
STEP FOUR: HELP MOTHERS INITIATE BREASTFEEDING WITHIN ONE HOUR OF BIRTH.

There is significant evidence for the positive effects of delayed cord clamping, a practice which facilitates optimal iron stores for infants. The WHO recommends delayed cord clamping unless the infant needs immediate medical attention. Studies also show this practice increases the need for neonatal phototherapy, and the American College of Obstetrics and Gynecologists conclude there is insufficient evidence to guide practice in resource rich settings such as the US. Considering the clinical benefits, delayed cord clamping should be considered, as long as access to phototherapy is readily available.

Health Benefits of Delayed Cord Clamping in Term Infants
- Higher hemoglobin levels in early neonatal period
- Lower rates of anemia at 4 months of age
- Higher ferritin levels at 2-4 months of age
- Higher iron stores at 2-4 months of age
- Increased transfer of vital stem cells

Comparing Early vs. Delayed Cord Clamping
In terms of immediate postpartum events, no significant difference was found in the following maternal and neonatal outcomes when comparing early vs. delayed cord clamping:
- Maternal postpartum hemorrhage (≥500 mls) or severe postpartum hemorrhage (≥1000 mls)
- Need for maternal blood transfusions
- Maternal retained placenta
- Infant Apgar scores, need for resuscitation, or umbilical cord pH values

- Frequency of neonatal respiratory distress
- Incidence of neonatal polycythemia, severe intraventricular hemorrhage or periventricular leukomalacia

Optimal Cord Clamping in Active Management of Third Stage Labor
Existing research has defined “delayed” cord clamping as anywhere between after 30 seconds elapsed to cessation of cord pulsing (usually around 3 minutes). It is generally recommended that 90 seconds may be the optimal duration between birth and cord clamping.

Collect remaining cord blood for donation or banking, as indicated. Maximize the collection, placing infant on mother’s abdomen.

For infants at risk of hypovolemia, research suggests that they can usually be lowered for 30-60 seconds before being placed on the abdomen for cord clamping.

CONTINUED ON REVERSE...
Delayed Cord Clamping:
A Guide for Healthcare Professionals

Optimal Cord Clamping and Cord Blood Banking/Donation

Many families want to donate or bank their infants’ cord blood. Like most other birthing practices, cord blood banking and donation warrants informed consent or refusal. Many families are unaware of the following:

- Early cord clamping for the purpose of collecting the sample may lead to lower blood volumes, lower hematocrit levels, and anemia in the newborn.
- Odds of using one’s own cord blood are incredibly low, 1/1,000-1/200,000, because the risks of relevant illness are low (and often dependent on family history) and many relevant diseases are better-treated with donations from relatives.
- Private cord blood banking (for families who want access to their own samples) costs $1500-$2000 at birth, and ~$125 in annual fees.
- Research demonstrates that delayed cord clamping and cord blood donation or banking are NOT mutually exclusive. There is a poor correlation between cord blood sample volume, nucleated stem cells and CD 34+ count. Thus, the required volume is not standardized because of the evidence that cell counts and blood volume are not directly related, recent scientific advances facilitate cell count expansion, and combination of multiple samples. Between 10mL and 150mL cord blood have proven to have enough CD34+ cells for transplantation. This amount may be collected after a 90 second delay.

REFERENCES:


Immediate “skin-to-skin” after delivery is when a newborn is dried and placed naked on the mother’s bare abdomen, and the two are covered with a blanket for warmth. Regardless of feeding intention, skin-to-skin care is critical for achieving newborn homeostasis and thermoregulation in the first hours of life. Skin-to-skin care is the best practice we have to ensure that newborns make an easy transition to life outside of the womb and breastfeeding gets off to a good start. Continued skin-to-skin on the mother’s chest throughout the first days and weeks is also very beneficial. Partners can practice skin-to-skin, too.

Immediate and continuous skin-to-skin contact between mother and baby encourages the infant to adjust to life outside the womb. Research shows skin-to-skin results in:

- Higher axillary temperatures for newborns – lowered risk for hypothermia
- Lower, more stable respiratory rates for newborns
- Higher blood glucose levels – lowered risk for hypoglycemia
- Faster return to physiologically normal heart rate for newborns
- Decreased crying in newborns
- Decreased anxiety for mothers
- Increased mother’s self-confidence in her parenting ability, measured at hospital discharge
- Stimulation of maternal oxytocin to enhance uterine contractions, access to colostrum and mother-baby bonding – allows mother and baby to smell and feel each other
- Encouragement of breastfeeding – the warmth, smell and closeness to the breast are associated with easier and longer breastfeeding

The infant should be placed belly-to-belly with the mother’s upper body slightly elevated. During skin-to-skin, the active and alert newborn naturally uses its legs to push up to and knead the breast. This helps the mother’s oxytocin release, stimulating let down of her milk. When suckling at the breast begins, colostrum is there as a reward. Because humans will repeat satisfying behaviors, skin-to-skin time encourages a high frequency of feeds, which helps to prevent newborn jaundice, hypoglycemia and weight loss.

CONTINUED ON REVERSE...
Practicing skin-to-skin immediately after birth and throughout the maternity stay may require consideration of new perspectives:

- Birth separates mother and infant for the first time
- Mothers need to be close to their infants, just like infants need to be close to their mothers
- Skin-to-skin is a simple, free, and evidence-based practice that is good for mothers and babies
- The experiences women and infants have around pregnancy and birth influence them for a lifetime

**TIP:** Some mothers may express concern about their baby being “wet and dirty” and will ask that the newborn be “cleaned off.” In order to avoid separation of mother and baby (maintaining warmth and respiratory health), we need to prepare mothers and partners in advance. For example, during early labor, during epidural rest, or even between pushes, we can say:

“As soon as you give birth, we will bring baby right to for his first hug. This snuggle time is important for helping your baby adjust to life outside of the womb.”

and/or

“When you see your baby for the first time, she may look very messy. The vernix on her skin helps to keep her warm and fight off bacteria. That’s why we try to delay the first bath.”

**REFERENCES:**


**Vitamin K Injections for Newborns**

Health organizations recommend administering vitamin K to prevent unexpected and/or excessive bleeding because newborns are born vitamin K deficient.

Many healthcare providers have requested clarification about requirements for administration of vitamin K. Currently there are no federal statutes requiring the administration of vitamin K. Note: Some states do have statutes or policies in place addressing time frames for administration but they are highly variable.

The American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) recommend administration after the first feeding is completed but within six hours of birth. As delayed and inadequate feeding is related to vitamin K deficiency bleeding (VKDB), both organizations emphasize the importance of prioritizing first feeding within one hour of birth; vitamin K may be administered during or after the first feeding.

**Newborn Eye Prophylaxis**

The US Preventative Services Task Force (USPSTF) maintain a Grade A recommendation that all newborns receive topical eye medication to prevent gonococcal ophthalmia neonatorum. According to the Centers for Disease Control and Prevention (CDC), this prophylaxis is required by law in most states.

The CDC guidelines suggest instilling Erythromycin (0.5%) ointment into both eyes of all neonates as soon as possible after birth. It is recommended that this prophylaxis be done with mother and baby skin-to-skin. The AAP recommends that routine procedures including eye prophylaxis can be delayed until the first feed is completed. If prophylaxis is delayed (i.e., not administered in the delivery room), a monitoring system should be established to ensure that all infants receive this eye care.
Many healthcare professionals have been doing newborn assessments on a warmer bed, and newborn observations in a nursery. A significant practice change is required when performing newborn assessments and observation protocols with mother and baby skin-to-skin. It is important to remember that this new practice does not mean that mother and baby are to be left alone; routine observations remain important. Protocols for continually assessing the health and well-being of the mother and newborn are essential.

Best Practices for Intrapartum Care

- **Mother’s Position** – Mothers should not lie flat on their backs but rather at a slightly elevated angle when their infants are skin-to-skin. This ensures the infant’s weight is not centered over his chest, and that he can utilize his feet to push and maneuver his body as needed.

- **Infant’s Position** – Be sure infants are placed in a position that allows for comfortable breathing. Avoid any obstructions to the mouth or nose areas. The newborn’s head should not be tucked down – keep the nose up in a “sniffing position” to ensure an open airway.

- **Warmth** – It is important that newborns have a dry cover or blanket over their back while they are skin-to-skin to prevent drops in temperature.

- **Color** – Periodically examine the color of the infant’s skin, and the lips/tongue area. Intervene immediately if pale or cyanotic skin is noticed. Follow your facility’s normal neonatal resuscitation algorithm.

- **Surveillance** – Maintain continuous observation of newborns, especially those with primiparous mothers.

- **Improvement** – Facilitate continual staff training and quality improvement regarding this important topic.

**TIP:** Practice changes require continual re-education and it may take time for healthcare professionals to become comfortable with them. Try role playing as an educational strategy. For example, you may wish to try one scenario in which the nurse and provider are assessing a pink, screaming newborn on a warmer, while in another scenario, the healthcare team is assessing a calmer infant who is skin-to-skin with mom.
The Basics of Milk Expression

- Wash hands well before expressing or handling milk or collection equipment.
- Wash equipment that touches the breast, milk or collection containers in hot, soapy water. Rinse thoroughly and air dry on a clean towel.
- Collect and store their milk in clean containers such as glass jars, hard plastic cups with tight caps or bags made for milk storage. Milk should not be stored in ordinary plastic storage bags as these could easily leak or spill.

Hand Expression

All new mothers should leave the hospital knowing how to manually (hand) express their milk. While many mothers use breast pumps, manual expression is an easy, cost-free alternative that will help them avoid painful episodes of engorgement that could lead to plugged ducts or even mastitis. The following three online videos show various helpful demonstrations of how to hand express. Please view them and share this knowledge with new mothers.

Storing Expressed Milk

It is important to teach new mothers the basics of storing and using their expressed milk:

- Just like any food, always wash hands before handling milk.
- Use the oldest milk first.
- Store milk in small quantities: 3–4oz. Label containers with date of expression.
- When freezing milk, leave space at the top of the container, because milk (like most liquids) expands as it freezes.
- Human milk is safe at room temperature for between 6 and 8 hours or longer, in some studies.
- If you are planning to use the milk within the next few days, refrigerate it right away. The milk will be safe in the refrigerator for up to 5 days.
- Human milk can be frozen for 3–6 months, depending on the type of freezer. See table on reverse.

Free Video Tutorials

- Dr. Ann Witt and Maya Bolman | Breastfeeding Medicine of Northeast Ohio | https://vimeo.com/65196007
- Texas WIC - Every Ounce Counts | http://www.breastmilkcounts.com/educational-activities.php and click on “Softening and Expressing”
Mother’s Milk Expression: A Guide for Healthcare Professionals

Defrosting and Feeding Expressed Milk

To defrost frozen milk, place it in a pan of warm water or defrost in the refrigerator. After defrosting, milk may separate, with the fat on top. The milk can look a little yellow, orange, white or even clear. Do no shake the milk—gently swirl the milk to combine all of the components back together. Shaking the milk disrupts some of the molecular bonds, which changes the composition.

Never microwave human milk. Microwaving can change the milk’s composition and create hot areas that can burn baby’s mouth. Previously frozen milk may be kept in the refrigerator for up to 24-hours. Do not re-freeze breast milk once it has been thawed.

Storage of Freshly Expressed Human Milk

<table>
<thead>
<tr>
<th>Location</th>
<th>Temperature</th>
<th>Duration</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countertop, table</td>
<td>Room temperature (up to 77°F or 25°C)</td>
<td>6-8 hours</td>
<td>Containers should be covered and kept as cool as possible; covering the container with a cool towel may keep milk cooler.</td>
</tr>
<tr>
<td>Insulated cooler bag</td>
<td>5-39°F or -15-4°C</td>
<td>24 hours</td>
<td>Keep ice packs in contact with milk containers at all times, limit opening the cooler bag.</td>
</tr>
<tr>
<td>Refrigerator</td>
<td>39°F or 4°C</td>
<td>5 days</td>
<td>Store milk in the back of the main body of the refrigerator.</td>
</tr>
</tbody>
</table>

Freezer

<table>
<thead>
<tr>
<th>Location</th>
<th>Temperature</th>
<th>Duration</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freezer compartment of a refrigerator</td>
<td>5°F or -15°C</td>
<td>2 weeks</td>
<td>Store milk toward the back of the freezer, where temperature is most constant. Milk stored for longer durations in the ranges listed is safe, but some of the lipids in the milk undergo degradation resulting in lower quality.</td>
</tr>
<tr>
<td>Freezer compartment of refrigerator with separate doors</td>
<td>0°F or -18°C</td>
<td>3-6 months</td>
<td></td>
</tr>
<tr>
<td>Chest or upright deep freezer</td>
<td>-4°F or -20°C</td>
<td>6-12 months</td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES:


Safe Bottle Feeding:

Bottle feeding can inadvertently be done unsafely. As a healthcare provider, you play a key role in teaching caregivers how to safely feed their babies, including when they are bottle feeding. Things to remember:

- For breastfed infants, avoid bottle nipples for 3–4 weeks or until a strong breastfeeding pattern is established. Infants can be fed using a cup, spoon, nursing supplementer, etc.
- Always hold the baby upright and support their head and neck with your hand rather than the crook of your arm. Support baby to keep the head in straight alignment with the body to facilitate full swallows (avoiding choking). Minimize air swallowing by tilting the bottle and allowing the milk to fill the end of the nipple before allowing baby to latch on.
- Always practice paced feeding. Paced feeding means that you feed a small amount, then remove the bottle to assess if the baby is satisfied, then resume as needed. This allows infants to take the frequent rests they need during a feed. It can be stressful to babies when they are not able to control the flow of milk. They may be gulping frantically to avoid choking. Paced feeding avoids this risk of bottle feeding.
- Before removing the nipple for a break, twist it to warn baby that the nipple is coming out. Between pauses, keep the nipple against baby’s cheek so she knows it is still available.
- Never force feed or over feed an infant. Doing so can override an infant’s natural satiety cue, causing the volume of the feed to be too much. This can cause gastric discomfort or irritation, possibly resulting in vomiting. Feed according to infant hunger and satiety cues. When bottle feeding, pause often and watch for fullness cues.
- Also keep in mind that some newborns are very sleepy and need to be woken up for feedings before they show hunger cues.
- Be sure to have the right nipple hole size; it should drip about 1 drop per second when completely inverted (avoiding choking that can result from fast flow nipples when paced feeding is not practiced).
- Recommend silicone nipples since rubber nipples leak nitrosamine and break down faster.
- Recommend BPA-free, PVC-free bottles (#7 for recycling).

CONTINUED ON REVERSE...
Safe Formula Preparation

Powdered infant formulas are not sterile. They may contain bacteria that can cause serious illness in newborns. By teaching caregivers how to prepare and store powdered infant formula correctly, you can reduce the risk of illness.

- Always start with clean hands and sterilized feeding equipment.
- Always follow manufacturers’ instructions for mixing powdered formulas. Adding more or less formula powder than instructed could cause harm.
- Measure the appropriate amount of cooled, boiled (or distilled) water into the bottle. Then, add the powder and shake until fully blended.
- Drip a few drops onto your forearm to ensure that the formula is body-temperature.
- After feeding, never store pre-made formula for later feedings. This may allow bacteria to grow in the bottle. Make what is needed as it is needed. If it will not be possible to access clean water, bring the bottle with water and add the powdered formula when the infant is ready to eat.
- NEVER microwave a bottle or any other container holding milk and feed its contents to an infant. The milk is likely to have “hot spots” that can cause severe burns.

TIP: Remember to recommend direct breastfeeding as the first choice unless it is clinically contraindicated. Start the feeding discussion with the question “What have you heard about breastfeeding?” and proceed accordingly, addressing concerns raised. Be sure that mom knows that there is support available for her—regardless of how she plans to feed her baby. Always document the education mothers’ receive, including education about the possible consequences to the health of her baby and/or the success of breastfeeding when introducing breastmilk substitutes.
Partners Need to Know Why They Should Support Breastfeeding

Research shows that partners want to know all about the benefits and ramifications of breastfeeding. Throughout the maternity stay, share these key talking points for partners:

- Breastfed infants sleep better than formula-fed infants.
- Breastfed infants are healthier than formula-fed infants. They get less diarrhea, fewer colds, fewer ear infections and have a decreased risk of Sudden Infant Death Syndrome (SIDS).
- Compared to formula-fed infants, as adults, breastfed infants continue to benefit from better health. In the long term, those that were breastfed are at lower risk of diabetes, asthma, allergies and childhood cancers.
- Breastfed children may have higher IQs than formula-fed children.
- The more a woman breastfeeds, the more health benefits she gets. For example, mothers who breastfed have less breast cancer and less ovarian cancer later in life.
- Breastfeeding burns calories, so mom can get back to her pre-pregnancy shape more rapidly.
- Formula is expensive! Formula alone costs about $1,700 per child, per year, which doesn’t include the bottles, nipples and other related equipment.

Encouragement for Tough Times

Partners may feel helpless if they see mom struggling with infant feeding. Engaging partners is best practice for moms and babies. Offer some encouragement for partners as well as mom:

- It may take a few weeks for mom and baby to find their rhythm with breastfeeding. Extra patience and support are needed during this unique time.
- Listening to what mom is experiencing, helping her stay focused on her goals, and doing some extra things for her to allow her more time with your baby are helpful ways to support her during this transitional time.
- Some mothers experience sore nipples when breastfeeding a newborn. Often, this soreness becomes more manageable with time, once the baby learns to latch well. If breastfeeding continues to be uncomfortable or painful, families should find support from a lactation consultant.

CONTINUED ON REVERSE...
Bonding Can Happen in Many Ways Other Than Feeding

All parents, not only breastfeeding parents, sometimes need to be reminded of the many opportunities for parenting and bonding with their newborns. Throughout the maternity stay, share these ideas with mom’s partner and family.

• Support mom and baby to get comfortable for a feeding. Make sure mom gets to eat and drink as much as she would like – don’t let her become hungry or thirsty.
• After a feeding, hold the baby skin-to-skin and upright to burp the baby and allow mom to rest.
• Talk, sing, and hum to the baby using a soft, calm voice and eye contact. This is a very important part of brain development.
• Try wearing the baby in a sling or other baby carrier. Babies love to be held close and they bond with people based on their individual scent.
• Massage your baby. Infant massage can help to relax babies, improving sleep and wellness overall. Start slowly and firmly by ‘milking’ the legs/feet away from the baby’s body toward you for just a few minutes. Over time, babies can accept longer massages including other parts of their bodies.
• Get involved in the bedtime routines. Bathe, sing or read to the baby. Rock the baby to sleep.
• Newborns spend most all of their time eating or sleeping. Baby will have many more needs and wants in the near future.

REFERENCES:


Facilitate Rooming-In of Mothers and Babies:
A Guide for Healthcare Professionals

STEP SEVEN:
PRACTICE ROOMING-IN - ALLOW MOTHERS AND INFANTS TO REMAIN TOGETHER 24 HOURS A DAY.

“Rooming-in” means that mothers and their babies stay together, in the same room, throughout their hospital stay. Necessary procedures such as pediatric evaluations and newborn screening tests can be done in the mother’s room. Supporting and encouraging the practice of no separation of mothers and newborns can have lasting beneficial impact.

Benefits of Rooming-In

• Infants sleep better and cry less. They are less stressed when their mothers are nearby.
• Mothers’ milk volume will increase sooner when babies are not removed to the nursery between feedings.
• Feedings occur more often, and infants gain weight better and have a lower risk of developing jaundice.
• Women feel that they know their infants better by the end of their stay as compared to women whose infants were in the nursery for significant stretches of time.
• Women breastfeed and exclusively breastfeed for longer.
• Women who room-in with their newborns report that they feel better prepared to take care of their infants when they go home, as compared to women whose infants were cared for in the nursery for significant stretches of time.
• Mothers enjoy the same amount and BETTER quality of sleep when rooming-in as when baby is away.

TIP: Some new mothers may ask to send their infants to the nursery when they are struggling with a certain aspect of caring for their newborn. Take advantage of these difficult moments to offer encouragement and support while reminding mom of the benefits of rooming-in.

CONTINUED ON REVERSE...
Facilitate Rooming-In of Mothers and Babies: A Guide for Healthcare Professionals

Shouldn’t Mothers Use Their Hospital Stay to Rest?

Yes! Being pregnant, giving birth and learning about a newborn is exhausting! However, when mothers are asked about maternity care practices that worked for them and why, most favor rooming-in because it helps them tune in to their babies. Bonding immediately after birth can help mothers be better caregivers. As a care provider, this is your opportunity to help new mothers learn how to rest with a newborn. You can set them up for success at home.

- **Encourage mothers to sleep when her infants sleeps.** Mother should place her infant in the bassinet when she plans to sleep, especially if she is alone.
- **Encourage skin-to-skin,** which minimizes infant crying and mothers’ stress levels.
- Remind mothers that the daytime is for sleeping, too. Limit distractions and visitors, but encourage the presence of a partner or trusted support person who can help during the hospital stay.
- **Teach experienced breastfeeders to nurse while side lying** so they can rest while feeding (if they are not on pain medication).
- For multiparas, the hospital stay may be the only significant time they get to bond with their newborn with limited presence of older children.

REFERENCES:


Evidence suggests that mothers who understand infant feeding cues are:

- More confident and satisfied with the hospital care they received
- More likely to succeed with breastfeeding
- More able to calm their infants

What are Infant Feeding Cues?

Cues are the infant’s language to let us know what they need. Newborns communicate with easy-to-recognize signs that let you know when they are hungry, full, tired, need to be changed and want quiet time. Learning the infant’s language is a new skill for all parents; let them know that it becomes easier the more they “listen”. You can help facilitate this process by teaching some common infant signs of hunger and fullness, shown in the table.

Feeding according to these cues ensures that infants receive small amounts of colostrum or breastmilk at very frequent intervals. This is exactly what a newborn’s stomach size is able to accommodate without uncomfortable overstretching (see image on reverse side). In addition, frequent feedings (8-12 times per 24 hours) help to prevent jaundice and hypoglycemia. Introducing pacifiers may make it difficult for parents to recognize their baby’s signs of hunger. In general, breastfed infants should not be given a pacifier, unless medically recommended, for the first 3 to 4 weeks.

<table>
<thead>
<tr>
<th>Infant Hunger Cues: Feed Me!</th>
<th>Infant Fullness Cues: That’s Enough!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nuzzling the breast</td>
<td>Relaxed position</td>
</tr>
<tr>
<td>Eye movement under closed eyelids</td>
<td>Slowing eating pace</td>
</tr>
<tr>
<td>Increased alertness (waking)</td>
<td>Stopping sucking</td>
</tr>
<tr>
<td>Sucking on hands or tongue</td>
<td>Turning face away from nipple</td>
</tr>
<tr>
<td>Rooting-searching for something to suck</td>
<td>Closing lips tightly when nipple is presented</td>
</tr>
<tr>
<td>Bringing hand to mouth</td>
<td>Becoming fussy</td>
</tr>
<tr>
<td>Squeaking or light fussing</td>
<td>Increasing attention to surroundings</td>
</tr>
<tr>
<td>Tongue thrusts</td>
<td>Falling asleep* (Some newborns sleep through their hunger cues and need to be aroused to feed with sufficient frequency.)</td>
</tr>
<tr>
<td>Crying is a late sign of hunger</td>
<td></td>
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</tbody>
</table>

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Infant Feeding Cues:
A Guide for Healthcare Professionals

Approximate Infant Stomach Capacity

When parents respond to their newborn’s feeding cues, they build trust and a sense of security. Infants learn that their needs are going to be met. This is the one aspect of responsive feeding, which, when practiced throughout young childhood leads to optimal growth and development.

Is crying a feeding cue?

Newborns have immature nervous systems, which are easily overloaded by excessive activity in their surroundings, resulting in crying. When newborns are ready to eat, they will first display one or more feeding cue rather than crying. It is best to avoid waiting to start a feed until the infant is crying. Infants latch best when they are organized and alert. When crying, they are less likely to demonstrate normal feeding responses.

TIP: Crying is a natural and normal behavior for infants. It can mean that something is making the infant uncomfortable, such as too much stimulation, a dirty diaper, or tummy pains. It can also mean that the infant needs to be close to mom or another familiar person. It is important to work with mothers to help them respond effectively to their crying newborn. You can:

- Suggest that the baby and mother rest skin-to-skin and belly-to-belly.
- Suggest that the baby be placed close to mom, with a supported back, and arms free to move.
- Suggest that the baby may feel comforted by the mother’s soothing voice.

If the infant is still crying, suggest additional calming techniques, such as:

- Gently rocking baby from side to side (ear to ear).
- Cocooning baby in mother’s arms, holding somewhat firmly in a fetal position.

Once the infant (and mother) are calm, suggest they start to nurse. Breastfeeding will calm both the infant and the mother even further. If the mother is still concerned, she may need some extra support at this time.

REFERENCES:


**Nipple Confusion: A Guide for Healthcare Professionals**

**REFERENCES:**

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**Many healthcare professionals are unsure about best practices regarding pacifier use, given the limited and conflicting evidence around nipple confusion. WHO and the Baby Friendly Hospital Initiative recommend avoidance of artificial nipple use in breastfeeding infants, while the Academy of Pediatrics recommends use of artificial nipples only after breastfeeding has been well established. Some studies suggest that pacifier use may reduce the risk of Sudden Infant Death Syndrome (SIDS). It is important to educate parents on the risks and benefits of pacifier and nipple use so that they can make informed choices.**

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**What is Nipple Confusion?**

Nipple confusion is a term that describes a newborn infant’s refusal of the breast or inability to properly latch to the breast after having been exposed to artificial nipples. This may occur because sucking at a bottle or pacifier requires different anatomical and physiological mechanisms than direct breastfeeding.

There is some evidence suggesting breastfeeding rates may be negatively affected by artificial nipple use. Due to the observational nature of the research, it is difficult to establish a direct causal link between pacifier and nipple use and breastfeeding cessation.

**Pacifiers and SIDS**

Because pacifier use has been associated with a reduction in SIDS incidence among infants habitually given pacifiers at bedtime, the American Academy of Pediatrics suggests that mothers of healthy term non-breastfed infants should be instructed to use pacifiers at infant nap or sleep time, but in breastfed infants, they should only be introduced after breastfeeding is well established, at approximately 3 to 4 weeks of age. The relationship between SIDS and pacifiers is still being explored. It is unclear whether there is a causal relationship or associated for some other reason.

It is also important to clarify that exclusive breastfeeding IS known to reduce the risk of SIDS. Human milk fights infection, resulting in clearer airways. Breastfeeding reduces gastroesophageal reflux (GER). And, breastfeeding organizes infants’ sleep/wake cycles in a manner that increases sensitivity to environmental context.

**Best Clinical Practice**

- Offer alternatives to bottles for breastfeeding newborns who require feeding(s) off the breast, including Nursing Supplementers, cups, fingers or syringes.
- Educate mothers who request pacifiers or bottles about the risks of nipple confusion and offer alternative options as appropriate and document this education. Pacifiers may also make it more difficult for parents to notice newborn hunger cues and may cause delays that impact the necessary frequency of these early feedings.
- Control the supply of nipples and pacifiers by storing them in a Pyxis® or use other supply management mechanisms.

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**REFERENCES:**
The World Health Organization recommends that women exclusively breastfeed for 6 months, and continue breastfeeding with appropriate complementary food for up to 2 years and beyond. Studies show that many women wean earlier than they desire, often due to breastfeeding difficulties, many of which may have been prevented with timely support. If new mothers are to achieve their breastfeeding goals, it is vital that they have adequate follow-up care and know where to find additional support in the community from both professionals and other mothers.

Best Practices Prior to Discharge

1. Assess any current or anticipated breastfeeding problems based on maternal and/or infant risk factors (these are reviewed in the ABM Protocol #2). Document and attend to all breastfeeding issues, whether observed by staff or raised by the mother. Create an action plan that includes a specific plan for follow-up after discharge.

2. Arrange for a postpartum follow-up visit, within 3-5 days of age or 48-72 hours after discharge, by a physician or midwife. Consider any home visiting opportunities for which she may be qualified. The mother’s 4 to 6 week follow-up visit to the obstetrician or family physician should also be scheduled.

3. If a mother is eligible for WIC, call her local agency to set up a new referral. Exclusive breastfeeding is rewarded in the WIC program in many ways.

4. Provide all breastfeeding mothers with contact information of professional services, including International Board Certified Lactation Consultants (IBCLCs,) who provide breastfeeding assessments, support, and counseling. Remind mothers that common breastfeeding difficulties can be addressed, that she should not suffer alone, and encourage her to reach out for assistance early when it is needed.

5. Refer patients to any local “warm lines” or national hotlines that offer postpartum support, both for breastfeeding questions and also for domestic violence or mental health concerns. La Leche League, for example, maintains a toll-free hotline with 24-hour support in English or Spanish.

6. Provide women with lists and contact information for local support groups and services for breastfeeding mothers. Include peer mother-to-mother support groups, clinic or hospital based support groups, and WIC peer counseling and support group information. Encourage mothers to contact and consider attending at least one of their local groups.

7. Inquire if a mother plans to return to work or school. Proper planning will help ensure she utilizes all available support. Refer appropriately to resources specifically tailored to help mothers plan for their return to work, including any local and/or state laws in place in support of breastfeeding mothers. Refer mothers to the Office of Women’s Health’s webpage on breastfeeding for helpful tips on breastfeeding and going back to work.

http://www.womenshealth.gov/breastfeeding/going-back-to-work.html

CONTINUED ON REVERSE...
Connecting Mothers with Community Resources:
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9. Encourage mothers to seek information from trusted sources such as health agencies. Many companies selling products to new families may offer “health advice” directed at new mothers’ concerns. Commercial health advice is at risk for biased information and/or claims that are not backed by high-quality evidence.

TIP: A new mother’s community of support begins with her immediate family and friends. Encourage mothers and partners to plan for a period of “nesting in” after returning home from the hospital. This means that visitors and phone calls are limited and responsibilities outside the family are put on hold. Encourage the creation of a network of support the family can call on during this special time by suggesting the following to new families:

• Create a list of chores such as laundry, cleaning, grocery shopping and meal preparation. When close friends and family are in touch with excitement and congratulations, request that they lend a helping hand with one of the chores on the list.

• Ask a close friend to organize frequent delivery of meals for your family. Neighbors, coworkers and other acquaintances will be happy to contribute this kind of support.

• Consider setting up frequent play dates or child care for any older children to ease the transition of the new baby at home.

• Talk about your feelings to trusted loved ones. Transitions can be difficult; be sure you are getting the support you need. If you are experiencing depressive symptoms, please notify your healthcare provider about your feelings.


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REFERENCES:


