**Introduction**

Effective documentation, data collection and analysis are critical to any quality improvement effort. This User’s Guide is intended to support optimal practices for hospitals participating in the Baby-Friendly® Hospital Initiative or implementing a quality improvement initiative for maternity care practices. It is designed to ease your transition to a newer set of documentation norms that better-reflect current standards of practice in maternity care.

This document:

1. Describes a set of measures designed to align with the Joint Commission Perinatal Core Measure 05\(^1\) and Baby-Friendly USA requirements;\(^2\)
2. Outlines several options for documenting each measure using standard selection tools that can easily be extracted for reports, and;
3. Summarizes recommendations for simple data collection and analysis of each measure.

**The Gold Standard: The Electronic Health Record**

The Electronic Health Record (EHR) is considered the *gold standard* in documentation for several reasons:

1. Research shows that well-designed documentation requirements often drive care practices, especially when staff are experiencing changes to their workflow. For example, requiring the nurse to check off the elements of patient education in the EHR cues the nurse to provide the information, ensuring comprehensive care and preventing oversights. Since “EHRs are tailored primarily to clinical work flows; information is often captured as narrative documentation. Differences in writing style, as well as desire to accurately record clinical details or degree of confidence in observations, lead to wide variations in clinicians' expression of a given fact, making automated interpretation difficult.”\(^3\)

Take for instance, Irene, a quality improvement advisor at a large teaching hospital who wanted to report on rates of instruction about feeding cues. Feeding cues were recorded in nurse progress notes using free text, so Irene had to search for the information. Nurses were using different words: cue, on-demand, baby-led, etc., which made it difficult to find. Furthermore, some nurses told her that they often forgot to document the instruction even if they did it. After making Feeding Cues a checkbox option in the patient education tab, Irene could auto-generate a report that showed how many mothers did have the feeding cues box checked. She still interviewed a sample of patients to ensure that they understood the instruction, but she now had census-level data with which to drive improvement efforts and hold staff accountable. She praised the staff for the improvement she saw in the EHR and heard about during patient interviews. The staff replied that it was much easier to remember when it was part of their standard teaching checklist.

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\(^1\) https://manual.jointcommission.org/releases/TJC2013A/MIP0170.html
\(^2\) https://www.babyfriendlyusa.org/get-started/the-guidelines-evaluation-criteria
\(^3\) http://www.academicpedsjnl.net/article/S1876-2859%2814%2900215-0/fulltext
2. Automating data collection, which is only possible in the EHR, will make it faster and easier for you to learn from your data. Yes, it can be challenging to add or change the EHR. However once complete, an EHR professional will be able to compile the information needed to track progress over time quickly and efficiently. This allows for more time to be spent on the real improvement work.

The control chart pictured in Figure 1 demonstrates best practice in a visual display of data. It pulls data on all post-partum patients from September of 2013 through September of 2014. In a few seconds, one can see rates of instruction about manual milk expression appeared to be rising for the first few months while data was being collected through patient interviews with a small sample of patients. However, the facility added documentation to the EHR at the end of November, 2013, and the practice actually appeared to decrease. This may have been a real practice change, or more likely, a reflection of the time it can take for staff to begin using the EHR documentation consistently and accurately. Within two months, the practice was back to the same median as before the documentation change, suggesting that their real practice was about 20%. In March, 2014, the IBCLC shifted some of the time she previously spent conducting patient interviews to facilitate a Nursing Hand Expression Competency Fair, after which rates of instruction rose significantly and continuously. The team can see their progress, tell their story, and make informed decisions about how to continue improving this priority practice. This illustrates a productive, meaningful use of data from the EHR.

“I used to spend tons of time conducting chart audits – searching through nursing and provider notes to see whether each practice was done. Now, I get an automated report from IT each month, including rates of each practice for ALL births. It took about two months for everyone to get used to checking the new boxes. Still, the results from the full census matches the results I get from patient interviews much better than the audits I used to do. I can spend more time with patients, and the quality of the data is more dependable!” Kim – Mother-Baby Nurse
3. The well-organized EHR is known to increase consistency and communication among the many health professionals responsible for caring for mothers and babies. This results in fewer omissions and errors, improved efficiency, and greater patient satisfaction.

**I always know which topics have already been discussed with my patient because they are setup like a checklist in the EHR. Before that, our stats showed that we were always missing a topic or two. Or, we would keep repeating and our patients would get annoyed. The checklist is great!**  - Beverly, Prenatal Nurse

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**Meaningful Use**

“Meaningful use” has become a hot topic in contemporary healthcare systems. According to the United States Government, the concept of meaningful use rests on the five pillars of health outcomes policy priorities, namely:

1. Improving quality, safety, efficiency, and reducing health disparities
2. Engage patients and families in their health
3. Improve care coordination
4. Improve population and public health
5. Ensure adequate privacy and security protection for personal health information

Electronic Health Records enable us to compile massive amounts of clinical data, driving the process of change. “The expansion of machine-readable health information provides new opportunities for quality measurement.” The trick is to document what is actually needed (nothing more and nothing less) to:

a) ensure safe patient care, and

b) allow efficient data gathering to aid in the improvement process. When we learn from our compilation of data, informed decisions about how to manage our quality improvement programs can be made.

**Using Your Data to Learn and Drive Improvement**

Once you have the documentation system you need to auto-generate regular reports, it is best to do so at least monthly since you are looking at fairly common events. You can even create visual displays of your data, and post it for staff and patients to see, making everyone a part of the improvement journey.

It is best to compare your EHR data with patient interviews, point-of-use inventory management programs (such as Pyxis) and other data sources. Doing so will provide additional information to use in deciding where to direct your improvement efforts and create a verification loop.

For example, you may wish to know how your feeding cues instruction is progressing. The EHR consistently reflects 95–100% rate of instruction. Using the Baby Friendly USA Post-Partum Woman Audit Tool, you ask a sample of moms, “What have you been told about how often and how long to feed

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4 http://www.cdc.gov/ehrmeaningfuluse/introduction.html

5 http://www.academicpedsjnl.net/article/S1876-2859%2814%2900215-0/fulltext
“your baby?” All of the moms say “every 2-3 hours.” Probing further, you ask the moms, “what, if anything, were you told about feeding cues?” Almost all of the mothers reply that the “nurse said to feed my baby when she shows the feeding cues.” This tells you that feeding cues are in fact being discussed, as indicated by the EHR. However, the mothers are not integrating the information as intended; they do not understand that they are being advised to feed their infants by the infants’ cues, as often and for as long as their baby shows hunger. Having compared the EHR data against patient interviews, you now know that you need to work with the staff to come up with better ways of getting the information across.

Electronic Health Record Formats and Adapting

In order to maximize meaning and minimize burden, we recommend that you convene a Documentation and Data Collection Sub-Committee to reconsider design, implementation and extraction data from the EHR.

1. Include managers of each unit, clinical users from each unit, a quality improvement advisor and data / EHR specialist from your facility.
2. Review documentation requirements.
3. Review current EHR, and discuss potential revisions to satisfy the requirements that will also simplify data extraction and fit in with the existing clinical work flow.
   For example, ask a Labor & Delivery nurse where they already document infant care during the time that skin-to-skin is ongoing. Then see if you can fit skin-to-skin documentation within that area. This way, the nurse will not have to navigate to a special page consuming unnecessary time, risking confusion or forgetting.
4. Make the changes, and review as a sub-committee before going live. Revise as needed.
5. Host staff huddles to inform staff of new documentation formats, emphasizing the efforts to set them up for success and ease their documentation burdens.
6. Set a date for feedback review. On that date, review the clinicians’ feedback and reports of extracted data. Ask yourselves:
   a. Did we document care accurately?
   b. Did we get the information needed to guide improvements?
   c. Were the clinical users satisfied?
   d. Was the extraction process as simple as possible?

Note: Changing your documentation standards is a process that should include staff. Organizations with setbacks to the adaptations of the EHR process should not get discouraged. Many have overlooked using their best asset to determine how their EHR system can not only function well but produce meaningful data; the people on the floor who use the system the most.6

Listening to those who use the system will ensure one of the most important factors in creating a well-balanced EHR; ensuring the same part of the chart where the staff is already documenting at that time is used to capture the data needed in order to ensure that they will remember and reduce time spent clicking into various components.

http://www.healthit.gov/sites/default/files/nlc_changemanagementprimer.pdf
Anatomy of the Electronic Health Record

Electronic Health Records are rapidly changing. Still, many facilities are working with a mix of different programs, and even a mix of paper and electronic documentation. This User’s Guide is created to support the lowest common denominator: medical records in which data on the mother and baby do not flow to each other. As your facility improves documentation programming, keep in mind that mothers and babies form a single couplet. Their physiology is intrinsically linked. As such, information about feedings, skin-to-skin, rooming-in and more should be shared across two records. It is not advisable to spend time documenting every practice in each record (i.e. double documenting). Therefore, is your mother and baby records do not cross-populate, be sure that all staff know where to document and retrieve information about each half of the couplet.

Every medical record template looks different. In order to ensure that facilities are reading this Guide with same understanding, we ask that readers consider the following description of the EHR.

System Components: Most Electronic Health Records are divided into Components, meaning separate templates for different types of information. Common System Components include Laboratory, Pharmacy, Computerized Provider Order Entry (CPOE), Clinical Documentation and Clinical Decision Support (CDS).

Within each System Component, there are typically Sub-Components. The Sub-Components of the Clinical Documentation are of utmost importance for implementing the recommendations herein. The Sub-Component Clinical Documentation typically includes Tabs for Flow Sheets (including Intake & Output), Discharge Summary Sheets, Delivery Summary Sheets, Provider Notes, Nurse Notes, etc. This Guide will show its users how to revise the templates for these Tabs to support clinical decision-making and patient education. Doing so depends on using structured templates, where staff are able to select from available options to standardize documentation and enable auto-generated monthly reports; an end to the dreaded searching of progress notes.

Each EHR is formatted differently. The examples contained within this guide are intended to show one of many ways the concepts are achieved. Every concept and data point can and should be adapted to fit your specific EHR. For example, in Skin-to-Skin – Vaginal Birth, the example shows Newborn Assessment as the component. It is also possible to insert skin-to-skin into Delivery Summary, Newborn Vitals, etc.

NOTE: While several software programs are shown in this guide, WISE does not endorse any particular electronic health documentation product or brand.

“A key lesson from the field: Listen to your staff—they are the experts in the operational nuances...They may know what is causing the most problems...and have ideas for fixing the problems. Leverage the staff’s knowledge, expertise, and experience, and foster their ideas for how the change can be best implemented. Enable their participation in the design, implementation, and evaluation of the progress of the initiative. When things go wrong, empower staff to find solutions and acknowledge the individual's contributions to workable solutions. Encourage other staff to do the same.”

http://www.healthit.gov/sites/default/files/nlc_change_managementprimer.pdf
Extraction Tables in this Guide

The Extraction Tables in this guide are intended to help users understand how to extract the data out of the HER and into a meaningful automated report. They are not meant as addition and subtraction symbols, as this would lead one to count the same patient multiple times. Instead, data should be run as the following to understand the inclusion or exclusion criteria for selection:

If the patient has the +, the patient is included.
If the patient has a -, the patient is excluded.

For example, look at the Extraction Tables for Exclusive Breastfeeding Infants:

<table>
<thead>
<tr>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>+ I&amp;O: Food: Formula <em>never</em> selected</td>
</tr>
<tr>
<td>+ I&amp;O: Food: Other <em>never</em> selected</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
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</thead>
<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
</tbody>
</table>

In narrative, this extraction table says: Only newborns who were discharged in the time period of analysis and for whom “formula” or “other” feedings were NEVER documented are included in the numerator.

Exclusion Criteria

The following are excluded from all measures pertaining to The Ten Steps to Successful Breastfeeding *except* “Expressing for Babies in Special Care.” The exclusion criteria are not listed out in the narrative or tables for each measure throughout this guide.

1. Admitted to the Neonatal Intensive Care Unit (NICU) for >4 hours during this hospitalization.
2. ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for galactosemia as defined in TJCManual2015A1 Appendix A, Table 11.21
3. ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for parenteral infusion as defined in TJCManual2015A1 Appendix A, Table 11.22
4. Experienced death
5. Length of stay >120 days
6. Enrolled in clinical trials (related to feeding)
7. Transferred to another hospital
8. Not term or <37 weeks gestation (≤36.6weeks)
Breastfeeding Infants – A Common Denominator

*Breastfeeding Infants* is a commonly used denominator in Ten Steps data. *Breastfeeding infants* should be defined as those whose mothers express an intent to breastfeed during this hospitalization; either exclusively or mixed with formula and/or infants who have breastfed at least once during hospitalization.

### Intent to Breastfeed

[Newborn Medical Record]
[Component] Clinical Documentation
[Sub-Component] Newborn Care Plan

- [Field] Feeding Plan [Drop Down]
  - Exclusive breastfeeding
  - Breastfeeding and formula feeding
  - Exclusive formula feeding (breastfeeding clinically contraindicated)
  - Exclusive formula feeding (maternal choice)

### Ever Breastfed

[Newborn Medical Record]
[Component] Clinical Documentation
[Sub-Component] Newborn Care Plan
[Tab] Ins & Outs

- [Field] Food [Drop Down]
  - Breastfeeding
  - Donor Human Milk
    - DHM, With Counseling
    - DHM, Without Counseling
  - Expressed Mother’s Milk
  - Formula
    - Formula, With Counseling
    - Formula, Without Counseling
  - Water – D5
  - Other: [free text]

### Extraction Table

<table>
<thead>
<tr>
<th>Denominator</th>
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<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>+ Feeding Plan: Exclusive breastfeeding AND/OR</td>
</tr>
<tr>
<td>+ Feeding Plan: Breastfeeding and Formula Feeding AND/OR</td>
</tr>
<tr>
<td>+ I&amp;O: Breastfeeding ever selected AND/OR</td>
</tr>
<tr>
<td>+ I&amp;O: Expressed mother’s own milk ever selected AND/OR</td>
</tr>
</tbody>
</table>
**Breastfeeding Initiation**

**Operational Definition:** Percent of infants who receive their mother's own milk at least once during hospital stay (from birth to discharge)

**Numerator:** # of infants who receive their mother's own milk at least once during hospital stay (from birth to discharge)

**Denominator:** # of eligible births

**Exclusions:** Joint Commission PC05 Exclusion Criteria

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**Breastfeeding Initiation**

[Newborn Record]

[Component] Ins & Outs

- [Field] Food [Drop Down]
  - Breastfeeding
  - Donor Human Milk
    - DHM, With Counseling
    - DHM, Without Counseling
  - Expressed Mother's Milk
  - Formula
    - Formula, With Counseling
    - Formula, Without Counseling
  - Water – D5
  - Other: [free text]

- [Field] Supplement Reason [Drop Down]
  - Counseled Maternal Request [Drop Down]
    - Admission Plan – Mixed Feeding
    - Admission Plan – Exclusive Formula-Feeding
    - Maternal Request [Drop Down]
      - Perceived low milk supply
      - Fussy baby
      - Sleepy baby, not interested in feeding
      - Stated intention to mixed-feed
      - Mother in pain / ill
      - Family Request
      - Other: [free text]
  - Maternal Contraindication
    - HIV infection
    - Human t-lymphotropic virus type I or II
    - Substance abuse and or alcohol abuse
    - Active, untreated tuberculosis
    - Contraindicated medications
    - Undergoing radiation therapy
    - Active, untreated varicella
    - Active herpes simplex virus with breast lesions
    - Admission to Intensive Care Unit (ICU) postpartum
    - Dyad will be separated after discharge from the hospital, and the mother will not be providing care for the newborn after the hospitalization.
    - Previous breast surgery where mother is unable to produce breast milk
    - Breast abnormality where the mother is unable to produce breast milk
  - Newborn Contraindications
    - Infant who is unable to feed at the breast due to congenital malformation or other illness
- Asymptomatic Hypoglycemia documented by laboratory blood glucose and unresponsive to appropriate frequent breastfeeding.
- Clinical and laboratory evidence of significant dehydration that is not improved after skilled assessment and proper management of breastfeeding.
- Weight loss of 8-10% accompanied by delayed lactogenesis II day 5 or beyond.
- Delayed bowel movements or continued meconium stools on day 5.
- Insufficient intake despite an adequate milk supply (poor milk transfer).
- Neonatal jaundice associated with starvation where intake is poor despite intervention.
- Breastmilk jaundice, levels >20-25 mg/dl in otherwise thriving infant.
- Macronutrient supplementation is indicated.
- Intolerable pain during feedings unrelieved by interventions.

- [Field] Delivery Route [Drop Down]
  - Spoon
  - Cup
  - 5F Feeding Tube / SNS
  - Syringe
  - Bottle with Nipple, Counselled Maternal Request
  - Bottle with Nipple, Maternal Request without Counseling
  - Other: [free text]

- [Field] Volume Offered: [free text] mL

- [Field] Volume Consumed: [free text] mL

- [Field] Equipment Used [Dropdown]
  - Nipple Shield
  - Breast Shells
  - Hydrogels
  - 5F Feeding Tube / SNS
  - Breast Pump: Flange Size [free text]
  - Other: [free text]

### Numerator
+ Newborn discharged in time period of analysis
+ I&O: Breastfeeding ever selected AND/OR
+ I&O: Expressed mother’s own milk ever selected

### Denominator
+ Newborn discharged in time period of analysis
Exclusive Human Milk Feeding (AKA Joint Commission PC05)

**Operational Definition:** Percent of infants receiving human milk feedings exclusively throughout hospital stay (from birth to discharge)

**Numerator:** # of infants receiving human milk feedings exclusively throughout hospital stay (from birth to discharge)

**Denominator:** # of eligible births

**Exclusions:** Joint Commission PC05 Exclusion Criteria

**Best Practice:** Documenting exclusive human milk feeding is best accomplished on the infant medical record, in the *Ins & Outs Component*, which most facilities already have built-in. Refer to the I&O, which is fully enumerated on pages 8-9 of this guide.

When supplementing a breastfeeding newborn, it is best to have a provider order for supplementation. Standing orders are not acceptable. When the Provider Order is identical to I&O documentation, it becomes possible to cross-check the documentation and communication between providers and nurses.

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**Extraction Tables: Joint Commission PC05**

<table>
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<tbody>
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<tr>
<td>+ I&amp;O: Food: Formula never selected AND</td>
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<tr>
<td>+ I&amp;O: Food: Other never selected AND</td>
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<tr>
<td>+ I&amp;O: Food: Water – D5 never selected</td>
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**Extraction Tables: Baby-Friendly® USA Evaluation Criteria**

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<td>+ Newborn discharged in time period of analysis</td>
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<tr>
<td>+ I&amp;O: Food: Formula never selected AND</td>
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<tr>
<td>+ I&amp;O: Food: Water – D5 never selected AND</td>
</tr>
<tr>
<td>+ I&amp;O: Food: Other never selected AND</td>
</tr>
<tr>
<td>- I&amp;O: Supplement Reason: none selected</td>
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<td>+ Newborn discharged in time period of analysis</td>
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Prenatal Education

Operational Definition: Percent of pregnant women; attending prenatal care in an affiliated clinic, receiving individual counseling / group education on breastfeeding. Including importance of breastfeeding, exclusivity, early initiation, skin-to-skin, rooming-in, feeding by cue, frequency of feeding in relation to milk supply, effective positioning and latch techniques, appropriate introduction of complimentary foods, and non-pharmacologic pain relief methods for labor

Numerator: # of pregnant women attending prenatal care at affiliated prenatal clinics who receive individual counseling / group education on breastfeeding. Including importance of breastfeeding, exclusivity, early initiation, skin-to-skin, rooming-in, feeding by cue, frequency of feeding in relation to milk supply, effective positioning and latch techniques, appropriate introduction of complimentary foods, and non-pharmacologic pain relief methods for labor

Denominator: # of pregnant women attending >2 prenatal visits at affiliated prenatal clinics

Exclusions: Women with <2 prenatal visits at the affiliated clinic.

NOTE: It is wise to gather data pertaining to prenatal education even if your facility does not have an affiliated clinic. If it is not possible to gather this data from the prenatal medical record (usually because you’re not affiliated), you may consider inquiring about prenatal education upon maternal admission. Many hospital teams are able to forge relationships with non-affiliated clinics and develop an agreement for collecting and sharing data for the benefit of shared patients. This data can be shared back to the prenatal care providers to inform performance improvement.

Prenatal Education
[Maternal Record]
[Component] Patient Education
  • [Sub-Component] Newborn Care [Select All]
    o importance of breastfeeding
    o importance of exclusive breastfeeding for six months
    o importance of early initiation of breastfeeding
    o importance of skin-to-skin
    o importance of rooming-in
    o importance of feeding by cue
    o frequency of feeding in relation to milk supply
    o effective positioning and latch techniques
    o continuation after introduction of appropriate complimentary foods
    o non-pharmacologic pain relief methods for labor

NOTE: Because pregnant women often attend prenatal care more than once per month, there is a high risk of double-counting if you try to sample pregnant women. Instead, your sample should be either a) the women who give birth each month, or b) the women attending their first third trimester visit this month.

<table>
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<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
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<tr>
<td>+ Prenatal Record: Patient Education: Newborn Care: All required topics selected</td>
</tr>
<tr>
<td>- Patients who attended prenatal care ≤2 times at an affiliated clinic during this pregnancy</td>
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<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>- Patients who attended prenatal care ≤2 times at an affiliated clinic during this pregnancy</td>
</tr>
</tbody>
</table>

7 See worksheet 1 to determine affiliated status
Skin to Skin – Vaginal / Cesarean Birth

Operational Definition: Percent of infants born [vaginally / by cesarean] who are placed skin-to-skin with their mothers immediately after birth, and continue uninterrupted until completion of first feeding (or for at least one hour, if exclusively formula feeding)

Numerator: # of infants born [vaginally / by cesarean] who are placed skin-to-skin with their mothers immediately after birth, and continue uninterrupted until completion of first feeding (or for at least one hour, if exclusively formula feeding)

Denominator: # of [vaginal / cesarean] births

Exclusions: Documented Clinical Indication; Documented Maternal Refusal after Counseling

NOTE: The measures “Skin-to-Skin – Vaginal Births” and “Skin-to-Skin – Cesarean Births” are to be calculated separately. However, the only difference in documentation and data collection is the definition of immediate. Each facility must determine when skin-to-skin can safely be initiated after cesarean. This may be in the operating room, or it may be in the recovery room. It may be initiated in the operating room, interrupted for transport to recovery, and re-initiated in recovery. That is up to your discretion. Define what immediate after cesarean means in your facility, and direct staff to document accordingly.

Skin-to-Skin
[Newborn Record]
[Component] Newborn Care
[Sub-Component]: Newborn Delivery Summary

  • [Field] Encourage Feeding by Cue
    o Yes
    o No, Couple Separated
    o No, other reason: [free text]

  • [Field] Immediate Initiation of Skin-to-Skin [Drop Down]
    o Yes
    o No, Maternal Refusal After Support
    o No, Newborn Clinical Indication [Drop Down]
      - Respiratory distress
      - Cyanosis
      - Major congenital anomalies
      - Meconium stained amniotic fluid
      - Hypotonia
      - Weak cry
      - Apnea
      - Bradycardia
      - Infection risk
      - Other: [free text]
    o No, Maternal Clinical Indication
      - Hyperemesis
      - Uncontrolled pain
      - Hemorrhage
      - Other: [free text]
    o No, not initiated for other reasons: [free text]

  • [Field] Delayed Initiation of Skin-to-Skin [Dropdown]
    o No, initiated immediately (not delayed)
    o Yes, Maternal Refusal Resolved
    o Yes, Newborn Clinical Indication – Resolved
- [Field] Interruption of skin-to-skin [Dropdown]
  - No, not interrupted
  - Yes, Transport from OR to PACU
  - Yes, Maternal Refusal After Support
  - Yes, Newborn Clinical Indication
  - Yes, Maternal Clinical Indication
  - Yes, interrupted for other reasons: [free text]

- [Field] Cessation of skin-to-skin [Dropdown]
  - Breastfeeding complete
  - 1 hour achieved, exclusively formula feeding
  - Maternal Request After Support
  - Newborn Clinical Indication
    - Preterm birth
    - Respiratory distress
    - Cyanosis
    - Major congenital anomalies
    - Meconium stained amniotic fluid
    - Hypotonia
    - Weak cry
    - Decreased muscle tone
    - Apnea
    - Bradycardia
    - Infection risk
    - Other: [free text]
  - Maternal Clinical Indication
    - Clinical exhaustion
    - Hyperemesis
    - Uncontrolled pain
    - Hemorrhage
    - Other: [free text]
  - Ended prematurely for other reasons: [free text]

**Extraction Tables**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Live [vaginal / cesarean] births in time period being analyzed</td>
<td></td>
</tr>
<tr>
<td>- Immediate Initiation: No, none of the above indications selected AND / OR</td>
<td></td>
</tr>
<tr>
<td>- Delayed Initiation: No, none of the above indications selected AND / OR</td>
<td></td>
</tr>
<tr>
<td>- Interruption of skin-to-skin: Yes, interrupted for other reasons selected AND / OR</td>
<td></td>
</tr>
<tr>
<td>- Cessation: Ended prematurely for other reasons selected</td>
<td></td>
</tr>
<tr>
<td>= Live [vaginal / cesarean] births in time period being analyzed</td>
<td></td>
</tr>
</tbody>
</table>
Rooming-In (Couplet Non-Separation)

Operational Definition: Percentage of dyads rooming-in 24 hours per day, throughout the entire hospital stay, from birth through discharge

Numerator: # of dyads rooming-in 24 hours per hour day, throughout the entire hospital stay, from birth through discharge

Denominator: # of eligible births

Exclusions: Documented Clinical Indication; Documented Maternal Refusal after Counseling

NOTE: Couplets may not be separated for routine procedures, regardless of duration or frequency.

BFUSA Evaluation Criteria states that couplets may be separated for up to one hour for clinically-indicated procedures. For this reason, the best practice documentation includes “Time of Separation” and “Time of Reunification.” This data can be used to determine whether procedures are taking longer than appropriate. However, some procedures may take longer than one hour. As long as the duration is truly indicated, it is acceptable. For this reason, the extraction tables do NOT factor in amount of time.

It is acceptable to separate a couplet due to maternal request when the mother has been advised re: importance of non-separation and has been provided ample support to comfortably care for her newborn. If >20% of couplets are separated for this reason, you need to re-evaluate your education and support protocols.

Rooming-In
[Newborn Record]
[Component] Newborn Care
[Sub-Component] Separations

- [Field] Location of Baby [Drop Down]
  - Mother-Baby Room
  - Operating Room
  - Neonatal Observation Unit
  - NICU
  - Other: [free text]

- [Field] Location of Mother [Drop Down]
  - Mother-Baby Room
  - Operating Room
  - PACU
  - Labor & Delivery
  - Other: [free text]

- [Field] Reason for separation [Drop Down] **Mandatory**
  - Infant clinical indication [Drop Down]
    - [List clinical reasons newborns are separated. Routine procedures that can be done without separation are not acceptable to list here.]
      - Maternal clinical indication: [free text]
      - Informed and supported maternal request
      - Adoption / Social Hold
      - Pediatrician Newborn Assessment / Rounds (<1 hour)
      - Other reasons not listed above [free text]

- [Field] Time of Separation: [free text]
- [Field] Time of Reunification: [free text]
- [Field] ID Bands Match: [Drop Down]
  - Yes
  - No
### Extraction Tables

<table>
<thead>
<tr>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>+  Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>-  Separations: Reason for Separation: “Other reasons not listed above”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
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</thead>
<tbody>
<tr>
<td>+  Newborn discharged in time period of analysis</td>
</tr>
</tbody>
</table>
Breastfeeding Assessment & Instruction

Operational Definition: Percent of breastfeeding mothers who receive breastfeeding assessment and instruction within 6 hours of giving birth, including positioning and attachment, comfort and feeding cues

Numerator: # of breastfeeding mothers received breastfeeding assessment and instruction within 6 hours of giving birth, including positioning and attachment, comfort and feeding cues

Denominator: # of breastfeeding mothers

Exclusions: Documented Clinical Indication; Documented Maternal Refusal after Counseling

NOTE: There are several methods for assessing breastfeeding. The recommended documentation format herein is built around the LATCH\(^8\) scoring, but could easily be modified to the Mother Infant Breastfeeding Progress Tool (MIBPT) or others that account for both the mother’s perception as well as nipple pain/trauma. As both of these indicators are important in assessment to ensure proper follow up and/or referrals for care,\(^9\) it is advisable to ensure that whatever assessment guideline your facility chooses is inclusive of them. Most EHR software programs will auto-tabulate a score such as the LATCH. (It is not advisable to report a score back to mothers. The scores are mere summary indicators for staff or serve as an indicator of action needed.)

Breastfeeding Assessment
[Newborn Record]
[Component] Clinical Documentation
[Sub-Component] Infant Feeding
[Tab] Breastfeeding Assessment

- [Field] Latch [Select All that Apply]
  - Infant too sleepy / reluctant
  - No latch achieved
  - Repeated attempts for sustained latch
  - Must hold nipple in mouth
  - Must stimulate to suck
  - Baby grasps breast
  - Tongue down
  - Lips flanged
  - Rhythmical sucking

- [Field] Audible Swallowing [Drop Down]
  - No
  - A few with stimulation
  - Spontaneous and intermittent
  - Spontaneous and frequent

- [Field] Type of Nipple [Drop Down]
  - Inverted
  - Flat
  - Everted
  - Other: [free text]

- [Field] Comfort [Select All that Apply]
  - Engorged
  - Cracked
  - Bleeding
  - Large blisters
  - Large bruises

\(^9\) http://www.medscape.com/viewarticle/565624_4
- Severe discomfort
- Filling
- Small blisters
- Small bruises
- Complaints of pinching
- Mild/moderate discomfort
- Soft
- Tender
- Intact Nipples

- [Field] Hold [Drop Down]
  - Full assist by staff
  - Minimal staff assist
  - Mother able to position and hold infant independently

- [Field] Equipment/Technique Used [Drop Down]
  - Nipple Shield
  - [free text] Size:
  - Breast Shell
  - Gel Pads/Soothies
  - Reverse Pressure Softening
  - Nipple Rolling

- [Field] Education
  - Infant Feeding Handout Reviewed [Dropdown]
    - Yes, exclusively breastfeeding
    - Yes, supplementing
    - Yes, breastfeeding and/or expressing milk for infant in special care
    - No

- [Field] Care Plan [Select All that Apply]
  - Refer to IBCLC
  - Other: [free text]

**Instruction: Option 1**

[Newborn Record]
[Component] Clinical Documentation
[Sub-Component] Infant Feeding
[Tab] Patient Education

- [Field] Breastfeeding [Select All that Apply]
  - Hand expression
  - Feeding by Cue
  - Comfort - Positioning and Attachment
  - Effectiveness - Positioning and Attachment
  - Risks of artificial nipples
  - Skin-to-skin
  - Rooming-in
  - Staff support
  - Pumping
  - Support after discharge

- [Field] Formula-Feeding [Select All that Apply]
  - Risks of formula
  - Risks of supplementation / not breastfeeding
  - Feeding by Cue
  - Paced feeding
  - AFASS (acceptable, feasible, affordable, sustainable, and safe)
  - Appropriate hygiene
Cleaning utensils and equipment
Appropriate reconstitution
Accuracy or measurement of ingredients
Safe handling
Proper storage
Appropriate feeding methods

- [Field] Expressing for Infant in Special Care [Select All That Apply]
  - Importance of human milk for infants in special care
  - Mother refuses instruction on milk expression
  - Hand expression
  - Use of hospital-grade double electric breast pump
  - Use of hands-on pumping to maximize yield
  - Collecting, labeling, storing and transporting expressed milk
  - Kangaroo care
  - Direct Breastfeeding in NICU

**Instruction: Option 2**
[Newborn Record]
[Component] Clinical Documentation
[Sub-Component] Infant Feeding
[Tab] Patient Education
  - [Field] Infant Feeding Handout Reviewed [Dropdown]
    - Yes, exclusively breastfeeding
    - Yes, supplementing
    - Yes, exclusively formula feeding
    - Yes, breastfeeding and/or expressing milk for infant in special care
    - No

**Extraction Summary:**
EMR software is typically programmed to note time of all documentation automatically, which is very helpful for detecting whether assessment and all education topics were completed within six hours of birth. This can be done by auto-calculating minutes between birth and feeding assessment documentation. Assessment and education must have been documented ≤359 minutes after birth.

**Extraction Tables**

<table>
<thead>
<tr>
<th>Numerator: Option 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>- Mother’s Feeding Plan: Exclusive Formula Feeding AND / OR</td>
</tr>
<tr>
<td>- BF Assessment NOT completed within 6 hours of birth AND / OR</td>
</tr>
<tr>
<td>- Instruction: Feeding by Cue NOT selected w/in 6 hours of birth AND / OR</td>
</tr>
<tr>
<td>- Instruction: Comfort – Position &amp; Attachment NOT selected w/in 6 hours of birth AND / OR</td>
</tr>
<tr>
<td>- Instruction: Effectiveness–Position &amp; Attachment NOT selected w/in 6 hours of birth AND / OR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator: Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>- Mother’s Feeding Plan: Exclusive Formula Feeding AND / OR</td>
</tr>
<tr>
<td>- BF Assessment NOT completed w/in 6 hours of birth AND / OR</td>
</tr>
<tr>
<td>- Instruction: Infant Feeding Handout Reviewed: “No” selected w/in 6 hours of birth AND / OR</td>
</tr>
<tr>
<td>- Instruction: Infant Feeding Handout Reviewed: none selected w/in 6 hours of birth AND / OR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator: Option 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>- Mother’s Feeding Plan: Exclusive Formula-Feeding</td>
</tr>
</tbody>
</table>
**Manual Milk Expression**

**Operational Definition:** Percent of breastfeeding mothers taught how to hand express their own milk before being discharged from their maternity stay

**Numerator:** # of breastfeeding mothers taught how to hand express their own milk before being discharged from their maternity stay

**Denominator:** # of breastfeeding mothers

**Exclusions:** Documented Clinical Indication; Documented Maternal Refusal after Counseling

**Best Practice:** Refer to Breastfeeding Assessment and Instruction on pages 16-18.

---

### Extraction Tables

**Numerator: Option 1**

<table>
<thead>
<tr>
<th>+ Newborn discharged in time period of analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Mother's Feeding Plan: Exclusive Formula Feeding AND / OR</td>
</tr>
<tr>
<td>- Instruction: Hand Expression NOT selected prior to discharge</td>
</tr>
</tbody>
</table>

**Numerator: Option 2**

<table>
<thead>
<tr>
<th>+ Newborn discharged in time period of analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Mother's Feeding Plan: Exclusive Formula Feeding AND / OR</td>
</tr>
<tr>
<td>- Instruction: Infant Feeding Handout Reviewed: “No” selected AND / OR</td>
</tr>
<tr>
<td>- Instruction: Infant Feeding Handout Reviewed: none selected prior to discharge</td>
</tr>
</tbody>
</table>

**Denominator: Options 1 & 2**

<table>
<thead>
<tr>
<th>+ Newborn discharged in time period of analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Mother's Feeding Plan: Exclusive Formula-Feeding</td>
</tr>
</tbody>
</table>
Expressing for Babies in Special Care

**Operational Definition:** Percent of mothers whose newborns are in special care who have been offered help to begin expressing and collecting milk within 6 hours of birth

**Numerator:** # of mothers whose newborns are in special care who have been offered help to begin expressing and collecting milk within 6 hours of birth

**Denominator:** # of mothers whose infants are in special care, and who intend to breastfeed

**Exclusions:** None. Optional: You may wish to exclude infants for whom being fed mother’s own milk is contraindicated.

**Best Practice:** Refer to Breastfeeding Assessment and Instruction on pages 16-18.

---

### Extraction Tables

<table>
<thead>
<tr>
<th>Numerator</th>
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</thead>
<tbody>
<tr>
<td>+  Newborn discharged in time period of analysis AND</td>
</tr>
<tr>
<td>+  Newborn admitted to NICU for &gt;4 hours transitional care</td>
</tr>
<tr>
<td>-  Mother’s Feeding Plan: Exclusive Formula Feeding AND / OR</td>
</tr>
<tr>
<td>-  Instruction: “Mother refuses instruction on milk expression” selected</td>
</tr>
<tr>
<td>-  Instruction: “importance of human milk for infants in special care” NOT selected w/in 359 min of birth AND / OR</td>
</tr>
<tr>
<td>-  Instruction: “Hand expression” “Use of hospital-grade double electric breast pump” nor “Use of hands-on pumping to maximize yield” NOT selected w/in 359 min of birth [One must be selected.] AND / OR</td>
</tr>
<tr>
<td>-  Instruction: “Collecting, labeling, storing and transporting expressed milk” NOT selected w/in 359 min of birth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
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</thead>
<tbody>
<tr>
<td>+  Newborn discharged in time period of analysis AND</td>
</tr>
<tr>
<td>+  Newborn admitted to NICU for &gt;4 hours transitional care</td>
</tr>
<tr>
<td>-  Mother’s Feeding Plan: Exclusive Formula-Feeding AND / OR</td>
</tr>
<tr>
<td>-  Instruction: “Mother refuses instruction on milk expression” selected</td>
</tr>
</tbody>
</table>
Uninformed Pacifier Use

**Operational Definition:** Percent of breastfeeding infants using pacifiers without counseling on risks to breastfeeding

**Numerator:** # of breastfeeding infants using pacifiers without counseling on risks to breastfeeding

**Denominator:** # of breastfeeding infants

**Exclusions:** Documented Clinical Indication; Documented Maternal Refusal after Counseling

---

**Uninformed Pacifier Use**

[Newborn Record]

[Component] Newborn Care

[Sub-Component] Comfort Measures

- Skin-to-Skin
- Check diaper
- Reduce stimulation
- Cuddling, Walking, Rocking
- Singing, Humming, Shhh-ing
- Pacifier [Mandatory drop down if Pacifier is selected]
  - Clinical Indication [Drop Down]
  - Maternal Request After Risk Counseling and Support
  - Family Provided, Given Risk Counseling and Support
  - No counseling provided

**NOTE:** As this measure is essentially infant feeding education, it can also be measured using the options provided in Breastfeeding Assessment and Instruction on pages 16-18.

---

**Extraction Tables**

<table>
<thead>
<tr>
<th>Numerator: Comfort Measures Option</th>
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<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>- Mother’s Feeding Plan: Exclusive Formula Feeding AND / OR</td>
</tr>
<tr>
<td>- Comfort Measures: “Pacifier &gt; No counseling provided” is selected</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator: BF Assessment and Instruction: Option 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>- Mother’s Feeding Plan: Exclusive Formula Feeding AND / OR</td>
</tr>
<tr>
<td>- Instruction: Risks of artificial nipples NOT selected prior to discharge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator: BF Assessment and Instruction: Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>- Mother’s Feeding Plan: Exclusive Formula Feeding AND / OR</td>
</tr>
<tr>
<td>- Instruction: “Infant Feeding Handout Reviewed” never selected prior to discharge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>- Mother’s Feeding Plan: Exclusive Formula Feeding</td>
</tr>
</tbody>
</table>
Safe Formula Use Instruction

Operational Definition: Percent of mothers who have decided to feed formula who receive counseling regarding risks and benefits of feeding options, and instruction on safe formula preparation and feeding

Numerator: # of mothers who have decided to feed formula who receive counseling regarding risks and benefits of feeding options, and instruction on safe formula preparation and feeding

Denominator: # of mothers who have decided to feed formula (both for preference and clinical indication)

Exclusions: None

Best Practice: Refer to Breastfeeding Assessment and Instruction on pages 16-18.

Note: Some families will request formula for their newborns. The healthcare team is responsible for inquiring about their reasons for requesting formula, and providing evidence-based education and support that responds directly to their concerns. The healthcare team is also responsible for ensuring that families looking to supplement are aware of the risks of not breastfeeding and the risks of formula. If the family elects to use formula, the healthcare team shall advise them on how to minimize the risks of formula-feeding, including appropriate hygiene, cleaning utensils and equipment, appropriate reconstitution, accuracy of measurement and ingredients, safe handling, proper storage and appropriate feeding methods.

Extraction Tables

<table>
<thead>
<tr>
<th>Numerator: Option 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>+   Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>-   I&amp;O: Formula NEVER selected</td>
</tr>
<tr>
<td>-   Instruction: Any topics under “Formula-Feeding” are NOT selected prior to discharge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator: Option 2</th>
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</thead>
<tbody>
<tr>
<td>+   Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>-   I&amp;O: Formula NEVER selected</td>
</tr>
<tr>
<td>-   Instruction: Infant Feeding Handout Reviewed: “Yes, Mixed Feeding” or “Yes, Exclusive Formula-Feeding” NEVER selected</td>
</tr>
</tbody>
</table>

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<tr>
<th>Denominator</th>
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</thead>
<tbody>
<tr>
<td>+   Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>-   I &amp; O: Formula NEVER selected</td>
</tr>
</tbody>
</table>
Uninformed Bottle-Top (Nipple) Use

**Operational Definition:** Percent of breastfeeding infants receiving feedings from a bottle with nipple without counseling on risks to breastfeeding

**Numerator:** # of breastfeeding infants receiving feedings from a bottle with nipple without counseling on risks to breastfeeding

**Denominator:** # of breastfeeding infants

**Exclusions:** Documented Clinical Indication; Documented Maternal Refusal after Counseling

**Best Practice:** Refer to the I&O, which is fully enumerated on pages 8-9 of this guide.

**Extraction Tables**

<table>
<thead>
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<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
<td></td>
</tr>
<tr>
<td>+ Delivery Summary: Mother’s Feeding Choice: Exclusive Formula-Feeding NOT selected AND / OR</td>
<td></td>
</tr>
<tr>
<td>+ I&amp;O: Breastfeeding ever selected AND / OR</td>
<td></td>
</tr>
<tr>
<td>+ I&amp;O: Mother’s Expressed Milk ever selected</td>
<td></td>
</tr>
<tr>
<td>- I&amp;O: Route: Bottle with Nipple, Maternal Request without Counseling ever selected</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
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<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
<td></td>
</tr>
<tr>
<td>+ Delivery Summary: Mother’s Feeding Choice: Exclusive Formula-Feeding NOT selected AND / OR</td>
<td></td>
</tr>
<tr>
<td>+ I&amp;O: Breastfeeding ever selected AND / OR</td>
<td></td>
</tr>
<tr>
<td>+ I&amp;O: Mother’s Expressed Milk ever selected</td>
<td></td>
</tr>
</tbody>
</table>
**Feeding Cue Instruction**

**Operational Definition:** Percent of infants whose mothers are taught to feed in response to infant feeding cues, without restriction on frequency or length of feeds

**Numerator:** # of infants whose mothers are taught to feed in response to infant feeding cues, without restriction on frequency or length of feeds

**Denominator:** # of eligible births

**Exclusions:** None

**Best Practice:** Refer to Breastfeeding Assessment and Instruction on pages 16-19.

---

**Extraction Tables**

<table>
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<tr>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>+ Breastfeeding: “Feeding by Cue” is ever selected AND/OR</td>
</tr>
<tr>
<td>+ Formula-Feeding: “Feeding by Cue” is ever selected AND/OR</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Denominator</th>
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</thead>
<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
</tbody>
</table>
Support after Discharge

**Operational Definition:** Percent of infants whose mothers are given information on how to access breastfeeding / infant feeding support upon discharge

**Numerator:** # of infants whose mothers are given information on how to access breastfeeding / infant feeding support upon discharge

**Denominator:** # of eligible births

**Exclusions:** None

[Maternal Record]
- [Component] Discharge Teaching
  - Support for Breastfeeding After Discharge [check all that apply]
    - Visit pediatrician within 24-72 hours of discharge
    - Refer to WIC
    - Refer to Private Lactation Care
    - Refer to Support Group
    - Other: [free text]

<table>
<thead>
<tr>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
<tr>
<td>- Discharge Teaching: “Support for Breastfeeding After Discharge” NOT selected</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Newborn discharged in time period of analysis</td>
</tr>
</tbody>
</table>
WORKSHEET 1: Affiliated Status

It is advisable to partner with all prenatal care providers whose patients give birth at your facility to ensure that all pregnant women present having been well-educated about infant feeding and care. That said, it may only be possible to enact systems’ improvement and oversight at affiliated clinics. Consider the following typical statements to determine if your clinics are considered affiliated with the hospital. If any of the following are true, it is prudent to consider the clinic to be “affiliated” with your facility. If you are seeking designation by Baby-Friendly USA, you must consult them to determine affiliate status.

- **Hospital ownership of clinic**
- **Public perception**
  - the facility and clinic are part of the same system (i.e. view materials provided by the clinic such as handouts where the health system logo is present)
- **Prenatal care providers at the clinic employed**
  - (either permanently or via temporary contract) by hospital
- **Nursing and non-clinical staff at the clinic employed**
  - (either permanently or via temporary contract) by hospital

**AFFILIATED**
# WORKSHEET 2: LATCH

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Questions to ask Mother If Feeding Not Observed</th>
<th>Scoring Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Latch</strong></td>
<td>Too sleepy or reluctant</td>
<td>Repeated attempts</td>
<td>Grasps breast</td>
<td>How did your baby grasp your breast?</td>
<td>Score 1 if a nipple shield is used for latch.</td>
</tr>
<tr>
<td></td>
<td>No latch obtained</td>
<td>Must hold nipple in mouth</td>
<td>Tongue down and forward</td>
<td>Did it take several tries?</td>
<td>After 24 hours, score 0 for 2 consecutive feeding attempts, refer to pediatrician, Lactation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Must stimulate to suck</td>
<td>Lips flanged</td>
<td>Did your baby suckle on his own or did you have to work with him?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rhythmic suckling</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Audible swallowing</strong></td>
<td>None</td>
<td>A few with stimulation</td>
<td>Spontaneous, intermittent</td>
<td>Did you hear your baby swallow?</td>
<td>Score 1 if swallows are heard only if mom uses breast compression. If 0 after 12 hours, consider colostrum supplements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(less than 24 hours old)</td>
<td>How frequently did you hear it?</td>
<td></td>
</tr>
<tr>
<td><strong>Type of nipple</strong></td>
<td>Inverted</td>
<td>Flat</td>
<td>Everted (after stimulation)</td>
<td>Do your nipples stand out or do they flatten easily?</td>
<td>Score 1 if mom must do Reverse Pressure Softening before latch</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comfort</strong></td>
<td>Engorged</td>
<td>Filling, Small blisters or bruises</td>
<td>Soft</td>
<td>Are your nipples tender? Are your breasts becoming full and heavy?</td>
<td>If score is 0 or 1, notify/refer to Lactation Consultant for consult. Apply lanolin or gel pads as indicated.</td>
</tr>
<tr>
<td></td>
<td>Cracked, bleeding, large blisters or bruises</td>
<td>Mother complains of pinching</td>
<td>Tender</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Severe discomfort</td>
<td>Mild/moderate discomfort</td>
<td>Intact nipples (no damage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hold Help</strong></td>
<td>Full assist (staff holds infant at breast)</td>
<td>Minimal assist (i.e. elevate head of bed, place pillows)</td>
<td>No assist from staff.</td>
<td>Did someone help you put your baby to breast?</td>
<td>If nurse has to be there for entire feeding, score this a 0.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teach one side, mother does other.</td>
<td>Mother able to position/hold infant.</td>
<td>Do you need help with the next feeding?</td>
<td>If the mother requests help next feeding, score this a 1.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff help, mother takes over feeding.</td>
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</tbody>
</table>