Complete Summary

GUIDELINE TITLE

Guidelines for hospital discharge of the breastfeeding term newborn and mother: "Going home protocol".

BIBLIOGRAPHIC SOURCE(S)

Academy of Breastfeeding Medicine Clinical Protocol Committee. ABM Clinical Protocol #2 (2007 revision): guidelines for hospital discharge of the breastfeeding term newborn and mother: "the going home protocol". Breastfeed Med 2007 Sep;2(3):158-65. [156 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Newborn and infant nutrition
- Medical problems that may impact on breastfeeding success

GUIDELINE CATEGORY

Counseling
Evaluation
Management
Prevention
Risk Assessment

CLINICAL SPECIALTY

Family Practice
Nursing
Nutrition
Obstetrics and Gynecology
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Dietitians
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To provide recommendations to facilitate optimal breastfeeding practices

TARGET POPULATION

Full-term newborns and mothers

INTERVENTIONS AND PRACTICES CONSIDERED

1. Documented assessment of breastfeeding effectiveness prior to discharge, including addressing all concerns raised by mother
2. Assessment and documented addressing of anticipated breastfeeding problems, based on risk assessment, along with plan of action for follow-up
3. Encouragement of exclusive breastfeeding for 6 months, with breastfeeding continuing to a year and beyond
4. Appointments for follow-up visits with mother and child
5. Efforts to keep mother and child together in hospital if mother is ready for discharge before the infant is
6. Patient education (verbal and written)
    - Advantages of exclusive breastfeeding
    - Provision of non-commercial materials
    - Anticipatory guidance
        - Engorgement
        - Signs of adequate intake
        - Signs of jaundice
        - Sleep patterns
        - Maternal medication use
        - Individual feeding patterns
        - Follow-up and contact information
    - Expressing and pumping of milk
    - Information on support for working mothers
    - Contact information for counseling or support groups

MAJOR OUTCOMES CONSIDERED

Duration and exclusivity of breastfeeding

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

An initial search of relevant published articles written in English in the past 20 years in the fields of medicine, psychiatry, psychology, and basic biological science is undertaken for a particular topic. Once the articles are gathered, the papers are evaluated for scientific accuracy and significance.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)
Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

I Evidence obtained from at least one properly randomized controlled trial

II-1 Evidence obtained from well-designed controlled trials without randomization

II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies and case reports; or reports of expert committees

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

An expert panel is identified and appointed to develop a draft protocol using evidence based methodology. An annotated bibliography (literature review), including salient gaps in the literature, are submitted by the expert panel to the Protocol Committee.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Draft protocol is peer reviewed by individuals outside of lead author/expert panel, including specific review for international applicability. Protocol Committee's sub-group of international experts recommends appropriate international reviewers. Chair (co-chairs) institutes and facilitates process. Reviews submitted to committee Chair (co-chairs).

Draft protocol is submitted to The Academy of Breastfeeding Medicine (ABM) Board for review and approval. Comments for revision will be accepted for three weeks following submission. Chair (co-chairs) and protocol author(s) amends protocol as needed.

Following all revisions, protocol has final review by original author(s) to make final suggestions and ascertain whether to maintain lead authorship.

Final protocol is submitted to the Board of Directors of ABM for approval.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

1. Formal documented assessment of breastfeeding effectiveness should be performed at least once during the last 8 hours preceding discharge of the mother and baby, by a medical professional trained in formal assessment of breastfeeding. Similar assessments should have been performed during the hospitalization, preferably at least once every 8 to 12 hours. These should include evaluation of positioning, latch, milk transfer, baby's weight and percent weight loss, clinical jaundice, and stool and urine output. All problems raised by the mother, such as nipple pain, ability to hand express, perception of inadequate supply, and any perceived need to supplement must also be addressed (Friedman & Spitzer, 2004; Langan, 2006; American Academy of Pediatrics [AAP] and the American College of Obstetricians and Gynecologists [ACOG], 2006; Johansson, 2004; Dewey et al., 2003; Sacco et al., 2006; Chapman & Perez-Escamilla, 1999; Ryan et al., 1990; Gartner et al., 2005; Kuan et al., 1999).
2. Prior to discharge, anticipation of breastfeeding problems should be assessed based on the maternal and/or infant risk factors (see Tables 1 and 2 in the original guideline document): All problems with breastfeeding, whether observed by hospital staff or raised by the mother should be attended to and documented in the medical record prior to discharge of mother and baby. A plan of action that includes follow-up of the problem after discharge must be in place (Friedman & Spitzer, 2004; Langan, 2006; AAP & ACOG, 2006; Johansson, 2004; Dewey et al., 2003; Sacco et al., 2006; Chapman & Perez-Escamilla, 1999; Ryan et al., 1990; AAP Section on Breastfeeding, 2005; Kuan et al., 1999; Yanicki et al., 2002; Ahluwalia, Morrow, & Hsia, 2005; Weiss, 2004; Britton et al., 2002; Madden et al., 2003; Taveras et al., 2003; Cernadas et al., 2003).
3. Physicians, midwives, nurses, and all other staff should encourage the mother to practice exclusive breastfeeding for the first 6 months of the infant's life and to continue breastfeeding through at least the first year of life, preferably to 2 years of life and beyond. The addition of appropriate complementary food should occur after 6 months of life (AAP & ACOG, 2006; AAP Section on Breastfeeding, 2005). Mothers will benefit from education about the rationale for exclusive breastfeeding. The medical, psychosocial, and societal benefits for both mother and baby and why artificial milk supplementation is discouraged should be emphasized. Such education is a standard component of anticipatory guidance that addresses individual beliefs and practices in a culturally sensitive manner (AAP & ACOG, 2006; AAP Section on Breastfeeding, 2005; Kuan et al., 1999; Taveras et al., 2003; Cernadas et al., 2003; Labbok et al., 2006; Kramer & Kakuma, 2002; Nelson, 2006; Taveras et al., "Opinions," 2004; Taveras et al., "Association," 2004; Scott et al., 2006; Kramer & Kakuma, 2004; James & Dobson, 2005; Moreland & Coombs, 2000; Donath & Amir, 2003; Li et al., 2004; Hannan et al., 2005; Walker, 1997; Philipp & Merewood, 2004; Brady, 1990). Special counseling is needed for those mothers planning to return to outside employment or school (AAP & ACOG, 2006; AAP Section on Breastfeeding, 2005). (See #7, below).
4. Families will benefit from appropriate, noncommercial educational materials on breastfeeding (as well as on other aspects of child health care) (Howard et al., 2000; Frank et al., 1987; Speer, 1996; Howard et al., 1994; Howard &

Howard, 1997; Neifert et al., 1988; Valaitis & Shea, 1993). Discharge packs containing infant formula, pacifiers, commercial advertising materials, and any materials not appropriate for a breastfeeding mother and baby should not be distributed. These may encourage poor breastfeeding practices, which may lead to premature weaning (AAP & ACOG, 2006; AAP Section on Breastfeeding, 2005; Howard et al., 2000; Frank et al., 1987; Speer, 1996; Howard et al., 1994; Howard & Howard, 1997; Neifert et al., 1988; Valaitis & Shea, 1993; Donnelly et al., 2000; Wright, Rice, & Wells, 1996; Perez-Escamilla et al., 1994; Snell et al., 1992; Frank, 1989; Cronenwett et al., 1992; Auerbach, 1987; Bliss et al., 1997; Victora et al., 1997; Howard et al., 2003; Howard et al., 1999; Aarts et al., 1999; Vogel, Hutchison, & Mitchell, 2001; Barros et al., 1995; Nelson, Yu, & Williams, 2005; Gorbe et al., 2002; Barros et al., 1997; Kramer et al., 2001; Righard, 1998; Benis, 2002; Righard & Alade, 1997; Adair, 2003; Binns & Scott, 2002; Ullah & Griffiths, 2003).

5. Breastfeeding mothers and appropriate others will benefit from simplified anticipatory guidance prior to discharge regarding key issues in the immediate future. Care must be given not to overload mothers. Specific information should be provided in written form to all parents regarding:
    a. Management of engorgement
    b. Indicators of adequate intake (yellow bowel movements by day 5, at least six urinations per day and three to four stools per day by the fourth day of life, and regain birth weight by days 10 to 14)
    c. Signs of excessive jaundice
    d. Sleep patterns of newborns, including safe cosleeping practices; (see Academy of Breastfeeding Medicine [ABM] Protocol #6: Guideline on Cosleeping and Breastfeeding)
    e. Maternal medication use
    f. Individual feeding patterns, including normality of evening cluster feedings
    g. Follow-up and contact information (AAP & ACOG, 2006; AAP Section on Breastfeeding, 2005; Neifert, 1999; AAP Subcommittee on Hyperbilirubinemia, 2004; Neifert, 2001; Gartner & Herschel, 2001).
6. Every breastfeeding mother should receive instruction on the technique of expressing milk by hand (whether she uses a pump or not), so she is able to alleviate engorgement, increase her milk supply, or prepare to use a pump. In addition, she may need to be taught to use a breast pump so that she can maintain her supply and obtain milk for feeding to the infant should she and the infant be separated or if the infant is unable to feed directly from the breast (AAP & ACOG, 2006; AAP Section on Breastfeeding, 2005; World Health Organization [WHO], United Nations Children's Fund [UNICEF], 1990; Schanler, 2005; Nyqvist, Sjoden, & Ewald, 1994; Auerbach & Walker, 1994; Forte, Mayberry, & Ferketich, 1986; Chamberlain et al., 2006).
7. If a mother is planning on returning to outside employment or school soon after delivery, she would benefit from additional written information. This should include social support, possible milk supply issues, expressing and storing milk away from home, the possibility of direct nursing breaks with the baby, and her local and/or state laws regarding accommodations for breastfeeding and milk expression in the workplace (AAP & ACOG, 2006; AAP Section on Breastfeeding, 2005; Chamberlain et al., 2006; Killien, 2005; Neilsen, 2004; Eldridge & Croker, 2005; Rea & Morrow, 2004; Click, 2006; Ryan, Zhou, & Arensberg, 2006; Kimbro, 2006; Dodgson, Chee, & Yap, 2004; Brown, Poag, & Kasprzycki, 2001; Bromberg Bar Yam, "Workplace lactation support, part II," 1998; Slusser et al., 2004; Stevens & Janke, 2003; Bocar,

1997; Greiner, 1993; Bridges, Frank, & Curtin, 1997; Bromberg Bar Yam, "Workplace lactation support, part I," 1998; O'Gara, Canahuati, & Moore Martin, 1994; Biagoli, 2003; Cohen, Mrtek, & Mrtek, 1995; Corbett-Dick & Bezek, 1997; Gielen et al., 1991; Greenberg & Smith, 1991; Meek, 2001; Pantazi, Jaeger, & Lawsin, 1998). It is prudent to provide her with this information in written form, so that she has resources when the time comes for her to prepare for return to work or school.

8. Every breastfeeding mother should be provided with names and phone numbers of individuals and medical services that can provide advice, counseling, and health assessments related to breastfeeding on a 24 hour-a-day basis if available, as well as on a less intensive basis (AAP & ACOG, 2006; Gartner et al., 2005; Kuan et al., 1999; Philipp, 2001; Philipp & Caldwell, 1999; Philipp, Merewood, & O'Brien, 2001; Chen, 1993; Houston et al., 1981; Long et al., 1995; Bonuck et al., 2005; Labarere et al., 2005; Nankunda et al., 2006; Chapman et al., "Effectiveness," 2004; Fetrick, Christensen, & Mitchell, 2003; Martens, 2002; Merewood & Philipp, 2003; Heinig et al., 2006; Anderson et al., 2005; Gross et al., 1998; Stremler & Lovera, 2004; Kistin, Abramson, & Dublin, 1994; Cohen, Lange, & Slusser, 2002; Graffy & Taylor, 2005; Chapman, Damio, & Perez-Escamilla, 2004; Bronner, Barber, & Miele, 2001; Bronner et al., 2001; Bronner, Barber, & Davis, 2001; McInnes, Love, & Stone, 2000; Ahluwalia et al., 2000; Shaw & Kazorowski, 1999; Morrow et al., 1999; Arlotti et al., 1998; Schafer et al., 1998; Grummer-Strawn et al., 1997; Milligan et al., 2000; Caulfield et al., 1998; Chapman et al., "Association," 2004; Perez-Escamilla & Guerro, 2004; Agrasada et al., 2005).
9. Mothers should be provided with lists of various local peer support groups and services (e.g., La Leche League, hospital/clinic based support groups, governmental supported groups, e.g., WIC [Women, Infants, and Children] in the U.S.) with phone numbers, contact names, and addresses. They should be encouraged to contact and consider joining one of them (AAP & ACOG, 2006; Gartner et al., 2005; Kuan et al., 1999; Philipp, 2001; Philipp & Caldwell, 1999; Philipp, Merewood, & O'Brien, 2001; Chen, 1993; Houston et al., 1981; Long et al., 1995; Bonuck et al., 2005; Labarere et al., 2005; Nankunda et al., 2006; Chapman et al., "Effectiveness," 2004; Fetrick, Christensen, & Mitchell, 2003; Martens, 2002; Merewood & Philipp, 2003; Heinig et al., 2006; Anderson et al., 2005; Gross et al., 1998; Stremler & Lovera, 2004; Kistin, Abramson, & Dublin, 1994; Cohen, Lange, & Slusser, 2002; Graffy & Taylor, 2005; Chapman, Damio, & Perez-Escamilla, 2004; Bronner, Barber, & Miele, 2001; Bronner et al., 2001; Bronner, Barber, & Davis, 2001; McInnes, Love, & Stone, 2000; Ahluwalia et al., 2000; Shaw & Kazorowski, 1999; Morrow et al., 1999; Arlotti et al., 1998; Schafer et al., 1998; Grummer-Strawn et al., 1997; Milligan et al., 2000; Caulfield et al., 1998; Chapman et al., "Association," 2004; Perez-Escamilla & Guerro, 2004; Agrasada et al., 2005).
10. In countries where discharge is common before or by 3 days of age, prior to discharge, appointments should be made for (a) an office or home visit, within 3 to 5 days of age, by a physician, midwife, or a physician-supervised breastfeeding trained licensed health care provider and (b) the mother's 6-week follow-up visit to the obstetrician or family physician who participated in the delivery of the baby. Infants discharged before 48 hours of age should be seen by 96 hours of age (AAP & ACOG, 2006; Gartner et al., 2005; "Management," 2004). Additional visits for the mother and the infant are recommended even if discharge occurs at greater than 5 days of age, until all

clinical issues such as adequate stool and urine output, jaundice, and the baby attaining birth weight by 10 days of age are resolved. (Note: a baby who is not back to birth weight at day of life 10, but who has demonstrated a steady, appropriate weight gain for a number of days, is likely fine. This baby may not need intervention, but continued close follow-up.) Any baby exhibiting a weight loss approaching 7% of his birth weight by 5 to 6 days of life needs to be closely monitored until weight gain is well established. Should 7% or more weight loss be noted after 5 to 6 days of life, even more concern and careful follow-up must be pursued. These babies require careful assessment, as by 4 to 6 days the infant should be gaining weight daily, so their "% weight loss" is actually more when that is taken into account. In addition to attention to these issues, babies with any of these concerns must be specifically evaluated for problems with breastfeeding and milk transfer (AAP & ACOG, 2006; Gartner et al., 2005; Neifert, 2001; Chen, 1993; Houston et al., 1981; Bonuck et al., 2005; Labarere et al., 2005; Fetrick, Christensen, & Mitchell, 2003; Martens, 2002; Graffy & Taylor, 2005; Morrow et al., 1999; Caulfield et al. 1998; Casiday et al., 2004; Svedulf et al., 1998; Madden et al., 2004; Madlon-Kay, DeFor, & Egerter, 2003; Galbraith et al., 2003; Winterburn & Fraser, 2000; Margolis & Schwartz, 2000).

11. If the mother is medically ready for discharge but the infant is not, every effort should be made to allow the mother to remain in the hospital either as a continuing patient or as a "mother-in-residence" with access to the infant for exclusive breastfeeding promotion. Maintenance of a 24-hour rooming-in relationship with the infant is optimal during the infant's extended stay (Rapley, 2002; Waldenstrom & Swenson, 1991; Yamauchi & Yamanouchi, 1990; Keefe, 1988; Keefe, 1987; Procianoy et al., 1983; Lindenberg, Cabrera Atroloa, & Jimenez, 1990).
12. If the mother is discharged from the hospital before the infant is discharged (as in the case of a sick infant), the mother should be encouraged to spend as much time as possible with the infant, practice skin-to-skin technique and Kangaroo care with her infant whenever possible, and to continue regular breastfeeding (Hurst et al., 1997; Browne, 2004; Carfoot, Williamson, & Dickson, 2003; Anderson et al., 2003; Bier et al., 1996; Wallace & Marshall, 2001; Kirsten, Bergman, & Hann, 2001). During periods when the mother is not in the hospital, she should be encouraged to express and store her milk, bringing it to the hospital for the infant.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

The recommendations were based primarily on a comprehensive review of the existing literature. In cases where the literature does not appear conclusive, recommendations were based on the consensus opinion of the group of experts.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Improved breastfeeding outcomes for mothers and infants

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

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

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Foreign Language Translations

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Academy of Breastfeeding Medicine Clinical Protocol Committee. ABM Clinical Protocol #2 (2007 revision): guidelines for hospital discharge of the breastfeeding term newborn and mother: "the going home protocol". Breastfeed Med 2007 Sep;2(3):158-65. [156 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2007 Sep

GUIDELINE DEVELOPER(S)

Academy of Breastfeeding Medicine - Professional Association

SOURCE(S) OF FUNDING

Academy of Breastfeeding Medicine

A grant from the Maternal and Child Health Bureau, US Department of Health and Human Services

GUIDELINE COMMITTEE

The Academy of Breastfeeding Medicine Clinical Protocol Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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Protocol Committee: Caroline J. Chantry, M.D., FABM, Co-Chairperson; Cynthia R. Howard M.D., MPH, FABM, Co-Chairperson; Ruth A. Lawrence, M.D., FABM; Kathleen A. Marinelli, M.D., FABM, Co-Chairperson; Nancy G. Powers, MD, FABM

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

None to report

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Academy of Breastfeeding Medicine Web site.

Print copies: Available from the Academy of Breastfeeding Medicine, 140 Huguenot Street, 3rd floor, New Rochelle, New York 10801.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Procedure for protocol development and approval. Academy of Breastfeeding Medicine. 2007 Mar. 2 p.

Print copies: Available from the Academy of Breastfeeding Medicine, 140 Huguenot Street, 3rd floor, New Rochelle, New York 10801.

A Korean translation of the original guideline document is available from the Academy of Breastfeeding Medicine Web site.

PATIENT RESOURCES

None available

NGC STATUS

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