CE 1.5 ANCC Contact Hours

BECOMING A BABY-FRIENDLY HOSPITAL

Abstract

The purpose of the Baby-Friendly hospital initiative is to encourage hospitals to use best practices to support infant feeding, as demonstrated by implementing the *Ten Steps to Successful Breastfeeding* recommended by the World Health Organization. The journey to becoming a Baby-Friendly designated hospital is challenging but ultimately rewarding. In October 2015, Boulder Community Foothills Hospital, a community hospital with a strong breastfeeding culture and a 98% rate of women who initiate breastfeeding postpartum, became one of the approximately 300 Baby-Friendly designated hospitals in the United States. Significant challenges and how we succeeded each step of the way are included. Even when a hospital is breastfeeding friendly, becoming Baby-Friendly is never a mere formality. Nursing leadership teams in other hospitals may find value in the details of our successful efforts to become a Baby-Friendly designated hospital.

Keywords: Baby-Friendly hospital designation; Breastfeeding.

The Baby-Friendly Hospital Initiative (BFHI) was started in 1991 by the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF) (WHO, 2016). The purpose of the BFHI is to encourage hospitals to use best practices to support infant feeding, as demonstrated by implementing the *Ten Steps to Successful Breastfeeding* (WHO & UNICEF, 1989) (Table 1). In the United States, Baby-Friendly designation is conferred by Baby-Friendly USA (BFUSA). Support and encouragement for hospitals to achieve this designation is growing and is endorsed by the American Academy of Pediatrics (Eidelman et al., 2012), Surgeon General (US Department of Health and Human Services, 2011), and Centers for Disease Control and Prevention (Shealy, Li, Benton-Davis, & Grummer-Strawn, 2005). Other professional organizations are listed on the BFUSA's Web site as endorsing the *Ten Steps* including the American Academy of Nursing; Association of Women's Health, Obstetric, and Neonatal Nurses; American College of Obstetricians and Gynecologists; and

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American College of Nurse-Midwives. In California, all hospitals with obstetric services are required to attain Baby-Friendly designation by the year 2025 (California Breastfeeding Coalition, 2013). Some researchers have found that the *Ten Steps* are associated with longer breastfeeding duration (DiGirolamo, Grummer-Strawn, & Fein, 2008; Forrester-Knauss, Merten, Weiss, Ackermann-Liebrich, & Zemp Stutz, 2013; Merten, Dratva, & Ackermann-Liebrich, 2005).

A tenet of being Baby-Friendly is compliance with the WHO (1981) *International Code for Marketing Breastmilk Substitutes*. Hospitals that are compliant with this code must pay fair market price for infant formula, and not advertise formula products. Historically, formula companies provided hospitals with free formula, or at very low cost. An advertising method used by formula companies is distribution of gifts such as diaper bags containing free formula and discount coupons. This practice can have a negative impact on breastfeeding (Rosenberg, Eastham, Kasehagen, & Sandoval, 2008).

Our Journey

In October 2015, Boulder Community Foothills Hospital, in Boulder, Colorado became one of the 300 Baby-Friendly designated hospitals in the United States. The journey was lengthy and challenging, but worthwhile. Our lactation program was created in 1989. It took 25 years to transition from a breastfeeding-friendly hospital to a Baby-Friendly designated hospital.

> The Baby-Friendly Hospital Initiative is gaining momentum in the United States.

Boulder Community Foothills Hospital is located in one of the healthiest cities in the United States; with the lowest obesity rate nationwide (Holohan, 2014). There is an emphasis on all aspects of a healthy lifestyle, including nutrition. The hospital has a reputation of being supportive of breastfeeding; 98% of mothers who give birth at our hospital choose to initiate breastfeeding. Achieving Baby-Friendly designation seemed possible, and perhaps even easy. In the mid 1990s, the idea was presented to our pediatricians. There was insufficient interest at that time to pursue the designation. Efforts were redirected toward eliminating distribution of formula marketing bags, which was successful in 2006. The general hospital policy forbidding any outside advertising convinced upper management leaders to apply it to baby formula. This was an important accomplishment in our Baby-Friendly journey.

The combined persistence of the lactation program coordinator and the neonatal intensive care unit (NICU) manager convinced the leadership team that we should begin the process of obtaining Baby-Friendly designation. In 2007, the NICU manager was appointed to lead the project, providing emphasis that support for Baby-Friendly does not only exist within a lactation program. We felt that we already met most of the *Ten Steps*. However, Step 2 provided the most significant challenge. Step 2 requires that hospitals educate all healthcare personnel so they have knowledge and skills necessary to implement practices outlined in a well-written, widely disseminated breastfeeding policy (WHO & UNICEF, 1989). Specifically, maternity and neonatal nurses are required to have 20 hours of breastfeeding education. We needed a cost-effective way to educate the current team, and those who were newly hired. The financial challenge seemed insurmountable, and our efforts came to a standstill.

A breakthrough came in April 2012 when the lactation program coordinator became aware of another hospital's educational program for the BFHI. The program included an educational binder with four components. There were 1) modules created by Wellstart International (2014), a nonprofit breastfeeding healthcare education organization that partially meet the educational requirements of the BFHI and available at no cost, 2) articles, with follow-up questions, 3) titles of videos to watch, and requirements of nurses to write a synopsis about effects of the information on personal practice, and 4) a log for shadowing and observing a lactation consultant. We felt that this was a cost-effective education plan that we could duplicate, so permission was obtained from the author to replicate the program.

An example binder with all of the materials was created. Required permissions were obtained from Wellstart International and from the Academy of Breastfeeding Medicine to use and copy their materials. The program was presented to the NICU manager and nursing director of the Family Birth Center. There was a consensus that this was a quality and cost-effective educational plan. Approval was obtained from hospital administrators in August 2012 to pursue Baby-Friendly designation.

Baby-Friendly USA 4-D Pathway Versus Our Path

In 2010, BFUSA initiated the *4-D Pathway to Baby-Friendly Designation*. The pathway consists of four phases, completed by accomplishing specific tasks to assist in achieving BFHI designation (BFUSA, 2010). The NICU manager had been given approval to start working on the process in 2007. Consequently, the initial work was not performed in the order recommended by the pathway.

Discovery Phase

We registered with BFUSA in 2012, officially beginning the pathway. A letter signed by our chief executive officer (CEO), which demonstrated leadership support to undertake the process, was submitted along with a *Facility Data Sheet* and *Self-Appraisal Tool*. These were required by BFUSA to complete the Discovery Phase. No fee is required for this phase, although fees are required to begin other phases.

Table 1. Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all healthcare staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within 1 hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in: allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.

WHO & UNICEF (1989) *Protecting, promoting and supporting breastfeeding: The special role of maternity services. http://apps.who.int/iris/bitstream/10665/39679/1/9241561300.pdf*

Our Baby-Friendly committee was formed in the Discovery Phase, although BFUSA recommends this task in the Development Phase. The committee was created right from the start to share the work among a group committed to the project. The core committee consisted of the NICU manager, serving as committee chair, lactation program coordinator, education coordinator, another lactation consultant, and nursing director of the Family Birth Center. Other committee members joined and left at different times, as needed. Throughout the journey, nurses from the NICU, labor and birth, and mother–baby units were represented. In January 2013, the nurse education program was implemented, during our Discovery Phase. Although BFUSA recommends this occur during the Dissemination Phase, this approach worked well for us because nurses received immediate breastfeeding education, boosting their knowledge and confidence during the rest of the process.

Development Phase

In September 2013, the Development Phase began. This is the phase that BFUSA recommends for convening a Baby-Friendly committee, a task we had already completed. Our committee worked together to complete the other tasks of this phase.

- Develop a work plan: Prepared by the NICU manager and lactation program coordinator, this identified the areas that needed improvement.
- Develop an infant feeding policy: A subcommittee created the policy and submitted it, along with our Supplementation policy to BFUSA for review. They evaluated whether the policies met their criteria, and provided feedback on any specific areas that did not.
- Develop a Patient Education Plan: Completed by a subcommittee.
- Develop a Data Collection Plan: Completed by a subcommittee.
- Develop a nurse and provider educational plan: Meeting Step 2 meant educating nurses and providers. Provider education lasts 3 hours. The lactation program coordinator and the education coordinator worked together to create 12 modules, which included the following topics: Becoming Baby Friendly, Practitioner Impact on Breastfeeding, Prenatal Guidance and Management, Anatomy and Physiology of Lactation, Benefits of Exclusive Breastfeeding, Frequency and Duration, Pacifiers and Breastfeeding, Breastfeeding Tools, Breastfeeding Resources, Office and Telephone Assessment of Breastfeeding, Breastfeeding Problems, and A Breastfeeding Friendly Practice

How We Addressed Challenges of Each Step

Throughout the Development Phase, we worked to ensure that we were compliant with BFUSA (2016) *Guidelines and Criteria*; "the standard of care that facilities should strive to achieve for all patients" and the "the minimum standard that a facility must achieve to become Baby Friendly designated." We complied with each of the *Ten Steps* as follows:

Step 1: We used resources made available by BFUSA to write our policy, *Care of the Breastfeeding Couplet with a Healthy Term Infant*.

Step 2: Each nurse received *The Binder,* a self-paced program to be completed by October 2013. Content of the educational program in the binder is listed in Table 2. Nurses attended a 2-hour class, offered four times during the year. Nurses hired after that year are required to review an electronic slide presentation that covers information from the class. Shadowing a lactation consultant for 4 hours was required. Nurses were observed for 1 hour, providing breastfeeding assistance to patients, to verify competence. Patient assistants and obstetric technicians attended the 2-hour class.

Step 3: Prenatal education was updated to ensure that it covered all 10 steps.

Step 4: The practice of helping mothers initiate breastfeeding within 1 hour of birth was well established. Skin-to-skin after birth is not one of the 10 steps, but is evaluated by BFUSA, and we had been practicing it for over 10 years.

Step 5: Mothers are routinely shown how to breastfeed and how to maintain lactation, even if they are separated from their infants. Education was offered to the nurses about importance of NICU moms with premature infants initiating breast pumping within 6 hours of birth.

Step 6: Since 2005, we have used human donor milk for any infant who requires medically indicated supple-

Table 2. Educational Materials

1) Wellstart Modules—Level I (Basic knowledge needed by all healthcare providers to support healthy mothers and their healthy full-term babies)
2) Articles: a) Achieving Baby-Friendly designation: Step-by-step (Goodman & DiFrisco, 2012). b) ABM Clinical Protocol# 2: Guidelines for hospital discharge of the breastfeeding term newborn and mother: "The going home protocol" (Academy of Breastfeeding Medicine Clinical Protocol Committee, 2007). c) ABM clinical protocol# 5: Peripartum breastfeeding management for the healthy mother and infant at term (Academy of Breastfeeding Medicine Clinical Protocol Committee, 2008). d) The effect of feeding method on sleep duration, maternal well-being, and postpartum depression (Kendall-Tackett, Cong, & Hale, 2011). e) Night rooming-in: Who decides? An example of staff influence on mother's attitude (Svensson, Matthiesen, & Widström, 2005). f) The burden of suboptimal breastfeeding in the United States: A pediatric cost analysis (Bartick & Reinhold, 2010).
3) Videos: a) From bottles to breasts to baby-friendly: The challenge of change (Injoy Birth and Parenting Education, 2001). b) Managing early breastfeeding challenges (Injoy Birth and Parenting Education, 2011). c) Getting started with breastfeeding (Standford Medicine Newborn Nursery at Lucile Packard Children's Hospital, 2012): A perfect latch Hand expressing milk Maximizing milk production

mentation. Education is offered on this topic in prenatal classes, the physicians and midwives (CNMs) promote it and the community knows about it. There are few requests for formula for elective supplementation.

Step 7: Mothers and babies routinely remain together 24 hours a day. We do not have a well-baby nursery, all infants room-in. However, this step was challenging because some nurses offer to take babies to the nurses' station to allow parents to sleep undisturbed. Through education and creating nurse accountability, we were working to resolve this issue before our decision to attempt Baby-Friendly designation. During our on-site assessment, 24-hour rooming-in was practiced 80% of the time, which is the minimum required by Baby-Friendly.

Step 8: Breastfeeding on demand is well established. Baby-Friendly encourages the promotion of cue-based feeding and the use of that verbiage. Words such as "cue-based" or "feed by cues" are encouraged and there are posted signs with these terms in the postpartum rooms.

Step 9: No pacifiers or artificial nipples for breastfeeding infants was one area that needed improvement. Education over the years reduced pacifier use, but it still occurred more than 20% of the time. Bottles were the first choice for supplementation. A committee member made an instructional video for the nurses about the Supplemental Nursing System (SNS), and education was provided promoting the use of spoon-feeding. After circumcisions, infants often went back to the room with the pacifier used to administer sucrose oral solution for comforting. A sign was posted in the circumcision procedure room as a reminder to discard the pacifier after the procedure. The sign was seen by practitioners and parents. Over time, pacifier use decreased, and spoon-feeding and use of the SNS for supplementation increased.

Step 10: Outpatient services for breastfeeding have been offered since the lactation program began 25 years ago. The weekly breastfeeding support group has been well attended since its inception, over 10 years ago. Mothers can call the lactation office with questions.

Dissemination Phase

The dissemination phase includes nurse, provider, and patient education and data collection. Education for the nurses had already been completed, so we were able to focus on provider education. We sent providers a letter informing them that Baby-Friendly education was required, and when it would occur. The 12 on-line modules could be completed at their own pace. All obstetricians, pediatricians, family practice physicians, neonatal nurse practitioners (NNPs), and CNMs were required to complete the education. New providers are required to complete the education as part of their credentialing. At the time of our site visit 94% of providers had accomplished the education.

In our prenatal breastfeeding class, we implemented a new presentation that addressed the *Ten Steps*. Our postpartum education included a booklet, *Understanding Mother and Baby Care: A Guide to the First Days and Weeks* (2016), produced by Injoy Birth and Parenting Education, which complied with the *Ten Steps*. Mothers who fed formula received a handout on formula preparation, *How to Prepare Formula for Bottle Feeding at Home* (2007), created by WHO and the United Nations (2007), along with individual, detailed instructions on safe formula preparation. We added items to our discharge-teaching sheet, such as hand expression and the

recommendation to breastfeed exclusively for the first 6 months, to ensure that those items that are required by BFUSA are included in patient education. Data collection included questionnaires that were given to every new mom to complete, medical record reviews, and in-person surveys of moms and nurses. When the audit results were satisfactory and 80% of the providers had completed the education, we applied to move to the Designation Phase.

Designation Phase

In this phase, the hospital is required to implement the *International Code of Marketing Breastmilk Substitutes* (WHO, 1981). We had accomplished this when we discontinued the distribution of the formula marketing bags in 2006, and began paying for our formula in 2008. Another task of this phase is to have a telephone readiness assessment phone call with a representative from BFUSA. Our nursing director of the Family Birth Center, education coordinator, and lactation program coordinator participated in this call. The purpose is to determine what areas a hospital might need to address in order to be ready for a site visit. The phone call went smoothly, reinforcing our sense that we were ready for our site visit.

The most significant outcome of the phone call related to Step 3. If a facility has affiliated prenatal services, those practices providing the prenatal services are included in the site visit. The practices will be visited and their patients will be interviewed. Our hospital does not own any obstetric practices, or employ any of the providers or staff working in them. There are two practices that lease space in a building owned by the hospital. When we began our journey in 2012, we used questions BFUSA had provided to assist hospitals in determining if they had affiliated prenatal services and determined that we did not. The questions had changed since 2012. We asked our telephone interviewer if we would be considered to have affiliated prenatal services. She was uncertain and said she would get back to us. Eventually, BFUSA decided the obstetric practices were considered affiliated because of the leased space and their mention on the hospital's Web site. This presented us with a significant challenge because these are private practices, and we cannot mandate the care or education they provide. Although the majority of the education provided by the practices was appropriate, we worked with them to ensure the inclusion of all topics required by BFUSA. These discussions helped open a dialogue with the providers in the practices about prenatal education that provides optimum support of breastfeeding. However, during the site visit, it was the assessors' determination that we, in fact, did not have affiliated prenatal services, and the practices were not visited.

Prior to the readiness telephone call and site visit, we had to complete new *Facility Data Sheets*, with current information. We conducted a medical record review of all births that had occurred the prior month to complete these data sheets. The final task of the Designation Phase is the site visit. In late June, we submitted a letter, signed by our CEO, requesting our site visit. We were contacted by BFUSA and given a date 6 short weeks away.

Five weeks after the site visit, we learned we had met criteria to be a Baby-Friendly designated hospital.

We prepared the team with on-line reviews, posters around the unit, and emails reinforcing the same information. We provided physicians, CNMs, NNPs, and our chief nursing officer (CNO) with talking points. *Ten Steps* posters were hung in the admissions/emergency department area, by the entrance to the Family Birth Center, in L&D, on the Mother–Baby Unit, the NICU, and Pediatrics. Our two obstetric provider practices posted the *Ten Steps* posters in their offices.

Baby-Friendly USA gave very detailed instructions about what was required during the site visit. To present our materials in an organized manner, three binders were prepared for the assessors. The education binder contained staff education materials, modules for the providers, list of providers who had completed the education, and a spreadsheet documenting the nurse education completion. The patient education binder included prenatal and postpartum patient education materials. The policy binder had our infant feeding policy, and all the other breastfeeding-related policies available for review. We were ready.

Site Assessment

The lactation program coordinator met the assessors in our admissions area and pointed out the *Ten Steps* posters, explaining that everyone who receives any services at the hospital enters through this area and will see the posters. The unit director, department manager, the lactation program coordinator, one of our Baby-Friendly committee members, and our CNO attended the initial meeting. We had originally been told that both the CEO and CNO must be available during the site assessment. However, it was determined that because our CNO is a senior-level executive, her presence alone would be sufficient.

The assessors asked questions of the committee about our policies and procedures. We indicated we had a long-standing history of strong breastfeeding support, and we really did not have to change much to meet the *Ten Steps*. They proceeded with interviews of patients, nurses on day and night shifts, and providers. Our census was below the required number of interviews, so phone calls were made to patients who had recently given birth. They interviewed 10 women who had given birth vaginally, 5 women who had cesareans, and 5 mothers whose babies were in the NICU. We had one formula-feeding mother as an inpatient that day. Escorts assisted the assessors to retrieve information from the electronic health record as needed. Three mothers said the nurse had taken the infant out of the room, so they could rest. Only once was it properly documented. These data meant we were at the minimum 80% for the 24-hour rooming-in measure.

We had one birth during the site visit, a cesarean. We offered to have the assessors go into the operating room (OR) because we do skin-to-skin in the OR, but they chose to wait until the mom was in the recovery room and observed breastfeeding there. The assessors met with our purchasing director. He did not have the required documentation for our formula purchases because there was a misunderstanding about what kind of documentation was required. We had to find the necessary documentation. The assessors explained that they had encountered hospitals that try to hide certain things, including not purchasing formula at a fair market value. As a consequence, specific documentation is required. We reviewed the binders with the assessors, allowing them to determine that we were compliant with education and policies. After spending 11 hours with us, they were finished by 9 p.m. They returned for a short time the next morning to do one last provider interview, and take a tour of the Family Birth Center. That completed the assessment.

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Each phase of the process involved significant and unique challenges.

Suggested Clinical Implications

The breastfeeding education program for nurses that we used is a cost-effective program that other hospitals could duplicate.

Support and leadership for Baby-Friendly designation can originate from team members other than the lactation consultants.

Baby-Friendly designation is possible, even when the journey is somewhat unconventional.

Achieving Baby-Friendly Designation

Five weeks later, we got a call that we had passed our site visit and were now a Baby-Friendly designated hospital! This achievement was a very large undertaking. We had started the process thinking it would be easy. Much more work was required than we expected. Benefits of the process included providing comprehensive education for the nurses and providers. Pacifier use was decreased, alternatives to bottles increased, and rates of 24-hour rooming-in increased. The process and eventual Baby-Friendly designation reinforced and recognized the incredible job we do every day for our patients.

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