**Steps to Successfully Assisting New Mothers in the Hospital**

**Dress appropriately (lab coat, identification, cleanliness, body odor, nails, hair, perfume, jewelry and clothing) should act, look and be professional!**

**How to triage patient list**

* Collect patient list, census sheet, consult requests, staff communication board/list, Drs. Request.
* Sort by:
* feeding preference, current feeding method, DOB, time of Birth, type of delivery including labor course, gravida/para, age of mother, gestation age, anticipated discharge date
* feeding hx-(breast, bottle, dual/ pumped) reason for feeding hx –(preference, spouse/family preference, convenience, fear, lack of knowledge, medical indication, medications taken, early separation, lactation failure, no/low milk supply, sore nipples, work/school, lack of support, surrogacy)
* acuity of mom/baby condition- ( PP hemorrhage, infection, PIH- Mag Sulfate, Coombs +, hyperbili, hypoglycemia, poor tone, torticollis, prematurity)
* separation-NICU/PACU
* anatomical anomalies identified -( inverted/flat nipples, wide spaced breasts, asymmetry of breasts, cleft lip/palate, short lingual frenulum, very large breasts/nipples, very small/ tight mouth)
* previous surgeries-(breast augmentation, lift or reduction, mastectomy, bariatric, thyroidectomy, removal/loss of limb, back)
* existing conditions-(sore/cracked/bruised or bleeding nipples, Peri-areolar edema-third spacing, rusty pipe syndrome, hypothyroid, deafness, paralysis, prolonged onset of lactogenesis ll, PCOS, GDM, absence of swallows, absence of or limited voids/stools, excessive wt loss, hypoglycemia, hyper-bilirubinemia, sleepy baby)
* Previous diagnosis/incidences - (GDM, infertility, low milk supply, mastitis, premature births, fetal/infant death, early cessation of breastfeeding due to surgery/medications, post- partum depression, Sheehan’s syndrome, goiter, hypothyroid)
* Current devices being used-(pump, breast shell, nipple shield, syringe, SNS, comfort gels, lanolin)
* Scheduled procedures/tests to be done-(blood glucose, x-ray, MRI, circumcision, ultra-sound, frenotomy)
* Organize list based on feeding preference, high acuity, high risk, identified problems/risks, devices being used, newborns current status-(wt loss, bili levels, voids/stools for DOL), Drs request-(assess latch, start SNS/supplementation, one or two f/u) and expected D/C date.
* May need to re-triage/shuffle list based on current status or needs identified.
* Communicate realistic expectations with caring staff when asked to see their patient

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**Prepare Expected Supplies/Tools:**

* In pockets-comfort gels, nipple shields, scissors, syringes, droppers, colostrum containers
* In hands: clip board (preferably storage board) with handouts/booklets needed
* On unit/close by-pumps, pump kits-short/long term, volu-feed bottles, feeding tubes, syringes, dispensing caps, formula, bottles, regular and slow flow nipples, nursing pads, ice packs, baby powder, blankets, cloth diapers, hospital approved antiseptic wipes, file with needed handouts/booklets/resources.

**Know Your Resources/Staff:**

* Who is the Peds MD/provider on staff for the day/shift
* Which staff are experienced and/or have attended breastfeeding/baby friendly training
* Which staff are CLE’s
* Which staff are positive and supportive of breastfeeding

**Individualize Care**

* Evaluate setting upon entering the room
* Initial response to your presence
* Are both parents present-appearance (tired, happy, stressed, experienced, ethnicity, culture, tattoos, body piercings, hair combed, wearing hospital gown, clothing make-up), current activity (awake, asleep, eating, watching TV, talking on the phone, on the computer, arguing, newborn skin to skin or in crib, sleeping or crying, feeding cues, wrapped or unwrapped, clothed or in diaper, hand mittens, pacifier), appear attentive to newborns needs.
* Evaluate room- size, cluttered, organized, bathroom/shower/sink, second bed, personal computer, breastfeeding pillows, pump, aids, bottles, formula (type) special foods/herbs/vitamins, music/lullabies playing, tracking/documentation sheets present, and admission packet/gifts.
* Visitors in the room (how many, family, friends, siblings), appearance, is it calm or chaotic, do they appear supportive or disruptive
* Other medical/hospital staff in the room(MD, RN, lab, social services, case manager, finance personal, birth certificate personal, housekeeping, photographer, engineering)

**Introduce Yourself**

* Name, position/role as staff member
* Smile
* Be relatable
* Have eye contact

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* Acknowledge all visitors in the room
* Make a GENUINE connection
* Within seconds you should be able to discern if the time is right for consult

**Initiate Consult**

* Provide appropriate privacy-(curtain pulled, ask if visitors need to be excused, close door, assist patient with preparing for consult)
* Make relatable comments: example “I see you got a special meal”; FOB “I see your wearing the right hat”; “What is your baby’s name?”; “You look a little tired, were you able to get a little rest”; FOB “How did you sleep last night?”; “Looks like your family is

very excited by this new little baby”; “I see this is your fourth baby how many boys/girls”; “How old are they”

“Wow your baby has so much hair” Make it specific to them to show that you care and are observant to their uniqueness.

* Stay away from potential offensive comments like: “Wow what a big baby you have”; “Who gave you the pacifier”; “Why are you all by yourself”; “Why isn’t the baby skin to skin” these comments are judgmental and may put your patient on the defense right away!
* Assess moms pain/comfort level-call caring RN if pain meds and/or care is indicated
* Wash your hands in room. Avoid Antibacterial foam!

**Begin Assessment** – (Suggest eye contact at eye level if possible, occasional touch when appropriate, engage FOB/significant other into discussion. Be constantly aware of parents responses both verbally and non-verbally so you can alter/adjust your consult to meet their needs and keep them engaged. Use key words or phrases that help stimulate memory and retention. Use discernment in your wording to maintain attention/engagement-not too bold and not too meek but confident and reassuring. Parents should feel safe and protected)

* Confirm feeding preference, duration and if attended any breastfeeding classes
* Ask mom how she feels about the feedings so far
* Address/confirm pertinent history that may alter, affect, and/or require special intervention, f/u and/or additional resources to breastfeed successfully.
* Address any concerns mom/FOB may have regarding barriers or perceived barriers to breastfeeding
* Ask when the newborn fed last and prepare for feeding session (unless newborn just fed and is asleep or is not displaying feeding cues even after assessment-at that point complete consult as usual without latching and have parents call you at next feeding)
* Assess mother’s breasts, areola, nipples, scars/surgery site, and presence of milk. Always acknowledge the presence or non-presence of milk to reassure mom’s ability to breastfeed successfully. At the same time you are aware of moms/FOB’s comfort level

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* with the consultation, assessment and touching of the breasts. This allows you to adjust your consult to ease tension and keep communication effective.
* Address your findings/concerns
* Assess newborn-unwrap and undress, observe: tone, color of skin, breathing effort, shape of head, presence of bruising, hematoma, asymmetry, torticollis, limbs, shape of mouth, chin, facial expression, activity level, feeding cues, tongue movement (extension/lift), frenulum and palate if indicated, presence of dried milk on face, wet/stooled diaper.
* Address any findings/concerns or abnormalities with parents and/or providers as indicated
* If newborn asleep demonstrate how to stimulate awake-if time, place skin to skin and stroke body with hands. If too sleepy, lay newborn on flat surface undressed, stroke body firmly, sit up and lay back down, burp, talk and rub from head to toe. Cool hands can be helpful.
* Based on age of newborn, mom’s condition, comfort level and breast anatomy all will guide you in the most effective position to use at the time. Suggest: laid-back/biological nursing, side-lying, cross cradle and/or football hold. Pillows are a must (4 preferable). **Avoid cradle or semi-cradle hold for two-four weeks!**
* Assist mom into chosen position using pillows as support. Engage FOB showing him how to effectively support mom’s position.
* Time to discuss importance of asymmetrical latch! (anatomy of chin, tongue/jaw strength, nipple position)
* Assist newborn to the breast demonstrating proper placement (ears, hips, shoulders aligned), holding newborn, supporting breast, lining nose to nipple, eliciting rooting reflex for wide open mouth, quickly bringing chin in first to breast while supporting shoulders (not head) and latching asymmetrically. Wait for latch/sucks then adjust lips out if needed. Adjust pillows/blanket rolls for adequate support. Ensure mom is comfortable and body in alignment.
* Observe latch, suckles and signs of milk transfer. Identify ability to maintain seal and organize jaw glides/rhythm. Determine ratio of sucks to swallows. Help parents identify milk transfer through audible swallows.
* Teach breast compressions and the benefits in the early post-partum period: Increased milk transfer, prolonged feeding, emptying of breast and provides added control/confidence of successful breastfeeding.
* Review newborn feeding patterns/behavior for the first few days of life and through the first month. Be sure to emphasize night two behavior (awake and frantic, transitional night with frequent feedings) and growth spurts! (about 2 weeks old-increased feedings 2-3 days prior to, breasts will feel soft and concerned newborn is not getting enough) Duration of breastfeeding session should be ongoing without limits during lactogenesis l and then somewhere averages between 15-40 minutes after lactogenesis ll occurs.

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* Provide feeding guidelines and assurance of adequate intake. (feed ad-lib, on demand 8-12 times in 24 hr period with no longer than 3 hr intervals between feedings for the first two weeks, adequate voids and stools representing day of life until 6 days old then stays the same 6-8 wet and 3-4 soiled diapers a day. Stool will change color until day 5-6 then resembles French’s yellow mustard, loose and seedy) Newborns feed non-stop until lactogenesis ll fully occurs! Their job is to drive your milk in through their insatiable need to suck. But they have to be at the workplace to do their job! They have 2-3 days to get their act together (coordinate Suck, swallow breathe) before the fountain (milk comes in) begins to flow.
* Discuss the importance and roll of Skin to skin for the first couple of weeks of life. (Thermoregulation, stabilization of heart rate, respiration, blood pressure, blood glucose levels and prevents cortisol release resulting from stress. Studies now being conducted on the role of microbes in/on the newborn body and means of acquiring them through birth, skin contact and feedings. Also STS stimulates oxytocin release which causes mom to feel relaxed and sleepy resulting in milk letdown, involution of uterus, bonding, mothering instincts and preps the newborns gut for absorption of nutrients/milk. Demonstrate how to secure with a blanket. Encourage STS with both parents for best outcomes.
* Share with mom that her newborn is a part of her physiology for 3 years as her Amygdala and Hypothalamus continues to regulate her newborns until this age. All newborns learn for the first three years through emotion bonding. It is important to engage with your newborn, meeting the physical/emotional needs through nurturing and bonding with the newborn.

**Nipple Pain Most Common Occurrence with Breastfeeding Post- Partum**

* How to identify:
* Mom verbally informs staff, MD, Lactation, spouse or family
* Nipples appear-red, bruised, presence of linear compression lines/stripes, cracked, bleeding, creased after latch
* Mom appears anxious to latch or flinches when newborn is put close to nipple/latches
* Mom pushes newborn off the breast or requests to have him removed
* Common Causes of nipple pain
* Flat, short, dimpled or inverted nipples
* Previous breast surgery that involved severing of nerves-hypersensitivity
* Previous nipple piercing-scar tissue
* Infection
* Breast lump/cyst/moles around areola or nipple base
* Rigid/firm areola-difficult to compress
* Engorgement

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* Mastitis
* Overactive letdown/supply
* Hx of sexual/physical/ emotional abuse
* Shallow latch
* Latch with chin tucked
* Disorganized suck-birth trauma, medications
* Short or tight labial/lingual frenulum
* High/bubble palate
* Cleft palate
* Tight bite
* Interventions: correct position and latch, nipple shield, pumping or rolling to evert nipple, wrapping newborn, resolve infection/mastitis, resolve engorgement, suck training, SNS use, refer to chiropractor/cranial-sacral therapy, frenotomy, use alternative form of feeding to rest breasts/nipples and time!

**Identify Need for Follow Up In-Hospital and/or After Discharge**

* Any concerns identified should be f/u until all issues/concerns are resolved.
* Determine if f/u is indicated before or after discharge. Before D/C indications may be: painful latch, poor milk transfer, rising bili levels, tight frenulum, post frenotomy, sleepy newborn beyond recovery phase, interventions initiated (nipple shield, triple feeding, NICU admission) insecure/psychological issues requiring further education and support, previous hx of low milk supply, breast reduction/lift. After D/C indications: borderline wt loss, borderline bili levels, engorgement, SNS use, nipple shield use, pumping for newborn in the NICU, hx of breast reduction/lift, low milk supply, hx of bariatric surgery ( newborn may need f/u with PEDs MD for testing)

**Document Assessment, Observation, Intervention and Plan**

* Try to document findings during consult or make notes
* Best to document right after consult before moving on to next patient
* Document to justify your interventions, teachings and plan
* Document so the staff and next lactation consultant can provide time managed consistent care
* Communicate with caring staff/ MD interventions, changes in feeding plan and/or need f/u

**Provide Community Resources**

* Lactation Clinics/Services
* Le Leche League
* Support Groups
* Loving Support-24 hr Helpline

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* WIC
* Home Lactation Visits
* Local Breastfeeding Coalition
* ILCA –list of Lactation Consultants in their area
* Pump Rental Stations/Business
* Baby Friendly Hospitals
* Baby Friendly Physicians
* Milk Bank (San Jose)