ENLOE MEDICAL CENTER

BREASTFEEDING
(All Procedures Involved in Infant Feeding of Human Milk)

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DEFINITION AND PURPOSE:

This policy was written to promote the philosophy of breastfeeding. The following guidelines are designed to promote optimal infant feeding and include alternative feeding methods. These alternative feeding methods are most often temporary and are carried out with the ultimate goal of transitioning to exclusive breastfeeding. Guidelines also include the collection, storage and feeding of human milk, including the use of donor human milk.

POLICY:

- Enloe Medical Center's breastfeeding policy is accessible to all health care staff. This policy will be updated annually by the Mother & Baby leadership team. The ultimate responsibility of implementation will reside with the Mother & Baby Care Center Director.
    - Information regarding the *Ten Steps to Successful Breastfeeding* will be posted for families and visitors in all areas of the hospital that serve women and children.
    - The manager or educator for each of the applicable departments will review the policy with all new employees within two weeks of hire.
    - Changes to the policy will be reviewed with staff and providers, via department meetings, prior to implementation.

STAFF TRAINING:

- Ongoing training shall be offered for all health care staff regarding the skills necessary to implement this policy. The Manager for the Enloe Mother & Baby Care Center will ensure that all providers registered nurses (RN) and RN/IBCLCs (International Board Certified Lactation Consultant) who work in the Mother & Baby Care Center will receive the required number of hours of training. The providers will complete three hours of education which includes policy review and module review. RNs and RN/IBCLCs will complete fifteen hours didactic plus five hours clinical competency on the topics that are specified by the *Baby Friendly Hospital Initiative.*
    - This training will be completed within six months of hire.
    - Staff training obtained prior to employment is not acceptable.
    - Details for the content of the training are specified in Appendix A.
    - Documentation of all training, and any competencies completed, will be maintained by the education department and stored in OAK electronically.
    - All RNs, RN/IBCLCs who work in the Mother & Baby Care Center are required to have a minimum of two hours of continuing education each year, addressing human lactation. These will be accomplished through updates presented at the annual Baby Friendly Updates class, "Keeping You Abreast" newsletter, educational modules, ancillary and licensed skills fair, competencies and staff meeting presentations.
- RNs will be knowledgeable regarding the benefits and management of breastfeeding and able to assist families as needed.

PRENATAL EDUCATION

- At Enloe Medical Center we will inform all pregnant women about the benefits and management of breastfeeding. This information will be shared both verbally and through educational brochures. Our hospital based prenatal clinics, outpatient education and

lactation center as well as the Mother and Baby Care Center will all participate in these educational offerings.

- Within our hospital based prenatal clinics, electronic medical record documentation is used in each prenatal chart to assure that all Baby Friendly topics have been covered with each patient. The prenatal breastfeeding education begins at the first trimester and will be completed by the third trimester. The education will be provided by clinic staff, nurses and providers. The educational topics include: the benefits of breastfeeding, the importance of exclusive breastfeeding, non-pharmacological pain relief methods for labor, baby-led feeding, early skin-to-skin contact, rooming-in on a 24-hour basis, early initiation of feeding in relation to establishing a milk supply, effective positioning and latch techniques, exclusivity of breastfeeding for the first 6 months, and continuation of breastfeeding after introduction of appropriate complimentary foods. The MBCC leadership team will collaborate to assess and revise the perinatal breastfeeding education curriculum assuring that the information is current, research based and consistent throughout the organization. Through educational opportunities and written information all clinic personnel will demonstrate working knowledge of all curriculum topics. All perinatal educational materials given to expectant and breastfeeding mothers are free from messages that promote or advertise infant food or drinks other than breastmilk. Group discussion covering the use of formula and infant feeding bottles is avoided.
- Breastfeeding education will also be reviewed during prenatal lactation consults, online virtual hospital tours, and prenatal breastfeeding classes.
- The staff at the Mother and Baby Care Center will also offer breastfeeding education to those mothers admitted prenatally; valuing any opportunity of interaction prior to delivery of the baby.

MEDICAL CONDITIONS AND POTENTIAL CONTRAINDICATIONS TO BREASTFEEDING

- A review of all medications given to any lactating woman will occur on an ongoing basis to assure compatibility with breastfeeding. Utilize Thomas Hale's *Medications in Breastmilk,* the hospital pharmacist, LactMed, and/or the infant's provider.
- If breastfeeding is contraindicated, note reason why in mother's electronic medical record.

Infant - Galactosemia	Contraindicated. A special lactose-free formula is needed.
Infant - Phenylketonuria	It is recommended that the mother continue to breastfeed and supplement with low phenylalanine formula. Blood monitoring is recommended.
Infant - G6PD (Glucose-6-phosphate-dehydrogenase deficiency	Fava beans, nitrofurantoin, primaquine, and phenazopyridine should be avoided by mother to minimize the risk of hemolysis in

	the infant. Blood monitoring is recommended.
Infant - Maple syrup urine disease	Not recommended. A special formula free of leucine, isoleucine and valine is needed.
Maternal - Untreated brucellosis	Contraindicated Breastfeeding should resume after an initial period of 48-96 hours of therapy required for the mother.
Maternal - HIV	Contraindicated in the United States of America

Maternal - Active untreated tuberculosis	Contraindicated (However, may resume when a mother is treated for a minimum of two weeks and has documentation to support that she is no longer infective. Separation from infant is recommended while mother has active infection. Expressed breastmilk may be used.
Maternal - Active herpes simplex lesions on the breast	Contraindicated. Direct contact between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved. Expressed breastmilk may be used.
Maternal - T-cell lymphotrophic virus I/II	Not recommended.
Maternal - Varicella (5 days before through 2 days after delivery)	Airborne and contact isolation are recommended for infants born to mothers with varicella. Recommendation is to treat infant with an antiviral and continue breastfeeding. However, expressed breastmilk can be used.
Maternal - influenza	Should temporarily be isolated from their infants until they are afebrile, but they can/ should provide expressed milk for feeding.
Maternal - CMV	The benefits of milk from CMV+ mothers outweigh the risks of clinical disease from CMV transmission.
Maternal - Use of "street drugs" (example, PCP, cocaine, heroin and methamphetamine.	Contraindicated
Maternal- Use of Cannabis	Not recommended. A discussion regarding risks should be held between the infant's

	provider and mother. Provide cannabis handout. A social work referral will be made.
Maternal- Use of Alcohol	Use with caution, not recommended. Monitor infant for sedation, poor feeding, decreased milk supply and altered milk taste.
Maternal- Use of tobacco	Not a contraindication but should be discouraged.
Maternal - Supervised Methadone/Subutex maintenance	With negative screening for HIV and illicit drugs should be encouraged to breastfeed.
Maternal medications	In general, breastfeeding is not recommended when mothers are receiving medication from the following classes of drugs: amphetamines, chemotherapy agents, ergotamine's, and statins. Comprehensive and up-to-date sources include: LactMed (an internet-accessed source published by the National Library of Medicine/National Institutes of Health) & Medications and Mothers Milk 2019, Thomas Hale, PhD.

Maternal - Hepatitis B	Breastfeeding is recommended without evidence of cracked, bleeding nipples or lesions. Infant will receive HBIG, and Hepatitis vaccine. The vaccine does not have to be given before the first feeding.
Maternal - Hepatitis C	Breastfeeding is recommended. Special attention to proper latching and positioning to avoid open lesions. Abstain from breastfeeding if nipples are cracked and bleeding
Syphilis	Any wet sores on the mother's body should be covered during breastfeeding. Breastfeeding should be avoided until skin sores completely heal.

SKIN-TO-SKIN CONTACT

- Immediately after birth, the nursing staff present have the responsibility to create the optimal environment for transition of the infant and initiation of the first breastfeeding to facilitate maternal-infant bonding. Assure best practices for breastfeeding support, and safely transition the infant from intrauterine life to extra-uterine life. All mothers will be encouraged to participate in skin-to-skin care, regardless of their feeding preference. The mother will be taught the normal phases of infant transition as well as signs or symptoms of readiness to feed.
    - It is imperative that the mother/caregiver who is providing skin to skin contact be awake and alert.
    - Skin-to-skin contact will be practiced in the following manner: baby is placed, prone, on the mother's chest and/or abdomen, Cover head with cap (optional) and place prewarmed blankets to cover body of newborn on mother's chest, leaving face exposed, and there will be no clothing between mother and infant.
    - The RN will perform frequent and repetitive assessments, including observation of newborn breathing, activity, color, tone, and position, in order to prevent positions that may obstruct the breathing of the newborn.
    - The infant should be able to access the mother's breast with no interference.
    - In the case of a vaginal delivery, skin-to-skin begins immediately if both are medically stable. For cesarean deliveries, skin-to-skin will occur when the mother is alert and able to respond to her infant.
    - Every reasonable effort will be made to ensure that skin-to-skin will continues uninterrupted for at least one hour, and until the completion of the first breastfeeding. Routine newborn procedures should be postponed until the first breastfeeding attempt occurs, during the initial period of skin-to-skin contact. Routine assessment procedures will be performed while infant is skin-to-skin with mother.
    - Healthy infants should be put to the breast within one hour after delivery. The infant suckling reflex is most intense 45 minutes to two hours after birth. A delay in feeding is linked with increased difficulties in the initiation of breastfeeding as well as shorter duration. At this time, the nurse will be able to assist with proper latching and positioning as well as encourage skin-to-skin contact, and hand expression of breast milk.
    - In the case where the mother chooses to formula feed, every reasonable effort will be made to ensure that the initial period of skin-to-skin lasts at least one hour.
    - If an infant is separated for a medical contraindication, or must be transferred immediately to special care, the staff will ensure mother and infant begin skin-to-skin care as soon as is possible. It is recommended to educate patient-partner and provide facilitation of hand expression within the first hour of birth.
    - Skin-to-skin care will be documented in the electronic medical record. If skin-to-skin contact is not possible, the reason will be documented in electronic medical record. Some of those reasons include medical complications.

ROOMING-IN

- **Practice rooming-in, where mothers and babies will stay together 24 hours per day, regardless of feeding choice, or delivery method unless medically necessary to separate.** Maintaining close contact between a mother and newborn, decrease the risk of infection and sepsis; increasing the opportunity for the development of a protective immunological environment; decreasing stress responses by the mother and her infant; and enhancing sleep patterns in the mother. Rooming in also enhances educational opportunities and is a current evidence-based practice that leads to optimal breastfeeding outcomes.
    - Rooming-in may include the exception of short periods of time, totaling one hour or less per 24 hours.
    - Procedures that can be performed at the bedside can be performed while the infant is preferably being held skin to skin or at least in the room with the mother. Being held skin to skin with the mother has been shown to decrease pain in the newborn undergoing painful procedures such as blood draws.
    - Educate patients and support persons to safely place newborns on a close but separate sleep bassinet when the mother falls asleep. Mothers who have had cesarean deliveries are particularly at risk because of limited mobility and effects of anesthesia and warrant close monitoring.
    - Avoid bed-sharing in the immediate postpartum period by assisting mothers to use a separate sleep surface for the infant.
    - Position the newborn in a manner that provides an unobstructed airway
    - Promote supine sleep in all infants
    - Conduct frequent assessments and monitoring of the mother-infant dyad during postpartum rooming-in settings, with close attention to high-risk situations such as nighttime and early morning hours.
    - If a mother requests that the infant be cared for in the nursery, the nurse caring for the mother-infant dyad will explore the reason for mother's request, address concerns, and educate the mother about the advantages of rooming in. If the mother still requests that the baby be cared in the nursery, the reason for interrupting rooming-in, the location of the infant during the interruption, the starting and ending time of respite care and the education given will be documented in the infant's electronic medical record.
    - If the infant is separated from the mother for any reason (excluding Special Care Nursery admits or unstable infants) the infant will be brought to the mother for feedings whenever infant shows feeding cues, to support exclusive breastfeeding.

CARE OF THE LACTATING MOTHER

ADMISSION AND ON-GOING NURSING ASSESSMENTS

- Discuss with the mother her plans for infant feeding. Educate the mother regarding the benefits of breastfeeding for both infant and herself. Support the mother so that she is able to make an informed decision.

- Assist to create an environment conducive to breastfeeding. Provide privacy, whenever possible, as well as comfort measures.
- Assessment of potential lactation difficulties is started on admission. The assessment should include the mother's past breastfeeding experiences, if applicable, any breast surgeries, chronic health issues and medications. Also to be noted: breast size, symmetry, shape, compressibility, scars and nipple structure. This information is used to establish a plan of care and possible lactation consult.
- Educate mother and family on feeding cues, especially with newborn (licking lips, clenched hands, flexed arms and legs, rooting, rapid eye movement, sucking on fists and fingers). Crying is a last sign, DO NOT wait for this, as infant may be too upset to coordinate latch easily. Place no limits on frequency or duration of feedings.
- A thorough assessment of breastfeeding will take place each shift, for every mother and infant, by the primary care nurse. Couplets considered at risk may need additional assessment and monitoring. This assessment will be documented using the latch score in the electronic medical record.
- Staff will examine patient's breasts once a shift for signs or symptoms of nipple trauma, delay in milk production or engorgement. This creates the perfect time to demonstrate the process of hand expression.
    - Each mother should receive information regarding hand expression prenatally, first hour of birth, throughout couplet care stay and before being discharged from the hospital.
- If breast engorgement is noted, assure that proper latching and positioning is being maintained. Encourage gentle breast massage toward the axilla alternating with hand expression prior to feeding (to help increase milk transfer). Apply warm/hot packs before a breastfeed and cold packs following a breastfeed (to help with soft tissue swelling). If engorgement is present, the mother may need to utilize a breast pump prior to latch, if hand expression is ineffective, to soften the areola and facilitate an effective latch.

<u>LATCHING AND POSITIONING</u>

- Encourage mothers to wash hands prior to breastfeeding, hand expression or pumping.
- Educate on the general principles of latching and positioning:
    - Baby should be brought to breast not breast to baby. Nursing pillows or bed pillows assist with this.
    - Baby lies tummy-to-tummy, head-to-toe. Mother should be able to draw an imaginary line from baby's ear through his/her shoulder to his/her hip.
    - Baby's nose and chin should touch breast. A baby's nose is designed to accommodate this without breathing difficulty.
    - Supporting the breast is sometimes necessary, especially as baby is learning. Attempt to latch where the breast naturally lies. If using the "C" hold keep thumb close to the nipple, and fingertips very low on the breast to facilitate an asymmetric latch. At times one fingertip placed next to the nipple at the level of the baby's nose will provide enough exposure to achieve an asymmetric latch.
- Assist mothers with the four common positions:

- **Cradle Hold:** Mom holds baby across her chest with his/her head resting on the upper forearm. The arm holding the baby is on the same side as the breast she is using. Mom's other hand supports the breast. Baby's arms straddle breast.
- **Cross Cradle:** As in the cradle hold, baby lies across mom's chest. However, in the cross cradle, baby nurses on the breast opposite the arm holding him/her. In doing this, mom's hand holds baby's upper back and neck while the rest of the baby lies tummy down across mom's chest. The other hand (on the same side as the breast being nursed) is used to support breast (this is a good beginning hold**,** as it increases mom's visualization of the latch). This position is a good choice for the premature baby, babies with low muscle tone, weak rooting reflex or suck**,** and mothers with large breasts.
- **Football Hold or Clutch Hold:** Mom sits up and holds baby at her side. Baby rests on pillow or pillows to reach the height of the nipple. Baby is then lifted under the neck and upper back to the latching position. Care is taken not to flex baby's neck or to push on back of head, as this is quite uncomfortable for the baby. At times the best latch will be achieved by turning the infant on his/her side; into the mother's torso (this is a good position for women with large breasts or if latching has been difficult in other positions).
- **Side Lying:** Mother and baby are on their sides, facing each other. The infant's nose is in alignment with the mother's nipple prior to latch, as with other positions (this is a good position if mom is tired or has had abdominal surgery such as a cesarean section).
- **Reclined or Biological:** Mother assumes a comfortable reclined position. Baby lies tummy-to-tummy on mother. Baby uses reflexes (natural latching) and mother assists as needed.

- Assist the mother with proper latching and identification of a suckling pattern. Instruct her to always use correct positioning. Touch or tickle lips with the nipple until baby gives a wide mouth, then roll baby quickly into breast, with tongue down and lips flanged.
- Help to encourage infants to maintain a nutritive sucking pattern. This is usually ten to 15 suckling bursts, with brief rest periods of five to ten seconds. If the infant is unable to self-start after ten seconds of rest, gently stimulate him/her. This can be done by massaging in small circular motions at the ear opening, stroking along jaw line or the "arm flap" (gently raising and lowering of infant's exposed arm).
  - These techniques can be taught to mother to avoid non-nutritive suckling patterns, which often materialize into "marathon feedings" without satisfaction. The infant will bypass these stimulations if full or tired, therefore we can be assured the infant is not being forced to feed beyond his/her desire.
- Educate mothers regarding the signs and symptoms of satiety. Show parents how to listen for swallows, as well as reading the body language that tells us a baby is satisfied (relaxed extremities).
  - Assist in establishing the breastfeeding log, located on the back page of the *Going Home booklet,* to keep track of feedings as well as voids and stools every 24 hours, especially within the first week.

MAINTAINING LACTATION

- When a mother must be separated from her infant the staff will support the mother in maintaining lactation.
- A mother may use hand expression or a breast pump to secure milk and promote lactogenesis when an infant is unable to nurse, to help reduce engorgement, and to accumulate milk for feedings when the mother is unable to be present for the feeding.
- If the inability to feed the infant at the breast will be prolonged the mother will begin pumping her breast milk no later than six hours of that separation
- The mother will then be encouraged to pump at least eight to ten times/day.
- The temporary use of alternative feeding methods will be used in the interim while breastfeeding difficulties are being resolved.

PUMPING OF BREASTMILK

- When assisting a mother with the pumping and storage of breast milk, these guidelines are intended to reduce the risk of bacterial contamination while collecting breast milk and to assure nutritional significance for the infant. If the mother is providing breast milk for her infant that will be or has been pumped outside of the hospital the *Administration of Expressed Breastmilk* (S7380200) consent must be signed. Assure if the mother is pumping for an infant in the Special Care Nursery that she receives the booklet*, Pumping Milk for Your Baby in the Special Care Nursery* (S6380245).
- Obtain a breast pump kit along with a large pink basin and dish soap for the cleansing kit. Supply storage containers, pumping and storage labels, and patient identification labels.
- Explain to the mother the importance of properly collecting and storing breast milk to reduce bacterial contamination of expressed milk as well as assuring optimal nutritional quality. Certain antibodies may be lost in improperly stored breast milk.
- Before pumping, mothers should wash her hands with soap and warm water, thoroughly, for 15 seconds. Alcohol rubs can be used in the hospital setting if hands are not visibly dirty.
- Make sure all parts of the breast pump coming into contact with the breast or breast milk are clean (washed in warm soapy water and rinsed well with clear warm water between uses).
- Assist the patient to a comfortable position, preferably where she can visualize her infant (even a picture of the infant), and provide for patient privacy. Encourage infant contact, if possible, during pumping. This increases the hormonal response and produces greater milk ejection.
- Introduce the breast pump to the patient and instruct her as to proper use. Refer the patient to the *Going Home* book as an additional reference for the patient. This is available in English and Spanish.
- Warm compresses placed against the breasts prior to pumping may help stimulate let-down.
- Instruct the patient to massage her breasts in a circular pattern, followed by gentle stroking of the breast from the outer edges toward the nipple. This also may help stimulate a letdown.

- Be sure the breast shield is centered over the nipple and areola. Assess to see that the shield size is appropriate for the patient. If the patient requires a different sized shield, refer to lactation services.
- The Symphony breast pump will start in the stimulation phase by pressing the power button. Vacuum can now be adjusted to patient's comfort level by turning the vacuum regulator knob. The LCD display will indicate vacuum level by drops.
- After two minutes, the stimulation phase will automatically change to the expression phase. For comfort, the patient can readjust the vacuum level. If the mother experiences a let-down prior to the two-minute marker, the expression phase can be manually initiated by pushing the "let-down" button to the right of the vacuum regulator knob.
- For double pumping, use both breast shields, and pump for 15 minutes in the expression phase or two minutes past last drip, if pumping to increase the volume. Double pumping should be used for maintenance of the milk supply when the infant is not breastfeeding, or if the mother is attempting to increase milk supply due to increased prolactin releases.
    - Manual pumps can take up to 20 minutes to drain each breast. Switch breasts every 5-7 minutes.
- After the patient has completed pumping, have her express a few drops of breast milk to her nipples, and allow to air dry. She may also add a small amount of highly purified USP Lanolin if breasts feel chapped.
- If pumping is painful, have the patient decrease the suction level. Milk volume is more influenced by frequency than by suction. If the suction is too high, it may cause swelling in the nipple and prevent milk ejection. Patients can also apply a small amount of highly purified USP Lanolin cream, either to the areola or to the breast shield, to decrease the discomfort caused by friction.
- After pumping, assist the patient to thoroughly wash all parts of the pumping kit in hot soapy water and rinse well with plain warm water. Place pump parts on a clean towel and dry place where easily accessible.

  After the breast pump has been used, it should be wiped down with a germicidal solution prior to use by a different patient or returned to the designated storage area.

INPATIENT EDUCATION FOR THE LACTATING MOTHER

- Staff will teach breastfeeding mothers about unrestricted breastfeeding as well as encourage parents to feed in response to infant feeding cues, along with the importance of exclusive breastfeeding for the first 6 months of life and maintenance. To assure sufficient milk transfer and breast stimulation, staff will promote eight to twelve feedings per 24 hours.
    - Parents will be able to track feedings on the breastfeeding log that is included on the back of the *Going Home* booklet (S6167001).
    - The mother will be educated regarding the signs of symptoms of feeding inadequacy and/or issues requiring a referral to a qualified health care provider through the use of the *Going Home* booklet, the *Hospital to Home* DVD, and individualized education. This will be charted on the education record.
    - Each mother will be taught how to manually express breast milk prenatally, first hour of birth, throughout couplet care stay and prior to discharge. This education will be documented in electronic medical record.

- Staff will refer breastfeeding mothers to Mother and Baby Education Center, or other local resources, for lactation assistance and ongoing support. These reference contact numbers are located in the Going Home book (S6167001).

ALTERNATIVE FEEDING METHODS

- When alternative feeding methods are in use, the mother and baby need to have follow-up plans until breastfeeding is well established. These procedures can be successfully taught to parents; after the parents observe the staff for one feeding, through return demonstration they may do the next feeding with the staff in attendance. The parents, then, should be able to use that specific alternative feeding method, independently, with close follow-up.

SYRINGE AND TUBE FEEDING

- If supplementation is needed or requested, the infant feeding should be given by syringe and tube (S & T), spoon, or cup. When supplementing with S & T at the breast, nipple confusion is avoided, the breasts are stimulated, and the infant benefits from receiving breast milk in addition to the measured supplement.
- Equipment:
  - For short term use (about one week), use a five French feeding tube and a ten mL syringe - this is the syringe and tube system (S&T).
  - Begin by filling a 10 mL syringe and 5 French tubing with expressed breast milk, donor milk or formula, if pumped breast milk is not available.
    - If using a nipple shield, place tubing outside of the shield to maintain the seal and infant's ability to create negative suction.
    - With in-hospital use, the equipment is discarded after each use. If a family is using this temporarily at home, they can simply wash out the syringe and tubing with warm soapy water and rinse thoroughly with clear warm water.

FINGER FEEDING

- Finger feeding is a process that assists in suck training by facilitating correct tongue movement. This is a temporary feeding technique, and infants should not be sent home on exclusive finger feeding.
- Equipment: A five French feeding tube and a ten mL syringe; expressed breast milk, donor milk or formula; tape (optional). NOTE: The fingernail on the feeding finger should be clean and clipped for parents and gloved for staff.
  - Begin by filling a syringe and tubing, with expressed breast milk, donor milk or formula, if pumped milk is not available. Tape feeding tube to the finger or wrap it around the finger to hold it in place.
  - The ideal position is on the center of the finger with pad side up. The tip of the feeding tube should be even with the tip of the finger.
  - Stimulate the baby's lips, gently, to elicit the rooting reflex until the baby's mouth is wide open. (This will teach/reinforce opening wide for breastfeeding).

- Allow the infant to draw the finger back into the throat area as it sucks, to a position of comfort.
- Try not to point your finger up, but keep it flat, thus maintaining the baby's tongue down and working the lower jaw forward. The person feeding should feel the tongue curled around their finger noting the drawing sensation. The mouth is fairly wide open, lips are curled outward, and the tongue is over the lower gum line as with breastfeeding.
- Allow the baby to suck until the sucking pattern slows or the baby comes off spontaneously. As with the S&T technique, the equipment is discarded after use.

CUP AND SPOON FEEDING

- When feeding directly at the breast is not possible, spoon or cup feeding can be used temporarily. Spoon feeding is an easy way to capture and deliver colostrum, or small volumes of milk, for non-breastfeeding infants.
  - Using a clean plastic spoon, the staff assists the mother with hand expression of colostrum.
  - When the volume reaches approximately one half of the spoon capacity, the milk is fed to the infant approximately one-half mL at a time.
  - The spoon is held at the lips of the upright infant, and the meniscus of milk touches the infant's lips, which will cause the tongue reflexively to extend out to lap at the milk.
  - This process is the same with a small clean medicine cup.

NIPPLE SHIELD

- The distribution of a nipple shield will be done by a lactation consultant or registered nurse after the need is verified and documented in electronic medical record.
  - The lactation consultant or RN will provide education to the mother regarding the proper application, use and cleansing of a nipple shield as well as potential complications and techniques for weaning off of the shield. Document that education was given in the electronic medical record. Recommend to wean from shield prior to discharge if possible, however it is essential for mother to set up an out-patient follow up appointment.

A request for lactation consult will be made on all mothers who receive a nipple shield from the nursing staff

NEWBORN 24 HOUR WEIGHT CHECK

- Infants will be weighed at birth and at 24 hours of age thereafter until discharge. If a morning discharge is anticipated and the 24-hour weight occurred before midnight, a repeat weight check will be done in the am.
- At 24 hours if the % of weight loss from birth weight is greater than 5%, staff is to advocate frequent feedings, check latch carefully, observe an entire feeding, add hand expression after feeding, and spoon feed EBM (expressed breast milk) if available. Normalize this process with the family.

- If 8 to 9% weight loss at less than 72 hours, verify latch, frequency of feeds, and nutritive feeding pattern. Consider hand expression or pumping after feedings 5 to 6 times per day to expedite lactogenesis. Supplement with the expressed breast milk by spoon, S&T (syringe and tube system), etc. Nursing staff will collaborate with the lactation team to establish a plan of care and a bedside lactation consult may be necessary.
- If 10% weight loss at less than 72 hours, supplementation may be necessary. Initiate a lactation consult and collaborate with the provider during rounds to determine if supplementation is recommended and ordered. Any artificial baby milk supplementation requires a provider written, order unless requested by the mother. Supplementation should be done at the breast S &T System if possible.

SUPPLEMENTAL FEEDING OF THE NEWBORN

If supplementation is considered medically necessary (greater than ten percent weight loss, hypoglycemia, dehydration or severe hyperbilirubinemia, etc.) or requested by the mother after education, alternative feeding methods should be considered versus a bottle.

- Recommended supplementation volumes for breastfed infants as per the Academy of Breastfeeding Medicine (ABM Clinical Protocol #3).
  - 5 to 15 mL/feeding at 24 to 48 hours of age
  - 15 to 30 mL/feeding at 48 to 72 hours or age

FORMULA FEEDING

- No supplement of formula will be offered to the infant unless requested by the mother or medically indicated. For all medically indicated supplementation, a written order is required. If the mother chooses to feed her infant formula, explore the reason, address the concerns, and educate about the possible consequences to the health of her infant and the success of breastfeeding. If the mother still requests formula, she will be given the *Safe Formula Feeding* booklet (S2006552). This education will be documented in electronic medical record.
- The Safe Formula Feeding booklet, offered in both English and Spanish languages, included the following information on:
  - Appropriates hygiene for formula preparation
  - Cleaning and sterilizing of equipment
  - How to prepare a formula feed
- Appropriate reconstitution
- Accuracy of measurement of ingredients
  - Safe handling and proper storage
  - Appropriate feeding methods
  - Powdered infant formula is not sterile

- Once a formula feeding has begun the formula must be discarded one hour after the initiation of the feeding
- All formula used and distributed by Enloe Medical Center will be purchased at fair market prices.

DONOR BREASTMILK

- The provider may discuss with the infant's mother, the appropriateness of donor milk for a particular infant's need. (Potential reasons may include prematurity, feeding intolerance, maternal insufficient supply, maternal substance abuse, or any condition where direct maternal milk is contraindicated.)
- When the use of donor milk has been suggested and approved by the provider, as well as the mother of the infant, an informational consent form will be signed by the mother of the baby. One copy will remain in the chart and one copy goes to the mother.
- To place an order from the Mother's Milk Bank. Contact a member of the lactation team or MBCC leadership team.

USE OF PACIFIERS

- Breastfeeding infants should not be given pacifiers.
- Discourage use of pacifiers in term infants, during the first three weeks, as they can lead to uncoordinated suck patterns and interference with milk production.
- Under these certain circumstance's pacifiers can be used:
  - To decrease pain during procedures, when the infant cannot safely be held or breastfed. Pacifiers should be discarded after these procedures.
  - A pacifier may be appropriate for those infants in the SCN who may have specific medical reasons.
- When a parent requests a pacifier, the reason is explored, concerns addressed, educate on the possible consequences to the success of breastfeeding and discuss alternative methods for soothing infant.

TRANSPORTING BREASTMILK

- When transporting, freshly expressed milk can be safely stored (for up to 24 hours) by using a plastic bag or a cooler brought in by parent with frozen gel packs. Wet ice can be used for unfrozen milk during short transports.
- When transporting frozen milk use frozen gel packs, not ice cubes, to keep milk frozen. The temperature of ice cubes is higher than the temperature of frozen milk and will thaw frozen milk.

STORAGE OF BREASTMILK

- Place breast milk in a collection container with a solid lid, or very small amounts can be stored in a syringe with a ~~black~~ stopper. Clean containers made of food grade hard plastic or glass are acceptable for the storage of human milk. Milk loses up to 60 percent of the SIgA when stored in polyethylene bags for 48 hours. Therefore, these are a poor choice for hospitalized infants.
  - Mothers will be given collection bottles as needed. These hard-plastic collection bottles can be washed out and reused.
  - Milk from each individual pumping session should be put into its own container.

  - Label each bottle or syringe with the patient's name, hospital identification number, date pumped, and the time.
  - If the milk has been frozen, it will receive a new date and time to reflect when the thawing process began.
  - Place the container into a clean baggie (use a different bag for each mother) prior to placing it in an appropriate refrigerator.
- Refrigerators/freezers will be labeled appropriately for the storage of human milk.
- The Refrigerator temperature should register zero to five degrees Celsius.
- The Freezer Temperature should register minus 18 degrees Celsius or colder.
- Plug refrigerators and freezers used for human milk storage into emergency power circuits.
- Put alarm thermometers in all freezers and refrigerators used to store human milk. This information is monitored and out of range temperature readings will be reported to MBCC leadership team.

FOR THE HEALTHY FULL-TERM INFANT:

- Freshly expressed breast milk is safe for four hours at room temperature.
- If milk will be stored, it should be placed in the appropriate refrigerator and used within four days.
- If milk will not be used within four days, it should be placed in the appropriate freezer. Fill the container only three-quarters full. This will allow for expansion if frozen.
- Nutritionally, fresh (not frozen) milk is always better if possible.
- Once an expressed breastmilk feeding has begun the breastmilk used for the feeding must be discarded one hour after the initiation of the feeding

FOR THE INFANT IN THE SPECIAL CARE NURSERY (SCN):

- Freshly expressed breast milk may be stored at room temperature for one hour prior to use.
- Once an expressed breastmilk feeding has begun the breastmilk used for the feeding must be discarded one hour after the initiation of the feeding
- If milk will be stored, it should be placed in the appropriate refrigerator and used within 48 hours.
- At 48 hours, the milk can be stored in an appropriate freezer. An additional label is attached to reflect the date and time of freezing.
- Fortified human milk may be refrigerated for 24 hours. Add fortifier as close to feed time as possible.
- Defrosted human milk may be refrigerated for 24 hours (date and time of thawing reflected on label). Never refreeze.
- Freezing (minus 18 degrees Celsius or colder) less than three months is optimal

BREASTMILK FEEDING PREPARATION

- All feeding preparation will be done at the infant feeding station.

- Prep the surface of the feeding station and breast milk warmer with a cleansing wipe. Place a clean barrier sheet on the clean prep surface.
- Check labeled milk container for correct milk/correct infant. This must be checked by two licensed staff members and documented in electronic medical record.
- Perform hand hygiene and don clean gloves
- Gently agitate containers to put fat in the solution
- Open milk container and fill appropriate feeding device.
- Label container for appropriate infant
- If milk is to be warmed or thawed, place the bottle or syringe insert then into the milk warmer. Inserts will be labeled and stored in a labeled paper bag in the plastic bin, located on the infant feeding station. These will be changed out every 12 hours.
- Cleanse breast milk warmer again after use.

SPECIAL CARE NURSERY CONSIDERATIONS

- When initiating breastfeeding after a period of medical instability (such as being oxygen dependent in SCN), a physician order is necessary to progress with infant feeding.
- An infant's tolerance to feeding will be observed closely. The use of alternative feeding methods may be helpful with transition to exclusive breastfeeding.
- For infants discharged with higher calorie needs these guidelines will be considered on a case by case basis to prevent the use of powdered formula:
    - Infants who have been receiving human milk fortifier for higher calorie supplementation will be discharged home on a 22 calorie/oz formula.
    - 4-6 bottles of ready-to-feed a 22 calorie/oz formula can be given to parents for a 2-day supply to use at home.
    - This will allow safe formula supplementation and give the parents an opportunity to acquire the formula. Parents will be provided safe formula preparation education, including the Safe formula feeding booklet.
    - Mother's milk supply at discharge will be supported by a feeding/pumping plan.

DISCHARGE EDUCATION:

- Educate patients about ongoing support within the community. Contained in the *Going Home* booklet, mothers will find a list of community lactation resources and support groups. This information is communicated verbally as well as shared in the *Going Home* booklet. Each mother receives the *Going Home* booklet upon arrival to the postpartum area.
- Recommendation for a routine follow-up visit with the health care provider per current national recommendations is reviewed with all patients.

COMMUNITY SUPPORT:

At Enloe Medical Center we foster and support community-based programs that make available individual or group lactation support. Within the *Going Home* booklet mothers will find a list of community lactation follow-up resources with contact phone numbers. Through

collaborative opportunities with our community partners we strive to provide a consistent/ research-based message regarding breastfeeding. An emphasis will be placed on the recommendation of exclusive breastfeeding for the first six months of life. Our community partners include Butte County WIC, Northern Valley Indian Health and La Leche League. The MBCC leadership team and/or a lactation team member will participate in this community collaboration.

INTERNATIONAL CODE OF MARKETING OF BREAST- MILK SUBSTITUTES
This policy upholds the WHO *International Code of Marketing of Breast-milk Substitutes* by offering education and materials that promote human milk rather than other infant food or drinks, and by refusing to accept or distribute free or subsidized supplies of breast milk substitutes, nipples and other feeding devices and ensuring all items are purchased at fair market value. This policy includes gifts, non-scientific literature, materials, equipment, money or support for breastfeeding education or events from manufacturers of breast milk substitutes, bottles, nipples and pacifiers. Employees of manufacturers or distributers of breast milk substitutes, bottles, nipples, and pacifiers have no direct communication with pregnant women and mothers. 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.

REFERENCED POLICIES:
All referenced policies and procedures impacting infant feeding are reviewed annually to assure support of breastfeeding consistent with this policy and evidence-based guidelines.

- *Newborn Admission and Care*
- *Weighing the Infant*
- *Gavage Feeding*
- *Special Care Admission*
- *Formula, Care of*
- *Standardized Procedure of the Newborn*

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APPENDIX A: ESSENTIALS OF LACTATION EDUCATION SERIES CONTENT

Objectives:

Upon completion, each participant will be able to:

- Acquire and apply knowledge of the lactation assessment, assist and educate breastfeeding mothers, with inclusion of those dyads with special circumstances.
- Describe and perform the use of proper breastfeeding management techniques and devices.
- Function as a resource for patients, families and healthcare professionals, by providing breastfeeding information and community referrals.

Module 1 Key Concepts:

- Facts on infant & young child feeding
- Benefits of breastfeeding
- Human milk vs. artificial milk properties
- Infant feeding history, political & cultural influences
- The Baby Friendly Initiative
- The Ten Steps to Successful Breastfeeding
- Patient-Centered Approach to Healthcare
- What is Your Role in Promoting Quality Outcomes?

Module 2 Key Concepts:

- Anatomy & physiology of the breast & nipples.
- Possible breast & nipple challenges.
- Breastfeeding management & technique from birth & beyond.
- Breastfeeding assessment tool-LATCH.
- Baby behavior states.
- The reluctant breastfeeding baby.
- Calming the crying baby- The 5 S's.
- Interactive lesson-30 minutes of clinical competency.

Module 3 Key Concepts:

- Special circumstances of mother
- Special circumstances of infant
- Medical indications for supplementation
- Ways to supplement with EBM, DBM, or ABM
- Hand expression review, pumping, storing & collecting breast milk
- The late pre-term infant & feedings in the SCN
- Breastfeeding & multiples
- Interactive lesson-clinical competency

Module 4 Key Concepts

- Contraindications to breastfeeding
- Maternal medications & breastfeeding
- Methadone maintenance & breastfeeding
- Induced lactation & re-lactation
- Safe sleep practices
- Donor milk
- Safe formula preparation & feeding
- Lactation & child spacing: contraceptive recommendations
- Back to work or school

- Anticipatory guidance for healthy infant growth & development patterns
- Breastfeeding beyond hospital