Waterford
BIRTH CENTRE

Breastfeeding

Policy

Version 17: 2019

Breastfeeding Policy

Purpose and scope:

Waterford Birth Centre is committed to the Protection, Promotion and Support of Exclusive Breastfeeding, achieved through implementation of the WHO/UNICEF Baby Friendly Hospital Initiative (BFHI).

Waterford Birth Centre applies the principle of the Treaty of Waitangi to breastfeeding to improve outcomes for Māori.

1. Breast milk is the optimal food for all babies; Waterford Birth Centre (WBC) recognises the health and well-being benefits for both mother and baby with breastfeeding. These benefits are both short and long term in nature and are summarised in the Ministry of Health Food and Nutrition guidelines for Healthy Infants and Toddlers (2008-Partially revised 2012) p14 – 17.

2. The Ten Steps to Successful Breastfeeding (The Ten Steps) and The WHO/UNICEF International Code of Marketing of Breast-milk Substitutes are the international best practice standard for breastfeeding and will be implemented at WBC.

3. This policy applies to all Waterford Birth Centre staff.

Policy Details:

Waterford Birth Centre Policy is based on the "Ten Steps To Successful Breastfeeding"; The WHO / UNICEF International Code of Marketing of breast-milk substitutes; Support for mothers who are not breastfeeding

Step ONE – Policy:
Have a written breastfeeding policy that is routinely communicated to all health care staff.

1.1 Waterford Birth Centre Breastfeeding policy was developed in consultation with Māori, consumers, staff, LMC's and other Health professionals and will be reviewed triennially.

1.2 WBC Breastfeeding Policy is available in the WBC Policy manual located in the staff office.

1.3 All Staff and LMC's will be orientated to the policy.

Establish ongoing monitoring and data management systems.

1.4 Breastfeeding data is documented by staff midwives on discharge, entered into client record management system by administrator and shared with NZBA by Clinical Manager.

Step TWO – Training:

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

2.1 Breastfeeding education and tuition needs to meet the standards as outlined in the BFHI documents for New Zealand.

2.2 New staff will commence the breastfeeding education component within six months of commencing their positions. Prior learning in breastfeeding is recognised provided there is sufficient documented evidence to support this and the learning has been within the last five years.

2.3 **Level Three: Specialist**. Midwives require 21 hours of initial breastfeeding education (or 21 hours education over the previous 5 years) which includes 3 hours of clinical supervision and one hour Breastfeeding for Māori Women education. Ongoing requirements will equate to 12 hours education which includes a minimum of 1 hour of clinical supervision annually, and a 30-minute Breastfeeding for Māori Women education programme over the previous 3 years.

2.4 **Level One: Awareness**. Ancillary staff, e.g. Administrator and House-hold staff require 2 hours initial education and 1 hour annually of ongoing education. If employed for over 3 years this must equate to 3 hours over the previous 3 years.

2.5 Waterford Birth Centre will keep accurate records of staff breastfeeding education for audit purposes.

Step THREE – Information:

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

3.1 All information given to pregnant women will be based around *The Ten Steps to Successful Breastfeeding*.

3.2 A variety of breastfeeding information will be available in Māori, including *Tekau Ngā Whakamārama Mo Te Ūkaipo.*

3.2 Antenatal class information on infant feeding must always be presented in the context of breastfeeding being the optimal form of infant nutrition.

3.3 All information given to pregnant women will be based around The Ten Steps to Successful Breastfeeding. Refer to the NZBA BFHI document Step three for a list of topics to be included when informing pregnant women about the benefits and management of breastfeeding.

3.4 The breastfeeding woman's significant other/support person shall be invited to education sessions to enhance their knowledge of breastfeeding.

Step FOUR – Initiating Breastfeeding

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

4.1 Place babies in skin to skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognise when their babies are ready to breastfeed, offer help if needed.

4.2 Skin to skin contact should be offered to mother's who elect NOT to breastfeed due to the benefits for bonding and temperature regulation.

4.3 Unnecessary procedures (e.g. weighing, bathing, wrapping) should be delayed until after the first breastfeed or for up to 2 hours.

4.4 The first breastfeed should be offered when mother and baby are ready. Observe and teach mother / whanau to observe for baby's feeding cues.

4.5 It is anticipated this first feed will be a long feed and as such should be left undisturbed, ensure both are warm and comfortable.

4.6 Documentation of this step is essential to ensure required breastfeeding statistics are captured.

4.7 If a successful breastfeed is not achieved within 2 hours of birth, despite the baby being given the opportunity of skin-to-skin contact,

expressing of colostrum will be commenced. This will be fed to the baby via cup, spoon or syringe.

4.8 A full term healthy baby who latches and suckles well within 1-2 hours following birth may sleep for 6-8 hours after which time the baby should be stimulated to breastfeed by being placed skin to skin again.

Step FIVE – Education:

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

5.1 All new breastfeeding mothers irrespective of previous breastfeeding experience will be offered support and guidance with breastfeeding. This will include correct information on latching techniques; baby led feeding; effective sucking and milk transfer.

5.2 Hand expressing is a valuable skill for mothers to learn. Midwives will give every woman the opportunity to know how to express her own breast milk by hand and how her milk may be safely stored.

5.3 Mothers who are expressing their milk will be shown how to sterilise equipment and how to safely store breast milk.

Step SIX – Sole Food Source.

Do not provide breastfed newborns any food or fluids other that breast milk, unless medically indicated. See NZBA BFHI standards 2011 Appendix Acceptable Sound Clinical Reasons for Supplementation.

6.1 Staff shall promote and support the physiological process of breastfeeding by avoiding inappropriate use of supplementation, pacifiers or teats.

6.2 Breastfed babies will be exclusively breastfed and will only receive supplementary feeding of breast milk substitutes when there is an acceptable medical reason or upon maternal request. Use day 4 (72-96 hour) assessment (appendix A & B), where appropriate. NB: Artificial formula amounts are always calculated from the Birth weight and age of the baby, not baby's current weight.

6.3 Assess baby at as close to 72 hours as possible, this is done for ALL babies born by LSCS and WITH the woman (hopefully whilst she is breastfeeding so that you can observe the baby and listen to the feed). Mothers need to understand the assessment and why. Maybe done earlier if you were able to have ***observed*** a transitional stool and large pu, heard the baby gulping mum's milk that is 'in'. Weighing the baby is to be done at the time of the assessment if required, i.e. at 2 am and if required a plan made and top-ups given. Document assessment and plan and add to notes so other staff know it was done. See appendix A of this document.

6.4 Written consent must be obtained from the mother when feeding the baby any fluid other than breast milk, following full information on the reason for the supplementary feed, benefits and risks, (appendix C).

6.5 No materials that recommend breast-milk substitutes or infant foods or drinks (other than breast milk), scheduled feeds or other inappropriate practices will be displayed or routinely given to mothers.

6.6 If a Breastfeeding mother requests a breastmilk substitute staff should ensure the mother has had the opportunity to make an informed decision but has first been offered adequate support for breastfeeding. Written consent is required from the mother on the *Breastmilk Substitutes for Newborn Babies (Mother's request)*

6.7 No materials that recommend breast-milk substitutes or infant foods or drinks (other than breast milk), scheduled feeds or other inappropriate practices are to be displayed or routinely given to mothers.

6.8 Breast milk substitute access and visibility should be limited to comply with the WHO Code, please refer to *Artificial Feeding policy.*

6.9 Staff Midwives will document Breastfeeding definition codes in the daily register for postnatal admissions and all discharges from the facility.

Step SEVEN – Rooming in:
Enable mothers and their infants to remain together and to practise rooming-in 24 hours a day.

7.1 The practice of rooming-in fulfils the basic physical, psychological and emotional needs of the mother and baby. Helps with the initiation and

establishment of breastfeeding and has a positive impact on breastfeeding duration.

7.2 Staff will empower mother, partner/significant other in gaining confidence and learning to cope and care for a new baby over a 24-hour period.

7.3 Staff will foster an environment of partnership with woman and whanau who add value and support normalisation of breastfeeding culture.

7.4 Examinations and routine tests of the baby should take place in the mother's room

Step EIGHT – Baby led feeding

Support mothers to recognise and respond to their infants' cues for feeding.

8.1 Staff shall facilitate unrestricted duration and frequency of breastfeeding. For a healthy full term infant who latched and suckled well at birth 6-8 feeds in the first 24 hrs times may be normal. There-after baby should feed 8-12 times every 24 hours.

8.2 Breastfeeding in the first 24 hours

If baby had a long and nutritive breastfeed following a physiological birth from a healthy pregnancy and with no medications / epidural / ventouse.

i. Within 6 hours place the baby skin to skin so hopefully feed, if not give some EBM – colostrum.
ii. Then try again 3-4 hourly. Licks of drops are acceptable but not optimal, volume not important.
iii. Try to keep the baby skin to skin as much as possible.

If baby has NOT has a good breastfeed at birth or the mother has had medications / epidural / ventouse or any other trauma. This also applies to women from impoverished backgrounds or with a history of drug or alcohol use and / or violence in pregnancy.

i. Do not wait 6 hours
ii. Give some colostrum on admission
iii. Baby will have as much skin to skin as possible.
iv. Every 3-4 hours give some more colostrum.

8.3 Babies who are not waking for feeds or feeding effectively when offered the breast must be assessed. Staff should assess signs of effective milk transfer at least once every shift and document in the baby notes (this is a minimum requirement). If sucking is ineffective take appropriate action.

8.3 Mothers shall be taught to recognise when their baby is breastfeeding effectively. This will be demonstrated by:

- A pain free latch
- Sustained rhythmic suck/swallow pattern with occasional pauses
- Audible swallowing
- Relaxed arms and hands
- Moist mouth
- Satisfied after feedings
- Passing of urine and meconium graduating to yellow stools.

8.4 Frequent feeding or cluster feeding in the first few days, particularly day two and three is common and normal newborn behaviour – it helps bring in the milk and initiates prolactin receptors in the breast which are responsible for ongoing lactation.

8.5 Mothers shall be taught how to recognise the early feeding cues from their baby such as:

- Sucking movements and sounds
- Hand to mouth movements
- Soft cooing or sighing sounds
- Fussiness
- Crying (being a late sign of hunger)

8.6 Staff will support and educate women in the importance of:

a. unrestricted duration and frequency of breastfeeding.
b. normal newborn behaviour – Frequent feeding or cluster feeding in the first few days
c. recognise the early feeding cues from their baby
d. recognise when their baby is breastfeeding effectively.
e. appropriate elimination patterns for newborns
f. prevention and management of common breast/nipple problems.

8.7 Women will be encouraged to view / use the resources in the WBC Red breastfeeding folder and watch the breastfeeding DVD's which include 'follow me mum' and Biological Nuturing.

8.8 Staff will orientate women to WBC Breastfeeding folder and encourage women to view Breastfeeding DVD's.

Step NINE – Artificial Teats

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

9.1 Staff will not encourage the use of pacifiers and the unnecessary use of teats and nipple shields.

9.2 If a breastfeeding baby is unable to latch at the breast, small amounts of colostrum will be given by syringe or spoon in the first 48 hours and larger amounts given by lactaid or cup. Thereafter, a feeding plan will need to be put in place.

9.3 Breastfeeding mothers who choose to use bottle teats and pacifiers will be fully informed of the disadvantages and the effects on the establishment and duration of breastfeeding.

Step TEN – Support

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

10.1 Information on breastfeeding support groups will be given to women. This information can be found in the WBC Breastfeeding Folder.

10.2 Community groups can provide breastfeeding support within the facility, when their services are requested by the woman.

10.3 Midwives will invite woman to attend the La Leche League meetings held at WBC every 3rd Thursday of the month.

10.4 WBC recognise the value of breastfeeding support groups, family, and Whanau in the community where a mother lives who may provide support that is appropriate to the woman's cultural, religious and social needs.

2 The WHO / UNICEF International Code of Marketing of breast-milk substitutes

WBC supports the WHO/UNICEF Code of Marketing Breast-milk Substitutes documents as the accepted standard in relation to the use of artificial baby milk.

2.1 No pregnant women, mothers or their families are given marketing materials or samples or gift packs by the facility that include breastmilk substitutes, bottles/teats, pacifiers, other infant feeding equipment or coupons.

2.2 Any contact from any formula company representative will be with the Clinical Manager.

2.3 Supplies of breast milk substitutes are locked in DD cupboard and accessories are stored in an area that is not accessible to consumers or the public.

3. Support for mothers who are not breastfeeding

WBC staff support a woman having made an informed decision to artificially feed her baby. This decision will be documented in her care plan and clinical records.

3.1 Parents will be given written information and staff shall provide education on how to safely feed their infant/s breast milk substitutes. This education will be given on a one to one basis.

3.2 Parents will be educated on the importance of:

- safe preparation of infant formula;
- safe handling and feeding of infant formula and the sterilisation of equipment
- recognising signs for cue based feeding, with given guidelines for appropriate amounts for age of baby
- skin to skin contact to gain knowledge of the benefits for baby and family. (see Breastfeeding policy 4.2)
- safe sleep practice for baby including the importance of rooming in.

3.3 All information given to mothers will be free from advertising, contain only scientific and factual information and comply with the Code.

3.4 Consent for Artificial Breastmilk substitutes must be obtained by either the LMC, or staff midwife (appendix C).

Success indicators

1. All staff and LMC's using the facility shall be aware of the breastfeeding policy and know how to access information on breastfeeding.

2 WBC will achieve BFHI accreditation standards.

3. WBC Breastfeeding audits will reflect a minimal exclusive breastfeeding rate of 85%, including Māori, on discharge.

Definitions: Breastfeeding Codes

E Exclusively Breastmilk Fed:
The baby has never, to the mother's knowledge, had any water, formula or other liquid. Only breastmilk, from the breast or expressed and prescribed medicines have been given from birth.

F Fully Breastmilk Fed:
The baby has taken breastmilk only, no other liquids except a minimal amount of water or prescribed medicines, in the past 48 hours.

P Partial Breastmilk Fed:
The baby has taken some breastmilk and some infant formula in the past 48 hours.

A Artificial Feeding
The baby has had no breastmilk but has had alternative liquid such as infant formula in the past 48 hours.

N Not Applicable: eg. NND, SB.

Supporting Documentation
- The Ten Steps to Successful Breastfeeding, WHO/UNICEF 2018
- The World Health Organisation's International Code of Marketing of Breastmilk Substitutes (WHO Code) 1981
- Innocenti Declaration – World Summit for Children, United Nations 1990
- Baby Friendly Hospital Initiative Statement, WHO/UNICEF, 1992
- Breastfeeding Handbook, NZCOM 1992

- The Breastfeeding answer Book, La Leche League 2003
- National Strategic Plan of Action for Breastfeeding 2008-2012 , National breastfeeding Advisory Committee of NZ advice to the Director-General of Health.
- Ministry of Health Food and Nutrition guidelines for Healthy Infants and Toddlers (2008 partially revised 2012)
- Waterford Birth Centre Māori Health Plan
- Waterford Birth Centre Quality and Risk Policy

Breastfeeding policy	Date Reviewed	Date of next review
Cathryn Knox - CM	February 2019	February 2022

Appendix A – DAY 4 BREASTFEEDING ASSESSMENT (72 – 96 HOURS)

Purpose: To identify those babies which need to be weighed prior to one week of age. To identify those babies who may need additional support with Breastfeeding.

Mothers name: NHI: Baby's name:

	72 hour assessment - assess from 1-4	**YES**	**NO**
1	**DOES THE BABY HAVE?** • Adequate feeding as observed by you with suck, swallow, pause pattern. • Transitional, runny brown/yellow stools • Dilute urine of increasing volume • Waking for feeds frequently or staying awake through feeds		
	IF ANSWERED **NO TO ANY ABOVE** CONSIDER BARE WEIGH or further assessment below:		
2	**Assess for additional risk factors.** • Small for dates or IUGR • Inadequate stooling /persistent urates • ANY Jaundice • Sleepy baby or Unsettled baby • Condition-high/dry cry; tone/skin; baby temperature • Medical risk factors or Palette or Tongue tie? • Twins • <37 weeks completed gestation For mother: • No breast changes since baby born • Latching difficulties WITH THIS BABY • History of previous insufficient supply • History of breast surgery • PET / Birth Story / Breast Odema **YES TO ANY OF THESE = BARE WEIGH**		
3	Bare weigh baby – 1. weight loss <7% = watchful eye and re-assess in 24 hrs 2. weight loss >7% = see below number 4.		
4	Create a feeding plan in consultation with client and her LMC (& paeds if necessary) which should include reweighing baby in 24-48 hours; express or pump and top up with EBM, donor milk or formula via a lactaid. Commence a baby feeding chart - Appendix B If weight loss 11-15% (or more) consult/refer with Paeds with LMC, baby may need CBC, U & E and SBR. Baby at risk of hypernatremia. Weight loss should be calculated by percentage. $\frac{Weight\ loss}{Birth\ weight}\ x\ \frac{100}{1}$		

Appendix B: Feeding Chart

For use only to support challenges with breastfeeding.

Mothers name: **Baby's name:**

DATE:	PLAN

Date	Time	Feed Notes	Any Addition	PU	BO

May want to note in feed notes that baby was:
1. Offered breast but does not attach. Not interested
2. Interested but does not attach
3. Attached - on and off
4. Attached but has uncoordinated suck
5. Good rhythmical sucking. Short feed.
6. Good rhythmical suckling. Long feed >10 mins

That mum required:
a. Full assistance
b. Verbal Guidance
c. Independent

Additional feed was given via:
S. Syringe
C. Cup
L. Lactaid
F. Finger tubing

Appendix C

Waterford Birth Centre
Consent for Breastmilk substitutes

I _____ (parent name)

Authorise my Baby: _____

To be given: _____

For the reason of: _____

By the method of: spoon / syringe / cup / lactaid / bottle
(please circle)

I have an understanding of the risks vs benefits as explained to

me by: _____ yes / no.

I have had an opportunity to have my questions answered fully.
yes / no.

Signed: _____ (parent)

Signed: _____ (midwife)

Date: _____

WBC BF Policy: Appendix D – Baby not feeding effectively.

Breastfeed babies will feed 8 – 12 times in a 24-hour period to establish mum's lactation in the first 24 to 48 hours.

A baby born following a physiological birth will usually have more reserves allowing a 6-8-hour birth sleep and 6-12 feeds in 24 hours.

For all unphysiological labour and births then extra vigilance will be needed to potentially sustain the new-born, this includes low Apgar scores, all resuscitation, IOL, ventouse etc.

Skin to skin contact, observing for feeding cues, working on correct positioning, and regular small but increasing amounts of colostrum are enough to sustain most new-borns.

Staff Midwives will: DOCUMENT (in mother and baby notes) at least once a shift their assessment of an **observed** breastfeed or the reason they are satisfied that baby is maintaining a latch, transferring colostrum and has appropriate output for age.

If you are concerned the baby is not feeding effectively in the first 24-48 hours consider:

Assessment: Baby not feeding effectively?

POTENTIAL PROBLEM	TRY FOR SOLUTION
Mother: Under Developed Breasts. Breast surgery Nipple Issues (e.g. sore, inverted) (flat, long, large)	Educate: Reposition and relatch. Evert nipple prn. Observe entire feed. Hand-express colostrum give via spoon / syringe
Unsatisfied/fussy baby Sleepy Baby Type of Birth / Drugs Tongue tie, under shot jaw.	Place mum and baby skin-to-skin, reposition, relatch, breast massage and compression. Hand-express colostrum give via spoon / syringe
Mother insists on supplementing	Re-enforce benefits of exclusive breastfeeding. We only supplement for medical reasons.
Baby: Concentrated or not enough urine Persistent urates. Meconium – scant for age, no colour or consistency changes.	Skin to skin Hand-express colostrum give via spoon / syringe

If still concerned that lack of feeding is causing harm then make a plan with LMC Midwife and mother – consider introducing donor milk / formula and/or checking BSL.

Other Policies:

Main folder; Section one:

- Breastfeeding
- Nipple shields