NURSING PRACTICE EXPECTATIONS OF CARE:

(77soc)

STANDARD 1:
Assessment and Diagnosis - The nurse collects relevant health data and analyzes the data to determine diagnosis.

Assessment:

1. Within 24 hours of delivery:
   
   A. Readiness of infant to breast feed

   B. Knowledge base of mother regarding: pumping, storage and transport of expressed mother’s milk (EMM) and establishing milk supply.

   C. Need for Electric Breast Pump (EBP) for mother’s home use. Notify Lactation Services which will provide documentation and/or prescription as applicable to the parent in order to obtain an EBP through private insurance or Women, Infants and Children (WIC).

2. Assess need for referral to Lactation Services based on the following criteria:

   A. Maternal
      
      a. Multiple birth
      b. History of breast surgery
      c. If multiparous, reports previous lactation failure.
      d. Perinatal complications that can affect lactogenesis such as PIH, postpartum hemorrhage, HELLP syndrome, PET, Diabetes, Hypothyroid, Polycystic Ovarian Syndrome.
      e. Nipples >2.5cm diameter.
      f. Inverted or flat nipples
      g. Mother undecided regarding whether to breast feed/provide EMM or provide formula.
      h. EMM <500ml/day, approximately 2-3 ounces/pumping, at any time after the 10th postpartum day.
      i. Nipple trauma, persistent nipple pain, red, swollen, hard and painful breast(s) and/or maternal fever.

   B. Infant
      
      a. Infant anomalies or neurological deficits affecting breastfeeding.
      b. Breastfeeding without milk transfer despite active suckling, appropriate latch and positioning.
      c. Inability to latch
      d. Hyperbilirubinemia

3. When stable enough to be held, assess infant readiness for kangaroo Care (KC) with every parental visit.

4. With every maternal visit assess infant readiness to breastfeed. and assist mother to position infant correctly. Observe for:

   a. correct breast feeding position for mother
   b. infant in correct position and able to deeply latch
   c. effective nutritive suckle – long rhythmic suck

      A. Observe breastfeeding session at frequent intervals.
      B. Observe for milk transfer.

STANDARD 2:
Outcome Identification - The nurse identifies individual expected outcomes for the patient.

Expected Outcomes:

1. Initiate lactation consult referral if expected outcomes are not met.
2. Maternal Outcomes:
A. Lactogenesis occurs 2-5 days postpartum through direct breast feeding and/or pumping.
B. Pumping initiated as soon as possible, no more than 6 hours after delivery.
C. EMM supply is maintained.
D. Pump Diary used consistently.
E. Demonstrates/verbalizes correct collection, storage and transport of EMM.
F. Has made arrangements to obtain an EBP by discharge.
G. Demonstrates appropriate positioning for kangaroo care.
H. Verbalizes infant breast feeding readiness cues.
I. Demonstrates appropriate positioning technique for breastfeeding
J. Recognizes Identifies correct latch and rhythmic suckle

3. Infant Outcomes:
   A. Prior to discharge, infant breastfeeds with sustained effort and nutritive suckling a minimum of two feedings/day.

STANDARD 3:

Develop and Implement Plan of Care - The nurse develops and implements a plan of care to assist the patient in achieving expected outcomes.

Procedures/Treatments:

1. Instruct mother and/or caregivers of need for mother to begin pumping ASAP, if possible within 6 hours after delivery.
2. Inform Lactation Services of need for EBP for home use.
3. During first contact with mother provide the following:
   A. literature related to breastfeeding support
   B. Instruct mother on the use of pump diary and pumping guidelines.
   C. Instruct mother on the correct technique for collection, storage and transport of EMM.
   D. Provide and instruct mother on assembly, use and care of pump kit for electric and manual use.
   E. Provide mother with washbasin and dish soap to clean pump kit.
   F. Demonstrate to mother where to obtain sterile bottles and labels for storage of EMM.
   G. Provide mother with insulated bag for transport of EMM, if available.
   H. Observe mother during a pumping session and assess for proper flange size.

4. Monitor mother’s milk supply.
   A. Encourage mother to drink fluids, e.g. water, juice, milk.
   B. Instruct mother to eat a healthy balanced diet and to continue prenatal vitamins.

5. Instruct parent(s) on the technique/benefits of providing Kangaroo Care, encouraging and assisting with KC every parental visit.
6. Instruct mother to observe for and respond to the infant’s feeding readiness cues.
7. Assist mother with breastfeeding, according to infant’s feeding readiness cues:
   A. Provide favorable environment for breastfeeding: privacy, pillows, footstool, etc.
   B. Observe breastfeeding and evaluate. Instruct and assist with latch and positioning as needed.
   C. Document breastfeeding session per unit protocol.

8. When mother’s milk supply is >30 ml per pumping and there is observed nutritive sucking, weigh baby before and after breast feeding.

Medications:

1. Review mother’s health record or ask mother for a list of all her current medications, and determine if all meds are compatible with breastfeeding. NOTE: Use: Medications in Mother’s Milk, by Thomas Hale, 13th edition, 2008.

Activity/Safety:

An interdisciplinary team approach will be utilized to determine appropriateness of breastfeeding in the following circumstances:

1. Mother and/or baby with a positive urine drug screen (UDS) should be discouraged from breastfeeding unless actively engaged in a drug treatment program.
2. Mothers who are Hepatitis B positive need not delay initiation of breastfeeding until after the infant is immunized.
3. Mothers infected with Hepatitis C should be advised that transmission of HCV by breastfeeding has not been documented. According to current guidelines of the CDC and AAP, maternal HCV infection is not a contradiction to breastfeeding. Mothers who are HCV positive and choose to breastfeed should consider abstaining if their nipples are cracked and/or bleeding.
4. Generally, mothers on methadone maintenance may breastfeed. (Per AAP guidelines there is no longer a dose restriction for methadone.)
Teaching/Discharge Planning:

1. Instruct the mother on:
   A. Infant feeding readiness cues
   B. Positioning techniques for breastfeeding.
   C. Correct latch.
2. Develop and discuss with mother breastfeeding plan for after infant's discharge.
3. Provide mother with information re: community resources for breastfeeding support after infant's discharge
4. Follow-up outpatient appointment for 3-5 days post-discharge with OHSU Lactation Services, or contact local Health Care Provider for referral information. Appointment to be made by Lactation Services or phone number given to mother to make appointment.

STANDARD 4:
Evaluation - The nurse evaluates the patients’ progress toward attaining expected outcomes as listed in Standard 2 and revises the plan of care accordingly.

Bibliography:

9. www.lalecheleague.org

Related Forms:

- Nursing Policy and Procedure Manual
- Nursing Standards of Nursing Care

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