Toward a Healthier Tomorrow

How Nevada Can Reach "Healthy People 2020" Breastfeeding Goals

A 2012 Assessment of Nevada Hospitals

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Going for the Goals

Breast milk is the gold standard for infant feeding[1]! No artificial food (e.g., commercially prepared infant formula) contains the over 200 bioactive substances found in human milk, including immune and growth factors. These factors protect infants from infections, stimulate brain growth and development of organs, and reduce the risk of future chronic diseases. Breastfeeding provides maternal benefits as well—enhanced bonding with infants, greater postpartum weight loss, and decreased risk of certain cancers, osteoporosis, type 2 diabetes, obesity, and cardiovascular disease.

In 2011, the Surgeon General issued a Call to Action[2], encouraging all Americans to reflect on their roles in promoting, supporting and protecting the women who have chosen to breastfeed their infants. Specific to this report, the Call to Action lists a hospital's responsibility to assist women in their goal to successfully breastfeed, as it is in the hospital that women begin to fulfill their decision.

Unlike in years past, the majority of pregnant women entering Nevada hospitals wish to breastfeed their infant, either exclusively or partially (Table 1: Healthy People 2020 Breastfeeding Goals).

The Outcome Indicators listed in the 2011 Report Card reflect the 2020 goals[3]. The highlighted columns indicate those goals that directly impact hospital maternity practices.

It is ethically imperative that hospitals adopt practices that enable women to fulfill their informed choice to breastfeed[4]. The 10 Steps to Successful Breastfeeding

Table 1: Healthy People 2020 Breastfeeding Goals

- Increase the proportion of infants who are breastfed to 81.9%
- Increase the proportion of infants who are breastfeeding at 6 months to 60.6%
- Increase the proportion of infants who are breastfeeding at 1 year to 34.1%
- Increase the proportion of infants who are EXCLUSIVELY breastfed through 3 months to 46.4%
- Increase the proportion of infants who are EXCLUSIVELY breastfed through 6 months to 25.5%
- Reduce the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life to 14.2%
- Increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies to 8.1%

Breastfeeding Report Card 2011,
United States: Outcome Indicators

For the time period: 2/2008-5/2010	Ever BF	BF at 6 months	BF at 12 months	Exclusive at 3 months	Exclusive at 6 months	% of breastfed infants receiving formula before 2 days	% babies born in facilities that provide recommended care
2020 GOAL	81.9	60.6	34.1	46.4	25.5	14.2	8.1
U.S. National	74.6	44.3	23.8	35.0	14.8	24.5	4.53
Nevada*	80.1	45.6	23.8	32.6	11.5	27.8	0

(Source: Centers for Disease Control and Prevention National Immunization Survey, Provisional Data, 2008 births. http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm).

* Data is obtained from the CDC National Immunization Survey. Using random-digit dialing to land lines only, households with children 19-35 months are asked questions about breastfeeding. Limitations to this survey design include recall difficulties, social desirability of the respondent (answer what thinks the interviewer may want to hear) and systematic exclusion of low-income families (about 60% of low-income families only have mobile phone service).

(Table 2) was issued to help hospitals assist women in reaching their goals[5]. As the 10 Steps are general statements, the World Health Organization developed a set of best practices, which are commonly referred to as the Baby-Friendly Hospital Initiative. Recently, the Joint Commission[6], the U.S. Breastfeeding Committee[7], and the Surgeon General[1] established standards and competencies for U.S. maternity practices aimed to address each of the 10 Steps.

The U.S. Baby-Friendly Hospital Initiative details specific guidelines and evaluation criteria required by maternity hospitals to be designated as Baby-Friendly[8]. At the time this study was initiated, none of the 19 Nevada maternity services hospitals (Table 3) were designated as Baby-Friendly. It should be noted, however, that beginning July 12, 2012, all U.S. maternity hospitals will be required to report at least one core Baby-Friendly Hospital Initiative standard—EXCLUSIVE BREASTFEEDING (defined as a newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines).

It is not expected that every maternity hospital will receive the Baby-Friendly designation; however, it is critical that basic policies that interfere with successful initiation, or prevent support of breastfeeding be replaced with ones that protect a woman's choice and allow her to sustain that choice for as long as she wishes.

Moreover, prior to this study, little was known about the extent to which each step was being met by Nevada maternity hospitals. To determine what Nevada hospitals are doing, and what they need in order to

Table 2: Ten Steps to Successful Breastfeeding

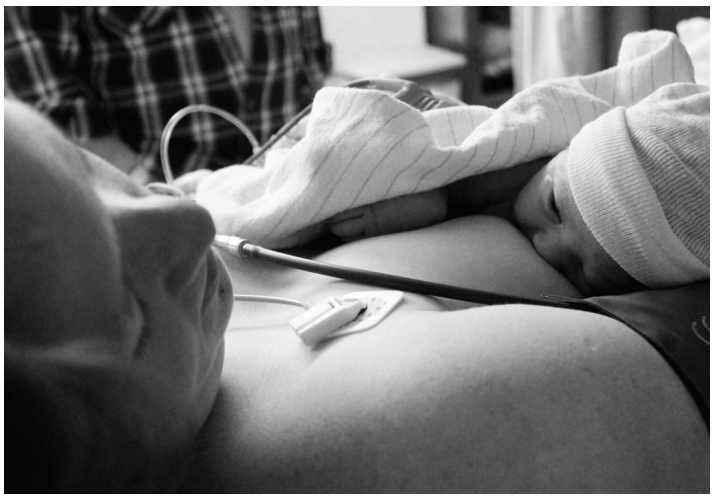
Every facility providing maternity services and care for newborn infants should:

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

Source: Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services, a joint WHO/UNICEF statement published by the World Health Organization.

Table 3: Nevada Hospitals Providing Maternity Services

NAME	COUNTY
Banner Churchill Community	Churchill
Carson Tahoe	Carson
Centennial Hills	Clark
Humboldt General	Humboldt
Mesa View Regional	Clark
Mike O'Callaghan	Clark
Mountain View	Clark
Northeastern Nevada Regional	Elko
Renown Regional	Washoe
St. Mary's Regional	Washoe
St. Rose Dominican—San Martin	Clark
St. Rose Dominican—Siena	Clark
Southern Hills	Clark
Spring Valley	Clark
Summerlin	Clark
Sunrise	Clark
University Medical Center	Clark
Valley	Clark
William Bee Ririe	Ely



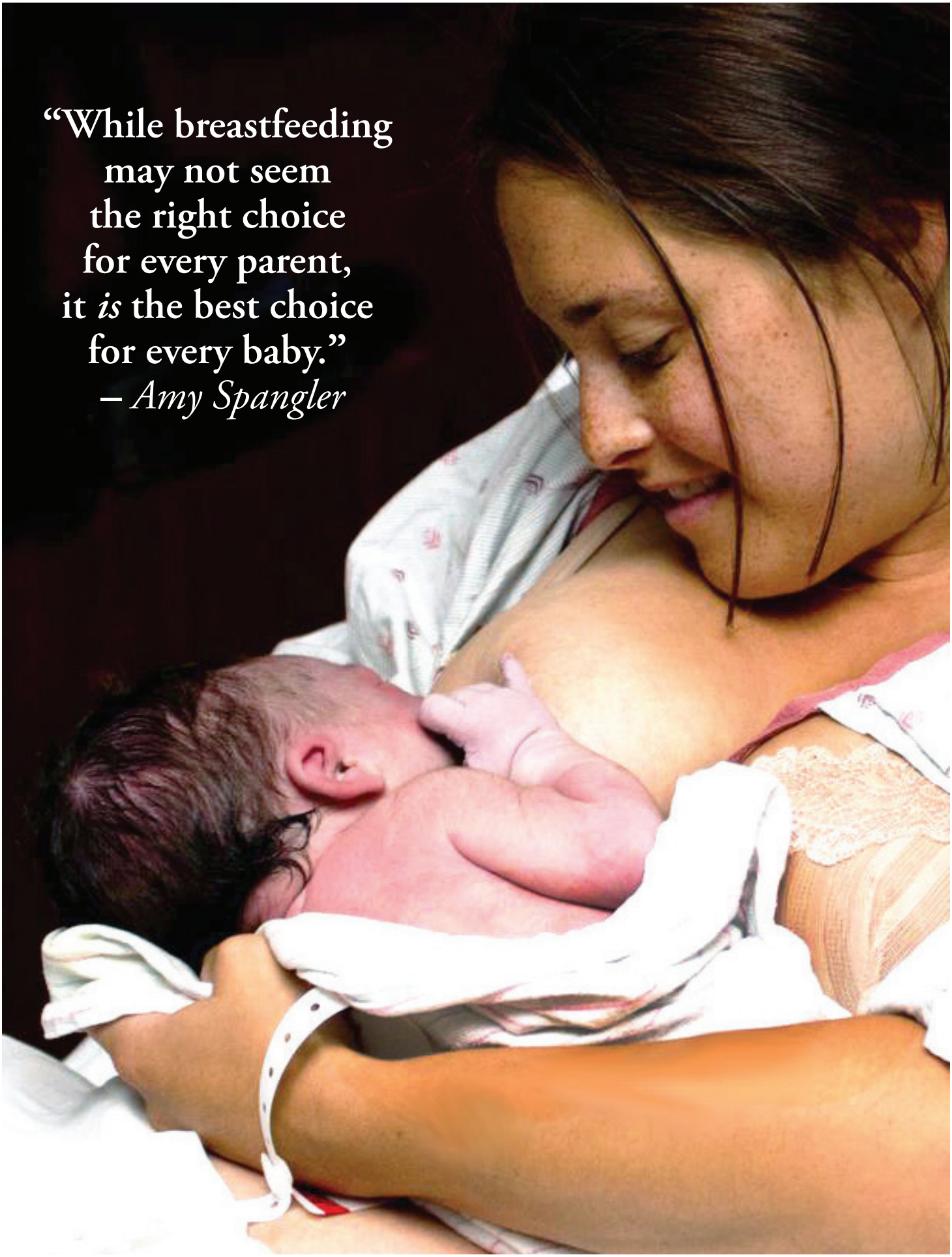
improve breastfeeding support, the Nevada State Health Division contracted with the Southern Nevada Breastfeeding Coalition to conduct interviews with representatives from each Nevada maternity hospital. Dr. Sigman-Grant, PhD, RD, was the principal investigator and Crystal Schulz, MPH, IBCLC, conducted the interviews. This report presents the study findings along with suggestions on how Nevada hospitals can reach the Healthy People 2020 Breastfeeding Goals.

CONDUCTING THE STUDY

Letters were sent from the Nevada State Breastfeeding Coordinator (K. Langdon) to the CEO of each maternity hospital announcing the study and requesting their infant feeding/breastfeeding written policies and/or procedures. Reminders were sent and phone calls made to ensure each maternity hospital had the opportunity to participate.

Using criteria from the U.S. Baby-Friendly Hospital Initiative, policies were reviewed in the following seven practice areas: Labor and Delivery Care; Postpartum Care; Breastfeeding Assistance; Contact between Mother and Infant; Assurance of Ambulatory Support; Staff Training, and Structural and Organizational Aspects of Care Delivery (Appendix, page 16). Under each area, specific actions are addressed and persons responsible for carrying out the practices are delineated.

Telephone interviews were conducted with at least one person identified by the hospital CEO or his/her representative. Hospital CEOs, nursing managers, labor and delivery staff, postpartum staff, and physicians were invited to be interviewed. Using each hospital's policies as guides, scripted interviews were


"While breastfeeding
may not seem
the right choice
for every parent,
it *is* the best choice
for every baby."
– *Amy Spangler*

Routine Epidurals: An Unrecognized Barrier to Meeting Breastfeeding Goals

ANESTHESIA decreases newborn alertness...

- WHICH IN TURN interferes with the infant's ability to initiate suckling WHICH IN TURN
- Delays stimulation of milk production WHICH IN TURN
- Can lead to dehydration jaundice WHICH IN TURN
- May require introduction of artificial formula feeds WHICH IN TURN
- Increases the infant's exposure to pathogenic gastro-intestinal organisms *AND* diminishes breast stimulation WHICH IN TURN
- Leads to abandonment of breastfeeding

individualized to address every practice area. Finally, interviewees were asked to provide some suggestions regarding what the Nevada State Health Division could do to help hospitals meet breastfeeding goals.

Following analytical review of the interviews and written policies, hospital practices were classified into one of three categories defining the degree to which they are meeting recommendations within each of the seven areas. Categories included Meeting Recommendations (defined as always or almost always reporting the practice was done), Partially Meeting Recommendations (defined as beginning to initiate practice but not always done with consistency), and Not Meeting Recommendations (defined as either practice was unknown or no attempt to initiate practice was being made).

RESULTS AND DISCUSSION

Every Nevada hospital offering maternity services provided written policies and/or procedures to the researchers as well as contact names and numbers of persons to be interviewed. Of the 26 persons interviewed, the majority was nurses (seven with training in lactation) and two were physicians.

Calls lasted from 35 to 70 minutes. Detailed notes were taken as answers were clarified. Spreadsheets of responses covering each area were created and responses categorized. For purposes of this report, specifics for some practice areas were consolidated whereas others were expanded.

Labor and Delivery Care

Five components were scored (Table 4, page 14). The most critically important practice for successful initiation of breastfeeding during labor and delivery is placing the infant skin-to-skin on the mother's chest, allowing the infant to find the breast on its own and letting the initial feed continue until baby stops. Almost 50% of hospitals report allowing skin-to-skin contact between mother and infant but it was difficult to determine from the interviews the extent each nurse and doctor followed this practice.

Postpartum Care

As mentioned above, the period immediately following birth is crucial for initiation of lactation. Practices important for successful breastfeeding include: keeping an infant skin-to-skin upon the mother's chest; conducting routine postpartum procedures while baby stays with the mother; limiting family members so that mothers can concentrate on breastfeeding, and altering protocols when mothers (and infants) have

been exposed to anesthesia during labor. Figure 1 details the proportion of NV hospitals reporting meeting these practices.

Perhaps the single most important barrier for women reaching their intention to exclusively breastfeed is the introduction of infant formula to the breastfeeding infant[9]. Inspection of Figure 2 reveals two major practices that most hospitals immediately need to address: having health care staff review the risks of infant formula being introduced to an exclusively breastfed baby and requiring a written order for supplemental formula.

Breastfeeding Assistance

Overall, hospitals report providing breastfeeding assistance by observing and documenting breastfeeding (80%), counseling lactating women (75%), and discussing fullness (80%) and hunger (69%) cues.

Contact between Mother and Infant

Almost 80% of hospitals report that their facility allows infants to room in with their mother.

Assurance of Ambulatory Support

Not surprising, most hospitals do not report fully meeting post discharge breastfeeding recommended practices (Figure 3). Providing ambulatory services for breastfeeding women after hospital discharge is not seen as a hospital responsibility. This reflects a nationwide attitude that individual hospitals may not be able to address without cooperation from community resources, including insurance companies.

Staff Training

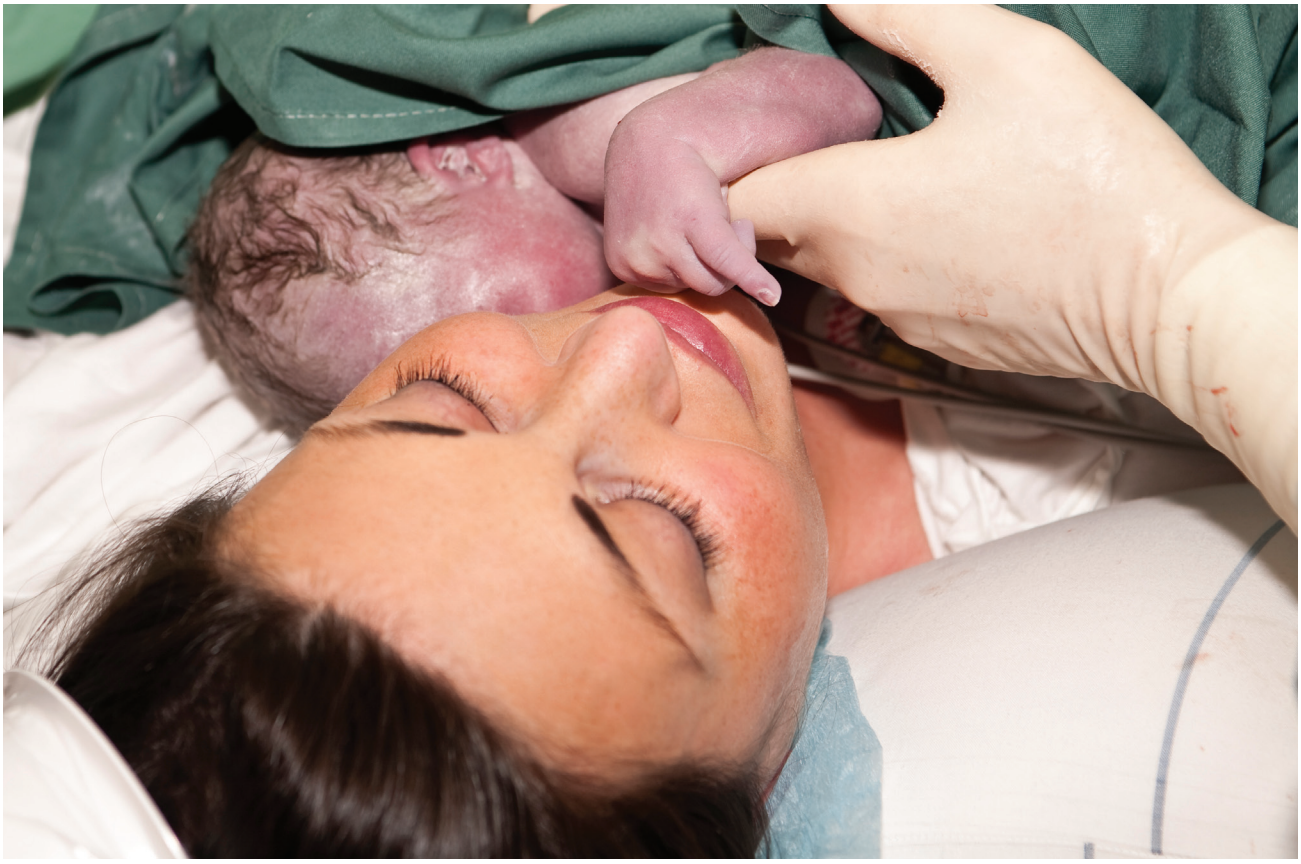
Clearly, one of the major needs for Nevada hospitals regarding support of breastfeeding is staff training (Figure 4).

Structural and Organizational Aspects of Care Delivery

While many hospitals report having components of the infrastructure and organization to operationalize best practices for infant feeding and maternity care, there is still much that can be done (Table 5). In particular, it is concerning that there is a lack of consequences to health care staff if written breastfeeding policy is violated. This would not be acceptable in other areas of hospital care.

HOW FAR TOWARD THE GOALS ARE NEVADA HOSPITALS?

All Nevada maternity hospitals have written breastfeeding policies that are available to all those involved in maternity practices. Several hospitals, however, seem unaware that their written policies are outdated. One particular practice that greatly disrupts lactation initiation is not addressed by any hospital—routine epidurals to all women in Labor and Delivery (see page 8). Practices such as tracking diapers for hydration status, no skin-to-skin time,



removing infants from mothers to perform routine baby assessments and care, or lack of accountability regarding distribution of formula or pacifiers are just a few erroneous practices that are either inappropriately included or totally missing from written policies. Moreover, over half of the hospitals have a relationship with formula company representatives that could be different from relationships with other pharmaceutical representatives.

To their credit, about half of Nevada's hospitals state their policies currently are being updated to meet the 2020 Goals of increasing exclusive breastfeeding and decreasing use of supplemental formula feeding. Many are not giving infant formula when discharging lactating mothers; others have stopped routine distribution of pacifiers. While progress is steady, it is slow due to resistance from both medical and nursing staff. Two hospitals, having addressed this resistance, are in the process of acquiring Baby-Friendly Hospital status (see pages 12 and 13 for their stories).

Where appropriate policies exist, in-depth interviews revealed major discrepancies between written documents and actual implementation. Most striking are reports of non-compliance by members of the nursing staff. Attitudes of "not wanting moms to feel bad" prevent many nurses from stating known risks of giving even one bottle of formula to a breastfed newborn. They are comfortable with talking about breastfeeding benefits, but do not want to state evidence-based risks. Whereas some nurses are great supporters of breastfeeding mothers (spending time educating, observing, and encouraging them), others sabotage mothers' intentions to breastfeed. These nurses press mothers to feed supplemental formula or give pacifiers to breastfed infants, remove babies from mothers' rooms, or assume that it is not their role to assist mothers with lactation.

While inappropriate practices could be attributed to lack of education, there are few consequences to nurses if written policies are not followed. For some hospitals, nothing is done when breastfeeding is undermined; others only issue verbal reprimands. A few follow the complete protocol used to address violations in other areas of medical practice by giving verbal followed by written reprimands, and when necessary, subsequent suspension.

It is encouraging to learn of the many changes being considered and implemented by Nevada hospitals. When queried about what the Nevada State Health Division could do to assist hospitals in their efforts, two major efforts were requested. One focused on mothers themselves (providing educational materials for mothers [63%], and community education such as Public Service Announcements [42%]). The other area focused on hospital needs (training of staff [42%], and educational materials for staff [47%]).

It is not expected or necessary for every Nevada hospital to apply for Baby-Friendly Hospital status. However, providing support, promotion, and protection to those mothers wishing to fulfill their informed choice of breastfeeding their baby is a medically ethical imperative for every Nevada hospital. As Secretary of the U.S. Department of Health and Human Services, Kathleen Sebelius, states: "I urge all Americans to be supportive of breastfeeding mothers and families in their communities and to extend their support so that these mothers get the health care, the help, and the encouragement they deserve" [2, page iii].

Carson Tahoe Regional Medical Center: Steps to Baby-Friendly

Sixteen years ago, Carson Tahoe Regional Medical Center began their Baby-Friendly journey. They started by educating families on the importance of breastfeeding. They showed mothers how to breastfeed and implement lactation (even when separated from their infants), and to breastfeed on demand. It was easy for them to give newborns nothing but breast milk to consume—unless medically indicated. For most of these years, this medical center has been practicing "rooming-in"—allowing mother and infant to be together 24 hours a day. For years, they have not been giving pacifiers or artificial nipples.

Despite the fact that Carson Tahoe Regional Medical Center has had the Baby-Friendly Hospital Initiative steps in the forefront when considering operations and policies, there were two major steps that were challenging to overcome. It has been within the last two years that they began addressing the challenge of lactation training for all staff and developing an appropriate written policy on lactation and routinely communicating that to all staff.

Currently, Carson Tahoe Regional Medical Center has met all ten of the Baby-Friendly Hospital Initiative Steps. They are in the process of being investigated, interviewed and officially named one of Nevada's first Baby-Friendly Hospitals!

St. Rose Dominican Hospital Siena Campus: Steps to Baby-Friendly

Seven years ago, St. Rose Dominican Hospital's Siena Campus began its Baby-Friendly process. This hospital makes great efforts to prenatally educate women and families on the importance of breastfeeding. Every woman who comes in to deliver is given education. This hospital also goes even further with strong efforts to educate women in the community on the importance of breastfeeding.

There are 12 IBCLC's on staff, and every year St. Rose sponsors five nurses to complete the Certified Lactation Consultant course. They have trained all maternity-related and postnatal services staff (including NICU) using the Baby-Friendly required 20-hour course. This training was their biggest hurdle to completing the 10 Steps. Aside from finding solutions to the training requirement, the St. Rose Baby-Friendly team has found it relatively smooth sailing to check off each of the 10 Steps.

Teaching mothers to breastfeed is included in nurses' job descriptions and it is their new standard of care. Rooming-in is the only option for healthy babies and mothers, and breastfeeding on demand is cultivated. Initially, the hospital had resistance from certain staff, but after the training, those nurses became breastfeeding cheerleaders!

St. Rose is now set to have their Siena Campus visited by summer's end, 2012, to become one of Nevada's first Baby-Friendly Hospitals!

Results*

Table 4. Percentage of Hospitals Reporting Meeting Baby-Friendly Labor and Delivery Recommended Practices

Factor	Meets (%)	Partially Meets (%)	Does Not Meet (%)
Skin-to-Skin for Normal Deliveries	42	42	16
Skin-to-Skin for C-Section	16	36	47
Routines Done Skin-to-Skin	53	16	32
Limit Family Members to <3	10	37	53
BF Plans Changes due to Anesthesia Procedures			100

Figure 1: Percentage of Nevada Hospitals Reporting Postpartum Care

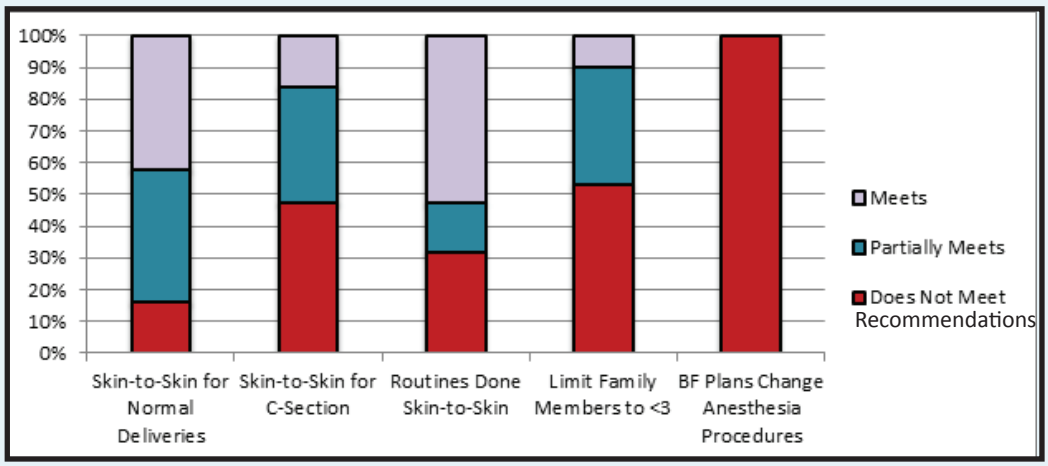
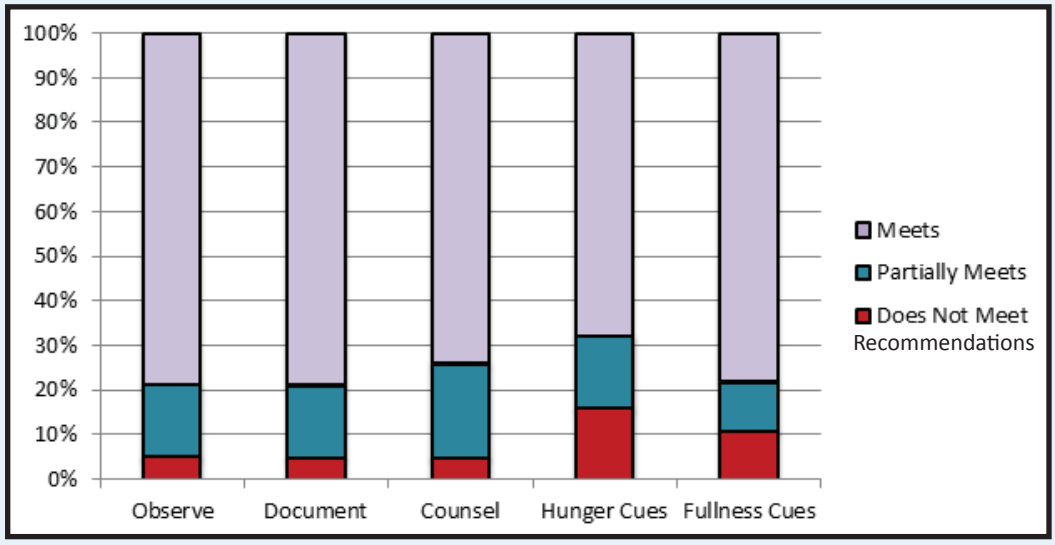


Figure 2: Percentage of Nevada Hospitals Reporting Supplemental Feedings



* *Meets defined as always or almost always reporting the practice was done; Partially Meets defined as beginning to initiate practice but not always done with consistency; and Does Not Meet defined as either practice was unknown or no attempt to initiate practice was being made.*

Figure 3: Percentage of Nevada Hospitals Assuring Ambulatory Support Upon and After Discharge

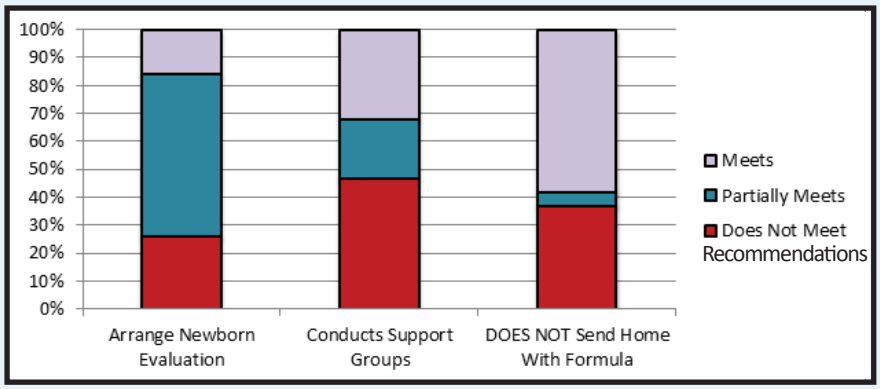


Figure 4: Percentage of Nevada Hospitals Reporting Staff Training

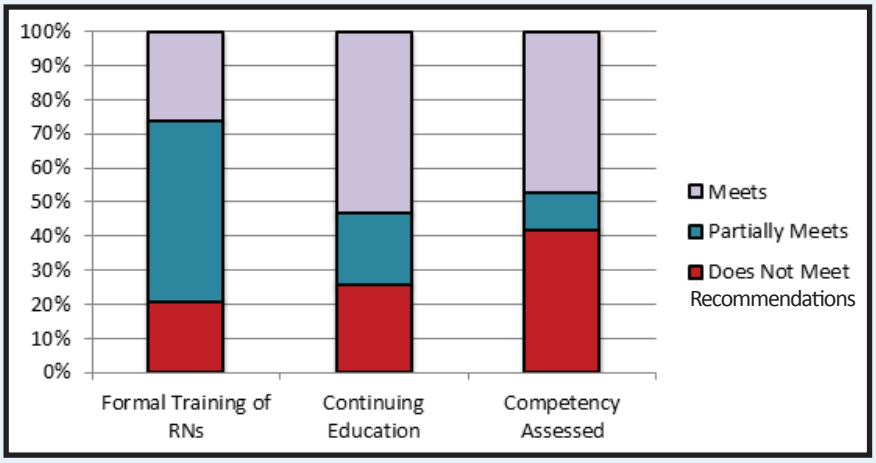


Table 5. Percentage of Hospitals Reporting Meeting Baby-Friendly Structural and Organizational Aspects of Maternity Care Delivery Recommended Practices

Factor	Meets (%)	Partially Meets (%)	Does Not Meet (%)
Written BF Policy Communicated	73	11	16
Consequences If Policy Not Followed	26	21	53
Formula Vendor Relationship	21	79	
Offers Warm Line	37	31	31
PP† Nurses Call BF Moms	37	16	47
PP BF Consult Available in Hospital	26	37	37
Home BF Visit	5	5	90

† *PP= Postpartum*

Appendix: Breastfeeding Health Care Recommendations

Recommendation From Core Competencies*	Implementation Strategies (Practice and Who To Involve)
Labor and Delivery Care	
Initial skin-to-skin contact	*Practice:* Emphasize skin-to-skin contact immediately after birth to facilitate imprinting of proper breastfeeding (BF) technique by the infant. For mothers having non-emergency cesarean births, immediate skin-to-skin contact after birth, while incisions are being closed, may help prevent both maternal and neonatal hypothermia and provide a pleasurable distraction during the remainder of the surgery. *Who:* **Prenatal Educators; Labor and Delivery Nurse Managers; Nursing Staff; Nurse Educators; Chief of Obstetrics and staff, including midwives; Chief of Pediatrics and staff; Chief of Family Practice and staff; Neonatal Intensive Care Unit staff**
Initial BF opportunity in first hour of life	*Practice:* Infants immediately placed skin-to-skin with their mother after birth without interruption tend to find the breast and spontaneously initiate BF within the first hour. It is usually not necessary to bring the infant to the breast. This crucial time can include transport of the infant and mother from the delivery area to the postpartum area while the infant is skin-to-skin on the mother's chest. During this time, the infant should not be removed for bathing, weighing, examinations, or medications. Diapering may also be postponed until after the first feed. Note that it may take some infants longer than one hour to spontaneously initiate BF, particularly if the mother was given sedating medications during labor. *Who:* **Prenatal Educators; Labor and Delivery Nurse Managers; Nursing Staff; Nurse Educators; Chief of Obstetrics and staff, including midwives; Chief of Pediatrics and staff; Chief of Family Practice and staff; Neonatal Intensive Care Unit staff**
Routine procedures performed skin-to-skin	*Practice:* Perform Apgar assessments and other procedures which may be painful (heel-sticks, medication administration) while mother and baby are skin-to-skin or BF. Choose the easiest task first, establish as the standard of care, and build other skin-to-skin performed procedures as staff confidence levels rise. *Who:* **Labor and Delivery and Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Chief of Obstetrics and staff; Chief of Pediatrics and staff; Chief of Family Practice and staff; Neonatal Intensive Care Unit staff**
Assure continuous physical, emotional, and informational support	*Practice:* Support to come from skilled, trained professionals during and just after birth, such as birth doulas, midwives, or registered nurses specially trained in the art of labor support. *Who:* **Hospital Administrator; Labor and Delivery Nurse Managers; Nursing Staff; Nurse Educators; Chief of Obstetrics and staff; Chief of Family Practice and staff; Chief of Anesthesia and staff**
Postpartum Care	
Feeding of Breastfed Infants	Initial feeding received after birth *Practice:* The infant should remain skin-to-skin with the mother until the first feeding spontaneously occurs and finishes. Who: **Labor and Delivery and Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Chief of Pediatrics and staff; Chief of Family Practice and staff**
	Supplementary feedings *Practice:* Include appropriate supplementation guidelines in your BF policy and documentation. This should include the reason for supplementation, the route (e.g., spoon, cup, syringe, etc.), the form (e.g., formula, expressed mother's own milk, donor human milk), and the appropriate amount given the infant's age and weight. It is preferable to use milk expressed from the infant's own mother or donor human milk as a supplement; this practice allows the infant to be counted as exclusively breast milk-fed for the core measure. *Who:* **Labor and Delivery and Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Chief of Pediatrics and staff; Chief of Family Practice and staff**
	Avoid using supplements for which there is no medical indication *Who:* **Labor and Delivery and Postpartum Nurse Managers; Nurse Educators; Chief of Pediatrics; Chief of Family Practice; Chief of Pharmacy; Purchasing Managers**
Encourage use of mother's own expressed milk or banked donor human milk	*Practice:* If not already in existence, consider developing a policy and procedure that encourages use of mother's own expressed milk or banked donor human milk as a preference over formula, when supplementation is indicated. *Who:* **Hospital Administrator; Labor and Delivery and Postpartum Nurse Managers; Nurse Educators; Chief of Pediatrics; Chief of Family Practice; Chief of Pharmacy**
Consult evidence-based resources on medication safety	*Practice:* When addressing questions about the effect of maternal medication on BF, consult evidence-based resources on medication safety† *Who:* **Chief of Obstetrics and staff; Chief of Pediatrics and staff; Chief of Family Practice and staff; Chief of Pharmacy and staff; Chief of Radiology and staff; Labor and Delivery and Postpartum Nurse Managers; Nursing Staff; Nurse Educators**

Code for identifying who is responsible for implementation: Green – CEO and other administrators; Blue – Nursing staff; Purple – Medical Staff; Orange – Others.

Assure accountability in distribution of infant formula and nipples.	*Practice:* Consider storing formula in a locked cabinet or medication dispensing system. When administered, record the amount, method of administration, lot number, time, reasoning for supplementation, person who administered the formula and patient number. *Who:* **Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Pharmacy Director (if using locked medication device); Chief of Pediatrics and staff**
Review the risk of routine or non-medically indicated formula use with all mothers	*Practice:* Review the risk of routine or non-medically indicated formula use with all mothers, including the risks to BF success as well as potential health risks to mother and infant, especially due to early weaning. Consider including nursing documentation that risks were reviewed with the mother. In addition, assure that all formula feeding mothers receive oral and written instructions explaining the appropriate mixing, storage, discarding, and feeding of formula. *Who:* **Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Pharmacy Director (if using locked medication device); Chief of Pediatrics and staff**
BF Assistance	
Documentation of feeding decision	*Practice:* Document that mother has received adequate information to make an informed feeding choice, and that she understands the risks of formula feeding to her health and that of her infant. *Who:* **Labor and Delivery and Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Chief of Obstetrics and staff; Chief of Pediatrics and staff; Chief of Family Practice and staff**
Assessment and observation of BF	*Practice:* Staff and parents should be taught the following information, both in the prenatal setting and in the hospital: • Avoid scheduled feedings. Feed at the earliest signs of hunger: baby's eyes open, rooting, yawning, and stretching. • It is normal for exclusively breastfed babies under six months to feed 8-11 times in 24 hours. Nursing more than the minimum (8 feedings per 24 hours) will help mature milk to come in sooner, avoiding high bilirubin levels and excessive weight loss. Babies commonly cluster feed, asking for several closely-spaced feeds followed by a longer sleep. • During the hospital stay, a newborn who does not wake to feed at least 8 times in 24 hours should be assessed for hydration status and signs of sepsis or hypoglycemia. If the baby appears healthy, continue to monitor until he is feeding effectively and spontaneously waking for feeds. • Use of supplements, especially in the early weeks, can decrease milk supply, cause undue engorgement, and risk early weaning. Frequent nursing helps increase milk supply. Discuss normal newborn behavior, so that parents will understand that it is normal for infants to breastfeed frequently or cluster feed. Explain to parents that babies may breastfeed for comfort as well as for nourishment, and that this does not reflect inadequate milk production. *Practice:* As much as possible, staff should allow mother to position the baby and achieve latch, with guidance if necessary, rather than positioning and latching on the infant for the mother. *Practice:* Be prepared to offer extra help for those mothers at increased risk for delay in milk production: cesarean delivery (especially if unscheduled), large infants (>3600g), primiparas, prolonged labor, obesity, infants of diabetic mothers, and possibly for those using selective serotonin-reuptake inhibitors. These mothers will need particular attention to assure frequent feedings, rooming-in, skin-to-skin contact, and appropriate latch and positioning, and may need heightened. *Who:* **Hospital Administrator; Lactation Managers; Chief of Obstetrics and staff; Labor and Delivery and Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Chief of Pediatrics and staff; Chief of Family Practice and staff**
Formal evaluation of BF	*Practice:* Evaluation should include observation of position, latch, and milk transfer, should be undertaken by trained caregivers at least twice daily and fully documented in the record during each day in the hospital after birth. During the last eight hours preceding discharge of the mother and baby, formal documented assessment of BF effectiveness should be performed by a BF-trained medical professional. *Who:* **Hospital Administrator; Lactation Managers; Chief of Obstetrics and staff; Labor and Delivery and Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Chief of Pediatrics and staff; Chief of Family Practice and staff**
Pacifier use	*Practice:* Include a policy with clear and limited indications for pacifier use, such as if needed during circumcisions for analgesia, or if parents supply their own. The policy may include informing parents of risk of interference with the establishment of BF. *Who:* **Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Chief of Obstetrics and staff; Chief of Pediatrics and staff; Chief of Family Practice and staff; Chief of Pharmacy**
	Practice: Restrict access to hospital-issued pacifiers. *Who:* **Prenatal Educators; Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Chief of Pediatrics and staff; Chief of Family Practice and staff; Chief of Obstetrics and staff; Chief of Pharmacy**
	Practice: Restrict use of pacifiers dipped in concentrated sucrose solution to circumstances in which they are needed for analgesia, and not for calming babies, delaying feedings, or attracting babies to the breast. *Who:* **Prenatal Educators; Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Chief of Pediatrics and staff; Chief of Family Practice and staff; Chief of Obstetrics and staff**

Contact Between Mother and Infant	
Separation of mother and newborn during transition to receiving patient care units	*Practice:* If mother and infant must be transported after birth, delay transferring until initial skin-to-skin contact and feeding have occurred. Mother and infant should remain in the same room for at least two hours after birth and be cared for as a unit ("pair" or "couplet care") *Who:* **Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Chief of Pediatrics and staff; Chief of Obstetrics and staff; Chief of Family Practice and staff**
Patient rooming-in	*Practice:* Emphasize rooming-in. All infants, regardless of feeding method, should be kept with the mother both day and night. Families should be informed about rooming-in and why it is important. *Who:* **Prenatal Educators; Postpartum Nurse Managers; Nurse Educators; Chief of Pediatrics and staff; Hospital Administrator**
Instances of mother infant separation throughout the intrapartum stay	*Practice:* Perform Apgar assessments, heel-sticks, and medication administration while mother and baby are skin-to-skin; with painful procedures performed while BF. Avoid waking the mother and/or infant and removing the infant from the mother's presence in order to obtain routine weights and vital signs. Baby should be transported while skin-to-skin on the mother. *Who:* **Labor and Delivery and Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Chief of Obstetrics and staff; Chief of Pediatrics and staff; Chief of Family Practice and staff**
Assurance of Ambulatory BF Support	
Post discharge BF infant evaluation	*Practice:* Arrange for evaluation of all BF newborns within 3-5 days of age, by a pediatrician or other knowledgeable health professional, as recommended by the AAP. *Who:* **Postpartum Nurse Managers; Nurse Educators; Chief of Pediatrics and staff; Chief of Family Practice and staff; Public Health Nurses; Visiting Nurses**
Offer BF support groups	*Practice:* Offer walk-in support groups for all new parents. These support groups should offer trained BF support, in addition to general support for new parents. *Who:* **Hospital Administrator; Postpartum Nurse Managers; Nurse Educators; Lactation Managers and staff**
Do not discharge with formula company materials	*Practice:* Refrain from giving BF mothers formula company discharge packs and/or extra bottles of formula upon discharge. Staff should refrain from giving the infant water, teas, or herbal preparations. *Who:* **Hospital Administrator; Risk Managers; Purchasing Managers; Labor and Delivery and Postpartum Nurse Managers; Nursing Staff; Nurse Educators; Chief of Obstetrics and staff; Chief of Pediatrics and staff; Chief of Family Practice and staff; Hospital Ethics Committee**
Staff Training	
a. Preparation of new staff **b. Continuing education** **c. Competency assessment**	*Practice:* Provide basic education to new staff regarding perinatal care practices that may impact BF, such as avoidance of mother-infant separation, skin-to-skin contact, early initiation of BF, and the hospital's BF policy. Individual training on latch, positioning, and swallowing should be incorporated. Also provide continuing education on BF to existing staff. All staff should be given competency assessments at least once a year. Staff education and competencies should be mandatory and assessed during yearly evaluations. Many online tools and in-person courses are available that can assist in both training and competency assessment. Note that policy changes should be implemented prior to staff training, to ensure training is most effective. *Who:* **Labor and Delivery and Postpartum Nurse Managers; Nurse Educators; Chief of Pediatrics; Chief of Obstetrics; Chief of Family Practice**
Structural and Organizational Aspects of Care Delivery	
Available written policies	*Practice:* Have a written BF policy that is communicated to all staff including physicians and allied health care providers. *Who:* **Hospital Administrator; Labor and Delivery and Postpartum Nurse Managers; Nurse Educators; Chief of Pediatrics; Chief of Obstetrics; Chief of Family Practice; Quality Improvement Committee; Compliance Officer**
Congruent infant formula vendor policy	*Practice:* Ensure that business relationships and vendor policies with formula and BF equipment companies are congruent with policies for other vendors. *Who:* **Hospital Administrator; Purchasing Managers; Labor and Delivery and Postpartum Nurse Managers; Nurse Educators; Chief of Pediatrics; Chief of Family Practice; Compliance Officer; Hospital Ethics Committee**
Post discharge lactation services	*Practice:* Provide access to lactation care and services after discharge. These services may take the form of general new parent support groups staffed by a trained lactation specialist or one-on-one lactation consultation, both of which may be required by some women. Most women could also benefit from community-run BF support groups. *Who:* **Hospital Administrator; Lactation Services Managers; Postpartum Nurse Managers; Nurse Educators**

* United States Breastfeeding Committee. Implementing The Joint Commission Perinatal Care core measure on exclusive breast milk feeding. Rev ed. Washington, D.C.: United States Breastfeeding Committee; 2010.

† For the purposes of this report, stated use of Medications and Mother's Milk by T. Hale was used to indicate meeting recommendation.

Code for identifying who is responsible for implementation: Green – CEO and other administrators; Blue – Nursing staff; Purple – Medical Staff; Orange – Others.

Taking the Next Steps Toward the Goals

NEVADA MATERNITY HOSPITALS:

- Review current written breastfeeding policies for accuracy
- Institute a strategic plan, defining implementation of evidence-based policies
- Require specific breastfeeding education for all involved with providing breastfeeding practices (including obstetric, pediatric and family practice medical and nursing professionals, pharmacists, and anesthesiologists). This may entail paid time for education
- Review current written breastfeeding policies to ensure violations of policy are addressed

NEVADA STATE HEALTH DIVISION:

- Provide training opportunities to maternity medical and nursing professionals
- Provide educational materials for maternity medical and nursing professionals
- Provide evidence-based references and resources regarding maternity hospital practices
- Work with the Health Care Insurance industry to provide reimbursement to hospitals for appropriate in-patient care
- Work with the Health Care Insurance industry to provide reimbursement to hospitals for appropriate out-patient follow-up

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Acknowledgements:

Kelly Langdon—Nevada State Breastfeeding Coordinator
Dr. Madeleine Sigman-Grant—MCH Extension Specialist
Crystal Schulz, President—Southern Nevada Breastfeeding Coalition
Karen Geller-Shinn—Designer
Sarah Boccolucci—Photographer, pages 7 and 13

We would like to thank all participating hospitals!

The Nevada State Health Division will provide resources and a framework to help facilities improve breastfeeding outcomes. For more information, please contact: Nevada State Health Division, 4126 Technology Way, Suite 102, Carson City, NV 89706; 775-684-4299; www.nevadabreastfeeds.org

This publication was developed in collaboration with the Nevada State Health Division, The Southern Nevada Breastfeeding Coalition and the University of Nevada Cooperative Extension. This report was supported by the Nevada State Health Division through Grant Number BO4MC21394 from the Health Resources and Services Administration. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Nevada State Health Division nor the Health Resources and Services Administration.

SOUTHERN NEVADA Breastfeeding COALITION

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