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Owner	Shannon Rodgers: Interim Assistant Director of Birth Center
Area	Birth Center
Applicability	Marshall Medical Patient Care

POLICY: Infant Feeding Policy

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PURPOSE

A. To promote a philosophy and practice of mother-baby care that supports optimal infant feeding and care, and increases the initiation, duration, and exclusivity of breastfeeding.

B. To encourage and promote a positive breastfeeding experience for mother and baby while respecting the role of cultural influences.

C. To support the training received by health care staff by defining actions necessary to promote exclusive breastfeeding and maternal infant attachment, and by providing the skills necessary to implement this policy.

PHILOSOPHY

This facility does not promote the use of breast milk substitutes and upholds the World Health Organization (WHO) International Code of Marketing of Breast Milk Substitutes. No pregnant women, mothers or families are given marketing materials, samples or gift packs by the facility that consist of breast milk substitutes, bottles, nipples, pacifiers or other infant feeding equipment or coupons for the above items.

POLICY

Step 1A– Comply fully with the International Code of Marketing of Breast milk Substitutes and relevant World Health Assembly resolutions.

1a. Any product under the Code that may be needed by the institution will be bought at fair market value. (American Academy of Breastfeeding Medicine) [ABM7]

1b.This institution promotes breastfeeding considering that it is the biological norm for the human mother and infant (dyad) and that artificial feeding and early weaning carries considerable maternal and infant health risks. [ABM7]

1c. Educational materials (including posters, applications, written handouts, etc.) with company logos from manufacturers or distributors of breast milk substitutes, feeding bottles, artificial nipples, and pacifiers directed to staff, pregnant women, or mothers are prohibited. (Baby Friendly USA)[BFUSA]

1d. Employees of manufacturers or distributors of breast milk substitutes, feeding bottles, artificial nipples, and pacifiers have no direct or indirect contact with pregnant women and mothers.

1e. The facility and any affiliated prenatal clinics do not receive free gifts, non-scientific literature, materials, promotional items, equipment, money, or support for breastfeeding education or support/sponsorship for events/meetings from manufacturers of breast milk substitutes, feeding bottles, artificial nipples, and pacifiers.

1f. No pregnant women, mothers, or families are given marketing materials or samples or gift packs by the facility that consist of breast milk substitutes, feeding bottles, artificial nipples, pacifiers, or other infant feeding equipment or coupons for the above items.

1g. Any educational materials distributed to pregnant women and breastfeeding mothers are free from messages that promote or advertise infant food or drinks other than breast milk feeding bottles, artificial nipples, and pacifiers (except safe sleep and Sudden Infant Death Syndrome [SIDS] reduction materials, which must comply with the requirements of Criterion 9.2.1).

1h. This institution does not give group instruction on formula and infant feeding bottle use. [BFUSA]

Step 1B– Have a written infant feeding policy that is routinely communicated to staff and parents.

1i. All direct care staff and direct care physicians/other licensed practitioners that provide prenatal, delivery and/or newborn care will receive appropriate orientation to the implementation of this policy within the first 12 weeks after hiring. [BFUSA]

1j. Minimally, every 2 years, to sustain safe and effective care, policy reviews/updates will be provided to direct care staff and direct care physicians/other licensed practitioners. [BFUSA]

Step 1C– Establish ongoing monitoring and data-management systems.

1k. The multidisciplinary committee will be composed of representatives of decision makers in the areas of maternal and newborn health, quality assurance and management, other licensed practitioners/physicians, nurses, midwives, lactation specialists, and other appropriate staff. [ABM7]

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1l. The multidisciplinary team will assess implementation of the policy and determine how often to assess institutional compliance with the policy. Committee members will define actions needed to remain compliant with the policy [ABM7 and BFUSA].

1m. The facility will routinely track breastfeeding and mother-infant care indicators and policy implementation will be in place to continually monitor and improve quality of perinatal care. Incorporation of breastfeeding indicators into the facility quality-improvement monitoring system is mandated. [ABM7]

- Early initiation of breastfeeding and exclusive breastfeeding are considered sentinel indicators and are routinely tracked. [ABM7]
- Other indicators for monitoring of key clinical practices are tracked and reported to the multidisciplinary committee and BFUSA, as needed. [BFUSA]

1n. The multidisciplinary committee will meet at least every 6 months (more frequently when the data indicates practices are below the expected metrics) to review monitored data. [BFUSA]

Step 2 – Ensure that staff have sufficient knowledge, competence, and skills to support breastfeeding.

2a. The Birth Center Director and Lactation Department are responsible for the development and oversight of the *Direct Care Staff and Direct Care Physician/Other Licensed Practitioner Competency Verification and Training Plan.* [BFUSA]

2b. The Birth Center Lactation Department and the Birth Center Director are responsible for ensuring that all direct care staff and direct care physicians/other licensed practitioners have had all training and competencies verified. [BFUSA]

2c. All direct care physicians/other licensed practitioners with privileges to provide care in labor and delivery, postpartum, and newborn units will have sufficient knowledge, competence, and skills in the required competencies listed in the *Baby-Friendly USA Guidelines and Evaluation Criteria-Appendix C.* [BFUSA]

2d. All facility-based direct care staff working in labor and delivery, postpartum, and newborn units who provide care will have sufficient knowledge, competence and skills in the required competencies listed in the *Baby-Friendly USA Guidelines and Evaluation Criteria-Appendix C.*[BFUSA]

2e. Direct care physicians/other licensed practitioners requiring assessment, training, and verification of applicable competencies are identified.

2f. All direct care staff/direct care physicians/other licensed practitioners who provide education on infant feeding and maternity care practices to pregnant women within the affiliated prenatal services will have sufficient knowledge, competence, and skills in the required competencies listed in the *Baby- Friendly USA Guidelines and Evaluation Criteria-Appendix C.* [BFUSA]

2g. All staff who assist mothers with infant feeding will have sufficient knowledge, competence,

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and skills in the required competencies listed in the *Baby-Friendly USA Guidelines and Evaluation Criteria-Step 2.*

2h. Minimally, every 2 years, this facility provides in-service training and competency assessments with appropriate content to ensure that skills and knowledge are current and consistent information and care are provided to pregnant women and mothers. [BFUSA]

2i. The lactation department keeps documentation of competency verification and training. [BFUSA]

2j. All competencies and necessary remedial training will be verified within 6 months of hire and as needed. [BFUSA]

Step 3 – Discuss the importance and management of breastfeeding with pregnant women and their families.

3a. Physicians/other licensed practitioners and staff that have had competencies verified ensure that all pregnant women receiving care at the affiliated prenatal services will be offered personalized prenatal breastfeeding support and education tailored to their concerns and needs. [ABM7]

3b. Prenatal education will include all the following topics:

- The importance of breastfeeding
- Global recommendations:
    - Exclusive breastfeeding for the first 6 months
    - The risks of giving formula or other breast-milk substitutes
- Breastfeeding continues to be important after 6 months when other foods are given
- The basics of good positioning and attachment
- Recognition of feeding cues
- The importance of immediate and uninterrupted (sustained) skin-to-skin contact
- The importance of early initiation of breastfeeding
- The importance of rooming-in

3c. The education provided at each prenatal visit will be documented in the patient's medical record. [BFUSA]

3d. Prenatal breastfeeding education classes will be offered to all pregnant women. [BFUSA]

3e. There is a written curriculum that includes all of the key topics recommended in the U.S. Baby-Friendly *Guidelines and Evaluation Criteria-Appendix A.* [BFUSA]

3f. The Education Department will offer Prenatal Breastfeeding Classes. The Health Educator and Lactation Department are responsible for developing, implementing, evaluating and revising the education curriculum and plan.

3g. This facility fosters the development of community-based programs that are available for

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individual counseling or group education on breastfeeding and collaborates with community-based programs to coordinate breastfeeding messages.

3h. Staff at this facility have provided to other organizations that offer prenatal services a sample curriculum that includes essential information to be taught to the pregnant woman regarding breastfeeding. In addition, members of the staff participate in the local breastfeeding coalition. [BFUSA]

Step 4 – Facilitate immediate and uninterrupted skin-to-skin (STS) contact and support mothers to initiate breastfeeding as soon as possible after birth.

4a. Regardless of feeding choice, all well and alert newborns will be placed prone on mother's bare chest, naked, immediately after birth. They will then be thoroughly dried (except hands), a diaper placed (if mother desires), and covered with a warm blanket to contain mother's heat. [ABM7]

4b. Following a **vaginal birth**, STS will begin immediately, unless there are documented medically justifiable reasons for delayed contact. [BFUSA]

- Following a **cesarean birth,** STS will begin when safe and feasible (minimally, following a cesarean birth, STS will begin in the recovery room when mother is responsive and alert), unless there are documented medically justifiable reasons for delayed contact. [BFUSA]

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4c. The initial period of STS contact will continue uninterrupted for at least 1 hour **and** through the completion of the first feeding (if breastfeeding), or for at least one hour if not breastfeeding, unless there are documented medically justifiable reasons to interrupt contact. [BFUSA]

4d. Staff must make frequent and repetitive assessments of the mother-infant dyad, including observation of newborn breathing, activity, color, tone, and position. (American Academy of Pediatrics) [AAP]

4e. All mothers and all newborns able to breastfeed shall be supported to breastfeed as soon as possible within the first 1 to 2 hours of birth. Help will be offered to facilitate the infant's first latch if the infant does not latch spontaneously in the first 1 to 2 hours, or at the request of the mother. [ABM7]

4f. APGAR scores will be performed with the infant STS. The infant's measurements, vitamin K administration, ophthalmic prophylactic antibiotics, and hepatitis B vaccine administration will be delayed until completion of first feeding or after the initial first hour of STS contact (if formula feeding). [ABM7]

4g. STS will be encouraged throughout their hospital stay for all mothers and newborns whenever stability of mother/infant allows. [BFUSA] Family members may also participate in skin-to-skin care, though skin-to-skin with mother is the priority to promote cue-based feeding.

4h. Time of initiation and end of STS shall be documented in the medical record. [BFUSA]

4i. If a delay or interruption of initial STS is necessary, staff will ensure that mother and infant receive STS as soon as clinically possible. [ABM7]

Step 5 – Support mothers to initiate and maintain breastfeeding and manage common difficulties.

5a. Every mother shall be offered as much help as needed with breastfeeding. Trained staff will observe carefully the first breastfeeding sessions, looking for signs of effective latch, position, and effective feeding. If everything goes well, they will not intervene. If improvement is needed, the mother will first be gently shown how to improve the latch and positioning herself and avoid having the staff do it for her. At-risk mothers (complicated and Cesarean deliveries, obese, adolescents, patients with tobacco use, lack of partner support, intimate partner violence) will have tailored extra help. [ABM7]

5b. Mothers identified prenatally or soon after delivery, as at risk of delayed lactogenesis II, will be assigned to special help as deemed appropriate. A feeding plan and close follow-up of the infant (for adequate hydration and nutrition besides help with expression) will be offered. At discharge, continuum of care will be ensured with a feeding plan and close follow-up. See Appendix A. [ABM7]

5c. Trained staff will observe and document at least one feed every shift until discharge and, with each staff contact with the mother whenever possible. Positioning, latch, milk transfer, infant's output frequency and characteristics, jaundice and infant's weight, and any feeding problem will be recorded in the clinical history. [ABM7]

5d. Mother and infants with identified risk factors must receive individualized care, including close observation and frequent assessments. [BFUSA]

5e. Postpartum education includes teaching the mothers all the key educational points listed below:

- How to breastfeed in a comfortable position without pain
- Signs of an adequate latch, swallowing, and milk transfer [ABM7]
- How to ensure and enhance milk production and let down [ABM7]
- Why and how to hand express colostrum/breastmilk and that obtaining only a few millimeters is within normal expectations during the first episodes of milk expression and does not signify low milk production [ABM7]
- Storage and handling of breast milk
- Recognize signs of undernourishment or dehydration in the infant and warning signs for calling a health professional including:
    - Infant: usually not waking for more than 4 hours or, always awake or, never seeming satisfied or, more than 12 feeds per day, or no signs of swallowing with at least every 3 to 4 sucks, too few wet/heavy or soiled diapers per day, fever [ABM7]
- The importance and maintenance of exclusive breastfeeding for the first 6 months

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[BFUSA]

- Management of common problems such as engorgement and sore and cracked nipples will be discussed prior to discharge [BFUSA]
- Recognize warning signs for calling a health professional including:
    - **Infant:** usually not waking for more than 4 hours or, always awake or, never seeming satisfied or, more than12 feeds per day, or no signs of swallowing with at least every 3 to 4 sucks, too few wet/heavy or soiled diapers per day, fever
    - **Mother:** persistent painful latch or, breast lumps, breast pain, fever, doubts with milk production, aversion to the child, profound sadness, and any doubt with breastfeeding self-efficacy [ABM7]

5f. Education will be documented in the medical record. [BFUSA]

Mother-Infant Separation or Neonatal Intensive Care Unit (NICU) transfers

5g. Mothers that are exclusively breast milk feeding, mothers of preterm infants on the postpartum unit, and mothers who are separated from their infants will be helped to start expressing within the first 6 hours after birth. This should preferably take place within 1 to 2 hours of birth and at completion of initial skin-to-skin contact unless there is a justifiable reason to delay initiation of expression. [BFUSA]

5h. Mothers will be supported and encouraged to pump at least 8 times in 24 hours to ensure an adequate milk supply. [BFUSA]

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Step 6 – Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.

6a. The process for supporting breastfeeding conversations with mothers who request breast milk substitutes as follows:

- Mothers who ask for supplementation when not medically indicated will have their reasons listened to and explored.
- A careful assessment of breastfeeding will be offered, and the risks of supplementing will be discussed with mothers. [ABM7] *This counseling conversation only needs to be provided once at first request.
- Staff will empower the mother's informed decision by listening to her specific concerns and personalizing the conversation to answer any concerns regarding the following evidence-based information:
    - Importance of exclusive breastfeeding
    - Possible risk factors that could influence health outcomes with the introduction of breast milk substitutes
    - Possible impacts to the success of feeding

6b. Informed mother decisions on supplementation with formula will be honored and documented in the medical record. [BFUSA]

6c. Contraindications to breastfeeding and medical indications for supplementation with breast milk substitutes for healthy, term infants are addressed in **Appendix B**. Medical indications for supplementation with breast milk substitutes for preterm infants being cared for on the postpartum unit are addressed.

Administration of the supplemental feeding is as follows:

- Preferred order will be colostrum/mother's own milk, pasteurized donor human milk, ready mixed formula, and powdered or concentrated formula mixed with clean water. [ABM7]
- Medically indicated supplements will not be given without a medical order. [BFUSA]
- Medical indications for supplementation will be documented in the clinical record. [BFUSA] **See Appendix B**

6d. The process for supporting conversations with mothers that state they have no plans to breastfeed is as follows:

- Mothers who report that they have chosen not to breastfeed when there is no medical indication will have their reasons listened to.
- A careful assessment will be made to explore challenges. If appropriate, options will be offered specific to her concerns.
- Staff will empower the mother's informed decision by supporting her and personalizing the conversation to answer any concerns regarding the following evidence-based information:
    - Importance of breastfeeding
    - Possible risk factors that could influence health outcomes when feeding breast- milk substitutes [BFUSA]

  * The counseling conversation only needs to be provided once at first request.

6e. Informed mother's decisions will be honored and documented in the medical record. [BFUSA]

6f. The process for supporting mothers who feed their infants breast milk substitutes is as follows:

- **Verbal education** is provided to mothers.
- Safe preparation, feeding, handling, and storage of breast milk substitutes will be individually taught to families who are feeding their infants any formula and plan to continue post-discharge, and **written instructions** will be given. [ABM7]

6g. Safe preparation, feeding, and storage of formula education includes teaching the mothers all the key educational points listed below and will be individualized and based on the recommendations in the *Baby-Friendly USA Guidelines and Evaluation Criteria-Appendix A:*

- Appropriate hand hygiene
- Cleaning infant feeding items/workspace surfaces

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- Appropriate and safe reconstitution of concentrated and powdered infant formula
- Accuracy of measurement of ingredients
- Safe handling of formula
- Proper storage of formula
- Appropriate feeding methods
- Powdered infant formula is not sterile and can cause illness in infants younger than 3 months old

6h. Staff will provide anticipatory guidance to mothers who are feeding their infants breast milk substitutes.

- Preventative steps to minimize engorgement (if mother plans to exclusively formula feed)
- Signs/symptoms of infant feeding issues requiring referral to a qualified physician/ other licensed practitioner

6i. Education will be documented in the medical record. [BFUSA]

6j. If a parent makes an informed choice to use breast milk substitutes, infants will only receive infant formula provided by the hospital. In the event a family brings in formula from home, they will be advised against using it and it will not be prepared or fed by staff. Education will be documented in the medical record. Any consumption of non-hospital provided formula will also be documented on medical record as parental formula choice against medical advice.

Step 7 – Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.

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7a. The description of safe rooming-in includes:

- In this institution, we recognize and facilitate the need for all mothers and healthy babies to remain together 24 hours per day (rooming-in) for their mutual well-being, regardless of parent's feeding choice, or delivery method and if necessary, there will be no more than a one hour per 24-hour period of separation.
- Staff is responsible for increased surveillance of mother-infant dyads that have been identified at a higher risk. [ABM7]
- Safe rooming-in practices training to prevent infant falls and suffocation incidents will be regularly offered to families. [ABM7]
- Breastfeeding mothers and families will be educated on the physiology of lactation that can lead to hormonally driven sleepiness and the importance of transitioning the newborn to a safer sleep surface for sleep. [AAP-BFUSA]
- All routine procedures, assessments, newborn screens, immunizations, hearing screens, and routine laboratory draws shall be performed at the mother's bedside. [ABM7]

7b. Documentation of interruption of rooming-in will include the reason for interruption, location of infant during interruption, time parameters for interruption, and infant feedings

during the separation. Rooming-in will be reinstated as soon as the reason ceases. [ABM7]

7c. Process of supporting conversations with mothers who request their infants be taken to the nursery is as follows:

- Whenever parents request their infant be kept apart from them, their reasons for such care will be listened to.
- A careful assessment will be made to explore challenges. If appropriate, solutions will be offered to safely avoid separation.
- Staff will empower the mother's informed decision by supporting her and personalizing the conversation to answer any concerns regarding the following evidence-based information:

  o Importance of rooming-in

  o If breastfeeding, a plan to support the exclusivity of breastfeeding will be developed [BFUSA]

7d. Informed mother decisions will be honored and documented in the medical record. [ABM7]

Step 8 – Support mothers to recognize and respond to their infants' cues for feeding.

8a. Mother education regarding feeding infants on cue is as follows:

- Hospital staff will ensure that all mothers, regardless of delivery method or feeding choice, know how to respond to their infant cues for feeding, closeness, and comfort. [ABM7]
- No restrictions will be placed on the frequency or length of breastfeeding. [ABM7]
- Mothers will be taught that *after the first 24 hours of life:*
  - Infants need to breastfeed at least 8 times per day, and many need more frequent feedings.
  - Cluster feedings (several feeds close together) are common in the first 24 to 36 hours and may stimulate breast milk production. They are not a sign of insufficient milk and supplementation is not required. Later, they may signal insufficient milk transfer. [ABM7]

8b. Education will be documented in the medical record. [BFUSA]

8c. Encourage breastfeeding ad libitum and on demand. However, it may be necessary to wake the infant if he or she does not indicate hunger cues within 4 hours of the previous feed, particularly in the late preterm infant. [ABM10]

Step 9 – Counsel mothers on the use and risks of feeding bottles, teats, and pacifiers.

9a. Pacifiers, artificial nipples, or teats will not routinely be used nor routinely offered to healthy breastfeeding infants. [ABM7]

9b. The process of educating all breastfeeding mothers on the proper use or avoidance of pacifiers, feeding bottles and artificial nipples includes:

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- The effects of pacifiers and artificial nipples on breastfeeding and why to avoid them until lactation is established. [ABM7]
- As a risk reduction measure for SIDS/Sudden Unexpected Infant Death (SUID), once breastfeeding is well established, a pacifier may be offered at naptime and bedtime. [BFUSA]

9c. The education will be documented in the medical record. [BFUSA]

9d. Breastfeeding will be the preferred soothing method for any breastfed infant undergoing a painful procedure. Pacifiers will be given for pain soothing during a procedure, only if breastfeeding is not possible and will be discarded after the procedure. [ABM7]

9e. Administration of the supplemental feeding has been addressed, including:

- Mothers will be encouraged to express colostrum or milk directly into the infant's mouth or to feed by alternative methods other than bottle/artificial teats (a cup, finger, syringe, or a spoon are preferred). Supplementing through tubing at chest may help stimulate the mother's breast while feeding the infant. [ABM7]
- Instructions given to mothers regarding how to administer the supplement including chosen method.

9f. Documentation will be recorded in the clinical record. [BFUSA]

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Step 10 – Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

10a. The process for community follow-up for breastfeeding dyads includes:

- Before discharge, the health care team will ensure that breastfeeding mothers are able to effectively breastfeed their infants and that continuity of care is guaranteed, either by follow-up visits or by arranging qualified primary care physicians/other licensed practitioners and/or lactation specialists visits, and/or support groups or peer counseling contacts. [ABM7]

10b. Prior to discharge, staff will coordinate ongoing support and care for all dyads:

- Written and/or electronic materials and verbal instructions regarding ongoing support and care will be provided to all mothers prior to discharge. [BFUSA]
- Contact information will be provided for all dyads on how to access local support groups or other breastfeeding support community resources after discharge. [BFUSA]
- All mothers will be provided with instruction to schedule a visit within 3 to 5 days of birth **and** within 48 hours to 72 hours after discharge with a skilled professional to evaluate feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction. [AAP]
- Mothers must be able to recognize maternal <u>and</u> infant warning signs that must receive urgent evaluation along with contact information for health professionals. [BFUSA]
- If the infant is still not latching or feeding well at the time of discharge, a written

individualized feeding plan will be devised and depending on the dyad's clinical situation and resources, the infant's discharge may be delayed. Whenever needed, a visit for specifically following up on feeding issues will be arranged. [ABM7]

- Mothers identified prenatally or soon after delivery, as at risk of delayed lactogenesis II, will be assigned special help as deemed appropriate. A feeding plan and close follow- up of the infant (for adequate hydration and nutrition besides help with expression) will be offered. At discharge, continuum of care will be ensured with a written feeding plan and close follow-up. [ABM7]

APPENDIX A

Risk Factors for Delayed or Failed Lactogenesis II or Low Milk Supply

Maternal factors

- Age greater than 30
- Primiparity .
- Breast problems: insufficient glandular tissue, flat or inverted nipples, history of breast surgery
- Delivery problems: Cesarean delivery (especially if unplanned), complicated delivery, significant hemorrhage, prolonged labor, preterm delivery (less than 37 weeks), retained placenta
- Postpartum depression
- Metabolic problems: Diabetes (gestational, types 1 or 2), hypertension, preeclampsia, polycystic ovary syndrome, obesity (pre-pregnancy) (BMI greater than 30), high cortisol levels, hypothyroidism, extreme tiredness, and fatigue or stress
- Poor or painful latch / restricted feedings
- Previous low supply
- Prelacteal feeds (the administration of any substances other than breast milk to newborn babies during the first 3 days after birth)
- Tobacco and some drugs and medications may cause low milk supply
- Delayed Lactogenesis II is defined as little or no maternal perception of breast fullness or leaking at least 72 hours post-birth

Infant factors

- Prematurity (less than 37 weeks)
- Early term birth (37 to 39 weeks)
- Low birth weight (less than 2,500g)
- High birth weight (greater than 3,600g)

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- Infant Apgar less than 8

APPENDIX B

Potential Contraindications to Breastfeeding

- Ebola Virus: suspected (until ruled out) or confirmed maternal Ebola virus.
- Herpes virus: Mothers with active herpetic lesions on the breast(s) should not breastfeed from the affected breast but may breastfeed from the unaffected breast. Milk can be pumped from the affected breast, as there is no concern of hematologic transmission through the milk itself. However, milk can become contaminated via the breast pump, and thus should any part of the breast pump come in contact with herpetic lesions, that milk should be discarded. In this case, expression with discarding of milk should be encouraged to maintain milk supply until breastfeeding is resumed.
- HIV infection – Refer to CDC Contraindications to Breastfeeding or Feeding Expressed Breast Milk to Infants webpage
- HLTV I and II infection
- Current use of illicit drugs
- Varicella: if there is onset of Varicella within 5 days before or up to 48 hours after delivery, separation of the mother and infant with feeding of expressed milk until mother is no longer contagious is recommended, with administration of Varicella-Zoster Immune Globulin to the infant as soon as possible. Avoid close contact with skin lesions. (For older infants, separation of the mother and infant is not recommended, as the mother was contagious prior to the appearance of skin lesions and thus the infant was already exposed.) Expert consultation is advised.
- Brucella: untreated maternal brucellosis.
- Tuberculosis: Mothers with active, untreated pulmonary tuberculosis (until no longer contagious: 15 days of treatment), should not breastfeed but infant can be given mother's own expressed milk. However, unless the diagnosis has been made in the 15 days pre-delivery, the infant will have been exposed by the time of the diagnosis and must receive prophylaxis with isoniazid. There might thus be no reason to separate them if the infant is already being treated. Expert consultation is advised.
- Medications: treatment with some medications such as chemotherapy, temporary or permanent cessation of breastfeeding may be advised. Check with LactMed, InfantRisk.com, or e-lactancia, Lactation Study or other local available accurate resources.

Infant's conditions

- Galactosemia (except for Duarte variant, in which partial breastfeeding is possible)
- Congenital lactase deficiency

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Possible Medical Indications for Supplementation

Infant indications

- Asymptomatic hypoglycemia, documented by laboratory blood glucose measurement (not bedside screening methods) that is unresponsive to appropriate frequent breastfeeding. [*parameters defined or referred to specific policy]*
- Symptomatic hypoglycemia infants
- Signs or symptoms that may indicate inadequate milk intake:
    - Clinical or laboratory evidence of significant dehydration (e.g., high sodium, poor feeding, lethargy, etc.) that is not improved after skilled assessment and proper management of breastfeeding.
    - Term: Weight loss greater than 75th percentile for age, however, a thorough evaluation is required before automatically ordering supplementation.
    - Late Preterm/Early Term: Excessive weight loss greater than 3% of birth weight by 24 hours of age or greater than 7% by day 3 merit evaluation.
- Delayed bowel movements, fewer than four stools on day 4 of life, or continued meconium stools on day 5
- Hyperbilirubinemia [*parameters defined or referred to specific policy]*
- Breast milk jaundice: first line diagnostic management should include laboratory evaluation, instead of interruption of breastfeeding.

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Maternal indications

- Delayed secretory activation
- Primary glandular insufficiency
- Breast pathology or prior breast surgery resulting in poor milk production
- Temporary cessation of breastfeeding due to certain medications (e.g., chemotherapy) or temporary separation of mother and baby without expressed breast milk available.
- Intolerable pain during feedings unrelieved by interventions.

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Approval Signatures

Step Description	Approver	Date
CNO	Cynthia Rice: CNO	11/2024
Standards Coordinator	Janice Weaver: Standards Coordinator	11/2024
Executive Director of Specialty Nursing Services	Nicole Lamm: Executive Director of Specialty Nursing Services	10/2024
Assistant Director-Birth Center	Jacqueline Rad: Assistant Director - Birth Center	10/2024
	Jacqueline Rad: Assistant Director - Birth Center	10/2024

Applicability

Marshall Medical - Patient Care