

Sample Hospital Breastfeeding Policy for Newborns

American Academy of Pediatrics Section on Breastfeeding

I. Purpose

To establish and promote a philosophy and policy on breastfeeding that is congruent with the recommendations and breastfeeding policy statements published by the American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists, and American Academy of Family Physicians.

II. Policy

A. Responsibility

The perinatal program leadership will assign a director to chair a multi-specialty task force that will be responsible for the implementation of the written breastfeeding policy. The task force will meet quarterly to develop and revise breastfeeding policies and procedures as needed and develop strategies for their implementation. This written policy will be regularly communicated to all health care staff who provide care for mothers and their newborns.

B. Staff Training for Policy Implementation

All providers for the mother-baby dyad will be responsible for acquainting themselves with the breastfeeding policy statement and acquiring the knowledge and skills to support the policy. Nursing staff will take responsibility for completing continuing education related to breastfeeding and should be capable of passing an annual competency evaluation. Identifiable members of the professional staff of the hospital (such as physicians, nurses, and licensed certified lactation consultants) will assume primary responsibility for supervising this continuous educational process.

III. Process

III-a. Process for Pregnant Mothers and Mothers With Healthy Newborns

A. Maternal Education

The decision whether to breastfeed or provide breast milk for her newborn should be an informed choice made by the mother. The obstetric, pediatric, and family physician staff shall recommend human milk for all babies in whom breastfeeding is not specifically contraindicated and provide parents with complete, up-to-date information to ensure that their feeding decision is a fully informed one. Exclusive breastfeeding will be recommended as the ideal nutrition for newborns. When appropriate, mothers who plan to combine breastfeeding and formula feeding should be educated about the advantages of beginning with full breastfeeding to establish milk supply. Mothers who choose not to breastfeed for medical or personal reasons shall be treated with respect and support.

The Hospital will not provide formula marketing materials to mothers and will discourage promotional paraphernalia and marketing efforts in all areas accessible to patients.

Clear contraindications to breastfeeding include maternal HIV, human T-lymphotropic virus (HTLV)-1 and HTLV-2 infection, herpes simplex virus infection (when a lesion is present on the breast), active tuberculosis (milk can be pumped and given to baby by another care provider), mothers on medications that contraindicate breastfeeding (eg, antimetabolites, therapeutic doses of radiopharmaceuticals, penicillamine), and a newborn with galactosemia. In the face of any situation where the presence or level of risk is unclear, the benefits should be weighed against the theoretic risk for the hazard involved and a decision made on an individual basis. When the risk is temporary, the mother should be taught methods to maintain her milk production.

B. Initiation of Breastfeeding

Except under unusual circumstances, the recommendations of the AAP to promote successful breastfeeding will be followed.

- Healthy term newborns with no evidence of respiratory compromise 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. Babies for whom an immediate pediatric assessment should take precedence over skin-to-skin contact include those who are preterm (born before 37 weeks' gestation), exhibit respiratory distress or cyanosis, have major congenital anomalies that might lead to cardiorespiratory compromise, are born through meconium-stained amniotic fluid and exhibit hypotonia or weak cry, are born in the context of markedly elevated infection risk (maternal temperature $\geq 101^{\circ}\text{F}$), or have evidence of perinatal depression (eg, decreased muscle tone, apnea, bradycardia).
- The alert, healthy newborn is capable of latching onto a breast without specific assistance within the first hour after birth. Dry the baby, assign Apgar scores, provide identification bracelets to mother and baby, and perform initial physical assessment while the newborn is with the mother. The mother is an optimal heat source for the neonate. Normal newborn care such as weighing, measuring, bathing, needlesticks, vitamin K, and eye prophylaxis should not delay early initiation of breastfeeding. Newborns affected by maternal medication and primiparous mothers may require assistance for effective latch-on and initiation of breastfeeding. Except under special circumstances, the newborn should remain with the mother throughout the recovery period.

C. Management of Lactation

Staff Assistance and Maternal Education

Nursing staff will offer each mother further assistance with breastfeeding within 6 hours of delivery. The mother should be guided so that she can help the newborn latch onto the breast properly. During the course of her hospitalization, she shall receive instruction on and be evaluated for

- Nutritional guidelines and expectations
 - a. Normalcy of weight loss (average of 7%, not to exceed 10% in term newborns)
 - b. Normal timing to regain birth weight (by day 10)
 - c. Expected feeding volumes in first 2 days (1–2 tsp or 5–10 mL/feed; 1–2 oz/d, term newborn)
 - d. Indicators of adequate hydration and nutrition (bright yellow bowel movements by day 4–5)
- Positioning and latch-on
- Hand expression and (if indicated) use of breast pump

Trained caregivers will undertake daily formal evaluation of the breastfeeding process in each mother-baby dyad, including observation of position, latch, and suckling. Each nursing shift will document these evaluations in the medical record.

Breastfeeding babies will be weighed each day. Weight loss in the first 72 hours of 7% or more from birth weight indicates a possible breastfeeding problem and requires more intensive evaluation of breastfeeding and possible intervention to correct problems and improve milk production and transfer.

Supplementation

It is uncommon for breastfeeding newborns to need any supplementation during the first week; thus, routine supplements (water, glucose water, formula, and other fluids) should not be given to breastfeeding newborns unless ordered by a physician. For mothers who choose partial breastfeeding, the request for formula for their babies should be respected by the staff and their preference should be documented in the chart.

For mothers who intend to breastfeed, distribution of formula on discharge will be discouraged, unless medically indicated. For breastfeeding mothers who intend to feed their newborns with formula, the distribution of formula on discharge will be consistent with the physician's written order. Newborns with hyperbilirubinemia may continue breastfeeding unless there are specific orders from the physician to the contrary.

Rooming-in

The establishment of successful breastfeeding is facilitated by continuous rooming-in, both day and night. Therefore, the newborn will remain with the mother throughout the postpartum period, except under unusual circumstances.

Frequency of Feeds

Mothers will be encouraged to offer a minimum of 8 feedings at the breast every 24 hours and to nurse whenever the newborn shows early signs of hunger, such as increased alertness, physical activity, mouthing, or rooting. Crying is a late sign of hunger. Nondemanding babies should be aroused to feed if 4 hours have elapsed since the beginning of the last nursing. Mothers separated from their healthy newborns will be encouraged and provided appropriate assistance with the same feeding frequency. Time limits for breastfeeding will be avoided. After 24 hours of life, if the baby has not latched onto the breast or latches on but feeds poorly, the mother will be instructed to initiate hand expression and electric pumping every 3 hours. Any collected colostrum will be fed to the newborn by an alternative method. Skin-to-skin contact will be encouraged. Until the mother's milk is available, a collaborative decision should be made among the mother, nurse, and clinician about the need to supplement the baby, the type of formula, the volume, and the mode of delivery. (If available, advice from a lactation consultant will be requested.)

Selective Use of Pacifiers and Assurance of Adequate Breastfeeding Assessment and Education

A series of observational studies and 2 limited clinical trials have investigated the relationship between pacifier use and breastfeeding. All but one study detected an association between pacifier use and earlier termination of breastfeeding. There are at least 2 possible explanations for these findings. Inadequate knowledge of breastfeeding principles and techniques or other problems with breastfeeding might contribute to pacifier use in association with early weaning. It is also possible that pacifier use interferes with breastfeeding by reinforcing maladaptive maternal breastfeeding practices, by disrupting suck mechanics, or through another mechanism. Pacifier use appears to be most strongly associated with termination of breastfeeding when it occurs in combination with improper newborn feeding or dysfunctional maternal styles of breastfeeding. Because existing data do not differentiate whether pacifier use causes disruption of breastfeeding or simply is a marker of breastfeeding difficulties, it is reasonable to advise parents to use pacifiers only when necessary.

More important than the focus on pacifier use, however, is provision of resources and support services that maximizes the number of mothers who choose to breastfeed and ensures their success. We recommend that each institution implement a formal assessment structure and individualized educational program to enhance breastfeeding success. To optimize breastfeeding success, each mother-baby dyad should undergo at least 2 formal, individualized, structured breastfeeding assessments by qualified personnel as well as expert individualized breastfeeding guidance before postpartum discharge to home. Examples of instruments that can be used for such an assessment are included in the AAP *Safe & Healthy Beginnings: A Resource Toolkit for Hospitals and Physicians' Offices* (Infant Breastfeeding Assessment Tool [IBFAT], LATCH: A Breastfeeding Charting System and Documentation Tool, Mother-Baby Assessment Tool). In addition, each mother

should receive a detailed education and counseling session that teaches the complexities of breastfeeding, including the importance of frequent on-demand breastfeeding, especially in the first weeks when breast milk supply is being regulated by baby demand and a healthy mother–baby dyad is established. Mothers should be counseled to routinely offer breastfeeding rather than a pacifier, reinforcing that a pacifier should not be used to diminish the frequency or duration of breastfeeding. Scheduled breastfeeding should be discouraged.

Although we recommend a conservative approach regarding pacifier use, we do not endorse a complete ban on the use of pacifiers, nor do we support an approach that induces parental guilt concerning their choices about the use of pacifiers. Five meta-analyses have shown an association between pacifier use and reduced risk of sudden infant death syndrome (SIDS). The AAP Task Force on Infant Positioning and SIDS recommends pacifier use at nap and bedtime as a SIDS reduction strategy (for breastfed newborns, after breastfeeding has been firmly established). Further, there are medical situations in which pacifier use is appropriate, including the use of pacifiers to provide comfort via oral stimulation for babies undergoing painful procedures or who are medically permitted no enteral intake and among whom developmentally supportive interventions have proven inadequate. Breastfeeding has been shown to have analgesic properties and also is an effective comfort strategy before or after a painful intervention.

D. Preparation for Discharge

An educational checklist designed to complement each mother's lactation needs is recommended for the nursing staff to help address any outstanding questions or concerns. Prior to discharge, mothers will be given the names and telephone numbers of community resources to contact for help with breastfeeding. According to the recommendations of the AAP, all breastfeeding newborns will be referred to a physician or other knowledgeable and experienced health care professional for a visit on the third to fifth day of age or within 24 to 72 hours. The newborn should be assessed for jaundice, adequate hydration, and age-appropriate elimination patterns.

If a newborn is not latching on or feeding well by the time of discharge, the feeding/pumping/supplementing plan will be reviewed and arrangements made for follow-up within 24 to 72 hours of discharge. Prior to discharge, arrangements will be made to secure an appropriate pump for home use, if needed.

III-b. Process for Mothers Who Deliver Prematurely or Are Separated From Their Newborns for Medical Reasons

A. Maternal Education

Mothers who deliver prematurely may not be aware of the benefits of human milk for their preterm newborns and commonly base their decisions on health-related issues. Staff (physicians and nurses) will therefore stress the protective properties of breast milk and recommend mothers provide breast milk without necessarily making the commitment to breastfeed.

B. Initiating Pumping

When direct breastfeeding is not possible, expressed human milk, fortified when necessary for the premature baby, is the preferred diet. Banked human milk may be a suitable feeding alternative for newborns whose mothers are unable or unwilling to provide their own milk. Human milk banks in North America adhere to national guidelines for quality control of screening and testing of donors and pasteurize all milk before distribution. Fresh human milk from unscreened donors is not recommended because of the risk of transmitting infectious agents.

The first postdelivery encounter with the physician, or as soon as it is appropriate, should include discussion of human milk, its role in the preterm newborn's care, and the urgency to begin expressing or pumping. The responsibility for initiating and maintaining an expressing or pumping routine (at least 6 times/day with a hospital-grade pump) will belong to the nursing staff and should begin within the first 6 hours postpartum, or as soon after delivery as the mother is stable (not "recovered"). The aim is to mimic the optimal breastfeeding stimulation provided by a healthy full-term newborn.

C. Management of Lactation

Mothers who are separated from their newborns for more than 8 hours will be

- Assisted with and instructed on how to hand-express colostrum.
- Assisted with and instructed on how to use the double electric pump every 3 hours (or 6–8 times per day, with no period >5 hours between 2 sessions).
- Encouraged and taught how to provide small volumes of fresh colostrum for their newborn.
- Provided a pumping diary/log to record their pumping history.
- Encouraged to practice skin-to-skin care as soon as the baby is stable.
- Encouraged to initiate nonnutritive suckling as soon as mother's and baby's condition permits. Initiating oral feedings at the breast is preferred over bottle feeding.
- Encouraged to initiate breastfeeding on demand as soon as mother's and baby's condition permits.
- Taught proper collection, storage, and labeling of human milk.
- Instructed on how to hand express and, if needed, use effective techniques with pumps once milk "comes in."
- Provided anticipatory guidance, when appropriate, on management of engorgement.
- Assisted with obtaining electric pump (hospital grade) for home usage prior to discharge.

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