
The Academy Of Breastfeeding Medicine

ABM Protocols

A central goal of **The Academy of Breastfeeding Medicine** is the development of clinical protocols for managing common medical problems that may impact breastfeeding success. These protocols serve only as guidelines for the care of breastfeeding mothers and infants and do not delineate an exclusive course of treatment or serve as standards of medical care. Variations in treatment may be appropriate according to the needs of an individual patient.

Clinical Protocol Number 2**Guidelines for Hospital Discharge
of the Breastfeeding Term Newborn and Mother****‘Going Home Protocol’****Background**

The ultimate success of breastfeeding is measured in the duration of breastfeeding and of exclusive breastfeeding, not solely in the initiation of breastfeeding. Anticipatory attention to the needs of the mother and baby at the time of discharge from the hospital is crucial in ensuring successful, long-term breastfeeding. The following principles and practices are recommended for consideration prior to sending a mother and her full term infant home.

Guidelines

1. Formal documented assessment of breastfeeding effectiveness should be performed at least once during the last 8 hours preceding discharge of the mother and baby by a medical professional trained in formal assessment of breastfeeding (in addition to similar assessments performed earlier in the hospitalization). This should include evaluation of positioning, latch, milk transfer, baby’s weight, clinical jaundice and all problems raised by mother such as nipple pain or perception of inadequate supply.
2. All problems with breastfeeding whether observed by hospital staff or raised by mother should be attended to and documented in the medical record prior to discharge of mother and baby, with a plan of action that includes follow-up of the problem after discharge.(1)
3. Physicians, nurses and all other staff should encourage the mother to practice exclusive breastfeeding for the first six months of the infant’s life and to continue breastfeeding until one year of age and beyond with the addition of complementary food after six months of life.(2) Mothers will benefit from education about the rationale for exclusive breastfeeding and why artificial milk supplementation is

- discouraged. Such education is a regular component of anticipatory guidance that addresses individual beliefs and practices in a culturally sensitive manner. Special counseling is needed for those mothers planning to return to outside employment or school.
4. Families will benefit from appropriate, non-commercial educational materials on breastfeeding (as well as on other aspects of child health care).(3) Discharge packs containing infant formula, pacifiers, commercial advertising materials and any materials not appropriate for a breastfeeding mother/baby should not be distributed.(2;4-8)
 5. Breastfeeding mothers and appropriate others will benefit from anticipatory guidance prior to discharge regarding the next month of breastfeeding (eg. engorgement, growth spurts, diminished milk supply). Specific guidance should be provided in written form to all parents regarding assessment of (a) adequacy of stool and urine output; (b) jaundice; and (c) sleep and feeding patterns.
 6. Every breastfeeding mother should receive instruction on techniques for expression of milk by hand and/or by pump so that she can maintain her milk supply and obtain milk for feeding to the infant should the mother and infant be separated or the infant be unable to feed directly from the breast.(9)
 7. Every breastfeeding mother should be provided with names and phone numbers of individuals and medical services who can provide advice, counseling and health assessments related to breastfeeding on a 24 hour-a-day basis, as well as on a less intensive basis.(1;5;10-12)
 8. Mothers should be provided with lists of various peer support groups (eg. La Leche League International) with phone numbers and addresses and encouraged to contact and consider joining one of these groups.(13;14)
 9. Prior to discharge, appointments should be made for (a) an office or home visit, within 2-3 days, by a physician or a physician-supervised breastfeeding-trained licensed health care provider (Nb. infants discharged before 48 hours of age should be seen by 2-4 days of age), and (b) the mother's six week follow-up visit to the obstetrician/family physician. Additional visits for the mother and infant are recommended until all clinical issues are resolved (eg. weight gain is well established, jaundice resolving). A routine preventive care visit should occur when the child is 2-4 weeks of age.(2;11;12;15;16)
 10. If mother is medically ready for discharge but the infant is not, every effort should be made to allow the mother to remain in the hospital either as a continuing patient or as a "mother-in-residence" with access to the infant for exclusive breastfeeding. Maintenance of a 24-hour rooming-in relationship with the infant is optimal during the infant's extended stay.(17-21)
 11. If the mother is discharged from the hospital before the infant is discharged (as in the case of a sick infant), the mother should be encouraged to spend as much time as possible with the infant and to continue regular breastfeeding.(22) During periods when the mother is not in the hospital, she should be encouraged to express and store her milk, bringing it to the hospital for the infant.

REFERENCE LIST

1. Kuan LW, Britto M, Decolongon J, Schoettker PJ, Atherton HD, Kotagal UR. Health system factors contributing to breastfeeding success. *Pediatrics* 1999;e28.
2. The American Academy of Pediatrics, Work Group on Breastfeeding. Breastfeeding and the use of human milk. *Pediatrics* 1997;1035-9.
3. Valaitis RK, Shea E. An evaluation of breastfeeding promotion literature: Does it really promote breastfeeding? *Canadian Journal of Public Health* 1993;24-7.
4. Dungy CI, Christensen-Szalanski J, Losch M, Russell D. Effect of discharge samples on duration of breast-feeding. *Pediatrics* 1992;233-7.
5. Frank DA, Wirtz SJ, Sorenson JR, Heeren T. Commercial discharge packs and breast-feeding counseling: Effects on infant-feeding practices in a randomized trial. *Pediatrics* 1987;845-54.
6. Bergevin Y, Dougherty C, Kramer M. Do infant formula samples shorten the duration of breast-feeding? *Lancet* 1983;1148-51.
7. Perez-Escamilla R, Pollitt E, Lonnerdal B, Dewey KG. Infant feeding policies in maternity wards and their effect on breast-feeding success: An analytical overview. *American Journal of Public Health* 1994;89-97.
8. Aarts C, Hornell A, Kylberg E, Hofvander Y, Gebre-Medhin M. Breastfeeding patterns in relation to thumb sucking and pacifier use. *Pediatrics* 1999;e50.
9. World Health Organization, United Nations Children's Fund. Protecting, promoting and supporting breastfeeding: The special role of maternity services (A joint WHO/UNICEF statement). *Int J Gynecol Obstet* 1990;171-83.
10. Bloom K, Goldbloom RB, Robinson SC, Stevens FE. Breast versus formula feeding. *Acta Paediatrica.Scandinavica.- Supplement.* 1982;1-26.
11. Chen CH. Effects of home visits and telephone contacts on breastfeeding compliance in Taiwan. *Maternal-Child Nursing Journal* 1993;82-90.
12. Houston MJ, Howie PW, Cook A, McNeilly AS. Do breast feeding mothers get the home support they need? *Health Bulletin* 1981;166-72.
13. Long DG, Funk-Archuleta MA, Geiger CJ, Mozar AJ, Heins JN. Peer counselor program increases breastfeeding rates in Utah Native American WIC population. *Journal of Human Lactation.* 1995;279-84.
14. Kistin N, Abramson R, Dublin P. Effect of peer counselors on breastfeeding initiation, exclusivity, and duration among low-income urban women. *Journal of Human Lactation.* 1994;11-5.

15. Jenner S. The influence of additional information, advice and support on the success of breast feeding in working class primiparas. *Child: Care, Health & Development* 1988;319-28.
16. Jones DA, West RR. Effect of a lactation nurse on the success of breast-feeding: A randomized controlled trial. *Journal of Epidemiology & Community Health* 1986;45-9.
17. Waldenstrom U, Swenson A. Rooming-in at night in the postpartum ward. *Midwifery* 1991;82-9.
18. Yamauchi Y, Yamanouchi I. The relationship between rooming-in/not rooming-in and breast-feeding variables. *Acta Paediatrica Scandinavica* 1990;1017-22.
19. Keefe MR. The impact of infant rooming-in on maternal sleep at night. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 1988;122-6.
20. Keefe MR. Comparison of neonatal nighttime sleep-wake patterns in nursery versus rooming-in environments. *Nursing Research* 1987;140-4.
21. Procianoy RS, Fernandes-Filho PH, Lazaro L, Sartori NC, Drebes S. The influence of rooming-in on breastfeeding. *J Trop Pediatr* 1983;112-4.
22. Hurst NM, Valentine CJ, Renfro L, Burns P, Ferlic L. Skin-to-skin holding in the neonatal intensive care unit influences maternal milk volume. *Journal of Perinatology* 1997;213-7.

ABM Protocol Committee