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New York State Model Hospital Breastfeeding Policy



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**October 2016
Second Edition**

New York State Model Hospital Breastfeeding Policy

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Background

Breastfeeding benefits infants by promoting overall health, growth and development, and by strengthening the bond between mother and baby. Breast milk helps protect infants from colds, gastroenteritis, lower respiratory infections and otitis media, and reduces the risk of food allergies, asthma, and Sudden Infant Death Syndrome (SIDS). Breastfeeding protects against chronic diseases such as diabetes in childhood and later in life.^{1,2}

Breastfeeding has economic and environmental advantages. Breastfeeding reduces or eliminates the cost of formula for families. Because breastfed babies and their mothers tend to be healthier, families, businesses and health insurers save money.^{1,3,4}

Breastfeeding saves lives, improves health and reduces costs. It is a public health issue. Improving breastfeeding rates is not the sole responsibility of individual women, rather governments, policy makers, hospitals, healthcare providers, communities and families all share responsibility. Health care providers and hospital staff can have a significant impact on improving breastfeeding rates by supporting breastfeeding women.^{1,5} Women who exclusively breastfeed in the hospital, compared to those who do not, are more likely to exclusively breastfeed during the early postpartum period and to breastfeed for a longer period of time.⁶⁻⁸

The Risks of Not Breastfeeding

The risks of not breastfeeding are more than not receiving the benefits of breast milk, but include the risks from receiving breast-milk substitutes. Breastfeeding is defined as the physiological norm compared to all other types of infant feeding, and therefore, the burden of proof should be that feeding breast-milk substitutes is equal to breast milk rather than breastfeeding is best, ideal or optimal.

The newborn's gastrointestinal microbiota is a complex and dynamic ecosystem. Gut microbiota composition is under the influence of internal and external factors. Colonizing bacteria are derived from the mother, breast milk, and the hospital environment, and are influenced by the mode of delivery, hygiene measures, feeding habits and drug therapies, including antibiotics. Infant feeding choices directly influence microbiota composition. Weaning to solid foods also profoundly impacts the microbial environment of breastfed infants.⁹

Breastfed newborns have a more stable and uniform microbiota composition. Breast milk supports long, healthy villi structures making the intestinal microbiome less porous to pathogenic bacteria and foreign and harmful antigens. Exclusively breast-fed newborns are colonized with the most beneficial gut microbiota. Relatively small amounts of supplemented formula provided

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to a breastfed infant will shift the breastfed pattern to a formula-fed microbiota pattern. This change in the gut microbiota will promote the growth and absorption of pathogenic bacteria, which increases the risk of acute infections and chronic diseases and conditions from infancy through adulthood. Feeding infant formula disrupts the development of the infant's immune system. This is especially true for preterm infants because of their diminished ability to break down toxins and reduced gut immune function. Feeding infant formula to these at-risk infants can cause gut inflammation which can be critical to the health of the newborn.⁹⁻¹¹

Infants who are not breastfed have increased risks of:^{1,2}

- Gastroenteritis (diarrhea and vomiting)
- Hospitalizations from bronchitis or other respiratory diseases in the first year of life
- Otitis media
- Asthma (especially among those with a family history)
- Sudden infant death syndrome (SIDS)
- Atopic dermatitis
- Necrotizing enterocolitis among preterm infants

Children who are not breast fed have increased risks of:^{1,2}

- Childhood obesity
- Type 2 diabetes mellitus
- High total cholesterol levels
- High blood pressure
- Leukemia
- Lower scores on intelligence tests

Women who breastfeed experience short- and long-term health benefits such as a faster return to their pre-pregnancy weight. **Women** who do not breastfeed their infants have increased risks of:^{1,2,12,13}

- Postpartum bleeding after delivery
- Breast cancer
- Ovarian cancer
- Type 2 diabetes mellitus
- Metabolic syndrome
- Myocardial infarction
- Cardiovascular disease

The American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP) and American College of Obstetricians and Gynecologists (ACOG) recommend exclusive breastfeeding for the first six months of life, with continued breast milk feeding until one year of age, or longer, as complementary foods are introduced.¹⁴⁻¹⁶

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Contraindications to Breastfeeding

The contraindications to breastfeeding are few, but it's important, that in the enthusiasm of promoting breastfeeding, that women's decisions to not breastfeed because of medical, psychological or personal reasons, be respected. For mothers who have a medical contraindication to breastfeeding, the decision not to breastfeed is further complicated if they come from cultures where breastfeeding is expected and their health condition has not been disclosed to others in their lives. Health care providers and staff must be sensitive to these women's concerns, and not inadvertently shame them or make them feel guilty for their decision and/or health condition. Furthermore, encouraging women who have contraindications to breastfeed to do so, may be malpractice.^{17,18}

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New York State Legislation and Regulations

All hospitals that provide maternity care services in New York (NY) must develop, update, implement and disseminate written policies and procedures annually to staff providing maternity or newborn care in accordance with Title 10, NY Codes Rules and Regulations (NYCRR), § 405.21 – Perinatal Services¹⁹ (effective September 2005, update effective January 2017) to assist and encourage mothers to breastfeed. Hospitals should have a procedure in place to regularly monitor the effectiveness of their maternity care, infant feeding and breastfeeding policies as part of their quality assurance process.

In addition, NY Public Health Law, Article 25, Title 1, § 2505-a - *Breastfeeding Mothers' Bill of Rights* (BMBR)²⁰ was passed August 2009, effective May 2010. The statute specifies the rights of pregnant women and new mothers to be informed about the benefits of breastfeeding and receive support from health care providers and health care facilities during pregnancy, after delivery and after discharge. The law requires that the BMBR be conspicuously posted in all NY hospitals and birthing centers that provide maternity care services and on the NY State Department of Health's (NYSDOH) public website, and a copy be provided to all pregnant women at the time of pre-booking or time of admission. Two amendments have updated the BMBR. The first amendment, effective November 2015, requires that child day care facilities support breastfeeding and post the BMBR. It states that women have the right to breastfeed their baby at their place of employment or child care center in an environment that does not discourage breastfeeding or the provision of breast milk. The second amendment, effective January 2016, requires language from Labor Law § 206-c to be included in the BMBR stating that women up to three years following childbirth have the right to take a reasonable number of unpaid breaks or use paid break or meal time at work to pump breast milk.

In August 2009 (effective May 2010), under the authority of Public Health Law § 2803-j, the Commissioner of Health required that hospital-specific annual measures of newborn infant feeding and breastfeeding be added to the Maternity Information Leaflet and publically reported on the NYSDOH's public website. Under Public Health Law § 2803-j, hospitals and providers must provide pregnant women at the time they register and/or are admitted to the hospital with a copy of the Maternity Information Leaflet.²¹

The NYCRR Perinatal Services regulations and the BMBR are based on the evidence-based principles included in the *Ten Steps to Successful Breastfeeding*²² and the *International Code of Marketing of Breast-milk Substitutes*.²³ NY legislation and regulations are the source of required components of the 2016 New York State Model Hospital Breastfeeding Policy.

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Purpose of the New York State Model Hospital Breastfeeding Policy

In October 2011, the initial New York State (NYS) Model Hospital Breastfeeding Policy was disseminated. This revised NYS Model Hospital Breastfeeding Policy reflects changes to both Title 10, NYCRR, § 405.21 – Perinatal Services and Public Health Law § 2505-a.^{19,20}

The goal of the NYS Model Hospital Breastfeeding Policy is to help NY hospitals that provide maternity services to improve their written hospital breastfeeding policies and maternity care practices to be compliant with NY laws, rules and regulations and in turn, provide evidence-based maternity care practices and breastfeeding support in their hospitals. This policy was designed to be used as a standard reference when reviewing and revising hospital breastfeeding policies.

The NYS Model Hospital Breastfeeding Policy is divided into **11** policy sections and each section contains:

Review of the Evidence

Each policy section begins with a short review of the evidence in support of each of the *Ten Steps to Successful Breastfeeding*²² and the *International Code of Marketing of Breast-milk Substitutes*.²³

Required Components

The language in the Required Components must be included in written breastfeeding policies at all NY hospitals or birthing centers that provide perinatal or maternity care services in accordance with Title 10, NYCRR § 405.21, Public Health Laws § 2505-a, § 2803-j, § 2803-n, and § 4130.^{19-21,24,25}

Recommendations

The language in the Recommended Components is not required by NY laws, rules or regulations, but they are encouraged. They have been recommended by professional expert groups and U.S. and international government agencies including:

- Academy of Breastfeeding Medicine (ABM)
- American Academy of Family Physicians (AAFP)
- American Academy of Pediatrics (AAP)
- American College of Obstetricians and Gynecologists (ACOG)
- American Medical Association (AMA)
- Baby-Friendly® USA, Inc.
- Centers for Disease Control and Prevention (CDC)

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- United States Breastfeeding Committee (USBC)
- U.S. Department of Health and Human Services, Office of the Surgeon General
- The United Nations Children’s Fund (UNICEF) and World Health Organization (WHO)

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1. Have a written breastfeeding policy that is routinely communicated to all health care staff.

A main organizational facilitator in the implementation of the Ten Steps to Successful Breastfeeding (Ten Steps) is having formal, written breastfeeding policies and protocols that are delineated as the standard of care and publicly available to the hospital staff. Whereas, having outdated and/or inconsistent breastfeeding policies or lack of enforcement of current policies are barriers to the implementation of the Ten Steps. A coordinated breastfeeding committee or task force with motivated, credible leaders, a shared vision, and engagement of multidisciplinary partners and staff from all levels of the organization is optimal in the promotion of a breastfeeding-friendly organizational culture.²⁶

Required Component:

- a. The hospital must develop, update, implement and disseminate annually written policies and procedures to staff providing maternity care or newborn care to assist, encourage and support the mother to breastfeed. (NYCRR)**

Recommendations:

- ✓ The hospital maternity staff will use current evidence-based research to annually review and update the hospital's written breastfeeding policy.²⁷
- ✓ The hospital will establish and maintain a hospital breastfeeding team/committee/task force to identify and eliminate institutional barriers to breastfeeding. The hospital team should be interdisciplinary, culturally-appropriate for the population served, and composed of the following individuals and groups:^{27,28}
 - hospital administrators;
 - physicians and nurses;
 - lactation consultants and specialists;
 - nutrition and other appropriate staff;
 - community breastfeeding support program staff; and
 - mothers and family members.
- ✓ The hospital breastfeeding team will institute methods to approve policy updates and verify that maternity care practices stay consistent with the hospital breastfeeding policy.^{27,28}
- ✓ The hospital will ensure that all hospital department policies are compatible with the promotion, protection and support of breastfeeding and their hospital breastfeeding policy.²⁹

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2. Train all health care staff in the skills necessary to implement this policy.

Health care providers have an important role in influencing and supporting a woman's decision to breastfeed her infant, yet insufficient training and skills are a major barrier to clinicians feeling competent in discussing breastfeeding with their patients. Hospital staff need continuing education opportunities to become competent in breastfeeding knowledge and management, and to maintain lactation counseling skills.^{26,28}

Required Components:

- a. The hospital must designate at least one person, who is thoroughly trained in breastfeeding physiology and management, to be responsible for ensuring the implementation of an effective breastfeeding program. (NYCRR)**
- b. At all times, there should be available at least one staff member qualified to assist, encourage and support mothers with breastfeeding. (NYCRR)**
- c. The hospital must provide someone trained in breastfeeding to assist mothers when they need help, inform them about their breastfeeding progress, and help counsel them to improve their breastfeeding skills. (BMBR)**
- d. The hospital must provide mothers with assistance from someone specially trained in breastfeeding support and expressing breast milk if an infant has special needs. (BMBR)**

Recommendations:

- ✓ At least one hospital maternity staff member will be an International Board Certified Lactation Consultant (IBCLC). The number of lactation counseling staff should be based on the number of annual births, the perinatal level of the hospital, and minimum International Board Certified Lactation Consultant Staffing Recommendations for the Inpatient Setting.³⁰
- ✓ All staff with primary responsibility for the care of mothers and their infants will complete comprehensive training on breastfeeding physiology and management, with annual updates, competency verification, and completion of continuing education in breastfeeding and lactation management.²⁹
- ✓ All physicians and other health care providers who have privileges to labor, delivery, maternity and nursery/newborn care will complete a minimum of three credit hours of training in breastfeeding management based on their role.²⁹
- ✓ All health care professionals who provide patient care will have minimal knowledge, skills and attitudes (the value of delivering breastfeeding care and services) necessary to protect, promote and support breastfeeding and facilitate the breastfeeding care process.³¹

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- ✓ All staff outside of maternity such as pharmacists, social workers, anesthesiologists, radiologists, dietary and housekeeping will receive training based on their job description and workplace exposure to breastfeeding mother/infant dyads.²⁹
- ✓ All staff who have contact with pregnant women, mothers, and/or infants, will receive orientation on the hospital's breastfeeding policy on arrival and training within 6 months.^{29,31}
- ✓ The hospital will support training maternity staff on mother-friendly care that supports breastfeeding success, including encouraging support persons to be present during labor and birth, using non-drug pain relief methods, and employing invasive procedures only when required based on a birth complication.³¹
- ✓ The hospital will support training maternity staff on maternal and infant health conditions that are contraindications to temporarily or permanently not breastfeeding or expressing breast milk and include any patient contraindication for feeding breast milk in maternal and infant admission orders and discharge summaries.^{14,29,32}

3. Inform all pregnant women about the benefits and management of breastfeeding.

Education on the value of breastfeeding, importance of exclusive breastfeeding, and the basics of breastfeeding management prior to delivery contributes to mothers being better prepared and motivated to initiate breastfeeding in the hospital. Consistent, culturally-sensitive breastfeeding education and lactation counseling and support throughout the perinatal period, including participation in hospital-affiliated or community-based breastfeeding education classes, individual professional counseling and support and peer support, helps build confidence and positively increases the duration and prevalence of breastfeeding, including exclusive breastfeeding.^{26,28,29,33-35}

Required Components:

- a. **The hospital or hospital-affiliated clinics must provide each maternity patient with complete information about the nutritional, medical and emotional benefits of breastfeeding for mother and baby and the possible impacts of not breastfeeding, in order to help her make an informed choice on how to feed her baby. (NYCRR and BMBR)**
- b. **The hospital or hospital-affiliated clinics must participate in and provide or arrange for effective prenatal activities including conducting effective community outreach programs either directly or in collaboration with community-based providers and practitioners who provide prenatal care and services to women in the hospital service area. Activities and services of a prenatal program must include but not be limited to the following: (NYCRR)**
 - **active promotion of prenatal care during each trimester;**
 - **initial visit with complete history, physical/pelvic examination, laboratory screening, initiation of patient education, nutrition screening and counseling, and prenatal risk assessment;**
 - **arrangement for follow-up care and education;**
 - **psychosocial support services as needed;**
 - **ongoing maternal and fetal risk assessment; and**
 - **HIV counseling and/or testing.**
- c. **The hospital or hospital-affiliated clinics must assure the availability of prenatal childbirth classes for all pre-booked women which should address as a minimum: (NYCRR and BMBR)**
 - **the anatomy and physiology of pregnancy, labor and delivery;**
 - **infant care and parenting;**
 - **infant feeding cues and feeding on demand;**
 - **breastfeeding including preparation to breastfeed, common problems and solutions;**
 - **maternal nutrition;**
 - **the effects of smoking, alcohol and other drugs on the fetus;**

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- what to expect if transferred; and
 - the newborn screening program with the distribution of newborn screening educational literature.
- d. The hospital or hospital-affiliated clinics must **not** use educational materials which refer to proprietary product(s) or bear product logo(s), unless specific to the mother's or infant's needs or condition, or distribute any materials that contain messages that promote or advertise infant food or drinks other than breast milk. (NYCRR)
- e. The hospital must provide breastfeeding information to a family member or friend when a patient request is made to staff. (BMBR)
- f. At the time of pre-booking or attendance at prenatal childbirth education classes or at admission, the hospital must provide copies of the BMBR and the maternity information leaflet. (NYCRR , BMBR and PHL § 2803-j)
- g. The hospital must include a copy or abstract of the existing prenatal record in the medical record for each maternity patient. The prenatal record must include maternal history and health, results of physical examinations, maternal and fetal risk assessments, and if done, maternal HIV, Hepatitis B and Group B strep testing. (NYCRR)
- h. The hospital must include, at minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments as part of inpatient maternity care. (PHL § 2803-n)

Recommendations:

- ✓ The hospital will incorporate education about breastfeeding in all routine prenatal group classes, taught by a certified lactation counselor.^{27,31}

Prenatal education, regardless of the mothers' infant feeding decision, will include information about:^{27,31}

- the benefits of breastfeeding, contraindications to breastfeeding and risks of formula feeding;
 - breastfeeding as the normative feeding for infants and young children unless medically contraindicated;
 - how breastfeeding impacts on mother's and infant's/children's health outcomes; and
 - the anatomy and physiology of lactation.
- ✓ The hospital will make available prenatal education, including individual and group lactation counseling and support, starting in the first trimester, to pregnant women at hospital-affiliated clinics and services, and as part of coordinated educational programs in the community.²⁹
 - ✓ At individual prenatal visits, the hospital staff will explore issues and concerns with women who are unsure how they will feed their babies or who have chosen not to breastfeed. Efforts will be made to address the concerns raised and each woman will be educated about her options. For women for whom breastfeeding is contraindicated, clinic staff will not counsel them to breastfeed

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and will fully support them to develop responses to why they are not breastfeeding and to help avoid feelings of guilt.^{27,29}

- ✓ In addition, the hospital will provide education around the following topics:^{29,32,36}
 - the importance of exclusive breastfeeding for the first six months; with continued feeding of breast milk until age one year or longer,
 - pain relief methods for labor, including non-pharmacologic methods;
 - the importance of early skin-to-skin contact for the mother and baby;
 - the importance of early initiation of breastfeeding;
 - rooming-in on a 24-hour basis;
 - feeding on demand or baby-led feeding;
 - frequent feeding to help assure optimal milk production;
 - the effect of formula supplementation on milk supply; and
 - manual expression and effective latch and milk transfer.
- ✓ The hospital will inform all potentially income-eligible women about, and facilitate referrals to, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) which offers nutrition, breastfeeding education and peer support during the prenatal and postpartum periods.^{1,37}

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4. Help mothers initiate breastfeeding within one hour of birth.

Mother-infant, skin-to-skin contact and the initiation of breastfeeding within the first hour after vaginal delivery and two hours after a cesarean delivery have been shown to have positive effects on maternal and infant health outcomes including increased breastfeeding exclusivity and longer duration. Post-delivery placement of the naked infant on the mother's bare chest provides a place of warmth, nutrition through breastfeeding, early-mother-infant attachment, and better cardio-respiratory stability. Separation lowers the newborn's body temperature and heartbeat, and increases stress hormones and crying. Skin-to-skin contact is even more important for premature newborns and infants delivered by cesarean section.^{36,38-41}

Required Components:

- a. Unless medically contraindicated or unacceptable to the mother, hospital maternity staff must allow the newborn to remain with the mother as the preferred source of body warmth providing maximum access after the birth, whether the delivery is vaginal or by cesarean section. (NYCRR and BMBR)**
- b. Hospital maternity staff shall encourage, assist and support mothers to breastfeed within one hour of birth which shall include placement of the newborn skin-to-skin for breastfeeding immediately following delivery unless contraindicated. (NYCRR and BMBR)**
- c. The hospital shall prohibit the application of standing orders for anti-lactation drugs. (NYCRR)**

Recommendations:

- ✓ Hospital maternity staff will document a mother's infant feeding method. If there are contraindications to breastfeeding and/or the mother has requested to formula feed or not breastfeed, or not receive any additional breastfeeding information and/or support, this will be documented in her medical record, the infant's medical record, and on the bassinet.²⁷
- ✓ The hospital will facilitate early skin-to-skin contact and allow the initial breastfeeding opportunity to take place in the delivery room and continue during transport from delivery to the recovery room or postpartum area.^{27,36}
- ✓ Hospital maternity staff will promote, support and protect exclusive breastfeeding throughout the hospital stay, unless medically contraindicated or the mother indicates that she has chosen not to breastfeed.²⁷
- ✓ Hospital maternity staff will place all newborns skin-to-skin immediately following birth regardless of the planned feeding method, unless there are medically-justified reasons to delay contact.²⁹

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- ✓ Hospital maternity staff will place the newborn skin-to-skin after a non-emergent cesarean birth while the incision is being closed as a distraction to clinical procedures and to give the mother a greater sense of control.^{36,39}
- ✓ Hospital maternity staff will document the duration of skin-to-skin contact time immediately after delivery and during the hospital stay.³⁶

5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.

Interventions starting in pregnancy, continuing during the birth hospitalization and postnatally after hospital discharge are the most effective in promoting and supporting breastfeeding. Professional breastfeeding support in the hospital, focused on empowering mothers with skills and knowledge, can increase breastfeeding initiation and duration.^{42, 43}

Early breastfeeding assessment and support are necessary when the mother and infant are separated because the preterm or sick infant needs special care such as placement in neonatal care or the mother's health is compromised. Special efforts in the Neonatal Intensive Care Unit (NICU), that have been shown to be effective, focus on early initiation of breastfeeding or expression of breast milk, facilitation of skin-to-skin contact, peer support, and the provision of family-centered care which accommodates the parents' presence and participation in their infant's care. Interventions providing skilled professional support from trained lactation staff has been shown to be cost-effective. Depending on the infant and/or mother's situation, breastfeeding or milk expression can be challenging due to dyad separation, patient transfers, staff workloads, or the design and medicalized nature of NICUs.^{42,44-46}

Required Policy Components:

- a. The hospital must provide an education program as soon after admission as possible that addresses the following subjects related to breastfeeding: (NYCRR and BMBR)**
 - **nutritional and physiological aspects of human milk;**
 - **the normal process for establishing lactation, including positioning and attachment, common problems associated with breastfeeding and recommended frequency of feeding (breastfeeding on demand);**
 - **the potential impact of early use of pacifiers on the establishment of breastfeeding;**
 - **diseases (contraindications for breastfeeding), medication or other substances which may have an effect on breastfeeding, including any drugs that may dry up their milk; and**
 - **information about safely collecting and storing human milk (hand-expressed or pumped breast milk).**
- b. The hospital must allow mothers to breastfeed their babies in the neonatal intensive care unit (NICU) unless medically contraindicated. If nursing is not possible, every attempt must be made to have the baby receive their mother's pumped or expressed milk. (BMBR)**
- c. If a transfer to another hospital providing a higher level perinatal care necessitates separating the mother and high-risk newborn, mothers who have chosen to breastfeed should be encouraged to maintain lactation and breast milk should be made available to the newborn. (NYCRR)**

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- d. If a mother or baby is re-hospitalized in a maternal care facility after the initial delivery stay, the hospital must make every effort to continue to support breastfeeding, and to provide a hospital grade electric pump and rooming-in facilities. (BMBR)**

Recommendations:

- ✓ Hospital maternity staff will observe mothers' breastfeeding sessions several times per day and provide additional support, if needed, to ensure successful breastfeeding.²⁷
- ✓ Hospital maternity staff will conduct and document breastfeeding teaching and assessment including latch, position and any problems encountered at least every shift and, whenever possible, with each staff contact with the mother.²⁷
- ✓ Hospital maternity staff will conduct and document a formal assessment of breastfeeding including position, latch and milk transfer to evaluate breastfeeding effectiveness and anticipate breastfeeding problems during the last eight hours prior to discharge.^{36,47}
- ✓ Hospital will provide close observation of the mother/infant dyad by trained professionals to help prevent complications associated with insufficient milk transfer.³⁶

Separation

- ✓ The hospital will develop and implement protocols for early breast milk pumping, hand expression and skin-to-skin opportunities if an infant is separated from the mother due to medical indications such as prematurity.²⁷
- ✓ Hospital maternity staff will ensure milk expression is begun as soon as possible but not more than 6 hours after birth and when medically appropriate, the mother's expressed milk is given before any supplementation with breast-milk substitutes as part of standard routine care. For high risk and special needs infants, manual expression is begun within one hour after birth.²⁹
- ✓ Hospital maternity staff will instruct mothers of infants in the NICU on how to hand express their milk and use a hospital-grade breast pump to keep up their milk supply until their infant is ready to nurse.^{27,28,32}
- ✓ Hospital maternity staff will teach mothers proper handling, storage and labeling of human milk and how to maintain storage facilities for expressed milk.^{27,42}
- ✓ Infants will be fed mother's expressed milk until the medical condition allows the infant to be breastfed on demand.^{27,36}
- ✓ The hospital will provide medical orders (prescriptions) for electric breast pumps and referrals to local breast pump rental services for mothers who require extended pumping.²⁷

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- ✓ The hospital will support increased staff education and skills, use of electric breast pumps and private lactation areas to increase the mothers' comfort and frequency of breastfeeding in the NICU.⁴⁵

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6. Give infants no food or drink other than breast milk, unless medically indicated.

The early introduction of formula to supplement breastfeeding infants by hospital staff is significantly related to exclusive breastfeeding and negatively impacts breastfeeding. Initiating breastfeeding in the delivery room decreases the likelihood of formula supplementation. Before supplemental formula feedings begin, a formal assessment should be conducted to verify if formula supplementation is warranted. There are many inappropriate reasons for supplementation such as a tired or sleeping mother and/or fussy infant. One of the top reasons breastfeeding mothers request formula is the concern about not producing enough breast milk. Breastfeeding education and assistance provide by skilled professional lactation consultants is crucial to increase maternal confidence and breastfeeding self-efficacy and to decrease formula supplementation.^{23,48-51}

Required Policy Components:

- a. The hospital must restrict supplemental feedings to those indicated by the medical condition of the newborn or mother. (NYCRR)**
- b. Hospital maternity staff must inform mothers if her doctor or the infant's pediatrician is advising against breastfeeding before any feeding decisions are made. (BMBR)**
- c. The hospital must allow mothers to have her baby not receive any formula feeding and to have a sign on her baby's crib clearly stating that her baby is breastfeeding and that no feeding of breast milk substitutes of any type is to be offered. (BMBR)**
- d. The hospital must provide individual training in formula preparation and feeding techniques for mothers who have chosen formula feeding or for whom breastfeeding is medically contraindicated. (NYCRR)**
- e. The hospital must report infant feeding data (breast milk only, formula only, both breast milk and formula, other or unknown) within five days of birth on the NYS or New York City birth certificate as prescribed by the NYS Commissioner of Health. (PHL § 4130)**

Recommendations:

- ✓ The hospital will track exclusive breast milk feeding according to the Joint Commission's Perinatal Care Core Measure PC-05 and document exclusion criteria (medical conditions as reason for not exclusively feeding breast milk).^{29,36,48}
- ✓ The hospital will develop policies to address the choices, volume and methods of supplemental formula feeding and protocols for evidence-based medical indications for supplementation such as hypoglycemia, weight loss and hyperbilirubinemia.^{29,48}

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- ✓ The hospital will educate staff and health care providers on common situations when breastfeeding management is necessary and supplementation is not indicated, and situations when there are infant/maternal indications for supplementation in term, healthy infants.⁴⁸
- ✓ If a breastfeeding mother requests formula, the hospital maternity staff will explore the reasons for this request, inform mothers of the risks of supplementation to establishing and sustaining breastfeeding prior to providing non-medically indicated supplementation. Staff will document that the mother has received this information and made an informed decision.^{27,29}
- ✓ Hospital maternity staff will provide a specific medical order when formula is provided to a breastfeeding baby and document the reason(s) for the provision of formula, the route of administration (i.e., spoon, cup, syringe, etc.), the form of supplement, and the amount given in the infant's medical chart.³⁶
- ✓ If possible, breastfed infants who cannot nurse at the breast will be fed in a manner that is consistent with preserving breastfeeding (i.e., by cup, dropper or syringe).^{27,29}
- ✓ Hospital maternity staff will not place bottles in or around the breastfeeding infant's crib.²⁷
- ✓ The hospital will store formula in a locked cabinet or medication dispensing system. When administered, the type, amount, method of administration, lot number, time, reason for supplementation, person who administered the formula and patient number will be recorded.³⁶
- ✓ The hospital will not accept free formula, breast milk substitutes, bottles or nipples.²⁷⁻²⁹

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7. Practice rooming-in – allow mothers and infants to remain together 24 hours a day.

There is an interactive relationship between mother-infant rooming-in, and feeding on demand. Opportunities for increased skin-to-skin contact, bonding and recognition of early infant feeding cues happen when mothers and infants remain together during the hospital stay. Increased separation of the mother-infant dyad can result in shortened breastfeeding duration.^{22,49,52}

Required Policy Components:

- a. The hospital must support rooming-in 24 hours a day and allow mothers to breastfeed their babies at any time day or night. (BMBR)**
- b. The hospital must establish and implement the option of rooming-in for each patient unless medically contraindicated or the hospital does not have sufficient facilities to accommodate all such requests. (NYCRR)**
- c. The hospital must not restrict fathers or other primary support person(s) from visitation to the mother during the recovery period, must promote family bonding by allowing regular visitation for the newborn's siblings in a manner consistent with safety and infection control, and must permit visitations by other family members and friends in a manner consistent with efficient hospital operation and standards of care. (NYCRR)**

Recommendations:

- ✓ When possible, hospital maternity staff, including physicians, will perform routine medical procedures in the room with mother and baby present, not in the nursery. The hospital will purchase portable scales, bath equipment, etc. which can be used at the mother's bedside to support this practice.²⁸
- ✓ Hospital maternity staff will make sure that healthy mothers and infants have ample opportunities for skin-to-skin contact and early learning of infant's feeding cues, regardless of the feeding choice, by supporting rooming-in 24 hours a day as the standard of care.^{28,29}
- ✓ The hospital will develop and implement policies regarding visitation that emphasize mother and infant bonding, and decrease interruptions to infant feeding and sleeping patterns, but do not unreasonably restrict visitation by the mother's partner and/or other primary support person(s).^{19,36}

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8. Encourage breastfeeding on demand.

No restrictions should be placed on the frequency or length of breastfeeds. Unrestricted frequency and duration of breastfeed sessions can provide reassurance to help prevent concerns with insufficient milk supply, and decrease problems with engorgement. Mothers should be taught infant feeding cues. Feeding on demand is dependent on the practice of rooming-in.^{22,53}

Required Policy Components:

- a. **The hospital must allow infants to be fed on demand (baby-led breastfeeding). (NYCRR)**
- b. **The hospital must allow mothers to breastfeed their babies at any time day or night. (BMBR)**

Recommendations:

- ✓ The frequency and duration of breastfeeding will be infant-led, based on infant's early feeding cues of readiness.²⁷
- ✓ The hospital will develop and implement policies regarding visitation that do not unreasonably restrict fathers and other primary support person(s), emphasize mother and infant bonding, and decrease interruptions to infant feeding and sleeping patterns.^{19,36}
- ✓ Hospital maternity staff will teach mothers feeding cues and encourage mothers to feed as soon as their infant(s) display early infant feeding cues. If a mother and infant are separated, hospital maternity staff will take the breastfeeding infant to the mother for feeding whenever the infant displays early infant feeding cues, including, but not limited to, sucking noises, sucking on fist or fingers, fussiness, or moving hands toward mouth.²⁸
- ✓ Hospital maternity staff will encourage mothers to avoid scheduled feedings and emphasize the importance and normalcy of frequent night feeds.^{36,52}
- ✓ Hospital maternity staff will document all feedings in the infant's medical record.²⁷
- ✓ The hospital will provide training to maternity staff about typical infant feeding cues and offer role playing opportunities to practice responding to parent's questions.²⁸

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9. Give no pacifiers or artificial nipples to breastfeeding infants.

Routine, early use of pacifiers has been associated with mothers' failure to fulfill their intention to exclusively breastfeed. Pacifier use may increase the risk of weaning within the first three months of age. Based on this concern, pacifier use is discouraged until breastfeeding is well-established at around one month of age.^{51,54-57}

Required Policy Components:

- a. **The hospital must respect a mother's decision to have her baby not receive any pacifiers. (BMBR)**
- b. **Pacifiers or artificial nipples may be supplied by the hospital to breastfeeding infants to decrease pain during procedures, for specific medical reasons, or upon the specific request of the mother. (NYCRR)**
- c. **Before providing a pacifier or artificial nipple that has been requested by the mother, the hospital must educate the mother on the possible impacts to the establishment and success of breastfeeding and discuss alternative methods for soothing her infant, and document such education. (NYCRR)**

Recommendations:

- ✓ The hospital will integrate skin-to-skin contact, rooming-in, and early breastfeeding into relevant infant care policies/protocols to promote infant soothing.^{28,36}
- ✓ The hospital will not accept free or low-cost pacifiers or routinely distribute pacifiers to pregnant women, mothers or their families.^{22,29}
- ✓ The hospital will store issued pacifiers in locked cabinets or locked medication dispensing devices and track pacifier use.³⁶
- ✓ The hospital will educate all mothers about pacifier use:^{14,58}
 - Pacifier use should be delayed until breastfeeding has been firmly established, usually about one month of age.
 - From age one month to six months of age, the infant can be offered a pacifier at nap time and bedtime to help decrease the risk of sudden infant death syndrome (SIDS).
 - Pacifier use should be limited or stopped during the second six months of life to reduce the risk of otitis media.

10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.

Lactation support following hospital discharge is crucial to ensure success with breastfeeding at home. This is especially important in the early postpartum period when mothers often stop breastfeeding due to a misperception about insufficient milk, or because of painful nipples or other latch problems. Short- and long-term breastfeeding duration is increased when mothers received facilitative-type help and support from lactation consultants either by phone calls (initiated by the mother or the consultant) or in-person via home, hospital, or office visits. Peer support, which can offer a shared experience combined with realistic information and practical help, increases breastfeeding initiation and duration. Peer support can be offered in-person or by phone, prenatally or postpartum. Women who receive support and encouragement to breastfeed from their health care providers breastfeed longer. Written discharge materials are not effective in increasing duration. Returning to work is often the reason many women report discontinuing breastfeeding. To be successful in continuing breastfeeding after returning to work or school takes planning and preparation. A woman will need to work with her employer or school to determine where and when she can pump and store her breast milk. Fortunately, federal and NYS laws guarantee women the right to time to pump breastmilk. NYS laws provide the right to breastfeed at the mother's workplace up to three years after the birth of her child.^{33,57,59-61}

Required Policy Components:

- a. Prior to discharge, the hospital must determine that sources of nutrition for the infant and mother will be available and sufficient and if this is not confirmed, the attending practitioner and an appropriate social services agency must be notified. (NYCRR)**
- b. The hospital must determine that maternity patients have been instructed on and can perform basic self-care and infant care techniques prior to discharge or make arrangements for post discharge instruction. Topics to be covered shall include but not be limited to: (NYCRR and BMBR)**
 - normal postpartum events and common signs of complications;
 - breast examination and care;
 - care of the perineum and urinary bladder;
 - amounts of activity and exercise allowed;
 - dietary requirements of breastfeeding;
 - sanitary procedures for collecting and storing human milk;
 - emotional responses (postpartum depression) and resumption of coitus;
 - infant care including taking temperature, feeding, bathing, diapering, infant growth and development;
 - parent-infant relationships;
 - sources of advice and information available following discharge; and
 - procedures to follow when a complication or emergency occurs after discharge.

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- c. Prior to discharge, the hospital must document the completion of the newborn physical examination, and verification of passage of stool and urine, normal sucking and swallowing abilities and that newborn is stable. (NYCRR)**
- d. The hospital must offer each maternity patient a program of instruction and counseling in family planning and, if requested by the patient, a list, compiled by the NYS Department of Health and made available to the hospital, of providers offering the services requested. (NYCRR)**
- e. The hospital must provide mothers with commercial-free information about breastfeeding resources in their community, including information on the availability of breastfeeding consultants, support groups and breast pumps following discharge. (BMBR)**
- f. The hospital must inform mothers of community services, including the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and make referrals to such community services as appropriate. (NYCRR)**
- g. The hospital must provide mothers with information to help them choose a medical provider for their baby and understand the importance of scheduling follow-up medical arrangements, consistent with current perinatal guidelines and recommendations, for mother and newborn care. (NYCRR and BMBR)**
- h. The hospital must inform mothers about their right to breastfeed in any location, public or private, where they are authorized to be. This includes their place of employment or child day care center in an environment that does not discourage breastfeeding or the provision of breast milk. (BMBR)**
- i. The hospital must inform mothers about their right to take a reasonable number of unpaid breaks or use paid break time or meal time each day so mothers can express breast milk at work for up to three years following childbirth under NY Labor Law § 206-c. (BMBR)**

Recommendations:

- ✓ The hospital will provide written information to and require that all breastfeeding mothers are able to do the following prior to discharge:²⁷
 - position the baby correctly at the breast with no pain during the feeding;
 - latch the baby to breast properly;
 - state when the baby is swallowing milk;
 - state that the baby should be nursed a minimum of eight to 12 times a day until satiety, with some infants needing to be fed more frequently;
 - state age-appropriate elimination patterns (at least six urinations per day and three to four stools per day by the fourth day of life);
 - list indications for calling a healthcare professional; and

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- manually express milk from their breasts.
- ✓ Prior to discharge, hospital maternity staff will give parents anticipatory guidance on:^{42,58}
 - prevention and management of engorgement;
 - interpretation of feeding cues;
 - signs of jaundice;
 - weight loss;
 - safe co-sleeping practices;
 - maternal medication, cigarette, and alcohol use;
 - individual feeding patterns; and
 - delay of pacifier use until breastfeeding is firmly-established at about one month. From age one to six months of age, parents should consider offering a pacifier at nap time and bedtime to help decrease the risk of sudden infant death syndrome (SIDS). Pacifier use should be limited or stopped after six months of age to reduce the risk of otitis media.
- ✓ The hospital will schedule a follow-up visit for all infants which includes a formal, observed evaluation of breastfeeding performance (position, latch and milk transfer), a weight check, physical examination, assessment of jaundice, dehydration, elimination patterns and breastfeeding issues, by a pediatrician or knowledgeable health professional within a timeframe consistent with current perinatal guidelines.^{27,36,52}
- ✓ The hospital will schedule a follow-up visit or contact within 24 hours for infants who are still not latching or feeding well at home discharge.²⁷
- ✓ The hospital will facilitate peer support groups (mother-to-mother) and/or groups staffed by lactation consultants, provide one-on-one lactation consultation at hospital-affiliated outpatient clinics or make home visiting referrals to support the continuation of breastfeeding.^{29,36}
- ✓ The hospital will inform mothers who plan to return to work or school about the NY Labor Law § 206-c, *Nursing Mothers in the Workplace Act*. Resources and tools are available to assist women in planning to return to work and in making arrangements with their employer. See www.breastfeedingpartners.org for more information.^{42,61}

The International Code of Marketing of Breast-milk Substitutes

11. Infant Formula Marketing Including Formula Discharge Packs

The International Code of Marketing of Breast-milk Substitutes was adopted in 1981 to promote, protect and support breastfeeding by ensuring appropriate feeding practices and the proper use of breast-milk substitutes and infant feeding bottles, when necessary. Infant formula marketing can undermine a mother's decision to breastfeed, and is associated with lower rates of exclusive breastfeeding and shorter duration of breastfeeding. Distribution of formula by hospitals implies hospital, health care provider and staff endorsement of infant formula use, an expectation of failure, and confusion about the importance of breastfeeding.^{23,32,62-64}

Required Policy Components:

- a. **The hospital or hospital-affiliated clinics must not distribute marketing materials, samples or gift packs that include breast milk substitutes, bottles, nipples, pacifiers, or coupons for any such items to pregnant women, mothers or their families. (NYCRR)**
- b. **The hospital or hospital-affiliated clinics must not use educational materials which refer to proprietary product(s) or bear product logo(s), unless specific to the mother's or infant's needs or condition, or distribute any materials that contain messages that promote or advertise infant food or drinks other than breast milk. (NYCRR)**

Recommendations:

- ✓ The hospital will keep all infant formula cans/containers and pre-prepared bottles of formula out of patient or public view unless in use.^{29,32}
- ✓ If a hospital provides materials at discharge to mothers, they will ensure they are commercial-free, are non-proprietary, and do not bear product logos.²⁸
- ✓ The hospital will not allow marketing representatives to directly or indirectly contact maternity care staff, providers, patients or their families in the hospital.²⁹
- ✓ The hospital will ensure that business relationships and vendor policies with infant formula and breastfeeding supply companies are congruent with policies for other vendors.³⁶
- ✓ The hospital or any hospital-affiliated clinic or primary care practice will not display pictures, posters or other materials provided by manufacturers or distributors of breast-milk substitutes, bottles, teats and pacifiers that promote the use of these products or contain any wording which may idealize the use of breast-milk substitutes.^{23,32,65}

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- ✓ All hospital staff, including support staff, will not use note pads, post-its, pens, or any other incentives obtained from commercial formula companies or other companies that violate the International Code of Marketing of Breast-milk Substitutes.²³

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Summary

Breastfeeding is once again becoming the norm in NY, the U.S., and the world. Breastfeeding saves lives, improves health and cuts costs. It is a public health imperative, not a lifestyle choice. Improving breastfeeding rates is not the sole responsibility of individual women, rather governments, policy makers, hospitals, healthcare providers, communities and families all share the responsibility for improving breastfeeding support.⁵ Hospitals and maternity care providers play a critical role implementing evidence-based maternity care policies and practices in support of breastfeeding, assuring that every newborn has a healthy start in life.

Hospitals that adopt the NYS Model Hospital Breastfeeding Policy can ensure compliance with NY laws, rules and regulations that promote, protect and support breastfeeding. The Model Policy is informed by the *Ten Steps to Successful Breastfeeding*²² and the *International Code of Marketing of Breast-milk Substitutes*.²³ By implementing the required policy components and recommendations and providing evidence-based infant and maternity care practices, hospitals will be protecting, promoting and supporting breastfeeding consistent with the global Baby-Friendly® Hospital Initiative.

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