I. POLICY STATEMENT

To promote successful breastfeeding, also known as chestfeeding, by ensuring that, in the absence of contraindications, all patients who elect to breastfeed will have a successful and satisfying experience; and to standardize information regarding care that is communicated by all staff caring for patients.

II. DEFINITIONS

A. Hand Expression: Method of removing milk from the breast through rhythmic manual hand compression.

B. Lactation Risk Standards: Breastfeeding risk factors identified at Stanford Medicine Children's Hospital that indicate that a patient will need more in-depth breastfeeding assessment and management from the RN, with initiation of a lactation consult order.

C. Skin-to-skin (STS): The technique of placing the naked infant prone on the birthing patient's bare chest immediately after delivery, or as soon as possible if no medical contraindications.

III. PROCESS

A. This facility acknowledges human milk feeding as the biological norm and the gold standard for optimal infant health. Obstetricians, Pediatricians, and all other health care staff will actively recommend and support breastfeeding as the preferred method of providing nutrition to infants unless breastfeeding is specifically contraindicated. When direct breastfeeding is not possible, expressed human milk should be provided.

   a. This institution abides by The International Code of Marketing Breastmilk Substitutes (the Code) and related World Health Assembly resolutions because noncompliance is a major undermining factor for breastfeeding. This institution does not promote formula (nor related products covered in the Code).
   b. Any product under the Code that may be needed by the institution will be bought at fair market value.
   c. Educational materials (including posters, applications, written handouts, etc.) with company logos from manufacturers or distributors of human milk substitutes, feeding bottles, artificial nipples, and pacifiers directed to staff, and patients are prohibited.
   d. Employees of manufacturers or distributors of human milk substitutes, feeding bottles, artificial nipples, and pacifiers have no direct or indirect contact with patients.
   e. The facility and any affiliated prenatal clinics do not receive free gifts, non-scientific literature, materials, promotional items, equipment, money, or support for breastfeeding education or support/sponsorship for events/meetings from manufacturers of human milk substitutes, feeding bottles, artificial nipples, and pacifiers.
   f. No pregnant persons or families are given marketing materials or samples or gift packs by the facility that consist of human milk substitutes, feeding bottles, artificial nipples, pacifiers, or other infant feeding equipment or coupons for the above items.
   g. Any educational materials distributed to pregnant persons and breastfeeding patients are free from messages that promote or advertise infant food or drinks other than human milk, feeding bottles, artificial nipples, and pacifiers (except safe sleep and Sudden Infant Death Syndrome (SIDS) reduction materials).

B. The infant feeding policy will be routinely communicated to staff, beginning with hospital orientation, and shall be clearly posted in the perinatal unit and on the health system Intranet web site.

C. The multidisciplinary committee will be composed of decision makers in the areas of maternal and newborn health, quality assurance and management, providers/physicians, nurses, midwives, lactation consultants, and other appropriate staff.

a. The multidisciplinary team will assess implementation of the policy and determine how often to assess institutional compliance with the policy. Committee members will define actions needed to remain compliant with the policy and Baby-Friendly USA criteria for evaluation.
b. A mechanism for data collection directed to routinely track breastfeeding and birthing person–infant care indicators and policy implementation will be in place to continually monitor and improve quality of perinatal care. Incorporation of breastfeeding indicators into the facility's quality improvement monitoring system is mandated.
c. The multidisciplinary committee members meet at least every 6 months (more frequently when the data indicates practices are below the expected metrics) to review monitored data.

D. All facility-based direct care staff working in antepartum, labor and delivery, postpartum, and newborn units who provide care will have sufficient knowledge, competence and skills in the required competencies listed in the *Baby-Friendly USA Guidelines and Evaluation Criteria-Appendix C.* These competencies will be reviewed biannually.
   a. All direct care staff and direct care providers that provide prenatal, delivery and/or infant care will receive appropriate orientation to the implementation of this policy within the first 16 weeks after hiring.
   b. The lactation department, in conjunction with Center for Professional Excellence and Inquiry (CPEI), is responsible for the development and oversight of the ***Direct Care Staff and Direct Care Provider Competency Verification.***
   c. CPEI and the medical staffing office are responsible for ensuring that all direct care staff and direct care providers have had all training and competencies verified via biannual in-service trainings. All competencies and necessary remedial training will be verified within 6 months of hire.
      i. The education department will keep documentation of competency verification and training.
   d. All direct care providers with privileges to provide care in labor and delivery, postpartum, and newborn units will have sufficient knowledge, competence and skills in the required competencies listed in the *Baby-Friendly USA Guidelines and Evaluation Criteria-Appendix C.*

E. The providers, nurses, and lactation consultants providing prenatal services are responsible for educating families about breastfeeding. The educational topics include all required in the Baby Friendly Guidelines and Evaluation Criteria.
   a. Written and web-based Information provided by the affiliated sites will be the basis of the education and include all key topics recommended in the U.S. Baby Friendly *Guidelines and Evaluation Criteria-Appendix A.* [BFUSA]

F. This facility fosters the development of community-based programs that make available individual counseling or group education on breastfeeding and collaborates with community-based programs to coordinate breastfeeding messages.

G. Exclusive breastfeeding will be recommended for the first 6 months with the addition of complementary foods at 6 months of age. Breastfeeding will be recommended for at least the first year of life, or as long as mutually desired.

H. After being informed of the benefits of breastfeeding and risks of formula feeding, birthing persons who choose to formula feed will be treated with respect and taught how to do so safely.

I. The hospital will collaborate with prenatal care providers in the community to provide breastfeeding education and support. Families will be encouraged to attend a prenatal breastfeeding class.

J. All families will be given patient education materials included in the admission packet, which reflects the breastfeeding practices at this facility.

K. The hospital will provide a weekly community-based support program and/or direct families to alternate sources of support within the community. A printed list of resources will be distributed to all families prior to discharge from the hospital.

L. The hospital will not provide formula marketing materials to families and will prohibit promotional materials and marketing efforts in all areas available to patients.

M. Initiation of Breastfeeding

1. Regardless of feeding preference, and unless there is a medically justified reason to postpone, birthing person-infant dyads will be offered skin-to-skin contact immediately after delivery. The infant will then be thoroughly dried excluding the hands, a diaper placed as desired and covered with a warm blanket to contain the birthing person's heat. Needed measures will be in place to facilitate immediate skin to skin after cesarean births, as soon as the birthing person is responsive and alert, and ideally in the operating room or the recovery area. Refer to Patient Care Manual: Neonatal Care: Skin-to-Skin Holding
2. Unless medically contraindicated, or if patient declines after education, healthy infants will be placed and remain in direct skin-to-skin contact with their birthing person immediately after delivery until the first feeding is accomplished or at least 1 hour regardless of feeding preference. Time of initiation and end of STS shall be documented in the medical record.
3. Apgar scores will be performed with the infant skin-to-skin. The infant's anthropometric measurements, intramuscular Vitamin K administration, ophthalmic prophylaxis, and hepatitis B vaccine administration will be delayed until completion of the first feeding or after the initial first hour of STS contact (if formula feeding). Refer to Newborn Nursery Standards of Care.
4. Staff must make frequent and repetitive assessments, including observation of newborn breathing, activity, color, tone, and position.
5. All birthing persons and all infants able to breastfeed shall be supported to breastfeed as soon as possible within the first 1-2 hours after birth. Help will be offered to facilitate the infant's first latch, if the infant does not latch spontaneously in the first 1-2 hours after birth or at the request of the mother.
6. Except under medical indications for parent or infant, the infant should remain with the birthing person throughout the recovery period.
7. If a delay or interruption of initial STS has been necessary, staff will ensure that the birthing person and infant receive STS as soon as clinically possible.
8. After the initial period of skin-to-skin after delivery, families will be encouraged to provide this type of care for the infant as much as possible during their hospital stay.
9. Birthing persons who have been identified as having a history of past or current use of illicit drugs will be counseled about the risks of drug use and breastfeeding by the provider.

N. Management of Lactation

a. Postpartum nursing staff will offer breastfeeding and lactation support within six hours of delivery, and will conduct a LATCH assessment every 8 hours. They will also assign a Lactation Acuity Score (LAS).
    i. A dyad with an LAS Score of 2 or higher will receive a referral to Lactation. (see Section N).
b. Staff will promote unrestricted breastfeeding and not place any limitations on how often or how long babies should breastfeed.
c. Families will be taught to put their breastfeeding infant(s) to breast at least 8 to 12 times in 24 hours on no specific time schedule. Families will be informed that a healthy infant may feed less often in the first twenty-four hours of life. They will also be informed that cluster feeding (several feeds close together) in the first 24 – 36 hours is normal infant behavior and may stimulate milk production; these are not signs of insufficient milk and do not indicate that supplementation is required.

d. Families will be taught signs of undernourishment or dehydration in the infant and warning signs for calling a health professional including: usually not waking for more than 4 hours or, always awake or never seeming satisfied or, more than 12 feeds per day, or no signs of swallowing with at least every 3-4 sucks, too few wet/heavy or soiled diapers per day, or fever.

e. Families, particularly those with preterm infants, will be taught that it may be necessary to wake the infant if they do not indicate hunger cues within 4 hours of the previous feed, which is not unusual in the late preterm infant.

f. Birthing persons that are exclusively human milk feeding, have preterm infants on the postpartum unit, and those who are separated from their infants will be helped to start expressing within the first 6 hours after birth, preferably within 1-2 hours of birth and completion of initial skin-to-skin contact, unless there is a justifiable reason to delay initiation of expression.

    i. Birthing persons will be supported and encouraged to pump at least eight times in 24 hours to ensure an adequate milk supply.

g. RNs will educate breastfeeding families about: feeding cues, hand expression, positioning and latch, skin-to-skin, intake/output requirements, and normal breastfeeding patterns.

h. Lactating birthing persons will be taught about the preventative management of common problems such as engorgement, sore and cracked nipples will be discussed prior to discharge.

i. All education will be documented in the electronic health record (EHR).

O. Supplementation

a. No supplemental water, glucose water, or formula will be given unless specifically ordered by a physician, or by the birthing person's documented and informed request.

b. If not medically contraindicated, human milk will be the first choice for supplementation and patients will be taught methods of milk expression, including hand expression, along with safe handling and storage of human milk.

c. Banked donor milk will be offered to birthing persons who intend to breastfeed and who themselves, or their infant, have a qualifying medical indication for donor milk. (see Section U).

d. Safe preparation, feeding, handling, and storage of human milk substitutes will be individually taught to families who prefer formula supplementation or who do not intend to breastfeed. These specific education points are listed in the *Baby Friendly-USA Guidelines and Evaluation Criteria – Appendix A*. Written instructions will be given, if appropriate, and the education documented in the EHR.

    1. Anticipatory guidance will be given to those who are planning to exclusively formula feed regarding preventative steps to minimize engorgement.

e. Staff will empower the families' informed decisions by listening to their specific concerns and personalizing the conversation to answer any concerns regarding the following evidence-based information (all education will be documented in their electronic health record (EHR):

    1. Importance of exclusive breastfeeding
    2. Possible risk factors that could influence health outcomes with the introduction of breast-milk substitutes
    3. Possible impacts to the success of breastfeeding

f. Acceptable Medical Reasons for use of Human Milk Substitutes (always use parents own milk prior to formula when available and not contraindicated) are listed in Section T, below.

g. Birthing persons will be encouraged to express colostrum or human milk directly into infant's mouth or to feed by alternative methods other than bottle/artificial teats (a cup, finger, syringe, or a spoon are preferred). Education will be given on the effects of artificial nipples on breastfeeding and why to avoid them until lactation is established will be given. Instruction will be given on how to administer supplement with chosen method. Education will be documented in the EHR.

h. Bottles will not be placed in an infant's crib.

i. All breastfeeding persons who supplement will be taught how to pump.

j. Families who choose to use the bottle will be taught paced bottle feeding.
k. Education will be provided in a family centered manner.

P. Pacifiers
a. Pacifiers or artificial nipples will not be routinely given by the staff to breastfeeding infants.
b. Education will be provided to breastfeeding families on the proper use or avoidance of pacifiers, including the negative impacts on early initiation of breastfeeding and the acceptable time for introducing a pacifier with a breastfeeding infant. This education will be documented in the EHR.
c. Breastfeeding during a painful procedure has been documented as an effective intervention for pain control. If breastfeeding is not possible during a painful procedure, a pacifier may be used temporarily for pain management. Pacifier use should be discontinued after procedure.
d. Non-medical staff in Newborn Nursery will not provide pacifiers to families while providing their services.
e. Exception: Pacifiers will be used for non-nutritive sucking and oral training of premature infants and other special care infants.

Q. Rooming-in
a. Unit staff will encourage all dyads to remain together, day and night, throughout the hospital stay, regardless of parent's feeding choice or delivery method. They will encourage skin-to-skin to help facilitate infant feeding cues and promote bonding.
b. Minimize the time of infant separation for a medical procedure (e.g., circumcision). If necessary, there will be no more than a one hour per 24-hour period of separation. Perform routine newborn procedures at the bedside.
c. Increased surveillance will be provided to dyads that have been identified at higher risk.
d. Breastfeeding persons and families will be educated on the physiology of lactation that can lead to hormonally driven sleepiness and the importance of transitioning the newborn to a safer surface for sleep.
e. Documentation of interruption of rooming-in will include the reason for interruption, location of infant during interruption, time parameters for interruption, and infant feedings during the separation. Rooming-in will be reinstated as soon as the documented reason ceases.
f. Whenever patients request their infant be kept apart from them, their reasons for such care will be listened to. A careful assessment will be made to explore challenges. If appropriate, solutions will be offered to safely avoid the separation. Staff will empower the patient's informed decision by supporting them and personalizing the conversation to answer any concerns.
g. Informed decisions will be honored and documented in the EHR.

R. Risk factors for breastfeeding failure and the associated Lactation Risk Standard (LRS).
a. The following breastfeeding risk factors indicate the patient will need more in-depth breastfeeding assessment and management from the RN. Initiate a lactation referral for a LRS score of 2 or higher. (The score is listed to the right).
1. Multiples (2)
2. No Latch after 24 hours (1)
3. Infant in NICU/ICN and/or Separation of Dyad. (2)
4. Borderline Term/Late preterm and Small for Gestational Age Infant (2)
5. Excessive Weight Loss from Birth Weight (2)
6. History of Breast Surgery (2)
7. History of Breastfeeding Issues/Early Termination of Breastfeeding (2)
8. Engorgement (1)
9. Flat or Inverted Nipples (1)
10. Vulnerable Populations (1)
11. Antepartum (1)

12. Hyperbilirubinemia (2)
13. Parental Request after Basic Breastfeeding Education

b. The LRS consists of a care plan for each of the risk factors listed above. RNs are responsible for initiating this care plan until a Lactation Consultant can evaluate the dyad further.

S. Discharge preparation

a. Written materials and verbal instructions regarding ongoing support and care will be provide to all families prior to discharge.
   i. Contact information will be provided for all patients on how to access local support groups or other breastfeeding support community resources after discharge.

b. Patients must be able to recognize maternal and infant warning signs that require urgent evaluation along with contact information for health professionals.

c. If the infant is still not latching or feeding well at the time of discharge, a written individualized feeding plan will be devised. Depending on the dyad's clinical situation and resources, the infant's discharge may be delayed. Whenever needed, a follow up visit specifically to address feeding issues will be scheduled.

d. All families will be provided with instruction to schedule a visit within 3-5 days of birth and within 48 hours to 72 hours after discharge with a skilled professional to evaluate feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluations, and their birthing persons should receive encouragement and instruction.

T. Contraindications for breastfeeding

Breastfeeding, although optimal for infants, may be contraindicated in some instances:

a. Inborn errors of metabolism
   i. Galactosemia (except for Duarte variant, in which partial breastfeeding is possible)
   ii. Congenital lactase deficiency
   iii. Some may require supplementation (phenylketonuria, maple syrup disease)

b. Active, untreated pulmonary tuberculosis (until no longer contagious: 15 days of treatment)
   i. Infants may be given expressed human milk.

c. Ebola Virus: Suspected (until ruled out) or confirmed

d. Varicella (expressed breast milk can be given, with administration of Varicella-Zoster Immune Globulin to the infant as soon as possible)

e. Untreated maternal Brucellosis

f. Herpes Virus: active lesions on breasts
   i. Infants should not breastfeed on affected breast but can breastfeed on unaffected side.
   ii. Expressed milk can be given as there is no concern of transfer through breastmilk.
   iii. Any milk that comes in contact with herpetic lesions (i.e., through contact with the breast pump) should be discarded.

g. Birthing Individuals who are receiving antimetabolites or chemotherapeutic agents
   i. For maternal diagnostic or pharmacological therapy, there are only a limited number of agents that are contraindicated, and an appropriate substitute usually can be found. The most comprehensive, up-to-date source of information regarding the safety of maternal medications when they are breastfeeding is LactMed, an Internet-accessed source published by the National Library of Medicine/National Institutes of Health.

h. Current use of illicit drugs (e.g., cocaine, heroin, phencyclidine) as determined on a case-by-case basis.

i. HIV and HTLV-1 and HTLV-II (in the United States, where there are safe and accessible alternatives to breastfeeding)

U. Medical indications for banked donor milk in the newborn nursery – "Medical indications for supplementation are defined according to the Academy of Breastfeeding Medicine's Clinical Protocol #3

a. Hypoglycemia
b. Late preterm infant
c. Excessive weight loss
d. Hyperbilirubinemia requiring treatment
e. Multiple gestation
f. Inadequate output
g. Small for gestational age infant
h. Birthing persons indication

The reason for the supplementation will be documented in the infant's medical record.

References

Reference	Level of Evidence	Review Date
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Breastfeeding Medicine: The Official Journal of the Academy of Breastfeeding Medicine ABM Clinical Protocol #3: Supplementary Feedings in the Healthy Term Breastfed Neonate, Revised 2017 (memberclicks.net)	D	11/2022
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A. Author/Original Date
Lactation Team/June 2009
Zakiyah Williams, November 2022 current document "Infant Feeding Policy"

B. Distribution and Training Requirements
This policy resides in the Patient Care Manual of Stanford Medicine Children's Health.

C. Review and Renewal Requirements
This policy will be reviewed and/or revised every three years or as required by change of law or practice.

D. Review and Revision History
Maternity LIT July 2015
Lactation Services December 2018,
Lactation Multidisciplinary Committee September 2020
Lactation Multidisciplinary Committee November 2022
K. Poon, 7/22
Z. Williams & L. Gurzi, 6/23

E. Approvals:
Perinatal Care Committee: 8/15, 12/18, 1/2023
Policy Program Review Committee: 2/2023
Nurse Executive Council: 3/2023
Medical Executive Committee: 6/23
Board of Directors: 6/23