Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

National Infant Feeding Policy for Primary Care Teams and Community Health Organisations

Is this document a:

Policy ✓ Procedure ☐ Protocol ☐ Guideline ☐

Insert Service Name(s), Directorate and applicable Location(s):
All HSE Directorates and Service Areas

Title of PPPG Development Group:	Primary Care Breastfeeding PPPG Development Group
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PART A: Outline of PPPG Steps

The following is a summary of the PPPG.

Title: National Infant Feeding Policy for Primary Care Teams and Community Health Organisations

1. **All members of the Primary Care Team and staff working within the Community Health Organisation support and protect breastfeeding.**
    - A summary of policy steps should be displayed in all Primary Care Centres and health care settings and clinics, within the Community Health Organisation.
    - A positive and supportive environment for breastfeeding is facilitated within the Community Health Organisation.
    - Staff working within the Community Health Organisation who are breastfeeding, should be supported to continue breastfeeding on return to work.
    - All staff are aware of the recommendation of exclusive breastfeeding of babies for six months from birth with timely adequate, safe and appropriate complementary feeding while continuing breastfeeding for two years of age and beyond.
    - All staff are aware pregnant women and mothers need support, knowledge and education about infant feeding.
    - All staff working within the Community Health Organisation have responsibility to comply fully with the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions.
    - There should be collaboration between health care professionals, breastfeeding support groups and the local community. This may include involvement of voluntary breastfeeding support organisations in staff training and representation on infant feeding committees.

2. **Health Care Professionals who work directly with pregnant women and mothers, discuss the importance and management of breastfeeding with pregnant women and their families.**
    - Pregnancy is an important time to promote the health and well being of the woman, her baby and family.
    - Pregnant women are enabled to have an opportunity to discuss feeding and caring for their baby in the antenatal period.
    - Pregnant women and their partners are encouraged to attend antenatal education programmes and breastfeeding preparation classes / workshops.
    - Pregnant women and their partners are encouraged to attend a breastfeeding support group before the birth of the baby.
    - Pregnant women and new mothers requiring additional breastfeeding support are enabled to receive the required support.

3. **Health Care Professionals who work directly with pregnant women and mothers, support breastfeeding following hospital discharge.**
    - A mother who has been discharged and the baby remains in the neonatal unit will be supported and assisted in establishing and maintaining lactation.

- The mother will be visited by the Public Health Nurse / Registered Midwife within 48-72 hours post discharge from the maternity and neonatal services, following receipt of the maternity services discharge notification.
- The Public Health Nurse / Registered Midwife will observe and assess the baby breastfeeding at the first / primary visit and will complete the Breastfeeding Observation and Assessment Tool (BOAT) resource.
- If a breastfeeding challenge is identified following completion of the BOAT, an individualised care plan is developed by the Public Health Nurse / Registered Midwife
- If the breastfeeding challenge is not resolved the Public Health Nurse / Registered Midwife consults with or refers to a HSE specialist breastfeeding professional.

4. **Health Care Professionals who work directly with pregnant women and mothers, facilitate breastfeeding supportive practices.**
    - All mothers are advised to have safe skin to skin contact with their baby.
    - All mothers are encouraged to exclusively breastfeed their baby.
    - Soothers/pacifiers are not recommended during the establishment of breastfeeding.
    - All mothers are informed that babies have regular growth spurts during which demand for breastfeeds by the baby, will increase for a period.

5. **Health Care Professionals who work directly with pregnant women and mothers, support mothers when exclusive breastfeeding is not possible.**

    - If exclusive breastfeeding is not possible, mothers and their partners are supported to and informed of, the value of partial or any breastfeeding.
    - Mothers who intend to 'mixed feed' (a combination of both breastfeeding and breastmilk substitutes) should be counselled on the importance of exclusive breastfeeding in the first few weeks of life, and how to establish a milk supply.
    - A mother who wishes to relactate is supported.
    - Nipple shields are not recommended unless there is a clinical reason for their use.
    - All mothers and their partners are encouraged to understand their baby's needs of frequent touch, sensitive verbal and visual communication, keeping baby close, responsive feeding and safe sleeping practice.
    - All mothers and their partners are informed of safe sleeping practice for their baby.

6. **Health Care Professionals who work directly with pregnant women and mothers, support mothers and their partners who are not breastfeeding.**

    - The mother and her partner who are not breastfeeding their baby are given the correct information to feed their baby responsively and safely, and care for the mother's breasts if they become engorged.

7. **Health Care Professionals who work directly with pregnant women and mothers, support mothers and their partners when introducing solids to the baby.**

    - All mothers and their partners are supported when introducing solids to their baby at around six months of age.

8. **Health Care Professionals who work directly with pregnant women and mothers, support mothers and their partners during a planned/unplanned separation from their baby.**

    - All mothers and their partners are supported if a planned or unplanned separation from their baby is necessary.

2.7 Outline of Policy Steps / Recommendations

All members of the Primary Care Team and staff working within the Community Health Organisation support and protect breastfeeding

2.7.1 All members of the Primary Care Team (PCT) and staff working within the Community Health Organisation (CHO) are aware of their responsibilities in relation to and adhere to this policy. The completed version of this policy will be available within the CHO, for pregnant women, their partners and parents to view on request and a summary of policy steps should be prominently displayed in all Primary Care Centres (PCCs) and health care settings and clinics, within the CHO.

2.7.2 It is the responsibility of all members of the PCT and staff working within the CHO to foster and facilitate a positive and supportive environment for breastfeeding within the CHO. Mothers will be enabled and supported, to breastfeed their babies in all PCCs and health care settings and clinics within the CHO. Mothers will be enabled and supported, to breastfeed their babies in all public service areas (restaurants, hotels, shops, public service offices, cinemas or others) within the CHO. Breastfeeding resources are available to order on www.healthpromotion.ie

2.7.3 All members of the PCT and staff working within the CHO who are breastfeeding should be supported to continue breastfeeding on return to work by the provision of lactation breaks, facilities and support from managers and co-workers. The minimum level of provision should be in accordance with the relevant legislation (Maternity Protection (Amendment) Act, 2004). Work is currently in progress on the development of a Health Service Executive (HSE) Workplace Breastfeeding Policy. This policy will provide guidance on the roles and responsibilities of all staff working within the HSE in relation to supporting employees who are breastfeeding and /or providing breastmilk to their infants /children upon their return to work within the HSE.

2.7.4 All members of the PCTs and staff working within the CHO advise pregnant women, mothers and their families of the recommendation of exclusive breastfeeding of infants for 6 months from birth with 'timely adequate, safe and appropriate complementary feeding while continuing breastfeeding for two years of age and beyond' (World Health Organisation / United Nations International Emergency Fund) (WHO/ UNICEF, 2003, p. 8).

2.7.5 All members of the PCT and staff working within the CHO are aware of the revised Ten Steps to Successful Breastfeeding (Appendix XV). These Ten Steps provide evidenced based guidance for the initiation and establishment of breastfeeding in the maternity hospitals and breastfeeding continuation in the community.

2.7.6 All members of the PCT and staff working within the CHO are aware that while breastfeeding is a natural process, pregnant women and mothers need support, knowledge and education. It is the responsibility of PCTs and CHO staff to be aware of

the local breastfeeding support groups. Staff will, if necessary, provide mothers with current written information on the local breastfeeding support groups including accessing this and other breastfeeding information on the Health Service Executive (HSE) breastfeeding website www.breastfeeding.ie

2.7.7 All members of the PCT and staff working within the CHO, are aware of their responsibilities to comply fully with the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions (Appendix VI). A policy on the Code of Marketing of Breastmilk Substitutes is currently being developed for all staff working within the Health Service Executive (HSE).

2.7.8 All members of the PCT and staff working within the CHO where possible should promote collaboration between HCPs, breastfeeding support groups and the local community. All members of the PCT and staff working within the CHO should work closely with voluntary breastfeeding support providers to ensure greater efficiency and coverage of services. This may include involvement of voluntary breastfeeding support organisations in staff training. It may also include their representation on infant feeding committees where the planning and organisation of services occurs. All HCPs make every contact count with positive breastfeeding messages including the importance of breastfeeding and it's promotion, protection and support within the community

Health Care Professionals who work directly with pregnant women and mothers, discuss the importance and management of breastfeeding with pregnant women and their families

2.7.9 The Health Care Professionals (HCP) will recognise that pregnancy is an important time to promote the health and well being of the woman, her baby and family. Pregnant women and their families are counselled about the benefits and management of breastfeeding. The HCP will support the provision of written information about feeding and caring for the baby and provide to parents, if necessary the booklet *Breastfeeding – A Good Start in Life* (HSE, 2015) and information on accessing the HSE breastfeeding website www.breastfeeding.ie

2.7.10 Pregnant women should be enabled, by the HCP to have an opportunity to discuss feeding and caring for their baby in the antenatal period. Woman centred conversations may include 'agreeing an agenda, asking open ended questions, listening actively, reflecting back, building on current known information, showing empathy, remaining neutral and not colluding'https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2016/10/meaningful_conversations.pdf

Following an exploration of parent's prior knowledge and experience in relation to breastfeeding, some of the following topics may be included in the conversations

- The importance of breastfeeding and the potential risks of not breastfeeding
- The value of breastfeeding as protection, comfort and food
- The value of connecting with their growing baby in utero
- Supportive labour and birth practices
- The importance of immediate and sustained safe skin to skin contact (SSC)

- The importance of early initiation of breastfeeding
- The importance of responding to their baby's needs for comfort, closeness and feeding after birth, and the role that keeping their baby close has in supporting this response
- The importance of responding to the baby's early feeding cues https://www.breastfeeding.ie/Uploads/files/Feeding-Cues-Infographic-English.pdf
- The importance of rooming- in, in the maternity hospital following the birth of the baby
- Basic breastfeeding management including correct positioning and attachment of the baby to the breast
- Breastfeeding support groups - the following link on the HSE breastfeeding website www.breastfeeding.ie provides information on the breastfeeding support groups in Ireland https://www.breastfeeding.ie/Support-search/ (Details are regularly updated).

These conversations are supported with written information including the booklet *Breastfeeding – A Good Start in Life* (HSE, 2015) and information on accessing the HSE breastfeeding website www.breastfeeding.ie

2.7.11 The HCP will support and encourage all pregnant women and their partners to attend antenatal education programmes and breastfeeding preparation classes / workshops provided either by the local maternity hospital or if applicable sessions provided within the CHO. Antenatal education programmes and breastfeeding preparation classes/workshops are participant / parent led with expectant mothers and their partners agreeing an agenda with the facilitator regarding the content and structure of the class / workshop. **No routine group instruction on the preparation of artificial feeds will be given in the antenatal period**.

2.7.12 The HCP will encourage and support attendance at the breastfeeding support group by the pregnant woman and her partner during her pregnancy. Information regarding local support groups will be provided to the pregnant woman. The following link on the HSE breastfeeding website www.breastfeeding.ie provides such information https://www.breastfeeding.ie/Support-search/ . Breastfeeding support groups are facilitated by maternity hospital International Board Certified Lactation Consultants (IBCLCs), Public Health Nurse (PHN) /IBCLCs, PHNs, Registered Midwives (RMs) and/or voluntary breastfeeding organisations.

2.7.13 The HCP will support pregnant women and new mothers requiring additional breastfeeding support and this may include mothers of low income, homeless mothers, teenage mothers, and mothers who experienced previous more complex breastfeeding challenges. These women may be referred to a specialist breastfeeding professional within the HSE namely a PHN/IBCLC within the PCT or CHO or the local maternity hospital Clinical Midwife Specialist (CMS) in Lactation or midwife with an IBCLC qualification.

Health Care Professionals who work directly with pregnant women and mothers, support breastfeeding following hospital discharge.

2.7.14 If a mother has been discharged and the baby remains in the neonatal unit (NNU), the

Public Health Nurse/ Registered Midwife (PHN / RM) will support and assist the mother in establishing and maintaining lactation. Mothers should be:

- Shown how to express breast milk by hand. The following video on the HSE breastfeeding website www.breastfeeding.ie provides information on the skill of hand expression https://www.breastfeeding.ie/Resources/Video/
- Shown how to use a breast pump following onset of Lactogenesis II or the onset of copious milk secretion, or sooner if desired.
- Informed of the need to breastfeed or express at least 8 times in 24 hours (to include at least once during the night) to establish their supply.
- Given information on how to safely handle and store breast milk. The booklet *Breastfeeding & Expressing for Your Premature or Sick Baby* (HSE, 2016) provides much information for parents of babies in NNUs. This booklet is available on the following link https://www.healthpromotion.ie/hp-files/docs/HPM00972.pdf
- The PHN / RM liaises with the NNU regarding the plan for how to attain the mother's breastfeeding goal (exclusivity and duration), if the baby is planned for discharge before breastfeeding is established. Sample NNU letter (Appendix VII).

2.7.15 The PHN / RM will visit mothers within 48-72 hours post discharge from the maternity and neonatal services, following receipt of the maternity services discharge notification. This primary or first visit will include a conversation about infant feeding and an assessment of baby's feeding using the 'Breastfeeding Observation and Assessment Tool' (BOAT) resource (Appendix VIII). The PHN / RM will discuss the following topics with the breastfeeding mother including:

- The importance of exclusive breastfeeding
- Responsive feeding including recognition of and response to the baby's early feeding cues - the following link provides an infographic of baby's early and later feeding cues https://www.breastfeeding.ie/Uploads/files/Feeding-Cues-Infographic-English.pdf
- The importance of having baby near / close in order to interpret and be responsive to baby's needs as part of a nurturing relationship between mother and baby.
- Normal feeding patterns including cluster feeding and 'growth spurts' and the importance of night feeding to maintain breastmilk production
- Signs the baby is transferring and getting plenty of breastmilk https://www.breastfeeding.ie/First-few-weeks/Guidelines-for-mothers/
- The skill of hand expression. The following video on the HSE breastfeeding website www.breastfeeding.ie provides information on the skill of hand expression https://www.breastfeeding.ie/Resources/Video/ This skill is important to empower and enable the mother to:
  - -Understand the mechanics of breastfeeding
  - -Gain confidence in her ability to produce breastmilk
  - -Produce a few drops of breastmilk to enable her baby to breastfeed
  - -To soften the breasts during Lactogenesis (II) to ease discomfort or enable the baby to attach to the breast
  - -Release a blocked duct and thus lessen the possible occurrence of mastitis

- Care of nipples and breast, including the management of engorgement, and prevention of sore nipples. https://www.breastfeeding.ie/Uploads/Nipple-Pain.pdf

  This verbal information is further supported by written information and follow up as required.

2.7.16 The PHN / RM will observe and assess the baby breastfeeding at the first / primary visit. The PHN / RM will inform the mother of the importance of and to practice hand hygiene before each breastfeed. The PHN / RM will ensure the mother's positioning and attachment of the baby to her breast is reviewed and will offer recommendations if necessary. The PHN / RM will complete the 'Breastfeeding Observation and Assessment Tool' (BOAT) resource (Appendix VIII) following observation of the breastfeed at this first / primary visit.

2.7.17 The PHN / RM following completion of the BOAT will identify if breastfeeding is effective. The PHN / RM will then encourage and support attendance at the breastfeeding support group by the mother and her partner. Information regarding local support groups will be provided to the parents.

2.7.18 If a breastfeeding challenge is identified following completion of the BOAT, an individualised care plan (Appendix IX) is developed by the PHN / RM, who then revisits and repeats the BOAT based on clinical judgement. The PHN / RM may use this resource at subsequent visits with adjustments made for wet and dirty nappies and baby's weight.

2.7.19 If the breastfeeding challenge is not resolved the PHN / RM consults with or refers using a referral form (Appendix X) to a HSE specialist breastfeeding professional and includes a copy of the completed BOAT resource, if a referral is necessary. The original BOAT remains in the mother's records.

Health Care Professionals, who work directly with pregnant women and mothers, facilitate breastfeeding supportive practices.

2.7.20 The HCP will encourage and advise safe SSC for the physiological and psychological well-being of both mother and baby. It is important that the baby is positioned correctly in safe skin to skin contact (SSC) (Appendix XI).

2.7.21 The HCP will encourage exclusive breastfeeding due to the important health benefits for both the mother and her baby. Exclusive breastfeeding from birth should result in ample milk production. Exclusive breastfeeding from birth is possible except for a few medical conditions (Appendix XII). If expressed breastmilk or other feeds are medically indicated, it is important to identify the most appropriate feeding method for the baby. Feeding methods such as cups, spoons or feeding bottles and teats may be used.

http://apps.who.int/iris/bitstream/10665/259386/1/9789241550086-eng.pdf. This is a temporary method of feeding while the baby learns how to breastfeed and should not be used indiscriminately or indefinitely

2.7.22 Soothers/pacifiers are not recommended during the establishment of breastfeeding. Parents wishing to use them are informed by the HCP of the implication their use may have on breastfeeding. The following Factsheet for Health Care Professionals (HCPs) on the HSE breastfeeding website www.breastfeeding.ie provides further information https://www.breastfeeding.ie/Uploads/The-use-soothers-and-nipple-shields.pdf

2.7.23 The HCP will inform parents that babies have regular growth spurts during which demand for breastfeeds by the baby, will increase for a period usually lasting 24-36 hours. The baby's feeding pattern during the growth spurt stimulates an increase in the mother's milk supply. The baby's feeding pattern often then reverts to a similar pattern prior to the growth spurt. HCPs reassure parents this is a normal feature of breastfeeding and encourage continuation of breastfeeding.

Health Care Professionals who work directly with pregnant women and mothers, support mothers when exclusive breastfeeding is not possible.

2.7.24 If exclusive breastfeeding is not possible, mothers and their partners are supported to and informed of, the value of partial or any breastfeeding, with emphasis on providing as much breastmilk as possible to the baby.

2.7.25 Mothers who intend to 'mixed feed' (a combination of both breastfeeding and breastmilk substitutes) should be counselled on the importance of exclusive breastfeeding in the first few weeks of life, and how to establish a milk supply and to ensure that the infant is able to feed and transfer milk from the breast. The HCP may consult with or refer if necessary to a specialist breastfeeding professional. The HCP also encourages the mother to attend or to continue attendance at the local breastfeeding support group.

2.7.26 The HCP will support a mother who wishes to relactate. This may involve commencing breastfeeding having initially formula fed her baby, having weaned her baby from the breast or prior to and following adoption of a new baby. The HCP will support the mother to ensure there is frequent and regular breast stimulation. The stimulation may be from the baby or from a hospital grade electric breast pump. The HCP may consult with or refer the mother to a specialist breastfeeding professional.

2.7.27 Nipple shields are not recommended by the HCP unless there is a clinical reason for their use and this reason should be discussed with the mother and documented. A plan of care is developed with the mother, and the mother will remain under the care of the HCP who may consult with or refer to a specialist breastfeeding professional. The mother is assisted to ensure the correct size shield is being used, and should be supported to discontinue its use if appropriate. Mothers using a nipple shield prior to lactogensis (II) should be given information on how to stimulate her milk supply by expressing. The infant's intake must be closely monitored. The factsheet for Health Care Professionals on the HSE breastfeeding website www.breastfeeding.ie provides further information https://www.breastfeeding.ie/Uploads/The-use-of-soothers-and-nipple-shields.pdf

2.7.28 The HCP will support all mothers and their partners to understand their baby's needs of frequent touch, sensitive verbal and visual communication, keeping baby close, responsive feeding and safe sleeping practice.

2.7.29 The HCP will support mothers and their partners on safe sleeping practice for their baby. They will ensure the provision of information on safe sleeping practice *Safe Sleep for Your Baby – Reduce the risk of Cot Death* (HSE, 2016).

Health Care Professionals who work directly with pregnant women and mothers, support mothers and their partners who are not breastfeeding.

2.7.30 The PHN / RM and all HCPs will support the mother and her partner who are not breastfeeding their baby to have the correct information to feed their baby responsively and safely. They will also be supported to achieve the practical experience to enable them to safely prepare, handle and store powdered infant formula. This is further supported with the provision of the booklet *How to Prepare your Baby's Bottle* (Safefood and HSE, 2017). A demonstration on the safe preparation, handling and storage of powdered infant formula may be necessary at the first or primary visit with an opportunity for individual parents to prepare a feed also.

2.7.31 The PHN / RM and all HCPs will support and encourage the mother and her partner who are not breastfeeding their baby to:

- Respond to their baby's needs for comfort, closeness, and feeding, and ensure their baby is near and close to them.
- Recognise and respond to early feeding cues
- Pace the feed hence enabling the baby to control both the amount of feed taken and the speed with which he feeds. Further information on paced bottle feeding is available from the following link https://www.breastfeeding.ie/Ask-our-expert/Questions/How-do-you-give-a-bottle-to-a-breastfed-baby.html
- Recognise the baby's feeding cues indicating the baby is satisfied and has finished the feed.
- Care for the mother's breasts if they become engorged.

Health Care Professionals who work directly with pregnant women and mothers, support mothers and their partners when introducing solids to the baby.

2.7.32 The HCP will support mothers and their partners who are introducing solids to their baby at around six months of age. Weaning clinics are offered in a number of areas in the community. The following booklet provides information on feeding baby and introducing family meals *Feeding Your Baby- Introducing Family Meals* (HSE, 2015). The following link on the HSE breastfeeding website www.breastfeeding.ie provides both written information and video content on the introduction of family meals https://www.breastfeeding.ie/As-baby-grows/Introducing-family-foods/.

Health Care Professionals who work directly with pregnant women and mothers, support mothers and their partners during a planned/unplanned separation from their baby.

2.7.33 The HCP will support mothers and their partners if a planned or unplanned separation from their baby is necessary.

2.7.34 Planned separation may be due to the mother returning to work. Some of the discussions may include the length of mother's working day, how she wishes to feed

her baby and if the mother plans to express and store her breastmilk. Information to be discussed may include:

- Maintaining breastmilk supply in such situations.
- The safe storage and handling of breastmilk.
- Use of the breastpump.

The following link on the HSE breastfeeding website www.breastfeeding.ie provides such information https://www.breastfeeding.ie/As-baby-grows/Breastfeeding-and-Work/ and also the booklet *Breastfeeding – A Good Start in Life* (HSE, 2015). The HCP will encourage the mother to discuss the following topics with her line manager before her return to work

- The importance *o*f a workplace environment that supports breastfeeding when an employee returning to work has requested breastfeeding support.
- The Provision of Lactation/Breastfeeding Breaks or Flexible Work Arrangements.
- Access to a room suitable for breastfeeding or breast milk expression.
- Access to breastfeeding information resources.

PART B: PPPG Development Cycle

1.0 INITIATION

1.1 Purpose

The purpose of this policy is to direct consistent evidenced based best practice in relation to infant feeding.

1.2 Scope

This policy and its appendices apply to all staff working directly and indirectly with pregnant women, mothers and their babies within the CHO. It also applies to those providing these services on behalf of the maternity services, to support pregnant and new mothers, and their partners, to feed and care for their baby.

1.2.1 Target Users of this policy include all staff working directly and indirectly with pregnant and new mothers, their babies and their partners

1.2.2 The population to whom this policy applies, includes pregnant and new mothers, their babies and their partners within the CHO.

1.3 Objective(s)

The objectives of the policy are

1.3.1 To ensure all members of the PCT and staff working within the CHO are aware of their roles and responsibilities in relation to this policy.

1.3.2 To ensure members of the PCT and staff working within the CHO will comply with this policy and integrate it into his/her work practice.

1.3.3 To ensure members of the PCT and all staff working within the CHO are aware of their roles and responsibilities to comply fully with the Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly resolutions.

1.3.4 To ensure all Health Care Professionals who work directly with pregnant women and mothers in providing infant feeding support are aware of their roles and responsibilities.

1.3.5 To ensure that evidenced based infant feeding information and clinical support will be provided by the Public Health Nurse (PHN) / Registered Midwife (RM) to pregnant and new mothers and their partners to feed and care for their baby.

1.3.6 To ensure that the PHN / RM will observe a breastfeed at the first / primary visit and will complete the Breastfeeding Observation and Assessment Tool (BOAT). This assessment will guide the management of the breastfeeding mother and her baby.

1.4 Outcome(s)

The outcomes / consequences of the policy include

1.4.1 An increase in breastfeeding duration rates, resulting in better health outcomes for the pregnant and new mother, her baby and partner.

1.4.2 Pregnant and new mothers and their partners receive evidenced informed and consistent information to feed and care for their baby.

1.4.3 Pregnant and new mothers and their partners have access to knowledgeable and skilled support to feed and care for their baby, that is non judgemental and family centred.

1.4.4 Pregnant and new mothers and their partners who may require additional breastfeeding support are enabled to have access to timely and appropriate

interventions.

1.5 PPPG Development Group

The Primary Care Breastfeeding PPPG Development Group (Appendix II) had responsibility for developing this Policy. This group has signed a Conflict of Interest Declaration Form (Appendix III).

1.6 PPPG Governance Group

1.6.1 The Approval Governance Group for this policy is the HSE National Breastfeeding Implementation Group (Appendix IV).

1.6.2 This policy update was sent for consultation to the National Quality Improvement Governance Group for PHN Services (Appendix XIII), Directors of Public Health Nursing, National Practice Development Co-ordinator, Public Health Nursing Services, Practice Nurse Development Co-ordinators and GPs.

1.7 Supporting Evidence

1.7.1 Relevant legislation / PPPGs.

Breastfeeding is incorporated into many current policy documents in Ireland.

- Healthy Ireland - a Framework for Improved Health and Wellbeing 2013-2025.(DoH, 2013)
- A Healthy Weight for Ireland - Obesity Policy and Action Plan 2016-2025. (DoH, 2016)
- Creating a Better Future Together - National Maternity Strategy 2016-2026. (DoH, 2016)
- HSE Breastfeeding Action Plan 2016-2021.(HSE, 2016)
- National Standards for Safer Better Maternity Services. (HIQA, 2016)
- National Infant Feeding policy for Maternity and Neonatal Services. (HSE, 2015)
- Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives. Nursing and Midwifery Board of Ireland (NMBI, 2014) https://www.nmbi.ie/nmbi/media/NMBI/Publications/Code-of-professional-Conduct-and-Ethics.pdf?ext=.pdf
- Recording Clinical Practice – Professional Guidance (NMBI, 2015) https://www.nmbi.ie/nmbi/media/NMBI/Publications/recording-clinical-practice-professional-guidance.pdf?ext=.pdf
- The International Code of Marketing of Breastmilk Substitutes and its subsequent relevant WHA resolutions

1.7.2 The 'Breastfeeding Policy for Primary Care Teams and Community Healthcare Settings' (HSE, 2015) will be replaced by this policy

1.7.3 The following are the PPPGs that are related to this policy

- National Infant Feeding policy for Maternity and Neonatal Services. (HSE, 2015)
- Guideline for the Observation of a Breastfeed & Use of the Breastfeeding Observation Assessment Tool (BOAT) Resource (HSE, 2018).

1.8 Glossary of Terms

- **Breastfeeding Self Efficacy:** includes a woman's confidence in her ability to perform specific tasks and behaviours related to successful breastfeeding. These expectancies may develop through women's personal experiences with breastfeeding, vicarious experiences with breastfeeding, verbal persuasion from influential others, and visceral cues of vulnerability such as pain, anxiety or fatigue (Dennis & Faux, 1999, p.406).
- **Consent:** is the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication in which the service user has received sufficient information to enable him/her to understand the nature, potential risks and benefits of the proposed intervention or service (HSE, 2013, p.13).
- **Competency:** is the ability of the nurse / midwife to practice safely and effectively, fulfilling their professional responsibility within their scope of practice (NMBI, 2014, p.2).
- **Exclusive breastfeeding:** is when an infant receives only breast milk (at the breast, own mother's expressed milk or donor human milk) and no other food or fluids except medicines (HSE, 2015, p.5).
- **Full term infant:** is an infant born between 37 weeks and 42 weeks gestation regardless of weight (Wambach and Riordan, 2016, p. 778).
- **Health Care Professional who works directly with pregnant women and mothers:** This is a health care professional providing infant feeding support to pregnant women and mothers and includes general practitioners, community medical doctors, dieticians, registered midwives, registered public health nurses and practice nurses.
- **Infant feeding cues:** involve early and late cues that indicate the baby is hungry they include, 'body wriggling, hand and foot clasping, bringing hands to mouth or face, light sucking motions followed by more vigorous sucking, rooting behaviour, tongue extension, light sounds or whimpering, body flexion and turning head to the side. Late cues include crying, exhaustion and falling asleep' (Wambach and Riordan, 2016, p. 805).
- **Lactation consultant. An International Board Certified Lactation Consultant (IBCLC):** is a health care professional with specialist knowledge and clinical expertise in breastfeeding and human lactation. IBCLCs are certified by the International Board of Lactation Consultant Examiners (IBCLE) www.iblce.org.
- **Lactogenesis:** describes the multiple stage process during which the mammary gland prepares to secrete milk, begins copious milk production, maintains production over time and involutes during weaning. (Wilson Clay and Hoover, 2013, p. 32)
- **Lactogenesis II**: The onset of Lactogenesis II is (the onset of copious milk secretion, or milk coming in), occurs on average 30-40 hours after the delivery of the placenta that triggers a sharp drop in circulating progesterone postpartum (Wambach and Riordan, 2016, p. 288).
- **Lactogenesis III.** The maintenance of milk production is influenced by three levels of controls: endocrine, autocrine (local) and metabolic. The endocrine system is thought to set each

individual woman's maximum potential to produce milk; but it is the local control mechanism acting in concert that actually regulates the short term synthesis of milk (Walker, 2016, p. 136).

- **Paced Bottle Feeding:** Is a method of bottle feeding that can help minimise the preference for the fast flow of a bottle enabling babies control the flow of the milk. https://www.breastfeeding.ie/Ask-our-expert/Questions/How-do-you-give -a-bottle-to-a-breastfed-baby.html

- **Public Health Nurse (PHN):** PHNs provide a range of services to people in a local community including child health visits (Nursing and Midwifery Board of Ireland, 2015, p. 4)

- **Registered Midwife:** A register midwife (RM) is a person who has successfully completed a midwifery education programme that is duly recognised in the country where it is located; who has acquired the requisite qualifications to be registered and / or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery (NMBI, 2015,p.9)

- **Relactation:** For a variety of reasons a mother may want to begin nursing after initially starting her baby on bottles, or to resume nursing after weaning her baby (Huggins, 2010, p.111). Relactation can also involve a woman who previously breastfed a biologic child, even years before and is now adopting a newborn (Lawrence and Lawrence, 2016, p667).

- **Responsive feeding (RF):** demand/baby led feeding refers to a sensitive, reciprocal feeding relationship between the infant and caregiver, characterised by the infant communicating feelings of hunger and satiety through verbal/nonverbal cues, followed by an immediate response from the caregiver which includes the provision of appropriate nutritious food in a supportive manner. RF is the breastfeeding foundation for healthy eating behaviour and skills for self-regulation and self-control of food intake and associated with optimal nutrient intake and long-term weight regulation (Harbron & Booley, 2013).

- **Specialist Breastfeeding Professional** within the HSE is a PHN/IBCLC within the PCT or CHO or the local maternity hospital CMS in Lactation or midwife with an IBCLC qualification.

- **Sudden Unexpected Postnatal Collapse (SUPC)** includes any term or near term (>35 weeks gestation) infant who is well at birth (normal 5 minute Apgar score and deemed well enough to have routine postnatal care) and, collapses unexpectedly requiring resuscitation with intermittent positive pressure ventilation within the first seven days of life and, who either dies or goes on to require intensive care or develops an encephalopathy (Wellchild, 2010).

- **The International Code of Marketing of Breast-milk Substitutes and relevant subsequent World Health Assembly resolutions.:** The Code aims to contribute "to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution (WHO, 2017, p2.) http://apps.who.int/iris/bitstream/10665/254911/1/WHO-NMH-NHD-17.1-eng.pdf?ua=1

- **Weaning:** Is the transfer of the infant from dependence on mother's milk to other sources of nourishment. It does not mean the total cessation of breastfeeding but the addition of other things (Lawrence and Lawrence, 2016, p. 320).

2.0 DEVELOPMENT OF PPPG

2.1 List the questions (clinical/non-clinical)

The following key questions were defined in order to identify the evidence required to address the policy topic.

- The importance of breastfeeding in Ireland and globally?
- The role and responsibility of all members of the PCT and staff working within the CHO to protect promote and support breastfeeding?
- What is the role of the PHN / RM to support the new mother and her partner, to feed and care for their baby at home?
- Education of those providing direct breastfeeding support to pregnant, new mothers their partners and babies?
- The Ten Steps to Successful breastfeeding?

2.2 Describe the literature search strategy

A review of the relevant literature was undertaken for the period 1989 to date. Based on the key questions defined, a literature search strategy was developed. The main databases used were Cinahl (Cumulative Index to Nursing and Allied Health), Cochrane Library, Pubmed, Medline and Sage Databases. The search included library searches of hard copy journals, books and online relevant government reports. In addition a search of relevant websites was also undertaken. Key words used were breastfeeding, nursing, breastfeeding support, Public Health Nurse (PHN), health visitor, Dad/partner, community, policy, postpartum and post natal.

2.3 Describe the method of appraising evidence

The evidence in relation to best practice to protect, promote and support breastfeeding in the community setting by all staff was considered. The evidence in relation to the support of the pregnant and new mother, and her partner to feed and care for her baby at home was also considered. When appraising all the research evidence the following areas were considered

- Are the results valid?
- What are the results?
- Are the results applicable/generalisable to the population of the policy?

2.4 Describe the process the PPPG Development Group used to formulate recommendations

The recommendations are formulated through a formal structured process whereby the following are considered and documented:

- What evidence is available to answer the clinical questions?
- What is the quality of the evidence?
- Is the evidence applicable to the Irish population and healthcare setting?
- What is the potential benefit verses harm to the population/patient?

2.5 Provide a summary of the evidence from the literature

The following is a summary of the supporting evidence from the literature for this policy. The summary will focus firstly on the importance of breastfeeding, the Irish policy documents in relation to breastfeeding. The evidence includes the role of all members of the PCT and staff working within the CHO including the Public Health Nurse (PHN) and Registered Midwives (RMs) in the protection, promotion and support of breastfeeding. The summary outlines the

importance of early breastfeeding support, the education of those providing direct breastfeeding support to pregnant, new mothers their partners and their babies, and lastly evidence in relation to the Ten Steps to Successful Breastfeeding.

The Global Strategy for Infant and Young Child Feeding (WHO/UNICEF, 2003, p.8) supports exclusive breastfeeding for six months from birth 'with timely adequate, safe and appropriate complementary feeding, while continuing breastfeeding for two years and beyond'. Breastmilk is the most natural first food because of its unique properties that cannot be replicated in other milks. 'Breastfeeding is one of the few interventions where survival benefits span the entire continuum of childhood: newborn, infancy and early childhood' (Sankar *et al* 2015, p.6). There is much evidence that breastfeeding is important for the health of both the mother and her baby (Victora *et al,* 2016). Breastfeeding gives protection against respiratory tract infection, gastroenteritis, otitis media, and may reduce diabetes, childhood cancers and SIDS (Victora *et al,* 2016). The protective effects of breastfeeding may extend into later life, with prolonged breastfeeding being directly related to a decreasing risk of obesity (Yan *et al,* 2014). Longer breastfeeding is associated with higher performance on intelligence tests among children and adolescents, controlling for maternal IQ (Victora *et al,* 2016). Children who are not breastfed have a higher incidence and severity of many illnesses including respiratory tract infection, gastroenteritis, otitis media, diabetes and SIDS.

Breastfeeding is incorporated into many current policy documents in Ireland. The vision of the Department of Health (DoH) 'Healthy Ireland - a Framework for Improved Health and Wellbeing 2013-2025' (DoH, 2013) is 'a healthy Ireland where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone's responsibility'. This document highlights the importance of addressing risk factors and promoting protective factors at every stage of life including the period from the pre-natal stage through childhood, to support health and wellbeing (DoH, 2013). The obesity strategy 'A Healthy Weight for Ireland - Obesity Policy and Action Plan 2016-2025' (DoH, 2016) supports breastfeeding having a significant protective factor against obesity in children. The strategy 'Creating a Better Future Together - National Maternity Strategy 2016-2026' (DoH, 2016) following public consultation identified areas of concern in breastfeeding. These concerns included 'lack of breastfeeding support in the hospital, community and the home setting'.

The vision of the HSE Breastfeeding Action Plan 2016-2021 (HSE, 2016) is to achieve ' A society where breastfeeding is the norm for individuals, families and communities in Ireland resulting in improved child and maternal health outcomes and where all women receive the support that they need, to enable them to breastfeed for longer'. The overarching aim of the Breastfeeding Action Plan 2016 – 2021 is to increase breastfeeding initiation and duration rates, by supporting and enabling more mothers to breastfeed. One of the actions in the Action Plan 2016 – 2021 (HSE, 2016, p. 10) is to 'implement, audit and review the Breastfeeding policy for Primary Care Teams (PCTs) in each CHO'.

A 'Review and Evaluation of Breastfeeding in Ireland – A 5 year Strategic Action Plan 2005-2010' (Mc Avoy *et al,* 2014, p.10) identified as determinants of breastfeeding in Ireland 'cultural, social and economic circumstances of the mother as well as aspects of maternal age, education and self efficacy'. 'This review (Mc Avoy *et al,* 2014, p.184) included among other factors 'poor latch, nipple pain, perceived insufficient milk supply and fatigue' as 'barriers to continued breastfeeding'. Among the common reasons for mothers not continuing to breastfeed according to Rollins *et al,* (2016) are advice and practices that undermine the mother's confidence and self efficacy, poor positioning and attachment of baby to the breast and inadequate support especially in the early weeks. Motherhood to a new baby can be a

powerful process, and success in breastfeeding may be an essential part of motherhood (Hjalmhult and Lomborg, 2012).

'Breastfeeding is a natural process, however mothers may require support, knowledge and education' (Royal College of Paediatrics and Child Health, 2017, p. 3). A recent umbrella review investigating interventions that promote increased breastfeeding rates conducted by the Health Research Board (Sutton *et al,* 2016) concluded that there is substantial and consistent evidence that education, counselling and support are required during the antenatal period through to the extended postnatal period. This support is more effective if provided 'face-to-face and on an ongoing and scheduled basis' (Sutton *et al,* 2016, p. 58). This face to face support provided by appropriately trained health professionals or peer counsellors is effective in improving breastfeeding duration and exclusivity (McAvoy *et al,* 2014). The UK study exploring women's experiences of breastfeeding and additional breastfeeding support emphasised the need for realistic antenatal preparation and parent centred breastfeeding support (Fox *et al,* 2015). A Cochrane review (McFadden *et al,* 2017) of support for breastfeeding mothers with healthy term babies highlighted, support when offered to women increases the duration and exclusivity of breastfeeding. According to this review (McFadden *et al,* 2017) this support is effective if offered by trained personnel, professional or lay, during the antenatal and postnatal period, and works best if it involves scheduled visits and is structured to meet the needs of the population.

Support in particular is necessary for vulnerable mothers. Disadvantaged mothers need more breastfeeding support to ensure a positive breastfeeding journey (MacGregor and Hughes, 2010). Low income mothers in Ireland according to Shortt *et al* (2013) favoured, in terms of breastfeeding support, a non pressurised approach including practical help. Teenage mothers where many of these mothers either did not breastfeed or ceased breastfeeding early after the birth of the baby, indicated the need for more proactive help and support with basic baby care tasks (Hunter, 2008). Sherriff and Hall (2011) reported that fathers required information regarding the importance of breastfeeding including practical measures to support their breastfeeding partner. Mothers who decided to give up breastfeeding needed special attention and support from health care professionals (Larsen and Kronborg, 2013). 'Some women cannot or choose not to breastfeed, this should be respected and appropriate support and education on infant feeding provided' (Royal College of Paediatrics and Child Health, 2017, p. 3).

The Academy of Breastfeeding Medicine (ABM) recommend infants are seen by a health care professional 'soon after hospital discharge to ensure infant health and optimal breastfeeding' and mothers when experiencing breastfeeding challenges seek help from a lactation specialist while in the maternity hospital or after discharge (Rosen-Carole, Hartman and the ABM, 2015, p.454). New parents when facing challenges require information, support and input from health professionals (Datta *et al,* 2012). Strategies should be developed according to Wagner *et al* (2013), to reduce breastfeeding concerns in the early post partum period.

The PHN / RM will visit all mothers ideally within 48 – 72 hours of discharge from the maternity and neonatal services following receipt of the maternity services discharge notification. The 'Guideline for the Observation and Assessment of a Breastfeed and use of the BOAT resource' (HSE, 2017) recommends the PHN / RM will discuss the following topics with the mother including, recognition of and response to the baby's feeding cues, signs the baby is getting plenty of breastmilk, the importance of exclusive breastfeeding, the skill of hand expression and care of nipples and breast. This verbal information is further supported by written information. The PHN / RM according to this guideline (HSE, 2017) will observe and assess the baby breastfeeding at the first / primary visit and will ensure the mother's positioning and attachment of the baby to her breast is reviewed and the BOAT is completed. If breastfeeding

challenges present, an individualised plan of care is developed, and the PHN / RM revisits and repeats the BOAT.

The support of the PHN is positively associated with breastfeeding duration in Ireland due to the frequency of 'direct /indirect contact with mothers during the postnatal period' (Tarrant *et al,* 2011, p.10). Mothers need support to become confident to breastfeed at home and in public, this support includes family, professional, the workplace and society (Royal College of Paediatrics and Child Health, 2017).

The PHN is educated to 'plan, implement and evaluate appropriate maternal and child health care interventions on the basis of research, evidence and evaluation' (Nursing and Midwifery Board of Ireland, 2015, p. 9). The maternity strategy 'Creating a Better Future Together - National Maternity Strategy 2016-2026' (DoH, 2016, p. 57) recommends ' all maternity service staff should receive training both on the importance of, and best methods to initiate and continue breastfeeding'. Midwives and health visitors promote health in the postnatal period, using their varied skills which can complement each other (Aaserud, 2017). There is a need according to Mulcahy *et al (*2011) for the educational requirements for PHNs, supporting breastfeeding families, to be standardised. Health care staff who provide infant feeding services including breastfeeding support should have sufficient knowledge, competence and skills to support women to breastfeed (WHO, 2017). A pilot educational initiative to enhance student PHN's breastfeeding support competence was positively evaluated and will be further evaluated by a more diverse cohort of HCPs (Mulcahy *et al,* 2017).

A review of the evidence identified a number of breastfeeding policies for hospital or community use by midwives or health visitors. Health Care professionals having meaningful conversations with mothers enables mothers have an opportunity for a discussion about feeding their baby, how to recognise and respond to their baby and develop a positive relationship with their growing baby in utero (United Nations International Children's Emergency Fund /United Kingdom/Baby Friendly Initiative - UNICEF/UK/BFI, p.5). https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2016/10/meaningful_conversations.pdf .

Some of the key tips for keeping the conversation woman centred include 'agreeing an agenda, asking open questions, active listening, reflecting back, showing empathy, remaining neutral and not colluding' (UNICEF/UK/BFI, P. 5).

The United Nations International Children's Emergency Fund /United Kingdom (UNICEF/UK) and Baby Friendly Initiative has produced a sample infant feeding policy https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/guidance-for-health-professionals/tools-and-forms-for-health-professionals/sample-infant-feeding-policies/

This policy is based on the Ten Steps to Successful Breastfeeding. Adherence to the Ten Steps to Successful Breastfeeding has a positive impact on short, medium and long term breastfeeding outcomes (Pérez-Escamilla *et al,* 2016). Essentials for sustaining breastfeeding include, early breastfeeding initiation, exclusive breastfeeding and community support of the breastfeeding mother (Pérez-Escamilla *et al,* 2016). A recent Guideline *Protecting, Promoting and Supporting Breastfeeding in Facilities providing Maternity and Newborn Services* (WHO, 2017) examined the evidence in relation to each of the practices of the Ten Steps to Successful Breastfeeding. http://apps.who.int/iris/bitstream/10665/259386/1/9789241550086-eng.pdf?ua=1

This WHO Guideline 'provides global evidence-informed recommendations on protection, promotion and support of optimal breastfeeding in facilities providing maternity and newborn

services as a public health intervention, to protect, promote and support optimal breastfeeding practices and improve nutrition, health and development outcomes' (WHO, 2017, p.2). This Guideline is 'an update of and supersedes the Ten Steps to Successful Breastfeeding (1989)' (WHO, 2017, p.2). A separate implementation guide that encompasses this guideline, the Code of Marketing and the Baby Friendly Hospital Initiative has recently been published (UNICEF/WHO, 2018) http://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018.pdf. This document '*Protecting, Promoting and Supporting Breastfeeding in facilities providing Maternity and Newborn services: the revised Baby Friendly Hospital Initiative'* (UNICEF/WHO, 2018) presents the first revision of the 'Ten Steps' since 1989. While the subject of each step is unchanged the wording has been updated. The steps are subdivided into '(i) the institutional procedures necessary to ensure that care is delivered consistently and ethically (critical management procedures); and (ii) standards for individual care of mothers and infants (key clinical practices)' (UNICEF/WHO, 2018, p.6). 'The International Code of Marketing of Breastmilk Substitutes and relevant World Health Assembly Resolutions (the Code) as well as ongoing internal monitoring of adherence to clinical practices, have been incorporated into step 1 on infant feeding policies' (UNICEF/WHO, 2018, p.6). Ten Steps to Successful Breastfeeding (revised 2018) Appendix (XV).

2.6 Detail resources necessary to implement the PPPG recommendations

The resource implications include the production and dissemination of the updated National Infant Feeding Policy for Primary Care Teams and Community Health Organisations, to all 31 of the LHOs within each of the nine CHOs. It will be available to view or download on the link where the current policy is available.
https://www.breastfeeding.ie/Uploads/files/Breastfeeding-Policy-for-Primary-Care-Teams-and-Community-Healthcare-Organisations.pdf

2.7 Outline of PPPG Steps/Recommendations

Refer to Part A for the policy process/steps

3.0 GOVERNANCE AND APPROVAL

3.1 Outline Formal Governance Arrangements

3.1.1 The formal governance arrangements for this policy is the responsibility of the HSE National Breastfeeding implementation Group (Appendix IV).

3.2 List method for assessing the policy in meeting the Standards outlined in the HSE National Framework for developing PPPGs.

3.2.1 The draft policy is developed and reviewed by the Primary Care Breastfeeding PPPG Development Group (Appendix II).

3.2.2 All feedback and subsequent changes are accompanied by supporting evidence.

3.2.3 The PPPG Checklist for developing Clinical PPPGs (Appendix V) is signed to ensure compliance with the standards outlined in the PPPG Development Cycle.

3.2.4 The intention to update the national policy was registered with the HSE National Breastfeeding Implementation Group (Appendix IV).

3.2.5 The final policy document is signed by the chairperson of the HSE National

Breastfeeding implementation Group.

3.2.6 The final version is converted to a PDF document to ensure the integrity of the policy.

3.2.7 A signed and dated master copy will be retained in an agreed central location with written or electronic signatures. This will ensure document control before dissemination.

3.3 Attach any copyright/permission sought

The chairperson of the Primary Care Breastfeeding PPPG Development Group has sought permission to update this policy, from the National Breastfeeding Co-ordinator author of the 'Breastfeeding Policy for Primary Care Teams and Community Healthcare setting' (HSE, 2015).

3.4 Insert approved PPPG checklist

Approved PPPG Checklist for developing Clinical PPPGs is included.

4. COMMUNICATION AND DISSEMINATION

A communication and dissemination plan is developed to ensure there is effective communication with all stakeholders and there is a procedure in place for dissemination of this updated National Infant Feeding Policy for Primary Care Teams and Community Health Organisations This will allow all relevant members of the PCT and staff working within the CHO to have easy access to the policy.

4.1 Chief Officers Group

4.1.1 It is the responsibility of the Chief Officer Group to ensure that Heads of Service within the PCT and CHO receive a copy and are aware of the policy update and their responsibility in its implementation.

4.2 Heads of Service

4.2.1 Heads of Service within the PCT and CHO include Heads of Primary Care, Heads of Social Care, Heads of Mental Health, Heads of Health and Wellbeing, Leads in Quality and Professional Development, Dietetic Leads, Community Medical Doctors, GP Leads and Heads of Business Support Function.

4.2.2 Heads of Service have responsibility to ensure the updated policy with links to related procedures and guidance is available for all members of the PCT and staff working within the CHO. The policy or a summary should be displayed in areas of the PCC providing services to pregnant women, infants and young children and their mothers. Where a summary of this policy is displayed in an area of the Primary Care Centre (PCC), a complete version should be available on request for mother / partner/ parent. A statement to this effect should be included in the summary version.

4.2.3 Heads of Service have responsibility to disseminate this updated policy to all members of the PCT and staff working within the CHO (full-time, temporary and agency staff).

4.2.4 Heads of Service have responsibility to ensure all staff are informed of their role in the implementation of this policy update and their responsibility to adhere to this policy update.

4.2.5 Heads of Service have responsibility to ensure each staff member signs the Signature

Sheet (Appendix I), indicating that the staff member has read and understands this policy update. A copy of these records are held by a named individual in a designated area of the PCC.

4.2.6 Heads of Service have responsibility to ensure new staff are informed of and receive a copy of this policy update, are informed of their responsibility to adhere to this update and their role in its implementation. It is the responsibility of Heads of Service to ensure new staff sign the Signature Sheet.

4.3 The Director of Public Health Nursing (DPHN)

4.3.1 The DPHN has responsibility to ensure the updated policy with links to related procedures and guidance is available for all members of the Public Health Nursing Service. The policy or a summary should be displayed in areas of the PCC providing services to pregnant women, infants and young children and their mothers. Where a summary of the policy is displayed in an area of the PCC, a complete version should be available on request for mother and her partner. A statement to this effect should be included on the summary version.

4.3.2 The DPHN has responsibility to disseminate this updated policy to all members of the Public Health Nursing Service (full-time, temporary and agency staff).

4.3.3 The DPHN has responsibility to ensure all staff of the Public Health Nursing Service are informed of their role in the implementation of this policy update and their responsibility to adhere to this policy update.

4.3.4 The DPHN has responsibility to ensure each staff member of the Public Health Nursing Service signs the Signature Sheet (Appendix I), indicating that the staff member has read and understands this policy update. A copy of these records are held by a named individual in a designated area of the PCC.

4.3.5 The DPHN has responsibility to ensure new staff members of the Public Health Nursing Service are informed of and receive a copy of this policy update, are informed of their responsibility to adhere to this update and their role in its implementation. It is the responsibility of DPHNs to ensure new staff sign the Signature Sheet.

4.4 Assistant Directors of Public Health Nursing (ADPHN)

The ADPHN has responsibility to ensure all registered PHNs and midwives (RMs), and and staff not directly involved in caring for the pregnant woman, new mother, her partner and her baby, in the PHN service receive an online copy of this updated policy, are informed of their responsibility in its implementation, and sign the Signature Sheet indicating that they have read and understand the policy. Records of these Signature Sheets are maintained and stored in a designated area of the PCC.

4.5 The Director of Midwifery (DOM)

4.5.1 The DOM has responsibility to ensure the updated policy with links to related procedures and guidance is available for all members of management and registered midwives (RMs) working in Midwifery Led Units, Domino or Early Transfer Home Service. A version of the policy should be available on request for mother/ partner/ parent.

4.5.2 The DOM has responsibility to disseminate this updated policy to all members of

management and RMs working in Midwifery Led Units, Domino or Early Transfer Home Service.

4.5.3 The DOM has responsibility to ensure all members of management and RMs working in Midwifery Led Units, Domino or Early Transfer Home Service are informed of their role in the implementation and their responsibility to adhere to this policy update.

4.5.4 The DOM has responsibility to ensure all members of management and RMs working in Midwifery Led Units, Domino or Early Transfer Home Service signs the Signature Sheet (Appendix I), indicating that the staff member has read and understands this policy update. A copy of these records are held by a named individual in a designated area of the PCC.

4.5.5 The DOM has responsibility to ensure new staff members of Midwifery Led units, Domino or Early Transfer Home are informed of and receive a copy of this policy update, are informed of their responsibility to comply with this update and their role in its implementation. It is the responsibility of the DOM to ensure new staff sign the Signature Sheet.

4.6 All members of the PCT and staff working within the CHO

4.6.1 All members of the PCT and staff working within the CHO have responsibility to read this policy update and sign the Signature Sheet (Appendix I).

4.6.2 All members of the PCT and staff working within the CHO have responsibility to comply with this policy update and integrate it into their work practice.

4.6.3 All members of the PCT and staff working within the CHO have responsibility to be aware of their role in the implementation of this policy update.

4.6.4 All new members of the PCT and staff working within the CHO have responsibility to read this policy update and sign the Signature Sheet. They have a responsibility to be aware of their role in the implementation of this policy update.

4.7 The Public Health Nurse (PHN) and Registered Midwife (RM)

4.7.1 The PHN / RM has responsibility to read this policy update and sign the Signature Sheet (Appendix I).

4.7.2 The PHN / RM has responsibility to comply with this policy update and integrate it into his / her work practice.

4.7.3 The PHN / RM has responsibility to be aware of his / her role in the implementation of this policy update.

4.7.4 All new PHNs / RMs have responsibility to read this policy update and sign the Signature Sheet. They have a responsibility to be aware of their role in the implementation of this policy update.

4.8 PHN / IBCLC dedicated post holder.

4.8.1 It is the responsibility of Heads of Service and Directors of Public Health Nursing to assign the responsibility of co-ordinating training and audit to an appropriate staff member, if the CHO does not have a PHN / IBCLC dedicated post holder.

4.8.2 The PHN / IBCLC dedicated post holder has responsibility to read this policy update and sign the Signature Sheet (Appendix I).

4.8.3 The PHN / IBCLC dedicated post holder has responsibility to comply with this policy update and integrate it into his / her work practice.

4.8.4 The PHN / IBCLC dedicated post holder has responsibility to be aware of his / her role in the implementation of this policy update.

4.8.5 The PHN / IBCLC dedicated post holder has responsibility to accept consultations from staff regarding mothers experiencing breastfeeding challenges and if necessary will accept referrals of mothers and their babies from staff, for specialist breastfeeding review.

5.0 IMPLEMENTATION

5.1 Describe implementation plan listings actions, barriers, facilitators and timelines

The updated Infant Feeding Policy for PCT and CHOs will be disseminated through the HSE National Breastfeeding Implementation Group (Appendix IV) to the Chief Officer Group. This group will then disseminate the policy update to all Heads of Service who have responsibility to disseminate to all members of the PCT and staff working within the CHO (permanent, temporary, agency and new staff). Heads of Service also have responsibility to ensure the implementation of this policy update. Heads of Service will ensure that the policy implementation and effectiveness is audited. Heads of Service have responsibility to ensure all staff have the knowledge, competence and skills to enable them to implement the policy within their role.

5.2 Describe education / training plans required to implement the policy.

5.2.1 Training of staff enables them to develop effective skills, give consistent messages and implement policy standards. All staff must receive training and continuing professional development at a level appropriate to their role to ensure they implement this policy update. All health care and support staff who have contact with pregnant women and mothers of infants and young children, should have the knowledge and skills to support breastfeeding. They should receive training and continuing professional development at a level appropriate to their role to ensure they implement this policy. Upon completion of the core training they should receive breastfeeding updates every two to three years. Core training courses should be accredited by relevant professional bodies.

5.2.2 New staff requiring training must receive this training within six months of taking up their posts, if this training was not received in previous employment/pre service training. Training should include both theoretical knowledge and supervised clinical practice.

5.2.3 All clerical and ancillary staff should be orientated to the policy update and receive training relevant to their role and responsibility.

5.2.4 A record of staff who have received training and those awaiting training should be kept in a designated space within the PCC or CHO and available on request.

5.2.5 Preceptors should ensure all student nurses/PHNs are exposed to infant feeding practices during their placement to build confidence and competence.

5.2.6 Written curricula covering all Ten Steps to Successful Breastfeeding, mother-friendly birth practices, International Code of Marketing and feeding of the infant who is not breastfed should be available for all staff training (Appendix XIV).The newly developed breastfeeding e-learning modules are available on HSELanD. Also a skills based programme of education for the provision of breastfeeding support is currently being developed nationally.

5.3 Chief Officers Group

5.3.1 It is the responsibility of the Chief Officers Group to ensure that the Heads of Service of PCTs and staff working within the CHO are aware of their responsibility in the implementation of this policy update.

5.4 Heads of Service

5.4.1 Heads of Service have responsibility to ensure policy linked training is facilitated for staff relevant to their role and ensure staff are facilitated to participate in this training.

5.4.2 Heads of Service have responsibility to ensure that appropriate training is available for staff to obtain the skills necessary to implement this policy update.

5.4.3 Heads of Service have responsibility to ensure training records are completed and online or hard copy records are stored in a designated area within the PCC or CHO.

5.4.4 Heads of Service have responsibility to ensure this policy implementation and effectiveness is audited.

5.5 Directors of Public Health Nursing (DPHNs)

5.5.1 DPHNs have responsibility to ensure policy linked training is facilitated for staff of the Public Health Nursing Service relevant to their role and ensure staff are facilitated to participate in this training.

5.5.2 DPHNs have responsibility to ensure that appropriate training is available for staff to obtain the skills necessary to implement this policy update.

5.5.3 DPHNs have responsibility to ensure training records are completed and online or hard copy records are stored in a designated area within the PCC or CHO.

5.5.4 DPHNs have responsibility to ensure this policy implementation and effectiveness is audited.

5.5.5 The ADPHNs have responsibility to ensure that all PHNs and RMs and staff not directly involved in caring for the pregnant woman, new mother her partner and her baby, in the PHN service are facilitated to attend training and maintain a copy of training records which are stored in a designated area of the PCC.

5.6 Directors of Midwifery (DOMs)

5.6.1 DOMs have responsibility to ensure policy linked training is facilitated for all members of management and RMs working in Midwifery Led Units, Domino, or Early transfer Home Services relevant to their role and ensure staff are facilitated to participate in this training.

5.6.2 DOMs have responsibility to ensure that appropriate training is available for staff to

obtain the skills necessary to implement this policy update.

5.6.3 DOMs have responsibility to ensure training records are completed and online or hard copy records are stored in a designated area within the maternity services.

5.6.4 DOMs have responsibility to ensure this policy implementation and effectiveness is audited.

5.7 Members of the PCT and staff working within the CHO

5.7.1 Members of the PCT and staff working within the CHO have responsibility to ensure policy linked training is completed relevant to this policy update.

5.7.2 Members of the PCT and staff working within the CHO complete a record of this training.

5.7.3 Members of the PCT and staff working within the CHO account for their practice including identifying any learning and education needs, to their line manager in relation to this policy update.

5.7.4 Staff directly involved in the care of pregnant women, infants and young children and their mothers, must determine their scope of practice, making a clinical judgement as to whether they are competent to carry out a particular role or function relevant to this policy update. It is the staff member's responsibility to take measures to ensure they have the necessary competencies for the integration of this policy into their work practice.

5.8 The Public Health Nurse (PHN) / Registered Midwife (RM)

5.8.1 The PHN / RM has responsibility to ensure policy linked training is completed relevant to this policy update.

5.8.2 The PHN /RM complete a record of this training.

5.8.3 The PHN / RM has responsibility to account for his/her practice including identifying any learning and education needs, to his / her line manager in relation to this policy update.

5.8.4 The PHN / RM involved in the care of pregnant women, infants and young children and their mother's, must determine their scope of practice, making a clinical judgement as to whether they are competent to carry out a particular role or function relevant to this policy update. It is the staff member's responsibility to take measures to ensure they have the necessary competencies for the integration of this policy into their work practice.

5.8.5 The PHN / RM has responsibility in the planning of care and record keeping relevant to this policy update.

5.9 PHN / IBCLC dedicated post holder.

5.9.1 The PHN / IBCLC dedicated post holder has responsibility to be aware of his/her role in the implementation of this policy update.

5.9.2 The PHN / IBCLC dedicated post holder has responsibility to facilitate policy linked training.

5.9.3 The PHN / IBCLC dedicated post holder has responsibility to ensure that appropriate breastfeeding and lactation management training and skills development is available for staff to have sufficient knowledge, competency and skills to support women to breastfeed, and to implement this policy.

5.9.4 The PHN / IBCLC dedicated post holder maintains a record of staff who have received training and those awaiting training, and online or hard copy records are stored in a designated area within the PCC and are available on request.

5.9.5 The PHN / IBCLC dedicated post holder has responsibility to ensure this policy implementation and effectiveness is audited.

6.0 MONITORING, AUDIT AND EVALUATION

6.1 Describe the plan and identify lead person(s) responsible for the following processes:

6.1.1 Heads of Service have responsibility to ensure the updated policy is monitored and a named health care professional within the PCT or staff member working within the CHO is assigned this responsibility.

6.1.2 Heads of Service have responsibility to ensure this policy update is audited and a named health care professional within the PCT or working within the CHO is assigned this responsibility.

6.1.3 Heads of Service have responsibility to ensure there is evaluation of the implementation and effectiveness of this policy by a named health care professional within the PCT or staff member working within the CHO.

7.0 REVISION/UPDATE

7.1 Describe procedure for the update of the PPPG (including date for revision).

The update of this National Infant feeding Policy for PCTs and CHOs will take place on a consistent, planned ongoing basis. The revision date will be agreed by members of the Primary Care Breastfeeding PPPG Development Group involved in the development of the document.

Updates will be carried out every three years unless the need to revise the policy is identified. If there are no amendments required to the policy following the revision date, details on the version tracking box must still be updated which will be a new version number and date.

7.2 Identify method for amending PPPG if new evidence emerges.

New evidence may emerge by audit evaluation, serious incident, organisational structural change, scope of practice change, advances in technology or significant changes in international evidence or legislation. The Primary Care Breastfeeding PPPG Development Group will refer to the process to ensure that the learning from the policy development and implementation process is used to amend and update or revise the original policy as new evidence emerges.

7.3 Complete version control update on PPPG Template cover sheet

8.0 REFERENCES AND BIBLIOGRAPHY

9.0 APPENDICES

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Appendix XV The Ten Steps to Successful Breastfeeding (Revised 2018).

8.0 REFERENCES AND BIBLIOGRAPHY

Aaserud T, Tveiten S and Gjerlaug A. Home visits by Midwives in the early Postnatal Period. *Norwegian Journal of Clinical Nursing.*2017;12: p.1-12.

Datta J, Graham B and Wellings K. The Role of Fathers in Breastfeeding: Decision-making and Support. *British Journal of Midwifery.* 2012; 20: p. 159-167.

Dennis C and Faux S. Development and Psychometric Testing of the Breastfeeding Self – Efficacy Scale. *Research in Nursing & Health.* 1999; 22: p. 399-409.

Department of Health (DoH). *A Healthy Weight for Ireland. Obesity Policy and Action Plan 2016-2025.* Government Publications: Dublin; 2016.

Department of Health (DoH). *Creating a Better Future Together*: *National Maternity Strategy 2016-2026.* Government Publications: Dublin; 2016.

Department of Health. (DoH). *Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2025.* Government Publications: Dublin; 2013.

Fox R, McMullen S, and Newburn M. UK Women's experiences of Breastfeeding and additional Breastfeeding Support: A Qualitative study of Baby Café Services. *BioMed Central Pregnancy and Childbirth.* 2015; 15: 147.

Harbron J & Booley S. Responsive Feeding: Establishing Healthy Eating Behaviour Early on in Life. *South African Journal of Clinical Nutrition.* 2013; 26.

Health Service Executive. *Breastfeeding & Expressing for Your Premature or Sick Baby.* Dublin: HSE; 2016.

Health Service Executive. *Breastfeeding – A Good Start in Life.* Dublin: HSE; 2015.

Health Service Executive. *Breastfeeding in a Healthy Ireland – Health Service Breastfeeding Action Plan 2016-2021. Dublin:* HSE; 2016.

Health Service Executive. *Breastfeeding Policy for Primary Care Teams and Community Healthcare Settings*. Dublin: HSE; 2015.

Health Service Executive. *Feeding Your Baby- Introducing Family Meals*. Dublin: HSE; 2015.

Health Service Executive. *Guidelines for the Observation and Assessment of a Breastfeed and use of the Breastfeeding Observation and Assessment Tool Resource.* Dublin: HSE; 2017.

Health Service Executive. *National Consent Policy*. Dublin: HSE; 2013

Health Service Executive. *National Infant Feeding policy for Maternity and Neonatal Services.* Dublin: HSE; 2015.

Health Service Executive. *Safe Sleep for Your Baby – Reduce the risk of Cot Death* Dublin: HSE; 2016.

HIQA. *National Standards for Safer Better Maternity Services*. Ireland: HIQA; 2016

Hjalmhult E and Lomborg K. Managing the First Period at Home with a Newborn: A Grounded Theory study of Mothers' Experiences. *Scandinavian Journal of Caring Sciences.* 2012; 26(4): p.654-662.

Huggins K. *The Nursing Mother's Companion.* 6th Ed. USA: The Harvard Common Press; 2010.

Hunter L. Teenagers Experiences of Postnatal Care and Breastfeeding. *British Journal of Midwifery.* 2008; 16(2): p. 785-790.

Larsen J and Kronborg H. When Breastfeeding is Unsuccessful – Mothers Experiences after Giving Up Breastfeeding. *Scandinavian Journal of Caring Sciences.* 2013; 27(4): p. 848-856.

Lawrence R and Lawrence R. *Breastfeeding- A Guide for the Medical Profession.* 8th Ed. Philadelphia: Elsevier; 2016.

McAvoy, H, Cotter, N., Purdy, J, Cleary, O, and Keating, T. Review and Evaluation of Breastfeeding in Ireland – A 5 Year Strategic Action Plan 2005 – 2010. Dublin: Institute of Public Health in Ireland and the Health Service Executive. 2014.

McFadden A, Gavine A, Renfrew M, Wade A, Buchanan P, Taylor J, Veitch E, Rennie A, Crowther S, Neiman S and MacGillivray S. Support for Healthy Breastfeeding Mothers with Healthy Term Babies. *Cochrane Database Systematic Review.* 2017; 28; 2: CD001141.

McGregor E and Hughes M. Breastfeeding Experiences of Mothers from Disadvantaged Groups: A Review. *Community Practitioner.* 2010; 83(7): p. 30-33.

Mulcahy H, O'Connor M, and Leahy-Warren P. A Pilot Educational Initiative to Enhance Student Public Health Nurses Breastfeeding Support Competence. *Internal Medicine Review.* 2017; 3(10): p. 1-9.

Mulcahy H, Phelan A, Corcoran P and Leahy-Warren P. Examining the Breastfeeding Support Resources of the Public Health Nursing Service in Ireland. *Journal of Clinical Nursing.* 2012; 21(7-8): p. 1097-1108.

NMBI. *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives*. Dublin: NMBI; 2014. https://www.nmbi.ie/nmbi/media/NMBI/Publications/Code-of-professional-Conduct-and-Ethics.pdf?ext=.pdf (Accessed June 2017).

NMBI. *Recording Clinical Practice – Professional Guidance*. Dublin: NMBI; 2015. https://www.nmbi.ie/nmbi/media/NMBI/Publications/recording-clinical-practice-professional-guidance.pdf?ext=.pdf (Accessed Nov 2018).

NMBI. *Public Health Nursing Education Programme- Standards and Requirements.* Dublin: NMBI; 2015

Pérez -Escamilla R, Martinez JL, Segura-Pérez S. Impact of Baby Friendly Hospital Initiative on Breastfeeding and Child Health Outcomes: A Systematic Review. *Maternal Child Nutrition.* 2016; 12(3): p. 401-417. Doi: 10.1111/mcn.12294.

Rollins N, Bhandari N, Hajeebhoy N, Horton S, Lutter C, Martinez J, Piwoz E, Richter L and Victora C. Why Invest, and what it will take to Improve Breastfeeding Practices? *The Lancet*. 2016; 387: p.17 - 30.

Royal College of Paediatrics and Child Health. *Position Statement: Breastfeeding in the UK.* UK: RCPCH; 2017.

Rosen – Carole C, Hartman S and the Academy of Breastfeeding Medicine. ABM Clinical Protocol 19: Breastfeeding Promotion in the Prenatal Setting, Revision 2015. *Breastfeeding Medicine*. 2015; 10: p.451-457.

Safefood and HSE. *How to Prepare your Baby's Bottle*. Dublin: HSE; 2017.

Sankar M, Sinha B, Chowdhury R, Bhandari N, Taneja S, Martines J and Bahl R. Optimal Breastfeeding Practices and Infant and Child Mortality: A Systematic Review and Meta-Analysis. *Acta Paediatrica.* 2015; 104(S467): p.3-13.

Sherriff N and Hall V. Engaging and Supporting Fathers to Promote Breastfeeding: A New Role for Health Visitors. *Scandinavian Journal of Caring Sciences.* 2011; 25(3): p. 467-475.

Shortt E, McGorrian C and Kelleher C. A Qualitative Study of Infant Feeding Decisions among Low income Women in the Republic of Ireland. *Midwifery.* 2013; 29(5): p.453-460.

Sutton M, O'Donoghue E, Keane M, Farragher L and Long J. *Interventions that Promote Increased Breastfeeding rates and Breastfeeding duration among Women. An Umbrella Review.* Health Research Board: Dublin; 2016.

Tarrant R, Younger K, Sheridan- Pereira M, and Kearney J. Factors Associated with Duration of Breastfeeding in Ireland: Potential Areas for Improvement. *Journal of Human Lactation.* 2011; 27 (3): p. 262-271.

United Nations International Children's Emergency Fund /United Kingdom/Baby Friendly Initiative. *Sample Infant Feeding Policy (Health Visiting).* UK: UNICEF/Baby Friendly; 2015. https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2016/08/sample_hv_policy.pdf (Accessed 24-10-17)

United Nations International Children's Emergency Fund /United Kingdom/Baby Friendly Initiative. Having Meaningful Conversations with Mothers. A Guide to Using the Baby Friendly Signature Sheets. UK: UNICEF/Baby Friendly; https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2016/10/meaningful_conversations.pdf (Accessed 20-11-17)

United Nations International Children's Emergency Fund /World Health Organisation. *Protecting, Promoting and Supporting Breastfeeding in facilities providing maternity and newborn services: The Revised Baby Friendly*

Hospital Initiative. Geneva: WHO; 2018. http://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018.pdf (Accessed 02-05-18)

Victora C, Bahl R, Barros A, Franca G, Horton S, Krasevec J, Murch S, Sankar M.J, Walker N, and Rollins N, Breastfeeding in the 21st Century: Epidemiology, mechanisms, and lifelong effect. *The Lancet*. 2016. Vol. 387: p.475-490.

Wagner E, Chantry C, Dewey K, Nommsen- Rivers L. Breastfeeding Concerns at 3 and 7 days Postpartum and Feeding Status at 2 Months. *Pediatrics.* 2013; 132 (4).

Walker M. *Breastfeeding Management for the Clinician, Using the Evidence*. 4th Ed. Massachusetts: Jones and Bartlett; 2016

Wambach K and Riordan J. *Breastfeeding and Human Lactation.* Enhanced 5th Ed. Boston: Jones and Bartlett; 2016.

Wellchild. *Guidelines for the Investigation of Newborn Infants who suffer a Sudden and Unexpected Postnatal Collapse in the first Week of Life- Recommendations from a Professional Group on Sudden Unexpected Postnatal Collapse*. London; 2010.

Wilson-Clay B and Hoover K. *The Breastfeeding Atlas.* 5th Ed. Texas: LactNews Press; 2013.

World Health Organisation/ United Nations International Children's Fund (WHO/UNICEF). *Global Strategy for Infant and Young Child Feeding.* Geneva: WHO; 2003.

WHO. *Guideline Protecting, Promoting and Supporting Breastfeeding in Facilities providing maternity and newborn services.* Geneva: WHO; 2017.

http://apps.who.int/iris/bitstream/10665/259386/1/9789241550086-eng.pdf

(Accessed 09-11-17)

WHO/UNICEF. *Protecting, Promoting and Supporting Breastfeeding: The special role of the maternity services.* Geneva: WHO; 1989.

Yan J, Liu L, Huang G and Wang P. The Association between Breastfeeding and Childhood Obesity: A Metanalysis. *BioMed Central Public Health.* 2014; 14: 1267.

http://apps.who.int/iris/bitstream/10665/254911/1/WHO-NMH-NHD-17.1-eng.pdf?ua=1 (Accessed 24-07-17)

https://iblce.org/ (Accessed 21-07-17)

https://www.breastfeeding.ie/ (Accessed 21-07-17)

https://www.breastfeeding.ie/Uploads/files/Feeding-Cues-Infographic-English.pdf (Accessed 24-07-17)

https://www.breastfeeding.ie/Uploads/The-use-of-soothers-and-nipple-shields.pdf (Accessed 24-07-17)

https://www.breastfeeding.ie/Support-search/ (Accessed 08-05-17)

https://www.healthpromotion.ie/hp-files/docs/HPM00367.pdf (Accessed 24-07-17)

https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/guidance-for-health-professionals/tools-and-forms-for-health-professionals/breastfeeding-assessment-tools/ (Accessed 08-05-17)

https://www.breastfeeding.ie/First-few-weeks/Guidelines-for-mothers/ (Accessed 08-01-18)

Appendix I:

Signature Sheet

I have read, understand and agree to adhere to this PPPG National Infant Feeding Policy for Primary Care Teams and Community Health Organisations.

Print Name	Signature	Area of Work	Date

Appendix II:

Membership of the PPPG Development Group

The members of the Primary Care Breastfeeding PPPG Development Group involved in the development of the document.

Siobhan Hourigan	Signature: Siobhan Hourigan
National Breastfeeding Coordinator	Date: 17/5/17
Una Dee	Signature: Una Dee
AD PHN/IBCLC	Date: 10/5/17
Mary O' Connor	Signature: Mary O'Connor
PHN/IBCLC	Date: 10/5/2017
Siobhan Bruton	Signature: Siobhán Bruton
PHN/IBCLC	Date: 10/05/17
Eileen Duggan	Signature: Eileen Duggan
PHN/IBCLC	Date: 10/5/17
Mary Creedon	Signature: Mary Creedon
PHN/IBCLC	Date: 10/5/17
Lynn Stoddart	Signature: Stoddart
Assistant Director of Public Health Nursing / IBCLC	Date: 10/5/17
Chairperson:	
Rebecca O Donovan	Signature:
Assistant National Breastfeeding Coordinator	Date: 10/5/17.

Appendix III:

Conflict of Interest Declaration Form

CONFLICT OF INTEREST DECLARATION

This must be completed by each member of the Primary Care Breastfeeding PPPG Development Group

_____

Please circle the statement that relates to you

1. I declare that I DO NOT have any conflicts of interest.

2. I declare that I DO have a conflict of interest.

Details of conflict (Please refer to specific PPPG)

_____
_____
_____
_____
_____

(Append additional pages to this statement if required)

Signature

Printed name

Registration number (if applicable)

Date

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that committee members act in the best interests of the committee. The information provided will not be used for any other purpose.

A person who is covered by this PPPG is required to furnish a statement, in writing, of:

(i) The interests of the person, and

(ii) The interests, of which the person has actual knowledge, of his or her spouse or civil partner or a child of the person or of his or her spouse which could materially influence the person in, or in relation to, the performance of the person's official functions by reason of the fact that such performance could so affect those interests as to confer on, or withhold from, the person, or the spouse or civil partner or child, a substantial benefit.

Appendix IV: Membership of the Approval Governance Group - The HSE National Breastfeeding Implementation Group

Name	Signature
Dr. Phil Jennings Director of Public Health. National Lead Healthy Childhood Prog	
Chairperson: Carmel Brennan Programme Manager National Healthy Childhood Programme	
Janet Gaynor Manager Health Promotion and Improvement HSE West	
Dr. Melissa Canny Specialist in Public Health Medicine	
Cara O Neill Health and Wellbeing Rep CHO 1	
Denise Curran Health and Wellbeing Rep CHO X	
Laura Mc Hugh National Breastfeeding Coordinator	
Rebecca O'Donovan Assistant National Breastfeeding Co-Ordinator	11/7/18
Margaret O'Neill National Dietetic Advisor	
Sarah O'Brien Lead Healthy Eating & Active Living Programme	
Jacinta Egan Admin Assistant National Healthy Childhood Programme	

Appendix V:

PPPG Checklist for Developing Clinical PPPGs

(This PPPG Checklist was developed to assist staff to meet standards when developing Clinical PPPGs)

Standards for developing Clinical PPPG	Checklist
Stage 1 Initiation	
The decision making approach relating to the type of PPPG guidance required (policy, procedure, protocol, guideline), coverage of the PPPG (national, regional, local) and applicable settings are described.	√
Synergies/co-operations are maximised across departments/organisations (Hospitals/Hospital Groups/Community Healthcare Organisations (CHO)/National Ambulance Service (NAS)), to avoid duplication and to optimise value for money and use of staff time and expertise.	√
The scope of the PPPG is clearly described, specifying what is included and what lies outside the scope of the PPPG.	√
The target users and the population/patient group to whom the PPPG is meant to apply are specifically described.	√
The views and preferences of the target population have been sought and taken into consideration (as required).	√ (healthcare professionals)
The overall objective(s) of the PPPGs are specifically described.	√
The potential for improved health is described (e.g. clinical effectiveness, patient safety, quality improvement, health outcomes, quality of life, quality of care).	√
Stakeholder identification and involvement: The PPPG Development Group includes individuals from all relevant stakeholders, staff and professional groups.	√
Conflict of interest statements from all members of the PPPG Development Group are documented, with a description of mitigating actions if relevant.	**N/A**
The PPPG is informed by the identified needs and priorities of service users and stakeholders.	√
There is service user/lay representation on PPPG Development Group (as required).	**N/A**
Information and support is available for staff on the development of evidence-based clinical practice guidance.	√

Stage 2 Development	Checklist
The clinical question(s) covered by the PPPG are specifically described.	**N/A**
Systematic methods used to search for evidence are documented (for PPPGs which are adapted/adopted from international guidance, their methodology is appraised and documented).	√
Critical appraisal/analysis of evidence using validated tools is documented (the strengths, limitations and methodological quality of the body of evidence are clearly described).	√
The health benefits, side effects and risks have been considered and documented in formulating the PPPG.	√ (health benefits of breastfeeding)
There is an explicit link between the PPPG and the supporting evidence.	√
PPPG guidance/recommendations are specific and unambiguous.	√
The potential resource implications of developing and implementing the PPPG are identified e.g. equipment, education/training, staff time and research.	**N/A** (update of previous policy)
There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care.	**N/A**
Budget impact is documented (resources required).	**N/A**
Education and training is provided for staff on the development and implementation of evidence-based clinical practice guidance (as appropriate).	√ (Elearning programme)
Three additional standards are applicable for a small number of more complex PPPGs: Cost effectiveness analysis is documented. A systematic literature review has been undertaken. Health Technology Assessment (HTA) has been undertaken.	**N/A**
Stage 3 Governance and Approval	**Checklist**
Formal governance arrangements for PPPGs at local, regional and national level are established and documented.	√

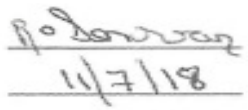
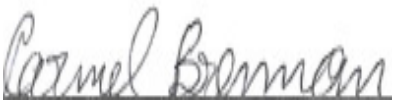
The PPPG has been reviewed by independent experts prior to publication (as required).	**N/A**
Copyright and permissions are sought and documented.	**N/A**

Stage 4 Communication and Dissemination	**Checklist**
A communication plan is developed to ensure effective communication and collaboration with all stakeholders throughout all stages.	√
Plan and procedure for dissemination of the PPPG is described.	√
The PPPG is easily accessible by all users e.g. PPPG repository.	√
Stage 5 Implementation	**Checklist**
Written implementation plan is provided with timelines, identification of responsible persons/units and integration into service planning process.	√
Barriers and facilitators for implementation are identified, and aligned with implementation levers.	√
Education and training is provided for staff on the development and implementation of evidence-based PPPG (as required).	√
There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care.	**N/A**
Stage 6 Monitoring, Audit, Evaluation	**Checklist**
Process for monitoring and continuous improvement is documented.	√
Audit criteria and audit process/plan are specified.	√ (via Baby Friendly Standards)
Process for evaluation of implementation and (clinical) effectiveness is specified.	√ (via Baby Friendly Standards)
Stage 7 Revision/Update	**Checklist**
Documented process for revisions/updating and review, including timeframe is provided.	√
Documented process for version control is provided.	√

I confirm that the above Standards have been met in developing the following:

Title of PPPG: National Infant Feeding Policy for CHOs

Name of Person(s) signing off on the PPPG Checklist:

Name: Rebecca O Donovan **Title:** Assistant National Breastfeeding Coordinator	
Name: Carmel Brennan **Title:** Programme Manager National Healthy Childhood Programme (Chairperson National Breastfeeding Implementation Group)	

This signed PPPG Checklist must accompany the final PPPG document in order for the PPPG to be approved.

Appendix VI:

International Code of Marketing of Breastmilk Substitutes

What is the Code?

The Code was adopted in 1981 by the World Health Assembly (WHA) to promote safe and adequate nutrition for infants, by the protection and promotion of breastfeeding and by ensuring the proper use of breast-milk substitutes, when these are necessary. One of the main principles of the Code is that health care facilities should not be used for the purpose of promoting breast milk substitutes, feeding bottles or teats. Subsequent WHA resolutions have clarified the Code and closed some of the loopholes, including maternity wards should purchase breastmilk substitutes, complementary foods are not marketed in ways that undermine exclusive and sustained breastfeeding and nutrition and health claims are not permitted for breastmilk substitutes (WHO, 2017)

Which products fall under the scope of the Code?

The Code applies to breast milk substitutes when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breast milk. Special formulas for infants with special medical or nutritional needs also fall under the scope of the Code.

Since exclusive breastfeeding is to be encouraged for 6 months, any food or drink during this period is a breast milk substitute and thus covered by the Code. This would include baby teas, juices and waters, as well as cereals, processed baby meals, including bottle-fed complementary foods, and other products marketed or otherwise represented for use before six months.

Since continued breastfeeding is to be encouraged for two years or beyond, any milk product shown to be substituting for the breast milk part of the child's diet between six months and two years, such as follow-on formula, is a breast-milk substitute and is thus covered by the Code.

The Code also applies to feeding bottles, teats and soothers.

What does the Code say?

The main points in the Code include:

- No advertising of breast-milk substitutes and other related products to the public;
- No free samples to mothers or their families;
- No promotion of products, i.e. no product displays, posters, calendars, or distribution of promotional materials;
- No donations of free or subsidised supplies of breast-milk substitutes or related products in any part of the health care system;
- No company-paid personnel to contact or to advise mothers;
- No gifts or personal samples to health workers;
- No pictures of infants, or other pictures or text idealizing artificial feeding, on the labels of the products;
- Information to health workers should only be scientific and factual;
- Information on artificial feeding should explain the importance of breastfeeding, the health hazards associated with artificial feeding and the costs of using artificial feeding ;
- All products should be of a high quality, and unsuitable products, such as sweetened condensed milk, should not be promoted for babies.

Who is a "health worker" for the purposes of the Code?

According to the Code, any person working in the health care system, whether professional or non-professional, including voluntary and unpaid workers, in public or private practice, is a health worker. Under

this definition, ward assistants, health care assistants, housekeeping, nurses, midwives, social workers, dieticians, physiotherapists in-hospital pharmacists, doctors, administrators, clerks, etc. are all health workers.

What are a hospital and health worker's responsibilities under the Code?

1. ***Encourage and protect breastfeeding****.*

Health workers involved in maternal and infant nutrition should make themselves familiar with their responsibilities under the Code, and be able to explain the following:

- The importance and superiority of breastfeeding;
- The role of maternal nutrition in breastfeeding;
- The preparation for and maintenance of breastfeeding;
- The negative effect on breastfeeding of introducing partial bottle-feeding;
- The difficulty of reversing the decision not to breastfeed; and where needed, the proper use of infant formula, whether manufactured industrially or home-prepared.

When providing information on the use of infant formula, health workers should be able to explain:

- The social and financial implications of its use;
- The health hazards of inappropriate foods or feeding methods; and
- The health hazards of unnecessary or improper use of infant formula and other breast-milk substitutes.

2. Ensure that the health facility is not used for the display of products within the scope of the Code, for placards or posters concerning such products, including logos of manufacturers. Ensure that packages of breast milk substitutes and other supplies purchased by the health facility are not on display or visible to mothers.
3. Refuse any gifts offered by manufacturers or distributors**,** including mugs, pens, Post-its, entertainment or financial support.
4. Refuse samples (meaning single or small quantities) of infant formula or other products within the scope of the Code, or of equipment or utensils for their preparation or use, unless necessary for the purpose of professional evaluation or research at the institutional level.
5. Never pass any samples to pregnant women, mothers of infants and young children, or members of their families. Samples of infant formula should not be given to mothers on discharge.
6. Disclose any contribution made by a manufacturer or distributor for fellowships, study tours, research grants, attendance at professional conferences, or the like to management of the health facility.
7. Be aware that support and other incentives for programmes and health professionals working in infant and young-child health should not create conflicts of interests.

Adapted from: UNICEF/WHO, *Baby-friendly Hospital Initiative: revised, updated and expanded for integrated care***,** *Section 1, Background and Implementation*, 2008 and

World Health Organisation. *The International Code of Marketing of Breast-Milk Substitutes. Frequently Asked Questions 2017 Update.* Geneva: WHO; 2017

Appendix VII: - Sample NNU Letter

PHN Discharge Letter

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Parents Details: Name: Discharge Address: Home Address: Contact Number: Mobile Number:		Hospital: Contact Number: GP:	
Baby Details Name: DOB: Birth History: Gestation: Type of delivery: Birth Weight: Discharge Weight: Weekly weight gain pre discharge:		Diagnosis	
Nutrition	*Breastfeeding* Expressing: Nipple Shield: Y N	*Formula*	*Other*
Feeding History (including any difficulties)			
Screening	*Newborn Bloodspot Screening* Date taken: Repeat: y n Date:	*Audiology* Date: Follow up: y n	Hips Other
Vaccinations/ Current Medications		Follow up: OPD GP Other	
Other Information:(e,g social history;bonding & attachment)			

Centile Chart with last plotted centile pre discahrge given to parent: □

Discharge Nurse Signature:_____ Print Name_____

Appendix VIII:

Breastfeeding Observation and Assessment Tool (BOAT) Resource - Page 1

Breastfeeding Observation Assessment Tool

(Please complete at the first or primary visit. This resource may also be used at subsequent visits. Always use a colour version)

Mother's Name: _____ Address: _____ Tel : _____ Mothers D.O. B: _____ Type of Birth: _____ Verbal Consent Given: Yes ☐ No ☐	Baby's Name: _____ DOB: _____ Baby's Age: _____ Baby's Birth Weight: _____ % Weight Loss_____ Current Weight: _____	Assessment performed by: Name: _____ Public Health Nurse / Registered Midwife (PHN/ RM) Date: _____

How to use the BOAT

- Please see *Guideline - Observation of a Breastfeed & Use of the BOAT*
- Observe the baby breastfeeding (following mother's verbal consent) and ensure correct positioning and attachment of baby to the breast
- Complete the BOAT resource, at the first/primary visit, by asking or observing all points in the white column on page 2
- Effective Breastfeeding is indicated if all boxes in the green column on page 2 are ticked. Please then go to green box (opposite) →
- If the amber column on page 2 has boxes ticked, it suggests a challenge with breastfeeding. Please then go to amber box (opposite) →

Green Box - Effective Breastfeeding

- Continue breastfeeding with PHN/RM support
- Encourage attendance at local breastfeeding support groups
- The following is the link to support groups facilitated by the HSE and voluntary breastfeeding groups

https://www.breastfeeding.ie/Support-search/

Amber Box - Suggestive of a Breastfeeding Challenge

- If there is an underlying medical issue for mother or baby the PHN / RM refers to the GP
- If there is a breastfeeding challenge the PHN / RM develops a care plan, takes corrective action, and refers to breastfeeding support group
- The PHN / RM revisits, and repeats the BOAT based on clinical judgment
- The PHN / RM continues corrective action until the breastfeeding challenge resolves
- If the challenge is not resolved the PHN / RM consults with or refers to a specialist breastfeeding professional (IBCLC) & includes BOAT.

Day	Wet Nappies	Dirty Nappies (Mohrbacher and Kendall Tackett, 2010, p.92)
1.	1 wet nappy + (over 24 hours)	One stool (black)+
2.	2 wet nappies +	Two stools (black)+
3.	3 wet nappies +	Three stools (black or greenish)+
4.	4 wet nappies +	Three to four stools (greenish or yellowish)+
5.	5 wet nappies +	Stools should turn yellow
6 days to 6 weeks	6 wet nappies +(pale, yellow or clear urine)	3 - 8 stools + (yellow, seedy, runny to loose) daily
6 weeks to 6 months		3 -5 stools + (daily but may skip days). (Yellow, soft may thicken over time because of milk compositional changes) (Wambach and Riordan, 2016, p.295)
Percentage weight loss calculation:	Weight loss ÷ birth weight x 100= % weight loss	Example weight loss = 226g. Birth Weight = 3500kg. 226 ÷ 3500 x 100 = 6.45% weight loss

1

Appendix VIII:

Breastfeeding Observation and Assessment Tool (BOAT) Resource - Page 2

What to observe / ask about	Green Column-Answer indicating Effective Breastfeeding		Amber Column-Answer Suggestive of a Breastfeeding Challenge	
Mother:	Mother looks healthy		Mother looks ill or unwell	
	Mother is relaxed and comfortable		Mother looks tense or uncomfortable	
	There is good eye contact between mother and baby		There is no eye contact between mother and baby	
Baby's wet nappies	Refer to wet nappies section page 1.		Refer to wet nappies section page 1.	
Appearance and Frequency of Baby's Stools?	Refer to dirty nappies section page 1.		Refer to dirty nappies section page 1.	
Baby's Colour, Alertness and Tone?	Baby may have evidence of normal physiological jaundice; Baby is alert; Baby has good tone		Baby's jaundice is worsening or not improving; baby is lethargic; not waking to feed; has poor tone	
Weight of Baby (following initial post birth loss)?	Baby's weight loss is < 10% of birth weight. (To record % weight loss see percentage weight loss calculation section page. 1). It is expected that babies will regain their birth weight by day 14.		Baby's weight loss is > 10% of birth weight. (To record % weight loss see percentage weight loss calculation section page 1. Birth weight is not regained by day 14.	
Number of Breastfeeds in the last 24 hours?	Baby breastfeeds on demand, or is fed responsively according to early feeding cues, with at least 8-12 feeds in a 24 hour period		Baby had fewer than 8 breastfeeds in the last 24 hour period	
Baby's behaviour during the Breastfeed?	Baby is generally relaxed and calm		The baby is unsettled during the breastfeed, or refuses to breastfeed	
Sucking pattern during the Breastfeed?	Initial rapid sucks changing to slower sucks with pauses and audible regular soft swallowing (may be less audible until milk comes in)		No change in sucking pattern, presence of noisy feeding (e.g. clicking)	
Type of Breastfeed?	Baby feeds actively from first breast until satisfied		Baby is unsatisfied despite regular breastfeeds	
Offer of Second Breast?	Second breast offered as recommended when establishing milk supply. Baby feeds from second breast or not, according to appetite		Mother restricts the baby to one breast per feed	
End of the Breastfeed?	Baby lets go spontaneously, or does so when breast is gently lifted		Baby does not release the breast spontaneously , mother removes the baby	
Baby's Behaviour after a Breastfeed?	Baby is content after most feeds		Baby is unsettled after breastfeeding	
Shape of Nipples at the end of the Breastfeed	The nipples are rounded similar to when the breastfeed began or the nipples may be slightly elongated		Nipples are misshapen or pinched at the end of the breastfeed	
Mother's report on her Nipples and Breasts	Nipples and breasts are comfortable		Nipples are sore or damaged, breasts are uncomfortable	
Observation of the Mothers Nipples and Breasts	Nipples are intact. Breasts are comfortable with no redness, lumps or areas of tenderness		Nipples may be infected, have symptoms of thrush or vasospasm. Mother's breasts may be engorged or have signs of mastitis. Yes (state which)	
Use of Dummy, Nipple Shields / Formula?	None used		Yes (state which) Ask why:	

(Content adapted from the Unicef UK Baby Friendly Initiative's Breastfeeding Assessment Tool and Dublin North Local Health Organisation's BOAT)

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Appendix IX:

Sample Care Plan

Care Plan

Following a joint discussion and assessment of how breastfeeding is going the following care plan has been developed, discussed and agreed with the mother. The care plan is placed in the mother's / baby's notes

Mother's Name: **Address:** _____ **Tel :** _____ **Mothers D.O. B:** _____ **Type of Birth:** _____ **Discussion with mother re Care Plan** **Yes** ☐	**Baby's Name:** **DOB:**_____ **Baby's Age:**_____ **Baby's Birth Weight:**_____ **% Weight Loss**_____ **Current Weight:** _____	**Care Plan completed by:** **Name:** _____ **PHN / RM** **Date:** _____

Date and Time	Need Identified	Action Plan/ Intervention	Expected Goal	Evaluation Timeframe	Outcome	Signature

Appendix X:

Sample Referral Form (BOAT)

Breastfeeding Challenge - Pathway of Referral to Specialist Breastfeeding Professional

If there is an underlying medical issue for mother or baby the PHN / RM refers to the GP

If there is a breastfeeding challenge identified from completion of the BOAT the PHN / RM develops a care plan, takes corrective action, and refers to breastfeeding support group

The PHN / RM revisits and repeats the BOAT based on clinical judgment

The PHN / RM continues corrective action until the breastfeeding challenge resolves

If the challenge is not resolved the PHN / RM consults with or refers to a HSE specialist breastfeeding professional (IBCLC) & includes BOAT

HSE Specialist Breastfeeding Professional (IBCLC)

Name

Email

Phone

1

Appendix XI:

Positioning during Skin to Skin Contact in the time immediately after birth

- The position of the infant is a key factor in minimizing the risk of Sudden Unexpected Postnatal Collapse (SUPC) while in skin to skin contact.
- Positioning in skin to skin contact Mother, or other person providing skin-to-skin contact, is in a slightly upright position, not lying flat Infant is dried, including hair, and positioned when at rest and not actively moving with legs flexed, shoulders flat against mother's chest, chest to chest with mother, not under or between breasts, head turned to one side with neck straight, not bent far forward or far back, face uncovered with nose and mouth visible and covered with dry blankets, with infant wearing a hat/cap if the room is cold or baby is low birth weight.
- Baby may be lying lengthways on mother's chest or across her chest above the level of her breasts.
- The midwife or recovery room nurse must educate mother and support person on the above points and assess the risk factors to determine the level of supervision required. Surveillance by the health professional responsible is recommended during the first hour post-birth, and appropriate supervision and parent education is provided during separate periods of skin to skin contact.
- The Neonatal Resuscitation Program (NRP) (in Ludington –Hoe and Morgan,2014) recommends that a health professional observes the following while infants are in skin to skin contact immediately after birth infant breathing (easy, grunting/flaring, retractions, tachypneic) activity (sleep, quiet alert, active alert/crying/breastfeeding/moving, non-responsive) colour (pink, pale, dusky) tone (head turned to one side, neck straight, face uncovered with nose and mouth visible), and well flexed extremities when the infant is lying prone on his/her abdomen.

Bibliography

Ministry of Health New Zealand, Observation of mother and baby in the immediate postnatal period: Consensus statements guiding practice – July 2012. http://www.health.govt.nz/publication/observation-mother-and-baby-immediate-postnatal-period-consensus-statements-guiding-practice

Neonatal Resuscitation Program (NRP) in Ludington-Hoe, S.M. and Morgan, K. (2014) Infant Assessment and Reducing Sudden Unexpected Postnatal Collapse During Skin to Skin Contact. Newborn and Infant Nursing News.14 (1):28-33. http://www.medscape.com/viewarticle/822017

Appendix XII:

Acceptable Medical Reasons for Use of Breastmilk Substitutes (WHO, 2009)

Introduction

Almost all mothers can breastfeed successfully, which includes initiating breastfeeding within the first hour of life, breastfeeding exclusively for the first 6 months and continuing breastfeeding (along with giving appropriate complementary foods) up to 2 years of age or beyond. Exclusive breastfeeding in the first six months of life is particularly beneficial for mothers and infants.

Positive effects of breastfeeding on the health of infants and mothers are observed in all settings. Breastfeeding reduces the risk of acute infections such as diarrhoea, pneumonia, ear infection, Haemophilus influenza, meningitis and urinary tract infection (1). It also protects against chronic conditions in the future such as type I diabetes, ulcerative colitis, and Crohn's disease.

Breastfeeding during infancy is associated with lower mean blood pressure and total serum cholesterol and with lower prevalence of type-2 diabetes, overweight and obesity during adolescence and adult life (2). Breastfeeding delays the return of a woman's fertility and reduces the risks of post-partum haemorrhage, pre-menopausal breast cancer and ovarian cancer (3).

Nevertheless, a small number of health conditions of the infant or the mother may justify recommending that she does not breastfeed temporarily or permanently (4). These conditions, which concern very few mothers and their infants, are listed below together with some health conditions of the mother that, although serious, are not medical reasons for using breast-milk substitutes.

Whenever stopping breastfeeding is considered, the benefits of breastfeeding should be weighed against the risks posed by the presence of the specific conditions listed.

INFANT CONDITIONS

Infants who should not receive breast milk or any other milk except specialized formulae
classic galactosaemia: a special galactose-free formula is needed;
maple syrup urine disease: a special formula free of leucine, isoleucine and valine is needed;
phenylketonuria: a special phenylalanine-free formula is needed (some breastfeeding is possible, under careful monitoring).

Infants for whom breast milk remains the best feeding option but who may need other food in addition to breast milk for a limited period:

- Very low birth weight infants (those born weighing less than 1500g);
- Very preterm infants, i.e. those born less than 32 weeks gestational age;
- Newborn infants who are at risk of hypoglycaemia by virtue of impaired metabolic adaptation or increased glucose demand (such as those who are preterm, small for gestational age or who have experienced significant intrapartum hypoxic/ischaemic stress, those who are ill and those whose mothers are diabetic if their blood sugar fails to respond to optimal breastfeeding or breast-milk feeding (5).

MATERNAL CONDITIONS
Mothers who are affected by any of the conditions mentioned below should receive treatment according to standard guidelines.

Mothers who may need to avoid breastfeeding
HIV infection (b) if replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) (6).

Mothers who may need to avoid breastfeeding temporarily
Severe illness that prevents a mother from caring for her infant, for example sepsis;
Herpes simplex virus type 1 (HSV-1): direct contact between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved;
Maternal medication:

- Sedating psychotherapeutic drugs, anti-epileptic drugs and opiods and their combinations may cause side effects such as drowsiness and respiratory depression and are better avoided if a safer alternative is available (7);
- Radioactive iodine-131 is better avoided given that safer alternatives are available - a mother can resume breastfeeding about two months after receiving this substance;
- Excessive use of topical iodine or iodophors (e.g., povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression or electrolyte abnormalities in the breastfed infant and should be avoided;
- Cytotoxic chemotherapy requires that a mother stop breastfeeding during therapy.

Mothers who can continue breastfeeding, although health problems may be of concern
- Breast abscess: breastfeeding should continue on the unaffected breast; feeding from the affected breast can resume once treatment has started (8).
- Hepatitis B: infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter (9).
- Hepatitis C.
- Mastitis: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition (8).
- Tuberculosis: mother and baby should be managed according to national tuberculosis guidelines (10).
- Substance use (11):
- Maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies;
- Alcohol, opiods, benzodiazepines and cannabis can cause sedation in both the mother and the baby.

Mothers should be encouraged not to use these substances and given opportunities and support to abstain (b).

Footnotes:
The most appropriate infant feeding option for an HIV-infected mother depends on her and her infant's individual circumstances, including her health status, but should take consideration of the health services available and the counselling and support she is likely to receive. When replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS), avoidance of all breastfeeding by HIV-infected women is recommended. Mixed feeding in the first 6 months of life (that is, breastfeeding while also giving other fluids, formula or foods) should always be avoided by HIV-infected mothers.

Mothers who choose not to cease their use of these substances or who are unable to do so should seek individual advice on the risks and benefits of breastfeeding depending on their individual circumstances. For mothers who use these substances in short episodes, consideration may be given to avoiding breastfeeding temporarily during this time.

References for Acceptable medical reasons for use of breast-milk substitutes (WHO 2009)

Technical updates of the guidelines on Integrated Management of Childhood Illness (IMCI). Evidence and recommendations for further adaptations. Geneva, World Health Organization, 2005.

Evidence on the long-term effects of breastfeeding: systematic reviews and meta-analyses. Geneva, World Health Organization, 2007.

León-Cava N et al. Quantifying the benefits of breastfeeding: a summary of the evidence. Washington, DC, Pan American Health Organization, 2002 (http://www.paho.org/English/AD/FCH/BOB-Main.htm, accessed 26 June 2008).

Resolution WHA39.28. Infant and Young Child Feeding. In: Thirty-ninth World Health Assembly, Geneva, 5–16 May 1986. Volume 1. Resolutions and records. Final. Geneva, World Health Organization, 1986 (WHA39/1986/REC/1), Annex 6:122–135.

Hypoglycaemia of the newborn: review of the literature. Geneva, World Health Organization, 1997 (WHO/CHD/97.1; http://whqlibdoc.who.int/hq/1997/WHO_CHD_97.1.pdf, accessed 24 June 2008).

HIV and infant feeding: update based on the technical consultation held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infection in Pregnant Women, Mothers and their Infants, Geneva, 25–27 October 2006. Geneva, World Health Organization, 2007 (http://whqlibdoc.who.int/publications/2007/9789241595964_eng.pdf, accessed 23 June 2008).

Breastfeeding and maternal medication: recommendations for drugs in the Eleventh WHO Model List of Essential Drugs. Geneva, World Health Organization, 2003.

Mastitis: causes and management. Geneva, World Health Organization, 2000 (WHO/FCH/CAH/00.13; http://whqlibdoc.who.int/hq/2000/WHO_FCH_CAH_00.13.pdf, accessed 24 June 2008).

Hepatitis B and breastfeeding. Geneva, World Health Organization, 1996. (Update No. 22).

Breastfeeding and Maternal tuberculosis Update No. 23. Geneva, World Health Organization, 1998.

Background papers to the national clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn. Commissioned by the Ministerial Council on Drug Strategy under the Cost Shared Funding Model. NSW Department of Health, North Sydney, Australia, 2006. http://www.health.nsw.gov.au/pubs/2006/bkg_pregnancy.html

Further information on maternal medication and breastfeeding is available at the United States National Library of Medicine (NLM) website: http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT
Full version of this document is available from Child and Adolescent Health, WHO, Geneva
http://www.who.int/child_adolescent_health/documents/WHO_FCH_CAH_09.01/en/index.html

Appendix XIII:
Members of the National Quality Improvement Governance Group for PHN Services

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14	*Brenda Golden*
15	*Lloyd Philpott*
16	*Sheena Hanrahan*
17	*Paula Duignan*
18	*Ina Crowley*

Appendix XIV:

Staff training

All clinical staff members who have contact with mothers and/or infants should receive training, either at the hospital or prior to joining the staff that covers:

Ten Steps to Successful Breastfeeding,

- Mother-friendly birth practices,
- The International Code of Marketing of Breast-milk Substitutes and relevant subsequent World Health Assembly resolutions.
- For staff with direct care responsibilities for assisting breastfeeding, it is likely that at least 20 hours of targeted training will be needed to develop the knowledge and skills necessary to adequately support mothers and should include supervised clinical practice. Thereafter staff should attend regular training and skills updates to ensure they have the knowledge and skills required.
- Training on how to provide infant feeding support for non-breastfeeding mothers is also provided to staff as relevant to their work. The training covers key topics such as:
- The risks and benefits of various feeding options,
- Helping the mother choose what is acceptable, feasible, affordable, sustainable and safe (AFASS) in her circumstances,
- The safe and hygienic preparation, feeding and storage of breast-milk substitutes,
- How to teach the preparation of various feeding options, and
- How to minimize the likelihood that breastfeeding mothers will be influenced to use formula.
- Non-clinical staff members receive training that is adequate, given their roles, to provide them with the skills and knowledge needed to implement this policy and support mothers in successfully feeding their infants.

From: UNICEF/WHO, *Baby-friendly Hospital Initiative: revised, updated and expanded for integrated care***,** Section 1, Background and Implementation, 2008

Appendix XV:

Ten Steps to Successful Breastfeeding (revised 2018)

Box 1. Ten Steps to Successful Breastfeeding (revised 2018)

Critical management procedures

1. a. Comply fully with the *International Code of Marketing of Breast-milk Substitutes* and relevant World Health Assembly resolutions.
   b. Have a written infant feeding policy that is routinely communicated to staff and parents.
   c. Establish ongoing monitoring and data-management systems.
2. Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.

Key clinical practices

3. Discuss the importance and management of breastfeeding with pregnant women and their families.
4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.
5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.
6. Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.
7. Enable mothers and their infants to remain together and to practise rooming-in 24 hours a day.
8. Support mothers to recognize and respond to their infants' cues for feeding.
9. Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

United Nations International Children's Emergency Fund /World Health Organisation. *Protecting, Promoting and Supporting Breastfeeding in facilities providing maternity and newborn services: The Revised Baby Friendly Hospital Initiative.* Geneva: WHO; 2018. http://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018.pdf


The TEN STEPS to Successful Breastfeeding
1 HOSPITAL POLICIES
Hospitals support mothers to breastfeed by..
2 STAFF COMPETENCY
Hospitals support mothers to breastfeed by..
3 ANTENATAL CARE
Hospitals support mothers to breastfeed by..
4 CARE RIGHT AFTER BIRTH
Hospitals support mothers to breastfeed by..
5 SUPPORT MOTHERS WITH BREASTFEEDING
Hospitals support mothers to breastfeed by..
6 SUPPLEMENTING
Hospitals support mothers to breastfeed by..
7 ROOMING-IN
Hospitals support mothers to breastfeed by..
Letting mothers and babies stay together day and night
Making sure that mothers of sick babies can stay near their baby
8 RESPONSIVE FEEDING
Hospitals support mothers to breastfeed by..
9 BOTTLES, TEATS AND PACIFIERS
Hospitals support mothers to breastfeed by..
10 DISCHARGE
Hospitals support mothers to breastfeed by..
World Health Organization
unicef