</p> <ul style="list-style-type: none"> • educating, evaluating and providing appropriate assistance to breastfeeding mothers . • avoiding routine feedings of artificial infant milk and other non-mother's milk fluids to breastfeeding infants (Refer to Policy #8). • educating the breastfeeding mother on the rationale for exclusive breastfeeding during the first six months. • counseling breastfeeding mothers who choose to supplement, on the importance of exclusive breastfeeding and the risks of early introduction of artificial infant milk. • requiring staff to demonstrate competency in lactation support, as defined by the institution. 	<p>4.1 Exclusive breastfeeding during the first six months is associated with optimal infant growth and development ^{3,13,18,19,22,39,43,45} and maternal health. ^{4,10,17,23,35}</p> <p>4.1.1 Encouraging exclusive breastfeeding during the first few weeks aids in the establishment of an adequate milk supply and appropriate breastfeeding technique. ^{7,11,24,26}</p> <p>4.1.2 Consistent information regarding breastfeeding, increases the likelihood of positive breastfeeding outcomes. ^{3,28,44}</p> <p>4.1.3 Nurses, doctors, pharmacists and registered dietitians should be knowledgeable of, and demonstrate compliance with, the American Academy of Pediatrics' policy statement on breastfeeding and the Surgeon General's goal for the nation. ³</p>
<p>4.2 The mother's circle of support should be included in the lactation education and decision making process. Staff should assist the family in making an informed infant feeding choice.</p>	<p>4.2 Nurses and doctors promote breastfeeding by identifying and including people who influence the mother's feeding choice. These may include the father of the baby, other family members, and friends. ^{8,20}</p>

INTERVENTION/MANAGEMENT	RATIONALE
<p>4.3 Nurses, certified nurse midwives and physicians should discuss current recommendations with new mothers regarding the specific medical risks of artificial infant milks to the infant.</p> <p>Most research has been done regarding the specific risks of cow-based and soy-based milks. It is assumed that other non-human milk sources pose risks for human infants. Species specificity of mammalian milks is well established. There is no evidence to assume that milk of any other species is without risk as a food for human babies.</p>	<p>4.3 Mothers should be well informed in order to make knowledgeable choices about feeding.^{7,29}</p> <p>4.3.1 Known risks associated with introduction of artificial infant milk may</p> <ul style="list-style-type: none"> • increase the risk of diarrhea, upper respiratory infections and otitis media.^{3,22} • provide less than optimal nutritional composition for central nervous system development.^{4,42} • increase the risk of juvenile diabetes^{3,22} some allergies^{3,24,44}, and the risk of Sudden Infant Death Syndrome.^{3,22} • increase the risk of Crohn’s disease, ulcerative colitis and childhood lymphomas^{3,22} and alter the flora of the baby’s gut.^{22,32} • decrease infant’s interest in nursing because of longer gut transit time compared to breastmilk.³⁰ • contribute to childhood obesity.^{5,9,15,16,32} <p>4.3.2 Routine use of soy-based artificial infant milk, in lieu of breastfeeding or cow-based artificial infant milk, is not recommended. Multiple concerns regarding soy have led the American Academy of Pediatrics to advise against the routine use of soy-based artificial infant milk. Soy based formulas should only be considered when there is a specific medical indication such as galactosemia or hereditary lactase deficiency.²</p>

INTERVENTION/MANAGEMENT	RATIONALE
	<p>Specific risks of soy-based artificial infant milk are listed below.</p> <ul style="list-style-type: none"> • Soy is at least as allergenic as cow milk.^{2,25} Soy is associated with a poorer response to vaccinations compared with breastmilk.³⁷ Soy-fed infants have a higher rate of illness than breastmilk fed infants.⁴³ • Soy-based artificial infant milk contains much higher levels of isoflavone (estrogen-like compounds) than maternal milk, and results in infant plasma levels of these compounds 200 times those of infants fed maternal milk. The health effects of prolonged exposure to these compounds are unknown.^{40,41} • Soy-based artificial infant milk has a relatively high content of aluminum (which competes with calcium for absorption and may contribute to osteopenia), and is not recommended for preterm infants < 1800 g. or infants with intrauterine growth restriction.² • Soy-based artificial infant milk contains much higher levels of manganese than human milk, but multiple infant and artificial milk factors raise questions as to whether infants fed on available soy-based products receive too little or too much manganese and other trace elements.³³ <p>4.3.3 Goat milk is not recommended as infant food.</p> <ul style="list-style-type: none"> • Initial studies show goat milk to be at least as problematic as modified cow milk substitutes. • The basic composition of goat milk is unlike that of human milk and would require modification to have protein content similar to that of human milk.

INTERVENTION/MANAGEMENT	RATIONALE
	<ul style="list-style-type: none"> Clinical and laboratory studies have shown allergic reactions to goat milk in nearly 100% of children allergic to cow milk.^{6,39}
<p>4.4 Nurses, certified nurse midwives and physicians should share current recommendations with new mothers regarding the specific nutritional and medical risks of early introduction of water or glucose water. Patient education should also include cautioning against the use of infant teas and electrolyte replacement fluids (Refer to Policy # 8 for a discussion of supplementation).</p>	<p>4.4 Rationale for avoiding introducing water or glucose water to the infant follows.</p> <p>4.4.1 Higher protein levels in colostrum have a more stabilizing effect on blood glucose levels than glucose water.^{30,32,34.}</p> <p>4.4.2 Glucose water with 6 kcal/oz can give the infant a sense of fullness without providing adequate nutrition (colostrum and breastmilk provide 17-20 kcal/oz).²⁴</p> <p>4.4.3 Water supplements have not been shown to prevent or ameliorate hyper-bilirubinemia in the neonatal period.^{1,30,32}</p>
<p>4.5 Nurses, certified nurse midwives, physicians and registered dietitians should educate breastfeeding mothers regarding the risks of introducing artificial infant milk and artificial nipples in order to optimize exclusive breastfeeding. Bottles should not routinely be placed in babies' cribs, care supplies, and/or mothers' rooms.</p>	<p>4.5 Mothers are likely to follow recommendations given by perinatal professionals. Supplementation during this time will decrease the likelihood that extended breastfeeding will occur.^{12,24,26,36,44}</p> <p>(Refer to Policy #7 for a discussion of the relationship between pacifiers, breast stimulation & milk production).</p>
<p>4.6 Information regarding the cost of purchasing artificial infant milk should be provided.</p>	<p>4.6 Artificial milks are expensive and less convenient than breastmilk.³</p> <p>4.6.1 Formula needs to be prepared carefully and with consistent accuracy to provide adequate nutrition to the infant. Pre-mixed formulas available in the hospital are often not available to the new mother after discharge. Therefore, non-breastfeeding mothers should be instructed and observed to assure competency with formula preparation.</p>

INTERVENTION/MANAGEMENT	RATIONALE
<p>4.7 The mother’s health status should be considered in relation to HIV serology, chemical dependency, chemotherapy treatments and other medical conditions or therapies where breastfeeding may be contraindicated.</p>	<p>4.7 Certain maternal conditions may preclude breastfeeding.</p> <p>4.7.1 Breastfeeding is contraindicated for HIV positive mothers in the United States. The risks of vertical transmission of infection to the infant via mother’s milk, and/or exposure to life-long medication, appear to exceed the risks of artificial infant milk feeding.^{31,32}</p> <p>4.7.2 Breastfeeding is contraindicated for mothers receiving chemotherapy.^{31,32}</p> <p>4.7.3 Breastfeeding is contraindicated for women who are positive for Human T Cell Leukemia Virus (HTLV-1 and HTLV-2).³¹</p>
<p>4.8 Medical conditions that may require extra counseling and supervision or a change from a less desirable to a more desirable medication in a given class, should be addressed.</p>	<p>4.8 Breastfeeding may be supported in other maternal conditions.</p> <p>4.8.1 Maternal Hepatitis A infection does not put the infant at risk for clinical disease, though the infant and mother should receive gammaglobulin.^{4,31}</p> <p>4.8.2 Breastfeeding is not contraindicated in infants of mothers who have active Hepatitis B, though these infants must be given Hepatitis B immune globulin and Hepatitis B vaccine as soon as possible postpartum.^{4,31}</p> <p>4.8.3 Mothers infected with hepatitis C virus (HCV) “should be counseled that transmission of HCV by breastfeeding is theoretically possible, but has not been documented. According to current guidelines of the US Public Health Service, maternal HCV infection is not a contraindication to breastfeeding. The decision to breastfeed should</p>

INTERVENTION/MANAGEMENT	RATIONALE
	<p>be based on informed discussion between a mother and her health care professional.”^{3,38}</p> <p>4.8.4. For other medical conditions or therapies, refer to a reliable reference to weigh the risks and benefits of breastfeeding.^{21,27,29,31}</p>
<p>4.9 Nurses, certified nurse midwives, physicians and registered dietitians should discuss exclusive breastfeeding with mothers and provide written material and specific resources for follow-up. The information should include normal breastfeeding patterns and normal output of urine and stool. Mothers should receive a tool to assess adequate feeding/output, e.g. feeding log.</p>	<p>4.9 Mothers who are encouraged to exclusively breastfeed need support and available resources in the event that early breastfeeding complications occur.^{20,29}</p> <p>The newborn can suffer from dehydration, hyperbilirubinemia and electrolyte imbalances if exclusive breastfeeding does not progress normally.^{1,3,4,11,14}</p>
<p>4.10 “All breastfeeding newborn infants should be seen by a pediatrician or other knowledgeable and experienced health care professional at 3-5 days of age as recommended by the AAP.”³</p>	<p>4.10 “Weight loss in an infant of greater than 7% from birth weight indicates possible breastfeeding problems and requires more intensive evaluation of breastfeeding and possible intervention to correct problems and improve milk production and transfer.”³</p>

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EXPANDED HOSPITAL POLICY #5

Nurses, certified nurse midwives, and physicians should encourage new mothers to hold their newborns skin to skin during the first two hours following birth and as much as possible thereafter, unless contraindicated.

INTERVENTION/MANAGEMENT	RATIONALE
<p>5.1 Assuming baby and mother are stable, the mother and baby should be skin-to-skin during the first several hours following birth. This includes the post-cesarean mother and baby, when alert and stable.</p> <p>5.1.1 Babies are usually most ready to breastfeed during the first hour following birth. For the normal newborn this should occur prior to such interventions as: the newborn bath, glucose sticks, foot printing, and eye treatments.</p> <p>5.1.2 During the first day of life, skin-to-skin time and breastfeeding should take priority over other routine events such as infant bathing, pictures, and visitors.</p>	<p>5.1 Mothers should be permitted to engage in this normal physiological process, regardless of birth method, as long as medically stable. Post-cesarean mothers can still engage in breastfeeding. Temperature stabilization will almost always occur best with the baby in skin-to-skin contact on the mother's chest, with a blanket covering the infant and mother. ^{1,2,4,5,8,9}</p> <p>5.1.1 The normal infant has a strong suck reflex during the first 20-30 minutes post-birth. Disturbing the mother and infant during this time can make it difficult for the infant to learn the suckling process. ^{7,11,12}</p> <p>5.1.2 Separation of mother and baby for routine procedures may be distracting and interfere with breastfeeding initiation unnecessarily. Organizing nursing care to focus on keeping the mother and newborn together will increase the opportunities for the newborn to demonstrate feeding readiness. ^{3,10,13}</p>

INTERVENTION/MANAGEMENT	RATIONALE
<p>5.1.3 If breastfeeding is delayed due to medical condition(s) of mother or baby, the baby should be put skin-to-skin and allowed to approach the breast as soon as possible after they are stable.</p> <p>5.1.4 The baby should be encouraged to breastfeed without restriction.⁷</p> <p>5.1.5 Nursing policies and practices should support care of the mother and infant together and should be documented in nursing charting.⁷</p> <p>(Refer to Policy #9 for safety considerations)</p>	<p>5.1.3 Early suckling allows the infant to receive the immunologic benefits of colostrum.⁷ Colostrum also stimulates digestive peristalsis of the infant. Suckling stimulates uterine involution and inhibits bleeding for the mother.^{6,7}</p> <p>5.1.4 Restricting breastfeeding may increase the degree of physiological breast engorgement that occurs during the transitional milk phase.</p>

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EXPANDED HOSPITAL POLICY #6

Mothers and their infants should be assessed for effective breastfeeding and mothers should be offered instruction in breastfeeding as needed.

INTERVENTION/MANAGEMENT	RATIONALE
<p>6.1 Nurses, certified nurse midwives and physicians should assist the mother with breastfeeding and provide guidance and support.</p> <p>6.1.1 When an assessment identifies a dysfunction or the infant displays signs of inadequate intake, a lactation consultation should be ordered.</p> <p>6.1.2 A functional reassessment of the infant at the breast should be performed by a trained physician, certified nurse midwife, nurse, or lactation specialist within 8 hours of birth, by utilizing an assessment tool (FAIB or LATCH) and at least once every 8 hours while in the hospital.</p>	<p>6.1 New mothers need consistent information and assistance in recognizing an adequate feeding.^{2,3,9}</p> <p>6.1.1 An assessment provides for early identification of latch-on difficulties and direct observation of the infant at breast to assure adequate breastfeeding prior to discharge.^{4,7,12}</p> <p>6.1.2 Although scoring can be misleading and inconsistent, assessment tools can help the provider identify areas of need for intervention.^{1,13,14,15}</p>
<p>6.2 Pillows should be available to support mother's arms and bring the baby to breast level.</p>	<p>6.2 Nipple trauma can be prevented and nipple soreness minimized with proper attachment and positioning. Support and comfort of the mother and baby prevents fatigue and facilitates proper positioning of the baby at breast.^{5,6,10,17}</p>
<p>6.3 Nurses, certified nurse midwives, and physicians should respond to complaints of nipple soreness by assessing the source of the discomfort and assisting the mother in resolving the problem.</p>	<p>6.3 Physiological nipple tenderness may occur during the first few minutes of a feeding and eases during the same feeding.^{8,10}</p>

INTERVENTION/MANAGEMENT	RATIONALE
	Nipple soreness is considered abnormal when a mother complains of nipple soreness throughout an entire feeding or between feedings. 5,10,12,16
6.4 Mothers should be educated on the “supply and demand” principle of milk production.	6.4 Understanding of basic physiology enhances the lactation process. ^{2,3}
6.5 Frequency and duration of feedings at the breast should be infant-led. Non-timed feedings and cue-based offerings will be the basis for mother-infant care. The infant needs to have active suckling and swallowing time at the breast during each feeding.	6.5 It often takes 1½-2 minutes after the onset of suckling for oxytocin release and subsequent milk ejection reflex. At times it may take as long as 6-10 minutes for oxytocin release. Limiting suckling time has not been shown to reduce nipple soreness or trauma and may result in a decreased milk supply and a delay of lactogenesis. ^{8,17,9,10}
<p>6.6 Mothers should be assisted in identifying infant’s hunger cues and readiness to feed.</p> <p>6.6.1 Breastfeeding according to baby’s cues should be supported by nurses and physicians who will help mothers respond to those cues.</p> <p>6.6.2 Mothers should be encouraged to monitor their own and the infant’s signs of adequate/inadequate intake and output.</p> <p>6.6.3 If the nurse or physician is concerned with the baby’s intake before discharge, consultation should be sought and the problem defined and addressed prior to discharge.</p>	<p>6.6 Newborns should be breastfed whenever they show signs of hunger such as increased alertness or activity, mouthing or rooting, rapid eye movement sleep, and hand-to-mouth movement.</p> <p>6.6.1 Infants are more organized in their behavior and will breastfeed more successfully if they are not crying. Crying is a late sign of hunger.</p> <p>6.6.2 Breastmilk is digested in approximately 90 minutes.¹⁰ Eight to twelve feedings every 24 hours has been associated with increased meconium passage and lower serum bilirubin levels in the infant.</p> <p>6.6.3 Maternal prolactin levels fall three hours after breastfeeding. Frequent and early feedings enhance duration of breastfeeding and enhance milk production. It is within</p>

INTERVENTION/MANAGEMENT	RATIONALE
	<p>normal range for babies to “cluster feed” by feeding several times close together and then going several hours without feeding. Normal, healthy newborns may breastfeed every hour, or several times in one hour, during the first days of life. 4,9,10,11,17</p>
<p>6.7 The nurse, certified nurse midwife or physician should discuss the importance of colostrum with the mother. After appropriate education, however, a mother who feels very uncomfortable giving colostrum should be encouraged to pump and may discard the colostrum. This may be all that is needed to ensure an adequate beginning with breastfeeding. The nurse, certified nurse midwife, or physician should be aware of cultural differences regarding colostrum and be trained to address these issues sensitively.</p>	<p>6.7 Some mothers may choose not to initiate early breastfeeding due to misinformation about the nature of colostrum. Some nurses and physicians have reported that encouraging mothers to express and discard a small amount of the first milk has sufficed to get breastfeeding started.³</p>

POLICY # 6

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EXPANDED HOSPITAL POLICY #7

Artificial nipples and pacifiers should be discouraged for healthy breastfeeding infants.

INTERVENTION/MANAGEMENT	RATIONALE
<p>7.1 Pacifiers should not be given to breastfeeding infants. Mothers should be encouraged to breastfeed frequently in response to hunger cues.</p>	<p>7.1 Breast stimulation is critical to milk production. When an infant needs to suck, in the first days of life, the breast should be offered. The use of pacifiers may shorten the duration of breastfeeding.^{1,4,5,6,7,11,12,13}</p> <p>Introducing artificial nipples</p> <ul style="list-style-type: none"> • is associated with decreased duration of breastfeeding.^{1,4,5,8,14} • may prevent establishing of milk supply. • may prevent optimal tooth, jaw and speech development. • may encourage the infant to suck incorrectly, since on an artificial nipple the baby will be rewarded even for a physiologically incorrect suck. This is sometimes referred to as “nipple preference.”^{3,8} • is associated with increased risk of otitis media.^{9,10}
<p>7.2 Mothers can be encouraged to hold and breastfeed their infants during routine painful procedures such as heel sticks and intra-muscular injections. If the mother chooses not to breastfeed during the painful procedure, a pacifier may be used and discarded after the procedure.</p>	<p>7.2 Infants breastfeeding during painful procedures demonstrate greatly diminished or zero response to pain.²</p>

POLICY #7

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EXPANDED HOSPITAL POLICY #8

Sterile water, glucose water, and artificial milk should not be given to a breastfeeding infant without the mother's informed consent and/or physician's specific order.

INTERVENTION/MANAGEMENT	RATIONALE
<p>8.1 Breastfeeding infants should be given only breastmilk, unless specifically ordered for a clinical condition by the physician or with the mother's informed consent.</p>	<p>8.1 Colostrum and breastmilk completely meet the normal newborn's nutritional and fluid needs (provides 67 to 75 kcal/dl).⁵ Colostrum is the least noxious substance if aspirated.^{4,5}</p> <p>8.1.1 Water interferes with breastfeeding and fills the baby with non-nutritive fluid so that the baby is not hungry. There is no medical or nutritional value to water. Water decreases the frequency of breastfeeding, which in turn decreases the mother's milk supply.⁴</p>
<p>8.2 When supplementation is medically indicated, an alternate feeding method should be utilized to maintain mother-infant breastfeeding skills. Alternate feeding methods include cup, dropper, gavage, finger or syringe.</p> <p>8.2.1 Artificial feeding should not exceed the physiologic capacity of the newborn stomach.</p>	<p>8.2 Some infants may have difficulty transitioning between an artificial nipple and the breast. Alternate feeding methods may be helpful in maintaining breastfeeding skills.^{2,3,6}</p> <p>8.2.1 Care should be taken not to exceed the physiologic capacity of the newborn stomach. In the first few days of life, volumes of less than 20cc should be given at each feeding.^{3,7}</p>
<p>8.3 Education regarding supplementation should be presented prior to obtaining consent for supplementation Risks of introducing artificial infant milk and/or water to the newborn should be discussed with the mother prior to</p>	<p>8.3 Mothers should be made aware of potential risks to the infant who receives artificial infant milk, or water, or is fed by artificial feeding methods.^{1,5}</p>

POLICY #8 REFERENCES

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EXPANDED HOSPITAL POLICY #9

Mothers and infants should be encouraged to remain together during the hospital stay.

INTERVENTION/MANAGEMENT	RATIONALE
<p>9.1 Babies should be cared for at their mothers' bedside. Both the mother and family should be encouraged to assist with infant care.</p>	<p>9.1 Bonding, adaptation to extra-uterine life, and attachment are facilitated by the infant being with the mother.</p> <p>9.1.1 If mother and infant are separated there is increased potential for supplementation with artificial milk.</p> <p>9.1.2 Caring for mother and baby together provides the opportunity for individualized teaching and enhances the mother's ability to learn her baby's cues. ^{1,4,6,7,8,12}</p>
<p>9.2 Both the mother and the family should be educated that rest and recovery for the mother and infant is vital.</p> <p>9.2.1 The nurse's role is to protect the dyad from disturbances that impact their ability to recover.</p> <p>9.2.2 Night feeding should be explained as a normal and healthy pattern for the infant.</p>	<p>9.2 Rest is an important physiologic and psychological need for all postpartum, lactating mothers.</p> <p>9.2.1 With liberalized visiting hours, there may be limited time for mothers to rest unless naps are planned. ^{2,3,4,9,10,11}</p> <p>9.2.2 Often mothers anticipate their infant will "sleep through the night" long before the infant is physiologically ready. This can create conflict between the mother's beliefs and the infant's behavior.</p>

INTERVENTION/MANAGEMENT	RATIONALE
<p>9.3 If, after encouragement to room in, the mother 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 every three hours, whichever comes first. If the mother chooses not to breastfeed at night, she should be educated on the potential for breast engorgement.</p>	<p>9.3 Prolactin levels are highest at night and may contribute to optimal breastfeeding. Rooming-in provides additional opportunities for mothers and babies to establish effective nursing patterns prior to discharge. 3,4,6,9,10,12</p>
<p>9.4 Evidence of patient teaching and professional recommendations should be documented in the patient's chart.</p> <p>9.4.1 An informed consent for supplementation plus a statement indicating the mother's request not to breastfeed during the night should be included in the patient chart.</p>	<p>9.4 The mother needs to clearly understand the risks of the introduction of artificial nipples, early introduction of artificial infant milk, and failure to optimally provide colostrum to the newborn.</p> <p>9.4.1 Due to potential complications for mother and baby related to early supplementation of the breastfed infant, informed consent is essential.</p>
<p>9.5 If the mother is unable or refuses to feed her infant during the night, the infant should be fed in a manner that is consistent with preserving breastfeeding and reflects the skills and knowledge of the perinatal caregivers in consultation with the infant's physician. Alternative feeding methods such as cup, finger, or tube feedings should be used to provide adequate calories to the newborn. Alternative feedings should include colostrum or breastmilk, if available. The use of pacifiers, bottles with artificial nipples and water feedings are discouraged (note policies #7 and #8).</p> <p>9.5.1 Mothers who receive sedative drugs, are out of the room for surgical procedures, or have an altered state of alertness should not bed-in with their newborn.</p>	<p>9.5 California law and hospital regulations, require a safe place for the infant to be during the hospital stay. If the mother chooses not to participate in rooming-in or chooses not to breastfeed her baby during the night, it is the responsibility of the nurses, in consultation with the patient's physician, to provide care that will best promote the long-term health of the mother and infant.^{5,7,10}</p> <p>9.5.1 The safety of the infant is paramount.</p>

POLICY #9

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EXPANDED HOSPITAL POLICY #10

At discharge, mothers should be given information regarding community resources for breastfeeding support.

INTERVENTION/MANAGEMENT	RATIONALE
<p>10.1 Breastfeeding mothers should routinely be referred to a breastfeeding support group and given the telephone number of a lactation specialist or community resource for breastfeeding assistance.</p>	<p>10.1 Discharge often occurs before breastfeeding is well established. 1,4,6,7,8,9,10,11</p>
<p>10.2 If a gift pack is provided, it should be appropriate for breastfeeding or formula feeding mothers. Many gift packs provided in the hospital contain items that discourage breastfeeding mothers. Commercial advertising of artificial infant milk or promotional packs should not be given to breastfeeding mothers.</p>	<p>10.2 Hospitals should carefully consider any items they give to mothers. Providing items to patients suggests hospital endorsement of these products. Giving parents artificial infant milk or advertising/ promotional packs prepared by artificial milk companies endorses supplementation and implies that breastmilk is inadequate to meet infants' needs.^{2,3,5}</p>

POLICY #10 REFERENCES

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Link to the Model Hospital Policies Toolkit: <http://www.mch.dhs.ca.gov/programs/bfp/toolkit/default.htm>