Maternal and child health work-stream

Breastfeeding and parent–baby attachment in neonatal units:

survey consultation results

Developing the evidence based statements

- Evidence review by NHS Health Scotland
- Quality assessment of evidence by SISCC
- Identification of evidence based statements
- Online questionnaire circulated to stakeholders

GRADE: quality assessment of evidence

- effective actions supported by high quality evidence
- promising actions supported by moderate quality evidence
- promising actions where there is a weak evidence base
- actions that are likely to be ineffective

Response options

- **Impact**
  - ✓ Most impact 5 >> 4 >> 3 >> 2 >> 1 Least impact
- **Feasibility**
  - ✓ Most feasible 5 >> 4 >> 3 >> 2 >> 1 Least feasible
- **Current Practice**
  - ✓ 1) doing it already, 2) working towards it, 3) not doing it, 4) don't know

Respondents

Which category best describes your current role?

		n	%
Advanced Neonatal Nurse Practitioner (ANNP)		2	3
Child Carer		1	1
General Practitioner		1	1
Lactation Consultant		1	1
Midwife		5	7
Neonatal Nurse/Midwife Qualified in Specialty (QiS)		39	52
Neonatologist		5	7
Paediatrician		2	3
Support Worker (e.g. health care assistant)		2	3
Support Worker (with neonatal training)		2	3
Registered Child Nurse (not QiS)		12	16
Other *(please specify)*	Infant feeding coordinator	1	1
	Neonatal Liaison	1	1
Missing		1	1

Evidence based statements rankings

ACTIONS LIKELY TO BE EFFECTIVE	HIGH IMPACT	HIGH FEASABILITY	CURRENT PRACTICE
Daily kangaroo skin-to-skin contact with mothers (ranging from 10 mins up to 2 hours) for very low birthweight infants (under 1,500g) increases the duration of any breastfeeding at discharge and up to one month after[1]	95	70	64
Any intermittent kangaroo skin-to-skin contact with mothers (of variable duration and frequency) is associated with an increase in any breastfeeding from discharge from NICU until 1-2 months follow up in stabilised infants born under 2,500g	94	89	85
Any duration of daily kangaroo skin-to-skin contact with mothers that promotes mother-infant interaction and touch results in mothers showing better adaptation to infant cues, better perception of their infant, less anxiety, a greater sense of competence with their infant and more sensitivity towards the infant	98	92	75
Intermittent kangaroo skin-to-skin contact with mothers is associated with an increase in mother-infant parent-baby attachment at 3 months follow up	95	90	76
Baby Friendly accreditation of the associated maternity hospital results in improvements in several breastfeeding - related outcomes for infants in neonatal units	87	88	72

PROMISING ACTIONS	HIGH IMPACT	HIGH FEASABILITY	CURRENT PRACTICE
Making donor human milk available in neonatal units has no negative impact on breastfeeding rates at discharge	79	81	78
Making donor human milk available in neonatal units decreases formula use during the first four weeks of life	92	80	71
Breastfeeding support increases breastfeeding rates and duration when parents are given a combination of the following messages: accurate information about the contribution of breast milk to the infants growth and well-being; opportunities for physical contact with the infant; accurate information regarding breast milk supply and breastfeeding techniques; and information about general infant behaviour	99	93	82
An individualised discharge plan for breastfeeding mothers with follow-up telephone calls maintains mothers confidence in breastfeeding and provides reassurance	93	56	18
Positive, consistent and continuous feedback and reinforcement stimulates mothers motivation, and educational programmes provided in the context of ongoing personal contact with a health professional are effective in promoting the initiation and prevalence of breastfeeding	95	80	49
Staff training and education on breastfeeding delivered to a multi- professional workforce improves staff knowledge and generates increased use of expressed breast milk, and initiation and duration of breastfeeding in neonatal units	99	96	75

POTENTIALLY PROMISING ACTIONS	HIGH IMPACT	HIGH FEASABILITY	CURRENT PRACTICE
Techniques (relaxation, warmth, massage, early initiation of pumping and increased frequency of pumping) significantly increase the quantity of milk obtained	97	85	79
Improving the neonatal unit environment (privacy, increased contact with infants, less emphasis on feeding routines) and staff support for parents (information, education and positive, consistent reinforcement and feedback) may enhance milk expression and supply during hospitalisation in the neonatal unit	93	85	53
Parents receiving breastfeeding support at the neonatal unit in the form of counselling, information (handouts and videos), practical help and group breastfeeding clinics are more likely to continue breastfeeding up to a month after discharge	92	76	46
Chat or social talk between nurses and parents has a positive influence on mothers confidence, their sense of control and their feeling of connection (parent-baby attachment) with their baby	90	96	81
Giving parents a photograph of their preterm infant in preparation for seeing the infant for the first time has a positive effect on improving parent- baby attachment with their infant	91	88	70
Interventions are likely to be less effective if implemented individually, instead interventions to support breastfeeding should be multi- faceted and should span both the antenatal and postnatal period	96	73	36

IMPACT OF ABANDONING ACTIONS LIKELY TO BE INEFFECTIVE	POSITIVE, ABANDON IT	NEGATIVE, DO NOT ABANDON	NOT CURRENTLY IN USE	DON'T KNOW
Supplementing breast feeds with cup feeding (as opposed to bottle feeding) during establishment of breastfeeding for preterm infants is unlikely to have any effect on exclusive breastfeeding beyond discharge and increases length of hospital stay considerably[1]	28	25	28	19
Early discharge from the neonatal unit, with home support for gavage feeding is unlikely to have a positive effect on duration rates of any and exclusive breastfeeding among clinically stable preterm infants[2]	15	13	43	29
Weighing the infant before and after feeds leads to no significant difference in the mothers confidence and competence in carrying out breastfeeding	44	4	49	3

Open ended questions

Q5A Please give examples of **other actions** that you think might be effective in **promoting breastfeeding** in neonatal units

Communication (generally and across Health Boards)
Education for staff (nursing and non-nursing)
Education for parents and families (pre and post natal)
Peer/community support
Set feeding times
Enable bedside expressing
Improved physical environment (eg more comfortable chairs, privacy screens)
Consistent advice
UNICEF standards
Early expressing
Increase mother and baby contact time
Staff support
Involve partners and families
Specialist BF Advisors
Free choice about whether to BF
Funding for travel
More staff
More time

Q5B Please give examples of **other actions** that you think might be effective in **promoting breastfeeding** in neonatal units, especially for mothers and babies from **vulnerable groups**, such as teenagers, women who do not speak English, and women with complex social problems.

Financial support for travel costs
Multi-disciplinary team support
Wider social support to help BF
Cultural sensitivity
Use visual aids
Non English language information
Frequent interaction
Positive imagery and role models
Peer and community support (diversity of peer support groups)
More time
Involve midwives
Interpreters
Interagency support
Parent education
Multi-disciplinary support

Q6A Please give examples of **other actions** that you think might be effective in **promoting parent-baby attachment** in neonatal units

Staff training
Parental education
Encouraging mother and baby communication (eg diary writing, “Before Words” project)
Before words project
Frequent visiting
Family involvement
Encouraging tactile stimulation
Tools to improve parental involvement (eg “our journey together” toolkit)
Physical environment (eg facilities for parent to stay)
Bonding squares
More Kangaroo care
Open visiting
Facilities for parents to stay
Free parking
Family integrated care models
Individual rooms for mum and baby
Privacy
Support
Information

Q6B Please give examples of **other actions** that you think might be effective in **promoting parent-baby attachment** in neonatal units, especially for mothers and babies from **vulnerable groups**, such as teenagers, women who do not speak English, and women with complex social problems

Diverse peer support
Information (eg teen friendly, culturally sensitive, different languages)
Training for staff (eg cultural sensitivity, vulnerable groups)
Photo and baby diary
Open visiting
Named staff contact
Privacy
Encouragement to BF
Kangaroo care
Parental and family involvement
Interpreter
Peer and ongoing community support
Visual aids and demonstrations
Family involvement
Parental education
Physical environment
More focus mental health

Q7A What are the key **barriers to promoting change** and achieving the cultural shift necessary to promote **breastfeeding and maternal-infant parent-baby attachment** in neonatal units?

Physical environment (eg facilities for parents to stay, lack of privacy)
Unequal power relations between staff and parent
Staff attitudes, knowledge and training (eg not prioritised by staff, staff fear of handling small babies, negative attitudes)
Lack of strategy
Lack of engagement of other staff
Complexity of baby needs (eg some babies too ill)
History of formula feeding in families
Communication
Physical separation of mothers and babies
Embarrassment of mothers and lack of family support for BF
Babies discharged too quickly
Evidencing positive outcomes
Staff numbers

Q7B What **actions** are likely to work **to overcome** these **barriers**?

Involve parents hands on care (Parental co-working)
Give more power to parents
Staff training
Open visits – day and night
Clear strategy
Engaging with midwives
Promote women's choices
More staff
More time
Support WHO code
BF Champions
Normalise, encourage and support BF
Managerial support
Education
UNICEF standards
Communication
More resources
Follow up home care
Support with child care (eg crèche facilities)
Evidence that change is effective
Peer support

Q7C Do you have any **examples of best practice** that would **support the actions suggested** in this questionnaire?

UNICEF standards
Parental involvement, inc fathers
Peer support and community support
Express beside babies
Dedicated BF advisor
Kangaroo care
Family integrated care model
Compassionate care/ Person centred care
Caring and supportive environment
Skin to skin contact
Early expressing
Information and support

Anything else about the topic in general?

Ensuring NHS Boards work will be evidence based
More specialist help for BF in busy areas
Weekend service needed too
Avoid pressure and guilt on women who don’t BF
Ongoing work to promote benefits of BF to parents and staff
Help parents take ownership of their own roles
Standards difficult to implement as individual needs are all different
Dedicated staff to provide ongoing support
Staff skills may need improving
Understanding/acceptance of when mothers can’t breastfeed

Questions?