



PROCEDURE	
Breastfeeding and lactation concerns - assessment	
Scope (Staff):	Community health staff
Scope (Area):	CAHS-CH, WACHS
<p>Child Safe Organisation Statement of Commitment</p> <p>The Child and Adolescent Health Service (CAHS) commits to being a child safe organisation by meeting the National Child Safe Principles and National Child Safe Standards. This is a commitment to a strong culture supported by robust policies and procedures to ensure the safety and wellbeing of children at CAHS.</p>	

This document should be read in conjunction with this [DISCLAIMER](#)

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Aim

To maximise maternal and infant health and infant developmental outcomes by providing information on breastfeeding and lactation as the physiological norm, and about the assessment and care planning of commonly reported breastfeeding and lactation concerns.

Risk

When there are delays in identifying risk factors and problems known to influence breastfeeding and lactation efficiency, breastfeeding and lactation duration may be negatively impacted. The health risks associated with not breastfeeding may negatively affect an infant's developmental, nutritional, physical and psychological wellbeing, as well as the mother's physical and psychological wellbeing.¹

Background

There is convincing evidence that having contact with clients in the antenatal and perinatal period (from conception through to twelve months) increases breastfeeding duration.² Community health nurses working in child health are well placed to enquire about breastfeeding and lactation, and respond to lactation and breastfeeding difficulties that require early intervention. This is most meaningful when nurses use evidence-informed knowledge and skills, and clinical judgement to conduct comprehensive and systematic enquiries through:

- Understanding normal breastfeeding and lactation
- Eliciting and responding to parental concerns
- Gathering information about the child's current abilities and functions
- Identifying protective and risk factors known to influence breastfeeding and lactation
- Using evidence-informed assessment methods and tools.³

When nurses use this assessment approach, it provides a framework for determining interventions according to client need. Care planning will include interventions to ensure the infant's nutritional requirements are being met, whilst enabling normal developmental feeding milestones.⁴

In the first months of life approximately one third of infants and mothers experience breastfeeding and lactation difficulties, often leading to introduction of complementary feeds and breastfeeding cessation.^{2,5} Australian data and maternal self-reports identify these difficulties as precipitated by infant and maternal breastfeeding problems, rather than a client's initial infant feeding decision. Australian breastfeeding initiation rates are reported to be 96%. However, exclusive breastfeeding duration rates are only 61% at less than four (4) months of age, which is below national and international recommendations.^{6,7} Mothers report concerns with milk volume, infants not attaching properly, unsettled infants and painful breastfeeding as reasons for breastfeeding cessation in the first six (6) months.⁸ Research indicates that most mothers lactate efficiently.⁸ Therefore, it is important to recognise the importance of the role of the infant in breastfeeding and lactation duration.

Community health nurses working in child health support a mother's breastfeeding goals, by providing evidence-informed advice and strategies to overcome breastfeeding concerns. Fathers, partners and family members also play a pivotal role in supporting breastfeeding. The attitudes and beliefs of key support people have a major influence on infant feeding.⁸

Literature shows that effective interventions include ongoing scheduled contacts where parents can predict when they will have contact with professionals. Face to face contacts are associated with higher exclusive breastfeeding rates.^{9,10}

Key Points

- Clients presenting with infant and maternal concerns will be assessed to identify the problem and possible causes.
- Clients will be offered evidence-informed strategies that include information and/or demonstration on breastfeeding and lactation physiology, infant reflexes and cues, and breastfeeding positioning and attachment using baby-led attachment principles.
- Where resolution of significant concerns is out of the Nurse's scope of practice, immediate referral is to be made.
- Nurses will use family-centred and strengths-based approaches to facilitate a shared understanding of concerns, and care planning that is proportionate to client needs.
- Nurses are required to complete training and refresher training as per the CAHS-CH Nurses working in Child Health Nursing Practice Framework or as directed by WACHS Community Health managers.
- Nurses think critically and use the best available evidence in making decisions and providing care that is safe, appropriate and responsive.

Tools

- *Breastfeeding Assessment Guide* (CHS012)
- *World Health Organization(WHO) 0-6 month Growth Charts*
- *World Health Organization(WHO) 0-2 years Growth Charts*
- *Fenton Growth Charts* for use with preterm infants

Process

Refer to [Appendix G for the Identification of feeding concerns flowchart](#) for an overview of the process steps.

Steps	Additional Information
<p>Breastfeeding and lactation assessment overview</p> <ul style="list-style-type: none"> • Obtain an infant and maternal history regarding the pregnancy, birth, postnatal period, neonatal period, infant feeding, current and past lactation experiences, and infant and maternal health. <ul style="list-style-type: none"> ○ Enquire about and review existing brief interventions or feeding plans. • Enquire about infant feeding and lactation goals. • When concerns have been identified, use the <i>Breastfeeding Assessment Guide</i> as part of a comprehensive systematic enquiry. <ul style="list-style-type: none"> ○ The <i>Breastfeeding Assessment Guide</i> provides information to assist nurses with determining the nature of the concerns and to plan care plan according to client need. ○ File the <i>Breastfeeding Assessment Guide</i> in electronic or MR600 child health 	<p>Refer to the following for more information throughout the process steps:</p> <ul style="list-style-type: none"> • <i>Breastfeeding Assessment Guide</i> form (CHS012) • <i>Clinical handover – nursing procedure</i> • <i>Early Parenting Groups: Facilitator Guide</i> for more information about breastfeeding, lactation and sensitive parenting • <i>Growth birth – 18 years guideline</i> • <i>Head circumference assessment procedure</i> • <i>Length assessment 0-2 years procedure</i> • <i>Nutrition for children – birth to 12 months guideline</i> • <i>Physical assessment 0-4 years guideline</i> • <i>Practice Guide for Community Health Nurses</i> • <i>Universal contact guidelines</i>

<p>records, according to CAHS-CH and WACHS processes.</p>	<ul style="list-style-type: none"> • <i>Weight assessment 0-2 years procedure</i> • <i>World Health Organization growth charts</i>
<p>Infant feeding assessment</p> <p>Discuss an infant's capacity to breastfeed as an essential developmental milestone, reinforcing that infant concerns require early intervention to maximise breastfeeding duration and healthy outcomes.</p> <p><u>Feeding efficiency and nutrition</u></p> <ul style="list-style-type: none"> • Enquire about infant feeding and nutrition by asking: <ul style="list-style-type: none"> ○ How is your baby feeding? ○ Do you have any concerns about how your baby is breastfeeding (and/or teat feeding)? • Nurses will be alert to responses that suggest: <ul style="list-style-type: none"> ○ Infant pain ○ Difficulties with milk transfer ○ Complementary feeds are being used. <p>Consider relevant risk factors that may result in delayed secretory activation or secondary lactation failure.</p> <p><u>No concerns identified</u></p> <p>Complete assessments and care planning as per <i>Universal contact guidelines</i>.</p> <p><u>Concerns identified</u></p> <p>Conduct the following assessments:</p> <ul style="list-style-type: none"> • <u>Physical assessment</u> <ul style="list-style-type: none"> ○ Focus on oral anatomy (lingual frenulum, mouth and lips, palate and tongue), head preference, head shape, posture, tone, reflexes, asymmetry in limb movement ability, state of arousal, colour and general appearance. • <u>Elimination</u> <ul style="list-style-type: none"> ○ Enquire about urine output (reduced volume, concentrated, offensive) ○ Enquire about stool output (transitional/brown, dry, hard, explosive, reduced bowel actions) • <u>Breastfeeding assessment</u> 	<p>Risk factors and infant concerns listed below may result in:</p> <ol style="list-style-type: none"> 1. <u>Delayed secretory activation</u> (onset of copious breastmilk production). This needs to be managed effectively to prevent secondary lactation failure. <ul style="list-style-type: none"> • Inefficient or infrequent infant feeding, delayed first feed 2. <u>Secondary lactation failure</u>. This is the most common cause of reduced milk volume, due to inefficient or infrequent milk removal. <ul style="list-style-type: none"> • Oral anatomy – cleft lip and palate, ankyloglossia, deviated septum and choanal atresia, micrognathia • Medical conditions such as congenital heart disease, respiratory conditions, cystic fibrosis, Down syndrome, gastro-oesophageal reflux disease and infections • Other conditions – plagiocephaly, breast refusal (aversion), pathological jaundice, sensory processing disorder, sedative medications (maternal or infant), pain, sleepiness • Other situations – separation of infant and mother, inappropriate dummy use, timed or scheduled feeds, infant formula supplementation without medical reason.¹¹ <p>Refer to the Physical Assessment 0 – 4 years guideline, and Appendices A – F for more information.</p>

<ul style="list-style-type: none"> ○ Observe a breastfeed to provide information on feeding efficiency and milk transfer. <ul style="list-style-type: none"> ○ Note attachment, sucking, swallowing, breathing patterns, infant behaviour (unsettled, pushes away from breast). ○ Additional lines of enquiry will include current feeding patterns including frequency, duration, one or both breasts offered at each feed, infant cry, cough, chokes, regurgitation, dribbles, dummy use, complementary feeding frequency and volumes, use of feeding aids. ● <u>Growth assessment</u> <ul style="list-style-type: none"> ○ Conduct a weight, length and head circumference assessment. ○ Use the WHO 0-6 month growth charts. 	
<p>Maternal assessment</p> <ul style="list-style-type: none"> ● Enquire about lactation and breastfeeding by asking: <ul style="list-style-type: none"> ○ Is breastfeeding comfortable for you? ○ Do you have any concerns with breastfeeding and/or lactation? ● Nurses will be alert to responses that suggest: <ul style="list-style-type: none"> ○ Maternal pain ○ Concerns regarding milk synthesis ○ Maternal feeding and lactation goals not being achieved. ● Enquire about physical and psychological conditions, maternal pain, lactation aids, expressing, and other issues known to impact lactation. ● Enquire about previous lactation experiences. ● Consider relevant risk factors and maternal concerns that may result in delayed secretory activation or primary lactation failure. <p><u>No concerns identified</u></p> <p>Provide anticipatory guidance and care planning as per <i>Universal contact guidelines</i>.</p> <p><u>Concerns identified</u></p> <p>Conduct the following assessments:</p>	<p>Relevant risk factors and maternal concerns listed below may result in:</p> <ol style="list-style-type: none"> 1. <u>Delayed secretory activation</u> (onset of copious breastmilk production). This needs to be managed effectively to prevent secondary lactation failure. <ul style="list-style-type: none"> ● Prolonged labour, caesarean section, retained placenta, obesity, diabetes 2. <u>Primary lactation failure</u>. Occurs rarely, and may result in complete absence of secretory activation or reduced milk volume. <ul style="list-style-type: none"> ● Hypoplastic breasts, mammary reduction/augmentation, breast and nipple scarring, polycystic ovarian syndrome, retained placenta, postpartum haemorrhage, thyroid conditions, previous chest trauma. 3. <u>Secondary lactation failure</u>. This is the most common cause of reduced milk volume due to ineffective or infrequent milk removal resulting in down-regulation of milk synthesis. <ul style="list-style-type: none"> ● Pain, breast conditions impacting breastmilk drainage, low confidence, postnatal depression, some medications and smoking.¹¹

<ul style="list-style-type: none"> • <u>Physical assessment</u> <ul style="list-style-type: none"> ○ Observe nipples for skin integrity, compression, trauma, colour, colour changes, discharge. ○ Observe breasts for fullness, blocked ducts, reddened areas, abnormally shaped breasts, reduced glandular tissue, breast implants, surgical scars. • <u>Breastfeeding assessment</u> <ul style="list-style-type: none"> ○ If pain is experienced, enquire about the onset, duration, description and location, and observe the shape of the nipple following detachment. 	
<p>Interventions for concerns</p> <ul style="list-style-type: none"> • When concerns have been identified, refer to the relevant clinical practice guidelines in the appendices, for specific information related to assessments and care planning. • Develop a plan with the client, considering the findings from assessments and outcomes of any previously implemented strategies. • Where significant anatomical or functional concerns impacting on infant or maternal wellbeing have been identified, make an immediate referral. • Refer to relevant community services, as required. 	<p>Refer to the following clinical practice guidelines (Appendices A – F) for detailed information:</p> <ul style="list-style-type: none"> • Maternal breast pain • Maternal nipple pain and trauma • Unsettled infant • Dysfunctional suck • Hypolactation • Hyperlactation <p>Determining the most appropriate strategies will ensure:</p> <ul style="list-style-type: none"> • The infant's nutritional requirements are being met • Breastfeeding is facilitated where possible, acknowledging that alternate strategies may be required, until such time as normal feeding skills are achieved • Mother's lactation is maintained • Mother's short and long term goals are considered.
<p>Care planning</p> <p>A 'take home action plan' is to be developed in partnership with the parent/carer, and a copy given to them to take home. The care plan will outline (where relevant):</p> <ul style="list-style-type: none"> • A summary of concern • Parent/carer breastfeeding goals • Strategies/plan for the parents/carers to implement • Review appointments • Referral point/s 	

<ul style="list-style-type: none"> • When to escalate care, if required. <p>Review</p> <ul style="list-style-type: none"> • Review the client within one to seven (1-7) days of the initial contact to determine the effectiveness of implemented strategies. • Review to be conducted as a Universal Plus appointment. • When the concern has: <ul style="list-style-type: none"> ○ Resolved - provide anticipatory guidance on universal contacts ○ Improved - re-assess the client to determine requirements for future review. ○ Not improved or there are sustained concerns: refer immediately to services or professionals, where available. Alternatively a referral will be made to a medical professional. <p>Referral</p> <ul style="list-style-type: none"> • Refer client to relevant services when: <ul style="list-style-type: none"> ○ Significant anatomical or functional concerns are impacting on health and wellbeing ○ There has been no improvement on review of client progress ○ There are sustained concerns from client or nurses. • Include the following key information when initiating a referral: <ul style="list-style-type: none"> ○ Breastfeeding and lactation assessment outcomes ○ Outcomes of implemented strategies ○ Breastfeeding Assessment Guide – a copy may be attached to the referral documentation ○ Growth assessment including serial measurements of weight, length and head circumference with trajectories determined ○ Feeding and lactation goals. • When a referral has been initiated and the client is waiting for further assessment, the referring nurse will provide ongoing client care as required. • Where relevant services are not available, nurses will offer additional contacts 	<p>Nurses will consider their scope of practice and consult with managers and/or professionals with breastfeeding and lactation expertise, to provide care that is responsive to the needs of clients.</p> <p>Timing of review will depend on the concern identified.</p> <ul style="list-style-type: none"> • Relevant services and professionals may include those providing expertise in breastfeeding and lactation. <p>For CAHS-CH staff:</p> <ul style="list-style-type: none"> • When clients are referred internally to CAHS-CH Breastfeeding Support Services, the completed Breastfeeding Assessment Guide must be uploaded into CDIS. • When clients are referred externally, the CHS 663 Clinical handover/referral form must also be completed. <p>Further assessments, including medical assessments may be required when there are concerns with the health status of the infant or mother.</p> <p>Hospital assessments may be required when there are immediate concerns with the health status of the infant or mother.</p>
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according to client need.	
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Documentation

Nurses maintain accurate, comprehensive and contemporaneous documentation of assessments, planning, decision making and evaluations; according to CAHS-CH and WACHS processes.

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Appendix A: Maternal breast pain clinical practice guideline ¹¹⁻¹⁴

Maternal breast pain may be associated with the following issues:

Physiological engorgement is swelling and distension of the breasts that occurs as milk production increases, typically on the third to fifth day after birth, leading to overfilling of the breasts.

Pathological engorgement shows more severe signs of engorgement, including maternal pain and inadequate breastmilk drainage.

Lactational mastitis is inflammation of the breast tissue which may or may not be caused by a bacterial infection.¹² However, there appears to be a continuum from engorgement to non-infective mastitis to infective mastitis, and then to breast abscess (a localised area of pus).

Blocked ducts result in milk building up behind the blockage and forming a painful lump, sometimes with associated engorgement and the presence of a white spot (bleb) on the nipple.

Candida infection can be difficult to identify as the nipples and breasts may look normal and milk culture may be unreliable. Candida is usually suspected when other causes of breast pain have been eliminated.

For additional information related to maternal breast pain refer to the following clinical practice guidelines:

- Maternal nipple pain and trauma
- Unsettled infant
- Dysfunctional suck.

Identifying signs

- Physiological engorgement presents as bilateral, diffuse breast fullness.
- Pathological engorgement presents as bilateral, swollen, firm, distended, painful, shiny, warm breasts and may be associated with a low-grade fever.
- Blocked ducts may present as a painful lump that may be red or hot.
- Mastitis presents as pain, oedema, erythema and warmth in the breast and/or nipple and temperature of 38°C or greater, chills, flu-like myalgia, often with rapid onset.
- Abscess formation presents as a well-defined painful mass in the breast that remains hard and red, despite appropriate mastitis management. There is often a fever.
- Candida may be experienced as burning nipple pain that radiates into the breast as a shooting, burning pain.

Possible causes

- Factors associated with milk stasis or inadequate milk removal may include:
 - Sub-optimal positioning and attachment to the breast.
 - Blocked ducts, nipple white spot (bleb) or hyperlactation.
 - Inappropriate expressing.
 - Underwire bra pressure, or restrictive clothing/external pressure on the breast.
 - Ductal abnormalities.
 - Infant dysfunctional sucking.
- Changing feeding patterns
 - Infrequent feeding or decreased feeding from usual pattern.
 - Scheduling the frequency or duration of feeding sessions.
 - Use of supplements including formula, water and/or solids.
 - Abrupt weaning.
- Factors that may predispose to mastitis include nipple trauma especially if colonised with *Staphylococcus aureus*, maternal or infant illness, and maternal stress and fatigue.
- Repeated courses of antibiotic therapy and infant oral Candida increase the risk of maternal nipple and ductal Candida.

Assessment

- Assess maternal pain, onset, duration, frequency, location, exacerbating and pain relieving factors.
- Observe a breastfeed and assess milk transfer.

Maternal breast pain (continued)

Care planning

- Determine the possible cause of maternal breast pain and implement brief intervention strategies and/or refer to relevant clinical practice guidelines.
- Aim to increase breastmilk drainage:
 - Refer to Clinical practice guideline: Dysfunctional suck, for infant causes and recommended strategies.
 - Express prior to breastfeeding to soften breasts/areola and aid in attachment.
 - Encourage unrestricted feeding without limiting the time at the breast.
 - Breastfeed from the affected breast first, gently stroke towards the nipple, and change positions to promote drainage from different quadrants.
 - Reattaching the infant after the first milk ejection reflex can assist with an even deeper attachment, resulting in increased breast drainage.
 - Ensure the first breast is drained before offering the second breast (for mastitis offer the affected breast first, if pain does not prohibit a milk ejection reflex).
 - When feeding from the unaffected breast remove bra to allow breastmilk drainage.
 - Warmth may be applied to the affected area while the infant feeds (for mastitis).
 - Breast milk expression may be required following breastfeeding, if maternal discomfort and engorgement persists.
 - Cool packs or cool cloths (from the refrigerator not freezer) after feeding can relieve swelling associated with oedema.
 - Avoid using a dummy or complementary feeds.
- Relieving pain:
 - Cool packs or cool cloths (from the refrigerator) after feeding.
 - Refer to pharmacist and/or general practitioner to discuss medications to reduce inflammation, discomfort and pain.
- If a white spot (bleb) is present, mother can soak the nipple with a warm moist cloth, and gently exfoliating the fine layer of skin growing over the duct opening, followed by feeding the infant or expressing, to allow the milk to flow again.
- When a mother presents acutely unwell with mastitis, refer immediately to a General Practitioner for further assessment and management. A penicillinase-resistant penicillin such as Flucloxacillin for is usually prescribed 10-14 days. Provide anticipatory guidance on repeated courses of antibiotics increasing the risk for breast and vaginal candida infections. Discuss strategies to increase breastmilk drainage. Reinforce that weaning at this time is not advisable, due to the risk of pathological engorgement and abscess formation. If breastfeeding is too painful, expressing with an electric pump is recommended. For more information on expressing breastmilk and providing expressed breastmilk to the infant, refer to the Women and Newborn Health Service *Breastfeeding and Breast care* resource and the Australian Breastfeeding Association. Discuss reintroducing the infant to breastfeeding as soon as possible, when issues have improved or resolved.
- If candida is suspected refer to a Pharmacist or General Practitioner for further assessment and management. A topical antifungal ointment or cream, or oral Fluconazole may be prescribed for mothers and an oral antifungal may be prescribed for infants.
- CHN review in 1-7 days to determine effectiveness of strategies.

Referral

- Refer to relevant professionals for further assessment, where significant anatomical, functional or medical conditions are suspected, when there has been no improvement from implemented strategies on review, or when there are sustained concerns from client or nurses.

Appendix B: Maternal nipple pain and trauma clinical practice guideline^{2, 8, 11, 14}

Nipple and breast pain is one of the most common reasons for breastfeeding cessation.

For additional information related to maternal nipple pain and trauma refer to the following clinical practice guidelines:

- Hypolactation
- Maternal breast pain
- Dysfunctional suck.

Identifying signs

- Maternal pain and concerns with skin integrity, colour, shape or discharge.
- Candida may present as pink nipples and areola, shiny or flaky appearance of the nipple, nipple pain out of proportion to clinical findings.

Possible causes

- Infant suck dysfunction.
- Sub-optimal infant positioning impacting on breast attachment.
- Infant oral and/or postural concerns.
- Compromised skin integrity – eczema, dermatitis, bacterial infections, candida.
- Breast (and areolar) – fullness, engorgement.
- Nipple – nipple bleb, vasospasm, Raynaud's phenomenon, nipple variations.

Assessment

- Assess maternal pain description, onset, duration, frequency, location, exacerbating factors (cold, initial attachment, expressing), pain relieving factors (warmth).
- Assess the nipples for trauma, compression, colour changes and discharge.
- Assess infant's oral cavity, posture, tone and movement for concerns impacting on breastfeeding efficiency.
- Observe a breastfeed and assess the infant's position, behaviour, evidence of pain, attachment, evidence of nipple compression, colour changes upon detaching, evidence of milk transfer.

Care planning

- Determine the possible cause of the nipple pain and trauma and implement brief intervention strategies and/or refer to relevant clinical practice guidelines.
 - Consider the Dysfunctional suck clinical practice guideline for strategies relating to possible infant causes of maternal pain and recommended strategies. These include strategies related to positioning and attachment.
- Continuation of previously established feeding method until the cause of maternal pain is identified and resolved. This may include expressing breastmilk or considering the temporary use of nipple shields. For more information on expressing breastmilk and providing expressed breastmilk to the infant, refer to the Women and Newborn Health Service *Breastfeeding and breast care* resource and the Australian Breastfeeding Association.
- Breast milk expression may be required if maternal pain prevents the infant from breastfeeding:
 - Ensure clients understand supply (milk production) and demand (milk removal).
 - Discuss milk removal via hand expressing or using a pump (manual, electric – single or double). Demonstrate hand expressing as required. Ensure the correct size breast shield is used for adequate breast drainage and to prevent nipple trauma.
 - Offer the CAHS-CH *Breastfeeding expressing and storing breastmilk* parent resource.
 - Develop a realistic expressing plan with the mother.
- White spots (bleb) – mother can soak the nipple with a warm moist cloth, and gently exfoliate the fine layer of skin growing over the duct opening, followed by feeding the infant or expressing to allow the milk to flow again.
- Raynaud's – Avoid cold exposure, apply warmth, avoid vasoconstrictive drugs.
- Provide information about how to reduce nipple irritation and promote healing - such as using Modified lanolin, replacing damp breast pads frequently, avoiding shampoo and soap on the nipples.
- Discuss reintroducing the infant to breastfeeding as soon as pain is improving or has resolved.

Breastfeeding and lactation concerns - assessment

- CHN review in 1-7 days to determine effectiveness of strategies.

Referral

- Refer to relevant professionals for further assessment, where significant anatomical, functional or medical conditions are suspected, when there has been no improvement from implemented strategies on review, or when there are sustained concerns from client or nurses.

Appendix C: Unsettled infant clinical practice guideline^{2, 15}

It is not uncommon for infants to have unsettled periods which can be distressing for parents. Causes are usually multifactorial and can be related to a range of issues. It is important to conduct a comprehensive assessment to determine the possible cause of the infant's unsettled behaviour, so that appropriate strategies can be implemented.

For additional information related to unsettled infants refer to the following clinical practice guidelines:

- Hypolactation
- Hyperlactation
- Dysfunctional suck.

Identifying signs

- Frequent and sustained crying.
- Signs of underlying medical condition or illness.
- Decreased sleep and increased awake time appropriate for age.
- Growth trajectory concerns.
- Breastfeeding duration, frequency and efficiency concerns.
- Signs of low maternal confidence and exhaustion.

Possible causes

- Normal developmental behaviour – adjustment to extra-uterine life, expected crying patterns.
- Pain – birth trauma, postural variations, immunisations, underlying medical conditions.
- Medical - temporary lactose overload, gastroesophageal reflux, infections, ill health.
- Infant sleep deficits or unrealistic parental expectations of infant sleeping patterns; misunderstanding of infant cues.
- Feeding – breastfeeding concerns resulting in reduced milk transfer, hypolactation, hyperlactation, incorrect infant formula preparation (diluted) or excessive/decreased volume to meet nutritional requirements, unrealistic parental expectations of infant feeding patterns.

Assessment

- Observe a breastfeed and assess the infant's position, behaviour, evidence of pain, attachment, evidence of nipple compression, colour changes upon detaching, evidence of milk transfer.
- Discuss unsettled behaviour, including character of crying, frequency, duration, exacerbating factors or strategies that promote infant calmness.
- Infant sleeping, awake and settling patterns to determine age appropriateness.
- Maternal wellbeing, support network.

Care planning

- Determine the possible cause of the infant's unsettled behaviour and implement brief intervention strategies and/or refer to relevant clinical practice guidelines.
- Discuss age appropriate development including crying, feeding, sleeping, wakefulness, tired signs and settling strategies. Refer to CAHS-CH *Sleep* guideline and Ngala for more information.
- CHN review in 1-7 days to determine effectiveness of strategies.

Referral

- Refer to relevant professionals for further assessment, where significant anatomical, functional or medical conditions are suspected, when there has been no improvement from implemented strategies on review, or when there are sustained concerns from client or nurses.

Appendix D: Dysfunctional suck clinical practice guideline^{4, 11}

A general term used to describe inefficient breastfeeding (incoordination of sucking, swallowing and/or breathing) that may be caused by infant anatomical and/or functional issues and may present as maternal concerns such as breast and nipple pain.

For additional information related to dysfunctional suck refer to the following clinical practice guidelines:

- Maternal nipple pain and trauma
- Hypolactation
- Maternal breast pain.

Identifying signs

Infant

- Discomfort/pain or concerns during postural assessment.
- Discomfort/pain during breastfeeding assessment.
- Reduced swallowing and milk transfer.
- Detaching, coughing, choking, and/or dribbling when feeding.
- Growth trajectory concerns.
- Reduced urine and stool volume.
- Breastfeeding frequency, duration and efficiency concerns.

Maternal

- Nipple pain, discomfort, trauma, compression, colour changes.
- Breast pain or discomfort, fullness, engorgement, blocked ducts, mastitis.
- Delayed secretory activation, reduced breastmilk volume.

Possible causes

- Oral – ankyloglossia, maxillary labial frenulum, tight temporomandibular joint, arched palate, candida.
- Posture and movement - head preferences, plagiocephaly; instability or unable to tolerate supine, prone, or side lying positions.
- Prematurity, jaundice, gastroesophageal reflux, birth trauma, pre-existing medical conditions.
- Sub-optimal positioning and attachment.

Assessment

- Observe a breastfeed and assess the infant's position, behaviour, evidence of pain, attachment, evidence of nipple compression and/or colour changes upon detaching and evidence of milk transfer.
- Assess oral anatomy for anatomical and functional concerns.
- Assess for postural, tone and movement concerns.

Care planning

- Determine the possible cause of suck dysfunction and implement brief intervention strategies and/or refer to relevant clinical practice guidelines.
- Discuss innate infant reflexes that aid in positioning and breast attachment.
- Promote and provide information about baby led attachment and infant feeding cues. Refer parents to the [Raising Children Network - Breastfeeding and baby led attachment video](#)
- Discuss and demonstrate postural and handling exercises. Refer to CAHS-CH publications *Welcome to your new baby* magazine and the *Personal Health Record* resource *Baby Moves*.
- Alternative feeding methods may be required – Refer to clinical practice guideline: Maternal nipple pain and trauma.
- Maintain or increase breast milk volume - Refer to the Hypolactation clinical practice guideline
- CHN review in 1-7 days to determine effectiveness of strategies.

Referral

- Refer to relevant professionals for further assessment, where significant anatomical, functional or medical conditions are suspected, when there has been no improvement from implemented strategies on review, or when there are sustained concerns from client or nurses.

Appendix E: Hypolactation (Low milk volume) clinical practice guideline ^{2,} 11

The majority of mothers have the capacity to lactate efficiently, however, in rare circumstances, maternal conditions or insufficient glandular tissue development and breast surgery may impact breastmilk volume. In these cases, partial breastmilk production may be possible.

For additional information related to low milk volume refer to the following clinical practice guidelines:

- Maternal nipple pain and trauma
- Unsettled infant
- Maternal breast pain
- Dysfunctional suck.

Identifying signs

Maternal

- Delayed secretory activation (onset of copious milk production) – no evidence by 72 hours postpartum.
- Maternal perception of inadequate milk volume to meet infant needs (low confidence, unsettled infant) often resulting in early cessation of breastfeeding.
- Pathological engorgement impacting on milk flow and removal.

Infant

- Growth trajectory concerns including:
 - Greater than 7-10% of birth weight in the first 3 days following birth.
 - Not returned to birth weight by 14 days.
 - Serial growth measurements indicating unexpected decreases or stasis on the percentile lines, from a previously established rate of growth.
- Reduced elimination – concentrated and offensive urine; still passing meconium on day 5 of the neonatal period, or brown, dry or firm stools for older infants.
- Elevated serum bilirubin levels.
- Behaviour/Appearance – may be unsettled, decreased alertness, poor skin turgor, pale skin colour, sleep deficits. *NOTE: unsettled infant behaviour has many possible causes and therefore breastmilk volume should not be considered the only cause of unsettled behaviour.*
- Dysfunctional sucking.

Possible causes

Maternal

- Medical – breast hypoplasia, diabetes, Polycystic Ovarian Syndrome, hypothyroidism, obesity, infertility, breast surgery.
- Birth complications - retained placenta, postpartum haemorrhage, maternal pain associated with birth intervention, intravenous fluids during labour.
- Medications/substances - oral contraceptive pill, some cold and flu medications, nicotine, alcohol and some recreational drugs.
- Delayed or reduced milk removal resulting from inappropriate expressing regimes.

Infant

- Delayed or reduced opportunities to breastfeed, inappropriate feeding routines impacting on feeding cues, use of supplements including infant formula, water and/or solids.
- Dysfunctional sucking.

Assessment

- Observe a breastfeed and assess the infant's position, behaviour and breast attachment, evidence of nipple compression and/or colour changes upon detaching, evidence of milk transfer.
- Conduct infant growth assessments to determine trajectories.
- Establish infant elimination status.
- Determine maternal pre-existing medical conditions.
- Assess the nipples and breasts for anatomical variations.

Hypolactation (continued)

Care planning

- When milk volume is determined to be adequate, discuss sensitively with client to restore maternal confidence.
- Determine the possible cause of low milk volume and implement brief intervention strategies and/or refer to relevant clinical practice guideline.
- Aim to increase breastmilk volume whilst meeting the infant's nutritional requirements for growth and development.
- Increasing breastmilk volume:
 - Offer both breasts at each feeding session and increase feeding frequency (if required).
 - Allow baby to feed on each breast until milk transfer (swallowing) has ceased or has slowed down, then offer second breast.
 - Consider a top up breastfeed 20 to 30 minutes following the initial breastfeed.
 - Gently massage or stroke the breast towards the nipple whilst the infant is breastfeeding.
 - If this does not result in visible nutritive sucking, consider gentle breast compressions if nurse is confident in supporting this strategy. Otherwise, refer.
 - Consider breastfeeding for infant comfort. Restrict dummy use.
 - Develop a realistic expressing plan, allowing some maternal rest time. Offer the CAHS-CH *Expressing and storing breast milk* resource. Determine how milk will be expressed - hand expressing or using a pump (manual, electric – single or double). When using a pump determine the correct breast shield size is used and that the pump is working.
 - Consider referral to General Practitioner to discuss pharmaceutical galactagogues.
- Assess maternal knowledge about milk production, supply and demand, normal breast softening around 6 weeks postpartum.
- Continuation of previously established feeding methods may be required until the cause of the hypolactation is identified and resolved. For more information on expressing breastmilk and providing expressed breastmilk to the infant, refer to the Women and Newborn Health Service *Breastfeeding and Breast care* resource and the Australian Breastfeeding Association.
- If medically indicated and in the absence of available expressed breastmilk, complementary feeding with infant formula may be required. Refer to the [Infant Feeding Guidelines Infant Formula](#) chapter for further information
- CHN review in 1-7 days to determine effectiveness of strategies.

Referral

- Refer to relevant professionals for further assessment, where significant anatomical, functional or medical conditions are suspected, when there has been no improvement from implemented strategies on review, or when there are sustained concerns from client or nurses.

Appendix F: Hyperlactation (Oversupply) clinical practice guideline ^{2, 11, 16}

Oversupply is generally considered to be the production of breastmilk in excess of the volume required for the growth of healthy infants. It is characterised by the failure to down-regulate milk synthesis to match the infant's appetite. It generally occurs after secretory activation and usually resolves by 4 weeks postpartum, but occasionally persists beyond this time. Oversupply is distinct from physiological and pathological engorgement, which occurs in the early postpartum period.

For additional information related to oversupply refer to the following clinical practice guidelines:

- Maternal nipple pain and trauma
- Unsettled infant
- Maternal breast pain
- Dysfunctional suck.

Identifying signs

Maternal

- Persistently full breasts that may be lumpy, fill quickly and leak milk excessively
- May have a forceful milk ejection reflex.
- May have a history excessive breast growth during pregnancy (> 2 cup sizes), nipple blebs, vasospasm, recurrent blocked ducts or mastitis.

Infant

- May only require the volume of milk from one breast for each feeding session (beyond normal expected timeframes).
- Behaviour - may be overly unsettled during and after feeds, detaching from the breast, short feeds, clamping down on nipple, crying, appearing uncomfortable, gulping, breast refusal (aversion). *NOTE: unsettled infant behaviour has many possible causes and therefore breastmilk volume should be not be considered as the only cause of unsettled infant behaviour – Refer to the Unsettled infant clinical practice guideline.*
- Elimination - increased urine output, frequent bowel actions that may be frothy, explosive, green in colour and resulting in anal excoriation (sometimes referred to as lactose overload).
- Excessive weight gain or compromised growth if prolonged breast refusal.
- Dysfunctional sucking.

Possible causes

- Stimulation of milk production by excessive expressing, inappropriate use of galactagogues (self-prescribed/self-initiated).
- Delayed diagnosis and management of infant or maternal concerns.
- Specific diseases or medications that impact on dopamine secretion.
- Maternal conditions – prolactinoma, pituitary adenoma, hyperthyroidism.
- Differential infant conditions include infantile colic, food allergy, secondary lactose intolerance, gastro-oesophageal reflux disease.

Assessment

- Observe a breastfeed and assess the infant's position, behaviour and breast attachment, evidence of nipple compression and/or colour changes upon detaching, and evidence of milk transfer.
- Determine the presence of maternal and infant pre-existing medical conditions, or the possibility of potential medical conditions.
- Assess the nipples and breasts for pain, fullness, blocked ducts, mastitis, nipple integrity, colour, compression, discharge and milk volume.
- Obtain a feeding history – frequency, duration of each feed, number of breasts used at each feeding session.

Hyperlactation (continued)

Care planning

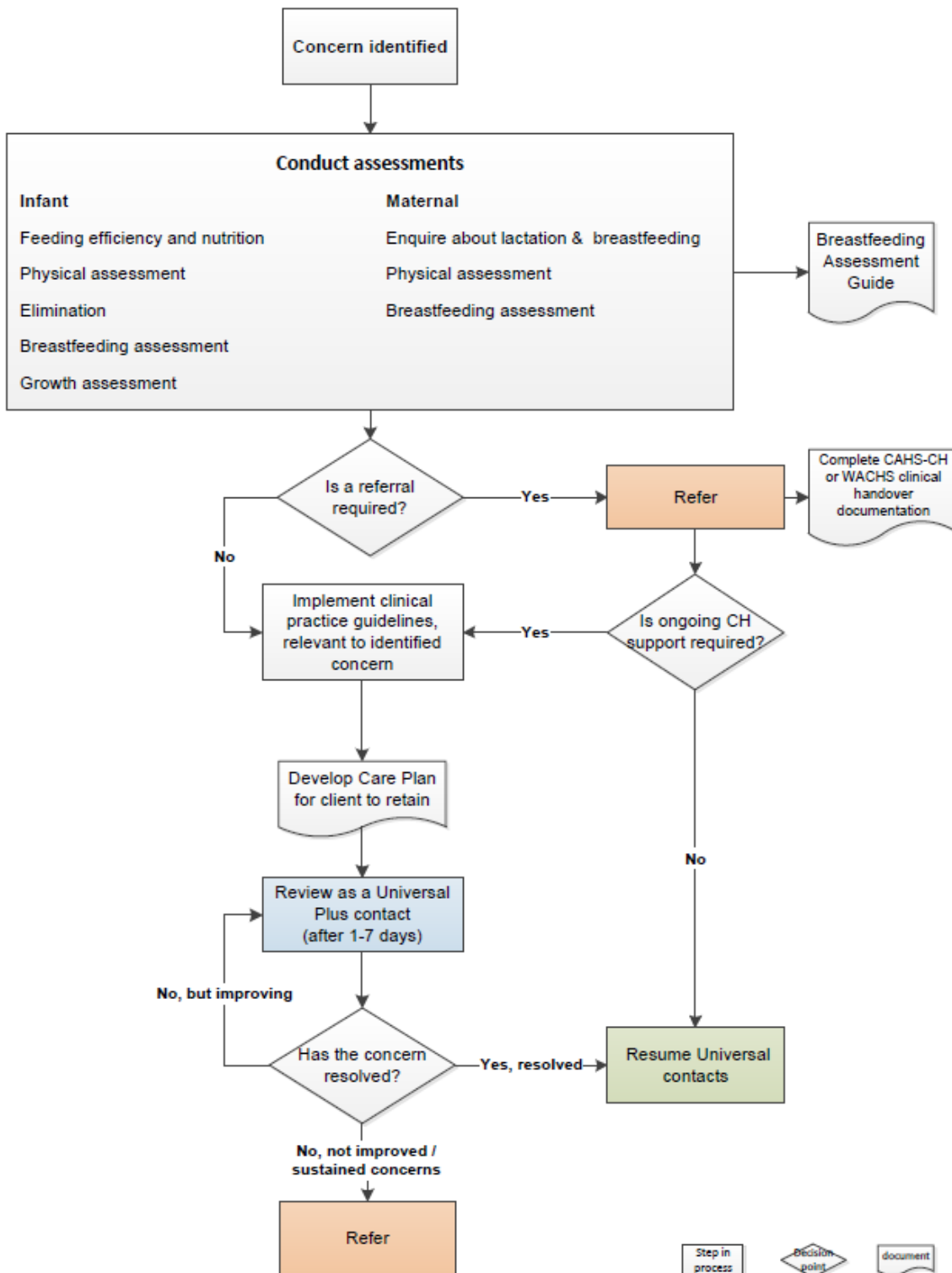
- Determine the possible cause of oversupply and implement brief intervention strategies and/or refer to relevant clinical practice guidelines.
- Ensure breastfeeding efficiency.
- Aim to adjust the breastmilk volume by decreasing overstimulation whilst meeting the infant's nutritional requirements:
 - Recognise infant feeding cues and breastfeed according to infant's need (avoid scheduled feeding or timed duration of feeding sessions).
 - Allow infant to feed from one breast until satiated. If the infant requires another breastfeed within 3 hours, consider feeding from the same breast. Continue this for a few days depending on the degree of breast fullness the mother is experiencing (block feeding). If this strategy is implemented ensure the 'second breast' does not become overfull.
 - Expressing a small amount before breastfeeding may assist the infant with attaching to the breast.
 - Decrease non-nutritive breastfeeding by offering alternative comfort strategies rather than breastfeeding.
- When breasts remain uncomfortably full consider expressing for 'comfort' (if the infant is not ready to breastfeed) and to alleviate potential complications. Offer the CAHS-CH *Expressing and storing breast milk* resource.
 - Discuss options for storing milk and/or donation of surplus breastmilk to a human milk bank if available.
- A cool pack placed under the breast between feeds may offer comfort.
- Reassure mother that the excessive milk volume is usually temporary.
- Provide anticipatory guidance on blocked ducts and mastitis.
- Some mothers perceive that if their baby is unsettled they have a low milk volume. However infants may present as being unsettled when mothers have hyperlactation. Assess maternal knowledge about efficient milk transfer, milk production, supply and demand, and infant growth and development.
- Refer to General Practitioner or Pharmacist to discuss any medications the mother may be taking
- CHN review in 1-7 days to determine effectiveness of strategies.

Referral

- Refer to relevant professionals for further assessment, where significant anatomical, functional or medical conditions are suspected, when there has been no improvement from implemented strategies on review, or when there are sustained concerns from client or nurses.

Appendix G: Identification of feeding concerns

At all contacts, enquire about breastfeeding and lactation efficiency. Complete the Breastfeeding Assessment Guide as a checklist, when the client presents with concerns and when nurses have identified deviations from the norm.



Related policies, procedures and guidelines
The following documents can be accessed in the Clinical Nursing Manual via the HealthPoint link, Internet link or for WACHS staff in the WACHS Policy link
Breastfeeding protection, promotion and support
Breastfeeding support services
Child health services
Clinical handover - nursing
Growth birth – 18 years
Growth faltering
Head circumference assessment
Length assessment 0-2 years
Nutrition for children – birth to 12 months
Nutrition for children – 1 to 11 years
Perinatal and infant mental health
Physical assessment 0-4 years
Sleep
Universal contact guidelines
Weight assessment 0-2 years
The following documents can be accessed in the Department of Health Policy Frameworks
Clinical Handover Policy (MP0095)

Related CAHS-CH forms
The following resources can be accessed from the CAHS-Community Health Forms page on HealthPoint
Breastfeeding Assessment Guide form (CHS012)
Fenton growth charts
WHO 0-6 months growth charts

Related CAHS-CH resources
The following resources can be accessed from the CAHS-Community Health Resources page on HealthPoint
Aboriginal Child Health Matrix
Breastfeeding - expressing and storing breastmilk
Early Parenting Groups: Facilitator Guide
How children develop
Indicators of Need
Practice guide for Community Health Nurses

Related external resources
Academy of Breastfeeding Medicine
Australian Breastfeeding Association Helpline 1800 686 268 is available 24 hours a day and 7 days a week. For clients requiring an interpreter phone the Translating and Interpreting Service (TIS) 131 450 and ask TIS to call the Breastfeeding Helpline.
Australian Breastfeeding Association Breastfeeding Confidence e-Book Available in 12 languages.
Australian Indigenous Health InfoNet
Breastfeeding Attachment YouTube video clip demonstrating correct attachment
Breastfeeding Centre of WA Statewide telephone counselling service, appointments for mothers and babies who have attended King Edward Memorial Hospital for their pregnancy or birth, and parent information including Breastfeeding and breast care and Pregnancy, Birth and your Baby (contains useful information regarding after the birth of a baby)
Book: Mary Sheridan's From Birth To Five Years Children's Developmental Progress. 2014. Ajay Sharma and Helen Cockerill.
Book: From Birth To Five Years Practical Developmental Examination. 2014. Ajay Sharma and Helen Cockerill.
Healthy WA website
Infant Feeding Guidelines – Information for health workers (National Health and Medical Research Council)
King Edward Memorial Hospital Obstetric Medicines Information Service
LactaMap – An online lactation care support system (intended for doctors). Provides easy to read information regarding breastfeeding and lactation.
Le Leche League International Breastfeeding Information in other languages

MedlinePlus Breastfeeding Multiple languages
Ngala – Assists parents, families, carers, children and young people in WA.
Nursing and Midwifery Board of Australia. Code of conduct for nurses and Code of conduct for midwives . 2018
Nursing and Midwifery Board of Australia. Registered Nurses Standards for Practice . 2016.
Queensland Health Aboriginal and Torres Strait Islander Select breastfeeding.
Queensland Health Multicultural Child Health Topics Select breastfeeding.
Raising Children Network Breastfeeding, Breastfeeding and baby-led attachment (video), Baby cues and baby body language: a guide (video)
The Royal Women's Hospital Melbourne Breastfeeding Factsheets in other languages Scroll down to Breastfeeding.

This document can be made available in alternative formats on request for a person with a disability.

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