TRAINER MANUAL

comprehensive training materials to implement skills-based competency in maternity care and breastfeeding

EMPower Training

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Preface

The EMPower Training initiative is focused on improving knowledge and skills in evidence-based maternity care practices supportive of optimal infant nutrition for healthy term infants. In 2018, the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) published revised Implementation Guidance for the Baby-Friendly Hospital Initiative (BFHI). This implementation guidance will be adapted to the US context by Baby-Friendly USA (BFUSA), the national authority for the BFHI in the United States.

In developing the EMPower Training manual and initiative, the EMPower team has taken into consideration the 2018 UNICEF-WHO Implementation Guidance and the 2016 Baby-Friendly USA Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation. The revised UNICEF-WHO Implementation Guidance contains nuanced information specific to small, sick, pre-term, and/or low birth weight newborns. For hospitals that are in Development (D2), Dissemination (D3), or Designation (D4) phases of the Baby-Friendly 4D designation pathway or in the process of re-designation, please refer to the Baby-Friendly USA Guidelines and Evaluation Criteria for information specific to small, sick, pre-term, and/or low birth weight infants to better understand how the EMPower Training materials may need to be adapted for these populations. In addition, training materials may need to be updated based on future US-specific implementation guidance published by Baby-Friendly USA.

As staff become trained they may realize that there are additional opportunities to improve maternity practices and your hospital will have to decide if and when it is ready to work to improve maternity practices supportive of breastfeeding. These decisions should be made with an understanding of the benefits and potential safety concerns associated with the practices and in the context of maternal and infant clinical factors as well as hospital considerations such as staffing and routine monitoring. For example, concerns have been identified in the peer reviewed literature related to safety during unobserved skin-to-skin care immediately after birth and throughout the hospital stay as well as unobserved rooming-in for at-risk mother-baby dyads.

As part of the EMPower Training initiative, we are promoting and providing training related to 1) immediate and uninterrupted skin-to-skin care and 2) rooming-in however, we are not promoting or training on skin-to-skin care throughout the hospital stay. Implementing this practice is a hospital specific decision, and should be considered in the context of clinical and hospital factors. Some hospitals may already be implementing skin-to-skin care while rooming-in and/or working toward implementing it. If so, we encourage hospitals to become familiar with and use the guidance related to safety concerns and suggestions to improve safety during rooming-in as described in the 2016 American Academy of Pediatrics (AAP) clinical report, Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns.

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GENERAL INFORMATION

EMPower Training

GENERAL INFORMATION

Introduction

The EMPower Training initiative is designed to support hospitals by improving knowledge and skills in evidence-based maternity practices supportive of optimal infant nutrition. EMPower Training includes tools, materials, and resources to build a sustainable, hospital-specific training plan. By providing skills-based competency training on these practices, hospitals can better ensure that related policies and procedures are implemented safely, as intended, for each mother and her infant. The EMPower Training Trainer Manual includes comprehensive training materials to implement skills-based competency in maternity care and breastfeeding, assisting maternity care staff to gain the confidence and skills necessary to implement optimal maternity and lactation care.

Step 2 of the *Ten Steps to Successful Breastfeeding* requires that staff have sufficient knowledge, competence and skills to support breastfeeding. For facilities to be fully compliant with the BFHI guidelines for Step 2, maternity care staff should complete a total of 20 training hours. Fifteen of the training hours, inclusive of the 15 sessions identified by UNICEF/WHO BFHI, are typically didactic (classroom, online learning, etc.). The remaining 5 hours are accomplished by supervised clinical experience and/or competency verification. The curriculum within this manual is intended to cover the 5-hour, supervised clinical experience required by the BFHI. Additional guidance has been incorporated for each required competency to ensure safety is at the forefront of implementation. BFUSA states that all maternity staff should receive the training and mentorship necessary to attain competence in counseling patients on:

- Feeding decisions
- Immediate and uninterrupted skin-to-skin care
- Comfortable and effective positioning and attachment at the breast
- Maintaining exclusive breastfeeding
- Responding to feeding cues
- Rooming-in
- Hand expression of milk
- Formula preparation and feeding (when applicable)
- Finding support upon discharge

The EMPower Training Competency Curriculum is inclusive of these skills. All training content, resources, and tools within this training manual are based on best practice and evidence-based care. To provide optimal and consistent care, facilities should strive to practice in accordance with these evidence-based guidelines. Modifications based on facility-specific information may be required. Areas where facility-specific information may be pertinent have been inserted within the training content.

The goal of the EMPower Training initiative is to give hospitals the tools and resources needed to train maternity care staff. It is important that hospitals set training goals that are in line with their facility's policies, procedures and designations. Verification and staff training tracking materials are provided for tracking and reporting progress.

The EMPower Training Initiative does not represent BFUSA or BFHI. Additionally, BFUSA does not endorse any training courses and/or training materials.

Who Should Train Maternity Care Staff?

While specialized lactation training and clinical experience is recommended, trainers are not required to be professionals in lactation care such as International Board Certified Lactation Consultants (IBCLCs). Trainers should have a minimum of 20 hours of breastfeeding education and knowledge of the *Ten Steps to Successful Breastfeeding*. Detailed teaching content for each Core Competency is outlined within the subsections of this manual, should trainers need to reference it.

When selecting trainers, consider individuals within your unit or facility that possess the following skillsets or job descriptions:

- Experience and/or competence in adult/staff education
  OR
- Experience in caring for or working with prenatal, postpartum, perinatal women, and newborn infants
  OR
- Experience and/or training as a lactation educator, counselor, or consultant

Consider a Team Approach

We strongly recommend that facilities consider a team approach to training efforts. This will ensure sustainability, distribute workload among individuals and maximize resources. Recommendations on how to form teams and divide work are included in the table below and are intended as suggestions only. Facilities should develop their training team within the capacity of their own unique culture.

Team Approach: Team Member Roles and Responsibilities

Role/Title	Responsibilities	Skill Sets to Consider in Selection
Training Team Lead	• Facilitate training plan implementation • Develop training team and task force • Assign roles/responsibilities • Communicate expectations and coordination of overall efforts • Hold team members accountable • Serve as point of contact for hospital Senior Leadership, Unit Leadership, or similar to provide updates on progress	• Experience in project management/ leadership • Good organizational skills • Strong in motivating and inspiring peers • Good communication skills • **Suggested**: Nursing Unit managers, Directors, Clinical Coordinators, Lead Lactation Consultants, Clinical Nurse Specialists
Trainer(s)	• Develop and facilitate training sessions • Teach and mentor maternity care staff in skills outlined in training plan • Validate competency of knowledge and skills	• Experience and/or competence in adult/staff education OR • Experience in caring for or working with prenatal, postpartum, perinatal women and newborn infants OR • Experience and/or training as a lactation educator, counselor, or consultant • **Suggested**: Lactation Consultants, Staff Educators, Childbirth Educators, Nursing Unit Managers, Staff Nurses, Peer Counselors
Training Tracker/ Data Collector	• Track completion of overall training plan • Track competency validation of each maternity care staff member • Organize training attendance and documentation of completion • Utilize recommended EMPower Training materials • Report Training completion to hospital Senior Leadership, Unit Leadership, staff and/or similar to provide updates on progress	• Experience with collection of data • Good organization skills • Knowledge in Excel and other computer technology systems • **Suggested**: Staff Educators, Quality Improvement Experts, Nursing Unit Managers, Nursing Directors, Clinical Nurse Specialists

Role/Title	Responsibilities	Skill Sets to Consider in Selection
Education Event Coordinator(s)	• Coordinate training events (i.e., skills labs/fairs, simulation labs, workshops, etc.) • Collaborate with Training Team Lead/ Training Team for training plan development • Complete tasks related to event planning: – Reserve training space – Print training materials – Advertise/communicate training event details to staff (flyers, emails, etc.) – Compile needed training supplies (baby dolls, breast models, etc.) – Put a "creative touch" into planned training events… make training "fun"	• Experience with event planning • Good organizational skills • Enjoys being creative • Good at motivating and inspiring • Experience and/or competence in adult/staff education • **Suggested**: Staff Educators, Childbirth Educators, Marketing, or really anyone that enjoys event planning and being creative!

How to Use the EMPower Training Trainer Manual

This manual contains the entire curriculum needed for a comprehensive 5-hour, skills-based breastfeeding training plan within your facility. Please refer to the accompanying Hospital Training Plan template in Appendix IV for additional guidance on successfully implementing your training plan.

The training curriculum is divided into four Core Competencies. Each of the four Core Competencies have unique learning objectives, safety considerations, related teaching outline, accompanying trainer content, suggested learning activities, and teaching resources:

- **Overview and Objectives:** The "Overview and Objectives" subsection gives trainers general information about the specific Core Competency and lists the related learning objectives.
- **Safety Considerations:** The "Safety Considerations" subsection gives general safety considerations as they relate to each Core Competency.
- **Teaching Outline and Accompanying Trainer Content**: The "Teaching Outline and Accompanying Trainer Content" subsection is divided into each of the related Core Competency Sections for quick reference to the specific Core Competency being taught and verified. Below each outline are tables with related content for the trainer that can be used as a reference while conducting suggested activities and exercises, and validating competency on skills. The trainer content is extensive and not meant to be taught in the allotted teaching and learning timeframes. The table of accompanying trainer content is intended to be utilized as background knowledge and for reference points for trainers only, not to be taught to learners in entirety.
- **Suggested Activities**: The "Suggested Activities" subsection gives trainers detailed information about how to facilitate activities that will assist with learning and competency verification related to each Core Competency. These sections walk the trainer through setting up and facilitating a skills lab and/or skills simulation activity. Teaching resources needed to facilitate each activity can be found in the Teaching Resources subsection that follows.
- **Teaching Resources**: The "Teaching Resources" subsection provides teaching resources related to the Core Competency that can be used as teaching visuals, staff handouts, etc. There are also resources within the subsections for the facilitation of the suggested activities. These resources can be used as templates for customization. Each resource item is numbered sequentially, identifying which Core Competency it applies to. They are referenced throughout the Related Trainer Content and Suggested Activities sections to indicate that there is a related teaching resource and where to locate it. Teaching Resources are

marked **blue** throughout the manual in the Accompanying Trainer Content subsections.

- **Additional Resources**: The "Additional Resources" subsection provides additional training resources and related content that is beyond the scope of this training. These resources should be adapted in a manner that aligns with your hospital policies and procedures, taking into account clinical situations and hospital factors unique to your setting.
- **References**: The "References" subsection lists the resources, articles and sources used in that competency.
- **Appendix I – Suggested Activities – Skills and Simulation Labs**: Many facilities find it helpful to plan activities that will assist with learning and competency verification such as skills and simulation labs. This appendix provides general information related to skills and simulation labs as well as customized approaches. Some facilities complete all learning objectives using one method while others prefer to use a combination of methods or create their own approach entirely. For this reason, more detailed information about facilitation of both skills and simulation lab activities are included in each of the Core Competency sections.
- **Appendix II – Documentation of Competency:** Each maternity care staff member must have a completed copy of a form in their education file indicating competency validation for each skill/objective. Facilities may have their own format for such documents or may use the recommended forms here. It is recommended that all components of the forms provided are included in any competency documentation form.
- **Appendix III – Core Competency Outline:** The Core Competency Outline is for documentation and overview purposes for use when a generalized teaching outline is needed for hospital leadership, Baby-Friendly Site Assessors, or any other authority. All learning objectives, training content, and related resources within this manual were developed from this framework. The Accompanying Trainer Content related to the topics outlined here are found in the related Core Competency subsections of this manual.
- **Appendix IV – Training and Tracking Materials:** The tools, resources and spreadsheets for facility use while planning and tracking training. It is recommended that hospitals use the included materials, however other facility specific materials may also be used.

Definitions and Acronyms Used throughout this Manual

- **BFHI** (Baby-Friendly Hospital Initiative): A global program to encourage implementation of the *Ten Steps to Successful Breastfeeding* and the *International Code of Marketing of Breast-milk Substitutes*. The BFHI assists hospitals in giving mothers the information, confidence, and skills necessary to successfully initiate and continue breastfeeding their babies or safely feed with infant formula and gives special recognition to hospitals that have met the requirements. The WHO and UNICEF administer the BFHI program internationally and work with the national authority in each country which confers the Baby-Friendly designation in their nation. More than 20,000 maternity facilities in 150 countries around the world have earned the Baby-Friendly designation.

- **BFUSA** (Baby-Friendly USA, Inc.): A non-profit organization and the accrediting body and national authority for the BFHI in the United States. In this capacity, BFUSA is responsible for coordinating and conducting all activities necessary to confer the Baby-Friendly designation and to ensure the widespread adoption of the BFHI in the United States.

- **Formula**: Infant formula or formula designed for infants. Also referred to as breast milk substitutes.

- **Maternity Care Staff/Learner:** Nursing staff caring for patients in the prenatal, perinatal, postpartum, newborn care areas of the facility (Labor and Delivery, Postpartum, Mother-Baby, Newborn Nursery). Some facilities find value in including specialty staff such as NICU depending on the model of care. You will find that, for purposes of this document, we may use the terms "Maternity Care Staff" and "Learner" interchangeably.

- **ToT:** Training of Trainers

- **Trainers:** Individuals appointed to teach, mentor, and validate competency in maternity care and lactation skills outlined in this curriculum (see 'Trainers' in the Team Approach table). You may find that, for purposes of this document, we may use the terms "Trainers" or "Trainers" interchangeably.

- **Training Curriculum**: The training components included in this manual. Think of it as a "syllabus."

- **Training Plan:** The plan/approach used to teach, mentor, and validate competency in the skills outlined in this manual.

CORE COMPETENCY 1 -

COMMUNICATING WITH PREGNANT AND POSTPARTUM WOMEN ABOUT INFANT FEEDING

EMPower Training

CORE COMPETENCY 1 – COMMUNICATING WITH PREGNANT AND POSTPARTUM WOMEN ABOUT INFANT FEEDING

Overview

Effective communication with patients and families is a basic but important skill that will greatly impact efficacy of education efforts. Pregnant and postpartum women should be educated about feeding options and maternity care practices and, in turn, be supported in their decisions. This lesson will focus on assisting staff with gaining confidence and competency with communicating and educating the patients and families they care for. It is important that staff utilize communication methods that enhance listening and learning skills when counseling mothers and families. Such encounters should consider the individual concerns of the patient and family while building confidence and reassurance of support.

Objectives

Learner will be able to demonstrate:

1. Application of effective patient interviewing, communication and counseling when educating and addressing common concerns that families may have about infant feeding and maternity care practices.
2. Competency in counseling/educating patients and families about evidenced-based maternity practices including immediate and uninterrupted skin-to-skin care, rooming-in, and feeding on cue.
3. Competency in counseling/educating patients and families about safety implications when implementing immediate and uninterrupted skin-to-skin care and rooming-in practices.
4. Competency in counseling/educating patients and families about infant feeding related decisions such as the benefits of breastfeeding, importance of exclusive breastfeeding, risks of infant formula, and artificial nipple use during the establishment of breastfeeding.
5. Competency in counseling/educating mothers' regarding individual concerns about health-related issues in a sensitive manner.
6. Competency in counseling/educating patients about discharge plans and referrals.
7. Ability to effectively evaluate patient's understanding of education and information provided.

Time: 1.5 hours

Safety Considerations

1. Counseling, communication, and education should be delivered in a sensitive manner with careful consideration of a patient's social, cultural, and/or health related circumstances.
2. Maternity staff should demonstrate the ability to recognize and counsel families appropriately when safety or medical concerns are identified resulting in modifications, delays, or contraindications to breastfeeding, skin-to-skin care, and/or rooming-in practices.
3. Counseling and educating families about responsive infant feeding, signs of adequate milk transfer/ intake, appropriate use of artificial nipples can help reduce adverse outcomes.
4. Early follow up care post discharge is important for feeding difficulties or other concerns. Follow up care should be in alignment with evidenced-based recommendations and staff should assure that families have adequate access to care.

Teaching Outline

Core Competency 1: Communicating with pregnant and postpartum women about infant feeding

A. Uses basic communication and patient interviewing skills
   i. Empathy, boundaries, and compassion
   ii. Application of effective communication strategies during patient interactions
   iii. Avoidance of Blame
B. Counsels/educates on immediate and uninterrupted skin-to-skin care
   i. Definition
   ii. Benefits/importance of immediate and uninterrupted skin-to-skin care
   iii. Expectations of immediate and uninterrupted skin-to-skin care following delivery
C. Counsels/educates on rooming-in
   i. Definition
   ii. Benefits of rooming-in
   iii. Addresses family concerns about rooming-in
   iv. Back to sleep, every sleep
D. Counsels/educates on benefits of breastfeeding and risks of infant formula
   i. Benefits of exclusive breastfeeding
   ii. Potential risks of infant formula
   iii. Contraindications to breastfeeding
   iv. Family concerns about infant feeding options
   v. Counsels/educates on exclusive breastfeeding
E. Counsels/educates on feeding cues
   i. Normal feeding behaviors and expectations of a healthy, well infant
   ii. Common feeding/hunger cues
   iii. Importance of early recognition and responsive feeding
F. Counsels/educates about the use of artificial nipple use during the establishment of breastfeeding
   i. Counsels mothers on the use and risks of pacifiers
   ii. Counsels mothers on the use and risks of bottles
G. Counsels mothers on health-related issues and addresses concerns in a sensitive manner
   i. Patient specific
   ii. Cultural/environmental specific
H. Includes appropriate discharge planning specific to patient needs
   i. Follow-up support available after discharge
   ii. Routine follow-up process for newborn (day 3-5 of life, 24-48 hours after discharge depending on length of hospital stay)
   iii. Evaluation of patient understanding of education/information provided

Accompanying Trainer Content

A. Uses Basic Communication and Patient Interviewing Skills

Competency Topic: Effective Patient Interviewing, Communication and Counseling when Educating and Addressing Common Concerns that Families May Have about Infant Feeding and Maternity Care Practices	
Subtopic	**Trainer Content**
i. Empathy, boundaries, and compassion	• Empathy: looking at a situation from someone else's viewpoint while staying out of judgement and recognizing emotion in others; also, communicating that recognition of the other's emotion • Sympathy does not drive connection • "Never" phrase = beginning a statement with "at least" or trying to silver-line the situation does not drive connection or demonstrate empathy
ii. Application of effective communication strategies during patient interactions	• Accept what the mother thinks and feels • Acknowledge the mother's feelings • Give information and practical help using suitable language and non-verbal communication • Make suggestions not commands • Ask mother frequently for input on suggestions and decide plans together
iii. Avoidance of Blame	• Assume that everyone is doing the very best that they can in the moment
Reference(s): 1. Breastfeeding Resources Ontario. (2018). *BFHI 20-Hour Course: Clinical Practice Options*. Ontario: BFI Strategy for Ontario. Retrieved from: http://breastfeedingresourcesontario.ca/sites/default/files/pdf/Res_Strategy_Clinical_Practice_Options_EN.pdf 2. Rollnick, S., Miller, W. R., & Butler, C. (2008*). Motivational interviewing in health care: Helping patients change behavior*. New York: Guilford Press.	
Related Teaching Resources: 1.4, 1.6, 1.7, 1.8	

B. Counsels/Educates on Immediate and Uninterrupted Skin-to-Skin Care

Competency Topic: Immediate and Uninterrupted Skin-to-Skin Care	
Subtopic	**Trainer Content**
i. Definition	• Skin-to-skin contact (SSC) begins ideally at birth and should last continually until the end of the first breastfeeding; SSC involves placing the dried, naked baby prone in direct contact with their mother on the mother's bare chest with ventral skin of the infant facing and touching the ventral skin of the mother (chest-to-chest); infant may be often covered with a warm blanket
ii. Benefits/importance of immediate and uninterrupted skin-to-skin care	**Newborns:** • Lowers risk for hypothermia • Provides cardiorespiratory stability • Lowers risk of hypoglycemia • Decreased crying **Mother:** • Decreases maternal anxiety • Increases maternal self-confidence in parenting ability • Stimulates oxytocin to enhance uterine contractions (less postpartum bleeding) **Both (newborn/mother):** • Facilitates breastfeeding after delivery and beyond • Promotes bonding

Competency Topic: Immediate and Uninterrupted Skin-to-Skin Care	
Subtopic	**Trainer Content**
iii. Expectations of immediate and uninterrupted skin-to-skin care following delivery	Staff should discuss the procedures and expectations of uninterrupted skin-to-skin care immediately after delivery. **Immediate, safe skin-to-skin care procedure recommendations:** **Vaginal Delivery:** • Newborns should be placed skin-to-skin immediately following delivery unless medical indication to separate **C-Section:** • Newborns should be placed skin-to-skin as soon as mother is responsive, alert, and safely able to respond to her newborn **General:** • Newborns should remain skin-to-skin uninterrupted until completion of the first breastfeeding (minimum of 1 hour if mother is choosing to formula feed) • Routine procedures such as weights, baths, measurements, etc. should be delayed after skin-to-skin is complete • Apgar scores and initial assessments can be completed while newborns remain skin-to-skin • Medications following delivery – AAP and AAFP recommend administration of Vitamin K following the first feeding but within 6 hours of birth – CDC guidelines suggest instilling Erythromycin (0.5%) ointment to both eyes of all newborns as soon as possible after delivery; this can be administered while infant is skin-to-skin. – AAP recommends that routine procedures including eye prophylaxis can be delayed until the first breastfeeding is completed; if prophylaxis is delayed (i.e., not in delivery room), a monitoring system should be established to ensure all infants receive this eye care. – Some states have more strict guidelines related to medication administration; check state guidelines • If medical indications present requiring separation, skin-to-skin care should be initiated as soon as mother and infant are stable

Competency Topic:
Immediate and Uninterrupted Skin-to-Skin Care

Reference(s):

1. Association for Women's Health, Obstetric and Neonatal Nurses. (2016). Immediate and sustained skin-to-skin contact for the healthy term newborn after birth: AWHONN practice brief number 5. Journal of Obstetric, Gynecologic, and Neonatal Nursing: JOGNN, 45(6), 842.
2. Beiranvand, S., Valizadeh, F., Hosseinabadi, R., & Pournia, Y. (2014;2015;). *The effects of skin-to-skin contact on temperature and breastfeeding successfulness in full-term newborns after cesarean delivery*. International Journal of Pediatrics, 2014, 846486-7. doi:10.1155/2014/846486
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10. World Health Organization. (1997*) Thermal protection of the newborn: A practical guide*. Geneva, Switzerland: World Health Organization, p. 7.
11. World Health Organization. (2018). *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva, Switzerland: World Health Organization.

Related Teaching Resource: 1.1 (Skin-to-Skin Care; Delayed Cord Clamping, Eyes and Thighs; Practicing Skin-to-Skin and Rooming-in Safely)

C. Counsels/Educates on Rooming-In

Competency Topic: Rooming-in Information	
Subtopic	**Trainer Content**
i. Definition	• Rooming-in means that mothers and babies stay together in the same room throughout their hospital stay • Rooming-in does NOT mean that the infant should share a bed with mother; bed sharing should be discouraged, and staff should take this opportunity to introduce safe sleep information and practices • Routine procedures such as routine assessments, uncomplicated lab work, newborn baths, and pediatric assessments should be done in the mother's room
ii. Benefits of rooming-in	• Infants sleep better and cry less when they are near mother • Feedings occur more often resulting in better newborn weight gain and less risk of jaundice • Facilitates breastfeeding exclusivity and duration • Facilitates bonding: mothers get to know their newborn better by the end of hospital stay • Mothers are better prepared to care for their newborns at home by the time of hospital discharge • Mothers enjoy the same amount and better quality of sleep when rooming-in as when baby is away • Can improve patient satisfaction and safety (decreased risk of infection, infant abduction, etc.)
iii. Addresses family concerns about rooming-in	• Some mothers/families may ask to send newborns to the nursery when struggling with a certain aspect of caring for their newborn • Staff should address these situations with sensitivity; support and encouragement should be offered along with education on the benefits of rooming-in (listed above) • If the mother is not able to care for the baby OR if the mother feels she is not able to safely care for her baby (due to medications, excessive sleepiness, etc.) then staff should provide appropriate support and intervention to ensure safety concerns are addressed
iv. Back to sleep, every sleep	• Maintain safe sleep positioning – firm, flat, separate sleep surface and back to sleep, every sleep • No excess bedding or objects in the bassinet/crib • Infant should sleep in same room with mother

Competency Topic: Rooming-in Information
References: 1. Ahn, S. Y., Ko, S. Y., Kim, K. A., Lee, Y. K., & Shin, S. M. (2008). The effect of rooming-in care on the emotional stability of newborn infants. *Korean Journal of Pediatrics, 51*(12), 1315. doi:10.3345/kjp.2008.51.12.1315 2. Bystrova, K., Ivanova, V., Edhborg, M., Matthiesen, A., Ransjö-Arvidson, A., Mukhamedrakhimov, R., . . . Widström, A. (2010). Early Contact Versus Separation: Effects on Mother-Infant Interaction 1 Year Later. *Obstetric Anesthesia Digest, 30*(2), 116-117. doi:10.1097/01.aoa.0000370536.74543.e3 3. Crenshaw, J. T. (2014). Healthy Birth Practice #6: Keep Mother and Baby Together— It's Best for Mother, Baby, and Breastfeeding. *The Journal of Perinatal Education, 23*(4), 211-217. doi:10.1891/1058-1243.23.4.211 4. Feldman-Winter, L., & Goldsmith, J. P. (2016). Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns. *Pediatrics, 138*(3). doi:10.1542/peds.2016-1889 5. Keefe, M. R. (1988). The Impact of Infant Rooming-In on Maternal Sleep at Night. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 17*(2), 122-126. doi:10.1111/j.1552-6909.1988.tb00522.x 6. Section on Breastfeeding, & SECTION ON BREASTFEEDING. (2012). Breastfeeding and the use of human milk. Pediatrics, 129(3), e827-e841. doi:10.1542/peds.2011-3552. Retrieved from: https://pediatrics.aappublications.org/content/pediatrics/129/3/e827.full.pdf 7. World Health Organization. (2018). *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva, Switzerland: World Health Organization.
Related Teaching Resource: 1.1 (Facilitate Rooming-In of Mothers and Babies; Practicing Skin-to-Skin and Rooming-In Safely)

D. Counsels/Educates on Benefits of Breastfeeding and Risks of Infant Formula

Competency Topic: **Infant Feeding Related Decisions Such as the Benefits of Breastfeeding, Importance of Exclusive Breastfeeding, and Risks of Infant Formula**	
Subtopic	**Trainer Content**
i. Benefits of exclusive breastfeeding	**Baby has decreased risk of:** • Asthma • Obesity • Type 2 diabetes • Ear infections • Respiratory infections • Sudden infant death syndrome (SIDS) • Gastrointestinal infections (diarrhea and vomiting) • Necrotizing enterocolitis (NEC) for preterm infants **Mother has decreased risk of:** • High blood pressure • Type 2 diabetes • Breast cancer • Ovarian cancer
ii. Potential risks of infant formula	• Conflicting messages about feeding may lead to unnecessary supplementation • Inappropriate supplementation may undermine a mother's confidence • Introduction of infant formula or other supplements may decrease the feeding frequency of the infant, thereby decreasing the amount of breast stimulation a mother receives, which results in a reduction of milk supply • Supplementation/infant formula use can lead to reduced health benefits of exclusive breastfeeding • Introduction of breast milk substitutes may lead to alterations in newborn gut flora which can result in inflammation and/or infection as well as sensitization to foreign proteins (allergy)
iii. Contraindications to breastfeeding	**Contraindications to breastfeeding or feeding expressed breast milk to infants:** • Physicians should make case-by-case assessments to determine whether a woman's environmental exposure, her own medical condition, or the medical condition of the infant warrants her to interrupt, stop, or never start breastfeeding **Mothers should NOT breastfeed or feed expressed breast milk to their infants if:** • Infant is diagnosed with classic galactosemia, a rare genetic metabolic disorder

Competency Topic: Infant Feeding Related Decisions Such as the Benefits of Breastfeeding, Importance of Exclusive Breastfeeding, and Risks of Infant Formula	
Subtopic	**Trainer Content**
	• Mother is infected with the human immunodeficiency virus (HIV) (Note: recommendations about breastfeeding and HIV may be different in other countries) • Mother is infected with human T-cell lymphotropic virus type I or type II • Mother is using an illicit street drug, such as PCP (phencyclidine) or cocaine; (Exception: Mothers receiving Buprenorphine for opiate use disorder in active treatment and have a negative screening for HIV infection and other illicit drugs can breastfeed) • Mother has suspected or confirmed Ebola virus disease **Mothers should <u>temporarily</u> NOT breastfeed and should NOT feed expressed breast milk to their infants if:** • Mother is infected with untreated brucellosis • Mother is taking certain **medications** • The mother is undergoing diagnostic imaging with radiopharmaceuticals • Mother has an active herpes simplex virus (HSV) infection with lesions present on the breast; (Note: Mothers can breastfeed directly from the unaffected breast if lesions on the affected breast are covered completely to avoid transmission) *Mothers may be able to resume breastfeeding after consulting with a physician to determine when their breast milk is safe for their infant. These mothers should be provided with lactation support to learn how to maintain milk production and feed their infants with pasteurized donor breast milk or infant formula while temporarily not breastfeeding. **Mothers should <u>temporarily</u> NOT breastfeed, but CAN feed expressed breast milk if:** • Mother has untreated, active tuberculosis (Note: The mother may resume breastfeeding once she has been treated appropriately for 2 weeks and is documented to be no longer contagious) • Mother has active varicella (chicken pox) infection that developed within the 5 days prior to delivery to the 2 days following delivery *Airborne and contact precautions may require temporary separation of the mother and infant, during which time expressed breast milk should be given to the infant by another care provider; mothers should be able to resume breastfeeding after consulting with a physician to determine when there is no longer a risk of spreading infection; these mothers should be provided with lactation support to learn how to maintain milk production while not breastfeeding and/or while expressing their milk

Competency Topic: **Infant Feeding Related Decisions Such as the Benefits of Breastfeeding, Importance of Exclusive Breastfeeding, and Risks of Infant Formula**	
Subtopic	**Trainer Content**
iv. Family concerns about infant feeding options	• Staff should demonstrate ability to address individual concerns related to infant feeding in a sensitive manner utilizing effective counseling skills while presenting factual evidence-based information to mothers and families
v. Counsels/educates on exclusive breastfeeding	• The AAP and the American Congress of Obstetricians and Gynecologists (ACOG) recommend "exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant." • "WHO recommends mothers worldwide to exclusively breastfeed infants for the child's first six months to achieve optimal growth, development and health. Thereafter, they should be given nutritious complementary foods and continue breastfeeding up to the age of two years or beyond."

Reference(s):

1. Centers for Disease Control and Prevention. (2018). *Breastfeeding: Contraindications to Breastmilk or Feeding Expressed Breast Milk to infants*. Retrieved from: https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/contraindications-to-breastfeeding.html
2. Centers for Disease Control and Prevention. (2019). *Breastfeeding: Why It Matters*. Retrieved from: https://www.cdc.gov/breastfeeding/about-breastfeeding/why-it-matters.html
3. Kellams et al. (2017). ABM Clinical Protocol #3: Supplementary Feedings in the Healthy Term Breastfed Neonate, Revised 2017. *Breastfeeding Medicine, 12*(4), 188-198. doi:10.1089/bfm.2017.29038.ajk
4. Section on Breastfeeding, & SECTION ON BREASTFEEDING. (2012). Breastfeeding and the use of human milk. Pediatrics, 129(3), e827-e841. doi:10.1542/peds.2011-3552. Retrieved from: https://pediatrics.aappublications.org/content/pediatrics/129/3/e827.full.pdf
5. World Health Organization. (2018). *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva, Switzerland: World Health Organization.
6. World Health Organization. (2018). *UNICEF Implementation Guidance Protecting, promoting, and supporting Breastfeeding in facilities providing maternity and newborn services: The revised BABY-FRIENDLY HOSPITAL INITIATIVE*. Retrieved from: http://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation/

Related Teaching Resource: 1.5

E. Counsels/Educates on Feeding Cues

Competency Topic: Feed on Cue/Responsive Feeding Information	
Subtopic	**Trainer Content**
i. Normal feeding behaviors and expectations of a healthy, well infant	• Newborns feed frequently, and often at irregular intervals, throughout the day and night • Parents should be encouraged to feed when newborn is showing early signs of hunger (feed on cue) • Most newborns will feed at least 8-12 feedings in a 24-hour period • Newborns at birth have a small stomach size, well-suited for small volumes of colostrum; as they grow and milk supply is established, the stomach capacity and volume of milk consumed increase together • See **Teaching Resource 1.3** to demonstrate infant stomach size and feeding volumes
ii. Common feeding/ hunger cues	**Signs of hunger:** • Nuzzling at the breast • Eye movements under closed eyelids • Increased alertness • Sucking on hand and tongue • Rooting • Bringing hands to mouth • Squeaking or light fussing • Tongue thrusts • Crying—late sign of hunger **Signs of fullness:** • Relaxed position • Slowing eating pace • Stopping sucking • Turning face away from nipple • Closing lips tightly when nipple presented • Becoming fussy • Increasing attention to surroundings • Falling asleep (some newborns sleep through hunger cues and need to be aroused to feed with sufficient frequency) • See **Teaching Resource 1.2** for link to feeding cue visual

Competency Topic: Feed on Cue/Responsive Feeding Information	
Subtopic	**Trainer Content**
iii. Importance of early recognition and responsive feeding	• Ensures that newborn receives adequate amounts of colostrum/milk • Helps reduce weight loss and facilitates weight gain of newborn • Helps reduce/prevent jaundice in newborns • Mothers that understand and respond to feeding cues are: – More confident and satisfied with hospital care – More likely to succeed with breastfeeding – More able to calm their infants

Reference(s):

1. Black, M. M., & Aboud, F. E. (2011). Responsive Feeding Is Embedded in a Theoretical Framework of Responsive Parenting. *The Journal of Nutrition, 141*(3), 490-494. doi:10.3945/jn.110.129973
2. Brown, A., & Arnott, B. (2014). Breastfeeding Duration and Early Parenting Behaviour: The Importance of an Infant-Led, Responsive Style. *PLoS ONE, 9*(2). doi:10.1371/journal.pone.0083893

Related Teaching Resources: 1.2 & 1.3

F. Counsels/Educates about the Use of Artificial Nipple Use during the Establishment of Breastfeeding

Competency Topic: Artificial Nipple Use during the Establishment of Breastfeeding	
Subtopic	**Trainer Content**
i. Counsels mothers on the use and risks of pacifiers	• Pacifiers replace suckling at the breast and can reduce the number of times an infant breastfeeds. This can lead to: – Reduction of maternal milk production – Interference with the mother's ability to recognize early feeding cues – Potential reduction of newborn's milk intake leading to related issues • Pacifier use is recommended by the AAP for safe sleep (SIDS reduction); however, breastfed infants should only be introduced to pacifiers after breastfeeding is well established • Facility staff should also inform mothers and family members of the hygiene risks related to inadequate cleaning of pacifiers
ii. Counsels mothers on the use and risks of bottles	• The physiology of suckling at the breast is different from the physiology of suckling from a feeding bottle; it is possible that the use of feeding bottles could potentially lead to breastfeeding difficulties • Facility staff should also inform mothers and family members of the hygiene risks related to inadequate cleaning of teats, feeding bottles, and feeding supplies

Reference(s):

1. Baby-Friendly USA. (2016). *Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation.* Albany, NY: Baby-Friendly USA.
2. Bu'Lock, F., Woolridge, M. W., & Baum, J. D. (2008). Development of Co-Ordination of Sucking, Swallowing and Breathing: Ultrasound Study of Term and Preterm Infants. *Developmental Medicine & Child Neurology, 32*(8), 669-678. doi:10.1111/j.1469-8749.1990.tb08427.x
3. World Health Organization. (2018). *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva, Switzerland: World Health Organization.
4. World Health Organization. (2018). UNICEF Implementation Guidance Protecting, promoting, and supporting Breastfeeding in facilities providing maternity and newborn services: The revised BABY-FRIENDLY HOSPITAL INITIATIVE. Retrieved from: http://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation/

Related Teaching Resource: 1.1 (Nipple Confusion)

G. Counsels Mothers on Health-Related Issues and Addresses Concerns in a Sensitive Manner

Competency Topic: Individual Concerns about Health-Related Issues	
Subtopic	**Trainer Content**
i. Patient specific	• There may be additional, facility-specific teaching content needed based on expression of patient concern or existing health condition revealed in conversation or medical history/exam • Additionally, there may be teaching content that is needed due to relevance in your own hospital environment (examples: sexual/domestic abuse, drug use during pregnancy/postpartum)
ii. Cultural/environmental specific	• Consider how staff can ensure that counseling is done equitably across linguistic and cultural groups, such as through use of interpreters • Staff should demonstrate competency in counseling on these topics
Reference(s): 1. World Health Organization. (1997). *Thermal protection of the newborn: A practical guide.* Geneva, Switzerland: World Health Organization. p. 7.	

H. Includes Appropriate Discharge Planning Specific to Patient Needs

Competency Topic: Discharge Plans and Referrals	
Subtopic	**Trainer Content**
i. Follow-up support available after discharge	**(Facility-Specific)** Staff should be knowledgeable about facility-based and community-based resources available to breastfeeding families after discharge • **General recommendations are:** – WIC encourages and promotes breastfeeding for WIC participants, and exclusive breastfeeding is supported in the WIC program in many ways – Contact information for peer counselors and mother-to-mother support groups – Contact information of for lactation professional services – "Warm lines" or any national hotlines that offer postpartum support • **Best practices while preparing for discharge:** – Assess any current or anticipated breastfeeding problems based on maternal and/or infant risk and feeding status – Create individualized action plans/discharge instructions based on risks/status – Arrange infant follow-up after hospital discharge* (by the third to fifth day of life, or approximately 24 to 48 hours from the time the newborn infant is discharged depending on the length of the hospital stay and individual newborn concerns (i.e. jaundice, weight loss)) – Arrange for maternal follow-up contact with OB provider within 2 weeks and a follow-up visit with OB provider should also be scheduled 4-6 weeks following delivery (or sooner depending on status) – Inquire if mother is returning to work or school and assist with proper planning and provide appropriate resources if applicable *Source: http://pediatrics.aappublications.org/content/139/5/e20170647; BFUSA and WHO guidance also suggest follow-up again in the second week to assess feeding progress, weight gain, and other parental concerns
ii. Routine follow-up process for newborn (day 3-5 of life, 24-48 hours after discharge depending on length of hospital stay)	• Staff should be knowledgeable about recommended follow-up processes in alignment with evidence-based care • Staff should understand their role in effective information transfer after discharge (for example, assisting families in identifying a practice where the newborn will be seen for follow-up, and ensuring discharge and lactation information is sent there) • Follow-up care is particularly important for preterm and low birth weight babies as the lack of clear follow-up plan could potentially lead to significant health hazards and adverse outcomes

Competency Topic: Discharge Plans and Referrals	
Subtopic	**Trainer Content**
iii. Evaluation of patient understanding of education/ information provided	• Staff should be knowledgeable about recommended follow-up processes in alignment with evidence-based care • Staff should understand their role in effective information transfer after discharge and ensuring discharge and lactation information is sent there; Refer to hospital policies regarding sharing patient information with affiliated and/or external providers

Reference(s):

1. Baby-Friendly USA. (2016). *Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation*. Albany, NY: Baby-Friendly USA.
2. Flaherman et al. (2017). ABM Clinical Protocol #22: Guidelines for Management of Jaundice in the Breastfeeding Infant 35 Weeks or More of Gestation—Revised 2017. *Breastfeeding Medicine, 12*(5), 250-257. doi:10.1089/bfm.2017.29042.vjf
3. Section on Breastfeeding, & SECTION ON BREASTFEEDING. (2012). Breastfeeding and the use of human milk. Pediatrics, 129(3), e827-e841. doi:10.1542/peds.2011-3552. Retrieved from: https://pediatrics.aappublications.org/content/pediatrics/129/3/e827.full.pdf
4. World Health Organization. (2018). *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva, Switzerland: World Health Organization.

Related Teaching Resource: 1.1 (Engaging Partners in Breastfeeding Support, Connecting Mothers with Community Resources)

Verification of Competency 1 – Suggested Activities

Skills Lab

Table Set-up (*Note: Welcome Table set-up is contained in Appendix I)

Skills Station 1: Communicating with pregnant and postpartum women about infant feeding

Anticipated teaching/learning time: 1.5 hours

Materials/Staff Needed

Training Staff	Training Materials (for Trainer Use, Visuals, Demonstration, etc.)	Staff Handouts (multiple copies of items listed)
(1) Training Team Member	• Core Competency 1 Teaching Outline and Trainer Teaching Content (previous section) • iPad/Computer/Electronic Display with Audiovisual (AV) and internet connection with the following videos loaded – Empathy: https://www.youtube.com/watch?v=1Evwgu369Jw – Boundaries, Empathy, and Compassion: www.theworkofthepeople.com/boundaries – Blame: Who's in Control: https://www.youtube.com/watch?v=RZWf2_2L2v8 – Video links also found **Teaching Resource 1.4** • Communication and Self-Reflection Worksheet Key (Trainer Version): (**Teaching Resource 1.7**) • Case Study/Scenario Card Sets (recommend at least 2 depending on anticipated size of group) (**Teaching Resource 1.9**) – Tip: Laminate scenario cards for durability – Place on ring or bind together if possible so that they do not get misplaced	• Communication Self-Reflection Worksheet (**Teaching Resource 1.8**) • Strategies for Meaningful Conversations **(Teaching Resource 1.6)** • CGBI Ten Step Tear Sheets: A Guide for Healthcare Professionals (**Teaching Resource 1.1**): Titled: – Skin-to-Skin Care – Delayed Cord Clamping – Eyes and Thighs – Practicing Skin-to-Skin and Rooming-In Safely – Engaging Partners in Breastfeeding Support – Facilitate Rooming-In of Mothers and Babies – Infant Feeding Cues – Nipple Confusion – Connecting Mothers with Community Resources

- **Station (Table) Set-up**
  - Signage indicating Station Title Station 1: Communicating with pregnant and postpartum women about infant feeding
  - Station 1: Communicating with pregnant and postpartum women about infant feeding
  - Table should be set up with:
    - AV equipment of choice
    - Stacks of copies the different staff handouts listed above (**Resources 1.1, 1.6**)
    - Copies of the Communication and Self-Reflection Worksheet (learner version) (**Resource 1.8**)
    - Scenario Cards

- **Description of Station Activity:**
  - **General Communication Skills Overview and Activities:** (anticipated time 45 min)
    - This station will start with a lesson/workshop on communication, empathy, and compassion which the learner will be expected to demonstrate throughout the counseling/teaching scenarios presented later in the session.
    - Due to audiovisuals needed, the trainer may want to limit the number of learners per session depending on the audiovisual set up/display. It's important that all learners can hear the short video clips and the trainer during the self-reflection exercises.
    - Trainer will welcome learners and hand them the "Communication Self-Reflection Worksheet" (Learner version). **(Resource 1.8)**
    - Trainer will have learners take a seat and give an overview of general tips and strategies of effective communication. See detailed teaching content in previous subsection (also listed in self-reflection handout)
    - Trainer will then show the short video clips in the order indicated on the Self-Reflection worksheet. After each video clip, the trainer should give learners time to answer the self-reflection questions before moving onto next clip.
    - Once learners have answered all questions, trainers should guide discussion on self-reflection by encouraging learners to share their answers with the group.
      - Tips to moderating discussion:
        - Encourage dialogue and problem solving among peers.
        - Do not correct wrong answers, but rather ask probing questions using information from the Trainer version of the Communication and Self-Reflection Worksheet **(Resource 1.7)** to encourage further discussion and more appropriate responses.

- **Application of Effective Communication Skills Exercise:** (45 min)
  - After Communication and Self-Reflection Worksheet and discussions are complete, the trainer will explain that competency verification will be accomplished by each learner responding to provided scenario cards **(Resource 1.9)**. The trainer should explain that it is expected that the effective communication skills are applied to each response. Key points of information are expected to be addressed in the scenario. These key points are located in the back of each scenario card.
  - The trainer can begin verification by asking for a volunteer to demonstrate competency first. If no one volunteers, the trainer will select a learner.
  - Each learner will demonstrate competency by responding to the scenario utilizing effective communication techniques just learned while demonstrating knowledge of information presented.
  - Trainer will decide how many correct responses meet minimum acceptance for competency verification. (example: learners will respond correctly to at least 6 out of 7 scenarios)
  - Trainer will repeat this with each learner in the group.
    - Considerations for trainers:
      - If a learner is not participatory in exercises or gives indication that they are not comfortable with application of communication skills or knowledge, then trainers should have the learner repeat session or do additional activities to demonstrate competency.
      - If a learner joins the session late, they will have to repeat missed activity in next session. If the session is too far progressed for it to benefit the learner, trainers may advise that the learner wait until next session or join another table session (if that's an option).
  - Once the trainer feels that learners have responded and/or learned from the exercise effectively, the trainer will validate learners' competency by dating and initialing the objectives under Core Competency 1 and signing the bottom on Employee Competency Verification Form.
  - The trainer should instruct the learners to take a copy of each handout provided to place in their folders.

Simulation Lab

- **Station Set up**
  - Signage indicating Station Title: Station 1: Communicating with pregnant and postpartum women about infant feeding
    - Room Set-up with:
      - Patient bed
      - Baby doll
      - Resource handouts listed above
      - Any additional supplies the team feels would help create an environment similar to a patient room

- **Description of Activity:**
  - **General Communication Skills Overview and Activities:** (anticipated time 45 min)
    - This activity will start with a lesson/workshop on communication, empathy, and compassion which the learner will be expected to demonstrate throughout the counseling/teaching scenario
    - Prior to starting simulation lab activities, provide the opportunity for learners to view the short video clips and the trainer during the self-reflection exercises
    - The trainer will provide the learners with the "Communication Self-Reflection Worksheet" (Learner version). **(Resource 1.8)**
    - The trainer will provide an overview of general tips and strategies of effective communication. See detailed teaching content in previous subsection (also listed in Self-Reflection handout).
    - Trainer will then show the short video clips as in the order indicated on the Self-Reflection worksheet. After each video clip, the trainer should give learners time to answer the self-reflection questions before moving onto next clip.
    - Once learners have answered all questions, trainers should guide discussion on self-reflection by encouraging learners to share their answers with the group.
      - Tips to moderating discussion:
        - Encourage dialogue and problem solving amongst peers.
        - If a learner gives a "wrong" or inappropriate answer, avoid outwardly correcting, but rather ask probing questions using information from the Trainer version of the Communication and Self-Reflection Worksheet **(Resource 1.7)** to encourage further discussion and more appropriate response.

- **Application of Effective Communication Skills Exercise:** (45 min)
  - After Communication and Self-Reflection Worksheet and discussions are complete, the trainer will explain that competency verification will be accomplished by each learner responding to provided scenario cards **(Resource 1.9)**. The trainer should explain that it is expected that the effective communication skills are applied to each response. Key points of information are expected to be addressed in the scenario. These key points are located in the back of each scenario card.
  - Each learner will demonstrate competency by responding to the scenario utilizing effective communication techniques just learned while demonstrating knowledge of information presented
  - Trainer will decide how many correct responses meet minimum acceptance for competency verification. (example: learners will respond correctly to at least 6 out of 7 scenarios)
  - Trainer will repeat this with each learner in the group.
    - Considerations for trainers:
      - If a learner is not participatory in exercises or gives indication that they are not comfortable with application of communication skills or knowledge, then trainers should have the learner repeat session or do additional activities to demonstrate competency.
      - If a learner joins the session late, they will have to repeat missed activity in next session. If the session is too far progressed for it to benefit the learner, trainers may advise that the learner wait until next session or join another table session (if that's an option).
  - Once the trainer feels that learners have responded and/or learned from the exercise effectively, the trainer will validate learners' competency by dating and initialing the objectives under Core Competency 1 and signing the bottom on Employee Competency Verification Form.
  - The trainer should instruct the learners to take a copy of each handout provided to place in their folders.

Teaching Resources for Core Competency 1

Note: The training resources provided may include content related to specific practices that is beyond the scope of this training. These resources should be adapted in a manner that aligns with your hospital policies and procedures, taking into account clinical situations and hospital factors unique to your setting.

Resource 1.1

CGBI Ten Step Tear Sheets: A Guide for Healthcare Professionals

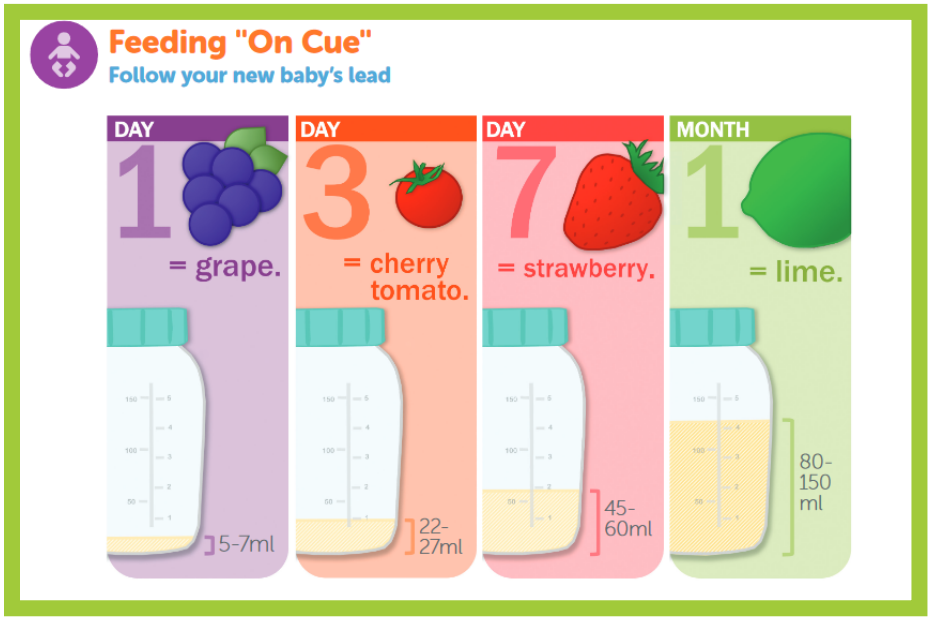
- Link: https://sph.unc.edu/files/2017/10/CGBI-Ten-Steps-Supplemental-Education-for-Staff-S.pdf
- For this Core Competency provide copies Tear Sheets titled:
  - Skin-to-Skin Care
  - Delayed Cord Clamping
  - Eyes and Thighs
  - Practicing Skin-to-Skin and Rooming-In Safely
  - Engaging Partners in Breastfeeding Support
  - Facilitate Rooming-In of Mothers and Babies
  - Infant Feeding Cues
  - Nipple Confusion
  - Connecting Mothers with Community Resources

Resource 1.2

Feed on cue/responsive feeding visual: Link: http://breastfeedla.org/feeding-cues-posters/

Resource 1.3

Feeding "On Cue," excerpted from Ready, Set, Baby Prenatal Education Curriculum from Carolina Global Breastfeeding Institute



Resource 1.4

Communication Videos: Links Used in Suggested Activity
• **Empathy:** https://www.youtube.com/watch?v=1Evwgu369Jw • **Boundaries, Empathy, and Compassion**: www.theworkofthepeople.com/boundaries • **Blame**: Who's in Control: https://www.youtube.com/watch?v=RZWf2_2L2v8

Resource 1.5

List of Recommended Resources on Medication Safety During Lactation: Titles and Links

• American Academy of Pediatrics Statement on the Transfer of Drugs into Human Milk
  ○ http://pediatrics.aappublications.org/content/108/3/776
• Breastfeeding: A Guide for the Medical Professional by R.A. Lawrence and R.M. Lawrence*
  ○ https://www.amazon.com/Breastfeeding-Guide-Medical-Profession-8e/dp/0323357768
• Drugs and lactation database of the U.S. National Library of Medicine: TOXNET: Toxicology Data Network (LactMed)
  ○ https://www.toxnet.nlm.nih.gov/newtoxnet/lactmed.htm
• Drugs in Pregnancy and Lactation by G.G. Briggs, R.K. Freeman, and S.J. Yaffe*
  ○ https://www.amazon.com/s/?ie=UTF8&keywords=drugs+pregnancy+lactation&tag=mh0b20&index=aps&hvadid=78065376997416&hvqmt=b&hvbmt=bb&hvdev=c&ref=pd_sl_3gljpvwkha_b
• Medications and Mothers' Milk by T. Hale*
  ○ https://www.medsmilk.com/
• Vaccinations, Medications and Drugs
  ○ https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/vaccinations-medications-drugs/index.html
 	
*Resource has an associated cost.

Resource 1.6

Scripting Resource: Strategies for Communicating with Mothers Related to Maternity Care and Infant Feeding	
General Tips: • Invite the mother to participate in the conversation and emphasize the important role she plays. • Listen and let the mother identify her own goals and concerns. • Validate and support her goals and concerns. • Provide evidence-based, unbiased information on the benefits and risks of the options. General Dialogue to consider after listening and validating concerns: • "As one of your health care providers, I will support you as you make a decision about (fill in topic). It is most important that you make a decision that works for you, your baby, and situation. I just want to be sure that you have enough information to make an informed decision."	
Common Difficult Conversations and Suggested Phrases/Scripts for Healthcare Staff	
Difficult Conversation Theme	**Suggested Phrases/Responses/Scripts**
Mother undecided about breastfeeding	• "It is great that you are considering breastfeeding, I would love to talk more about this, would that be ok with you?" • "What do you expect breastfeeding to be like?" • "What have you learned about breastfeeding thus far?" • "What have your friends/family told you about breastfeeding?"
Breastfeeding mother requesting to give her baby infant formula (non-medical need for supplementation)	• "I understand that you are feeling overwhelmed because you are tired, and your baby has been feeding for a long time and is not settling. Tell me what you have tried, to settle your baby?" • "It is common to feel unsure and concerned in the early days when babies feed so frequently. While tiring, frequent feeding is normal and helps babies learn while increasing your milk supply." • "Why are you interested in using formula for your baby?" • "I understand you would like to give your baby some formula. Before that happens, I would like to be sure you have information to make the best decision for you and your baby. Would that be ok?"
Breastfeeding mother requesting to use an artificial nipple (pacifier or bottle nipple)	• "How are feedings going?" • "I understand that you are feeling overwhelmed because you are tired, and your baby is not settling. Tell me what you have tried, to settle your baby?" • "I understand you would like to give our baby a (bottle nipple/pacifier). Before that happens, I want to be sure that you have information to make the best decision for you and your baby. Would that be ok?" • "You may be able to consider giving a pacifier when breastfeeding is going well. Would you consider holding off for now?"

Scripting Resource: Strategies for Communicating with Mothers Related to Maternity Care and Infant Feeding	
Breastfeeding mother planning to exclusively breastfeed but needing to give infant formula for medical reason	• "I understand that you were planning to exclusively breastfeed. How do you feel that feedings are going?" • "We would like to get you back to exclusively breastfeeding your baby as soon as possible, but for now, the benefits of giving formula do outweigh the risks. While you are supplementing we will work with you to protect your milk supply by pumping. It is important that we stimulate your breast to produce milk so that it will be easier to transition back to exclusive breastfeeding.
Mother upset or anxious about continuous rooming-in	• "I understand that you are concerned about sleep and the ability to care for your newborn. I will be continuously checking in to be sure that you have the assistance that you need." • "You and your baby's safety and wellbeing are our priority." • "Many moms report that they actually get the same amount of rest when baby remains in the room. We will be checking with you regularly, and if at any point you have a concern about safely caring for your infant, then we will be there to assist."

Resource 1.7

Communication and Self-Reflection Worksheet (Trainer)

Communication Skills

Communication Self-Reflection Worksheet

Boundaries, Empathy, and Compassion: Self-Reflection of Boundaries with Brené Brown (www.theworkofthepeople.com/boundaries)

1. What are your initial thoughts about the speaker's perspectives? How do you think this will make a difference in your practices?
   *Note: Answers will vary greatly. Trainers should look for themes and evidence of self-reflection.
2. What are some examples of boundaries as they apply to your work with mothers, babies, and families?
   - It is not ok to recommend non-evidence-based recommendations just to be agreeable with the patients or families.
   - It is not ok to withhold information from families because of our own fear of inducing guilt.
   - It is not ok to let our own personal biases and experiences impact how we counsel and educate patients.
   - *Note: answers may vary widely. Trainers use judgement.
3. What are some tips and take-aways that you find valuable from this -video clip?
   - Compassionate people have boundaries.
   - Boundaries are what's "ok" and not "ok."
   - When I assume people are doing the best they can, it makes my life better.
   - To assume the best about people, changes your life.
   - Consider what boundaries need to be in place to keep integrity and make the most generous assumptions about others.
   - We are often not comfortable with boundaries because we want people to like us, but boundaries are the key to self-love and sustainably treating others with kindness.
   - Compassion is a belief that we are all connected.
   - Empathy brings compassion to life. We can have a deep love for people, so they know that they are not alone.
   - Empathy minus boundaries is not empathy; compassion minus boundaries is not genuine; vulnerability without boundaries is not vulnerability.
   - *Note: other responses may be correct. Trainer use judgement.

Empathy: Self-Reflection of Dr. Brené Brown on Empathy (www.youtube.com/watch?v=1Evwgu369Jw)

- What are the qualities of empathy?
  a. Perspective taking-looking at the situation from another person's vantage point
  b. Staying out of judgment
  c. Recognizing emotion in others
  d. Communicating that you recognize the other's emotion. Feeling with the person
- What is a phrase that the speaker suggests avoiding? Do you find yourself using this phrase often in conversations with patients?
  - "At least'': trying to create a silver lining
  - Learner will give experience with doing this in work setting…no right or wrong answer.
- Give two examples of how to start a response to a mother/family having trouble or concern related to infant feeding or care:
  a. "You sound worried"
  b. "I hear that you are concerned about your baby"
  - *Note: other responses may be correct. Trainer use judgement.

Communication and Self-Reflection Worksheet (Trainer)

Blaming, Accountability, and Opportunities for Empathy: Self-Reflection of Dr. Brené Brown on Blame (https://www.youtube.com/watch?v=RZWf2_2L2v8)

- Can you recall a time that you have defaulted to blame at work? What was the result or impact?
  - *Note: Answers will vary greatly. Trainers should look for themes and evidence of self-reflection.
- How will you use accountability and find opportunities for empathy?
  - *Note: Answers will vary greatly. Trainers should look for themes and evidence of self-reflection.

Discuss tips below to summarize and assess learner's application to counseling scenarios:

Listen and Learn: Helpful Tips

- Use non-verbal communication to show that you are giving your full attention
- Ask open-ended questions (not yes or no questions)
- Use words/phrases to reflect what the mother says or expresses to you
- Show empathy to demonstrate understanding and connection
- Avoid words that sound judgmental (i.e. should/should not)

Building Confidence and Giving Support: Helpful Tips

- Accept what the mother thinks and feels. This is HER truth.
- Acknowledge that the mother and baby are doing well.
- Give relevant information and practical help using suitable language and non-verbal communication.
- Make suggestions, not commands.
- Ask the mother for input on suggestions and decide a plan together.

This resource was adapted with permission from the BFI Strategy for Ontario. The BFI Strategy is a partnership of Michael Garron Hospital, Best Start by Health Nexus and the Provincial Council for Maternal and Child Health. The Ontario version of this resource was funded by the Government of Ontario, released in 2018 and is available at http://breastfeedingresourcesontario.ca/resource/bfi-20-hour-course-clinical-practice-options.

Resource 1.8

Communication and Self-Reflection Worksheet (Learner)

Communication Skills
Communication Self-Reflection Worksheet

Boundaries, Empathy, and Compassion: Self-Reflection of Boundaries with Brené Brown (www.theworkofthepeople.com/boundaries)

- What are your initial thoughts about the speaker's perspectives? How do you think this will make a difference in your practices?

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- What are some examples of boundaries as they apply to your work with mothers, babies, and families?

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- What are some tips and take-aways that you find valuable from this film?

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Empathy: Self-Reflection of Dr. Brené Brown on Empathy (www.youtube.com/watch?v=1Evwgu369Jw)

- What are the qualities of empathy?

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- What is a phrase that the speaker suggests avoiding? Do you find yourself using this phrase often in conversations with patients?

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- Give two examples of how to start a response to a mother/family experiencing difficulty or concern related to infant feeding or care:

  _____
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Communication and Self-Reflection Worksheet (Learner)

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_____
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Blaming, Accountability, and Opportunities for Empathy: Self-Reflection of Dr. Brené Brown on Blame (https://www.youtube.com/watch?v=RZWf2_2L2v8)

- Can you recall a time that you have defaulted to blame at work? What was the result or impact?

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- How will you use accountability and find opportunities for empathy?

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Listen and Learn: Helpful Tips

- Use non-verbal communication to show that you are giving your full attention.
- Ask open-ended questions (not yes or no questions).
- Use words/phrased to reflect what the mother says or expresses to you.
- Show empathy to demonstrate understanding and connection.
- Avoid words that sound judgmental.

Building Confidence and Giving Support: Helpful Tips

- Accept what the mother thinks and feels. This is HER truth.
- Acknowledge that the mother and baby are doing well or having difficulty.
- Give relevant information and practical help using suitable language and non-verbal communication.
- Make suggestions, not commands.
- Ask the mother for input on suggestions and decide a plan together.

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Resource 1.9

Scenario Cards: (*Note to Trainer: you will find the detailed information on key points for expected learner responses in the Detailed Teaching Content section of Core Competency 1)

Card: Scenario	Back: Key Points Needed in Learner Response
Julia is pregnant with her first baby and was admitted to the LD unit for a scheduled induction. She is accompanied by her family members. During her admission, Julia's mother begins making remarks about holding the baby soon after the baby is born, declaring and requesting that she be the first to hold the baby after the baby is weighed and gets his "shots" while Julia is recovering from the birth. Julia looks uneasy about this. How should you respond to this? (Note: Healthy term baby)	• Benefits of immediate and uninterrupted skin-to-skin care for newborns and/or mothers (at least 3 benefits total) • Expectations of uninterrupted skin-to-skin care immediately following delivery (both VD and CS): – When skin-to-skin initiated – How long newborn should remain uninterrupted – Delay of routine procedures (bath, weight, medications)

Card: Scenario	Back: Key Points Needed in Learner Response
Gigi is pregnant with her 3rd baby. You are giving her a tour of the maternity care unit. She is expressing concerns about the new practices that the maternity unit has implemented since having her previous children. She is particularly concerned about continuous rooming-in. Previously, she sent her babies to the nursery overnight while she was in the hospital so that she could rest. She also stated that the nurses would come to get her baby frequently during the day to get them for their "tests" and doctor check-up. She is wondering if she will have that option again and why she should choose to have her baby room in with her. How should you respond to this? (Note: Healthy term baby)	• Benefits of rooming-in (at least 3) • Addresses Gigi's concerns of sleep and rest appropriately

Card: Scenario	Back: Key points needed in learner response
Catherine is expecting her first baby. She expresses to you that she is considering breastfeeding. However, she is having hesitations. She is unsure if she can breastfeed because she takes medication for a chronic illness. She is also worried about the commitment and thinks that she may want to also use formula sometimes instead of breastfeeding exclusively. She asks for your opinion. What should you tell her? (Note: Healthy term baby)	• Benefits of breastfeeding (at least 4 for infant/mother) • Recommendations about breastfeeding exclusively • Discuss potential risks of introducing infant formula (at least 3) • Addresses medication use while breastfeeding… general information about the contraindications of breastfeeding and advice…does not need to know drug specifics

Card: Scenario	Back: Key points needed in learner response
Kathy just gave birth to her 2nd baby and is breastfeeding. She feels that breastfeeding is going well but expresses confusion about why her baby seems to be fussy way before his scheduled feeding time and sometimes they experience latch difficulty because of his fussiness. Kathy states that she has been feeding him every 3 hours for 15 min on each breast just as she was instructed to do for her previous child. (Note: Healthy term baby)	• Normal infant feeding expectations and behaviors (at least 3) • Signs of hunger/signs of fullness • Importance of early hunger cue recognition and responsive feeding (at least 3)

Card: Scenario	Back: Key points needed in learner response
Abby is 2 days postpartum and breastfeeding her term baby. She is requesting a pacifier so that the baby can get used to it and doesn't use her breast to pacify. She also remembers learning that babies should get pacifiers during sleep to prevent SIDS. How should you respond to Abby's request? (Note: Healthy term baby)	• Impact of early pacifier use on breastfeeding • Correctly address safe sleep recommendations

Card: Scenario	Back: Key points needed in learner response
Daina is 48 hours postpartum and has been breastfeeding her term baby. This morning the physician ordered for the baby to receive supplementation with infant formula due to excessive weight loss, decreased output, as well as ongoing hypoglycemia concerns. Daina is very worried and requests that the baby receive the infant formula via bottle. How should you respond to Daina's request? (Note: Healthy term baby)	• Impact of early bottle use on breastfeeding • Alternative feeding methods such as spoon or cups • Appropriate volume of supplement (short-term use of limited quantities) • Protecting and promoting milk production during supplementation discussion

Card: Scenario	Back: Key points needed in learner response
Thea is 2 days postpartum, and she and her term baby are being discharged from the maternity unit. She has been breastfeeding exclusively through her hospital stay and seems to be doing well. However, she is nervous about how things will go once she is home and wants to know how she can get help outside of the hospital. What should you tell Thea? (Note: Healthy term baby)	• Correctly describe the discharge, follow-up, and referral process • Discuss available support in community

CORE COMPETENCY 2 -

OBSERVING, ASSESSING, AND ASSISTING WITH BREASTFEEDING

EMPower Training

CORE COMPETENCY 2 – OBSERVING, ASSESSING, AND ASSISTING WITH BREASTFEEDING

Overview

Timely and appropriate care for breastfeeding mothers can only be accomplished if staff have comprehensive knowledge, competence, and tactile skills. It is important that staff apply their knowledge of evidence-based care and breastfeeding support. This lesson will focus on assisting staff with gaining confidence and competence with applying knowledge and skills in everyday practice to the patients and families they care for. Such encounters and application techniques should consider the individual, evolving concerns and status of the couplet while continuing to build confidence and reassurance of support.

Objectives

Learner will be able to demonstrate the ability to:

1. Provide proper skin-to-skin care placement and techniques after delivery while utilizing evidenced-based assessment and monitoring recommendations.
2. Promote safe rooming-in and safe sleep environments for families that can room in with their infants.
3. Assess a breastfeed, looking for characteristics of proper latch and adequate milk transfer.
4. Coach and assist with a breastfeed, utilizing proper positioning and latch techniques.
5. Appropriately manage care of patients presenting with common problems and risk factors impacting infant feeding (maternal and newborn) and consult with a lactation specialist as needed.
6. Provide adequate supplementation (when indicated) to a breastfeeding newborn utilizing alternative feeding methods.

Time: 1.5 hours

Safety Considerations

1. When implementing practice changes, facilities should consider using a quality improvement approach. Testing processes on a small scale before implementing widely can facilitate a positive and safe change environment.
2. It is important that maternity staff demonstrate the ability to intervene appropriately when safety concerns, risk factors, and/or medical conditions related to breastfeeding, skin-to-skin care, rooming-in are identified. Assessment and identification of these concerns can result in modifications, delays, and/or contraindications to these practices.

Teaching Outline

Core Competency 2: Observing, assessing, and assisting with breastfeeding

A. Implementation of immediate and uninterrupted skin-to-skin care
   i. Standardization of procedure following vaginal delivery (including appropriate timing and duration)
   ii. Standardization of procedure following C-section (including appropriate timing and duration)
   iii. Initiation of breastfeeding within the first hour of life
   iv. Ensuring safety during immediate and uninterrupted skin-to-skin care
      1. Positioning and placement considerations
      2. "RAPP" Assessments (respiratory activity, perfusion, and position)
      3. Sudden Unexpected Postnatal Collapse (SUPC)
         a. Definition
         b. Identification of risk factors for SUPC
      4. Infant falls
         a. Definition
         b. Identification of risk factors
   v. Documentation of immediate and uninterrupted skin-to-skin practices

B. Implementation of rooming-in practices
   i. Identification of patients that may be at risk for unsafe rooming-in practices
   ii. Identification of appropriate interventions when safety of rooming-in is a concern
   iii. Promotion of a safe rooming-in and safe sleep environment and role model safe sleep practices
   iv. Demonstration of appropriate support for families when rooming-in is not possible due to safety concerns or medical indications
   v. Documentation of rooming-in practices

C. Assessment of breastfeeding
   i. Assessment of breast and nipples
   ii. Assessment of latch
      1. Characteristics of proper latch
      2. Signs of improper latch
   iii. Assessment of milk transfer
      1. Signs of adequate milk transfer
      2. Signs of inadequate milk transfer
   iv. Utilization of breastfeeding assessment tool (i.e., LATCH)
   v. Documentation of assessment

D. Coaching and assisting (when needed) with breastfeeding
    i. Demonstration of proper positioning to facilitate effective latching and feeding
    ii. Utilization of proper latch techniques to facilitate proper latch and optimal milk transfer
    iii. Documentation of assistance and education provided
E. Management of common problems and risk factors
    i. Maternal
        1. Nipple soreness and cracking
        2. Breast engorgement
        3. Mastitis
        4. Flat or inverted nipples
        5. Low maternal confidence about milk supply
        6. Breast anomaly and/or medical issue
            a. Delayed secretory activation
            b. Primary glandular insufficiency
            c. Prior breast surgery or pathology
            d. Temporary cessation due to contraindicated medication use
    ii. Newborn
        1. Latch difficulty or breast refusal
        2. Frequent crying/inconsolable infant
        3. Sick or preterm infants
        4. Low-birthweight infants
        5. Newborn weight loss
        6. Hypoglycemia
        7. Hyperbilirubinemia
F. Supplementation and alternative feeding methods
    i. Common medical indications that may require individualized feeding plans and potential supplementation of expressed breast milk and/or donor milk and/or infant formula
    ii. Access hospital's supplementation protocol and review (Hospital will need to develop if one doesn't exist)
    iii. Supplementary feeding choices
    iv. Amount of supplementation needed
    v. Demonstration of proper alternative feeding method techniques
        1. Supplemental Nursing System (SNS)
        2. Cup
        3. Spoon
        4. Syringe
    vi. Documentation of medical indication for supplementation. If maternal request, documentation of education

Accompanying Trainer Content

A. Implementation of Immediate and Uninterrupted Skin-to-Skin Care

Competency Topic: Implementing Immediate and Uninterrupted Skin-to-Skin Care: Placement, Techniques, Assessment, and Monitoring	
Subtopic	**Trainer Content**
i. Standardization of procedure following vaginal delivery (including appropriate timing and duration)	**Vaginal Delivery:** • Newborns should be placed skin-to-skin immediately following delivery unless medical contraindication • Procedure for immediate skin-to-skin care as outlined in AAP Clinical Report: Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns – Delivery of newborn – Dry and stimulate for first breath/cry and assess newborn – If the newborn is stable, place skin to skin with cord attached (with option to milk cord), clamp cord, and reassess newborn to permit physiological circulatory transitions; The American College of Obstetricians and Gynecologists (ACOG) now recommends a delay in umbilical cord clamping for all healthy infants for at least 30-60 seconds after birth – Continue to dry entire newborn except hands to allow the infant to suckle hands bathed in amniotic fluid (which smells and tastes similar to colostrum), which facilitates rooting and first breastfeeding – Cover head with cap (optional) and place pre-warmed blankets to cover body of newborn on mother's chest, leaving face exposed – Assess Apgar scores at 1 and 5 minutes – Replace wet blankets and cap with dry warm blankets and cap – Assist and support to breastfeed
ii. Standardization of procedure following C-section (including appropriate timing and duration)	**C-Section:** • Newborns should be placed skin-to-skin as soon as mother is responsive, alert, and safely able to respond to her newborn • Procedure for immediate skin-to-skin care adapted from AAP Clinical Report: Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns. Adapted for initiation in the PACU – Delivery of newborn – Dry and stimulate for first breath/cry, and assess newborn – Continue to dry entire newborn except hands to allow the infant to suckle hands bathed in amniotic fluid (which smells and tastes similar to colostrum), which facilitates rooting and first breastfeeding. – If the newborn is stable and mom is responsive and alert, then place skin to skin – Cover head with cap (optional) and place pre-warmed blankets to cover body of newborn on mother's chest, leaving face exposed – Assess Apgar scores at 1 and 5 minutes – Replace wet blankets and cap with dry warm blankets and cap

Competency Topic: Implementing Immediate and Uninterrupted Skin-to-Skin Care: Placement, Techniques, Assessment, and Monitoring	
Subtopic	**Trainer Content**
	– Assist and support to breastfeed
iii. Initiation of breastfeeding within the first hour of life	• Newborns should remain skin-to-skin uninterrupted until completion of the first breastfeeding (minimum of 1 hour if mother is choosing to formula feed) • Routine procedures such as weights, baths, measurements, etc. should be delayed until skin-to-skin care is complete • Apgar scores and initial assessments can be completed while newborns remain skin-to-skin • Maternity care staff should encourage mother to watch for feeding cues after delivery • Maternity care staff should offer to assist mothers with feeding while being careful not to interrupt the newborns natural progression to the breast
iv. Ensuring safety during immediate and uninterrupted skin-to-skin care 1. Positioning and placement considerations 2. "RAPP" Assessments (respiratory activity, perfusion, and position) 3. Sudden Unexpected Postnatal Collapse (SUPC) a. Definition b. Identification of risk factors of SUPC c. Infant falls a. Definition b. Identification of risk factors	• Skin-to-skin care is defined as placing infant in direct contact with their mother with ventral skin of the infant facing and touching the ventral skin of the mother (chest-to-chest) – **Components of safe positioning for the newborn while skin-to-skin:** i. Infant's face can be seen ii. Infant's head is in "sniffing" position iii. Infant's nose and mouth are not covered iv. Infant's head is turned to one side v. Infant's neck is straight, not bent vi. Infant's shoulders and chest face mother vii. Infants legs are flexed viii. Infant's back is covered with blankets ix. Mother-infant dyad is monitored continuously by staff in the delivery environment and regularly on the postpartum unit x. When mother wants to sleep, infant is placed supine in bassinet or with another support person who is awake and alert • Mothers should not lie flat on their backs but rather at a slightly elevated angle when their infants are skin-to-skin • **Risks of hazardous positioning (including with caregiver):** – Fatigue (Prolonged labor/delivery, medications) – Impaired mobility – Distraction such as from extensive cell phone use See **Teaching Resource 2.3** for visual and guidance

Competency Topic: Implementing Immediate and Uninterrupted Skin-to-Skin Care: Placement, Techniques, Assessment, and Monitoring	
Subtopic	**Trainer Content**
	• **Maintain Warmth**- Staff should place a dry cover or blanket over infant's back; if blankets get wet or soiled, they should be replaced quickly • **Assess Color**- Staff should periodically assess the color of newborn's skin for signs of central cyanosis and intervene immediately if needed following your facility's normal Neonatal Resuscitation Program (NRP) protocols • **Continuous Surveillance**- Staff should monitor dyad continuously with frequent monitoring of infant vital signs; during immediate skin-to-skin care staff should take sensible vigilance and safety precautions to observe for any signs of distress (for 2-4 hours or with more as indicated by mother/ infant status • There currently is no standard definition for SUPC; the British Association of Perinatal Medicine offers the following definition: *Any term or near-term (defined as >35 weeks' gestation in this review) infant who meets the following criteria: 1. Is well at birth (normal 5-minute Apgar and deemed well enough for routine care) 2. Collapses unexpectedly in a state of cardiorespiratory extremis such that resuscitation with intermittent positive-pressure ventilation is required, 3. Collapses within the first 7 days of life, and 4. Either dies, goes on to require intensive care, or develops encephalopathy • Frequent and repetitive assessments, including observation of newborn breathing, activity, color, tone, and position, may avert positions that obstruct breathing or events leading to collapse; in addition, continuous observation by trained staff members and the use of checklists may improve safety (**Teaching Resources 2.4 & 2.5**) Given the occurrence of events in the first few hours of life, it is prudent to consider staffing the delivery unit to permit continuous staff observation with frequent recording of neonatal vital signs. • A procedure manual that is implemented in a standardized fashion and practiced with simulation drills may include sequential steps; see sample in **Teaching Resource 2.2** • Infants at higher risk of SUPC, falls, and suffocation include: – Required resuscitation (i.e., any positive pressure ventilation) – Low Apgar score – Late preterm (34-36 6/7 weeks gestation) infants – Early term (37-39 week's gestation) infants – Difficult delivery

Competency Topic: Implementing Immediate and Uninterrupted Skin-to-Skin Care: Placement, Techniques, Assessment, and Monitoring	
Subtopic	**Trainer Content**
	– Mother receiving codeine or other medications that may affect the newborn (e.g., general anesthesia or magnesium sulfate) – Sedated mother – Excessively sleepy mother/or newborns • Some mothers may wish to continue skin-to-skin while being transferred to another location; this transfer may be accomplished safely with a standardized process and skilled staff; a newborn should be properly secured during the transfer otherwise they may be at risk for falls or unsafe positioning that could lead to suffocation
v. Documentation of immediate and uninterrupted skin-to-skin practices	**(Facility-Specific)** Staff should cite appropriate area and procedure for documenting immediate, uninterrupted skin-to-skin practices in health record **Consider including:** • Start and stop times of skin-to-skin after delivery • The ability to document/specify reasons that skin-to-skin was delayed or interrupted • Continuous monitoring efforts and infant status (i.e., RAPP Assessments); see Teaching Resources **2.4** & **2.5**

Reference(s):

1. Ainsworth, R. M., Summerlin-Long, S., & Mog, C. (2016). A Comprehensive Initiative to Prevent Falls Among Newborns. *Nursing for Women's Health, 20*(3), 247-257. doi:10.1016/j.nwh.2016.04.025
2. Baby-Friendly USA. (2016). *Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation*. Albany, NY: Baby-Friendly USA.
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Competency Topic: Implementing Immediate and Uninterrupted Skin-to-Skin Care: Placement, Techniques, Assessment, and Monitoring	
Subtopic	**Trainer Content**
Related Teaching Resources: 2.1, 2.2, 2.3, 2.4, 2.5, Skin-to-Skin/Rooming-in Safety Quiz 2.16 & 2.17	

B. Implementation of Rooming-in Practices

Competency Topic: Implementing Safe Rooming-in Practices	
Subtopic	**Trainer Content**
i. Identification of patients that may be at risk for unsafe rooming-in practices	• Use of sedating analgesia or medications • Seizure precautions • Mother with limited mobility • Mothers with uncontrolled pain • Lack of support person • First time mothers
ii. Identification of appropriate interventions when safety of rooming-in is a concern	If risk factors are identified, staff should: • Ensure that there is an additional responsible person with mother to assist with newborn • Make safety assessments during all rounds and any time they enter patient room • Conduct safety assessments more frequently • Stay at bedside during feedings • Consider removing infant from parent's room into a safe observation space if conditions decline and mother/family is unable to respond to infant safely • Monitor mothers according to their risk assessment: for example, observing every 30 minutes during nighttime and early morning hours for higher-risk
iii. Promotion of a safe rooming-in and safe sleep environment and role model safe sleep practices	• No bed sharing • Maintain safe sleep positioning – firm, flat, separate sleep surface and back to sleep, every sleep • No excess bedding or objects in the bassinet/crib • No bassinet propping • Infant should sleep in same room with mother • Education provided on safety precautions during admission, at every shift, when giving pain medication, and as determined by staff • Instruction to parents not to lift newborns when feeling sleepy or unsteady, but instead ask for assistance • Instruction to parents to never leave infant unattended in room especially on unsafe surfaces such as hospital bed, couch, or chair

Competency Topic: Implementing Safe Rooming-in Practices	
Subtopic	**Trainer Content**
	• Mother's bed should be in low position • Upper side rails raised during newborn feeding • Review mother-infant equipment to ensure proper function and demonstrate the appropriate use of equipment, such as bed rails and call bells, with mothers and families
iv. Demonstration of appropriate support for families when rooming-in is not possible due to safety concerns or medical indications	• Utilize effective and considerate communication skills when specific to patient/dyad situation or assessment findings
v. Documentation of rooming-in practices	**(Facility-Specific)** Staff should cite appropriate area, time away from the mother and reason for separation. Rooming-in practices/infant location/safety precautions should be documented in health record

Reference(s):

1. Ainsworth, R. M., Summerlin-Long, S., & Mog, C. (2016). A Comprehensive Initiative to Prevent Falls Among Newborns. *Nursing for Women's Health, 20*(3), 247-257. doi:10.1016/j.nwh.2016.04.025
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3. Feldman-Winter, L., & Goldsmith, J. P. (2016). Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns. *Pediatrics, 138*(3). doi:10.1542/peds.2016-1889
4. World Health Organization. (2018). *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva, Switzerland: World Health Organization.

Related Teaching Resources: 2.1, 2.2, 2.3, 2.4, 2.5, Skin-to-Skin/Rooming-in Safety Quiz 2.16 & 2.17

C. Assessment of Breastfeeding

Competency Topic: Breastfeeding Assessment	
Subtopic	**Trainer Content**
i. Assessment of breast and nipples	**Breast Shape:** • When completing the breast assessment, notice the symmetry, spacing, shape, and size of the breasts • Inquire about previous breast surgery. Do not assume because you do not see any scar tissue that a patient has not had surgery • Breasts that are asymmetrical, tubular and widely spaced (greater than 1.5 inches between breasts) may be a sign of insufficient glandular tissue which affects the amount of milk a mother makes • Large pendulous breasts may need additional support during breastfeeding to achieve the best latch. Description in in **Teaching Resource 2.6** **Nipples:** • The size and shape of the nipples could potentially affect latch impacting milk production and transfer • In addition to the shape of the breasts, note the shape of the nipple and the length of the shank; is the nipple flat, inverted or retracted? • When assessing the breast, compress each breast to see how the nipple reacts; some women may have a nipple that looks retracted or inverted but then becomes erect with stimulation; others may have a nipple that looks erect but retracts when stimulated; description in **Teaching Resource 2.6**

Competency Topic: Breastfeeding Assessment	
Subtopic	**Trainer Content**
ii. Assessment of latch 1. Characteristics of proper latch 2. Signs of improper latch	**Proper Latch:** • Most of the areola, or as much of the areola as possible, is in the infant's mouth; the tip of the nipple should reach the infant's soft palate at the back of the mouth • Breast is supported to keep pressure on the tongue; support the weight to prevent the infant from pulling down on the nipple or losing the latch • Infant's chin is touching the breast; the infant's mouth should be brought up over the areola with the infant's chin touching the breast first • Latch should be asymmetric: more of the areola is visible beyond the infant's upper lip than lower lip • Infant's lips are flanged, forming a seal around the nipple; the mother can gently roll out the lips, if they are curled in, or re-latch the infant • Breast is not pulled back from baby's nose; when the mother pulls back on the breast, it can cause the infant to bite/clamp down or lose the latch; infants will be able to breathe, even when the nose is close to the breast • The infant's cheeks are not touched; touching the cheeks can elicit the rooting reflex, causing the infant to turn head and/or the bite reflex • Also note that the mother's hand is supporting the infant between the shoulders rather than behind the head; when a hand is placed behind the infant's head, the infant's reflex is to push back again the hand **Signs of improper latch:** • Audible clicking or sucking • Dimpling of infant's cheeks • Nipple pain reported by mother • Nipple trauma/skin breakdown • Infant does not stay attached Visuals and videos in **Teaching Resources 2.7** & **2.18** (videos listed on worksheet)

Competency Topic: Breastfeeding Assessment	
Subtopic	**Trainer Content**
iii. Assessment of milk transfer 1. Signs of adequate milk transfer 2. Signs of inadequate milk transfer	**Infant signs of effective milk transfer in the early postpartum period include:** • Releases breast easily at the end of the feeding • Mouth is wet at the end of the feeding • 3-4 substantive stools per 24 hours by day 4 • Transitioning to yellow, seedy bowel movements by day 5 • 5-6 wet diapers per 24 hours by day 5 **Infant signs of inadequate milk transfer in the early postpartum period include:** • Inability to maintain an effective latch • Increasingly lethargic or periods of inconsolable crying even after feedings • Diaper output not meeting normal newborn expectations • Excessive weight loss beyond normal expectations; weight loss ≥ 8-10% at day 5 or later is an indication for further evaluation • Supplementation may not be indicated; the weight loss may be normal if there are no additional indications of inadequate milk transfer or low milk production *Note: Use of an assessment tool such as the NEWT tool could be helpful in determining individualized plans of care related to infant feeding. Newt is the first tool created that allows pediatric healthcare providers and parents to see how a newborn's weight during the first days following childbirth compares with a large sample of newborns. Using a research sample of birth weights from more than 100,000 breastfed newborns, the tool uses a nomogram to plot a baby's weight percentile at any given time in the first few days following birth compared with the research population. The results can be used for early identification of neonates on a trajectory for greater weight loss and related complications. Link provided in **Teaching Resource 2.21.**
iv. Utilization of breastfeeding assessment tool (i.e., LATCH)	• While more research is still needed to empirically validate one certain tool to evaluate breastfeeding effectiveness and risks, the purpose of these tools is to provide a

Competency Topic: Breastfeeding Assessment	
Subtopic	**Trainer Content**
	systematic approach to assessment and risk identification so that appropriate interventions and referrals can be made • There are multiple examples of breastfeeding assessment tools; the facility should decide on what type of assessment works best within their facility • Commonalities of various breastfeeding assessment tools are evaluation of: – Infant's readiness to feed and ease of obtaining an effective latch – Latch – Positioning – Maternal comfort/pain – Suckling and signs of effective milk transfer Positioning Examples of breastfeeding assessment tools provided in **Teaching Resources 2.8**, **2.9**, **2.10**
v. Documentation of assessment	**(Facility-Specific)** Staff should cite appropriate area and procedure for documenting breastfeeding assessment in health record • Consider including maternal and infant status • See **Teaching Resources 2.8**, **2.9**, **2.10** for assessment components to consider

Competency Topic: Breastfeeding Assessment
Reference(s): 1. Berens, P., Eglash, A., Malloy, M., & Steube, A. M. (2016). ABM clinical protocol #26: Persistent pain with breastfeeding. *Breastfeeding Medicine: The Official Journal of the Academy of Breastfeeding Medicine, 11*(2), 46. 2. Bu'Lock, F., Woolridge, M. W., & Baum, J. D. (1990). Development of co-ordination of sucking, swallowing and breathing: Ultrasound study of term and preterm infants. *Developmental Medicine and Child Neurology, 32*(8), 669-678. doi:10.1111/j.1469-8749.1990.tb08427.x 3. Ingram, J., Johnson, D., Copeland, M., Churchill, C., & Taylor, H. (2015). The development of a new breast feeding assessment tool and the relationship with breast feeding self-efficacy. *Midwifery, 31*(1), 132-137. doi:10.1016/j.midw.2014.07.001 4. Jensen, D., Wallace, S., & Kelsay, P. (1994). LATCH: a breastfeeding charting system and documentation tool. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 23(*1), 27-32. 5. Kellams, A., Harrel, C., Omage, S., Gregory, C., & Rosen-Carole, C. (2017). ABM clinical protocol #3: Supplementary feedings in the healthy term breastfed neonate, revised 2017. *Breastfeeding Medicine: The Official Journal of the Academy of Breastfeeding Medicine, 12*, 188. 6. Lawrence, R. A., & Lawrence, R. M. (2011). *Breastfeeding: A guide for the medical profession*. (Seventh ed.). Maryland Heights, MO: Mosby/Elsevier. 7. Macdonald, P. D. (2003). Neonatal weight loss in breast and formula fed infants. *Archives of Disease in Childhood – Fetal and Neonatal Edition, 88*(6), *F472-476*. doi:10.1136/fn.88.6.f472 8. Paul, Ian, et al. (2019). "Newborn Weight Loss Tool." Newt. Retrieved from: www.newbornweight.org/ 9. Wilson-Clay, Kay Hoover. (2017). The Breastfeeding Atlas, 6th ed. Lactnews Press, Manchaca, Tx.
Related Teaching Resources: 2.6, 2.7, 2.8, 2.9, 2.18 (videos), 2.21 (NEWT Tool Link)

D. Coaching and Assisting (when needed) with Breastfeeding

Competency Topic: Breastfeeding Assistance	
Subtopic	**Trainer Content**
i. Demonstration of proper positioning to facilitate effective latching and feeding	Staff should adequately demonstrate ability to assist mother with common breastfeeding positions appropriate for maternal/infant anatomy, potential mobility constraints, and comfort of the dyad. • Cradle hold • Cross-Cradle hold • Football/Clutch hold • Leaning back/Laid back/Biological nursing position • Side-lying position • See **Teaching Resource 2.11** for positioning visuals **General positioning information to observe when learner is demonstrating positioning assistance:** • Infant and mother are belly to belly- when babies feel gravity on their front body, they can utilize instinctive reflexes that can help them attach to the breast • Infant nose and mother's nipple are aligned so that optimal latch technique is easily obtained • Staff should emphasize and prioritize comfort of mother—adding pillows or materials for physical support to maintain position if she looks strained or reports discomfort **Certain mothers may need additional support. Examples include:** • First-time mothers • Mothers who have not breastfed before • Mothers who have had previous negative breastfeeding experience • Mothers who have had C-section • Mothers who are obese

Competency Topic: Breastfeeding Assistance	
Subtopic	**Trainer Content**
ii. Utilization of proper latch techniques to facilitate proper latch and optimal milk transfer	Staff should adequately demonstrate the ability to assist a mother with obtaining an optimal latch during feeding attempts. **Learner should be able to:** • Help the mother into a comfortable position (see above) • Help mother to position and support the baby; mother should support the infant's head by placing her hand from the infant's shoulder blades to the base of the infant's skull, not on the head itself as this will cause baby to push back from the breast • Guide the mother's hands, as needed to provide breast support; mothers fingers/hands should be placed away from the nipple but close to areola for breast support • Bring the infant to the breast, not the breast to the infant; bringing the breast to the infant will cause the mother to bend over and eventually lead to fatigue, discomfort or lack of adequate support for baby • Infant's nose should align with nipple and nipple should be pointing up towards roof of infant's mouth • Infant's chin should approach breast first • More of the mother's areola should be visible above baby's top lip • Have the mother give a return demonstration by doing it without your guidance
iii. Documentation of assistance and education provided	• (Facility-Specific) Staff should cite appropriate area and procedure for documenting breastfeeding assistance and education in health record • Consider including maternal and infant status; many breastfeeding assessment tools capture the amount of maternal assistance needed during positioning and latching • See **Teaching Resources 2.8, 2.9, 2.10** for assessment components to consider

Reference(s):

1. Ingram, J., Johnson, D., Copeland, M., Churchill, C., & Taylor, H. (2015). The development of a new breast-feeding assessment tool and the relationship with breast feeding self-efficacy. *Midwifery, 31*(1), 132-137. doi:10.1016/j.midw.2014.07.001
2. Jensen, D., Wallace, S., & Kelsay, P. (1994). LATCH: a breastfeeding charting system and documentation tool. Journal of Obstetric, Gynecologic, & Neonatal Nursing, 23(1), 27-32.
3. Lawrence, R. A., & Lawrence, R. M. (2011). *Breastfeeding: A guide for the medical profession* (Seventh ed.). Maryland Heights, MO: Mosby/Elsevier.
4. World Health Organization. (2018). *WHO recommendations: Intrapartum care for a positive childbirth expe*rience. Geneva, Switzerland: World Health Organization.

Related Teaching Resources: 2.8, 2.9, 2.10, 2.11

E. Management of Common Problems and Risk Factors

Competency Topic: Management of Common Problems and Risk Factors Impacting Infant Feeding (maternal and newborn)	
Subtopic	**Trainer Content**
i. Maternal 1. Nipple soreness and cracking 2. Breast engorgement 3. Mastitis 4. Flat or inverted nipples 5. Low maternal confidence about milk supply 6. Breast anomaly and/or medical issue a. Delayed secretory activation b. Primary glandular insufficiency c. Prior breast surgery or pathology d. Temporary cessation due to contraindicated medication use	With any presenting breast/nipple complication or complaint of pain (breast pain/nipple soreness, breast engorgement and/or mastitis), staff should demonstrate the ability to perform the following: • **Pain history** from mother, noting: – Onset postpartum – Signs and location of early nipple trauma (abrasions, cracks, bleeding) – Context (with latch, during breastfeeding, between breastfeeds, with milk expression) – Location (nipple and/or breast; superficial versus deep) – Duration (timing, intermittent, or constant) – Character (burning, itching, sharp, shooting, dull, aching) – Pain severity using rating scale, such as 0–10 – Associated signs and symptoms (skin changes, nipple color change, nipple shape/appearance after feeding, fever) – Exacerbating/ameliorating factors (cold, heat, light touch, deep pressure) – Treatment thus far (analgesia, including nonsteroidal anti-inflammatory drugs and/or narcotic preparations), antibiotics, antifungals, steroids, herbs, lubricants, other supplements **Physical assessment** should include: • **Mother** – General appearance and mood (pale [anemia], exhaustion) – Assessment of nipples (skin integrity, sensitivity, purulent drainage, presence/absence of rashes, lesions) – Breast examination (masses, tenderness to light/deep pressure) – Sensitivity to light or sharp touch on body of breast, areola, and nipple – Manual expression of milk (assess for pain with maneuver) • **Infant** – Symmetry of head and facial features (including jaw angle, eye/ear position) – Oral anatomy (assess for signs of presence/absence of lingual frenulum, palate abnormality, submucosal cleft) – Airway (looking for nasal congestion) – Head and neck range of motion – Infant muscle tone – Refer to advanced practitioner as needed (Provider, IBCLC, OT, PT, ST)

Competency Topic: Management of Common Problems and Risk Factors Impacting Infant Feeding (maternal and newborn)	
Subtopic	**Trainer Content**
	• **Breastfeeding assessment/observation**, noting: – Maternal positioning – Infant positioning and behavior at the breast – Latch (wide-open mouth with lips everted) – Suck dynamics—pattern of feeding, nutritive and non-nutritive sucking, sleeping – Shape and color of nipple after feeding • **Observation of milk expression*** (if applicable), noting: – Hand expressing technique – Breast shield/flange fit – Breast pump dynamics, including suction and cycle frequency with the pump the mother is using – Evidence of trauma from the breast pump *Note: more on milk expression in next Core Competency • **Referral to provider for additional laboratory studies** such as milk and nipple cultures may be considered based on the history and physical exam findings such as the following: – Acute mastitis or mastitis that is not resolving with antibiotics – Persistent nipple cracks, fissures, or drainage – Erythema or rashes suggesting viral or fungal infection – Breast pain out of proportion to examination (appear normal, but very tender, breasts or nipples) – Refer to advanced practitioner as needed • **Management of nipple soreness/abrasion**: – Assess for underlying factors (see above) such as poor positioning/latch techniques, infant oral anatomy, etc. – Correct/address any underlying issues if they are identified and within scope of practice; this may require referral if underlying complications identified are beyond the scope of the practitioner; only licensed independent practitioners can 'diagnose and treat'; for example, medication prescription for infection or procedure needed – If abrasion noted, have mother facilitate healing by keeping skin dry and clean, changing breast pads/soiled clothing often – The use of breast shells may be helpful if mother reports extreme pain to touch of clothing. Hygienic precautions should also be taken if these devices are used

Competency Topic: Management of Common Problems and Risk Factors Impacting Infant Feeding (maternal and newborn)	
Subtopic	**Trainer Content**
	• **Management of breast engorgement**: – Prevent engorgement by encouraging frequent feeding and milk removal using optimal positioning and latch techniques described above – Breast massage – Warmth/Heat Therapy: where milk ejection reflex is thought to be compromised or slow, warmth has been shown to improve oxytocin uptake, thus improving milk ejection – Cold Therapy: there is wide variation of clinical use of cold therapy (ice packs, gel packs, frozen vegetables, etc.); cold therapy can reduce inflammatory response and lessen pain and edema. – Hand expression/pumping to relieve engorgement if breasts are uncomfortable even after feeding or if infant is having difficulty maintaining latch **see next competency** – Anticipatory guidance regarding the occurrence of breast engorgement should be given to all breastfeeding mothers before birth center or hospital discharge • **Management of mastitis:** – Follow guidance above to ensure adequate and frequent milk removal and breast drainage; it is rare that breastfeeding is contraindicated for cases of mastitis – Follow engorgement management recommendations (see above) – Encourage rest and fluids – Pain management with NSAIDS (as recommended by provider) – Antibiotic therapy may be necessary if symptoms do not subside within 12-24 hours or if mother is acutely ill (provider referral needed) • **Management of flat or inverted nipples:** – Have mother stimulate nipple prior to feeding – Facilitate optimal latch by assisting mother with proper positioning and latch techniques – In some cases, nipples can appear flat due to breast edema; teach mother to perform reverse pressure softening as a technique to reduce edema in areola area and facilitate latch • **Management of low maternal confidence of milk supply:** – Use active listening to further explore reasons for low maternal confidence – Reassure mother if there are no underlying medical reasons for low confidence; discuss specifics openly – Offer to observe and assist with breastfeeding; share assessment findings with mother – Review the mother's options by letting her know that you would like to ensure that she has all the information needed to make decisions that is best for her and her newborn

Competency Topic: Management of Common Problems and Risk Factors Impacting Infant Feeding (maternal and newborn)	
Subtopic	**Trainer Content**
	– Visuals such as infant belly size and volume visuals may help (see **Teaching Resource 1.3 (Core Competency 1)**) – See **Teaching Resource 1.6 (Core Competency 1)** for communication/scripting options when exploring and addressing issues of low maternal confidence • **Breast anomaly/medical issues:** – Delayed secretory activation-defined as no evidence of increasing/copious milk production by day 3–5 or later [72–120 hours] postpartum and inadequate intake by the infant – Primary glandular insufficiency- (less than 5% of women—primary lactation failure), as evidenced by abnormal breast shape, poor breast growth during pregnancy, or minimal indications of secretory activation. Visual in **Teaching Resource 2.6** – Prior breast surgery or pathology can result in poor milk production – Temporary cessation due to contraindicated medication use- staff should utilize evidenced-based resources to determine the safety and recommendations related to maternal medication use during lactation; the mother should receive support with expressing and/or maintaining milk supply; see Resources on Medication Safety During Lactation/ Breastfeeding in **Teaching Resource 1.5 (Core Competency 1)**
ii. Newborn 1. Latch difficulty or breast refusal 2. Frequent crying/inconsolable infant 3. Sick or preterm infants 4. Low-birthweight infants 5. Newborn weight loss 6. Hypoglycemia 7. Hyperbilirubinemia	**General recommendations/actions for at-risk newborns** (note additional recommendations/actions beyond the general guidance noted under each condition below): • Conduct thorough maternal and newborn assessments (see previous sections and teaching resources) • Assist dyad with positioning and attachment utilizing positioning and attachment techniques previously discussed • Encourage feeding at earliest signs of feeding cues and encourage rooming-in • If newborn is unable to meet feeding expectations due to risk factors or declining conditions/assessment findings, consider hand expression and feeding expressed colostrum to the infant with a spoon, cup, or other device after attempted breastfeeds (see next competency topic for alternative feeding method techniques) • Utilize communication and counseling skills to assist mother with determining feeding plans and solutions **Frequent crying/inconsolable infant:** • Rule out underlying conditions that may be leading to infant discomfort – Signs/symptoms inadequate milk transfer: inadequate latch, maternal indications, diaper output, weight loss/gain, torticollis, etc.

Competency Topic: Management of Common Problems and Risk Factors Impacting Infant Feeding (maternal and newborn)	
Subtopic	**Trainer Content**
	– Newborn physical assessment: Signs/symptoms of birth trauma, physical discomfort, etc. • Assess mother's ability to cope, support in the room, other stressors • Engage family partners to assist with newborn care and soothing techniques (i.e. safe swaddling) **At risk preterm, and/or low birthweight infants:** • Observe the infant closely for 12–24 hours after birth; watch for signs of physiologic instability (hypothermia, apnea, tachypnea, oxygen desaturation, hypoglycemia, poor feeding); if the mother and infant are separated, teach mother to hand express within the first hour of birth and at 3-hour intervals (see next competency for hand expression techniques) • Even if the mother and infant are not separated, many of these infants will not effectively suckle when first offered the breast, so consider hand expression and feeding expressed colostrum to the infant with a spoon, cup, or other device after attempted breastfeeding (see next competency topic for alternative feeding method techniques) • Encourage breastfeeding on demand, feeding at the earliest sign of hunger; realize that hunger cues in these infants can be very subtle • It may be necessary to wake the infant if he or she does not indicate hunger cues within 4 hours of the previous feed • The infant should be breastfed (or breast milk fed) 8–12 times per 24-hour period; instruct and help initiate milk expression by pump or hand in mothers whose infant is smaller, sleepier, or unable to successfully latch in the first 24 hours • These infants, especially if they have intrauterine growth retardation (IUGR), may need supplemental feeds (preferably of expressed breast milk) for low blood glucose levels, or excessive weight loss **Newborn weight loss:** • Recognize newborn weight as one (of many) ways to evaluate newborn feeding and nutritional status. • Newborn weight loss of greater than 7% from birth and/or newborns that are losing weight more than 5 days post-birth should be evaluated closely for possible intervention. *Note: Use of an assessment tool such as the NEWT tool could be helpful in determining individualized plans of care related to infant feeding. Newt is the first tool created that allows pediatric healthcare providers and parents to see how a newborn's weight during the first days following childbirth compares with a large sample of newborns. Using a research sample of birth weights from more than 100,000 breastfed newborns, the tool uses a nomogram to plot a

Competency Topic: Management of Common Problems and Risk Factors Impacting Infant Feeding (maternal and newborn)	
Subtopic	**Trainer Content**
	baby's weight percentile at any given time in the first few days following birth compared with the research population. The results can be used for early identification of neonates on a trajectory for greater weight loss and related complications. Link provided in **Teaching Resource 2.21** • Discharge planning should ensure that infant receives follow-up after hospital discharge (by the third to fifth day of life, or approximately 24 to 48 hours from the time the newborn infant is discharged depending on the length of the hospital stay*) **Hypoglycemia:** • Encourage frequent feeding • Follow hospital specific protocols/orders for hypoglycemic management. See **Teaching Resources 2.13 & 2.14** for evidence-based recommendations for treatment and management of hypoglycemia. **Hyperbilirubinemia:** • Assist mother with positioning if using phototherapy during breastfeeding sessions (e.g., biliblanket, etc.) • Encourage frequent feeding • Supplementation with water or glucose water is contraindicated because it does not reduce serum bilirubin • If urgent clinical need requires temporary interruption of breastfeeding (this is very rare), teach the mother to effectively and frequently express milk by hand or pump; this is imperative because the infant needs to return to a good supply of milk when breastfeeding resumes, or poor milk supply may result in a return of higher bilirubin levels • Discharge planning should ensure that infant receives follow-up after hospital discharge (by the third to fifth day of life, or approximately 24 to 48 hours from the time the newborn infant is discharged depending on the length of the hospital stay*) is recommended for all newborns but earlier follow-up may be needed depending on maternal/infant-specific risk factors *Source: http://pediatrics.aappublications.org/content/139/5/e20170647; BFUSA and WHO guidance also suggest follow-up again in the second week to assess feeding, growth, and parental concerns

Competency Topic:
Management of Common Problems and Risk Factors Impacting Infant Feeding (maternal and newborn)

Reference(s):

1. American Academy of Pediatrics. (2011). The AAP Guideline for Hyperbilirubinemia: Management of Hyperbilirubinemia in the newborn infant 35 or more week's gestation. *Pediatrics, 114*(297), 969-970.
2. Amir, L. H., & Academy of Breastfeeding Medicine Protocol Committee. (2014). ABM clinical protocol #4: Mastitis, revised march 2014. Breastfeeding Medicine: *The Official Journal of the Academy of Breastfeeding Medicine, 9*(5), 239.
3. Baby-Friendly USA. (2016). *Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation*. Albany, NY: Baby-Friendly USA.
4. Berens, P., & Brodribb, W. (2016). ABM clinical protocol #20: Engorgement, revised 2016. *Breastfeeding Medicine: The Official Journal of the Academy of Breastfeeding Medicine, 11*, 159.
5. Berens, P., Eglash, A., Malloy, M., & Steube, A. M. (2016). ABM clinical protocol #26: Persistent pain with breastfeeding. *Breastfeeding Medicine: The Official Journal of the Academy of Breastfeeding Medicine, 11*(2), 46.
6. Boies, E. G., & Vaucher, Y. E. (2016). ABM clinical protocol #10: Breastfeeding the late preterm (34-36 6/7 weeks of gestation) and early term infants (37-38 6/7 weeks of gestation), second revision 2016. *Breastfeeding Medicine: The Official Journal of the Academy of Breastfeeding Medicine, 11*, 494.
7. Flaherman, V. J., Maisels, M. J., & Academy of Breastfeeding Medicine. (2017). ABM clinical protocol #22: Guidelines for management of jaundice in the breastfeeding infant 35 weeks or more of gestation-revised 2017. *Breastfeeding Medicine: The Official Journal of the Academy of Breastfeeding Medicine, 12*(5), 250.
8. Flaherman, V. J., Schaefer, E. W., Kuzniewicz, M. W., Li, S. X., Walsh, E. M., & Paul, I. M. (2015). Early weight loss nomograms for exclusively breastfed newborns. *Pediatrics, 135*(1), e16-e23. doi:10.1542/peds.2014-1532
9. Kellams et al. (2017). ABM Clinical Protocol #3: Supplementary Feedings in the Healthy Term Breastfed Neonate, Revised 2017. *Breastfeeding Medicine, 12*(4), 188-198. doi:10.1089/bfm.2017.29038.ajk
10. Macdonald, P. D., Ross, S. R. M., Grant, L., & Young, D. (2003). *Neonatal weight loss in breast and formula fed infants. Archives of Disease in Childhood - Fetal and Neonatal Edition, 88*(6), F472-476. doi:10.1136/fn.88.6.F472
11. Adamkin, D. H., & Committee on Fetus and Newborn. (2011). Postnatal glucose homeostasis in late-preterm and term infants. *Pediatrics, 127*(3), 575-579. doi:10.1542/peds.2010-3851
12. Wight, N., Marinelli, K. A., & Academy of Breastfeeding Medicine. (2014). ABM clinical protocol #1: Guidelines for blood glucose monitoring and treatment of hypoglycemia in term and late-preterm neonates, revised 2014. *Breastfeeding Medicine: The Official Journal of the Academy of Breastfeeding Medicine, 9*(4), 173.

Related Teaching Resources: 1.3, 1.5, 1.6, 2.6, 2.12, 2.13, 2.14, 2.21 (NEWT Tool Link)

F. Supplementation and Alternative Feeding Methods

Competency Topic: Supplementation and Alternative Feeding Methods	
Subtopic	**Trainer Content**
i. Common medical indications that may require individualized feeding plans and potential supplementation of expressed breast milk and/or donor milk and/or infant formula	**Maternal** • Breast pain/nipple soreness • Breast anomaly/medical issue – Delayed secretory activation – Primary glandular insufficiency – Prior breast surgery or pathology – Temporary cessation due to contraindicated medication use **Newborn** • Latch difficulty or breast refusal • Frequent crying/inconsolable infant • Sick or preterm infants • Low-birthweight infants • Newborn weight loss • Hypoglycemia • Hyperbilirubinemia ***The above is not a comprehensive list. Please review table within ABM protocol for more comprehensive list. See **Teaching Resource 2.15** for table.
ii. Access hospital's supplementation protocol and review (Hospital will need to develop if one does not exist)	**(Facility-Specific)** Protocol should be reviewed with staff. Protocols should be evidence-based. Please refer to ABM Clinical Protocol #3: Supplementary Feedings in the Healthy Term Breastfed Neonate (Revised 2017) for evidence-based guidance with protocol development/review; **Teaching Resources 2.12 & 2.15**
iii. Supplementary feeding choices	**Order of recommended:** • Expressed mother's milk • Donor breast milk • Formula

<table>
<tr><th colspan="2">Competency Topic:
Supplementation and Alternative Feeding Methods</th></tr>
<tr><th>Subtopic</th><th>Trainer Content</th></tr>
<tr><td>iv. Amount of supplementation needed</td><td>
Based on the limited research available, suggested intakes for healthy, term infants are given in Table 2 (see below), although feedings should be based on infant cue
TABLE 2. AVERAGE REPORTED INTAKES OF COLOSTRUM BY HEALTHY, TERM BREASTFED INFANTS
<table>
<tr><th>Time (hours)</th><th>Intake (mL/feed)</th></tr>
<tr><td>First 24</td><td>2–10</td></tr>
<tr><td>24–48</td><td>5–15</td></tr>
<tr><td>48–72</td><td>15–30</td></tr>
<tr><td>72–96</td><td>30–60</td></tr>
</table>
(Table excerpted from ABM Clinical Protocol #3: Supplementary Feedings in the Healthy Term Breastfed Neonate, Revised 2017.)
</td></tr>
<tr><td>v. Demonstration of proper alternative feeding method techniques
1. SNS
2. Cup
3. Spoon
4. Syringe</td><td>
Have staff demonstrate proper technique of the following:
Supplementation at the breast (Supplemental Nursing System-SNS):
Use a fine (no larger than 6.5 fr) nasogastric tube and a container (syringe, cup, storage container) to hold the milk; if there is no very fine tube, use the best available ***note: some facilities may have commercial SNS devices available; if so, you will not have to utilize the adaptation instructions provided; simply follow manufacturer’s instructions for the use and cleaning of such devices
Prepare cup of breast milk (expressed breast milk, donor milk) or infant formula containing the amount of breast milk or infant formula that baby needs for one feed
Put one end of the tube along mother’s nipple, so that baby suckles the breast and the tube at the same time; tape the tube in place on breast
Place the other end of the tube in the container of breast milk or infant formula
Tie a loose knot in the tube if it is wide or pinch it; this controls the flow of breast milk, so that her baby does not finish the feed too fast (may not be needed for certain commercial SNS’s)
Control the flow of breast milk or infant formula so that her baby suckles for about 30 minutes at each feed if possible; (raising the cup makes the breast milk or infant formula flow faster, lowering the container makes the breast milk flow more slowly)
</td></tr>
</table>

Competency Topic: Supplementation and Alternative Feeding Methods	
Subtopic	**Trainer Content**
	– Encourage nursing at any time baby is willing-even if not using supplementer at breast – Let her baby suckle at any time the baby is willing – not just when she is using the supplementer – Clean the tube of the supplementer and the cup or bottle, each time she uses them **Cup (suggested procedure):** • Wash hands thoroughly with soap and water • Hold the baby sitting upright or semi-upright on your lap • Hold the small cup of breast milk to the baby's lips • Tip the cup so that the breast milk just reaches the baby's lips • The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper lip • The baby will become alert and open mouth and eyes – A preterm baby may start to take the breast milk into mouth with his tongue – A full-term or older baby more likely will suck the breast milk • DO NOT POUR the breast milk into the baby's mouth; just hold the cup to lips and allow the baby to take in • When the baby has had enough, he/she will close mouth and will not take any more; if the baby does not take the calculated amount, he may take more next time, or you may need to feed him more often • Assess intake over 24 hours – not just at each feed **Spoon:** • Same procedure above (cup) but using spoon **Finger feeding with syringe or dropper:** • Wash hands well with soap and water; use a clean glove or finger cot • Be sure the baby is awake and alert • Hold the baby in an upright sitting position • Gently touch your covered finger to the infant's lips; encourage the infant to take your finger into his/her mouth • Position your finger with the ball of your finger nestled in the curve of the hard and soft palettes; this is called the S spot since touching it will elicit a suck response; if the infant gags, pull your finger back ¼ inch

Competency Topic: Supplementation and Alternative Feeding Methods	
Subtopic	**Trainer Content**
	• Observe that the top and bottom lips are flared out, similar to the breastfeeding position • The infants tongue should cup your finger; the tongue should be positioned between your finger and the infant's lower gum line • Feel for a front to back wave like motion of the tongue on your finger this "milking" action of the tongue is needed to strip milk from the breast • Insert the filled feeding syringe or dropper into the corner of the baby's mouth; (the syringe or dropper should not be extended along the length of the finger) • When the baby sucks the finger, the plunger of syringe should be slowly depressed or dropper should administer small amount of breast milk into the baby's mouth • When the baby pauses, the feeder should also pause, depress the plunger again when the baby starts to suck; be sure to mimic the suck pattern felt • Allow the baby to set a pattern of suck, swallow, and breathe • Don't rush the baby. You want this to be a pleasant experience • See **Teaching Resource 2.18** for video on cup/spoon feeding listed in worksheet
vi. Documentation of medical indication for supplementation. If maternal request, documentation of education	**(Facility-Specific)** Staff should cite appropriate area and procedure for documenting feeding assistance and interventions in health record.

Reference(s):

1. Flaherman, V. J., Maisels, M. J., & Academy of Breastfeeding Medicine. (2017). ABM clinical protocol #22: Guidelines for management of jaundice in the breastfeeding infant 35 weeks or more of gestation-revised 2017. *Breastfeeding Medicine: The Official Journal of the Academy of Breastfeeding Medicine, 12*(5), 250.
2. Kellams, A., Harrel, C., Omage, S., Gregory, C., & Rosen-Carole, C. (2017). ABM clinical protocol #3: Supplementary feedings in the healthy term breastfed neonate, revised 2017. Breastfeeding Medicine: The Official Journal of the Academy of Breastfeeding Medicine, 12, 188.
3. World Health Organization. (2014). *Breastfeeding counselling: A training course*. Geneva, Switzerland: World Health Organization. Retrieved from: http://www.who.int/mater nal_child_adolescent/documents/who_cdr_93_3/en/

Related Teaching Resources: 2.12, 2.15, 2.18

Verification of Core Competency 2 – Suggested Activities

Skills Lab

Table Set-up

Skills Station 2: Observing, assessing, and assisting with breastfeeding

Anticipated teaching/learning time: 1.5 hours

Materials/Staff Needed

Training Staff	Training Materials (for Trainer Use, Visuals, Demonstration, etc.)	Staff Handouts (multiple copies of items listed)
(1*) Training Team Member: *more than one trainer could be beneficial due to the extensive training content in this session	Core Competency 2 Teaching Outline Trainer Teaching content (located in previous section) Consider printed visuals of the following: • Feeding on Cue Visual **(Teaching Resources 1.2 & 1.3)** • Sample Procedure for Skin-to-Skin Care Immediately Following Delivery **(Teaching Resource 2.2)** • Safe positioning Guide to Skin-to-Skin Care **(Teaching Resource 2.3)** • Visuals demonstrating breasts and nipple assessments **(Teaching Resource 2.6)** • Visuals demonstrating proper/improper latch **(Teaching Resource 2.7)** • Breastfeeding Assessment Tool (several examples provided **Teaching Resources 2.8, 2.9, 2.10**, this may be facility-specific, however) • RAPP Assessment **(Teaching Resource 2.4)** and/or Checklist for Newborn Infants in the First 2 Hours of Life **(Teaching Resource 2.5)** *Tip: laminate visuals for durability and/or consider placing on display board to reference during general instruction activity and/or future learning activities. • iPad/Computer/Electronic Display with audiovisual and internet connection with the following videos loaded: – Latching and attachment: https://www.healthyfamiliesbc.ca/home/articles/video-latching-your-baby – Getting enough milk: https://globalhealthmedia.org/portfolio-items/is-your-baby-getting-enough-milk/?portfolioID=5623 – Cup and spoon feeding (only 1st 5 min): https://globalhealthmedia.org/portfolio-items/cup-feeding/?portfolioID=5623 • Safety Quiz (Trainer Version) **(Teaching Resource 2.16)** • Infant Feeding Video Self-Reflection/Discussion Worksheet (Trainer Version) **(Teaching Resource 2.18)** • **NEWT Tool Link (Teaching Resource 2.21) for explanation of use** • Scenario Cards (recommend at least 2 sets depending on anticipated size of group) **(Teaching Resource 2.20)** *Tip: laminate scenario cards for durability. Bind cards with ring so that they do not get misplaced • Baby Doll(s) • Breast model(s) • Alternative Feeding Method Supplies: – SNS/at breast supplementer	• CGBI Ten Step Tear Sheets: A Guide for Healthcare Professionals **(Teaching Resource 2.1)**: Titled: – Practicing Rooming-In Safely • Safety Quiz (Learner Version) **(Teaching Resource 2.17)** • Infant Feeding Video Self-Reflection/ Discussion Worksheet (Learner Version) **(Teaching Resource 2.19)** • Trainers may decide to give handouts of any of the training materials listed in Training Materials column

Training Staff	Training Materials (for Trainer Use, Visuals, Demonstration, etc.)	Staff Handouts (multiple copies of items listed)
	– Syringe(s) – Small cup – Plastic spoon	

- **Station (Table) Set-up**
  - Signage indicating Station Title: Station 2: Observing, assessing, and assisting with breastfeeding
  - Table should be set up with:
    - AV equipment of choice
    - Stacks of copies the different staff handouts listed above
    - Copies of the Safety Quiz and Infant Feeding Video Self-Reflection/Discussion Worksheet (learner versions) **(Teaching Resources 2.17 & 2.19)**
    - Scenario Cards **(Teaching Resource 2.20)**

- **Description of Station Activity:**
  - General Information Session and Exercises: (anticipated time 45 min)
    - This station will start with a lesson and activities on safety and basic infant feeding that should be applied throughout the patient scenarios presented later in the session.
    - Due to audiovisuals needed, the trainer may want to limit the number of learners per session depending on the audiovisual set up/display. It's important that all learners can hear the short video clips and the trainer during the self-reflection exercises.
    - If audiovisual not available, the trainer can utilize teaching resources/handouts as visuals to instruct on the following:
      - Latching and attachment
      - Assessment of milk transfer (how to know that baby is getting enough milk?)
      - Alternative feeding methods
        *trainer can still use "Infant Feeding Self-Reflection and Discussion" worksheet and exercise **(Teaching Resource 2.18, 2.19)** but adapt accordingly if AV not available
    - Trainer will welcome learners and hand them the learner versions of the "Infant Feeding Self-Reflection and Discussion" worksheet **(Teaching Resource 2.19)** and "Immediate and Uninterrupted Skin-to-Skin Care and Rooming-in Practices: Safety Quiz" **(Teaching Resource 2.17)**.
    - Trainer will have learners take a seat and give an overview of session objectives and activities.
    - Trainer will then give learners time to answer the "Immediate and Uninterrupted Skin-to-Skin and Rooming-in Practices: Safety Quiz" **(Teaching Resource 2.17).**

        - Trainer will then show the short video clips as in the order indicated on the "Infant Feeding Self-Reflection and Discussion" worksheet **(Teaching Resource 2.19)** After each video clip, the trainer should give learners time to answer the self-reflection questions before moving onto next clip.
        - Once learners have answered all questions, trainers should guide discussion on the Safety Quiz and Infant Feeding Self-Reflection and Discussion by encouraging learners to share their answers with the group.
            - Tips to moderating discussion:
                - Encourage dialogue and problem solving amongst peers.
                - If a learner gives a "wrong" or inappropriate answer, avoid outwardly correcting, but rather ask probing questions using information from the Trainer Safety Quiz and Infant Feeding Self-Reflection and Discussion **(Teaching Resource 2.18)** to encourage further discussion and more appropriate response.

- Competency Verification Exercise: (45 min)
    - After Safety Quiz and Self-Reflection Worksheet **(Teaching Resource 2.17)** discussions are complete, the trainer will explain that competency verification will be accomplished by each learner responding to provided scenario cards **(Teaching Resource 2.20)**. The trainer should explain that it is expected that the effective communication skills are applied to each response. Key points of information are expected to be addressed in the scenario. These key points are located in the back of each scenario card.
    - The trainer can begin verification by asking for a volunteer to demonstrate competency first. If no one volunteers, the trainer will select a learner.
    - Each learner will demonstrate competency by responding to the scenario utilizing effective communication techniques while demonstrating knowledge of key points.
    - Learners should be encouraged to role play (if possible) and use props provided.
    - Trainer will decide how many correct responses meet minimum acceptance for competency verification (example: learners will respond correctly to at least 6 out of 7 scenarios).
    - Trainer will repeat this with each learner in the group.
        - Considerations for trainers:
            - If a learner is not participatory in exercises or gives indication that they are not comfortable with application of communication skills or knowledge, then trainers should have the learner repeat session or do additional activities to demonstrate competency.
            - If a learner joins the session late, they will have to repeat missed activity in next session. If the session is too far progressed for it to benefit the learner, trainers may advise that the learner wait until next session or join another table session (if that's an option).

- Once the trainer feels that learners have responded and/or learned from the exercise effectively, the trainer will validate learners' competency by dating and initialing the objectives under Core Competency 2 and signing the bottom on Employee Competency Verification Form.
- The trainer should instruct the learners to take a copy of each handout provided to place in their folders.

Simulation Lab

- Station (Table) Set-up
  - Signage indicating Station Title: Station 2: Observing, assessing, and assisting with breastfeeding
    - Room Set-up with:
      - Patient bed
      - Baby doll
      - Resource handouts listed above
      - Any additional supplies the team feels would help create and environment similar to a patient room
      - Copies of the Safety Quiz and Infant Feeding Video Self-Reflection/Discussion Worksheet (learner versions) **(Teaching Resources 2.17 & 2.19)**
      - Scenario Cards (**Teaching Resource 2.20**)

- **Description of Station Activity:**
  - **General Information Session and Exercises:** (anticipated time 45 min)
    - This station will start with a lesson and activities on safety and basic infant feeding that should be applied throughout the patient scenarios presented later in the simulation.
    - It's important that all learners can hear the short video clips and the trainer during the self-reflection exercises.
    - If audiovisual not available, the trainer can utilize teaching resources/handouts as visuals to instruct on the following:
      - Latching and attachment
      - Assessment of milk transfer (how to know that baby is getting enough milk?)
      - Alternative feeding methods
        *trainer can still use Infant Feeding Self-Reflection and Discussion Worksheet and exercise **(Teaching Resource 2.18, 2.19)** but adapt accordingly if AV not available
    - The trainer will provide the "Infant Feeding Self-Reflection and Discussion" worksheet **(Teaching Resource 2.19)** and "Skin-to-Skin and Rooming-in Practices: Safety Quiz" **(Teaching Resource 2.17)**.
    - The trainer will provide an overview of session objectives and activities.
    - The trainer will then give learners time to answer the "Skin-to-Skin and Rooming-in Practices: Safety Quiz" **(Teaching Resource 2.17)**.

        - The trainer will then show the short video clips as in the order indicated on the "Infant Feeding Self-Reflection and Discussion" worksheet **(Teaching Resource 2.19)**. After each video clip, the trainer should give learners time to answer the self-reflection questions before moving onto next clip.
        - Once learners have answered all questions, trainers should guide discussion on the Safety Quiz and Infant Feeding Self-Reflection and Discussion by encouraging learners to share their answers with the group.
            - Tips to moderating discussion:
        - Encourage dialogue and problem solving amongst peers.
        - If a learner gives a "wrong" or inappropriate answer, avoid outwardly correcting, but rather ask probing questions using information from the Trainer Safety Quiz and Infant Feeding Self-Reflection and Discussion **(Teaching Resource 2.18)** to encourage further discussion and more appropriate response.

- **Competency Verification Exercise:** (45 min)
    - After Safety Quiz and Self-Reflection Worksheet **(Teaching Resource 2.17)** discussions are complete, the trainer will explain that competency verification will be accomplished by each learner responding to provided scenario cards **(Teaching Resource 2.20)**. The trainer should explain that it is expected that the effective communication skills are applied to each response. Key points of information are expected to be addressed in the scenario. These key points are located in the back of each scenario card.
    - Each learner will demonstrate competency by responding to the scenario utilizing effective communication techniques while demonstrating knowledge of key points.
    - Each learner will complete competency through role playing in the simulation lab.
    - The trainer will decide how many correct responses meet minimum acceptance for competency verification. (example: learners will respond correctly to at least 6 out of 7 scenarios)
    - The trainer will repeat this with each learner.
        - Considerations for trainers:
            - If a learner is not participatory in exercises or gives indication that they are not comfortable with application of communication skills or knowledge, then trainers should have the learner repeat session or do additional activities to demonstrate competency.
    - Once the trainer feels that learners have responded and/or learned from the exercise effectively, the trainer will validate the learners' competency by dating and initialing the objectives under Core Competency 2 and signing the bottom on Employee Competency Verification Form.
    - The trainer should instruct the learners to take a copy of each handout provided to place in their folders.

Teaching Resources for Core Competency 2

Note: The training resources provided may include content related to specific practices that is beyond the scope of this training. These resources should be adapted in a manner that aligns with your hospital policies and procedures, taking into account clinical situations and hospital factors unique to your setting.

Resource 2.1

CGBI Ten Step Tear Sheets: A Guide for Healthcare Professionals

- Link: https://sph.unc.edu/files/2017/10/CGBI-Ten-Steps-Supplemental-Education-for-Staff-S.pdf
- For this Core Competency provide copies Tear Sheets Titled:
  - Practicing Skin-to-Skin and Rooming-In Safely

Resource 2.2

See Box 1: Procedure for Immediate Skin-to-skin Care
Source: Feldman-Winter, L., Goldsmith, J. P., TASK FORCE ON SUDDEN INFANT DEATH SYNDROME, & COMMITTEE ON FETUS AND NEWBORN. (2016). Safe sleep and skin-to-skin care in the neonatal period for healthy term newborns. *Pediatrics, 138*(3), e20161889-e20161889. doi:10.1542/peds.2016-1889 Link: https://pediatrics.aappublications.org/content/138/3/e20161889

Resource 2.3

See Safe Positioning Checklist

Photo excerpted from Ready, Set, Baby Prenatal Education Curriculum

Source: Ludington-Hoe, S. M., & Morgan, K. (2014). Infant Assessment and Reduction of Sudden Unexpected Postnatal Collapse Risk During Skin-to-Skin Contact. Newborn and Infant Nursing Reviews, 14(1), 28-33. doi:10.1053/j.nainr.2013.12.009

Link*:* https://www.sciencedirect.com/science/article/pii/S1527336913001384

Resource 2.4

See Figure 1. The RAPP™ Assessment
Source: Ludington-Hoe, S. M., & Morgan, K. (2014). Infant Assessment and Reduction of Sudden Unexpected Postnatal Collapse Risk During Skin-to-Skin Contact. Newborn and Infant Nursing Reviews, 14(1), 28-33. doi:10.1053/j.nainr.2013.12.009 Link*:* https://www.sciencedirect.com/science/article/pii/S1527336913001384

Resource 2.5

See Figure 1 Checklist for Newborn Infants in the First 2 Hours of Life, Particularly during Skin-to-Skin Care
Source: Davanzo et al. (2014). Making the First Days of Life Safer. *Journal of Human Lactation*, 31(1), 47-52. doi:10.1177/0890334414554927 Link: https://journals-sagepub-com.libproxy.lib.unc.edu/doi/full/10.1177/0890334414554927?utm_source=summon&utm_medium=discovery-provider

Resource 2.6

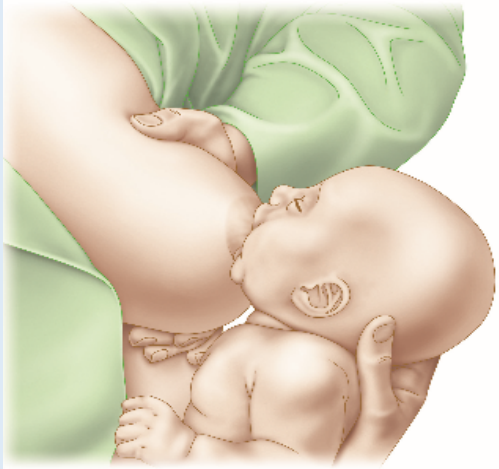
Visuals Demonstrating Breast and Nipple Assessment	
Breast Shape	• When completing the breast assessment, notice the symmetry, spacing, shape, and size of the breasts. • Breasts that are asymmetrical, tubular and widely spaced (greater than 1.5 inches between breasts) may be a sign of insufficient glandular tissue which affects the amount of milk a mother makes. • Large pendulous breasts may need additional support during breastfeeding to achieve the best latch.
Nipples	• The size and shape of the nipples also may affect milk production and transfer. • In addition to the shape of the breasts, note the shape of the nipple and the length of the shank. Is the nipple flat, inverted or retracted? • When assessing the breast, you should compress each breast to see how the nipple reacts. Some women may have a nipple that looks retracted or inverted but then becomes erect with stimulation. Others may have a nipple that looks erect but retracts when stimulated.
Reference: Please visit ATLAS for more information on breast and nipples assessment. Wilson-Clay, Kay Hoover. (2017). The Breastfeeding Atlas, 6th ed. Lactnews Press, Manchaca, Tx.	

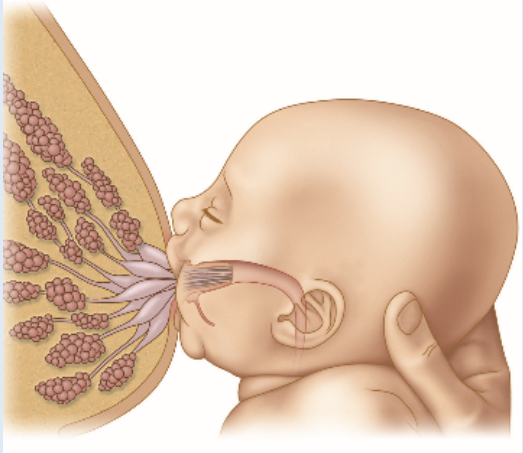
Resource 2.7

Visuals Demonstrating Successful/Unsuccessful Latch

The characteristics of a successful latch include:

- Photo excerpted from Ready, Set, Baby Prenatal Education Curriculum. Most of the areola, or as much of the areola as possible, is in the infant's mouth. The tip of the nipple should reach the infant's soft palate at the back of the mouth.
- Breast is supported to keep pressure on the tongue. Support the weight to prevent the infant from pulling down on the nipple or losing the latch.
- Infant's chin is touching the breast. The infant's mouth should be brought up over the areola with the infant's chin touching the breast first.
- Infant's lips are flanged, forming a seal around the nipple. The mother can gently roll out the lips, if they are curled in, or re-latch the infant.
- Breast is not pulled back from baby's nose. When the mother pulls back on the breast, it can cause the infant to bite/clamp down or lose the latch. Infants will be able to breathe, even when the nose is close to the breast.
- The infant's cheeks are not touched. Touching the cheeks can elicit the rooting reflex, causing the infant to turn head, and/or the bite reflex.
- Also note that the mother's hand is supporting the infant between the shoulders rather than behind the head. When a hand is placed behind the infant's head, the infant's reflex is to push back again the hand.





Images: excerpted from Ready, Set, Baby Prenatal Education Curriculum from Carolina Global Breastfeeding Institute

Resource 2.8

See LATCH Tool
Source: Jenson D, Wallace S, Kelsay P (1994): LATCH: a breastfeeding charting system and documentation tool. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 23(1):29. Link: https://www.sciencedirect.com/science/article/abs/pii/S0884217515330811

Resource 2.9

See Figure 1: Bristol Breastfeeding Assessment Tool
Source: J. Ingram et al. (2015) The development of a new breast feeding assessment tool and the relationship with breast feeding self-efficacy. *Midwifery* 31 132-137 Link: https://www.sciencedirect.com/science/article/pii/S0266613814001788

Resource 2.10

Breastfeeding Observation Aid	
Signs that Breastfeeding is Going Well	**Signs of Possible Difficulty**
General	
Mother: ☐ Mother looks healthy ☐ Mother relaxed and comfortable ☐ Signs of bonding between mother and baby	Mother: ☐ Mother ill or depressed ☐ Mother uncomfortable ☐ No signs of bonding between mother and baby
Baby: ☐ Baby looks healthy ☐ Baby quiet/alert, calm, relaxed ☐ Baby actively reaches or roots for breast	Baby: ☐ Baby lethargic or ill ☐ Baby inconsolable/crying ☐ Baby does not reach or root
Breasts	
☐ Breasts look healthy ☐ No pain or discomfort visible or reported by mother ☐ Breast well supported during feeding ☐ Nipple protractile	☐ Breasts red, swollen, or sore ☐ Breast or nipple painful ☐ Breast inadequately supported during feeding ☐ Nipple flat/not protractile
Positioning	
☐ Baby's head and body in alignment ☐ Baby held closely to mother's body ☐ Baby's body supported adequately ☐ Baby approaches breast, nose to nipple	☐ Baby misaligned (head and neck turned to feed) ☐ Baby not held close ☐ Baby supported in adequately ☐ Baby approaches breast with lower lip/chin to nipple
LATCH	
☐ More areola is seen above baby's top lip ☐ Baby's mouth opens wide ☐ Lower lip turns outwards ☐ Baby's chin touches breast	☐ More areola seen below bottom lip ☐ Baby's mouth not open wide ☐ Lips pointing forward or turned in ☐ Baby's chin not touching breast
Suckling	
☐ Slow, deep rhythmic sucks with pauses ☐ Cheeks rounded without dimpling ☐ Baby readily releases when finished ☐ Mother reports signs of milk ejection (uterine contractions or milk leakage/let down)	☐ Rapid, shallow sucks only ☐ Cheeks dimpled while suckling ☐ Mother takes baby off breast or infant pulls away ☐ No signs of milk ejection noted
Adapted from Breastfeeding Counselling: A Training Course World Health Organization. (2014). Breastfeeding counselling: A training course. Retrieved from https://www.who.int/maternal_child_adolescent/documents/who_cdr_93_3/en/	

Resource 2.11

Cross-Cradle Hold | Football Hold | Cradle Hold

Leaning Back

Excerpted from Ready, Set, Baby Prenatal Education Curriculum

Resource 2.12

<table>
<tr><th colspan="3">Example Hospital Policy Statement on Supplementation</th></tr>
<tr><td colspan="3">Policy Statement: Expressed breast milk/colostrum is the first nutrition of choice when supplemental feedings are indicated. Mothers should be taught and encouraged to express breast milk each time a baby receives a supplemental feeding to ensure adequate breast stimulation and emptying and to provide volume for supplemental feedings. If supplementation beyond colostrum/breast milk volume is indicated, and it is determined that infant cannot receive donor breast milk, hydrolyzed protein formula should be used.</td></tr>
<tr><th>Latch Not Achieved, Infant > 24 hrs of age</th><th>Weight loss > 10% and Medical Need for Supplementation Determined*</th><th>Late Preterm/Small for Gestational Age (SGA)/Large for Gestational Age (LGA)</th></tr>
<tr><td>Feeding Intervention:
Feed colostrum/ expressed breast milk
Approximate volume per feed:
• 24-48 hrs old: 5-15 ml
• 48-72 hrs old: 15-30 ml
• 72-96 hrs old: 30-60 ml</td><td>Feeding Intervention:
Feed colostrum/ expressed breast milk
• < 24 hrs old: contact provider
• 24-48 hrs old: 5-15 ml
• 48-72 hrs old: 15-30 ml
• 72-96 hrs old: 30-60 ml</td><td>Feeding Intervention:
Feed colostrum/expressed breast milk (to equal at least 8 feedings/24 hrs) if > 1 missed feeding or weight loss >7%
• < 24 hrs old: contact provider
• 24-48 hrs old: 5-15 ml
• 48-72 hrs old: 15-30 ml
• 72-96 hrs old: 30-60 ml</td></tr>
<tr><td colspan="3">Route:
• At breast with supplementer (SNS or tube)
• Spoon
• Cup
• Bottle**</td></tr>
<tr><td colspan="3">Note:
*Weight loss > 10% with signs/symptoms of dehydration, hyperbilirubinemia judged secondary to poor intake, maternal milk supply insufficient for time postpartum, baby frantically hungry or excessively sleepy at the breast, output lower than appropriate for age, meconium stools > 4 days, and formal feeding evaluation has been performed and weight not improved after skilled assessment and proper management
** Bottles and artificial nipples only if breastfed infant unable to tolerate alterative feeding methods. Alternative feeding methods are preferred.</td></tr>
<tr><td colspan="3">Maternal indications or risk factors:
• Delayed lactogenesis II (72-120h or later) and inadequate intake by the infant
• Breast pathology or prior breast surgery resulting in poor milk production
• Intolerable pain during feedings unrelieved by interventions
• Maternal illness resulting in separation of mother and infant
• Maternal medications requiring short-term use of previously expressed breast milk, donor milk, or infant formula
• Postpartum hemorrhage/anemia
• Primary glandular insufficiency</td></tr>
<tr><td colspan="3">Reviewed By: Maternal Child Divisional Practice Council</td></tr>
</table>

Example Hospital Policy Statement on Supplementation

References

- American Academy of Pediatrics, Section on Breastfeeding. Breastfeeding and the use of human milk. Pediatrics. 2012 Mar;129(3):e827-41. doi: 10.1542/peds.2011-3552. Epub 2012 Feb 27. Review. http://pediatrics.aappublications.org/content/129/3/e827.full.pdf+html
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- Flaherman, V. J., Maisels, M. J., Brodribb, W., Noble, L., Brent, N., Bunik, M., Young, M. (2017). ABM Clinical Protocol #22: Guidelines for Management of Jaundice in the Breastfeeding Infant 35 Weeks or More of Gestation—Revised 2017. Breastfeeding Medicine, 12(5), 250-257. doi:10.1089/bfm.2017.29042.vjf
- Hubbard E, Stellwagen L, Wolf A. The Late Preterm Infant: A Little Baby with Big Needs. Contemporary Pediatrics 2007:24;11;51-58.
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- Wight, N., & Marinelli, K. A. (2014). ABM Clinical Protocol #1: Guidelines for Blood Glucose Monitoring and Treatment of Hypoglycemia in Term and Late-Preterm Neonates, Revised 2014. Breastfeeding Medicine, 9(4), 173-179. doi:10.1089/bfm.2014.9986
- Winnipeg Regional Health Authority. Breastfeeding practice guidelines for the healthy term infant. 2005 http://www.wrha.mb.ca/healthinfo/prohealth/files/BF_Guidelines.pdf

Acknowledgment: This resource was adapted with permission from University of Kansas Medical Center located in Kansas City, Kansas

Resource 2.13

Sample Algorithm for Management of Documented Hypoglycemia	
Infant with No Clinical Signs	**Infant with Clinical Signs or Plasma Glucose Less than 20-25 mg/dL (less than 1.1-1.4 mmol/L)**
Interventions	**Interventions**
1. Continue breastfeeding (approximately every 1–2 hours) or feed 1–5 mL/kg of expressed breast milk or substitute nutrition. 2. Recheck blood glucose concentration before subsequent feedings until the value is acceptable and stable* 3. Avoid forced feedings (see above). 4. If the glucose level remains low despite feedings, begin intravenous glucose therapy. 5. Breastfeeding may continue during intravenous glucose therapy. *6. Carefully document response to treatment* *Additional information is available in ABM Protocol #3: Supplementary Feedings in the Healthy Term Breastfed Neonate, Revised 2017. Table 1	1. Initiate intravenous 10% glucose solution with a mini-bolus.* 2. Do not rely on oral or intragastric feeding to correct extreme or clinically significant hypoglycemia. 3. The glucose concentration in infants who has clinical signs should be maintained at >45 mg/dL (>2.5 mmol/L). 4. Adjust intravenous rate by blood glucose concentration. 5. Encourage frequent breastfeeding (minimum of 8 feedings in a 24 hour period) 6. Monitor glucose concentrations before feedings while weaning off the intravenous treatment until values stabilize off intravenous fluids. 7. Carefully document response to treatment. *Breastfeeding should continue during intravenous glucose therapy
Adapted from ABM Protocol #1: Guidelines for Blood Glucose Monitoring and Treatment of Hypoglycemia in Term and Late-Preterm Neonates, Revised 2014 Table 6. Wight, N., & Marinelli, K. A. (2014). ABM Clinical Protocol #1: Guidelines for Blood Glucose Monitoring and Treatment of Hypoglycemia in Term and Late-Preterm Neonates, Revised 2014. Breastfeeding Medicine, 9(4), 173-179. doi:10.1089/bfm.2014.9986	
Note: The example provided is meant to serve as example of specific facility guidance that can be developed to ensue system-wide consistency in hypoglycemia management. These are not meant to serve as a standard of care, and clinical care may need to be individualized to meet needs in specific situations.	

Resource 2.14

Sample Algorithm for Hypoglycemia Management: American Academy of Pediatrics

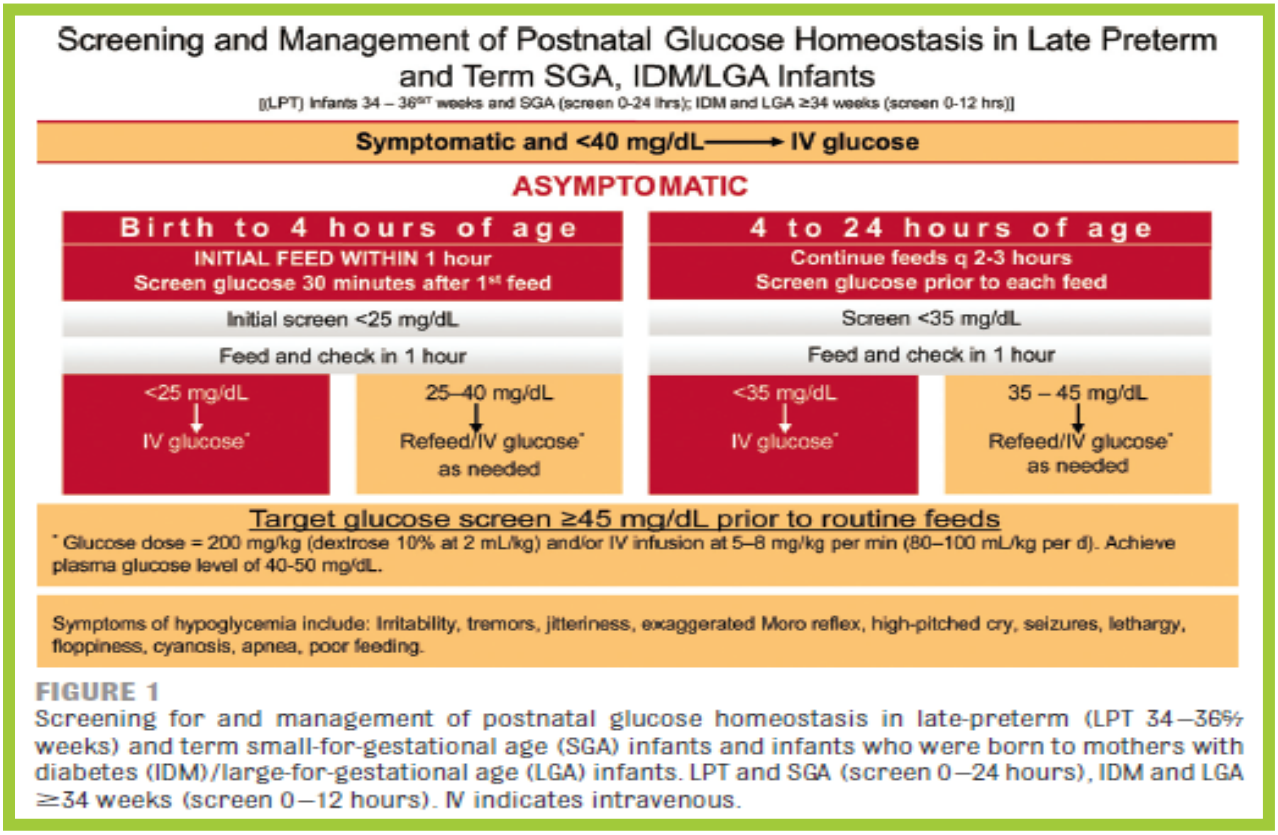

FIGURE 1
Screening for and management of postnatal glucose homeostasis in late-preterm (LPT 34–36⅙ weeks) and term small-for-gestational age (SGA) infants and infants who were born to mothers with diabetes (IDM)/large-for-gestational age (LGA) infants. LPT and SGA (screen 0–24 hours), IDM and LGA ≥34 weeks (screen 0–12 hours). IV indicates intravenous.

Source: Adamkin, D. (2011) Postnatal Glucose Homeostasis in Late-Preterm and Term Infants. *Pediatrics*, 127(3), 575-579. doi:10.1542/peds.2010-3851

Note: The example provided is meant to serve as example of specific facility guidance that can be developed to ensure system wide consistency in hypoglycemia management. These are not meant to serve as a standard of care, and clinical care may need to be individualized to meet needs in specific situations.

Resource 2.15

Possible Indications for Supplementation in Healthy, Term Infants (37–41 6/7 Weeks Gestational Age)	
Infant Indications	**Maternal Indicators**
Asymptomatic hypoglycemia • Documented by laboratory blood glucose measurement, (not bedside screening methods) that is not responsive to appropriate frequent breastfeeding • Supplementation should be considered only if unresponsive to appropriate frequent breastfeeding. *Note: Routine testing of asymptomatic healthy, term infants who do not have risk factors should be discouraged and can be potentially harmful establishment of a healthy mother-infant relationship and successful breastfeeding patterns. **Signs or symptoms that may indicate inadequate milk intake:** • Evidence of significant dehydration • Weight loss of ≥8–10% (day 5 [120 hours] or later), or weight loss greater than 75th percentile for age • Delayed bowel movements, fewer than four stools on day 4 of life, or continued meconium stools on day 5 • Adequate urine output **Hyperbilirubinemia** • Suboptimal intake jaundice of the newborn associated with poor breast milk intake despite appropriate intervention. This characteristically begins at 2–5 days and is marked by ongoing weight loss, limited stooling and voiding with uric acid crystals. Suboptimal intake jaundice is usually resolved within 2 weeks. • Breast milk jaundice when levels reach 340–425 mol/L (20–25 mg/dL) in an otherwise thriving infant and where a diagnostic and/or therapeutic interruption of breastfeeding may be under consideration. Breast milk jaundice can last up to 3 months. First line diagnostic management should include laboratory evaluation, instead of interruption of breastfeeding. **Macronutrient supplementation** is indicated, such as for the rare infant with inborn errors of metabolism	**Delayed secretory activation** • Day 3–5 or later [72–120 hours] and inadequate intake by the infant). **Primary glandular insufficiency** • Less than 5% of women—primary lactation failure, as evidenced by abnormal breast shape, poor breast growth during pregnancy, or minimal indications of secretory activation. **Breast pathology or prior breast surgery resulting in poor milk production** **Temporary cessation of breastfeeding due to certain medications** (e.g., chemotherapy) **Temporary separation of mother and baby without expressed breast milk available** **Intolerable pain during feedings unrelieved by intervention**
Adapted from ABM Protocol #3: Table 1 **Source:** Kellams et al. (2017). ABM Clinical Protocol #3: Supplementary Feedings in the Healthy Term Breastfed Neonate, Revised 2017. *Breastfeeding Medicine*, 12(4), 188-198. doi:10.1089/bfm.2017.29038.ajk Flaherman et al. (2017). ABM Clinical Protocol #22: Guidelines for Management of Jaundice in the Breastfeeding Infant 35 Weeks or More of Gestation—Revised 2017. *Breastfeeding Medicine*, 12(5), 250-257. doi:10.1089/bfm.2017.29042.vjf	

Resource 2.16

Immediate and Uninterrupted Skin-to-Skin Care and Rooming-in Practices: Safety Quiz (Trainer Version)

1. What describes optimal immediate skin-to-skin positioning for mother/baby? (circle all that apply)
   a. Infant placed naked (hat and diaper allowed) on their mothers with no barrier (blanket, clothing etc.) between mother and infant.
   b. Mothers should be lying flat on their backs with no bed elevation when they are skin-to-skin with their infants.
   c. Infants should be placed in a position that allows for breathing with mouth and nose visible.
   d. Infant should be in sniffing position.
   e. Dry blanket(s) or cover(s) over infant's back to maintain warmth.
   All should be circled except for the second bullet. Mothers should be in semi-reclined position, not flat.

2. Number in order the correct sequence of events regarding immediate and uninterrupted skin-to-skin care following delivery: (place # next to bullet)
   - Assess Apgar scores at 1 and 5 minutes (5)
   - Assist and support to breastfeed instructing mother on feeding cues and how to recognize and respond to them (7)
   - If the newborn is stable, place skin-to-skin with cord attached (with option to milk cord), clamp cord after 1 minute or after placenta delivered, and reassess newborn to permit physiological circulatory transition (2)
   - Continue to dry entire newborn except hands (3)
   - Cover head with cap (optional) and place pre-warmed blankets to cover body of newborn on mother's chest, leaving face exposed (4)
   - Dry and stimulate, and assess newborn (1)
   - Replace wet blankets and cap with dry warm blankets and cap (6)

3. (True/False) A definition of SUPC is Sudden Unexpected Postnatal Collapse: a rare but severe condition in which a newborn considered to be "well" at birth requires sudden resuscitation/intensive care, dies, or develops encephalopathy (True)

4. Frequent and repetitive assessments during immediate skin-to-skin care by staff should include (circle all that apply)
   a. Activity
   b. Tone
   c. Color
   d. Caregiver/mother fatigue, mobility, or distraction
   e. Vital signs
   f. Positioning
   Circle all answers

5. _____ is an evidence-based tool that can be used to guide assessment and appropriate action by staff during immediate skin-to-skin care.
   a. CAP Assessment
   b. NRP
   c. CPR
   d. RAPP Assessment
   Answer is D

Immediate and Uninterrupted Skin-to-Skin Care and Rooming-in Practices: Safety Quiz (Trainer Version)

6. What type of patients may be at risk during rooming-in?
   a. Use of sedating medications and uncontrolled pain
   b. Seizure precautions
   c. Extreme limited mobility
   d. All of the above

   Answer is D

7. If safety is a concern, which are appropriate actions by staff? (circle all that apply)
   a. Always remove infant from room and bring to newborn nursery or surveillance area
   b. Conduct safety assessments more frequently
   c. Stay at bedside during feedings
   d. Ensure that there is an additional responsible person with the mother to assist with newborn care
   e. Consider removing infant if conditions decline and mother/family cannot respond to infant safely

   Circle B, C, D, E

8. What statement best characterizes an optimal safe sleep environment?
   a. Infant is sharing bed with mother during periods of sleep, mother's bed in is lowest position with siderails up.
   b. Infant is in bassinet in prone position during sleep with pacifier, mother's bed is highest position so that she can always see infant.
   c. Infant swaddled on family member in chair during sleep periods
   d. Infant in bassinet in supine position during sleep, with no excess bedding, mother's bed in lowest position

   Answer is D

9. What are some actions that can promote a safe rooming-in environment? (circle all that apply)
   a. Education provided on safety precautions during admission, at every shift, when administering sedating pain medication, and as often as determined by staff
   b. Instruct parents to ask for assistance with lifting or handling infant if feeling unsteady, or extremely fatigued
   c. Review mother/infant equipment to ensure proper function and demonstrate appropriate use such as bed rails, call bells with mothers and families
   d. Do safety rounds frequently scanning room and patient status for any risks

   All answers should be circled

Resource 2.17

Immediate and Uninterrupted Skin-to-Skin Care and Rooming-in Practices: Safety Quiz (Learner Version)

1. What describes optimal immediate skin-to-skin positioning for mother/baby? (circle all that apply)
   a. Infant placed naked (hat and diaper allowed) on their mothers with no barrier (blanket, clothing etc.) between mother and infant.
   b. Mothers should be lying flat on their backs with no bed elevation when they are skin-to-skin with their infants
   c. Infants should be placed in a position that allows for breathing with mouth & nose visible
   d. Infant should be in sniffing position
   e. Dry blanket(s) or cover(s) over infant's back to maintain warmth

2. Number in order the correct sequence of events regarding immediate and uninterrupted skin-to-skin care following delivery: (place # next to bullet)
   a. Assess Apgar scores at 1 and 5 minutes
   b. Assist and support to breastfeed instructing mother on feeding cues and how to recognize and respond to them
   c. If the newborn is stable, place skin-to-skin with cord attached (with option to milk cord), clamp cord after 1 minute or after placenta delivered, and reassess newborn to permit physiological circulatory transition
   d. Continue to dry entire newborn except hands
   e. Cover head with cap (optional) and place prewarmed blankets to cover body of newborn on mother's chest, leaving face exposed
   f. Dry and stimulate, and assess newborn
   g. Replace wet blankets and cap with dry warm blankets and cap

3. (True/False) The definition of SUPC is Sudden Unexpected Postnatal Collapse: a rare but severe condition in which a newborn considered to be "well" at birth requires sudden resuscitation/intensive care, dies, or develops encephalopathy

4. Frequent and repetitive assessments during skin-to-skin care by staff should include (circle all that apply)
   a. Activity
   b. Tone
   c. Color
   d. Caregiver/mother fatigue, mobility, or distraction
   e. Vital signs
   f. Positioning

5. _____ is an evidence-based tool that can be used to guide assessment and appropriate action by staff during skin-to-skin care.
   a. CAP Assessment
   b. NRP
   c. CPR
   d. RAPP Assessment

6. What type of patients may be at risk during rooming-in?
   a. Use of sedating medications and uncontrolled pain
   b. Seizure precautions
   c. Extreme limited mobility
   d. All of the above

Immediate and Uninterrupted Skin-to-Skin Care and Rooming-in Practices: Safety Quiz (Learner Version)

7. If safety is a concern, which are appropriate actions by staff? (circle all that apply)
   a. Always remove infant from room and bring to newborn nursery or surveillance area
   b. Conduct safety assessments more frequently
   c. Stay at bedside during feedings
   d. Ensure that there is an additional responsible person with the mother to assist with newborn care
   e. Consider removing infant if conditions decline and mother/family cannot respond to infant safely

8. What statement best characterizes an optimal safe sleep environment?
   a. Infant is sharing bed with mother during periods of sleep, mother's bed in is lowest position with siderails up.
   b. Infant is in bassinet in prone position during sleep with pacifier, mother's bed is highest position so that she can always see infant.
   c. Infant swaddled on family member in chair during sleep periods
   d. Infant in bassinet in supine position during sleep, with no excess bedding, mother's bed in lowest position

9. What are actions that can promote a safe rooming-in environment? (circle all that apply)
   a. Education provided on safety precautions during admission, at every shift, when administering sedating pain medication, and as often as determined by staff
   b. Instruct parents to ask for assistance with lifting or handling infant if feeling unsteady, or extremely fatigued
   c. Review mother/infant equipment to ensure proper function and demonstrate appropriate use such as bed rails, call bells with mothers and families

Resource 2.18

Infant Feeding Self-Reflection and Discussion (Trainer Version)

Watch: Latching and attachment: https://www.healthyfamiliesbc.ca/home/articles/video-latching-your-baby

- What are some simple "catch phrases" that you can share with parents about positioning and latching their baby?
  - Tummy to tummy or chest to chest
  - Nose to nipple
  - Mouth wide
  - Lips flanged out

There may be variation in responses. Have staff talk about what they feel works best with patients and what mothers seem to remember best.

Watch: Getting enough milk:
https://globalhealthmedia.org/portfolio-items/is-your-baby-getting-enough-milk/?portfolioID=5623

- What are 3 signs that indicate that a baby is getting enough milk?
  - Diaper output
  - Deep rhythmic sucking
  - Alert and active while feeding

These were the main takeaways from the video, but staff may have additional answers or variations of these answers that are also appropriate.

Watch: Cup and spoon feeding (only 1st 5 min):
https://globalhealthmedia.org/portfolio-items/cup-feeding/?portfolioID=5623

- What are key techniques to cup and spoon feeding?

1. Wash hands
2. Hold baby upright supporting head and neck
3. Rest cup lightly on lower lip and tip cup until breast milk reaches edge and to baby's lip
4. Baby will actively take breast milk with pauses
5. Do not pour breast milk into baby's mouth

   Answers may vary slightly.

- What alternative feeding method do you typically feel most comfortable with? Why?

Answers will vary, but this is a way to begin dialogue and discuss staff's learning needs

Resource 2.19

Infant Feeding Self-Reflection and Discussion (Learner Version)

Watch: Latching and attachment: https://www.healthyfamiliesbc.ca/home/articles/video-latching-your-baby

- What are some simple "catch phrases" that you can share with parents about positioning and latching their baby?

_____
_____
_____

Watch: Getting enough milk:
https://globalhealthmedia.org/portfolio-items/is-your-baby-getting-enough-milk/?portfolioID=5623

- What are 3 signs that indicate that a baby is getting enough milk?

1. _____
2. _____
3. _____

Watch: Cup and spoon feeding (only 1st 5 min): https://globalhealthmedia.org/portfolio-items/cup-feeding/?portfolioID=5623

- What are key techniques to cup and spoon feeding?

_____
_____
_____

- What alternative feeding method do you typically feel most comfortable with? Why?

_____
_____
_____

Resource 2.20

Scenario Cards: (*Note to Trainer: you will find the detailed information on key points for expected learner responses in the Detailed Teaching Content section of Core Competency 1)

Card: Scenario	Back: Key Points Needed in Learner Response
Sasha just delivered her first baby. She had an uncomplicated vaginal delivery. She plans to breastfeed her baby. You are the nurse attending the delivery. What are actions that will help Sasha and her baby get the best possible start? (Note: Healthy Term Infant)	• Place the baby skin-to-skin ensuring safe positioning • Explain feeding cues and help with feeding

Card: Scenario	Back: Key Points Needed in Learner Response
Julianna is 2 days postpartum. She had a healthy term baby boy and reports having a lot of trouble breastfeeding her baby and is worried that her baby is not getting enough to eat. How would you respond to and assist Julianna? (Note: Healthy Term Infant)	• Offer to assist with feeding • Assess breasts and describe to trainer what you are assessing for • Assess infant and describe to trainer key points of assessment • Assist with proper positioning and attachment • Teach signs of effective milk transfer

Card: Scenario	Back: Key Points Needed in Learner Response
Carisa is 3 days postpartum. The pediatrician is concerned because of feeding difficulties. The baby was born term and Appropriate for Gestational Age but is down 8% from birthweight. Carisa reports intense nipple and breast pain. Upon assessment, you note that her breasts are extremely full. She reports that the fullness started the night before, but she does not feel relief between feedings. There is slight abrasion to both nipples. She reports that the baby had been latching well before her breasts became full but now seems to be having difficulty. How should you respond to this situation? (Note: Healthy Term Infant)	• Complete breast assessment and pain history. Verbalize components of assessment to trainer. • Physical assessments of mother and infant. Verbalize components of assessment to trainer. • Feeding Assessment • Observation of milk expression (hand and pumping) • Management of nipple soreness • Management of engorgement • Warning signs of Mastitis • Feeding plan moving forward • Follow-up plan

Card: Scenario	Back: Key Points Needed in Learner Response
Kate is 24 hrs postpartum with her first baby. The baby was born term but LGA. The health record reveals a history of gestational diabetes. Kate reports having a lot of difficulty feeding and that the baby has not successfully latched since delivery. Last night, the baby was very fussy but now is hard to arouse. Breast and nipple assessment reveals that Kate has inverted nipples. Breasts appear widely spaced and size notably asymmetrical. The baby's output has been sufficient for age, but weight has already dropped significantly. What are your priorities and plan of care moving forward? (Note: Healthy Term Infant)	• Explain priorities and recommended plan of care moving forward addressing: – Infant risks and feeding interventions – Address maternal risks noted and interventions – Individualized feeding plans (including appropriate supplementation amounts) – Continued monitoring and follow-up planning

Card: Scenario	Back: Key Points Needed in Learner Response
It is 2am and you get a frantic, emotional call from Sara. Sara is a first-time mom 48 hrs postpartum. She is exhausted and very emotional because her baby is very fussy and not settling between feedings. She reports that he is latching well, but seems to always be hungry. Sara states that this is a huge contrast to his behavior that day, which was calm and content between feedings. She wants you to take him to the newborn nursery for the night and feed him formula so that she and her partner can get rest. How should you respond to this request? (Note: Healthy Term Infant)	• Describe actions to trainer

Card: Scenario	Back: Key Points Needed in Learner Response
Betty (G1P1) delivered a healthy baby boy 10 hours ago via cesarean after a long trial of labor. He latches onto the breast, but after a couple sucks, falls asleep. She wants to exclusively breastfeed; however, she is concerned her baby is not feeding well. How would you support this mom? (Note: Healthy Term Infant)	• Describe actions to trainer

Card: Scenario	Back: Key Points Needed in Learner Response
Seth was born at 29 weeks, and mom is unsure of her feeding plans. What counseling will you provide regarding this decision? If she decides to breastfeed, how will you help her get off to a good start?	• Importance of breast milk particularly for very premature or sick babies. • Frequency of breast milk expression for preterm or late preterm babies. • Review support services.

Card: Knowledge and Skills Demo of the Following	Back: Key Points Needed in Learner Response
• Supplementation policy (if applicable) • Name at least 3 possible medical indications for supplementation. • Demonstrate each of the following alternative feeding methods using props/equipment: – SNS at breast – Finger feeding with syringe – Cup feeding – Spoon feeding	• Describe and demonstrate of specified skills to trainer.

Resource 2.21

New Born Weight Tool (NEWT)

- Link: www.newbornweight.org
- NEWT is the first tool created that allows pediatric healthcare providers and parents to see how a newborn's weight during the first days following childbirth compares with a large sample of newborns.

CORE COMPETENCY 3 -

TEACHING HAND EXPRESSION AND SAFE STORAGE OF BREAST MILK

EMPower Training

CORE COMPETENCY 3 – TEACHING HAND EXPRESSION AND SAFE STORAGE OF BREAST MILK

Overview

All breastfeeding mothers should be taught how to manually express their breast milk. It is an easy and useful skill that can assist the breastfeeding mother to manage common breastfeeding issues like engorgement and plugged ducts. Additionally, it can be a useful technique that can facilitate latch and attachment to the breast during breastfeeding attempts. It is imperative that if mothers are separated from their infants, they be taught to express their milk and maintain lactation. In these situations, mothers and families should also be taught how to appropriately handle and store expressed breast milk so that it can safely be fed to their infants. This competency lesson will focus on proper milk expression techniques and proper, evidence-based handling and storage guidance for expressed breast milk.

Objectives

Learner will:

1. Demonstrate the ability to simulate and verbalize instruction of proper hand expression techniques.
2. Demonstrate the ability to properly assemble a breast pump and instruct a mother on proper usage including frequency and duration of expression and hygiene and cleaning instruction.
3. Describe evidence-based safe handling and storage guidelines for expressed milk.

Time: 1 hour

Safety Considerations

1. Counseling, communication, and education should be delivered in a sensitive manner with careful consideration of a patient's social, cultural, and/or health related circumstances.
2. Counseling, communication, and education related to proper breast pump instruction and milk storage should be based on updated evidence and practices to minimize risks of contamination of milk.
3. It is important that maternity staff demonstrate the ability to intervene appropriately when safety concerns, risk factors, and/or medical conditions related to milk expression, and safe handling and storage guidelines for expressed milk are identified. Assessment and identification of these concerns can result in modifications, delays, and/or contraindications of these practices.

Teaching Outline

Core Competency 3: Teaching hand expression and safe storage of breast milk

A. Hand expression
   i. Demonstration of hand expression technique
   ii. Verbalization of instruction/technique
   iii. Documentation of demonstration and instruction

B. Use of electric hospital grade pump
   i. Pump set up and instruction
   ii. Milk expression techniques that optimize milk production
   iii. Hygiene and cleaning of pump and supplies
   iv. Documentation of education, assistance, and resources provided

C. Storage and safe handling of expressed breast milk
   i. Importance of safe storage and handling of expressed milk
   ii. Evidence-based breast milk storage and handling guidelines for home settings

Accompanying Trainer Content

A. Hand Expression

Competency Topic Hand Expression	
Subtopic	**Trainer Content**
i. Demonstration of hand expression technique	• **Hand Expression Technique:** – Wash hands well with soap and water for 20 seconds. If soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol – Consider stimulating breast with gentle massage and nipple stimulation – Have mother sit or stand comfortably and hold a clean collection container near her breast – Place thumb on breast ABOVE the nipple and areola, and first finger on the breast BELOW the nipple and areola, opposite the thumb – Press thumb and first finger slightly inwards towards the chest wall – Press her breast behind the nipple and areola between her finger and thumb – Press and release, press and release in continuous motion. This should not be painful for mother – Avoid rubbing or sliding fingers along the skin; the movement of the fingers should be more like rolling – Avoid squeezing the nipple itself; pressing or pulling the nipple cannot express the milk – At first no milk may come, but after pressing a few times, milk should begin to flow – Rotate fingers around the areola pressing and releasing in the same way to ensure that milk is expressed from all quadrants of the breast – Express one breast for at least 3 - 5 minutes until the flow slows; then express the other side; and then repeat both sides; mother can use either hand for either breast and change when she tires – Explain that it takes 20 - 30 minutes to express breast milk adequately, especially in the first few days when only a little milk may be produced • See **Teaching Resource 3.4** for link to video on hand expression and **Teaching Resource 3.2** for visual
ii. Verbalization of instructions and technique	• Staff should be able to describe general instructions with proper technique
iii. Documentation of demonstration and instruction	**(Facility-Specific)** Staff should cite appropriate area for documenting teaching and assistance in health record

Competency Topic Hand Expression
Reference(s): 1. Baby-Friendly USA. (2016). *Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation*. Albany, NY: Baby-Friendly USA. 2. Stanford Medicine. (n.d.). *Hand Expression of Breastmilk* [Video file]. Retrieved from: https://med.stanford.edu/newborns/professional-education/breastfeeding/hand-expressing-milk.html 3. World Health Organization. (2014). *Breastfeeding counselling: A training course*. Geneva, Switzerland: World Health Organization. Retrieved from: http://www.who.int/maternal_child_adolescent/documents/who_cdr_93_3/en/
Related Teaching Resources: 3.2 & 3.4

B. Use of Electric Hospital Grade Pump

Competency Topic: Breast Pump	
Subtopic	**Trainer Content**
i. Pump set up and instruction	***Staff should demonstrate knowledge of facility-specific pumping procedures. Below is a standard example.** ***Product specific information regarding cleaning breast pumps should be obtained from manufacturer instruction manual.** **Sample Pumping Procedure** **Equipment needed**: • Double electric breast pump • Double Pumping System/pumping supplies • Infant or mother identification labels (for labeling collection containers of expressed milk) • Warm compresses (optional) • Picture of baby or articles of baby's clothes **Pumping procedure:** 1. Wash hands before handling breast pump parts. Have mother wash hands well with soap and water for 20 seconds; if soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol 2. Assemble breast pump kit/pumping system (follow manufacturing manual); inspect the pump kit and tubing to make sure it is clean; discard and replace moldy tubing immediately; if using a shared pump kit, clean pump dials, power switch, and countertop with disinfectant wipe 3. Assist mother to a comfortable position, provide privacy and instruct patient to fully expose breast 4. Suggest that mother establish pumping routine to assist with letdown (i.e., applying warm compresses, using deep breathing and relaxation techniques, looking at baby's photo and having a glass of water) 5. Center the breast shield(s) over the nipple(s) and press shield(s) against breast(s) for proper seal 6. Instruct mother to hold collection system upright to keep milk from overflowing into tubing 7. Set pumping cycles and suction to mimic newborn suck patter (if possible). Suction intensity should be comfortable for mother 8. Make sure cycle speed is on max; newborns suck rapidly in the early days of life and the max setting best mimics this

Competency Topic: Breast Pump	
Subtopic	**Trainer Content**
	9. It may be necessary to increase suction intensity gradually during pumping session; turn suction down if there is any discomfort 10. A seal should be made with suction; if seal is not achieved, press the bell of the breast shield back toward the chest wall; if you are not getting suction, remove and check all connections 11. Pump a minimum of 10-15 minutes if using a double collection system; if milk is still flowing well at 15 minutes, continue pumping until milk flow decreases; if using a single collection system, pump 3-5 minutes on the first breast, then 3-5 minutes on the second; return to the first breast 2-3 minutes, then the second 2-3 minutes 12. Turn pump off 13. Advise mom not to fill the bottle more than 2/3 full 14. Have mother air-dry nipples after pumping 15. Pour milk collected into breast milk collection and storage container with lid, label with name, date, and time of pumping; immediately place in refrigerator, freezer or cooler/ice packs depending on how soon milk will be used 16. Clean pumping area, especially if using a shared pump, clean the dials, power switch, and countertop with disinfectant wipes 17. Take apart and inspect pump kit; take apart breast pump tubing and separate all parts that come in contact with breast/breast milk (for example, flanges, valves, membranes, connectors, and milk collection bottles) 18. Rinse pump kit; rinse breast pump parts that come into contact with breast/breast milk under running water to remove remaining milk 19. Clean pump kit; as soon as possible after pumping, clean pump parts that come into contact with breast/breast milk in one of the following ways

Competency Topic: Breast Pump	
Subtopic	**Trainer Content**
ii. Milk expression techniques that optimize milk production	• Expressing milk consistently at least 8 times in 24 hours, avoiding long lapses between • Breast massage, compression during pumping • Hand expression (technique above) after pumping sessions **Hands-on pumping technique**: • Massage both breasts • Double pump (techniques described above) • Stop pumping and repeat breast massage • Single pump and/or hand express alternating breasts from right to left • See **Teaching Resource 3.4** for video link to demonstrate Hands-on Pumping Technique *NOTE: Mothers separated from their infants should always use the double collection system, which increases prolactin and decreases pumping time. Single pumping should be used for prn basis.

Competency Topic: Breast Pump	
Subtopic	**Trainer Content**
iii. Hygiene and cleaning of pump and supplies	**Cleaning Procedure** **Clean by hand:** 1. **Use a wash basin.** Place pump parts in a clean wash basin used only for washing infant feeding equipment. Do not place pump parts directly in the sink, because germs in sinks or drains could contaminate the pump. 2. **Add soap and water.** Fill wash basin with hot water and add soap. 3. **Scrub.** Scrub items using a clean brush that is used only to clean infant feeding items. 4. **Rinse.** Rinse by holding items under running water, or by submerging in fresh water in a separate basin that is used only for cleaning infant feeding items. 5. **Dry.** Allow to air-dry thoroughly. Place pump parts, wash basin, and bottle brush on a clean, unused dish towel or paper towel in an area protected from dirt and dust. Do not use a dish towel to rub or pat items dry because doing so may transfer germs to the items. **Clean in a dishwasher** (if recommended by pump kit manufacturer): 1. **Wash.** Place disassembled pump parts in dishwasher. Be sure to place small items into a closed-top basket or mesh laundry bag so they don't end up in the dishwasher filter. **If possible, run the dishwasher using hot water and a heated drying cycle (or sanitizing setting); this can help kill more germs.** 2. **Remove from dishwasher.** Wash your hands with soap and water before removing and storing cleaned items. If items are not completely dry, place items on a clean, unused dish towel or paper towel to air-dry thoroughly before storing. Do not use a dish towel to rub or pat items dry because doing so may transfer germs to the items. **Clean wash basin and bottle brush.** If you use a wash basin or bottle brush when cleaning your pump parts, rinse them well and allow them to air-dry after each use. Consider washing them every few days, either in a dishwasher with hot water and a heated drying cycle if they are dishwasher-safe, or by hand with soap and warm water. • Please refer to **Teaching Resource 3.7** for guidance on Breastpump cleaning recommendations.
iv. Documentation of education, assistance, and resources provided	**(Facility-Specific)** Staff should cite appropriate area for documenting teaching and assistance in health record

Competency Topic: Breast Pump
Reference(s): 1. Baby-Friendly USA. (2016). *Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation.* Albany, NY: Baby-Friendly USA. 2. Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report. (2015). *Sexually Transmitted Diseases Treatment Guidelines*. Retrieved from: https://www.cdc.gov/std/tg2015/tg-2015-print.pdf 3. Centers for Disease Control and Prevention. (2018). *Breastfeeding: Contraindications to Breastmilk or Feeding Expressed Breast Milk to infants*. Retrieved from: https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/contraindications-to-breastfeeding.html 4. Centers for Disease Control and Prevention. (2018). *Proper Storage and Preparation of Breast Milk.* Retrieved from: https://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.html 5. Centers for Disease Control and Prevention. (2019). *How to Keep Your Breast Pump Kit Clean*. Retrieved from: www.cdc.gov/healthywater/pdf/hygiene/breast-pump-fact-sheet.pdf 6. Jones, F. (2011). *Best Practice for Expressing, Storing and Handling Human Milk in Hospitals, Homes, and Child Care Settings* (3rd Ed.). Fort Worth, TX: HMBANA. 7. Stanford Medicine. (n.d.). *Hand Expression of Breastmilk* [Video file]. Retrieved from: https://med.stanford.edu/newborns/professional-education/breastfeeding/hand-expressing-milk.html 8. World Health Organization. (2014). *Breastfeeding counselling: A training course*. Geneva, Switzerland: World Health Organization. Retrieved from: http://www.who.int/materna l_child_adolescent/documents/who_cdr_93_3/en/
Related Teaching Resource: 3.4, 3.8

C. Storage and Safe Handling of Expressed Breast Milk

Competency Topic: Handling and Storage of Expressed Breast Milk Please indicate if this is for home settings or hospital settings.	
Subtopic	**Trainer Content**
i. Importance of safe storage and handling of expressed milk	• To reduce bacterial growth in breast milk that can potentially harm newborns, specifically sick or preterm newborns • To protect the nutritional and protective integrity of the expressed breast milk
ii. Evidence-based breast milk storage and handling guidelines for home settings	• Basics of milk expression and storage in home setting: **Storing breast milk after expressing:** • Use breast milk storage bags or clean food-grade containers with tight fitting lids made of glass or plastic to store expressed breast milk – Avoid bottles with the recycle symbol number 7, which indicates that the container may be made of a BPA-containing plastic • Never store breast milk in disposable bottle liners or plastic bags that are not intended for storing breast milk • Freshly expressed or pumped milk can be stored: – At room temperature (77°F or colder) for up to 4 hours – In the refrigerator for up to 4 days – In the freezer for about 6 months is best; up to 12 months is acceptable. Although freezing keeps food safe almost indefinitely, recommended storage times are important to follow for best quality **Storage tips:** • Clearly label the breast milk with the date it was expressed • Do not store breast milk in the door of the refrigerator or freezer; this will help protect the breast milk from temperature changes from the door opening and closing • If you don't think you will use freshly expressed breast milk within 4 days, freeze it right away; this will help to protect the quality of the breast milk • Freeze breast milk in small amounts of 2 to 4 ounces (or the amount that will be offered at one feeding) to avoid wasting breast milk that might not be finished • When freezing breast milk, leave about an inch of space at the top of the container because breast milk expands as it freezes

Competency Topic: Handling and Storage of Expressed Breast Milk Please indicate if this is for home settings or hospital settings.	
Subtopic	**Trainer Content**
	• If you will be delivering breast milk to a childcare provider, clearly label the container with the child's name and talk to your childcare provider about other requirements they might have for labeling and storing breast milk • Breast milk can be stored in an insulated cooler bag with frozen ice packs for up to 24 hours when you are traveling; once you arrive at your destination, milk should be used right away, stored in the refrigerator, or frozen • Please refer to **Teaching Resource 3.3 & 3.9** for guidance about milk storage in home setting • Ideally such guidance should be kept on unit for staff reference and to provide patients needing the information • Milk should not be thawed or warmed in a microwave • Staff should be able to locate this information

Reference(s):

1. Centers for Disease Control and Prevention. (2018). *Proper Storage and Preparation of Breast Milk*. Retrieved from: https://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm
2. Eglash, A., Simon, L., & Academy of Breastfeeding Medicine. (2017). ABM clinical protocol #8: Human milk storage information for home use for full-term infants, revised 2017. *Breastfeeding Medicine: The Official Journal of the Academy of Breastfeeding Medicine, 12*(7), 390.
3. Jones, F. (2011). *Best Practice for Expressing, Storing and Handling Human Milk in Hospitals, Homes, and Child Care Settings* (3rd Ed.). Fort Worth, TX: HMBANA.

Related Teaching Resource: 3.3

Verification of Core Competency 3 – Suggested Activities

Skills Lab

Table Set-up

Skills Station 3: Teaching hand expression and safe storage of breast milk

Anticipated Teaching/Learning Time: 1 hour

Materials/Staff Needed

Training Staff	Training Materials (for Trainer Use, Visuals, Demonstration, etc.)	Staff Handouts (multiple copies of items listed)
(1) Training Team Member (minimum)	• Core Competency 3 Teaching outline and trainer teaching content (located in previous section) • Consider printed visuals of the following: – CDC Proper Storage and Preparation of Breast Milk (**Teaching Resource 3.3**) – Hand Expression Visual **(Teaching Resource 3.2)** ▪ Tip: laminate visuals for durability and/or consider placing on display board to reference during general instruction activity and/or future learning activities • iPad/Computer/Electronic Display with audiovisual and internet connection with the following videos loaded: – Hand Expression: https://med.stanford.edu/newborns/professional-education/breastfeeding/hand-expressing-milk.html – Pumping: https://med.stanford.edu/newborns/professional-education/breastfeeding/maximizing-milk-production.html – Video Links above also provided in **(Teaching Resource 3.4)** • Milk Expression Video Self-Reflection/Discussion Worksheet (Trainer Version) **(Teaching Resource 3.5)** • Scenario Cards/Skills Demonstration Cards (recommend at least 2 sets depending on anticipated size of group) (provided) **(Teaching Resource 3.7)** • How to Keep Your Breast Pump Kit Clean **(Teaching Resource 3.8)** *Tip: laminate scenario cards for durability. Bind cards with ring so that they do not get misplaced • Milk Storage Guidelines (Teaching Resource 3.9) • Baby doll(s) • Breast model(s) • Hospital Grade Electric Breast Pump • Pump set up parts/accessories • Milk collection containers	• CGBI Ten Step Tear Sheets: A Guide for Healthcare Professionals **Teaching Resource 3.1**: Titled – Mother's Milk Expression • Milk Expression Video Self-Reflection/ Discussion Worksheet (Learner Version) **(Teaching Resource 3.6)** • How to Keep Your Breast Pump Kit Clean **(Teaching Resource 3.8)** • Trainers may decide to give handouts of any of the training materials listed in previous column • CDC Milk Storage Guidelines (Teaching Resource 3.9)

- **Station (Table) Set-up**
  - Signage indicating Station Title Station 3: Teaching hand expression and safe storage of breast milk
  - Table should be set up with:
    - AV equipment of choice
    - Stacks of copies the different staff handouts listed above
    - Milk Expression *Video Self-Reflection/Discussion Worksheet* (learner version) **(Teaching Resource 3.6)**
    - Scenario/Skills Demonstration Cards **(Teaching Resource 3.7)**

- **Description of Station Activity:**
  - **General Information Session and Exercises:** (anticipated time 30 min)
    - This station will start with a lesson and self-reflection activity on milk expression.
    - Due to audiovisuals needed, the trainer may want to limit the number of learners per session depending on the audiovisual set up/display. It's important that all learners can hear the short video clips and the trainer during the self-reflection exercises,
    - If audiovisual not able to be provided, the trainer can utilize teaching resources/handouts as visuals to instruct on the following:
      - Hand Expression
      - Pumping
        *trainer can still use Milk Expression Video Self-Reflection/ Discussion Worksheet and exercise, but adapt accordingly if AV not available.
    - Trainer will welcome learners and hand them the learner versions of the "Milk Expression Video Self-Reflection/Discussion Worksheet" **(Teaching Resource 3.6).**
    - Trainer will have learners take a seat and give an overview of session objectives and activities.
    - Trainer will then show the short video clips as in the order indicated on the "Milk Expression Video Self-Reflection/Discussion Worksheet."
    - After each video clip, the trainer should give learners time to answer the self-reflection questions before moving onto next clip.
    - Once learners have answered all questions, trainers should guide discussion on the Milk Expression Video Self-Reflection/Discussion by encouraging learners to share their answers with the group.
      - Tips to moderating discussion:
        - Encourage dialogue and problem solving amongst peers.
        - If a learner gives a "wrong" or inappropriate answer, avoid outwardly correcting, but rather ask probing questions using information from the Trainer version of the worksheet **(Teaching**

Resource 3.5) and teaching content to encourage further discussion and more appropriate response.

- **Competency Verification Exercise:** (30 min)
  - After Self-Reflection Worksheet discussions are complete, the trainer will explain that competency verification will be accomplished by each learner responding to provided scenario/skills demonstration cards **(Teaching Resource 3.7)**. The trainer should explain that it is expected that the effective communication skills are applied to each response. Key points of information are expected to be addressed in the scenario.
  - The trainer can begin verification by asking for a volunteer to demonstrate competency first. If no one volunteers, the trainer will select a learner.
  - Each learner will demonstrate competency by responding to the scenario utilizing effective communication techniques while demonstrating knowledge of skill.
  - Learners should be encouraged to role play (if possible) and use props provided.
  - Trainer will decide how many correct responses meet minimum acceptance for competency verification (example: learners will respond correctly).
  - Trainer will repeat this with each learner in the group.
    - Considerations for trainers:
      - If a learner is not participatory in exercises or gives indication that they are not comfortable with application of communication skills or knowledge, then trainers should have the learner repeat session or do additional activities to demonstrate competency.
      - If a learner joins the session late, they will have to repeat missed activity in next session. If the session is too far progressed for it to benefit the learner, trainers may advise that the learner wait until next session or join another table session (if that's an option).
    - Once the trainer feels that learners have responded and/or learned from the exercise effectively, the trainer will validate learners' competency by dating and initialing the objectives under Core Competency 3 and signing the bottom on Employee Competency Verification Form.
    - The trainer should instruct the learners to take a copy of each handout provided to place in their folders.

Simulation Lab

- **Station (Table) Set-up**
  - Signage indicating Station Title Station 3: Teaching hand expression and safe storage of breast milk
  - Table should be set up with:
    - AV equipment of choice
    - Milk Expression *Video Self-Reflection/Discussion Worksheet* (learner version) **(Teaching Resource 3.6)**
    - Scenario/Skills Demonstration Cards **(Teaching Resource 3.7)**
  - Room Set-up with:
    - Patient bed
    - Baby doll
    - Resource handouts listed above
    - Any additional supplies the team feels would help create an environment similar to a patient room

- **Description of Station Activity:**
  - **General Information Session and Exercises:** (anticipated time 30 min)
    - This station will start with a lesson and self-reflection activity on milk expression.
    - Due to audiovisuals needed, the trainer may want to limit the number of learners per session depending on the audiovisual set up/display. It's important that all learners can hear the short video clips and the trainer during the self-reflection exercises.
    - If audiovisuals are not able to be provided, the trainer can utilize teaching resources/handouts as visuals to instruct on the following:
      - Hand Expression
      - Pumping
        *trainer can still use Milk Expression Video Self-Reflection/ Discussion Worksheet and exercise, but adapt accordingly if AV not available.
    - The trainer will provide the "Milk Expression Video Self-Reflection/Discussion Worksheet" **(Teaching Resource 3.6)**.
    - The trainer will provide an overview of session objectives and activities.
    - The trainer will show the short video clips as in the order indicated on the "Milk Expression Video Self-Reflection/Discussion Worksheet."
    - After each video clip, the trainer should give learners time to answer the self-reflection questions before moving onto next clip.
    - Once the learner has answered all questions, trainers should guide discussion on the Milk Expression Video Self-Reflection/Discussion by encouraging learners to share their answers with the group.

        - Tips to moderating discussion:
            - Encourage dialogue and problem solving amongst peers.
            - If a learner gives a "wrong" or inappropriate answer, avoid outwardly correcting, but rather ask probing questions using information from the Trainer version of the worksheet **(Teaching Resource 3.5)** and teaching content to encourage further discussion and more appropriate response.
- **Competency Verification Exercise:** (30 min)
    - After Self-Reflection Worksheet discussions are complete, the trainer will explain that competency verification will be accomplished by each learner responding to provided scenario/skills demonstration cards **(Teaching Resource 3.7)**. The trainer should explain that it is expected that the effective communication skills are applied to each response. Key points of information are expected to be addressed in the scenario.
    - Each learner will demonstrate competency by responding to the scenario utilizing effective communication techniques while demonstrating knowledge of skill.
    - The trainer will decide how many correct responses meet minimum acceptance for competency verification (example: learners will respond correctly).
    - The trainer will repeat this with each learner.
        - Considerations for trainers:
            - If a learner is not participatory in exercises or gives indication that they are not comfortable with application of communication skills or knowledge, then trainers should have the learner repeat session or do additional activities to demonstrate competency.
    - Once the trainer feels that learners have responded and/or learned from the exercise effectively, the trainer will validate learners' competency by dating and initialing the objectives under Core Competency 3 and signing the bottom on Employee Competency Verification Form.
    - The trainer should instruct the learners to take a copy of each handout provided to place in their folders.

Teaching Resources for Core Competency 3

Note: The training resources provided may include content related to specific practices that is beyond the scope of this training. These resources should be adapted in a manner that aligns with your hospital policies and procedures, taking into account clinical situations and hospital factors unique to your setting.

Resource 3.1

CGBI Ten Step Tear Sheets: A Guide for Healthcare Professionals

- Link: https://sph.unc.edu/files/2017/10/CGBI-Ten-Steps-Supplemental-Education-for-Staff-S.pdf
- For this Core Competency provide copies Tear Sheets Titled:
  - Mother's Milk Expression

Resource 3.2

Hand Expression Visual/Handout

- Link: https://www.lllc.ca/sites/lllc.ca/files/Hand-expression_WAB.pdf

Resource 3.3

CDC Proper Storage and Preparation of Breast Milk
(Guidelines are for home settings and not for hospital setting)

Human Milk Storage Guidelines			
Storage Locations and Temperatures			
Type of Breast Milk	**Countertop** 77°F or colder (25°C) (room temperature)	**Refrigerator** 40°F (4°C)	**Freezer** 0°F or colder (-18°C)
Freshly Expressed or Pumped	Up to **4 hours**	Up to **4 days**	Within **6 months** is best Up to **12 months** is acceptable
Thawed, Previously Frozen	**1-2 hours**	Up to **1 day** (24 hours)	**Never** refreeze human milk after it has been thawed
Left Over from a Feeding (*baby did not finish the bottle*)	Use within **2 hours** after the baby is finished feeding		

Adapted from "ABM Clinical Protocol #8: Human Milk Storage Information for Home Use for Full-Term Infants," Revised 2017.

Link:
https://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm

*Hospitals may purchase guidelines for breast milk storage in the hospital setting from Human Milk Banking of North America. www.hmbana.org

Resource 3.4

Milk Expression Video Links: (used in suggested activity)
• **Hand Expression:** https://med.stanford.edu/newborns/professional-education/breastfeeding/hand-expressing-milk.html • **Pumping:** https://med.stanford.edu/newborns/professional-education/breastfeeding/maximizing-milk-production.html

Resource 3.5

Milk Expression Video Self-Reflection/Discussion Worksheet (Trainer Version)

Watch Hand Expression Video: https://med.stanford.edu/newborns/professional-education/breastfeeding/hand-expressing-milk.html and then answer the following:

1. What are some benefits of early hand expression?
   - Answers may vary. Improves milk production, colostrum provided to infant, could reduce need for supplementation with infant formula, can improve maternal confidence in milk production.

2. Was there anything from the technique demonstrated in the video that you found particularly helpful or surprising?
   - Answers will vary. Encourage group discussion.

3. Which patients/dyads could benefit the most from early hand expression? Why?
   - Any dyad with risk factors (Maternal or newborn). Mothers/Infants that are separated or cannot successfully or effectively breastfeed at the breast.
   - Early removal of milk helps maximize milk production later. Infant can receive milk reducing need for supplementation with infant formula.
   - Other answers may be appropriate. Encourage group discussion.

Watch Pumping Video: https://med.stanford.edu/newborns/professional-education/breastfeeding/maximizing-milk-production.html

1. How soon after delivery should mothers begin expressing their milk if they are separated from their infant? And why is this important?
   - Ideally milk expression should begin within the first hour. At minimum, milk expression should begin within 3-6 hours after delivery.

2. Was there anything from the technique demonstrated in the video that you found particularly helpful or surprising?
   - Answers will vary. Encourage group dialogue and discussion.

3. Will this information impact or change your practices? Explain.
   - Answers will vary. Encourage group dialogue and discussion.

Resource 3.6

Milk Expression Video Self-Reflection/Discussion Worksheet (Learner Version)

Watch Hand Expression Video: https://med.stanford.edu/newborns/professional-education/breastfeeding/hand-expressing-milk.html and then answer the following:

What are some benefits of early hand expression?

_____
_____
_____

Was there anything from the technique demonstrated in the video that you found particularly helpful or surprising?

_____
_____
_____

Which patients/dyads could benefit the most from early hand expression? Why?

_____
_____
_____

Watch Pumping Video: https://med.stanford.edu/newborns/professional-education/breastfeeding/maximizing-milk-production.html

How soon after delivery should mothers begin expressing their milk if they are separated from their infant? And why is this important?

_____
_____
_____

Was there anything from the technique demonstrated in the video that you found particularly helpful or surprising?

_____
_____
_____

Will this information impact or change your practices? Explain.

_____
_____
_____

Resource 3.7

Scenario/Skills Demonstration Cards

Card: Knowledge and Skills Demo of the Following	Back: Key Points Needed in Learner Response
You are caring for a breastfeeding mother whose baby is at risk for hypoglycemia. You feel that this baby would benefit from extra breast milk. Demonstrate how you would instruct this mother to hand express her milk.	Describe and demonstrate specified skills to trainer using props/supplies • Hand expression • Expression duration and frequency

Card: Knowledge and Skills Demo of the Following	Back: Key Points Needed in Learner Response
You are caring for a mother who just delivered her baby at 30 weeks gestation. The baby was admitted to the NICU immediately following delivery, 1 hour ago. What do you need to teach this mother?	Describe and demonstrate specified skills to trainer using props/supplies • Importance of initiation of milk expression within 1 hour, but no later than 6 hours • Pumping technique • Expression duration and frequency • Breast pump hygiene

Card: Scenario	Back: Key Points Needed in Learner Response
Abby is expecting her first baby. She plans to breastfeed her baby and has taken breastfeeding classes. Abby is scheduled for a cesarean section due to breech positioning. She goes into spontaneous labor 5 days before the scheduled C-section. The infant is delivered and shows signs of distress. The NICU team has determined that the baby needs to be admitted to the NICU for further evaluation. Baby is term and being kept for elevated bilirubin levels. How can you best support this mother's breastfeeding goals?	• Initiation of milk expression within 1 hour (preferable) but no later than 6 hours. • Recommendations about how often to pump • Recommendations on safe milk storage for home setting • Recommendations on how to safely clean pump supplies • How to hands-on pump • Teach hand-expression

Resource 3.8

CDC Cleaning Breast Pump Resources (used in suggested activity)
How to Keep Your Breast Pump Kit Clean • English: https://www.cdc.gov/healthywater/pdf/hygiene/breast-pump-fact-sheet.pdf • Spanish: https://www.cdc.gov/healthywater/pdf/hygiene/breast-pump-fact-sheet-sp.pdf

Resource 3.9

CDC Proper Storage and Preparation of Expressed Breastmilk
• English: https://www.cdc.gov/breastfeeding/pdf/preparation-of-breast-milk_H.pdf • Spanish: https://www.cdc.gov/breastfeeding/pdf/preparacion-de-la-leche-materna-508.pdf

CORE COMPETENCY 4 -

TEACHING SAFE FORMULA PREPARATION AND FEEDING

EMPower Training

CORE COMPETENCY 4 – TEACHING SAFE INFANT FORMULA PREPARATION AND FEEDING

Overview

While breastfeeding should be promoted and supported throughout the facility, some mothers and families will choose not to breastfeed for medical reasons or personal reasons. Mothers and families using infant formula should be fully respected and supported in their feeding decisions and should be taught how to properly prepare and handle the infant formula in the safest way possible. In addition, families using feeding bottles should be taught how to feed responsively and in a way that promotes safety and bonding. The following competency lesson will focus on safe infant formula preparation, hygienic handling practices of feeding supplies, and methods of bottle feeding that emphasize safety, bonding, and responsive feeding.

Objectives

Learner will:

1. Demonstrate the ability to properly prepare and reconstitute infant formulas
2. Demonstrate the ability to teach responsive feeding techniques to mothers/families using infant formula.
3. Demonstrate the ability to teach safe bottle-feeding techniques (including proper hygiene) to mother/families using feeding bottles.
4. Describe the importance of practicing within compliance of the International Code of Marketing of Breast milk Substitutes (WHO Code).

Time: 1 hour

Safety Considerations

1. Counseling, communication, and education will be delivered in a sensitive manner with careful consideration of a patient's social, cultural, and/or health related circumstances.
2. Counseling and educating families about responsive infant feeding, signs of proper preparation and reconstitution of infant formulas and, safe bottle-feeding techniques will help reduce additional risks of formula feeding.

Teaching Outline

Core Competency 4: Teaching safe infant formula preparation and feeding

A. Proper infant formula preparation instruction and reconstitution
   i.General instruction for preparation and handling, including proper hygiene
   ii.Bottle feeding at home
   iii.Ready to feed
   iv.Concentrate
   v.Powder (including liquid concentrate, powder, ready to feed)
   vi.Proper sanitary water sources for mixing infant formula
B. Cue based/responsive feeding to families using infant formula
   i.Suggested feeding amounts
   ii.Signs of hunger
   iii.Signs of satiety (fullness)
C. Bottle feeding techniques
   i.Paced bottle feeding
   ii.Eye contact
   iii.Safety
D. Implementation/upholding the *International Code of Marketing of Breast milk Substitutes* within the health facility
   i. Code of Marketing of Breast Milk Substitutes within the health facility
E. Written materials provided and reviewed with families using infant formula
   i. Review and provide written materials
F. Documentation of education, assistance, and resources provided
   i. Document education, assistance, and resources

Accompanying Trainer Content

A. Proper Infant Formula Preparation Instruction and Reconstruction

Competency Topic: Proper Infant Formula Preparation Instruction and Reconstitution	
Subtopic	**Trainer Content**
i. General instruction for preparation and handling, including proper hygiene	• **Clean up before preparation** – **Wash your hands** with soap and water – **Clean bottles** in a dishwasher with hot water and a heated drying cycle, or wash bottles in hot, soapy water by hand and then sanitize them – Clean work surfaces, such as countertops and sinks • It is not ideal to store pre-made, reconstituted infant formula for later feeding; this increases the risk of bacteria growth • Check label and packaging to verify which type of infant formula you are feeding your infant; it can be common to mistake concentrate preparations for ready to feed • Never microwave a bottle or any other container holding milk; this can cause "hot spots" and severe burns • Use infant formula within 2 hours of preparation; if the infant does not finish the entire bottle of formula, discard the unused formula • See **Teaching Resources 4.1 & 4.2**
ii. Bottle feeding at home	• Liquid formulations of infant formula are made to be sterile and should not transmit Cronobacter infection when handled carefully; to prevent contamination of infant formula: – Wash hands with soap and water before preparing bottles or feeding your baby – Clean your baby's feeding bottles in a dishwasher or by hand; in a dishwasher, use hot water and a heated drying cycle; by hand, scrub in hot, soapy water in a tub or basin reserved for washing bottles, then rinse well and air dry on a clean rack or dish towel; consider using a bottle sterilizer or boiling the bottles after washing and rinsing them by hand • If your baby does not finish drinking a bottle within 2 hours, throw away the unfinished infant formula
iii. Ready to feed	• Once container is opened, do not leave at room temperature for an extended length of time; facilities may have their own policies about this as per infection control • Once an infant has fed from the feeding bottle, the remaining infant formula must be discarded and not stored for later feedings
iv. Concentrate	• Follow manufacturer's instructions for reconstitution; adding more or less concentrated infant formula than instructed can cause harm to the infant • Shake container or concentrated infant formula well to ensure even distribution • Measure the appropriate amount of water into the bottle and then add appropriate amount of concentrate

Competency Topic: Proper Infant Formula Preparation Instruction and Reconstitution	
Subtopic	**Trainer Content**
	• Shake or swirl bottle gently to ensure thorough mixing
v. Powder (including liquid concentrate, powder, ready to feed)	• Follow manufacturer's instructions for reconstitution; adding more or less powder than instructed can cause harm to the infant • In most cases, it is safe to mix powdered infant formula following manufacturer's instructions. But if your baby is very young (<3 months), was born prematurely, or has a weakened immune system, you may want to take extra precautions to protect against *Cronobacter*; good hygiene, mixing the infant formula with water hot enough to kill germs, and safely storing infant formula can prevent growth of *Cronobacter* and other germs, like *Salmonella; f*or this reason, the following guidelines are recommended: – Keep powdered infant formula lids and scoops clean (be careful about what they touch) – Close containers of infant formula or bottled water as soon as possible – Clean work surfaces, such as countertops and sinks – Boil water and allow to cool to no less than 158° F/70°C before pouring into a clean and sterilized feeding cup or bottle; to achieve this temperature, the water should be left for no more than 30 minutes after boiling – Microwave ovens should never be used in the preparation of powdered infant formula as uneven heating may result in 'hot spots' that can cause burns – Pour the appropriate amount of boiled water, which has been allowed to cool slightly, but not below 158 °F/70 °C, into a cleaned and sterilized feeding cup or bottle; the temperature of the water should be checked using a sterile thermometer – If making a batch in a larger container: the container should have been cleaned and sterilized; it should be no larger than 1 liter, be made from food-grade material and be suitable for pouring hot liquids – To the hot water, add the exact amount of infant formula as instructed on the label – Carefully shake, rather than stir, infant formula in the bottle – Immediately cool infant formula to body temperature by running the prepared, capped bottle under tap or placing in a container of cool water or placing it into an ice bath; ensure that the level of the cooling water is below the top of the feeding cup or the lid of the bottle to keep the cooling water from getting into the bottle or on the nipple – Dry the outside of the feeding cup or bottle with a clean or disposable cloth – Before feeding the baby, test the temperature by shaking a few drops on your wrist; because very hot water has been used to prepare the infant formula, it is essential that the feeding temperature is checked before feeding to avoid scalding the infant's mouth; if necessary, continue cooling – Use infant formula within 2 hours of preparation; if the baby does not finish the entire bottle of infant formula, discard the unused infant formula – If you do not plan to use the prepared infant formula right away, refrigerate it immediately and use it within 24 hours

Competency Topic: Proper Infant Formula Preparation Instruction and Reconstitution	
Subtopic	**Trainer Content**
vi. Proper sanitary water sources for mixing infant formula	• Use water from a safe source to mix infant formula; if parents are not sure if the tap water is safe for use then instruct them to contact the local health department

Reference(s):

1. Centers for Disease Control and Prevention. (2018). *Cronobacter: Prevention and Control*. Retrieved from: https://www.cdc.gov/cronobacter/prevention.html
2. World Health Organization. (2017*). Safe preparation, storage and handling of powdered infant formula*. Geneva, Switzerland: World Health Organization. Retrieved from: http:/ /www.who.int/foodsafety/publications/powdered-infant-formula/en/

Related Teaching Resources: 4.1, 4.2, 4.7, 4.8

B. Cue Based/Responsive Feeding to Families using Infant Formula

Competency Topic: Cue Based/Responsive Feeding to Families Using Infant Formula	
Subtopic	**Trainer Content**
i. Suggested feeding amounts	• Feeding amounts should be based on newborn physiologic needs and stomach capacity; amounts should be increased over time • Feeding amounts should be based on individualized feeding plans and condition of infant • If the infant is not tolerating feeding amounts, consider feeding smaller amounts more frequently • Feeding amounts and frequencies may vary, refer to inpatient registered dietitian for calculation of needs • Health care professionals should help all mothers, regardless of feeding choices to understand that no restrictions should be placed on frequency or length of feeding and that newborns usually feed a minimum of 8 times in 24 hours
ii. Signs of hunger	• Nuzzling at the breast • Eye movements under closed eyelids • Increased alertness • Sucking on hand and tongue • Rooting • Bringing hands to mouth • Squeaking or light fussing • Tongue thrusts • Crying—late sign of hunger
iii. Signs of satiety (fullness)	• Relaxed position • Slowing eating pace • Stopping sucking • Turning face away from nipple • Closing lips tightly when nipple presented • Becoming fussy • Increasing attention to surroundings • Falling asleep (some newborns sleep through hunger cues and need to be aroused to feed with sufficient frequency)

Competency Topic: Cue Based/Responsive Feeding to Families Using Infant Formula
Reference(s): 1. Black, M. M., & Aboud, F. E. (2011). Responsive feeding is embedded in a theoretical framework of responsive parenting. *The Journal of Nutrition, 141*(3), 490-494. doi:10.3945/jn.110.129973 2. Brown, A., & Arnott, B. (2014). Breastfeeding duration and early parenting behaviour: The importance of an infant-led, responsive style. *PloS One, 9*(2), e83893-e83893. doi:10.1371/journal.pone.0083893 3. World Health Organization. (2014). *Breastfeeding counselling: A training course.* Geneva, Switzerland: World Health Organization.Retrieved from: http://www.who.int/mate rnal_child_adolescent/documents/who_cdr_93_3/en/
Related Teaching Resources: 1.2 & 1.3 (Core Competency 1)

C. Bottle Feeding Techniques

Competency Topic: Bottle Feeding Techniques	
Subtopic	**Trainer Content**
i. Paced bottle feeding	**Things to remember:** • For breastfed infants, avoid bottle nipples for 3-4 weeks or until a strong breastfeeding pattern is established; breastfed infants can be fed using a cup, spoon, nursing supplementer, etc. • Paced bottle 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 – Positioning- Start by holding baby in an upright/semi-reclined position; 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) – Nipple selection-Be sure to have the right nipple hole size; it should drip about 1 drop per second when completely inverted (slow flow); recommend silicone nipples since rubber nipples leak nitrosamine and break down faster; recommend BPA-free, PVC-free bottles (#7 for recycling) – Hold the bottle horizontal being sure that the nipple is filled with milk – Allow infant to actively root and search for nipple and eventually latch on – Allow infant to actively draw milk from the bottle – Paced feeding allows infants to take the frequent rests they need during a feed See **Teaching Resource 4.1**
ii. Eye contact	• **Bonding:** – Remind families to hold infant close during bottle feedings – Encourage them to interact with baby by maintaining eye contact
iii. Safety	• 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

Competency Topic: Bottle Feeding Techniques
Reference(s): 1. Baby-Friendly USA. (2016). *Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation*. Albany, NY: Baby-Friendly USA 2. Black, M. M., & Aboud, F. E. (2011). Responsive Feeding Is Embedded in a Theoretical Framework of Responsive Parenting. *The Journal of Nutrition, 141*(3), 490-494. doi:10.3945/jn.110.129973 3. World Health Organizations. (1981). *International Code of Marketing of Breast-milk Substitutes*. Geneva, Switzerland: World Health Organization. Retrieved from: http://www.who.int/nutrition/publications/code_english.pdf 4. World Health Organization. (2017). *Safe preparation, storage and handling of powdered infant formula.* Geneva, Switzerland: World Health Organization. Retrieved from: http://www.who.int/foodsafety/publications/powdered-infant-formula/en/
Related Teaching Resources: 4.1, 4.2, 4.3, 4.4, 4.5, 4.6

D. Implementation/Upholding the *International Code of Marketing of Breast Milk Substitutes* within the Health Facility

Competency Topic: Implementation/Upholding the International Code of Marketing of Breast Milk Substitutes within the Health Facility	
Subtopic	**Trainer Content**
i. Code of Marketing of Breast Milk Substitutes within the health facility	• *The Code* applies to the marketing, and practices related to the following products: – Breast-milk substitutes, including infant formula; other milk products, foods and beverages, including bottle fed complementary foods, when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breast milk – Feeding bottles and teats – It also applies to their quality and availability, and to information concerning their use • Accepting and distributing free, branded feeding products is against most facilities' vendor and ethics policies regarding appropriate interaction between vendors of such items and facility staff • Acceptance and distribution of feeding marketing materials and products can negatively influence new parents' perception of infant feeding choices; inappropriate marketing of food products that compete with breastfeeding is an important factor that often negatively affects the choice of a mother to breastfeed her infant optimally • Health facilities and staff should practice in accordance with the WHO Code by not distributing or displaying branded educational, marketing materials, or images to patients • See **Teaching Resources 4.3** (video) & **4.4** (visual)
Reference(s): 1. Baby-Friendly USA. (2016). *Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation*. Albany, NY: Baby-Friendly USA 2. International Code of Marketing of Breast-milk Substitutes. (n.d.). Retrieved from: http://www.who.int/nutrition/publications/code_english.pdf	
Related Teaching Resources: 4.3, 4.4, 4.5, 4.6	

E. Written Materials Provided and Reviewed with Families Using Infant Formula

Competency Topic: Written Materials	
Subtopic	**Trainer Content**
i. Review and provide written materials	• Families using infant formula should be given comprehensive, non-branded information reinforcing infant formula preparation and bottle-feeding practices (if using bottles); Education should be individualized for each patient and not provided in a group setting • See teaching resources **(Teaching Resource 4.2)** for examples/reference to use when drafting infant formula/bottle feeding information for families

Reference(s):

1. Baby-Friendly USA. (2016). *Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation*. Albany, NY: Baby-Friendly USA
2. World Health Organization (2014). *Safe preparation, storage and handling of powdered infant formula.* Geneva, Switzerland: World Health Organization. *Retrieved from:* http://w ww.who.int/foodsafety/publications/powdered-infant-formula/en/

Related Teaching Resources: 4.2

F. Documentation of Education, Assistance, and Resources Provided

Competency Topic: Documentation of Education, Assistance, and Resources Provided	
Subtopic	**Trainer Content**
i. Document education, assistance, and resources	**(Facility-Specific)** Staff should cite appropriate area for documenting teaching and assistance in health record

Reference(s):

1. Baby-Friendly USA. (2016). *Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation*. Albany, NY: Baby-Friendly USA
2. Black, M. M., & Aboud, F. E. (2011). Responsive Feeding Is Embedded in a Theoretical Framework of Responsive Parenting. *The Journal of Nutrition, 141*(3), 490-494. doi:10.3945/jn.110.129973
3. International Code of Marketing of Breast-milk Substitutes. (n.d.). Retrieved from: http://www.who.int/nutrition/publications/co de_english.pdf
4. World Health Organization (2014). *Safe preparation, storage and handling of powdered infant formula.* Geneva, Switzerland: World Health Organization. Retrieved from: http://w ww.who.int/foodsafety/publications/powdered-infant-formula/en/

Verification of Core Competency 4 – Suggested Activities

Skills Lab

Table Set-up

Skills Station 4: Teaching safe infant formula preparation and feeding

Anticipated Teaching/Learning Time: 1 hour

Materials/Staff Needed

Training Staff	Training Materials (for Trainer Use, Visuals, Demonstration, etc.)	Staff Handouts (multiple copies of items listed)
(1) Training Team Member	• Core Competency 4 Teaching outline and Trainer Teaching Content (located in previous section) • Formula Safety Quiz (Trainer Version) **(Teaching Resource 4.7)** • iPad/Computer/Electronic Display with Audiovisual and internet connection with the following videos loaded – International Code of Marketing of Breast milk Substitutes: https://vimeo.com/103257095 (play minutes 2:00- 24:00) – Link in **Teaching Resource 4.6** • Consider printed visuals of WHO Code Visual/Teaching Tool **(Teaching Resource 4.4)** *Tip: laminate visuals for durability and/or consider placing on display board to reference during general instruction activity and/or future learning activities • WHO Code Self-Reflection Worksheet (Trainer Version) **(Teaching Resource 4.5)** • Demonstration areas for infant formula preparation and bottle-feeding instruction: (products should be non-branded. Brands removed or covered) – Ready to feed infant formula/nurser – Concentrate infant formula – Powdered infant formula – Water for demonstration purposes – Bottle feeding instruction and techniques: ▪ Baby doll ▪ Bottle/nurser • Skills Demonstration Cards for each demonstration area: to guide competency demonstration **(Teaching Resource 4.9)** *Tip: laminate for durability and future use • Master copy of WHO Bottle/Formula Preparation Guide: http://www.who.int/foodsafety/document_centre/PIF_Bottle_en.pdf?ua=1 **(Teaching Resource 4.2)**	• CGBI Ten Step Tear Sheets: A Guide for Healthcare Professionals **(Teaching Resource 4.1)**: Titled – Bottle and Formula Feeding • Formula Safety Quiz (Learner Version) **(Teaching Resource 4.8)** • WHO Code Self-Reflection Worksheet (Trainer Version) **(Teaching Resource 4.6)** • Copy of **Teaching Resources 4.2** (1) http://www.who.int/foodsafety/document_centre/PIF_Bottle_en.pdf?ua=1 (2) http://www.who.int/foodsafety/publications/powdered-infant-formula/en/

- **Station (Table) Set-up**
  - Signage indicating Station Title: Station 4: Teaching Safe Infant Formula Preparation and Feeding
  - Table should be set up with:
    - AV equipment of choice
    - Stacks of copies the different staff handouts listed above
    - Formula Safety Quiz **(Teaching Resource 4.8)**
    - WHO Code Self-Reflection/Discussion Worksheet (learner version)
  - Demonstration/preparation areas for the following types of infant formula and bottle-feeding techniques:
    - Ready to feed
    - Concentrate
    - Powder
    - Bottle feeding instruction and technique
    - Skills Demonstration Cards correlating to appropriate demonstration/preparation area (to guide competency demonstration. These should be displayed at each demonstration area) **(Teaching Resource 4.9)**

- **Description of Station Activity:**
  - **General Information Session and Exercises:** (anticipated time 30 min)
    - Trainer will welcome learners and hand them the learner versions of the "WHO Code Self-Reflection/Discussion Worksheet" and the Formula Safety Quiz **(Teaching Resource 4.6)**
    - This station will start with a lesson and self-reflection activity on the International Code of Marketing of Breast-milk Substitutes (also known as the WHO Code).
    - Due to audiovisuals needed, the trainer may want to limit the number of learners per session depending on the audiovisual set up/display. It's important that all learners can hear the short video clip and the trainer during the self-reflection exercises.
    - If audiovisual not able to be provided, the trainer can utilize teaching resources visual and speaker notes **(Teaching Resource 4.4)** to instruct on the WHO Code.
      *trainer can still use the WHO Code Self-Reflection Worksheet **(Teaching Resource 4.5)** and exercise, but adapt accordingly if AV not available.
    - Trainer will have learners take a seat and give an overview of session objectives and activities.
    - Trainer will then show the short video clip as in the order indicated on the "WHO Code Self-Reflection/Discussion Worksheet" **(Teaching Resources 4.5/4.6)**
    - After the video clip, the trainer should give learners time to answer the self-reflection questions.

        - Once learners have answered all questions, trainers should guide discussion on the WHO Code Self-Reflection/Discussion by encouraging learners to share their answers with the group.
            - Tips to moderating discussion:
                - Encourage dialogue and problem solving amongst peers.
                - If a learner gives a "wrong" or inappropriate answer, avoid outwardly correcting, but rather ask probing questions using information from the Trainer version of the worksheet **(Teaching Resource 4.5)** and teaching content to encourage further discussion and more appropriate response.
        - After Self-Reflection Discussions are done, the trainer will have learners complete the Formula Safety Quiz **(Teaching Resource 4.8)**
        - Once learners have answered all questions, trainers should review the quiz and facilitate discussion by encouraging learners to share their answers with the group.
            - Tips to moderating discussion:
                - Encourage dialogue and problem solving amongst peers.
                - If a learner gives a "wrong" or inappropriate answer, avoid outwardly correcting, but rather ask probing questions using information from the Trainer version of the quiz **(Teaching Resource 4.7)** and teaching content to encourage further discussion and more appropriate responses.

- **Competency Verification Exercise:** (30 min)
    - After Self-Reflection Worksheet and Quiz discussions are complete, the trainer will explain that competency verification will be accomplished by each learner rotating through each of the demonstration areas for infant formula preparation and bottle-feeding instruction. Learners should use the skills demonstration cards **(Teaching Resource 4.9)** at each station to guide. The trainer should explain that it is expected that the effective communication skills are applied to each response. Key points of information are expected to be addressed in the scenario.
    - The trainer can begin verification by asking for a volunteer to demonstrate competency first. If no one volunteers, the trainer will select a learner.
    - Learners should be encouraged to role play (if possible) and use props provided.
    - Trainer will decide how many correct responses meet minimum acceptance for competency verification (example: learners will respond correctly).
    - Trainer will repeat this with each learner in the group.
        - Considerations for trainers:
            - It could be helpful to have multiple trainers/trainers so that learners can move through the skills demonstration areas simultaneously.
            - If a learner is not participatory in exercises or gives indication that they are not comfortable with application of communication skills or

knowledge, then trainers should have the learner repeat session or do additional activities to demonstrate competency.
        - If a learner joins the session late, they will have to repeat missed activity in next session. If the session is too far progressed for it to benefit the learner, trainers may advise that the learner wait until next session or join another table session (if that's an option).
    - Once the trainer feels that learners have responded and/or learned from the exercise effectively, the trainer will validate learners' competency by dating and initialing the objectives under Core Competency 4 and signing the bottom on Employee Competency Verification Form.
    - The trainer should instruct the learners to take a copy of each handout provided to place in their folders.

Simulation Lab

- **Station (Table) Set-up:**
    - Signage indicating Station Title: Station 4: Teaching Safe Infant Formula Preparation and Feeding
    - Table should be set up with:
        - AV equipment of choice
        - Stacks of copies the different staff handouts listed above
        - Formula Safety Quiz **(Teaching Resource 4.8)**
        - WHO Code Self-Reflection/Discussion Worksheet (learner version)
    - Demonstration/preparation areas for the following types of infant formula and bottle-feeding techniques:
        - Ready to feed
        - Concentrate
        - Powder
        - Bottle feeding instruction and technique
        - Skills Demonstration Cards correlating to appropriate demonstration/preparation area (to guide competency demonstration. These should be displayed at each demonstration area **(Teaching Resource 4.9)**
    - Room Set-up with:
        - Patient bed
        - Baby doll
        - Resource handouts listed above
        - Any additional supplies the team feels would help create and environment similar to a patient room

- **Description of Station Activity:**
  - **General Information Session and Exercises:** (anticipated time 30 min)
    - The Trainer will provide the "WHO Code Self-Reflection/Discussion Worksheet" and the Formula Safety Quiz **(Teaching Resource 4.6)**
    - This station will start with a lesson and self-reflection activity on the International Code of Marketing of Breast-milk Substitutes (also known as the WHO Code).
    - It's important that all learners can hear the short video clip and the trainer during the self-reflection exercises
    - If audiovisual not able to be provided, the trainer can utilize teaching resources visual and speaker notes **(Teaching Resource 4.4)** to instruct on the WHO Code.
      *trainer can still use the WHO Code Self-Reflection Worksheet **(Teaching Resource 4.5)** and exercise, but adapt accordingly if AV not available
    - The trainer will provide learners with an overview of session objectives and activities.
    - Trainer will then show the short video clip as in the order indicated on the "WHO Code Self-Reflection/Discussion Worksheet" **(Teaching Resources 4.5 & 4.6)**
    - After the video clip, the trainer should give learners time to answer the self-reflection questions.
    - Once learners have answered all questions, trainers should guide discussion on the WHO Code Self-Reflection/Discussion by encouraging learners to share their answers with the group.
      - Tips to moderating discussion:
        - Encourage dialogue and problem solving amongst peers.
        - If a learner gives a "wrong" or inappropriate answer, avoid outwardly correcting, but rather ask probing questions using information from the Trainer version of the worksheet **(Teaching Resource 4.5)** and teaching content to encourage further discussion and more appropriate response.
    - After Self-Reflection Discussions are done, the trainer will have learners complete the Formula Safety Quiz **(Teaching Resource 4.8)**
    - Once learners have answered all questions, trainers should review the quiz and facilitate discussion by encouraging learners to share their answers with the group.
      - Tips to moderating discussion:
        - Encourage dialogue and problem solving amongst peers.
        - If a learner gives a "wrong" or inappropriate answer, avoid outwardly correcting, but rather ask probing questions using information from the Trainer version of the quiz **(Teaching Resource 4.7)** and teaching content to encourage further discussion and more appropriate response.

- **Competency Verification Exercise:** (30 min)
  - After Self-Reflection Worksheet and Quiz discussions are complete, the trainer will explain that competency verification will be accomplished by each learner participating in a simulation lab. Trainers/actors should use the scenario cards **(Teaching Resource 4.9)** to guide learner responses. The trainer should explain that it is expected that the effective communication skills are applied to each response. Key points of information are expected to be addressed in the scenario. These are located on the back of the scenario cards.
  - Trainer will decide how many correct responses meet minimum acceptance for competency verification. (example: learners will respond correctly)
    - Considerations for trainers:
      - If a learner is not participatory in exercises or gives indication that they are not comfortable with application of communication skills or knowledge, then trainers should have the learner repeat session or do additional activities to demonstrate competency
  - Once the trainer feels that learners have responded and/or learned from the exercise effectively, the trainer will validate learners' competency by dating and initialing the objectives under Core Competency 4 and signing the bottom on Employee Competency Verification Form.
  - The trainer should instruct the learners to take a copy of each handout provided to place in their folders.

Teaching Resources for Core Competency 4

Note: The training resources provided may include content related to specific practices that is beyond the scope of this training. These resources should be adapted in a manner that aligns with your hospital policies and procedures, taking into account clinical situations and hospital factors unique to your setting.

Resource 4.1

CGBI Ten Step Tear Sheets: A Guide for Healthcare Professionals

- Link: https://sph.unc.edu/files/2017/10/CGBI-Ten-Steps-Supplemental-Education-for-Staff-S.pdf
- For this Core Competency provide copies of tear sheets titled:
  - Bottle and Formula Feeding

Resource 4.2

WHO Infant Formula Preparation

- Link to Document: http://www.who.int/foodsafety/publications/powdered-infant-formula/en/
- Link to Guidelines Document: http://www.who.int/foodsafety/document_centre/PIF_Bottle_en.pdf?ua=1

Resource 4.3

International Code of Marketing of Breast-milk Substitutes: (video used in suggested activity)

- Video Link: https://vimeo.com/103257095 (play minutes 2:00-24:00)

Resource 4.4

Talking points for trainer: Can be placed behind visual for reference:

- This visual highlights some key components of the Code. Please note that this summary is not all-inclusive. This is an extensive document that facilities should have knowledge of.
- Baby-Friendly Designated facilities must adhere to the International Code of Marketing of Breast-Milk Substitutes.
- In summary, the Code aims to protect and promote breastfeeding by ensuring appropriate marketing and distribution of breast milk substitutes.
- Breast-milk substitutes encompasses:
  - Infant formula, other non-breast milk products,
  - Infant cereals,
  - Vegetable mixes,
  - Baby teas/juices
  - Feeding bottles and teats, and pacifiers.
- Health care facilities should not engage in the promotion of these products by not advertising such products to the public and not distributing free samples to mothers, families and health workers.
- Furthermore, health care facilities should not accept free or low-cost supplies of these products to any part of the healthcare system.
- Baby-Friendly USA provides tools and assistance to facilities related to Code implementation.

Resource 4.5

WHO Code Self-Reflection Exercise Worksheet (Trainer Version)

Watch International Code of Marketing of Breast-milk Substitutes and Promoting and Supporting Exclusive Breastfeeding: https://vimeo.com/103257095 (min 2:00-24:00) and answer the following questions:

1. What are your initial reactions to the information presented in this video?
   - *Answers may vary. Look for themes and understanding of information presented.*

2. Do you feel that our facility practices in accordance with the WHO Code? Why or why not? Name examples of areas of improvement?
   - *Answers will vary. Promote discussion amongst staff.*

3. Why do you think it's difficult for facilities to fully adopt or implement the Code?
   - *Answers will vary. Promote discussion amongst staff.*

4. What are some ideas or suggestions to address these barriers?
   - *Answers will vary. Promote discussion amongst staff.*

5. Will the information provided change the way you deliver care to your patients? Why or why not?
   - *Answers will vary. Promote discussion amongst staff.*

Resource 4.6

WHO Code Self-Reflection Exercise Worksheet:
(Learner Version)

Watch International Code of Marketing of Breast milk Substitutes and Promoting and Supporting Exclusive Breastfeeding: https://vimeo.com/103257095 (min 2:00-24:00) and answer the following questions:

What are your initial reactions to the information presented in this video?

_____

_____

_____

Do you feel that our facility practices in accordance with the WHO Code? Why or why not? Name examples of areas of improvement?

_____

_____

_____

Why do you think it's difficult for facilities to fully adopt or implement the Code?

_____

_____

_____

What are some ideas or suggestions to address these barriers?

_____

_____

_____

Will the information provided change the way you deliver care to your patients? Why or why not?

_____

_____

_____

Resource 4.7

Formula Safety Quiz:
(Trainer Version)

1. True/False? The reason that powdered infant formula is not the best choice for young or compromised infants is because the water to prepare the infant formula is not sterile and can lead to infection or illness in the infant.
   False: Powdered infant formula is not the best choice for young/compromised infants because the formula (powder) is not sterile and can be contaminated with bacteria harmful to young (< 3 months) or compromised infants.

2. What are the key general recommendations of safely preparing and feeding infant formula?
   a. Use safe water for cleaning equipment and preparing infant formula
   b. Sterilize feeding equipment/supplies prior to use
   c. Reconstitute infant formula following instructions according to manufacturer's packaging: water/ infant formula ratio as recommended on packaging
   d. Never microwave a bottle or any other container holding infant formula
   e. All of the above
      Answer is E

3. The safest way to prepare infant formula is using water that has been boiled and cooled no less than 70°C /158°F. What should you recommend if the patient states that she has no access to boiling water?
   a. Use sterile, liquid infant formula preparations
   b. Prepare infant formula using fresh, safe water at room temperature and consume immediately (do not store for later use)
   c. Neither of these options are appropriate
      Answer is A

4. Leftover infant formula should be discarded after:
   a. 2 hours
   b. 30 min
   c. 4 hours
   d. 24 hours
      Answer is A

5. Can infant formula be pre-prepared for later use?
   a. Only if necessary and the patient has access to a refrigerator. Infant formula should be prepared in individual bottles and cooled quickly and stored at temperatures lower than 5°C/41°F. All pre-prepared infant formula should be used within 24 hours.
   b. No, it is never appropriate to pre-prepare infant formula
   c. Only if the infant formula can be sterilized in a microwave prior to feeding the infant
   d. None of the above are correct
      Answer is A

Resource 4.8

Formula Safety Quiz: (Learner Version)
1. True/False: The reason that powdered infant formula is the best choice for young or compromised infants is because the water to prepare the infant formula is not sterile and can lead to infection or illness in the infant. 2. What are the key general recommendations of safely preparing and feeding infant formula? a. Use safe water for cleaning equipment and preparing infant formula b. Sterilize feeding equipment/supplies prior to use c. Reconstitute infant formula following instructions according to manufacturer's packaging: water/infant formula ratio as recommended on packaging d. Never microwave a bottle or any other container holding milk e. All of the above 3. The safest way to prepare a feed is using water that has been boiled and cooled no less than 70°C /158°F. What should you recommend if the patient states that she has no access to boiling water? a. Use sterile, liquid infant formula preparations b. Prepare feeds using fresh, safe water at room temperature and consume immediately (do not store for later use) c. Neither of these options are appropriate 4. Leftover feeds should be discarded after: a. 2 hours b. 30 min c. 4 hours d. 24 hours 5. Can feedings be pre-prepared for later use? a. Only if necessary and the patient has access to a refrigerator. Feeds should be prepared in individual bottles and cooled quickly and stored at temperatures lower than 5°C/41°F. All pre-prepared feedings should be used within 24 hours. b. No, it is never appropriate to pre-prepare feedings c. Only if the feedings can be serialized in a microwave prior to feeding infant d. None of the above are correct

Resource 4.9

Skills Demonstration Cards

Powdered Infant Formula
Staff will demonstrate the follow in this session: • General hygiene and safety recommendations • Steps of preparation of infant formula (in correct order and method) • Safe storage and handling of infant formula

Concentrated Infant Formula
Staff will demonstrate the follow in this session: • General hygiene and safety recommendations • Steps of preparation of infant formula (in correct order and method) • Safe storage and handling

Ready to Feed Infant Formula
Staff will demonstrate the follow in this session: • General hygiene and safety recommendations • Steps of preparation of infant formula (in correct order and method) • Safe storage and handling of infant formula

Bottle Feeding Instruction and Techniques
Staff will demonstrate the following in this session: • Suggested feeding amounts • Responsive feeding • Bottle feeding techniques: – Paced feeding – Positioning during feeding – Promotion of bonding – Safety

Card: Scenario	Back: Key Points Needed in Learner Response
Gigi has made the decision to provide infant formula to her infant. How can you best support this mother's infant feeding goals and ensure she is safely feeding her infant?	• Suggested feeding amounts • Responsive feeding • Bottle feeding techniques: – Paced feeding – Positioning during feeding – Promotion of bonding – Safety • General hygiene and safety recommendations • Steps of preparation of infant formula (in correct order and method) • Safe storage and handling of infant formula • Safe water sources

APPENDIX I -

SUGGESTED ACTIVITIES: SKILLS AND SIMULATION LABS

EMPower Training

APPENDIX I – SUGGESTED ACTIVITIES: SKILLS AND SIMULATION LABS

Many facilities find it helpful to plan activities that will assist with learning and competency verification such as skills and simulation labs. Below is general information related to skills and simulation labs, as well as customized approaches. Some facilities complete all learning objectives using one method while others prefer to use a combination of methods or create their own approach entirely. For this reason, more detailed information about facilitation of both skills and simulation lab activities are included in each of the Core Competency sections.

Skills Labs

Overview

Skills labs facilitate learning by providing the learner with the models, equipment, and supplies necessary to develop hands-on clinical skills through practice, feedback and evaluation in a safe environment. Facilities choosing to verify clinical competency using a skills lab can do this in a variety of ways. Below is general guidance on how to set up a skills lab to verify the Core Competencies outlined in this manual. Much more detailed information related to each of the Core Competency Skills Stations (1-4) are found within the Suggested Activities subsections within each of the Core Competency sections. Facilities can choose to utilize this example in its entirety or chose a different method to satisfy components of the 5-hour curriculum.

Simulation Labs

Overview

Simulation labs/activities are designed to give staff a replication of an actual hands-on clinical experience. The experience is typically followed by a debriefing or reflective learning exercise in which learners review their own performance and receive feedback from the trainer. Simulation labs differ from skills labs in that they often use an actor (often a trainer or peer) who acts out a specific scenario for the learner to engage with. Simulation labs can utilize simulation models or dolls in place of human actors. Information on how to facilitate a simulation using live actors are provided in this Trainer Manual. In these examples, the actors are actual trainers so that they can react to the learner's responses in ways that will further facilitate instruction. Below is general guidance on how to set up a simulation experience to verify the Core Competencies outlined in this manual. More detailed information related to each of the Core Competency Simulations (1-4) are found within the Suggested Activities subsections within each of the Core Competency sections. Facilities can choose to utilize this example in its entirety or chose different methods to satisfy different components of the 5-hour curriculum.

Planning Your Skills or Simulation Lab

The following tasks should be completed in advance of skills lab. Listed in (anticipated) order of importance:

1. **Training team should decide on date(s)/timing of skills lab**

   Tips/considerations:
   - Some facilities find it helpful to offer "open labs" in which the lab is assembled and staffed over several pre-secured dates and time blocks so that maternity care staff can drop in at any of the indicated date(s)/times to complete the activities at their own pace and availability.
   - Other facilities may find it beneficial to have set date/times for the lab and require advanced registration and attendance.
   - Consider availability of training team when deciding on date(s)/timing.

2. **Secure training space**

   Tips/considerations:
   - Space should be big enough to accommodate staff members and 4 competency stations or simulation areas with 1 trainer at each station or area.
   - Remember that skills labs encourage learner participation and open conversations with trainers. Space should be large enough to accommodate this without competing noise between competency stations or simulation areas.

3. **Communicate skills lab dates/times/expectations to maternity care staff**

   Tips/considerations:
   - Use various methods of communication: verbal (meetings, huddles, etc.); written (memos, flyers, signage); electronic (email, text messaging, app messaging, etc.)
   - Remind staff often of expectations and dates.
   - Welcome questions from staff and address concerns.

4. **Consider a "non-compliance" plan of action for staff members that do not attend or complete the training requirements within the allotted timeframe**

   Tips/considerations:
   - Consider deviations from expected attendance: for example, some staff members may be sick, on medical leave or have planned vacation time scheduled for your lab dates. How will you accommodate staff who must make up training?
   - Clearly communicate early and often that attendance is mandatory and will be monitored.
   - Welcome staff members to communicate anticipated conflicts so that accommodations can be considered.
   - Consider the best method to encourage willing participation and accountability.

5. **Secure training materials needed (print handouts, develop learning materials/resources, compile items/equipment)**
   - This manual has supplied an itemized list of suggested materials for each skills station.
   - Many of the printed materials related to each Core Competency can be found within the Teaching Resources subsections.

Skills or Simulation Lab Details

General Set-up

- Skills Lab: Large room with tables.
- Simulation Lab: Large room subdivided into different areas. Each section of the room replicating the setting portrayed in the simulated scenarios. (example: replication of a patient room, or care area, etc.) OR Actual care areas that are "blocked" or reserved for purposes of simulation activities (example: you may wish to block off a patient room or specific care area for a timeframe to conduct your simulation).

Clearly Mark Tables or Areas

- Table/Area 1: Welcome Table: Staff should start here to sign in and gather needed materials (see below for details)
- Table/Area 2: Station 1: Communicating with pregnant and postpartum women about infant feeding
- Table/Area 3: Station 2: Observing, assessing, and assisting with breastfeeding
- Table/Area 4: Station 3: Teaching hand expression and safe storage of breast milk
- Table/Area 5: Station 4: Teaching safe infant formula preparation and feeding

Tips/Considerations

- Color code your tables with teaching materials.
- Use fun teaching "themes" to coordinate tables and materials.

Welcome Table Set-up

Staff should start here and receive a warm welcome with gratitude for attending.

Have this table located close to the entrance or a location where staff would be inclined to go first.

Materials/Staff Needed for Welcome Table		
Training Staff	**Training Materials**	**Staff Handouts**
(1) Training Team Member	Sign-in sheet (staff should sign in upon entering to verify attendance) • Example provided below titled "Employee Sign-In Form"	• Folder containing Employee Competency Verification Form. • Each maternity care staff member will be responsible for obtaining verification/validation of competency of each objective listed on this form. Staff members should keep this form in folder and safe place until all objectives are validated by trainers. • Once all objectives are validated, they should submit completed forms to indicated training team member. • Folder should be used to collect training handouts/learning materials provided in learning activities to be used for future reference if needed.

Employee Sign-In Form

Event: Infant Feeding Competency Verification Date: Time:		
Staff Member Name	**Position**	**Unit**

APPENDIX II -

DOCUMENTATION OF COMPETENCY

EMPower Training

APPENDIX II – DOCUMENTATION OF COMPETENCY

It is recommend that all competency logs are compiled for all maternity care staff and store them in a secure location.

Each maternity care staff member should have a completed copy of a form in their education file indicating competency validation for each skill/objective. Facilities may have their own formatting/templates for such documents. It is recommended that all components of the form below are included in any competency documentation form.

Employee Competency Verification Form

Competency 1: Communicating with Pregnant and Postpartum Women about Infant Feeding		
Time: 1.5 hours		
Objective	**Competency Met: Date/Trainer's Initials**	**Verification Method** (**V**erbalized, **D**emonstrated, **O**bserved, etc.)
Demonstrate application of effective patient interviewing, communication and counseling when educating and addressing common concerns that families may have about infant feeding and maternity care practices.		
Demonstrate competency in counseling/educating patients and families about evidenced-based maternity practices including immediate and uninterrupted skin-to-skin, rooming-in, and feeding on cue.		
Demonstrate competency in counseling/educating patients and families about safety implications when implementing immediate and uninterrupted skin-to-skin and rooming-in practices.		
Demonstrate competency in counseling/educating about infant feeding-related decisions such as the benefits of breastfeeding, importance of exclusive breastfeeding, risks of infant formula, and artificial nipple use during the establishment of breastfeeding.		
Demonstrates competency in counseling/educating mothers' individual concerns about health-related issues in a sensitive manner.		
Demonstrate competency in educating patients about discharge plans and referrals.		
Demonstrates the ability to effectively evaluate patient's understanding of education and information provided.		

Competency 2: Observing, Assessing, and Assisting with Breastfeeding		
Time: 1.5 hours		
Objective	**Competency Met: Date/Trainer's Initials**	**Verification Method**
Demonstrate proper placement and for immediate and uninterrupted skin-to-skin care after delivery while utilizing evidenced based assessment and monitoring recommendations.		
Demonstrate the ability to promote safe rooming-in and safe sleep environments for families that can room in with their infants.		
Demonstrate the ability to assess a breastfeed looking for characteristics of proper latch and adequate milk transfer.		
Demonstrates the ability to coach and assist with a breastfeed utilizing proper positioning and latch techniques.		
Demonstrates the ability to appropriately manage care of patients presenting with common problems and risk factors impacting infant feeding (maternal and newborn).		
Demonstrates the ability to provide adequate supplementation (when indicated) to a breastfeeding newborn utilizing alternative feeding methods.		

Competency 3: Teaching Hand Expression and Safe Storage of Breast Milk		
Time: 1 hour		
Objective	**Competency Met: Date/Trainer's Initials**	**Verification Method**
Demonstrate the ability to simulate and verbalize instruction of proper hand expression techniques.		
Demonstrate the ability to properly assemble a breast pump and instruct a mother on proper usage including frequency and duration of expression and hygiene and cleaning instruction.		
Verbalize evidence-based safe handling and storage guidelines for expressed breast milk.		

Competency 4: Teaching Safe Infant Formula Preparation and Feeding		
Time: 1 hour		
Objective	**Competency Met: Date/Trainer's Initials**	**Verification Method**
Demonstrate the ability to properly prepare and reconstitute infant formulas.		
Demonstrate the ability to teach responsive feeding techniques to mothers/families using infant formula.		
Demonstrate the ability to teach safe bottle-feeding techniques (including proper hygiene) to mother/families using feeding bottles.		
Verbalize the importance of practicing within compliance of the International Code of Marketing of Breast-milk Substitutes (WHO Code).		

Staff Name: _____ Staff Signature: _____ Date:_____
Trainer Name: _____ Trainer Signature: _____ Date:_____
Trainer Name: _____ Trainer Signature: _____ Date:_____
Trainer Name: _____ Trainer Signature: _____ Date:_____
Trainer Name: _____ Trainer Signature: _____ Date:_____
Date Full Competency Verification Met:_____
Trainer Name:_____ Trainer Signature:_____

APPENDIX III -

CORE COMPETENCY OUTLINE

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APPENDIX III – CORE COMPETENCY OUTLINE

This outline is for documentation and overview purposes for use when a generalized teaching outline is needed for hospital leadership, Baby-Friendly Assessors, or any other authority. All learning objectives, training content, and related resources within this manual were developed from this framework. The teaching content related to the topics outlined below are found in the related Core Competency subsections of this manual.

Staff Training 5-Hour Core Competency Objectives and Outline Overall Learning Objectives

1. Staff will be able to successful demonstrate core competencies to assist with evidence-based practices at the bedside.
2. Staff will be able to describe possible indications for supplementation (including choice of supplement, volume and methods).
3. Staff will be able to support safe immediate and uninterrupted skin-to-skin care.
4. Staff will be able to support safe rooming-in environment and identify if and when intervention may be warranted.
5. Staff will ensure they are using a safety lens in the care they provide for the couplet.

Outline

1. **Core Competency 1: Communicating with pregnant and postpartum women about infant feeding**
   - A. Uses basic communication and patient interviewing skills
     - i. Empathy, boundaries, and compassion
     - ii. Application of effective communication strategies during patient interactions
     - iii. Avoidance of Blame
   - B. Counsels/educates on immediate and uninterrupted skin-to-skin care
     - i. Definition
     - ii. Benefits/importance of immediate and uninterrupted skin-to-skin care
     - iii. Expectations of immediate and uninterrupted skin-to-skin care following delivery
   - C. Counsels/educates on rooming-in
     - i. Definition
     - ii. Benefits of rooming-in
     - iii. Addresses family concerns about rooming-in
     - iv. Back to sleep, every sleep
   - D. Counsels/educates on benefits of breastfeeding and risks of infant formula
     - i. Benefits of exclusive breastfeeding
     - ii. Potential risks of infant formula
     - iii. Contraindications to breastfeeding
     - iv. Family concerns about infant feeding options
     - v. Counsels/educates on exclusive breastfeeding
   - E. Counsels/educates on feeding cues
     - i. Normal feeding behaviors and expectations of a healthy, well infant
     - ii. Common feeding/hunger cues
     - iii. Importance of early recognition and responsive feeding
   - F. Counsels/educates about the use of artificial nipple use during the establishment of breastfeeding
     - i. Counsels mothers on the use and risks of pacifiers
     - ii. Counsels mothers on the use and risks of bottles
   - G. Counsels mothers on health-related issues and addresses concerns in a sensitive manner
     - i. Patient specific
     - ii. Cultural/environmental specific
   - H. Includes appropriate discharge planning specific to patient needs
     - i. Follow-up support available after discharge
     - ii. Routine follow-up process for newborn (day 3-5 of life, 24-48 hours after discharge depending on length of hospital stay)
     - iii. Evaluation of patient understanding of education/information provided

2. **Core Competency 2: Observing, assessing, and assisting with breastfeeding**
    A. Implementation of immediate and uninterrupted skin-to-skin care
        i. Standardization of procedure following vaginal delivery (including appropriate timing and duration)
        ii. Standardization of procedure following C-section (including appropriate timing and duration)
        iii. Initiation of breastfeeding within the first hour of life
        iv. Ensuring safety during immediate and uninterrupted skin-to-skin care
            1. Positioning and placement considerations
            2. "RAPP" Assessments (respiratory activity, perfusion, and position)
            3. Sudden Unexpected Postnatal Collapse (SUPC)
                a. Definition
                b. Identification of risk factors for SUPC
            4. Infant falls
                a. Definition
                b. Identification of risk factors
        v. Documentation of immediate and uninterrupted skin-to-skin practices
    B. Implementation of rooming-in practices
        i. Identification of patients that may be at risk for unsafe rooming-in practices
        ii. Identification of appropriate interventions when safety of rooming-in is a concern
        iii. Promotion of a safe rooming-in and safe sleep environment and role model safe sleep practices
        iv. Demonstration of appropriate support for families when rooming-in is not possible due to safety concerns or medical indications
        v. Documentation of rooming-in practices
    C. Assessment of breastfeeding
        i. Assessment of breast and nipples
        ii. Assessment of latch
            1. Characteristics of proper latch
            2. Signs of improper latch
        iii. Assessment of milk transfer
            1. Signs of adequate milk transfer
            2. Signs of inadequate milk transfer
        iv. Utilization of breastfeeding assessment tool (i.e., LATCH)
        v. Documentation of assessment
    D. Coaching and assisting (when needed) with breastfeeding
        i. Demonstration of proper positioning to facilitate effective latching and feeding
        ii. Utilization of proper latch techniques to facilitate proper latch and optimal milk transfer
        iii. Documentation of assistance and education provided

E. Management of common problems and risk factors
    i. Maternal
        1. Nipple soreness and cracking
        2. Breast engorgement
        3. Mastitis
        4. Flat or inverted nipples
        5. Low maternal confidence about milk supply
        6. Breast anomaly and/or medical issue
            a. Delayed secretory activation
            b. Primary glandular insufficiency
            c. Prior breast surgery or pathology
            d. Temporary cessation due to contraindicated medication use
    ii. Newborn
        1. Latch difficulty or breast refusal
        2. Frequent crying/inconsolable infant
        3. Sick or preterm infants
        4. Low-birthweight infants
        5. Newborn weight loss
        6. Hypoglycemia
        7. Hyperbilirubinemia
F. Supplementation and alternative feeding methods
    i. Common medical indications that may require individualized feeding plans and potential supplementation of expressed breast milk and/or donor milk and/or infant formula
    ii. Access hospital's supplementation protocol and review (Hospital will need to develop if one doesn't exist)
    iii. Supplementary feeding choices
    iv. Amount of supplementation needed
    v. Demonstration of proper alternative feeding method techniques
        1. Supplemental Nursing System (SNS)
        2. Cup
        3. Spoon
        4. Syringe
    vi. Documentation of medical indication for supplementation. If maternal request, documentation of education

3. **Core Competency 3: Teaching hand expression and safe storage of breast milk**
   A. Hand expression
      i. Demonstration of hand expression technique
      ii. Verbalization of instruction/technique
      iii. Documentation of demonstration and instruction
   B. Use of electric hospital grade pump
      i. Pump set up and instruction
      ii. Milk expression techniques that optimize milk production
      iii. Hygiene and cleaning of pump and supplies
      iv. Documentation of education, assistance, and resources provided
   C. Storage and safe handling of expressed breast milk
      i. Importance of safe storage and handling of expressed milk
      ii. Evidence-based breast milk storage and handling guidelines for home settings

4. **Core Competency 4: Teaching safe infant formula preparation and feeding**
   A. Proper infant formula preparation instruction and reconstitution
      i. General instruction for preparation and handling, including proper hygiene
      ii. Bottle feeding at home
      iii. Ready to feed
      iv. Concentrate
      v. Powder (including liquid concentrate, powder, ready to feed)
      vi. Proper sanitary water sources for mixing infant formula
   B. Cue based/responsive feeding to families using infant formula
      i. Suggested feeding amounts
      ii. Signs of hunger
      iii. Signs of satiety (fullness)
   C. Bottle feeding techniques
      i. Paced bottle feeding
      ii. Eye contact
      iii. Safety
   D. Implementation/upholding the *International Code of Marketing of Breast milk Substitutes* within the health facility
      i. Code of Marketing of Breast Milk Substitutes within the health facility
   E. Written materials provided and reviewed with families using infant formula
      i. Review and provide written materials
   F. Documentation of education, assistance, and resources provided
      i. Document education, assistance, and resources

APPENDIX IV -

ADDITIONAL TRAINING MATERIALS

EMPower Training

APPENDIX IV – ADDITIONAL TRAINING MATERIALS

Facility Assessments

Breastfeeding Training Facility Assessment

INSTRUCTIONS: The purpose of this exercise is to assist you in identifying your current processes related to staff training and competency verification for breastfeeding/infant feeding.

Please note, this is for informational purposes only and there are no "right" or "wrong" answers. If you do not find a preset option specific to your unique process or situation located within the check boxes, then type additional information into the text boxes.

For purposes of this exercise, maternity care staff are defined as any nursing staff that have routine direct contact with patients in Labor and Delivery, Newborn Nursery, Mother/Baby Unit, and Post-Partum. If you have a specialized newborn care area such as NICU, you may also choose to include these staff in your training efforts.

Existing Training Processes

1. **What percentage of maternity care staff have completed any education related to breastfeeding/infant feeding?** (Note: this can be an estimate)

2. **Please describe your current training processes related to breastfeeding/infant feeding.** In your description, (at minimum) please indicate approximate number of education hours, how the education is implemented, how often is this education offered, how often is the education updated, what staff are required to complete this education, and who is responsible for tracking and documentation of training.

   ☐ N/A. We currently do <u>not</u> have training processes related to breastfeeding/infant feeding. If you do not currently have a training process related to breastfeeding/infant feeding, please skip to question 11.

   Description of current training process:

3. **Is there an educational curriculum utilized for the described breastfeeding/infant feeding related education?**

   ☐ Yes
   ☐ No

4. **How would you best describe the current learning environment in which this curriculum is implemented?** Check all that apply.

   ☐ Didactic with limited opportunity for learner participation
   ☐ Interactive and dependent on learner participation and interaction
   ☐ Online education
   ☐ Classroom/ face-to-face education
   ☐ Other/ Comments (please describe in the text box below):

5. **Does the current breastfeeding/infant feeding educational curriculum incorporate the following components?** Please check all that apply

   ☐ Communicating with pregnant and post-partum women about infant feeding
   ☐ Counseling mothers regarding maintaining exclusive breastfeeding
   ☐ Evidenced-based and safe supplementation considerations
   ☐ Counseling and educating mothers regarding feeding cues
   ☐ Providing skin-to-skin contact in the immediate postpartum period and beyond
   ☐ Safe implementation of skin-to-skin practices
   ☐ Assuring and promotion of keeping mother and infant together (rooming in)
   ☐ Safe implementation of rooming in practices
   ☐ Observing, assessing, and assisting with breastfeeding (to include achievement of comfortable and effective positioning and attachment)
   ☐ Teaching hand expression and safe storage of milk
   ☐ Teaching safe formula preparation and feeding to parents when necessary. Ideally only to parents whose infant's individualized feeding plans warrant the use of formula.

6. **Please indicate the person/ position(s) responsible for developing and/or updating this curriculum.** Please check all that apply.

   ☐ We currently do not have a person/position responsible for developing and/or updating this curriculum
   ☐ IBCLC/Lactation Specialist
   ☐ Staff Educator
   ☐ Nurse Manager/Director
   ☐ Staff Nurse
   ☐ Other (please specify):

7. **Please indicate the person/position(s) responsible for implementing this training and assuring that maternity care staff are competent in providing breastfeeding/infant feeding support.**

   ☐ BCLC/Lactation Specialist
   ☐ Staff Educator
   ☐ Nurse Manager/Director
   ☐ Staff Nurse
   ☐ Other (please specify):

8. **Approximately how often are training updates related to infant feeding provided to existing staff who have received initial training?**

   ☐ Annually
   ☐ Other (please specify):

9. **How do you track/document staff education/training related to infant feeding?** Please check all that apply and/or describe:

   ☐ Internal documentation (this can include certificates of completion, internal spreadsheets, or anything developed specific to the maternal unit)
   ☐ Online Learning System
   ☐ Other (please describe):

10. **Please indicate the person/ position(s) responsible for keeping documentation of this education/training?**

    ☐ IBCLC/ Lactation Specialist
    ☐ Staff Educator
    ☐ Nurse Manager/ Director
    ☐ Staff Nurse
    ☐ Other (please specify):

11. **Please describe staff skills competency and verification processes.** Please note, this does not have to be specific to infant feeding. We would like to understand more about how you assure competency in other unit specific nursing skills and how the skills competencies are assured on an ongoing basis.

Staffing

1. **Are there FTE's allotted to ONLY Lactation Care?**

   ☐ Yes; If yes, state how many:
   ☐ No

2. **Describe Lactation Care coverage:**

   ☐ N/A
   ☐ Part-time/partial coverage (describe coverage):
   ☐ 24/7 coverage
   ☐ Day shift only (check to indicate: ☐ 8-hr coverage; ☐ 12-hour coverage)
   ☐ Day and Evening Coverage (please describe below):

3. **What type of training do the staff providing ONLY Lactation Care have?** Check all that apply.

   ☐ N/A
   ☐ IBCLC
   ☐ Registered Nurse
   ☐ Registered Dietitian
   ☐ Other (please specify):

4. **Please specify the number of nursing staff employed on each of the following maternity units:**

   Labor and Delivery:
   Nursery:
   Post-Partum:
   Mother/ Baby Unit (if couplet care/ shared staffing):
   NICU/ Special Care Nursery (if including in training efforts. See instructions at beginning of form to determine if these staff members should be included in training efforts):

Quality Improvement Capacity Facility Assessment

INSTRUCTIONS: Before you develop your EMPower Training Plan, we recommend conducting a quality improvement (QI) facility assessment. The purpose of this facility assessment is to help you identify QI methods and tools that you may want to strengthen to help facilitate implementation of your training plan. This is not an exhaustive QI facility assessment; rather, it is an assessment of a focused set of QI skills and capacity that are most relevant to EMPower Training. The assessment is designed to be completed as a team exercise during a team meeting.

Quality Improvement Context and Resources

1. **Does your facility use a designated, common approach to QI?** (examples: Lean, Six Sigma, Model for improvement)

   ☐ No
   ☐ Yes; If yes, describe here:

2. **Does your facility have a designated QI staff member or department?**

   ☐ No
   ☐ Yes; If yes, describe here:

3. **To what extent <u>is</u> your facility's identified QI personnel currently involved in working with maternity and/or pediatric care?**

   ☐ Not at all
   ☐ A little
   ☐ Somewhat
   ☐ To a great extent

   Please describe:

4. **To what extent <u>could</u> your facility's identified QI personnel be involved in your EMPower Training effort?**

   ☐ Not at all
   ☐ A little
   ☐ Somewhat
   ☐ To a great extent

   Please describe:

5. **What steps can your team take to move toward greater future involvement of your QI personnel in your EMPower Training effort?**

Quality Improvement and Change Management Methods, Skills, and Tools

1. Please rate how proficient your team is in the following QI methods, skills, or tools.

QI Method/Skill/Tool	1 Not at All	2 Slightly	3 Somewhat	4 Moderately	5 Extremely
Small Cycle Tests of Change					
a. PDSA Cycles	☐	☐	☐	☐	☐
Measurement for Quality Improvement					
a. Quality Improvement Measures	☐	☐	☐	☐	☐
b. Data Collection and Analysis	☐	☐	☐	☐	☐
c. Interpreting Run Charts	☐	☐	☐	☐	☐
Change Management					
a. Teamwork (Creating/ Sustaining Effective Teams)	☐	☐	☐	☐	☐
b. Addressing Resistance & Gaining Buy-in	☐	☐	☐	☐	☐
c. Project Management (e.g., Gantt chart, project schedule, communication)	☐	☐	☐	☐	☐
d. Gaining and Retaining Leadership Support	☐	☐	☐	☐	☐
Continuous Improvement					
a. Sustainability	☐	☐	☐	☐	☐

Hospital Training Plan Template

EMPower Training Plan Implementation Checklist

☐ **1. Convene your EMPower Training project team.** We suggest that you include one or more front line staff members from the maternity and postpartum units, nurse manager, nursing director, member of hospital leadership, lactation specialist, staff educator, QI/Safety department representation and a family/patient representative.

☐ **2. Complete the EMPower Training project charter.** A project charter is a systematic, structured way to organize your training plan and implementation. It includes the project focus, goal, timeline, scope, and team members. On page 2, you will find a charter template that you can customize (see green font for directions on the customizable sections, also noted with an asterisk *). Be sure to fill in the following information:

a. **Project Approach.** Typical approaches involve hands on skills fairs, simulations labs, and bedside check observation.
b. **Scope.** This section describes activities that are considered in or out of scope for your training plan. You may add to the list started here to ensure that everyone on your team remains focused on the in-scope tasks.
c. **Team Members.** Consider which individuals will be key to implementing your training plan.
d. **Stakeholders.** Consider which individuals and organizations may be impacted by your training plan, in addition to those on your multidisciplinary team.
e. **Communication Plan.** Consider how information about your training plan can be spread most effectively through your facility.
f. **Sustainability Plan.** Think about how you plan to continue training beyond your initial training plan.
g. **Training Timeline.** Be sure to complete a training timeline – and update it as needed – to ensure that you remain on track to achieve your training goal.

☐ **3. Share your Hospital Training Plan with your project team and senior leadership.**

☐ **4. Begin training implementation and track staff training.** Use the EMPower Training resources, including the Training of Trainers manual and staff training tracker.

☐ **5. Review this Hospital Training Plan regularly with your team and coaches and make additions and updates as needed.** This is intended to be a living document to organize and guide the work of your team over time.

EMPower Training Plan Charter

Aim Statement	By **[insert date]**, our hospital will improve the capacity of hospital staff to implement evidence-based maternity care practices supportive of optimal infant nutrition. Our specific goal is to have **[insert percentage]% of maternity care staff** complete the EMPower Training hands-on competency training by this date.
Deliverables	Project deliverables include • A facility-specific hospital training plan (completion of this document) • Completed staff training tracker
Approach	***Think about your approach to training your staff. Which method will you use, based on the options you know or learned through the EMPower Training modules? How will you roll out the training? Use the accompanying customizable timeline at the end of this charter to help you develop a plan.** **Selected Training Method:** ☐ Hands-On Skills Fairs ☐ Simulation Labs ☐ Alternative/Other (Please specify) **Plan to Track Training:** Track using your own system or use the EMPower Training Staff Training Tracker (separate Excel file). Note here who will be responsible for tracking and any details on how you plan to get the required information and frequency at which it will be updated. **Other Notes / Considerations:** Fill in any additional comments about your approach here:
Scope	***Note here any additional in- or out-of-scope considerations that are specific to your hospital.** **In Scope** • Hospital structure and policies to support breastfeeding training • Process for staff training and education re: breastfeeding support **Out of Scope** • Hospital policies and structures unrelated to labor and delivery/breastfeeding • Achieving Baby Friendly Designation

Team Members	***Identify your project team members here. We make suggestions in gray for who may be a good fit for the role. See Appendix A for descriptions of the responsibilities for each role and modify according to your hospital's needs. You may document updates to this section if team members change during the project.** **Project Sponsor:** Hospital CEO **Project Leader / Training Team Lead:** Nurse manager for labor & delivery (or another similar leader) **Trainer(s):** Lactation Consultants, Staff Educators, Childbirth Educators, Nursing Unit Managers, Staff Nurses, Peer Counselors **Training Tracker / Data Collector:** Staff Educators, Quality Improvement Experts, Nursing Unit Managers, Nursing Directors, Clinical Nurse Specialist **Education Event Coordinator:** Staff Educators, Childbirth Educators, Marketing **Patient or community champion(s):** Mother who recently delivered at hospital or WIC, La Leche League representative
Stakeholders	***Consider who has a stake in the success of this project. We've started a list for you here that you can edit as needed. Once you've identified stakeholders, make sure your communication plan includes them so that you are keeping them in the loop on your training progress.** 1. Hospital CEO 2. Mother/Baby Physicians and Extenders 3. Pregnant women, new mothers, other family members 4. WIC

Communication Plan

***Consider how information about your training plan can be spread most effectively through your facility. Typical methods of communication include email, daily huddles, periodic staff meetings, posted flyers, and new staff orientation. Fill in the table below to help you stay on track with communicating to your key audiences – both internal and external.**

Audience (Person / Group)	Information to be Shared	Method	Frequency	Who will Communicate	Notes

Sustainability Plan

***Consider how you will maintain staff training knowledge over time, including retraining existing staff and training new staff. We have started a list of potential steps to promote sustainability. Please edit and add additional steps as needed.**

Consideration	Sustainability Plan
1. Plan for providing regular updates to hospital leadership to maintain support:	
2. Plan for making training efforts visible within hospital:	
3. Plan for ensuring training of all new maternity care staff:	
4. Plan for and timing of refresher training of existing staff:	
5. Plan for ensuring availability of maternity care staff time for training:	
6. Plan for ensuring availability of funding for maternity care staff training:	
7. Plan for linking maternity care training to hospital QI infrastructure and efforts:	
8. Plan for hospital policy needed to support ongoing staff training:	

EMPower Training Timeline

*Please modify and customize this timeline as you see fit to suit your hospital's training plan.

Task	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Attend Welcome Webinar												
Complete Breastfeeding & QI Capacity Assessment												
Complete Staff List												
Attend ToT Meeting												
Fill out Hospital Training Plan and Submit to Coach Dyad												
Schedule Individual Call with Coach Dyad (to be held prior to Nov 15th)												
Train the trainers												
Implement Training Plan												
Update Senior Leadership at Hospital												
Staff Training Measurement												
Attend EMPower Training Cohort Call (exact dates TBD)												

Appendix A: Team Member Roles and Responsibilities

Your team should review these roles and responsibilities and make edits where appropriate. For instance, you may decide to have the training team lead track completion of the overall training plan rather than a data collector. If that is the case, you can move that responsibility accordingly.

- Project sponsor:
    - Provide funding and high-level support
    - Assist with communication and implementation of new policies to support initiative
- Project Leader/Training Team Lead:
    - Overall facilitation of training plan implementation
    - Development of training team
    - Assign roles/responsibilities
    - Communicate expectations and coordination of overall efforts
    - Hold team members accountable
    - Point of contact for EMPower Training Coaches
    - Communicate training plans to team members and senior leadership
- Trainer(s):
    - Develop and facilitate training sessions
    - Teach and mentor maternity care staff in skills outlined in training plan
    - Validate competency of knowledge and skills
- Training Tracker/ Data Collector:
    - Track completion of overall training plan
    - Track competency validation of each maternity care staff member
    - Organize training attendance and documentation of completion
    - Utilize EMPower Training Tracking materials
    - Report Training completion to EMPower Training Coaches
- Education event coordinator(s):
    - Coordination of training events (i.e. Skills labs/fairs, simulation labs, workshops, etc.)
    - Collaborates with Master Trainers/Team for training plan development
    - Tasks related to event planning: Reserve training space, print training materials, advertise/communicate training events details to staff (flyers, emails, etc.), compile needed training supplies (baby dolls, breast models, etc.)
    - Put a "creative touch" into planned training events….makes training "fun"

- Patient or community champion(s):
    - Provide input to ensure that training results in patient and family-centered care
    - Assist with ensuring training appropriateness and availability for all populations

Healthy Hospital Example Training Plan

EMPower Training Plan Implementation Checklist

☐ **1. Convene your EMPower Training project team.** We suggest that you include one or more front line staff members from the maternity and postpartum units, nurse manager, nursing director, member of hospital leadership, lactation specialist, staff educator, QI/Safety department representation and a family/patient representative.

☐ **2. Complete the EMPower Training project charter.** A project charter is a systematic, structured way to organize your training plan and implementation. It includes the project focus, goal, timeline, scope, and team members. On page 2, you will find a charter template that you can customize (see green font for directions on the customizable sections, also noted with an asterisk *). Be sure to fill in the following information:

- **a. Project Approach.** Typical approaches involve hands on skills fairs, simulations labs, and bedside check observation.
- **b. Scope.** This section describes activities that are considered in or out of scope for your training plan. You may add to the list started here to ensure that everyone on your team remains focused on the in-scope tasks.
- **c. Team Members.** Consider which individuals will be key to implementing your training plan.
- **d. Stakeholders.** Consider which individuals and organizations may be impacted by your training plan, in addition to those on your multidisciplinary team.
- **e. Communication Plan.** Consider how information about your training plan can be spread most effectively through your facility.
- **f. Sustainability Plan.** Think about how you plan to continue training beyond your initial training plan.
- **g. Training Timeline. Be** sure to complete a training timeline – and update it as needed – to ensure that you remain on track to achieve your training goal.

☐ **3. Share your Hospital Training Plan with your project team and senior leadership.**

☐ **4. Begin training implementation and track staff training.** Use the EMPower Training resources, including the Training of Trainers manual and staff training tracker.

☐ **5. Review this Hospital Training Plan regularly with your team and coaches and make additions and updates as needed.** This is intended to be a living document to organize and guide the work of your team over time.

EMPower Training Plan Charter

<table>
<tr><td>Aim Statement</td><td>By [insert date], our hospital will improve the capacity of hospital staff to implement evidence-based maternity care practices supportive of optimal infant nutrition.

Our specific goal is to have [insert percentage]% of maternity care staff complete the EMPower Training hands-on competency training by this date.</td></tr>
<tr><td>Deliverables</td><td>Project deliverables include

• A facility-specific hospital training plan (completion of this document)
• Completed staff training tracker</td></tr>
<tr><td>Approach</td><td>*Think about your approach to training your staff. Which method will you use, based on the options you know or learned through the EMPower Training modules? How will you roll out the training? Use the accompanying customizable timeline at the end of this charter to help you develop a plan.

Selected Training Method:
☐ Hands-On Skills Fairs
☐ Simulation Labs
☐ Alternative/Other (Please specify)

Plan to Track Training: Track using your own system or use the EMPower Training Staff Training Tracker (separate Excel file). Note here who will be responsible for tracking and any details on how you plan to get the required information and frequency at which it will be updated.

Other Notes / Considerations: Fill in any additional comments about your approach here:</td></tr>
<tr><td>Scope</td><td>*Note here any additional in- or out-of-scope considerations that are specific to your hospital.
<table><tr><th><u>In Scope</u></th><th><u>Out of Scope</u></th></tr><tr><td>• Hospital structure and policies to support breastfeeding training
• Process for staff training and education re: breastfeeding support</td><td>• Hospital policies and structures unrelated to labor and delivery/breastfeeding
• Achieving Baby Friendly Designation</td></tr></table></td></tr>
</table>

Team Members	***Identify your project team members here. We make suggestions in gray for who may be a good fit for the role. See Appendix A for descriptions of the responsibilities for each role and modify according to your hospital's needs. You may document updates to this section if team members change during the project.** **Project Sponsor:** Hospital CEO **Project Leader / Training Team Lead:** Director of Maternal-Child Health **Trainer(s):** Lactation Consultant, Nurse Clinicians, Department of Professional Development and Nursing Education, Staff Educators, Nurse Managers **Training Tracker / Data Collector:** CNS, Lactation Consultant, Nurse Managers **Education Event Coordinator:** Nurse Clinicians, Department of Professional Development and Nursing Education (Director, Educators, CNS staff) **Patient or community champion(s):** Mother who recently delivered at hospital
Stakeholders	***Consider who has a stake in the success of this project. We've started a list for you here that you can edit as needed. Once you've identified stakeholders, make sure your communication plan includes them so that you are keeping them in the loop on your training progress.** 1. Hospital CEO 2. Hospital COO 3. Hospital CNO 4. Physicians (Obstetrics, Family Medicine, Anesthesia) 5. Pregnant women, new mothers, other family members 6. Nurses (Maternal-Child) 7. Lactation Consultant 8. WIC 9. OB Clinic Staff

Communication Plan

***Consider how information about your training plan can be spread most effectively through your facility. Typical methods of communication include email, daily huddles, periodic staff meetings, posted flyers, and new staff orientation. Fill in the table below to help you stay on track with communicating to your key audiences – both internal and external.**

Audience (Person / Group)	Information to be Shared	Method	Frequency	Who will Communicate	Notes
1. Hospital CEO/COO/CNO/ Board of Directors Nursing leadership	Program info, training plan, expected outcomes, impact of patient safety and satisfaction	Ask to be placed on meeting agenda Email updates as necessary	Upon initiation of plan and then every 6 months During planning And PRN	Director of Maternal-Child Health	
2. Policy/Practice Committee	Teaching plan and outcomes expected Policies required Practice changes required survey to discussion what breast feeding info is understood and what myths or bias exist;	Meeting In person/on unit; Staff meetings	Prior to Plan, Initiation of plan, monthly	CNS Lactation Consultant	
3. Mother/Physicians (Obstetricians, Family Medicine, Anesthesiologists)/ Clinical Staff	Provide written information on Empower purpose (info provided at conference); Discuss Teaching plan;	Email	Survey before implementation, upon completion and 6 months and 12 months after roll out	Lactation Consultant Nurse Clinician Nurse Educator Director of maternal-Child Health	
4. Internal WIC resources	Education on the EMPower initiative/ purpose and implementation plan. Discuss WIC inpatient requirement changes	WIC Staff Meetings. Meeting with Managers Emails Distribution of Literature	Initially after plan finalized After education complete and upon implementation of changes	Lactation Consultant Director of Maternal-Child Health	

Sustainability Plan

***Consider how you will maintain staff training knowledge over time, including retraining existing staff and training new staff. We have started a list of potential steps to promote sustainability. Please edit and add additional steps as needed.**

Consideration	Sustainability Plan
1. Plan for providing regular updates to hospital leadership to maintain support:	Quarterly Updates at Hospital based Board Meeting where all stakeholders are present
2. Plan for making training efforts visible within hospital:	Brief description of Empower training, purpose, and goals to be listed on Hospital intranet under Nursing Education. To be mentioned in nursing newsletter quarterly
3. Plan for ensuring training of all new maternity care staff:	Each new staff to complete unit competency training within 6 months from date of hire. Training to be included with orientation plan, beginning with Learning Management System (LMS) module didactics and preceptor modeling.
4. Plan for and timing of refresher training of existing staff:	Annual mandatory Didactic training on (LMS) and in-person competencies
5. Plan for ensuring availability of maternity care staff time for training:	Managerial oversight of staff schedule and maintaining an annual training schedule to appropriately time the required training for the initiative
6. Plan for ensuring availability of funding for maternity care staff training:	Quarterly presentation to Board of Directors and key stakeholders justifying the need for sustainment of the initiative.
7. Plan for linking maternity care training to hospital QI infrastructure and efforts:	Make part of Nursing dashboard for breastfeeding rates at the unit level and discussed monthly at OB QI with a roll-up to the nursing organizational dashboard for quality discussed quarterly.
8. Plan for hospital policy needed to support ongoing staff training:	Place precise language, applicable to maternal-child health staff for requirement and levels of training required.

EMPower Training 2018-2019 Timeline

*Please modify and customize this timeline as you see fit to suit your hospital's training plan.

Task	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019
Attend Welcome Webinar								Core Competency 1: Introduce one (1) Core competency over a 6 week period		Core Competency 2		Core Competency 3	Core Competency 4		
Complete Breastfeeding & QI Capacity Assessment			x												
Complete Staff List			x												
Attend ToT Meeting			x												
Fill out Hospital Training Plan and Submit to Coach Dyad				Due Sep 21st											
Schedule Individual Call with Coach Dyad (to be held prior to Nov 15th)					x										
Train the trainers						x	x								
Implement Training Plan								x							
Update Senior Leadership at Hospital						x			x			x			x
Staff Training Measurement				Pre-survey						x	x	x	x		

Task	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019
Attend EMPower Training Cohort Call (exact dates TBD)								X			X			X	

EMPower Training 2019-2020 Timeline

Task	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020
Obtain Supplies needed				X								
Identify training location												
Put together supplies, schedule, flyers and all learning material for core Competency 1 and 2				X X								
Submit Ceu application for 1; Finalize trainer schedule				 X								
Set up LMS class registration Complete/begin LMS training for core 1 and 2				 X								
Training Begins					X							
Begin collecting and input of completed education in staff training tracker (Excel file)					X							
Put together supplies, schedule, flyers and all learning material for core Competency 3 and 4					X							
Complete/ begin LMS training for core 3 and 4						X						
Training ends										X	X	

Appendix A: Team Member Roles and Responsibilities

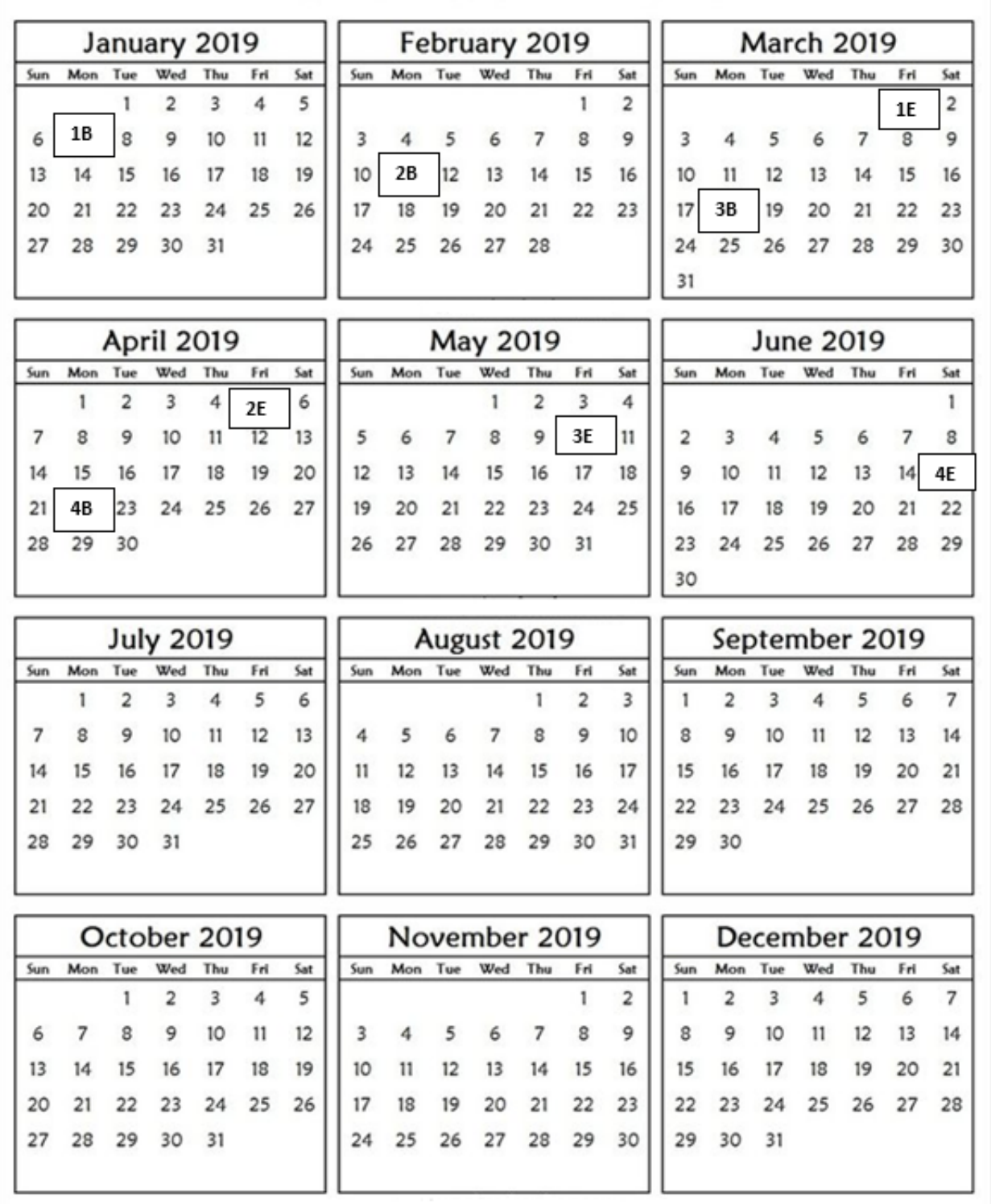
Your team should review these roles and responsibilities and make edits where appropriate. For instance, you may decide to have the training team lead track completion of the overall training plan rather than a data collector. If that is the case, you can move that responsibility accordingly.

- Project sponsor:
    - Provide funding and high-level support
    - Assist with communication and implementation of new policies to support initiative
- Project Leader/Training Team Lead:
    - Overall facilitation of training plan implementation
    - Development of training team
    - Assign roles/responsibilities
    - Communicate expectations and coordination of overall efforts
    - Hold team members accountable
    - Communicate training plans to team members and senior leadership
    - Serve as point of contact for hospital Senior Leadership, Unit Leadership, or similar to provide updates on progress
- Trainer(s):
    - Develop and facilitate training sessions
    - Teach and mentor maternity care staff in skills outlined in training plan
    - Validate competency of knowledge and skills
- Training Tracker/Data Collector:
    - Track completion of overall training plan
    - Track competency validation of each maternity care staff member
    - Organize training attendance and documentation of completion
    - Utilize EMPower Training Tracking materials
    - Consider reporting Training completion to hospital Senior Leadership, Unit Leadership, staff and/or similar to provide updates on progress
- Education event coordinator(s):
    - Coordination of training events (i.e. Skills labs/fairs, simulation labs, workshops, etc.)
    - Collaborates with Master Trainers/Team for training plan development
    - Tasks related to event planning: Reserve training space, print training materials, advertise/communicate training events details to staff (flyers, emails, etc.), compile needed training supplies (baby dolls, breast models, etc.)

- Put a "creative touch" into planned training events….makes training "fun"

- Patient or community champion(s):
  - Provide input to ensure that training results in patient and family-centered care
  - Assist with ensuring training appropriateness and availability for all populations

Proposed training schedule: First session to Begin January 7, 2019. New session begins every 6 weeks. Each session to run for 8 weeks. Final session ends June 15, 2019. Numbers 1-4 indicate session (there are 4 sessions (Core competencies). S= sessions starts. E= Session ends:



January 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	1B	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

February 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	8	9
10	2B	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28		

March 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1E	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	3B	19	20	21	22	23
24	25	26	27	28	29	30
31						

April 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	2E	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	4B	23	24	25	26	27
28	29	30				

May 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8	9	3E	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

June 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	4E
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

July 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

August 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

September 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

December 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Tentative Schedule of Classes
(4 days a week with 4 sessions each = 16 sessions per week x 8 weeks =128 sessions per competency with 2 nurses per session = 256 nurses trained)

Each trainer takes 0.5 to 1 day each week (TBD) for 6 months

Use LMS to register 2 participants per schedule

Schedule to accommodate all 3 shifts.

Mondays:

7:30 am-9:00am
9am-10:30am
10:30am-12:00pm
1:30-3:00pm

Tuesdays:

11:00am-12:30pm
12:30pm2:00pm
2:00pm-3:30pm
5:00pm-6:30pm

Wednesdays:

7:30 am-9:00am
9am-10:30am
10:30am-12:00pm
1:30-3:00pm

Thursdays:

11:00am-12:30pm
12:30pm2:00pm
2:00pm-3:30pm
5:00pm-6:30pm

EMPower Training Tracker

Instructions

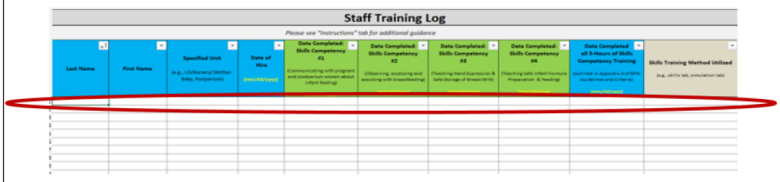
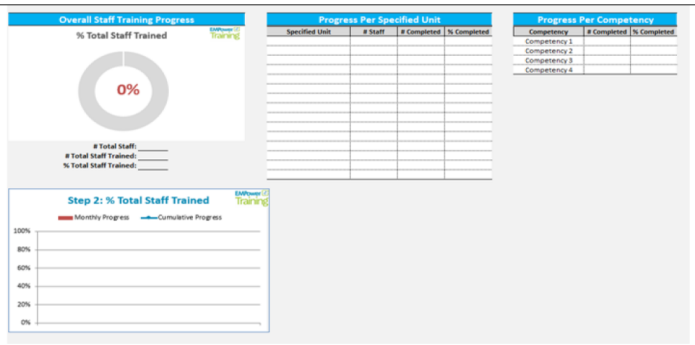
The following instructions will lead you through the process of how to input your data into this workbook in order to track your staff training.

As you read through these instructions, you will see that they reference the tabs of the spreadsheet throughout. The table below shows the names and functions of each tab.

Tab	Function
Staff Training Log	This worksheet is used to enter and keep track of staff training.
Training Progress	This tab is where your run chart and other display items will be shown. They will update automatically as you enter data into the "Staff Training Log" tab.

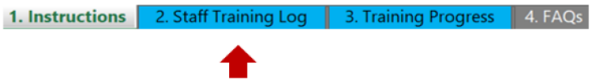
Step-by-Step Instructions for the EMPower Training Tracker

HOW TO ADD STAFF AND VIEW YOUR PROGRESS:

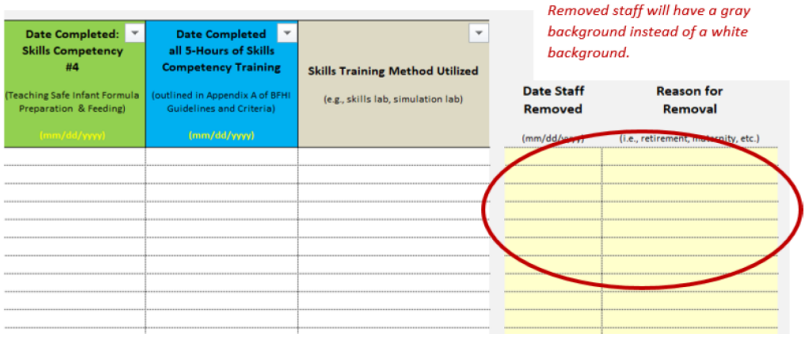
No.	Step	Example
1.	At the bottom of the file, click on the tab "2. Staff Training Log"	
2.	Complete each column in the tab. New staff can be added at any time on the next blank line	
3.	Select the "3. Training Progress" tab	
4.	This tab will display progress as staff complete training. Overall progress, progress per unit, and progress per competency will be shown. ***Note**: The run chart will show monthly and cumulative data over time as staff complete training.*	

HOW TO REMOVE STAFF:

1. To remove staff without deleting previous data from your run chart, return to the "2. Staff Training Log" tab.

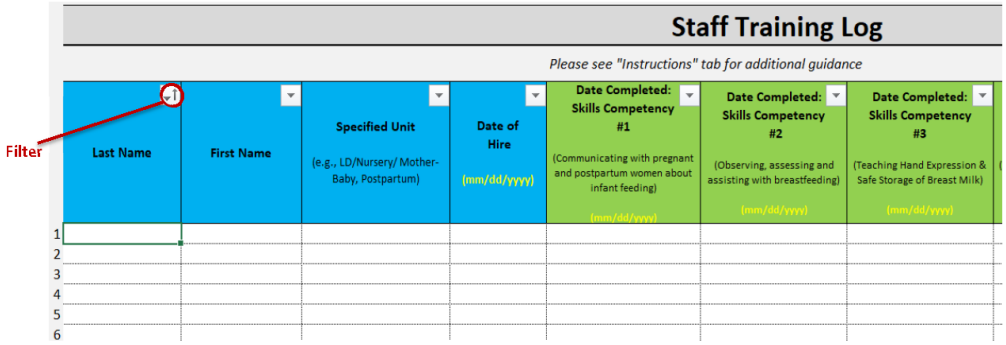


2. Go to columns M – N. Enter the date the staff member is to be removed and the reason for the staff's removal. This will automatically remove the staff member from your "% staff trained" beginning in the month the staff member was removed.



HOW TO SORT STAFF:

1. Use filters located in each column at the top of the table.



Staff Training Log

Please see "Instructions" tab for additional guidance

	Last Name	First Name	Specified Unit (e.g., LD/Nursery/ Mother-Baby, Postpartum)	Date of Hire (mm/dd/yyyy)	Date Completed: Skills Competency #1 (Communicating with pregnant and postpartum women about infant feeding) (mm/dd/yyyy)	Date Completed: Skills Competency #2 (Observing, assessing and assisting with breastfeeding) (mm/dd/yyyy)	Date Completed: Skills Competency #3 (Teaching Hand Expression & Safe Storage of Breast Milk) (mm/dd/yyyy)	Date Completed: Skills Competency #4 (Teaching Safe Infant Formula Preparation & Feeding) (mm/dd/yyyy)	Date Completed all 5-Hours of Skills Competency Training (outlined in Appendix A of BFHI Guidelines and Criteria) (mm/dd/yyyy)	Skills Training Method Utilized (e.g., skills lab, simulation lab)	Date Staff Removed (mm/dd/yyyy)	Reason for Removal (i.e., retirement, maternity, etc.)
1												
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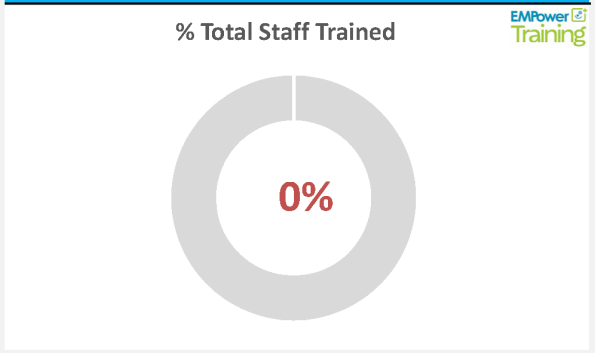
Training Progress

Overall Staff Training Progress



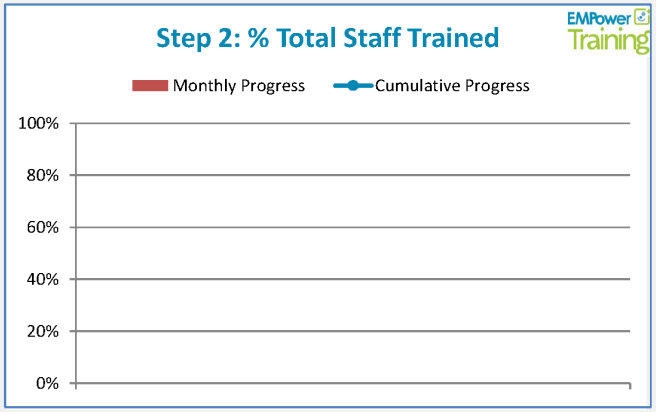
 # Total Staff: _____
 # Total Staff Trained: _____
% Total Staff Trained: _____

Progress Per Specified Unit

Specified Unit	# Staff	# Completed	% Completed

Progress Per Competency

Competency	# Completed	% Completed
Competency 1		
Competency 2		
Competency 3		
Competency 4		



Frequently Asked Questions

WHAT SHOULD I DO WHEN ...

1. **The number of staff on my staff list (tab "2. Staff Training Log") does not match the numbers or percentages on my charts and tables (tab "3. Training Progress")?**

   Solution: Go to tab "2. Staff Training Log."
   Make sure dates for each staff member have been entered into columns E - J.
   Ensure all the dates are in the correct format (mm/dd/yyyy).
   Inspect each date to make sure the dates are correct and there are no missing or extra numbers inserted into them (i.e., 20119, 2109).
   If you do not have a date then leave the cell blank (do not add "na").

2. **Staff member has not been removed even though I've added a removal date and a reason for removal in columns M - N on tab "2. Staff Training Log"?**

   Solution: Go to tab "2. Staff Training Log".
   Check that all the dates are in the correct format (mm/dd/yyyy).
   Inspect each date to make sure the dates are correct and there are no missing or extra numbers inserted into them (i.e., 20119, 2109).
   If you do not have a date then leave the cell blank (do not add "na").

3. **I have staff that I know will be leaving next week but I can't add the date for next week?**

   Solution: Future dates cannot be entered for staff removal. Add the appropriate dates once the staff member has left.

4. **I know the upcoming completion dates for competencies but when I add them to the list they won't show on the charts?**

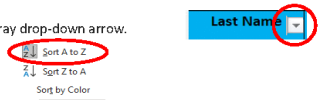
   Solution: Future dates will not register on the charts or tables. Add the appropriate dates once the staff member has been trained.

5. **My individual competency graphs are populating, but my overall % trained is not.**

   Solution: Go to tab "2. Staff Training Log".
   Check that completion dates have been entered into column J, "Date Completed All 5-Hours of Skills Competency Training".
   Ensure all the dates are in the correct format (mm/dd/yyyy).
   Inspect each date to make sure the dates are correct and there are no missing or extra numbers inserted into them (i.e., 20119, 2109).
   If you do not have a date then leave the cell blank (do not add "na").

6. **I can't get my staff names in order when adding a new staff member.**

   Solution: Go to tab "2. Staff Training Log".
   To sort by last name, go to column B, "Last Name". Click on the gray drop-down arrow.
   In the box that pops up, select 'sort A to Z' and then 'ok'.
   The staff should now be sorted alphabetically from A to Z.
   You can sort by any column by following the above steps.

7. **The spreadsheet is asking me for a password.**

   Solution: The spreadsheets are password protected due to hidden formulas that make the calculations work and prevent errors or modifications from being made that may affect the functionality of the tool. You will only ever need to enter data into columns B-N on tab "2. Staff Training Log." If you would like to modify the tool, you may unprotect the sheet using the password, empower (all lower case). Please note, however, that ongoing support for any modifications made to the tool is not available.