PURPOSE: To establish and promote a philosophy on breastfeeding that is congruent with the recommendations and breastfeeding policy statements published by the American Academy of Pediatrics [AAP] and the American College of Obstetricians and Gynecologists.

POLICY STATEMENT: The goal is to assure that all women who choose to breast-feed will have a successful and satisfying experience through education and support by health care professionals at Sarasota Memorial Hospital (SMH). Exclusive breastfeeding will be the recommended nutrition for newborns as per the AAP guidelines which firmly adheres to the position that breastfeeding ensures the best possible health as well as the best developmental and psychosocial outcomes for the infant.

DEFINITIONS: “Normal Newborn” is the term infant [≥37 weeks gestation] with no known medical problems.

EXCEPTIONS: 1. Mothers who choose formula for their method of feeding.
2. Clear contraindications to breastfeeding include:

**MATERNAL:**
- HIV
- Human T-lymphotropic virus (HTLV)-1 and HTLV-2 infection
- Herpes simplex virus infection when a lesion is present on the breast
- Active tuberculosis (milk can be pumped and given to baby by another care provider)
- Mothers that are on medications that contraindicate breastfeeding (e.g. antimetabolites, cancer chemotherapy, therapeutic doses of radioactive pharmaceuticals, penicillamine).
- Mothers who use illicit drugs

**INFANT:**
- Galactosemia

In the face of any situation where the risk is unclear, the benefits should be weighed against the theoretic risk. The decision will be made on an individual basis. When the risk is temporary, the mother should be taught methods to maintain her milk production.

➢ **First Feeding**
   a) Breastfeeding should be initiated within the first hour of life in the majority of cases or as soon as possible in the delivery room, recovery area or post-partum area.

   b) The first feeding will be evaluated by a nurse. Hand expressed drops of colostrum into infant’s mouth or latch at the breast is considered the “First Feeding”.

➢ **During the course of the mother’s hospitalization, she shall receive instruction on and be evaluated for:**

   a. Knowledge of:
      - the benefits of breastfeeding
      - the importance of exclusive breastfeeding and AAP recommendation for exclusivity for 6 months
      - non-pharmacological options for labor pain relief
      - the importance of early skin to skin contact
      - the benefits of 24-hour rooming-in
      - feeding infant on demand
      - frequency of feeding to establish milk supply
      - effective positioning and latch techniques
      - recommendations for continuation of breastfeeding after introduction of complimentary foods at 6 months

   b. Nutritional guidelines and expectations:
• Normalcy of weight loss (average of 7%, not to exceed 10% in term newborns)
• Normal timing to regain birth weight (by day 10)
• Expected feeding volumes in first 2 days: 1 – 2 teaspoons (5-10 mL) per feed
• Indicators of adequate hydration and nutrition: yellow bowel movements by day 4 – 5

c. Positioning, latch, nutritive suckling, and swallowing

d. Hand expression and if indicated, use of breast pump

e. The recommended follow-up care. See ‘Follow Up Appointments’ page 8.

f. Reasons for contacting the clinician regarding breastfeeding include, but are not limited to:
• Daily goals for output not met (1st 24 hours - 1 void & 1 stool (black); 2nd 24 hours - 2 voids & 2 stools (greenish/black); 3rd 24 hours - 3 voids & 3 stools (greenish/yellow); 4th – 5th 24 hours – greater than or equal to 4-6 voids & 4 stools (yellow/seedy)).
• Eating poorly or refusing to eat
• Increase in yellow color of skin or eyes
• Listlessness
• White patches found in baby’s mouth

➢ Normal Newborn Feeding Expectations
• Mothers will be encouraged to breastfeed on demand, i.e. to offer a minimum of 8 feedings at the breast every 24 hours and to nurse whenever the newborn shows early signs of hunger, such as increased alertness, physical activity, mouthing, or rooting. Crying is a late sign of hunger.
• During the first 24 hours for non-demanding babies, attempts should be made to arouse to feed after 4 hours have elapsed since the beginning of the last nursing.
• After 24 hours of life, if the baby has not latched onto the breast, or latches on but feeds poorly, the mother will be instructed to initiate hand expression and electric pumping 8 or more times every 24 hours. See ‘Supplementation’ on page 6 for feeding methods.
• Scheduled breastfeeding, and time limits for breastfeeding, will be avoided.

➢ Frequency of Feeds for Other Babies:
• **Late preterm baby:** follow the Late Preterm Order Set.
• **Baby with cleft lip/palate:** offer a minimum of 8 feedings every 24 hours and consult Speech Therapy upon delivery for feeding evaluation and
development of feeding plan. Additional resources:

- place a Lactation Consult
- CMS Cleft Palate Team

**Skin to Skin**

Skin to skin care is when baby wearing only diaper is in direct skin to skin contact on the mother or support person’s bare chest. Skin to skin will be encouraged for all mothers of well infants regardless of feeding choice or delivery method.

Uninterrupted until the first breastfeeding, and for at least the first hour for formula feeding infants. One nurse on the delivery team will be responsible for the baby and for helping with breastfeeding.

For the well infant, Apgars and vitamin K, ophthalmic ointment, and routine assessments can be completed while infant is skin to skin.

Infants delivered by cesarean section may need a brief period of separation from skin to skin in order to safely transfer mother from OR table and will be replaced as soon as the mother is able to respond to her infant and is medically stable.

Staff will encourage and enable couplets be transported to MBU skin to skin regardless of delivery method.

Mothers will be educated on the benefits of skin to skin and it will be encouraged throughout hospital admission.

When mother is not available dad/support person may provide skin to skin care.

Skin to skin or delay of skin to skin due to medical contraindication or safety concern will be documented in the electronic medical record.

**Rooming-In**

24-hour rooming in will be encouraged for all couplets regardless of feeding choice. 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.

Routine newborn procedures will be performed at the mother’s bedside. If separation of couplet is necessary, the reason, location and time of separation will be documented. Couplet ID bands will be verified by staff member and mother at time of separation and upon reuniting.

For mothers who request their baby to be cared for away from her bedside, exploration of this request will be made and education given regarding benefits of keeping infant in close proximity will be completed.

Education will be documented in the medical record. Exceptions may be made in case of surrogacies or
adoptions.

- **Pacifiers**
  Pacifiers will not be routinely given to full-term breastfeeding newborns by the staff. Newborns undergoing painful procedures (e.g., circumcision) may be given a pacifier or gloved finger with or without 24% sucrose solution or a mother's colostrum as a method of pain management during the procedure. The infant will not return to the mother from circumcision with a pacifier.
  Education will be given that breastfeeding has been shown to have analgesic properties and also is an effective comfort strategy before, after or during a painful intervention.
  If a mother requests a pacifier, education should be given on the negative effects pacifiers can have on breastfeeding and to routinely offer breastfeeding rather than a pacifier. Reinforcing that a pacifier should not be used to diminish the frequency or duration of breastfeeding.
  After breastfeeding is well established, (approximately 3 – 4 weeks) pacifiers may be introduced due to their role in SIDS risk reduction.
  Documentation of education on pacifier use will be completed. This education will be documented in the EMAR.

- **Breastfeeding Assessments**
  Breastfeeding assessment, teaching, and documentation will be done frequently with the mother throughout each nursing shift. After each feeding, staff will document information about the feeding in the infant’s medical record. This documentation may include the latch, the position, the breastfeeding assessment (for observed feedings) and any problems encountered. For feedings not directly observed, maternal report may be used. Twice a shift, a direct observation of the baby’s position and latch-on during feeding will be performed and documented so that breastfeeding is accurately assessed.

- **Nipple Care**
  Routine use of nipple creams, ointments, or other topical preparations will be avoided unless such therapy has been indicated for a dermatologic problem.
  Mothers with sore nipples will be observed for latch-on techniques and will be instructed to apply expressed colostrum or breast milk to the areola after each feeding.

- **Supplementation**
It is uncommon for breastfeeding term newborns to need any supplementation during the first week, thus, routine supplements should not be given to breastfeeding newborns unless ordered by a physician. Formula will be given to breastfeeding babies only when medically indicated such as hypoglycemia of an infant that is unresponsive to breastfeeding (nurses to follow hypoglycemia orders) or for medical indications as determined by the physician. Absence of urinary output in the first 24 hours is not considered a good reason to supplement.

For ordered supplementation: collected colostrum or if not available, formula will be fed to the newborn by an alternative method. A collaborative decision should be made among the mother, nurse, and clinician about the need to supplement the baby, the type of supplement, and mode of delivery (cup/spoon, syringe, supplemental nursing system) and volume.

Education on the possible negative consequences of choosing bottle feeding for temporary supplementation of the breastfeeding infant will be given and documented in the electronic medical record.

- **Hyperbilirubinemia Due to Physiologic Jaundice**
  - Clinicians should advise mothers to nurse their infants at least 8 – 12 times per day for the first several days.
  - Routine supplementation of non-dehydrated breastfed infants should be avoided.
  - Newborns with hyperbilirubinemia may continue breastfeeding unless there are specific orders from the physician to the contrary.
  - Providing appropriate support and education to breastfeeding mothers increases the likelihood that breastfeeding will be successful.
  - Formula supplementation should be a collaborative decision among the mother, nurse and clinician and include the type of supplement, mode of delivery, and volume.
  - Treatment of jaundice should be arranged to avoid separation of mother and baby and encourage skin to skin contact.

- **Weight loss greater than 10%**
  Weight loss greater than 10% may indicate a possible breastfeeding problem and requires more intensive evaluation of breastfeeding and possible intervention to correct problems and improve milk production and transfer. Re-evaluation of breastfeeding by the Pediatrician and certified lactation nurse is required:
  - Review of maternal history for possible
explanations for infant weight loss including breast pathology/surgery, diabetes, hemorrhage
  - Place a Lactation Consult Order
  - Assess hydration status
  - Evaluate positioning & latch
  - Evaluate evidence of milk transfer
  - Assess for tongue tie
  - Nurse to evaluate all feedings during shift
  - Consider delaying discharge
  - Recommend follow up at Pediatrician office 24 hours after discharge
  - Recommend follow up at SMH Latch Clinic

- **Partial Breastfeeding**
  Reasons will be explored with mothers who choose partial breastfeeding and will be educated on the benefits of exclusive breastfeeding and the possible negative consequences on breastfeeding if supplementation of formula is used. Should they still prefer to practice partial breastfeeding, their decision will be respected. The education given, and their feeding preference, will be documented in the medical record.

Mothers who choose partial formula feeding or full formula feeding will receive written and verbal education individually on the following and this will be documented in the electronic medical record:
  - good hand hygiene
  - utensil and equipment cleaning
  - appropriate formula reconstitution
  - accuracy of measurement of ingredients
  - safe handling
  - proper storage
  - appropriate feeding methods
  - Group talk of formula and bottle use will be avoided

- **Prior to discharge**
  An educational checklist designed to complement each mother’s needs is to be used by the nursing staff to help address any outstanding questions or concerns. Each mother will receive a New Beginnings handbook in English or Spanish.
  Mothers will also be given the names and telephone numbers of SMH resources (Latch Clinic) and community resources (Healthy Start, Le Leche League, WIC, etc.) to contact for help with breastfeeding.
  Couplets and families will be encouraged to attend the daily MBU Discharge Celebration at which breastfeeding education will be reviewed.
  Group talk of formula and bottle use will be avoided.
  There will be no display of formula in the Celebration
Discharge class and any formula teaching will be done on an individual basis.

- **Follow Up Appointments**
  All newborns will be referred to a physician or their physician extender for a visit on the 3rd to 5th day of age or within 24 to 72 hours of discharge. Babies at high risk should be seen within 24 to 48 hours of discharge.

**PROCEDURE FOR MOTHERS WHO ARE SEPARATED FROM THEIR NEWBORNS FOR MEDICAL REASONS:**

- Mothers who whose baby is sick or delivered prematurely may not be aware of the benefits of human milk for their newborns and commonly base their decisions on health-related issues. Staff (physicians and nurses) will therefore stress the protective properties of breast milk and recommend mothers provide breast milk without necessarily making the commitment to breastfeed. For infants who qualify, the staff and physicians will discuss and education mothers on the option for human donor milk as may be needed for premature or sick newborns (see Nursing Procedure “nur 53 Use of Donor Breast Milk”).

- The responsibility for initiating and maintaining an expressing or pumping routine, at least 8 – 12 times in 24 hours with a hospital grade pump will belong to the nursing staff and should begin within the first 6 hours postpartum, or as soon after delivery as the mother is stable. The aim is to mimic the optimal breastfeeding stimulation provided by a healthy full-term newborn (see Nursing Procedure nur24 “Collection, Storage and Handling of Expressed Breast Milk; Use of Pump and Pump Room”).

- Mothers who are separated from their newborns will be:
  - Assisted and instructed on how to use the double electric pump 8 – 12 times in 24 hours, with no period greater than 5 hours between 2 sessions
  - Provided a pumping log to record their pumping history
  - Taught proper collection, storage, and labeling of human milk (see Nursing Procedure nur24 “Collection, Storage and Handling of Expressed Breast Milk; Use of Pump and Pump Room”).
  - Assisted with obtaining electric pump for home usage prior to discharge
  - Encouraged to practice skin–to-skin care as soon as the baby is stable
  - Encouraged to initiate non-nutritive suckling as soon as the mother’s and baby’s condition permits
  - Encouraged to initiate breastfeeding on demand
as soon as the mother’s and baby’s condition allows.

**PROCEDURE RELATED TO THE NEWBORN EXPOSED TO NARCOTICS:**

- **The Drug Dependent Mother**

  a. Women who meet the following criteria should be supported in their decision to breastfeed their infants:

    - Women who have been abstinent from illicit drug use or licit drug abuse for 90 days prior to delivery and have demonstrated the ability to maintain sobriety in an outpatient setting.
    - Women who have a negative maternal urine toxicology testing at delivery except for prescribed medications.
    - Women engaged in substance abuse treatment who have provided their consent to discuss progress in treatment and plans for postpartum treatment.
    - Women who plan to continue in substance abuse treatment in the postpartum period.
    - Women who received consistent prenatal care.
    - Women who do not have a medical contraindication to breastfeeding (such as HIV).
    - Women who are not taking a psychiatric medication that is contraindicated during lactation.
    - Stable methadone-maintained women wishing to breastfeed should be encouraged to do so regardless of maternal methadone dose.

  b. Women under the following circumstances could put their infants at risk with breastfeeding:

    - Women with positive maternal urine toxicology testing for drugs of abuse or misuse of licit drugs at delivery.
    - Women relapsing to illicit substance use or licit substance misuse in the 90-day period prior to delivery.
    - Women who did not receive prenatal care.
    - Women who are not willing to engage in substance abuse treatment or who are engaged in treatment but are not willing to provide consent for contact with the counselor.
    - Women who do not have confirmed plans for postpartum substance abuse treatment and pediatric care.
    - Women who demonstrate behavioral qualities or
other indicators of active drug use.
- Women with concomitant use of other prescription (i.e. psychotropic) medications.
- Women who engaged in prenatal care and/or substance abuse treatment during or after the second trimester.
- Women who attained sobriety only in an inpatient setting.

- A mother who is enrolled and compliant in PAR (place ICM consult to verify compliance), who has been free from illicit drug use or licit drug abuse for at least 90 days prior to delivery and whose admission urine drug screen is positive only for methadone may breastfeed.

- A mother who has been prescribed a narcotic based medication from her provider, should have a urine drug screen and test positive only for that medication. Begin collaboration with Pediatrician and Pediatric Pharmacist.

- all Pediatrician about mothers who desire to breastfeed who fall into any of the categories listed above in the section, 1.b. “Women under the following circumstances could put their infants at risk with breastfeeding”.

**Formula Marketing**

For mothers who intend to breastfeed, distribution of formula on discharge will be discouraged, unless medically indicated. For breastfeeding mothers who intend to feed their newborns with formula, the distribution of formula on discharge will be consistent with the physician’s written orders.

Sarasota Memorial Hospital will not provide formula marketing materials to mothers and will discourage promotional paraphernalia and marketing efforts in all areas accessible to patients. Procurement of formula, bottles, nipples and any other formula vendor items will be conducted through SMH Supply Chain Department at fair market value.

Formula company vendors will have no direct communication with pregnant or postpartum women during prenatal visits, hospital admission, or at any of SMH’s Facilities.

SMH facilities, pregnant women, and postpartum mothers will not be given free gifts, marketing material, breastfeeding education/events, coupons or other items from formula company vendors.
All educational materials for breastfeeding mothers are free from messages that promote infant foods/drinks other than breast milk.

PROCEDURES RELATED TO SMH STAFF:

1. Prenatal education on breastfeeding including the topics required in the Baby Friendly Guidelines and Evaluation Criteria will be offered to and available in written form for pregnant women obtaining prenatal services in SMH OB offices. Documentation of that education will be made in the prenatal record.

2. Current information and ongoing educational activities regarding lactation will be provided to all maternal/child hospital personnel. The Manager, Childbirth Education & Lactation Services will be responsible for implementation and review of breastfeeding education content.

3. New nurse employees in the W&C Division will receive breastfeeding education and practical skills instruction from their preceptor during orientation. New employees will be given a printed copy and shown how to access this breastfeeding procedure on the SMH intranet. MBU nurses will also be scheduled during orientation to shadow the Discharge Facilitator/Lactation Nurse for rounding for additional educational opportunity.

4. Nurses in LD and MBU will be required to have a minimum of 15 hours identified by the WHO, to have 5 hours of competency skills training for a total of at least 20 hours education during their employment on these units. Records of this training will be kept by the Manager, Childbirth Education & Lactation Services. This will be completed within 6 months of hire.

5. The Manager of each unit in the W&C Division and the Manager of Childbirth Education & Lactation Services will be responsible for ensuring that nurses in their units are trained per this procedure.

6. For staff who are hired having had previous lactation/breastfeeding education, that education curriculum will be reviewed and verified by the Manager, Childbirth Education & Lactation Services/MBU Advanced Practice Nurse and any recommendations for additional education will be made as necessary.

7. Physicians of the Pediatric Department who have privileges and Active Status on the Mother Baby Unit, per vote of that Department 12/8/15, will be required to obtain one-time, 3-hours of breastfeeding education during their first hospital privilege time period. In addition, all
8. Information about breastfeeding will be included in all childbirth education classes and other prenatal education activities to increase the incidence and duration of breastfeeding.

**RESPONSIBILITY:**

9. Hospital administrative, medical, nursing and nutrition staff establish a strategy, which promotes breast-feeding through the formation of an interdisciplinary team.

10. Information regarding the 10 Steps and statement on breast milk substitutes will be displayed in areas that serve women and children such as MBU, LD, OBECC and main ECC.

SMH/FPG staff and physicians that interact with childbearing women and babies.
REFERENCES:


AUTHOR(S): J. Isaac, MD, J. Tolosa, MD, Leah Brown RN, CBC., Mary O’Connor, MSN, RNC, IBCLC

REVIEWING AUTHOR(S): Pediatric Department, 8/11/16
APPROVALS:

<table>
<thead>
<tr>
<th>Committees/Sections/Departments:</th>
<th>Pediatric Department</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>8/11/16</td>
</tr>
<tr>
<td>Director/Responsible Owner:</td>
<td>Pam Beitlich, Director</td>
<td>10/11/6</td>
</tr>
<tr>
<td>Vice President/Executive Director:</td>
<td>Connie Andersen, CNO</td>
<td>10/12/16</td>
</tr>
<tr>
<td>Chief of Medical Operations:</td>
<td>Dr. Stephen Taylor, CMO</td>
<td>10/13/16</td>
</tr>
<tr>
<td>(if clinical policy or appropriate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief of Staff:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(if clinical policy or appropriate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Executive Committee:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(if clinical and review requested by CMO and COS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Executive Officer:</td>
<td>David Verinder, CEO</td>
<td>10/14/16</td>
</tr>
</tbody>
</table>