

## **Lincoln Community Breastfeeding Initiative**

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# The Lincoln Community Breastfeeding Initiative



In 2011, the US Surgeon General issued a national *Call to Action to Support Breastfeeding*. This report recommends widespread community efforts to create a supportive environment for new mothers in order to increase breastfeeding rates and improve the health of the nation.

This recommendation as well as feedback from Lincoln mothers, was the motivation behind the development of the Lincoln Community Breastfeeding Initiative. New mothers report that breastfeeding support services in the Lincoln community are fragmented, inconsistent, and often inaccurate. “Everyone tells me something different.” “Where and how do I get help?” This frustration often results in an abrupt discontinuation of breastfeeding.

The Lincoln Community Breastfeeding Initiative is a partnership of health care providers and community organizations that began in the spring of 2012 to improve breastfeeding rates in the community by creating consistent, accurate breastfeeding messages for new mothers across the spectrum of health care.

Infant nutrition is a key component to sustained infant and child health. Research indicates that increased breastfeeding rates (initiation, duration, and exclusivity) contribute to a reduced risk of obesity and diabetes, as well as the development of a stronger immune system. The community of Lincoln is working to improve the health of Lincoln’s children by asking health care providers across the city to encourage breastfeeding education, support consistent messages, and guide mothers to appropriate breastfeeding assistance as it is needed.

A leadership team composed of representatives from Bryan Health, Saint Elizabeth Regional Medical Center, the Lancaster County Medical Society, Lincoln Pediatric Group, MilkWorks, Partnership for a Healthy Lincoln, Milius, Gibbens, Friesen, Hattan, Martin, Rauner, and Rutan, and the Lincoln Lancaster County Health Department WIC program have developed a strategy for change within the community. Focus groups have been developed to coordinate both inpatient and outpatient care. A variety of health professionals and breastfeeding advocates from the community have been recruited to serve as resources for the project.

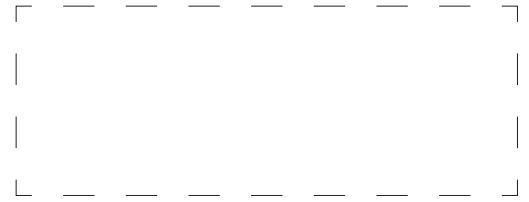
Prenatally, the focus is to encourage providers to recommend breastfeeding during the first trimester, indicate a mother’s feeding choice in her chart, provide an accurate list of community resources, and discontinue the use and dissemination of free formula samples or coupons in each clinic.

The inpatient focus is to establish a set of shared community standards for both of Lincoln’s delivering hospitals. These standards will serve as a common breastfeeding policy in both organizations and will guide hospital staff through the process of making breastfeeding the standard for mothers and their newborns. Lincoln mothers will know that regardless of which hospital they choose, the breastfeeding information and support they receive will be consistent and accurate.

Postpartum care will focus on connecting breastfeeding mothers with community resources as needed. Hospital staff and well-baby providers will educate women on what resources are available as well as helping them identify what is “normal” in the first weeks of breastfeeding and when and how to seek professional breastfeeding assistance.

The Lincoln Community Breastfeeding Initiative hopes to engage the entire health care community in establishing standards and creating the type of environment outlined by the US Surgeon General. In doing so, providers will better understand the important role they play in assisting new mothers, families will develop a sense of trust in knowing they will receive accurate, consistent information and support, and the community will benefit from improved overall infant health.

# R<sub>x</sub> for breastfeeding



I recommend that you breastfeed your baby.

The American Academy of Pediatrics and American Academy of Family Physicians recommend exclusive breastfeeding for about 6 months with continuation of breastfeeding for 1 year or longer as mutually desired by a mother and infant.

**Breastfeeding decreases your BABY'S risk of:**

- Ear Infections, Colds, and Diarrhea
- Sudden Infant Death Syndrome (SIDS)
- Obesity
- Diabetes
- Asthma
- Childhood Leukemia

**Breastfeeding decreases YOUR risk of:**

- Breast Cancer
- Ovarian Cancer
- Type II Diabetes

We encourage you to set a breastfeeding goal for you and your baby. While experts recommend breastfeeding for one year, every day that your baby is breastfed makes a difference to your baby's health.

### At our office we provide:

- Breastfeeding Classes     Breast Pumps  
 Lactation Consultants     Mom's Groups     Other \_\_\_\_\_

### Other Community Resources

#### Bryan Health

Lactation Consultants 402-481-7103  
Breastfeeding Classes 402-481-8070  
[www.bryanhealth.org](http://www.bryanhealth.org)

#### Saint Elizabeth Regional Medical Center

Lactation Consultants 402-219-7471  
Breastfeeding Classes 402-219-7000  
[www.saintelizabethonline.com](http://www.saintelizabethonline.com)  
[lactation@stez.org](mailto:lactation@stez.org)

#### MilkWorks

MilkWorks, a community breastfeeding center, offers classes, consultations, moms' groups and breast pumps.  
402-423-6402 • [www.milkworks.org](http://www.milkworks.org)

#### La Leche League of Lincoln, NE

La Leche League's trained volunteer Leaders provide mother-to-mother support, encouragement, information, and education.  
<http://www.llofne.org>

#### Women Infants and Children (WIC)

WIC provides breastfeeding education and support, breastfeeding peer counselors, breast pumps, referrals, and supplemental foods to qualifying pregnant and nursing moms.  
[www.dhhs.ne.gov/wic](http://www.dhhs.ne.gov/wic)

Lincoln Lancaster County Health Department WIC  
402-441-6200

Family Service WIC 402-441-8655

For more information about breastfeeding resources in your community visit

[www.healthylincoln.org/breastfeeding](http://www.healthylincoln.org/breastfeeding)



# A Guide for Prenatal Providers to Further Promote Breastfeeding

The **Lincoln Community Breastfeeding Initiative** would like to share our summary of the latest breastfeeding protocols from the American Academy of Pediatrics and the Academy of Breastfeeding Medicine to assist you in your ongoing efforts to support mothers. We hope this information lessens the burden of “keeping up” with the latest information, as more research is being revealed in the area of breastfeeding medicine.

The American Academy of Pediatrics recommends breastfeeding for 1 year or longer, as mutually desired by mother and infant.

**Exclusive breastfeeding** is recommended for about 6 months, which implies the consumption of human milk with no supplements of food, water, juice, or nonhuman milk. Breastfeeding is continued as complementary foods are introduced at about 6 months of age.

The **2012 CDC Breastfeeding Report Card** (2009 data) revealed that ~75% of US mothers left the hospital intending to breastfeed.

- At 6 months old ~50% of US babies were **receiving breastmilk**, and at 12 months old 25% were receiving breastmilk.
- **Exclusive breastfeeding** occurred in ~35% of 3 month olds and in ~15% of 6 month olds.

**A mother’s PRENATAL intention to breastfeeding is greatly influenced by the opinion and support of the healthcare providers she encounters.**

## The Influence of Your Obstetric Office

### **Establish a breastfeeding friendly environment**

Develop a written breastfeeding-friendly office policy in collaboration with colleagues and office staff and routinely discuss and review it.

- Allow and encourage breastfeeding in the office and waiting room. Provide a comfortable private area as requested.
- Display noncommercial posters, pamphlets, pictures, and photographs of breastfeeding mothers.
- Avoid formula displays and refuse promotional items (pens, calendars, etc) from formula companies.
- Do not distribute educational materials or promotional items to parents which advertise formula, bottles, or nipples.
- Educate and empower your staff.
  - Identify one or more breastfeeding resource personnel on staff.
  - Educate and train all staff members, including front office staff, nurses, and medical assistants.
  - Provide quick reference resources for healthcare professionals in your practice (books, protocols, Web links).
  - Provide a lactation room with supplies for your employees who breastfeed or express milk at work and have a written breastfeeding employee policy.

### **Promote, support and discuss breastfeeding with the expectant and the new mother**

- As part of routine pregnancy care, discuss breastfeeding at the first prenatal visit, at around 28 weeks, and again at 35 weeks. Express your support of breastfeeding at other visits as well.
- Identify lactation risk factors and share these findings with the mother so she can seek specialized breastfeeding care for her particular situation. (See Table 5)
- Offer culturally competent care. Some cultures may discard colostrum, follow a maternal lactation diet, and introduce solid foods early.
- Educate and empower the mother, the father and their support system.
  - Provide educational material that highlights the many ways in which breastfeeding is superior to formula feeding.
  - Strive to maintain a current list of local breastfeeding specialists.
  - Encourage both parents to attend prenatal breastfeeding classes and to utilize community support groups.

## Your Influence In The Hospital

\*These 5 postpartum practices have been shown to increase breastfeeding duration, regardless of socioeconomic status.

- \*Encourage breastfeeding in the first hour after birth and promote early skin-to-skin contact.
- Encourage breastfeeding on demand, following infant’s states of alertness and cues of hunger and satiety.
- \*Encourage rooming-in with unlimited breastfeeding duration and mother-infant contact.
- Remind mothers that newborns should breastfeeding 8-12 times in 24 hours.
- \*Remind mothers to avoid pacifiers and bottles until breastfeeding is well established.
- \*Reiterate the importance of avoiding supplemental formula, glucose water, or other liquids unless medically indicated.  
(In 2011, ~1 in 5 Nebraska facilities adhered to standard clinical practice guidelines against routine supplementation with formula, glucose water, or water)
- Encourage mothers to exclusively breastfeed for 6 months and then add complementary foods while continuing to breastfeed for at least 1 year or as long as is mutually desired by mother and baby.
- \*Be sure Mom is given a phone number for breastfeeding support after hospital discharge.
- Support policies that prohibit commercial discharge bags containing infant formula, formula coupons, and/or feeding bottles to mothers.

## Your Influence In Our Community

- Advocate for policy that incorporates the costs of breastfeeding care into routine health services, including costs of consultation and equipment that may be needed for particular clinical situations.
- Enforce workplace laws that support breastfeeding and encourage employers and daycare providers to support breastfeeding.

## References and Recommended Reading

### Academy of Breastfeeding Medicine Protocols:

- #4: Mastitis (Revision, May 2008) [http://www.breastfeedingmed.org/Media/Files/Protocols/protocol\\_4mastitis.pdf](http://www.breastfeedingmed.org/Media/Files/Protocols/protocol_4mastitis.pdf)
  - #14: Breastfeeding-Friendly Physician's Office: Optimizing Care for Infants and Children (Revised 2013)  
[http://www.breastfeedingmed.org/Media/Files/Protocols/Protocol\\_14\\_revised\\_2013.pdf](http://www.breastfeedingmed.org/Media/Files/Protocols/Protocol_14_revised_2013.pdf)
  - #15: Analgesia and Anesthesia for the Breastfeeding Mother (Revised 2012)  
[http://www.breastfeedingmed.org/Media/Files/Protocols/Protocol\\_15\\_revised\\_2012.pdf](http://www.breastfeedingmed.org/Media/Files/Protocols/Protocol_15_revised_2012.pdf)
  - #18: Use of Antidepressants in Nursing Mothers [http://www.breastfeedingmed.org/Media/Files/Protocols/Protocol\\_18.pdf](http://www.breastfeedingmed.org/Media/Files/Protocols/Protocol_18.pdf)
  - #19: Breastfeeding Promotion in the Prenatal Setting  
<http://www.breastfeedingmed.org/Media/Files/Protocols/Protocol%2019%20-%20Breastfeeding%20Promotion%20in%20the%20Prenatal%20Setting.pdf>
  - #20: Engorgement <http://www.breastfeedingmed.org/Media/Files/Protocols/Protocol%2020%20-%20Engorgement%206-2009.pdf>
- Caring for new mothers: diagnosis, management and treatment of nipple dermatitis in breastfeeding mothers. Misha M. Heller BA, Honor Fullerton-Stone MD, and Jenny E. Murase MD. International Journal of Dermatology 2012, 51, 1149–1161.
- Breastfeeding and the Use of Human Milk. American Academy of Pediatrics Policy Statement PEDIATRICS Vol. 129 No. 3, March 1, 2012, pp.e827-e841 (doi: 10.1542/peds.2011-3552) <http://pediatrics.aappublications.org/content/129/3/e827.full?sid=62be6fa8-d66a-4c2c-916f-a0b5176b8fe#ref-2>
- Breastfeeding Management 2 mobile app
- Medications and Mothers' Milk by Thomas Hale
- LactMed mobile app or <http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT> (Safety of maternal medications when the mother is breastfeeding.)

**Table 1: Maternal Medications and Breastfeeding** (refer to LactMed or Hale as noted above)

- Do not breastfeed if mother is taking amphetamines, chemotherapy agents, ergotamines and statins.
- Temporarily cease breastfeeding after maternal exposure to diagnostic radioactive compounds.  
Guidelines are provided by the US Nuclear Regulatory Commission and are summarized in the above drug references.
- Psychotropic drugs which are least likely to be problematic are:
  - Tricyclic antidepressants (amitriptyline [Elavil]; clomipramine [Anaphranil])
  - SSRIs (paroxetine[Paxil]; sertraline [Zoloft])
- If an infant has G6PD, the nursing mother should avoid fava beans, nitrofurantoin, primaquine and phenazopyridine to minimize the risk of hemolysis in the infant.

**Table 2: Contraindications to Breastfeeding**

Do not put baby to the breast, however expressed breastmilk CAN be given to the baby	No breastfeeding and no expressed breastmilk	HIV
<ul style="list-style-type: none"> <li>• Active tuberculosis (Resume at breast when not infectious, ie after treated 2 weeks)</li> <li>• Active Herpes Simplex Virus on breast</li> <li>• A mom who develops varicella 5 days before through 2 days after delivery should be separated from infant.</li> </ul>	<ul style="list-style-type: none"> <li>• Infant galactosemia</li> <li>• HTLV I or II</li> <li>• Untreated brucellosis.</li> </ul>	<p>Industrialized world - No breastfeeding or expressed breastmilk</p> <p>Developing world --- Benefits of breastfeeding outweighs the risk of acquiring HIV from breastmilk. Six months of exclusive breastfeeding PLUS 6 months of antiretroviral drugs significantly decreases postnatal acquisition of HIV-1.</p>

**Table 3: OK to Breastfeed with Caution**

- Mom is CMV positive and baby is full term.
- Nursing mother in a supervised methadone maintenance program. Must be negative for HIV and illicit drugs.
- Occasional alcohol intake, not to exceed 0.5 grams of alcohol per kg body weight. (60kg mother → 2oz liquor, 8oz wine, or 2 beers.)  
There is no need to “pump and dump” if the mother waits 2 hours after 1 drink before nursing, as there would be minimal concentrations of alcohol in the breastmilk by then. Alcohol does not increase supply but blunts the prolactin response to suckling. It slows the baby's motor development.
- Smoking increases the incidence of respiratory allergy, SIDS, low supply and poor gain. Second hand smoke exposure should be avoided.

### How often does breastfeeding just not work?

#### How many women's milk never comes in with a healthy full term new born, in an environment supportive of breastfeeding?

Lactation is part of normal human physiology, and like all other human physiology, it can fail. Marianne Neifert estimates that “as many as 5% of women may have primary insufficient lactation because of anatomic breast variations or medical illness that make them unable to produce a full milk supply despite heroic efforts.” (Neifert MR (2001). "Prevention of breastfeeding tragedies." *Pediatr Clin North Am* 48(2): 273-97.) Research is underway to try to estimate the proportion of women who experience unplanned, undesired weaning due to physiologic problems with breastfeeding, but it's difficult to tease out the issue of lacking “a supportive environment” vs biological problems with lactation. Some mothers have ample milk supplies and babies born with champion suck-swallow patterns, who would likely breastfeed successfully in almost any environment. There are other dyads for whom one piece of bad advice or unsupportive comment is enough to throw lactation completely off track. Women socialized to mistrust their bodies are vulnerable to interpreting early feeding challenges as evidence that their bodies can't sustain breastfeeding, and they are thus more likely to wean and attribute their decision to a physiological problem. Research is needed in order to develop the tools that will identify the underlying problems and allow us to implement the appropriate treatment. We also need to step back from assertions that every mother can breastfeed, if she just tries hard enough.

*Adapted from an ABM blog post by Alison Stuebe, MD, MSc, a maternal-fetal medicine physician, breastfeeding researcher, and assistant professor of Obstetrics and Gynecology at the University of North Carolina School of Medicine. She is a member of the board of the Academy of Breastfeeding Medicine.*

**Table 4: BENEFITS OF BREASTFEEDING**

**The Dose Response Benefits of Breastfeeding for Infants**

EXCLUSIVE Breastfeeding	ANY Breastfeeding
<p><b>for 6 months:</b></p> <ul style="list-style-type: none"> <li>• 63% ↓ in serious colds, ear and throat infections</li> </ul> <p><b>for &gt;4 months:</b></p> <ul style="list-style-type: none"> <li>• 72% ↓ in risk for hospitalization for lower respiratory tract infections in the 1<sup>st</sup> year of life</li> <li>• 74% ↓ in severity of RSV bronchiolitis</li> </ul> <p><b>for 3 months or more:</b></p> <ul style="list-style-type: none"> <li>• Significantly higher intelligence scores</li> </ul> <p><b>for 3-4 months:</b></p> <ul style="list-style-type: none"> <li>• 30% ↓ in incidence of juvenile diabetes</li> <li>• 50% ↓ in risk of otitis media</li> <li>• 27% ↓ in asthma and atopic dermatitis in a low risk population and 42% ↓ in a high risk population (positive family history allergy)</li> </ul>	<p>↓ in incidence of:</p> <ul style="list-style-type: none"> <li>• otitis media = 23%</li> <li>• nonspecific GI infections = 64% (Effect lasts 2 months after stopping breastfeeding.)</li> <li>• necrotizing enterocolitis in premis = 58-77%</li> <li>• Type 2 diabetes = 40% (possibly related to breastfeeding's effect on feeding self-regulation)</li> </ul> <p>↓ risk of:</p> <ul style="list-style-type: none"> <li>• SIDS associated with breastfeeding = 36%</li> <li>• celiac disease if breastfeeding when gluten-containing foods are introduced = 52% ↑ duration of breastfeeding is associated with a ↓ risk of celiac disease</li> <li>• childhood inflammatory bowel disease = 31%</li> </ul> <p>↓ Obesity:</p> <ul style="list-style-type: none"> <li>• 15-30% ↓ in adolescent and adult obesity rates. Breastfed sibs weighed 14 lbs less than formula fed siblings and were less likely to be obese. Each month of breastfeeding was associated with a 4% reduction in risk of being overweight..</li> <li>• ↓ BMI, LDLs, BP later in life, ↑ HDLs, and improved insulin metabolism</li> </ul> <p><b>Any breastfeeding for &gt;6 months:</b></p> <ul style="list-style-type: none"> <li>• 4 fold ↑ in risk of pneumonia if <b>breastfeeding 4-6 months vs &gt;6 months.</b></li> <li>• 20% ↓ in risk of ALL and 15% ↓ in risk of AML. Breastfeeding &lt;6 months is protective but less so (12% and 10% respectively)</li> </ul>

Premis who Consume Breastmilk	Mothers who Breastfeed
<ul style="list-style-type: none"> <li>• Lower rates of sepsis, necrotizing enterocolitis, retinopathy of prematurity, and metabolic syndrome</li> <li>• Lower hospital readmissions in the year after NICU discharge</li> <li>• Quicker full enteral feeds and improved clinical feeding tolerance</li> <li>• Significantly improved neurodevelopmental outcomes are such that all premis, especially under 1.5kg, should get breastmilk. Such outcomes are associated with predominant and not necessarily exclusive breastmilk feeding. <ul style="list-style-type: none"> <li>◦ Micro-premis who got the greatest proportion of breastmilk had significantly greater mental, motor, and behavior rating scores at 18 and 30 months old.</li> <li>◦ Babies had greater intelligence test results, white matter and total brain volumes.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Less postpartum blood loss and faster involution of uterus</li> <li>• Increased child spacing</li> <li>• Less post partum depression and lower rates of abuse and neglect</li> <li>• Duration of breastfeeding: <ul style="list-style-type: none"> <li>◦ Moms exclusively breastfeeding &gt;6 months weighed 1.38kg less than those who didn't breastfeeding.</li> <li>◦ For each year of breastfeeding: <ul style="list-style-type: none"> <li>▪ 4-12% decreased risk of Type 2 diabetes (if there is no h/o gest diabetes)</li> <li>▪ 4.3% reduction in breast cancer</li> </ul> </li> <li>◦ 28% decrease in breast and ovarian cancer is associated with a total duration of breastfeeding of more than 12 months</li> <li>◦ Longer total time of breastfeeding is related to a decreased risk of developing rheumatoid arthritis.</li> <li>◦ A cumulative lactation history of 12-23 months had a significant reduction in hypertension, hyperlipidemia, cardiovascular disease and diabetes.</li> </ul> </li> </ul>

**Table 5: Risk Factors for Lactation Problems**

MATERNAL		INFANT
<p><b>History/social factors</b></p> <ul style="list-style-type: none"> <li>• Primiparity</li> <li>• Early intention to both breastfeed and bottle or formula feed and to use pacifiers</li> <li>• Early intention to return to work or school</li> <li>• History of previous breastfeeding problems or breastfeeding infant with slow weight gain</li> <li>• History of infertility</li> <li>• Significant medical problems (untreated hypothyroidism, diabetes, cystic fibrosis)</li> <li>• Maternal age (teen mother or advanced age)</li> <li>• Psychosocial problems (depression, poor, or negative support of breastfeeding)</li> <li>• Perinatal complications (hemorrhage, hypertension, infection)</li> <li>• Plans to use hormonal contraceptives before breastfeeding is well established</li> <li>• Perceived inadequate milk supply</li> <li>• Maternal meds (inappropriate advice about compatibility with breastfeeding is common)</li> </ul>	<p><b>Anatomic/physiologic factors</b></p> <ul style="list-style-type: none"> <li>• Lack of noticeable breast enlargement during pregnancy</li> <li>• Flat or inverted nipples</li> <li>• Variation in breast appearance (hypoplastic, tubular, marked asymmetry)</li> <li>• Any previous breast surgery, including plastics procedures</li> <li>• Previous breast abscess</li> <li>• Maternal obesity (BMI &gt; 29)</li> <li>• Extremely/persistently sore nipples</li> <li>• Failure of lactogenesis stage 2 (milk did not noticeably "come in." Can be difficult to evaluate prior to discharge before 24-48 hours.)</li> <li>• Mother unable to hand express colostrum</li> <li>• Discharge from hospital using a nipple shield or other "appliance"</li> </ul>	<p><b>Medical/anatomic/physiologic factors</b></p> <ul style="list-style-type: none"> <li>• Low birth weight or premature (&lt;37weeks)</li> <li>• Multiples</li> <li>• Difficulty latching on to one or both breasts</li> <li>• Ineffective or unsustained suckling</li> <li>• Oral anatomic abnormalities (cleft lip/palate, micrognathia, macroglossia, tight frenulum)</li> <li>• Medical problems (jaundice, hypoglycemia, infection, respiratory distress)</li> <li>• Neurologic problems (genetic syndromes, hypotonia, hypertonia)</li> <li>• Persistently sleepy infant</li> <li>• Excessive infant weight loss</li> </ul> <p><b>Environmental factors</b></p> <ul style="list-style-type: none"> <li>• Mother-baby separation or breast pump dependency</li> <li>• Formula supplementation</li> <li>• Effective breastfeeding not established by hospital discharge</li> <li>• Early discharge from the hospital (&lt;48 hours of age)</li> <li>• Early pacifier use</li> </ul>

Adapted with permission from Pediatr Clin North Am 2001;48:285, and AAP and ACOG: Breastfeeding Handbook for Physicians 2006, pp. 82-83.

# What you can expect during your hospital stay

*This is intended for all babies unless your baby needs special attention after birth for their health.*

## **Breastfeeding Promotion**

We encourage you to breastfeed your baby and want to help you learn more about it. Please consider taking a breastfeeding class prior to delivery. Breastfeeding is a wonderful opportunity for you and your baby and preparing yourself will help start you off in the right direction. We want you to be successful and will make every effort to help. If you have any questions please contact our lactation office.

### **Breastfeeding decreases your BABY'S risk of:**

- Ear infections, colds, and diarrhea
- Sudden Infant Death Syndrome (SIDS)
- Obesity
- Diabetes
- Asthma
- Childhood Leukemia

### **Breastfeeding decreases YOUR risk of:**

- Breast cancer
- Ovarian Cancer
- Type II Diabetes

## **Skin-to-Skin**

After delivery, you and your baby will be placed in direct skin-to-skin contact and covered with warm blankets. You will be encouraged to continue holding your baby skin-to-skin until the first breastfeeding is completed. Skin-to-skin will be encouraged throughout the hospital stay. This may be done as much as desired by both mother and/or family member/partner regardless of feeding choice.

Skin-to-skin will help your baby in many ways. Some of them include: increase success with breastfeeding, stabilization of vital signs (heart rate, breathing rate, temperatures, and oxygen levels), stabilization of blood sugar, decrease pain, improves brain development, relaxes your baby, and promotes bonding.

## **The First Breastfeeding**

You can expect the first breastfeeding to occur as soon as possible after the baby is born, within the first hour after delivery, unless medically unstable. Staff will be available to help with this first feeding.

You and your baby are most ready and willing to learn how to breastfeed during the first hours of life.

## **Rooming-in**

You and your baby are encouraged to remain together throughout your hospital stay including at night regardless of your feeding choice. You may hear this being called rooming-in.

Keeping your baby with you helps him/her breastfeed better while you learn your baby's feeding cues. It will promote bonding with your baby and increase your confidence in caring for him/her. Babies who stay near their mothers sleep better, cry less, and mothers get the same amount of sleep whether their babies are in their room or the nursery.

There may be times when your baby has to leave the room for routine procedures. Your baby will be returned as soon as possible. You may be allowed to go with your baby at these times.

## **Baby feeding and sleeping patterns-First 24 hours of life**

During the first few hours of life your baby will be very alert and ready to breastfeed. After this he/she will become very sleepy and less interested in breastfeeding. This is a normal way for your baby to recover from the delivery. We encourage you to place your baby skin-to-skin and try feeding at least every 2-3 hours around the clock.

## Baby feeding and sleeping patterns-After 24 hours of life

After this sleepy period, your baby will begin to wake up and nurse more frequently. We encourage you to feed your baby at the first signs of hunger cues, offering both breasts at each feeding. At some feedings your baby will be more sleepy and feed for shorter times. At other feedings your baby may be more awake and feed for longer. We encourage you to follow the signs that your baby gives you, you will not need to time or schedule your breastfeeding sessions. This is called feeding on demand.

You may hear the term cluster feeding. This is a normal instinctive feeding pattern that often occurs at night time. During this time your baby may want to breastfeed often. This may last for several hours, and is usually followed by a period of rest. You may feel tired during this time but your baby is helping you by preventing engorgement.

It is normal for your baby to lose weight during your hospital stay. Your baby will be weighed at birth and daily until discharge. Your baby's doctor will monitor this closely until your baby returns to birth weight.

## Risks of elective supplementation

We encourage you to exclusively breastfeed your baby. Exclusive breastfeeding in the hospital helps to establish a full milk supply. There may be medical reasons when supplementing is indicated. During these times we will explain other feeding options and how they can work for you to reach your breastfeeding goal.

Formula supplementation that is not medically needed may change your baby's hunger drive, altering your milk supply. This may lead to a decrease in your milk supply and may cause difficulty breastfeeding. Formula may pose risks to the baby such as: changing the natural stomach lining, increased risk of allergies, fussiness at breast, increased spitting-up, and the process of learning to breastfeed may be disrupted due to the change in suckle.

We will support the feeding decision of every mother.

## Limiting visitors to promote parental bonding during hospital stay

We recognize and support that your family and friends want to come to meet your new baby. During your hospital stay we encourage you to allow private time for your new family to bond. Consider limiting visiting hours to allow you and your baby time to get to know each other. This will allow your baby time to learn to breastfeed and allow yourself time to rest.

## Breastfeeding concerns

If you have any breastfeeding questions or concerns during your hospital stay there are trained staff to help. Lactation Consultants available 7 days a week during the daytime hours. If one is not available, there are trained staff to help you with breastfeeding.



CATHOLIC HEALTH  
INITIATIVES®

Saint Elizabeth  
Regional Medical Center



**The American Academy of Pediatrics recommends exclusive breastfeeding for about 6 months with continuation of breastfeeding for 1 year or longer as mutually desired by a mother and infant.**



# Key Shared Prenatal Teaching Concepts

## Benefits of Breastfeeding

- Human milk is real food designed for human babies.
- The breastfeeding process promotes socialization.
- Refer to 2007 meta-analysis data for health impact.

## Why Exclusive for ~6 Month?

- Avoidance of foreign proteins.
- Developmental readiness signs for solids.

## Importance of Skin to Skin Contact in First Hour

- Helps a baby learn to breastfeed in the first hour, or at any time.
- Promotes maternal confidence
- May look different or be delayed if pain medications were used.

## Importance of Rooming-In and Support from Family, LCs, Nurses

## Effective Latching

- Should not hurt.
- Return to skin to skin at any time to promote latch.
- No pacifiers in hospital and until breastfeeding well established – feed baby instead.
- If no latch in the first 12-24 hours of life, start pumping on a regular basis until regular latching is achieved.
- If remains dependent on a nipple shield, seek lactation assistance and monitor weight gain and milk supply closely.

## Frequency of Feedings/Output/Weight Gain in an Ideal Breastfeeding Scenario

- Birth to Day 3 (Birth – 96)
  - Frequency of Feedings:
    - Offer breast 8-12 times in 24 hours if baby does not ask
    - Baby may be sleepy after first feeding and feedings may be inconsistent first 24-48 hours  
Frequency of feedings should increase from 24-48 as milk “comes in” (commonly known as cluster feeding).
  - Outputs:
    - 0-48 hours: at least 1 wet, 1 stool per 24 hours.
    - 49-72 hours: 2 wets and 2 stools per 24 hours.
    - 73-96 hours: 3 wets and 3 stools per 24 hours.
  - Weight Loss: Acceptable loss is up to 10%
- Day 4 (97 - 120 hours)
  - Frequency of Feedings:
    - Baby is now asking for feeds 8-12 times in 24 hours, can be heard swallowing milk, acts content between feeds, and self-awakens for most feedings.
    - Try to soften the first breast before switching to the second breast.
  - Outputs:
    - Minimum of 6 wets and 4 yellow stools in a 24 hour period.
- Day 5 (121+)
  - Weight gain around an ounce per day and return to birth weight within 14 days.

## Engorgement

- Occasionally both breasts become swollen, tender, red, and shiny as milk comes in. Milk may not flow out easily, which can lead to plugged ducts and mastitis.
- To prevent engorgement, remove milk frequently and avoid constricting clothing/bras.
- To manage engorgement, apply heat before and cold packs after nursing, remove milk frequently, and seek lactation assistance if symptoms do not improve.

## Maintaining Supply and Demand

- If weight loss is excessive and supplemental milk is fed, this may reduce a baby's hunger drive and result in a baby stimulating the breast less often. Therefore, be sure to express breastmilk/colostrum (by hand or pump) each time the baby is supplemented.
- Throughout the duration of breastfeeding, the breastfeeding rule of "Supply and Demand" should be followed: *If the baby is supplied from a bottle/syringe, the breasts must be demanded of, in order to keep supply and demand in check.*

## Pumps and Bottles

- In certain situations it may be medically necessary to rent a hospital grade pump in order to further optimize milk production.
- A high quality double electric pump will be needed if you plan to pump at work, and if milk supply becomes an issue.
- Wait until 3-4 weeks of age before introducing a bottle (unless instructed otherwise). Local experts agree that a standard slow flow nipple with baby's lips completely covering the nipple far into the baby's mouth helps protect the baby's ability to latch at the breast.

## Culture of Breastfeeding

- Fair Labor Standards Act and work place support  
Employers are required to provide "reasonable break time for an employee to express breastmilk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk." Employers are also required to provide "a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk."
- Protection for breastfeeding in public  
Neb. Rev. Stat. §25-1601-4 (2003) states that a nursing mother is excused from jury duty until she is no longer breastfeeding and that the nursing mother must file a qualification form supported by a certificate from her physician requesting exemption. (LB 19)  
2011 Neb. Laws, L.B. 197 specifies that a mother may breastfeed her child in any public or private location where the mother is otherwise authorized to be.

## Support in Community once Home from Hospital

- Hospital will help you determine if mom and baby need to be seen within 24-48 hours post discharge by a health care provider or breastfeeding specialist.
- All babies should have a weight check within 72 hours post discharge from hospital.
- Resources in community: MD offices, La Leche League, MilkWorks, WIC – Health Department and Family Service.

## **Teaching Concepts from Shared Hospital Policy**

### **Proper positioning and latch**

- Mother relaxed and comfortable
- Baby well supported with infant's chest and hips facing mother
- Baby's lips flanged outwards
- Cheeks full and round with no dimpling noted
- No audible clicking or smacking while suckling.
- Latch should not be painful
- Skin to skin helps to promote normal latch instincts.

### **Non-nutritive and Nutritive Suckling and Swallowing**

- Non-nutritive suckling defined as short rapid sucks with minimal swallowing noted.
- Less than 48 hours: able to detect intermittent swallowing
- Greater than 48 hours: able to detect frequent, audible swallowing
- Initial rapid suckle transitions to long rhythmic suckles of jaw into the temple region.
- Nutritive suckling encouraged by breast compressions, frequent stimulation of infant and skin to skin.

### **Feeding Patterns**

- Feed baby on demand 8-12 times in 24 hours.
- Avoid scheduling feeds.
- Do not limit time of breastfeeding on each side.
- Offer both breasts at each feed, but infant may only want one side.
- Recognize feeding cues: increased alertness and activity, smacking, rooting, bringing hands to mouth.
- Feed with cues; crying is a late sign of hunger.

### **Milk Production**

- Frequent stimulation of both breasts 8-12 times around the clock through direct breastfeeding and/or pumping, if baby is unable to latch or mother and baby are separated.

## **Milk Expression**

- Hand expression or pumping will be utilized if direct breastfeeding cannot be accomplished.
- If baby has not latched or fed effectively by 12-24 hours of life, mother will be taught to hand express or pump and feed baby colostrum by cup, syringe or SNS.
- If baby and mother are separated, hand expression or pumping will be initiated within 3-6 hours of baby's birth.
- Pumping will continue every 2-3 hours round the clock until effective feeding patterns are established. Both breasts should be expressed for 15 minutes.
- When indicated, instruction on proper set up, use and cleaning of breast pump.
- Milk storage guidelines will be taught. (ABM guidelines)
- Minimal milk may be collected the first several times a mother expresses her milk.

## **Normal Intake and Output**

- Breast milk volumes continue to increase each day relative to increasing infant stomach capacity, from drops to 15-30 cc per feeding session by 72 hours (about 6 oz per 24 hours).
- Between day 3 and 5, milk supply is established. Mothers will notice increased fullness in breasts as well as increased audible swallowing when baby is at breast.
- Routine supplementation of infants (water, glucose water, formula or other non-human milk fluids) are not given to breastfeeding infants unless specifically ordered by a physician or requested by a parent.
- It is acceptable for a baby to lose up to 10% of their weight.
- By Day 5 infants should be gaining about an ounce per 24 hours and return to birth weight within 14 days.
- Normal elimination patterns are:
  - 0-48 hours: at least 1 wet, 1 stool per 24 hours.
  - 49-72 hours: 2 wets and 2 stools per 24 hours.
  - 73-96 hours: 3 wets and 3 stools per 24 hours.
  - By day 4 infant should have at least 6 wet diapers and 4 yellow stools in a 24 hour period.

## **Normal Newborn Behavior**

- Babies are generally born in an alert state. They are often very receptive to feeding. They may then go into deep sleep.
- Feeding may be inconsistent during first 24-48 hours. Continue to offer breast every 2-3 hours and provide frequent, prolonged skin to skin contact.
- Cluster feeds: may begin around 24 hours of age. Periods of frequent feeds followed by periods of rest. Cluster feeds help to build a milk supply. Frequent feeds may be frustrating to mother at night.
- Sleepy infants, especially those with an increased bilirubin level, may need to be woken for feeds every 2-3 hours round the clock.
- Infants may demonstrate both fussy and sleepy behaviors at breast.

## **Non-Medical Supplementation of Infant may:**

- Alter the normal intestinal flora of the infant.
- Sensitize an infant to foreign proteins and increase their risk of allergies.
- Disrupt supply/demand cycles of milk production, leading to an inadequate milk supply, delayed milk supply, and long term supplementation due to a low milk supply.
- Result in a latch difficulty if fed by an artificial nipple.
- Cause increased maternal engorgement due to decreased frequency of feeds.
- Cause an infant's stomach to stretch too quickly, interrupting the natural increase in a baby's stomach capacity.
- Shorten breastfeeding duration or result in early weaning.

## **Rooming-In**

- Infants are kept with their mothers room day and night throughout the hospital stay so that:
  - Parents learn to recognize feeding cues.
  - Infants have uninterrupted opportunities to feed frequently.
  - Mothers and their babies can bond.
  - Mothers can gain confidence in caring for their newborns.
- Infants who are near their mothers sleep better and cry less.
- Mothers get the same amount of sleep whether the infant is in their room or the nursery.
- Newborn procedures will be conducted at the bedside whenever possible. If a baby is removed from the room, baby will be returned as soon as possible.
- If a mother request separation, her infant will be returned with the first signs of hunger.

## **Pacifiers**

- Suckling on a pacifier is different from suckling on a breast.
- Pacifier use may mask signs of hunger or delay feedings, leading to excess weight loss or dehydration.
- Avoid introducing until baby is 3-4 weeks of age or breastfeeding is well established: baby is latching comfortably and gaining weight well.
- A pacifier may be offered during a circumcision as a form of pain management.
- Pacifiers may be used with preterm infants, or infants with special medical conditions for non-nutritive sucking.

## **Nipple Shields**

- If a nipple shield is used to manage a latch difficulty, a mother should receive follow-up from a breastfeeding specialist once she leaves the hospital.

## **Nipple Soreness**

- Review positioning and latch, including skin to skin.
- May hand express and apply breast milk after feeding. Allow to air dry.
- Lanolin or hydrogel pads may be used.
- Hand express or use a pump to remove milk until baby is latching comfortably.

## Shared Community Breastfeeding Standards between Lincoln Hospitals

**This education and information is directed at all infants except with medical conditions including but not limited to respiratory distress, seizures, etc. who may require alteration in expectations and breastfeeding patterns during the acute phase.**

1. Bryan Medical Center and Saint Elizabeth Regional Medical Center will each have a written breastfeeding policy that is routinely communicated to all healthcare staff. This will be based on current research and guidelines from the United States Breastfeeding Coalition, American Academy of Pediatrics, Academy of Breastfeeding Medicine, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, World Health Organization and UNICEF.
  - a. Definition: Written policy
    - i. Each staff is expected to follow the written policy with follow-up for non-compliance.
    - ii. Reinforcement of breastfeeding policy will be addressed as needed.
  - b. Evaluation: Policy revised/evaluated every 3 years:
    - i. By both hospitals and bring back to the task force for major changes.
    - ii. Annual competencies with staff will be completed.

2. All staff caring for mothers and babies will be trained in the skills necessary to support breastfeeding based on current and consistent evidence based care.
  - a. Definition: Core Education
    - i. Importance of skin-to-skin
    - ii. Early initiation of breastfeeding
    - iii. Effective latch
    - iv. Expected feeding patterns and weight loss
    - v. Maintaining breast milk supply during mother infant separation
    - vi. Importance of exclusive breastfeeding
    - vii. Risks of non-medically indicated supplementation
    - viii. Importance of rooming-in
    - ix. Instruction on artificial nipples and pacifiers
    - x. Contraindications to breastfeeding
  - b. Evaluation:
    - i. For all staff caring for breastfeeding dyads, core education listed above must be completed by end of staff orientation
    - ii. Competency of core education will be evaluated by preceptor and/or management
    - iii. Nursing staff will have a minimum of 4 hours of supervised clinical experience (with an IBCLC) assisting with breastfeeding. This will be completed within 6 months of employment.
    - iv. Annual competencies will be completed to ensure staff competency.



3. Education will be provided to all pregnant women about the benefits and management of breastfeeding, contraindications to breastfeeding, and implications of formula feeding.
  - a. Definition
    - i. Verbal and written information will be provided in prenatal classes (i.e. childbirth, breastfeeding)
    - ii. Written information will be included in the preadmission packet given to patients in the physician offices
      1. Importance of exclusive breastfeeding
      2. Importance of early skin-to-skin contact
      3. Early initiation of breastfeeding
      4. Rooming-in
      5. Feeding patterns
        - a. First 24 hours of life
        - b. After 24 hours of life
      6. Risks of elective supplementation to breastfeeding/milk supply
      7. Limiting visitors to promote parental bonding during hospital stay
    - iii. Mother's informed feeding decision will be documented in medical record.
    - iv. Contraindications to breastfeeding and other special medical conditions will be discussed on an individual basis.
    - v. The hospital will not provide formula marketing materials to mothers and will discourage promotional material and marketing efforts in all areas accessible to patients.
  - b. Evaluation
    - i. Educators will be responsible for implementing/updating education for prenatal classes respectively.
    - ii. Preadmission packet given to patients in the physicians' offices will be evaluated every 3 years and/or updated as needed.

4. All healthy newborns will be placed and remain in direct skin-to-skin contact with their mothers immediately after delivery until the first feeding is accomplished, unless medically contraindicated, including cesarean births.
  - a. Definition-Skin-to-skin is the act of placing the dry, undressed infant against the bare skin (no bra) of the mother's chest. Then mother and baby are covered, except baby's head, with warm blankets.
    - i. Place infant skin-to-skin immediately after birth without interruption until first feeding is accomplished. In cases of cesarean birth immediate skin-to-skin should be initiated as soon as possible after delivery and can be done while incision is being closed.
    - ii. The infant should not be removed for routine assessments, bathing, medications, during procedures which may be painful, or during mother/infant transport. Cord clamping and APGAR scoring can be done with the infant skin-to-skin.
    - iii. If skin-to-skin is delayed due to medical necessity, resume skin-to-skin as soon as medically possible.
    - iv. Skin-to-skin contact should be encouraged throughout the hospital stay.
  - b. Evaluation
    - i. Skin-to-skin contact will be documented in the medical record
    - ii. The evaluation of the process will be performed as needed by each facility

5. All mothers will be shown how to recognize effective breastfeeding and how to maintain lactation if separated from their infant(s).
  - a. Definition: Effective latch, feeding patterns, maintaining milk production, hand expression, infant intake and output, and follow-up.
    - i. Staff will instruct breastfeeding mothers about:
      1. Proper positioning and latch.
        - a. Mom should be relaxed and comfortable
        - b. Baby should be well supported with infant's chest and hips facing mother
        - c. Baby's lips should be flanged outward
        - d. Cheeks should be full and round, no dimpling noted
        - e. No audible clicking or smacking while suckling
        - f. Latch should not be painful
      2. Nutritive suckling and swallowing.
        - a. Initial rapid suckle transitioning to long rhythmic suckles of the jaw into the temple region. Nutritive sucking can be encouraged by breast compressions, frequent stimulation of the infant, and skin-to-skin.
        - b. Intermittent swallowing less than 48 hours of life and frequent audible swallowing greater than 48 hours of life.
        - c. Non-nutritive suckling is defined as short rapid sucks with minimal swallowing noted.
      3. Infant feeding patterns.
        - a. Mothers will be instructed to feed their baby on demand 8-12 feeds in 24 hours, avoid scheduling feeds.
        - b. Mothers will be instructed to avoid time limits for breastfeeding on each side. Infants can be offered both breasts at each feeding but may be interested in feeding only on one side at a feeding during the early days.
        - c. Mothers will be able to recognize infant feeding cues. Indicators of hunger are; increased alertness or activity, smacking, rooting, or bringing hands to the mouth. Feed at the first signs of hunger, crying is a late sign of hunger.
      4. Maintaining milk production.
        - a. Frequent stimulation to both breasts (8-12 times per day around the clock) through direct breastfeeding and/or pumping, if baby is unable to successfully latch or mother/infant are separated.
      5. Hand expression of milk and use of a pump if indicated.

- a. Mothers will be instructed on how to effectively hand express breast milk. When indicated, instruction will be given on proper set-up, use, and cleaning of breast pump per manufacturer guidelines.
  - b. Hand expression/pumping will be used when direct breastfeeding cannot be accomplished (i.e. separation from baby, ineffective latch, sore/healing nipples)
    - i. If after 12-24 hours of life the infant has not latched or fed effectively, the mother will be taught to hand express or pump colostrum every 2-3 hours around the clock until effective feeding patterns are established. Any expressed breast milk shall be fed to the infant by cup, syringe, or SNS.
    - ii. If mother and infant are separated, expression by hand or pump shall be initiated within 3-6 hours of life and continued every 2-3 hours around the clock until effective feeding patterns are established. Mother should express both breasts for 15 minutes.
  - c. Mother will be instructed on the correct collection and storage guidelines of freshly expressed breast milk. Written guidelines will be provided at discharge.
  - d. Mother will be reminded that she may not obtain much milk or any milk the first few times she expresses her breasts.
6. Normal infant intake and output:
- a. Normal breast milk volumes
    - i. Breast milk volumes continue to increase each day relative to increasing infant stomach capacity, from drops to 15-30 cc per feeding session by 72 hours (about 6 oz per 24 hours).
    - ii. Milk supply begins to establish between day 3-5. Mom will notice increased fullness in her breasts accompanied with increased audible swallowing.
  - b. Assessment of adequate hydration.
    - i. Acceptable weight loss up to 10%.
    - ii. Infants are expected to return to birth weight within 14 days.
    - iii. Until breast milk supply is established normal age appropriate elimination patterns are:
      1. 0-48 hours: at least 1 wet, 1 stool per 24 hours.
      2. 49-72 hours: 2 wets and 2 stools per 24 hours.
      3. 73-96 hours: 3 wets and 3 stools per 24 hours.
    - iv. By day 4 infant should have at least 6 wet diapers and 4 yellow stools in a 24 hour period.
7. Reasons for contacting the healthcare professional (i.e. Family Physician, Pediatrician, IBCLC)
- a. Difficult, painful, or refusal latch

- b. Inadequate wets and stools
- c. Not waking to feed every 2-3 hours
- d. Infant acts hungry or fussy all the time

b. Evaluation

- i. Breastfeeding assessment will be done at least once every 12 hours or more frequent if necessary using LATCH score (or other mutually agreed upon evidence based assessment tool).
- ii. Staff will document education given to mother in mother/infant medical record.

6. Mothers will be encouraged to exclusively breastfeed, unless medically contraindicated. Exclusive breastfeeding is defined as providing human milk as a sole source of nutrition. Routine supplementations (water, glucose water, formula, and other fluids) will not be given to breastfeeding infants unless specifically ordered by a physician or if the mother insists after receiving verbal and written education.
  - a. Definition: The Joint Commission defines exclusive breast milk feeding as: “a newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines.” Breast milk feeding includes expressed mother’s milk as well as donor human milk, both of which may be fed to the infant by means other than suckling at the breast.
    - i. In the event a mother requests non-medically indicated supplementation, staff should:
      1. Educate the mother on effective breastfeeding.
        - a. Have a direct breastfeeding evaluation of positioning, latch, and ability to transfer milk.
        - b. Be educated on normal newborn behaviors that do not require supplementation but do require breastfeeding evaluation and assistance.
          - i. Sleepy infant with fewer than 8-12 feedings in the first 24-48 hours with a normal weight loss (<8%) and no signs of illness.
            1. Instruct on skin-to-skin.
            2. Educate on normal sleep-wake cycles.
            3. Careful attention to infant’s early feeding cues and gentle awakening techniques every 2-3 hours around the clock.
            4. Encourage hand expression and/or pumping after feeding attempts if infant is not effectively latching at breast.
          - ii. Cluster feeding: Instinctive feeding patterns that often begin around 24 hours of life, demonstrating periods of frequent feeding followed by periods of rest.
            1. Instruct mother on normal infant behavior during cluster feeding.
            2. Assist on breastfeeding management that optimizes infant feeding at breast.
              - a. Skin-to-skin
              - b. Correct latch
              - c. Gentle stimulation of baby
              - d. Breast compressions
          - iii. Low-risk jaundice
            1. Healthy term AGA infants with bilirubin levels within normal limits for age who is feeding well, demonstrating age appropriate eliminations with weight loss 8%.

- a. Be provided education on risks or non-medically indicated supplementation
  - i. Altering normal intestinal flora of the infant
  - ii. Sensitizing infant to foreign proteins increasing the risk of allergies
  - iii. Disrupting supply/demand cycles leading to inadequate milk supply, delayed lactogenesis, and long-term supplementation.
  - iv. Latch difficulty if fed by artificial nipple
  - v. Causes increased maternal engorgement due to decreased frequency of feeds.
  - vi. Causes infant's stomach to stretch too quickly, interrupting the natural increasing stomach capacity.
  - vii. Shortened breastfeeding duration/early weaning
- 3. Educate the mother on alternative feeding methods (EBM)
  - a. Instruct on hand expression and/or pumping.
  - b. Instruct on finger/syringe, cup, or SNS for feeding of EBM
- 4. Non-medically indicated supplementation (Formula)
  - a. Staff will respect and support mother's informed decision on non-medically indicated supplementation.
  - b. Any supplementation should be given by finger/syringe, cup, or SNS unless mother chooses otherwise.
- ii. Medically indicated supplementation:
  - 1. Physician order is required
  - 2. Mothers own expressed milk or banked donor human milk should be encouraged when supplementation is indicated. If formula is used for supplementation hypoallergenic formula is preferred over standard formulas.
  - 3. Medically indicated supplementation may include:
    - a. Maternal delayed lactogenesis II
    - b. Abnormal weight loss
    - c. Hypoglycemia
    - d. Hyperbilirubinemia
    - e. Clinical evidence of significant dehydration
    - f. Delayed bowel movements or continued meconium stools on day 5
- iii. Medical Contraindications for breastfeeding
  - 1. Mother's medications that are unsafe for the breastfeeding infant.

2. Medical condition of mother
    - a. May be given expressed breast milk if mother has:
      - i. Untreated Tuberculosis
      - ii. Active Herpes Simplex virus on the breast
      - iii. Onset of Varicella within 5 days before or up to 48 hours after delivery until she is no longer infectious
    - b. HIV
    - c. Human T-cell lymphotropic virus Type-I or Type-II
  3. Mothers currently using illicit drugs
  4. Infants with galactosemia
  - iv. Staff shall recognize Mothers and Infants at increased risk of breastfeeding difficulty or delayed lactogenesis which may increase risk of supplementation.
    1. Cesarean delivery
    2. LGA/SGA infants
    3. Primiparas
    4. Prolonged labor
    5. Obesity
    6. Infants of diabetic mothers
    7. Postpartum hemorrhage
    8. Breast irregularities (flat/inverted nipples, surgeries, breast development, history of low milk supply, etc.)
    9. Infant conditions (down syndrome, cleft lip/palate, or other genetic disorders)
    10. Multiples
    11. Maternal hormone imbalances (i.e. PCOS)
  - v. Avoid using the term “bottle” as a synonym for formula feeding. Bottles may contained expressed or donor human milk. Formula may be given by other means besides a bottle.
- b. Evaluation
- i. Staff will document in medical record: breastfeeding assistance provided, counseling on risks of non-medically indicated supplementation, mothers educated decision.
  - ii. Handwritten information regarding supplementation will be provided.



7. Newborns will be encouraged to room-in with their mother day and night to establish successful breastfeeding.
  - a. Definition- all infants regardless of feeding method should be kept with the mother both day and night throughout the hospital stay.
    - i. Parents will be educated on the benefits of rooming-in.
      1. Promotes exclusive breastfeeding and longer breastfeeding duration
        - a. Parents learn to recognize feeding cues and feed at the earliest signs of hunger.
        - b. Infant will have uninterrupted opportunities to feed frequently therefore:
          - i. Infant's weight loss/gain is more likely to remain within normal parameters.
          - ii. Infant is less likely to become jaundice.
      2. Promotes bonding.
      3. Infants who stay near their mothers sleep better and cry less, and mothers get the same amount of sleep whether the infant is in their room or the nursery.
      4. Mother gains confidence in caring for her newborn.
    - ii. Staff will minimize infant-mother separation
      1. Conduct newborn procedures at the mother's bedside whenever possible, and should avoid frequent separation and/or absences of the newborn from the mother.
      2. If the infant must be removed from the mother's room, baby should be returned as soon as circumstances allow.
      3. If mother requests separation, infant will be brought to the mother with the first signs of hunger.
  - b. Evaluation: Education on the importance of rooming-in will be documented appropriately in the medical record.

8. Mothers will be instructed to feed their baby on demand with a minimum of 8-12 feeds in 24 hours.
  - a. Definition: Mothers should be encouraged to feed her infant per hunger cues. Healthy newborns typically feed 8-12 times in 24 hours, with some infants needing to be fed more frequently.
    - i. Birth-24 hours
      1. Infant should be fed within the first hour of life for vaginal deliveries. Post-Cesarean-birth babies will be encouraged to breastfeed as soon as possible.
      2. After initial wake period infant may become very sleepy and not interested in breastfeeding. Infant goes into a deep recuperative sleep cycle.
      3. Offer breast at least every 2-3 hours, placing infant skin-to-skin with attempts at breast to encourage a more alert infant.
      4. Normal for infants to be periodically uninterested in feeding during the first 24 hours of life. If blood sugar is within normal limits and infant has latched successfully, no intervention is needed at this time. Continue to encourage mother to offer breast every 2-3 hours.
    - ii. After 24 hours of life
      1. Infants begin to wake-up and begin to nurse more frequently. Offer both breasts at first signs of hunger cues
      2. Continue offering both breasts at each feeding but may be interested in feeding only one side at a feeding during the early days. No restrictions should be placed on the frequency or the length of feedings. Limiting feedings can lead to low milk supply, low weight gain, delayed lactogenesis, jaundice, engorgement, and/or mastitis.
    - iii. Cluster feeding often begins around 24 hours of life, and can be defined as a normal and distinctive feeding pattern.
      1. Cluster feeding occurs due to infant eating small volumes with better digestion, leading to more frequent feeds.
      2. Infant has periods of frequent feeds followed by periods of rest.
      3. Cluster feeding is a necessary instinctive feeding pattern as it helps to build mothers milk supply and establish a successful long term supply, though can be frustrating as it often occurs at night.
      4. Encourage mother to continue feeding infant on demand during these feeding patterns. Breast compressions should be encouraged throughout feeds to facilitate and increase transfer of colostrum.
      5. Mother can expect infant to behave both fussy and sleepy when at the breast. Skin-to-skin and gentle stimulation may help calm and awaken infant encouraging them to feed more effectively.
    - iv. Painful procedures
      1. Mother should be educated on infant behaviors following painful procedures (i.e. circumcision), which may temporarily affect infant feeding patterns and/or breastfeeding by making infant sleepy, uninterested in feeds, or dis-coordination of suckle. This may be followed by a period of cluster feeding.
  - b. Evaluation: Staff will document each feeding and all education provided in medical record.

9. Mothers will be instructed on not using artificial nipples or pacifiers until breastfeeding is well established (the first 3-4 weeks of life). Staff will not initiate the use of artificial nipples or pacifiers.
  - a. Definition:
    - i. Artificial nipples should not be offered to a breastfeeding infant for supplementation, sore nipples, or medications.
      1. If mother requests artificial nipple, she will be educated on how it may interfere with optimal breastfeeding if introduced before breastfeeding is well established. This may be demonstrated by refusal to breastfeed, ineffective latch, and fussiness at breast due to differences of flow between an artificial nipple and breast flow.
      2. If supplementation is medically indicated, mother will be offered a cup, syringe/feeding tube, or SNS to give additional volumes. Staff will instruct and observe one or more successful supplemental feedings.
    - ii. Pacifiers have been shown to interfere with establishment of breastfeeding and are not necessary in the early weeks.
      1. Mother will be educated on the risks of pacifier use.
        - a. Suckling at breast differs from sucking on pacifier. This may cause problems with latch therefore increasing risk of nipple tenderness
        - b. Pacifiers may mask signs of hunger and/or delay feedings, leading to excessive weight loss or dehydration.
      2. Newborns undergoing painful procedures (i.e. circumcision) may be given a pacifier as a form of pain management during the procedure. Pacifiers should be immediately discarded once procedure is complete. Alternatively, consider putting the infant to breast for heel sticks procedures.
      3. Mothers will be instructed on current recommendations of delayed pacifier use until 3-4 weeks of age, or until breastfeeding is well established.
      4. Pacifier use for preterm infants in NICU, special care units, or infants with specific medical conditions may be given pacifiers for non-nutritive sucking.
    - iii. Nipple shields
      1. Will not be routinely used to cover mother's nipples for latch problems, to prevent or manage sore or cracked nipples, or when a mother has flat or inverted nipples.
      2. Nipple shields will only be used in conjunction with an IBCLC evaluation and after other attempts to correct the latch difficulty have failed. Direct observation of feeding using a nipple shield should be done initially by an IBCLC followed by continued observation by staff.
      3. IBCLC will discuss risks of nipple shield
        - a. Low milk supply due to artificial barrier placed between infant and mother decreasing hormone release caused by a decrease in nerve stimulation.
        - b. Difficulty weaning from nipple shield

c. Risk of decrease milk transfer resulting in low weight gain and low milk supply.

4. Education will be provided on maintaining milk supply and early follow-up with healthcare professional after discharge.

iv. Nipple Soreness

1. Mothers with sore nipples will be observed for latch technique and correct latch as needed.

2. Instruct mother on hand expression and apply breast milk to nipple after each feeding and allow to air dry.

3. Lanolin or hydrogel pads may be used as appropriate.

4. Follow-up with an IBCLC if nipple soreness persists.

b. Evaluation:

i. Staff will document

1. Education on artificial nipples, pacifiers, alternative feeding methods, nipple shields, and nipple soreness

2. Observation of alternative feeding methods, use of nipple shields, and correct use of nipple treatment.

ii. Reinforcement of policy and procedures as needed.

10. Prior to going home staff will ensure all breastfeeding education is completed and provide all mothers with the names and telephone numbers of support groups and community resources that are available to help mothers with breastfeeding.
  - a. Definition: Prior to leaving the hospital breastfeeding mothers should be able to:
    - i. Identify effective breastfeeding
      1. Position and latch baby properly with no pain
      2. Be able to identify nutritive versus non-nutritive suckling and recognize swallowing
      3. State that the baby should breastfeed 8-12 times/day, with some infants needing to feed more frequently.
      4. Describe typical newborn feeding cues and state that the baby should breastfeed on demand and preferably before crying ensues.
      5. State expected elimination patterns (at least 6 wets and 4 yellow stools per 24 hours by day 4)
      6. State that by day 5 the baby should be gaining about an ounce per day and be back to birth weight within 14 days.
      7. Be able to hand express milk and know how to use a pump correctly, if indicated.
      8. Provide anticipatory guidance on things that may be encountered after the hospital: the management of engorgement and mastitis, signs of excess jaundice, sleep patterns, individual feeding patterns, and cluster feedings.
    - ii. If the Shared Hospital Discharge Worksheet for Breastfeeding Mothers identifies a risk factor, an infant will be referred to a health care provider or IBCLC within 24-48 hours of discharge from the hospital. Prior to discharge arrangements will be made to secure a pump for home use if needed.
    - iii. Identify indications for calling a health care professional.
      1. Staff will provide each mother with names and numbers of support groups and community resources.
      2. All breastfeeding newborns will be referred to a healthcare professional for a visit within 24-72 hours of discharge from the hospital.
    - iv. Written information will be provided at discharge.
  - b. Evaluation: Staff will document all discharge education in medical record.

Hospital Evaluation Bundle-Evaluation will exclude NICU babies

1a) All mothers should be given their babies to hold with uninterrupted and continuous skin-to-skin contact immediately after birth and until the completion of the first feeding or one hour, unless there are medically justifiable reasons for delayed contact.

1b) After cesarean birth, babies will be placed in uninterrupted and continuous skin-to-skin contact with their mother as soon as medically indicated within the first hour of life.

This applies to all babies, regardless of feeding method.

2. a) Mother able to breastfeed exclusively in hospital setting, only supplementing when medically necessary.

Exclusion Criteria: medically indicated supplementation WITH physician order and mothers who intend NOT to do ANY breastfeeding.

2. b) Documentation of education for those choosing elective supplementation.

3. Discharge Assessment performed to identify those at risk for breastfeeding problems

# Shared Hospital Discharge Worksheet for Breastfeeding Mothers

Please complete this form after midnight on the day a mother and baby are scheduled for discharge from the hospital. This form helps to assess a baby's need for early follow up to promote breastfeeding duration.

**Baby's Age:**  Birth – 24 hrs.  25 – 48 hrs.  49 – 72 hrs.  73 – 96 hrs.  5 days +

**Baby's Birth Weight** \_\_\_\_\_

**Baby's Discharge Weight** \_\_\_\_\_

## Please assess and note whether any of the following risk factors are present:

\_\_\_\_\_ Weight Loss of  $\geq 8\%$  <sup>(1,3,4)</sup>

\_\_\_\_\_ Age at Discharge is <24 hours <sup>(1,4)</sup>

\_\_\_\_\_ Gestational Age is <38 weeks <sup>(3)</sup>

\_\_\_\_\_ Latch is Painful or Inconsistent <sup>(4)</sup>

\_\_\_\_\_ Mother is using a nipple shield with feedings. <sup>(4)</sup>

\_\_\_\_\_ Mother is triple feeding\* <sup>(4)</sup>

\*Triple feeding: Feeding at breast, supplementing, and pumping at each feeding

\_\_\_\_\_ Bilirubin Level <sup>(5)</sup> is \_\_\_\_\_ High Intermediate Risk or \_\_\_\_\_ High Risk

\_\_\_\_\_ Other risk factors present \_\_\_\_\_

- Current guidelines <sup>(1,2,4)</sup> recommend that a newborn be seen within **48-72 hours** after hospital discharge.
- Schedule this follow-up visit in **24-48 hours** if there are risk factors (noted above).

The Academy of Breastfeeding Medicine (ABM) recommends this visit should be with a pediatrician, family physician, or other qualified healthcare professional for a formal breastfeeding evaluation, weight check, and jaundice assessment.<sup>(4)</sup>

1. **ABM Clinical Protocol #2:** Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: "The Going Home Protocol," Revised **2014**. BREASTFEEDING MEDICINE Vol.9, No.1, 2014 <sup>a</sup> Mary Ann Liebert, Inc. DOI: 10.1089/bfm.2014.9996
2. **AAP Policy Statement:** Eidelman, A., & Schanler, R. (**2012**). Breastfeeding and the use of human milk. Journal of the American Academy of Pediatrics, 129(3), e827-e841. doi: 10.1542/peds.2011-3552
3. **ABM Clinical Protocol #10:** Breastfeeding the Late Preterm Infant (34 0/7 to 36 6/7 Weeks Gestation) (First Revision June 2011)\* BREASTFEEDING MEDICINE Vol.6, No.3, **2011** <sup>a</sup> Mary Ann Liebert, Inc. DOI: 10.1089/bfm.2011.9990
4. **ABM Clinical Protocol #7:** Model Breastfeeding Policy (Revision **2010**). BREASTFEEDING MEDICINE Vol.5, No.4, 2010 <sup>a</sup> Mary Ann Liebert, Inc. DOI: 10.1089/bfm.2010.9986
5. **ABM Clinical Protocol #22:** Guidelines for Management of Jaundice in the Breastfeeding Infant Equal to or Greater Than 35 Weeks' Gestation. BREASTFEEDING MEDICINE Vol.5, No.2, **2010** <sup>a</sup> Mary Ann Liebert, Inc. DOI: 10.1089=bfm.2010.9994



MD notified \_\_\_\_\_ Date/Time \_\_\_\_\_ Initials

## Key Shared Postpartum Teaching Concepts

### Normal Newborn Breastfeeding: Day 3 (73-96 hours old) to Day 14

- **Latching**
  - A baby should be able to latch to both breasts without any pain, although tugging or pulling is acceptable.
  - Nipples should not be cracked, blistered or bleeding.
  - Heat and massage will help with milk let-down. If firm full breasts make latching difficult, soften breasts by expressing some milk (by hand or pump).
- **Indicators of Sufficient Intake**
  - By day 4 a baby should be waking and asking for feeds 8-12 times in 24 hours and be content between feedings. Swallowing should be heard.
  - By day 4 a baby should have 6 wets and 4 yellow stools in 24 hours
  - By Day 5, a baby should be gaining about an ounce a day and be back to birth weight within 14 days.
- **Empty the Breasts Regularly**
  - Frequent breast emptying stimulates more milk production.
  - Empty/soften the first breast before switching to the second breast.
  - Use “breast compressions” to prompt a sleepy baby to keep swallowing or help empty/soften a breast. This insures that a baby gets the hind milk deep in the breast.
  - A typical baby takes about 30 minutes to complete a feeding.
  - While milk supply is establishing, always offer both breasts at a feeding. Most babies will empty one breast well and then take less milk from the second breast. Some babies will feed only from one breast at a feeding and some babies will always feed from both breasts at a feeding. The goal is a satisfied baby who is gaining well.
- **Nurse on Demand / Avoid Scheduled Feedings**
  - Babies nurse between 8-12 times in 24 hours.
  - Some babies nurse quickly and others take more time.
  - Some moms produce large volumes of milk quickly, while others slowly produce smaller amounts.
  - Since the amount of milk per feeding is unknown, babies should be fed when they act hungry. A baby should not have to “wait for” a feeding.



- **Promote Daytime Feedings So Baby Will Eventually Sleep More at Night**

- During the day, nurse at least every 3 hours (start to start). At night, allow one 4-5 hour stretch of sleep.
- Once a baby is back to birth weight, gaining adequate weight and waking for most feedings, allow baby to wake up on his/her own at night.
- Infrequent milk removal may decrease supply. Consider expressing milk at night if baby wants to sleep longer than six hours and milk supply decreases.

- **Supply and Demand**

Ideally a baby will ask for feedings and remove an adequate amount of milk, while a mother will make enough milk that her baby is satisfied and gains weight well.

- **Too little milk consumed:** An underfed baby may nurse ineffectively for long time periods (more than 40 minutes) and be hungry and fussy between feedings. Some babies will not wake and ask for feedings or act hungry but fall asleep at the breast. “Triple feeding” is a regimen that provides for time at the breast, good milk removal and good weight gain. It also allows a baby to mature and gain energy in order to breastfeed better.

Triple Feeding consists of three steps:

- 1) Put baby to breast, practicing a good latch. If baby will not latch, may hold skin to skin.
- 2) Feed baby expressed breastmilk (or donor milk or formula).
- 3) Remove remaining milk in breasts by pumping or hand expression.

Because this cycle will occur about 8 times in 24 hours, it is important to limit time at the breast to 15-20 minutes total to make sure baby gets fed well and mom has a break between feeds.

Once a baby is latching, removing milk well, gaining weight well and milk supply is adequate, triple feeding may be gradually discontinued.

- **Too much milk produced:** Some mothers produce too much milk, which may cause breast discomfort and a fussy baby. Because frequent milk removal from both breasts will further increase milk supply in these mothers, the goal is to empty/soften one breast well before offering the second breast. This may involve feeding from only one breast at a feeding, or even staying on one breast for two feedings in a row. It may help to *slightly* soften the non-nursed breast with hand expression or a pump until supply slows down.

- **How to Give Supplemental Milk**

- If a baby is not latching well, or not vigorous and alert, position a feeding tube attached to a syringe or container of milk alongside your finger and encourage baby to suckle on your finger to obtain the milk.
- If a baby is vigorous and latching well, but mom’s supply is low, practice supplementing baby at the breast with a feeding tube attached to a syringe or inserted in a container of milk.

- Avoid introducing a bottle unless baby cannot be fed at the breast. Use a slow-flow nipple that requires a baby to suckle to remove milk, allows a baby to pause when desired and makes a baby open the mouth wide. Use of a wide mouth nipple (versus a standard, regular-size nipple) often causes a baby to suckle with a “closed mouth” latch, taking just the tip of the nipple in their mouth. A bottle feeding should not cause a baby to tense or gulp or struggle to protect their airway.
- **Engorgement, Plugged Ducts and Mastitis**
  - Breast swelling is common when milk first comes in. If milk is not removed frequently, engorgement may present as painful, red, shiny breasts. Tissue swelling may compress the milk ducts so milk can’t flow freely. Cold packs between feedings may help reduce the swelling.
  - Milk that is not removed frequently may result in “milk stasis,” which can lead to a “plugged duct,” resulting in more milk stasis. A lump or rope-like area may be noticed in the breast. Frequent milk removal, while massaging over the lump towards the nipple, should help the lump to become smaller. Warm moist heat prior to breastfeeding or pumping may also help relieve the plug.
  - Mastitis can evolve from unresolved milk stasis, a plugged duct, or engorgement. An area on one breast may suddenly appear swollen, red, hot, painful and firm. A mother may have a fever, chills, body aches and fatigue. Encourage rest, apply heat to breast, and remove milk frequently (breastfeed or pump/hand express). A baby may breastfeed or drink expressed breastmilk from the affected breast. An antibiotic may be needed if symptoms don’t improve in 12 to 24 hours.
- **If any of the following high risk factors are present**, mother and baby should be followed closely until back to birth weight and gaining well:
  - Previous breastfeeding problems
  - Breast issues: surgery, hypoplastic, asymmetrical
  - Maternal health issues: diabetes, obesity, hypertension, infertility, thyroid problems or PCOS
  - Latching issues: nipple pain/trauma, tongue tie
  - Nipple shield dependence
  - Triple feeding due to: slow weight gain, poor milk removal, or poor milk supply
  - Infant jaundice
- **All babies should have a weight check at 2 weeks old** to verify that baby is gaining about an ounce per day and is at or above birth weight. Babies that are slow to gain may benefit from more frequent and long term follow up. All babies require a 1 month check-up with their health care provider, at which time growth will be plotted on a growth chart and monitored thereafter.

- **Breast Milk Storage Guidelines** (American Academy of Breastfeeding Medicine, 3/10)
  - Wash hands well.
  - Containers - Use bpa (bisphenol A) free glass or polypropylene containers (clean, not sterile). Seal containers well.
  - Storage - Guidelines are variable due to a lack of research. Influencing factors include: cleanliness of hands, pump parts and storage containers, temperature of storage environment, and access to alternative milk for the baby.
    - Room temperature (16-29 C or 60-85 F) for 3 hours (optimal) to 8 hours (very clean)
    - Refrigerator ( $\leq 4$  C or 39 F) for 3 days (optimal) to 8 days (very clean)
    - Freezer ( $\leq 17$  C or 0 F) for 6 months (optimal) to 12 months acceptable.
      - Thaw frozen milk overnight in refrigerator or in container of warm water.
      - Do not store at room temperature longer than 3 hours.
      - Use within 24 hours.
      - Do not re-freeze milk.
  - Once a baby drinks from a container of milk, the remaining milk may be fed to the baby up to 2 hours after the feeding has finished.
  - Do not microwave breastmilk.
  - Use fresh breastmilk when available. If there is no fresh milk available, use the oldest milk in the refrigerator or freezer first.