



HOSPITAL BREASTFEEDING TOOLKIT



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HOSPITAL BREASTFEEDING TOOLKIT

We are very excited that the State of Illinois has taken on promoting, protecting and supporting breastfeeding, in particular hospital practices that impact breastfeeding outcomes. This toolkit was developed in order to provide a set of resources for Illinois maternity hospitals working towards implementing steps of the Baby-Friendly Hospital Initiative.

Your work towards improving breastfeeding-related maternity care practices will be significant for improving the health of both mothers and infants in Illinois by providing infants with the best start in life.

Introduction



HOSPITAL BREASTFEEDING TOOLKIT

Introduction

“Virtually all mothers can breastfeed, provided they have accurate information, and the support of their family, the health care system and society at large ... Breast milk is ... the perfect food for the newborn, and feeding should be initiated within the first hour after birth.”

~The World Health Organization

Background

In Illinois, starting in 2010, suburban Cook County and the City of Chicago were fortunate to receive funding through the Center for Disease Control and Prevention’s (CDC) Communities Putting Prevention to Work (CPPW) grant for obesity prevention. Part of this CPPW two-year project work focused specifically on hospital breastfeeding-related maternity care practices, given the fact that breastfeeding has been shown to reduce a child’s risk of being obese or overweight by 22%.¹ HealthConnect One and the Illinois Chapter of the American Academy of Pediatrics (ICAAP) were partners on the suburban Cook County CPPW breastfeeding initiative and the City of Chicago’s Healthy Places breastfeeding initiative. Both collaborations provided training and technical assistance to maternity hospitals working towards implementation of the Baby-Friendly Hospital Initiative’s (BFHI) Ten Steps to Successful Breastfeeding.

The Ten Steps to Successful Breastfeeding

The BFHI promotes, protects, and supports breastfeeding through The Ten Steps to Successful Breastfeeding for Hospitals, as outlined by UNICEF/WHO. The steps for the United States are:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Practice “rooming in”-- allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.



This tool kit reflects lessons learned, identifies challenges and illustrates strategies discovered during this project. These tools were developed to help guide all Illinois maternity hospitals through the process of implementing a breastfeeding quality improvement initiative. Many individuals and organizations contributed to this collection, as you will see in the pages which follow. This tool kit reflects the voices of those working in maternity hospitals, as heard at nurse trainings, physician presentations, and at meetings of the Hospital Breastfeeding Council of Metro Chicago.

¹ Arenz S, Rückerl R, Koletzko B, von Kries R. Breast-feeding and childhood obesity – a systematic review. *Int J Obes.* 2004;28:1247-1256.

In the spring of 2012, Illinois' Perinatal Advisory Committee approved a 2013 quality improvement project that asks Illinois maternity hospitals to implement the following breastfeeding-related maternity care practices:

For All Infants

- Provide **Skin to Skin** contact for at least 30 minutes to all patients without complications regardless of feeding method within 2 hours of delivery.
- Promote **24 hour rooming in** to keep mothers and babies together unless medically indicated.



Photo courtesy of Bella Baby Photography Inc.

For Breastfeeding Infants

- **Initiate breastfeeding within 60 minutes** for all uncomplicated vaginal and cesarean births.
- Facilitate **breastfeeding on demand**.
- Educate and promote the benefits of **exclusive breastfeeding** with patients and families.
- Support **exclusive breastfeeding** by avoiding the use of routine supplementation of breastfeeding infants through the use of formula, glucose, or water unless medically indicated.
- For mothers who are separated from their babies, educate and **initiate breast pumping** as soon as possible post-delivery or within 6 hours.

The state breastfeeding quality improvement project will coincide with new legislation (House Bill 4968) in Illinois called the Hospital Infant Feeding Policy Act which goes into effect January 1, 2013.

Synopsis of HB 4968

Provides that every hospital that provides birthing services must adopt an infant feeding policy that promotes breastfeeding. Requires a hospital to routinely communicate the infant feeding policy to staff in the hospital's obstetric and neonatal areas; authorizes posting of the policy on the hospital's Internet or Intranet web site or on the Internet or Intranet web site of the health system of which the hospital is a part. Requires that the policy apply to all mother-infant couplets in the hospital's obstetric and neonatal areas.

It is the project team's hope that the resources available in this tool kit provide valuable guidance and support for maternity hospitals throughout Illinois as they implement the 2013 breastfeeding quality improvement project and become compliant with the policy requirements established in the Illinois Hospital Infant Feeding Act.



Pat Quinn, Governor
LaMar Hasbrouck, MD, MPH, Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

September 25, 2012

Dear Hospital Administrator:

Since evidence has shown the maternity practices in hospitals during the initiation of breastfeeding have an impact on breastfeeding success, the Illinois Department of Public Health's Perinatal Advisory Committee has decided to embark on a quality initiative to establish minimum quality indicators for breastfeeding practice in hospitals.

The goal of the Evidenced Based Breastfeeding Hospital Initiative (EBBHI) is to encourage hospital environmental changes in maternity care practices to support the mother's choice of breast milk feeding. Hospitals can enable mothers to breastfeed successfully by enhancing breastfeeding environments and by establishing systems, protocols and practices that support the initiation, continuation and maintenance of breastfeeding. As a reminder, Public Act 097-0713, which is effective Jan. 1, 2013, requires each birthing hospital to adopt and routinely communicate an infant feeding policy that promotes breastfeeding.

The benefits of breastfeeding are many. Breastfeeding is the best source of infant nutrition and immunologic protection, and it provides remarkable benefits to mothers as well. Breastfed babies also are less likely to become overweight or obese.

Many mothers want to breastfeed and most try, and more than three quarters initiate breastfeeding in the hospital, according to the 2012 Centers for Disease Control and Prevention Report Card. However, in Illinois, by 3 months of age, the number of babies exclusively breastfed has dropped to 36 percent and the number drops to just 14 percent at 6 months of age.

A virtual EBBHI toolkit, which contains resources to evaluate, to update and to monitor breastfeeding practice, has been developed to enable hospitals to implement this statewide quality initiative. The toolkit is available through the Illinois Breastfeeding Blueprint website at www.ilbreastfeedingblueprint.org.

We invite you to assist us in supporting women with their initial nutrition decision for their babies.

Sincerely,

A handwritten signature in blue ink, appearing to be "LaMar Hasbrouck", written over the word "Sincerely,".

LaMar Hasbrouck, MD, MPH
Director

Improving public health, one community at a time

printed on recycled paper

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And many thanks to the members of the Hospital Breastfeeding Council of Metro Chicago.

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HOSPITAL BREASTFEEDING TOOLKIT

Initial Planning

Initial Planning

When starting a breastfeeding quality improvement project, it is important to conduct an assessment of current breastfeeding-related maternity practices and evaluate the facility's readiness for change. All relevant stakeholders should be engaged in this process including but not limited to hospital staff, patients, and community partners.

Building a Breastfeeding Multi-disciplinary Committee

Introduction

Forming a Breastfeeding Multi-disciplinary Committee (MDC) is one of the best and most strategic approaches to identifying and implementing hospital-based policies and practices to promote and support breastfeeding.¹ An MDC can provide a forum for identifying and prioritizing issues, solving problems, identifying champions and addressing barriers.

Changing hospital policies and practices can be a complex, time-intensive process – one that is often met with resistance. Ensuring that the right people are at the table, from the beginning, is important. Failure to involve key players can slow down a project or even bring it to a complete standstill. Conversely, providing an opportunity for representatives from different departments to explain how the change process will affect them, and their staff, can foster goodwill, energy and a team mentality for the challenging, but worthwhile, road ahead.

Convening a Committee

It is key to start by identifying breastfeeding “champions”. Champions are internal staff members who feel strongly about the importance of breastfeeding. They often go the extra mile to ensure that breastfeeding receives appropriate attention or can make the case for breastfeeding to different audiences. Once champions are identified, the next step is for the hospital to bring them and other staff together.

Encouraging units to come together to focus on a specific project is critical to creating a strong foundation and ensuring the long-term sustainability of the work. It is a good idea to have someone higher up in the hospital convene the team, or welcome everyone to the first meeting. Having the president, CEO, chief medical officer, chief of staff, or other high-ranking administrator present and active can indicate to participants that promoting breastfeeding is a priority for the hospital. Sustainable systems-level change requires participation from many departments within the hospital.

Meetings

MDC meetings are typically held once a month, in-person, with a limited number of people joining by conference call. Membership is typically 12 to 20 staff. The meetings should be led by the staff person in the best position to manage the change process, facilitate the meetings, mediate challenging issues and keep things moving. This could be a different person at different hospitals – such as a lactation counselor, a nurse or a doctor.

Finding a convenient meeting time can be a challenge. Find out about existing hospital structures, because there may already be a regular hospital meeting that could be expanded into the Breastfeeding Multi-disciplinary Committee meeting. Or perhaps a Maternal-Child Health Quality Improvement group could create a subcommittee.

Approach

There should always be an agenda. The initial meeting(s) should focus on establishing a purpose and goals for the MDC and identifying and prioritizing areas for improvement. Ensure that there are internal breastfeeding champions that attend the meetings. Respect that everyone is busy and that making changes to support breastfeeding represents additional (but worthwhile) responsibilities.

It can be a mistake to assume that everyone is on the same page already. The same message may need to be said in multiple ways in order for all staff to understand how they fit into the change process.

¹ Hannon PR et al., A Multidisciplinary Approach to Promoting a Baby Friendly Environment at an Urban University Medical Center, J Hum Lact 1999 (15):289

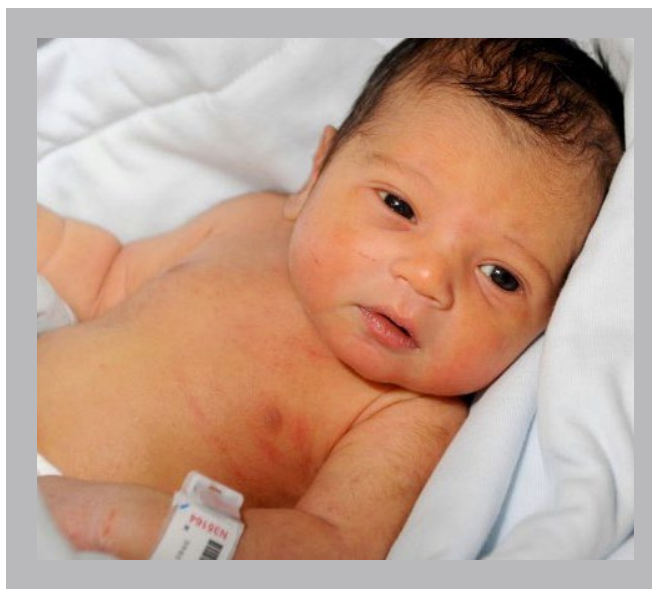


Photo courtesy of Bella Baby Photography Inc.

Breastfeeding Multi-disciplinary Committee Membership

Team Member	Name	Email	Phone
Physicians			
Obstetrics			
Pediatrics			
Family Practice			
Neonatology			
Other			
Administration			
Nursing			
Labor & Delivery			
Mother/Baby			
Normal Newborn Nursery			
NICU			
Nurse education			
Quality Improvement			
Nutrition/Dietitian			
Lactation Consultants			
Mother/Baby			
NICU			
Outpatient			
Possible Additional Members			
Pharmacist			
OB Clinic			
Peds Clinic			
WIC			
Medical education			
Information Technology (IT)			
Other			

Multidisciplinary Subcommittees	
Gaining support from upper level administration Identify and engage champions within the hospital's administration	Leader:
	Members:
Policy Subcommittee Develop evidence-based infant feeding policy and submit for approval	Leader:
	Members:
Training Subcommittee Develop action plan for training hospital staff on maternity practices being implemented	Leader:
	Members:
Practice Subcommittee Monitor progress of practices implementation and provide strategies for addressing barriers	Leader:
	Members:
Continuity of Care Subcommittee Assess prenatal education and postpartum support available and develop action plan for improvement	Leader:
	Members:
Marketing Develop marketing materials and distribute to relevant partners (clinics, physicians' offices)	Leader:
	Members:
Data Collection, IT Develop and implement action plan for collecting data on breastfeeding practices	Leader:
	Members:

Hospital Breastfeeding Multi-Disciplinary Committee MEETING MINUTES

Meeting Date:

Note taker:

Chair:

Members present:

Members absent:

Guests present:

ISSUE	DISCUSSION	ACTIONS	RESPONSIBLE PARTY	TARGET DATE
MDC Committee Members – Who should be included?				
MDC Committee Purpose/Mission statement				
Strengths and challenges of current lactation support				
Review of baseline assessment results and prioritization				

ISSUE	DISCUSSION	ACTIONS	RESPONSIBLE PARTY	TARGET DATE
MDC Committee Meeting Schedule				

Baseline Assessment – Maternity Care Practices

The following are two existing assessment tools that can be used to assess a hospital's current breastfeeding-related maternity care practices. Either tool can be used for baseline assessment of maternity care practices.

Baby-Friendly USA 2012 Self-Appraisal Tool and CDC National Survey

<http://www.babyfriendlyusa.org/get-started/d1-discovery> (near the bottom of the page)

This assessment tool can be used to review current maternity care policies and practices in optimal infant feeding and help appraise your current practices in relation to the Tens Steps to Successful Breastfeeding. Each step has a number of questions to be answered. The more YES responses that a hospital has the closer they are to having a step fully implemented. A facility is asked to complete the Self-Appraisal Tool as one of the initial requirements of pursuing official Baby-Friendly designation.

Self-Appraisal Tool Summary Report

STEP	STATUS # of questions answered YES	NOTES (what barriers contributed to a NO response, what successes contributed to a YES response)
Step 1: Policy	___/11 ___%	
Step 2: Training	___/10 ___%	
Step 3: Inform all women	___/10 ___%	
Step 4: Skin to skin**	___/4 ___%	
Step 5: Show mothers how	___/9 ___%	
Step 6: No food or drink except breast milk**	___/8 ___%	
Step 7: Rooming-in**	___/5 ___%	

Step 8: Feeding on cue	___/2 ___%	
Step 9: No pacifiers/artificial nipples**	___/4 ___%	
Step 10: Support and referrals**	___/7 ___%	
The WHO Code <i>International Code of Marketing of Breast-milk Substitutes</i> http://www.who.int/nutrition/publications/code_english.pdf	___/8 ___%	
Overall Score		

**Denotes steps that significantly increase breastfeeding exclusivity and duration.

CDC National Survey of Maternity Practices in Infant Nutrition and Care (mPINC) Hospital Survey

http://www.cdc.gov/breastfeeding/pdf/mPINC/mpinc_hospital_survey.pdf

The Center for Disease Control and Prevention (CDC) administers the national mPinc survey to every facility in the US that routinely provides maternity care services. The survey has been administered every two years since 2007 (2007, 2009, 2011). It is encouraged that All Maternity facilities in the United States are encouraged to complete this survey in order to assess on a national level maternity care practices in infant nutrition and care. If your facility completed the mPinc survey, the results can be used to assess current practices.

mPinc Summary Report

Dimensions of Care in the mPINC Survey		Score	NOTES (Successes and Challenges)
Labor and Delivery Care	Initial skin-to-skin contact Initial breastfeeding opportunity Routine procedures performed skin-to-skin		
Postpartum Care			
Feeding of Breastfed Infants	Initial feeding received after birth Supplementary feedings		
Breastfeeding Assistance	Documentation of feeding decision Breastfeeding advice and counseling Assessment and observation of breastfeeding Pacifier use		
Contact Between Mother and Infant	Separation of mother and newborn during transition to receiving patient care units Patient rooming-in Instances of mother infant separation throughout the intrapartum stay		
Facility Discharge Care	Assurance of ambulatory breastfeeding support Distribution of "discharge packs" containing infant formula		
Staff Training	Preparation of new staff Continuing education Competency assessment		
Structural and Organizational Aspects of Care Delivery	Breastfeeding policy Communication of breastfeeding policy Infant feeding documentation policy Employee breastfeeding support Facility receipt of free infant formula Prenatal breastfeeding instruction Coordination of lactation care		

Baseline Assessment – Community Needs and Resources

During our interaction with various hospitals throughout Cook County the authors learned that many healthcare providers and institutions were not aware of breastfeeding community resources available or the type of services that some of these organizations offer to their clients.

We highly encourage collaboration with:

Clients who delivered or will be delivering at your hospital
Community Leaders
Community Organizations
WIC
Case Management Organizations
Church Leaders
Federally Qualified Health Centers
Home Visiting Programs
Doula Programs
Childcare Facilities
Insurance Companies
Employers

Suggestions for collaborating:

Host several stakeholder meetings to discuss implementing Baby-Friendly at your hospital.
Invite stakeholders to be part of your Baby-Friendly Workgroup.
Invite your local WIC to present on the services available for your patients
Host focus groups with clients that have delivered or will be delivering at your hospital, to obtain feedback.



Photo courtesy of Bella Baby Photography Inc.

See the next two pages for a sample invitation letter and sample flier for a stakeholder meeting.

Sample Invitation Letter - Stakeholder Meeting

Dear Community Partner,

We are pleased to contact you as a stakeholder in promoting and supporting breastfeeding in our hospital. Research has shown that there is no better food than breast milk for a baby's first year. One of the goals of our hospital is to promote practices that enhance breastfeeding success among our clients. We believe that by examining our current system, policies, and environment, as well as working with community partners like you, we can increase our breastfeeding outcomes.

We are inviting community members with a vested interest in breastfeeding to join us in finding creative, successful strategies for improving breastfeeding support and success for new mothers who deliver at our hospital. We are optimistic that a comprehensive support program can result in dramatic increases in our breastfeeding rates. We believe that together, we can develop a plan to address the specific needs of breastfeeding mothers in our community. We would be honored if you or a designated representative from your group could join this important community-wide effort.

DATE _____

TIME _____

LOCATION _____

To learn more, contact:

NAME _____

PHONE _____

E-MAIL _____

Sample Flier - Stakeholder Meeting

HOPITAL's NAME BABY-FRIENDLY HOSPITAL INITIATIVE



WHAT: We are inviting community members with a vested interest in breastfeeding to join us in finding creative, successful strategies for improving breastfeeding support and success for new mothers who deliver at our hospital.

Come and learn about our Baby-Friendly Initiative
and provide your input.

WHO: Pregnant Women, Fathers, WIC staff, Case Managers, Home Visitors, Childbirth Educators, Dieticians, Church Leaders, Childcare Managers, Community Leaders.

WHEN:

WHERE:

RSVP to by..... at.....

Please contact.... with any questions at

**REFRESHMENTS WILL BE SERVED.
GREAT RAFFLE PRIZES.**

CHILDCARE PROVIDED IF REQUESTED BY _____(date).



HOSPITAL BREASTFEEDING TOOLKIT



Feeding Policy

Developing a Hospital Infant Feeding Policy

In June of 2012, Illinois passed House Bill 4968. This important legislation provides that every maternity hospital in Illinois shall adopt an infant feeding policy that promotes breastfeeding and follows guidance from the Baby-Friendly Hospital Initiative. This legislation is effective January 1, 2013.

Hospital Infant Feeding Act (Illinois House Bill 4968)

Synopsis As Introduced

Creates the Hospital Infant Feeding Act. Provides that every hospital that provides birthing services must adopt an infant feeding policy that promotes breastfeeding. Requires a hospital to routinely communicate the infant feeding policy to staff in the hospital's obstetric and neonatal areas; authorizes posting of the policy on the hospital's Internet or Intranet web site or on the Internet or Intranet web site of the health system of which the hospital is a part. Requires that the policy apply to all mother-infant couplets in the hospital's obstetric and neonatal areas. Effective January 1, 2013.

Public Act 097-0713

HB4968 Enrolled LRB097 18751 DRJ 65112 b

AN ACT concerning health.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Hospital Infant Feeding Act.

Section 5. Definitions. In this Act:

"Baby-Friendly Hospital Initiative" means the voluntary program sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) that recognizes hospitals that meet certain evaluation criteria regarding the promotion of breastfeeding. "Department" means the Department of Public Health. "Hospital" has the meaning ascribed to that term in the Hospital Licensing Act. "Infant nutrition resource" means breastfeeding education and infant formula safety and preparation.

Section 10. Infant feeding policy required.

(a) Every hospital that provides birthing services must adopt an infant feeding policy that promotes breastfeeding. In developing the policy, a hospital shall consider guidance provided by the Baby-Friendly Hospital Initiative.

(b) An infant feeding policy adopted under this Section shall include guidance on the use of formula (i) for medically necessary supplementation, (ii) if preferred by the mother, or (iii) when exclusive breastfeeding is contraindicated for the mother or for the infant.

Section 15. Communication of policy.

A hospital shall routinely communicate the infant feeding policy to staff in the hospital's obstetric and neonatal areas, beginning with hospital staff orientation. The hospital shall also ensure that the policy and infant nutrition resources are posted (i) in a conspicuous place in the hospital's obstetric or neonatal area or (ii) on the hospital's Internet or Intranet web site or on the Internet or Intranet web site of the health system of which the hospital is a part. The hospital shall make copies of the policy available to the Department upon request.

Section 20. Application of policy.

A hospital's infant feeding policy adopted under this Act must apply to all mother-infant couplets in the hospital's obstetric and neonatal areas.

Section 99. Effective date.

This Act takes effect January 1, 2013.

Full details available here:

<http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=097-0713>

Key Considerations in Policy Development

Policy drives practice. Therefore, an up-to-date infant feeding policy is a key component to your breastfeeding quality improvement initiative. You might start by assessing the current policies in place pertaining to infant feeding and work towards revising these. Below are steps and strategies for updating your hospital's infant feeding policy.

Obtain current breastfeeding policy and/or any tangential policies that include breastfeeding (hypoglycemia policy, jaundice policy, etc.).

Find out how your system works with regard to policy creation and implementation. Who are you required to collaborate with? Is it done through a committee or department? Who provides final approval? How is it implemented? How is the implementation communicated to staff? How is the policy enforced?

Utilize sample policies from other institutions and organizations (see Model Hospital Infant Feeding Policies, beginning on the next page). There is no need to recreate the wheel. However, understand that you will need to take this information and adapt it to meet your institutional needs.

Create a broad over-arching policy that includes all of the Baby-Friendly Ten Steps to Successful Breastfeeding.

Write specific protocols, which delineate how the policy is implemented. This will be specific to how your institution practices – it may differ from other hospitals and require flexibility. Examples of protocols include skin-to-skin and rooming-in.

Obtain feedback from your champions, multi-disciplinary committee, and staff. Different professional roles bring different perspectives regarding practice. It's valuable to receive their input and to identify potential barriers so you can align your policy to minimize the barriers as much as possible.

Go through proper administrative channels to gain approval and support from management.

Educate all staff (including MD's, RN's, CNA's, etc.) on changes in practice. Keep communication channels open to identify and discuss any areas of difficulty with implementation.

Utilize the following policy development resource:

United Nations Children's Fund (UNICEF) United Kingdom

*The UNICEF UK Baby Friendly Initiative
audit tool to monitor breastfeeding support in the
maternity services
Appendix 1: Writing and evaluating the
breastfeeding policy*

www.unicef.org.uk/Documents/Baby_Friendly/Guidance/4/audit_policy_tool_maternity.pdf?epslanguage=en

Model Hospital Infant Feeding Policies

Academy of Breastfeeding Medicine

ABM Clinical Protocol #7: Model Breastfeeding Policy

www.bfmed.org/Media/Files/Protocols/English%20Protocol%207%20Model%20Hospital%20Policy.pdf

American Academy of Pediatrics

Sample Hospital Breastfeeding Policy for Newborns

<http://www.aapnj.org/uploadfiles/documents/f48.pdf>

Arizona Baby Steps to Breastfeeding Success

Model Hospital Policy Resource Guide 2010

www.azdhs.gov/phs/bnp/gobreastmilk/hospitalPolicy.htm

California Department of Public Health

Model Hospital Policy Recommendations On-Line Toolkit

www.cdph.ca.gov/healthinfo/healthyliving/childfamily/Pages/MainPageofBreastfeedingToolkit.aspx

Coalition of Oklahoma Breastfeeding Advocates

Model Hospital Policy on Breastfeeding

www.okbreastfeeding.org/uploads/Model_Breastfeeding_Policy_Final_with_Endorsemnts_02-04-09.pdf

New York State Department of Health and Mental Hygiene

Model Hospital Breastfeeding Policy: Implementation Guide

www.health.ny.gov/community/pregnancy/breastfeeding/docs/model_hospital_breastfeeding_policy_implementation_guide.pdf

Academy of Breastfeeding Medicine – Clinical Protocols

The ABM's Clinical Protocols can assist in the policy development process, as well as serve as a great resource on guidelines for the care of breastfeeding mothers and infants.

<http://www.bfmed.org/Resources/Protocols.aspx>



HOSPITAL BREASTFEEDING TOOLKIT



Data Collection

Data Collection: Monitor Your Progress

Introduction

Data collection is one of the most important and challenging activities necessary in implementing a breastfeeding quality improvement initiative. Good data is essential to determining a starting point, setting manageable benchmarks for improvement, and documenting progress. Most importantly, an effective data collection system allows for the collection of accurate data. Depending on the charting system you use, a number of techniques can be employed to collect breastfeeding-related data, including electronic and paper data collection.

Baseline Data Collection

If the current charting system being used either cannot be adapted to include all of the infant feeding practices data (i.e., skin to skin, rooming-in, pacifier use), or if it takes a significant amount of time to update the charting system, simple paper form tools can be used to collect certain baseline data. Two templates have been included in this tool kit in order to facilitate baseline data collection; these include the Baseline Labor and Delivery Questionnaire and the Baseline Postpartum Questionnaire. The Baseline Labor and Delivery Questionnaire provides relevant data pertaining to infant feeding practices that occur during a patient's labor and delivery, including skin to skin and initiation of breastfeeding. The Baseline Postpartum Questionnaire includes data on postpartum practices, such as rooming-in and pacifier use. These questionnaires can be implemented quickly and easily to initiate the data collection process while a more permanent data collection process is established.

Chart Auditing

Chart auditing is another technique for assessing current practices. Looking into a mother's entire hospital stay through a chart audit can help to identify which barriers are most significant in

breastfeeding success (i.e., lack of rooming-in, physician suggestion of supplementation). To achieve statistical significance of findings, a specific number of patient charts need to be reviewed. The number of patient charts to be reviewed depends on the number of births in a year at the hospital. This practice also allows random collection of data that is reflective of the population and annual births. It is also suggested that chart data be collected across shifts and reflect the percentage of vaginal and C-section births.

Summary Reports

The data collection process can be facilitated by creating summary reports (see Summary Infant Feeding Report) and presenting them regularly to hospital staff at appropriate meetings. Reviewing uniform, summary data (including missing or not collected data) provides hospital staff with an opportunity to focus on both the successes and challenges of their breastfeeding activities. Quality improvement department staff can help create summary reports at most hospitals. Random sampling can be achieved by using an alphabetical or numerical sampling strategy. The following table provides the number of charts required to review annually based on the number of yearly births at the hospital. The percent of NICU admissions should be excluded from the total births.

Hospital Breastfeeding Data Chart Review Significance Table					
# Births	# Chart Reviews @ 95% Confidence Level		# Births	# Chart Reviews @ 95% Confidence Level	
	Per Year	Per Month		Per Year	Per Month
100	90	8	1,200-1,299	320	27
200-299	150	13	1,300-1,499	330	28
300-399	190	16	1,500-1,699	340	28
400-499	210	18	1,700-2,099	350	29
500-599	260	22	2,100-2,499	360	30
600-699	270	23	2,500-2,999	370	31
700-799	280	23	3,000-3,899	380	32
800-899	290	24	3,900-5,599	390	33
900-999	300	25	5,600-9,099	400	33
1,000-1,199	310	26	9,100-15,000	410	34

Joint Commission Perinatal Care Core Measures on Exclusive Breast Milk Feeding

The Joint Commission recently published guidelines on implementing its new Perinatal Care Core Measures on Exclusive Breast Milk Feeding. To align data collection with the Joint Commission's guidance, the following conditions should be included as contraindications for which infants can be excluded from the denominator of those eligible for exclusive breastfeeding: alcohol abuse; medications, (i.e., antiretroviral medications, and other medications where the risk of morbidity outweighs the benefits of breast milk feeding), undergoing radiation therapy, active varicella, and active herpes simplex virus with breast lesions.

<http://manual.jointcommission.org/releases/TJC2010A/MIF0170.html>

Data Collection Resources

Information on the Perinatal Care Core Measure for Exclusive Breast Milk Feeding

The Joint Commission Perinatal Care Core Measure for Exclusive Breast Milk Feeding: Specifications Manual for Joint Commission National Quality Core Measures (2010A1)

<http://manual.jointcommission.org/releases/TJC2010A/MIF0170.html>

Implementing the Joint Commission Perinatal Care core measure on exclusive breast milk feeding
United States Breastfeeding Committee

<http://www.usbreastfeeding.org/HealthCare/HospitalMaternityCenterPractices/ToolkitImplementingTJCCoreMeasure/tabid/184/Default.aspx>

Breastfeeding data collection sample tools

Birth & Beyond California Evaluation Toolkit

<http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/Evaluationtoolkit.aspx>

Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation
Baby-Friendly USA

http://babyfriendlyusa.org/eng/docs/2010_Guidelines_Criteria_Rev%2011_28_11.pdf



HOSPITAL BREASTFEEDING TOOLKIT

Hospital Logo

BASELINE LABOR AND DELIVERY QUESTIONNAIRE

Please answer the following on each delivery:

☐ Vaginal ☐ Vacuum ☐ Forceps *C-section is excluded at this time

Baby's Sticker here please
Will include birth date and time

1. SKIN-TO-SKIN CONTACT INITIATED IN DELIVERY ROOM: ☐ Yes ☐ No

If not, please state reason(s):

- ☐ Maternal Request
- ☐ Physician/Midwife Request
- ☐ Clinical Contraindication (specify) _____
- ☐ Other _____

2. SKIN-TO-SKIN DURATION:

(hour and minute)

Start Time: _____

Stop Time: _____

3. BREASTFED IN DELIVERY ROOM:

☐ **Yes** (hour and minute)

Start Time: _____ Stop Time: _____

☐ **No** If not, please state reason(s):

- ☐ Maternal Refusal
- ☐ Unsuccessful Latch
- ☐ Clinical Contraindication (specify) _____
- ☐ Other _____

Nurse's Name (please print) _____



HOSPITAL BREASTFEEDING TOOLKIT

Hospital Logo

BASELINE POSTPARTUM QUESTIONNAIRE

Please answer the following on each discharge:

☐ Vaginal ☐ Cesarean Section

1. INFANT FEEDING:

Intention: ☐ Exclusive breast milk
☐ Exclusive formula feeding
☐ Mixed feeding (breast milk and supplements)

ACTUAL (THROUGHOUT HOSPITAL STAY)

☐ Exclusive breast milk feeding
☐ Exclusive formula feeding
☐ Breast milk and supplementation

Type of feed:
☐ Breast
☐ Bottle
☐ Other: _____

Reason for supplementation:
☐ Mother's request
☐ Physician's order
☐ Other: _____

2. PACIFIER USE:

If a breastfeeding infant, did the infant receive a pacifier?
☐ NO
☐ YES If yes, please explain reason: _____

3. ROOMING IN:

Did the infant room in 24 hrs per day?
☐ YES
☐ NO If no, please explain reason: _____

Nurse's Name (please print) _____



HOSPITAL BREASTFEEDING TOOLKIT

Name of health facility: _____
 Period of data collection: _____ to _____
 Reporter: _____
 Date of report: ____/____/____ (day/month/year)

SUMMARY INFANT FEEDING REPORT

TYPE OF DATA	NUMBER	PERCENTAGE
Total number of babies discharged in the period of data collection:		
MOTHER'S FEEDING INTENT:		
Exclusive breast milk (no supplements)		_____%
Mixed feeding (breast milk and supplements)		_____%
Replacement feeding (no breast milk; other liquids or foods given)		_____%
Type of delivery:		
Vaginal		_____%
Caesarean section		_____%
Skin-to-skin contact for at least 30 minutes within 2 hours after birth (or ability to respond)		_____%
Early Latch (within 60 minutes of delivery)		_____%
TYPE OF FEEDING: (Totals should equal 100%)		
Exclusive breast milk (no supplements)		_____%
Mixed feeding (breast milk and supplements)		_____%
Replacement feeding (no breast milk, other liquids or foods given)		_____%
HOW BABIES ARE FED:		
Breast		_____%
Bottle		_____%
Cup		_____%
Other (please list)		_____%
BABIES' LOCATION		
Rooming-in		_____%
Normal newborn nursery		_____%
Special care unit _____%		_____%
Other _____%		_____%
Data sources:		



HOSPITAL BREASTFEEDING TOOLKIT

Strategies for Practice Change

Introduction and Background

In 2010, HealthConnect One began working in collaboration with several partners on a breastfeeding initiative through the Center for Disease Control and Prevention's (CDC) Communities Putting Prevention to Work (CPPW) grant for obesity prevention. This partnership worked with maternity hospitals in suburban Cook County and the City of Chicago to implement breastfeeding quality improvement initiatives. This toolkit was developed after listening to the same challenges and lessons-learned shared by many of the people we interacted with at these hospitals.

As health care providers strive to implement skin to skin contact, rooming-in, exclusive breastfeeding, and other maternity care practices which support breastfeeding, some obstacles prove to be persistent. Some of these barriers are situational, related to the working environment, including hospital policies and routines. Other barriers are related to nurses' and physicians' attitudes, beliefs, and dispositions. For example, negative attitudes based on stereotypes can sometimes influence a healthcare provider's practices. Other interference comes from outside the hospital, including visitors, smart phones and social media.

It is important to figure out what these barriers are in your hospital.

Engage staff's hearts and minds. Knowledge is not enough.

Each hospital has its own culture. Listening to people talk about their work experiences, challenges, and attitudes is a necessary first step in identifying issues. Then work toward finding solutions. Be willing to explore possibilities for modifying routines. If it is not possible to

change policies, at least listen and acknowledge the legitimacy of people's concerns and feelings.

Another guiding principle is to allow time for people's voices to be heard. Overcoming barriers to maternity care practices that promote breastfeeding requires motivating people - as much as informing them. Implementing new practices is often more about changing mindsets than teaching, although providing up-to-date information is essential. Health care providers may have decades of experience. Listen to their concerns, acknowledge and affirm their points of view and solicit their ideas.

Bringing the most updated evidence-based information to nurses, physicians, patients, and family members is essential. Whenever possible, use a peer-to-peer approach: have nurses talk with other nurses, physicians talk to physicians, and peer counselors talk to pregnant women and their families.

Also recommended, however, is inter-professional education, which can enhance collaboration between nurses and physicians.

Recruiting physician champions is another key element of success.



This work is deeply personal, and without permitting communication about people's underlying attitudes and beliefs, and the personal experiences on which those attitudes and beliefs are often based, the challenges are more difficult to overcome.

Understanding the barriers at your hospital will help you to implement new approaches. Addressing what motivates specific behaviors can facilitate organizational change.

Be strategic about how to motivate people to change; help them understand both the positive impact on their jobs and the optimal outcomes for mothers and infants.

Small steps count; celebrate every success. Incremental change leads to cumulative effects.

Cultural Barriers

There are known disparities in rates of breastfeeding initiation and duration among different racial, ethnic, and socioeconomic groups in the United States – and in Illinois. Some of the underlying barriers that influence feeding decisions have been well identified. However, one that needs to be addressed by healthcare professionals is the lack of support resulting from negative attitudes and assumptions on the part of some providers, often based on stereotypes.

A painful example of this attitude was articulated openly by a 4th-year medical student who said, “I don’t talk to African-American women about breastfeeding.”

What do we already know about disparities?

“The vast majority of low-income mothers we serve in the WIC program are motivated and supported by WIC to breastfeed their newborns, but many of them are giving birth in hospitals with such poor policies that breastfeeding is being systematically undermined,” says Laurie True, Executive Director of California WIC Association. She goes on to say, “This is not only a health equity issue, it’s a social justice issue.”

What did we learn from the Illinois Hospital Breastfeeding Blueprint data?

- Illinois women do not all share the same hospital experience in terms of breastfeeding support practices.
- Illinois statewide data points to racial disparities in hospital experiences:
 - Black women are less likely to report supportive breastfeeding practices than white and/or Hispanic women.
 - Black women are also more likely than white and Hispanic women to experience the hospital practices that discourage breastfeeding: pacifier use and formula gift packs.

One assumption commonly heard among nurses and lactation consultants is that the majority of Latina moms supplement with formula. The reasons for this are complex. When mothers are asked why they are giving formula, they often say it’s because the nurse gave it to them. Often nurses say that Hispanic moms always supplement; it’s their ‘culture’, so they give them bottles, expecting that this is what they want. So, how often are moms who are given formula by a nurse using formula because the nurse expects them to?

What can be done? What can we learn from California’s experience? Hospital practices really matter!

51 out of 143 Baby-Friendly designated hospitals in the U.S. (as of May, 2012) are in California.

“San Francisco General is the public hospital in San Francisco. They serve the poorest of the poor, the women who live in chaos and have no other options for health care. They provide breastfeeding support and consistent messaging to all patients. They show us that it is not about the mothers being poor or ignorant or of color, exclusive breastfeeding success depends upon hospital policies and practices.” (Birth & Beyond California: Continuous Quality Improvement Project Decision Maker Course)

“Exclusive breastfeeding rates in California vary widely by ethnicity: while more than two-thirds of women within all ethnic groups provide breast milk to their infants, the exclusive breastfeeding rate among white women (63.6%) is nearly twice that of African American (33.1%) and Hispanic (32.4%) women.

However, this disparity in exclusive breastfeeding rates disappears in California's Baby-Friendly facilities. In Baby-Friendly hospitals, 62% of African American women, 66% of Hispanic women, and 71% of white women provide only breast milk to their infants. It would seem, then, that hospital policies have far greater impact on exclusive breastfeeding rates in California than regional or ethnic differences that may exist."

(Depends on Where you Were Born, A Policy Update on California Breastfeeding and Hospital Performance Produced by the California WIC Association and the UC Davis Human Lactation Center)

Strategies:

- Provide education for nurses and physicians about cultural competency.
- Educate about effective communication skills, both verbal and nonverbal.
- Bridges to Breastfeeding (linking hospitals and WIC)
- Increase and improve parent education (Loving Support)
- Employ peer counselors.
- Recruit more nurses that reflect the patient population.
- Display culturally appropriate materials for breastfeeding promotion and education.

Communicate in a patient-centered manner to build relationships and enhance learning.

"There should be prenatal conversations rather than prenatal education. The conversations allow you to answer their questions and concerns in that moment so that when that baby comes, she's more likely to breastfeed because you addressed her personal concerns." (Dana Posley, breastfeeding peer counselor, Little Company of Mary Hospital, Evergreen Park)

Resources

For a list of resources about cultural barriers please visit

http://www.ilbreastfeedingblueprint.org/pages/hospital_toolkit/35.php

How we talk about breastfeeding...and why it matters.

The Importance of the Language We Use

Does it matter if we say, ‘breastfed babies get sick less often’ or ‘formula-fed babies get sick more often’? If we talk about the ‘benefits of breastfeeding’ or the ‘risks of not breastfeeding’?

Yes!

“For many years, public health campaigns and the medical literature have described the ‘benefits of breastfeeding.’ Although statistically the same as reporting the ‘risk of not breastfeeding,’ this approach implicitly defines infant formula as the normal way to feed an infant. This subtle distinction substantially affects perceptions of infant feeding. If ‘breast is best,’ then formula is implicitly ‘good’ or ‘normal.’

“These distinctions appear to influence feeding decisions...Women who were advised about the ‘benefits of breastfeeding’ viewed lactation as optional, like a multivitamin, that was helpful but not essential for infant health. In contrast, when the same data were presented as the ‘risk of not breastfeeding,’ women were far more likely to say that they would breastfeed their infants”.¹

A maternal-child nurse and lactation consultant describes her experiences with a breastfeeding challenge with her firstborn and her decision to wean him to formula.

“How was I supposed to know that there are risks to giving formula and that there are other options besides weaning to formula (such as pumping and bottle feeding expressed milk) when no one ever told me? In all of my preparation for having a baby (and even my preparation to become a nurse) nothing was ever mentioned about the risks of feeding something other than breastmilk. Like everyone else, I was surrounded by the message that “breast is best”, but formula is ok too.” (Fleur Bickford, RN, IBCLC)

What do we know about how people make decisions about risk?

People are more likely to avoid a loss than to seek a gain. So, information about breastfeeding framed as losses or risks associated with formula, are more motivating than the same information framed as gains or benefits from breastfeeding.

Language matters!

Appearing completely neutral about breastfeeding (asking “Do you plan to breastfeed or bottle feed?”) confuses mothers about best practice. Start by asking “what do you know about breastfeeding?” This question will indicate that breastfeeding is considered the normal infant feeding method. Provide women with complete, accurate information to ensure truly informed decision-making. Help women understand that breastfeeding is not simply a lifestyle choice – but a public health issue.

Resources

¹Stuebe AM; Schwarz EB. The Risks and Benefits of Infant Feeding Practices for Women and Their Children. *Journal of Perinatology*, 2010; 30(3):155-162.

<http://www.nature.com/jp/journal/v30/n3/abs/jp2009107a.html>

The Language of Breastfeeding

Watch Your Language! By Diane Wiessinger, MS, IBCLC

<http://www.bobrow.net/kimberly/birth/BFLanguage.html>

The Risks of Not Breastfeeding for Mothers and Infants
Rev Obstet Gynecol. 2009 Fall; 2(4): 222–231.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2812877/>

Why I Don’t Feel Guilty For Weaning to Formula

Fleur Bickford, RN, IBCLC

<http://blog.nurturedchild.ca/index.php/2012/05/27/why-i-dont-feel-guilty-for-weaning-to-formula/>

Engaging Physicians

“As far as doctors, especially house staff, most tell you that they have no training in breastfeeding at all. For those of us who work in teaching hospitals, it is critical that we be involved with that education. And not just lectures, but day-to-day interactions with pediatricians and obstetricians. When lactation consultants work in isolation, little change will occur. So it is imperative to identify senior medical staff who can take some leadership in this area.” (Charlotte Johnson, MSN, IBCLC, RNC)

How can we encourage physician buy-in and education?

Help physicians understand that there is momentum gathering in the U.S. We’ve reached a tipping point, as a result of recent initiatives and professional organizations’ embrace of breastfeeding. Now is the time to engage and educate physicians about breastfeeding.

- **Advice from a physician:**
“Provide them with an opening to learn new things. Rather than making them feel as if you’re saying, “You haven’t cared about breastfeeding,” say, “We’re at a watershed moment. Everything has changed and because of new evidence of significant improved health outcomes, there’s a new emphasis on breastfeeding as a proven intervention to improve outcomes for mothers and babies... Because of this new evidence, the CDC and Surgeon General have issued a “Call to Action” to improve breastfeeding rates in our country. Did you know that ACOG thinks the importance of breastfeeding is a big deal – and now recommends talking to women about breastfeeding at every prenatal visit?” (Ann Borders, MD, Maternal Fetal Medicine, Northwestern Memorial Hospital, Chicago)

Share Current Evidence-Based Information:

Illinois Physicians’ Statement on Breastfeeding
Developed by the Illinois Chapter of the American Academy of Pediatrics, the Illinois Academy of Family Physicians, and the Illinois Section of the American Congress of Obstetricians and Gynecologists
<http://illinoisap.org/wp-content/uploads/ILPhysiciansStatementOnBreastfeeding.pdf>

Surgeon General’s Call to Action:
<http://www.surgeongeneral.gov/topics/breastfeeding/>

The Joint Commission’s Speak Up™ Campaign
http://www.jointcommission.org/speakup_breastfeeding/

The Joint Commission’s Speak Up™ Campaign State Breastfeeding Coalition Webinar
<http://www.usbreastfeeding.org/Portals/0/Coalitions/Teleconferences/2011-10-11-Teleconf-Slides.pdf>

Appeal to Physicians’ Desire to Remain Current – and Competitive.

Tell them that women are more aware of the importance of breastfeeding. Women increasingly expect physicians to be knowledgeable about breastfeeding and hospitals to be supportive. Women today are seeking providers who accommodate their wishes. One example of a competitive marketing strategy is ‘gentle’ Cesareans. Women anticipating a Cesarean have begun changing hospitals or providers to find this option. (see “Gentle” Cesareans at http://www.ilbreastfeedingblueprint.org/pages/hospital_toolkit/35.php)

Promote Inter-Professional Collaboration and Education:

Encourage collegial and collaborative relationships among nurses, lactation consultants, breastfeeding peer counselors, and physicians.

“We have begun to realize that the future of medicine and nursing are inextricably linked. It will be impossible to change the clinical environment to one that encourages doctors and nurses to work alongside each other in teams without also changing education.” (Association of American Medical Colleges President and CEO Darrell G. Kirch, M.D.)

There are some exciting initiatives at a few organizations:

Pediatric Residency Training at Lutheran General's Children's Hospital

Educational Initiative by Medical Students at UIC College of Medicine

Please visit http://www.ilbreastfeedingblueprint.org/pages/hospital_toolkit/35.php to read about these initiatives.

We might also:

- Talk with physicians one-on-one about breastfeeding.
- Use physician-to-physician support.
- Invite outside speakers to meetings and grand rounds.
- Cultivate champions.
- Recruit physicians to be on a multidisciplinary committee to support breastfeeding.

Encourage Continuing Medical Education in Lactation:

American Academy of Pediatrics residency curriculum “The American Academy of Pediatrics developed this Breastfeeding Residency Curriculum to help residents develop confidence and skills in breastfeeding care”.
<http://www2.aap.org/breastfeeding/curriculum/>

Virginia Department of Health and the University of Virginia Health System Breastfeeding Training
This FREE online Breastfeeding Training Course

will provide health professionals with detailed information regarding the theory and practice of lactation management. The course hopes to encourage health care professionals in all specialties to become teachers and supporters of breastfeeding and lactation management. Each individual module is designated for 0.5 AMA PRA Category 1 Credit™.

<http://www.breastfeedingtraining.org/>

The Revised 3rd Edition of Wellstart's Lactation Management Self-Study Modules Lactation management curriculum for health care providers.

Wellstart International:

<http://www.wellstart.org/>

Breastfeeding Management, Educational Tools for Physicians and Other Professionals by Jane Morton, MD, FAAP, for a live demonstration of how to observe and assess breastfeeding. (Streaming Video)
<http://newborns.stanford.edu/Breastfeeding/FifteenMinuteHelper.html>

Resources:

American Academy of Pediatrics Breastfeeding Initiatives
How To Have a Breastfeeding Friendly Practice
<http://www2.aap.org/breastfeeding/files/pdf/AAP%20HaveFriendlyPractice.pdf>

Academy of Breastfeeding Medicine
Physician organization provides helpful professional resources, policies and education:
<http://www.bfmed.org/>

10 Steps to a Breastfeeding-Friendly Obstetric Practice
<http://massbreastfeeding.org/providers/10stepsob.html>

10 Steps to a Breastfeeding-Friendly Pediatric Practice
<http://massbreastfeeding.org/providers/10stepsped.html>

Skin to Skin

Skin to skin contact has become the new standard of care – and widely recommended by professional organizations, including: the Academy of Breastfeeding Medicine; American Academy of Pediatrics; the American College of Obstetricians and Gynecologists; the Association of Women’s Health, Obstetric and Neonatal Nurses; the World Health Organization; the Joint Commission.

The American Academy of Pediatrics’ Sample Hospital Breastfeeding Policy for Newborns states that “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.”

This is due to the undeniable amount of research to support the benefits of skin to skin contact.

<p>What is the impact on breastfeeding? ^{1, 3, 4, 5, 8, 10}</p> <ul style="list-style-type: none">• Increased breastfeeding success for initiation, duration, and exclusivity	<p>What is the impact on infants? ^{2, 5, 6, 8, 10}</p> <ul style="list-style-type: none">• Improved temperature regulation• Stable heart and respiratory rates• Improved oxygen saturation• Stable blood glucose• Reduced crying• Reduced pain perception• Improved sleep• Decreased stress• Less weight loss/faster weight gain• Earlier hospital discharge (for preterm infants)• Enhanced brain development
<p>What is the impact on mothers? ^{6, 9, 10}</p> <ul style="list-style-type: none">• Decreased stress• Improved interactions with infant• Enhanced Attachment• Enhanced sensitivity and responsiveness	

Challenges

Issues for staff related to work environment

- Concern about how mother might respond/ react to the practice of skin to skin.
- Concerns about interference with routines and sufficient time for completion of tasks prior to transferring to postpartum.
- Concerns about staff availability to stay with mother and baby.
- Feeling overwhelmed and under stress; this viewed as one more thing to add to their workload.
- Concerns about having to chart additional information.

- Distractions of smart phones and Facebook
- Visitors (who are eager to hold baby - and parents who are eager to share the baby).

Concerns about mother or baby

- Concern that the baby will get cold.
- Concern for infant safety.
- Interference with examining and caring for the mother/baby couplet.
- Mother’s episiotomy or laceration needs to be repaired.

Strategies

Discuss with nurse the impact on their job
Explain the impact on nurses at hospitals where skin to skin contact has become routine for all mothers and newborns. Inform staff that patient satisfaction increases when skin to skin contact is supported. At hospitals that have implemented routine skin to skin contact, as staff feel more knowledgeable and confident and see improvements in breastfeeding outcomes, they become enthusiastic about skin to skin contact.

“Seeing is believing”:

When nurses become comfortable with supporting skin to skin contact and see that it does not increase their workload – that they can still complete tasks while the newborn is on the mother’s chest – and that everyone benefits, they gradually become champions. Each success story reduces skepticism and reluctance.

Educate staff:

- Address specific concerns about making the job harder related to providing care to mothers and infants.
- Use a variety of teaching tools and approaches, including films and streaming videos, lectures and conversations, written materials, step-by-step demonstrations and role-plays that allow for practice of hands-on skills.
- Use film testimonial about the impact on parents, or invite parents to share their experiences.

Beth Seidel, IBCLC, Pekin Hospital shares the use of one mother’s personal story at staff training:

“Helping the staff to understand the importance of skin to skin from the mother’s perspective is an important part of getting them to buy in to the importance of skin to skin. In a recent perinatal network training, we had a mother of four share her skin to skin experience with her children. It varied from child



to child and improved in its “immediateness” and duration with each child. The mother’s account of how it made her feel when her first baby was handed off to her mother-in-law, and how that actually affected her relationship with her mother-in-law for a while brought a more human face to the impact of skin to skin rather than simply presenting it as another procedural change. This was an ‘aha’ moment for staff who heard what it meant to the mom. To understand how this affects moms and babies made a powerful impression – more than listening to a nurse describing the science of skin to skin.”

Problem solve with staff about ways to overcome barriers.

- Acknowledge and reward outstanding job performance.
- Recognize a “nurse of the month”; offer rewards and incentives.

Janet Tolley, IBCLC, St. John’s Hospital, Springfield, describes how she rewards outstanding nurses: “Once a month I pick a nurse to showcase as the ‘nurse of the month’. I have offered to make them jewelry or give them a gift card, and I post a photo of the RN with her jewelry on their bulletin board.”

Educate pregnant women and family members:

- Facilitate prenatal education by talking to physicians, midwives, and office staff.
- Provide written materials (commercial or developed by hospital staff) about breastfeeding to obstetricians, nurse-midwives, and family practice physicians.
- Suggest that practitioners display a variety of materials about breastfeeding and skin to skin contact. Place posters and brochures in doctors’ and midwives’ office waiting rooms and exam rooms, clinic waiting and exam rooms, antepartum testing areas, and other places where pregnant women spend time.
- Take advantage of opportunities while women sit for a long time in waiting rooms.

- Educate women prenatally wherever possible: in classes, on tours, in labor and delivery. Give information to pregnant women and family members.
- Utilize social media to reach pregnant women and new mothers.



Dana Posley, a breastfeeding peer counselor at Little Company of Mary Hospital, Evergreen Park, shares how she talks to mothers about skin to skin contact. “One thing that I say to mothers about skin to skin and the first hour is share all the information about needing the first hour after the baby’s birth with everyone who will be in the delivery room. Then when they ask what are they to do while mom and baby are having their moment, advise them that they are now on TMZ’s payroll (paparazzi.)”

The “Golden Hour”

What is the Golden Hour?

“It is the first time Mommy, Daddy and Baby spend together as a family! It is a bonding time for you and your baby that is a once in a lifetime event and needs to be celebrated! We want to give you and your baby that first hour together, uninterrupted, so you can get to know each other. We know you want to introduce your family and friends to your baby and we encourage you to welcome them after you have had this time alone”. (Golden Hour brochure, Sierra View District Hospital, California)

Model programs that work:

If your hospital decides to implement the ‘Golden’ or ‘Sacred’ Hour, consider promoting a dialogue between nurses and physicians:

Shifting the Paradigm

This case study describes the process at one hospital based on the formation of a subcommittee, which included family medicine physicians, a neonatologist, a pediatric physician, nursing, and a mediator to implement skin to skin contact and the Golden Hour.

http://www.californiabreastfeeding.org/Judy_Lavoie_Presentation.pdf

Recruit physician champions:

One anesthesiologist, deeply skeptical of skin to skin contact following a Cesarean, observed a newborn doing the breast crawl and self-attaching to the breast. He became an immediate convert and began to enthusiastically promote immediately skin to skin after Cesarean deliveries.

Skin to Skin References

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Skin to Skin Resources

For a list of resources on skin to skin please visit
http://www.ilbreastfeedingblueprint.org/pages/hospital_toolkit/35.php

STEP 4: Help mothers initiate breastfeeding within an hour of birth (US Standard).

Place all babies in skin to skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognize when their babies are ready to breastfeed, offering help if needed.

Action Items				Due Date	Primary Team Members
Policy Revision	Revise (or draft new) policy to include skin to skin and early latch protocols	<ul style="list-style-type: none">Utilize recommended templates as a guide:<ol style="list-style-type: none">The Academy of Breastfeeding Medicine <i>Clinical Policy #7: Model breastfeeding policy</i> (Revision 2010). Available at: http://www.bfmed.org/Media/Files/Protocols/Protocol%207%20-%20Model%20Hospital%20Policy%20(2010%20Revision).pdfThe American Academy of Pediatrics, Section on Breastfeeding <i>Sample Hospital Breastfeeding Policy for Newborns</i>. Available at: http://www.aap.org/breastfeeding/curriculum/documents/pdf/Hospital%20Breastfeeding%20Policy_FINAL.pdfBaby-Friendly USA, <i>The Baby-Friendly Hospital Initiative: Guidelines and evaluation criteria for facilities seeking Baby-Friendly designation</i>. Available at: http://babyfriendlyusa.org/eng/docs/2010_Guidelines_Criteria_4.19.11.pdfPolicy should include: definitions of skin to skin and early latch, documentation methods, exclusion criteria, and delay of routine procedures until after first feeding			
Data Collection Plan Development	Submit revised policy to administration for approval				
	Update data collection process to capture skin to skin and early latch variables				
	a) Define data collection variables and exclusion criteria (See				
	b) Revise L&D nurse charting flowsheet(s)				
	c) Revise physician charting flowsheet (optional)				
	d) Determine primary person(s) to conduct chart audits and/or run EMR reports				
Staff Training	e) Determine monthly audit schedule				
	Train all staff on the importance of skin to skin, early latch, feeding cues, policy revisions and documentation changes				

Action Items			Due Date	Primary Team Members
	a)	Develop education plan to train all maternity nursing staff on revised policy, procedures and documentation methods (Examples: Staff meeting in-service, lunch & learn, email in-service)		
	b)	Implement education plan to train all maternity nursing staff on revised policy, procedures and documentation methods		
	c)	Track participation in training sessions to ensure all staff are trained		
	d)	Work with medical and non-clinical staff to ensure all physicians and staff are educated on policy changes		
Data Collection Plan Implementation		<i>Collect, analyze and report data at regular intervals (recommended: monthly)</i>		
	a)	Collect data per previously determined method and schedule (Refer to Data Collection Plan Development)		
	b)	Report data summaries to breastfeeding multi-disciplinary committee		
	c)	Identify inconsistencies with policy compliance and documentation		
	d)	Examine barriers to implementing policy changes		
	e)	Develop strategies to address identified barriers		
Patient Education		<i>Inform patients of post-delivery procedures and the benefits of skin to skin and early latch</i>		
	a)	Revise (or create new) patient education materials to include skin to skin and early latch information		
	b)	Develop staff scripts to assist staff in notifying patients of skin to skin and early latch procedures post-delivery (optional)		

Skin to skin and early latch data collection

Sample data collection variable definitions and exclusion criteria:

a. Skin to skin (%):

1. Hospitals may determine their own measurement criteria, but these are Baby-Friendly USA definitions:
 - a) Vaginal – within 5 minutes continued through first feeding
 - b) C-section – within 5 minutes of mother responsive through first feeding; NICU – opportunity for Kangaroo Care.
2. “Yes (1) ” or “No (0)”
 - a) If Yes, when was skin to skin initiated?
 - i. Within 5 minutes
 - ii. 6-15 minutes
 - iii. 16-30 minutes
 - iv. 31-45 minutes
 - v. 46-60 minutes
 - vi. >60 minutes
 - b) If “No,” Reason:
 - i. Maternal request
 - ii. Physician request
 - iii. Neonatal resuscitation
 - iv. Clinical contraindication (maternal or infant factor) – See below
 - v. Other

b. Early latch (%):

1. Definition: Neonate latches or successfully breastfeeds within 60 minutes of birth.
2. Time of 1st latch – EMR can calculate duration between delivery time and time of first latch
3. “Yes (1) ” or “No (0)”
 - a) If “No,” Reason:
 - i. Maternal refusal
 - ii. Unsuccessful latch
 - iii. Clinical contraindication (maternal or infant factors)
 - iv. Other

c. Exclusion criteria/Clinical contraindications (Utilize the criteria already in place at your facility to determine if mother/baby dyad is ineligible for breastfeeding/breast milk):

1. Maternal
 - i. HIV+
 - ii. Active TB
 - iii. HTLV+
 - iv. HSV breast lesions
 - v. Radiation therapy
 - vi. Active varicella
 - vii. Illicit drug use
 - viii. Alcohol abuse
 - ix. Lead $\geq 40\text{mcg/dL}$
 - x. Medications contraindicated with breastfeeding
 - xi. ICU admission
 - xii. Demise
2. Infant
 - i. Galactosemia
 - ii. Demise
 - iii. Adoption
 - iv. NICU admission
 - v. DCFS hold
 - vi. Transferred out

Promoting, Supporting and Protecting Exclusive Breastfeeding

The WHO (World Health Organization) recommends that mothers exclusively breastfeed their infants for the first 6 months of life “to achieve optimal growth, development and health.” This recommendation is also supported by the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American College of Nurse-Midwives, and the American Dietetic Association.

Hospitals can support exclusive breastfeeding by avoiding the use of routine supplementation of breastfeeding infants through the use of formula, glucose, or water, unless medically necessary. Infants that receive supplements earlier in life are at risk for shorter duration of breastfeeding and less exclusivity.¹⁻⁶ Research has shown that mothers who intend to exclusively breastfeed, are less likely to achieve intended duration when their infants are supplemented in the hospital.⁴

Challenges

Accountability

One barrier to exclusive breastfeeding can be an institutions’ failure to hold health care providers accountable for adherence to professional standards. Having good policies is not sufficient. The policies must be known, and enforced.

Even once a policy exists, it may still prove challenging to get nurses and physicians to comply. Some follow American Academy of Pediatrics or Academy of Breastfeeding Medicine guidelines for supplementation, but others have their own approach, which may not follow any protocol.

When talking with one nurse about her hospital’s potential for following the Baby-Friendly pathway, she said simply, “Our doctors don’t care about the Academy of Breastfeeding Medicine Protocols.”

“At the hospital where I used to work, all the nurses were responsible for basic breastfeeding support,” reported another. “At the hospital where I work now, if there is no lactation consultant on, the mom is out of luck. They’ll be given bottles.”



Supplementation by Staff

A myriad of factors contribute to nurses or physicians providing a breastfeeding mother with formula. Sometimes, the decision is based on a health care provider's personal attitudes and beliefs. As one nurse explained during a Baby-Friendly training, for example: "We have some nursing staff who feel since they didn't breastfeed, they can't help moms - or really don't need to."

- Formula is viewed as a 'quick fix' to calm a fussy baby or if there are difficulties with breastfeeding. "If a baby cries, we give formula and wait for the lactation consultant."
- Force of habit; that's what has always been done.
- Concerns about baby being too sleepy, too large, too small, weight loss, dehydration, or falling blood sugar, even when these concerns are not medically indicated.
- Uncertainty about possible contraindications to breastfeeding, e.g. misinformation about safety of medications or other contraindications for breastfeeding.
- Belief that giving 'just one bottle' so mothers can rest is in her best interest.

When formula is given for these reasons, it is usually based on the perception of formula as a neutral or safe intervention.

Health care providers may also encourage supplementation for reasons related to their work environment, for example:

- Delay of first breastfeeding.
- The nurse lacks sufficient time to work with a mother/baby dyad. (Staffing challenges may contribute.)
- Insufficient skill in supporting breastfeeding.
- Lack of a hospital policy about supplementation.
- Lack of compliance with the policies for supplementation.
- Arbitrary orders for supplementation based on number of hours between feedings.
- Easy access to formula.

Minimal Utilization of Hand Expression

There are times when supplements are medically required. In these situations, mothers should be

instructed about hand expression so that their newborns can receive their mother's own milk.

However, relatively few nurses teach hand expression, even when they know that this can reduce or eliminate the need for supplemental feedings. Some may not be knowledgeable about the benefits and multiple applications. Others find hand expression distasteful and are uncomfortable teaching it to mothers.

Maternal Request for Formula

There are several possible reasons for these requests, which account for the majority of supplementation at many hospitals. These include (but are not limited to):

- Fear that baby isn't getting enough milk due to lack of self-confidence, knowledge about potential impact of supplementing, etc.
- Exhaustion and a desire for sleep.
- Intention to do mixed feedings.
- Difficulty with latching the baby on or nipple pain.

Visitors

Visitors can distract mothers from information being shared by nurses and may also delay breastfeeding if a mother is not comfortable feeding her infant in front of guests. Few topics evoke such strong feelings as visitors during the laboring woman and new mother's hospital stay. These are just a few of countless statements voiced by nurses, lactation consultants, and peer counselors:

"Last winter was wonderful. When we had the H1N1 flu, the visitors stayed away for months. It was such a relief - so much calmer, and we were able to spend time with patients, do teaching. And the moms kept their babies more and breastfed better."

"We used to have a strict two-visitor rule, which the clerk enforced. Recently, to compete with other hospitals, they opened that up and it is very annoying having six people in the room while you are trying to educate a new mother. It comes down to birth is business and hospitals will compete to get births."

"We struggle with this daily. I actually talk

about visitors in my prenatal class and ask couples to limit their visitors as they are only here for 48 hours and they should take advantage of what we have to teach them.”

Nurses and lactation consultants sometimes adopt different approaches to visitors. Some feel uncomfortable suggesting that visitors leave, unless the mother asks for her to play that role. Many are concerned about ‘customer’ satisfaction and worry that surveys will be negative if the nurse is too “pushy” since this is such a sensitive subject.

Strategies

Promote accountability:

- Adopt evidence-based policies to support breastfeeding.
- Require documentation of reason for supplementation in charting.
- Base staff performance reviews on compliance with policies.

Beth Seidel, IBCLC, Pekin Hospital, talks about accountability:

We track our Baby-Friendly practices in various ways. The nurses chart after admission whether baby was placed skin-to-skin immediately or within five minutes. They also have to chart whether the baby was weighed and measured before or after feeding and whether or not the sacred hour was observed. In addition, we have a paper form the nurses fill out with all her breastfeeding information, including her experience right after birth with feeding, risk factors for low milk supply and previous breastfeeding experience, if any. The moms fill out a survey that helps us to track our Baby-Friendly practices such as skin-to-skin and rooming in and overall breastfeeding assistance. The moms also have the opportunity to name staff that were particularly helpful during her stay. This survey is given to the mom and collected before discharge. These different methods of data collection have helped our staff to realize that they do need to be accountable and has helped us to keep on track with Baby-Friendly practices.

Encourage nurses to assess reasons for formula requests and provide information to mothers about the potential risks of supplemental formula and bottle feeding to ensure informed consent.

Educate staff about effective communication skills: win-win-win strategy

- Encourage staff to ask open-ended questions to assess the reasons behind maternal requests for formula.
- Train staff in using the quick and effective approach to communication known as the Best Start Three-Step Counseling Strategy: Step 1. Ask an open-ended question. Step 2. Affirm her concerns. Step 3. Provide targeted education directed to her specific concerns.
- Change how you ask mothers about their feeding intention.

Ask, “How do you plan to feed your baby while you’re in the hospital?” instead of “How do you plan to feed your baby?” If the mother says she plans to ‘do both’, then the staff may feel comfortable giving formula to the baby. However, this may be the mother’s eventual plan, e.g. for returning to work – but not necessarily her intention during her hospital stay. Her answer may be ambiguous if she is not asked explicitly. Use open-ended questions to find out what she means by ‘both’.

Provide Scripted Messages to Staff

Encourage staff to recommend ‘laid back’ breastfeeding and baby-led attachment: a win-win-win strategy

Help mothers to use this alternative approach to positioning and latching the baby on, showing mothers how to recline, with their baby’s tummy down on their bodies. Skin to skin contact is recommended but not necessary to do ‘laid back’ breastfeeding. It complements traditional positions that can offer better results with less time

and effort and reduce the mother’s anxiety. “We have lactation counselors who practice ‘laid back nursing’ which involves placing baby skin to skin on mom’s chest and allowing baby to naturally seek out the breast and latch on.



We have had tremendous success with this practice and it really helps new moms relax and enjoy the bonding of breastfeeding. On Friday, we had a mom who was struggling with breastfeeding and was incredibly stressed by the process. One of our lactation counselors asked the mom to try ‘laid back nursing’ and, although mom was hesitant, she agreed. Baby relaxed and latched on within 3 minutes! Mom cried for 10! It was beautiful!” (Lori Stevenson, St. Elizabeth’s Hospital, Belleville)

Nurses who are unfamiliar with ‘laid back’ breastfeeding may be skeptical; however many have become enthusiastic supporters when they realize that it often makes everyone’s job easier – and saves them time.

- Provide staff training so that staff is more capable of offering mothers assistance.
- Many health care providers have not seen a baby self-attach.
- Show film clips of this to demonstrate how simple and effective this approach can be.
- Promote this as a time-saving approach and a win-win-win for mothers, infants, and staff.
- Educate about ‘laid back’ breastfeeding (See resources, including film clip, Sample of Biological Nurturing: <http://www.biologicalnurturing.com/video/bn3clip.html> and website: Biological Nurturing - <http://www.biologicalnurturing.com/>)

DVD- Biological Nurturing: Laid Back Breastfeeding for Mothers <http://www.geddesproduction.com/breast-feeding-laid-back.php>

Provide training to staff to ensure skill competency in hand expression. Provide opportunities to acknowledge and discuss how many nurses feel uncomfortable teaching this skill to mothers. <http://newborns.stanford.edu/Breastfeeding/HandExpression.html>

- Brainstorm ways to deal with this discomfort, including different approaches to teaching this technique (i.e., demonstrating with a breast model).
- Provide a variety of training tools, including streaming video, breast models, and role-plays.
- Promote teaching hand expression as the norm.
- Communicate that this is an expectation for all nurses and include in performance reviews. Breastmilk: Manual Expression Competency and Performance Criteria Labor and Delivery and Maternity <http://carolmelcher.com/assets/Manual%20Expression%20Competency.pdf>

Inform mothers of normal infant behavior and appropriate maternal responses:

- Teach mothers about early hunger cues.
- Assess possible reasons for crying and teach techniques to comfort a crying baby.
- Foster the mother’s confidence in her ability to care for her newborn.

Breastfeeding mothers sometimes choose to supplement with formula, believing that they will get more sleep and a greater sense of well-being. Research has shown that this approach actually results in the opposite outcome.

Read about this surprising finding:

<http://www.nancymohrbacher.com/blog/2011/5/23/formula-supplements-put-mothers-at-risk.html>

Promote opportunities for rest

Some nurses feel comfortable taking the initiative to ask visitors to leave. Beth Seidel at the Baby-Friendly Pekin Hospital explains her approach. “When visitors seem to be keeping the mom from feeding her baby, I will go into the room and talk to the mom about feeding her baby. When we are getting to ready to feed I will ask her how she feels about an audience, and often the visitors will just leave at that point. Sometimes they ask me how long ‘this will take’, and I usually say, ‘Well, that is not up to me. I don’t know how long he will want to eat...Maybe we will ask him!’ Of course the baby does not answer and I will suggest that they go grab something to eat, or go for a walk in the park across the street.”

- Place signs on mother’s room door.
- Offer to advocate for the mother if she is reluctant to ask visitors to leave.
- A creative solution to this challenge is providing a daily rest time, an afternoon respite from visitors, to give mothers and newborns time together. There are several hospitals in Illinois that have employed this strategy.

For a valuable description of the development and implementation of an effective strategy to support mothers by providing daily rest time, please read about Snooze and Snuggle Time at Blessing Hospital here:

http://www.ilbreastfeedingblueprint.org/pages/hospital_toolkit/35.php

Exclusive Breastfeeding References

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- ² American Academy of Family Physicians. Breastfeeding (policy statement). 2012. Available at: <http://www.aafp.org/online/en/home/policy/policies/b/breastfeedingpolicy.html>
- ³ American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women, and Committee on Obstetric Practice. ACOG committee opinion #361: breastfeeding: maternal and infant aspects. Obstet Gynecol 2007; 109(2Pt1):479–480. Available at: http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Breastfeeding_Maternal_and_Infant_Aspects
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- ¹⁰ World Health Organization. Evidence for the ten steps to successful breastfeeding. Geneva: The Organization; 1998. Web site: http://whqlibdoc.who.int/publications/2004/9241591544_eng.pdf
- ¹¹ James DC, Lesson R, American Dietetic Association. Position of the American Dietetic Association: promoting and supporting breastfeeding. J Am Diet Assoc 2009; 109:1926–1942. Available at: <http://www.eatright.org/About/Content.aspx?id=8377>

Exclusive Breastfeeding Resources

For a list of resources on exclusive breastfeeding please visit

http://www.ilbreastfeedingblueprint.org/pages/hospital_toolkit/35.php

STEP 6: Give newborn infants no food or drink other than breastmilk, unless *medically* indicated.

Action Items		Due Date	Primary Team Members
Policy Revision	Revise (or draft new) policy to include exclusive breastfeeding protocols		
	<ul style="list-style-type: none"> Utilize recommended templates as a guide: <ol style="list-style-type: none"> The Academy of Breastfeeding Medicine <i>Clinical Policy</i> #7: <i>Model breastfeeding policy</i> (Revision 2010). Available at: http://www.bfmed.org/Media/Files/Protocols/Protocol%20-%20Model%20Hospital%20Policy%20(2010%20Revision).pdf The American Academy of Pediatrics, Section on Breastfeeding <i>Sample Hospital Breastfeeding Policy for Newborns</i>. Available at: http://www.aap.org/breastfeeding/curriculum/documents/pdf/Hospital%20Breastfeeding%20Policy_FINAL.pdf Baby-Friendly USA, <i>The Baby-Friendly Hospital Initiative: Guidelines and evaluation criteria for facilities seeking Baby-Friendly designation</i>. Available at: http://babyfriendlyusa.org/eng/docs/2010_Guidelines_Criteria_4.19.11.pdf Policy should include: <ul style="list-style-type: none"> Definition of exclusive breastfeeding Staff documentation procedures Contraindications to breastfeeding (See exclusion criteria) Medical indications for formula supplementation Requirement of physician order for formula supplementation Preferred feeding methods when supplementation is indicated Restrictions on access to formula (only certain staff types may have access) Formula, bottles, nipples and pacifiers are not routinely stocked in cribs of breastfeeding infants 		
	Submit revised policy to administration for approval		
	Create physician orders for formula supplementation		
	a) Meet with key pediatrics staff to develop physician order set		
	b) Meet with IT department to enter physician order set		

Data Collection Plan Development	<i>Update data collection process to capture exclusive breast milk feeding and related variables</i>			
	a) Define data collection variables and exclusion criteria			
	b) Develop plan to track exclusive breast milk feeding according to the Joint Commission's Perinatal Care Core Measure Set			
	c) Revise nurse charting flowsheet(s) and patient education documentation			
	d) Revise pediatrician charting flowsheet (optional)			
	e) Determine primary person(s) to conduct chart audits and/or run EMR reports			
	f) Determine monthly audit schedule			
Patient Education	<i>Mothers choosing not to breastfeed or to provide formula supplementation should be counseled in order to make an informed feeding decision</i>			
	a) Develop documentation procedure for counseling and informed consent process			
	b) Develop scripting for RNs to be able to counsel mothers that request formula supplementation			
	c) Develop or revise patient education material related to the importance of exclusive breastfeeding, the risks of formula feeding, and medical indications for formula feeding			
Staff Training	<i>Train all staff on the benefits of exclusive breastfeeding, the risks of formula, contraindications to breastfeeding, medical indications for formula supplementation, patient education and counseling protocols, revised policy and procedures, and documentation.</i>			
	a) Develop education plan to train all maternity nursing staff on revised policy, procedures and documentation methods, importance of exclusive breastfeeding, risks of formula feeding, and acceptable medical reasons for formula feeding. (Examples: Staff meeting in-service, lunch & learn, email in-service)			

	b) Implement education plan to train all maternity nursing staff on revised policy, procedures, documentation methods, importance of exclusive breastfeeding, risks of formula feeding, and acceptable medical reasons for formula feeding		
	c) Track participation in training sessions to ensure all staff are trained		
	d) Work with medical and non-clinical staff to ensure all other staff are educated on policy and procedure changes		
Data Collection Plan Implementation	<i>Collect, analyze and report data at regular intervals (recommended: monthly)</i>		
	a) Collect data per previously determined method and schedule (Refer to Data Collection Plan Development)		
	b) Report data summaries to breastfeeding multi-disciplinary committee (Work with QI Dept.)		
	c) Identify inconsistencies with policy compliance and documentation		
	d) Examine barriers to implementing policy changes		
	e) Develop strategies to address identified barriers to implementing policy changes		

Sample data collection variable definitions and exclusion criteria:

a. Definitions:

1. Exclusive breast milk feeding - Neonate receives breast milk only, either through breastfeeding or on the consumption of pumped or expressed breast milk. This may include expressed breast milk from a donor. This excludes intake of fortified breast milk.
2. Formula feeding only - Neonate receives formula and/or other liquids including water, sugar water, fortified or specialty formula.
3. Both (Breastfeeding and Formula feeding) - Neonate receives breast milk and formula, but does not consume any other fluids (water, sugar water, etc.) Fortifier is to be treated as “formula” when added to breast milk and specialty formula should be treated like any other type of formula

b. Exclusion criteria/Clinical contraindications (Utilize the criteria already in place at your facility to determine if mother/baby dyad is ineligible for breastfeeding/breast milk):

3. Maternal

- i. HIV+
- ii. Active TB
- iii. HTLV+
- iv. HSV breast lesions
- v. Radiation therapy
- vi. Active varicella
- vii. Illicit drug use
- viii. Alcohol abuse
- ix. Lead $\geq 40\text{mcg/dL}$
- x. Medications contraindicated with breastfeeding
- xi. ICU admission
- xii. Demise

2. Infant

- a. Galactosemia
- b. Demise
- c. Adoption
- d. NICU admission
- e. DCFS hold
- f. Transferred out

Sample data collection variables:

- a. Intended feeding method
(collected at 3 points – on admission, postpartum, at discharge)
 1. Breast milk only
 2. Formula only
 3. Both
- b. Feeding method throughout hospital stay (%):
 1. Breast milk only
 2. Formula only
 3. Breast milk and formula supplementation
 4. Other (water, sugar water, etc.)
- c. Supplementation method
 1. Bottle
 2. Cup
 3. Finger feeding
 4. Supplemental nursing system (SNS)

5. Syringe
6. Nasogastric tube
7. Other
- d. Type of supplementation
 1. Pumped breast milk
 2. Donor breast milk
 3. Formula
 4. Other
- e. Supplementation reason
 1. Medical indication
 2. Pediatrician order (outside of a medical indication)
 3. Maternal request
 4. Jaundice
 5. Excessive weight loss ($>10\%$)
 6. Hypoglycemia
 7. Inadequate output
 8. Late pre-term

Promote Rooming-In

The American Academy of Pediatrics' Sample Hospital Breastfeeding Policy for Newborns states, "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."

Practice rooming-in, allowing mother and infants to remain together 24 hours a day.

This is often easier said than done. Rooming-in is a topic that seems to arouse strong feelings. Why?

Challenges

For Staff

- Assumption that mother will get more rest if baby goes to nursery.
- Discomfort with the feeling that they are forcing mothers to room-in.
- Families' recommendations to send the baby to the nursery.
- Mixed messages from health care providers (e.g. some providers who say things such as, "There's nothing wrong with having the baby in the nursery at night.")
- Lack of policy or enforcement of policy regarding visitors.

When asked about rooming-in, nurses' first response is often, "Yes, we do that." But with a little probing, they often reveal that mothers ask to send the baby to the nursery so they can sleep. Lactation consultants often complain that nurses actively encourage mothers to do this, e.g. by saying "Don't you want me to take your baby to the nursery so you can get some rest?"

For Families

- Lack of prenatal information on the importance of early contact to learn baby's cues and how to respond.
- Assumption that sleep quality is improved when mothers and babies are separated.
- Assumption that routine separation is necessary for observation and medical procedures.

Benefits of Rooming-In¹⁻⁶

- Improve breastfeeding outcomes
- Facilitates on cue feeding
- Higher weight gain in infant
- Can help early breast milk production
- Increased maternal attachment
- Infants cry less and soothe more quickly
- Infants less likely to develop jaundice
- Lowers rates of child abuse, neglect and abandonment

Strategies

Train staff about getting better results with couplet care.

- Emphasize and support the nurse's role in facilitating the relationship between mother and newborn.
- Emphasize that rooming-in is best practice for all mothers and newborns, regardless of type of feeding.
- Help nurses understand the importance of early opportunities to learn baby's cues, value of bonding and about the impact of early attachment.
- Encourage nurses to model nurturing behavior as an example to mothers.
- Procedures such as blood work, baths, etc., and examinations of the infant can be done in the mother's room and can offer opportunities for teaching mothers and families.
- Rooming-in can be a time-saver for staff.
- Provide staff with key messages for mothers.
- Provide staff with opportunity to role-play responses to requests for babies to be taken to the nursery.

Inform staff about the impact of rooming in on mothers' sleep.^{1,4}

- Review evidence regarding the impact of rooming-in on rest.
- Share research that shows that mothers who room in do not sleep better or longer than those whose babies go to the nursery at night. For example: A study from the journal, *Clinical Lactation*, “found that exclusively breastfeeding mothers not only slept significantly more hours during the night than other mothers but also reported significantly more energy during the day, a better mood, better overall health, and a greater sense of well-being.”

Promote a period of dedicated afternoon rest and a break from visitors.

Develop a mother-baby unit policy requiring a rest period without visitors every afternoon. There are several hospitals in Illinois that have adopted a special rest time in the afternoon. Lori Stevenson, director of the Maternal Child Center at St. Elizabeth's Hospital in Belleville shares an example of this approach. “We have instituted “Lullaby Time” every afternoon from 2:30-4:30 to encourage limited visitors and parent/newborn bonding. We dim the lights on the unit and ask that just mom and dad remain in the room with the new baby. We limit staff interruptions and focus on allowing the new family to bond.”

- Place posters in physicians' offices, clinics, and hospitals' waiting, examining, and patient care rooms. See ‘Benefits of Rooming In’: <http://www.nyubaby.org/baby-friendly-care>

Even if there is no formal rest period, nurses can informally encourage visitors to leave. At Pekin Hospital in Pekin, IL (a Baby-Friendly hospital), Beth Seidel explains, “We have recently started encouraging no more than one or two people in the room while mom is feeding and this is really helping us in our feeding education efforts, and in observing and assessing feedings. It also helps in decreasing distractions in the room, and competition for mom's attention. Visitors are informed of this by the nurse while the mom is still in labor.”

Performance expectations:

- Staff will promote rooming-in as the norm.
- Staff will explore reasons for requests by mother for sending her baby to the nursery.
- Staff will chart each time a newborn is separated from the mother, providing the reason.
- Audit outcomes and share results.

Rooming-in References

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- ⁴ Doan, T., Gardiner, A., Gay, C. L., & Lee, K. A. (2007). Breast-feeding increases sleep duration of new parents. *J Perinat Neonatal Nurs*, 21(3), 200-206.
- ⁵ Keefe MR. The Impact of Infant Rooming-In on Maternal Sleep at Night. *JOGNN*. 1988; 17: 122-126.
- ⁶ Murray EK, Ricketts S, Dellaport J. Hospital Practices that Increase Breastfeeding Duration: Results from a population-based study. *Birth*. 2007; 34 (3): 202-211. http://pediatrics.aappublications.org/content/122/Supplement_2/S43.full.pdf+html
- ⁷ Procianoy RS, Fernandes-Filho PH, Lazaro L, Sartori NC, Drebes S. The influence of rooming-in on breastfeeding. *J Trop Pediatr*. 1983;29:112-114
- ⁸ World Health Organization. Evidence for the ten steps to successful breastfeeding. Geneva: The Organization; 1998. Web site: http://whqlibdoc.who.int/publications/2004/9241591544_eng.pdf

Rooming-In Resources

Staff Education Resources

The Science of Attachment PowerPoint presentation from Birth and Beyond California: Breastfeeding Training and QI Project.
<http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Documents/MO-BFP-BBC01-ScienceOfAttachment2.ppt>

Expanded Hospital Policy #9: Mothers and infants should be encouraged to remain together during the hospital stay.
<http://cdph.ca.gov/healthInfo/healthyliving/childfamily/Pages/BFP-MdlHospToolkitPolicy9.aspx>

Blog:

<http://www.nancymohrbacher.com/blog/2011/5/23/formula-supplements-put-mothers-at-risk.html>

Patient Education Resources

Rooming-In fact sheet
<http://www.suttermedicalcenter.org/services/files/smh-rooming-in.pdf>

Practice Togetherness: Rooming-in fact sheet
New York University Langone Medical Center
http://webdoc.nyumc.org/nyumc_d6/files/nyubaby/rooming_in.pdf

Rooming-in poster and I am breastfeeding!

Crib card

University of Rochester Medical Center
<http://www.urmc.rochester.edu/flrpp/breast-feeding-hospital-policy/tool-kit.cfm>
(Under #9 Floor Tools)

STEP 7: Practice rooming in – Allow mothers and infants to remain together twenty-four hours a day.

This step applies to ALL babies, regardless of feeding method.

Action Items			Due Date	Primary Team Members
Policy Revision	Revise (or draft new) policy to include rooming in protocols			
	<ul style="list-style-type: none"> Utilize recommended templates as a guide: <ol style="list-style-type: none"> The Academy of Breastfeeding Medicine <i>Clinical Policy #7: Model breastfeeding policy</i> (Revision 2010). Available at: http://www.bfmed.org/Media/Files/Protocols/Protocol%207%20-%20Model%20Hospital%20Policy%20(2010%20Revision).pdf The American Academy of Pediatrics, Section on Breastfeeding <i>Sample Hospital Breastfeeding Policy for Newborns</i>. Available at: http://www.aap.org/breastfeeding/curriculum/documents/pdf/Hospital%20Breastfeeding%20Policy_FINAL.pdf Baby-Friendly USA, <i>The Baby-Friendly Hospital Initiative: Guidelines and evaluation criteria for facilities seeking Baby-Friendly designation</i>. Available at: http://babyfriendlyusa.org/eng/docs/2010_Guidelines_Criteria_4.19.11.pdf Policy should include: definition of rooming-in, documentation method for separation, documentation procedure for patient education, exclusion criteria/acceptable reasons for separation, and procedure for educating families about rooming in 			
	Submit revised policy to administration for approval			
	Update data collection process to capture rooming in variables			
Data Collection Plan Development	a) Define data collection variables and exclusion criteria (See			
	b) Revise L&D nurse charting flowsheet(s)			
	c) Revise physician charting flowsheet (optional)			
	d) Determine primary person(s) to conduct chart audits and/or run EMR reports			
	e) Determine monthly audit schedule			
	f) Create a nursery log to track times when infants check in and out of nursery (optional)			
Staff Training	Train all staff on the importance of rooming in, informed consent, policy revisions and documentation changes			

Action Items			Due Date	Primary Team Members
	a)	Develop education plan to train all maternity nursing staff on the importance of rooming in, revised policy, procedures and documentation methods (Examples: Staff meeting in-service, lunch & learn, email in-service and reminders)		
	b)	Implement education plan to train all maternity nursing staff on the importance of rooming in, revised policy, procedures and documentation methods		
	c)	Track participation in training sessions to ensure all staff are trained		
	d)	Work with medical and non-clinical staff to ensure all physicians and staff are educated on rooming in policy changes		
Data Collection Plan Implementation		<i>Collect, analyze and report data at regular intervals (recommended: monthly)</i>		
	a)	Collect data per previously determined method and schedule (Refer to Data Collection Plan Development)		
	b)	Report data summaries to breastfeeding multi-disciplinary committee		
	c)	Identify inconsistencies with policy compliance and documentation		
	d)	Examine barriers to implementing policy changes		
	e)	Develop strategies to address identified barriers		
Patient Education		<i>Inform patients of post-delivery procedures and the benefits of rooming in</i>		
	a)	Revise (or create new) patient education materials to include rooming in information		
	b)	Develop scripts to assist staff in discussing rooming in benefits and policy changes with patients (optional)		

Rooming in data collection

Sample data collection variable definitions and exclusion criteria:

- a. Rooming in (%):
 1. Definition: Hospitals may determine their own measurement criteria, but Baby-Friendly USA defines rooming in as:
 - a) Vaginal: Mothers and babies are kept together immediately following birth for 23 of 24 hours each day, unless separation is medically necessary
 - b) C-section: Mothers and babies are kept together 23/24 hours each day beginning as soon as mothers are able to respond to their infants (ideally in the recovery room), unless separation is medically necessary
 - c) Rooming in applies to all couplets independent of feeding method.
 2. “Yes (1) ” or “No (0)” (collected at intervals determined by your facility)
 - a) Yes (1)
 - b) If “No,” Reason:
 - i. Maternal request
 - ii. Procedure(s)
 - iii. Clinical contraindication (maternal or infant factor) – See below
 - iv. Other
 - c) Documentation of education of family if request for separation is made.
 3. Length of Separation
 - a) Time separation began (check in time to nursery)
 - b) Time separation ended (check out time from nursery)
 - c) Total time mother and infant separation (minutes)
- b. Exclusion criteria/Clinical contraindications to rooming in (Utilize the criteria already in place at your facility to determine if mother/baby dyad is ineligible for breastfeeding/breast milk):
 2. Maternal
 - i. Active TB
 - ii. Active varicella
 - iii. ICU admission
 - iv. Demise
 3. Infant
 - i. Demise
 - ii. Adoption
 - iii. NICU admission
 - iv. DCFS hold
 - v. Transferred out

A *Nursery Log* may be helpful in tracking rooming in. A sample log could look like this:

DATE: _____

MR #	Name	DOB	Time In	Time Out	Total Time in Nursery (minutes)	Reason for Separation
Ex. 123456789	Smith, Baby Boy	5/30/12	11:03	11:55	52	Procedure: phlebotomy

Encourage Breastfeeding On Demand (Feeding on Cue)

The Academy of Breastfeeding Medicine's Model Breastfeeding Policy states that "breastfeeding infants should be put to breast a minimum of eight to 12 times each 24 hours, with some infant needing to be fed more frequently"¹⁻⁴ and that "infant feeding cues (e.g., increased alertness of activity, mouthing, or rooting) will be used as indicators of the baby's readiness for feeding".

The frequency of infant feeding is important to the establishment of milk supply and also infant weight gain. Feeding on cue has been shown to increase the success of lactation, decrease peak serum bilirubin levels, and decrease nipple pain and tenderness.¹⁻⁴ All mothers in the hospital should be informed by healthcare staff on how to identify their infants feeding cues and encourage mothers to feed their infants on cue.

Common infant hunger cues include:

Early

- Rapid eye movements (fluttery eye movements while eyes are closed)
- Smacking or licking lips
- Opening and closing mouth
- Sucking on lips, tongue, hands, fingers, toes, toys, or clothing



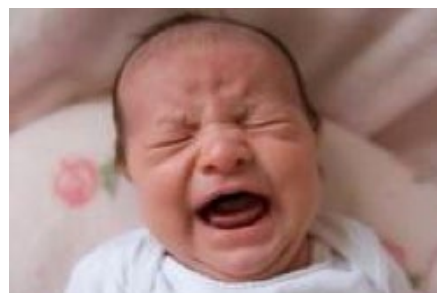
Active

- Hand to mouth movement (even if eyes are closed, may include sucking on own hand)
- Rooting (when touch on either cheek results in their actively turning towards anything, including their own hand, shoulder, any inanimate object, a finger on their cheek, or any other part of another person's body)
- Trying to position for nursing, either by lying back or pulling on your clothes
- Wriggling or fidgety body movements
- Vocalization
- Muscle tension, such as flexed arms or closed fists
- Fussing or breathing fast



Late

- Moving head frantically from side to side
- Crying



Feeding on Cue References

¹De Carvalho M, Robertson S, Friedman A, Klaus M. Effect of frequent breast-feeding on early milk production and infant weight gain. *Pediatrics*. 1983;72:307–311

²Dewey KG, Nommsen-Rivers LA, Heinig MJ, Cohen RJ. Risk factors for suboptimal infant breastfeeding behavior, delayed onset of lactation, and excess neonatal weight loss. *Pediatrics*. 2003;112(3 pt 1):607–619.

³Kandiah J, Burian C, Amend V. Teaching new mothers about infant feeding cues may increase breastfeeding duration. *Food and Nutrition Sciences*. 2011; 2: 259-264. Available at <http://www.scirp.org/journal/fns>.

⁴Klaus MH. The frequency of suckling. A neglected but essential ingredient of breast-feeding. *Obstet Gynecol Clin North Am*. 1987;14:623–633

Feeding on Cue Resources

Healthcare Provider Education Resources
Early Steps to Lasting Health: A Self-Study Curriculum on Infant Feeding and Assessment
Module Three: Reading Infant Cues
<http://nutrition.utk.edu/EarlySteps/user/Module-03.pdf>

WIC Learning Online -- Infant Hunger and Satiety Cues
http://www.nal.usda.gov/wicworks/WIC_Learning_Online/support/job_aids/cues.pdf

Patient Education Resources
Hunger Cues – When do I feed baby?
<http://kellymom.com/ages/newborn/bf-basics/hunger-cues/>

La Leche League – Feeding on Cue
<http://www.llli.org/nb/nbjulaug03p126.html>

How much can my new baby eat? (English and Spanish)
<http://www.dhs.state.il.us/OneNetLibrary/27897/documents/Brochures/4592.pdf>

Sleepy Baby Patient Education Pamphlet (English and Spanish)
<http://www.dhs.state.il.us/page.aspx?item=52018>

Patient education tear pads related to feeding on cue from Child birth graphics in English and Spanish
How to tell when your baby is hungry and Waking a Sleeping Baby
<http://www.childbirthgraphics.com/>

Your Baby the Night Owl
http://webdoc.nyumc.org/nyumc_d6/files/nyubaby/NightOwl.pdf

Videos
Infant Cues: A Feeding Guide Video from Childbirth Graphics (Item # 47652 or 49652)
http://www.childbirthgraphics.com/storefrontB2CWEB/browse.do?action=refresh_browse&ctg_id=581

STEP 8: Encourage breastfeeding on demand.

This step applies to ALL babies, regardless of feeding method, and is now interpreted as “Encourage feeding on cue.”

Action Items				Due Date	Primary Team Members
Policy Revision	Revise (or draft new) policy to include language about helping all mothers learn to feed their babies on cue.				
	<ul style="list-style-type: none"> Policy should include the following protocol for helping mothers to understand feeding on cue: <ul style="list-style-type: none"> Restrictions will not be placed on the frequency or length of feedings All patients will understand newborns typically feed 8-12 times in 24 hours All patients will learn to recognize feeding cues (rooting, hands to mouth, mouth movements, small sounds) All patients will understand the benefits of physical contact and nourishment that infants receive during feedings 				
	Submit revised policy to administration for approval				
	Patient education related to feeding on cue is documented in the patient care record				
Documentation	a) Determine where feeding on cue education should be documented in medical record (patient education form, discharge checklist, etc.)				
	b) Develop (or revise) documentation form in medical record to document feeding on cue patient education (patient education form, discharge checklist, etc.)				
	c) Conduct chart audits on a regular schedule to ensure patient education is being documented				
	Train all staff on the importance of assisting families to recognize feeding cues and the importance of feeding on cue, policy revisions and documentation changes				
Staff Training	a) Develop education plan to train all maternity nursing staff about feeding cues and the related revised policy, procedures and documentation methods (Examples: Staff meeting in-service, lunch & learn, email in-service and reminders)				
	b) Implement education plan to train all maternity nursing staff on feeding cues and the related revised policy, procedures and documentation methods				
	c) Track participation in training sessions to ensure all staff are trained				

	Action Items		Due Date	Primary Team Members
	d)	Work with medical and non-clinical staff to ensure all physicians and staff are educated about feeding on cue and policy changes		
Patient Education		<i>Educate all patients and families about feeding on cue</i>		
	a)	Revise (or create new) patient education materials to include feeding on cue information, including: <ul style="list-style-type: none"> a. Not placing restrictions on the frequency or length of feedings b. Newborn feeding patterns (8-12 feedings in 24 hours, cluster feeding, no feeding schedules) c. Feeding cues (rooting, hands to mouth, mouth movements, small sounds) d. The benefits of physical contact and nourishment infants receive during feedings 		
	b)	Document patient education in medical record (See <i>Documentation</i> above)		

Scripting for Staff

During training sessions we found that staff requested specific scripting on how to best respond to a mother's concern or request.

Recommendations:

- Train staff in using the Best Start Three-Step Counseling Technique:
 1. Ask an Open-Ended Question
 2. Affirm Feelings (most important step)
 3. Educate (provide targeted information on issue uncovered)
 - o This technique saves staff time
 - o Addresses the needs of the birthing family
 - o Builds rapport and increases client self-confidence.
- Engage staff in developing their own scripting
 - o Provides opportunities for staff to share what has worked for them
 - o Increases comfort level
 - o Increases buy-in
- Provide Role-Play Opportunities
 - o Increases staff confidence
 - o Provided opportunities for problem solving
 - o Provided opportunity to practice

Sample Scripting for Mothers Who Want to “Do Both”

Begin by exploring the mother's reasons. “Tell me a little more about what you plan to do.”

Affirming Statements

- “Many women are in the same situation.”
- “A lot of women feel the same way.”

Scripting Statements

- “This is the time for your baby and you to learn how to breastfeed.”
- “It can be confusing for the baby to be expected to learn how to do two things at the very beginning.”
- “It is really important that you feed your baby on demand. This establishes your milk supply and comforts your baby.”

- “This is your window of opportunity to create your baby's milk supply.”

Suggestions from Nurses in the field:

- Let me help you reach your goal.
- It's important to acknowledge moms common anxiety and validate moms concerns.
- Describe difference between obtaining milk flow from bottle vs. breastfeeding.
- Stress how smart their baby is.
- Inform moms that sucking makes milk and their body is trying to figure out how much milk to make.
- Avoid yes or no questions.
- Less bottles equals more production of milk.
- Talk about stomach capacity and the impact of over distending baby's tummy.

Sample Scripting for Rooming-In

If the mother says that she wants her baby to spend the night in the nursery:

Affirming Statements

- “I understand that you're tired.”
- “I understand that you need to get some sleep. And I want you to get the rest that you need.”

Scripting Statements

- “In fact, new research has shown that mothers actually get better sleep when their babies stay in the room.”
- “It might seem like you'll never get enough sleep again, but you will. One of the great things about breastfeeding is that you won't need to get up and fix bottles during the night.”
- “Would you like me to ask your visitors to leave when it's time to feed the baby? That way you don't have to ask them.”
- “Keeping your baby in the room gives you lots of opportunities to get to know your baby.”

- “When you have your baby close by you get a chance to see when he’s getting hungry.”
- “By keeping your baby in the room with you, you’ll be able to respond when your baby is ready to feed. This is the best way to make sure that you’ll produce lots of milk for your baby.”
- “Breastfeeding will go much better if you feed your baby as soon as he/she shows early signs of hunger. This may not happen if your baby is in the nursery.”
- “Our hospital staff supports bonding between new mothers and their babies and we have found that separation interferes with the bonding process.”
- “Rooming in with your baby will help you get to know him/her better.”

Sample Scripting for Avoiding Supplementation

If the mother asks for formula due to concerns about insufficient milk/infant’s weight loss (lack of self-confidence), ask open-ended questions “Tell me how you can tell that your baby is getting enough milk?”, “Tell me what you know about how breastfeeding works?”

Affirming Statements

- “I can see that you are worried about your baby. I hear that from so many moms that I take care of.”
- “I understand that you’re concerned that your baby gets enough to eat. That shows how much you love your baby.”
- “At the end any mothers find these first few days difficult – and scary. I’m here to help you.
- “A lot of the mothers I take care of describe feeling exactly the way that you do. You’re not alone.”

Scripting Statements

- “Did you know how tiny your baby’s stomach is the first couple of days?” (Demonstrate with belly balls.)
- “The baby’s stomach can only hold about a teaspoon of milk at a time in the beginning. So, you have the perfect amount of milk to meet your baby’s needs.”

- “Have you heard the expression, ‘supply and demand’? The more often you nurse your baby, the more milk you’ll have.”
- “I just want to be sure you have all the information you need before you decide to give your baby formula.”
- “Formula is harder to digest than breast milk and makes your baby feel full longer so that he/she will not want to breast feed as often as needed to establish your milk supply.”
- “Your baby only needs a small amount of breast milk at each feeding but needs to have it often.”

If the mother asks for formula to calm a fussy baby:

- “Crying doesn’t always mean that your baby is hungry.”
- “Babies love to be held, and they cry less when you hold them skin to skin.”
- “Have you ever heard the term ‘cluster feeding’? It’s very common for babies to eat a bunch of times in a row when they’re awake. Then they may sleep for a while.”

Suggestions from Nurses in the Field:

- Help the staff understand why mom wants to give formula and how to best address their concerns.
- Allow mom to understand the relationship between breastfeeding, skin to skin and milk supply.
- Find out what the mom understands.
- Allow moms to make an informed decision.

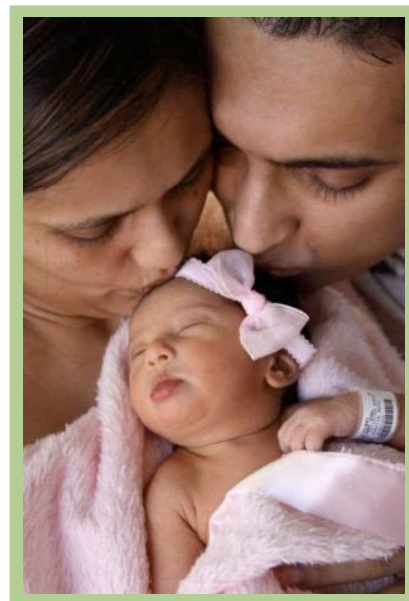


Photo courtesy of Bella Baby Photography Inc.

Staff Education and Training Resources

For Healthcare Providers

Breastfeeding Training - Virginia Department of Health and the University of Virginia Health System (FREE)

This FREE online Breastfeeding Training Course will provide health professionals with detailed information regarding the theory and practice of lactation management.

Each individual module is designated for 0.5 AMA PRA Category 1 Credit™.

<http://www.breastfeedingtraining.org/>

Breastfeeding Basics (FREE)

Breastfeeding Basics is an academic, non-commercial, short course on the fundamentals of breastfeeding. It is geared primarily for the medical practitioner, although anyone is welcome to browse or take the course.

<http://www.breastfeedingbasics.org/>

Staff Training – 16 Hour Learner Workshop (FREE)

California Department of Public Health – Birth & Beyond California

The 16-Hour BBC Learner Workshop is designed to provide healthcare workers, including physicians, nurses, lactation educators, and others in routine contact with mothers, with the knowledge and skills to support a mother's decision to breastfeed.

<http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/16HourLearnerWorkshop.aspx>

Wellstart's Lactation Management Self-Study Modules Revised 3rd Edition (FREE)

Downloadable self-study modules with three sections that take around 6-7 hours to complete.

<http://www.wellstart.org/>

Breastfeeding Management, Educational Tools for Physicians and Other Professionals (FREE VIDEO)

by Jane Morton, MD, FAAP

A live demonstration of how to observe and assess breastfeeding. (Streaming Video)

<http://newborns.stanford.edu/Breastfeeding/FifteenMinuteHelper.html>

Healthy Children's Center for Breastfeeding Certified Lactation Counselor (CLC) Training Program

Applied Teaching Methods in Lactation Education: Learn to Teach the 20 Hour Course

<http://healthychildren.cc/>

Baby Friendly Education

Baby Friendly Education offers an online staff education program called Breastfeeding Essentials to Hospitals and Health Groups requiring staff education for Baby Friendly accreditation or reaccreditation.

<http://www.babyfriendlyeducation.com/>

Breastfeeding: A Continuing Education

Program for Health Care Providers

Guided self-study program

<http://www.risingstareducation.net/>

For Residents

Breastfeeding Residency Curriculum – American Academy of Pediatrics (FREE)

“The American Academy of Pediatrics developed this Breastfeeding Residency Curriculum to help residents develop confidence and skills in breastfeeding care”.

<http://www2.aap.org/breastfeeding/curriculum/>

Patient Education

One of the themes that emerged from hospital trainings in the Chicago area was a frustration with the lack of counseling that clients receive prenatally regarding their infant feeding options. Below you will find some ideas and resources that can help your organization tackle this issue.

Tips:

- Train all staff in using the Best Start Three Step Counseling Technique (see Below).
- Provide cultural sensitivity training to all staff.
- Collaborate with Federally Qualified Health Centers and healthcare providers to enhance methods of providing breastfeeding information and support.
- Have culturally sensitive breastfeeding posters and material available.
- Conduct needs assessment with clients regarding the type of breastfeeding information needed and how to best provide it.
- Implement a breastfeeding peer counselor program to provide culturally appropriate education and support.
- Consider offering a prenatal breastfeeding class facilitated by breastfeeding peer counselor.

One of the techniques developed to counsel women regarding their infant feeding options is Best Start's Three-Step Counseling Strategy® by Best Start Social Marketing. This simple technique is an evidence-based strategy designed to address the barriers to breastfeeding. This technique will help staff to engage with their clients to discuss their questions and concerns.

Show Me Video Vignettes: Video 1:

Using 3 Step Counseling with New Mothers (07:37) http://www.nal.usda.gov/wicworks/Learning_Center/BF_training_videos.html

Best Start Three Step Strategy Handout

http://nursing.advanceweb.com/sharedresources/Downloads/2004/020104/NP/np020104_p22table2.pdf

Breastfeeding is often called a “confidence” game. For some staff this seems overwhelming to achieve during the hospital stay. Using the 3-Step strategy assists staff in providing a strong foundation to get moms started on the right track. This strategy helps staff members to meet clients where they are and works towards supporting clients to accomplish their own breastfeeding goal. If we truly listen and ask the right questions clients will feel that we genuinely care.

Resources:

DVD- Biological Nurturing: Laid Back Breastfeeding for Mothers <http://www.geddesproduction.com/breast-feeding-laid-back.php>

Better Breastfeeding: Your Guide to a Healthy Start

<http://www.injoyvideos.com/result.php?catid=13&prodtype=>

Better Breastfeeding: A Guide for Teen Parents

<http://www.injoyvideos.com/result.php?catid=13&prodtype=>

Breastfeeding for Working Mothers: Planning, Preparing, & Pumping

<http://www.injoyvideos.com/result.php?catid=13&prodtype=>



HOSPITAL BREASTFEEDING TOOLKIT

Thank you for working towards implementing steps of the Baby-Friendly Hospital Initiative. You are breastfeeding champions and because of your work, babies in Illinois will begin life with the best start.

Please visit the Illinois Breastfeeding Blueprint website to access additional resources, including editable versions of the forms provided in this toolkit.

http://www.ilbreastfeedingblueprint.org/pages/hospital_toolkit/35.php



Photo courtesy of Bella Baby Photography Inc.