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Infant Feeding Policy

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It is the policy of Providence to promote, support, and protect breastfeeding as optimal nutrition for all infants by adhering to the evidence-based guiding principles outlined by the World Health Organization (WHO) and UNICEF.

PURPOSE

WHO and UNICEF launched the Baby-friendly Hospital Initiative (BFHI) to help motivate facilities providing maternity and newborn services worldwide to implement the *Ten Steps to Successful Breastfeeding (Ten Steps).* The *Ten Steps* emphasizes global standards to protect, promote, and support breastfeeding in facilities that provide maternity and newborn services.

The purpose of this policy is to provide a unified approach and framework to the adherence of the *Ten Steps,* which will be over-seen by Providence, including data tracking, state and national quality benchmarking, and compliance measures.

Step 1a - Facility policies

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

A. Will not provide commercial materials to breastfeeding mothers which promote or encourage formula feeding or interfere with breastfeeding.
B. Will not accept or distribute free or subsidized supplies of breastmilk substitutes, artificial nipples, and other feeding devices.
C. Will purchase formula following the WHO guidelines.
D. Staff will not engage in any form of promotion or permit the display of any type of advertising of breast-milk substitutes, including the display or distribution of any equipment of materials bearing the brand of manufacturers of breast-milk substitutes, or discount coupons, and they

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should not give samples of infant formula to mothers to use in the facility or to take home.

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

A. The clinical practices articulated in the *Ten Steps* guarantee that appropriate care is equitably provided to all mothers and babies and is not dependent on the preferences of each care provider.

B. A summary of the policy should be visible to pregnant women, mothers, and their families.

C. The policy will be reviewed every two years or sooner when change in standard applies.

Step 1c – Establish ongoing monitoring and data-management systems.

A. Each facility within Providence will integrate monitoring of clinical practices related to breastfeeding into their quality-improvement/monitoring systems.

B. Quality measures will be determined by the system breastfeeding program. Additional measures can be added by hospitals.

C. Facilities should review their quality data at a minimum of once every six months, but quarterly if one or both measures fall below 80% or below national standards.

D. Each facility will review their quality data related to breastfeeding at least quarterly and give improvement recommendations, as well best practice sharing, to individual hospital leadership

E. Each ministry within Providence will complete Ten Step checklist every three years, to be reviewed by Providence leadership. If there is a minimum of 80% compliance on each component of the checklist, Providence leadership will award an Infant Feeding Program designation to that ministry.

F. Annual audit of identified steps will be conducted to identify opportunities for improvement.

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Step 2. Staff competency - Ensure that staff have sufficient knowledge, competence, and skills to support breastfeeding.

[Ministries: WHO/UNICEF 2018 "Ten Steps to Successful Breastfeeding"

A. Caregivers will be educated regarding this policy during their first 30 days as a new hire, as well as breastfeeding basics during department specific orientation, to be completed within six months of hire date.

B. All staff who help mothers with infant feeding will demonstrate the following competencies:

1. Use listening and learning skills to counsel a mother.
2. Use skills for building confidence and giving support to counsel a mother.
3. Counsel a pregnant woman about breastfeeding.
4. Assess a breastfeeding for positioning and latch.
5. Educate mother on the anticipated of breastfeeding.
6. Help a mother on the following:
    a. Establishing milk supply
    b. Express her breast milk.

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c. Alternative feeding methods, as applicable
d. Initiate breastfeeding within the first hour after birth
e. Whose baby is crying frequently or whose baby is refusing to breastfeed.
f. Engorged breasts, flat or inverted nipples, and sore or cracked nipples
g. Breastfeeding a low-birth-weight baby or sick baby

Step 3. Antenatal Information – Discuss the importance and management of breastfeeding with pregnant women and their families.

A. Education, counseling, and breastfeeding educational materials will be provided to all pregnant women during their **first trimester**, whenever possible (see addendum X for ministry specific materials).
B. Any educational materials distributed to pregnant women and breastfeeding mothers will be free from messages that promote or advertise infant food or drinks other than breast milk.
C. Mothers will be encouraged to utilize available breastfeeding resources, including classes, written materials, and application/internet resources, as appropriate.
D. Each ministry will collaborate with clinics and community-based programs to provide prenatal breastfeeding education and breastfeeding support (see addendum X a list of community resources).
E. All pregnant women and their support people as appropriate will be provided with information on breastfeeding. Topics addressed in classes and/or educational materials will include but are not limited to:
    1. The benefits of breastfeeding for both mother and infant.
    2. The recommendation of exclusive breastfeeding for the first 6 months, as well as continuation of breastfeeding after introduction of appropriate complimentary foods and throughout the first year of life.
    3. Labor management techniques to allow for non-pharmacological pain relief.
    4. Basic breastfeeding management, including proper positioning and latching techniques, and recognition of feeding cues.
    5. Early initiation of breastfeeding.
    6. Early skin-to-skin contact.
    7. How to assure adequacy of milk supply, production and release.
    8. Hand expression of breast milk and use of breast pump if indicated.
    9. Safe handling and storage of breast milk.
    10. Feeding on demand; infant-led feeding.
    11. Frequent feeding to assure optimal milk production.
    12. How to assess if infant is adequately nourished.
    13. Typical infant feeding behaviors.
    14. The couplet care unit and the importance of rooming-in on a 24-hour basis.

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15. Psychological factors and socio-cultural barriers or constraints influencing the decision to breastfeed.
16. Dietary concerns.
17. Indications for supplementing breast milk.
18. Reasons for contacting a healthcare professional related to breastfeeding.
19. Individualized education when indicated on documented contraindications to breastfeeding and other medical indications.
20. Appropriate outpatient resources.
21. Education will be documented in EMR.
22. There will be no group education or counseling on formula feeding.

F. Instruction about formula feeding by bottle will be provided on an individual basis as appropriate to:
    1. Women who explicitly state they are making an informed choice not to breastfeed. [Risks and Benefits Acknowledgment Consent will be documented in EMR]
    2. When breastfeeding is medically contraindicated, and formula is medically indicated.

Step 4. Immediate Postnatal Care - Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.

A. Skin-to-skin
    1. Mothers will be encouraged to hold their baby skin-to-skin without interruption, regardless of feeding choice, immediately following birth, if mother and infant are stable.
    2. Skin-to-skin contact should continue uninterrupted until the completion of the first breastfeeding. In the case of formula-feeding infants, initial skin-to-skin contact should continue uninterrupted for at least 60 minutes.
    3. Routine procedures (e.g. assessments, Apgar scores, etc.) will be done while the infant is skin-to-skin with the mother. Procedures requiring separation of the mother and infant (e.g. bathing or weighing) will be delayed until after this period of skin-to-skin contact and will be conducted, whenever feasible, at the mother's bedside.
    4. If mother and infant are separated for medical reasons, skin-to-skin contact will be initiated as soon as the mother and infant are reunited, and medical condition allows. Following cesarean delivery, staff will place healthy newborns skin-to-skin with mother as soon as baby is stable, and mother is able to interact with her baby. Staff will offer the mother assistance to initiate breastfeeding.
    5. Mothers and infants who are being cared for in a neonatal intensive care unit will be informed about and encouraged to practice Kangaroo care when infant is considered ready for such contact.
    6. Even if mothers are not able to initiate breastfeeding during the first hour after birth, they should still be supported to provide skin-to-skin contact and to breastfeed as soon as they are able.

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7. Frequent and prolonged skin-to-skin is encouraged during the postpartum period (throughout hospital stay) to facilitate bonding, promote breastfeeding initiation, and support thermoregulation in the newborn.

B. Procedure

1. Explain the process for skin-to-skin time and the benefits with the mother and family.
2. The newly delivered infant is placed prone on the mother's abdomen or chest with no clothing separating them.
3. To ensure newborn safety during skin-to-skin, the following measures are to be followed:
    a. Side rails in the up position while in bed
    b. Support person at the bedside
    c. Care must be taken to verify the newborn's head is turned for a clear airway with frequent observation to make sure no airway compromise occurs.
4. Document the following:
    a. Education on the benefits of breastfeeding and skin-to-skin
    b. Skin-to-skin time of initiation
    c. Medical reason for any delay in initiation of breastfeeding or skin-to-skin.

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Step 5. Support with Breastfeeding - Support mothers to initiate and maintain breastfeeding and manage common difficulties.

A. **Breastfeeding education** will begin during pregnancy and continue throughout the labor and delivery hospital stay. Topics of education include but are not limited to:

1. Techniques for proper positioning, latching and detaching.
2. Milk supply within the first 2 days; production and release.
3. Supply and demand principle of milk production.
4. Infant feeding, frequency and readiness cues.
5. Nutritive sucking and swallowing.
6. Maternal pain level.
7. Normal infant urine output and bowel movements.
8. Manuel expression of breast milk.
9. Importance of exclusive breastfeeding for 6 months.
10. Sustaining milk supply if not exclusively breastfeeding.

B. Maternal child staff will assess the mother's breastfeeding techniques and assist with appropriate breastfeeding, positioning, and attachment as needed no later than 6 hours after birth.

C. Each shift and whenever possible the RN will assess and document the newborn's ability to

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breastfeed effectively. Direct observation of a feed is necessary to ensure that the infant can attach to and suckle at the breast and that milk transfer is happening. Refer to Addendum B: LATCH Scoring Tool.

D. Mothers of babies who are separated for medical reasons will be encouraged and assisted in establishing and maintaining lactation. They will receive education regarding the following:
    1. Pumping, handling and storage of breast milk.
    2. How to express their milk eight times or more (including at least once during the night) every 24 hours to establish their milk supply.
    3. Milk expression to be started within 6 hours of birth, preferably within 1-2 hours after birth.
    4. The importance of providing expressed milk to their infant as soon as the infant can tolerate feedings.

E. Mothers should receive practical support to enable them to initiate and maintain breastfeeding, which includes:
    1. Providing emotional and motivational support.
    2. Teaching concrete skills to enable mothers to confidently breastfeed and long-term success.
    3. How to express breastmilk via hand-expression and manual or electric pump.

F. **Common breastfeeding difficulties** which require an individualized education plan (e.g., consider utilizing a Lactation Consultant) include, but are not limited to the following:
    1. The management of engorged breasts
    2. Ways to ensure a good milk supply.
    3. Prevention of sore and cracked nipples.
    4. Evaluation of milk intake.
    5. Flat or inverted nipples.
    6. History of breast surgery.
    7. Multiple infants.
    8. Difficulty with latch or breast refusal by infant.
    9. Excessive weight loss (7-10%).

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

A. Mothers will be encouraged to exclusively breastfeed their infants while in the hospital and to continue exclusive breastfeeding for six months and after introduction of solids.

B. Exclusive breast milk feeding as defined by the Joint Commission Perinatal Core Measure includes all liveborn newborns discharged from the hospital with the following exceptions:
    1. NICU admission/discharged from
    2. Diagnosed with galactosemia during the hospital stay

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3. Fed parenterally during the hospital stay
4. Experienced death
5. Had a length of stay greater than 120 days
6. Were enrolled in clinical trials
7. Documented reason for not exclusively feeding breast milk.

C. Maternal and newborn history will be assessed and analyzed for any contraindications to breastfeeding. Contraindications outlined by the WHO and UNICEF include:
Infant Conditions
    1. Classic galactosemia
    2. Maple syrup urine disease (may breastfeed under supervision of provider)
    3. Phenylketonuria (may breastfeed under supervision of provider)

D. Maternal Conditions
    1. HIV+
    2. Herpes simplex virus lesion present on the breast
    3. Varicella lesion on breast
    4. Infection with human T-cell lymphotropic virus
    5. Severe maternal illness that prevents a mother from caring for her infant
    6. Maternal medication including but not limited to:
        i. Anti-cancer medications
        ii. Lithium
        iii. Oral retinoids
        iv. Amiodarone
        v. Gold salts
        vi. Refer to medication resources for more information.

E. Infants for whom breast milk remains the best feeding option but who may need other food in addition to breast milk for a limited period:
    1. Infants born weighing less than 1500 g (very low birth weight)
    2. Infants born at less than 32 weeks of gestational age (very pre-term).
    3. Infants at risk of hypoglycemia – preterm, diabetic mother, small for gestational age, asphyxiated or illness.
    4. If blood sugar fails to respond to optimal breastfeeding or breast milk feeding (follow Newborn Hypoglycemia Protocol).

F. Maternal conditions during which breastfeeding can continue, although health problems may be of concern:
    1. Breast abscess: breastfeeding should continue on the unaffected breast; feeding from the affected breast can resume once treatment has started.

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2. Hepatitis B: infants should be given hepatitis B vaccine and immune globulin, within the first 12 hours of life.
3. Hepatitis C
4. Mastitis: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition
5. Active, untreated, tuberculosis
6. Illicit drug use or alcohol abuse; mothers should be encouraged not to use these substances and given opportunities and support to abstain

G. Staff shall not provide supplementation to breastfeeding infants unless specifically requested by the mother or ordered by a physician when a medical indication exists.

H. Mothers who have chosen **not** to exclusively breastfeed will be counselled on the importance of breastfeeding and reasons for the request will be explored, addressing the concerns raised, and education provided about the possible consequences to the health of her baby and/or the success of breastfeeding.

I. Supplementation or alternate feeding options may include:
1. Cup feeder
2. Syringe or eyedropper
3. Spoon
4. Paced bottle feeding
5. Supplemental nursing system (SNS)

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J. Artificial feeding should not exceed the capacity of the newborn stomach. General guideline of amounts to supplement:
1. Day of life #1: 5-10 mL/feeding
2. Day of life #2: 10-15 mL/feeding
3. Day of Life #3: 15-30 mL/feeding

K. Mothers who are feeding breast-milk substitutes, by necessity or by choice, will be given written and verbal information regarding safe preparation, storage, handling and feeding of formula. Thia will include appropriate hygiene, cleaning utensils and equipment, appropriate reconstitution, accuracy of measurement of ingredients, safe handling, proper storage, and appropriate feeding methods. Education will be provided on how to respond to feeding cues. This will be documented in the EMR.

Step 7. Rooming-In – Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.

A. Accommodations for mothers and infants to remain together 24-hours a day is the standard for mother-infant care for healthy infants regardless of infant feeding choice and assured throughout their hospital stay, unless contraindicated.

B. Whenever possible, both mother and infant will be transported to the Mother Baby Unit together.

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C. If medically safe, mother and baby should be recovered after cesarean section, in the same room.

D. Assessments and procedures will be performed at the mother's bedside with the focus of keeping the mother and newborn together, whenever possible, and should avoid separations and/or absences of the newborn from the mother for more than one hour per day.

E. Mother/Infant dyad will always be protected from disruption that may impact their ability to bond or interfere with breastfeeding needs. Breastfeeding takes priority over tasks whenever possible. Staff will advocate for the couplet including asking visitors to wait in an appropriate area while mother is breastfeeding or during mother/infant bonding, or periods of rest if necessary.

F. Whenever rooming-in is interrupted, the reason for the interruption, the location of the infant during the interruption, and the time the infant leaves and returns to the mother's room (the duration) will be documented.

G. Educate mother (family) regarding the positive impacts of rooming-in:

    1. Parents learn the infant's feeding cues
    2. Increased frequency of feedings
    3. Faster rate of weight gain at 1 week
    4. Higher rate of exclusive breastfeeding
    5. Longer duration of breastfeeding
    6. Promotes synchronization of sleep/wake patterns between mother and bab

H. If mother and infant are separated, due to medically justified reasons (i.e. NICU admission for preterm or illness), mothers should be given adequate space and opportunity to express milk adjacent to their infant and breastfeed as soon as medically stable.

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Step 8. Responsive Feeding – Support mothers to recognize and respond to their infants' cues for feeding.

A. Mothers will be encouraged to breastfeed on demand or when the newborn exhibits hunger cues or signals. Mothers will be educated about these feeding readiness cues (e.g. rooting, increased alertness or activity) to be used as indicators of the infant's readiness for feeding.

B. Education will be provided by the nurse or lactation consultant and includes the following, but is not limited to:

    1. Hunger/feeding cues
    2. Frequency of feeding (Responsive feeding, also called on-demand or baby-led feeding) – puts no restrictions on the frequency or length of the infant's feeds (a minimum of 8-12 times/day).
    3. "Scheduled feedings" or "time-restricted frequency and schedule of feeds" is not recommended – mothers are advised to breastfeed whenever the infant is hungry or as often as the infant wants.
    4. Sleep/feeding cycle or periods, normalcy of cluster feedings, and the possible necessity of waking the infant for feeds if the breasts are full and/or infant is sleeping through feedings.

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5. Breastfeeding promotes bonding between mother and infant through physical contact and nourishment.
6. Time limits for breastfeeding will be avoided. Infants can be offered both breasts at each feeding but may be interested in feeding only on one side per feeding during the early days.
7. If mother and infant are separated, support the mother to visit her infant as often as possible, so that she can recognize feeding cues. When staff notice feeding cues, they should bring the mother and baby together.
8. Feeding cues include:
    a. Early cues – stirring, mouth-opening, turning head, and sucking/rooting
    b. Mid-cues – stretching, increasing physical movements, and hand-to-mouth
    c. Late cues – crying, agitated body movements, and color turning red. If infant is showing late cues, teach parents to calm before feeding.

Step 9. Feeding bottle, teats and pacifiers – Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.

A. Staff will avoid using pacifiers and/or feeding bottles until the successful establishment of breastfeeding, at about 3-4 weeks per American Academy of Pediatrics.
B. Pacifiers may be used for the breastfeeding infant during painful and/or therapeutic medical procedures. Discard pacifier after use.
C. If possible, consider an alternative to a pacifier for a "pain free newborn care approach", such as allowing infant to be breastfed or placed skin-to-skin during a heel stick procedure.
D. Pacifiers are not to be routinely issued. If the mother requests a pacifier, education will be provided, enabling informed decisions; staff should explore and document the reasons for the request, instructing her regarding the possible negative consequences of prolonged use of artificial nipples and pacifiers which may include:
    1. Hygiene risks of inadequate cleaning (bacterial growth)
    2. Hindrance of breastfeeding attachment and the recognition of feeding cues
    3. Production and establishment of breastmilk supply
E. Artificial nipples, pacifiers, other soothers, bottles, and breast milk substitutes will not be included in any gift packs given to pregnant patients or breastfeeding mothers. Marketing and coupons for these items will be excluded as well.

Step 10. Care at discharge – Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

A. Identify appropriate hospital and community resources for continued and consistent breastfeeding support.
B. Circle App resource for infant feeding education.
C. Upon discharge, all postpartum moms will be encouraged to participate in breastfeeding support groups. Information regarding location and schedule will be provided. For a complete list of community partners and breastfeeding support see attachment X.[attachment –

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ministry specific]

D. Any nursing concerns related to the infant's ability to latch or effectively suckle at the breast will be communicated to the infant's health care provider prior to discharge.

E. Discharge planning will include phone numbers for the lactation support phone line.

F. Upon discharge, mothers will be instructed to contact their health care provider/clinic for any concerns or questions about breastfeeding. All parents will be given instructions to contact their infant's healthcare provider for an appointment within 48-72 hours or the appointment is scheduled before discharge.

G. Providence ministries will continue to seek opportunities for growing and supporting lactation services in their surrounding community.

H. Education will be documented in EMR.

REFERENCES

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Approval Signatures

Step Description	Approver	Date
	Naydu Lucas: Chief Nursing Officer	10/11/2023
Medical Director	Deepak Stokes	10/3/2023
	Michelle Harrison: Director Nursing	8/25/2023

Standards

No standards are associated with this document

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