Royal College of Nursing

Breastfeeding in children's wards and departments

Guidance for good practice

Royal College of Nursing

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Foreword

The RCN unequivocally endorses the recommendations from the World Health Organization (WHO 2003) that exclusive breastfeeding is the optimal means of infant feeding for the first six months of an infant's life. This guidance aims to improve the care of mothers and their infants by providing information which supports breastfeeding in neonatal units, children's wards and other hospital departments. The original guidance, published in 1998, followed a demand from nurses for information and was developed by a working party set up by the Royal College of Nursing (RCN) Society of Paediatric Nursing. This third edition updates the 2009 guidance.

Introduction

An increasingly significant body of research indicates that breastfeeding is the healthiest way for a woman to feed her infant. These health benefits not only offer advantages to the infant, but to the mother as well. The following are examples of the literature:

The Lullaby Trust (formally FSID) has made it clear that breastfeeding should be recommended, in conjunction with other practices, as a protective measure against sudden infant death syndrome (SIDS) (NHS choices 2011, Lullaby Trust, Hauck, Thompson Tanabe et al 2011). Infants who are not breastfed are more likely to develop a range of diseases and conditions throughout their life (Robinson and Fall 2012, Stuebe 2009). Breastfed infants have fewer infections. This includes lower respiratory tract infection, gastrointestinal infection and otitis media. They also have a reduced risk of obesity which can lead to diabetes which is becoming an increasing burden on the NHS (Oddy 2012, Fisk, Crozier, Inskip, et al 2011, Horta, Bahl, Martines et al, 2007, Quigley, Kelly and Sacker 2007, Owen, Marin, Whincup et al 2005, Kramer, Chalmers, Hodnett et al 2001).

Pre-term infants who are not breastfed or who do not receive breastmilk are more likely to develop necrotising enterocolitis (Morgan, Young and McGuire 2011, Henderson, Craig, Brocklehurst et al 2009). Necrotising enterocolitis is not only a potentially devastating condition in the neonate but has significant childhood morbidity (Pike Brocklehurst Jones et al 2012). There are some indications that breastfeeding influences a child's cognitive development (Kramer, Aboud, Mironoova 2008 Nyaradi, Jianghong, Hickling et al 2013).

The benefits are not only for infants, mothers who breastfeed are less likely to develop breast cancer (do Carmo Franca-Botelho, Ferreira, Franca et al 2012, Ip, Chung, Raman et al 2007). Mothers who do not breastfeed are also at greater risk of ovarian cancer (Jordan, Cushing-Haugen, Wicklund 2012). Breastfeeding is such an important indicator of health that it has been included in the Public Health Outcomes Framework for England (Department of Health, 2012).

Accordingly, all health care professionals working with infants should, therefore, promote, protect, and support breastfeeding to actively encourage women to continue feeding their infant in this way.

Although this guidance focuses on inpatient children's services and aims to ensure that mothers are supported in breastfeeding while they or their infant are in hospital, there are elements of transferability across departments. This publication will consider the circumstances where breastfeeding is contraindicated and the implications of weighing infants and plotting the infants weight on the infant growth chart. It will justify using breastfeeding as a pain-relieving and distracting intervention during painful procedures.

Key steps to encourage breastfeeding in children's wards and departments

The measures which children's inpatient units can adopt to help mothers breastfeed while their baby is in hospital remain as pertinent and as valuable as ever. These are expanded in the *Guidance for supporting breastfeeding* section and reflect the steps to successful breastfeeding outlined by the UNICEF Baby Friendly Initiative (see www.babyfriendly.org.uk).

Every children's inpatient unit should:

- have in place an up-to-date breastfeeding policy which is routinely communicated to all health care staff, and provide health care staff with training to acquire the skills necessary to implement this policy
- provide mothers with the environment and facilities which meet their needs for privacy, information and appropriate nutrition
- support mothers in their choice of feeding method, and assist them in establishing and maintaining breastfeeding
- provide parents with written and verbal information about the benefits of breastfeeding and breast milk
- use alternative techniques conducive to breastfeeding if a baby is unable to feed at the breast
- give no bottles or dummies to breastfeeding babies, unless medically indicated and with parents' permission
- provide facilities that allow mothers and babies to be together 24 hours a day to promote breastfeeding on demand
- plan all care, ward rounds and other interventions to minimise disturbance to breastfeeding
- provide mothers who need to express breast milk with a dedicated facility that is appropriately furnished with well-maintained and sterilised equipment for the safe expression and storage of breast milk
- provide parents with information about breastfeeding support groups during admission and on discharge from the hospital.

Guidance for supporting breastfeeding

1. An up-to-date breastfeeding policy is routinely communicated to all health care staff, and staff are provided training to acquire the skills necessary to implement this policy.

To avoid disparity and confusion the breastfeeding policy should be formulated by the children's units in conjunction with the hospital's maternity services (where relevant) and neonatal services to ensure continuity of advice and practice.

The policy should be displayed with any supporting guidance (for example, this publication) in appropriate areas of the hospital and where required, the policy translated into the other languages which are spoken locally.

All staff should have their own copy of the policy and the expectation of compliance with the policy must be routinely communicated to all health care staff within the care setting.

New staff must have the appropriate induction to this policy with training to acquire the skills necessary to implement this policy within three months of their start date. Existing staff must be updated as part of annual mandatory training for nursing staff within the children's unit.

There should be regular auditing of compliance with the breastfeeding policy.

Staff training programmes must emphasise:

i) the importance and benefits of breastfeeding for the mother and her baby

ii) all aspects of lactation management, positioning and attachment, at a level relevant for each professional group i.e. registered nurse, health care support worker

iii) methods of and equipment for expressing milk. All mothers should be shown how to hand express as demonstrated by NHS Choices (2012).

Breastfeeding champions are members of staff who are committed to breastfeeding, have undertaken an individualised programme of preparation and who have close links and extensive networks with breastfeeding support organisations and charities.

Breastfeeding champions should link with schools of nursing and midwifery and promote the organisation's policy on breastfeeding. This is important to ensure that all nursing students, from all fields of practice, are fully informed and equipped to promote and support breastfeeding.

2. Provide mothers with an environment and facilities that meet their needs for privacy, information and appropriate nutrition.

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

Resident mothers of sick children need to be provided with relevant information and education to sustain breastfeeding. The resident breastfeeding mother needs to be provided with appropriate drinks, snacks and wholesome nutrition to meet her and her infant's calorie requirement. The standards and provisions of the facilities and the quality of the sustenance offered should be the subject of regular audit. This should be the responsibility of senior nursing staff. An audit tool relating to the guidance in this document is provided in Appendix.

For mothers who need to express their breast milk there should be a dedicated private and comfortable area for expressing. Units should provide equipment for expressing and a means to ensure the safe storage of breast milk. Neonatal units and children's departments should provide information about where to hire breast pumps so that mothers can use at home. Many neonatal units have an in-house lending scheme for mothers of infants who are resident.

Staff should also be able to teach mothers how to hand express milk if they would prefer to do this. Information on breastfeeding and expressing breast milk should be translated into other languages as appropriate, so that women whose first language is not English can access it (NICE, 2008).

3. Support mothers in their choice of feeding method, and assist them in establishing and maintaining breastfeeding

Health care staff need to support mothers in their choice of feeding method, and assist them in establishing and maintaining breastfeeding. This includes among other things staff having a discussion with the parents regarding their chosen method of feeding and the current feeding history on admission to hospital. This detail needs to be recorded in the infant's or mother's care plan commensurate with the NMC standards for record keeping (2009).

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

4. Provide parents with written and verbal information about the benefits of breastfeeding and breast milk

Trained staff, provided by the hospital or community services, should be available to breastfeeding mothers to discuss the benefits of breastfeeding and good

breastfeeding management. All written information describing the benefits of breastfeeding and good breastfeeding management practices should be readily available and translated as necessary (NICE 2008). A designated person within the children's unit will need to ensure that these materials are updated each year.

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

5. Use alternative techniques conducive to breastfeeding if a baby is unable to feed at the breast

Health care staff, need to use alternative feeding techniques conducive to breastfeeding when an infant cannot feed at the breast, these should be discussed and agreed with the parents. Bottles should never be given to breastfed infants without the explicit consent from the parents. Feeding options include bottle and teat, cup and nasal/oral gastric tube, and the staff should be sufficiently skilled to either perform the feed themselves or teach and support the parents to feed their infant. Unless clinically prohibited because of maternal medication or the infants condition the use of expressed breast milk would remain the feed of choice.

Dummies are constructed of latex or silicone and elicit a reflexive sucking action in the infant which can be distracting and soothing. They can also be called pacifiers or soothers. Some studies have recommended that dummies should only be given to infants if they are medically indicated and following discussion with the parents (WHO1989; Joanna Briggs Institute, 2006). Some work has challenged that a dummy will have a detrimental effect on breastfeeding (Bu'Lock, 2004, Cinar, 2004, Haycock and Greenough 2007). Consequently health care staff need to be sufficiently knowledgeable to discuss the benefits and the detriments of using dummies with the parents, respect the parents' choice and obtain parents' consent before offering a dummy to an infant. This should be clearly documented in the infants care plan.

6. Supporting the mother and infant relationship: provide facilities that allow mothers and babies to be together 24 hours a day to promote breastfeeding on demand

Health care settings need to provide facilities that allow mothers and babies to be together day and night to promote infant led breastfeeding on demand. This is also important to sustain lactation. Staff in health care settings where breastfeeding is being supported and encouraged should be able to facilitate skin to skin contact where the infant or the mother is clinically stable (Moore, Anderson and Bergman 2009). As with all infants who are in the prone position it is important that staff check on the infant frequently and ensure that they are not overwrapped and that their nose and mouth remain unobstructed (Poets, Urschitz, Stenfeldt et al 2012)

7. Plan all care, ward rounds and other interventions to minimise disturbance to breastfeeding

Staff should plan any non-emergency nursing care or intervention in such a way that any disturbance to breastfeeding is avoided. Staff should carry out any patient care required with minimal disturbance to the mother and breastfeeding infant. Where disturbance is unavoidable (for example, acute clinical crisis or appropriately managed intervention), the mother should be encouraged and supported to express her milk six to eight times over a 24 hour period, to establish and/or maintain lactation until she can resume breastfeeding her infant.

If an infant needs to undergo surgery, the fasting time for breast milk is four hours (RCN, 2005) and following medical or surgical procedures, infants should be put to the breast as soon as they are alert and wanting to feed, unless medically contraindicated (RCN, 2005). All staff should be aware of the implications of drugs on initiating and maintaining breastfeeding (BMA and Royal Pharmaceutical Society of Great Britain, 2006). See also NICE 2008 Maternal and Child Nutrition recommendation 15.

8. Provide mothers who need to express breast milk with a dedicated facility that is appropriately furnished with well-maintained and sterilised equipment for the safe expression and storage of breast milk.

Breastfeeding mothers admitted to hospital should never be separated from their infants unless they are unable to care for their babies for clinical reasons. Mothers should be able to express milk at their baby's bedside if they wish and appropriate screening should be available to them to maintain their privacy and dignity.

Health care settings should provide a separate, dedicated room, that is private and suitably furnished, for breastfeeding mothers so that, if required, they can express breast milk. Information about the facilities for breastfeeding at the hospital needs to be prominent and readily available to mothers. Well-maintained, sterile equipment for mothers to use when expressing and storing of breast milk needs to be provided. Ensure that the collection and storage of breast milk meets the required standards of the hospital's infection control policy.

Staff handling expressed breast milk should practise good hand hygiene at all times and wear gloves. Staff should ensure that all expressed breast milk is labelled correctly with the mothers name, the time and the date of expression. Fridge temperatures should be kept at 4°C or lower (NHS Choices 2012) and there will be a need to compile a daily record of temperatures and a fridge cleaning rota, there will need to be an audit process to ensure adherence. Fridges used to store expressed breast milk should be labelled as such and posters or advice leaflets on safe storage instructions provided. Fridges where expressed breast milk is stored need to be appropriately secured to prevent unwarranted access. Breastfeeding mothers who are not on children's units will also require access to facilities for breastfeeding, as well as to equipment for expressing and storing breast milk.

In some circumstances breast milk may need to be frozen if the anticipated storage time is more than 24 hours. In these circumstances the breast milk should be frozen as soon as possible after expression to maintain the nutritional and microbiological quality of the milk. If a standard freezer is being used the temperature should be set at -18°C or lower (NICE 2010). Designated staff should check and document the freezer temperature every day.

9. Provide mothers with information about breastfeeding support groups during admission and on discharge from hospital.

The discharge planning of a breastfeeding mother should include providing information about local breastfeeding support groups and counsellors (for example, Association of Breastfeeding Mothers, The Breastfeeding Network, La Lèche League, National Childbirth Trust) (Britton et al., 2007).

Ensuring follow-on care and support by providing the relevant health visitors, midwives, community children's nurses and/or community neonatal nurses with the full details of each mother and infant's breastfeeding history, to ensure continuity of advice and care.

Encourage mothers to engage with her local breastfeeding support groups and liaise with them in partnership working to inform hospital staff to promote awareness of the information about services and the support available in the community (NICE, 2008).

Circumstances when breastfeeding is thought to be contraindicated

Contraindications to breastfeeding are few. Infant factors may include: some inborn errors of metabolism; challenges to successful breastfeeding caused by sucking difficulties such as tongue tie (NICE 2005) or cleft lip can be managed by careful positioning. Prematurity is not a contraindication to breastfeeding. NICE (2010) have made it clear in their quality statement that mothers of infants receiving specialist neonatal care are to be supported to start and continue breastfeeding, including being supported to express milk. This milk can be stored using elements from the same good practice that applies to donor milk (NICE 2010). Kangaroo skin-to-skin contact, peer support, simultaneous breast

milk pumping, multidisciplinary staff training and the award of the Baby Friendly accreditation of the associated maternity hospital have been shown to be effective and cost effective (Renfrew, Craig, Dyson, McCormick et al 2009). If there is a feeling that there is insufficient breast milk, or if the dietician or medical team feel that the breast milk contains insufficient calories for growth, special 'fortifiers' can be added to expressed breast milk. This should be done in such a way that the mothers confidence in her ability is not undermined and supplementation with this fortified milk can be combined with natural breastfeeding. When used, these fortifiers must be added as close to the feed times as possible and using a safe aseptic non-touch technique (GOSH clinical guideline 2011). This way the infant can continue to receive the additional benefits of breastfeeding and breastmilk with the additional calories.

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

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

The British HIV Association and Children's HIV Association (BHIVA/CHIVA) continue to recommend the complete avoidance of breastfeeding for infants born to HIV-infected mothers, regardless of maternal disease status, viral load or treatment (Taylor, Anderson, Claydon et al 2011). The Royal College of Paediatrics and Child Health (RCPCH) (2012) annual report indicated that approximately 30 children a year are still acquiring HIV infection perinatally or through breastfeeding.

Breastfeeding as a pain-relieving measure during painful procedures

There is good evidence confirming the effectiveness of non-pharmaceutical analgesia in infants and also on the adverse effects of poorly managed pain in infants in the short term with decreased oxygenation and haemodynamic instability for example (Ismail and Gandhi 2011). Pain can cause a range of detrimental long-term effects (Grunau, Holsti and Peters 2006). A series of reviews support breastfeeing or supplemental breast milk as effective measures in relieving prodcedural pain. Breastfeeding is more effective than swaddling or the use of a dummy (pacifier) and although results seem to be mixed, breastfeeding may have a similar efficacy to the administration of sucrose. Efe and Ozer (2007) found that breastfeeding was an effective way of relieving pain during neonatal immunisations. Efe and Savaser (2007) found no difference in the analgesic effect of breastfeeding and the administration of sucrose during venepuncture. Given that the long-term use of sucrose in neonates is not yet fully understood, giving breast milk and breastfeeding could be considered as an alternative (Murki and Subramanian 2011).

Growth charts and breastfed babies

The UK-WHO growth chart combines World Health Organization (WHO) standards with UK pre-term and birth data. The chart from two weeks to four years of age is based on the WHO growth standard, derived from measurements of healthy, non-deprived, breastfed children of mothers who did not smoke (WHO 2006). The charts depict a healthy pattern of growth that is desirable for all children, whether breast fed or formula fed and of whatever ethnic origin (Scientific Advisory Committee on Nutrition 2007). These charts were developed because there was evidence that the growth trajectory of a bottle-fed infant was very different from that of a breastfed infant (Dewey et al., 1992, Whitehead and Paul, 1984; Hediger et al., 2000; Cole and Whitehead, 2002). This meant that when the old format was used some breastfed babies appeared not to be gaining weight as

quickly as they should. This was potentially discouraging to breastfeeding mothers and there was some anecdotal evidence that this could lead to mothers discontinuing breastfeeding. Although there is individual variation plotting an infant's weight on a chart based on data from breast fed infants is likely to be more reassuring than when the old charts were used.

Under normal circumstances infants should be weighed in the first week of life as part of an assessment of feeding and subsequently as needed. Recovery of birthweight, passing of urine and stools indicates that feeding is effective and that the infant is well. Once feeding is established, infants should usually be weighed at around eight, twelve and sixteen weeks and one year, at the time of routine immunisations.

If there are concerns, there may be a requirement to weigh more often. However, weights measured too close together are often misleading, so infants should be weighed no more than once a month up to six months of age, once every two months from six to twelve months of age, and once every three months over the age of one year. However, most infants do not need to be weighed this often. Infants who are admitted to hospital are going to deviate from these recommendations and if infants appear to have lost weight this can be a focus of concern to a breastfeeding mother. A drop in an infant's weight need not have a direct correlation to the success of the mother's breastfeeding but be related to other aspects of the infant's health. Each circumstance is different but in many cases reassurance and support as to the likely temporary nature of this weight loss should be provided and once the need for the infant to have been admitted to hospital is addressed and breastfeeding is re-established the likelihood is that the infant will continue on their own growth trajectory.

The RCN supports maternal choice and where the mother choses not to breastfeed, professional guidance on formula feeding *Formula feeds* can be found at www.rcn.org.uk/publications

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Organisations supporting breastfeeding

The Breastfeeding Network

www.breastfeedingnetwork.org.uk
(Accessed September 2013)

National Childbirth Trust

www.nct.org.uk
(Accessed September 2013)

La Lèche League

www.laleche.org.uk
(Accessed September 2013)

Association of Breastfeeding Mothers

http://abm.me.uk
(Accessed September 2013)

Additional links and resources

Expert Group on Growth Standards of the Scientific Advisory Committee on Nutrition and Royal College of Paediatrics (2007) Application of the new WHO growth standards to the UK, London: RCPCH.
www.sacn.gov.uk/pdfs (Accessed September 2013)

Drugs and Lactation Database LacMed
http://toxnet.nlm.nih.gov
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UK Drugs in Lactation Advisory Service
www.ukmicentral.nhs.uk
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Appendix: Audit checklist – Breastfeeding practice

Photocopy this checklist and use these key criteria from the breastfeeding guidance to audit your unit/hospital. Refer to the guidance to prepare an action plan if improvements are needed.

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

If this audit tool identifies any defects an action plan should be devised and a plan to re-audit in 6 months

Notes

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