Complete Summary

GUIDELINE TITLE

Evidence-based guidelines for breastfeeding management during the first fourteen days.

BIBLIOGRAPHIC SOURCE(S)

International Lactation Consultant Association. Evidence-based guidelines for breastfeeding management during the first fourteen days. Raleigh (NC): International Lactation Consultant Association; 1999 Apr. 31 p. [109 references]

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

Infant health

GUIDELINE CATEGORY

Counseling
Evaluation

CLINICAL SPECIALTY

Nursing
Nutrition
Obstetrics and Gynecology
Pediatrics

INTENDED USERS

Advanced Practice Nurses
Dietitians

Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To present guidelines focusing on the establishment and maintenance of breastfeeding during the first 14 days for healthy, term infants.

TARGET POPULATION

New mothers of healthy, term infants

INTERVENTIONS AND PRACTICES CONSIDERED

Breastfeeding management:

1. Facilitate early breastfeeding
2. Facilitate correct positioning
3. Facilitate rooming-in
4. Encourage frequent, unrestricted breastfeeding
5. Confirm parents' knowledge of early feeding readiness cues
6. Confirm parents' understanding of the basis for milk production
7. Confirm parents' knowledge of measures for waking a sleepy infant
8. Avoid pacifiers and supplements, unless medically indicated
9. Observe a minimum of one breastfeeding every eight hours
10. Assess for signs of ineffective breastfeeding
11. Intervene if ineffective breastfeeding
12. Identify infant risk factors that impact breastfeeding
13. Identify maternal risk factors that impact breastfeeding or lactation
14. Identify maternal and infant contraindications to breastfeeding
15. Facilitate supplementation, if medically indicated
16. Confirm parents' understanding of lactation and breastfeeding
17. Confirm scheduling of follow-up visit with primary care provider
18. Provide education materials
19. Support breastfeeding during hospitalization/separation of mother and infant
20. Avoid distribution of infant feeding products
21. Include family members or significant others in education
22. Provide anticipatory guidance for problem solving
23. Reinforce facts, dispel myths and misconceptions, and establish realistic expectations
24. Discuss contraceptive options

MAJOR OUTCOMES CONSIDERED

Healthy, term, breastfeeding infants will:

- Exclusively feed at the breast
- Lose no more than 7% of birth weight
- Regain to birth weight by 14 days of age
- Have at least 3 bowel movements and 6 wet diapers per 24 hours by day 4

- Gain 4-8 ounces per week (approximately 1 ounce or 30 grams per day)

Mothers of health term breastfeeding infants will:

- Exclusively breastfeed
- Recognize and respond appropriately to early infant feeding cues
- Recognize signs of effective breastfeeding
- Have breasts and nipples that are pain-free
- Confirm knowledge of appropriate breastfeeding management

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developer performed literature searches using the National Library of Medicine MEDLINE database and the Cochrane database.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Evaluation Criteria for Type of Evidence

I: Evidence obtained from at least one properly randomized study.

II-1: Evidence obtained from well-organized, 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 program.

III-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

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

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

Not stated

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Management Strategy

1. Facilitate breastfeeding as soon as possible after birth, ideally within the first 2 hours
    - Provide continuous skin-to-skin contact for at least the first 2 hours after birth or until after the first breastfeeding
    - Delay unnecessary procedures for a least the first 2 hours after birth or until after the first breastfeeding
2. Help the mother choose a comfortable position

    Observe infant for correct positioning:

    - Held at the level of the breast
    - Body facing the breast with head and body aligned

    Observe infant for signs of correct latch-on:

- Wide opened mouth
- Flared lips
- Nose, cheeks, and chin touching, or nearly touching, the breast

Observe infant for signs of milk transfer:

- Sustained rhythmic suck/swallow pattern with occasional pauses
- Audible swallowing
- Relaxed arms and hands
- Moist mouth
- Satisfied after feedings

Observe mother for signs of milk transfer:

- Strong tugging which is not painful
- Thirst
- Uterine contractions or increased lochia flow during or after feeding for the first 3-5 days
- Milk leaking from the opposite breast while feeding
- Relaxation or drowsiness
- Breast softening while feeding
- Nipple elongated after feeding but not pinched or abraded

3. Facilitate rooming in 24 hours a day

   Conduct examinations and routine tests of the infant in the mother's room

4. Facilitate unrestricted breastfeeding 8-12 times per 24 hours
5. Confirm that parents know to respond to early feeding readiness cues:
   - Sucking movements
   - Sucking sounds
   - Hand-to mouth movements
   - Rapid eye movements
   - Soft cooing or sighing sounds
   - Fussiness
6. Confirm the parent's understanding the amount of milk removed from the breast determines the amount of milk produced. To facilitate milk production:
   - Breastfeed when infant exhibits feeding readiness cues
   - Feed on the first breast without time restriction (approximately 15-20 minutes) before offering the second breast
   - Feed until the infant is satisfied (some infants are satisfied with one breast)
7. Confirm that parents know when and how to wake a sleepy infant:
   - Wake at least every third hour, or when any feeding readiness cues are exhibited (see strategy #4)
   - Stimulate the infant by: removing blanket and clothing; changing diaper; putting baby skin-to-skin with the mother or father; massaging back, arms, and legs.
8. Encourage parents to avoid the use of pacifiers, artificial nipples, and supplements unless medically indicated, until breastfeeding is well

established. For most infants, this is after 4-6 weeks. Some infants never use pacifiers or bottles.

9. Observe at least one breastfeeding in each 8 hour period during the hospital stay and document the following:
    - Condition of breasts and nipples
    - Position of mother and infant
    - Correct latch-on
    - Signs of milk transfer
    - Mother/infant interaction
    - Frequency of feedings
    - Number of wet diapers
    - Number and character of bowel movements
    - Weight/gain/loss pattern
10. Know the signs of ineffective breastfeeding
    - Infant weight loss >7%
    - Continued weight loss after day 3
    - Less than 3 bowel movements in 24 hours
    - Meconium stools after day 4
    - Less than 6 wet diapers in 24 hours after day 4
    - Infant who is irritable and restless or sleepy and refusing to feed
    - No audible swallowing during feedings
    - No discernible change in weight or size of breasts and no discernible change in milk volume and composition by 3-5 days
    - Persistent to increasingly painful nipples
    - Engorgement unrelieved by feeding
    - Infant who does not begin to gain weight by day 5
    - Infant who has not returned to birth weight by day 14
11. If effective breastfeeding, as demonstrated by milk transfer, is not observed within the first 24 hours:
    - Re-evaluate breastfeeding techniques (see strategy #2 and stimulate sucking with expressed colostrum or drops of water, if necessary
    - Initiate pumping with a hospital-grade pump
    - If medically indicated, explore alternative methods or feeding (see strategy #15)
    - Delay discharge until effective breastfeeding has been observed
    - Refer to a health care professional with breastfeeding expertise, such as International Board Certified Lactation Consultant (IBCLC), physician, midwife, nurse, or dietitian
    - Coordinate care with infant's primary care provider to schedule a weight check within 24-48 hours of discharge and assure sufficient breast stimulation with a hospital-grade pump to develop a milk supply, if necessary.
12. Identify risk factors that can affect the infant's ability to breastfeed effectively. Provide necessary feeding assistance and monitor closely. Risk factors include:
    - Birth trauma
    - <38 weeks gestation
    - Inconsistent ability to latch on
    - Sleepiness or irritability
    - Hyperbilirubinemia or hypoglycemia
    - Small (SGA) or large (LGA) for gestational age, intrauterine growth retardation (IUGR)
    - Tight frenulum

- Multiple birth
- Neuromotor problems (i.e. Down syndrome)
- Oral anomalies (i.e. cleft lip/palate)
- Acute or chronic illness

13. Identify maternal risk factors for breastfeeding difficulty. Provide appropriate assistance and follow-up. Risk factors include:
    - Previous breastfeeding difficulty
    - Cracked or bleeding nipples
    - Severe engorgement
    - Persistent breast pain
    - Acute or chronic disease
    - Medication use
    - Breast or nipple abnormality
    - Breast surgery or trauma
    - Absence of prenatal breast changes
14. Identify maternal and infant contraindications to breastfeeding, including

    Maternal:

    - HIV positive status
    - Substance abuse
    - Tuberculosis (only until treatment is initiated and the mother is no longer infectious)

    Infant:

    - Galactosemia
15. If medically indicated, provide supplementation utilizing a method of feeding that does not compromise transition to the breast:
    - Use mother's own colostrum or milk as a first choice
    - Determine volume of supplement based on infant's age and weight; allow for any intake from the breast
    - Reassure mother that infant benefits from any amount of breast milk provided
    - If using formula, select on which takes into account any family history of allergies
16. Confirm parents' knowledge of:
    - Appropriate breastfeeding behavior
    - Signs of effective breastfeeding
    - Appropriate elimination patterns
    - Management of common concerns including engorgement and sore nipples
17. Confirm the parents have scheduled a follow-up visit with the infant's primary care provider within 2-3 days of hospital discharge.

    Schedule additional visits as needed until an appropriate weight gain pattern has been established.

    Identify lactation support resources within the community.

18. Provide educational materials that:

- Are clinically accurate
- Are consistent
- Are reading-level appropriate
- Are culturally sensitive
- Are free of commercial advertising
- Include a list of available community breastfeeding resources:
    - IBCLC lactation consultants
    - WIC program staff
    - Health department staff
    - Volunteer breastfeeding support groups
    - Knowledgeable breast pump rental and sales outlets

19. Support continued breastfeeding during any re-hospitalization of mother or infant.
20. Avoid distribution of sample packs that include infant feeding products or advertising for such products.
21. Include family members or significant others in breastfeeding education.
22. Provide anticipatory guidance for common problems that can interfere with continued breastfeeding.

Nipple pain

- Initially, mild discomfort can occur at the beginning of each feeding when the infant latches on to the breast
- Often pain is the result of incorrect position and latch-on
- Pain that persist during or after the feeding, or between feedings, should be evaluated
- Consider other causes such as bacterial or fungal infections

Engorgement

- Occurs in some mothers approximately 3-5 days after birth
- Swelling is minimized with frequent, effective feeding
- Treatment should focus on measures to reduce swelling, such as cold compresses (ice, bags of frozen vegetables, cabbage leaves), breast massage, milk expression (pumping), and ibuprofen or acetaminophen for pain.
- Avoid use of heat unless breasts are freely leaking

Perceived insufficient milk supply

- In the second week of life, initial breast swelling decreases but this does not signal a decrease in milk production
- When an infant has a growth or appetite spurt, more frequent feedings for about 48 hours will increases total milk production. The first appetite spurt is often in the second week of life.
- Stool and urine output by the infant at the best indicators of adequate intake
- If the fussy infant is having appropriate output and gaining weight, low milk supply is not the cause of fussiness

Infant crying

- No crying should go unattended
- Not every cry is a hunger cry-infants will cry to signal other needs; if the infant is not exhibiting feeding cues, parents can try other comfort measures before offering the breast.
- Reassure parents that, as infants mature, they sleep longer between feedings.

Maternal diet

- Dietary restrictions are seldom necessary; few infants are affected by foods eaten by the mother
- The mother should eat a variety of foods from all the food groups and drink to satisfy thirst

Going out with or without the baby

It is possible to:

- Plan feedings around mother's or family's activities
- Learn to breastfeed discreetly
- Learn to express, collect, and store breast milk
- Provide breast milk using an alternative feeding method
- Introduce a supplement

23. Reinforce the following important facts and help parents establish realistic expectations regarding:

Frequency and duration of feedings:

- Expect a minimum of 8-12 feedings in 24 hours
- Some infants will breastfeed every 3 hours day and night
- Others will cluster-feed feedings every hour for 4-6 feeds then sleeping 4-6 hours.
- Expect to feed 15-20 minutes on the first breast and 10-15 minutes on the second but do not be concerned if the infant is satisfied after one breast
- If necessary, wake a sleepy infant for feedings until an appropriate weight gain pattern is established.
- Expect feeding frequency to decrease as the infant gets older

Infant output

- Expect at least 3 bowel movements each 24 hours; some infants have a bowel movement with every feeding
- Expect at least 6 urinations a day by day 4
- Expect bowel movements to change from meconium to a yellow, soft, and watery consistency by day 4

Infant weight loss/gain

- Expect < 7% weight loss the first week
- Expect return to birth weight by 14 days of age

- Expect weight gain of 4-8 ounces (120-240 grams) a week until the infant has doubled birth weight

24. Discuss contraceptive options, including:
    - Barrier devices
    - Hormonal methods
    - Lactational amenorrhea method (LAM)

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Evidence to support these guidelines comes from research when available. Some management strategies are not amenable to the control and randomization of true experimental design, but are based on clinical experience and logical deductions from know scientific facts. Supporting documentation ranges from original research to works based on years of clinical experience. Using the model developed by the U.S. Preventive Services Task Force, the quality of the evidence for each standard is ranked. Specific references for each intervention are provided in the guideline document.

Strategy	Rationale	Evidence
1. Facilitate early breastfeeding		
	Early initiation of breastfeeding is associated with:	
	o Earlier establishment of effective suckling and feeding behaviors	I, II-1, II-2, III
	o Enhanced maternal-infant interaction	II-1
	o Improved neonatal temperature control	II-1
	o Stabilized neonatal blood sugar levels	II-2
	o Increased bowel movements and decreased jaundice	II-3
	o Longer duration of breastfeeding	I, II-1, II-3

Routine procedures, such as prophylactic administration of vitamin K and erythromycin, interrupt maternal-infant interaction and delay breastfeeding	I,II-1, II-2,III

2. Facilitate correct positioning

Milk transfer occurs more readily with appropriate positioning and latch-on (attachment). The position that best facilitates correct latch-on will vary from mother to mother and infant to infant.	II-3, III
Correct positioning and latch-on minimizes nipple tenderness and trauma.	III

3. Facilitate rooming-in

Rooming-in facilitates the breastfeeding process.	I, II-1, III
Hospital routines often interfere with development of effective breastfeeding.	I, II-2
Hospital routines and staff attitudes influence long-term behavior more than verbal teaching.	I, II-2, III
Breastfeeding frequency is greater and supplementation with artificial baby milk (formula) occurs less often when mothers and infants room-in compared with when they do not.	II-1, II-2, II-3
Mothers do not get more sleep when the infant is taken to the nursery at night.	II-3

4. Encourage frequent, unrestricted breastfeeding

Unrestricted breastfeeding (as opposed to time feedings on a schedule):

o Helps prevent pathologic engorgement	II-3, III
o Decrease the incidence of jaundice	II-3
o Stabilizes neonatal serum glucose levels	II-2
o Decreases initial infant weight loss and increases rate of weight gain	II-1, II-3

o Promotes earlier onset of mature milk production (lactogenesis)	I, II-3
o Increases the duration of breastfeeding	

5. Confirm parents' knowledge of early feeding readiness cues

Attention to early feeding cues facilitates correct latch-on and effective suckling which reinforces the mother's response to her infant.	II-1, II-2, III

6. Confirm parents' understanding of the basis for milk production

Milk volume increases with increased feeding frequency during the first 14 days. Prolactin receptors that regulate milk production are established during this early period.	II-1, II-3
Total time breastfeeding remains positively correlated with infant intake and weight at 3 months of age.	II-3
Fat content of milk increases during the feeding; therefore time limits or enforced change from the fist to the second breast should be avoided.	II-1
Infants whose mothers' milk has a lower fat content will breastfeed longer to obtain sufficient calories.	II-2

7. Confirm parents' knowledge of measures for waking a sleepy infant

Some infants shut-down (sleep) to cope with discomfort, including hunger.	II-2
Infants have several states: deep sleep, light sleep, drowsy, quiet alert, fussing or active alert, and crying. It is easiest to initiate feedings when the infant is in drowsy, quiet alert, or active alert states.	III

8. Avoid pacifiers and supplements, unless medically indicated

Human milk provides all of the fluid and nutrients necessary for optimal infant growth.	II-1, II-2, II-3
Use of supplements or pacifiers in the hospital is associated with a risk for early weaning.	II-2, II-3

9. Observe a minimum of one breastfeeding every eight hours

Direct observation in part of assessment. Assessment is a prerequisite to intervention and provides opportunity for positive reinforcement and reassurance.	III
The healthy, term, newborn infant should gain at least to birth weight by 14 days.	II-1, II-2

10. Assess for signs of ineffective breastfeeding

Although a single sign may not indicate a problem, further investigation and follow-up are indicated.	III
Normative clinical patterns of bowel movements in the breastfed newborn vary widely. However, output is a key indicator of adequate intake.	II-2, II-3
Continued weight loss on day 3 is strongly correlated with untimely weaning.	II-1
Incorrect positioning and/or latch-on can cause nipple trauma and pain. If pain persists despite correct positioning and latch-on, consider other causes such as bacterial or fungal infections.	II-3
Audible swallowing is a positive sign of milk transfer.	

11.
12. Intervene if ineffective breastfeeding

Breastfeeding duration increases when hospital and follow-up services support continued evaluation and appropriate intervention.	II-2, III
Adequate breast stimulation and milk removal is critical to developing a sufficient milk supply.	I
Infant liver stores of glycogen are 90% diminished by 3 hours of age and completely depleted by 12 hours.	III

13. Identify infant risk factors that impact breastfeeding

Early weaning has been associated with rating by nursing staff or infants having excessive crying demanding personality, and trouble with feeding.	III
There is no research to support that any of the risk factors are contraindication to breastfeeding.	III

14. Identify maternal risk factors that impact breastfeeding or lactation

Mothers often cite one of these factors as the reason for discontinuing breastfeeding.	II-2, II-3
Most problems are amenable to treatment intervention	II-2, II-3, III
o Few medications are contraindicated for the breastfeeding mother.	III
o Women who have had breast surgery (augmentation or reduction) have an increased risk of lactation insufficiency when compared to women who have not had breast surgery.	II-3, III
o Treatment for breast cancer does not preclude breastfeeding after a subsequent pregnancy.	III

15. Identify maternal and infant contraindications to breastfeeding

There are few contraindications to breastfeeding.	II-2, III

16. Facilitate supplementation, if medically indicated

Appropriate growth is supported by 108 kcal per kilogram of weight per day or 2.5 ounces milk per pound of weight per day.	II-3
A nursing supplementer allows supplementation at the breast while providing the mother with suckling stimulation to appropriately increase milk production. This also decreases time feeding and pumping, since everything is being done at once.	III
Using a cup to supplement an infant decreases the likelihood of causing nipple confusion.	III

17. Confirm parents' understanding of lactation and breastfeeding

Anticipatory guidance regarding common concerns increases duration of breastfeeding.	II-3
Awareness of appropriate signs of milk transfer is associated with breastfeeding success.	II-3

18. Confirm scheduling of follow-up visit with primary care provider

The primary care provider evaluates weight gain and other clinical factors that indicate effective breastfeeding.	III
Positive and knowledgeable breastfeeding support increases the incidence, duration, and exclusivity of breastfeeding.	II-1, II-2, II-3, III

19. Provide education materials

Adult learners are more likely to utilize materials that are relevant to a specific learning need.	III
Printed or other audiovisual materials reinforce verbal instruction.	I
Some audiovisual materials may transmit subtle, undesirable messages, reinforce stereotypes or contradict verbal messages.	II-2
Women breastfeed longer when support systems are available.	II-2, III

20. Support breastfeeding during hospitalization/separation of mother and infant

Continued breastfeeding during hospitalization is important for the well-being of mother and infant.	III

21. Avoid distribution of infant feeding products

Distribution of infant feeding products decreases breastfeeding duration.	I, II-2

22. Include family members or significant others in education

Support of family members and significant others increases the duration of breastfeeding.	II-1, II-3, III

23. Provide anticipatory guidance for problem solving

A. Nipple pain and engorgement

Sore nipples, engorgement, pain and mother's perception of insufficient supply, are most common reasons given for stopping	I, III

breastfeeding in the first two weeks

Inconsistent or inaccurate information given by health care professionals contributes to maternal confusion and premature weaning.	I, III
Previous breastfeeding experience and current feeding routine may play an important role in the timing and level of breast engorgement.	II-3, III

B. Perceived insufficient milk supply and infant crying

Perceived insufficient milk supply is a significant cause of untimely weaning and occurs in up to 50% of all breastfeeding mothers.	II-3
Research has shown that support of the mother to continue breastfeeding through this perceived low milk supply "crisis" increases breastfeeding duration and that infant growth is not affected.	II-2
Infants whom hospital nurses identified as crying excessively or having a demanding personality were significantly less likely to be breastfed at 2 weeks of age.	II-2
A crying infant needs attention.	

C. Maternal diet

Myths about dietary rules are a barrier to breastfeeding and have no basis in fact.	III
Increased maternal fluid intake does not affect the quantity of milk produced.	I
Fluid intake beyond natural inclination may negatively affect milk production.	II-1

24. Reinforce facts, dispel myths and misconceptions, and establish realistic expectations

Realistic expectations of the breastfeeding process prevent premature weaning.	I, II-1, III
Use of anticipatory guidance as a primary intervention positively influences the breastfeeding process.	II-3, III
Positive, knowledgeable support promotes breastfeeding satisfaction and duration.	I, II-3, II-2, III

Early identification of problems facilitates early intervention. III

25. Discuss contraceptive options

Barrier devices do not introduce synthetic hormones in that woman's system and, therefore, do not interfere with milk production.

Synthetic hormones taken by the breastfeeding mother may affect milk production.

Specifically,

- Estrogen-containing pills often decrease milk production and should be avoided

- Progestin-only pills, injections or implants inhibit milk production if given before lactogenesis occurs, and should be delayed for at least 6 weeks

- Progestin-only methods begun after a milk supply is well established, usually do not interfere with milk production, however, pills which can easily be discontinued are preferred over injections or implants. III

- The lactational amenorrhea method (LAM) focuses on use of the body's own rhythms. Used appropriately, it is 98% effective in preventing pregnancy. I

Evaluation Criteria for Type of Evidence:

I: Evidence obtained from at least one properly randomized study.

II-1: Evidence obtained from well-organized, controlled trials without randomization.

strongII-2/strong>: Evidence obtained from well-designed cohort or case control analytic studies preferably from more than one center or research program.

III-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.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

ICLA hopes that these management strategies, which are designed to give guidance in providing optimal care to mothers and infants, will improve both breastfeeding initiation and duration rates.

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

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)

International Lactation Consultant Association. Evidence-based guidelines for breastfeeding management during the first fourteen days. Raleigh (NC): International Lactation Consultant Association; 1999 Apr. 31 p. [109 references]

ADAPTATION

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

DATE RELEASED

1999 Apr

GUIDELINE DEVELOPER(S)

International Lactation Consultant Association - Professional Association

SOURCE(S) OF FUNDING

United States Maternal-Child Health Bureau

GUIDELINE COMMITTEE

Technical Advisory Group

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Review Committee: Susan M. Ellerbee, PhD, RNC, IBCLC; Martha Hall, MSN, RN, IBCLC; Mary L. Overfield, MN, RN, IBCLC; Amy Spangler, MN, RN, IBCLC; Mary Rose Tully, MPH, IBCLC

Panel Members: Diana Belles, MSEd; Barbara Bennett, MD; Denise Breheny, RN, IBCLC; Marlene Hegge, RN; Pamela Hill, PhD, RN; Kevin Moore, MD: Warren Newton, MD; Patricia Payne, CNM; Nancy Powers, MD; Nancy Pribble, IBCLC; Kiran Saluja, RD; Robert Singletary;Thomas Storch, MD

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Not available at this time.

Print copies: Available from the International Lactation Consultant Association, 1500 Sunday Dr, Suite 102, Raleigh, NC 27607; Web site: www.ilca.org.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on October 28, 1999. The information was verified by the guideline developer as of December 27, 1999.

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