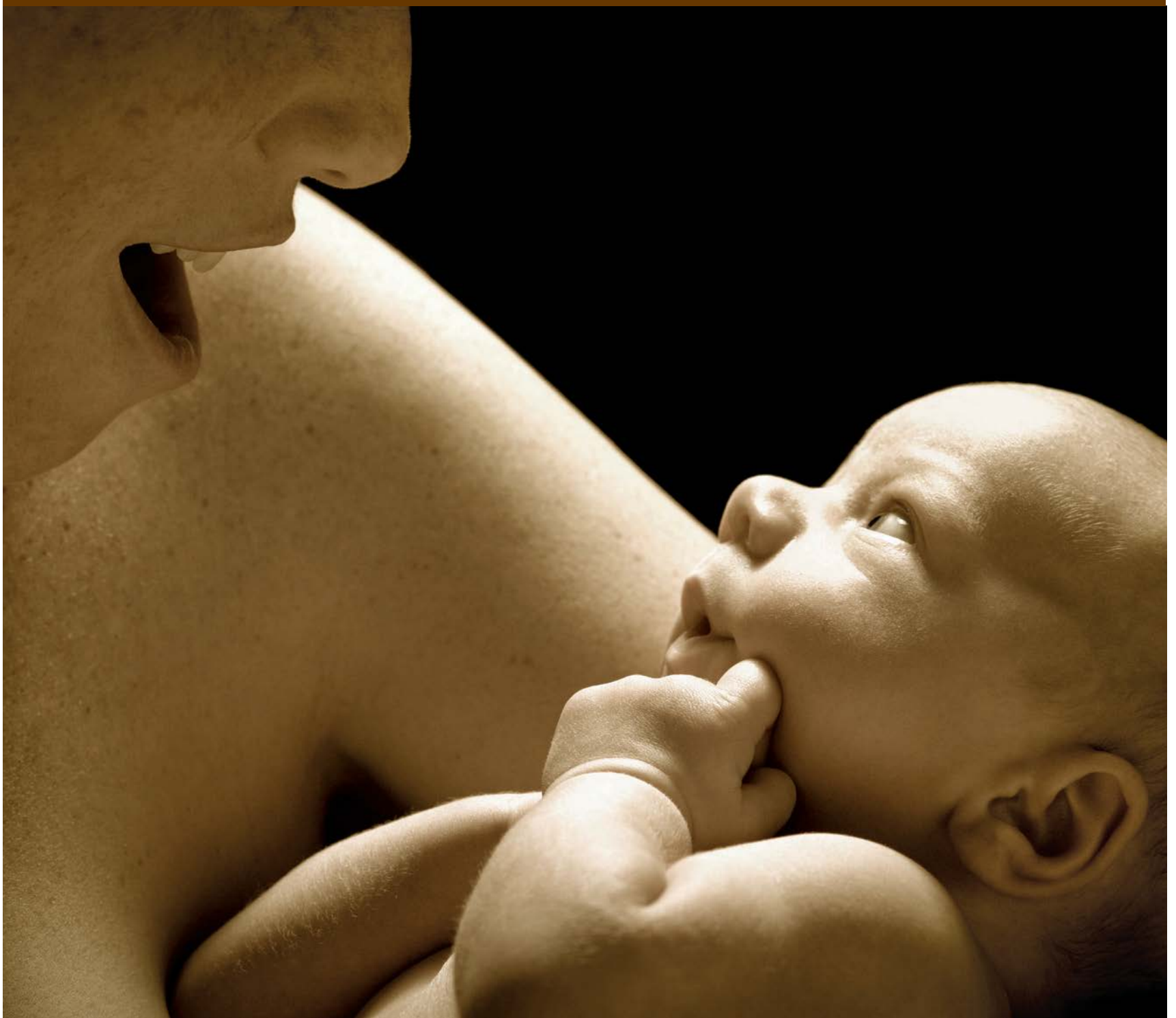
Step 8

Encourage breastfeeding on demand.

Teach mothers cue-based feeding regardless of feeding method.



Objectives

1. Educate families to understand the baby's cues for feeding readiness and satiety.

2. Educate families about the baby's ability to self-regulate appetite and to optimize the mother's milk supply.

3. Empower mothers to establish infant-feeding rhythms and patterns driven by their and their infants' needs.

4. Provide unlimited, 24-hour opportunities for babies to learn to suckle at the breast effectively.

Step 8

Goal: To assure responsiveness to babies' signs for feeding readiness as well as the mother's need for breast comfort and to promote establishment of maximal milk supply.

Background

Fixed feeding schedules were developed at the beginning of the 20th century, based on theoretical (and since disproven) assumptions about gastric emptying, infant development and avoidance of breastfeeding problems. [1-3] Current literature solidly indicates that restricted or scheduled feedings can be problematic and that demand-feeding results in improved outcomes. However, misconceptions are pervasive about appropriate feeding intervals and length of feedings, and many parents and healthcare providers favor scheduled baby-care routines and limited or "measured" feedings.

In contrast to measured feedings, demand-feeding - also known as "unrestricted," "baby-led" or "cue-based" feeding - is the practice of feeding an infant whenever the infant signals hunger or the need to suckle or whenever a mother desires to feed her baby. Under conditions of demand-feeding, it is normal for newborn infants to feed every hour and a half to three hours, which is approximately eight to twelve times or more in a 24-hour period. Feedings can occur at irregular intervals and last for varying lengths of time.

The ideal of "scientific child raising" became popular at the turn of the 20th century. Experts recommended strictly scheduled feedings and discouraged rocking, holding, cuddling, etc. for fear that doing so would weaken the child's constitution or spoil the child. These ideals were pervasive until the 1960s when concepts of child socio-emotional development, such as Erik Erickson's Eight Stages of Development, began to emerge.

The benefits of demand-based, unrestricted breastfeeding, when compared to scheduled feeding routines, include:

- Better establishment of exclusive breastfeeding and milk sufficiency.
  - More frequent feedings [4,5]
  - Increased infant milk intake [6,7]
  - Earlier establishment of breast milk supply and flow [7-9]
  - Increased duration [9-13] and exclusivity of breastfeeding [10,14,15]
- Support of ideal infant nutrition and health. [6,7,10,16-22]
- Earlier passage of meconium,[7,23] a lower level of serum bilirubin [4] and decreased incidence of hyperbilirubinemia. [4,7]
- Maternal health and well being
  - Helping mothers meet personal breastfeeding goals. [24]
  - Preventing pathologic engorgement. [25,26]
  - Nipple soreness should not increase with unrestricted feeding usually associated with demand- feeding. [5,27,28] (Nipple soreness is usually caused by poor attachment at the breast and is not related to duration of suckling. [10,29])

> "During the early weeks of breastfeeding, mothers should be encouraged to have eight to twelve feedings at the breast every 24 hours, offering the breast whenever the infant shows early signs of hunger, such as increased alertness, physical activity, mouthing or rooting. Crying is a late indicator of hunger."
>
> American Academy of Pediatrics

Implementation Strategy

Implementation: Best Practice for Success

Parents should be informed and encouraged to breastfeed on demand, with no restrictions placed on frequency or length of feeding unless clinically indicated. Demand-feeding is fundamental to the successful establishment and maintenance of exclusive breastfeeding. Each baby's pattern of feeding should be decided by physiological rhythms of the mother-baby dyad and not restricted by a schedule based on assumptions or bell curve averages. Demand feeding during the postpartum hospital stay ensures that maximal milk supply will be established, the baby's needs for nourishment will be fully

met and that mother and baby will have ample opportunity to practice positioning, attachment and responsive interaction. Demand-feeding also means that intake is self-regulated and that overfeeding does not occur.

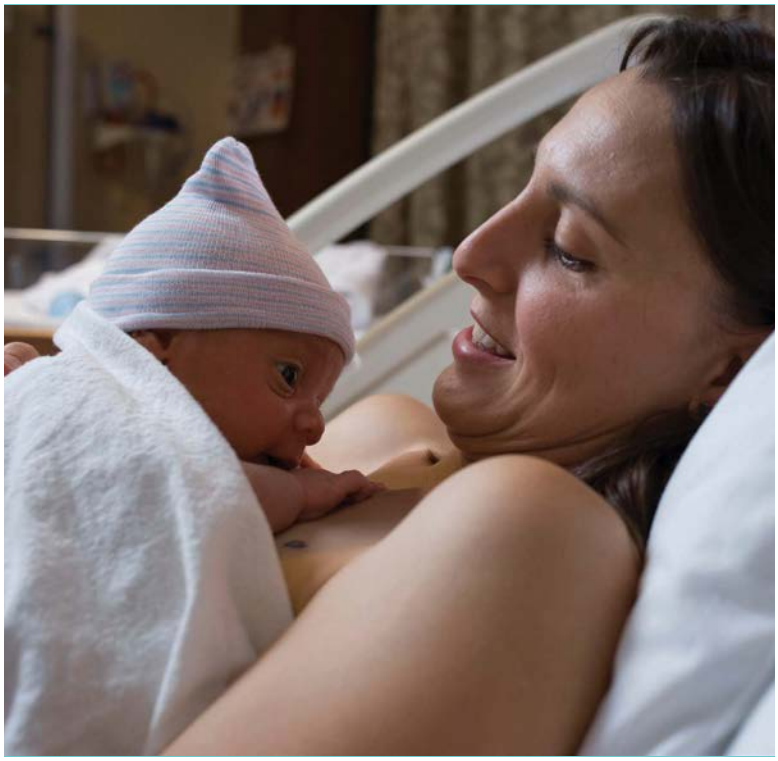
Parents and health professionals alike gain insight with additional information about the principles and physiologic importance of demand-feeding. This applies to multiparous mothers as well as first time mothers and their families. Frequent feeding, based on the signals of the mother's body and the baby's hunger, helps establish and abundant milk supply and reduces complications such as engorgement, plugged ducts or mastitis.

> "Infants who are breastfeeding well will feed eight to twelve times or more in 24 hours, for a minimum of eight feedings every 24 hours. Limiting the time at the breast is not necessary and may be harmful to the establishment of a good milk supply. Infants usually fall asleep or release the breast spontaneously when satiated."
>
> Academy of Breastfeeding Medicine

Guidance for Parents for Successful Demand-Feeding

- Provide anticipatory guidance about normal infant-state behavior. When parents are equipped to understand and to anticipate normal behavior, it helps ensure they will recognize when a baby is not behaving normally and to seek help when needed.
- Teach mothers the signs of successful milk exchange and cues of infant satiety to build their confidence in effective feeding and to help them learn to detect situations that may require more help.
- Tell mothers not to limit the lengths of feeding. While both short and very long feedings can be normal, staff and mothers should be made aware that persistently widely spaced, very brief feedings or persistently frequent and prolonged feedings may indicate ineffective attachment or ineffective milk exchange. Skilled assessment and help, if indicated, should be sought in these instances.
- Tell the mother that when her breasts feel full or if her milk lets down in anticipation of a feeding, she does not have to wait for her baby's signals to offer the breast.

It is important to have policies specific to reluctant feeders, or to those infants who are unable to demand feed on their own in the early days postpartum. There are many reasons - including prematurity, traumatic or stressful birth or illness - that an infant's normal hunger cues maybe blunted in the early days after birth. Evidence-based labor and delivery policies can reduce birth practices that may negatively impact infant feeding. Policies that support early contact and feeding, rooming-in and anticipatory guidance can optimize feeding outcomes for infants at risk for poor feeding.



In addition to the standard recommendations for encouraging demand-feeding, procedures should be in pace to identify sleepy babies and reluctant feeders and to encourage mothers to feed them frequently.

The needs of these infants can be addressed through the following practices:

- By teaching mothers to play a proactive role in timing feedings if the baby is particularly sleepy or a "reluctant feeder".
- By teaching parents how to wake a sleepy baby, and avoid overstimulating disorganized infants, and how to identify subtle hunger cues or feeding opportunities.
- By teaching mothers to entice reluctant feeders with skin-to-skin contact and to increase milk production with regular and effective stimulation of the breasts (e.g. through hand expression and, if indicated, pumping). Frequent skin-to-skin contact and proactive hand expression of breast milk can maximize intake and milk

"The most common cause of low milk supply is ineffective suckling and/or infrequent feeding routines that do not adequately stimulate milk production and milk removal."

production and avoid the need for supplemental feedings.

For infants who require a structured feeding regimen while in the hospital because they are weak, premature or ill, counseling parents to understand their infant's current condition and the rationale for the current feeding regimen as well as the time frame during which the regimen will be in effect. Let them know that demand-feeding is the goal and that the regimen is intended only to address the infant's needs until the infant can demand feedings on his or her own.

"There is no evidence that long inter-feed intervals adversely affect healthy newborns who are kept warm and who are breastfed when they show signs of hunger. An infant who shows no signs of hunger or who is unwilling to feed should be examined to exclude underlying illness."

World Health Organization.

Preparation: Getting Ready for On-Demand, or "Baby-Led" Feeding

Suggested Action Steps for implementing Step 8 Include:

1. The policy written in Step 1 should include guidance for on-demand feeding for all healthy, term babies.

2. Planning

   - A policy of 24-hour rooming-in must be in place and fully implemented prior to implementing a demand-feeding policy. It is impossible for a mother to respond to her infant's early hunger cues when the infant does not remain in close proximity to her throughout their entire hospital stay.
   - Ensure that staff-training need related to implementation of Step 8 are met for all levels of staff throughout the facility.
   - Develop a system for tracking and addressing lapses in policy.
   - Develop indicators for evaluating the impact of actions taken to support Step 8.
   - Review and adapt or develop educational materials for patients to reinforce teaching about demand-feeding.
   - Work with prenatal care professionals and childbirth educators and with those responsible for prenatal hospital tours to inform patients about demand-feeding.

3. Implementing

   - Inform all staff of the importance of Step 8 for accomplishing quality improvement goals.

- Adhere to 24-hour rooming-in policies.
- Educate all parents about demand-feeding, and reinforce throughout the entire hospital stay.
- Implement a system for monitoring policy adherence.
- Implement a system for addressing policy lapses.

4. Evaluate the impact of Step 8.

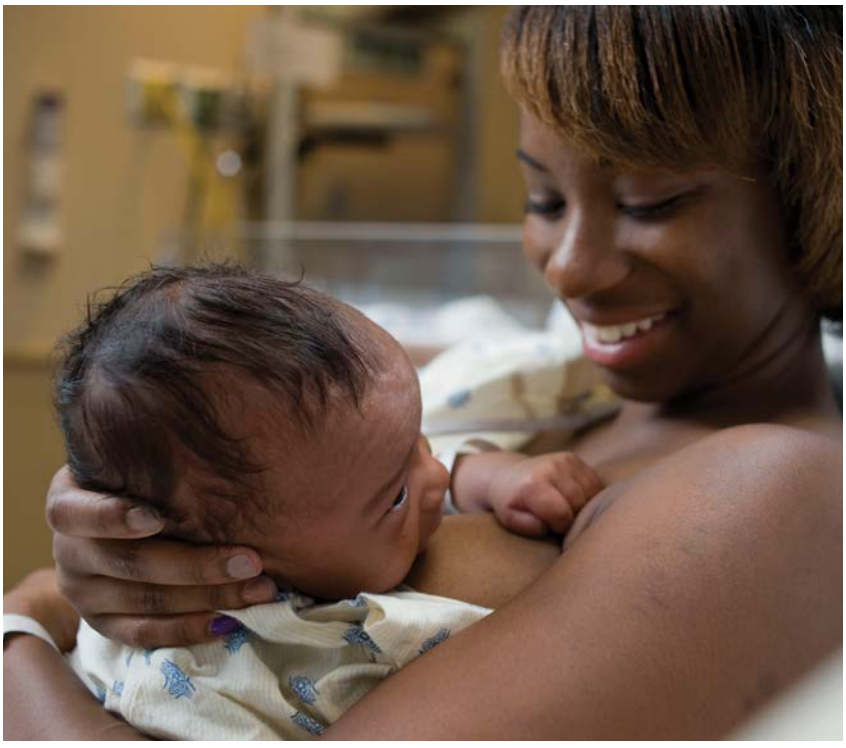
Overcoming Barriers: Strategies for Success

The most common concerns related to implementing demand-feeding are detailed below, along with strategies for overcoming them.

1. **Belief that infant care and feeding should occur on a predictable schedule.** Many grandparents and new parents may still be influenced by child rearing recommendations based on "scientific child rising." [37] Hospital practices, which frequently focus heavily on schedules and precise measurement, may reinforce these expectations.

Implementation of demand-feeding requires both staff and parents to:

- Trust breastfeeding and believe that it is normal, desirable and achievable.
- Learn the "language" of babies and be aware that infants are born competent and able to effectively judge and communicate their own physiologic needs.
- Replace highly regimented schedules and routines with a more flexible, responsive style of care. Parents may need to be reassured that it is normal for feeding patterns to be irregularly spaced, clustered, frequent and of differing lengths.



If infants are exceptionally drowsy from the effects of maternal analgesia or for other reasons, instruct mothers to initiate the feedings until their babies can demand feedings on their own. Teach parents how to recognize very subtle huger cues and how to gently wake a sleeping baby. These facilities should be counseled that they should anticipate and allow a transition from a parent-led to infant demand-led feeding once the infant is more stable.

Principles of demand-feeding include promoting close, uninterrupted maternal-infant contact and learning and responding to infant's feeding cues. These principles have value for **all** families and apply equally to breastfeeding families and families who are using formula. Responsive, baby-led feeding sets patterns for healthy eating throughout a child's lifetime.

Facility staff should:

- Understand why demand-feeding is important and how to communicate the concept of demand-feeding to parents. Role- playing with staff to address the question, "How often should I feed my baby?" may help.
- Encourage demand-feeding for all babies, regardless of feeding type, unless clinically indicated.
- Ensure that families understand the principles of demand-feeding, including infant states, infant hunger and satiety cues, the acceptability of waking an infant to feed for the mother's own comfort and how to assess feeding efficacy.
- Educate parents prenatally about demand-feeding and reinforce throughout the hospital stay and at the postpartum follow-up.
- Educate parents that newborn babies feed, on average, a minimum of eight times in a 24-hour period, with ten to twelve times or more in a 24-hour period being more typical. The importance of nighttime feeding for milk production should be explained.
- Inform mothers that demand-feeding is responsive not only to babies' hunger cues but also to the mother's physical needs. Encourage them to wake the baby for a feeding if their breasts feel full.
- Facility staff should not instruct parents to feed infants every two to three hours (or any other time intervals), as feeding should not occur in regular time intervals.
- Facility staff should not instruct mothers to nurse for specified lengths of time on each breast and then switch. Studies demonstrate that the baby's appetite

should determine the length of time at each breast as well as whether feeding occurs at both breasts during a given feeding session. [30,31] Switching breasts at specified intervals, rather than allowing the baby's appetite to determine length of the feeding may be associated with the increased likelihood of maternal breast engorgement and infant colic. [30] The baby should lead the feeding and nurse as long as he or she needs to on a given breast. The other breast can then be offered, though baby may not take it.

Each baby has different needs that should be respected and responded to. Demand-feeding allows all babies, regardless of feeding method, to regulate their individual appetites.

- Be sure that staff members are trained in both recognizing and teaching how to assess a breastfeeding.
- Ensure that there is consistency in messaging.
- Ensure that all educational materials support demand-feeding and don't provide instruction for scheduled or limited feedings.
- Feeding logs should be geared toward demand-feeding.
- Staff should not emphasize length of feedings, but should teach parents to assess the efficacy of feedings.

2. **Lack of awareness by parents of early infant feeding cues.** Because of old infant-care regimes, many families may believe that infants signal a need to eat by crying. In fact, crying is a sign of distress that occurs when parents or caregivers have not responded to early signs of hunger. While early hunger cues such as rooting, licking and hand-to-mouth behavior indicate readiness to feed, a crying infant has moved past readiness and must be calmed before he or she is able to suckle. When feeding occurs at early signs of hunger, infants feed most effectively, contributing to physical growth and the establishment of an abundant milk supply.

Educate staff to:

- Understand infant state behaviors.
- Recognize signs of hunger and satiety.

Important points of patient education include recognizing:

- Signs of hunger
- Signs of satiety
- Normal infant feeding patterns
- Signs that breastfeeding is going well

- Teach families about feeding cues.
- Assess effectiveness of a breastfeeding.

Discourage parents from focusing on the timing and length of feeds. Instead, educate and encourage parents - prenatally and throughout the hospital stay - to:

- Recognize hunger and satiety cues.
- Notice the number of feedings in a 24-hour period.
- Allow their baby, rather than the clock, to guide timing and duration of feedings.
- Assess effectiveness of a breastfeeding.

HUNGER AND SATIETY CUES

Hunger cues include rooting, suckling, and head and limb movement.

Satiety cues include stopping suckling, letting go of the breast or turning away, paired with relaxation of the hands and body.

For detailed information and visuals, consult the DSHS Infant Feeding Cues: A Feeding Guide lesson plan: http://bit.ly/2jYJm52 Additional resources are available at the end of Step 8.

3. **Babies not near their mothers when they are most ready to eat.** For families to be able to learn and respond to their infant's feeding cues, they must be physically close to their infants and be relatively free from distraction.

4. **Demand-feeding is only feasible when a 24-hour rooming-in policy (Step 7) is implemented**. Infants should be routinely kept in the mother's room 24 hours a day, and procedures, exams, lab tests, measurements and physician rounds should be held at the bedside whenever possible. This saves time in transport and allows opportunities for education and the answering of questions at the same time clinical routines occur. Schedule procedures that must occur outside of the room around feedings, and encourage mothers to accompany the baby so that breastfeeding can occur as needed.

Unrestricted demand-feeding cannot occur without true 24-hour rooming-in as well as a clear policy for staff to prioritize infant demand-feeding over other routine tasks. Feedings should not be interrupted or delayed for the convenience of staff or physicians.

Instruct staff not to supplement infants if separated from the mother for a procedure. Instead, train them to recognize feeding cues so that they can summon the mother for a feeding when needed.

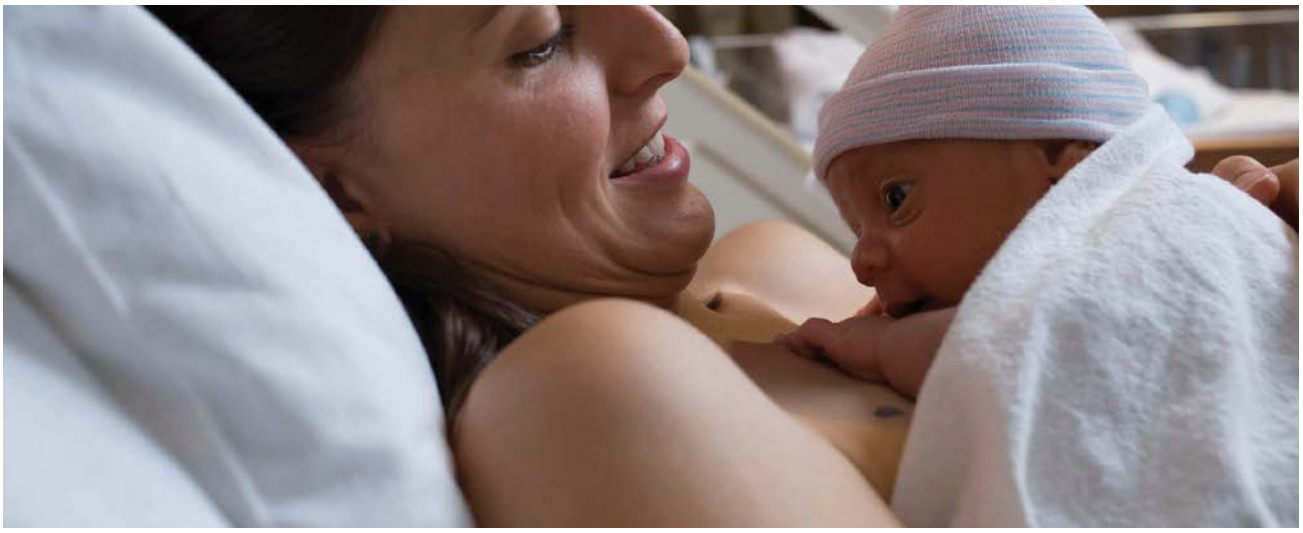
Consider limiting general visiting hours from four to eight p.m., limiting the number of visitors at one time and encouraging mothers to disconnect from their phones.

5. **To foster an environment of on-demand feeding, hospitals should evaluate their visitation policies in their maternal units.** Between social visitation, phone calls and hospital routines, the number of interruptions for a new mother-baby dyad can be overwhelming. Mothers and their families may use tremendous amounts of energy entertaining guests and taking phone calls, and mothers may be embarrassed to breastfeed in front of visitors.

It is normal for close family and friends to want to support a new family and welcome a new baby into the world. Below are some suggestions for how to meet the needs of the new families and of the people who care about them:

- Shorten and enforce visiting hours with families designating one or two immediate support people who may "break the rules" and remain with the mother-baby dyad outside of visiting hours. Another way to approach limiting visiting hours is to institute regular rest periods or quiet hours during which time visitors are restricted.
- Provide families with signs they can place on the door to notify visitors not to disturb the family. The sign can list other things the visitor can do to support the new family, such as bring food, do laundry, run errands, etc.
- Ask prenatal care providers and childbirth educators to educate families about uninterrupted time in the hospital. Provide families with realistic expectations for usual hospital routines, information about important postpartum tasks for the new baby and family (e.g., learning about each other, establishing feeding, recovery and rest) and explain the importance of limiting visitors and phone calls. The hospital can provide expectant parents with a template for an e-mail or letter to extended families and friends about the importance of limiting visitors in the early days, hospital policies about visitation and suggestions for how people can help celebrate and support the birth while also providing the family with needed privacy and time.
- As part of admission and orientation to the unit, reinforce the importance of limiting visitors, and post signs around the unit to remind staff, patients and visitors about the importance of frequent, uninterrupted mother-baby time.

6. **For mothers to learn about their babies and observe early signs of hunger, they should be physically close and engaged in frequent skin-to-skin contact, even when**



mother and baby room-in 24 hours a day and external distractions are minimized. Ideally, mother and baby will be in frequent skin-to-skin contact from the first hour or two postpartum through the remainder of their hospital stay and continuing after discharge.

Hospital staff should encourage unrestricted skin-to-skin contact to maximize feeding opportunities and to support maternal-infant bonding and the infant's physiologic stability. Fathers or other caregivers and babies can also be encouraged to spend time skin-to-skin, particularly when the new mother needs or wants a break or to sleep. When babies are not in skin-to-skin contact or being held, they should be placed on their backs in a bassinet close to the mother's bed, within arm's reach and in clear face-to-face view of the mother. Babies' hands should be left free (e.g., not swaddled), and pacifiers should be avoided so that babies may clearly signal hunger.

7. **Parents or staff are unsure if mother's colostrum or milk sufficiently meets the newborn's needs.** A focus on precisely measuring feeding volumes - as with strictly scheduled feeding regimens - is a legacy of the "scientific child-rearing" period. Fortunately, the adequacy and sufficiency of colostrum and breast milk is well documented, and tools for their measurements do exist. [32-34] To reassure new mothers that they are producing enough:

   - Feeding should be assessed twice daily to check efficacy of attachment and milk exchange, rather than milliliter marks of a bottle as is done for formula.
   - Data should be collected to measure the number of breastfeeding sessions in a 24-hour period, infant output (especially number of stools) as indicators of input and infant weight status as an indicator of sufficient hydration.

Staff and family members should be educated about the physiologic stomach capacity of a newborn infant, and this information should be regularly reinforced. A newborn infant's physiologic-stomach capacity is estimated to by an average of only 7 mL (2 mL/kg). By day two, the stomach capacity is estimated to be, an average, of only 13 mL (4 mL/kg) body weight. [35] The volume of mother's colostrum is well matched to this capacity. Explaining the small size of a baby's stomach can also reinforce why frequent feedings are needed - the infant's stomach fills quickly, and breast milk is easily, comfortably and efficiently digested. The stomach empties quickly, and the baby will likely be ready to eat again shortly after this. Unrestricted, frequent, and effective breastfeeding sessions help larger volumes of milk to come in more quickly than do restricted feedings, so the mother's milk volume will continue to keep pace with the growth of the infant's stomach.

To help staff and families gain confidence in the adequacy of exclusive breastfeeding:

- Assure families that frequent feeding in the early days is beneficial - as it stimulates milk production - and that the baby will have more efficient, less-frequent feedings once breastfeeding is well established.
- Use visual cues such as belly balls, balloons filled with fluids or other means to demonstrate the small size of an infant's stomach at days one and two.
- Remind staff that, though an infant may have the ability to take in greater volume through bottle-feed boluses, excess fluid may cause discomfort, vomiting and stretching of the infant's stomach. Families that use formula should be taught to pace bottle-feeds and be encouraged to pour out formula that is in excess of their infant physiologic stomach capacity. Urging infants to empty a bottle is common, and bottle-emptying behavior has been linked to a risk for excess weight gain. [36]
- Teach mothers to hand express milk so they can have visual evidence of the presence of their colostrum. Educate

The time of birth is associated with the frequency of suckling during the first 24 hours of the hospital stay. Infants born between midnight and six a.m. were nursed more frequently than infants born between one p.m. and midnight.[7] This may reflect hospital practices related to rooming-in and night feeding. The practice of removing babies to the nursery the first night after birth limits the suckling of infants born in the afternoon and in the evening.

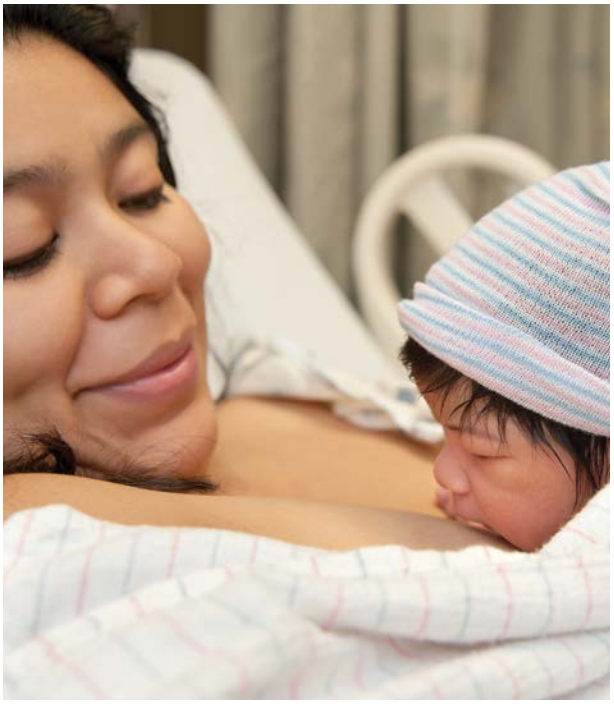
families about the potency of this "liquid gold" and how, though small in volume, colostrum provides infants with everything they need to have the very best start in life.

- In addition to teaching early hunger cues, teach families to recognize signs of infant satiety. Teach them how to assess a breastfeeding by describing signs of oxytocin release/let-down and milk exchange. Knowing these signs will provide the family with tangible ways to "measure" that their baby is getting plenty to eat and will increase their confidence in their ability to care for their infant. Praise families for their competence in responding to their infants and in meeting their babies' need through breastfeeding.

8. **Settling a crying baby.** Though crying is often normal, families sometimes interpret a baby's cries as indicative that the mother's milk is insufficient or is "not good." For the mother, difficulty comforting a baby can cause anxiety and reduce her confidence.

If a baby cries frequently, look for a cause. Observe breastfeeding, listen to the mother and examine the baby. There may be a medical reason or pain that is causing the baby to cry; or the baby may be crying due to hunger, but may also be crying due to discomfort, loneliness, fatigue, overstimulation, boredom or other reasons.

Listen to the parents' concerns and reinforce what is working well. Offer practical solutions that can address any identified needs and that can help parents feel competent in caring for their baby. Skin-to-skin contact and holding the baby close while singing and rocking may be possible strategies. Involve other family members so that they all understand what is normal, why supplemental feedings are often not the most effective solution and how to help comfort the baby.



9. **Having twins or multiples**. The benefits of breastfeeding are especially important for twins and other multiples, which are often born early and may have fragile health in the first few weeks of life. Mothers of twins should be educated that milk production follows the law of supply and demand - her body will produce enough milk for her babies when they are fed on demand.

Moms can feed two babies in many different ways and holds. Some moms prefer to breastfeed each baby individually, which

allows her focus on each baby during feedings, get comfortable with breastfeeding her baby and ensure a good latch. Other moms may want to start out breastfeeding them together. Moms usually find it beneficial to get the babies on a similar schedule, and still feed on demand. Staff should advise the mother to feed the baby that shows hunger cues first, and then, if the other baby is sleeping, wake him or her up to feed.

Once breastfeeding is established a mother can breastfeed however she and her babies desire. She can breastfeed both at the same time or breastfeed them one at a time. See the RESOURCES section for suggestions on positions for feeding two infants at the same time.

Evaluating Success

Use the information in this section and the additional tools provided in the IMPLEMENTATION RESOURCES section at the end of this step as checkpoints to verify that you are successfully implementing Step 8. Assign one or two staff members with the best perspective on day-to-day operations to complete these checkpoints. This section is for your information only. UCATS does not require submission of these tools for certification.

Process changes. When evaluating your facility's success in implementing Step 8, consider the following:

- Are 24-hour rooming-in policies implemented?
- Have staff member been educated in principles that support demand-feeding?
- Does staff knowledge, attitudes and practices support demand-feeding?
- Are visitation procedures in place?
- Are procedures in place that protect and promote demand-feeding in relation to the timing and location of routine clinical care?
- Do educational materials support principles of demand-feeding?
- Do charting forms and patient feeding logs support principles of demand-feeding?
- Do all policies, procedures and standing orders support principles of demand-feeding for healthy, term infants who are able to signal hunger cues?
- Do mothers report that:
    - No restrictions have been placed on the frequency or duration of feeding their babies?
    - They have been instructed to breastfeed whenever and for as long as their baby wants?
    - They have been instructed to wake their infant from a light sleep as needed for feeding?

- They have had early infant feeding cues described to them?

Facility management should use the included Step 8 Action Plan to assess progress on this Step.

Determine impact on patient experience. Your facility should track data about on-demand breastfeeding. Data to track include:

- Percentage of mothers who report breastfeeding eight to twelve times a day in a 24-hour period.
- Percentage of mothers who report confidence identifying early and active signs of hunger, signs of effective feeding and signs of satiety.
- Average percentage of infant weight loss.
- Average onset of weight gain.
- Average time on onset of lactogenesis II.
- Average length of time for regaining of birth weight.
- Percentage of women experiencing engorgement.
- Percentage of breastfed infants receiving supplemental feedings.

Assess value to the facility. Use the chart titled "Facility Impact - Demand-feeding" included in the IMPLEMENTATION RESOURCES documents section to track your facility's time and money spent on the measures recommended and to assess cost savings that may be attributed to the changes made. Include:

- Staff time spent in restructuring infant-care routines.
- Reported patient satisfaction.
- Staff time spent on soothing fussy babies.
- Staff time spent waking sleeping babies.

Please see IMPLEMENTATION RESOURCES for UCATS certification application.

Resources

Anticipatory Guidance Resources on Infant State and Breastfeeding Norms in the Early Postpartum Period

- Norms in the First Three Days (from Jones & Green, 2004, from On-Line Breastfeeding Course: A clinical introduction. C & W. Learning and Development. Adapted from R. Hewat, University of British Columbia School of nursing: http://bit.ly/2jYMVII
- Understanding the Behavior of Term Infants. White Plains, NY: March of Dimes Birth Defects Foundation: http://bit.ly/2jYI3TQ
- California WIC California Baby Behavior Campaign http://bit.ly/2jYRe6s

Infant Cues

- Hunger Cues: http://bit.ly/2jYMJJ8
- Baby Cues Video Guide: http://bit.ly/2jYTR8E
- Baby's Cues: http://bit.ly/2jYQIWs

Newborn's Stomach Capacity

- The Size of a Newborn's Belly: http://bit.ly/2khZCwF
- Newborns have small stomachs, La Leche League: http://bit.ly/2jYNyBK

Breastfeeding Crib Cards

- Breastfeeding Crib Cards from the Centers for Disease Control and Prevention:
  For girls: http://bit.ly/2jYZFir
  For boys: http://bit.ly/2jYZrYH

Breastfeeding Twins and Multiples

- A How to Guide: Breastfeeding Twins and Tandem Nursing: http://bit.ly/2jYV3ZC

Feeding Log

- How Do I Know – Combined Form "How Do I Know Breastfeeding is Going Well" is an instructional guide that informs new moms when they should call for breastfeeding assistance. The reverse side of the form provides a breastfeeding log that gives women the opportunity to track their breastfeeding progress

  - English: http://bit.ly/2jZ73u9
  - Spanish: http://bit.ly/2jYRQJA

Supporting Demand-feeding with "Sleepy Babies" or "Reluctant Feeders"

- Breast Compression by Jack Newman MD, FRCPC, IBCLC: http://bit.ly/2jZ7yV3
- Help — My Baby Won't Nurse! (from kellymom.com): http://bit.ly/2jZ2fFd

Protocols and Guidelines

- Academy of Breastfeeding Medicine Protocols: http://bit.ly/2jOLZnA

  - Wight N, Marinelli KA; Academy Of Breastfeeding Medicine Protocol Committee ABM Clinical Protocol #1: Guidelines for Glucose Monitoring and Treatment of Hypoglycemia in Breastfed Neonates. Breastfeed Med. 2006;1(3):178–84.

- Academy Of Breastfeeding Medicine Protocol Committee. Protocol #10: Breastfeeding the near-term infant (35 to 37 weeks gestation).

- Academy of Breastfeeding Medicine Protocol Committee. ABM clinical protocol #22: guidelines for management of jaundice in the breastfeeding infant equal to or greater than 35 weeks' gestation. Breastfeed Med. 2010 Apr;5(2):87–93.

- Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation Clinical Practice Guideline, American Academy of Pediatrics, 2004. http://bit.ly/2jZ6kJf
- World Health Organization. Hypoglycaemia of the newborn, 1997. http://bit.ly/2jS6ekg
- UNICEF/UK Baby Friendly Hospital Initiative Guidance on the development of policies and guidelines for the prevention and management of Hypoglycaemia of the Newborn: http://bit.ly/2jZaT6r
- California Perinatal Quality Care Collaborative Care and Management of the Late Preterm Infant Toolkit: http://bit.ly/2jOISvX

Implementation Resources

- Action Plan
- Facility Impact
- The Size of the Newborn's Belly
- UCATS Application Form

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Step 8
Action Plan

Primary Goals of Step 8:

- ☐ Educate families to understand babies' cues for feeding readiness and satiety.
- ☐ Educate families about the baby's ability to self-regulate appetite and to optimize the mothers' milk supply.
- ☐ Provide guidance for demand feedings for all healthy term babies for both families and health-care providers.
- ☐ Empower mothers to establish infant-feeding rhythms and patterns driven by their and their infants' needs.
- ☐ Provide unlimited, 24–hour opportunities for babies to learn to suckle at the breast effectively.

Resources for implementation:		
Resources area	**Description**	**Budgeted amount**
Staffing and training: May include the importance of baby-led feeding, recognizing and teaching hunger and satiety cues, assessing the efficacy of a breastfeed, minimizing separations of mother-baby dyads, clinical indications necessitating regimented feeding, the importance of skin-to-skin contact, hand expression and night-time feeding for milk production.		$
Materials development: Resources for clinicians, updates and revisions to existing policies.		$
Handouts for families on visiting restrictions and importance of demand-feeding.		$
Other costs related to implementation of Step 8.		$
Total expected costs		$

Implementation

Does the facility:

- ☐ Educate all parents about demand-feeding and reinforce teaching throughout the entire hospital stay?
- ☐ Apply no restrictions on the frequency or length of feeds except when clinically indicated?
- ☐ Adhere to 24-hour rooming-in policies? (see *Step 7*)
- ☐ Adhere to a visiting policy to restrict visitors?
- ☐ Present a system for monitoring policy adherence?
- ☐ Present a system for addressing policy lapses?

Implementation Tracking

Use the table below as a checkpoint for your unit and facility planning and for assessing your progress on Step 8. Set unit goals in terms of the month in which you plan to achieve each goal below, and assign each goal to be monitored to a specific person on staff.

Each goal below should be documented and archived so that your facility can verify progress and assess future goals.

Implementation Tracking				
At Month		**Person Responsible**	**Initials**	**Date completed**
	The facility has been assessed to determine areas for improvement, such as evaluating how routine procedures that impact infant feeding can be modified to minimize disruption and resolving how to reduce separations of mother-baby dyads.			
	Policies specific to reluctant feeders or infants who are unable to demand-feed on their own have been established and distributed.			
	Staff have been trained to provide guidance about normal infant-feeding patterns, recognize and teach hunger and satiety cues, and assess the efficacy of a breastfeed.			
	Educational materials for staff and patients have been updated to clearly outline policies imposing no restrictions on frequency or duration of feedings.			

Step 8
Facility Impact

Costs to Facility		
	Description/Notes	**Dollar Amount**
Staffing and training: May include time spent revising facility policies and training staff to provide guidance about normal infant-feeding patterns, recognize and teach hunger and satiety cues and assess the efficacy of a breastfeed.		$
Production of new or revised staff training materials and educational resources for parents.		$
Other costs related to promotion of baby-led feeding practices.		$
	Subtotal	$

Savings to Facility		
	Description/Notes	**Dollar Amount**
Fewer hours of staff time dedicated to addressing feeding complications, comforting fussy babies and attending to maternal and infant health complications.		$
Fewer hours of staff time dedicated to waking sleeping babies.		$
Less space and other resources necessary for the purchase and storage of formula and feeding systems.		$
Increased breastfeeding duration and exclusivity among mothers.		$
Increased reports of patient satisfaction.		$
Other savings and benefits to facility.		$
	Subtotal	$
		Net Annual Loss or Gain to Facility
		$
What can be done differently next year?		

The Size of a Newborn's Belly

Objectives:

- Describe the stomach size and capacity of a newborn.
- Understand the change in stomach capacity over the first few days of life.
- Help parents visualize the size of their infants stomach to reinforce exclusive breastfeeding.

Materials:

- Handouts on belly size
- Belly Balls (Instructions included on how to make your own)

Description:

This training focuses on the size and capacity of an infant's stomach. It was developed to use on a bulletin board. This can be set up in a break room, and nurses can sign in and out when they read the information.

Instructions on Making Belly Balls

Decide what would be most useful for your staff. Do they need a few ziplock bags of belly balls at the nurses' station to help parents visualize the size of the belly? Will you use these in prenatal classes? Do you want every nurse to have the "first day belly size" hanging off of her lanyard? Do you want to make cards for every mother to take home?

Once you decide what is best for your facility you can decide what materials you need.

DAY ONE: The "first day" belly ball is the size of a shooter marble. These can be bought at most toy stores. There are also wooden beads with holes for stringing this size. They are very light and can be strung to comfortably hang on lanyards.

DAY THREE: The "day three" belly ball is the size of a ping pong ball. These can also be found at toy stores.

DAY TEN: The "day ten" belly ball is about the size of a plastic Easter egg.

ADULT: The "adult" belly ball is the size of a softball. It probably won't fit in your ziplock belly ball bag. However, it normally surprises people when they think about what they had for dinner last night. This is a great ice breaker for discussing the size of your baby's belly.

The Size of Your Baby's Belly

DAY ONE: Your baby's belly can hold approximately 5-7 ml (that is only one sixth to one quarter of an ounce). His stomach is about the size of a shooter marble. Your colostrum is the perfect nutrition for your baby.

DAY THREE: Your baby's belly is doing some stretching today (your breasts probably are as well) His belly is the size of a ping pong ball and can hold approximately 22-27 ml. This is another example of how perfectly your body works with your baby in order to meet his needs.

DAY TEN: Your baby may be getting much more efficient at transferring milk. His belly has stretched to the size of a plastic Easter egg and holds 60-81 ml.

Step 8

UCATS Stepping Up For Utah Babies

Application

Maternity care nurses in inquiring health facility are expected to offer breastfeeding assistance to 100% of mother-baby dyad, through direct observation during every shift. 100% of mother are taught: how to recognize their infants' early feeding cues (hunger and satiety) and to fed their infant as often and for as long as the baby wants to, waking the baby if needed.

1. What percent of mothers are taught how to recognize the cues that indicate their babies are hungry? _____%

   Numerator: # of mothers who are taught hot to recognize hunger cues
   Denominator: # of mothers

2. What percentage of mothers are encouraged to feed their infants as often and for as long as their infants wants to do so? _____%

   Numerator: # of mothers who are taught to feed their infants on demand

   Denominator: # of mothers

3. What percentage of breastfeeding mothers received directly observed breastfeeding assessments during every shift?

   Numerator: # of breastfeeding mothers who had a directly observed breastfeeding assessment during every shift
   Denominator: # of breastfeeding mothers