MaineGeneral Medical Center
Maternity & Pediatrics

Breast Feeding/Breast Care

I. PURPOSE

To promote a philosophy of mother-infant care that establishes breast milk as the standard for infant feeding and supports the "Ten Steps to Successful Breastfeeding" recommended by WHO/UNICEF and The Baby-Friendly Hospital Initiative.

II. POLICY

Every mother has the right to receive current, impartial information that will enable her to make a fully informed choice, regardless of how she feeds her baby. Health care staff will not discriminate against any woman in her chosen method of infant feeding and will fully support her decision.

The board certified lactation consultants at the Maternity & Pediatrics Unit will keep up with lactation research and provide timely updates to hospital breastfeeding protocols.

Step 1: Have a written policy that is routinely communicated to all health care staff.

- The hospital will have a written breastfeeding procedure that is available with references and routinely communicated to all Maternity & Pediatrics staff and other practitioners with privileges on the Maternity & Pediatrics Unit.

- Within the first six weeks of hire, the Maternity & Pediatrics Nurse Manager, Nursing Supervisor or the Board Certified Lactation Consultant will orient new staff to the procedure through readings and discussion of each section of the procedure. The new individual will then sign off on the policy and this will be documented in their education folder.

- Under the supervision of the Nurse Manager or Nursing Supervisor of the Maternity & Pediatric Unit, the Lactation Consultants will be responsible for implementation and maintenance of the policy as well as ensure that Maternity & Pediatric Staff are trained in skills necessary to implement this procedure.

- These policies will be reviewed yearly and revised as needed. Staff will participate in yearly mandatory updates based on current evidence – based practices and quality improvement indicators and any policy revisions. This education will be documented in their education folder.

- Other policies/ procedures that are related to maternity or infant feeding will be reviewed by Maternity & Pediatric Unit staff to ensure their support of breastfeeding according to current evidence-based practice and do not conflict with any other institutional policies, nor do they hinder successful breastfeeding.

III. PROCEDURE

Step 2: Staff will be trained in skills necessary to implement this policy.

- The Maternity & Pediatric Unit staff will be required to complete 20 hours of lactation training, using The Curriculum in Support of the Ten Steps to Successful Breastfeeding including 15 of the sessions required by WHO/UNICEF plus 5 hours of supervised clinical experience.
  All new staff and providers will be trained within 6 months of hire.
  This training and verification of staff competency will be documented by the designated lactation consultant and maintained by the Maternity & Pediatrics Nurse Manager or Nursing Supervisor in the employee file on the Maternity & Pediatrics unit.

- Providers and advanced practice nurses or other practitioners with privileges on the Maternity & Pediatrics unit will complete a minimum of 3 hours of breast-feeding management education. This training will be documented.

- Annual mandatory updates to the lactation procedures will be conducted according to the Baby-Friendly Hospital Initiative guidelines or as indicated by needs-assessment and quality improvement indicators.

- Training acquired prior to employment with this facility will be accepted, upon review, verification, and receipt of certificate of completion of the 20-Hour WHO/UNICEF Ten Steps to Successful Breastfeeding Training. This is the only prior training that will be accepted for meeting the minimum competencies for all staff other than Board Certified Lactation Consultants, who will be evaluated on an individual basis with respect to the objectives of the WHO/UNICEF training. This training will be documented.

- Maternity & Pediatrics ancillary staff will receive orientation to the breastfeeding/breast care policy and The 10 Steps to Successful Breastfeeding. This orientation will be documented. All staff will also receive training on The 10 Steps to Successful Breastfeeding and lactation services available. This orientation will be documented.

Step 3: Inform pregnant women about the benefits and management of breastfeeding.

- The lactation consultants at this facility will develop the curriculum content, train and collaborate with prenatal care providers and programs in the community, such as the WIC program, to ensure they are providing individual counseling or group breastfeeding education and support. They will also participate in other community-based programs, such as statewide breastfeeding coalitions.

Maternity & Pediatrics
Level II
Breast Feeding/Breast Care

▪ The midwives, physicians, and nurses providing prenatal services are responsible for educating pregnant women about breastfeeding. This will be documented in the prenatal record and will be available upon admission. Families will receive education regarding;

1. Benefits of breastfeeding
2. Importance of exclusive breastfeeding the first 6 months
3. Non-pharmacologic pain relief methods for labor
4. Early initiation of breastfeeding
5. Early skin-to-skin contact
6. Rooming-in on a 24-hour basis
7. Baby-led feeding
8. Frequency of feeding in relation to establishing a milk supply
9. Effective positioning and latch techniques
10. Exclusivity of breastfeeding the first six months
11. Continuation of breastfeeding after introduction of appropriate complementary foods

▪ As much of this education as possible (listed above) will also be provided, as often as possible, at prenatal intakes, prenatal testing on the Maternity & Pediatrics Unit, breastfeeding classes and other pertinent out-patients and in-patient services and opportunities. (All of the listed items will be addressed in the breastfeeding class, which is part of the regular childbirth education series). This education will also be documented and accessible upon admission to the hospital. The Maternity & Pediatrics nurse or lactation consultant working in the prenatal areas will be responsible for this teaching. Documentation of this education will be kept in the patient's chart or childbirth education records.

▪ This facility offers no group education on the use of formula or infant feeding bottles. No education Materials distributed to pregnant women will contain product names, images or logos of infant formula, foods, bottles, feeding devices or other related items.

Step 4: Staff will help initiate breastfeeding within one hour of birth

▪ Newborns, regardless of mothers feeding choice, will be placed in skin-to-skin contact with mother immediately after birth, for at least one hour or until the completion of the first feeding, unless there are medically permissible reasons for postponed contact. Staff will assist mother as needed and teach her how to recognize when infant is ready to feed.

Skin-to-skin contact is defined as: *holding the baby prone right after birth, unwrapped and unclothed between the baby's front and the mother's bare chest, uninterrupted until the completion of the first feeding (or for one hour if the mother is not breastfeeding).*
A pre-warmed blanket may be placed on the outside of the mother-baby dyad.
The time that skin-to-skin begins and length of skin-to-skin contact will be documented in the infants chart. If there is a medical contraindication to skin-to-skin care, or the mother refuses, this will be documented.

Mothers who decline skin-to-skin contact will have been educated on the rationale prior to making this decision, including:

- Stabilizes newborn temperature

- Minimizes crying and grimacing
- Promotes uterine involution and decreases the risk of postpartum hemorrhage
- Normalizes infant heart rate and blood sugar
- Improves mother-infant interaction (bonding)

- If the baby requires care in the nursery due to a medical emergency, such as respiratory distress, low Apgar's, congenital anomaly, skin-to-skin will be attempted as soon as the emergency is resolved and the baby is stable.

▪ In the case of vaginal birth, the infant will be dried and immediately placed skin-to-skin with the mother. After cesarean birth, skin to skin will begin as soon as the mother is responsive and alert and will continue uninterrupted. A Maternity & Pediatrics nurse or lactation consultant will assist with the first feeding if needed and will teach the mom how to identify feeding cues. If skin-to-skin and the first feeding (or attempt) does not occur within the first hour, a reason will be documented in the baby's record.

▪ The newborn should remain with the mother throughout the recovery period.

▪ During the initial period of skin to skin contact, routine newborn procedures will be delayed until the first breastfeeding has been completed. Monitoring and assessments will be performed while infant is skin to skin with mother. If mother and infant are separated for medical reasons, skin to skin will occur as soon as possible. Additionally, skin to skin contact should be encouraged throughout the hospital stay.

▪ Infants in special care nurseries will be placed skin-to-skin as soon as the infant is considered ready. Mothers will be encouraged to hold their infant's skin-to-skin as much as possible in the special care unit.

Step 5: Show mothers how to breastfeed, and how to maintain lactation even if they are separated from their infants.

▪ Newborns should be nursed whenever they show early signs of hunger, such as increased alertness or activity, mouthing, rooting, or sucking. Mothers are to be instructed in these cues and that crying is a ***late*** hunger cue.

▪ In-Patient Education
In-patient breastfeeding mothers will be taught how to breastfeed, including:
(1) Benefits of breastfeeding and the importance of exclusive breastfeeding
(2) This facility's hospital care practices regarding infant feeding
(3) Non-pharmacological pain relief methods for labor
(4) Early initiation of breastfeeding, feeding cues (importance and identification of feeding on cue, regardless of feeding choice), how often to feed the baby based on baby-led feeding with comfortable latch (attachment) and positioning, in relation to establishing a milk supply; importance of both physical contact and nourishment
(5) Early unlimited skin-to-skin contact and rooming-in on a 24-hour basis
(6) Nutritive sucking and swallowing and other indicators of adequate intake, such as how many wet diapers and bowel movements to expect daily in the first two weeks, and normal weight gain patterns.
(7) Meeting individual goals, based on informed choices

(8) Information about breastfeeding support groups in hospital and community.
(9) Importance and definition of exclusive breastfeeding for the first six months; continuance of breastfeeding after introducing appropriate complementary foods; possible influence of early introduction of the use of bottles and pacifiers
(10) Manual expression of breast milk will be taught to all breastfeeding mothers, in addition to the use of a manual or electric breast pump if indicated for non-latching babies, separation of mother and baby, or other evidence-based medical reasons. (Refer to Supplementation Policy and Collection/Storage and Use of Breast Milk Procedure for specifics on when/how to initiate breast pumping, frequency of expression, and the proper storage and handling of breast milk.)
(11) Signs/symptoms of infant feeding issues requiring referral to the appropriate clinical care provider

- The skills (listed above) will be taught, documented, and reviewed with all breastfeeding mothers.

- A lactation risk assessment will be completed for all couplets. Staff will review and discuss the history of maternal anatomic/physiologic occurrences that may interfere with breastfeeding including but not limited to lack of noticeable breast enlargement during puberty or pregnancy, flat or inverted nipples, breast surgery, diabetes, hypothyroidism, PCOS, glandular insufficiency, and / or infertility.

- Formal evaluation of breastfeeding, including position, latch, and milk transfer will be undertaken and fully documented by lactation consultants or nurses who have completed the WHO/UNICEF lactation training.

- The assessment of the mother's techniques of demonstrating appropriate positioning and and attachment will occur optimally within three hours and no later than six hours after birth. Every feeding will be assisted, assessed and documented until effective latch is achieved, and then at least once per shift.

- Infants should be put to breast at least 10-12 times per 24 hours. Babies who are not showing feeding cues with this pattern will be gently aroused for feedings, including skin-to-skin contact. Encourage the mother to offer both breasts at each feeding, but let her know its normal if the baby only nurses on one breast for some feedings.

- If infant is stable but hasn't had an effective latch initiate hand expressions and/or breast pumping with instruction as soon as possible but no more than 6 hours after delivery. If infant continues to be unable to latch, continue hand expression and/or breast pumping every 2-3 hours.

- For infants who cannot go skin to skin immediately after delivery due to medical reason, milk expression and /or breast pumping should begin within 6 hours of the separation of mother and infant then continue every 2-3 hours. (Refer to Collection, Storage and Transportation of Human Breast Milk procedure.)

- Non-breastfeeding mothers and those who have chosen to mix feed their infants will be individually assisted to safely prepare and feed formula to their babies. Group talk/classes on the use of formula and infant feeding bottles will not be offered.

▪ Mothers choosing to formula feed, "combo feed", or will require supplementation with formula for their infant at the time of discharge will be given written instruction and verbal information to include;

(1) Appropriate hand hygiene
(2) Cleaning infant feeding items (bottles, nipples, rings, caps, syringes, cups, spoons, etc.)
(3) Appropriate and safe reconstitution of concentrated and powdered infant formulas
(4) Accuracy of measurements of ingredients
(5) Safe handling of formula
(6) Proper storage of formula
(7) Appropriate feeding methods which may include feeding on cue, frequent low volume feeds, paced bottle technique, eye-to-eye contact, and holding the infant closely
(8) Powdered infant formula is not sterile and may contain pathogens that can cause serious illness in infants younger than 3 months.

Step 6: Babies will not be given food or drink other than breast milk unless medically indicated.

▪ No supplements will be given to breastfeeding infants unless ordered by physician or per hypoglycemia protocol. If baby is NPO or unable to achieve an effective latch, refer to Supplementation Procedure.

▪ If a mother requests a pacifier or infant formula that has not been ordered by a physician, the health care provider will first explore the reasons for this. The mother will receive education regarding the possible negative consequences of using infant formula, bottles with nipples, and pacifier use, such as:

- nipple or fast flow preference
- breast refusal or ineffective latch
- sore nipples
- engorgement
- reduced milk supply
- change in normal gut flora
- shortened duration of breastfeeding

▪ After giving informed consent regarding the possible negative consequences, if she chooses to use such devices or formula, the nurse or lactation consultant will chart in the appropriate place that informed consent and education of the possible negative consequences were done.

▪ Prior to supplementing the infant, the staff will discuss the feeding options available with the mother. When a decision has been made as to the choice of alternative feeding device to be utilized, the mother will be taught how to safely administer the feeding with the device.

Step 7: All mothers and infants will room-in together, including at night.

▪ 24-hour rooming-in will apply to all mothers and infants, regardless of feeding choice. Rooming-in will begin immediately after birth, or as soon as mother and baby are both stable, and will continue until both are discharged from the hospital, except for a maximum period up to one hour for separation due to medical procedures that can't be done in the mother's room.

- If a mother requests that her baby be taken to the nursery for periods longer than one hour, or for non-medical reasons, the care provider will explore the reason for her request; educate her on the benefits of keeping her infant in close proximity, support the exclusivity of breastfeeding for infants taken to the nursery, and document all of the above (see below).

- Staff will not suggest taking the baby to the nursery so the mother can rest, except for documented medical reasons.

- If the baby is in the nursery for medical reasons, the mother will be provided access to feed her baby at any time.

- Benefits of rooming-in to be discussed include:
    - Babies kept with parents cry less than those sent to nursery
    - Promotes bonding
    - Mother learns babies cues faster and how to care for baby at night
    - Earlier milk production, less weight loss and jaundice, earlier weight gain
    - Studies show that mothers do not get more sleep with baby in the nursery
    - Security issues – babies are safer in mom's room

- As is appropriate, all routine newborn procedures will be performed at the mother's bedside.
- If normal rooming-in is interrupted, the following will be documented in the baby's chart:
    (1) Reason for the interruption
    (2) Location of the infant during the interruption
    (3) Time parameters of the interruption

Step 8: Mothers are taught to recognize their infant's feeding cues and to feed on-demand.

- Mothers will be informed of normal newborn feeding behaviors and readiness to feed such as cluster feeding, feeding through the night, and feedings of at least 10-12 in a 24-hour period.

- No limitations will be taught to mothers regarding the frequency or length of feedings.

Step 9: Pacifiers and artificial nipples will not be given by the staff to breastfeeding mothers, except for certain medical exceptions as outlined.

- The use of bottle nipples, nipple shields and pacifiers will be discouraged for all normal full-term infants.

- For medically indicated supplements, as well as non-medical supplements, informed consent will be given regarding the negative consequences using a bottle, such as nipple preference making it more difficult to breastfeed. Alternate feeding methods will be discussed (finger feeding, syringe feeding, cup feeding or supplemental feeding system.) Documentation of informed consent will be done.

- Acceptable medical reasons for pacifier use may include, mother-baby separation, non-nutritive sucking if baby is NPO, gavage feeding, and NAS infants, when other calming techniques are not working and the baby's weight is stable.

- If a mother brings in a pacifier for her infant to use, the staff will first explore reasons for wanting to use a pacifier, educate her about the possible negative consequences and document the education.

- Preterm infants or infants with medical conditions that lessen the time at the breast may be given pacifiers for non-nutritive sucking, with parent's permission. Education on these topics will be documented in the infant's chart.

Step 10: This facility will foster the establishment of breastfeeding support groups and refer mothers to them on discharge.

- Supply all mothers with phone numbers to the Maternity and Pediatrics Unit, Lactation Consultant's Office, and their provider's office to call if breastfeeding problems develop. Breast problems should be referred to the mother's provider. Feeding problems should be referred to the infant's provider.

- For general information and mother-to-mother support, encourage attendance at MaineGeneral breastfeeding support groups and other breastfeeding and parenting support groups, including but not limited to, La Leche League, WIC educational and support offerings, and other approved community based programs. Mother's will be given this information by a nurse or lactation consultant prior to discharge and this will be documented in the mother's chart. Non-MGMC patients will be allowed to participate in MGMC breastfeeding support programs.

- This facility will foster on-going development of community-based programs that make available individual counseling or group education on breastfeeding. The facility also collaborates with such programs to coordinate breastfeeding messages. Staff at this facility have provided to other organizations that offer prenatal services a sample curriculum that includes essential information to be taught to the pregnant woman regarding breastfeeding.

- One-to-one lactation consultation with a board certified lactation consultant is provided by appointment from provider referrals, self-referral, or by other health care providers. Clients who have not delivered at MaineGeneral will be accepted as outpatients for lactation care.

- A 48-72 hour follow-up appointment with the newborn's provider will be arranged prior to discharge. This appointment will be documented in the medical record and an appointment card will be provided to the newborn's caretaker. All patients will be given information about using MGMC's 24 hour warm line at time of discharge. The nurse or lactation consultant will instruct the patient regarding routine follow-up care and how to obtain referral if indicated.

- Follow-up telephone consultations will be made by the lactation consultant to all breastfeeding mothers, at least once within the first week.

- At least one hospital-employed lactation consultant will represent MaineGeneral at local and state breastfeeding coalitions, task forces, and conferences in order to assess and coordinate information and messages about breastfeeding with those of MaineGeneral's programs and local support groups.

    - The lactation consultant will maintain records of breastfeeding initiation and duration for the hospital maternity population, as well as any other audits of quality

improvement indicators.

Breast milk Substitutes/WHO Code

- Easy-to-read instructional written materials will be available prior to discharge. Such materials will not be prepared by manufacturers of breast milk substitutes, nor companies or the manufacturers of artificial feeding equipment, and will be free from messages that promote or advertise infant food or drinks other than breast milk.

- This applies to pre-natal and postpartum education. Staff will be able to give two reasons why it's important not to give free samples or other items from formula companies to mothers.

- The following practices apply to out-patient pre-natal services and classes, as well as in-patient procedures and services.

(a) This facility does not accept free formula or free breast milk substitutes. Employees of manufacturers or distributors of breast milk substitutes, bottles, nipples, or pacifiers are not allowed to have direct contact with pregnant women or mothers. All artificial nipples, infant feeding bottles and breast milk substitutes are purchased at a fair market value by this facility.

(b) The facility does not receive free gifts, non-scientific literature, materials, equipment, money, or support for breastfeeding education or events from manufactures of breast milk substitutes, bottles, nipples and pacifiers.

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

(d) Any educational materials distributed to breastfeeding mothers are free from messages that promote or advertise infant food or drinks other than breast milk. Any educational materials will not bear the company logo of any other companies, unless specific to the mother's or baby's needs or condition. For example, information about how to use a breast pump if indicated.

- **For evidence- based medical indications for supplementation**, refer to policies/ procedures "Hospital Guidelines for Use of Supplementing Feedings in the Healthy Full-Term Breastfeeding Infant" and PDHM (Pasteurized Donor Human Milk)

- CONTRAINDICATIONS TO BREASTFEEDING:

- If the mother is taking medications or having diagnostic tests that are essential for her well-being, but may be harmful to her infant (Refer to Medications and Mother's Milk by Thomas Hale) NOTE: This may be accessed on the hospital library web site.
- If the mother is a known user of cocaine, heroin or other street drugs.
- If the mother has active tuberculosis (breastfeeding is allowed after she has received adequate drug therapy and is no longer considered to be infectious).
- If the mother is HIV positive or human T-cell lymphoprophic virus type I or II positive.
- If there are active herpes lesions on mother's breasts, do not breastfeed on the affected breast(s).
- If the infant has galactosemia.
- If the mother has varicella that has determined to be infectious to the infant.
- If the mother is identified with primary cytomegalovirus infections, she should not breastfeed during the acute phase of the infection.
- If the infant has maple syrup urine disease.
- If the infant has phenylketonuria.

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Manager of Maternity & Pediatrics	**Chair of Obstetrics and Gynecology**
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Maternity & Pediatrics
Level II
Breast Feeding/Breast Care

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RELATED POLICIES/PROCEDURES:
Supplementary Feeding of the Healthy Breastfed Infant
Collection, Storage and Transportation of Human Breast Milk