SLHD Policy Compliance Procedure

SLHD Breastfeeding	
TRIM Document No.	SD23/93355 (POL/145)
Policy Reference No.	SLHD_PCP2023_040
Related MOH Policy	PD2018_034 Breastfeeding in NSW - Promotion, Protection and Support GL2023_021 Breast Milk: Safe Management PD2023_025 Infection Prevention and Control in Healthcare Settings
Keywords	Breastfeeding; Breast; Milk; Colostrum; Infant; Breastmilk; Supplement, Formula; Dummies; Expressed; Lactation; Weaning
Applies to	All clinical staff providing care to breastfeeding women
Clinical Stream(s)	All Clinical Streams
Tier 2 Sign-off	Clinical Director Women's Health, Neonatology and Paediatrics SLHD
Date approved by SLHD Policy Committee	07/09/2023
Author	Donna Size Clinical Midwife Consultant, Lactation and Parenting, SLHD
Status	Active
Review Date	30/09/2028
Risk Rating	H
Replaces	SLHD_PCP2017_013

Version History	
Current Version	V.3 - 30/04/2025 – removed links to parent handouts and added as appendices.
Previous Version	V.2 - 07/03/2025 – new parent handouts, added term speech therapist to page 27 and added a principle. V.1 – 07/09/2023

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Contents

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1. Introduction

The SLHD supports safe feeding for all infants and children. All families are provided with support to feed their infant with their chosen method of feeding in response to their culture, beliefs and gender identity. The district recognises that all mothers have the right to receive clear and impartial information to enable them to make a fully informed choice as to how they feed their baby.

The district promotes, protects and supports breastfeeding as the optimal way to feed and women are encouraged and supported to breastfeed as breastfeeding offers important health benefits for both mother and infant. Breastmilk has all the nutrients an infant need for the first 6 months of life at which time family foods or solids should be introduced while breastfeeding is continued. Breastfeeding until two years of age and beyond is recommended by the World Health Organisation (WHO) and the Baby Friendly Health Initiative (BFHI).

Royal Prince Alfred Hospital (RPAH) and The Canterbury Hospital (TCH) are BFHI accredited facilities. The BFHI is a Global Accreditation process first launched in 1991 by the WHO and United Nations International Children's Emergency Fund (UNICEF) to encourage health facilities world-wide to improve support for breastfeeding. The initiative developed the Ten Steps to Successful Breastfeeding, evidence based clinical practices to promote optimal clinical care for new mothers and their infants.

The first few days of a newborn's life is a critical period for providing mothers with the support they need to breastfeed. In line with NSW Health's PD2018_034 *Breastfeeding in NSW – Promotion, Protection and Support*, both hospitals adhere to the BFHI framework. Hospital maternity practices are based on the BFHI principles and the Ten Steps to Successful Breastfeeding which is supported by The Australian National Breastfeeding Strategy: 2019 and Beyond (the Strategy) is an enduring policy framework for all Australian governments to provide a supportive and enabling environment for breastfeeding.

This Policy Compliance Procedure (PCP) operationalises the requirements of Breastfeeding in NSW - Promotion, Protection and Support (PD2018_034).

This document aims to use inclusive language to acknowledge that gender identity is personal and evolving. When 'woman' and 'mother' is used, this refers to current biological status rather than an individual's personal identity.

2. The Aims of this Policy Compliance Procedure

- Women are supported in their choice of infant feeding.
- To promote, protect and support breastfeeding by implementing "The Ten Steps to Successful breastfeeding" framework.
- To adhere to the WHO International Code of Marketing of Breastmilk Substitutes (WHO Code).
- To facilitate health workers to give consistent evidenced based infant feeding advice and support to ensure optimal standard of care to women and infants accessing healthcare in the SLHD.
- All pregnant women are provided with evidenced based information on the importance and management of breastfeeding and the potential health risks

associated with giving a breastmilk substitute so they can make an informed decision regarding infant feeding. Women are supported to optimally feed their baby. This includes exclusive breastfeeding or where this is not possible to partially breastfeed or exclusively give a breastmilk substitute.

- Women who have made an informed decision to use infant formula or whose infant require a breastmilk substitute are provided with individual instruction and written information on safe preparation, handling and storage of reconstituted powdered infant formula and the giving of the formula of their choice.

3. Risk Statement

SLHD Enterprise Risk Management System (ERMS) Risk # 1: Unwarranted Deviation from standards of clinical care

- The health of a woman or baby may be compromised by not breastfeeding.
- Inappropriate breastfeeding support and /or management of breastfeeding problems.
- Non-compliance with the WHO Code.

4. Scope

All SLHD clinical staff who care for pregnant or breastfeeding women and infants.

5. Education and Training

- Education will take place via orientation programs and 'in service education' sessions. Recognition of prior learning is possible when supported by evidence such as certificate of completion or other relevant documentation.
- Group 1 staff - All staff who counsel and assist mothers to breastfeed and provide education in relation to breastfeeding. This includes: midwives, nurses, students, parenting educators, AIMs/AINs working within the maternity unit, antenatal clinic, nurseries and paediatric units (permanent and casual staff). Staff who have been at the facility for 6 months or more must complete at least 8 hours of competency based infant feeding in-service education to demonstrate skills in the 20 core competencies which are considered essential skills. This education must be commenced within 6 months of employment at the facility and completed within 12 months. All staff are introduced to the breastfeeding policy at staff orientation.
    - In-service education is delivered using online platforms and face to face interactive education sessions with a focus on practical skills. Sessions are designed to meet the individual learning needs of participants to assist them to develop confidence and competence in the 20 core competencies.

  Staff are required to complete My Health Learning Breastfeeding Modules:
    - Breastfeeding Promotion Course – 30 minutes
    - Breastfeeding Module 1 – 1 hour
    - Breastfeeding Module 2 – 3 hours
- Group 2 staff – Staff who may provide general breastfeeding advice but do not assist mothers to breastfeed. All medical staff who have been at RPAH or TCH for 3 months or more are required to complete breastfeeding education related to the facilities policy and BFHI principles. This includes: obstetricians, paediatricians, other medical staff, most paediatric unit staff and allied health professionals. Education is provided during staff orientation and in-service or through a BFHI breastfeeding module available on an online platform.
- Group 3 staff – Staff who have contact with pregnant women and mothers but do not assist with breastfeeding or infant feeding advice. This may include: administration

staff, patient care assistants, volunteers, relevant domestic staff, environmental services staff, theatre and recovery room and emergency department staff.

6. Implementation

- Distribution and notification of this policy to midwifery, nursing and medical staff within SLHD via Memo, email and staff meetings.
- This PCP will be published on the SLHD intranet and accessible to all staff.
- Local education and in-service will be delivered as required.

7. Key Performance Indicators and Service Measures

- Incidents and consumer feedback will be reported and managed through ims+ and may include:
  - Complaints regarding inconsistent or conflicting advice.
  - Inappropriate feeding management of infants accessing SLHD services.
  - Non-compliance with the WHO Code for the Marketing of Breastmilk Substitutes.
- Review and audit process includes data collection through PowerChart Maternity.
  - Monthly monitoring and reporting of breastfeeding initiation, supplementation, breastfeeding at hospital discharge rates and skin to skin compliance rates.
  - Quarterly manual audits are conducted for the 8 Key Clinical Practice Steps as per BFHI requirements.
  - Trends in breastfeeding rates reviewed quarterly and reported at the bi-monthly SLHD Breastfeeding Committee meeting and tabled at the SLHD Breastfeeding Reference Group Committee meeting.

8. Key Principles

- SLHD employees refer to this policy when caring for a breastfeeding woman or infant as it provides a comprehensive, evidenced based approach to support breastfeeding practices and challenges for breastfeeding women and their infants.
- A copy of this policy is available through the SLHD website and the summary poster “SLHD Breastfeeding Policy Statement” is displayed in relevant clinical areas.
- Breastfeeding is welcome anywhere within SLHD Health Services. All hospital services are to support breastfeeding families in response to their culture, beliefs and gender identity. If a woman requests privacy to breastfeed a suitable location should be provided.
- Staff are aware that RPAH and TCH are Baby Friendly Health Initiative accredited facilities and support the “Ten Steps to Successful Breastfeeding”. All staff are to comply with the WHO International Code of Marketing Breast milk Substitutes and subsequent World Health Assembly (WHA) resolutions, and the Marketing in Australia of Infant Formula: Manufacturers and Importers (MAIF) Agreement.
- All staff receive education on breastfeeding appropriate to their professional group to ensure that they have sufficient knowledge, skills and competence to support breastfeeding. Clerical and ancillary staff are to be orientated to the policy and refer breastfeeding queries to appropriately trained staff.
- Any breastfeeding woman presenting to an Emergency Department or non-maternity ward will have their lactation needs identified and attended to promptly. A breastfeeding mother with a baby under 6 months is encouraged to have the baby remain with them during the hospitalisation of the mother or a sibling of the baby, so that breastfeeding is not interrupted.
- The SLHD is committed to supporting employees who choose to continue breastfeeding following their return to work after maternity leave, or commencement

of paid work with SLHD. The SLHD Breastfeeding and Employment policy (SLHD_PD2021_043) is available for all staff.

- All pregnant or breastfeeding women and their support person are given access to clear and correct information about the benefits of breastfeeding, for themselves, their infants and their families. They should receive information that will help to increase their skills and confidence to breastfeed and care for their infant. Partner support and breastfeeding education during pregnancy and lactation has been shown to improve breastfeeding outcomes.
- Any research being undertaken in a SLHD Health Facility that involves mothers and babies must be carefully scrutinised for potential implications on infant feeding, or interference with the full implementation of the policy.

This information includes:

- The benefits of breastfeeding for the infant and the mother.
- Information on the benefits of uninterrupted skin-to-skin contact with the baby immediately after birth, until after the first breastfeed or for at least an hour to facilitate the infants transition to the changed environment, facilitate the first breastfeed and promote bonding (regardless of infant feeding choice).
- Importance of non-separation of mother and baby during their hospital stay so that the mother gains confidence in recognising and responding to their baby's feeding cues.
- Recommendations to exclusively breastfeed until around 6 months and to continue breastfeeding while introducing solid family foods until at least 12 months, and for as long as both mother and infant desire.
- Avoiding giving a breastfed infant anything other than breastmilk unless medically indicated.
- Informing parents about the risks of using artificial teats or dummies for normal healthy babies as this may reduce the chance of successful breastfeeding. Finger feeding, cup or a supply line at the breast are encouraged and used, in preference to bottle and teat for breastfed babies.
- How to recognise and respond to their infant's cues for feeding.
- Importance of baby-led attachment, how to position and attach the baby to their breast and how to recognise the baby is feeding effectively.
- No restrictions on the length or frequency of feeds in a well term baby, provided the baby is feeding effectively.
- Education and assistance to initiate and maintain the milk supply if mother and baby are separated for any reason e.g., prematurity, illness in the mother.
- Education on the method of hand expression and the rationale for performing.
- Importance of seeking skilled assistance to work through breastfeeding challenges.
- Written information about professional community support e.g., Child and Family Health Nurse, as well as mother to mother support e.g., Australian Breastfeeding Association.

This whole of district Policy Compliance Procedure meets the requirements of the BFHI to 'have a written breastfeeding policy' in Maternity, Paediatric and Community Health Services. See Section 28 and 29 for Background Baby Friendly Health Initiative and the International Code of Marketing of Breastmilk Substitutes.

9. Related Policies

This PCP should be read in conjunction with the policy documents below:

- SLHD_PD2021_043 SLHD Breastfeeding and Employment
- SLHD_PCP2022_013 Maternity: Safe Management of Expressed Breastmilk in Hospital
- SLHD_GL2021_050 Infant Formula Feeding (includes preparation and sterilisation of feeding equipment and parent education)
- SLHD_GL2020_036 Maternity: Antenatal Expression of Breastmilk
- SLHD_PCP2021_069 Boarder Babies in SLHD
- SLHD_GL2022_050 Mastitis and Breast Abscess in the Lactating Woman
- SLHD_GL2022_12 Maternity: Late Preterm Infants and Infants < 2500 grams on the Postnatal Ward
- SLHD_PCP2025_007 Maternity - Consent for supplementary feeding a breastfed baby
- RPAH_GL2023__011 RPA Women and Babies: Neonatal Hypoglycaemia: Prevention and Management
- CANT_GL2020_MP370 Hypoglycaemia in the Newborn: Prevention, Identification and Management.
- GL2023_021 Breast Milk: Safe Management
- MOH PD2018_034 Breastfeeding in NSW - Promotion, Protection and Support
- MOH PD2019_008 *The First 2000 Days Framework*
- MOH PD2023_025 Infection Prevention and Control in Healthcare Settings
- MOH GL 2021 013 Recommended Safe Sleep Practices for Babies

10. Work Health and Safety

Breastfeeding Procedures to assist in reducing Manual Handling Injuries

Goal: The midwife or health worker will assist the mother with breastfeeding and

a) Position them so that their spine remains in alignment.

b) Sustain no manual handling injury during the procedure.

Assisting the mother to breastfeed when they are sitting in the chair

When called to assist the mother with breastfeeding, check the type of assistance they require e.g. how much the mother is able to manage with feeding themselves.

- Ensure that mother is comfortable with good support e.g., a pillow or footstool.
- Sit on the breastfeeding stool, if available.
- Adjust the breastfeeding stool so that it is slightly higher than the seat of the mother's chair.
- Assess the mother's ability to latch the baby.
- Explain the physiology as required.

Mother requiring verbal support only

If the mother requires only **verbal** assistance:

- The midwife or health worker is to observe the baby feeding and
- Sit on the breastfeeding stool in an erect position while observing so that the shoulders and hips are in line.

Mother requiring hands on physical support with attachment

If the mother requires physical support to attach baby while they sit in a chair:

- Sit on the breastfeeding stool in an erect position and bring it as close as possible to the mother.
- Adjust the height of the stool according to:

  a) The maternal needs e.g., maternal height, level of breasts.
  b) The midwife or health worker's needs e.g., height.

The midwife is to sit in an erect position on the stool so that shoulders and hips are in a line.

For the ***cradle position for feeding***, have the breastfeeding stool as close as possible to the mother so that the midwife sits at a ***90-degree angle to the mother's shoulder***. This may mean the nurses will need to spread their knees wide to accommodate the mother's knees or arm of the chair to avoid the need to lean forward excessively and to avoid twisting of the spine (see figure).

If the mother requires physical support to attach baby while they remain in bed:

- Adjust the height of the bed so that it is at hip height and the midwife is not bending down.
- Assist the mother as necessary but when physical assistance is required the midwife or health worker should only maintain the selected posture for a maximum of 3 minutes only. Stretches are to be performed after 3 minutes and then the selected posture may be re-adopted.
- At no time is the midwife or health worker to twist their spine.
- Shoulders and hips are to be kept in line.
- Once the baby is successfully feeding, the midwife is to stand up straight, put their hands behind their hips, place feet well apart and bend backwards 2-3 times.

Outcomes: The midwife or health worker have assisted and observed for correct positioning and attachment, their spine remained in alignment and sustained no manual handling injury.

11. Standard Precautions

Standard Precautions represent the minimum infection prevention measures that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where healthcare is delivered. These evidence-based practices are designed to both protect and prevent spread of infection among patients and health workers. These practices include, hand hygiene, Respiratory Hygiene (cough etiquette), use of Personal Protective Equipment (PPE), Aseptic Technique, prevention of Needle-stick and Sharps Injury prevention, cleaning and disinfection and waste disposal.

12. Antenatal Care

12.1 Antenatal breastfeeding care

- Discuss feeding intention and importance of breastfeeding at the first booking visit and include the mother's partner / support person.
- A visual breast check on all pregnant women is offered at booking or if not done at booking then around the 20 week visit.
- Provide the mother written information and electronic breastfeeding resources available on SLHD and NSW Health Websites.
- Encourage mother and their partner or support person to attend antenatal breastfeeding classes which are available through Parent Education.

12.2 Antenatal Lactation Consult

If concerns are identified about the women's ability to breastfeed due to medical/surgical/psychosocial history or previous breastfeeding difficulties, they are offered a referral to the CMC-Lactation. This should be documented on EMR.

Mother's receiving antenatal care may request an appointment and women with the following should be offered an appointment:

- Previous breastfeeding difficulties
- Breast surgery (reduction, augmentation, cancer)
- Hypoplasia (lack of breast tissue)
- Nipple anomalies (inverted/surgery)
- Previous low milk supply
- Previous preterm birth
- Multiples
- Endocrine disorders (e.g.: Type 1 diabetes)
- Any breast pathology

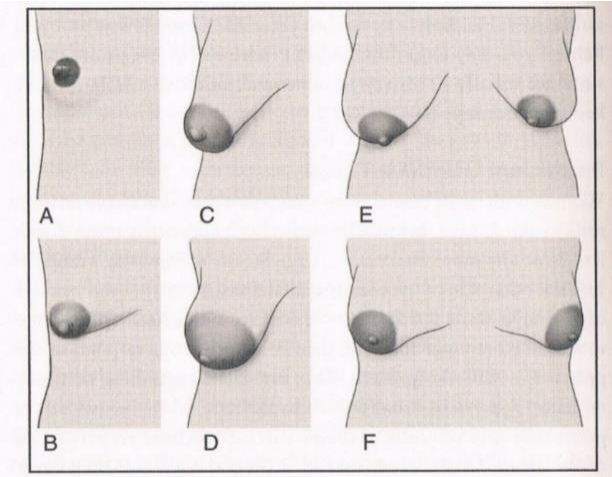
12.3 Breast Hypoplasia

Breast hypoplasia is insufficient development of the mammary glands. Small breasts do not mean hypoplasia. Clinical features include:

- Greater than 4 cm spacing between the breasts
- Breasts may be asymmetrical
- Small breast base (less distance than between the 2nd and 6th rib)
- Areola may be disproportionately large or bulbous
- Many women report few if any breast changes during pregnancy

Whilst breast hypoplasia is associated with low supply, it has been found that 39% of women with clinical features of breast hypoplasia were able to meet their baby's nutritional needs with exclusive breastfeeding when they had early lactation support postnatally.

If breast hypoplasia is suspected adopt a "wait and see" approach. The mother should be encouraged to breastfeed but also informed of the importance of early post discharge support including follow up for their baby to ensure adequate nutrition. In the antenatal period, discuss postnatal strategies to optimise their supply such as frequent breastfeeding in the first few days as well as hand expressing after breastfeeds. Domperidone may also be used from early as 5 days. If long term supplementation with a breast milk substitute is necessary, consider use of a supply line.



Hypoplasia variations: A—incomplete development before puberty; B—poorly developed upper portion, scant lower tissue; C—tubular with bulbous areola; D—long, bowed to outside, with extra-large areola; E—classic wide-spaced and uneven; F—wide-spaced with scant tissue.

13. Postnatal Care

13.1 Initiating Breastfeeding

Mothers are encouraged to place their infant's skin-to-skin after birth regardless of their chosen method of feeding. Skin-to-skin helps to stabilise the infant's temperature, heart rate, respiratory rate and blood glucose levels. Infants that are placed skin-to-skin are more settled and cry less. Uninterrupted skin-to-skin during the first hour facilitates maternal release of oxytocin.
Infants are born with innate reflexes that allow them to search and attach to the breast i.e. the rooting and sucking reflexes. They learn to suckle at the breast when their instincts are switched on in that first hour following birth. Evidence shows infants who are given early skin-to-skin contact and are kept with their mothers from birth are breastfed for longer.

Early skin-to-skin contact involves placing the naked baby prone on the mother's bare chest at birth or soon afterwards (within 5 minutes). This is a 'sensitive period' for priming mothers and infants to develop a reciprocal, interaction pattern, provided they are together and in intimate contact. Routine separation shortly after hospital birth e.g., to weigh the baby, is a uniquely western cultural phenomenon that may be associated with harmful effects including discouragement of successful breastfeeding.

13.2 Skin-to-Skin Contact and the First Feed

- Ensure mother is in a comfortable semi-reclined position. If they require perineal suturing or has had a caesarean section, ensure that they are well supported and remains comfortable throughout. On average, it takes approximately 1 hour for a baby to self-attach after birth.
- Ensure the positioning of the infant enables a patent airway. Cover infant with a dry towel/blanket ensuring face is visible. See MOH GL2021_013 Recommended Safe Sleep Practices for Babies.
- After the initial birth cry, the baby may rest vertically on mother's chest between mother's breasts, before the infant displays signs of feeding cues.
- The nipple must be accessible for the infant. The infant will use its reflexes to lift the head so the nose and mouth can be free.

- During this time, it is important for staff to encourage the parents to observe the infant and for the mother to recognise their baby's feeding cues and respond. Staff only assist if necessary. Encourage the mother to support the baby behind the shoulder blades and allow baby to move their head freely around breast. It may be necessary for the mother to assist the baby so that their chin and lower lip are directed towards the lower segment of the areola. The baby's head will normally be extended when going to the breast.
- If the infant does not optimally attach and breastfeed (at least code 5 breastfeed) within 1 hour of birth or is separated from their mother, support mother to hand express colostrum to provide for their infant. Ideally this should be performed in the Birthing Unit when the mother's hormones (oxytocin and prolactin) are at optimal levels for milk production and expression.
- Document the time of "skin to skin contact", the first breastfeed and the time of hand expression (if infant does not breastfeed in the first hour). This should be documented in the mother's birth record and progress notes and infant's iView feed record.

13.3 Ongoing Positioning & Attachment Facilitation

All infants should have their breastfeeding observed at least 12 hourly. If mother and infant are having difficulty with latching, start by facilitating skin-to-skin contact.

1. Encourage the mother to adopt a comfortable position that provides good back and neck support as well as arms and legs. This will assist them to relax and sustain the position for long periods of time. They may need a foot stool if sitting out of bed.
2. Often, the most comfortable position is semi – reclined or leaning back a little so the mother's body takes some of their infant's weight and the infant does not display anti-gravity reflexes.
3. Encourage mother to follow the infant's lead with infant unwrapped to allow the infant to get much closer to the mother's breast and body, avoid overheating and use their hands.
4. If infant has been placed skin-to-skin cover infant to prevent excess heat loss.
5. Encourage the mother to lay the infant prone/ facing them with their face near the breasts and allow the infant to begin searching for their nipple.
6. If necessary, suggest the mother supports their infant behind the shoulder blades with their body in close contact with the rest of the torso.
7. The mother may need to bring the infant's lower arm around under the breast to get closer to the breast and allow the weight of their head to tilt back, presenting their chin first to the breast.
8. A wide gape can be encouraged by allowing the baby to feel the underside of the nipple and areola with their bottom lip. The baby's nose may be level with the nipple.
9. The mother may need to shape their breast to enable the infant to take a good mouthful of breast. When infant gapes widely, infant should be brought to the breast with the nipple aimed towards the roof of infant's mouth and chin kept well tucked into the breast. This will enable the underside of the nipple to fold past the top lip. Their head will remain slightly extended and the breast should be kept still during this process.

10. After an initial short burst of sucking, the rhythm will be slow and even with deep jaw movements. This should not cause the mother any discomfort. Pauses are a normal part of the feed, and these become more frequent as the feed progresses.

11. When the mother feels comfortable with this process they can bring their other arm around to cradle their infant in a more natural position if they have not already done so. The baby often adopts an oblique lie across the mother's body.

12. Infant should finish the feed of their own accord by coming off the breast spontaneously. The nipple will appear slightly elongated but there should be no evidence of nipple trauma or compression.

13.4 Sucking Code for Breastfed Neonates

1. Offered but does not attach	• Deeply asleep, drowsy, could not be roused. • Search reflex poor or not at all	
2. Interested but does not attach	• Rooting, mouthing, sucking fists, crying	
3. Attaches on and off	• Rooting effectively with or without coaxing • Attaches, but does not sustain	
4. Attaches but has an uncoordinated suck	• Chomping at the breast • Audible clicking whilst sucking • Dimpling of the cheeks	
5. Good nutritive sucking, short feed.	• Long, slow, bursts of nutritive sucking, followed by a pause in response to the release (let-down) of milk into the baby's mouth. • Feeding takes less than 15 minutes.	
6. Good nutritive sucking, long feed	• Long, slow, bursts of nutritive sucking, followed by a pause in response to the release (let-down) of milk into the baby's mouth. • Feeding takes more than 15 minutes	
A= Assisted	**O=Observed**	**U= Unobserved**

14. Breastfeeding flowchart for babies ≥ 37 weeks with no identified risk factors

If an infant has not had at least one code 5 breastfeed by 6 hours and is not showing active feeding behaviours then a BGL and full assessment should be attended.

Has infant had at least a **code 5 feed** within **1-2** hours of birth?

NO

- Ensure no risk factors for sepsis or hypoglycaemia
- Assess RR, HR, T and oxygen saturation
- Assess tone and colour
- **Escalate as per CERS if any clinical concerns**.
- Support mother to hand express and give EBM by syringe droplet / cup at least 3hrly
- Educate parents to respond to early feeding cues
- If **No EBM** available –
  - Encourage prolonged skin to skin contact
  - Assist woman to express 3 hrly

YES

- Encourage breastfeeding on both breasts, feeding on early feeding cues, skin to skin and warmth

YES

NO

Infant had a **code 5** breastfeed or received EBM **within 6 hours** of birth or infant is alert

NO

Assess infant to exclude hypoglycaemia, sepsis, neurological disorder:

- Record **BGL**, RR, HR, T and O_2 saturation
- Assess tone, colour, mouth, suck, reflexes, responsiveness, output, mucousy?
- Escalate as per CERS

YES

6 hrs after birth

- Offer BF in response to early feeding cues or EBM 3 hourly if less than Code 5 BF
- If not code 5 breastfeed or if < 0.5mls EBM repeat assessment and BGL 6 hrly or before this time if concerns about baby behaviour (not cueing, sleepy)
- Formula supplementation is not usually required in the first 24 hours in the well term infant
- If hypoglycaemic follow hypoglycaemia policy
- Lactation review if required

If BGL
RPA: BGL <2.1mmol/L
Canterbury:
BGL <2.6mmol/L

NO

If BGL
RPA: BGL ≥2.1mmol/L
Canterbury:
BGL ≥2.6 mmol/L

YES

IF HYPOGLYACEMIC

Follow Hypoglycaemic Policy
Continue hand expressing at least every 3 hours to give EBM for infant.

YES

After 24 hrs

- Continue breastfeeding on early feeding cues and offer breast 8 – 12 times per 24 hours. If not cueing, minimum 6 feeds
- Give EBM by syringe / cup if not attaching
- Offer formula if EBM not available.
- Any concerns about feeding or baby behaviour assess infant as above (RPA: after 24 hours BGL should be ≥2.6 mmoL)
- Lactation review if concerns

Suggested supplementation volumes for breastfed infants	
24-48 hours	5 -15mls / feed
48-72 hours	15 – 30mls / feed
72-96 hours	30 – 60mls / feed

15. Monitoring Infant's Progress – First Week

Baby should be alert and responsive when awake with bright eyes and good skin turgor. A breastfeed should be observed by midwife at least once per shift.
Refer to the Breastfeeding flowchart for infants ≥ 37 weeks with no identified risk factors

15.1 Feeding Needs:

- A full-term healthy infant should be fed to need. Needs will vary according to the individual infant. An infant may have less feeds in the first 24 hours. After 24 hours, it is normal for an infant to feed 8 – 12 times/day, however, some may feed less. Cluster feedings (several feeds close together) are common in the first 24–36 hours and may stimulate breast milk production. They are not a sign of insufficient milk at this time. Long intervals between feeds (> 6 hrs) should be avoided.
- Encourage the mother to be aware of infant's early feeding cues and respond e.g., awake, alert, searching, sucking on fingers. Crying is a late feeding cue.
- Infant's attachment to the breast and sucking ability should be observed, along with the mother's comfort during the feed. Infant should be offered both breasts each feed alternating the starting breast. Offering both breasts in the first few days assists to maximise volume of milk available and stimulate breasts. Length of each feed is variable and can take up to an hour.
- Once the milk "comes in" (increase in copious milk production) mother should be advised to finish the first breast prior to offering the second breast i.e., if the first breast remains full and lumpy after the feed, infant should be encouraged to reattach to the same breast before changing breasts. Breasts should become softer and more comfortable over the next few days.

15.2 Infant's Behaviour

Infant should appear satisfied after the feed but will not always sleep immediately. Encourage mother to cuddle the infant for a little while before putting them into the cot and to respond promptly when infant displays feeding cues. Just prior to the milk "coming in", the infant usually seems very hungry and wants to feed more frequently. The infant may also have a low-grade temperature. Mother should be encouraged to respond to the baby and see this as normal.

After the first week, there will usually be one period during the day when infant does not settle in the cot but is often happy being held.

15.3 Use of Dummies

The use of dummies in full term breastfed infant is discouraged for the following reasons:

- It may interfere with recognising infant's feeding cues.
- Sucking at the breast differs from sucking on a bottle or dummy.
- Offering a dummy may reduce infant's time at the breast and reduce mother's breast stimulation which is necessary for optimal milk production.
- May increase the risk of:
- Poor establishment of breastfeeding for the mother and infant.
- Inadequate breast drainage and milk production for the mother.
- Inadequate nutrition and hydration for the infant.

NB: The hospital does not supply dummies in the post-natal ward

15.4 Urine Output

Urinary output is spasmodic in the first 48 hours. As long as the infant is voiding one or more times per 24 hours during this time there is usually no cause for concern and the presence of urates is not clinically significant. As milk volume increases around day 4-5, infant's urinary output should be colourless and increase to a minimum of six wet nappies in 24 hours.

15.5 Bowel Actions

For the first 24-48 hours the baby passes meconium that is greenish-black in colour. This changes to greenish brown transitional stools by day 3 and by day 4 the stools should be loose and mustard/yellow in colour. A baby who is still passing meconium at this stage may be signalling a problem with attachment to the breast or ability to suck correctly and this should be observed.

15.6 Weight

Infant's may lose up to 10% of their birth weight in the first 3 – 5 days, however, a weight loss of 8 -10 % is an indication that a feed or feeding should be assessed. An infant who is not breastfeeding well will show other signs of being dehydrated from about the third day and weighing should not be seen as the main indicator. It is expected that a breastfed infant will regain birth weight by day 10-14.

16. Weight loss more than 10% in the normal term baby

An initial weight loss of up to 10% of birth weight in the first week of life is considered the upper limit of normal. Between days 4 and 6 the baby usually starts to regain weight and should have returned to birthweight by 2 weeks of age.

Delayed lactogenesis has been shown to strongly correlate with increased weight loss. Recent studies have shown that intravenous fluids during the intrapartum period may influence excessive weight loss in the baby in the first week.

Babies should be weighed at 72 hours coupled with appropriate lactation support as this has been shown to have higher breastfeeding rates in the short and long term. If discharged from hospital before 72 hrs they should be weighed on day of discharge and at 72 hrs if receiving continued midwifery care in the home (Domiciliary care).

If a normal term baby has lost more than 10% of birth weight it is important to assess both mother and baby. 10 % weight loss is not an automatic indication for supplementation. Baby and mother should be referred to a lactation consultant for feed review. Weight loss over 10% can often be managed without the need for formula supplementation.

It is important to consider both mother and baby history. Observing a feed for optimal attachment and nutritive sucking is essential. Frequency of feeds, baby's output and behaviour should be assessed. Mother's breasts should be assessed to ensure breast changes indicating increasing milk production. An appropriate management plan can then be implemented. Weight loss of more than 12% indicates a medical review is necessary.

Continued monitoring of milk supply, feeding and infant weight is required until milk supply and feeding is optimal and infant weight gain is consistent.

All women and their infants are referred to local Child and Family Health Nurse (CFHN) via Child Health Information Link (CHIL). A priority referral should be sent to CFHN for all infants that have > 10 % weight loss for term infants or >7 % for preterm infants or if there are breastfeeding concerns that require early review. Referral is made by completing the Perinatal Psychosocial Referral form in the mother's eMR. For urgent referrals contact Perinatal Coordinator CNC CFHN.

Observe a breastfeed and assess the following	
Maternal factors • Breastfeeding history – has the mother successfully breastfed a previous child • Any medical maternal issues such as PPH or hypertension in pregnancy • Breasts for normal growth and development during pregnancy • Breast changes since birth • Nipples (normal, intact) • Responding to early feeding cues • Offering both breasts	**Infant Factors** • Baby's age in hours • Percentage of weight loss • Output particularly colour of stools • Frequency of feeds (8-12 is normal) • Behaviour (alert and eager to feed) • Skin tone and colour • Optimal attachment • Nutritive sucking • Oral assessment • Dummy use

Weight <u>< 12%</u> at 72 hrs (weight loss with no adverse findings)	**Weight Loss <u>≥ 12</u>% at 72 hours**
<u>If mother reports breast changes</u> • Reassure mother • Encourage frequent feeding on early feeding cues • At least 8 feeds in 24 hours • Ensure mother is offering both breasts • Ensure nutritive sucking with at least a short, settled period after feeding • Consider expressing after feeds and give EBM via cup	• Reassure mother • Encourage frequent feeding on early feeding cues • At least 8 feeds in 24 hours • Ensure mother is offering <u>both</u> breasts • If baby is non-nutritively sucking, then limit time at the breast • Express after breastfeeds, give EBM after breastfeeds preferably by cup • Consider formula supplementation dependent on amount of EBM expressed and baby behaviour
<u>If no breast changes</u> • Encourage expressing after all feeds • Give EBM via cup if possible • Consider formula supplementation	**Management:** • Paediatric review - exclude medical issues • Refer to Lactation Consultant • **Do not discharge - review weight in 12 - 24 hours** • **Priority referral to CFHN on eMR**
Management: • Refer to Lactation Consultant • Weigh and review in 12 - 24 hours • Priority referral to CFHN on eMR • Paediatric review if concerns	

17. Supplementary Feeds for Breastfed Babies

There is no place for routine use of supplementary feeds in a healthy term newborn

In assessing the wellbeing of a newborn, it is important to look at the full picture including the baby's age, colour, feeding patterns, change in stools, behaviour and level of hydration. If the baby is not feeding, EBM should be given to the baby. Discourage dummy use until milk supply is well established.

The unnecessary use of infant formula will decrease the baby's need to breastfeed, delay initiation of a full milk supply and increase the risk of maternal engorgement. Supplementation with formula in hospital is associated with shorter breastfeeding duration. A breastfed baby may be sensitised to a cow's milk protein by giving one supplementary feed during the first few days of life. It will also alter the flora of a baby's gut making it more susceptible to bacterial invasion for two to four weeks. The mother may be undermined with their ability to breastfeed and may become focused on measured amounts. The baby may expect an instant reward when initiating sucking and a very full stomach on completion of the feed. Exclusive breastfeeding is the norm. In a small number of situations there may be a medical indication for supplementing breastmilk or for not using breastmilk at all.

17.1 Preventing the Need for Supplementation

Many practices will prevent or reduce the need for supplementation, including:

- Knowledgeable, competent and skilled staff.
- Early initiation of breastfeeding or expression.
- Early skilled evaluation and adjustments to positioning and attachment.
- Rooming-in and careful attention to an infant's early feeding cues.
- Increased skin-on-skin time to encourage more frequent feeding.
- Responsive or baby-led feeding.
- Gently rousing the sleepy infant to attempt frequent breastfeeds.
- Teaching the mother hand expression of drops of colostrum.
- Understanding that cluster feeding is normal newborn behaviour, but it warrants a feeding evaluation to ensure that the infant is attached deeply and effectively.
- Using ten percent weight loss an indicator for infant evaluation, not necessarily an indicator for supplementation.
- Postnatal counselling and support of mothers.

17.2 Possible Medical Indications for Supplementation in Healthy Term Infants (37-42 weeks)

In each case, a decision must be made as to whether the clinical benefits outweigh the potential negative consequences of such feedings. The Maternity Facility handbook, BFHI Australia, Baby Friendly health Initiative, Australia recommend that facilities follow Academy of Breastfeeding Medicine. ABM Clinical Protocol #3: Supplementary feedings in the healthy term breastfed neonate, revised 2017 guidelines. Supplementation BFHI Appendix 3.

Infant Indications

- Hypoglycaemia, documented by laboratory blood glucose measurement or similar reliable measurement that is unresponsive to appropriate frequent breastfeeding or measures such as the application of a glucose gel inside of the infant's cheek. (It is

acknowledged that this protocol is for healthy term infants. Protocols for e.g., babies of women with diabetes may be different.)

- Clinical or laboratory evidence of significant dehydration (e.g., high sodium, poor feeding, lethargy, etc.)
- Significant weight loss may be an indication of inadequate milk transfer or low milk production, but a thorough evaluation of infant feeding is required before automatically ordering supplementation. It should also be noted that excess newborn weight loss is correlated with positive maternal intrapartum fluid balance (received through intravenous fluids) and may not be directly indicative of breastfeeding success or failure.
- Delayed or inadequate bowel movements or continued meconium stools on day 5 may be an indication of inadequacy of breastfeeding. Newborns with more bowel movements during the first 5 days following birthday have less initial weight loss, earlier transition to yellow stools, and earlier return to birth weight.
- Hyperbilirubinemia associated with poor breast milk intake despite appropriate intervention and marked by ongoing weight loss and limited stooling.
- Macronutrient supplementation is indicated, such as for the rare infant with inborn errors of metabolism.

Maternal Indications

- Delayed secretory activation [72–120 hours] with signs of inadequate intake by the infant.
- Primary glandular insufficiency as evidenced by abnormal breast shape, poor breast growth during pregnancy, and minimal indications of secretory activation.
- Breast pathology or prior breast surgery resulting in poor milk production.
- Certain maternal medications (e.g., chemotherapy, psychotherapeutic drugs, anti-epileptic drugs, long-lasting radioactive compounds).
- Intolerable pain during feedings unrelieved by interventions.
- Severe illness that prevents a mother caring for their infant, e.g. sepsis.

17.3 Suggested intake per feed of a healthy term breastfed baby

Suggested intake per feed of a healthy term breastfed baby is outlined below[3]. Feeding should be varied to suit the individual baby's cues, satiation and/or if the baby is breastfeeding prior to having the supplementary feed:

Avoid bottles and teats by giving supplementary feeds using a cup.

First 24 hours	24 – 48 hours	48 – 72 hours	72 – 96 hours
2 - 10 mls / feed	5 -15mls / feed	15 – 30mls / feed	30 – 60mls / feed

If mother's milk supply is not adequate by discharge, the formula should be continued and mother should be encouraged to express after all feeds or feed attempts until the baby is seen by the appropriate community support person for help with lactation. After 96 hrs volume of feed required should be calculated using 150 mL/kg/day for the first 3 months. Some infants, especially those who were preterm, may require up 180 mls/kg/day.

18. Late preterm flowchart

Late Preterm Infant Quick Reference Flowchart. Refer to SLHD_GL2022_12 Maternity: Late Preterm Infants and Infants < 2500 grams on the Postnatal Ward

	Feeding	Thermoregulation	Prevention of hypoglycaemia	Jaundice
First 24 hrs **Give parents the 'Late preterm Infants**	• Encourage a minimum of **8 feeds per 24hrs** • Attempts to attach infant should last no longer than 10 – 15 mins if not sucking well. • **Hand express after every feed / feed attempt to stimulate supply** • **If code 5/6 feed ►** give EBM if available • **If not code 5/6 feed ► 5mL-10mL** EBM/ formula	Refer to relevant **facility** policy • Encourage skin to skin time in accordance with safe sleeping guidelines • Double wrap all infants when not skin to skin unless ≥ 37.2C	**Refer to facility hypoglycaemia policy** • Ensure first BGL is attended by 6 hours of age preferably after the second feed	Observe and document 8 – 12 hourly for early signs of jaundice. • TcB at 12 hrs
24 – 48 hrs	• Continue same management • Increase volume to **10 – 20mL** of EBM / formula if infant not feeding code 5 /6 • Consider using adding breast pump as well as hand expressing after each feed	Refer to thermoregulation policy • Encourage skin to skin time in accordance with safe sleeping guidelines • Double wrap all infants when not skin to skin unless ≥ 37.2C	Consider BGL and medical review if symptomatic of hypoglycaemia such as: • jitteriness and irritability • hypotonia and lethargy	Observe and document 8 – 12 hourly for early signs of jaundice. • TcB at 24 and 48 hrs
48 – 72 hrs	• Continue same management as above • Increase volume to **20 - 30mL** of EBM / formula if infant not feeding code 5 /6 Consider double pump after feeds combined with hand expressing	Refer to thermoregulation policy • Encourage skin to skin time Double wrap all infants when not skin to skin unless ≥ 37.2C		• TcB at 72 hours • TcB should not be used on infants <35 weeks. Inform neonatal SRMO if concerned
> 72 hrs	**Weight loss >7%** • Refer to policy p.6 • Assess BF • Ensure 8 feeds • Express and top up • Inform Lactation team • Priority Referral to CFHN on eMR	Refer to thermoregulation policy • Encourage skin to skin time • Double wrap all infants when not skin to skin unless ≥ 37.2C		Continue to observe for jaundice. Inform neonatal SRMO if concerned

19. Droplet Feeding EBM (Temporary Measure in Hospital Only)

NB: formula is not to be droplet feed with a syringe

Rationale for procedure

A baby has difficulty latching to the breast and:

1. Skin- to- skin contact has been tried without success.
2. Baby is alert and interested, but unable to latch.

Goals

- To aid the initiation of milk supply by early and regular expression.
- To ensure that baby safely receives all expressed breastmilk available.
- To support the infant to initiate or return to breastfeeding.

Potential Hazard

Aspiration of breastmilk (although research shows that this may not be an irritant to baby's lungs).

Equipment

- Gloves
- Clean container to collect milk - 2ml syringe

Procedure

- Perform hand hygiene prior to donning gloves.
- Latching at the breast should be attempted for 5-10 minutes at each feed time unless baby becomes distressed. If the baby does not latch, encourage/assist the mother with hand expressing both breasts. The electric pump may be used after 24 - 48 hours in combination with hand expressing, starting on a low setting and increasing according to mother's comfort.
- If there is more than 5 -10 mls consider cup/spoon feeding.
- Remove gloves, perform hand hygiene and don clean gloves prior to opening the infant's mouth. Using a gloved finger (usually index finger) encourage infant to open mouth wide to take in finger. The pad of the finger should be facing roof of infant's mouth.
- While the infant suckles on the finger droplet feed a small amount (no more than 10mls in total) of expressed breastmilk (EBM) directly into the corner of the baby's mouth with the following precautions:
    - The baby must be alert.
    - Do not use a larger than 2ml sterile disposable syringe.
    - Infant should be placed in a semi upright position.
    - Drip EBM slowly into the corner of the infant's mouth and observe for swallowing.
    - Discourage the infant from sucking on the syringe.

Outcome

- Milk supply initiated by early and regular expression.
- The baby safely receives all expressed breastmilk available.
- Infant establishes breastfeeding.

20. Cup/ Spoon (Temporary Measure Only)

Spoon is not used in hospital

Rationale for procedure

- Skin-to-skin contact has been tried without success.
- Baby is alert and interested, but unable to latch.
- Baby requires nutritive fluids in addition to breastfeeding.
- Cup/Spoon feeding has been shown to be safe and may help preserve breastfeeding duration in situations where multiple supplemental feedings are required.
- Step 9 of "The Ten Steps to Successful Breastfeeding" implementation standards require that when a woman is unable to breastfeed the use of a teat should be avoided.

Contraindications

Cup/spoon feeding is contraindicated in infants who are not alert and infants with marked neurological defects.

Goals

- An alternative feeding method is provided to newborns when unable to directly breastfeed.
- Additional nutritive fluids are provided to the breastfed baby utilising a method that supports Baby Friendly Health Initiative implementation standards.

Potential Hazard

Aspiration of breastmilk / breastmilk substitute

Equipment

- In the hospital setting a sterilised infant feeding cup is used. This is single use disposable equipment.
- At home a clean 30ml plastic feeding cup or plastic spoon.
- Expressed breastmilk.
- Infant formula (if required).
- Gloves (if required).

Procedure

- Observe all preliminary standards appropriate to the procedure e.g., hand hygiene and a clean surface.
- Assess each mother and baby's needs individually and discuss reason for cup/spoon with parents.
- Consider whether adequate volume can be fed in 20 – 30 minutes.
- Obtain verbal consent for procedure and written consent if using infant formula.

- Staff are to educate and supervise parents on cup/spoon feeding until they are proficient and confident.
- Wrap baby securely and support the baby in an upright position on your lap.
- If possible, have the cup at least half full for the beginning of the feed.
- Rest the cup/spoon on the baby's lower lip lightly and allow the baby to sip milk from the rim of the cup.
- Tilt the cup/spoon so the milk is just touching the lips. As the infant opens their mouth a small amount of the feed will be taken and swallowed, either by lapping or sipping.
- DO NOT POUR MILK INTO THE INFANT'S MOUTH
- Hold the cup/spoon steady while the infant is actively drinking. Remove when the infant stops.
- Return the cup/spoon when the infant is showing signs of readiness to feed again.
- Repeat procedure until feed completed – should be completed within 20 – 30 mins.
- Assess parent's understanding and comfort with cup/spoon feeding procedure.
- Provide parent with Cup Feeding Parent Handout
- Perform hand hygiene, document indication for use, feed and outcome, revise feeding plan as required.
- Wash the feeding cup/spoon after each use and for added protection sterilise after each use.

21. Ongoing Monitoring of Baby's progress

Needs and/or Problems	Action	Rationale
Baby's behaviour	Adequacy of breastfeeding can be assessed by baby's behaviour as well as other assessments – a non - demanding baby may not be getting enough milk and an unsettled baby may be getting adequate breastmilk. • Assessing feeding patterns, urine output, bowels, weight as well as behaviour • If all assessments are reassuring and baby unsettled - support mother and offer options: - Rocking - Patting - Use of pram or sling - Offering breast for comfort	From 3 weeks to 3 months' babies become more wakeful and unsettled. A young baby needs the comfort of an adult to assist with moving to a more organised state
Bowel Motions	• Typical stools are loose mustard yellow but can sometimes be orange or green • Frequent runny stools do not mean the baby had diarrhoea • Prior to 6 weeks it is normal for the baby to open bowels 2 – 3 /24 hrs • Between 6 weeks and 3 months the frequency often decreases. There can be intervals of several days or more between stools	Bowel motions are a good indicator of baby getting enough milk in the first week. After breastfeeding is established urine output is a better indicator
Urinary Output	After day 4-5 there should be 5-6 or more pale odourless nappies over 24 hours	Adequate urine output is one of the indicators of adequate breastmilk supply
Baby's Weight	• Weight should not be used alone to determine progress and should be used with clinical assessment • Weight should be assessed over an average of four weeks on the same calibrated scales • If using growth charts the WHO Growth Charts should be used. Only bare weights should be plotted on the growth charts • Breastfed babies have a lower velocity of growth after 2-3 months: when plotted on a growth chart they may appear to be faltering, even if thriving • A normal baby may cross percentiles (to attain their genetic potential), and this should be correlated with length	Baby should regain birth weight by 2 weeks Approximate weekly weight gain averaged over 4 weeks: 2 weeks-3 months --- 150-200gms 3-6 months --- 100-150gms 6-12 months --- 70-90gms
Baby's unsettled behaviour	• Increase mother's awareness of baby's tired signs and sleep needs • Soothing techniques such as massage, sling wearing, cuddling, feeding, rocking, patting and bathing, soothing sounds. • Rule out Neonatal Abstinence Syndrome (NAS)	• Unexplained crying for short periods for 1-4 hours every 24 hours occurs in a large number of healthy infants • Baby's do not have the ability to settle themselves • Unsettled behaviour may indicate drug withdrawal including excessive amounts of caffeine
Frequent feeding	• Feed as the baby demands, average is between 8 – 12 times per 24 hours. • Ensure positioning and attachment is correct • Reassure mother that baby may need to feed frequently to maintain an adequate supply • Encourage rest between feeds when possible	• Exclusively breastfed babies up to 6 months of age were found to feed on average 8 – 12 times per 24 hours. Babies will vary taking one breast or two at each feed. If the baby is not attached well and nutritively sucking then insufficient breastmilk will be removed from the breast for the baby's growth and for maintaining a good breastmilk supply Breastfeeding works on supply and demand • If the baby is spending a long period of inactivity on the first breast, encourage mother to change to the second breast
Baby's need for stimulation	• Encourage the parents to be interactive with their baby • Interactive floor play should be encouraged	• Babies are naturally attracted to faces • Babies need appropriate stimulation to enhance brain development and attachment as well as develop gross motor, visual and language skills

22. Breast Refusal

Needs and/or Problems	Action	Rationale
Baby refusing both breasts	Full history • Age of baby • How long has baby been refusing • Feeding, sleeping pattern • Solids/formula use, when and how much • Dummy use • Assess baby for signs of (a) Illness (b) Lethargy (c) Teething (d) Recent immunisation Assess mother and eliminate/treat obvious causes: • Mastitis • Breast changes • Oversupply • Strong milk ejection reflex • Commencement of contraception • Pregnancy • Low supply Menstruation **Never force-feed. Reassure mother it is usually temporary** Offer suggestions for encouraging baby to feed: • Minimise distractions • Try different positions • Skin to skin contact • Offer breast when baby is sleepy • Suspend solids Reduce sucking from other sources e.g. dummy • **NB Maintain milk supply by expressing**	• May be age appropriate e.g. baby may be self-weaning, attracted by another source Baby may be tired not hungry Baby may be disinterested due to illness • Milk may taste hotter and saltier • Hormonal changes of pregnancy can affect taste of breastmilk
Refusing one breast only, after previously having both breasts	Examine breast fully to assess for breast changes and refer for further investigation if necessary	May be an early sign of breast cancer.

23. Ankyloglossia (Tongue Tie) assessment

Needs and/or Problems	Action	Rationale
Assessment for lingual frenulum restriction Ankyloglossia refers to the restricted movement of the tongue causing functional limitations. It is accompanied by a visually restricted lingual frenum.	Perform oral assessment – Note: • appearance of tongue e.g. heart shaped, frenulum short and tight • tongue function – tongue lift, lateralisation, protruding forward, cupping around finger and ability to suck with peristaltic movement and sustain sucking movement • palate – high arched palate is associated with tongue and can contribute to painful attachment painful and poor milk transfer Assess nipple and observe a breastfeed • nipple damage evident? • Painful attachment? • Attaching on and off? • Milk transfer evident? • If any of the above suggest a laid-back breastfeeding position and as deep a latch as possible If improvement with attachment with positioning advice, then reassure mother and watch and wait May need to express and give EBM at some or all feeds to ensure breastmilk supply, drainage of the breasts and allow damaged nipples to heal. If unable to improve attachment with positioning, then discuss options and refer for lactation assessment specialist assessment if appropriate.	Oral frena can show variability without functional issues. Diagnosis of ankyloglossia should not be based solely on anatomic appearance. Tongue function is the most important indicator for referral for oral assessment Ankyloglossia may cause some infants to experience functional limitations, such as difficulty breastfeeding. If a baby is unable to attach and feed well despite positioning and attachment support and advice refer to GP for referral to an appropriately qualified health professional for specialist assessment of tongue function. This may include: Speech Therapist, (ENT) surgeon, paediatrician, paediatric surgeon, paediatric dentist. Frenotomy is not always effective in improving attachment issues and lactation support post procedure is usually necessary. Research is needed regarding other reported adverse health outcomes for ankyloglossia

24. Maternal Issues

24.1 Expressing Breastmilk

Needs and/or Problems	Action	Rationale
Antenatal - inpatient Risk of mother - baby separation (e.g. Type 1 diabetic, threatened premature labour, planned neonatal admission to SCN /NICU)	• Discuss the benefits of colostrum for baby with the woman and their family. • Discuss the importance of early expressing within the first hour hours of birth (at least within 6 hours of birth). • Educate mother and support people on the importance of frequent expressing 8 times per day if separated from baby postnatally • Educate the woman and their family on the technique of hand expressing, collection and labelling of EBM in oral syringes • Advise mother that not all women are able to express breastmilk antenatally. Women may be able to see a glisten, express 1 drop or 1 ml. • Consider encouraging the mother to express and collect their colostrum if over 36 weeks gestation, being induced or planned caesarean within 24 hours if nil identified risk factors for performing same • Provide mother with antenatal expressing fact sheet	• Family gains information of importance of colostrum in improving heath of their baby. Also, that early expressing promotes adequate initiation of lactation to assist long term milk supply • Family will be more independent with the procedure and welcome the early initiation of hand expressing • Mother will know what to expect • Written information increases understanding
Postnatal - inpatient Mother wishes to **initiate** lactation but is unable to put baby to the breast successfully e.g. baby in nursery, sleepy baby, uncoordinated suck, inverted nipples	• All mothers should be educated on hand expressing • Use a hands-off approach when educating and supporting the mother to express • Discuss the current situation / reason for expressing with the mother and their supports • Encourage early initiation of hand expressing within 1 hr of birth and continue 8 or more times daily or if baby is with mother – each time baby has attempted a feed • Advise mother when you first express you may only be able to see a glisten of breastmilk or express 1 drop to a couple of mls. As milk production increases you will be able to express larger volumes of breastmilk. • Ensure mother has Expressing and Storing Breastmilk handout • If expressing continues beyond 24 – 48 hours introduce the electric pump **in combination with hand expressing** and aim for 8 times/24 hours	Mothers need to know how to hand express if: • separated from their baby • attachment difficulties arise • breasts are very full and uncomfortable and baby is asleep • Increasing the mother's understanding increases their self-efficacy • During the colostrum phase hand expressing is the most effective method of breast milk removal and stimulates improved breastmilk production. • Written information increases understanding • After 48 hours combining breast pump with hand expressing increases and maintains breastmilk production
Mother wishes to **maintain** lactation but is unable to put baby to the breast at some or all feeds e.g. mother working. Mother being discharged from care still expressing	• Discuss pump options with the mother e.g. hiring hospital grade / purchase of electric or hand pump • Encourage mother to express at the time baby would normally feed • Try to get one feed ahead • Double pumping may be encouraged	• Hospital grade breast pumps are generally better at establishing lactation than other breast pumps which maintain lactation once established • The breastmilk needs to be regulated by the baby's need • Double pumping may save time for the mother so they can express more often

24.2 Expressing Breastmilk Hygiene

Needs and/or Problems	Action	Rationale
Mother is expressing their breastmilk by hand	• Educate mother on importance of hand washing prior to expressing • Express into a clean container • Container to store the breastmilk must have a lid • Ensure mother has written instructions on expressing and storing breastmilk	• Reduces risk of contamination of breastmilk

Mother is expressing with a breast pump at home	• Educate mother on the importance of hand washing prior to using or cleaning the breast pump kit.
	• The breast pump kit must be cleaned and sterilised/sanitised prior to the first use
	• Thoroughly wash the kit after each use by:
	  ○ Following the manufacturer's instructions
	  ○ Use a bowl or container to clean pump kit (do not clean directly in sink)
	  ○ Rinse in cold water,
	  ○ Wash parts thoroughly with a bottle / teat brush in warm soapy water (dishwashing liquid is appropriate). Refer to SLHD_PCP2022_013 *Maternity: Safe Management of Expressed Breastmilk in Hospital* for cleaning instructions.
	  ○ Remember to go around the grooves in the neck of the bottle as milk often collects there
	  ○ Rinse thoroughly with warm running water.
	  ○ Invert and air dry or dry with a paper towel and store in a clean covered container.
	• For added protection it is advised to clean and sterilise the breast pump kit after each use. See cleaning and sterilising parent handout.
		• Reduces risk of colonisation of pathogens
		• A baby who is unwell or preterm may be at greater risk of infection

24.3 Nipple Shield Use

Needs and/or Problems	Action	Rationale
Nipple shield should be tried if baby is **unable to latch** and feed effectively due to: • Breast refusal • Inco-ordinate suck • Inverted/flat nipples • Psoriasis, eczema of the nipple or areola • Extreme nipple pain (used as a last resort in preference to weaning) May sometimes be useful if: • Baby has a weak, disorganised suck or unable to open their mouth wide enough to get a deep latch • Congenital conditions e.g., cleft palate, short frenulum • Upper airway problems such as laryngomalacia	• Should **only** be used once milk supply has been established (usually day 3 onwards) • If baby unable to attach and feed effectively, offer positioning and attachment support and encourage extended skin to skin. If unable to attach support mother to express until milk yield is 20 – 30 mls, (hand expressing for the first 24 – 48 hours then add pumping until expressing 20 -30 mls) • Encourage use as a short-term measure • Discuss information in nipple shield handout and give them a copy	• Risk of poor transfer of highly viscous colostrum through the shield. This may lead to engorgement, increased weight loss in baby and low supply as well as frustration to mother and baby. Also, the baby may improve ability to attach to breast in the first few days and not require the nipple shield despite flat or inverted nipples. Nipple shield use during the postnatal stay has been associated with greater risk of weaning at less than 6 months. • Short term use may preserve the breastfeeding relationship as it keeps baby at the breast and avoids the need for expressing. • Long term use of nipple shields has been associated with risk of early cessation of exclusive breastfeeding than no nipple shield. • Mother has information regarding use, cleaning and weaning off the shield.
Reduced milk transfer if infant is not attached optimally, further nipple damage and mastitis	Problems can be reduced by the following: • Use of a suitable appropriately sized silicone shield • Being shown how to use the shield correctly and ongoing follow up • Assessing baby's ability to latch well with the shield, not just the teat portion of the shield and observe for changes in baby's sucking pattern • Educate mother to palpate their breast before and after the feed to assess breast softening • Correct cleaning and storing of shield between uses • Ongoing follow-up to try baby directly to the breast. Ideally within 2-3 weeks. • Extra expressing may be necessary if there is evidence of reduced milk supply	• May need large or small shield dependant on nipple size • Lack of direct stimulation may lead to a lower milk supply and poor weight gain in the baby • Avoid any nipple damage and ensure adequate breast drainage and lessen the risk of mastitis • Lessen the risk of infection • Baby may prefer nipple shield and may be difficult to get directly onto breast • To increase milk supply

24.4 *Use of a Lactation Aid (Supply Line)*

Needs and/or Problems	Action	Rationale
Mother is unable to supply sufficient breastmilk for their baby's needs and their baby requires extra nutrition and they would like to use a lactation aid. May be related to: • Maternal issues e.g. breast hypoplasia or surgery or mother may wish to induce lactation or relactate. • Baby issues may include weak, disorganised or dysfunctional suck A lactation aid may be either: • Trial use: an infant feeding tube attached to a bottle with formula or 20 ml syringe. • Mother decides to use at breast supplementation and purchases the manufactured model. It is a vented system with a bottle or breast milk bags and notched cap that enables pinching off of the tubing as required. It hangs by a cord around the mother's neck.	• An experienced health care professional should discuss suitability, available options, benefit and cost in feeding lines with the mother. • Explain it may keep baby feeding at the breast for longer and may reduce the need for as much expressing after feeds due to the baby sucking for longer • A decision is made about appropriate supplementation e.g. EBM or infant formula and the amount required • Demonstrate the use feeding tube for at breast supplementation • Mother is shown how to use the supply line appropriately • A full feed is observed and assessed • Check baby's weight and progress regularly.	• A baby using a feeding tube must be able to latch-on and do some form of sucking. • Creates a behaviour-modification situation that shapes baby's sucking pattern to one suitable for obtaining milk from the breast • Adding flow at the breast using a feeding –tube device can improve the sucking pattern and efficiency • Sucking stimulation by the baby lessens the need for extra expressing. • Gives mother and baby opportunity to trial feeding at breast supplementation before deciding to use the manufactured model • Aim to maximise mother's milk production by minimising the amount of supplementation required. • Adjust amount of supplementation according to individual progress

24.5 Medications and Breastfeeding

Needs and/or Problems	Action	Rationale

Mother requires medication for a specific condition	• Use appropriate resource to evaluate transference into breastmilk and the degree of exposure to the baby.
	  • Mothersafe 9382 6539 or 1800 647848
	  • Lactmed database (via CIAP)
	  • Consider purchase of an appropriate reference book Hale T, *Medication & Mothers' Milk,* 2021
		All medications penetrate milk to some degree, however concentrations of most medications are exceedingly low (usually<1%)

	General Rules: • Determine if drug is absorbed from GI tract	Many drugs e.g. some antibiotics are poorly absorbed. Compare the paediatric dose and determine if amount absorbed by baby has been reported to produce side effects
	• Determine if milk/plasma ratio is high	If the milk concentration of the drug is high it should be avoided if possible
	• Be cautious of drugs that have long paediatric half-lives	Medications with shorter half-lives tend to peak rapidly and dissipate rapidly but may continually build up in the baby's plasma over time
	• Choose drugs that have a higher protein binding	These do not transfer as readily to the milk or the baby
	• Be cautious with drugs that affect the brain and CNS, such as lipid soluble drugs, which readily enter breastmilk e.g. psychotherapeutic drugs.	Frequently transfers into breastmilk at higher levels due to their lipid solubility.
	• Consider peak time of drug and encourage breastfeeding just before the dose	This is when the drugs are in their highest concentration in the breastmilk **Do not exceed recommended doses**
	The benefits of breastfeeding often outweigh the risks to the baby's well being	
Information for use of recreational drugs safety and breastfeeding - Mother Safe, Medications in Pregnancy and Lactation Service (phone 9382 6539 or 1800 647 848) can be contacted for advice about medication and recreational drugs safety in breastfeeding. ***Please note: Pharmaceutical insert may not have the most up to date information.***		

24.6 Breastfeeding during Pregnancy and Tandem Breastfeeding

Needs and/or Problems	Action	Rationale
Mother is pregnant and wishes to continue breastfeeding another child	Reassure mother that they can continue to breastfeed during the pregnancy without any known risk to the baby they are expecting	In mothers with no history of miscarriage or premature labour, breastfeeding through pregnancy carries no added risk Breastfeeding the toddler does not deprive the unborn child of any nutrients needed to grow
Maternal nutrient and energy needs	Encourage mother to have a well-balanced diet and plenty of rest	Both pregnancy and breastfeeding increase requirements for energy, protein, iron, folic acid and vitamin C
Nipple discomfort	Reassure mother that some degree of nipple discomfort may occur during breastfeeding, varying greatly in degree and duration.	Appears to be related to hormonal changes during pregnancy and is unlikely to respond to any special treatment
Decline in milk supply	Reassure mother that this is common during pregnancy but if their older baby is growing well there is no problem. May need to increase the number of breastfeeds	Many mothers report a decrease in milk production during a subsequent pregnancy
Change in taste of milk	Reassure mother that this is normal	Lactose in milk decreases, whilst sodium increases, changing the taste
Child decides to wean	Reassure mother	Some children wean because of decline in milk volume and change in taste
Uterine Contractions	Reassure mother that unless the contractions are painful there are no problems. If the contractions become painful or they are concerned, they should contact their antenatal care provider	There is no documented danger to fetus or mother when mothers breastfeed through a healthy pregnancy and no other risk factors are present
Preparation of toddler for baby's arrival	Encourage mother to develop some pattern with breastfeeding the toddler e.g. morning and night	This may make managing the breastfeeding post birth a little easier
After delivery Availability of colostrum	• Reassure mother that colostrum is available for the newborn post birth for a short period • Mother should consider having 24 hours of getting to know their newborn and ensuring positioning and attachment are correct • Mother should be encouraged to feed the newborn before the toddler.	Mother has the opportunity to concentrate on the newborn's needs
Ongoing Abundant milk supply – baby not coping with fast flow	• Consider giving each child their own breast or feed the toddler first until the flow subsides	Each child's needs are being met

24.7 Caesarean Section and Breastfeeding

Needs and/or Problems	Action	Rationale
Post-operative breastfeeding difficulties due to pain, anxiety and lack of mobility	• Initiate skin-to-skin contact as soon as possible • Educate mother re appropriate analgesia • Discuss/educate mother re various breastfeeding positions to alleviate incision pain. Some suggestions are a pillow on mother's lap to protect wound, side lying and underarm hold • Encourage mother to ask for assistance with feed	• Skin to skin encourages oxytocin release and onset of lactogenesis 2 which can be delayed after caesarean section • Maintain comfort of mother and baby during breastfeeds • Should encourage an efficient let-down reflex and reassure mother
Mother requiring extra and ongoing physical and emotional support	• Facilitate and plan with practical methods of help and support in partnership with the family	• To have a well-rested mother to promote physical and emotional recovery and become d=confident
Unfulfilled expectations e.g. disappointment re birthing experience (leading to conflicting feelings re mothering)	• Reassurance and debriefing • Empower mother so that breastfeeding meets their expectations and goals • Refer to appropriate services e.g. counselling, lactation specialist if needed	• To promote emotional wellbeing and support breastfeeding
After effects of anaesthetics/analgesics e.g. sleepy baby	• Discuss/give information so that mother can identify babies feeding cues • Give adequate education re: supply/demand usually 8 or more feeds per 24 hours from day 2	• Mother will be able to maximise feeding opportunities • To ensure baby has adequate nourishment
Delayed Lactogenesis II	• Reassure mother that the milk may take longer to "come in", but this is common after a caesarean and the baby may require feeding more frequently. • Encourage extended skin to skin between feeds	• Explanation may reassure mother and encourage them to persist and feed more frequently. • Skin to skin contact is comforting to babies and assists with mother's oxytocin release

24.8 Breastfeeding Multiples

Needs and/or Problems	Action	Rationale
Both babies with mother postnatally	• Encourage early initiation of breastfeeding within first 1-2 hrs of birth with each infant and early frequent feeding or milk expression. • Encourage individual rather than tandem feeding until at least one baby is assessed for effective feeding • Feed both babies from the breasts at all feeds although may be one baby at a time. • Allocate one breast per baby per feed • Mother to decide - rotate breasts on a day to day basis or alternate breasts and babies at each feed • Only feed babies together if awake and additional help available • Progress to tandem feeding when mother feels ready and attempt this prior to leaving hospital unless mother prefers not to • Attach more difficult baby first **NB** if < 37- 38 weeks gestation mother may not be able to successfully tandem feed until the babies are older due to less ability to suck effectively. May need to alternate each baby at the breast / EBM and express after feeds for other baby.	• Promotes milk production. • Encourages mother to become familiar with individual baby's needs • Both breasts are evenly stimulated • Baby gets slower flowing high fat milk • Mother gains experience whilst there is professional assistance available
One baby in nursery	• Allocate one breast per baby per day. Express other breast and take EBM to nursery if baby is not going to the breast	• Ensures both babies receive breastmilk and both breasts are evenly stimulated
Both babies in nursery	• Initiation early of hand expressing progressing to use of double pump in combination with hand expressing on day 2 • See Expressing Breastmilk	• Should provide maximum stimulation to breasts
Mother has triplets	• As above • Discuss options with mother e.g. breastfeeds two and bottle feeds one or fully breastfeeds three babies – will need to limit feeding time of first two babies and feed the third from both breasts using a system of "triangular rotation"	• Supply should equal demand

24.9 Engorgement

Needs and/or Problems	Action	Rationale
Fullness / Physiological Engorgement **Normal fullness** Breasts full, heavy, slightly tender	• Counsel mother that this is normal physiology of establishing lactation • Keep breasts well supported between feeds e.g., advise mother to wear a well-fitting nursing bra (not constricting) • Remove bra while feeding and allow 2nd breast to leak • Assist mother with gentle hand expression prior to latching baby • Ensure first breast is soft and comfortable before offering second breast	• There is an increase in blood supply and lymph in the breast tissue that subsides with an increase in milk production • Will support the heaviness and reduce pain and oedema • To maintain drainage and prevent back pressure in ducts, which would depress milk production • Will soften areola and produce a small amount of flow • This should avoid a blocked duct which may lead to mastitis
Pathological Engorgement (rare) Breasts hard, red, shiny, painful and milk does not flow	• See Action for Normal Fullness • Focus treatment on measures to reduce swelling and reduce pain • Apply and reapply cold packs if mother is agreeable and reassess in 2 hours • Gently massage breast towards the axilla to encourage lymphatic drainage • Handle breasts as little as possible during this time • Offer regular paracetamol or anti-inflammatory medication • Attempt to breastfeed / hand express • If using a breast pump, ensure the pressure is low	• Will reduce vascularity and oedema and encourage milk flow • Unnecessary stimulation may increase supply further • Will relieve pain and alleviate any elevation in temperature • Vascularity and oedema should be reduced • May draw more oedema into the areola area and hinder breast draining
Unable to attach and feed or express milk by hand or pump due to true engorgement (ensure there are no signs of mastitis)	• Continue management as above • Advise intermittent compression around areola (reverse pressure softening) Prior to attaching baby to breast or expressing o Press inward toward the chest o wall with fingers evenly around the o areola and hold for about a minute.	• The areola is softer so the baby can attach better and remove milk from the breast and engorgement improves

24.10 Nipple Vasospasm

Needs and/or Problems	Action	Rationale
Vasospasm occurs when the blood vessels supplying the nipple go into spasm (constrict) reducing blood flow to the nipple. This may cause: Numbness, burning, tingling and pain of nipple occurring during / between feeds. Pain can focus on the nipple and radiate deep into the breast and may last over 30 minutes. Associated with nipple blanching post feed and maybe triphasic colour change to white to blue to red. Cold exposure may trigger the symptoms.	• Check for oral anomaly in the baby • Observe feed • Ensure positioning and attachment are optimal • Assess nipple post feed for signs of compression	• Blanching of the nipple due to mechanical compression may occur with poor positioning and attachment
Compression persists, despite optimal attachment Blanching and pain persist despite optimal attachment	• Manually reshape nipple after feed • Feed in warm environment. Avoid cold air and keep the breast warm. • Apply warm compress to nipple immediately after feed. • Ensure breast pads are changed regularly • Breast warmers may be beneficial e.g.: Flectalon • Avoid caffeine • Discourage smoking refer for extra support e.g. Quit Program • Suggest that mother breastfeeds for as many feeds as they can and expresses at other feeds and offers EBM	• Attempt to minimise nipple compression • Encourages blood flow to nipple • Caffeine may induce vasoconstriction • Cigarettes per day may increase vascular resistance and decrease cutaneous blood flow • May encourage mother to continue with breastfeeding. Compression tends to improve as baby grows
Mother has family history of circulation problems/Raynauds phenomenon	As above • Breastfeed in a warm environment • Supplemental magnesium and calcium • Medication Nifedipine (calcium channel blocker) in sustained release formulation providing 30-60mg per day may be appropriate in severe cases. Refer to medical professional • Refer to an Immunologist for full investigation	• May be induced by cold exposure or emotional stress • Has been found clinically useful for nipple vasospasm and transfer through breastmilk is clinically insignificant • Has been linked with auto-immune conditions

24.11 Nipple issues

Needs and/or Problems	Action	Rationale
Painful nipples No obvious damage	• Ensure correct positioning and attachment • Assess baby for any structural abnormalities • Reassure mother that their nipples will not be damaged if their baby is well attached. • Some nipple tenderness may be experienced in first days postpartum. • Encourage mother to detach or reattach if pain persists into feed • Encourage to seek further assistance if pain increases	• A well attached baby is unlikely to cause nipple damage • Hormonal changes may cause tenderness • If pain persists nipple damage will increase
Damaged nipples Grazes, fissures or bleeding	• Obtain history and examine nipples • Try to offer breast at early feeding cues before baby starts crying • Observe breastfeed and offer support to ensure optimal attachment • Apply warmth and express a little milk by hand just prior to the feed • If breasts are full, may need to hand express to soften the areola prior to latching • Apply breastmilk after the feed and leave bra open for a few minutes and allow to dry • Any blood ingested by the baby will not cause harm unless mother has Hepatitis C	• Easier to achieve optimal attachment • May be able to suggest changes to attachment technique • Gets milk flowing so first sucking is not as strong • May enable deeper attachment • Assists the healing and helps prevent the breast pad / bra sticking to nipple
Pain persists	If pain persists, discuss the following options: • Continuing to feed • Offer less sore side first • Resting and expressing for 12 – 24 hours (1 or 2 feeds may be all that is necessary) then assist with feed. Alleviate the underlying cause of nipple damage by improved attachment technique • Offer symptomatic relief if required e.g. paracetamol and apply breastmilk post feed • If pain experienced detach and reattach • If using breast pads, change regularly (may need to express prior to removal to avoid sticking and further damage) • Ointment and creams should not be advised. • Avoid soap on nipples • Alternate position depending on area of damage e.g. Madonna, twin fashion	Mother can make an informed choice • To prevent further trauma which may lead to early weaning • To relieve the pain so that mother can tolerate attempting to attach baby correctly • To assist restoration of skin integrity and protect against infection • There is insufficient evidence to support the use of ointments, sprays or creams to prevent or treat nipple soreness • Soap washes away normal secretions and may have a drying effect • To prevent further damage and make attachment more comfortable
Other causes	Nipple Vasospasm Nipple White spot Thrush Baby tongue tie Baby has an unco-ordinate suck Eczema, psoriasis	

24.12 White Spot/Milk Blister

Needs and/or Problems	Action	Rationale
Visible white spot on the nipple which may be accompanied by persistent pain especially during feeding and/or blockage. It usually appears like a tiny milk filled white blister. Usually occurs after milk supply well established and 4mm or less in diameter If **not** accompanied by pain or blockage	• Breastfeed should be observed. • Ensure optimal positioning and attachment. • Warm soaks (may assist the thin epidermis layer to shed spontaneously within a few day)	• May improve spontaneously so the unnecessarily risk of infection is avoided
If accompanied by pain and blockage	• Rarely, unroofing is performed if persistent pain and blockage. • Must be performed by an experienced health professional. • Prior to procedure advise mother there is risk of infection and gain their verbal consent. Encourage them to seek medical advice for antibiotics if signs of infection manifest Use aseptic technique, (thorough hand washing, sterile gloves, alcohol wipes to the area prior to procedure) • Peel away epidermis overlaying the milk spot with a sterile disposable 25-gauge needle using the bevelled edge of the needle not the point sterile • Gently compress around the areola and express any stringy plugs into a small bowl • Observe a feed	Rarely encouraged due to the risk of infection and potential trauma caused by procedure. • Continued blockage will lead to further complications
Persistent White Spot	• Reassurance of mother • Give mother input on self -management technique • Regularly, rub the affected nipple gently with a damp cloth after softening skin (e.g. in warm bath)	• Mother is able to self - manage

24.13 Nipple Thrush (Candida)

Needs and/or Problems	Action	Rationale
Maternal Nipple Thrush **NB:** Differentiate between nipple vasospasm • Mother's nipples can become infected if oral thrush is not treated in their breastfed baby. • More likely in mothers with grazed or cracked nipples or where there has been recent antibiotic use in mother or baby Symptoms • Itchy pink/red painful nipples and areola sometimes associated with nipple damage that is slow to heal. Nipple and areola may be dry / flaky • Sore breast/nipple during and after feeds with no apparent nipple damage • May be in one nipple/breast or both • Shooting, burning pain radiating through the breast (only if in combination with other symptoms) **If slow or no improvement**	• Both mother and baby need to be treated for a week or even longer, though the breast pain and other symptoms should show some improvement within 2 – 3 days. • Antitifungal treatment (miconazole cream) thinly applied to nipples 4 times a day after feeds. It does not need to be wiped off the nipples before a breastfeed. Topical cream is preferred over gel. • Infant's mouth can be treated with Nystatin • Hygiene e.g. meticulous hand washing, wash underwear, towels etc. in hot water and sundry. • Keep nipples dry by changing nursing pads frequently and air nipples when possible. • Change and wash bra daily • Ensure any dummies or teats are cleaned thoroughly and boiled for 5 mins after use • If symptoms or pain not improving, women should consult their doctor as there are oral antifungal medications that are safe to take whilst breastfeeding.	• May eliminate fungal infection • Risk of gel causing asphyxiation in babies if gel is applied to nipples especially prior to a feed • Good hygiene will prevent the spread of thrush should speed up resolution • If infection is chronic mother may require systemic treatment A specific oligosaccharide in human milk should protect the baby from thrush
Sterilisation of Feeding Utensils	• Boiling for 5 minutes is recommended	
*** It is unusual for exclusively breastfed infants from birth to be infected with thrush due to the oligosaccharides in breastmilk.** **** Mammary ductal thrush has not been proven in the literature**		

24.14 Lactational Mastitis and breast abscess

SLHD_GL2022_050 Mastitis and Breast Abscess in the Lactating Woman

24.15 Low Supply of Breastmilk

Needs and/or Problems	Action	Rationale
Low supply suspected due to any combination of the following: • Limited nutritive sucking when breastfeed observed • Minimal wet nappies (less than 6 wet cloth or 5 heavy disposable per day) • Unsatisfied baby post feed • Poor weight gain -see on-going monitoring of progress **NB: It is important to differentiate between perceived low supply and real low supply.** **Assess mother's understanding of normal baby behaviour, number of feeds etc. and give appropriate education if required.**	**Observation of a breastfeed to assess attachment and milk transfer** • If indicated support mother to improve positioning and attachment	• Poor attachment will decrease breastmilk transfer and milk removal contributing to low supply • Limited nutritive sucking when baby is latched well is a reliable indicator for low supply
	Attain a full history in an attempt to eliminate the following: **Maternal Considerations** • Mother on medication • Mother feeding to schedule (rather than need) • Limiting time at the breast, unrelieved engorgement • Only offering one breast per feed • Inappropriate formula supplementation • Early introduction of solids • Inadequate diet/fluids • Inadequate rest • Over exercise • Overuse of alcohol • Overuse of caffeine • Overuse nicotine	Factors may impede on mother's ability to produce sufficient milk
	Baby Considerations • Overuse of dummy • Baby extending periods of sleep overnight • Sucking problems and oromotor dysfunction e.g. tongue tie • Any medical condition that may affect weight gain e.g. cardiac • Airway problems e.g. laryngo/ trachea malacia,	Decrease in stimulation to the breast and inadequate removal of milk will decrease supply
	Other contributing factors: • Breast Hypoplasia • Breast surgery • Retained products • Postpartum haemorrhage • Anaemia • Endocrine problems e.g. diabetes • Mother/baby separation	• Mother's milk production capacity may be reduced if there are hypoplasia or breast surgery • Retained products inhibit prolactin levels from rising • Postpartum haemorrhage or anaemia may impact on milk production and mother may require additional support to increase breastmilk production • May cause a 15-20 hour delay in Lactogenesis II • Expressing is not as stimulating as the baby feeding at the breast
Low Supply (continued next page)		

Needs and/or Problems	Action	Rationale
Low supply identified	• Feed more frequently, finishing the first breast and offer second. • Use breast compression during feeds • Encourage mother to express breasts after each feed either by hand, manual pump or electric pump. • A realistic guide is 10 -15 mins per breast,- total 20-30 mins. Consider double pumping • If using electric pump combine with hand expessing techniques • Encourage skin-to-skin contact between feeds • Resume overnight feeding • Cease unnecessary solids/formula • Ensure mother has a good diet • Discuss with mother their ability to get adequate rest • Check that mother has a good support network • Lower caffeine/alcohol/nicotine intake • Consider option of supply line use	• More frequent and proper feeds will increase stimulation of the breast • Will increase stimulation of the breast and any extra EBM may be offered to baby • Increases baby's natural instinct to breastfeed More stimulation to breast • Exclusive breastfeeding may increase supply • A good basic diet is essential • Fatigue contributes to inadequate milk supply. • A breastfeeding mother needs support and someone to care for them • Let-down response may be inhibited by caffeine/alcohol/nicotine • Baby will provide better stimulation
No improvement in supply with above management	Discuss use of galactagogues (medications that may stimulate milk production) with mother. There is not a medication specifically manufactured to increase milk production. Drugs that are prescribed as galactogogues are used off label. Prescription drugs • Domperidone – see Parent Handout Guidelines for Use NB These drugs have not been approved by the manufacturer's for this use • Herbal (mother's choice) **Medication should not replace breastfeeding management. Each mother should have close follow-up by a clinician**	Domperidone acts primarily in the periphery with minimal access across blood/brain barrier-now considered drug of choice There should be noticeable difference 3 – 5 days into the course
As above with a history of PPH, fatigue, hair loss, continuing amenorrhoea	Investigate for Sheehan's syndrome (rare)	Severe PPH may cause infarction of the pituitary gland
Baby requires supplementary feeds with a breastmilk substitute	If supplementary feeds are temporarily necessary offer both breasts first, then offer just enough volume for the baby to be satiated preferably via cup. Express after feeds. If ongoing supplementation is indicated consider a Lactation Aid or bottle and continue to offer both breasts first	Supplementation may be essential for the baby's wellbeing while the mother's milk supply is increased. Extra stimulation to the breast will help increase supply and keep baby near breast

24.16 Oversupply of Breastmilk

Needs and/or Problems	Action	Rationale
Maternal symptoms: • Breast not draining adequately • Breast remaining hard/lumpy post feed • Mastitis **Baby symptoms** • Gulping or having difficulty coping with milk flow • Short, frequent feeds • Frequent loose stools (often green and frothy) • Posseting/vomiting after feeds • Extremely unsettled • Minimal weight loss post birth followed by large weight gains	**If baby under 4 weeks** • May need to express some milk prior to latching baby if breast very full • Optimise positioning and attachment • Encourage baby to finish the first breast prior to being offered the second breast. May require the baby to go back to the same breast several times at the same feed rather than offer the other side • Monitor other breast for signs of mastitis. May need to express a small amount from the other breast to relieve pressure if baby does not feed from that breast • Aim for minimum three hours from commencement of one feed to commencement of the next • Gentle handling post feed • Discuss settling techniques with parents and reassure them that supply should settle over a few weeks	• Initiation of breastfeeding reliant on endocrine factors as well as milk removal • Encourages good breast drainage • Higher risk of mastitis • Should help to reduce supply and encourage a longer feed • Minimise posseting • Parents are more aware of how to pacify baby
	If baby over 4 weeks Avoid extra expressing if possible As above plus: • Feed baby in an upright, laid back or straddle position • Do not force feed • If baby detaches when letdown occurs allow milk flow to settle before re-offering	• Breasts more reliant on removal of milk (autocrine control). Extra expressing more likely to increase supply • Baby should manage fast flow a little better

24.17 Hepatitis B and Breastfeeding

Needs and/or Problems	Action	Rationale
Risk of transmission of Hepatitis B at birth through breastfeeding	• All women receive Hepatitis B testing during pregnancy as part of routine antenatal care	• To identify HbsAg positive women
	• All neonates born to Hepatitis B Surface Antigen (HbsAg) positive women should be given immunoglobulin and 1st dose of Hepatitis B vaccine as soon as possible after birth. • Baby then has vaccines at 2, 4 and 6 months as per normal Hepatitis B protocol.	• This protocol has been successful in reducing the risk of neonatal transmission during birth and breastfeeding
	• Mother is encouraged to breastfeed	• As soon as vaccination is given breastfeeding should begin • Benefits of breastfeeding outweigh risks of transmission
Mother has cracked/bleeding nipples	• Educate and assist as necessary to improve positioning and attachment • If unable to attach and feed then mother to rest/express for 24 hours or until completely healed • If baby has been given Hepatitis B vaccine and immunoglobulin the baby can receive the expressed breast milk, continue feeding	• Support mother through attachment difficulties and damaged nipples • Hepatitis B vaccination and Hepatitis B immunoglobulin virtually eliminates the risk of transmission via breastmilk • Appropriate care should be taken to prevent infant contact with maternal blood.
Risk of transmission of HBV from patient to health worker	• Practice standard precautions when handling breastmilk and other body fluids see p14 • Hepatitis B immunisation for Health workers	• Prevent transmission of HBV from patient to health workers • NHMRC recommends all health workers involved in patient care or in the handling of human milk or human blood/tissue be vaccinated

24.18 Hepatitis C and Breastfeeding

Needs and/or Problems	Action	Rationale
Mother has Hepatitis C and wishes to breastfeed.	• Inform mother re benefits of breastfeeding • Inform mother hep C is passed on through blood to blood contact and is not passed on through breastmilk. • Inform mother of known methods of Hepatitis C transmission - blood and sexual relations	Mother can make an informed decision re breastfeeding • Hep C RNA is has not been found in breastmilk and the transmission via breastfeeding has yet to be documented
Woman Is co-infected with HIV	• See HIV and Breastfeeding	
Mother has cracked/bleeding nipples	• Rest/express until completely healed • EBM should be discarded until nipples are completely healed. • There should not be blood visible on nipple or in milk if nipples are healed.	• Lessens the chance of transmission to baby
Risk of transmission to staff	• Practice standard precautions when handling breastmilk and other body fluids.	• Prevent Hepatitis C transmission from mother to staff

24.19 Human Immunodeficiency Virus (HIV) and Breastfeeding

Needs and/or Problems	Action	Rationale
Mother has HIV Risk of transmission of HIV from mother to baby via breastmilk	• Inform mother regarding the known risks of transmission of HIV via breastmilk • Mother should be advised if HIV virus is detectable in the blood it is detectable in the breastmilk and will be transferred to their baby during feeding. • Inform mother regarding factors likely to increase risk of transmission • Discuss and recommend formula feeding	• In Australia where there is clean water and good sanitation and safe alternatives to breastfeeding are available breastfeeding is not recommended to a HIV positive mother. • Formula feeding is the safest option.

Mother has HIV and is determined to breastfeed
Risk of transmission can be minimised, however, not eliminated if mother has an undetectable viral load, is on Anti- Retro-Viral medications, and if "exclusive breastfeeding" is practiced.
	• Women should be advised to make a decision whether to breastfeed after talking to their HIV health team.
	• Early initiation of antiretroviral therapy (ART) in pregnancy and continuing to the end of the breastfeeding period is recommended. Time of commencement of therapy will depend on the viral load.
	• Do not mix feed. Exclusive breastfeeding up to 6 months is safer than mixed feeding.
	• If you switch to formula feeding do not go back to breastfeeding.
	• It is recommended to formula feed after 6 months of exclusive breastfeeding or when your baby is about to start solids.
	• Inform mother regarding factors likely to increase risk of transmission, advise mother to get help early, express and discard breast milk and stop breastfeeding if the following develop and see healthcare professional for advice:
	  ◦ If HIV becomes detectable in your blood
	  ◦ Mixed feeding
	  ◦ Cracked or bleeding nipples
	  ◦ Mastitis
	  ◦ Diarrhoea and/or vomiting in the mother
	  ◦ Diarrhoea and/or vomiting in the infant.
	If mother is not receiving ART, when mother is ready to introduce other food to the baby they should be advised to abruptly wean baby from the breast
		• Breastfeeding can be supported only if the mother is fully compliant with their medication, and breastfeeding remains exclusive up to six months.
		• Several clinical trials have shown the efficacy of antiretroviral in preventing transmission to the infant while breastfeeding
		• Exclusive breastfeeding up to 6 months is safer than mixed feeding. Mixed feeding may lead to gastrointestinal injury and disruption of immune barriers and increase risk of infection with HIV.
		• Medical team should be consulted as may need to check viral load in mother's blood. Infant may require testing.
		• Infant is at risk of transmission of HIV from breastfeeding. Breastfeeding should be stopped and infant should start formula feeding. Infant should not go back to the breast.

24.20 Alcohol Considerations when Breastfeeding

Needs and/or Problems	Action	Rationale
For the mother who wishes to consume alcohol	• Advise mother that the safest option is to avoid alcohol while breastfeeding • Particularly avoid alcohol in the first 4 weeks and while breastfeeding is being established.	• Alcohol enters the breastmilk and reaches a concentration similar to the mother's blood level. It may persist for several hours after maternal consumption. • The alcohol may harm the developing infant if ingested via the breastmilk. The infant's brain keeps developing after birth. • Large quantities of alcohol decrease the volume of breastmilk produced by interfering with the let down reflex.
	• If mother chooses to drink alcohol –advise them to limit alcohol intake to no more than 2 standards drinks per day. • It is best to avoid drinking immediately before breastfeeding. • Women who wish to drink alcohol could consider expressing milk in advance so there is milk available if a feed is missed or while waiting for the level of alcohol in breastmilk to fall	• Limiting intake of 10 to 20 gms in a day is considered the safest option (<2 standard drinks). • Drinking > 2 standard drinks per day may affect the infant's psychomotor development and disrupt their sleep – wake behavioural patterns. • Infant will still receive the benefits of breastmilk • Alcohol may make the baby drowsy or unsettled and may reduce the intake of breastmilk interfering with growth
	• It is best to consume the alcoholic drink just after a feed when the baby may not be feeding again for a few hours • Consider expressing in advance if the mother intends to drink alcohol and express and discard their milk when drinking alcohol	• Alcohol is transferred through the breastmilk at a level similar, or just lower than, that in the mother's blood. Consumption of alcohol just after the baby has been breastfed (and, therefore, a few hours before the next feed) ensures that the breastmilk the baby consumes at the next feed will contain less/no alcohol

24.21 Tobacco Smoking and Breastfeeding

Needs and/or Problems	Action	Rationale
Mother is a smoker	• Encourage mother to cease smoking and explain the risks associated with smoking for the baby. • Encourage the mother to breastfeed and explain the benefits. • Discuss strategies to manage smoking while breastfeeding such as: - Limit smoking if unable to quit and only smoke straight after they have breastfed their infant and not just before a feed - Do not smoke in the house or car - Consider having a smoking "outfit" e.g. jacket, scarf, and after the cigarette remove the outfit, wash hands and rinse mouth • Refer mother to a suitable program e.g. Quit program • Nicotine replacement therapy (NRT) is acceptable during breastfeeding. - Intermittent delivery methods are preferred (gum, lozenges and patches) - Advise the mother to breastfeed first then use one method above to maximise the time between the use of NRT and the next feed to reduce the baby's exposure to nicotine - Refer to product information of preferred therapy replacement. - Nicotine patches are a preferred option	• Nicotine and cotinine and other toxicants of tobacco smoking enter the breastmilk and can transfer to the infant. • Smoking is not a contraindication to breastfeeding • Women who smoke are less likely to breastfeed and are likely to breastfeed for a shorter time than non-smokers • Breastfed babies of smoking mothers have less incidence of respiratory illness than formula fed babies of smoking mothers. • It takes 95 mins for half of the nicotine to be excreted from the mother's system • Second hand smoke also transfers chemicals through inhaled tobacco smoke.to the infant. • Smoke is trapped in clothing, hair and on hands • Babies are exposed to secondary smoke and at an increased risk of SIDS • Smoking can decrease milk volume and fat content and depress the milk ejection reflex prior to breastfeeding • No untoward effects were noted in the infant from mother's using Nicotine replacement therapy
Partner is a smoker	• Explain the risks to the baby associated with passive smoking • Encourage the partner to join a suitable program with the baby's mother • If partner continues suggest the same strategies as above – smoke outside, smoking outfit etc.	• A baby exposed to tobacco smoke has a higher risk of SIDS however breastfeeding is protective • Baby is at greater risk of pneumonia, bronchitis, meningococcal disease, asthma and middle ear infection

25. Paediatric Ward Flow Chart for Breastfeeding mother/infant

1. Bare weigh baby as soon as possible after admission
2. Is the baby **exclusively** breastfed?

- *Calculate baby's expected weight gain (indicator for feeding / milk supply)*
- *Observe baby feeding at the breast and note the following:*
  - *Breast fullness prior to and after a feed*
  - *Correct positioning and attachment*
  - *Baby's ability to suck and transfer milk*
  - *Baby's contentment post feed*
  - *Baby's output*

Baby is feeding well + normal observations *NB. If the baby is unwell the feeds may be shorter and more frequent*	**Baby is not feeding well**	**Baby is unable to feed**
Encourage mother to continue their normal feeding pattern and offer support as required (pump is not needed)	●Offer both breasts at each feed ●Assist with latching as required ●Express after each feed and offer baby any EBM Refer for Lactation Consultant review	●Work out baby's fluid requirement on 8 feeds per day ●Encourage mother to express every feed ●Offer baby EBM as required Refer for Lactation Consultant review

Allocate an electric breast pump to the mother and explain the following:

- How the pump works and the frequency and duration of use
- How to clean the pump after each use
- How to assemble and use the pump kit
- How to collect and store the breastmilk
- Document in the notes that this has been explained

If mother's milk supply is low:

Express after each feed for extra stimulation. Consider recommending Domperidone to increase milk supply if the mother does not have any risk factors for taking this.

- Judicial use of formula if considered necessary.
- Refer to Lactation Staff if available. Refer to Child and Family Health Nursing on discharge

26. Definitions

WHO Breastfeeding Definitions

Feeding Practice	Infant receives	Allows the infant to receive	Does not allow the infant to receive
Exclusive breastfeeding	Only breastmilk including expressed breastmilk	Medicines, vitamins, minerals	Anything else
Predominant breastfeeding	Breastmilk as the predominant source of nourishment	Water and juice, medicines, vitamins and minerals	Anything else (particularly non – human milk and food based drinks)
Complementary feeding*	Breastmilk including expressed breastmilk	Anything else including non-human milk and solid foods	NA
Breastfeeding	Breastmilk including expressed breastmilk	Anything else including non-human milk and solid foods	NA
Bottle feeding	Any liquid or semi - solid food from a bottle with a teat	Anything else including non-human milk and solid foods	NA
*Complementary feeding is no longer used to assess infant feeding practices. Previously, it was used to indicate timely complementary feeding with solid foods and now a different indicator is used “introduction of solid and semi-solid or soft foods” in breastfed children as it was difficult to interpret**.**			

Artificial feed	Formula feed, Breastmilk Supplement
MRN	Medical Record Number
PDHM	Pasteurised Donor Human Milk
CMC	Clinical Midwifery Consultant
CME	Clinical Midwifery Educator
MUM	Midwifery Unit Manager
NUM	Nurse Unit Manager
CFHN	Child and Family Health Nurse

27. Consultation

Coordinator, Enterprise Risk Management System SLHD
SLHD Sydney Education
SLHD Maternity Policy Committee
Lactation Specialists
Neonatologists, RPAH
Clinical Midwifery Managers/Consultants/Educators

28. Education Points

28.1 International Code of Marketing of Breastmilk Substitute

Development and adoption of the International Code of Marketing of Breastmilk Substitutes (The WHO Code) occurred in 1981 at the World Health Assembly and Australia was a signatory to this Code. The aim of the Code is to contribute to the provision of safe and adequate nutrition for infants by the protection and promotion of breastfeeding. It also aims to ensure the proper use of breastmilk substitutes when these are necessary, based on adequate information and through appropriate marketing and distribution. The WHO Code applies to all products marketed as partial or total substitutes for breastmilk and includes infant formula, bottles and teats.

Summary of the International Code for the Marketing of Breastmilk Substitutes

1	**Advertising**	No advertising of infant formula products to the public
2	**Samples**	No free samples to mothers, their families or health care workers.
3	**Health Care Facilities**	No promotion of products to the public No infant formula company staff to advise mothers No gifts or personal samples to health workers e.g. diaries No free or low cost supplies to be given
4	**Information**	No words or pictures idealising artificial feeding, including pictures of infants, on the labels of products. Information to health workers should be scientific and factual
5	**Labels**	All information on artificial infant feeding, including the labels, should explain the benefits of breastfeeding, and the costs and hazards associated with artificial feeding
6	**Products**	Unsuitable products, such as sweetened condensed milk, should not be promoted for babies. All products should be of high quality and take account of the climatic and storage conditions of the country where they are to be used
World Health Organization. Geneva 1981 (Courtesy IBFAN 1982) World Health Organization 2008 The International Code of Marketing of Breast-Milk Substitutes: frequently asked questions.		

28.2 Innocenti Declaration

In 1990, the Innocenti Declaration was produced and set international standards for breastfeeding to empower, "…all women to exclusively breastfeed their children for 4-6 months and to continue breastfeeding with complementary food well into the second year of life".

In 2001, the World Health Assembly acting on a recommendation from the WHO Expert consultation recommended exclusive breastfeeding for 6 months with the introduction of complementary food and continued breastfeeding thereafter.

In 2005, the Global Strategy operational targets recommended protection, promotion and support of exclusive breastfeeding for six months and continued breastfeeding up to two years of age or beyond, while providing women access to the support they require – in the family, community and workplace.

28.3 Baby Friendly Health Initiative

The Baby Friendly Health Initiative (BFHI), a global accreditation process, is a quality assurance measure that demonstrates a facility's commitment to offer the highest standard of maternity care to mothers and babies. The BFHI was launched in 1991 by the WHO and the United Nations Children's Fund with the aim of improving standards and increasing breastfeeding rates by encouraging hospitals to implement the "The Ten Steps to Successful Breastfeeding" as a minimal standard, adopt practices that "protect, promote and support" breastfeeding and adhere to the WHO Code.

Health Services can apply for this status and are assessed by an external team of trained assessors. Once awarded, this accreditation lasts for three years at which time a further reassessment must be undertaken to retain the status. Health services who are awarded this status can then be easily identified as being up to date in their approach to breastfeeding.

In 2006 the *Breastfeeding in NSW: promotion, protection and support policy* was released and then reviewed in 2011 and 2018, with the aim of providing direction for NSW Health and Local Health Districts on how to promote, protect and support breastfeeding in the community and among staff[5].

The NSW Health Breastfeeding in NSW - Promotion, Protection and Support (PD2018_034) endorses the implementation and maintenance of Baby Friendly Health Accreditation for health services, including compliance with the WHO Code for the Marketing of Breastmilk Substitutes.

28.4 Ten Steps to Successful Breastfeeding

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

Critical Management Procedures

1a. Comply fully with the International Code of Marketing of Breastmilk Substitutes and relevant World Health Assembly resolutions.

1b. Have a written infant feeding policy that is routinely communicated to staff and parents. Inform all pregnant women about the benefits and management of breastfeeding.

1c. 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 breastmilk, 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 recognise and respond to their infant's 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.

28.5 Seven Point Plan for Community Health Services

1. Have a written breastfeeding policy that is routinely communicated to all staff and volunteers.
2. Educate all staff in the knowledge and skills necessary to implement the breastfeeding policy.
3. Inform women and their families about breastfeeding being the biologically normal way to feed a baby and about the risks associated with not breastfeeding.
4. Support mothers to initiate and maintain exclusive breastfeeding for six months.
5. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.
6. Provide a supportive atmosphere for breastfeeding families, and for all users of the child health service.
7. Promote collaboration between staff and volunteers, breastfeeding support groups and the local community in order to protect, promote and support breastfeeding.

28.6 Paediatric Services Ten Steps

1. Have a written breastfeeding policy that is routinely communicated to all health care staff and provide people with training to acquire the skills necessary to implement this policy.
2. Provide mothers with an environment and facilities, which meet their needs for privacy, information and appropriate nutrition.
3. Support mothers in their choice of feeding method and assist in the establishment and maintenance of breastfeeding.
4. Provide parents with written and verbal information about the benefits of breastfeeding and breastmilk.
5. Use alternative techniques conducive to breastfeeding if a baby is unable to feed at the breast.
6. Give no bottles or dummies to breastfeeding babies unless medically indicated and with parents' permission.
7. Provide facilities that allow parents and babies to be together 24 hours a day in order to promote breastfeeding on demand.
8. Plan all nursing and medical care to minimise disturbance to the breastfeeding relationship.
9. Provide mothers with a dedicated facility that is appropriately furnished with well-maintained and sterilised equipment for the safe expression and storage of breastmilk.
10. Provide parents with information about breastfeeding support groups during admission and on discharge from hospital.

(Maternity Facility Handbook, BFHI Australia, Baby Friendly Health Initiative, Australia. Updated 2020 incorporating the revised World Health Organisation (WHO) & UNICEF Global Standards for BFHI)

29. Infant Formula Company Representatives

SLHD promotes exclusive breastfeeding for infant nutrition for the first six months of life and support to continue breastfeeding with the appropriate introduction of solids for as long as the mother chooses. SLHD also supports a mother's informed choice in the use of infant formula but does not support the promotion of infant formula to the general public. This includes the display of any material which refers to a product that is within the scope of the World Health Organisation Code for the Marketing of Breastmilk Substitutes (WHO Code)

Under no circumstances are promotional material or product samples to be left with or accepted by any staff member.

Managers of Maternity, Child & Family and Community Health Services require product information for the education of staff and therefore the following standards have been formulated:

Formula company representatives are only to contact the nominated staff below, at each facility, for the purpose of making an appointment to discuss their products. If any clinical staff member is contacted, they must refer the formula company representative to the nominated staff at their facility. This nominated person is then responsible for ensuring that the information is disseminated to staff without being in breach of the WHO Code.

Nominated staff are:

- Principal Midwifery Manager – Women's Health, Paediatric and Neonatology
- Nurse Managers – Maternity Services, Paediatrics & Community Health Services
- Nursing/Midwifery Unit Managers – Maternity and Child & Family Health Services
- Clinical Nurse/Midwifery Consultant – Maternity and Child & Family Health Services
- Clinical Nurse Consultant/Specialist (Lactation) – Maternity and Child & Family Health Services
- Designated Neonatologist
- Dieticians

30. How Breastfeeding Works

Endocrine (Hormonal) Control

Milk is produced in the glandular epithelial cells within the breast and is stored in clusters of alveoli. Each alveolus is surrounded by myoepithelial (muscle) cells. Adequate milk production is thought to be initially dependent on two main factors:

- Prolactin release from the anterior pituitary which stimulates milk production.
- Oxytocin release from the posterior pituitary causes the myoepithelial cells to contract and allow the produced milk to be released and pushed down the ductal system towards the nipple. The baby's sucking stimulates nerve endings in the nipple and areola triggering this oxytocin release which is known as milk-ejection reflex or "let-down". Removal of milk is then made possible by the rhythmical, negative pressure of the baby's sucking.

Autocrine (Local) Control

The two most important factors in successful ongoing lactation are:

- The efficient removal of milk from the breasts.

- The ability of the correctly latched baby to feed to need.

The lactating breast exercises a local feedback control known as autocrine control. Two local mechanisms are thought to control this: feedback inhibitor of lactation (FIL) which is a component of whey fraction in the breastmilk and prolactin receptor theory. When FIL reduces as the milk is removed from the breast the milk synthesis speeds up and when the alveoli cell is distorted due to milk fullness the prolactin cannot bind to the receptor at the base of the cell. This action is thought to match the rate of milk production to the amount of milk removed and comes into play in the early weeks of lactation.

The average mother's potential for milk production is much greater than the average baby's appetite. The wide range of milk intake by babies

31. Antenatal and Postnatal Breastfeeding Education Content

The following information should be discussed and documented in the eMR education check list. Information should be provided in a non-judgemental manner by the antenatal care provider and included in antenatal and postnatal classes:

- Why breastfeeding is important for mother and infant.
- The risks associated with not breastfeeding.
- The benefits of having a support person of the mother's choice throughout labour and birth.
- Ways to help with comfort and non-pharmacological pain relief during labour.
- Importance of early uninterrupted skin-to-skin for all infants including mothers for whom breastfeeding is not their chosen method of breastfeeding and the first breastfeed particularly the first hour.
- How to recognise when the infant is ready to attach to the breast for the first feed.
- Basic breastfeeding management including baby-led attachment, positioning and attachment, feeding cues and frequency of feeding.
- Indications that an infant is getting enough milk.
- Why staying with the infant (rooming in) is important.
- Why bottles and teats and dummies are discouraged while breastfeeding is being established.
- Recommendation: exclusive breastfeeding for the first six months with introduction of other foods at around 6 months. Continue breastfeeding until at least 12 months with 2 years and beyond benefiting mothers and babies.
- Ensure spoon, cup, finger feeding or a supply line at the breast are encouraged and used, in preference to bottle and teat for breastfed babies. Educate the parents about the risks of using artificial teats should they choose to do so.
- Professional support - Child and Family Health Nursing Breastfeeding Support Clinics in SLHD
- Breastfeeding support in the community – Australian Breastfeeding Association provides phone and website support and information: ph. 1 800 MUM 2 MUM https://www.breastfeeding.asn.au/

Advice on prenatal nipple care - avoid drying agents on nipples. Specific nipple preparation is not considered necessary, however there are advantages in encouraging women to be comfortable with handling their own breasts.

32. References

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2. Becker GE, Smith HA, Cooney Becker GE, Smith HA, Cooney F. Methods of milk expression for lactating women. Cochrane Database of Systematic Reviews 2015, Issue 2
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20. Infant NSW Health The First 2000 Days Framework NSW Health PD2019_008
21. Maternity Facility Handbook, BFHI Australia, Baby Friendly Health Initiative, Australia. Updated 2020 incorporating the revised World Health Organisation (WHO) & UNICEF Global Standards for BFHI
22. National Health and Medical Research Council (2012) Infant Feeding Guidelines, Canberra
23. The Australian National Breastfeeding Strategy: 2019 and Beyond (the Strategy)

33. National Safety and Quality Standard/s, 2nd ed


Clinical Governance Standard


Partnering with Consumers Standard


Preventing and Controlling Infections Standard


Comprehensive Care Standard


Communicating for Safety Standard


Recognising and Responding to Acute Deterioration Standard

34. Parent Handouts (pages 57-67)

1. Expressing breastmilk in hospital
2. Expressing breastmilk
3. Increasing your breastmilk supply
4. Nipple shields
5. Cup feeding
6. Cleaning equipment
7. Suppression of lactation
8. Mastitis
9. Care of your breasts when your baby dies
10. Guidelines for use of Domperidone tablets

34.1 Expressing breastmilk in hospital

Women and babies
Expressing breastmilk in hospital

Hand expressing

It is important for you to know how to express your breast milk. Hand expressing is a learned skill and is best done by you. If your baby is unable to breastfeed hand expressing within 1 -2 hrs of birth and regular expression (3 rd hrly) will support milk production and provide important protective antibodies for your baby.

When should you hand express:

- if you are separated from your baby
- you are unable to give a breastfeed at the time your baby wants to feed
- your baby has difficulties attaching, and is demanding a feed
- to soften your areola (darkened skin around nipple) to make attaching easier
- to increase your milk supply

How to hand express

1. Wash your hands with soap and water.
2. Gently massage your breasts, starting from the top and stroking towards your nipple, not forgetting the underneath.
3. Collect any drops of expressed breast milk (EBM) in a sterile syringe or hold a sterile container under your breast to collect your milk.
4. Put your thumb and first finger opposite each other on your areola (coloured area surrounding your nipple) about 2 cm back from the nipple, see picture.
5. Gently push back towards the centre of your breast and rib cage, squeezing your thumb and finger together with the pad of your thumb and finger meeting behind the nipple. Repeat in a rhythmic action until the milk starts to flow. It should not be painful.
6. When the flow stops move your finger and thumb around your areola and repeat steps 4-6. To continue gentle massage between expressions.
7. Aim to express the breasts for about 10–15 mins each side. Then change to other breast.
8. You may swap to the other breast after about 5 minutes if the milk has stopped flowing, or your hands are tired. By changing back and forth from breast to breast you may be able to improve the flow of milk, particularly if your supply is low.
9. Twist cap onto syringe /container to seal.
10. Write expressed breastmilk (EBM), date, time of expression on Babys /Mothers Medical Record Name (MRN) label and stick label to the syringe / container.
11. The labelled, EBM syringe / container can be stored at room temperature for up to 4 hrs. If you are not going to be giving the baby the breastmilk at the next feed it should be stored in the fridge in the milk room.
12. If your baby is in the NICU your EBM should be placed in the fridge or taken to the NICU within the hour.

Photo acknowledgements: ILCA's inside track, a resource for breastfeeding mothers, 2013 Yvette Dowd and the Australian Breastfeeding Association

Sydney Local Health District

CONSUMER REVIEWED

231576
Consumer/carer reviewed: 04/23
Next review: 04/25

34.2 Expressing breastmilk

Women and babies
Expressing breastmilk

Hand expressing

It is important for you to know how to express your breast milk. Hand expressing is a learned experience and is best done by you.

When you need to hand express:

- if you are separated from your baby
- you are unable to give a breastfeed at the time your baby wants to feed
- your baby has difficulties attaching, and is demanding a feed
- to soften your areola (darkened skin around nipple) to make attaching easier
- to increase your milk supply

How to hand express

1. Wash your hands with soap and water.
2. Gently massage your breasts, starting from the top and stroking towards your nipple, not forgetting the underneath.
3. Hold a clean container under your breast to collect your expressed breastmilk (EBM).
4. Put your thumb and first finger opposite each other on your areola (coloured area surrounding your nipple), see pictures below.

Photo acknowledgements: ILCA's inside track, a resource for breastfeeding mothers, 2013 Yvette Dowd and the Australian Breastfeeding Association

5. Gently push back towards the centre of your breast and rib cage, squeezing your thumb and finger together with the pad of your thumb and finger meeting behind the nipple. Repeat in a rhythmic action until the milk starts to flow. It should not be painful.
6. When the flow stops move your finger and thumb around your areola and repeat steps 4 to 6.
7. Aim to express the breasts for about 10 to 15 minutes each side, then change to other breast.
8. You may swap to the other breast after about 5 minutes if the milk has stopped flowing, or your hands are tired. By changing back and forth from breast to breast you may be able to improve the flow of milk, particularly if your supply is low.

Expressing using a hand or electric breast pump

- Hand expressing is recommended in the first 24 to 48 hrs after birth. After this time a breast pump can be used. It is recommended that you combine hand expressing with pumping if you decide to use a breast pump.
- Before using the breast pump wash hands and gently massage your breasts as in steps 1 to 2 above.
- Gently hand express for a minute or two to get your milk flowing.
- Ensure correct sizing of pump kit. Centre the funnel of the pump over your nipple and follow manufacturer's instructions.
- If pump has adjustable suction pressures always start on minimum / low and build up to a comfortable level. If there is a rate setting, start on a fast rate, reducing the rate as milk flows.
- Your nipple should move freely in the pump flange without being squashed in around the edge
- Higher pressures can be used as long as they cause no discomfort.
- The pump if used correctly, should not cause pain, and will become easier to use with practice.

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CONSUMER REVIEWED
231576
Consumer/carer reviewed: 04/23
Next review: 04/25

Storing your breast milk

Breast Milk	Room Temperature (26°C or lower)	Refrigerator (4°C or lower)	Freezer
Freshly expressed into a closed container	When expressing for your baby in the hospital, your milk needs to be refrigerated within 2 hours of completing the expression. At home it can last up to 6 to 8 hours out of the fridge.	In hospital 48 hours. At home 3 days (72 hrs). Store in back of the fridge, where it is coolest.	2 weeks in freezer compartment inside refrigerator. 3 months in freezer section of refrigerator with separate door. 6 to 12 months in deep freeze (-20° C)
Previously frozen – thawed in refrigerator but not warmed	24 hours	Use within 24 hours	Do not refreeze
Thawed outside refrigerator in warm water	For completion of the feed. Use straight away do not store	4 hours or until next feeding	Do not refreeze
Baby has begun feeding	Discard when the feed is finished	Discard	Discard

- Breastmilk often separates when stored and may need to be shaken before use.
- Breastmilk can be stored in glass or plastic containers.
- Fresh breastmilk that is being refrigerated or frozen should be stored in a new container rather than being added to previously refrigerated or frozen milk.
- Only fill the container ¾ full with breast milk as it will expand on freezing and the container may burst or leak in the freezer. Refrigerate within 2 hours of expressing.
- Label the container with date and time and use the oldest milk first.
- Expressed breast milk (EBM) only needs to be warmed to room temperature to feed to your baby.
- **NEVER USE A MICROWAVE** to warm baby's milk, as this may cause burns in the baby's mouth and throat and may change the nutritional content of the milk.
- Transport breastmilk in an insulated esky with a freezer brick and put in the refrigerator or freezer (if still frozen) immediately upon arrival.

Labelling and storage of EBM if expressing for infant in hospital

- The container that holds your breastmilk needs to be capped and labelled with a sticker that has:
  - baby's surname, date of birth and medical record number
  - contents (EBM) date and time of expressing (please write this on the sticker)
  - date and time thawed if appropriate (please write this on the sticker)
- **Milk not intended for use at the next feed** must be labelled and placed in the fridge as soon as possible and within 2 hours of expressing. Milk may be stored in the fridge for up to 48 hours.

References

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231576JULY2023

34.3 Increasing your breastmilk supply

Women and babies
Increasing your breastmilk supply

Production of breastmilk relies on the regular and effective removal of milk from your breasts.

This is best achieved by feeding your baby to his or her need. It is also important for your baby to be well positioned at your breast and attached correctly so you are comfortable when your baby sucks.

Your baby's suck should be slow and rhythmical with deep jaw movements and you may see swallowing. It is normal to have 8 to 10 breastfeeds in a 24 hour period.

If concerned about your supply, talk to a health professional such as your Child and Family Health Nurse, Lactation Consultant or an Australian Breastfeeding Association counsellor.

What you can do to increase your breastmilk supply

- Increase how often you feed your baby or express your breasts including during the night.
- Ensure you finish one side first (it should feel soft all over) then always offer the second.
- Do not use a dummy - use the breast to comfort your baby.
- Express your breasts for 10 to 15 mins each side after breastfeeding your baby. You can do this by hand or use a manual or electric pump. Consider double pumping for 10 to 15 mins. This increases stimulation to your breast and may produce more milk.
- Any expressed breast milk you are able to express can be offered to your baby after feeds.
- Increase skin to skin contact time with your baby.
- Avoid giving your baby any fluids or foods other than breastmilk unless it is necessary for their health.

Remember the breastmilk flows best when you are relaxed and calm. Accept any practical help at home as you try to rest, drink adequate fluids and have a well balanced diet. Limit caffeine, including tea, coffee and cola as these may decrease your breastmilk.

Use of medication to increase your supply would only be suggested if other methods have been unsuccessful after the first week. You must continue with increased stimulation and removal of milk while taking the medication for it to work effectively.

Contacts

Child and Family Health Nursing – contact Child Health Information Link (CHIL) 9562 5400

www.slhd.nsw.gov.au/chil

Australian Breastfeeding Association Helpline
1800 686 268

Mothersafe (Medications in Pregnancy and Lactation Service) 02 9382 6539
1800 647 848 (non- metropolitan)

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Sydney Local Health District

231576
Consumer/carer reviewed: 04/23
Next review: 04/25

231578JULY2023

34.4 Nipple shields

Women and babies
Nipple shields

Nipple shields are silicone covers that are placed over the nipple and areola to assist with breastfeeding. Their use is usually temporary.

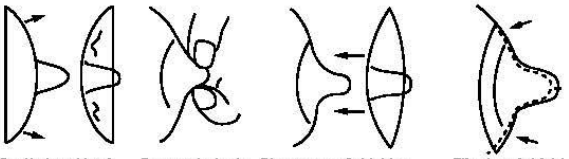
The most common reason for using a nipple shield is flat or inverted nipples when other attempts to attach baby have been unsuccessful.

Nipple shields should not be used:

- until milk is in and flowing well
- when nipples are damaged from poor attachment to the breast

How to breastfeed with a nipple shield

- Express a small amount of milk into the cone of the shield
- Apply the nipple shield centrally over the nipple and hold it in place with your fingertips on the outer edge of the shield as your baby attaches onto your breast
- Ensure your baby's mouth is wide around the nipple shield so the lips are not just on the teat part of the nipple shield
- Once on the breast you will need to move your fingers so your baby has plenty of room to attach well
- It is important that the baby does not slip back off the shield as this will cause pinching and nipple damage
- Make sure the baby is swallowing and sucking
- It should look like your baby is feeding as if the shield is not there



Gently bend back rim of nipple shield | Draw out nipple | Place cone of shield as far onto nipple as possible | Flip rim of shield back against breast

Adapted from: - "Breastfeeding Matters" as supplied from John Radcliffe Hospital UK. September 2003; & NSW Health Using Nipple Shields (SESIH Area Lactati

Cleaning:

- ensure nipple shield is cleaned and sterilised/ sanitised before first use
- follow the manufacturer's instructions for methods of cleaning
- clean nipple shield in a separate container, not directly in the sink
- rinse nipple shield under cold running water. Clean shield thoroughly in warm soapy water then rinse again and dry with a clean cloth. Store in a clean covered airtight container between feeds
- nipple shield should be cleaned after each use. Sterilise for added protection at least once in 24 hours (e.g. boil for 5 minutes)

Problems associated with use of a nipple shield include:

- lack of direct stimulation to the breast may lead to a lower milk supply and poor weight gain in the baby
- baby may prefer the nipple shield and may be difficult to get feeding directly at the breast

The likelihood of problems can be reduced by:

- being shown how to use the shield correctly by an experienced midwife / nurse or lactation consultant
- assessing baby's ability to attach well with the shield and observing for changes in baby's sucking pattern during the feed
- ensuring good milk flow and breast is softening after feed. It may be necessary to express for a few minutes after feeds
- ensuring follow up with breastfeeding support so that baby's growth and progress may be checked

Weaning from the nipple shield

It is recommended that baby eventually feed directly from the breast. The transition from nipple shield to breast can sometimes take time. Removing the shield part way through a feed when the nipple is drawn out may make direct attachment easier.

Assistance can be obtained from a lactation consultant, or Child and Family Health Nurse.

References

Campbell S, Lauwers J, Mannel R, Spencer B Core Curriculum for Interdisciplinary Lactation Care: Published Jones & Barlett Learning 2019

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CONSUMER REVIEWED
231576
Consumer/carer reviewed: 04/23
Next review: 04/25

231576JULY23

34.5 Cup feeding

Women and babies
Cup feeding

- Cup feeding provides a safe alternative to bottles and teats when your baby is unable to breastfeed effectively or requires additional fluids.
- It can also be used if you are temporarily unable to breastfeed your baby.
- Expressed breastmilk should be used. Where medically indicated or at your request a breastmilk substitute (formula) may be given. A written consent for a breast milk substitute is required in the hospital setting.
- The cup used should be small and smooth edged, the capacity should be no more than 30mls.

How to cup feed

1. Before starting, wash your hands thoroughly and place the milk into a clean and dry cup.
2. Ensure your baby is awake and alert prior to starting a cup feed.
3. Wrap your baby securely to prevent his/her hands from knocking the cup.
4. Place a bib under your baby's chin; the baby may dribble some of the milk.
5. Hold your baby in a supported sitting position on your lap, so that you are both comfortable.
6. Keep your baby in an upright position throughout the feed.
7. The cup should be no more than half full.
8. Place the cup so the rim is gently resting gently on your baby's lower lip.
9. Tilt the cup until the milk is at the rim.
10. Your baby will open his/her mouth and begin to sip or lap up the milk. You will hear swallowing.
11. Leave the cup in place while your baby is feeding actively. Your baby will regulate the pace and volume of the feed. Remove the cup when the baby stops drinking.
12. Return the cup when your baby is showing signs of being ready to feed again.
13. Repeat this process until the feed is finished, usually within 20 to 30 minutes.
14. Following the feed wash the cup in hot soapy water then rinse and dry. The cup can be stored in a clean container (with a lid) in the fridge for later use.
15. For added protection sterilise cup after cleaning each feed.
16. In the hospital setting a sterile cup is used.

Acknowledgements

1. Spoon and Cup feeding – alternative feeding methods in the early postnatal period, Royal Hospital for Women
2. PR2011_353 Cup Feeding Breastfed Well Babies – NSLH

References

National Health and Medical Research Council (2012) Infant Feeding Guidelines. Canberra: National Health and Medical Research Council, 2012

NSW GOVERNMENT Sydney Local Health District

CONSUMER REVIEWED 231576
Consumer/carer reviewed: 04/23
Next review: 04/25

231576JULY2023

34.6 Cleaning equipment

Women and babies
Cleaning equipment

Instructions for the care and cleaning of your breast pump kit at home

Non disposable pump kit:

- follow manufacturers instruction for use and cleaning method
- pump kit must be thoroughly cleaned and sterilised before first use.
- your breast pump kit should be cleaned after each use
- sterilise your breast pump kit after each use for added protection for your infant

Disposable pump kit:

- if you have been supplied with a disposable pump kit by the hospital it is designed for reuseable single patient use
- your breast pump kit must be cleaned after each use. The 24 hour pump kit must be discarded after 8 uses or 24 hours
- if pump kit ceases to work effectively discard sooner
- disposable pump kits cannot be placed in the dishwasher or sterilised

Cleaning of pump kit:

- wash hands thoroughly before handling equipment
- follow the manufacturer's instructions regarding assembly, use, cleaning and sterilising methods of electric pump equipment
- dismantle all the breast pump set parts prior to washing
- remove tubing from pump flange and set aside. Do not wash
- rinse all the flange parts in cold water
- use a bucket or container to wash pump set in the sink. Submerge and wash all parts in warm, soapy water (washing up detergent)
- rinse thoroughly in warm water and be sure to remove all traces of your milk and soap
- dry thoroughly with single use clean cloth/ paper towel
- wash and dry bucket / container thoroughly using single use cloth/ paper towel
- store dry pump kit in bucket /container with lid on for use next time

Cleaning bottles and teats

For the protection of your baby your bottles and teats must be thoroughly cleaned and sterilised before first use and after each use.

Cleaning:

- wash hands thoroughly before handling equipment
- follow the manufacturer's instructions regarding assembly, use, cleaning and sterilising methods
- use a bucket or container to wash equipment in. Not directly in sink
- all equipment needs to be:
  - rinsed in cold water
  - washed thoroughly with a bottle / teat brush in warm soapy water (dishwashing liquid is appropriate). Remember to go around the grooves in the neck of the bottle as milk often collects there
  - rinsed thoroughly with warm running water

Sterilising Equipment

Follow manufacturer's instructions

Before sterilising any equipment including breast pump parts or bottles and teats, they must be cleaned.

Two methods of sterilisation are:

- boiling
- steam sterilisation

Boiling:

- choose a saucepan with a lid large enough to hold all the items
- place all items in saucepan and add sufficient water to completely submerge all articles

NSW GOVERNMENT Sydney Local Health District

CONSUMER REVIEWED

231576
Consumer/carer reviewed: 04/23
Next review: 04/25

- bring water to boil and boil for five minutes. Turn off – don't allow it to boil dry
- remove saucepan from heat and allow to cool and then remove items with clean hands
- invert and air dry or dry with a paper towel and store in a clean covered container
- store equipment that is not being used in a clean container in the fridge. It will need to be re-sterilised every 24 hours if not used

Steam sterilising:

There are two types of steam sterilisers available. Microwave steamers and Electric steamers.

- Place items in the steriliser, make sure any liquid will be able to drain from bottles, teats etc.
- Use steriliser according to manufacturer's instructions.
- Remove items with clean hands.

Sterilising unit needs to be cleaned regularly

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1. Fehr K, Moossavi S, Sbihi H, Boutin RCT, Bode L, Robertson B, Yonemitsu C, Field CJ, Becker AB, Mandhane PJ, Sears MR, Khafipour E, Moraes TJ, Subbarao P, Finlay BB, Turvey SE, Azad MB. Breastmilk Feeding Practices Are Associated with the Co-Occurrence of Bacteria in Mothers' Milk and the Infant Gut: the CHILD Cohort Study. Cell Host Microbe. 2020
2. National Health and Medical Research Council (2012) Infant Feeding Guidelines. Canberra: National Health and Medical Research Council 2012
3. Reyes SM, Allen DL, Williams JE, McGuire MA, McGuire MK, Hay AG, Rasmussen KM. Pumping supplies alter the microbiome of pumped human milk: An in-home, randomized, crossover trial. Am J Clin Nutr. 2021 Dec

231576JUL2023

34.7 Suppression of lactation

Women and babies
Suppression of Lactation (immediately after delivery)

It is normal for your breasts to start to fill with milk by about the second or third day following the birth of your baby. If you have decided to suppress lactation, in order to minimise the discomfort, it is advisable to take measures to suppress lactation as soon as possible after delivery. You may experience breast sensitivity, breast fullness, engorgement and leakage of milk. Discomfort and pain with lactation, and even mastitis, may result if symptoms are not managed.

If your breasts become uncomfortable

- A comfortable, supportive bra and breast pads may be useful.
- Apply cold packs and change often (e.g. chilled washers or a bag of frozen peas wrapped in a light cloth).
- Avoid heat on your breasts. Try not to have hot long showers.
- Avoid breast stimulation.
- If your breasts become very full and painful you may need to express enough milk to relieve some of fullness and keep your breasts comfortable. This should not increase your supply because you are not emptying the breasts.
- It may be necessary to continue to express for several days to help prevent the pain of sudden engorgement or mastitis.
- Pain relief may be needed for discomfort. An analgesic such as paracetamol may be taken, in accordance with manufacturer's directions.

Observe for any hard red areas and if accompanied by fevers, joint aches and pains or hot and cold shivers it is advisable to see your doctor as you may require antibiotics.

The role of medication

Medication, Cabergoline (Dostinex®), is available to assist with the suppression of breastmilk, however, it is not seen as the first option for treatment. Known side effects of this medication include: dizziness, headache, fatigue, insomnia, nausea, palpitations, dry mouth, constipation, anorexia and lowering of blood pressure. Please discuss with your midwife, lactation consultant or doctor if you would like more information about this medication.

If you decide you would like to take this medication, a script from your doctor is required. It is most effective if given as a single 1 mg dose, within 24 hours of delivery. If given once the milk is 'in' the dose is 250 micrograms every 12 hours for two days (total of 1mg).

References

1. Campbell S, Lauwers J, Mannel R, Spencer B Core Curriculum for Interdisciplinary Lactation Care: Published Jones & Barlett Learning 2019
2. Hale T, Hale's Medication & Mothers' Milk, 2021
3. Lawrence, RA & RM, Breastfeeding, A Guide for the Medical Profession, 9 th Edition 2018.

NSW GOVERNMENT Sydney Local Health District

CONSUMER REVIEWED
231576
Consumer/carer reviewed: 04/23
Next review: 04/25

Women and babies
Suppression of Lactation (gradual)

If you have been breastfeeding and decide to wean/ suppress lactation it is better to do it slowly. Gradual weaning allows fat tissue in your breast to replace milk producing tissue over a longer period of time.

You can do this by:

- reduce the number of breastfeeds given to your baby each day. This can be done by replacing one breastfeed with a breastmilk substitute bottle feed. When your breasts have adjusted to this reduction then another breastfeed can be reduced and so on. This may be every 3 to 4 days or longer

or

- gradually reduce the number of time you express your milk each day. This can done by stretching the time between expressions. For example, if you are expressing every 3 hours stretch that to every 4 hours. When your breasts adjust and are comfortable again stretch to 5 hours and so on.
- when you are only expressing or breastfeeding once or twice a day, only express / breastfeed for comfort until this is no longer necessary

As all mothers are different, it is best to seek the guidance of a health professional for your particular situation.

References

1. Campbell S, Lauwers J, Mannel R, Spencer B Core Curriculum for Interdisciplinary Lactation Care: Published Jones & Barlett Learning 2019
2. Lawrence, RA & RM, Breastfeeding, A Guide for the Medical Profession, 9 th Edition 2018, .

Sydney Local Health District

231576
Consumer/carer reviewed: 04/23
Next review: 04/25

231576JULY23

34.8 Mastitis

Women and babies
Mastitis

Inflammation of the breast tissue which may be due to:

- poor milk flow from the breast
- trauma – massage, excessive pressure on breast
- inappropriate use of the breast pump
- oversupply- this may predispose women to mastits

Symptoms of mastitis

- Red, painful and sometimes a 'hot' and swollen area on your breast.
- Feeling 'unwell' and having flu like symptoms such as aches and pains, lethargy, headache and nausea. The skin may appear shiny and tight with red streaks.
- High temperature > 38 to 38.5º C.

Avoiding Mastitis

- Ensure good positioning and attachment to promote good milk flow.
- Ensure the first breast is soft and comfortable before offering the other side.
- Ensure strict hand washing.
- Feeding baby according to their need. If there is a sudden change in baby's feeding needs and the breasts become very full such as your baby sleeps through the night or you are away for a feed then it is important to express your breasts or wake the baby to feed.

Treatment

- Effective milk removal is most important.
- Feed baby to need according to baby feeding cues.
- Ensure optimal positioning and attachment at the breast.
- Ensure breast is soft and comfortable before offering the second breast.
- If the baby does not feed from the other unaffected breast, mother may need to express for comfort.
- Support very gentle massage over affected area during the feed. (Avoid deep massage as this can cause increased inflammation and tissue swelling).
- If unable to breastfeed it is important to hand express or pump to soften the breast.
- If too painful to attach or mother is separated from baby, it is important to hand express or use a breast pump. There will be more milk removed with a well attached baby sucking at the breast than with a breast pump.
- Gentle hand compressions during breast pump usage may assist milk flow/removal.
- Care must be taken to ensure breast flange is not displaced during pumping.
- Advise rest, adequate fluid intake and good nutrition.
- Ensure that your bra is not tight and is not causing pressure on your breasts.
- Take pain relief as required – for example, paracetamol. Consider Ibuprofen. Discuss with health professional.
- If there is no improvement in the next 2 to 3 feeds, see your doctor as you may need antibiotics.
- In the presence of inflammation / mastitis your milk supply may decrease. Continue to feed baby to need. Do not do extra expressing.

The current recommendations are Flucloxacillin 500mg orally, 6-hourly for 5 days if symptoms resolve rapidly, if not continue for 10 days. (Cephalexin if allergic to penicillin). You should be reviewed by your doctor if you still have symptoms prior to completing your first course of antibiotics

This antibiotic can be used safely when you are breastfeeding. Your baby will not get ill as the infection involves the breast tissue not the breastmilk.

Contact your Child & Family Health Nurse or the Australian Breastfeeding Association (1800 686 268) for further support and information.

References

1. Campbell S, Lauwers J, Mannel R, Spencer B Core Curriculum for Interdisciplinary Lactation Care: Published Jones & Barlett Learning 2019
2. National Health and Medical Research Council (2012) Infant Feeding Guidelines. Canberra: National Health and Medical Research Council
3. Therapeutic guidelines: Antibiotic. Version 16. Melbourne: Therapeutic Guidelines Limited; 2019.

NSW GOVERNMENT Sydney Local Health District

CONSUMER REVIEWED
231576
Consumer/carer reviewed: 04/23
Next review: 04/25

231576JULY23

34.9 Care of your breasts when your baby dies

Women and babies
Care of your breasts when your baby dies

We are sorry for the loss of your baby. It can be a time of deep sadness and grief. Many women find it physically and emotionally exhausting. The Midwifery and Lactation team are available to support you.

Colostrum (early breastmilk) is produced as early as 16 weeks into a pregnancy. In the event of early or late miscarriage, stillbirth or neonatal death your breasts will make milk. This may start between 24 to 72 hours after your baby's birth. Some women welcome this while other women find the reminder very painful. Caring for your breasts is important, as it will help make them more comfortable and reduce the risk of inflammation and mastitis.

Your emotional response to the production of breastmilk is personal to you and will vary across individuals, families, religions, or cultures. Whatever your feelings are and choices you make towards management of breastmilk will be supported.

Breast changes you may experience associated with milk production

You may experience breast sensitivity, breast fullness, engorgement and leakage of milk, this is normal. Discomfort and pain with lactation, and even mastitis, may result if symptoms are not managed. The following information discusses management of these changes based on the choices you make about your milk.

Deciding what to do about your breastmilk

There are different options to choose from when considering how to manage breastmilk supply. You may choose to:

- stop your milk production (called lactation suppression)
- establish a supply by expressing or continue expressing if you already are
- donate your breastmilk (where available)
- collect some of your breastmilk to make memory items

About lactation suppression

Lactation can be suppressed either naturally or with the assistance of medication.

It may take days up to weeks to stop producing milk. Your body will have an individual response to your changing hormones.

Natural suppression management

- A comfortable, supportive bra and breast pads may be useful.
- Apply cold packs and change often (e.g. chilled washers or a bag of frozen peas).
- Avoid heat on your breasts (e.g. when showering avoid direct heat to the breasts).
- Take paracetamol as directed to relieve pain and discomfort.
- If your breasts become very full and painful you may need to hand express enough milk to relieve some of fullness and keep your breasts comfortable.
- It may be necessary to continue to hand express for several days to help prevent the pain of sudden engorgement or mastitis.

Suppression after you have an established supply

Gradually decrease over several days the number of times you express and the amount of milk removed from your breasts while still maintaining breast comfort. This is particularly important for any mother who has been expressing with a pump for more than two weeks. Depending on your circumstances, this could take place either in hospital or at home. If you are unsure about your individual situation seek the guidance of a healthcare professional (e.g. Child and Family Health Nurse / GP / ABA).

It may take some weeks (or even longer) for your milk to disappear completely. Leakage may continue for some time after the discomfit has settled. If you are unsure, talk with your midwife or doctor.

NSW GOVERNMENT Sydney Local Health District

CONSUMER REVIEWED

231576
Consumer/carer reviewed: 04/23
Next review: 04/25

Suppression with assistance of medication

Medication, Cabergoline (Dostinex®), is available to assist with the suppression of breastmilk however, it is not seen as the first option for treatment. Known side effects of this medication include: dizziness, headache, fatigue, insomnia, nausea, palpitations, dry mouth, constipation, loss of appetite and lowering of blood pressure. Please discuss with your midwife, lactation consultant or doctor if you would like more information about this medication.

If you decide you would like to take this medication, a script from your doctor is required. It is most effective if given as a single 1mg dose, within 24 hours of delivery. If given once the milk is 'in' the dose is 250 micrograms every 12 hours for two days (total of 1mg).

Taking Cabergoline at this time will not influence lactation in the future.

Care of breasts on significant days

If you are having a funeral or gathering with others in the days or weeks following the death of your baby, this may be a long and emotional day. The following tips may help you manage your breasts during this time:

- express milk for comfort before the event and during the day if needed
- your breasts may leak milk, so be prepared with breast pads and have some spare
- wear your bra comfortably firm but **NOT** tight
- dark-coloured or patterned tops are less likely to show wet patches
- a cardigan or jacket may help hide wet spots
- paracetamol taken as directed will help ease breast pain

Other options for breast milk

Breastmilk donation

Expressed breastmilk can be donated to The Red Cross Milk Bank. Becoming a milk donor involves a screening process similar to donating blood. When you start the process please be sure to indicate that you have experienced the death of your baby. To find out more about donating milk, visit **lifeblood.com.au/milk/** or call 13 14 95

Memory making

Some mothers may like to freeze a small amount of breastmilk as a memento. This can be used in many ways or simply kept as a keepsake.

The social work team will provide you with resources that may assist you with navigating the emotional complexities of this time. Resources specific to lactation that may help you during this period are below.

Contacts

Lifeblood **www.lifeblood.com.au/milk/** or call 131495

Australian Breastfeeding Association [ABA]. 2022. Lactation after your baby dies. **breastfeeding.asn.au/resources/lactation-after-your-baby-dies**

References.

1. Core Curriculum for Interdisciplinary Lactation Care: Edited by Campbell S, Lauwers J, Mannel R, Spencer B. Published Jones & Barlett Learning 2019
2. Hale T, Hale's Medication & Mothers' Milk, 2021.
3. Katherine, C., Noble-Carr, D., Sweeney, L., & Waldby, C. (2020). The "Lactation After Infant Death (AID) Framework": A Guide for Online Health Information Provision about Lactation After Stillbirth and Infant Death. Journal of Human Lactation. 36(3). 480-491
4. Lawrence, RA & RM, Breastfeeding, A Guide for the Medical Profession, 9 th Edition 2018
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231576JULY2023

34.10 Guidelines for use of Domperidone tablets

Women and babies
Guidelines for use of Domperidone (motilium®) tablets

While taking this medication ensure that your baby is fed whenever he/she is hungry.

Expect at least 8 feeds in 24 hours (encourage your baby to feed at least every 3 to 4 hours)

Expressing after feeds is recommended for added stimulation.

Presentation and storage

Domperidone is only available in oral medication in Australia and comes in a 10mg tablet. It is usually taken for about 28 days. If your supply does not increase or is not maintained after this consult with the health professional who is supporting your breastfeeding.

The recommended dose is 10 to 20mgs three times per day.

The regime is as follows

Dose

Day 1 to 7: 10mgs (1 tablet) every 8 hours

After 1 to 2 weeks: decrease to 10mgs every 12 hours for 7 days

Day 21 to 28 days: 10mgs every morning for 7 days

If there has been no effect after 3 to 4 days the Domperidone dose can be increased to 20mgs

(2 tablet) provided there are no side effects or risks

There is no evidence that taking higher doses of domperidone (taking more than 10 to 20mgs, three times per day) is more effective. Taking higher doses may increase the risk of cardiac arrhythmia (Hale 2021).

How does Domperidone work?

Domperidone is a prescription medicine that increases the production of the milk making hormone prolactin and will only be effective along with good breastfeeding and / or expressing. It usually takes 3 to 5 days to show an increase in supply.

Side effects

If side effects such as dry mouth and thirst, skin rashes, headaches, depressed mood, abdominal cramping, constipation or diarrhoea occur then cease the medication and consult your GP. Withdrawal symptoms may be experienced if taken in high doses.

Contraindications

While on domperidone the use of some medications may not be recommended. You should discuss with your GP all medications that you are taking. Domperidone is not recommended in women with pre-existing cardiac arrhythmias or for concurrent use of other medications which can also prolong the QTc interval. You should discuss this with your doctor before commencing Domperidone.

All women must be reviewed medically prior to being prescribed domperidone.

Mothers should be screened for pre-existing cardiac arrhythmias, history of cardiac disease, medical conditions or for concurrent use of other medications which can also prolong the QTc interval.

For further advice contact Mothersafe: 9382 6539 or 1800 647 848

References

1. ABM Clinical Protocol #9: Use of Galactogogues in Initiating or Augmenting Maternal Milk Production, Second Revision 2018 Wendy Brodribb and the Academy of Breastfeeding Medicine
2. Hale T, Hale's Medication & Mothers' Milk, 2021. Domperidone pp197 -198
3. Lawrence, RA & RM, Breastfeeding, A Guide for the Medical Profession, 9 th Edition 2018
4. National Health and Medical Research Council (2012) Infant Feeding Guidelines. Canberra: National Health and Medical Research Council, 2012

Sydney Local Health District

CONSUMER REVIEWED

231576
Consumer/carer reviewed: 04/23
Next review: 04/25

231576JULY2023