BREASTFEED: SHOWING THE WOMAN HOW TO
BFHI STEP 4- SHOW MOTHERS HOW TO BREASTFEED AND HOW TO MAINTAIN LACTATION EVEN IF THEY SHOULD BE SEPARATED FROM THEIR INFANTS

PURPOSE

- To nurture the woman’s confidence in her ability to breastfeed.
- To assist women and babies in achieving successful breastfeeding by standardising teaching, eliminating contradictory advice and implementing practices which contribute to breastfeeding success.
- To encourage mothers to recognize nutritive sucking which will result in
  - Optimal intake
  - Weight gain
  - Appropriate growth and development

KEY POINTS

1. Mothers shall be shown the positioning skills involved using a “Hands off approach”.
2. The laminated ‘Baby Led Breastfeeding’ and ‘Holding Me, Touching You’ charts found attached to the baby cots, can be used in a hands off approach (HOT) to coach the mother.
   - The DVD/Video “Follow me Mum” is available in all ward areas and in each VMS car.
   - Positioning the baby at the breast can be demonstrated by using a doll and breast model.

3. The baby needs to be lying in firm contact with the mother’s body.
4. This will allow the baby to key into its instinctive behaviour to seek the breast.
5. Supporting the baby correctly allows the baby to attach well. It prevents pulling and chewing on the nipple. Good attachment means the baby is able to have enough areola and breast tissue in the mouth to stimulate the palate: this initiates effective sucking. There needs to be sufficient breast tissue over the baby's tongue in order for effective sucking and milk transfer to take place.
6. After the feed the nipple should look as it did before – not compressed, elongated or misshapen.
7. If the baby is sleepy or disinterested in feeding, refer to the section Strategies to Overcome Lack of Interest in Breastfeeding in KEMH Clinical Guideline ‘The First Feed’.
8. However, if the baby is unable to latch on, the mother needs to initiate lactation by expressing and giving all expressed breast milk (EBM) to the baby.

HOW A MOTHER CAN ASSIST HER BABY TO ATTACH TO THE BREAST

A healthy term baby is born with the ability to search for the breast. Allowing the baby to do the following will trigger baby’s innate instincts and facilitate imprinting on how to latch effectively. See ‘Baby Led Breastfeeding’ poster on the next page (Courtesy Kaleeya Maternity Unit).
Baby Led Breastfeeding

Babies are born with the ability to search for the breast and feed without much help. A mother’s role is mainly to support and encourage her capable newborn.

1. Place your baby upright skin-to-skin, supported, calming them by gentle rocking, stroking, and talking.

2. Baby starts to follow their instincts, allow your baby to ‘bob’ their head around on your chest, they may look at you.

3. They may nuzzle your breast and lick for a little while. That is fine.

4. They are using their cheek to feel their way. This is a learning process for both of you. It is okay to take your time.

5. Digging in their chin, the baby reaches up with an open mouth, and attaches to the breast.

6. If the baby’s back is straight, their body touching yours, and you are both feeling comfortable, that is all that matters.

Allow your baby to finish feeding from the first breast before offering the second. If you feel pain after the first few sucks, the baby may not have taken a big enough mouthful of breast. Break the suction with a clean finger, take your baby off the breast and let them try again.
CRADLEHOLD

- The baby's body should be supported by firm contact with the mother's body, chest to chest.
- Baby's head should be free and his/her top lip in line with the nipple.
- If the mother is using her hand to guide the baby onto the breast, her hand should cradle the baby's shoulders- not the back of his / her head.
- The mother holds the baby's chin and bottom lip- against the underside of her areola to stimulate the baby to open his / her mouth. The nipple points to the baby's nose.
- When the baby's mouth is wide open with the baby's bottom lip well down on the underside of the areola, the mother moves the baby quickly onto the breast.
- The baby needs to take the nipple and 2-3 cm of breast behind the nipple into his/her mouth. The areola should be well into the mouth. Less of the areola is visible below the bottom lip than the top lip.
- The lips form a seal.
- The nose is free.
- The baby's chin should be in contact or pressing into the breast.
- The baby will start with short quick sucks; this stimulates let down. Once let down occurs, the sucking changes to a slower rhythmic, suck-swallow pattern, with short resting pauses.
- Swallowing can be seen (and heard if lactogenesis and letdown have occurred).
- Once the baby is attached and sucking effectively there is no nipple pain or trauma

UNDERARM HOLD (FOOTBALL HOLD).
Sometimes correct attachment takes more than one attempt.

ASSESSMENT OF A BREASTFEED

1. When the baby is actively feeding there should be movement of the whole jaw and swallowing is observed. Non-nutritive sucking occurs in short sharp bursts, at the rate of 2-3 per second. Nutritive sucking occurs at a slower rate of about 1 per second\(^4,5\). It is important to ensure the woman can differentiate the type of sucking to ensure her baby is feeding effectively. A sleepy baby may need encouragement to persist with a nutritive sucking pattern – this may be achieved by breast compression.

2. After the breastfeed, the breast/s should feel soft and light with no lumpy/heavy areas. If the baby’s appetite is small or the woman has more milk than the baby can drink, he/she may only drain the first breast. Ensure he/she has drained the first breast before offering the second one.

3. The woman should be advised to alternate the side she offers first.

4. Until the milk ‘comes in’, the baby will not pass urine frequently. He / she may only void once or twice per day. There is no cause for concern in the first few days. By 96 hours (4 days), a baby would be expected to have at least 3 wet nappies of pale / clear urine a day. As the milk volume increases, so will the urine output.

5. A newborn baby will have at least 2-3 bowel movements a day. Milk stools (Yellow) should be seen by day 4. A baby should continue to have several bowel movements a day at least until 4-6 weeks of age\(^6\).

6. If the baby is unsettled or has lost greater than 10% of birth weight, or the woman has become engorged, the attachment and sucking technique of the baby should be rechecked with an experienced midwife/lactation consultant.

7. If the urine becomes scanty and strongly yellow in colour, suggesting the development of dehydration, feeding frequency, milk transfer and mother’s breasts must be evaluated with an experienced midwife/lactation consultant and an appropriate plan implemented. The baby is to be reviewed by the paediatrician.

BREASTFEEDING AFTER CAESAREAN SECTION\(^7\).

- Caesarean birth will not directly affect the mother’s ability to breastfeed. However, a mother who has given birth this way will require additional assistance to enable her to breastfeed e.g. lifting the baby out of the cot and adequate pain relief.

BREASTFEEDING MULTIPLES

- The mother will require additional assistance at each feed, with much reassurance and professional guidance throughout her hospital stay.
- Show the mother various feeding positions and allow her to decide which methods suit her own and her babies needs. Some mothers can twin feed the babies from birth, others will prefer single feeding until more confident. Support the mother in her decision.
- Babies from multiple births can often be preterm or small for gestational age. It is important that the mother be able to manage the breastfeeding plan independently prior to discharge. She may need to hire an electric pump on discharge to maintain her breast milk supply whiles the babies learn to breastfeed.
REFERENCES (STANDARDS)

National Standards – 1 Clinical Care is Guided by Current Best Practice
Legislation - Nil

Related Policies – Obstetric and Midwifery Clinical Guidelines: Newborn Feeding
Other related documents – Nil

RESPONSIBILITY
Policy Sponsor | Nursing and Midwifery Director OGCCU
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