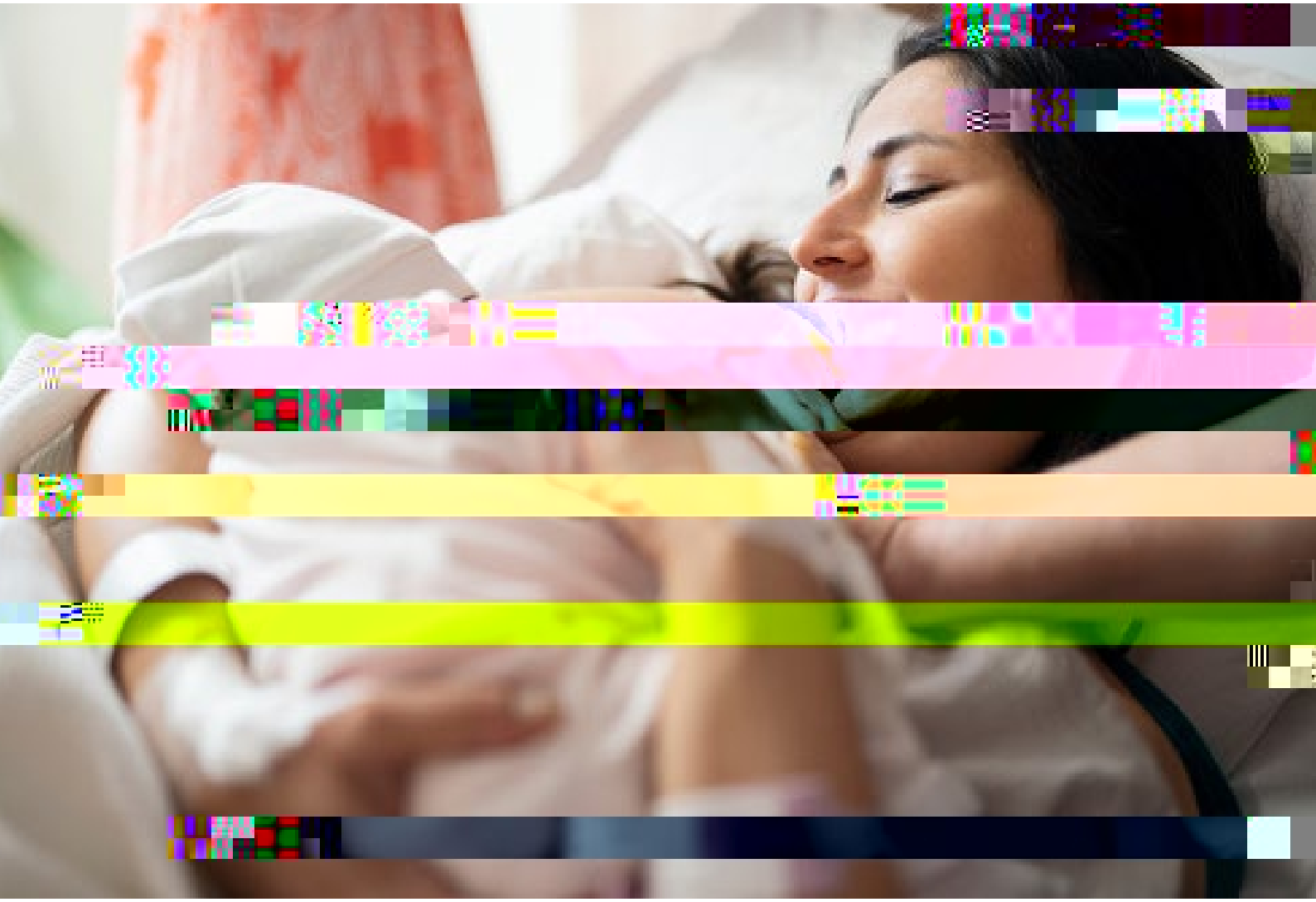
Promoting Optimal Breastfeeding in Children's Wards and Departments



The Royal College of Nursing would like to acknowledge the team led by Professor Alison Twycross who developed the original document and thank all of those who were involved in updating this guidance in 2019:

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Professor Dave Clarke, Associatec0o ())]TJ8dgv.1 (v)5 (s)]TJ0. (a, S8 (i)9..6 (t)25.6 (e)-1l, Aol (n 2)-3.5 (n)2.

The RCN unequivocally endorses the recommendations from the World Health Organization (WHO, 2003) that exclusive breastfeeding is the optimal means of infant feeding for the first six months of an infant's life. After this, to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond. This and subsequent WHO guidance recognises the health benefits of

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Step 1 (a, b, c): An up-to-date written breastfeeding policy which is routinely communicated to all health care staff, and provide health care staff with training to acquire the skills necessary to implement this policy.

To help units, wards and departments adhere to the 10 steps each hospital /care setting where infants are cared for should ensure that they have an updated written breastfeeding policy. To avoid disparity and confusion the breastfeeding policy should be formulated by the children's units in conjunction with the hospital's maternity services (where relevant) to ensure continuity of advice and practice. This policy should

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Step 3: Sustaining and supporting choice - support mothers in their choice of feeding method, and assist them in establishing and maintaining breastfeeding

Health care staff need to support mothers in their choice of feeding method and assist them in establishing and maintaining breastfeeding. This includes upon the mother's or her infant's admission to hospital, staff having a discussion with the parents regarding their chosen method of feeding and the current feeding history. This detail needs to be recorded in the infants or mothers care plan commensurate with the NMC Code (NMC, 2018).

During admission, the breastfeeding mother should have information to support breastfeeding and access to trained staff (throughout the hospital and community services) or to counsellors with specialist knowledge in breastfeeding management (NICE, 2008). The National Childbirth Trust, La Lèche League and the Association of Breastfeeding Mothers provide trained breastfeeding counsellors. Combined support was particularly effective in areas where initiation and continuation of breastfeeding were not high (Britton, McCormick, Renfrew et al., 2007). The Breastfeeding Network (**www.breastfeedingnetwork.org.uk**) offers peer support from trained volunteers to support breastfeeding.

Where an infant's parents have chosen not to breastfeed or when breastfeeding is contra-indicated, healthcare professionals can refer to First Steps Nutrition, an independent charity offering nutrition advice (**www.firststepsnutrition.org**).

Quality information - provide parents with written and verbal information about the benefits of breastfeeding and breast milk:

Trained staff, provided by the hospital or community services, should be available to breastfeeding mothers to discuss the benefits of breastfeeding and good breastfeeding management. All written information describing the benefits of breastfeeding and good breastfeeding management practices should be readily available and translated as necessary (NICE, 2008). A designated person within the children's unit will need to ensure that these materials are updated each year. Staff providing this advice should have knowledge of the wide range of breastfeeding benefits outlined earlier in this guidance, including: nutritional benefits; comfort; pain relief; protection against infection.

All staff need to be aware of and adhere to the (WHO, 1981) and avoid using documentation that promotes the use of breast milk substitutes. These will include the use of pens, posters, calendars, height charts and other promotional materials with recognisable logos. Health care staff may occasionally need to provide impartial information about breast milk substitutes to parents as needed (NICE, 2008 and RCN, 2013).

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Step 4/5/6: The environment - provide mothers with the environment and facilities which meet their needs for privacy, information and appropriate nutrition

Mothers need to be provided with a supportive environment conducive to breastfeeding regardless of the reason for her being in a health care recommendation relates as much to out-patients departments and X ray departments as much as any other. All wards and departments need to provide breastfeeding mothers with facilities which will meet the mothers' need for privacy and maintain her dignity.

Resident mothers of sick children need to be provided with relevant information and education to sustain breastfeeding. The resident breastfeeding mother ndres ao beduonrs ndent m (r0 0 document is provided in

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Step 9: Feeding techniques and use of teats and pacifiers - use alternative techniques conducive to breastfeeding if an infant is unable to feed at the breast

Health care staff need to use alternative feeding techniques conducive to breastfeeding when an infant cannot feed at the breast, these should be discussed and agreed with the parents. Bottles should never be given to breastfed infants without the explicit consent from the parents. Alternative feeding techniques should, where possible, replicate the physical and emotional feeling of breastfeeding, Techniques such as skin to skin and responsive feeding are useful and further information can be found at: **http://attachmentparenting.co.uk/responsive-bottle-feeding/**. Feeding options include bottle and teat, cup, spoon and nasal/oral gastric tube and the staff should be sufficiently skilled to either perform the feed themselves or teach and support the parents to feed their infant. Unless clinically prohibited because of maternal medication or the infants condition the use of expressed breast milk would remain the feed of choice. If expressed breastmilk is not available donor breastmilk would be the next preferred choice.

Dummies are constructed of latex or silicone and elicit a reflexive sucking action in the infant which can be distracting and soothing. They can also be called pacifiers or soothers; the terms would seem to be interchangeable. Some studies have recommended that dummies should only be given to infants if they are medically indicated and following discussion with the parents (WHO, 1989; Joanna Briggs Institute, 2006). However, dummies interfere with feeding cues and alter the feeding action. Some works have challenged that a dummy will have a detrimental effect on breastfeeding (Bu'Lock, 2004; Cinar, 2004; Haycock and Greenough, 2007). Consequently, health care staff need to be sufficiently knowledgeable to discuss the benefits and the detriments of using dummies

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Contraindications to breastfeeding are few and rare, infant factors may include: some inborn errors of metabolism; challenges to successful breastfeeding caused by sucking difficulties such as tongue tie (NICE, 2005) or cleft lip can be managed by careful positioning. Prematurity is not a contraindication to breastfeeding. NICE (2010) have made it clear in their quality statement that mothers of infants receiving specialist neonatal care are to be supported to start and continue breastfeeding, including being supported to express milk (NICE, 2010). This milk can be stored using elements from the same good practice that applies to donor milk (NICE, 2010). Kangaroo skin-to-skin contact, peer support, simultaneous breastmilk pumping, multidisciplinary staff training and the award of the Baby Friendly accreditation of the associated maternity hospital have been shown to be effective and cost effective (Renfrew, Craig, Dyson, McCormick et al., 2009). If insufficient breast milk is suspected the mother and infant should be assessed by a trained breastfeeding advisor. If it is confirmed that there is insufficient milk (which is rare) or the dietician or medical team consider that that the breastmilk contains insufficient calories for growth, special 'fortifiers' can be added to expressed breast milk. It should be noted that fortifiers are derived from cows milk and may be contraindicated in some cases. This should be done in such a way that the mothers confidence in her ability is not undermined and supplementation with this fortified milk can be combined with natural breastfeeding. When used these fortifiers must be added as close to the feed times as possible and using a safe aseptic non-touch technique (GOSH clinical guideline, 2011). This way the infant can continue to receive the additional benefits of breastfeeding and breastmilk with the additional calories.

Nurses who prescribe or dispense drugs to breastfeeding mothers should consult supplementary sources to ensure the infants safety (see the Drug and Lactation Database in the links section) and should discuss the benefits and risks associated with the prescribed medication and encourage the mother to continue breastfeeding, if reasonable to do so. In most cases, it should be possible to identify an alternative and suitable medication which is safe to take during breastfeeding by analysing pharmokinetic and study data.

Breastfeeding should never be stopped abruptly, mothers who are unwell and receiving medication contraindicated to breastfeeding should not routinely stop breastfeeding but could consider expressing their milk as lactation and breastfeeding once stopped is very difficult to recommence.

The current WHO recommendations on HIV and infant feeding stated that mothers living with HIV should exclusively breastfeed for six months and may continue breastfeeding for up to two years or longer (similar to the general population) while being fully supported for Antiretroviral Therapy (ART) adherence (WHO, 2016). This reflects the fact that there are areas in the world where the risks from formula feeding are higher than the risks to the infant from HIV transmission through breastmilk (Fawzy, Arpadi, Kankasa et al., 2011; Kafulafala, Hoover, Taha et al., 2010).

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However, in 2014 the British HIV Association provided an interim review and continued to recommend that in the UK mothers known to be HIV positive, regardless of ART, should be advised to exclusively formula feed from birth. There have also been advocates for providing free formula milk to families so adverse social factors do not increase the risks of transmission (House of Lords, 2011).

The differences in guidance make advising mothers who are HIV positive and promoting breastfeeding can be problematic in the UK. On one hand, there have been studies from Africa would indicate that where women are on ART and have an undetectable viral load the risks of HIV transmission through breastfeeding is small (Thomas et al. 2011). Furthermore, women from countries where HIV rates are high who now reside in the UK can experience stigma when not seen to breastfeed. On the other, formula feeding, would obliterate any risk of transmission. It is absolutely the mother's choice and the health care professional should support her in her choice unreservedlymu n h.9 (e)1.7 (a)9.46 (t)25.6 (e)-6

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There is good evidence confirming the effectiveness of non-pharmaceutical analgesia in infants and also on the adverse effects of poorly managed pain in infants (Ismail and Gandhi, 2011) in the short term with decreased oxygenation and haemodynamic instability for example. Pain can cause a range of detrimental long term effects (Grunau, Holsti and Peters, 2006). A series of reviews have supported the effectiveness of breastfeeding or supplemental breast milk in relieving procedural pain (Agarwal, 2011; Codipietro, Ceccarelli and Ponzone, 2008; Shah, Aliwalas and Shah, 2006). Breastfeeding is more effective than swaddling or the use of a pacifier and although results seem to be mixed, breastfeeding may have a similar efficacy to the administration of sucrose. Efe and Ozer (2007) found that breastfeeding was an effective way of relieving pain during neonatal immunisations (Efe and Ozer, 2007). Efe and Savaser (2007) found no difference in the analgesic effect of breastfeeding and the administration of sucrose during venepuncture (Efe and Savaser, 2007). Given that the long-term use of sucrose in neonates is not yet fully understood giving breastmilk and breastfeeding should be considered as an alternative (Murki and Subramanian, 2011). The release of oxytocin in the infant whilst breastfeeding activates the limbic system and relaxes the infant especially if the infant is also in skin to skin contact. This also enables full participation in care by parents.

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Jordan, S, Cushing-Haugen, K, Wicklund, K, Doherty, J and Rossing, M (2012). Cancer Causes Control 23 (6) 919–927.

Kafulafala, G, Hoover, D and Taha, T et al. (2010)

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Syrad, H, Llewellyn, C, Johnson, L, Boniface, D, Jebb, S, van Jaarsveld, C and Wardle, J (2016)

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Organisations supporting breastfeeding

The Breastfeeding Network – see: **www.breastfeedingnetwork.org.uk**.

National Childbirth Trust – see: **www.nct.org.uk**.

La Lèche League – see: **www.laleche.org.uk**.

Association of Breastfeeding Mothers – see **http://abm.me.uk**.

Additional links and resources

Expert Group on Growth Standards of the Scientific Advisory Committee on Nutrition and Royal College of Paediatrics (2007)
London: RCPCH. Available from: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/338922/SACN_RCPCH_Application_of_WHO_Growth_Standards.pdf**. [Accesssed November 2020].

Drugs and Lactation Database LacMed **http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT**

UK Drugs in Lactation Advisory **https://www.sps.nhs.uk/articles/ukdilas/**.

UNICEF baby friendly initiative: **http://www.unicef.org.uk/babyfriendly/.**

World Health Organisation (2007)
Geneva: WHO. **http://www.who.int/maternal_child_adolescent/documents/9241595230/en/**

World Health Organisation and UNICEF (2003)
, Geneva: WHO. **http://www.who.int/nutrition/publications/gs_infant_feeding_**

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Photocopy this checklist and use these key criteria from the breastfeeding guidance to audit your unit/hospital.

Refer to the guidance to prepare an action plan if improvements are needed.

Is your policy relating to breastfeeding mothers displayed in all areas of the hospital?	
Is your policy relating to breastfeeding mothers translated, if appropriate?	
Is your policy relating to breastfeeding mothers given to new staff?	
Are training programmes on breastfeeding available for staff?	
Is an update about the breastfeeding policy part of the annual mandatory training?	
Is there a private, comfortable area dedicated to breastfeeding?	
Can mothers express at the bedside if they want?	
Are all nursing staff trained in the use of breast pumps?	
Do you provide information to parents about how to hire a breast pump for use at home?	
Can you name your staff member (or counsellor) with specialist knowledge in breastfeeding management?	
Do nurses discuss the chosen method of feeding with parents of infants on admission and record it in the care plan?	
Do you have written information about breastfeeding and local support groups available to give to breastfeeding mothers?	
Is there any breast milk substitute promotional material (posters, calendars etc) visible?	
Are there facilities for all breastfeeding mothers to remain with their babies 24 hours a day?	
Are breastfed babies starved for no more than four hours pre-operatively?	
Is there regular monitoring of the system for collecting and storing expressed breast milk?	
Do you have a list of the contacts for your local breastfeeding support group?	

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