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A Model Infant Feeding Policy for Baby-Friendly Designation in the USA

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Abstract

Background: In June 2010, the Communities Putting Prevention to Work program (Centers for Disease Control and Prevention) funded a New Jersey (NJ) Office on Nutrition and Fitness, Department of Health and Senior Services project to reduce obesity and increase exclusive breastfeeding by increased implementation of the Baby-Friendly Hospital Initiative in the state of NJ. At baseline, NJ had no Baby-Friendly hospitals and no hospital was using an infant feeding policy that conformed to standards required by Baby-Friendly USA for designation.

Goal: To create a model infant feeding policy that would be adaptable for use at multiple NJ hospitals preparing for Baby-Friendly designation.

Methods: Project consultants created a policy based on existent policies from the American Academy of Pediatrics, the Academy of Breastfeeding Medicine, certified Baby-Friendly hospitals, and guidance from Baby-Friendly USA. This policy was submitted to Baby-Friendly USA, the US body responsible for Baby-Friendly designation.

Results: Baby-Friendly USA requested changes; after adaptations, the policy was made available to targeted NJ hospitals via a statewide portal. The hospitals made relevant adaptations for their setting, and those that were ready submitted the policy during the Baby-Friendly designation process. The policy was acceptable to Baby-Friendly USA.

Conclusion: A collaborative initiative can use a single breastfeeding policy template as an aid toward Baby-Friendly designation. Such work streamlines the process and saves time and resources.

Keywords

Baby Friendly USA, Baby-Friendly Hospital Initiative (BFHI), hospital policies, New Jersey

Background

In 2010, fewer than 4% of United States (US) hospitals were Baby-Friendly designated.¹ The Centers for Disease Control and Prevention, via the Communities Putting Prevention to Work (CPPW) program and the American Recovery and Reinvestment Act (ARRA) of 2009, sponsored a US national effort to increase breastfeeding rates, with part of the funding targeted for improvement of breastfeeding-supportive maternity care practices in the hospital. In June 2010, the New Jersey (NJ) Office on Nutrition and Fitness (ONF), Department of Health and Senior Services obtained one of the CPPW grants for a project to decrease obesity by increasing exclusive breastfeeding. The NJ ONF subcontracted with the American Academy of Pediatrics NJ (AAPNJ) chapter and consultants to implement a Baby-Friendly Hospital Initiative coalition in the state of NJ.

When funds were granted, NJ had no Baby-Friendly hospitals, although 2 NJ hospitals had Certificates of Intent to become Baby-Friendly. A multidisciplinary team including state employees, the AAPNJ and affiliated Pediatric Council on Research and Education (PCORE); and consultants

including a physician champion formulated a statewide strategy to work toward Baby-Friendly designation. In late 2010, this team selected 10 NJ hospitals via a competitive process, each of which would receive a \$10,000 mini-grant and intensive technical assistance over an 18-month period. The 10 funded hospitals, only 1 of which had a Certificate of Intent to become Baby-Friendly, represented diverse geographic and socioeconomic populations throughout the state of NJ. The goal in the 18-month project period was to designate 2 hospitals as Baby-Friendly, and to have the remaining 8 hospitals fully implement at least 2 of the Ten Steps to

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Successful Breastfeeding. The first of these 10 hospitals, Capital Health, received Baby-Friendly designation in March 2012. This project is ongoing; additional outcomes will be analyzed and disseminated after the project is completed in 2012.

At the same time as the NJ project began, Baby-Friendly USA rolled out the new 4D Pathway, with its 4 phases of Discovery, Development, Dissemination, and Designation.² Previously, hospitals seeking designation as Baby-Friendly institutions in the United States submitted a Certificate of Intent, then began working toward full implementation of the Ten Steps. Baby-Friendly USA created the new 4D Pathway as a more structured, step-by-step process toward Baby-Friendly assessment and eventual designation. At the same time, Baby-Friendly USA, in parallel with Baby-Friendly certifying bodies in many other nations, responded to updated guidelines from UNICEF and the WHO, which recommended some adaptations to the designation requirements.³ This step heralded many changes in the US designation process, including the requirement of a more detailed and complex policy than had previously been accepted, and development of the policy earlier in the process than may have been done in the Certificate of Intent pathway.

One problem identified early in the NJ project was that no hospital in the state had a completed breastfeeding policy that was already approved by Baby-Friendly USA, although 1 of the coalition hospitals that was going through the Certificate of Intent process had a policy that approached the new standards and had already received feedback. The NJ project consultants reviewed policies from hospitals already designated as Baby-Friendly, and model policies created by the American Academy of Pediatrics (AAP)⁴ and the Academy of Breastfeeding Medicine (ABM),⁵ consulted with Baby-Friendly USA, and determined that the policies would no longer be acceptable because specific elements required by Baby-Friendly USA are not addressed, although many of the principles contained in these policies were relevant and useful. For example, the AAP and ABM policies were written specifically as breastfeeding policies, without reference to formula preparation and use. The new standard currently required by Baby-Friendly USA, and taken from WHO global criteria for Baby-Friendly,³ is that the hospital has 1 universal infant feeding policy applicable to all mother-infant dyads. Thus, issues such as supplementation or exclusive formula feeding, specific requirements about teaching mothers about formula preparation and feeding, and use of alternate feeding devices must be included in the same policy as the recommendations for breastfeeding. Furthermore, the revision of Step 4, to place infants in skin-to-skin contact with their mothers immediately following birth and for the first hour, applies to all mothers, not only breastfeeding mothers.

The goal of this project was to create a model policy acceptable for Baby-Friendly designation in the United States, which could also be adapted to the needs of numerous

hospitals on the Baby-Friendly pathway. Adaptability of the policy was considered key, because each hospital was at a different stage regarding policy change, and as an operating body with legal requirements, a hospital cannot pass a policy that is not already being applied. For example, a Baby-Friendly policy would require that a hospital pay for infant formula, but a hospital cannot approve a policy stating that the hospital pays for infant formula if the hospital is not yet actually paying for infant formula. Becoming Baby-Friendly is an ongoing process that typically takes 1-2 years, and not all steps can be implemented at the same time. Thus, interim policies may be needed as the hospital moves toward Baby-Friendly status. Similarly, within each hospital there are certain established precedents, some of which need to be managed differentially, and the institution's Breastfeeding Policy needs to be adapted accordingly. Baby-Friendly USA provides materials for policy development as part of the 4D pathway, including a "Policy Check Tool" in the Development phase, and permits hospitals to seek feedback on the policy after it is created. The process requires that the complete policy be in place before a hospital can move into Dissemination, the third phase of the 4D pathway, such that it is implemented during this phase.

Methods

The project consultants gathered a range of policies including those from the NJ hospital in the COI pathway, the AAP,⁴ the ABM,⁵ and currently designated US Baby-Friendly hospitals. The consultants then approached Baby-Friendly USA, which was fully informed about the project from the outset, and discussed the practicalities of creating 1 model policy for New Jersey. Given that 10 NJ hospitals were working toward certification as part of the funded project, with several others independently working toward designation, it was agreed that time and resources were best used by both project and Baby-Friendly USA staff on 1 acceptable policy, rather than on 10 individually created, independent policies.

In addition to external reference sources, input for the policy came from the consultants' experience, the 10 NJ hospitals via monthly technical assistance teleconferences, written responses and guidance from Baby-Friendly USA, and direct use of Baby-Friendly USA designation materials. The Policy Checklist and specific written feedback from Baby-Friendly USA regarding language to be included were used to ensure that all aspects of the new requirements were included in the model policy.

Results

Based on the sources listed above, the project team created an over-arching infant feeding policy encompassing the many elements required by Baby-Friendly USA. Unique to

many hospital policies, the NJ Baby-Friendly Hospital Policy is organized according to the Ten Steps to Successful Breastfeeding, and it is therefore easy to identify the components of care that hospitals will need to satisfy to become designated.

An initial policy was submitted to Baby-Friendly USA, which requested multiple changes; some areas were debated more than others. For example, Baby-Friendly USA suggested detailed language on the use of alternative feeding methods. The project consultants disagreed with this requirement, given the lack of evidence for the efficacy of any alternative feeding methods in the literature.⁶⁻⁹ After 2 rounds of revisions, the final policy (Appendix 1) was accepted by Baby-Friendly USA.

Initially, the policy was circulated to the 10 coalition hospitals to begin the process of hospital adaptation, to use as a template or guide for changes to hospital systems, and for staff and physician education. The policy was also posted on a statewide portal created for the purpose of sharing resources and communications for the 10 funded hospitals; after the project period, the policy will be circulated to all NJ hospitals.

Capital Health, the hospital already on the Certificate of Intent pathway, immediately adopted the new policy and sent it to Baby-Friendly USA with a few small changes as part of their documentation of readiness for assessment. Baby-Friendly USA returned the policy for additional minor revisions, and the policy was resubmitted, accepted, and has now become the policy for the hospital in question, which was designated Baby-Friendly in March 2012. All 9 remaining hospitals have adapted and endorsed the policy, and 2 of these hospitals have had the completed policy accepted by Baby-Friendly USA, and have been assessed (outcomes not yet known).

Discussion

A statewide policy was developed to satisfy the needs of a range of different hospitals, and this policy met the requirements of Baby-Friendly USA in 2012. Although creation of this policy required an initial intensive investment of time by project consultants, involved hospitals, and Baby-Friendly USA, long-term, it will assist other US hospitals in the Baby-Friendly process as they adapt it to their needs.

This policy differs from organizational policies, such as those of the AAP and the ABM, and standard hospital policies on breastfeeding in several ways. In drafting the model policy, the authors were attentive to procedural elements of the Ten Steps to Successful Breastfeeding, yet they recognized that hospitals may choose to separate these procedures from the

overall policy. Although most hospital policies do not include procedures, and procedures are typically contained in separate documents that are unit specific in hospitals, their inclusion here was meant to ensure that every step is fully addressed according to requirements of the new Baby-Friendly USA guidance and Policy Check Tool. Hospitals choosing to separate the procedures into a separate document may find that this is an acceptable approach according to Baby-Friendly USA. In addition, many hospital policies addressing breastfeeding are stand-alone policies and do not address formula feeding. Baby-Friendly USA, in adopting the Global Criteria for policy development, now requires hospitals have 1 comprehensive infant feeding policy that is consistent and specific about the recommendations for infants who are breastfeeding *and* formula feeding. The policy must provide guidance on education that mothers receive (that is, mothers must be taught formula preparation one-on-one, and not in group sessions) and education about the preparation and feeding of infant formula. Another aspect of this model policy that distinguishes it from already published documents is the details of staff training, which were requested by Baby-Friendly USA. Finally, although other policies may discourage infant formula marketing, this model policy delineates multiple aspects of the International Code of Marketing of Breast-milk Substitutes, including not accepting free or discounted infant formula.

Model policies will need adaptations for each hospital seeking designation. Prior to submission to Baby-Friendly USA, a hospital will check for compliance with Baby-Friendly USA by using the Policy Check tool provided in the Development Phase Toolkit. Therefore, hospitals need to build into their work plan adequate time to adapt the model policy, to compare their adaptation to the Baby-Friendly Check tool, and to allow Baby-Friendly USA time to provide feedback. This model policy therefore will need to be adapted according to both individual hospital standards and potential ongoing adaptation of Baby-Friendly designation guidelines. As such, the authors cannot guarantee that Baby-Friendly USA will accept this exact policy from a hospital seeking designation; however, if revisions are required, we expect that they would be minor.

Conclusion

A statewide coalition expedited hospital-based environmental and policy changes that moved them toward Baby-Friendly designation. The development of a universal model Baby-Friendly-sanctioned infant feeding policy will facilitate and expedite the process toward becoming Baby-Friendly designated.

Appendix I

Model Infant Feeding Policy for Baby-Friendly Hospital Initiative

Name of hospital: _____

Policy & Procedure: Infant Feeding

Responsible for Development/update:
Breastfeeding Committee

Applicable Departments:
Mother/Baby, Pediatrics, Medical, Surgical

Applicable Professionals: MD/DO, APRN, PA, RN, RD,
IBCLC

Responsible for Implementation:
Mother/Baby Unit Nurse Manager

Effective Date: _____ Replaces policy dated: _____
Update frequency: annual

APPROVED BY:

_____	_____
Signature	Signature
_____	_____
Print name and Date	Print name and Date
_____	_____
Signature	Signature
_____	_____
Print name and Date	Print name and Date

Step 1

PURPOSE

To promote successful breastfeeding by ensuring that, in the absence of contraindications, all mothers who elect to breast-feed will have a successful and satisfying experience.

To ensure that care is congruent with the Ten Steps to Successful Breastfeeding as endorsed by the UNICEF/World Health Organization Baby Friendly Hospital Initiative.

To standardize information regarding care that affects infant feeding received by all staff through routinely communicating this policy to staff and making all practitioners and staff aware of its location and how to access it to optimize care.

POLICY

Step 2

This facility upholds the WHO International Code of Marketing of Breastmilk Substitutes by declining to accept or distribute free or subsidized supplies of breast milk substitutes, nipples and other feeding devices.

Employees of manufacturers or distributors of breastmilk substitutes, bottles, nipples, and pacifiers will have no

direct contact or communication with pregnant women and mothers.

This facility does not receive free gifts, non-scientific literature, materials, equipment, money, or support for breastfeeding education or events from manufacturers of breastmilk substitutes, bottles, nipples, and pacifiers.

Pregnant women, mothers, and families will not be given marketing materials or samples or gift packs by the facility that consist of breastmilk substitutes, bottles, nipples, pacifiers, or other infant feeding equipment or coupons for the above items.

The World Health Organization Ten Steps to Successful Breastfeeding, and policies to support non-breastfeeding mothers, will be posted in all locations where care is provided to mothers and young children in languages and with wording that staff and families can easily understand.

The manager of each applicable department will review the policy with all new employees within two week of hire.

All staff will receive training necessary to implement this policy within 6 months of hire.

Training will include 20 hours of education, 5 of which will be under direct supervision of a supervisory staff member.

Physicians and advanced practice nurses will receive a minimum of 3 hours of education and training

Details of the training plan are included in Appendix 1: Hospital Specific "*BFHI Training Procedures.*"

The procedure for acceptance of staff training obtained prior to employment is described in the *BFHI Training Procedures.*

Documentation of staff training will be maintained in each staff member's (physician's) employee portfolios. Academic physicians, advanced practice nurses and staff members will maintain records of faculty development related to breastfeeding and evidence of completion of 3 hours of required instruction in their teaching portfolios. Staff is aware of the safe storage and handling of human milk

Training will include breastfeeding, provision of human milk, and feeding the infant who is not breastfed, as well as alternative methods of feeding if not breastfeeding.

Step 3

All pregnant women will be provided with information on breastfeeding and counseled on the benefits of breastfeeding, contraindications to breastfeeding, and management of breastfeeding. The facility will collaborate with prenatal care providers in the community to provide breastfeeding education and support.

All mothers will receive information described in Appendix 2: Hospital Specific "*Procedure on Infant Feeding Education for Families.*"

The method of instruction and how this information is provided is described in the *Procedure on Infant Feeding Education for Families*

Pregnant women and families will receive no information that promotes use of human milk substitutes, including no information with industry logos or promotional materials. Educational sessions that promote use of infant formula or other human milk substitutes will be replaced by sessions that promote breastfeeding or use of human milk. Mothers will be informed of the risks of giving supplements to breastfeeding infants in the first 6 months. If a mother chooses to formula feed or if she or her infant(s) has (have) a contraindication to breastfeeding or receipt of human milk she will be provided information about how to safely prepare and feed infant formula as described in the *Procedure on Infant Feeding Education for Families*.

Education is provided in a family centered manner.

Education provided will be documented in the mother's medical record.

Mothers will be taught safe handling and storage of human milk

Mother will be taught methods of milk expression including hand expression.

The method of feeding will be documented in the medical record of every mother and newborn.

Educational materials will not contain product names, images, or logos of infant formulas, foods, bottles, feeding devices and other related items.

For bottle/formula feeding mothers education will be provided on an individual basis, group educational sessions on bottle/formula feeding will be avoided.

Step 4

Mother-Newborn couples (dyads) will be:

Offered skin to skin contact (SSC) immediately after birth unless medically unstable.

All mother/infant dyads regardless of feeding preference are supported to have immediate SSC

Routine newborn procedures are postponed until after the first feed during the initial period of SSC

When a delay of SSC has occurred staff will ensure that mother and infant have SSC as soon as medically possible

Routine assessments are performed while SSC

Procedure for SSC will be standardized:

Infant dried and placed ventral-to-ventral on mother's chest

cap placed on head

doubled pre-warmed blankets over both

may suction if necessary while in SSC

assess and assign APGARS

replace damp blankets as needed

Dyads will be monitored while in SSC

SSC begins immediately after birth and continues for at least 1 hour

Offered assistance to assess baby's readiness for feeding within one hour of birth.

Placed skin-to-skin contact which will continue, uninterrupted, until the baby completes the first feeding.

All mothers of cesarean section delivery should be given their babies to hold with skin-to-skin contact as soon as the mother is safely able to hold and respond to her baby. Routine skin-to-skin contact should be the practice regardless of the mother's feeding intention.

Routine newborn procedures will be postponed until the first breastfeeding attempt occurs during the initial period of skin-to-skin contact.

Routine assessment procedures will be performed while the infant is skin-to-skin with the mother.

When a delay of initial skin-to-skin contact has occurred staff will ensure that mother and infant received skin-to-skin care as soon as medically possible.

Initiation of skin-to-skin care for infants being cared for in the special care nursery or NICU is addressed in Appendix 3: Hospital Specific *Skin-to-Skin Care for Special Care Neonates Protocol*.

Mother and baby will remain together throughout the entire stay. Frequent skin-to-skin contact will be encouraged.

Encouraged to exclusively breastfeed unless medically contraindicated

Educated and assisted with breastfeeding

Step 5

Mothers will be taught how to breastfeed and maintain lactation if they are separated from their newborns (See: **Procedure- Step 5**).

Step 6

Formula will not be given to any breastfed infant unless specifically ordered for a medical indication or by the mother's informed and documented request.

When a breastfeeding mother requests a human milk substitute the staff will explore the mother's reason for the request as well as any concerns she has. The staff will educate the mother regarding the negative consequences of feeding infants human milk substitutes and the counseling and education will be documented in the mother's chart.

If there is a medical indication for use of supplements this will be documented in the chart.

Acceptable reasons for formula use per the Joint Commissions Peri-natal Care Core Measures are:

Maternal:

-HIV infection

-Human t-lymphotrophic virus type I or II

-Substance abuse and/or alcohol abuse

-Active, untreated tuberculosis

-Taking certain medications, i.e., prescribed cancer chemotherapy, radioactive isotopes, antimetabolites, antiretroviral medications and other medications where the risk of morbidity outweighs the benefits of breast milk feeding

-Undergoing radiation therapy

- Active, untreated varicella
- Active herpes simplex virus with breast lesions

Infant:

- Galactosemia

d. If supplementation is provided staff will inform mothers of various methods to provide alternative feedings. Devices other than bottles and artificial nipples will be offered according to the best scientific evidence available.

Anti-lactation drugs will not be used

Nipples shields, nipple creams, ointments, or other topical preparations for mothers will be used only if clinically indicated and requested after a lactation consultation.

Step 7

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

Separation of mothers and infants will occur only if medically indicated and justification is documented in the chart.

Step 8

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

No restrictions are placed on mothers regarding frequency or duration of breastfeeding.

Step 9

Pacifiers or artificial nipples will not be given by the staff to breastfeeding infants with the following exceptions:

Pre-term infants in the NICU or infants with medical conditions that are benefitted by non-nutritive suckling

Newborns undergoing painful procedures when breastfeeding to comfort the infants is not available. If a pacifier is used, it will be discarded following the procedure and will not return to the mother.

If a mother requests a pacifier the staff will explore reasons for this request and address the mother's concerns and educate her on potential problems with pacifier use. This education will be documented. If a mother insists on using a pacifier, this will be provided by the family and not by the hospital.

Infants who are receiving supplemental nutrition will be offered alternative feeding methods to avoid use of bottles and nipples if acceptable to mother and achievable according to staff.

Mothers will be taught the rationale for avoidance of bottles and nipples according to the best scientific evidence available.

Step 10

All breastfeeding newborns will be scheduled to see a pediatrician or other knowledgeable healthcare professional at 3 to 5 days of age.

For infants who are still not latching on or breastfeeding well at the time of discharge, the feeding/pumping/supplementation plan will be reviewed with the mother in addition to the routine breastfeeding instructions.

A follow-up visit to the pediatrician or a home nurse visit should be scheduled within 24 hours of discharge. Depending on the clinical situation, it may be appropriate to delay the discharge of a newborn with feeding difficulties

If the institution decides to offer a gift at discharge, this gift will not contain industry-sponsored materials, logos, or supplies that related to infant feeding.

Mothers will not receive any infant formula, coupons, or logos of formula companies, or literature with formula company logos or materials produced by companies related to infant feeding.

Breastfeeding mothers will be referred to community breastfeeding resources and support groups.

A list of resources will be printed and distributed to all breastfeeding families in their discharge information package. This list will be printed in the languages most frequently spoken/read by mothers delivering at this hospital.

EXCEPTIONS

Breastfeeding is contraindicated in the following situations:

HIV-if status is unknown a rapid HIV test will be available while the mother is in the delivery room, and the dyad is skin to skin but not breastfeeding until a result is available.

Mother is using illicit drugs (refer to *Illicit Drug Use and Breastfeeding Guideline* or *ABM clinical protocol#21*)

Mother is taking certain medications that cannot be substituted. Use of LactMed is recommended: <http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT>

Mother has active untreated tuberculosis

HTLV 1 and 2

Infant has classic form of Galactosemia

Step 5

PROCEDURE

Labor and Delivery Unit RN will:

Document the desired feeding method in the mothers' and infants' chart

Place the newborn skin to skin immediately following birth and encourage breastfeeding within the first hour when clinically stable and appropriate

Document breastfeeding assessment and teaching

Report feeding status upon transfer to mother/infant or NICU

For the mother who is separated from her sick or preterm newborn, the nurse will encourage the mother to express milk as soon as clinically able (within 6 hours after birth) using manual and mechanical method of milk expression.

Educate and assist mother with proper technique of pumping and proper cleaning of pump equipment.

Mother/Infant Unit RN will:

Document the desired feeding method for the newborn in the newborn's chart

Distribute the breastfeeding information packet upon admission

Encourage skin-to-skin and 24-hour rooming-in

All infants regardless of feeding method will practice rooming in

Mother-infant separation will be minimized and occur for medical procedures or indications

All routine newborn procedures will be performed at the bedside

Any interruption in rooming-in will be documented in the infant's chart including the reason for separation, time separation began and time the infant returned to the mother's room.

When a mother requests that her infant be cared for in the nursery the staff should explore reasons for the request and should encourage and educate the mother about the advantages of having her infant(s) stay with her in the same room continuously throughout the delivery hospital period. This education should be documented in the mother's chart.

If the mother insists that her infant be cared for in the nursery, the infant will be brought to the mother for feedings whenever the infant shows feeding cues, and interruption of rooming-in will be documented.

Teach manual breast massage techniques

Teach infant feeding cues, assess newborn's readiness to feed and assist with breastfeeding when the newborn cues and document

Assess and document breastfeeding using the assessment guide in this policy and LATCH scores done at least twice daily.

Eliminate bottles from bassinets and rooms

Assess breasts and nipples for any issues that would affect feeding and document findings

Encourage mother to attend breastfeeding class and/or view the educational video

Teach proper breastmilk storage using referenced materials on storage guidelines

Refer to a lactation consultant per referral guidelines

For unstable infants in the observation nursery, transitional nursery or NICU RN's staffing these units will:

Document the desired feeding method for the newborn in the newborn's chart

Encourage mother to pump as soon as clinically able (ideally within 6 hours after birth)

Encourage mother to pump every 2-3 hours during the day and at least 1-2 times during the night for 15-20 minutes or until the milk stops flowing. Mothers should be instructed not to pump for longer than 30 minutes

Educate and assist mother with proper cleaning of pumping kit as needed

Encourage manual expression to augment pumping success

Teach proper labeling and storage of breast milk for the sick newborn

Refer to lactation consultant

Assist in obtaining a double set up electric pump prior to discharge

Support the breastfeeding dyad using the guidelines developed for feeding in the special care unit

DOCUMENTATION FORMS

Popras* form number 4A, and 6. (<http://www.popras.com/images/Forms/4a.jpg>); (<http://www.popras.com/images/Forms/6.jpg>)

Mother and infant critical pathways.

Popras form number 8a. (<http://www.popras.com/images/Forms/8a.jpg>)

Newborn flowsheet.

Patient educational record.

Mother's and infant's electronic medical records

Electronic birth certificate

* Popras=A Problem Oriented Perinatal Risk Assessment System (since 1975)

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STANDARD DEFINITIONS FOR THE INFANT RESPONSE TO BREASTFEEDING

Breastfeeding should be baby led, not clock led. Not all babies nurse in the same manner.

Utilize these standard definitions in assessing infant's response to breastfeeding when documenting on the feeding section of the infant flow sheet. Documenting time does not necessarily predict how well the infant nursed. Assessment of the mother/infant couple who is breastfeeding will be complete by using these definitions and the Latch Score. The Lactation Consultant will see all breastfeeding families while in the hospital. Infants who consistently breastfeed poorly must have an additional consultation and be weighed daily.

NW – nursed well:

1. Good latch (score 8-10*)

Lips flanged and take in as much of the areola as possible
Nurse actively for sustained period on both breasts or
Longer duration on one breast until satisfied
Audible swallowing (during Lactogenesis II or later)
Mother's breast softened after feeding**

NF – nursed fair:

1. Fair latch (score 5-7*)

Doesn't open mouth wide
Only nipple and small amount of areola are in mouth
Sleepy at breast
Nursing off and on with short periods of sustained suckling
Periodic swallow
Mother's breasts softened slightly after feeding**

NP – nursed poor:

1. Poor latch (score 0-4*)

Only nipple in mouth
Sleepy
Nursed briefly without sustained suckling
No audible swallows
Mothers breasts not softened at all after feeding**
For documentation purposes, the breastfeeding couple must demonstrate at least three criteria in any given category.
* Using "LATCH tool"-see Kumar et al. 2006
** Once lactogenesis II established

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