



National Infant Feeding Policy for Maternity & Neonatal Services

Is this document a:

Policy ☒ Procedure ☐ Protocol ☐ Guideline ☐

Insert Service Name(s), Directorate and applicable Location(s):

Maternity Services and Neonatal Services in Maternity & Paediatric Hospitals & Units, Acute Hospitals Division

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Table of Contents:

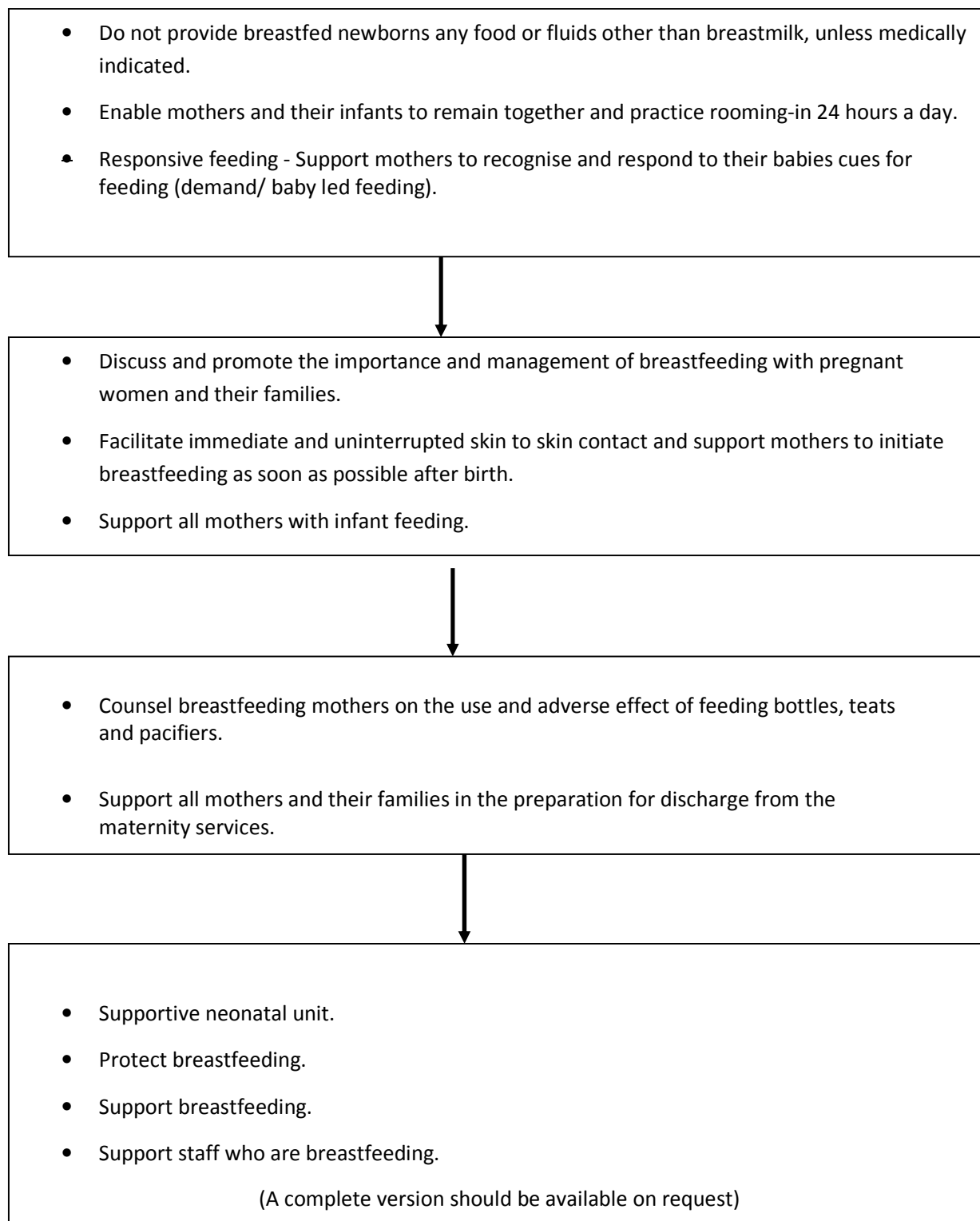
PART A: Outline of PPPG Steps	4
Figure 1: Outline of the Guideline Steps:.....	4
2.7 Outline of Policy Steps/Recommendations	5
 PART B: PPPG Development Cycle.....	16
1.0 INITIATION	16
1.1-1.4 Purpose/Scope/Objective/Outcome	16
1.5 PPPG Development Group	16
1.6 PPPG Governance Group	17
1.7 Supporting Evidence	17
1.8 Glossary of Terms	17
2.0 DEVELOPMENT OF PPPG	19
2.1 List the questions (clinical/non-clinical).....	19
2.2 Describe the literature search strategy	20
2.3 Describe the method of appraising evidence	20
2.4 Describe the process the PPPG Development Group used to formulate recommendations	20
2.5 Provide a summary of the evidence from the literature	20
2.6 Detail resources necessary to implement the PPPG recommendations	23
2.7 Outline of PPPG Steps/Recommendations	24
3.0 GOVERNANCE AND APPROVAL	24
3.1 Outline Formal Governance Arrangements.....	24
4.0 COMMUNICATION AND DISSEMINATION.....	24
5.0 IMPLEMENTATION	26
6.0 MONITORING, AUDIT AND EVALUATION	28
7.0 REVISION/UPDATE	28
8.0 REFERENCES and BIBLIOGRAPHY	29
9.0 APPENDICES	34
Appendix I: Signature Sheet.....	35
Appendix II: Membership of the PPPG Development Group.....	36
Appendix III: Conflict of Interest Declaration Form	37
Appendix IV: Membership of the Approval Governance Group - The HSE National Breastfeeding implementation Group	38

Appendix V: PPPG Checklist for developing Clinical PPPGs	39
Appendix VI: Antenatal information.....	43
Appendix VII: Positioning during Skin to Skin contact in the time immediately after birth	45
Appendix VIII Newborn Observation Section MNCMS	46
Appendix IX: Flow Chart to Support Implementation of SSC following Caesarean Birth	47
Appendix X: Acceptable Medical Reasons for Use of Breastmilk Substitutes (WHO 2009)	48
Appendix XI: Breastfeeding Observation and Assessment Tool (BOAT) resource p. 1.....	51
Appendix XI: Breastfeeding Observation and Assessment Tool (BOAT) resource p. 2.....	52
Appendix XII: Breastfeeding Equipment in neonatal units	53
Appendix XIII: Suggested Priority for Dispensing Donor Human Milk – Human Milk Banking Association of North America.	54
Appendix XIV: International Code of Marketing of Breastmilk Substitutes.....	55
Appendix XV: Staff training.....	57
Appendix XVI: Ten Steps to Successful Breastfeeding (revised 2018)	58

PART A: Outline of PPPG Steps

The development of the PPPG is outlined in the following flow chart.

Figure 1: Outline of the Guideline Steps:



2.7 Outline of Policy Steps/Recommendations

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

- 2.7.1 Pregnant women and their families should be counselled about the benefits and management of breastfeeding. All pregnant women are given information and opportunities for one-to-one or small group discussion with a health care professional (HCP) before 32 weeks gestation. Women centred conversations may include agreeing an agenda determining what the woman wants to talk about and addressing her needs first. These conversations also include asking open ended questions, listening actively, reflecting back, building on current known information, showing empathy, remaining neutral and not colluding. Information should also be available to their partners and other support persons.

https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2016/10/meaningful_conversations.pdf

- 2.7.2 Antenatal education and discussion should extend throughout the antenatal period. Following an exploration of parent's prior knowledge in relation to breastfeeding some of the following topics may be included in the conversation (Appendix VI)

- The value of connecting with their growing baby in utero. Taking time out to connect: talking to baby, noticing and responding to movements.
- The value of skin contact.
- How closeness, comfort and love can help baby's brain development.
- Responsive feeding, recognition of and response to baby's early feeding cues
<https://www.breastfeeding.ie/Uploads/files/Feeding-Cues-Infographic-English.pdf>
- The value of breastfeeding as protection, comfort and food.
https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2016/10/meaningful_conversations.pdf
- Practices that support the initiation and continuation of breastfeeding, including labour and birth practices.
- The importance of immediate and sustained safe skin to skin contact (SSC).
- The importance of early initiation of breastfeeding.
- The importance of rooming-in.
- The importance of exclusive breastfeeding to baby and to mother in the first six months and breastfeeding's continued importance after 6 months when other foods are added to the infant's diet.
- The potential adverse effects for children who are not breastfed.
- Basic breastfeeding management – including correct positioning and attachment of the baby to the breast.
- Breastfeeding support groups – the following link on the HSE breastfeeding website www.breastfeeding.ie provides information on the breastfeeding support groups in Ireland <https://www.breastfeeding.ie/Support-search/>

These conversations are supported with written information including the booklet *Breastfeeding – A Good Start in Life* (HSE, 2015), provided during the

antenatal period, and information on accessing the HSE breastfeeding website www.breastfeeding.ie

- 2.7.3 Documentation of the discussion, and oral and written information provided should be recorded in the Antenatal Checklist in the woman's Maternity Healthcare Record or in the Maternal Newborn –Clinical Management System (MN-CMS) following implementation by the maternity hospital (Appendix VI). It is then signed by the HCP providing the information.
- 2.7.4 It should be assumed that all women will breastfeed. Women should not be asked to state their infant feeding intention antenatally, unless there is a specific medical reason why a decision needs to be made during pregnancy.
- 2.7.5 Pregnant women who request information on using infant formula should be provided with accurate, research based information. The following is a link to the booklet '*How to prepare your Baby's Bottle*' (SafeFood and HSE, 2017) <https://www.healthpromotion.ie/hp-files/docs/HPM00481.pdf>
- 2.7.6 Pregnant women and their partners are encouraged to attend antenatal education programmes and breastfeeding preparation classes / workshops provided either by the local maternity hospital or if applicable sessions provided within the Community Health Organisation (CHO). The programmes /workshops include a partnership approach between the participants and facilitator when setting the learning agenda. No routine group instruction on the preparation of artificial feeds will be given in the antenatal period.
- 2.7.7 Pregnant women who are in-patients should also be provided with antenatal information and opportunities for discussion as outlined above.
- 2.7.8 Pregnant women who have experienced difficulties with previous breastfeeding, or where breastfeeding challenges are anticipated, should be given extra time to discuss their individual situation and given relevant information by the HCP.
- 2.7.9 When admission to the neonatal unit is expected, antenatal information and discussion should take place specific to the importance of mother's milk and the practices in the neonatal unit to establish and support breastfeeding.
- 2.7.10 Pregnant women should be encouraged to attend breastfeeding support groups in their local area to help them gain confidence from meeting experienced breastfeeding mothers, counsellors and HCPs. Information on the venues, dates and times of these support groups should be provided. The following link on the HSE breastfeeding website www.breastfeeding.ie provides such information <https://www.breastfeeding.ie/Support-search/>.

Facilitate immediate and uninterrupted skin to skin contact (SSC) and support mothers to initiate breastfeeding as soon as possible after birth

- 2.7.11 Research shows that mother-friendly birthing practices have a positive effect on mothers and babies, regardless of infant feeding intention. The following practices should, therefore, be provided unless medically contraindicated, in which case the reason should be explained to the woman, and the reason recorded in her notes or in the MN-CMS following implementation by the maternity hospital.
- 2.7.12 Women in labour should be encouraged to have a support person of their choice with them during labour and birth.
- 2.7.13 Women should be permitted to drink and eat light foods during labour, if desired.

- 2.7.14 Women should be encouraged to walk and move about during labour, if desired, and to assume the positions of their choice while giving birth.
- 2.7.15 Women should be encouraged to consider the use of non-drug methods of pain relief, while respecting the personal preferences of the woman.
- 2.7.16 Invasive procedures such as rupture of membranes, episiotomies, induction or acceleration of labour, caesarean births or instrumental deliveries should be avoided, unless medically indicated.
- 2.7.17 Immediate and safe skin to skin contact (SSC) is important for the physiological and psychological well-being of both baby and mother. It commences with delivery of the baby onto the mother's chest while waiting for the cord to be ready for clamping. Babies may manoeuvre themselves towards the breast (breast crawl) over the first hour or may be supported and assisted by the midwife to the breast when feeding cues are evident.
- 2.7.18 The position of the baby is a key factor in minimising the risk of Sudden Unexpected Postnatal Collapse (SUPC) while in SSC. For safe positioning in SSC the mother, or other person providing SSC, is in a slightly upright position, not lying flat. The baby is dried, including hair, and positioned when at rest and not actively moving with legs flexed, shoulders flat against mother's chest, chest to chest with mother, not under or between the breasts. The infant's head is turned to one side with neck straight, not bent far forward or far back, the infant's face is uncovered with nose and mouth visible and the infant is covered with dry blankets wearing a hat/cap if the room is cold or baby is low birth weight (Appendix VII).
- 2.7.19 Sensible vigilance and safety precautions should be taken while the baby is in SSC. Initial observations are recorded while the baby is in safe SSC at birth and at other times according to local hospital policy. The observations are recorded in the woman's Maternity Healthcare Record or in the Maternal Newborn - Clinical Management System (MN-CMS) following implementation by the maternity hospital (Appendix VIII).
- 2.7.20 All mothers and their babies should have unhurried SSC immediately following the birth and it should be continued uninterrupted for at least 60 minutes. All mothers are supported to appreciate the importance of closeness and responsiveness for mother/baby wellbeing.
- 2.7.21 If SSC is delayed or interrupted for medical reasons or maternal choice it should be re-instigated as soon as possible.
- 2.7.22 Staff should not interrupt this early SSC for routine procedures.
- 2.7.23 SSC may continue during transfer to the ward and may continue thereafter.
- 2.7.24 If for medical reasons the mother is unable to hold her baby in SSC immediately after birth her partner/birth partner should be given the opportunity to do so until the mother's condition allows.
- 2.7.25 If a mother has had a caesarean birth the following flow chart gives information on how to support the implementation of SSC (Appendix IX). If a mother has received a general anaesthetic, SSC should commence as soon as the mother is alert and responsive, unless her partner and HCP can supervise the baby's safety while in SSC with the mother until she is alert.
- 2.7.26 Newborns requiring transfer to the neonatal unit for non-emergency reasons should be given the opportunity to have safe SSC with their mothers and initiate breastfeeding prior to transfer. Newborns needing emergency transfer to the neonatal unit should be held in SSC as soon as their condition allows.

- 2.7.27 Most healthy newborns in SSC will initiate feeding within the first hour of life. All mothers should be supported to understand responsive feeding, shown how to recognise the signs of their babies' readiness to feed, and encouraged to offer this first feed.
[https://www.hse.ie/eng/health/child/newbornscreening/newbornbloodspotscreening/Information for Professionals/Conditions/Gal/](https://www.hse.ie/eng/health/child/newbornscreening/newbornbloodspotscreening/Information%20for%20Professionals/Conditions/Gal/)
- 2.7.28 Mothers should not be asked about their proposed method of feeding until after the first SSC with their newborn baby.
- 2.7.29 Mothers should be supported and assisted by the HCP, with feeding their baby, in the delivery suite. Mothers are informed about the importance of and to practice good hand hygiene before each feed. Mothers who are breastfeeding are supported and assisted if it is needed, without interfering with the baby's natural ability to self-attach. Direct observation of a feed is necessary to ensure that the baby is able to attach and to feed at the breast and that milk transfer is happening.
- 2.7.30 Mothers who are formula feeding their baby are enabled to do so as responsively and safely as possible. Mothers who are formula feeding are encouraged to hold their baby close during feeds and offer the majority of feeds to their baby themselves, to help enhance the mother baby relationship.

Support all mothers with infant feeding.

- 2.7.31 All mothers should be supported and assisted with feeding on the postnatal ward. A midwife or other trained person should be available to assist a mother at all feeds during her postnatal stay, if needed. Direct observation of a breastfeed is necessary to ensure that the baby is able to attach and to feed at the breast and that breastmilk transfer is happening.
- 2.7.32 All breastfeeding mothers should be offered assistance and support to acquire the skills of positioning and attachment for effective feeding, the skill of hand expression of breastmilk, to identify feeding cues and recognise if feeding is effective. Mothers need to be educated on the management of engorged breasts, ways to ensure a good milk supply, prevention of sore nipples and evaluation of milk intake.
- 2.7.33 Additional support with feeding should be offered to women who have had:
- A narcotic analgesic or a general anaesthetic, as the baby may not initially be responsive to feeding.
 - A caesarean birth, and will experience limited movement.
 - Delayed initial contact with their baby.
 - Previous issues with breastfeeding, to reduce the risk of challenges occurring again.
 - When the baby has experienced birth trauma or instrumental birth.
 - When the mother feeds her baby in bed (see 2.7.50).
- 2.7.34 Classical Galactosaemia is also an autosomal recessive condition caused by a deficiency of an enzyme galactose-1-phosphate uridyl transferase. Infants born to Irish Traveller parents, have a higher risk of Galactosaemia. A special screening test, the Beutler test, is offered to all infants born to Traveller parents and to siblings of known cases at birth (Day 1 of life). These infants should be offered a galactose free feed (Soya-based) and should not breast feed until the result of the test is available. This protects the infant should he/she have the condition. For those mothers wishing to breast feed, they should discuss this with their midwife – they can express their milk until the result of the test is available. (The tests for all maternity units are currently

performed in the metabolic laboratory at the Children's University Hospital Temple Street)
<https://www.hse.ie/eng/health/child/newbornscreening/newbornbloodspotscreening/InformationforProfessionals/Conditions/Gal/>.

The Galactose free feed (Soya based) is not available in a sterile ready-to-feed liquid formula form. Written procedures should be in place in each institution for the safe preparation and handling of this powdered infant formula.

2.7.35 Mothers of babies in neonatal units who cannot immediately initiate breastfeeding should be:

- Offered help to initiate lactation ideally within the first hour of the birth of their baby.
- Shown how to express their breast milk by hand 2-3 hourly for the first 48 hours. The following video on the HSE breastfeeding website www.breastfeeding.ie provides information on the skill of hand expression <https://www.breastfeeding.ie/Resources/Video/>
- Following onset of Lactogenesis II (onset of copious milk secretion) or sooner if desired, shown how to use a breast pump. Decontamination of breast pump attachments is managed in accordance with the local hospital decontamination policy.
- Informed of the need to breastfeed or express at least 8 times in 24 hours (to include at least once during the night) to establish their supply.
- Given information on how to safely handle and store breast milk.
- Provided with assistance to put the baby to the breast as soon as the baby's condition is sufficiently stable, to provide comfort and to develop the skills of breastfeeding. The booklet *Breastfeeding & Expressing for Your Premature or Sick Baby (HSE, 2016)* provides much information for parents of babies in neonatal units.

2.7.36 If the mother has been discharged and the baby remains in the neonatal unit, the hospital HCPs should continue to provide assistance and support to the mother in establishing and maintaining lactation (See additional points in Section 2.7.65).

2.7.37 A mother who is formula feeding her baby should be provided with individualised information and time for discussion with the HCP and:

- Informed about the possible adverse effects. The mother is also informed about the management of various feeding options and helped to decide what is suitable in her circumstances.
- Supported when feeding her baby to pace the feed hence enabling her baby to control both the amount of feed taken and the speed the feed is taken. Further information on paced bottle feeding is available from the following link <https://www.breastfeeding.ie/Ask-our-expert/Questions/How-do-you-give-a-bottle-to-a-breastfed-baby.html>
- Supported to recognise her baby's feeding cues indicating her baby is satisfied and has finished the feed.

- Assisted to learn how to choose, prepare, handle and give artificial feeds and how to effectively clean and sterilise feeding equipment. This is further supported with the provision of the booklet *How to Prepare your Baby's Bottle* (SafeFood and HSE, 2017)
- Provided with an opportunity to prepare a feed to ensure she can do so safely and accurately, either individually or in small groups, in the postnatal period.
- Given information on how to care for her breasts if they become engorged.

Do not provide breastfed newborns any food or fluids other than breastmilk unless medically indicated

- 2.7.38 Exclusive breastfeeding should be the normal practice.
- 2.7.39 Clear local evidence-based protocols or guidelines should be in place for the management of conditions such as hypoglycaemia, jaundice, dehydration or excessive weight loss where supplementation may be considered. These guidelines should firstly require an assessment of breastfeeding effectiveness and address this as a priority. If there is a history of allergies refer also to local hospital policy.
- 2.7.40 Pregnant women known to be HIV positive should have a discussion with their HCP regarding infant feeding.
- 2.7.41 No materials should be given to any mother that suggest the option to include formula supplements to healthy breastfeeding infants, scheduling feedings, or other practices unsupportive of establishing and sustaining breastfeeding.
- 2.7.42 Supplements/replacement feeds may be medically/clinically indicated, if so, the reasons should first be discussed with the mother (Appendix X). If a supplement is indicated, the first and optimal choice of supplement should be the mother's own expressed breast milk. Formula supplements should only be given when medically indicated, with the mother's informed consent and when own mother's milk or donor milk is not available.
- 2.7.43 Parents who request formula supplementation should be informed of the implications and impact this may have on breastfeeding to enable them to make a fully informed decision. A record of this discussion should be made in the mother's and baby's healthcare records, or the MN-CMS following implementation by the maternity hospital.
- 2.7.44 Reasons for supplement, type, amount given and feeding method should be documented in the mother/baby's healthcare records or the MN-CMS following implementation by the maternity hospital.
- 2.7.45 Mothers who intend to 'mixed feed' (a combination of both breastfeeding and formula feeding) should be counselled on the importance of exclusive breastfeeding in the first few weeks of life, and how to establish a milk supply and to ensure that the baby is able to feed and transfer breastmilk from the breast.

Enable mothers and their babies to remain together and to practice rooming-in 24 hours a day

- 2.7.46 Rooming-in is necessary to enable mothers to practice responsive feeding, as mothers cannot learn to recognise and respond to their baby's cues for feeding if they are separated from them. The mother has primary responsibility for the care of her baby, and they should remain together 24 hours a day. This applies to all mothers and babies.

- 2.7.47 Hospital HCPs should educate and support the mother in the care of her baby.
- 2.7.48 Mothers recovering from caesarean birth should be given appropriate care to enable keeping mother and baby together.
- 2.7.49 Rooming-in may not be possible in circumstances when babies need to be moved for specialised medical care. If separation occurs, the reason for the separation and the length of the separation should be documented in the mother's and baby's healthcare records, or the MN-CMS following implementation by the maternity hospital. Documentation must include, information on the care and support provided for the mother, who removed the baby and the reason, who was responsible for the baby, where the baby was cared for and the care provided, who returned the baby to its mother and signed to say that identification bands were checked.
- 2.7.50 All mothers and their partners should be given appropriate information about safe sleeping. Information on safe sleeping practice is provided in the booklet *Safe Sleep for Your Baby Reduce the risk of Cot Death* (National Paediatric Mortality Register/ HSE, 2017). When a mother feeds her baby in bed in the maternity hospital it is important to have appropriate and adequate lighting to ensure safe observation of the baby. The call bell system needs to be proximate to the mother and she needs to have been orientated to same. Mothers need to be aware of how to safely observe their baby and a midwife or other trained person should be available to assist a mother at all times during her postnatal stay, if required.

Responsive feeding - Support mothers to recognise and respond to their babies cues for feeding (demand/ baby led feeding)

- 2.7.51 Mothers should be supported to recognise their baby's cues for feeding, closeness and comfort and enabled to respond accordingly, as part of a nurturing relationship between mother and baby. Mothers should be assisted to learn how to recognise normal baby behaviours and supported to practice responsive feeding as part of nurturing care. Mothers are assisted to recognise the early signs indicating that their baby needs feeding, how to wake a sleepy baby, and when their baby has fed sufficiently. Learning of these skills applies to mothers who are formula feeding as well as those who are breastfeeding.
- 2.7.52 No restrictions should be placed on the frequency or duration of breastfeeds for healthy babies. Where there is a medical indication, due to the baby's condition, for scheduled feeding or limited feeding, this should first be discussed with the mother.
- 2.7.53 Hospital routines or non-urgent procedures should not interfere with responsive feeding.
- 2.7.54 If a baby is high risk or if a mother's breasts are overfull and uncomfortable it may be necessary to wake a baby for feeds. This should be instigated as a temporary measure until the clinical rationale for doing this no longer applies.

Counsel breastfeeding mothers on the use and adverse effect of feeding bottles, teats and pacifiers.

- 2.7.55 HCPs should not recommend the use of artificial teats and soothers during the establishment of breastfeeding. Parents wishing to use these should be advised of the possible effects such use may have on breastfeeding to enable them to make a fully informed choice. A record of the discussion and parents' decision should be documented in the mother/baby's healthcare records or in the MN-CMS following implementation by the maternity hospital.
- 2.7.56 Nipple shields should not be recommended, unless there is a clinical reason for their use and this reason should be discussed with the mother and documented. A plan of care is developed

with the mother and she remains under the care of a skilled practitioner whilst using the shield. Mothers using a nipple shield prior to the onset of Lactogenesis II or (onset of copious milk secretion) should be assisted to stimulate her milk supply by hand expressing. The baby's intake must be closely monitored.

- 2.7.57 Mothers are informed of the importance of and to practice good hand hygiene. They are also informed of the infection control policy on the care of equipment if teats, soothers and nipple shields are being used.
- 2.7.58 If expressed breastmilk or other feeds are medically indicated for term babies it is important to identify the most appropriate feeding method for the baby. Feeding methods such as cups, spoons or feeding bottles and teats may be used during their stay in the maternity hospital. Syringes may also be used to give expressed colostrum. This is a temporary method of feeding while baby learns how to breastfeed and should not be used indiscriminately or indefinitely.

Support all mothers and their families in the preparation for discharge from the maternity services.

- 2.7.59 As part of protecting, promoting and supporting breastfeeding, discharge from the maternity services should be planned and coordinated so that mothers, their partners and their baby have access to ongoing support and receive appropriate care. Any feeding challenges must be highlighted and communicated to the Public Health Nurse (PHN) /Registered Midwife (RM) to facilitate continuity of care.
- 2.7.60 Hospitals should liaise with the public health nursing service to ensure that all mothers are visited within 48 - 72 hours of discharge. Mothers who receive their care in Midwifery Led Units, the Domino or Early Transfer Home receive postnatal care for the first few days at home as an outreach service by hospital midwives. The RM / PHN should observe and assess the baby breastfeeding at the first / primary visit. The RM / PHN should ensure the mother's positioning and attachment of the baby to her breast is reviewed and will offer recommendations if necessary. The RM / PHN should complete the 'Breastfeeding Observation and Assessment Tool' (BOAT) resource (Appendix XI) following observation of the breastfeed at this first / primary visit. The RM / PHN should then develop a plan of care for mother and baby, with the mother.
- 2.7.61 Prior to discharge from the postnatal unit all mothers should be given information about the support services available to them. Breastfeeding support groups are facilitated by maternity hospital IBCLCs, PHN/IBCLC, PHNs and/or voluntary breastfeeding organisations. This information should include how and where to access hospital, community health services, other professional support, such as lactation consultants, and voluntary mother-to-mother support services such as provided by La Leche League and Cuidiú. The following link on the HSE breastfeeding website www.breastfeeding.ie provides such information <https://www.breastfeeding.ie/Support-search/>.
- 2.7.62 Contact details for hospital and community support groups should be available throughout the maternity unit. These details should be regularly checked and updated to ensure correct information is distributed.
- 2.7.63 Hospitals should if possible provide out-patient breastfeeding support services with appropriate referral pathways, particularly for infants discharged from neonatal units or where clinical issues exist that could impact adversely on breastfeeding.

- 2.7.64 The hospital should support co-operation between hospital HCPs and voluntary support groups. This may include involvement of representatives of community and voluntary providers of breastfeeding services in staff training. It may also include their representation on infant feeding committees where the planning and organisation of services occurs .

Supportive neonatal unit

- 2.7.65 Provision of care in the neonatal unit should include an individualised developmentally supportive environment that is appropriate for the infant and the parents, and facilitates breastfeeding.
- 2.7.66 The unit should provide family-centred care that facilitates breastfeeding, supports the 24/7 presence of parents and involvement in care of the infant. A unit providing family-centred care assists to develop a parental identity and orients parents to facilities. Breastfeeding supports parent care role when the baby is admitted.
- 2.7.67 Parents should be informed about the importance of and to practice good hand hygiene. Parents are encouraged to commence provision of SSC as early as possible, ideally from birth, without unjustified delay. Parents should be encouraged and facilitated to provide Kangaroo Mother Care (KMC) each day for as long as they want, without unjustified restrictions or interruptions.
- 2.7.68 The importance of mother's milk for the baby should be promoted and prioritised even if direct breastfeeding is challenging for a period of time. Information, support, facilities and equipment should be provided that assist in the timely initiation and maintenance of milk production (Appendix XII).
- 2.7.69 Skilled lactation assistance should be available from the time of the baby's admission to support the mother in breastfeeding/providing her milk. This will assist to develop and implement a care pathway towards baby feeding at the breast, with pre-feeding skills (non nutritive sucking) at the breast recognised as an important part of this pathway.
- 2.7.70 Infant stability should be the only criterion for early initiation of breastfeeding (nutritive sucking at the breast) and for transition from tube to feeding at the breast.
- 2.7.71 Donor bank human milk should be available in the unit at all times and offered to parents of all suitable infants. Local evidenced based protocols or guidelines may be in place with criteria for use and duration of donor bank human milk. Suggested priority for dispensing donor human milk (Appendix XIII). Parents should not need to incur financial cost or to arrange for supplies of donor human milk themselves.
- 2.7.72 The first nutritive sucking experience for infants of mothers who intend to breastfeed, should be at the breast. Bottles should not be introduced to breastfed infants and to infants whose mothers intend to exclusively feed at the breast unless the mother explicitly requests it and has been informed of the possible adverse impact.
- 2.7.73 Appropriate feeding strategies for increasing infants' breast milk intake should be applied before introduction of fortifiers or artificial formula. Routine administration of milk after each breastfeeding episode given by another feeding method should be avoided, unless medically indicated.
- 2.7.74 Parents are informed about justifiable reasons for use of pacifiers in the neonatal unit, when the mother is unavailable for comforting the infant and giving pain relief at her breast, and informed about alternative ways of soothing the infant, and how to minimise pacifier use after discharge from the neonatal ward.

- 2.7.75 Administration of medications and performance of procedures should be scheduled to cause the least possible disturbance of breastfeeding and mother/baby contact. Withholding of breastfeeding (fasting or fluid restrictions) related to tests and procedures should be monitored and restricted no longer than is strictly necessary.
- 2.7.76 Facilities should provide a place to rest, and access to food and fluids for mothers who are not resident in the hospital. Mothers of infants in a neonatal unit should be considered as needing additional supports.
- 2.7.77 Continuity of care should include antenatal information and discussion when admission to the neonatal unit is expected. Continuity of care also includes coordination of care between neonatal and postnatal units, through to planned discharge ensuring parental skills and access to support and follow-up after discharge.
- 2.7.78 When the infant is transferred to another hospital the transfer notes should include information on stocks of mother's milk being transferred with the infant, mother's skills and needs related to providing her milk, and development of the infants's ability to feed at the breast, as well as parental involvement in care.
- 2.7.79 If the infant is being discharged home directly from the neonatal unit, the mother/parent should be provided with facilities to care for their baby for at least a full 24 hours before discharge, with the support of hospital HCPs during this time.
- 2.7.80 When the infant of a mother who intends to breastfeed, is discharged before breastfeeding is established there should be a plan for how to attain her breastfeeding goal (exclusivity and duration).
- 2.7.81 Parents of an infant who will be formula feeding after discharge should be provided with education appropriate to their needs by the HCP, including how to safely prepare, handle and give feeds with an opportunity to prepare a feed before discharge.
- 2.7.82 Practices listed in other sections of this policy will apply in the neonatal unit as standard care unless there is a medical reason, which will be recorded in the baby's healthcare record or in the Maternal Newborn –Clinical Management System (MN-CMS) following implementation by the maternity hospital.

Protect breastfeeding

- 2.7.83 The hospital should comply fully with the International Code of Marketing of Breastmilk Substitutes and the subsequent relevant World Health Assembly resolutions and related Irish legislation thereby protecting babies, their families, hospital staff, and assisting safe feeding (Appendix XIV). Work is currently in progress on the development of a HSE Code of Marketing of Breastmilk substitutes policy.
- 2.7.84 HCPS should not promote one brand of formula or feeding equipment over another brand. Where there is a clinical indication for a specific brand of product, information on this product should be provided without marketing.
- 2.7.85 Where specific instruction materials produced by a commercial company on the use of a specialised feeding product is deemed essential in an individual circumstance, approval for its use should be sought from hospital management.
- 2.7.86 Stocks of artificial infant feeds should not be on display in ward areas. In-patient babies who are formula feeding should be given feeds as needed and stocks of formula feeds should be

stored securely and accessed only by staff. Mothers, whether breastfeeding or formula feeding, should not be given bottles of ready-to-feed or any formula products on discharge.

- 2.7.87 Any contribution made by a manufacturer or distributor to an employee, or accepted on their behalf, for fellowships, research grants, study, or the like should be disclosed by the recipient and by the sponsoring company to hospital management.
- 2.7.88 The hospital environment must not facilitate marketing events of manufacturers of breast milk substitutes, including advertising of sponsored events and study days. The hospital or institution name must not be associated with marketing events or sponsored study days.
- 2.7.89 Contact between a manufacturer or distributor of a Code related product and all hospital staff should be restricted to providing information that is accurate, scientific and factual and related to the specific product. Care should be taken that this contact is not used as a marketing event.
- 2.7.90 No direct or indirect contact is permitted or facilitated between employees of manufacturers or distributors of breast milk substitutes, feeding bottles, teats, dummies or other feeding equipment, and pregnant women, mothers or members of their families.

Support breastfeeding

- 2.7.91 Mothers, babies and visitors attending the services should be facilitated and supported to feed their babies in all public areas of the facility. A place should be made available for mothers who request privacy while breastfeeding.
- 2.7.92 Breastfeeding mothers, who are in-patients of the hospital, other than in the Maternity Department, should also be supported to continue to breastfeed their baby.
- 2.7.93 Breastfeeding mothers of infants and young children who are in-patients of the hospital, other than the Maternity or Neonatal Department, should also be supported to continue to breastfeed.
- 2.7.94 When the medical condition of the mother or baby cannot accommodate breastfeeding, information and facilities to express and store breast milk should be provided.
- 2.7.95 Every effort should be made to use treatments and medications that are compatible with breastfeeding. If breastfeeding is contraindicated for a medical reason, this should be discussed with the mother and recorded. If cessation of breastfeeding is essential, mothers and babies should be assisted to stop breastfeeding in a manner conducive to good health. If breastfeeding cessation is only temporary, mothers and babies should be assisted to maintain/re-establish lactation and breastfeeding as soon as it is appropriate and safe to do so.

Support staff who are breastfeeding

- 2.7.96 Staff members who are breastfeeding should be supported to continue breastfeeding on return to work by the provision of lactation breaks, facilities and support from managers and co-workers. The minimum level of provision should be in accordance with the relevant legislation (Maternity Protection (Amendment) Act 2004).
- 2.7.97 Work is currently in progress on the development of a HSE Workplace Breastfeeding Policy. The policy will provide guidance on the roles and responsibilities of all staff working within the HSE, in relation to supporting employees who are breastfeeding and /or providing breastmilk to their infants / children upon their return to work within the HSE.

- 2.7.98 Any deviation from the policy must be documented in the mother and baby's healthcare records, as relevant, or in the MN-CMS following implementation by the maternity hospital, including the rationale.

PART B: PPPG Development Cycle

1.0 INITIATION

1.1 Purpose

The purpose of this policy is to ensure consistent evidence based best practice in relation to infant feeding

1.2 Scope

- 1.2.1 This policy, and its appendices, apply to all staff providing maternity and neonatal hospital services to pregnant women, infants, young children and their mothers and families, and to those providing these services on behalf of the maternity services.
- 1.2.2 In accordance with HSE, DOH and WHO/UNICEF recommendations, all hospital staff should encourage and enable mothers to breastfeed exclusively for the first 6 months and continue thereafter as part of a wider diet until two years of age or beyond.
- 1.2.3 All parents have the right to receive clear evidence-based information to enable them to make fully informed decisions about how their babies are fed and cared for.
- 1.2.4 Staff should support women in carrying out their chosen method of infant feeding.

1.3 Objective(s)

The objectives of this policy are

- 1.3.1 To ensure that evidenced based infant feeding information and clinical support will be provided to mothers and babies by HCPs working within the maternity and neonatal services.
- 1.3.2 To ensure the provision of an infant feeding service for pregnant women, infants, young children and their mothers and families.
- 1.3.3 To ensure that consistent infant feeding information is given to users and providers of services
- 1.3.4 To ensure that legislative and regulatory requirements are met
- 1.3.5 To act as a basis for audit and evaluation.

1.4 Outcome(s)

The outcomes / consequences of this policy include

- 1.4.1 To ensure consistent best practice in relation to infant feeding, and in the care and management of the breastfeeding mother and her baby.
- 1.4.2 To contribute to an increase in breastfeeding rates, supporting better health outcomes for the breastfeeding mother and her baby.

1.5 PPPG Development Group

The Maternity & Neonatal Breastfeeding PPPG Development Group (Appendix II) had

responsibility for developing this policy. This group has signed a Conflict of Interest Declaration Form (Appendix III).

1.6 PPPG Governance Group

- 1.6.1 The Approval Governance Group for this PPPG update is the HSE National Breastfeeding implementation Group (Appendix IV).
- 1.6.2 This policy update was sent for consultation to Directors of Midwifery, National Clinical Programmes Obstetrics & Gynaecology, Paediatrics and Neonatology, Neonatal Dieticians and the National Women and Infant Health Programme.

1.7 Supporting Evidence

- 1.7.1 Relevant legislation /PPPGs.
Breastfeeding is incorporated into many current policy documents in Ireland.
 - Healthy Ireland - a Framework for Improved Health and Wellbeing 2013-2025.(DoH, 2013)
 - A Healthy Weight for Ireland - Obesity Policy and Action Plan 2016-2025. (DoH, 2016)
 - Creating a Better Future Together - National Maternity Strategy 2016-2026. (DoH, 2016)
 - HSE Breastfeeding Action Plan 2016-2021.(HSE, 2016)
 - National Standards for Safer Better Maternity Services. (HIQA, 2016)
 - Breastfeeding Policy for Primary Care Teams and Community Healthcare Settings.(HSE, 2015)
 - Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives. Nursing and Midwifery Board of Ireland (NMBI, 2014)
<https://www.nmbi.ie/nmbi/media/NMBI/Publications/Code-of-professional-Conduct-and-Ethics.pdf?ext=.pdf>
 - The International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA resolutions
- 1.7.2 This policy is an update of the National Infant Feeding Policy for Maternity and Neonatal Services (HSE, 2015).
- 1.7.3 The following are the PPPGs that are related to this policy
 - Breastfeeding Policy for Primary Care Teams and Community Healthcare Settings (HSE, 2015).
 - Guideline on the Observation of a Breastfeed & Use of the Breastfeeding Observation Assessment Tool (BOAT) Resource (HSE, 2018).

1.8 Glossary of Terms

Areas that provide maternity and neonatal care to pregnant women, infants and their mothers include the Maternity Unit, Delivery Suite, Theatre, Neonatal units, Out Patient Departments, Gynaecological Department and A & E, as well as general public areas of the hospital including reception areas, hospital shop, and cafe. Aspects of the policy may apply to other areas as well as those providing care for women and infants.

Competence: The ability of the staff member to practice safely and effectively fulfilling his/her responsibility within their scope of practice.

Donor human milk: Milk that is provided by donors. Milk is collected from donors all over Ireland. The milk

is then processed in accordance with United Kingdom Association of Milk Banking (UKAMB) Guidelines and distributed to units throughout Ireland by Irvinestown Human Milk Bank; it is run as part of the Western Health and Social Care NHS Trust.

Exclusive breastfeeding: Infant receives only breast milk (at the breast, own mother's expressed milk or donor human milk) and no other food or fluids except medicines.

Father and Family: Father includes partner or significant other person. Family includes significant others and is defined by the parents.

Galactosaemia Classical Galactosaemia is also an autosomal recessive condition caused by a deficiency of an enzyme galactose-1-phosphate uridyl transferase. This enzyme is important for the breakdown of galactose, one of the two sugars that make up lactose in human and cow's milk. Approximately one in every 19,000 infants born in Ireland may have this condition. However, it is particularly common among infants born to Traveller parents in whom the incidence is approximately 1 in 450 births. Consequently in the non-traveller Irish community the incidence occurs in about one in every 36,000 births.
https://www.hse.ie/eng/health/child/newbornscreening/newbornbloodspotscreening/Information_for_Professionals/Conditions/Gal/

Healthcare worker/staff: Medical, midwifery, nursing, other professional and non-professional staff including agency, voluntary or unpaid workers, who provide care for pregnant women, infants and their mothers, attending the hospital or associated services such as off-site clinics.

Hospital: this term will be used to include associated services such as off-site clinics.

Infant feeding cues involve early and late cues that indicate the baby is hungry they include, 'body wriggling, hand and foot claspings, bringing hands to mouth or face, light sucking motions followed by more vigorous sucking, rooting behaviour, tongue extension, light sounds or whimpering, body flexion and turning head to the side. Late cues include crying, exhaustion and falling asleep' (Wambach and Riordan, 2016, p. 805).

Infant Formula Feeding: Infant receives artificial infant formula that conforms to the nutritional requirements for babies from birth to one year of age as set down by the relevant EU Directives.

Kangaroo Mother Care (KMC) The definition of the KMC method is: Early, prolonged and continuous skin-to-skin care between a mother and her low birth weight infant in hospital and after early discharge, with (ideally) exclusive breastfeeding, early discharge and adequate follow-up. In this document, KMC is used for all models of skin-to-skin care (intermittent and continuous) between parents and preterm/low birth weight/ill infants requiring neonatal care.

Lactation consultant: An International Board Certified Lactation Consultant (IBCLC) is a health care professional with specialist knowledge and clinical expertise in breastfeeding and human lactation. IBCLCs are certified by the International Board of Lactation Consultant Examiners, Inc. (www.iblce.org).

Lactogenesis describes the multiple stage process during which the mammary gland prepares to secrete milk, begins copious milk production, maintains production over time and involutes during weaning. (Wilson Clay and Hoover, 2013, p. 32).

Lactogenesis II. The onset of Lactogenesis II is (the onset of copious milk secretion, or milk coming in), occurs on average 30-40 hours after the delivery of the placenta that triggers a sharp drop in circulating progesterone postpartum (Wambach and Riordan, 2016, p. 288).

Lactogenesis III. The maintenance of milk production is influenced by three levels of controls: endocrine, autocrine (local) and metabolic. The endocrine system is thought to set each individual woman's maximum potential to produce milk; but it is the local control mechanism acting in concert that actually regulates the short term synthesis of milk (Walker, 2016, p. 136).

Managers: health service managers, both clinical and administrative.

Maternal and Newborn Clinical Management System This Project is working on the design and implementation of an electronic health record for all women and babies in maternity services in Ireland. This record will allow information to be shared with relevant providers of care covering all antenatal, intrapartum and postnatal women and the newborn, until discharge from either the hospital or community care, to the care of the public health nurse (DoH, 2016, p.15).

Neonatal units: These include special care baby units (SCBU), neonatal intensive care units, high dependency neonatal units, low dependency neonatal units, neonatal surgical units etc. This may be in a maternity, paediatric or general hospital.

Paced Bottle Feeding: Is a method of bottle feeding that can help minimise the preference for the fast flow of a bottle enabling babies control the flow of the milk. <https://www.breastfeeding.ie/Ask-our-expert/Questions/How-do-you-give-a-bottle-to-a-breastfed-baby.html>

Public Health Nurse (PHN): PHNs provide a range of services to people in a local community including child health visits (Nursing and Midwifery Board of Ireland, 2015, p. 4).

Registered Midwife (RM): A registered midwife is a person who has successfully completed a midwifery education programme that is duly recognised in the country where it is located; who has acquired the requisite qualifications to be registered and / or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery (NMBI, 2015, p.9).

Responsive feeding (RF) demand/baby led feeding refers to a sensitive, reciprocal feeding relationship between the infant and caregiver, characterised by the infant communicating feelings of hunger and satiety through verbal/nonverbal cues, followed by an immediate response from the caregiver which includes the provision of appropriate nutritious food in a supportive manner. RF is the breastfeeding foundation for healthy eating behaviour and skills for self-regulation and self-control of food intake and associated with optimal nutrient intake and long-term weight regulation (Harbron J & Booley, 2013).

Stable infant: means absence of severe apnoea, desaturation and bradycardia.

Sudden Unexpected Postnatal Collapse (SUPC) includes any term or near term (>35 weeks gestation) infant who is well at birth (normal 5 minute Apgar score and deemed well enough to have routine postnatal care) and, collapses unexpectedly requiring resuscitation with intermittent positive pressure ventilation within the first seven days of life and, who either dies or goes on to require intensive care or develops an encephalopathy (Wellchild, 2010).

The International Code of Marketing of Breast-milk Substitutes and relevant subsequent World Health Assembly (WHA) resolutions.: The Code aims to contribute "to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution (WHO, 2017, p2.)

<http://apps.who.int/iris/bitstream/10665/254911/1/WHO-NMH-NHD-17.1-eng.pdf?ua=1>

2.0 DEVELOPMENT OF PPPG

2.1 List the questions (clinical/non-clinical)

The following key questions were defined in order to identify the evidence required to address the PPPG topic. What is current evidence based best practice in relation to:

- The importance of breastfeeding in Ireland and globally.

- The role of health care and support staff in the maternity and neonatal services in the protection, promotion and support of breastfeeding
- Education of those providing direct breastfeeding support to pregnant, new mothers their partners and their babies.
- The Ten Steps to Successful Breastfeeding

2.2 Describe the literature search strategy

A review of the relevant literature was undertaken for the period 1989 to date. Based on the key questions defined, a literature search strategy was developed. The main databases used were Cinahl (Cumulative Index to Nursing and Allied Health), Cochrane Library, Pubmed, Medline and Sage Databases. The search also included library searches of hard copy journals, books and online relevant government reports. In addition a search of relevant websites and other assessment tools was undertaken. Key words used were breastfeeding, lactation, breastmilk feeding, assessment, breastfeeding support, maternity services, neonatal services post natal breastfeeding supports, preterm infants and the Ten Steps to Successful Breastfeeding.

2.3 Describe the method of appraising evidence

The evidence in relation to the best practice to protect, promote and support breastfeeding in the maternity and neonatal services was considered. The evidence in relation to the support of pregnant and new mothers and their partners to feed and care for their baby after birth and in the early postnatal period was also considered

Are the results valid?

What are the results?

Are the results applicable/generalisable to the population of the policy?

2.4 Describe the process the PPPG Development Group used to formulate recommendations

The recommendations are formulated through a formal structured process whereby the following are considered and documented:

- What evidence is available to answer the clinical questions?
- What is the quality of the evidence?
- Is the evidence applicable to the Irish population and healthcare setting?
- What is the potential benefit verses harm to the population/patient?

2.5 Provide a summary of the evidence from the literature

The following is a summary of the supporting evidence from the literature for this policy. The summary will focus firstly on the importance of breastfeeding, the Irish policy documents in relation to breastfeeding and breastfeeding in an Irish context. The evidence will be explored in relation to the role of health care and support staff in the protection, promotion and support of breastfeeding and the education of those providing infant feeding information and direct breastfeeding support to pregnant, new mothers their partners and their babies. Finally there will be a review of the evidence in relation to the Ten Steps to Successful Breastfeeding.

The Global Strategy for Infant and Young Child Feeding (WHO/UNICEF, 2003, p.8) supports exclusive breastfeeding for six months from birth 'with timely adequate, safe and appropriate complementary feeding, while continuing breastfeeding for two years and beyond'. Breastmilk is the most natural first food because of its unique properties that cannot be replicated in other milks. 'Breastfeeding is one of the few interventions

where survival benefits span the entire continuum of childhood: newborn, infancy and early childhood’ (Sankar *et al* 2015, p.6). There is substantial evidence available that breastfeeding is important for the health of both the mother and her baby (Victora *et al*, 2016). Breastfeeding gives protection against respiratory tract infection, gastroenteritis, otitis media, and may reduce diabetes, childhood cancers and Sudden Infant Death Syndrome (SIDS) (Victora *et al*, 2016). The protective effects of breastfeeding may extend into later life, with prolonged breastfeeding being directly related to a decreasing risk of obesity (Yan *et al*, 2014). Longer breastfeeding is associated with higher performance on intelligence tests among children and adolescents, controlling for maternal IQ (Victora *et al*, 2016). ‘Breastfeeding can make a significant contribution to population health by improving health outcomes for both mother and child’ (Purdy *et al* 2017, p.2). Children who are not breastfed have a higher incidence and severity of many illnesses including respiratory tract infection, gastroenteritis, otitis media, diabetes and SIDS. The risks of not breastfeeding for preterm infants include an increased risk of necrotising enterocolitis (NEC), sepsis and neurodevelopmental impairment. Breast milk is vital in preventing NEC in preterm infants. NEC is associated with increased morbidity and mortality, and neurodevelopmental impairment (American Association of Paediatrics (AAP), 2012). Due to the importance of breast milk in preventing NEC, sepsis, reducing length of NICU stay and readmissions and in improved neurodevelopmental outcomes, the AAP (2012, p. 831) states ‘the potential benefits of human milk are such that all preterm infants should receive human milk’, ‘mother’s own milk fresh or frozen should be the primary diet’. ‘If mother’s own milk is unavailable despite significant lactation support pasteurised donor milk should be used’ (AAP, 2012, p. 831).

Breastfeeding is incorporated into many current policy documents in Ireland. The vision of the Department of Health (DoH) ‘Healthy Ireland - a Framework for Improved Health and Wellbeing 2013-2025’ (DoH, 2013) is ‘a healthy Ireland where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone’s responsibility’. This document highlights the importance of addressing risk factors and promoting protective factors at every stage of life including the period from the pre-natal stage through childhood, to support health and wellbeing (DoH, 2013). The obesity strategy ‘A Healthy Weight for Ireland - Obesity Policy and Action Plan 2016-2025’ (DoH, 2016) supports breastfeeding having a significant protective factor against obesity in children. The strategy ‘Creating a Better Future Together - National Maternity Strategy 2016-2026’ (DoH, 2016) following public consultation identified areas of concern in breastfeeding. These concerns included ‘lack of breastfeeding support in the hospital, community and the home setting’. Promotion of breastfeeding, infant nutrition and parent child relationships are among the early intervention programmes proven to be effective (Royal College of Physicians of Ireland, 2017).

The vision of the HSE Breastfeeding Action Plan 2016-2021 (HSE, 2016) is to achieve ‘A society where breastfeeding is the norm for individuals, families and communities in Ireland resulting in improved child and maternal health outcomes and where all women receive the support that they need, to enable them to breastfeed for longer’. The overarching aim of the Breastfeeding Action Plan 2016 – 2021 is to increase breastfeeding initiation and duration rates, by supporting and enabling more mothers to breastfeed. One of the actions in the Action Plan 2016 – 2021 (HSE, 2016, p. 10) is to ‘implement, audit and review the Infant Feeding Policy for Maternity and Neonatal Services’.

A ‘Review and Evaluation of Breastfeeding in Ireland – A 5 year Strategic Action Plan 2005-2010’ (McAvoy *et al*, 2014, p.10) identified as determinants of breastfeeding in Ireland ‘cultural, social and economic circumstances of the mother as well as aspects of maternal age, education and self efficacy’. This review (Mc Avoy, 2014, p.184) included among other factors ‘poor latch, nipple pain, perceived insufficient milk supply and fatigue’ as ‘barriers to continued breastfeeding’. Among the common reasons for mothers not continuing to breastfeed according to Rollins *et al*, (2016) are advice and practices that undermine the mother’s confidence and self efficacy, poor positioning and attachment of baby to the breast and inadequate support especially in the early weeks. Motherhood to a new baby can be a powerful process, and success in breastfeeding may be an essential part of motherhood (Hjalmhult and Lomborg, 2012).

‘Breastfeeding is a natural process, however mothers may require support, knowledge and education’ (Royal College of Paediatrics and Child Health, 2017, p. 3). A recent umbrella review investigating interventions that promote increased breastfeeding rates conducted by the Health Research Board (Sutton *et al*, 2016) concluded that there is substantial and consistent evidence that education, counselling and support are required during the antenatal period through to the extended postnatal period. This support is more effective if provided ‘face-to-face and on an ongoing and scheduled basis’ (Sutton *et al*, 2016, p. 58). This face to face support provided by appropriately trained health professionals or peer counsellors is effective in improving breastfeeding duration and exclusivity (McAvoy *et al*, 2014). The UK study exploring women’s experiences of breastfeeding and additional breastfeeding support emphasised the need for realistic antenatal preparation and parent centred breastfeeding support (Fox *et al*, 2015). A Cochrane review (McFadden *et al*, 2017) of support for breastfeeding mothers with healthy term babies highlighted, support when offered to women increases the duration and exclusivity of breastfeeding, is effective if offered by trained personnel, professional or lay, during the antenatal and postnatal period, and works best if it involves scheduled visits and is structured to meet the needs of the population.

Support in particular is necessary for vulnerable mothers. Disadvantaged mothers need more breastfeeding support to ensure a positive breastfeeding journey (MacGregor and Hughes, 2010). Low income mothers in Ireland according to Shortt *et al* (2013) favoured, in terms of breastfeeding support, a non pressurised approach including practical help. Teenage mothers where many of these mothers either did not breastfeed or ceased breastfeeding early after the birth of the baby, indicated the need for more proactive help and support with basic baby care tasks (Hunter, 2008). Sherriff and Hall (2011) reported that fathers required information regarding the importance of breastfeeding including practical measures to support their breastfeeding partner. Mothers who decided to give up breastfeeding needed special attention and support from health care professionals (Larsen and Kronborg, 2013). ‘Some women cannot or choose not to breastfeed, this should be respected and appropriate support and education on infant feeding provided’ (Royal College of Paediatrics and Child Health, 2017, p. 3).

The Academy of Breastfeeding Medicine (ABM) (2015, p. 454) recommend mothers when experiencing breastfeeding challenges seek support from a lactation specialist while in the maternity hospital or after discharge (Rosen-Carole, Hartman and the ABM, 2015). New parents when facing challenges require information, support and input from health professionals (Datta *et al*, 2012). Strategies should be developed according to Wagner *et al* (2013), to reduce breastfeeding concerns in the early post partum period.

The maternity strategy ‘Creating a Better Future Together - National Maternity Strategy 2016-2026’ (DoH, 2016, p. 57) recommends ‘all maternity service staff should receive training both on the importance of, and best methods to initiate and continue breastfeeding’. Midwives and health visitors promote health in the postnatal period, using their varied skills which can complement each other (Aaserud, 2017). ‘Midwives use comprehensive professional knowledge and skills to provide safe, competent, kind, compassionate and respectful care and keep up to date with midwifery practice by undertaking relevant continuing professional development (NMBI, 2015, p.8). Action 2.1 of HSE Breastfeeding Action Plan 2016-2021 (HSE, 2016) is to ‘develop a framework and implementation plan for breastfeeding training and skills development for health care professionals’. The Public Health Nurse (PHN) is educated to ‘plan, implement and evaluate appropriate maternal and child health care interventions on the basis of research, evidence and evaluation’ (Nursing and Midwifery Board of Ireland, 2015, p. 9). The maternity strategy (DoH, 2016) refers to women who receive their care in Midwifery Led Units, the Domino or Early Transfer Home Services. It states these women ‘receive post natal care for the first few days at home’ and ‘this care is provided as an outreach service by hospital midwives’ (DoH, 2016, p. 16). ‘However in the main, post-natal care is provided by PHNs who visit mother and baby at home soon after discharge from hospital’ (DoH, 2016, p. 16). Post natal care may also be provided by registered midwives (RMs) employed within the Local Health Organisations (LHOs).

An assessment of the mother and baby’s breastfeeding progress must be undertaken at the first postnatal visit by the PHN / RM and an individualised plan of care developed as necessary (HSE, 2015). ‘The PHN will ensure

the mother knows how to check her baby is effectively feeding, how to correctly position and attach her baby at the breast, and how to maintain an adequate milk supply' (HSE, 2015, p.8). The support of the PHN is positively associated with breastfeeding duration in Ireland due to the frequency of 'direct /indirect contact with mothers during the postnatal period' (Tarrant *et al*, 2011, p.10).

A review of the evidence identified a number of breastfeeding policies and guides for maternity hospitals. Health Care Professionals (HCPs) having meaningful conversations with mothers enables mothers have an opportunity for a discussion about feeding their baby, how to recognise and respond to their baby and develop a positive relationship with their growing baby in utero (BFI/UNICEF).

https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2016/10/meaningful_conversations.pdf .

Some of the key tips for keeping the conversation woman centred include 'agreeing an agenda, asking open questions, active listening, reflecting back, showing empathy, remaining neutral and not colluding' (BFI/UNICEF, P. 5).

The United Nations International Children's Emergency Fund /United Kingdom (UNICEF/UK) and Baby Friendly Initiative has produced a sample infant feeding policy <https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/guidance-for-health-professionals/tools-and-forms-for-health-professionals/sample-infant-feeding-policies/>. This policy is based on the Ten Steps to Successful Breastfeeding. Practices including early skin to skin contact encourages exclusive breastfeeding (Bramson *et al*, 2010) however formula supplementation of breastfed babies and contact time between mothers and their babies remain practices that need to be addressed (Crivelli-Kovach and Chung, 2011). Adherence to the Ten Steps to Successful Breastfeeding has a positive impact on short, medium and long term breastfeeding outcomes (Pérez-Escamilla *et al*, 2016). Essential for sustaining breastfeeding includes early breastfeeding initiation, exclusive breastfeeding and community support of the breastfeeding mother (Pérez-Escamilla *et al*, 2016). Improved hospital breastfeeding policies are a critical first step to improve the care provided in the maternity services to protect, promote and support breastfeeding families (Hawke *et al*, 2013).

A recent Guideline *Protecting, Promoting and Supporting Breastfeeding in Facilities providing Maternity and Newborn Services* (WHO, 2017) examined the evidence in relation to each of the practices of the Ten Steps to Successful Breastfeeding. <http://apps.who.int/iris/bitstream/10665/259386/1/9789241550086-eng.pdf?ua=1>

This WHO Guideline 'provides global evidence-informed recommendations on protection, promotion and support of optimal breastfeeding in facilities providing maternity and newborn services as a public health intervention, to protect, promote and support optimal breastfeeding practices and improve nutrition, health and development outcomes' (WHO, 2017, p.2). This Guideline is 'an update of and supersedes the Ten Steps to Successful Breastfeeding' (WHO, 2017, p.2). A separate implementation guide that encompasses this guideline, the Code of Marketing and the Baby Friendly Hospital Initiative has recently been published (UNICEF/WHO, 2018) <http://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018.pdf>. This document '*Protecting, Promoting and Supporting Breastfeeding in facilities providing Maternity and Newborn services: the revised Baby Friendly Hospital Initiative*' (UNICEF/WHO, 2018) presents the first revision of the 'Ten Steps' since 1989. While the subject of each step is unchanged the wording has been updated. The steps are subdivided into '(i) the institutional procedures necessary to ensure that care is delivered consistently and ethically (critical management procedures); and (ii) standards for individual care of mothers and infants (key clinical practices)' (UNICEF/WHO, 2018, p.6). 'The International Code of Marketing of Breastmilk Substitutes and relevant World Health Assembly Resolutions (the Code) as well as ongoing internal monitoring of adherence to clinical practices, have been incorporated into step 1 on infant feeding policies' (UNICEF/WHO, 2018, p.6). Ten Steps to Successful Breastfeeding (revised 2018) Appendix (XVI).

2.6 Detail resources necessary to implement the PPPG recommendations

The resource implications include the production and dissemination of the updated National Infant Feeding Policy for Maternity and Neonatal Services to all 19 maternity hospitals within the Republic of Ireland.

2.7 Outline of PPPG Steps/Recommendations

Refer to Part A for the policy process steps.

3.0 GOVERNANCE AND APPROVAL

3.1 Outline Formal Governance Arrangements

- 3.1.1 The formal governance arrangements for this PPPG is the responsibility of the HSE National Breastfeeding Implementation Group (Appendix IV).

3.2 List method for assessing the PPPG in meeting the Standards outlined in the HSE National Framework for developing PPPGs.

- 3.2.1 The draft PPPG is developed and reviewed by the Maternity & Neonatal Breastfeeding PPPG Development Group.
- 3.2.2 All feedback and subsequent changes are accompanied by supporting evidence
- 3.2.3 The PPPG checklist for developing Clinical PPPGs (Appendix V) is signed to ensure compliance with the standards outlined in the PPPG Development Cycle.
- 3.2.4 The intention to update the national policy was registered with the HSE National Breastfeeding Implementation Group (Appendix IV).
- 3.2.5 The final PPPG document is signed by the chairperson of the HSE National Breastfeeding Implementation Group (Appendix IV).
- 3.2.6 The final version is converted to a PDF document to ensure the integrity of the PPPG.
- 3.2.7 A signed and dated master copy will be retained in an agreed central location with written or electronic signatures. This will ensure document control before dissemination.

3.3 Attach any copyright/permission sought

The chairperson of the Maternity & Neonatal Breastfeeding PPPG Development Group has sought permission to update this policy from the owner of the Infant Feeding Policy for Maternity and Neonatal Services (HSE, 2015) the National Breastfeeding Coordinator. This policy was developed by The National Breastfeeding Coordinator, The National Coordinator of the Baby Friendly Health Initiative and CMS Lactation Portiuncula Hospital in consultation with Maternity and Neonatal Services.

3.4 Insert approved PPPG checklist

Approved PPPG checklist for developing clinical PPPGs is included.

4. COMMUNICATION AND DISSEMINATION

A communication and dissemination plan is developed to ensure there is effective communication with all stakeholders and there is a procedure in place for dissemination of this updated National Infant Feeding Policy for Maternity and Neonatal Services. This will allow all relevant staff in Maternity and Neonatal Services to have easy access to the policy.

4.1 Hospital Group Chief Executive Officers (CEOs) and Directors

- 4.1.1 It is the responsibility of all Hospital Group CEOs and Directors to ensure that management in maternity and neonatal services receive a copy and are aware of the policy update and their responsibility in its implementation.

4.2 Management

- 4.2.1 Managers of services in contact with pregnant women, infants and young children and their mothers in their own areas and as part of the hospital management team, including nursing and midwifery managers; clinical medicine leads including consultant obstetricians, paediatricians, neonatologists and anaesthetists; managers of all hospital departments, i.e. pharmacy, radiology, laboratory, physiotherapy, dietetics, speech and language therapists, catering, hygiene services, porters, security and administration.
- 4.2.2 Managers have responsibility to ensure the updated policy should be available on Q-pulse (or similar system) with links to related procedures and guidance. The policy or a summary should be displayed in all areas of the hospital providing services to pregnant women, infants and young children and their mothers. Where a mother/parent summary of the policy is displayed in patient areas, a complete version should be available on request in each service area. A statement to this effect should be included on the mother/parent summary version. The summary policy should also be available ideally in audio format and in other languages, as needed.
- 4.2.3 Managers have the responsibility to disseminate this updated policy to all staff (full-time, temporary and contract staff) within the maternity and neonatal services.
- 4.2.4 Managers have responsibility to ensure all staff are informed of their role in the implementation of this policy update and their responsibility to adhere to this policy update
- 4.2.5 Managers have responsibility to ensure each staff member signs the Signature Sheet (Appendix 1), indicating that the staff member has read and understands this policy. A copy of this record is held by a named individual in a designated area of the maternity and neonatal services.
- 4.2.6 Managers have responsibility to ensure all staff obtain and maintain the knowledge and skill base to enable them to implement the policy within their role.
- 4.2.7 Managers have responsibility to ensure new staff are informed of and receive a copy of this policy update, are informed of their responsibility to adhere to this update and their role in its implementation. It is the responsibility of maternity and neonatal managers to ensure new staff sign the Signature Sheet and obtain the knowledge and skill base to enable them to implement the policy within their role.

4.3 Staff of maternity and neonatal services

- 4.3.1 All staff have responsibility to read this policy update and sign the Signature Sheet (Appendix I)
- 4.3.2 All staff have responsibility to adhere to this policy in its entirety
- 4.3.3 All staff have responsibility to be aware of their role in the implementation of this policy update and attend policy linked training relevant to their role

- 4.3.4 All new staff have responsibility to read this policy update and sign the Signature Sheet. They have a responsibility to be aware of their role in the implementation of this policy update and attend policy linked training relevant to their role.

4.4 Clinical Specialists in Lactation

- 4.4.1 It is the responsibility of management to assign the responsibility of co-ordinating training and audit to an appropriate staff member if a unit does not have a Clinical Specialist in Lactation post.
- 4.4.2 The Clinical Specialist in Lactation has responsibility to read this policy update and sign the Signature Sheet (Appendix I)
- 4.4.3 The Clinical Specialist in Lactation has responsibility to adhere to this policy in its entirety and integrate it into his/her work practice.
- 4.4.4 The Clinical Specialist in Lactation accepts consultations from staff members, of mothers experiencing breastfeeding challenges while in the maternity hospital or after discharge.

5.0 IMPLEMENTATION

5.1 Describe implementation plan listings actions, barriers, facilitators and timelines

The updated Infant Feeding Policy for Maternity and Neonatal Services will be disseminated through the Hospital Group CEOs and Directors. All managers of services in contact with pregnant women, infants and young children and their mothers in their own areas, and as part of the hospital management team, have responsibility to disseminate this updated policy to all staff (full-time, temporary, contract and new staff) within the maternity and neonatal services. They also have responsibility to ensure its implementation. Managers will ensure that the policy implementation and effectiveness is audited. Managers have responsibility to ensure all staff have the knowledge, competence and skills to enable them to implement the policy within their role.

5.2 Describe education / training plans required to implement the PPPG

- 5.2.1 Training of staff enables them to develop effective skills, give consistent messages and implement policy standards. All health care and support staff who have contact with pregnant women and mothers of infants and young children should have the knowledge, competence and skills to support breastfeeding. They should receive training and continuing professional development at a level appropriate to their role to ensure they implement this policy. All staff must receive training and continuing professional development at a level appropriate to their role to ensure they implement this policy. Core training courses should be accredited by relevant professional bodies.
- 5.2.2 Written curricula covering all Ten Steps to Successful Breastfeeding, mother-friendly birth practices, International Code of Marketing and feeding of the infant who is not breastfed should be available for all staff training (Appendix XV). There will also be an online training portfolio developed, employing e-learning to support the implementation of this policy. This work is currently in progress.
- 5.2.3 New staff requiring training must receive this training within six months of taking up their

posts, if this training was not received in previous employment/pre service training. Training must include both theoretical knowledge and supervised clinical practice.

- 5.2.4 All clerical and ancillary staff should be orientated to the policy and receive training relevant to their role and responsibility.
- 5.2.5 A record of staff who have received training and those awaiting training should be kept and available on request.

5.3 Hospital Group Chief Executive Officers (CEOs) and Directors

- 5.3.1 It is the responsibility of all Hospital Group CEOs and Directors to ensure that management in maternity and neonatal services receive a copy and are aware of their responsibility in the implementation of this policy update.

5.4 Managers

- 5.4.1 Managers have responsibility to ensure policy linked training is facilitated for staff relevant to their role and ensure staff participate in this training.
- 5.4.2 Managers have responsibility to ensure that appropriate breastfeeding and lactation management training is available for staff to obtain the knowledge and skills necessary to implement this policy update.
- 5.4.3 Managers have responsibility to ensure training records are completed and online or hard copy records are stored in a designated area within the maternity and neonatal services.
- 5.4.4 Managers have responsibility to ensure this policy implementation and effectiveness is audited.

5.5 Staff of Maternity and Neonatal Services

- 5.5.1 All staff have responsibility to ensure policy linked training is completed relevant to this policy update.
- 5.5.2 All staff complete a record of this training.
- 5.5.3 All staff comply with this policy and integrates it into their work practice.
- 5.5.4 All staff accounts for their practice including identifying any learning and education needs to their line manager in relation to this policy update.
- 5.5.5 Staff directly involved in the care of pregnant women, infants and young children and their mothers, must determine their scope of practice, making a clinical judgment as to whether they are competent to carry out a particular role or function relevant to this policy update. It is the staff member's responsibility to take measures to ensure they have the necessary competencies for the integration of this policy into their work practice.

5.6 Clinical Specialists in Lactation

- 5.6.1 The Clinical Specialist in Lactation has responsibility to facilitate policy linked training.
- 5.6.2 The Clinical Specialist in Lactation has responsibility to ensure that appropriate breastfeeding and lactation management training and skills development is available for staff to obtain the knowledge and skills necessary to implement this policy.

- 5.6.3 The Clinical Specialist in Lactation maintains a record of staff who have received training and those awaiting training, and online or hard copy records are stored in a designated area within the maternity and neonatal services and are available on request.
- 5.6.4 The Clinical Specialist in Lactation has responsibility to ensure this policy implementation and effectiveness is audited.

6.0 *MONITORING, AUDIT AND EVALUATION*

6.1 Describe the plan and identify lead person(s) responsible for the following processes:

- 6.1.1 Managers have responsibility to ensure the updated policy is monitored and a named health care professional with the maternity and neonatal services is assigned this responsibility.
- 6.1.2 Managers have responsibility to ensure this policy update is audited and a named health care professional within the maternity and neonatal services is assigned this responsibility.
- 6.1.3 Managers have responsibility to ensure there is evaluation of the implementation and effectiveness of this policy by a named health care professional within the maternity and neonatal services.

7.0 *REVISION/UPDATE*

7.1 Describe procedure for the update of the PPPG (including date for revision).

The update of this National Infant feeding Policy for Maternity and Neonatal Services will take place on a consistent, planned ongoing basis. The revision date will be agreed by members of the Maternity and Neonatal Breastfeeding PPPG Development Group involved in the development of the document.

Updates will be carried out every three years unless the need to revise the policy is identified. If there are no amendments required to the policy following the revision date, details on the version tracking box must still be updated which will be a new version number and date.

7.2 Identify method for amending PPPG if new evidence emerges.

New evidence may emerge by audit evaluation, serious incident, organisational structural change, scope of practice change, advances in technology or significant changes in international evidence or legislation. The Maternity and Neonatal Breastfeeding PPPG Development Group will refer to the process to ensure that the learning from the policy development and implementation process is used to amend and update or revise the original policy as new evidence emerges.

7.3 Complete version control update on PPPG Template cover sheet

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9.0 APPENDICES

- Appendix I Signature Sheet
- Appendix II Maternity & Neonatal Services Breastfeeding PPPG Development Group
- Appendix III Conflict of Interest Declaration Form
- Appendix IV Membership of the Approval Governance Group - Members of the HSE National Breastfeeding Implementation Group
- Appendix V PPPG checklist for developing Clinical PPPG
- Appendix VI Antenatal Information
- Appendix VII Positions during Skin to Skin Contact in the time immediately after birth
- Appendix VIII Newborn Observation Section MN CMS
- Appendix IX Flowchart to Support the Implementation of SSC following Caesarean Birth
- Appendix X Acceptable Medical Reasons for Use of Breastmilk Substitutes
- Appendix XI Breastfeeding Observation and Assessment Tool (BOAT) resource
- Appendix XII Breastfeeding Equipment in the neonatal unit
- Appendix XIII Suggested Priority for Dispensing Donor Human Milk
- Appendix XIV International Code of Marketing of Breastmilk Substitutes
- Appendix XV Staff Training
- Appendix XVI Ten Steps to Successful Breastfeeding (revised 2018)

Appendix I: Signature Sheet

I have read, understand and agree to adhere to this PPPG National Infant Feeding Policy for Maternity and Neonatal Services.

[illegible]

Appendix II: Membership of the PPPG Development Group

The members of the Maternity & Neonatal Services Breastfeeding PPPG Development Group

Membership of the PPPG Development Group

The members of the Maternity & Neonatal Services Breastfeeding PPPG Development Group

Siobhan Hourigan National Breastfeeding Coordinator	Signature: <u>Siobhan Hourigan</u> Date: <u>26/9/17</u>
Rebecca o Donovan Assistant National Breastfeeding Coordinator (Chairperson)	Signature: <u>Rebecca o Donovan</u> Date: <u>26/9/17</u>
Regina Keogh Neonatal CNS. Our Lady's Children's Hospital Crumlin	Signature: <u>Regina Keogh</u> Date: <u>14/12/17</u>
Linda O Callaghan Acting Clinical Placement Coordinator Midwifery. University Hospital Waterford.	Signature: <u>Linda O Callaghan</u> Date: <u>26/9/17</u>
Denise Mc Guinness CMS Lactation. National Maternity Hospital	Signature: <u>Denise McGuinness</u> Date: <u>26/9/2017</u>
Mary Coole CMS Lactation. Coombe Women and Infant University Hospital	Signature: <u>Mary Coole</u> Date: <u>26/9/17</u>
Mary Sammon CMM2. Mayo University Hospital	Signature: <u>Mary Sammon</u> Date: <u>4/10/17</u>
Mary Mahon CMS Lactation. Portlincul Hospital	Signature: <u>Mary Mahon</u> Date: <u>26/9/17</u>
Margaret Hynes CMS Lactation. University Maternity Hospital Limerick	Signature: <u>Margaret Hynes</u> Date: <u>26/9/2017</u>
Marie Woodcock Acting Lactation Consultant. St Luke's Hospital Kilkenny	Signature: <u>Marie Woodcock</u> Date: <u>26/09/17</u>
Geraldine Gordon Lactation Consultant Parentcraft Dept. Our Lady of Lourdes Hospital	Signature: <u>Geraldine Gordon</u> Date: <u>26/9/17</u>

33

PPPG Title: Infant Feeding Policy for Maternity and Neonatal services

PPPG Reference Number: Version No: Draft v. 1 Approval Date: 2017 Revision Date: 2020

PPPG Title: National Infant Feeding Policy for Maternity and Neonatal services

PPPG Reference Number: Version No: 3 Approval Date: 2019 Revision Date: 2022

Appendix III: Conflict of Interest Declaration Form

CONFLICT OF INTEREST DECLARATION

This must be completed by each member of the Maternity & Neonatal Services Breastfeeding PPPG Development Group

Please circle the statement that relates to you

1. I declare that I DO NOT have any conflicts of interest.

2. I declare that I DO have a conflict of interest.

Details of conflict (Please refer to specific PPPG)

(Append additional pages to this statement if required)

Signature

Printed name

Registration number (if applicable)

Date

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that committee members act in the best interests of the committee. The information provided will not be used for any other purpose.

A person who is covered by this PPPG is required to furnish a statement, in writing, of:

(i) The interests of the person, and

(ii) The interests, of which the person has actual knowledge, of his or her spouse or civil partner or a child of the person or of his or her spouse which could materially influence the person in, or in relation to, the performance of the person's official functions by reason of the fact that such performance could so affect those interests as to confer on, or withhold from, the person, or the spouse or civil partner or child, a substantial benefit.

Appendix IV: Membership of the Approval Governance Group - The HSE National Breastfeeding implementation Group

Name	Signature
Dr. Phil Jennings Director of Public Health. National Lead Healthy Childhood Prog	
Chairperson: Carmel Brennan Programme Manager National Healthy Childhood Programme	
Janet Gaynor Manager Health Promotion and Improvement HSE West	
Dr. Melissa Canny Specialist in Public Health Medicine	
Cara O'Neill Health and Wellbeing Rep CHU 1	
Denise Curran Health and Wellbeing Rep CHO X	
Laura Mc Hugh National Breastfeeding Coordinator	
Rebecca O'Donovan Assistant National Breastfeeding Co-Ordinator	
Margaret O'Neill National Dietetic Advisor	
Sarah O'Brien Lead Healthy Eating & Active Living Programme	
Jacinta Egan Admin Assistant National Healthy Childhood Programme	

Appendix V: PPPG Checklist for developing Clinical PPPGs

Standards for developing Clinical PPPG	Checklist
Stage 1 Initiation	
The decision making approach relating to the type of PPPG guidance required (policy, procedure, protocol, guideline), coverage of the PPPG (national, regional, local) and applicable settings are described.	✓
Synergies/co-operations are maximised across departments/organisations (Hospitals/Hospital Groups/Community Healthcare Organisations (CHO)/National Ambulance Service (NAS)), to avoid duplication and to optimise value for money and use of staff time and expertise.	✓
The scope of the PPPG is clearly described, specifying what is included and what lies outside the scope of the PPPG.	✓
The target users and the population/patient group to whom the PPPG is meant to apply are specifically described.	✓
The views and preferences of the target population have been sought and taken into consideration (as required).	✓ (healthcare professionals)
The overall objective(s) of the PPPGs are specifically described.	✓
The potential for improved health is described (e.g. clinical effectiveness, patient safety, quality improvement, health outcomes, quality of life, quality of care).	✓
Stakeholder identification and involvement: The PPPG Development Group includes individuals from all relevant stakeholders, staff and professional groups.	✓
Conflict of interest statements from all members of the PPPG Development Group are documented, with a description of mitigating actions if relevant.	N/A
The PPPG is informed by the identified needs and priorities of service users and stakeholders.	✓
There is service user/lay representation on PPPG Development Group (as required).	N/A
Information and support is available for staff on the development of evidence-based clinical practice guidance.	✓

Stage 2 Development	Checklist
The clinical question(s) covered by the PPPG are specifically described.	N/A
Systematic methods used to search for evidence are documented (for PPPGs which are adapted/adopted from international guidance, their methodology is appraised and documented).	✓
Critical appraisal/analysis of evidence using validated tools is documented (the strengths, limitations and methodological quality of the body of evidence are clearly described).	✓
The health benefits, side effects and risks have been considered and documented in formulating the PPPG.	✓ (health benefits of breastfeeding)
There is an explicit link between the PPPG and the supporting evidence.	✓
PPPG guidance/recommendations are specific and unambiguous.	✓
The potential resource implications of developing and implementing the PPPG are identified e.g. equipment, education/training, staff time and research.	N/A (update of previous policy)
There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care.	N/A
Budget impact is documented (resources required).	N/A
Education and training is provided for staff on the development and implementation of evidence-based clinical practice guidance (as appropriate).	✓ (Elearning programme)
Three additional standards are applicable for a small number of more complex PPPGs: Cost effectiveness analysis is documented. A systematic literature review has been undertaken. Health Technology Assessment (HTA) has been undertaken.	N/A
Stage 3 Governance and Approval	Checklist
Formal governance arrangements for PPPGs at local, regional and national level are established and documented.	✓

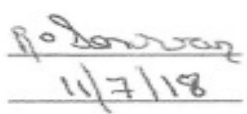
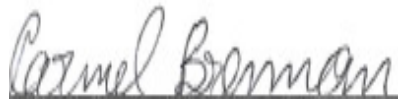
The PPPG has been reviewed by independent experts prior to publication (as required).	N/A
Copyright and permissions are sought and documented.	N/A

Stage 4 Communication and Dissemination	Checklist
A communication plan is developed to ensure effective communication and collaboration with all stakeholders throughout all stages.	√
Plan and procedure for dissemination of the PPPG is described.	√
The PPPG is easily accessible by all users e.g. PPPG repository.	√
Stage 5 Implementation	Checklist
Written implementation plan is provided with timelines, identification of responsible persons/units and integration into service planning process.	√
Barriers and facilitators for implementation are identified, and aligned with implementation levers.	√
Education and training is provided for staff on the development and implementation of evidence-based PPPG (as required).	√
There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care.	N/A
Stage 6 Monitoring, Audit, Evaluation	Checklist
Process for monitoring and continuous improvement is documented.	√
Audit criteria and audit process/plan are specified.	√ (via Baby Friendly Standards)
Process for evaluation of implementation and (clinical) effectiveness is specified.	√ (via Baby Friendly Standards)
Stage 7 Revision/Update	Checklist
Documented process for revisions/updating and review, including timeframe is provided.	√
Documented process for version control is provided.	√

I confirm that the above Standards have been met in developing the following:

Title of Policy: Infant Feeding Policy for Maternity and Neonatal Services

Name of Person(s) signing off on the PPPG Checklist:

Name: <u>Rebecca O Donovan</u> Title: <u>Assistant National Breastfeeding Coordinator</u>	 <u>11/7/18</u>
Name: <u>Carmel Brennan</u> Title: <u>Programme Manager National Healthy Childhood Programme – (Chairperson National Breastfeeding Implementation Group)</u>	

This signed PPPG Checklist must accompany the final PPPG document in order for the PPPG to be approved.

Appendix VI: Antenatal information

The antenatal information and discussion with all pregnant women should cover:

- Breastfeeding as the normal way to feed and care for a baby, and the importance of breastfeeding,
- Supportive labour and birth practices
- The importance of early skin-to-skin contact and early initiation of breastfeeding,
- Rooming-in on a 24 hour basis,
- Good positioning and attachment for effective feeding,
- Feeding on demand or baby-led feeding, and frequent feeding to help ensure a good milk supply,
- Exclusive breastfeeding for the first 6 months, and that breastfeeding continues to be important after 6 months when other foods are given,
- Avoidance of artificial teats and supplements,
- The risks of giving formula or other breast milk substitutes
- Availability of postnatal assistance to establish feeding, and where mothers can find help on feeding their infants after return home.

A pregnant woman who request information on formula feeding should be given information and the opportunity to have an individual discussion, including:

- Types of formula suitable for newborn infants
- The importance of safe preparation and use of formula
- Equipment required
- The cost of using formula
- The safety of local water supply / bottled water
- Social aspects of feeding decisions and health risks
- Availability of postnatal assistance to safely preparing formula, and where mothers can find help on feeding their infants after return home.

From: UNICEF/WHO, *Baby-friendly Hospital Initiative: revised, updated and expanded for integrated care*, Section 1, Background and Implementation, 2008, and BFHI Link, newsletter of the Baby Friendly Initiative in Ireland www.babyfriendly.ie Discussing infant *formula use: Issue 43*

The Infant Feeding Antenatal Checklist in the National Maternity Chart covers the areas for discussion in the antenatal period NMHCR-QPSD-D-008-1

http://hse.ie/Intranet/qualitypatientsafety/?importUrl=http://localhost:82/eng/about/Who/qualityandpatientsafety/safepatientcare/healthrecordsmgt/Healthcare_Records_Management.html

Discussions and information provided should be recorded on the Infant Feeding Antenatal Checklist. Discussions should be modified to meet the individual woman's needs. Open questions should be included and opportunities for the woman to ask questions. Information can be provided by the antenatal team /midwife / obstetrician/ GP / Practice nurse and documented in the checklist.

The MN-CMS Infant Feeding Education and History

- Importance of Exclusive Breastfeeding
- Early initiation of Breastfeeding
- Breastfeeding and Skin to Skin contact
- Positioning and Attachment

- Breastfeeding on Demand
- Breastfeeding and Rooming In with Infant
- Breastfeeding a NICU Baby
- Vitamin D Supplements
- Importance of Breastfeeding Beyond 6 Months
- Breastfeeding History
- Breastfeeding History Length of Time
- Historical Breastfeeding Issues

Appendix VII: Positioning during Skin to Skin contact in the time immediately after birth

- The position of the infant is a key factor in minimizing the risk of Sudden Unexpected Postnatal Collapse (SUPC) while in skin to skin contact.
- Positioning in skin to skin contact Mother, or other person providing skin-to-skin contact, is in a slightly upright position, not lying flat Infant is dried, including hair, and positioned when at rest and not actively moving with legs flexed, shoulders flat against mother's chest, chest to chest with mother, not under or between breasts, head turned to one side with neck straight, not bent far forward or far back, face uncovered with nose and mouth visible and covered with dry blankets, with infant wearing a hat/cap if the room is cold or baby is low birth weight.
- Baby may be lying lengthways on mother's chest or across her chest above the level of her breasts.
- The midwife or recovery room nurse must educate mother and support person on the above points and assess the risk factors to determine the level of supervision required. Surveillance by the health professional responsible is recommended during the first hour post-birth, and appropriate supervision and parent education is provided during separate periods of skin to skin contact.
- The Neonatal Resuscitation Program (NRP) (in Ludington –Hoe and Morgan,2014) recommends that a health professional observes the following while infants are in skin to skin contact immediately after birth infant breathing (easy, grunting/flaring, retractions, tachypneic) activity (sleep, quiet alert, active alert/crying/breastfeeding/moving, non-responsive) colour (pink, pale, dusky) tone (head turned to one side, neck straight, face uncovered with nose and mouth visible), and well flexed extremities when the infant is lying prone on his/her abdomen.

Bibliography

Ministry of Health New Zealand, Observation of mother and baby in the immediate postnatal period: Consensus statements guiding practice – July 2012. <http://www.health.govt.nz/publication/observation-mother-and-baby-immediate-postnatal-period-consensus-statements-guiding-practice>

Neonatal Resuscitation Program (NRP) in Ludington-Hoe, S.M. and Morgan,K. (2014) Infant Assessment and Reducing Sudden Unexpected Postnatal Collapse During Skin to Skin Contact. Newborn and Infant Nursing News.14 (1):28-33. <http://www.medscape.com/viewarticle/822017>

Appendix VIII Newborn Observation Section MNCMS

Appendix VIII:

Newborn Observation Section MN CMS

Test Patient, Mncms Three - 6440844 Opened by Sheehan, Orla DBA 064304

Task Edit View Patient Record Links Notifications Options Documentation Orders Help

Patient List Multi-Patient Task List Home Message Centre CareCompass Patient Access List Scheduling Maternity Whiteboard Collection Runs Staff Assignment Case Selection Dynamic View Perioperative Tracking

Discern Reporting Portal AGFA Xero Neonate Guidelines BNF Reminds

Tear Off Exit AdHoc Specimen Collection PM Conversation Depart Communicate Medical Record Request Result Copy Related Records Create PHI iAware Collections Inquiry Scheduling Appointment Book

Test Patient, Mncms Three

Test Patient, Mncms Three Age: 32 years Sex: Female Loc: CUMH Floor 3 South: Room 3S: Bed 44 Dosing Weight: 65 kg
Allergy: Penicillin - class of antibiotic, Egg DOB: 06/Aug/85 MRN: 6440844 Inpatient(Public) [28/Jun/2017 14:44 - 29/Jun/2017 09:53]
Research: EDD: 06/01/2018 Consultant:

Full screen Print 0 minutes ago

Antenatal Clinic Visit
Antenatal Day Care
Antenatal Inpatient
Fluid Balance
Maternal Lines - Devices
Labour
Delivery
Newborn Delivery Information
Newborn Delivery Information
Vitals/Measurements
Initial Exam
Newborn Observations
Clinician Notification
Student Documentation Authentication

Postnatal Care
HDU Assessments
Maternal Systems Assessment
Maternal Education
Maternal Quick View
OT-Recovery Lines and Devices
OT-Recovery Obstetrics
OT-Recovery Gynae
Diabetes Care
Blood Product Administration Maternity
Bereavement

Last 24 Hours

Find Item Critical High Low Abnormal Unauth Flag And Or

Result Comments Flag Date Performed By

07/Nov/17
09:05 GMT

Newborn Observations

Baby A

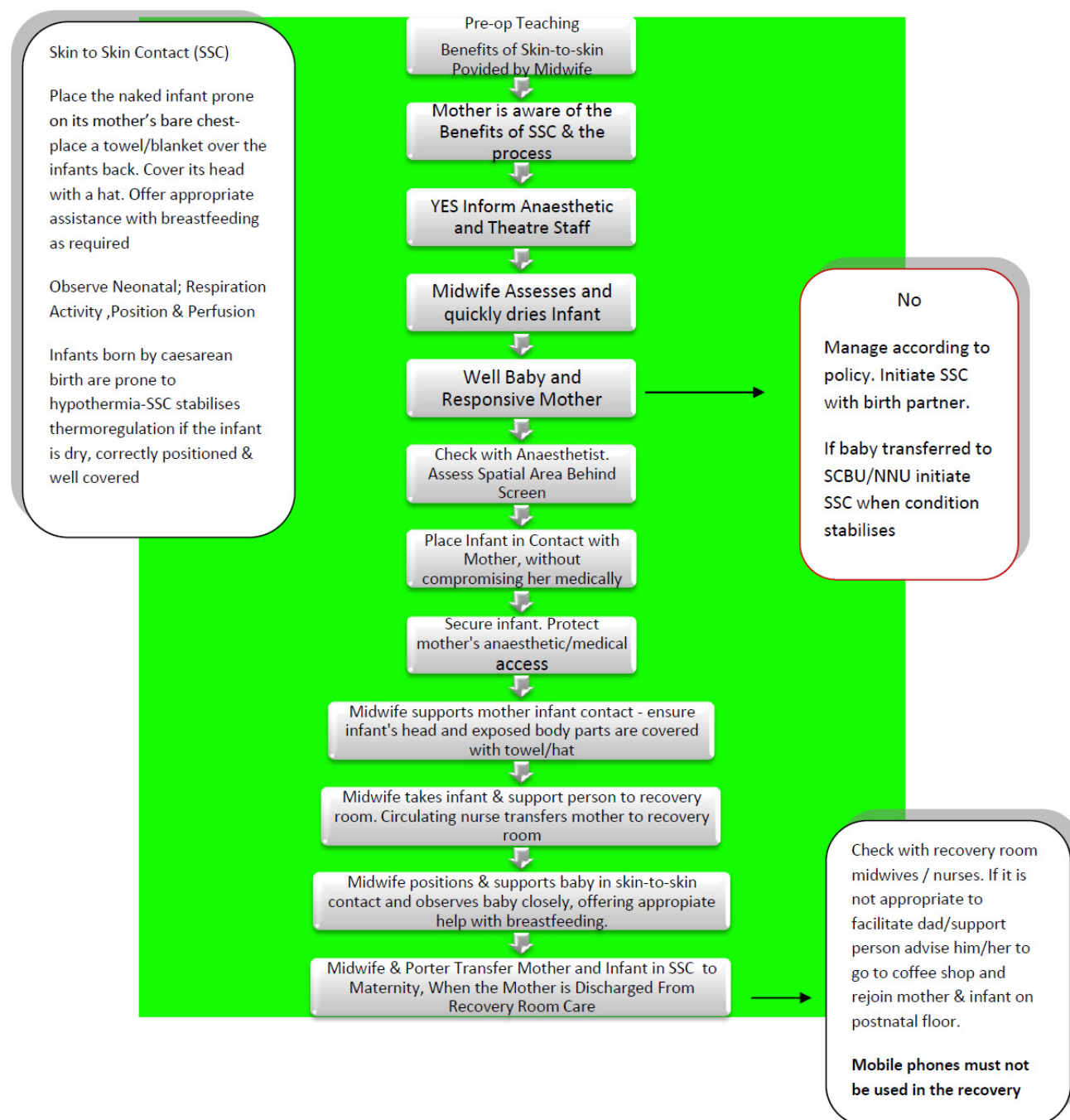
Newborn Observations, 30 Minutes
Newborn Observations, 60 Minutes
Newborn Observations, 90 Minutes
Newborn Observations, 120 Minutes

Newborn Observations, 30 Minutes
Unobstructed mouth
Nose visible
Pink colour (skin and/or mucous membranes)
Normal respiratory rate (30-60/min)
No grunting/nasal flaring/retractions
Other

PROD ORLASHEEHANIDBA 07 November 2017 09:05 GMT

09:05
07/11/2017

Appendix IX: Flow Chart to Support Implementation of SSC following Caesarean Birth



Berg, O. and Hung, K. Early Skin-to-Skin to Improve Breastfeeding After Cesarean Birth. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*. 2011. 40(1): p.18-19.

(Adapted and used with permission from Mary Mahon CMS Lactation Portiuncula Hospital)

Appendix X: Acceptable Medical Reasons for Use of Breastmilk Substitutes (WHO 2009)

Introduction

Almost all mothers can breastfeed successfully, which includes initiating breastfeeding within the first hour of life, breastfeeding exclusively for the first 6 months and continuing breastfeeding (along with giving appropriate complementary foods) up to 2 years of age or beyond. Exclusive breastfeeding in the first six months of life is particularly beneficial for mothers and infants.

Positive effects of breastfeeding on the health of infants and mothers are observed in all settings. Breastfeeding reduces the risk of acute infections such as diarrhoea, pneumonia, ear infection, Haemophilus influenza, meningitis and urinary tract infection (1). It also protects against chronic conditions in the future such as type I diabetes, ulcerative colitis, and Crohn's disease.

Breastfeeding during infancy is associated with lower mean blood pressure and total serum cholesterol and with lower prevalence of type-2 diabetes, overweight and obesity during adolescence and adult life (2). Breastfeeding delays the return of a woman's fertility and reduces the risks of post-partum haemorrhage, pre-menopausal breast cancer and ovarian cancer (3).

Nevertheless, a small number of health conditions of the infant or the mother may justify recommending that she does not breastfeed temporarily or permanently (4). These conditions, which concern very few mothers and their infants, are listed below together with some health conditions of the mother that, although serious, are not medical reasons for using breast-milk substitutes.

Whenever stopping breastfeeding is considered, the benefits of breastfeeding should be weighed against the risks posed by the presence of the specific conditions listed.

INFANT CONDITIONS

Infants who should not receive breast milk or any other milk except specialized formulae

classic galactosaemia: a special galactose-free formula is needed;

maple syrup urine disease: a special formula free of leucine, isoleucine and valine is needed;

phenylketonuria: a special phenylalanine-free formula is needed (some breastfeeding is possible, under careful monitoring).

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:

- Very low birth weight infants (those born weighing less than 1500g);
- Very preterm infants, i.e. those born less than 32 weeks gestational age;
- Newborn infants who are at risk of hypoglycaemia by virtue of impaired metabolic adaptation or increased glucose demand (such as those who are preterm, small for gestational age or who have experienced significant intrapartum hypoxic/ischaemic stress, those who are ill and those whose mothers are diabetic if their blood sugar fails to respond to optimal breastfeeding or breast-milk feeding (5)).

MATERNAL CONDITIONS

Mothers who are affected by any of the conditions mentioned below should receive treatment according to standard guidelines.

Mothers who may need to avoid breastfeeding

HIV infection (b) if replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS)(6).

Mothers who may need to avoid breastfeeding temporarily

Severe illness that prevents a mother from caring for her infant, for example sepsis;

Herpes simplex virus type 1 (HSV-1): direct contact between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved;

Maternal medication:

- Sedating psychotherapeutic drugs, anti-epileptic drugs and opioids and their combinations may cause side effects such as drowsiness and respiratory depression and are better avoided if a safer alternative is available (7);
- Radioactive iodine-131 is better avoided given that safer alternatives are available - a mother can resume breastfeeding about two months after receiving this substance;
- Excessive use of topical iodine or iodophors (e.g., povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression or electrolyte abnormalities in the breastfed infant and should be avoided;
- Cytotoxic chemotherapy requires that a mother stop breastfeeding during therapy.

Mothers who can continue breastfeeding, although health problems may be of concern

- Breast abscess: breastfeeding should continue on the unaffected breast; feeding from the affected breast can resume once treatment has started (8).
- Hepatitis B: infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter (9).
- Hepatitis C.
- Mastitis: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition (8).
- Tuberculosis: mother and baby should be managed according to national tuberculosis guidelines (10).
- Substance use (11):
- Maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies;
- Alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby.

Mothers should be encouraged not to use these substances and given opportunities and support to abstain (b).

Footnotes:

The most appropriate infant feeding option for an HIV-infected mother depends on her and her infant's individual circumstances, including her health status, but should take consideration of the health services available and the counselling and support she is likely to receive. When replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS), avoidance of all breastfeeding by HIV-infected women is recommended. Mixed feeding in the first 6 months of life (that is, breastfeeding while also giving other fluids, formula or foods) should always be avoided by HIV-infected mothers.

Mothers who choose not to cease their use of these substances or who are unable to do so should seek individual advice on the risks and benefits of breastfeeding depending on their individual circumstances. For mothers who use these substances in short episodes, consideration may be given to avoiding breastfeeding temporarily during this time.

References for Acceptable medical reasons for use of breast-milk substitutes (WHO 2009)

Technical updates of the guidelines on Integrated Management of Childhood Illness (IMCI). Evidence and recommendations for further adaptations. Geneva, World Health Organization, 2005.

Evidence on the long-term effects of breastfeeding: systematic reviews and meta-analyses. Geneva, World Health Organization, 2007.

León-Cava N et al. Quantifying the benefits of breastfeeding: a summary of the evidence. Washington, DC, Pan American Health Organization, 2002 (<http://www.paho.org/English/AD/FCH/BOB-Main.htm>, accessed 26 June 2008).

Resolution WHA39.28. Infant and Young Child Feeding. In: Thirty-ninth World Health Assembly, Geneva, 5–16 May 1986. Volume 1. Resolutions and records. Final. Geneva, World Health Organization, 1986 (WHA39/1986/REC/1), Annex 6:122–135.

Hypoglycaemia of the newborn: review of the literature. Geneva, World Health Organization, 1997 (WHO/CHD/97.1; http://whqlibdoc.who.int/hq/1997/WHO_CHD_97.1.pdf, accessed 24 June 2008).

HIV and infant feeding: update based on the technical consultation held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infection in Pregnant Women, Mothers and their Infants, Geneva, 25–27 October 2006. Geneva, World Health Organization, 2007 (http://whqlibdoc.who.int/publications/2007/9789241595964_eng.pdf, accessed 23 June 2008).

Breastfeeding and maternal medication: recommendations for drugs in the Eleventh WHO Model List of Essential Drugs. Geneva, World Health Organization, 2003.

Mastitis: causes and management. Geneva, World Health Organization, 2000 (WHO/FCH/CAH/00.13; http://whqlibdoc.who.int/hq/2000/WHO_FCH_CAH_00.13.pdf, accessed 24 June 2008).

Hepatitis B and breastfeeding. Geneva, World Health Organization, 1996. (Update No. 22).

Breastfeeding and Maternal tuberculosis Update No. 23. Geneva, World Health Organization, 1998.

Background papers to the national clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn. Commissioned by the Ministerial Council on Drug Strategy under the Cost Shared Funding Model. NSW Department of Health, North Sydney, Australia, 2006. http://www.health.nsw.gov.au/pubs/2006/bkg_pregnancy.html

Further information on maternal medication and breastfeeding is available at the United States National Library of Medicine (NLM) website: <http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT>

Full version of this document is available from Child and Adolescent Health, WHO, Geneva http://www.who.int/child_adolescent_health/documents/WHO_FCH_CAH_09.01/en/index.html

Appendix XI: Breastfeeding Observation and Assessment Tool (BOAT) resource p. 1

Breastfeeding Observation Assessment Tool

(Please complete at the first or primary visit. This resource may also be used at subsequent visits. Always use a colour version)

Mother's Name: _____ Address: _____ Tel: _____ Mothers D.O. B: _____ Type of Birth: _____ Verbal Consent Given: Yes <input type="checkbox"/> No <input type="checkbox"/>		Baby's Name: _____ DOB: _____ Baby's Age: _____ Baby's Birth Weight: _____ % Weight Loss _____ Current Weight: _____		Assessment performed by: Name: _____ Public Health Nurse / Registered Midwife (PHN/ RM) Date: _____	
---	--	--	--	--	--

How to use the BOAT <ul style="list-style-type: none"> Please see <i>Guideline - Observation of a Breastfeed & Use of the BOAT</i> Observe the baby breastfeeding (following mother's verbal consent) and ensure correct positioning and attachment of baby to the breast Complete the BOAT resource, at the first/primary visit, by asking or observing all points in the white column on page 2 Effective Breastfeeding is indicated if all boxes in the green column on page 2 are ticked. Please then go to green box (opposite) → If the amber column on page 2 has boxes ticked, it suggests a challenge with breastfeeding. Please then go to amber box (opposite) → 	Green Box - Effective Breastfeeding <ul style="list-style-type: none"> Continue breastfeeding with PHN/RM support Encourage attendance at local breastfeeding support groups The following is the link to support groups facilitated by the HSE and voluntary breastfeeding groups https://www.breastfeeding.ie/Support-search/ 	Amber Box - Suggestive of a Breastfeeding Challenge <ul style="list-style-type: none"> If there is an underlying medical issue for mother or baby the PHN / RM refers to the GP If there is a breastfeeding challenge the PHN / RM develops a care plan, takes corrective action, and refers to breastfeeding support group The PHN / RM revisits, and repeats the BOAT based on clinical judgment The PHN / RM continues corrective action until the breastfeeding challenge resolves If the challenge is not resolved the PHN / RM consults with or refers to a specialist breastfeeding professional (IBCLC) & includes BOAT.
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Day	Wet Nappies	Dirty Nappies (Mohrbacher and Kendall Tackett, 2010, p.92)
1.	1 wet nappy + (over 24 hours)	One stool (black)+
2.	2 wet nappies +	Two stools (black)+
3.	3 wet nappies +	Three stools (black or greenish)+
4.	4 wet nappies +	Three to four stools (greenish or yellowish)+
5.	5 wet nappies +	Stools should turn yellow
6 days to 6 weeks	6 wet nappies + (pale, yellow or clear urine)	3 - 8 stools + (yellow, seedy, runny to loose) daily
6 weeks to 6 months		3 - 5 stools + (daily but may skip days). (Yellow, soft may thicken over time because of milk compositional changes) (Wambach and Riordan, 2016, p.295)
Percentage weight loss calculation:	Weight loss ÷ birth weight x 100= % weight loss	Example weight loss = 226g. Birth Weight = 3500kg. 226 ÷ 3500 x 100 = 6.45% weight loss

Appendix XI: Breastfeeding Observation and Assessment Tool (BOAT) resource p. 2

What to observe / ask about	Green Column-Answer indicating Effective Breastfeeding	Amber Column-Answer Suggestive of a Breastfeeding Challenge
Mother:	Mother looks healthy	Mother looks ill or unwell
	Mother is relaxed and comfortable	Mother looks tense or uncomfortable
	There is good eye contact between mother and baby	There is no eye contact between mother and baby
Baby's wet nappies	Refer to wet nappies section page 1.	Refer to wet nappies section page 1.
Appearance and Frequency of Baby's Stools?	Refer to dirty nappies section page 1.	Refer to dirty nappies section page 1.
Baby's Colour, Alertness and Tone?	Baby may have evidence of normal physiological jaundice; Baby is alert; Baby has good tone	Baby's jaundice is worsening or not improving; baby is lethargic; not waking to feed; has poor tone
Weight of Baby (following initial post birth loss)?	Baby's weight loss is < 10% of birth weight. (To record % weight loss see percentage weight loss calculation section page 1). It is expected that babies will regain their birth weight by day 14.	Baby's weight loss is > 10% of birth weight. (To record % weight loss see percentage weight loss calculation section page 1. Birth weight is not regained by day 14.
Number of Breastfeeds in the last 24 hours?	Baby breastfeeds on demand, or is fed responsively according to early feeding cues, with at least 8-12 feeds in a 24 hour period	Baby had fewer than 8 breastfeeds in the last 24 hour period
Baby's behaviour during the Breastfeed?	Baby is generally relaxed and calm	The baby is unsettled during the breastfeed, or refuses to breastfeed
Sucking pattern during the Breastfeed?	Initial rapid sucks changing to slower sucks with pauses and audible regular soft swallowing (may be less audible until milk comes in)	No change in sucking pattern, presence of noisy feeding (e.g. clicking)
Type of Breastfeed?	Baby feeds actively from first breast until satisfied	Baby is unsatisfied despite regular breastfeeds
Offer of Second Breast?	Second breast offered as recommended when establishing milk supply. Baby feeds from second breast or not, according to appetite	Mother restricts the baby to one breast per feed
End of the Breastfeed?	Baby lets go spontaneously, or does so when breast is gently lifted	Baby does not release the breast spontaneously, mother removes the baby
Baby's Behaviour after a Breastfeed?	Baby is content after most feeds	Baby is unsettled after breastfeeding
Shape of Nipples at the end of the Breastfeed	The nipples are rounded similar to when the breastfeed began or the nipples may be slightly elongated	Nipples are misshapen or pinched at the end of the breastfeed
Mother's report on her Nipples and Breasts	Nipples and breasts are comfortable	Nipples are sore or damaged, breasts are uncomfortable
Observation of the Mothers Nipples and Breasts	Nipples are intact. Breasts are comfortable with no redness, lumps or areas of tenderness	Nipples may be infected, have symptoms of thrush or vasospasm. Mother's breasts may be engorged or have signs of mastitis. Yes (state which)
Use of Dummy, Nipple Shields / Formula?	None used	Yes (state which) Ask why:

(Content adapted from the Unicef UK Baby Friendly Initiative's Breastfeeding Assessment Tool and Dublin North Local Health Organisation's BOAT)

Appendix XII: Breastfeeding Equipment in neonatal units

All neonatal units should have:

- Simple model for demonstrating hand expression (knitted or cloth breast, balloon or inflated plastic glove)
- Hospital grade electric breast pump(s) (closed system) that can be used as single or double pumping with sufficient number of pumps for the number of infant
- Single use pumping sets or a procedure for adequate sterilisation of individual use sets
- Supplies of sterile milk containers
- Freezer for expressed milk with means of separating each mother's milk containers (shelf dividers, plastic box or bag etc)
- Refrigerator or other designated place for defrosting of frozen milk
- Comfortable chairs for mothers with cushions and foot stools available if needed
- Private place to express milk if mother would like privacy
- Hand washing facilities in or near where mothers are expressing milk

Appendix XIII: Suggested Priority for Dispensing Donor Human Milk – Human Milk Banking Association of North America.

Appendix XIII:

Suggested Priority for Dispensing Donor Human Milk - Human Milk Banking Association of North America

1. Recipient factors to consider:
 - Age
 - Projected length of need
 - Medical condition
 - Prognosis
 - Prevention of problems
 - Research
 - Ability to pay (may be a factor where medical need is not evident)
2. Maternal factors to consider:
 - Insufficient milk supply
 - Medical contraindication to breastfeeding
 - Adoption
 - Choice
3. Time factors to consider:
 - Short-term use
 - Likely to recover
 - Preventive treatment
4. Ethical Values:
 - Community benefit (CB)
 - Individual benefit/choice (IB)

Going from highest to lowest priority, based on these factors, from most critical (1) to least critical (3), and community benefit (CB) to individual benefit/choice (IB):

1. Premature infants, sick [1, 2, 3 – CB & IB]
2. Premature infants, well [2, 3 – CB & IB]
3. Infants less than 12 months old with medical conditions likely to respond to donor human milk therapy [1, 2, 3 – CB & IB]
4. Individuals more than 12 months old with medical conditions likely to respond to donor human milk therapy [1, 2 – CB & IB]
5. Research contracts for clinical use in well-designed studies [1, 3 – CB & IB]
6. Individuals more than 12 months old with chronic medical conditions and high normal functioning and low dose need for donor human milk therapy [3 – CB & IB]
7. Individuals more than 12 months old with chronic medical conditions and high normal functioning and high dose need for donor human milk therapy [3 – CB & IB]
8. Individuals more than 12 months old with chronic medical conditions and low level functioning and low dose need for donor human milk therapy [IB]
9. Individuals more than 12 months old with chronic medical conditions and low level functioning and high dose need for donor human milk therapy [3 – CB & IB]
10. Infants for short-term use, no specific medical condition [IB]
11. Laboratory research (milk that cannot be used for human consumption due to drugs used by the donor or lack of complete testing of the donor) [1 – CB]

Appendix XIV: International Code of Marketing of Breastmilk Substitutes

What is the Code?

The Code was adopted in 1981 by the World Health Assembly (WHA) to promote safe and adequate nutrition for infants, by the protection and promotion of breastfeeding and by ensuring the proper use of breast-milk substitutes, when these are necessary. One of the main principles of the Code is that health care facilities should not be used for the purpose of promoting breast milk substitutes, feeding bottles or teats. Subsequent WHA resolutions have clarified the Code and closed some of the loopholes, including maternity wards should purchase breastmilk substitutes, complementary foods are not marketed in ways that undermine exclusive and sustained breastfeeding and nutrition and health claims are not permitted for breastmilk substitutes (WHO, 2017)

Which products fall under the scope of the Code?

The Code applies to breast milk substitutes when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breast milk. Special formulas for infants with special medical or nutritional needs also fall under the scope of the Code.

Since exclusive breastfeeding is to be encouraged for 6 months, any food or drink during this period is a breast milk substitute and thus covered by the Code. This would include baby teas, juices and waters, as well as cereals, processed baby meals, including bottle-fed complementary foods, and other products marketed or otherwise represented for use before six months.

Since continued breastfeeding is to be encouraged for two years or beyond, any milk product shown to be substituting for the breast milk part of the child's diet between six months and two years, such as follow-on formula, is a breast-milk substitute and is thus covered by the Code.

The Code also applies to feeding bottles, teats and soothers.

What does the Code say?

The main points in the Code include:

- No advertising of breast-milk substitutes and other related products to the public;
- No free samples to mothers or their families;
- No promotion of products, i.e. no product displays, posters, calendars, or distribution of promotional materials;
- No donations of free or subsidised supplies of breast-milk substitutes or related products in any part of the health care system;
- No company-paid personnel to contact or to advise mothers;
- No gifts or personal samples to health workers;
- No pictures of infants, or other pictures or text idealizing artificial feeding, on the labels of the products;
- Information to health workers should only be scientific and factual;
- Information on artificial feeding should explain the importance of breastfeeding, the health hazards associated with artificial feeding and the costs of using artificial feeding ;
- All products should be of a high quality, and unsuitable products, such as sweetened condensed milk, should not be promoted for babies.

Who is a “health worker” for the purposes of the Code?

According to the Code, any person working in the health care system, whether professional or non-professional, including voluntary and unpaid workers, in public or private practice, is a health worker. Under this definition, ward assistants, health care assistants, housekeeping, nurses, midwives, social workers, dieticians, physiotherapists in-hospital pharmacists, doctors, administrators, clerks, etc. are all health workers.

What are a hospital and health worker's responsibilities under the Code?

1. **Encourage and protect breastfeeding.**

Health workers involved in maternal and infant nutrition should make themselves familiar with their responsibilities under the Code, and be able to explain the following:

- The importance and superiority of breastfeeding;
- The role of maternal nutrition in breastfeeding;
- The preparation for and maintenance of breastfeeding;
- The negative effect on breastfeeding of introducing partial bottle-feeding;
- The difficulty of reversing the decision not to breastfeed; and where needed, the proper use of infant formula, whether manufactured industrially or home-prepared.

When providing information on the use of infant formula, health workers should be able to explain:

- The social and financial implications of its use;
- The health hazards of inappropriate foods or feeding methods; and
- The health hazards of unnecessary or improper use of infant formula and other breast-milk substitutes.

2. Ensure that the health facility is not used for the display of products within the scope of the Code, for placards or posters concerning such products, including logos of manufacturers. Ensure that packages of breast milk substitutes and other supplies purchased by the health facility are not on display or visible to mothers.

3. Refuse any gifts offered by manufacturers or distributors, including mugs, pens, Post-its, entertainment or financial support.

4. Refuse samples (meaning single or small quantities) of infant formula or other products within the scope of the Code, or of equipment or utensils for their preparation or use, unless necessary for the purpose of professional evaluation or research at the institutional level.

5. Never pass any samples to pregnant women, mothers of infants and young children, or members of their families. Samples of infant formula should not be given to mothers on discharge.

6. Disclose any contribution made by a manufacturer or distributor for fellowships, study tours, research grants, attendance at professional conferences, or the like to management of the health facility.

7. Be aware that support and other incentives for programmes and health professionals working in infant and young-child health should not create conflicts of interests.

Adapted from: UNICEF/WHO, *Baby-friendly Hospital Initiative: revised, updated and expanded for integrated care, Section 1, Background and Implementation*, 2008 and

World Health Organisation. *The International Code of Marketing of Breast-Milk Substitutes. Frequently Asked Questions 2017 Update*. Geneva: WHO; 2017

Appendix XV: Staff training

All clinical staff members who have contact with mothers and/or infants should receive training, either at the hospital or prior to joining the staff that covers:

Ten Steps to Successful Breastfeeding,

- Mother-friendly birth practices,
- The International Code of Marketing of Breast-milk Substitutes and relevant subsequent World Health Assembly resolutions.
- For staff with direct care responsibilities for assisting breastfeeding, it is likely that at least 20 hours of targeted training will be needed to develop the knowledge and skills necessary to adequately support mothers and should include supervised clinical practice. Thereafter staff should attend regular training and skills updates to ensure they have the knowledge and skills required.
- Training on how to provide infant feeding support for non-breastfeeding mothers is also provided to staff as relevant to their work. The training covers key topics such as:
- The risks and benefits of various feeding options,
- Helping the mother choose what is acceptable, feasible, affordable, sustainable and safe (AFASS) in her circumstances,
- The safe and hygienic preparation, feeding and storage of breast-milk substitutes,
- How to teach the preparation of various feeding options, and
- How to minimize the likelihood that breastfeeding mothers will be influenced to use formula.
- Non-clinical staff members receive training that is adequate, given their roles, to provide them with the skills and knowledge needed to implement this policy and support mothers in successfully feeding their infants.

From: UNICEF/WHO, *Baby-friendly Hospital Initiative: revised, updated and expanded for integrated care*, Section 1, Background and Implementation, 2008

Appendix XVI: Ten Steps to Successful Breastfeeding (revised 2018)

Box 1. Ten Steps to Successful Breastfeeding (revised 2018)

Critical management procedures

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

Key clinical practices

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

15

United Nations International Children's Emergency Fund /World Health Organisation. *Protecting, Promoting and Supporting Breastfeeding in facilities providing maternity and newborn services: The Revised Baby Friendly Hospital Initiative*. Geneva: WHO; 2018. <http://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018.pdf>

The TEN STEPS to Successful Breastfeeding*



Well trained health workers provide the best support for breastfeeding.



Most women are able to breastfeed with the right support.



Hospital policies help make sure that all mother and babies receive best care, and support staff who wish to continue breastfeeding on return to work.



Immediate, unhurried and uninterrupted skin to skin contact after birth helps breastfeeding get started.



Breastfeeding is natural, but many mothers need help at first.



Giving formula to a breastfed baby without an indication makes it harder to get breastfeeding established.



Mothers need to be near their babies to recognise and respond to feeding cues.



Feeding babies (breast/bottle) whenever they are ready helps everybody.



It is important that everything that goes in the baby's mouth needs to be clean.



Learning to breastfeed takes time. More information on breastfeeding support is available on www.mychild.ie



*Incorporated into the HSE Infant Feeding Policy for Maternity and Neonatal Services (2018)