Best Practices for Easier Infant Feeding at the Breast or Chest

BUILDING BRIDGES – Hospital Practices

1

What is the goal??

Make feeding at the breast or chest easier for…

- Babies
- Lactating parents and families
- Staff

2

Exclusive Human Milk Feeding

- Why is this important?
  - Health of the baby
    - Anything other than *human milk* changes the normal infant gut microbiome which increases the risk of illness

3

Why is feeding at the breast/chest so hard?

- Babies are hard wired to feed at the breast/chest
- Born with reflexes and the ability to "get to the breast/chest" for survival
- The hard wiring for milk production develops through pregnancy and the birth process

It simply shouldn't be so difficult for so many…

4

The Ease of Feeding Begins…

- BEFORE the baby is born!
- It begins with…
  - Decisions the birthing parent & their HCP about labor and birth
  - What happens in labor & birth may impact how easily feeding gets started & impacts the entire birth experience
- This also impacts the exclusivity of human milk feeding…

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Labor & Birth…

- What does "normal" birth look like?
- Babies born in a hospital setting, typically include numerous labor, birth, & postpartum interventions
  - **Thought for the day**: **Just because something is common doesn't make it normal**

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Attitudes About Childbirth

- What response have they received from family & friends?
- Is the healthcare provider TRULY supportive of the birth preferences?
- How is the parent treated by the nursing staff?
  - 65% of medical personnel believe that having a birth plan predicts a worse obstetrical outcome
    Afshar, 2018

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Why decrease the use of interventions during the labor process?

- Reclaim birth as empowering
- Support and honor the parent's wishes and desires for the birth experience
  - Birth plan/preferences
- How ?
  - Use doulas!
  - Use alternative pain relief options when possible

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Do We Think About…

- How interventions during birth can impact feeding?
- How interventions immediately after the birthing process can impact the parent/infant bond?

We have to begin by asking "What is a birth intervention?"

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Labor and Birth

- Interventions in L&D are often *encouraged* because many HCPs hold the perspective that birth is inherently fraught with risk and danger
- Safety is assumed/assured thru routine use of EFM, IVs and restrictions on eating, drinking and mobility – none of which are evidence based
  (White-Corey, 2013)

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Electronic Fetal Monitoring

- Routine EFM is associated in many studies with an unnecessary increase in C/Section rates
  (Paterno, 2016)
- Often delayed onset of lactogenesis 2 with C/Section

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Labor and Birth

- "One out of 4 mothers who received an induction or cesarean said she felt pressure to do so, and 1 in 5 mothers who did not have an epidural stated she felt pressure to have one."
  (Lowry, 2013)
- Women are frequently offered induction of labor at 39 weeks for no medical reason
  (Breedlove, 2018)

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News from ACOG!

- The ACOG Committee on Obstetric Practice in collaboration with the ACNM developed "Approaches to Limit Interventions During Labor & Birth" in order to help women meet their goals for labor and birth
  - "Many common obstetric practices are of limited or uncertain benefit for low-risk women in spontaneous labor"
    (February 2019 – Committee Opinion #766, Reaffirmed 2021)

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Recommendations to Enhance Physiologic Birth

- Provide prenatal care that reduces stress and anxiety in the pregnant person
- Foster the biological onset of labor at term
- Encourage admission to hospital in active labor
- Provide privacy and reduce anxiety and stress in labor

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Recommendations to Enhance Physiologic Birth

- Make non-pharmacologic comfort measures for pain relief routinely available
- Use analgesic medications sparingly

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Recommendations to Enhance Physiologic Birth

- Promote continuous support during labor
- Foster spontaneous vaginal birth and avoid unneeded cesarean births
- Support early and unrestricted skin-to-skin contact after birth between birthing parent and newborn
- Support early, frequent, and ongoing feeding at the breast/chest after birth
  (Stark, 2016)

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Common Birthing Practices NOT Conducive to Bonding or Feeding After Birth

- Infant weight & exam in L&D/immediately after birth
- Routine Suctioning
- "Eyes & Thighs" immediately after birth
- Swaddling
- Hand mittens
- Separation of birthing parent and baby

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What about Vitamin D?

- Essential for optimal human health
- Low concentrations of blood vitamin D have been associated with pregnancy complications
- It is thought that additional vitamin D through supplementation during pregnancy might be needed to protect against pregnancy complications
  (Palacios, et al. 2019)

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Low Vitamin D Levels

- Associated with immune deficiency, cancer, diabetes, schizophrenia, mood disorders, autism, hypertension, rheumatoid arthritis, multiple sclerosis, childhood asthma, **preeclampsia, gestational diabetes, postpartum depression**
- May be associated with adverse events- such as postpartum hemorrhage

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Vitamin D

- Major source from sunlight
- Human milk is poor source unless parent's levels are adequate
- Academy of Breastfeeding Medicine recommendations
  - Infant 400 IU of vitamin D daily
  - Alternative option is lactating parent can take 6400 IU daily

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Vitamin D

We need to know starting level to know how much supplement is needed

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Vitamin D

How to best provide Vitamin D
- Good Stores at birth
- Supplement parent or supplement the Baby
- 2017 Study:
- Reports only 55% compliance with supplements
- Mothers would prefer to take supplements
  - Umaretiva 2017

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Vitamin D Recommendations

- Study found that if a breastfeeding mother took 6400 units of Vit D
- Mother's levels stabilized around 58.8 ng/ml
- Infant's levels increased from 13–14 ng/ml to:
  - 33 – 36 ng/mL at 4 months
  - 43 – 48 ng/mL at 6 months
    - Wagner, 2010

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Hospital Interventions: Impact on Feeding at the Breast /Chest

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Pharmacological Pain Relief

Nutritive sucking is adversely affected by CNS depressant drugs given to mom in labor

Matthews, 1989, Righard, 1990, Crowell, 1994, Nissen, 1995, Ransjo-Arvidson, 2001, Brimdyr, 2019

Fentanyl and Duramorph are CNS depressant drugs

(Hale, 2019)

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Studies on Epidurals

Several studies documented in your handouts….

26

Epidural Analgesia/Anesthesia

- Epidurals with fentanyl are:
  - Less likely to fully feed at the breast/chest in the first days after birth
  - More difficulty in establishing feeding at the breast/chest
  - More likely to stop feeding at the breast/chest in the first 24 weeks
    - (Torvaldsen, 2006)

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Epidurals

- After adjusting for standard demographics and intrapartum factors, *epidural anesthesia significantly predicted breastfeeding cessation*

  (Dozier, 2013)

- More women receiving pain medication in labor – *epidural/spinal – experienced DOL > 3 days*

  (Lind, 2014)

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Epidurals: Bottom Line

- Often leads to a cascade of events which may impact ease of breastfeeding
  - French, 2016
- Found to be associated with…
  - Impaired spontaneous breastfeeding after birth
  - Increase in supplementation in the hospital
    - Wiklund, 2009
- May lead to lower oxytocin levels during and following labor
  - Dozier, 2013

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Epidural Analgesia/Anesthesia

- Families often told that epidural medications DON'T get into the baby… the truth is THEY DO!
  - Epidural fentanyl found in baby's urine 24 hours after birth

    (Moore, 2016)
- Parents have the right information to make an informed choice
- And if they choose unmedicated birth, they need to be fully supported in that decision by medical & nursing staff

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Non-Pharmacological Pain Control Options

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Nitrous Oxide-A Better Option?

- Self administered so can't get too much
- Considered to be safe and effective when used in labor and helpful for mild to moderate labor pain
  - Collins, 2018 (AWHONN Practice Brief), Houser, 2019
- Effect on baby is minimal
- Crosses placenta but eliminated quickly once baby starts to breathe on own
  - Pinyan, 2017, Collins, 2018
- No data on transfer into milk
  - Ingestion orally via milk is unlikely
    - Hale, 2017

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Pitocin

- Inductions prevalent
  - "Social" and "Quasi-medical", ARRIVE study
  - Higher incidence of late preterm and early term infants
  - Increased dosages often needed
  - Used for longer periods of time

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Go the Full 40

- AWHONN's Public Health Campaign Promotes Spontaneous Labor and Normal Birth to Reduce Overuse of Inductions and Cesareans
- Physiologic benefits of full-term pregnancy for women and their babies.

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Pitocin

Given in labor

- Impaired first hour breastfeeding
  - Gomes, 2018, Brimdyr, 2019

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Pitocin

- May inhibit the expression of several primitive neonatal reflexes associated with breastfeeding
  - Gabriel, 2015
- Use of Pitocin in women with a history of pre-pregnancy depressive or anxiety disorder…
  - Increased risk of PMAD by 36%
- Use of Pitocin in women with no previous history of depression/anxiety
  - Increased risk of PMAD by 32%
    - Kroll-Desrosiers, 2017

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Effects of Pitocin

- Antidiuretic effect – increased water reabsorption – possibility of water intoxication & edema
- Neonatal jaundice
  (JHP package insert, 2007)

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Effects of Pitocin

- The longer the induction with Pitocin, the lower the mother's own endogenous oxytocin levels during a breastfeed on day 2
  (Jonas, 2009; Bell, 2014)
- Increases the risk of bottle-feeding and weaning from the breast by 3 months
  (Garcia-Fortea, 2014)

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Combination of Epidurals & Pitocin

High or prolonged doses of fentanyl and synthetic oxytocin (Pitocin)

- Significantly decreased the likelihood of the baby suckling while skin-to-skin during the first hour after birth
- Mothers need to be informed of this possibility
  - Brimdyr, 2015, 2019

Nurses encouraged to offer other modes of pain management first

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Labor & Birth

- Excessive IV fluids
  - Leads to edema in the extremities
  - Pitocin adds to the edema
    - Edema in nipples causing firmness
    - Baby can't latch
  - Excessive engorgement
  - Are we getting an accurate birth weight?

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Effects of IV Hydration

- Knowledge of parent's fluid intake and baby's output thru weighing diapers can prevent needless supplementation
- Women receiving >1200 ml fluid during labor
  - Average weight loss in babies at 60 hours 6.93%
  - Diuresis takes place first 24 hours to normalize body fluids in infant
  - Recommends a baseline weight at 24 hours rather than at birth
    (Noel-Weiss, 2011)

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Techniques

- Reverse Pressure softening
- Lymphatic Breast Drainage

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Delayed Cord Clamping

Erasmus Darwin, MD in 1801 wrote:

Another thing very injurious to the child is the cutting of the navel-string too soon; which should always be left till the child has not only repeatedly breathed, but till pulsation in the cord ceases. As otherwise the child is much weaker than ought to be; a part of the blood being left in the placenta which ought have been in the child

(Gams, 2017)

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Delayed Cord Clamping

ACOG Committee Opinion #814 in 2020 wrote:

Given the benefits to most newborns and concordant with other professional organizations, the American College of Obstetricians and Gynecologists now recommends a delay in umbilical cord clamping in vigorous term and preterm infants for at least 30–60 seconds after birth.

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Benefits of Delayed Cord Clamping

- Improved neonatal hemoglobin levels >> Lower risk for iron-deficiency anemia
- In preterm infants, lower risk for intraventricular hemorrhage (Bryant 2014)
- Oxygen still flowing to baby as long as cord pulsing
- Increase in antioxidant capacity & moderation of inflammatory-mediated effects induced during delivery (Diaz-Castro 2014)
- Improved scores in fine-motor & social domains at 4 years of age, especially in boys (Andersson 2015)

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Delayed Cord Clamping

- WHO recommends DCC for "all births" stating it should be **enthusiastically supported** and promoted as best practice (2014)
- No credible evidence to support routine intervention of Early cord clamping (Leslie, 2015)
- Evidence that early cord clamping can cause harm with a doubled risk of anemia at 3-6 months (McDonald 2013)

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Delayed Cord Clamping

- WHO recommends DCC for 1-3 minutes after birth
- ACOG recommends DCC for "at least 30-60 seconds after birth"
  - ACOG Committee Opinion #684, January, 2017
- AAP endorsed ACOG's Committee opinion, June, 2017

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Skin to Skin After Birth

Facilitate immediate and uninterrupted skin-to-skin contact and support parent **to initiate feeding as soon as possible after the birth**

- Uninterrupted until after first feed at breast/chest
- Uninterrupted for at least 60 minutes for formula feeding babies
- Until parent requests to end

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Optimal Positioning - Safety is Key

Parent is sitting semi-upright or leaning back slightly - NOT FLAT

Baby and parent are chest to chest with legs tucked

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"Visible & Kissable"

- Baby's face can be seen
- Nose & mouth are not covered by anything
- Head can move freely at all times & is turned to one side
- Neck is straight not bent
- Back is covered with blanket and tucked under parent's arms

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Role of Staff / Family

- Continue to assess color, breathing, tone & temperature
- Teach parent/visitors to notify staff of changes
- Someone to watch over the parent/baby if they become sleepy
- If no one is present, dress and place baby in crib
- Swaddling can prevent baby from waking and showing feeding cues

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What happens during skin to skin immediately after birth?

- Initiates strong instinctive behaviors in both the parent & baby
- Parent has surge of hormones
- Begin to smell, stoke, & engage with baby
- Baby's instincts drive a unique process
- IF left uninterrupted, often results in first feed
- **IF baby is enabled to familiarize with their parent's breast/chest & achieve self-attachment, it encourages recall at future feeds, which results in fewer feeding problems**

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Benefits for Baby

- Decreases baby's stress
- Optimal thermoregulation
- Less crying
- Improved cardiopulmonary dynamics
- Increase breastfeeding initiation and exclusivity
- Colonization of baby with parent's friendly bacteria
- Reduce formula supplementation
- Earlier successful first breastfeed

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Benefits for SCN/NICU Baby

Improve oxygen saturation

Reduces cortisol levels, particularly after painful procedures

Encourages pre-feeding behaviors

Assists with growth

May reduce hospital stay

Improves milk volume expressed following skin to skin=most up to date antibodies

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Benefits for Parent

- Earlier expulsion of placenta
- Reduced bleeding
- Lowered maternal stress levels
- Enhanced breastfeeding self-efficacy
- Rise in oxytocin
- Promotes parenting behaviors, bonding and attachment
- Decrease in PMAD risk
- Less guilt associated with C-Section

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Skin-to-Skin

- Baby is placed and dried directly on parent's body, without delay
- Baby stays on the parent's body for at least one hour
- If parent is breastfeeding, baby stays skin too skin until the first feeding is accomplished
- Baby stays on the parent's body for at least one hour
- If parent is breastfeeding, baby stays skin too skin until the first feeding is accomplished

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What is Uninterrupted Skin-to-Skin?

- Giving baby time to figure life out with minimal assistance
- Vitals and assessment with gentle movement of the baby
- Parent eats or shifts position without disturbing baby
- Moving the parent rooms without removing baby from her body

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Nine Stages after Birth

- Birth Cry
- Relaxation
- Awakening
- Activity
- Rest
- Crawling
- Familiarization
- Suckling
- Sleeping

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How can what happens or doesn't happen affect future feeds?

- Most healthy full term babies will follow this process if they are not interrupted
- Interrupting process before sequence is completed or trying to assist to hurry them along, may actually lead to feeding difficulties at future feedings
- Process may take longer in births that involve a lot of analgesia as baby may be more drowsy

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Barriers to S2S

- Visitors in the room
- Others wanting to hold the baby
- Safety concerns about parent feeling groggy
  - Is this from the meds administered in labor?
  - CNS depressants from the epidural?
    - Ferrarello, 2014

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What if Baby Does Not Feed In 1st Hour?

- Hand Express
- Feed Milk to baby with spoon/cup/syringe

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Skin to Skin During Postpartum Stay

Encourage prolonged skin to skin throughout hospital stay & NOT just after birth

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First Feeding After Birth

- Place baby skin to skin immediately after birth
- Keep S2S, uninterrupted until after first feed when possible
- Goal is the first feed within 60-90 minutes of birth
- First feed is generally "good"
  - Can last any length of time
  - Breast Crawl
  - Self Attachment

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First Day Feedings: 24 Hours

Birth to 2 hours	2-20 Hours	20-24 Hours
Alert & active	Light & Deep Sleep	Increasing wakefulness
Typically latches & feeds well	Feeds during light wakeful sleep	Cluster feeds
Then falls into a deep sleep for several hours	Returns to deep sleep	Periods of deep sleep

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Second Day Feedings: 24 - 48 Hours

- Feedings often improve in frequency & duration
- Goal "8 or more in 24"
- Baby's second night
  - Prepare parents
  - Rest
  - Follow baby's lead

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Feedings Within First 3 days

Some feedings close together & others further apart

Goal remains "8 or more in 24"

- Offer breast when baby is showing readiness
  - Cues may be subtle
  - Crying is late sign

Anticipatory guidance

ASSESS a feeding

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Feedings Within First 3 Days

- Length of feed does not = amount of milk consumed - No relationship!
  - Ramsay, Kent et al, 2004
- Watch for signs of active feeding rather than the clock

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Feedings in the First 3 Days

What parents may hear from staff/providers:

- "Time to feed the baby"
- "It's been __ hours, the baby needs to feed"
- "You need to wake the baby"

Instead could we say…

- Watch baby for feeding cues
- Keep baby skin to skin
- Baby will wake & feed when ready

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Feedings in the First 3 days

Babies need to be READY to feed

- May not be successful unless baby is ready
- Breastfeeding is a baby driven activity
- Bottle feeding is caregiver driven

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Assessing a Feeding at the Breast/Chest

- Are the parent and baby comfortable?
- Is the baby rooting with a wide open gape?
- Is the latch asymmetrical?
- Is the baby feeding actively?
- Is the parent having pain that lasts beyond initial latch?
- Is the parent feeling signs of oxytocin release?
- Is baby satisfied after feeding?

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BASICS

- B=Belly to belly
- A=Alignment of ears, shoulders, & hips
- S= Space between the chin & chest
- I=In close
- C=Chin and cheeks touching the breast
- S=Swallows

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Feeding At the Breast/Chest

- Feedings begin with short, rapid sucks
- Move to active feeding as milk starts to flow
  - Sucking bursts
  - More rhythmical pattern
  - Hearing or seeing swallows

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Swallows

- Teach parent to identify swallows
- Swallows may be less frequent in the first 24-48 hours
- Swallowing frequency increases as supply increases
- Swallowing is brought to you…

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Indicators of Effective Feeds After Milk Volume Increases

- Hands are baby's "gas tank gauge"
- Eyes open at beginning of feeding
- Falls asleep toward the end of the feeding
- STAYS asleep for a period of time
- Breast/chest softer after feeding

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Is this really working?

- Baby is gaining weight + parent's nipples do not hurt = BF going well
- "Pain-free weight gain"
- REASSURE PARENT THAT IT IS WORKING!

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What If Baby is Not Feeding Effectively In the First 24 hours?

- Hand express after every feeding session & feed baby the colostrum obtained, by spoon or syringe
  - Bonus feeds
  - "Appetizer" or "dessert"
- Helpful for lactation specialist and nurse to make brief bedside rounds daily to discuss any issues that may be of concern
  - *Morton, 2014*

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Overcoming Effects of Interventions: Staff Responsibilities

- Encourage frequent skin-to-skin
- Encourage patience and perseverance
- Assist with pumping/hand expression if baby does not latch/breastfeed
- Develop daily feeding plan with mother
- Provide written discharge plan
- Provide phone number for questions, concerns, assistance
- Follow-up plan

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Your Role

- Support parent's feeding goal
- Listen to concerns, validate feelings
- Observe & assess feeding session
- Reassure parents & teach "normal"
- Meet needs of parents and baby
- Encourage and instill self-efficacy

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Wait to Bathe

- Delay bath 8-24 hours
  - Helps regulate temperature
  - Helps regulate blood sugar
- Trial at a hospital in OH – delayed bath 12 hours
  - In hospital exclusive breastfeeding rates increased from 59.8% to 68.2% (DiCioccio, 2019)
- Trial at Advocate Sherman Hosp – IL (2016-2017)
- Delay bath 14 hours if healthy, full term
  - Hypothermia rates decreased
    - 21% to 7%
  - Hypoglycemia rates decreased
    - 21% to 4%
  - Breastfeeding rates increased
    - 51% to 78%

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Nursery/Postpartum Routines

- Supplementation without medical need
  - "Topping off" feeds because WE think the baby isn't getting enough
  - Given "just in case"
- If supplementation necessary
  - Give options & include parent in plan of care
  - Use Parent's own expressed milk
  - Use alternative feeding method

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Nursery/PP Routines

- Mittens
- Radiant warmers
- Taking babies back to nursery/out of room to do "stuff"
- Swaddled babies left in cribs

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Hospital Policies & Procedures

- Do they follow the 10 Steps to Successful Breastfeeding?
- Are your policies based on what is good for…
  - The parents/baby?
  - Or what is convenient for the staff?

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Nicholson, Pennsylvania

Baby's Second Night

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Second Night

- Common reaction to life outside the uterus usually on the second night
  - Infant may feed and **fall asleep**, then wake up crying
  - Seems fretful, always rooting
  - Seems to only be comfortable at the breast/chest

  Parents (and staff) are convinced it is due to lack of milk

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Second Night

- This is not about food
- Baby's overwhelmed CNS + immature
- Wakes up on the second night and discovers they were born
- Needs the comfort of the breast/chest to cope
- Parents are exhausted – adrenalin depleted

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Second Night Strategies

- When baby falls asleep after a good feed, break the suction gently
- Don't move them. Don't burp them (Don't BURP them?!)
- Just snuggle them
- Allow them to return to the breast/chest if they need to
- Keep them there until they move from light sleep to deep sleep
- Light sleep=rapid eye movement (REM)/irregular breathing
- Deep sleep=No REM regular/very quiet breathing

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Second Night

- Happens at home for first couple of months with environment changes
  - Doctor visit, mall, library, church, & anything else!
- Baby's neurological development will mature as they grow – this doesn't last forever
- Provide anticipatory guidance
  - Video
  - Handout on Second Night to prepare them
    - Available from LEC

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Second Night

- Need to assess that feeding is going well
- Is baby feeding or hanging out?
- How does the baby act after coming off the breast/chest?
- Is baby's output normal for age?-amount/color
- Is weight WNL for age?-loss/gain/growth curve
- How can we help parents through second night?

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Common Problems Seen in the Hospital

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Sleepy Infant

- Is it the effect of labor & birth?
- Is it because of missed feeding cues which can be subtle?
- Is it the normal part of first 24 hours?
- Is it related to the gestational age of the baby?
- Is it because the baby is "non-compliant" with what WE think they should be doing?
- Are we more concerned than we need to be?

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Sleepy Infant

- When do we intervene?
- What do we do?
- Skin to skin!
  - Do not TRY to wake the sleepy baby
  - Down to diaper & put skin to skin
    - Some sleepy babies will latch on their own even without being woken up if you leave them alone
  - Allow to wake on their own
  - Gentle stimulation for a few minutes if at all

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Infants Who Are Not Latching

- Review the birth history
- Review what has happened to the infant since the birth
  - Separation
  - Stress
  - Hospital routines
  - Prolonged efforts at trying to get them to nurse
  - Waking to MAKE baby nurse
- Is baby trying to latch & can't figure it out?
  - Check mouth and frenulum

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Infants Who Are Not Latching

- Has Baby ever feed & how did it go?
- Has "laid back breastfeeding" been attempted?
- How long has baby been skin to skin?
- Are we waiting for baby readiness cues?
- Give hand-expressed colostrum
  - Buys some time
  - Gets some food in the baby
  - Stimulates milk production

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Infants Who Are Not Latching

- Tip #1 – You CANNOT MAKE a baby feed at the breast/chest just because…
  - "It's time"
  - "They should"
  - "It's been ___ hours"
- You CAN make a baby bottle feed
- Bottle feeding and feeding at the breast/chest are NOT the same thing
- Traditional bottle feeding often is an adult driven

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Infants Who Are Not Latching

- Tip # 2 – Keep birthing parents and babies SKIN TO SKIN
  - Want baby to fed? S2S with birthing parent
  - Want baby to sleep? S2S with support person
- Usually 30 minutes of S2S will trigger baby's feeding instincts
  - Keeping babies in the nursery and bringing them to parents to feed can hinder

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Infants Who Are Not Latching

- Tip # 3 – ROOTING
  - Baby MUST be rooting before they will latch effectively
  - Don't try to force baby to breast/chest
  - Place skin to skin for 30 minutes & wait for ROOTING

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Infants Who Are Not Latching

- Tip # 4 – Laid Back Positioning
  - Get parent & baby in comfortable laid back position
  - Use the baby's instincts!
- Tip # 5 – Dominant Hand Position
  - Teach parent how to use their dominant hand to latch baby
    - Use if "laid back" position isn't working

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- Tip #6 – Don't stress out the parent & baby
  - Be alert for signs of shutdown in both!
- Tip #7 – Express colostrum, feed with spoon
- Remember-Feeding at the breast/chest is biological, if a baby CAN'T latch – there is a problem and need to figure out what it is

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Infants Who Are Not Latching

- Outcome
  - Bottle feeding seems easier so parent often will quit and either pump or go to formula
    - The baby likes me better when I bottle feed them
    - It's such a relief just to have them eat and not fight with them

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Non-Latching Babies

- If baby not latching & feeding effectively at discharge
  - Teach hands on pumping
  - Encourage a good, hospital-grade pump if possible
  - Appointment to be seen w/n two days after d/c by both HCP & lactation specialist

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Make Feeding at the Breast/Chest Easier & Save You Time!!

- SKIN to SKIN
- WAIT until baby is AWAKE, ROOTING and READY to nurse
- Start with Laid Back Breastfeeding before you try a specific technique or position

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Other Common Hospital Concerns

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Sore Nipples

- Is it initial latch pain?
  - Should only last for a few seconds
- Is it pain all the way thru the feeding?
- Does the nipple look flattish after the feed?
- Is there trauma to the nipple?

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Sore Nipples

- Common causes
  - Poor or shallow latch
  - "Hanging out" for long periods of time because baby is "still sucking"
  - Tight frenulum, tight jaw

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Sore Nipples

- What to do about sore nipples
  - Identify the problem
    - Why are nipples sore?
  - Address the problem
    - Fix the cause

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Sore Nipples

- Helpful healing modalities
  - Coconut oil/Olive oil
  - Expressed milk
  - Lanolin?
  - Hydrogel dressings
  - Nipple shield ?
  - "Nipple Rest"

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Tongue Tie

- Can cause:
  - Sore nipples
  - Inability to latch
  - Poor/no weight gain
  - Low milk supply
- Evaluate for tongue tie before discharge
- Keep in mind it is the FUNCTION of the tongue, not the appearance that determines treatment

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The Late Preterm Infant

Senegal, West Africa

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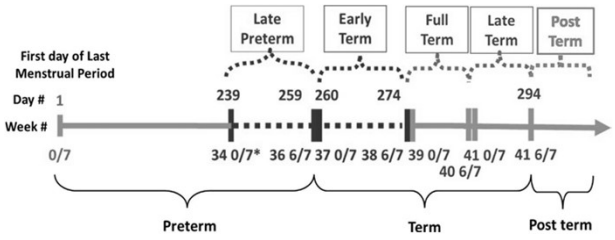

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The Late Preterm Infant

- May be unable to initiate and maintain milk supply
- May be AT the breast/chest, but not transferring milk due to ineffective suckling- The Great Pretenders!
- Even when parent has an abundant supply, baby may not be able to transfer what they need

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Late Preterm Infant Feeding Guidelines

- "Insurance" pumping
  - Go to the breast/chest as often as possible
  - PUMP 4-5 times/day for 10 minutes with a double electric breast pump for added stimulation
  - PUMP 8X/day to establish milk supply or if baby not feeding at the breast/chest
- Supplement baby with parent's milk obtained or donor milk if available
- Use of nipple shield may help infant transfer milk more effectively
  (Meier, 2007)

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Late Preterm at Home

- Lots of skin to skin
- Teach parent how to do it so they do not feel confined to couch/bed/chair
- Close follow-up

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Nipple Shields

- Appropriate size
- Make sure you know HOW to apply the shield and teach the parent how to apply it
  - Turn partially inside out
  - Nipple should be pulled into shield
  - Insurance pumping until baby is consistently taking full feed with the shield, growing well, and milk supply is established

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Early Postpartum Engorgement

- AKA Early PP engorgement
- Results from secretory activation (lactogenesis II)
- Increased blood & lymph circulate in the breast/chest
  - Needed for milk production
- Bilateral breast/chest tenderness/pain, firmness/swelling, and possibly warm to touch
- Typically occurs PP days 3-5
- Goal: Good management to keep the breast "happy"

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Tips to Prevent Engorgement

- Feed early & often
- Rooming in
- Deep latch with effective milk removal
- Feed at night
- Feed rather than use pacifier
- Give medically indicated supplements at the breast/chest if possible
- Proper use of the electric breast pump or hand expression when needed

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Recommendations for Primary Engorgement

- Anti-Inflammatory/Ibuprofen
- Ice
- Hand express or pump until tolerable not empty
- Reverse pressure softening /HE or use hand pump prior to attempting latch
- Lymphatic breast drainage

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Parental Concerns

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"I Need to Sleep"

- Primary concern through first months
- "When will baby sleep through the night?"
- "Please take him to the nursery so I can sleep"

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How Can We Help?

- Decrease interruptions on PP unit
- Cluster Care
- All concerns addressed and service offered:
  - Is there anything I can help you with?
  - Do you need anything for pain? More water? Help up to the bathroom?
  - Call me if you need me. Otherwise I'll be back in an hour to check on you.

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What About Guilt?

Columbus, Indiana

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Guilt

As health care providers, our responsibility is to provide current, evidence based information, support and help in ALL aspects of health care that impact our families

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Guilt

- Human milk feeding advocates have been accused of "making" parents feel guilty for wanting/needing/having to formula feed or supplement their babies

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Do We Hesitate….

- …to tell people the truth (or our opinions) about…
  - Car seats
  - Home births
  - Smoking
  - Obesity
  - Exercise
  - -Vaccinations
  - -Saturated fats
  - -Bedsharing
  - -Flossing

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Guilt

- Yes – some parents may feel guilty for not providing human milk – often because they KNOW human milk is best for the baby, but they simply DON'T. WANT. TO.

124

Guilt

- And sometimes, what feels like guilt is actually grief -- grieving a lost feeding experience when things don't go as expected

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The Real Question Is…

- Are parents just given a list of "rules" and then simply told to "try harder?"
  - Just feed more often or frequently
  - Just pump more often or frequently
  - "If you really wanted this to work, you would make it happen."

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The Worst Kind of Parental Guilt?

- Regret – "I wish I had known . . . ."
- Giving factual, evidence based information and appropriate help/support does not place blame or cause feelings of guilt

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So…Our Responsibility is:

- … to tell families the facts and the truth about why human milk feeding is important – for parent and baby!
  SHARE THE EVIDENCE
- …to give current information on the "how to" and where to get help
- …to help families to make the best decisions they can for themselves and their baby based on the evidence
- …to help them know they have the right to expect support and acceptance from HCPs to meet their goals

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