

Guidelines for Breastfeeding Initiation and Support



*Massachusetts Department of Public Health
Bureau of Family Health and Nutrition*

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INTRODUCTION – WHY GUIDELINES?

Breastfeeding has long been recognized as one of the most important contributors to infant health. New and continuing research is increasing our understanding that the absence of breastfeeding is a significant public health issue, and is associated with excess risk of morbidity and mortality in infants, children and in women. Increasing breastfeeding rates has been on the national health agenda for several years, strengthened by the publication of the *HHS Blueprint for Action on Breastfeeding* in 2000 and the development of breastfeeding initiation, duration and exclusivity goals for *Healthy People 2010*.

Healthy People 2010 Objectives

Increase the proportion of mothers who breastfeed their babies:

	Target
In the early postpartum period:	75%
At 6 months:	50%
At 1 year:	25%
Exclusively through 3 months:	40%
Exclusively through 6 months:	17%

The Agency for Healthcare Research and Quality recently published a report of the effects of breastfeeding on infant and maternal health outcomes based on a review of nearly 500 studies. The authors confirmed that breastfeeding is associated with an infant's reduction in risk of acute otitis media, non-specific gastroenteritis, severe lower respiratory tract infections, necrotizing enterocolitis and SIDS. The review of the literature also demonstrates that the lack of breastfeeding and early formula feeding contribute to the rising incidence of chronic diseases in childhood and adolescence, including type I and type II diabetes, asthma, atopic dermatitis, childhood leukemia and overweight. For maternal outcomes, a history of lactation was associated with a reduced risk of breast and ovarian cancer as well as type II diabetes.

In order to achieve many of these health benefits, breastfeeding must be the primary method of feeding during the first year of life. The American Academy of Pediatrics recommends that babies be exclusively breastfed (i.e., fed only breastmilk) for the first 6 months, and continue to be breastfed, with the addition of other appropriate foods, until at least one year of age.

In Massachusetts, the percentage of mothers who report their intention to breastfeed at the time of hospital discharge (79.3% in 2005) meets the *Healthy People 2010* goal for breastfeeding initiation. However, many of these mothers stop breastfeeding in the early weeks following their baby's birth, and by 6 months, less than half of all mothers report they are still nursing. Only one-third of infants in Massachusetts are *exclusively* breastfeeding at three months of age; just twelve percent are doing so at six months. (National Immunization Survey, Centers for Disease Control and Prevention, 2004).

Why Were These Guidelines Developed?

Hospital maternal-newborn care practices have been clearly linked to the successful initiation *and continuation* of breastfeeding – and, conversely, have also been linked to mothers' failure to establish lactation and to early weaning of babies whose mothers desired and intended to breastfeed. The World Health Organization's Baby Friendly Hospital Initiative, launched in 1991, established 10 steps that have been shown to result in improved breastfeeding rates. In 2005, the Centers for Disease Control and Prevention released *The CDC Guide to Breastfeeding Interventions* and cited maternity care practices as a core area for delivering evidence-based interventions known to better breastfeeding outcomes. (CDC, 2005).

The Massachusetts Hospital Licensure Regulations for Maternal and Newborn Services, revised in 2006 and issued by the Department of Public Health, support family-centered maternity care and breastfeeding through a number of specific requirements. The regulations parallel many of the steps suggested by the WHO and CDC. To maximize the benefit of these regulations to families, however, hospital staff must be aware not only of “what” must be done, but also “why” and “how-to”. These guidelines are intended to complement and support the maternal-newborn licensure regulations, and provide hospitals more detailed information on how to implement them successfully.

The guidelines reflect current literature and best practice in breastfeeding management strategies, consistent with the WHO’s *10 Steps*. The Massachusetts chapters of the American Academy of Pediatrics (AAP), the American College of Obstetrics and Gynecology (ACOG) and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) have all endorsed these guidelines.

Using these Guidelines

The Guidelines outline basic breastfeeding principles and practices that apply to the general population of nursing mothers and newborns. This information may apply but may need to be supplemented for certain high-risk situations or for families with special needs. The guidelines are organized first by timeframe of hospitalization (e.g., “getting started,” then “preparing for discharge”) and then by specific circumstances and conditions. Special attention is paid to common practices associated with breastfeeding difficulty and early termination. Some of this information may be repeated throughout the Guidelines as these are some of the most frequently reported and observed detrimental practices, even in hospitals that are making concerted efforts to promote and support breastfeeding.

The guidelines are presented as “headlines” – brief key points – to be easily accessible within the very busy and demanding working environment of today’s hospital maternal-newborn services. Each of these key points is backed by current literature and evidence-based practice. References and resources are included in the appendices.

Feedback to the Department of Public Health

The Department of Public Health is interested in learning how these guidelines meet your facility’s needs and what additional support DPH could provide you in the promotion and support of breastfeeding and in adhering to the perinatal hospital regulations. We are eager to receive feedback on these guidelines as well as identify those interested in assisting DPH to develop future breastfeeding policies and support materials.

Getting additional information

Of course, not all special circumstances can be addressed in general guidelines. For guidance in finding more specific information or to learn more about breastfeeding training opportunities in Massachusetts, please contact the State Breastfeeding Coordinator at (617) 624-6100.

The Department of Public Health encourages all hospitals to strive to implement the breastfeeding promotion recommendations set forth by the Baby Friendly Hospital Initiative. Baby Friendly hospitals and birth centers create an optimal environment for the initiation of breastfeeding and receive local and national recognition as sources of excellent care for infants and their families. If your facility is interested in pursuing Baby Friendly status, you can get more information by contacting Baby Friendly U.S.A. at 1-508-888-8044.

BREASTFEEDING PROMOTION

This section highlights key actions hospitals can take that have been shown to positively influence women's decision to breastfeed, and to increase initiation and continuation rates of breastfeeding. These actions provide the foundation for all other patient care efforts related to breastfeeding.

Breastfeeding-friendly environment Display posters and patient education literature that promote breastfeeding. Avoid the display of posters, patient education literature, and promotional items (pens, name tags, etc.) that promote formula feeding or contain a formula company's name – even if they appear to encourage breastfeeding.

Enable informed infant feeding choices Actively encourage breastfeeding with families before delivery. Consider familial and cultural values and beliefs related to breastfeeding when counseling. Ensure that a mother's partner and other key individuals providing her support are expressly involved in breastfeeding education and counseling. Explore family's reasons for not breastfeeding, if applicable. Offer unbiased accurate information about actions required to successfully initiate and maintain lactation, the risks of not breastfeeding for both mother and baby and the inherent attributes of breastfeeding as the normative model of infant nutrition . *See Appendix for the American Academy of Pediatrics' Policy Statement: Breastfeeding and the Use of Human Milk.*

Assess the mother and infant for conditions that are contraindications to breastfeeding. While the majority of illnesses and medications are compatible with breastfeeding, maternal human immunodeficiency virus (HIV) and human T-cell lymphotropic virus (HTLV type I or type II) are contraindications to breastfeeding. A mother with active tuberculosis or herpetic breast lesions should not breastfeed until the condition has resolved. Breastfeeding may be contraindicated among mothers who are receiving diagnostic or therapeutic radioactive isotopes or have had exposure to radioactive materials (for as long as there is radioactivity in the milk) and mothers who are receiving antimetabolites or chemotherapeutic agents (until they clear the milk). Current use of drugs of abuse is a contraindication to breastfeeding, but alcohol intake, cigarette smoking and methadone use do not prohibit the mother from nursing. Galactosemia is the only outright contraindication to breastfeeding for infants.

Keep mothers and their infants together 24 hours a day Create a hospital environment where rooming-in is the norm. Rooming-in enables mothers to respond rapidly to infant feeding cues, which helps to establish a good milk supply and decreases the likelihood of breastfeeding difficulties. Rooming-in benefits all mothers and babies, regardless of feeding choice. A number of studies show that mothers whose infants are returned to the nursery at night do not get more sleep than mothers who room-in with their infants. In fact, research suggests that mothers who share a room with their infants may be more rested due the baby's higher quality sleep when rooming-in.

Avoid unnecessary introduction of supplements (water or formula) and artificial nipples (bottles or pacifiers)

Make supplemental bottle-feeding available only for medical reasons or upon request of the mother (i.e., do not maintain supplies of formula and bottles in bassinets, crib carts, patient rooms or in other patient areas). Provide information on the negative effects of early introduction of formula, bottles, and pacifiers on breastfeeding success. If the family does request supplements, explore reasons for doing so and continue to actively promote breastfeeding in the context of combination feeding.

Document and monitor feeding practices

Accurately record feeding method (breast, formula, or combination feeding) in both mother's and baby's medical records. Include teaching done, counseling provided, family's feeding preference and provider's feeding care plan. Ensure documentation of at least two successful feedings prior to discharge that have been observed by a nurse or lactation consultant and that have shown the baby to be swallowing. Document that the mother can state when the baby is swallowing at the breast.

Adopt standardized forms (such as discharge forms) to collect pertinent breastfeeding information. Collect infant feeding statistics regarding feeding method to determine performance in reference to national standards/guidelines. Include mother's breastfeeding intention prior to delivery and infant feeding method at discharge, noting the degree of breastfeeding exclusivity. Work to remedy large discrepancies between current rates and goals for best practice.

Accommodation of visitors

Constant visitors may interfere with mother and baby learning to breastfeed, tire mothers, and limit nursing staff's ability to provide mothers with sufficient breastfeeding instruction and support. Interruption of early feedings can hamper the development of an adequate milk supply. Conversely, the presence of experienced and knowledgeable friends or family who can support and advocate for a mother through the early breastfeeding period may enhance breastfeeding success. Visiting hours should be determined based on individual patients' needs. Some mothers may need to be supported in establishing reduced visiting hours.

Work toward Baby-Friendly status

Appoint administrative staff to investigate movement towards Baby-Friendly Hospital status. Endeavor to follow the best practices contained in the 10 Steps to Successful Breastfeeding. *See Appendix for the Ten Steps to Successful Breastfeeding.*

BREASTFEEDING INSTRUCTION AND SUPPORT

This section outlines the minimum key points mothers need to know right from the start, ideally even before they begin breastfeeding. These are not all-inclusive; and as in all patient education efforts, teaching and support must be individualized according to the mother's and family's needs, learning style and pace, cultural and health beliefs, infant characteristics, and unique circumstances. Include family members to the greatest extent possible and appropriate, as their support – or lack of it – will be key to the successful initiation and continuation of breastfeeding.

GETTING STARTED—Admission through first 24 hours post delivery

Basic anatomy and physiology of lactation

Explain that the first milk present at birth is called colostrum. Colostrum is critical in boosting an infant's immune system and in encouraging the passage of the first stool. Stress that colostrum, although present only in small amounts, provides concentrated and sufficient nutrition for a newborn; supplements are not necessary. Describe how milk will quickly change in color, consistency, and volume over the next several days.

Explain that lactation is based on supply and demand. The more milk a baby removes from the breast, the more milk will be made.

Briefly describe hormones of lactation and that the suckling action of the baby causes levels of these hormones to increase. Explain sensations that a mother might experience during let-down. Advise parents that the hormones of lactation are often suppressed when a mother experiences substantial stress and anxiety and that relaxation assists in the initiation and maintenance of successful breastfeeding.

Reassure mothers that the amount of fat tissue in the breast (or size of the breast) has no effect on milk supply. However, mothers with smaller breasts and lower storage capacity may need to feed their babies more frequently.

Remind families to be patient, as breastfeeding is a learned process. It may take a little extra time and encouragement before some mother and infant dyads are able to breastfeed easily and successfully.

Explain the common physical sensations associated with breastfeeding, including those related to let-down and uterine cramping.

The first feeding

Explain that breastfeeding should be initiated as soon as possible after delivery, preferably within an hour of birth. Early skin-to-skin contact and opportunity to suckle has been shown to improve breastfeeding outcomes. Optimally, the infant should be left continuously with the mother from birth and allowed to nurse at any time. If a mother must be separated from her infant due to medical conditions, demonstrate and encourage building milk supply using a breast pump.

Babies that are too sleepy to feed or who do not latch over a period of many hours should be fed with colostrum that has been hand expressed. Teach mothers how to hand express for these early feedings when needed.

Explain that frequent skin to skin contact between mother and baby is important for promoting bonding and facilitating breastfeeding throughout the early months of life and greatly assists the infant in adjusting to the extrauterine environment.

Positioning baby at the breast

Show mother how to support baby's head, neck and shoulders, turn baby's body towards her, and direct baby's nose to her breast. Mother should be comfortable, using pillows or blankets to help hold the baby at breast height. *See Appendix for examples of proper breastfeeding positions.*

Latching baby onto the breast

Explain that proper latch is essential for milk production and transfer and to reduce the risk of pain while nursing.

Demonstrate supporting the breast with the hand in the shape of a "C" (fingers under the breast and thumb on top) with fingers placed behind the areola.

Instruct mom to achieve a wide, deep latch by planting the baby's chin below the areola and bring the baby close as he draws in the nipple and areola. The nipple and as much of the alveolar tissue as possible should be in baby's mouth.

Explain the following characteristics of a good latch:

- *Wide open mouth (nearly a 180 degree opening at the corner of the mouth)*
- *Lips turned out, not rolled in.*
- *Baby's chin touches the breast.*
- *Baby's tongue should be under the nipple.*

Explain the following signals to remove the baby from the breast and re-try the latch:

- *Mother experiences strong discomfort or pain.*
- *Baby sucks in his cheek pads with each suckle.*
- *Baby makes clicking or smacking noises.*
- *Baby does not suck and swallow rhythmically.*

Frequency and duration of feedings

Discourage scheduled or timed feedings. Explain hunger cues and stomach capacity of newborns. Remind parents that crying is a late sign of hunger. Teach mothers to identify infant feeding readiness cues, especially if the baby is sleepy; e.g., rapid eye movements under eyelids, sucking movements of the mouth and tongue, hand-to-mouth movements, body movements, small sounds, etc.

Encourage frequent feedings in the early newborn period to build milk supply, feeding at least 8-12 times in 24 hours. Provide reassurance that frequent nursing does not cause sore nipples. Sore nipples are due to improper positioning and latch onto breast.

Encourage baby-led feedings. Encourage nursing on one side until baby finishes, offering the second breast and feeding according to infant's interest. Discourage time limits at the breast. Teach the mother that her baby will typically come off the breast independently, fall asleep or appear disinterested in nursing when he has finished feeding at a breast. Teach method to end a feeding (if necessary) by breaking suction between baby's mouth and nipple.

Due to medications during labor, traumatic birth experiences, or other reasons, some infants may be excessively sleepy and may not display hunger cues frequently enough to build a good milk supply. Advise mothers to keep these babies skin-to-skin and feed when the baby moves into a lighter sleep state. Skin-to-skin contact between a mother and her infant helps to elicit a baby's early feeding cues and facilitates the mother's timely response. Mothers should feed at least 8 times in 24 hours.

Avoid unnecessary introduction of artificial nipples and supplements (water and formula)

Instruct the mother to delay introduction of bottles and formula until breastfeeding is well established, usually around 3-4 weeks after delivery, in order to maximize milk supply and overall breastfeeding success. Encourage exclusive breastfeeding for optimal health outcomes and reinforce the concept that the introduction of supplemental formula will decrease a mother's supply of breastmilk. Pacifiers should also be avoided during the first weeks of life, as they may mask hunger cues, decrease the amount of baby's suckling at the breast, decrease milk supply, and create other subsequent nursing challenges.

Rooming-in

Encourage mother to sleep near her baby to maximize opportunities for frequent nursing. Rooming-in can actually increase a mother's opportunity for rest. Remind families that frequent skin-to-skin contact, promoted by keeping mothers and babies together, improves breastfeeding outcomes and helps mothers soothe and bond with their babies

Newborn stool and urine patterns

Explain passing of meconium stools and expectations for urine output and bowel movements during the first 24 hours. Consider providing parents with tools to track the frequency of soiled diapers—as well as the frequency of feeds—as needed to reinforce normal newborn behavior as well as to provide reassurance regarding the sufficiency of a mother's milk supply.

Maternal nutrition

Encourage mother to eat a variety of healthy foods and drink ample fluids. Explain that under most circumstances it is not necessary to eat or to avoid certain foods in an effort to affect milk supply or prevent infant digestive problems. Women may interpret strict dietary recommendations literally and decide NOT to breastfeed based on their perceived inability to follow a dietary plan. While good nutrition plays an important role in a mother's recovery from pregnancy and delivery as well as in overall health, maternal nutrition does not affect the overall quality of breast milk, except in extreme situations.

Breast care

Encourage the mother to let her breasts air dry after a feeding. Healthy skin and nipples require no special breast care. Breastfeeding creams, lotions and lubricants are not typically recommended. Drying agents, such as soap and shampoo should be avoided. Rinsing with water in the shower provides sufficient cleansing.

Lactation support

Ensure around-the-clock care by staff educated in the skills that support breastfeeding. All nursing staff on the maternal-newborn unit should achieve and maintain basic breastfeeding management and counseling skills.

Provide consistent, accurate breastfeeding information regardless of time of day or staffing pattern. Consider staffing patterns that assure at least one staff person with advanced knowledge or certification is available for consultation on each shift, to encourage peer learning and help with difficult situations. Ensure the ongoing availability of an International Board Certified Lactation Consultant (IBCLC) or an individual with equivalent training and experience to each family requiring advanced lactation support throughout the hospital stay.

Indications for referral to an IBCLC:

Immediately provide a referral to an IBCLC or an individual with equivalent training and experience for the following situations: prematurity/low birthweight, multiple birth, symptomatic hypoglycemia, weight loss over 8-10%, clinical dehydration, jaundice, inability to latch at 24 hours, problems with maternal breast anatomy, persistent or excessively sore or cracked nipples, separation of mother and infant for medical reasons, medically required nutritional supplementation of infant, or a previous unsuccessful breastfeeding experience. Mothers who undergo cesarean section may require assistance from an IBCLC to ensure timely initiation of breastfeeding and appropriate breastfeeding positioning.

KEEPING BREASTFEEDING GOING – Preparation for discharge

Signs of adequate milk supply and transfer	<p>Describe signs of adequate milk supply and transfer throughout the hospital stay:</p> <ul style="list-style-type: none">• mouth movements, drawing in of areola, and audible swallow• adequate weight gain of 4-6 oz/week• 6 wet/heavy diapers every 24 hours AFTER DAY 4• 4 or more bowel movements every 24 hours AFTER DAY 4
Stool patterns	<p>Describe changes in stool color during first week and differences in stool texture/color between breastfed and formula fed infants.</p>
Anticipatory guidance	<p>Provide anticipatory breastfeeding guidance regarding milk “coming in”, sleeping patterns, growth spurts, potential breast/nipple problems, maintenance of milk supply, and baby’s need to suckle for comfort vs. sustenance.</p>
Referrals to community supports	<p>Provide referrals to hospital or community lactation specialists, La Leche League leaders, Nursing Mothers Council, WIC programs, and other breastfeeding resources to every breastfeeding mother at discharge. Encourage making contact and seeking help or answers to questions <i>early</i>, rather than waiting for a problem to develop or worsen. Recommend an infant weight check and breastfeeding assessment at 2 days post-discharge, either in the pediatrician’s office or during a home visit. <i>See Resources in Appendix for community breastfeeding support organizations in Massachusetts.</i></p>
Mechanism for response to patient questions after discharge	<p>Consider creation of a breastfeeding “warm line” or hotline to be available to families with breastfeeding questions post discharge.</p>

PRACTICES THAT INTERFERE WITH SUCCESSFUL BREASTFEEDING

Introduction of supplements (water and formula) and artificial nipples (bottles and pacifiers)

Supplement with water or formula only on request of the mother or the written order of the health care provider. Develop a written policy for supplementation. If the mother requests a bottle or pacifier, use the opportunity to explore her reasons and educate about the risks of early introduction of supplements and artificial nipples. Provide continued reinforcement of the signs of an infant's adequate milk intake and offer frequent reassurance regarding normal newborn feeding behavior as needed. Document education and consent. Use alternative feeding methods (such as dropper or medicine cup) to feed supplements or pumped breast milk when medically necessary. Whenever possible, use expressed breast milk before formula. Avoid stocking patient rooms with bottles and formula.

Distribution of formula focused gifts and feeding information upon discharge

Eliminate the distribution of materials and gifts, including hospital discharge bags (even if the formula has been removed), that feature or include the name or logo of an infant formula company. *Even breastfeeding promotion materials produced by formula companies may subtly promote formula feeding.* It is well documented that these practices are associated with early cessation of breastfeeding.

Policies and procedures that separate mothers and babies or that interfere with initiation of feeding within the first hour after birth

Encourage rooming-in of all mothers and babies. Delay newborn care procedures such as eye prophylaxis, weighing, measuring and bathing until after the first feeding to promote sucking and imprinting of breastfeeding. Encourage bedside exams, portable baby scales and treatment carts to avoid separation of mother and baby for weight checks. Rapidly reunite mothers and babies who must be separated for medical/surgical procedures, including cesarean section and circumcision.

Anesthetics/Analgesics during Labor & Delivery

To the extent possible, encourage anesthetic/analgesic decisions that minimize infant drowsiness in the immediate postpartum period. Initiation of breastfeeding should be encouraged as soon as possible and may occur within the first hour after delivery, depending on the type of anesthesia given and surrounding circumstances.

Inconsistent adherence to hospital breastfeeding policies and regulations regarding breastfeeding

Design evidence-based breastfeeding policies and procedures and include these in staff and physician education and competency reviews. Make breastfeeding policies known to all patients. Endeavor to provide parents with consistent breastfeeding information from all staff (physicians, nurses, dietitians, etc.). Reinforce positive breastfeeding messages at all times. Formula company salespersons should adhere to hospital vendor policies.

SPECIAL CONSIDERATIONS

This section contains general recommendations for common breastfeeding problems encountered in the newborn period. Individual care plans should be developed by a team that includes an IBCLC or individual with equivalent training and experience.

C-Section

A mother who has had a cesarean delivery is likely to need extra support in the first days to initiate lactation. She may have difficulty finding a comfortable position for nursing and picking up the baby at the first signs of hunger, due to post-operative pain and decreased mobility. Also, some medications may cause her and the baby to be sleepy initially.

The first feeding should be encouraged as soon as possible after delivery, preferably within the first hour, depending on the type of anesthesia given and surrounding circumstances. Demonstrate nursing positions that minimize contact with the incision. Reassure the mother that these difficulties are temporary, and that she can successfully breastfeed regardless of method of delivery. Mothers should feed at least 8 times in 24 hours.

Multiple births

Successful breastfeeding of multiples is possible. Describe potential timing of feedings, feeding rotations and feeding positions.

Premature infants

Encourage mothers of premature babies strong enough to suckle at the breast to initiate breastfeeding as soon as possible after delivery. Encourage skin-to-skin contact (kangaroo care) for all dyads, regardless of current breastfeeding status. If nursing at the breast is not possible, the building of milk supply should be initiated with the use of a hospital grade electric breast pump with a double collection kit as soon as maternal condition permits. Encourage mom to pump regularly (8 to 10 times in 24 hours) to increase and then maintain adequate milk supply. A mother's own pumped milk is the first choice for infant nourishment when she cannot nurse the baby directly. Provide instruction for safe storage of expressed breast milk upon mother's discharge. All premature infants should have written breastfeeding plans to protect the mother's milk supply and to move forward towards full feeding at the breast.

Pasteurized, donor milk from milk banks that adhere to the national guidelines set forth by the Human Milk Banking Association of North America (HMBANA) may be a resource to consider when the mother of a premature or other medically fragile infant is unable to produce sufficient milk.

Closely assess and monitor the breastfeeding status of late preterm infants. While they may appear developmentally mature, late preterm infants may be sleepier and have less stamina than full term infants, affecting their

ability to latch, suck and swallow effectively. Ongoing skin-to-skin contact, as well as frequent feeds, is especially vital to this group of newborns.

Sore nipples

Provide reassurance that frequent nursing does not cause sore nipples. Discomfort while breastfeeding is usually due to improper latching or positioning at the breast. Breastfeeding creams and lotions are not typically recommended to heal or soothe sore nipples. Additional support, ideally from an IBCLC, prior to discharge is essential to assess current positioning and demonstrate more effective, comfortable nursing positions for the breastfeeding dyad.

Engorgement

Provide anticipatory guidance to all mothers that initial engorgement or over-fullness is expected when milk first “comes in”. Nursing the infant is the most effective method of relieving discomfort associated with engorgement; a breast pump should be used when an infant is unable to go to breast. Breastfeeding on-demand (or frequent pumping when necessary) is the best prevention of a recurrence of engorgement. Sometimes, an infant has difficulty latching on comfortably to an engorged breast. In this situation, encourage a mother to manually express enough milk to slightly soften the breast and then nurse the baby. A mother with unresolved engorgement should be referred to an IBCLC.

Flat, retracted or inverted nipples

Flat, retracted or inverted nipples are often corrected by the infant’s suckling. However, mothers with non-protracted nipples may require additional support as breastfeeding is established. An IBCLC should be consulted to assist with nipples that do not protract naturally or with the suckling of the infant.

Hypoglycemia

Risk for hypoglycemia should not prevent initiation or continuation of breastfeeding. In fact, hypoglycemia can be minimized by early and frequent breastfeeding, prevention of crying, and skin-to-skin contact.

Jaundice

Frequent breastfeeding (8-12 times every 24 hours) helps infant to pass meconium stools. Supplementation is not indicated in infants with bilirubin levels <20 mg/dl who are feeding well, stooling adequately, and experiencing normal weight loss. If phototherapy is warranted, breastfeeding can and should be continued with the use of equipment that allows an infant to be held. If breastfeeding is interrupted for diagnostic purposes or due to more significantly elevated bilirubin levels or other clinical situations, encourage maintenance of milk supply with frequent pumping of the breasts. Provide affected families with additional support and encouragement, as many mothers may discontinue breastfeeding unnecessarily when they believe it has caused the baby’s jaundice.

Management of mother's medications

Most medications are compatible with breastfeeding. Chemotherapy, treatment with radioactive elements, and a limited number of other medications require interruption or discontinuation of breastfeeding. Refer to a medication and breastfeeding handbook or to LactMed to determine safety of a particular drug. To minimize infant exposure to medications, instruct mothers to take medication just after nursing and avoid long-acting preparations. When breastfeeding is temporarily discontinued due to presence of certain drugs, encourage expressing breast milk and discarding it until nursing can resume. *See Appendix for References and Resources regarding medications and breastfeeding.*

Separation of mother and baby due to medical reasons

If the infant cannot be put to breast immediately, instruct the mother to pump her breasts regularly (every 2 to 3 hours) to build milk supply and provide breastmilk to infant until infant is able to nurse. Provide mother with a hospital-grade electric double breast pump. Provide instructions for safe storage of expressed breastmilk. If separation is temporary, the mother can hand express colostrum for feeding to the baby.

Infants with special health care needs

While infants with other special needs or medical conditions may require special assistance or adjustments to typical breastfeeding management protocols, breastfeeding remains the optimal method of feeding for most babies. When appropriate, actively encourage and support breastfeeding with the help of an IBCLC.

EXPRESSION, HANDLING AND STORAGE OF BREAST MILK

Indications for use of breast pumps	Encourage nursing at the breast whenever possible, as active nursing is more effective than pumping for increasing milk supply. Limit breast pump use during the immediate postpartum period to situations of separation of mother and baby, ineffective suck, contraindicated maternal medication and maternal aversion to nurse at the breast (with determination to provide breast milk). Hand expression should be taught to provide colostrum supplements if necessary.
Electric breast pump specifications	When necessary, provide mothers access to hospital-grade electric double breast pumps to maximize milk supply.
Breast pump instruction	Encourage hand washing prior to pumping. Suggest breast massage as preparation for pumping. Demonstrate assembly and mechanics of breast pump prior to initiation of use. Discuss appearance of breast milk and relationship between amount pumped and potential milk supply.
Collection and storage of breast milk	<p>Provide clean hard plastic or glass containers for collection. Label all containers with date and time of expression and baby's identification. Breast milk storage guidelines are more strict for hospitalized infants than for infants receiving pumped milk at home. Limit standing time at room temperature to 4 hours. Limit storage in refrigerator to no more than 48 hours. Breast milk can be frozen in the freezer for up to 3 months, and in a deep freezer for up to 6 months. Defrosted milk must be used within 24 hours.</p> <p>Never microwave expressed breast milk to reheat. Warm breast milk to room temperature by running it under warm running water or by submerging it in a container of warm water. When possible, provide expressed breast milk to infant via medicine dropper, cup, or other approved alternative feeding device rather than in a bottle.</p>
Provision of manual breast pumps at hospital discharge	If providing manual breast pumps to all mothers at hospital discharge, instruct mothers to delay use of pump until 3-4 weeks postpartum in order to maximize milk supply. In some situations, however, limited use of a pump in the early postpartum period can be helpful during extreme engorgement. <i>See Appendix for Breast Pumps: Indications for Use and Selection Criteria.</i>

TRAINING, STAFFING AND ADMINISTRATION

This section highlights major considerations in assuring that all nursing staff gain and maintain competency in basic breastfeeding counseling and management, with suggestions for building additional staff capacity.

Provision of opportunities for breastfeeding training

Provide nursing and medical staff with regular and repeated opportunities to attend breastfeeding continuing education courses. Effective training on breastfeeding, including practical sessions and an emphasis on counseling skills, should be included in all plans for staff orientation and in-service training. Specialty training for especially challenging or atypical breastfeeding situations (such as prematurity, multiple births, and special needs infants) should be available. Training should not be provided by formula company representatives or funded by formula companies. *See Appendix for Resources for Breastfeeding Education for Professionals.*

Breastfeeding training and education content and competencies

Ensure that all staff receive sufficient training to support families in initiating breastfeeding, building and maintaining milk supply, troubleshooting common breastfeeding difficulties, identifying problems needing IBCLC consultation, breastfeeding under special circumstances, and expressing and storing breast milk. In particular, ensure that training includes full explanation, evidence-based rationale, and practical application for each of the specific points highlighted in these guidelines. Ensure that training is sufficient to allow appropriate provision of discharge instructions for breastfeeding beyond the immediate postpartum period.

Consider staff's personal and cultural perspectives and biases related to breastfeeding when planning or providing breastfeeding education.

Develop a competency checklist to determine staff knowledge and to assist in assessing training needs. Ensure that staff demonstrate current competency in providing breastfeeding care on a regular basis. *See Appendix for a sample breastfeeding competency checklist for staff and a breastfeeding discharge knowledge checklist for patients.*

Encourage hospital staff to acquire certificates of added qualification as lactation specialists. *See Appendix for Resources for Breastfeeding Education for Professionals.*

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