

# Providing Breastfeeding Support: Model Hospital Policy Recommendations



Fourth edition  
**2022**

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The California Department of Public Health, Maternal, Child and Adolescent Health (MCAH) Division is responsible for developing the model hospital policy recommendations that California hospitals can use to develop their infant feeding policy and practices. This fourth Edition of **Providing Breastfeeding Support: Model Hospital Policy Recommendations** was developed under the leadership of the Perinatal Advisory Council: Leadership, Advocacy and Consultation's (PAC/LAC) with contributions from the expertise of the Regional Perinatal Programs of California (RPPC) as authors, reviewers, and editors. Every effort has been made to ensure accuracy, consistency, and timeliness of inclusions to support hospitals throughout the state of California. All recommendations are evidence-based and supported by national organizations. Individual contributors are listed below.

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- ▶ promotes access to risk–appropriate perinatal care for pregnant individuals and their infants through parental and infant transport and regional quality improvement activities;
- ▶ works to reduce adverse parental and neonatal outcomes; and
- ▶ strives to eliminate disparities in infant and parental morbidity and mortality.

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# Introduction

## A. California Legislation and Regulations

California state laws and regulations require any general acute care hospital providing care for infants must have an infant feeding policy that promotes breastfeeding and by 2025 adopt additional hospital practices that promote and support breastfeeding. **Providing Breastfeeding Support: Model Hospital Policy Recommendations**, utilizes evidence-based practices that promote, protect, and support breastfeeding across the continuum of parent-child care.<sup>1</sup> The Model Hospital Policy Recommendations are referred to in the following law:

*Breastfeeding* (Cal. Health and Safety Code § 123367). All general acute care hospitals and special hospitals, as defined in subdivisions (a) and (f) of Section 1250, that have a perinatal unit shall, by January 1, 2025, 1) adopt the “Ten Steps to Successful Breastfeeding,” as adopted by Baby-Friendly USA, per the Baby-Friendly Hospital Initiative, OR 2) an alternate process adopted by a health care service plan that includes evidenced-based policies and practices and targeted outcomes, OR 3) the Model Hospital Policy Recommendations as defined in paragraph (3) of subdivision (b) of Section 123366.<sup>1</sup>

## B. Background

**Providing Breastfeeding Support: Model Hospital Policy Recommendations** (hereafter referred to as “Model Hospital Policy”) is based on current evidence-based best practices organized by periods of perinatal care, resulting in some topics being a major focus in a specific time period and then reinforced in another. This document is a framework intended to allow hospitals to modify and construct policies and procedures that best suit their facility and can be incorporated into standard parent-baby care.

The recommendations apply to normal, healthy, full-term infants and are not intended to apply to the specific needs of high-risk infants. Reference to “parent” throughout the Model Hospital Policy is intended to be inclusive of all birthing parents and lactating individuals. Clinicians should practice respect and compassion in recognizing unique subsets of patients for breastfeeding or chest feeding in family-centered care. “Chest feeding” is a term suggested for respectful inclusion of transgender and gender nonbinary people. Refer to [Hospital Breastfeeding Policy Resources](#) for more information on Transgender and Gender Nonbinary people.

*Providing Breastfeeding Support: Model Hospital Policy Recommendations* promotes the normal infant feeding method, defined by the American Academy of Pediatrics as “exclusive

breastfeeding for the first six months of life, followed by breastfeeding and the introduction of iron-rich complementary foods around the age of six months, with continuation of breastfeeding for one year or longer as mutually desired by parent and infant.”<sup>2</sup>

“There is overwhelming scientific evidence that human breast milk is the optimal food for human infants. Professional health organizations and government entities actively promote breastfeeding including, but not limited to: the American Academy of Pediatrics (AAP), the American College of Obstetrics and Gynecologists (ACOG), the American Academy of Family Physicians (AAFP), the Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN), the Academy of Nutrition and Dietetics (formally the American Dietetic Association), the U.S. Department of Health and Human Services (DHHS), the American Public Health Association (APHA), the World Health Organization (WHO), and the United States Breastfeeding Committee.”<sup>3</sup>

### **C. Baby-Friendly Hospital Initiative**

The Baby-Friendly Hospital Initiative (BFHI) was launched in 1991 by the WHO and the United Nations Children’s Fund (UNICEF) as a global program to promote, protect, and support breastfeeding. It encourages the broadscale implementation of the Ten Steps to Successful Breastfeeding (listed below) and the International Code of Marketing of Breast-milk Substitutes (WHO Code).<sup>4</sup>

The BFHI assists hospitals in giving parents the information, confidence, and skills necessary to successfully initiate and continue breastfeeding their babies and gives special recognition to hospitals that have done so. The Ten Steps have been shown to increase breastfeeding initiation and duration.<sup>5</sup>

Each of the Ten Steps contributes to improving breastfeeding outcomes. Optimal impact on breastfeeding practices and thereby on parental and child well-being is achieved when all Ten Steps are implemented as a package.<sup>4</sup> A dose-response relationship exists between the number of baby-friendly hospital practices and breastfeeding exclusivity and duration.<sup>5</sup> The more baby-friendly hospital practices parents encounter, the better the breastfeeding outcomes.<sup>6</sup>

The Baby-Friendly Hospital Initiative Global Standards from the “Implementation Guidance: Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services – the Revised Baby-friendly Hospital Initiative”<sup>4</sup> are referenced throughout this document. See Appendix for numbered Global Standards.



The Ten Steps to Successful Breastfeeding (revised 2018) are:<sup>4</sup>

### **Critical Management Procedures**

- 1.A. Comply fully with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly Resolutions.
- 1.B. Have a written infant feeding policy that is routinely communicated to staff and parents.
- 1.C. Establish ongoing monitoring and data management systems.
2. Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.

### **Key Clinical Practices**

3. Discuss the importance and management of breastfeeding with pregnant individuals and their families.
4. Facilitate immediate and uninterrupted skin-to-skin contact and support parents to initiate breastfeeding as soon as possible after birth.
5. Support parents to initiate and maintain breastfeeding and manage common difficulties.
6. Do not provide breastfed newborns any food or fluids other than breast milk unless medically indicated.
7. Enable parents and their infants to remain together and to practice rooming-in 24 hours a day.
8. Support parents to recognize and respond to their infants' cues for feeding.
9. Counsel parents on the use and risks of feeding bottles, teats and pacifiers.
10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

## D. Baby-Friendly USA

Baby-Friendly USA, Inc. (BFUSA) is the accrediting body and national authority for the BFHI in the United States. In this capacity, BFUSA is responsible for coordinating and conducting all activities necessary to confer the Baby-Friendly® designation and to ensure the widespread adoption of the BFHI in the United States.

To pursue this designation and for more information visit [www.babyfriendlyusa.org](http://www.babyfriendlyusa.org).

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<sup>1</sup> California Health and Safety Code: HSC. Division 106. Personal Health Care (including maternal, child, and adolescent) [123100 - 125850] Part 2. Maternal, child, and adolescent health [123225 – 124250 Chapter 1. General Provisions [123225 - 123371] ARTICLE 3. Breast Feeding [123360 - 123367]: [https://leginfo.legislature.ca.gov/faces/codes\\_displayText.xhtml?lawCode=HSC&division=106.&title=&part=2.&chapter=1.&article=3](https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=106.&title=&part=2.&chapter=1.&article=3).

<sup>2</sup> Eidelman AI, Schanler RJ, Johnston M, et al. American Academy of Pediatrics (AAP) Policy Statement: Breastfeeding and the use of human milk. *Pediatrics*. 2012; 129(3):3827-e841. doi:10.1542/peds.2011-3552

<sup>3</sup> Haydu S, Gamba R. California Infant Feeding Guide. California Department of Public Health. Sacramento, CA. 2016: <https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/NUPA/California-Infant-Feeding-Guide-2016.pdf>.

<sup>4</sup> World Health Organization. *Implementation Guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services-the revised Baby-friendly Hospital Initiative*. Geneva, Switzerland; 2018. <https://apps.who.int/iris/handle/10665/272943>.

<sup>5</sup> Perrine CG, Scanlon KS, Li R, Odom E Grummer-Strawn L. Baby-Friendly Hospital Practices and Meeting Exclusive Breastfeeding Intention. *Pediatrics*. 2012;130 (1):54-60. doi:10.1542/peds.2011-3633

<sup>6</sup> Jung S, Nobari T, Shaley S. Breastfeeding Outcomes Among WIC-Participating Infants and Their Relationships to Baby-Friendly Hospital Practices. *Breastfeeding Med*. 2019; 14(6):424-431. doi:10.1089/bfm.2019.0004

# Part I: Review and Revise Existing Infant Feeding Policy

## A. Recommended Procedures for Reviewing and Revising an Infant Feeding Policy as required by the Hospital Infant Feeding Act (Cal. Health and Safety Code § 123366)<sup>1</sup>

1. Designate the hospital departments and/or person(s) responsible for planning, implementing, and monitoring the Infant Feeding Policy. Hospital administration is responsible for this designation.
2. Analyze current benchmark breastfeeding data and complete a self-appraisal to establish a baseline of practices and improvement needs. Use the results of this self-appraisal to define the current unit culture and guide the change process and Infant Feeding Policy formulation. Since culture changes may be difficult to sustain, it is recommended that this self-appraisal be repeated annually, and practices align with the Infant Feeding Policy.<sup>2,3,4</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for a Hospital Self-Appraisal.)
3. Review the hospital Infant Feeding Policy and practices that are congruent with the WHO/UNICEF Baby-Friendly Hospital Initiative (BFHI). This Infant Feeding Policy is written to meet the BFHI standards and advocates exclusive breastfeeding practice as optimum for the total health of both parent and infant.<sup>5,6</sup>
4. Review the Infant Feeding Policy per organization policy review standards and inform staff of any changes prior to implementation. (Global Standard 1.c.2)<sup>7</sup>
5. Ensure the Infant Feeding Policy is based on recent scientific evidence, addresses all areas of the hospital where childbearing individuals and infants may visit, and includes protocols and standards that promote, protect and support breastfeeding. (Global Standards 1.b.2 & 1.b.3)<sup>7</sup>
6. Establish measures for ongoing monitoring using publicly available data and data management systems to assess compliance processes and clinical practices to guide improvement efforts. (Global Standard 1.c.1)<sup>7</sup>
7. Ensure this Infant Feeding Policy is readily available for reference in the perinatal and pediatric unit as required in the State of California Hospital Infant Feeding Act. (Global Standard 1.b.1)<sup>7</sup>
8. Communicate the written Infant Feeding Policy to all health care staff, stating that breast milk is the standard for infant feeding.

9. Prominently display a statement that the hospital adheres to the WHO International Code of Marketing of Breast-milk Substitutes and a summary of the Infant Feeding Policy in all areas that serve parents, infants and young children.<sup>5</sup> This statement should be written in a low literacy level and in the languages most commonly understood by hospital visitors. (Global Standard 1.b.2)<sup>7</sup> Ensure that there are clearly written accountability mechanisms to address complaints and a clear comment mechanism for parents and families.
10. Uphold the WHO International Code of Marketing of Breast-milk Substitutes by offering education and materials that promote human milk rather than other infant food or drinks and by refusing to accept or distribute free or subsidized supplies of breast milk substitutes, nipples and other feeding devices.<sup>5,6</sup> (Global Standards 1.a.1, 1.a.2, & 1.a.3)<sup>7</sup>
11. Document all patient education and care provided according to hospital guidelines.

## **B. Recommended Infant Feeding Policy Guidelines Specific to Non-Perinatal and Pediatric Units**

1. All areas of the hospitals that interact with parents and infants should have language in their policies regarding the promotion, protection, and support of breastfeeding. (Global Standard 1.b.2)<sup>7</sup>
2. The hospital should support breastfeeding parents admitted to non-perinatal and pediatric units to continue breastfeeding and/or pumping breast milk unless it is contraindicated by their condition. (Refer to [Hospital Breastfeeding Policy Resources](#) for a Contraindication Table.) Additionally, the hospital should include the following supports on non-perinatal units:
  - a. A lactation consultation should be offered to help support the parent to continue to breastfeed.
  - b. Unlimited visitation should be allowed to the breastfeeding infant and the caregiver.
  - c. The infant should be allowed to room-in with the parent when the parent is admitted to the hospital. If the parent is not capable of taking care of themselves and/or the infant, a responsible adult should be allowed to assist the parent and infant.
  - d. The admitting physician should be informed that the patient is breastfeeding and requested to prescribe medications compatible with breastfeeding.<sup>8</sup>

3. If a parent has a condition or is on a medication that is contraindicated for breastfeeding infants, breast milk should be expressed and discarded to maintain milk supply. Banked human milk is the preferred food while the parent is unable to breastfeed.<sup>8, 9, 10</sup> (Global Standards 6.4 & 6.5)<sup>7</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for medications that may be contraindicated for breastfeeding.)

## C. Recommendations Regarding the Important Role of Facility Administration

1. Ensure that hospital administrators and directors receive lactation education and technical assistance in guiding and overseeing implementation of policies and procedures that protect, promote, and support breastfeeding.<sup>5,11</sup>
2. Ensure that employees of manufacturers or distributors of breast milk substitutes, bottles, nipples, and pacifiers have no direct communication with parents. (Code of Marketing)
3. Ensure that the facility does not receive gifts, non-scientific literature, materials, equipment, money, or support for breastfeeding education or events from manufacturers of breast milk substitutes, bottles, nipples, and pacifiers.
4. Ensure that no parents or families are given marketing materials or samples or gift packs by the facility that consist of breast milk substitutes, bottles, nipples, pacifiers, or other infant feeding equipment or coupons for the above items.
5. Ensure that any educational materials distributed to breastfeeding parents are free from messages that promote or advertise infant food or drinks other than breast milk.
6. Ensure that professionals and departments responsible for implementing the Infant Feeding Policy are identified.

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<sup>1</sup> California Health and Safety Code: HSC. Division 106. Personal Health Care (including maternal, child, and adolescent) [123100 - 125850] Part 2. Maternal, child, and adolescent health [123225 – 124250 Chapter 1. General Provisions [123225 - 123371] ARTICLE 3. Breast Feeding [123360 - 123367]: [http://leginfo.legislature.ca.gov/faces/codes\\_displayText.xhtml?lawCode=HSC&division=106.&title=&part=2.&chapter=1.&article=3](http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=106.&title=&part=2.&chapter=1.&article=3)

<sup>2</sup> DiGirolamo AM, Grummer-Strawn LM, Fein SB. Do perceived attitudes of physicians and hospital staff affect breastfeeding decisions? *Birth*. 2003; 30(2):94-100. doi:10.1046/j.1523-536x.2003.00227.x

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- <sup>7</sup> World Health Organization. *Implementation Guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services—the revised Baby-friendly Hospital Initiative*. Geneva, Switzerland; 2018. <https://apps.who.int/iris/handle/10665/272943>.
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- <sup>11</sup> World Health Organization. *Guideline: Protecting, promoting, and supporting of breastfeeding in facilities providing maternity and newborn services*. Geneva. 2017. <https://apps.who.int/iris/bitstream/handle/10665/259386/9789241550086-eng.pdf;jsessionid=5EEB32BF8D19C8D0C4D678E561916EA1?sequence=1>

# Part II: Guidance for Implementing Model Hospital Policy Recommendations

## A. Recommendations Regarding Training and Education of Perinatal and Pediatric Staff and Medical Providers

### 1. Training Standards for Perinatal Staff, Pediatric Staff, and Medical Providers

- a. Perinatal and pediatric units develop and sustain a breastfeeding supportive culture and embrace evidence-based breastfeeding practices that ensure every parent and infant receives consistent and accurate breastfeeding education and support that are respectful of their beliefs and values.<sup>1,2</sup>
- b. Designated hospital staff determine the amount and content of training required by staff in non-pediatric units and roles based on their exposure to parents and infants.<sup>1</sup> (Global Standards 2.1, 2.2, & 2.3)<sup>1</sup>

### 2. Evidence-Based Training Competencies

- a. Competency of direct care providers to integrate evidence-based knowledge, skills, and attitudes into implementing best practices should be evaluated through use of an evidence-based competency focused training framework such as the World Health Organization (WHO) 2020 Competency Verification Toolkit.<sup>3</sup>
- b. The WHO 2020 Competency Verification Toolkit outlines performance indicators and defines essential competencies. WHO also organized 64 performance indicators by BFHI step.<sup>3</sup> The Competency Verification Toolkit provides a systematic evaluation of a direct care provider's ability to perform the following:
  - i. Engage in antenatal conversation with parents about breastfeeding that includes:
    - A) the importance of breastfeeding;
    - B) reasons why effective exclusive breastfeeding is important;
    - C) care practices a parent/infant dyad should experience at the birthing facility that should support breastfeeding; and
    - D) assessment of pregnant parent's knowledge about breastfeeding and their learning needs.

- ii. Support immediate and uninterrupted skin-to-skin contact/early initiation of breastfeeding by:
  - A) routinely implementing immediate, uninterrupted and safe skin-to-skin contact between breastfeeding parent and infant, regardless of method of birth;
  - B) employing a safety assessment when parent and baby are skin-to-skin during the first two hours postpartum, regardless of method of birth;
  - C) demonstrating safe care of the newborn in the first two hours post-birth;
  - D) engaging in a conversation with parents about why suckling at the breast in the first hour is important, when the baby is ready; and
  - E) describing to parents pre-feeding behaviors babies show before actively suckling at the breast.
  
- iii. Observe and support breastfeeding parents to maintain comfortable, adequate and effective breastfeeding by:
  - A) explaining infant feeding patterns in the first 36 hours of life;
  - B) describing signs of adequate transfer of milk in the first few days;
  - C) evaluating a full breastfeeding session;
  - D) helping breastfeeding parents achieve a comfortable and safe position for breastfeeding within the first six hours after birth and later as needed during the hospital stay;
  - E) helping breastfeeding parents achieve an effective and comfortable latch;
  - F) engaging in conversation with parents regarding ways to facilitate breastfeeding to prevent or resolve most common conditions of the lactating breasts (sore nipples, engorgement, parent who thinks they do not have enough milk, infants who have difficulty suckling, etc.);
  - G) engaging in conversation with parents regarding why effective exclusive breastfeeding is important for baby and for mother; and



- H) engaging in conversation with parents regarding the importance of rooming-in 24 hours per day.
- iv. Demonstrate how to effectively hand express breast milk.
- v. Help a breastfeeding parent to breastfeed a preterm, low-birth weight or sick baby by:
  - A) assisting breastfeeding parents to achieve a comfortable and safe position for breastfeeding with their preterm, late preterm or weak infant at the breast;
  - B) facilitating learning needs of parents of a preterm, late preterm or low-birth weight infant not suckling effectively at the breast;
  - C) engaging in conversation with parents separated from their preterm or sick infant regarding reasons to be with their infant in the intensive care unit; and
  - D) engaging in conversation with parents of a preterm, late preterm or vulnerable infant (including multiple births) regarding the importance of observing subtle signs and behavioral state shifts to determine when it is appropriate to breastfeed.
- vi. Demonstrate the skills needed for safe cup feeding an infant by:
  - A) engaging in conversation with parents who request feeding bottles, pacifiers and soothers without medical indication and explain potential impact on effective feeding at the breast; and
  - B) demonstrating how to safely cup-feed the infant when needed.
- vii. Help mothers who do not exclusively breastfeed by:
  - A) engaging in conversation with parents who intend to feed their baby formula, responding to concerns, preferences and values related to mixed feeding while encouraging exclusive breastfeeding;
  - B) demonstrating safe preparation of infant formula to parents who need that information; and
  - C) describing steps to feed an infant a supplement in a safe manner.

- viii. Develop individualized discharge feeding plans that include possible warning signs of infant undernourishment and dehydration and how to contact a health care professional after discharge.

### **3. Perinatal Staff, Pediatric Staff and Medical Providers Competencies**

1. Initial orientation to the Infant Feeding Policy should be completed within two weeks of hire for all nursing staff and other staff within the hospital that have a role in caring for breastfeeding parents and infants.
2. Health care professionals with lactation specialization should be responsible for planning, implementing and documenting training, which ensures that all perinatal and pediatric staff caring for parents and infants have the knowledge and skills needed for appropriate care and breastfeeding management.<sup>4</sup> The designated staff should regularly examine the care practices of units and staff and reinforce core competencies related to breastfeeding care and services.<sup>5</sup> At a minimum this designated staff should ensure that staff:
  - i. recognize the limitations of their own breastfeeding care knowledge and expertise;<sup>3</sup>
  - ii. know when and how to consult with a designated breastfeeding expert;<sup>3</sup> and
  - iii. can identify the role of lactation, human milk and breastfeeding in:
    - A) the optimal feeding of infants and young children; and
    - B) enhancing health and reducing:
      - 1) long-term morbidities in infants and young children; and
      - 2) morbidities in parenting individuals.
3. Assess at hiring and periodically thereafter the knowledge and skills of breastfeeding management, parent-infant care, interpersonal communications, and counseling.<sup>6</sup> Whenever prior education and/or training does not meet facility requirements, additional training and competencies should be verified within six months of hire, but ideally within three months of hire. In-service training and periodic updates with the appropriate content and duration to ensure compliance to this hospital breastfeeding policy should be provided as needed.<sup>4</sup>
4. The hospital determines the amount and content of the recommended training required by staff in non-pediatric units based on their occupational role and workplace exposure to parents and infants.<sup>1</sup> (Global Standards 2.1, 2.2, & 2.3)<sup>1</sup>

## **B. Recommendations Regarding Training and Education of Non-Perinatal and Pediatric Staff and Medical Provider**

Staff outside of the maternity unit are to receive breastfeeding training in order to understand the importance of the protection, promotion, and support of breastfeeding specific to their roles and workplace exposure to parent/infant dyads.<sup>6,7</sup> Examples of staff outside the maternity unit include, but are not limited to the following:

1. Pharmacist - Understand and identify common breastfeeding problems and the use of medications that affect breastfeeding parents, including but not limited to appearance in human milk, effects on milk production, and potential adverse effects on the infant; utilize resources for safe medication use such as LactMed, drug information services/references, and consult with the healthcare providers and breastfeeding parents as needed.
2. Social worker or discharge planner - Understand the importance of immediate skin-to-skin contact and provide resources in the community that support continued breastfeeding.
3. Anesthesiologist - Understand the importance of immediate skin-to-skin contact.
4. Radiologist - Identify resources for safe medication use during lactation and how to locate appropriate information regarding use of radioisotopes during lactation.
5. Registered Dietitian/Registered Dietitian Nutritionist - Provide parents with evidence-based information on breastfeeding and lactation related to milk supply and normal infant nutrition, including recognizing early feeding cues, identifying appropriate latch and adequate transferring of milk, assessing the nutritional status of the infant, and recognizing when to refer to an International Board of Lactation Consultant (IBCLC).
6. Food Service Specialist - Know the importance of practices that support exclusive breastfeeding.
7. Housekeeping staff - Know about practices that support breastfeeding, the hospital's philosophy on infant nutrition and who to contact when a parent needs help.
8. Speech therapist, Occupational therapist (OT) and Physical therapist (PT) - Know the importance of practices that support exclusive breastfeeding.

## C. Recommendations Regarding Assessment and Support During Prenatal and Antepartum Patient Education

### 1. General Guidelines for Education and Support

- a. Education and support are provided to parents and their families and documented in the medical record. Education is based on clear health communication principles which should guide words used, directions given, and materials provided.<sup>8,9,10</sup> Education and support are individualized by considering a parent’s culture, primary language, literacy level, feeding goals, previous breastfeeding experience, current knowledge, and level of confidence.<sup>11</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for Patient Education Materials.) (Global Standard 5)<sup>1</sup>

### 2. Hospital-Based Prenatal Clinic

- a. Provide an education plan in the prenatal clinic for the development, implementation, evaluation, and revision of breastfeeding education to be offered to pregnant individuals and their families, which includes key teaching points.<sup>9</sup>
- b. During the first visit, assess breastfeeding intention, experience, and confidence by using open-ended questions. Examples of open-ended questions are: “What have you heard about breastfeeding?” and “What are two questions you have about feeding your baby breast milk?”<sup>12</sup>
- c. Identify those in their personal support system and include them whenever possible.<sup>12</sup>
- d. Provide culturally and literacy-level appropriate patient education and materials related to evidence-based infant feeding regarding the importance of breastfeeding, the basic lactation process, initiation of breastfeeding in the hospital setting, the benefits of exclusive breastfeeding for the infant’s first six months and the continued benefits after six months when other foods are provided, and the impact of supplementation with breast milk substitutes on breast milk supply and gut microflora.<sup>12,13,14</sup> (Global Standards 3.1, 3.2, & 3.3)<sup>1</sup> Adverse impacts of supplementing with breast milk substitutes should be shared in a way that respects the parent and allows them to make an informed decision regarding infant feeding.
- e. Assess patient’s future reproductive plan and birth spacing, and counsel the patient regarding potential impact of family planning options on breastfeeding.<sup>15,16</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for information on Family Planning.)

- f. Advise parents of the adverse effects of substance use while breastfeeding.<sup>17</sup> Advise that secondhand smoke, parental alcohol and cannabis consumption, and illicit and prescription drug use have negative effects on the infant and on the breastfeeding process.<sup>17,18,19</sup> Discourage parents from using these substances and provide resources and support to abstain.<sup>17</sup>
- g. Distribute educational materials to pregnant individuals that are free of product names, images or logos of breast milk substitutes, feeding bottles and teats in alignment with WHO Code.<sup>20</sup>
- h. If breast milk substitute use is anticipated, or necessary due to contraindications to breastfeeding, education on the safe preparation and use of infant breast milk substitutes should be provided on an individual basis and not in a group setting.<sup>14,21</sup>
- i. Coordinate and collaborate with community-based prenatal clinics and public health programs, such as The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), to provide education and support for breastfeeding to pregnant and breastfeeding individuals.<sup>14</sup> (Global Standards 10.1 & 10.2)<sup>1</sup>

### **3. Antepartum Assessment Within the Hospital**

- a. During the first clinical encounter, ask expectant parents and their support persons what they have heard about breastfeeding.<sup>12</sup>
- b. A registered nurse should conduct a clinical assessment that includes:
  - i. parental lactation history;
  - ii. physical breast exam to assess breast and nipples to identify potential challenges to breastfeeding such as flat or inverted nipples or previous breast surgery, while also identifying any concerns from the patient;
  - iii. identifying educational needs and providing appropriate education;<sup>12</sup>
  - iv. assessing a patient's future reproductive plan and birth spacing and counseling them on the potential impact of family planning options on breastfeeding;<sup>15,16</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for information on Family Planning.) and
  - v. screening for fetal and parental medical conditions, medications and infectious diseases.<sup>17,18,19</sup>

- A) Refer to [Hospital Breastfeeding Policy Resources](#) for information on Medications and Lactation.
- B) Refer parents with the following who desire to breastfeed to a clinical provider
  - 1) HIV.
    - a) discuss the risk of transmission and encourage them to obtain comprehensive counseling from their health care professionals.<sup>22,23</sup>
  - 2) History of substance use that adversely impacts breastfeeding.
    - a) Advise parents of the adverse effects of substance use on breastfeeding.<sup>17,18</sup> Educate that secondhand smoke, parental alcohol and cannabis consumption, and illicit and prescription drug use have negative effects on the infant and on the breastfeeding process.<sup>17,18,19</sup>
    - b) Discourage parents from using these substances and provide opportunities and support to abstain.<sup>17,18,19</sup>
    - c) Counsel parents who choose not to end their use of these substances or who are unable to do so. Provide parents individual advice on the risks, benefits, and alternatives of breastfeeding depending on their specific circumstances.<sup>17</sup>
- C) Review hospital practices that occur immediately after birth and explain to the parent that their infant is observed and monitored during skin-to-skin contact and through the progression of the nine instinctive stages.<sup>24,25,26</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for Newborn’s Nine Instinctive Stages.)
- D) When appropriate, request a lactation consult.

## **D. Recommendations for Assessment and Support During Intrapartum and Immediate Postpartum Patient Education**

### **1. Intrapartum Assessment and Education**

- a. Ask expectant parents and their support persons what they have heard about breastfeeding and their feeding plans.<sup>12,13</sup>

- b. Validate the patient’s understanding regarding the benefits of exclusive breastfeeding and the impact that supplementation with a breast milk substitute may have on their breast milk supply and meeting their breastfeeding goals.<sup>12</sup>
- c. Provide the parent and/or other support person(s) anticipatory guidance about what to expect in the immediate post-delivery time period and the importance of this private, uninterrupted, critical time to breastfeed and bond with the infant.<sup>12,25,26</sup>
- d. Educate the parent that immediate and uninterrupted safe skin-to-skin contact has multiple benefits including regulating the infant’s temperature, heart rate and breathing, and encourages infant-led breastfeeding in the first hours of life.<sup>4,25,26,27</sup>
- e. Inform the parent about labor comfort measures and pain management including non-pharmacological and pharmacological choices and their potential risks and benefits including impact on breastfeeding.<sup>28,29</sup> Associations impacting breastfeeding and lactation have been made for:
  - i. labor epidurals (especially those with higher fentanyl doses), which may lower breastfeeding success rates; <sup>30,31,32,33</sup> and
  - ii. opioid administration, which may affect the normal suckle reflex in the newborn in the first one to two hours of life.<sup>28,31,34</sup>
- f. Assess for parental conditions and use of medications, tobacco, alcohol, and other substances and request appropriate consult.<sup>17,35</sup>

## **2. Immediate Postpartum Support**

- a. Offer the parent assistance in breastfeeding as needed as soon as possible during the first hours after birth and as the newborn appears ready.<sup>36,37</sup> (Global Standard 4.2)<sup>1</sup>
- b. Protect the first hours after birth as a developmentally unique time to enhance parent and infant bonding and stabilization, regardless of feeding choice. Limit extra visitors, non-urgent tasks, and social media to facilitate bonding and early breastfeeding.<sup>38,39</sup>
- c. Offer safe skin-to-skin care immediately after vaginal and cesarean births and encourage skin-to-skin for all parents and newborns without complications, regardless of feeding choice.<sup>35</sup>

- d. Prioritize care and assessment of a compromised newborn over skin-to-skin contact.
- e. Ensure immediate, uninterrupted safe skin-to-skin contact to facilitate early breastfeeding behaviors and breastfeeding success until the nine instinctive stages are completed.<sup>24,39</sup> These developmental tasks take approximately 1½ to 2 hours.<sup>24,25,26</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for the Newborn's Nine Instinctive Stages.) Safe skin-to-skin should continue until the completion of the first feeding for breastfed infant, unless parent and/or infant is medically unstable.<sup>24,25,26,35</sup> (Global Standard 4.1)<sup>1</sup>
- f. Do not interrupt safe skin-to-skin contact until completion of the first feeding or one hour for breast milk substitute fed infants.<sup>36,40</sup> (Global Standard 4.1)<sup>1</sup>
- g. Perform the following safe skin-to-skin practices immediately after birth:
  - i. Place the well and alert naked infant prone on the parent's bare chest.<sup>4</sup>
  - ii. Ensure the newborn's head is on the parent's chest and is turned to one side. The head should be in a sniffing position with the neck straight and the chest and shoulders facing the parent. The infant's legs should be flexed and a pre-warmed blanket placed over the infant's back.<sup>26,41,42</sup> Perform continuous supervision and safe positioning to minimize the risk of Sudden Unexpected Postnatal Collapse.<sup>4</sup>
  - iii. Dry the infant and avoid wiping the hands and the face as the smell of amniotic fluid assists with the early initiation of breastfeeding.<sup>43</sup>
  - iv. Replace damp blankets as needed. You may place cap on the infant's head, assess and assign Apgar scores, and place pre-warmed blankets over both parent and infant(s). Apply a diaper if desired.<sup>35</sup>
  - v. Complete assessments, complete Apgar scoring and provide supportive care during transition and while skin-to-skin. Observe for any signs of compromise and ensure airway is always unobstructed and the nose and mouth can be seen.<sup>39</sup>
  - vi. When procedures such as administration of Vitamin K (one to four hours after birth), eye prophylaxis (within two hours of birth) or blood glucose testing are performed before completion of the nine stages, do them while maintaining safe skin-to-skin contact.<sup>44,45,46,47</sup> (Refer to [Hospital Breastfeeding Policy](#)



[Resources](#) for the Title 22 California Code of Regulations Division 5 §70547 Perinatal Unit General Requirements, AAP Guidelines for Perinatal Care: Conjunctival [Eye] Care and Administration of Vitamin K.)

- vii. Document in the medical record the time of skin-to-skin contact initiation as well as the time this contact ends.

### **3. Supporting Breastfeeding and Safe Skin-to-Skin in Special Circumstances**

- a. If the parent and infant are separated for medical reasons, safe skin-to-skin contact is initiated as soon as parent and infant are reunited.
- b. For very low birthweight infants, refer to the latest version of the California Perinatal Quality Care Collaboration (CPQCC) “Nutritional Support for the Very Low Birth Weight Infant.”<sup>48</sup>
- c. If the birth was via cesarean section perform the following:
  - i. Initiate safe skin-to-skin contact in the operating room when the parent is responsive and alert.<sup>49,50</sup>
  - ii. Initiate or resume safe skin-to-skin contact in the recovery area as soon as medically possible, and continue uninterrupted until completion of the first feeding or for at least one hour if not breastfeeding.<sup>49,50</sup>
- d. If the parent is incapacitated perform the following:
  - i. Provide safe skin-to-skin contact by another adult, such as the other parent or a grandparent.<sup>51</sup>
  - ii. Provide privacy and place warm blankets over the newborn while on the adult’s chest to facilitate relaxed and comfortable safe skin-to-skin contact and bonding.
  - iii. Promote safe positioning, support and observation as noted above.<sup>26,40,42</sup>
- e. When the breastfeeding dyad is separated perform the following:
  - i. Provide safe skin-to-skin contact by another adult, such as the other parent or a grandparent.<sup>51</sup>

- ii. If transported to another room for the postpartum period, transport the parent and infant safely while skin-to-skin, taking care to minimize interruptions.<sup>35</sup>
  - iii. Initiate safe skin-to-skin contact as soon as the parent and infant are reunited and medically stable if skin-to-skin is delayed for medical reasons.<sup>36</sup> Mild respiratory distress in the newborn often improves with safe skin-to-skin contact.<sup>26</sup>
  - iv. Offer parents of infants cared for in a special care nursery opportunity for safe skin-to-skin contact as soon as the infant is ready.
- f. In the event of a natural disaster affecting a hospital (such as an earthquake or fire), it is important to support and maintain the breastfeeding dyad to initiate and/or continue breastfeeding.<sup>52,53</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for information on Infant Feeding in Disasters and Emergencies.)

## E. Recommendations for Assessment and Support During Postpartum and Newborn Patient Education

### 1. Parental Assessment - Initial and Throughout Hospitalization

- a. Utilize sensitivity when communicating with the parent regarding infant feeding decisions.<sup>12</sup> Support the parent to make an informed infant feeding decision.
- b. Verify the parent's current infant feeding plan, which may have been altered related to their recent experience with skin-to-skin contact and the infant's behavior. Ask open-ended questions to facilitate non-judgmental communication, such as "How can I help you feed your baby?"
- c. Assess educational needs according to the parent's response and consider previous prenatal education received and any identified breastfeeding challenges.<sup>12</sup>
- d. Assess breasts and nipples to identify any potential challenges to breastfeeding. Information regarding inverted nipples, breastfeeding after breast surgery, etc. is provided when appropriate. (Refer to [Hospital Breastfeeding Policy Resources](#) for information on Breastfeeding Assessment.)
- e. Request a lactation consult as indicated by the assessment.

## 2. Newborn Assessment - Initial and Throughout Hospitalization

- a. Strive to perform assessments while infant is skin-to-skin.  
(Refer to Part II-D-2: Safe Skin-to-Skin Contact and Breastfeeding Initiation.)
- b. Consider birth injury, delivery room resuscitation efforts, risk of infection, late preterm or low birth weight infants, and any other factors that may affect breastfeeding. Communicate any issues during the handoff report.
- c. Address thermoregulation and blood glucose levels according to hospital policy.<sup>54,55</sup>
  - i. Achieve thermoregulation of the newborn through safe skin-to-skin contact.<sup>54</sup>
  - ii. Encourage asymptomatic infants with low blood glucose levels to breastfeed or be fed parent's expressed colostrum via alternative feeding methods to maintain blood glucose within normal limits.<sup>56</sup>
  - iii. Assist and instruct parents who are separated from their infants with hand expression of colostrum or milk and save colostrum and/or milk.<sup>57</sup> This includes all infants at-risk for hypoglycemia and other risk factors such as Small for Gestational Age (SGA) or Large for Gestational Age (LGT). (Refer to [Hospital Breastfeeding Policy Resources](#) for information on Hand Expression.)
- d. Assess for signs of difficulty with latching or sustaining a latch, gumming or chewing on the nipple, and nipple pain and/or trauma. Request a lactation consult as soon as possible when indicated.<sup>58,59,60,61</sup>
- e. Assess infant behavioral state and transitions (e.g., quiet, alert, drowsy, irritable, quiet sleep) for readiness to feed.<sup>24</sup>
- f. Use a scoring system such as the LATCH Assessment tool for assessing breastfeeding effectiveness during the first two feedings and ongoing throughout the hospital stay, at least once per shift.<sup>62</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for information on Breastfeeding Assessment.)

## 3. Practices that Support Exclusive Breastfeeding Following the Immediate Postpartum Period

- a. Skin-to-Skin
  - i. Continue to encourage and practice safe skin-to-skin contact throughout the entire postpartum period.

- ii. Facilitate positioning of the newborn by keeping the neonate in an upright position on the parent's chest so that the mouth and nose are visible, and parent is reclined at a 35 to 80-degree angle to minimize the risk of Sudden Unexpected Postnatal Collapse.<sup>26,40,41,42</sup>
  - iii. Perform routine procedures such as vital signs, blood draws, heel sticks, and injections while infant is skin-to-skin. Maintaining safe skin-to-skin contact during painful procedures decreases expression of newborn pain and minimizes an increase in heart rate related to stress.<sup>42,43</sup>
- b. First Bath
- i. Delay the first bath for healthy term newborns for at least 24 hours.
  - ii. Considerations for the timing of the first bath should include the impact on skin-to-skin time, breastfeeding initiation, and early family interaction.<sup>42,63,64</sup>
  - iii. Do not provide the first bath until vital signs, especially temperature, are stable.<sup>63</sup>
  - iv. Allow time for skin-to-skin contact, transition, and early breastfeeding to reduce the incidence of hypothermia and hypoglycemia.<sup>64</sup>
  - v. Remove blood and meconium during the first bath, leaving residual vernix. Avoid washing face and hands with soap, as the smell of amniotic fluid assists breastfeeding efforts.<sup>43,62,64</sup>
- c. Rooming-In
- i. Ensure that all infants room-in with their parents from birth to discharge unless there are medical indications for admission and/or observation in a special care nursery. (Global Standards 7.1 & 7.3)<sup>1</sup>
  - ii. Do not separate rooming-in infants from their parents for more than one hour in a 24-hour period.<sup>65</sup> (Global Standard 7.1)<sup>1</sup>
  - iii. Perform all routine newborn procedures during skin-to-skin time at the parent's bedside as appropriate.<sup>36</sup>
  - iv. Promote successful breastfeeding by clustering parental and infant nursing care to allow for uninterrupted periods of rest, recovery, and supported breastfeeding.

- v. Provide an uninterrupted period of time so the parent can sleep for at least two hours to “protect their sleep.” The need for rest is often cited as the reason parents request for the infant to be cared for in the nursery. Every effort should be made to align this period of rest with the newborn’s rest period, including after a feeding or cluster of feedings when the infant is in deeper sleep.<sup>66</sup>
  - vi. If a parent requests that the infant be cared for in the nursery, explore the reasons with them and document the request. Provide education to the parent about the advantages of having the infant in the same room for 24 hours per day.
  - vii. If the infant is separated from the parent for any reason, the infant should be brought to the parent for feedings whenever the infant shows feeding cues.
  - viii. Document any interruption of rooming-in, including the reason, time, and duration of the separation.
- d. Education
- i. Provide face-to-face education and support in the postpartum period.
  - ii. Provide in-person reassurance and education regarding the normal physiology of breastfeeding and assistance with breastfeeding techniques.<sup>13,67</sup> (Global Standard 5.1)<sup>1</sup>
  - iii. Education includes:
    - A) practical support to enable initiation and maintenance of breastfeeding and managing common breastfeeding difficulties;<sup>67</sup>
    - B) proper positioning and latch; (Global Standard 5.3)<sup>1</sup>
    - C) nutritive suckling and swallowing;
    - D) milk production and release; (Global Standard 5.4)<sup>1</sup>
    - E) how to assess if the infant is adequately nourished, including normal newborn elimination patterns during the first four days of life; (Global Standard 5.5)<sup>1</sup>

- F) expected intake related to newborn age; (Refer to [Hospital Breastfeeding Policy Resources](#) for information on the Average Intake of Colostrum/Milk.)
  - G) infant feeding cues and responsive feeding as part of nurturing care (e.g., increased alertness or activity, mouthing, or rooting);<sup>66</sup> (Global Standard 8.1)<sup>1</sup>
  - H) infant satiety cues (e.g., hands open and relaxed, body feels relaxed, may fall asleep, seems peaceful, may have “wet burp”);
  - I) behavioral cues for comfort and closeness (e.g. skin-to-skin, cuddling, talking, and singing to infant);
  - J) reasons to contact a lactation specialist or health care provider; and
  - K) instructions on putting the infant to breast a minimum of eight or more times within 24 hours with no limitations on frequency or duration of feeding.<sup>68</sup> (Global Standard 8.2)<sup>1</sup>
- e. Unrestricted Breastfeeding/Feeding on Demand
- i. Strive for early initiation of breastfeeding, exclusive breastfeeding and following early feeding cues.
  - ii. Educate the parent regarding early infant feeding cues and encourage responsive feeding as part of nurturing care.<sup>67</sup> (Global Standard 8.1)<sup>1</sup>
  - iii. Instruct and assist parent to breastfeed early, often, and exclusively.
  - iv. Encourage frequent breastfeeding, especially in the first 24 hours of life. Nine to 11 feedings significantly reduce incidence of neonatal hyperbilirubinemia.<sup>69,70</sup> (Global Standard 8.2)<sup>1</sup>
- f. Milk Expression
- i. Provide all breastfeeding parents with culturally sensitive and linguistically appropriate education and support around hand expression and pumping.<sup>71</sup> (Global Standard 5.6)<sup>1</sup>
  - ii. Teach parents and families that obtaining only a few milliliters is common during the first episodes of milk expression and does not signify low milk production.<sup>66</sup>

- iii. Educate that hand expression may be used to stimulate attachment and effective suckling at the breast. Educate that hand expression and pumping can also serve to maintain lactation in the event of temporary separation of infant and parent.<sup>66</sup>
- iv. For better outcomes, coach the parent on how to massage their breasts prior to hand expression or pumping.<sup>72,73</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for information on Hand Expression.)
- v. Use hand expression, a handheld pump or electric pump in a clean environment.<sup>71,74,75</sup>
  - A) Wash hands prior to expression and clean containers with lids for storage.<sup>71</sup>
  - B) Ensure all containers are labeled with name, date of birth or medical record number, and the date and time it was expressed and frozen.
  - C) When pumped milk is stored in the refrigerator and taken out for feeding preparation, use a two-patient identifier and a two-nurse verification process prior to feeding infant.<sup>75</sup>
- vi. If parent and newborn are separated for any reason, the parent is instructed to begin pumping within six hours of childbirth, preferably within the first one to two hours.<sup>76,77</sup>
  - A) Support and encourage parents to pump at least five to eight times during the day, including at least one night session to ensure an adequate milk supply for the first 24 hours.
  - B) When separation lasts longer than two days, parents should be encouraged to use a double electric breast pump at least eight times per day along with hand expression.<sup>76</sup>
  - C) Provide parents resources to obtain a double pump for continuing pumping at home.
  - D) Start the newborn on feeding at the breast as soon as medically possible.

vii. Teach the following practices for home sanitation of breast pump parts:

A) After each use, the pump parts that touch the milk and bottles are rinsed with cool water before washing with hot soapy water.<sup>73,75</sup>

B) Wash pump parts that touched the milk with liquid dish detergent.<sup>70,74</sup>

viii. Storing Breast Milk

A) Teach and follow safe storage guidelines. (Refer to [Hospital Breastfeeding Policy Resources](#) for information on Storage Duration of Fresh Human Milk.)

B) Educate parents that breast milk that has been thawed after refrigeration should be used within 24 hours.

C) Advise parents that when pumping and storing their own milk for their own infant that they should comply with the guidelines set forth by the Human Milk Banking Association of North America, according to California Health and Safety Code 1648.<sup>71,78</sup>

D) Advise parents to never warm breast milk in the microwave oven.<sup>73</sup>

E) Advise parents that the best practice for warming breast milk is to stand the container in warm water or hold under warm running water, keeping the lip under the cap dry to avoid contamination.<sup>75,79</sup>

#### 4. Additional Education

a. Supplementation

i. Term infants on the first one to two days of life do not need more than 2-15 ml per feeding.<sup>4</sup>

A) If supplementation is medically indicated, the preferred order should be expressed colostrum/breast milk from the infant's parent is the first choice, followed by donor human milk, ready-to-feed formula, concentrated formula mixed with clean water, and powder formula reconstituted with boiled water no less than 70° C.<sup>21</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for information on Safe preparation, storage and handling of powdered infant formula.)



- ii. If the parent requests their infant to be supplemented or solely fed with breast milk substitute, explore and address the parent's concerns and provide support to the family.<sup>67</sup> (Global Standard 6.2)<sup>1</sup>
  - iii. Evaluate breastfeeding dyads for comfortable position, optimal latch, and effective milk transfer prior to any supplemental feedings.<sup>21,35,80</sup> (Global Standard 6.1)
  - iv. Inform the parent of the effects of feeding their infant a breast milk substitute (formula feed) on their breast milk supply.<sup>21,67</sup>
  - v. When indicated, inform the family when banked donor human milk is available.<sup>81,82</sup>
  - vi. Document interactions and communicate during patient handoffs to avoid repetitive conversations and to respect the parent's feeding plan.<sup>21</sup>
  - vii. Provide written and verbal instructions about safe preparation, storage, feeding of infant and cleaning of feeding devices directly with families and not in a group setting. (Global Standard 6.3)<sup>1</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for information on Infant Supplementation.)
  - viii. Prior to supplementing the infant, staff should discuss with the parent the feeding options, including the types of supplements available and the available methods for feeding supplements. The parent should be taught how to safely administer a feeding with the selected device.<sup>67</sup>
  - ix. Instruct the parent on paced bottle feeding if he/she is using a bottle.<sup>83</sup>
  - x. Encourage and support the overweight/obese parent with potential issues related to position, latch and transfer, specifically parental size, large breasts and delayed lactogenesis.<sup>84</sup>
- b. Artificial Nipples and Pacifiers
- i. Pacifiers and artificial nipples should not routinely be issued to healthy-term breastfeeding infants.<sup>85</sup> If pacifier use is strongly preferred and/or initiated by the parent, educate about the impact on milk supply of delaying or replacing suckling at the breast while lactation is being established.<sup>67,83,86</sup> (Global Standard 9.1)<sup>1</sup>

- ii. Do not give or place bottles, artificial nipples, or pacifiers in or around the newborn's crib.<sup>67</sup>
- iii. Document related discussions with the family in the medical chart.
- iv. Breastfeeding is the preferred soothing method to reduce the pain babies feel during minor painful procedures.<sup>87</sup>
- v. Pacifiers may be used during painful procedures or therapeutic medical procedures if breastfeeding is not possible.<sup>67</sup>

## 5. Medical Complications

- a. Weight loss in the newborn
  - i. Normal weight loss requires no intervention.<sup>21</sup>
  - ii. Consider weight loss in the newborn carefully with an understanding of the following factors:<sup>88, 89</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for information on Patient Education Materials.)
    - A) Parental IV fluids received during labor, especially in the last two hours prior to birth, are associated with fetal volume expansion.<sup>88</sup>
    - B) In the first 24 hours after birth, the newborn may experience increased urine output (diuresis) to correct fluid overload and achieve fluid balance.
    - C) Set the baseline weight after infant diuresis has occurred (typically within 24 hours of birth) and utilize this weight for baseline assessment.
    - D) Weight loss after the first 72 hours is not likely connected to parental fluids and should not be dismissed as a fluid correction.<sup>88,90</sup>
    - E) There is a positive correlation between late onset (after day three) of lactogenesis II (“milk coming in” or “increasing in volume”) and increased parental fluids received during labor.<sup>88</sup>
  - iii. A lactation consultation is recommended for breastfeeding infants who have excessive weight loss (over 10%) between 72 and 96 hours of life.<sup>21</sup> Consultations for excessive weight loss are shown to improve breastfeeding outcomes.

- iv. Supplementation of a healthy term infant for weight loss after 72 hours requires a medical order and documentation of the following:
    - A) Significant clinical and laboratory confirmation of dehydration, with greater than 10% weight loss, hypernatremia, observed poor feeding, and a difficult to arouse/lethargic infant.<sup>21</sup>
    - B) Poor milk transfer/milk volume despite breast massage, hand expression and pumping.<sup>4</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for information on Hand Expression.)
  - v. Use of a nomogram to determine the newborn's weight loss trajectory may be helpful for an assessment, plan of care and intervention.<sup>87</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for a nomogram example.)
- b. Phototherapy
- i. When phototherapy is ordered for jaundice it should be provided in the parent's room to help facilitate continued breastfeeding.<sup>69</sup>
  - ii. When an infant is readmitted for phototherapy, the parent should reside with the infant for the entire stay whenever possible.
  - iii. If medically indicated, expressed breast milk from the infant's parent is the first choice, followed by donor human milk, ready to mix formula, and then powdered or concentrated formula mixed with clean water.<sup>21,69</sup>
- c. Late Preterm Infant Cared for in the Postpartum Unit
- i. Healthy late-preterm infants (34<sup>0/7</sup>- 36<sup>6/7</sup> weeks gestational age) and early term infants (37<sup>0/7</sup>-38<sup>6/7</sup> weeks gestational age) should:
    - A) be closely observed for signs of respiratory distress, temperature instability, hypoglycemia, jaundice, or infection while avoiding automatic separation of the dyad during evaluations;
    - B) undergo weight tests one to two times a day before and after a feeding to determine adequate milk transfer, with particular monitoring for weight loss not to exceed 3% at 24 hours of life and no greater than 7% by day 3 of life;

- C) be assessed for sleepiness and lack of feeding cues and potentially waking the infant if it has been four hours since the previous feeding;
  - D) be assessed for lack of strength in latching and suckling, or lack of adequate milk transfer; and
  - E) have a written, individualized feeding plan formulated to address any special needs.
- ii. Parents of healthy late-preterm infants and early term infants are recommended to receive a referral to a lactation specialist.

(Refer to [Hospital Breastfeeding Policy Resources](#) for information on breastfeeding the late preterm infant.)

#### d. NICU Admission

- i. Parents with an infant admitted to the NICU should receive a lactation consultation to understand the role of human milk to their infant's health.<sup>91</sup>
- ii. Breast milk expression is recommended to begin as soon as possible, but no later than six hours after birth.<sup>87</sup> (Global Standard 6.6)
- iii. Expressed breast milk is given as soon as the infant is medically ready.
- iv. Provide an opportunity for parents to practice kangaroo care.<sup>92</sup>
- v. Parents should be provided private space to pump near their infants in the neonatal ward.
- vi. Offer guidance on breast massage, hand expression and use of an electric breast pump. (Refer to [Hospital Breastfeeding Policy Resources](#) for information on breast massage guidance.)

## F. Recommendations for the Discharge Home Period

### 1. Education and Support

- a. Instruct parents to schedule routine follow-up visits for their infant at three to five days of age or within 48 hours of infant discharge (if not already scheduled) per the American Academy of Pediatrics recommendations.<sup>36,99</sup> Infants should be seen again the next week.<sup>4</sup>

- b. Provide the parent general anticipatory guidance and education for at home.<sup>99,93</sup>
- i. During patient education, include the importance of:
- A) protecting access to rest and sleep for parent and baby;
  - B) preparing new parents for the “day two” crying infant (overstimulation) and ways to limit stimulation, including limiting visitors and distractions, and keeping lights low;
  - C) helping parents understand normal infant sleep patterns to allow them to support the sleeping newborn without interrupting the sleep cycle;
  - D) helping parents get to know their baby’s predictable patterns; and
  - E) providing written information to all parents regarding:
    - 1) prevention and management of engorgement;
    - 2) interpretation of infant cues and feeding “on cue/demand”;
    - 3) indicators of adequate intake;
    - 4) signs of excessive jaundice;<sup>68</sup>
    - 5) sleep patterns of newborns, including safe sleeping and night nursing practices;
    - 6) parental medication, cigarette and alcohol use.<sup>18,28,34,94</sup> (Note: if the parent is taking medication for a mental health condition, encourage them to continue to take the medication and speak to their OB/GYN about safety.);<sup>95</sup>
    - 7) individual feeding patterns and evening cluster feedings associated with growth spurts;<sup>96</sup>
    - 8) current recommendations on pacifier use;<sup>66,97</sup> and
    - 9) information about California breastfeeding laws and regulations including, but not limited to the right to breastfeed in public and breastfeeding at work.<sup>98</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for California Breastfeeding Laws and Regulations links.)

- c. Provide the parent breastfeeding guidance and education for at home.
  - i. Verify that the baby is positioned and latched correctly and is swallowing during a feeding. Ensure that the parent knows how to watch for baby’s swallowing.
  - ii. Recommend to parents that they exclusively breastfeed for six months. As complementary foods are introduced, breastfeeding continues for one year or longer as mutually desired by parent and infant.<sup>99,100</sup>
  - iii. Inform the parents to continue breastfeeding during times of family emergencies or during increased stress.<sup>101</sup> (Refer to [Hospital Breastfeeding Policy Resources](#) for links on Infant Feeding in Disasters and Emergencies.)
  - iv. Schedule breastfeeding parents an in home, in clinic or telephone follow-up prior to discharge.<sup>99</sup> Ensure parents can feed and care for their infants and have access to continued breastfeeding support, including referring them to WIC Program breastfeeding services, as appropriate.<sup>67</sup>(Global Standards 10.1 & 10.2)<sup>1</sup>
  - v. Provide verbal and written resources to the parent for 24 hours per day breastfeeding support in the community.<sup>89,91</sup> Refer them to support persons, the WIC program, or support groups and encourage them to connect before challenges arise.<sup>91</sup> (Global Standard 10.2)<sup>1</sup>
- d. Mothers that have decided not to breastfeed or have decided to “mixed-feed” with formula for their infants at the time of discharge must receive written and verbal information regarding preparation, storage, handling and feeding of the substitute, and this education should be documented. This education is not provided in a group setting.

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# Part III: Supporting Breastfeeding Employees and Visitors

## A. Lactation Accommodation

Hospital administrators and human resource directors should ensure lactation accommodations follow federal and state laws that protect, promote and support breastfeeding, including:<sup>1,2,3,4</sup>

1. lactation breaks at work;
2. breastfeeding in public;
3. providing a returning employee with clear, written policy outlining their right to:
  - a. a private, clean, safe room or other location that is not a bathroom in which they can express milk;
  - b. a location with a place to sit, a surface to place a pump and access to electricity for powering a pump; and
  - c. access to a sink with running water and a refrigerator or other cooling device suitable for storing milk;
4. protection from discrimination for reasons related to breastfeeding; and
5. unpaid leave for pregnancy and breastfeeding.

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<sup>2</sup> California Department of Public Health. Lactation Accommodation Laws for Workplace, Jails, and School. <https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/Pages/Laws.aspx>

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<sup>4</sup> US Department of Labor: Wage and Hour Division. Break Time for Nursing Mothers. US Department of Labor. <https://www.dol.gov/agencies/whd/nursing-mothers>

Visit the California Department of Public Health’s website for the [Hospital Breastfeeding Policy Resources](http://www.cdph.ca.gov/Breastfeeding) ([www.cdph.ca.gov/Breastfeeding](http://www.cdph.ca.gov/Breastfeeding))

# Appendix: Ten Steps to Successful Breastfeeding Global Standards (revised 2018)\*

## *Critical management procedures*

### **Step 1 Facility Policies**

*1. a. Comply fully with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions.*

#### Global Standards

**1.a.1** All infant formula, feeding bottles and teats used in the facility have been purchased through normal procurement channels and not received through free or subsidized supplies.

**1.a.2** The facility has no display of products covered under the Code or items with logos of companies that produce breast-milk substitutes, feeding bottles and teats, or names of products covered under the Code.

**1.a.3** The facility has a policy that describes how it abides by the Code, including procurement of breast milk substitutes, not accepting support or gifts from producers or distributors of products covered by the Code and not giving samples of breast-milk substitutes, feeding bottles or teats to mothers.

**1.a.4** At least 80% of health professionals who provide antenatal, delivery and/or newborn care can explain at least two elements of the Code.

*1. b. Have a written infant feeding policy that is routinely communicated to staff and parents.*

#### Global Standards

**1.b.1** The health facility has a written infant feeding policy that addresses the implementation of all eight key clinical practices of the Ten Steps, Code implementation, and regular competency assessment.

**1.b.2** Observations in the facility confirm that a summary of the policy is visible to pregnant women, mothers and their families.

**1.b.3** A review of all clinical protocols or standards related to breastfeeding and infant feeding used by the maternity services indicates that they are in line with BFHI standards and current evidence-based guidelines.

**1.b.4** At least 80% of clinical staff who provide antenatal, delivery and/or newborn care can explain at least two elements of the infant feeding policy that influence their role in the facility.

*1. c. Establish ongoing monitoring and data-management systems.*

Global Standards

**1.c.1** The facility has a protocol for an ongoing monitoring and data-management system to comply with the eight key clinical practices.

**1.c.2** Clinical staff at the facility meet at least every 6 months to review implementation of the system.

**Step 2: Staff competency**

*2. Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.*

Global Standards

**2.1** At least 80% of health professionals who provide antenatal, delivery and/or newborn care report they have received pre-service or in-service training on breastfeeding during the previous 2 years.

**2.2** At least 80% of health professionals who provide antenatal, delivery and/or newborn care report receiving competency assessments in breastfeeding in the previous 2 years.

**2.3** At least 80% of health professionals who provide antenatal, delivery and/or newborn care are able to correctly answer three out of four questions on breastfeeding knowledge and skills to support breastfeeding.



## ***Key clinical practices***

### **Step 3: Antenatal Information**

*3. Discuss the importance and management of breastfeeding with pregnant women and their families.*

#### Global Standards

**3.1** A protocol for antenatal discussion of breastfeeding includes at a minimum:

- the importance of breastfeeding;
- global recommendations on exclusive breastfeeding for the first 6 months, the risks of giving formula or other breast-milk substitutes, and the fact that breastfeeding continues to be important after 6 months when other foods are given;
- the importance of immediate and sustained skin-to- skin contact;
- the importance of early initiation of breastfeeding;
- the importance of rooming-in;
- the basics of good positioning and attachment;
- recognition of feeding cues.

**3.2** At least 80% of mothers who received prenatal care at the facility report having received prenatal counselling on breastfeeding.

**3.3** At least 80% of mothers who received prenatal care at the facility are able to adequately describe what was discussed about two of the topics mentioned above.

### **Step 4: Immediate postnatal care**

*4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.*

#### Global Standards

**4.1** At least 80% of mothers of term infants report that their babies were placed in skin-to-skin contact with them immediately or within 5 minutes after birth and that this contact lasted 1 hour or more, unless there were documented medically justifiable reasons for delayed contact.

**4.2** At least 80% of mothers of term infants report that their babies were put to the breast within 1 hour after birth, unless there were documented medically justifiable reasons.

### **Step 5: Support with breastfeeding**

*5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.*

#### Global Standards

**5.1** At least 80% of breastfeeding mothers of term infants report that someone on the staff offered assistance with breastfeeding within 6 hours after birth.

**5.2** At least 80% of mothers of preterm or sick infants report having been helped to express milk within 1–2 hours after birth.

**5.3** At least 80% of breastfeeding mothers of term infants are able to demonstrate how to position their baby for breastfeeding and that the baby can suckle and transfer milk.

**5.4** At least 80% of breastfeeding mothers of term infants can describe at least two ways to facilitate milk production for their infants.

**5.5** At least 80% of breastfeeding mothers of term infants can describe at least two indicators of whether a breastfed baby consumes adequate milk.

**5.6** At least 80% of mothers of breastfed preterm and term infants can correctly demonstrate or describe how to express breast milk.

### **Step 6: Supplementation**

*6. Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.*

#### Global Standards

**6.1** At least 80% of infants (preterm and term) received only breast milk (either from their own mother or from a human milk bank) throughout their stay at the facility.

**6.2** At least 80% of mothers who have decided not to breastfeed report that the staff discussed with them the various feeding options and helped them to decide what was suitable in their situations.

**6.3** At least 80% of mothers who have decided not to breastfeed report that the staff discussed with them the safe preparation, feeding and storage of breast milk substitutes.

**6.4** At least 80% of term breastfed babies who received supplemental feeds have a documented medical indication for supplementation in their medical record.

**6.5** At least 80% of preterm babies and other vulnerable newborns that cannot be fed their mother's own milk are fed with donor human milk.

**6.6** At least 80% of mothers with babies in special care report that they have been offered help to start lactogenesis II (beginning plentiful milk secretion) and to keep up the supply, within 1–2 hours after their babies' births.

### **Step 7: Rooming-In**

*7. Enable mothers and their infants to remain together and to practise rooming-in 24 hours a day.*

#### Global Standards

**7.1** At least 80% of mothers of term infants report that their babies stayed with them since birth, without separation lasting for more than 1 hour.

**7.2** Observations in the postpartum wards and wellbaby observation areas confirm that at least 80% of mothers and babies are together or, if not, have medically justifiable reasons for being separated.

**7.3** At least 80% of mothers of preterm infants confirm that they were encouraged to stay close to their infants, day and night.

### **Step 8: Responsive Feeding**

*8. Support mothers to recognize and respond to their infants' cues for feeding.*

#### Global Standards

**8.1** At least 80% of breastfeeding mothers of term infants can describe at least two feeding cues.

**8.2** At least 80% of breastfeeding mothers of term infants report that they have been advised to feed their babies as often and for as long as the infant wants.

## **Step 9: Feeding bottles, teats and pacifiers**

*9. Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.*

### Global Standards

**9.1** At least 80% of breastfeeding mothers of preterm and term infants report that they have been taught about the risks of using feeding bottles, teats and pacifiers.

## **Step 10: Care at Discharge**

*10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.*

### Global Standards

**10.1** At least 80% of mothers of preterm and term infants report that a staff member has informed them where they can access breastfeeding support in their community.

**10.2** The facility can demonstrate that it coordinates with community services that provide breastfeeding/ infant feeding support, including clinical management and mother-to-mother support.

\* World Health Organization. *Implementation Guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services-the revised Baby-friendly Hospital Initiative*. Geneva, Switzerland; 2018. <https://apps.who.int/iris/handle/10665/272943>.