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"A family-centered and breastfeeding friendly NICU layout is paramount to increase the rate of very low birth weight infants discharged home on human milk."

Biography

I graduated in medicine and surgery at Campus Bio-Medio University and then attended the paediatric residency program at Catholic University of Sacred Heart in Rome. My main interest is in perinatal cardiology. Since 2015 I have been working as an attending neonatologist in the neonatal intensive care unit of Ospedale Fatebenefratelli Isola Tiberina in Rome. Giving birth to more than 60 critical congenital heart defect per year, Fatebenefratelli Isola Tiberina is the referral centre for congenital heart lesion for all the centre and southern part of Italy.

Following parents from the diagnosis to the delivery, my personal goal is to avoid unnecessary detachment right after birth, to facilitate bonding and to ensure skin to skin contact after birth even for most critical heart defects, when possible, trying to establish breastfeeding as soon as in the delivery room. Since January 2018, I have followed the "screen to screen" project by Philips, which ensures that every mother and father whose baby is admitted to our neonatal intensive care unit can watch their child from home through an application in their smartphone, as part of our family-centered care environment.

Optimizing NICU care environment to support breast milk expression and feeding

Having a baby in the neonatal intensive care unit (NICU) is a stressful, overwhelming experience and feeding a preterm infant is a challenge even for mothers with a predetermined resolve to breastfeed. Even though breast-feeding is an efficient and cost-effective therapeutic approach to lessen the morbidity associated with preterm birth, a very low percentage of infants are discharged on exclusive human milk. Infant's first oral feed is a critical window during which mothers must be encouraged to put their baby to breast. Early initiation of oral feeding with breast milk may improve neuropsychomotor development of low birth weight preterm infants within the NICU setting. Despite evidence that the use of human milk in the NICU is compelling, the translation of this evidence into best practices, toolkits, policies and procedures, talking points, and parent information packets is limited. In fact, as compared to other therapies, feedings are not yet prioritized and NICU staff members and families have inconsistent information and a lack of lactation technologies to optimize the dose and exposure period of human milk feedings.

Stimulating a culture of using the evidence about breastfeeding in the NICU can change this circumstance and requires use of evidence-based quality indicators to benchmark the use of human milk, consistent messaging by the entire NICU team about the importance of breastfeeding for infants in the NICU, establishing procedures that protect maternal milk supply, and incorporating lactation technologies. Bedside nurses should frequently receive mandatory breastfeeding training. Mothers needs to be prepared for this first feed through education, reinforcing milk expression practices, and facilitating skin-to- skin contact.

A family-centered and breastfeeding-friendly layout is paramount, this may include privacy measures such as visual barriers, the chance of rooming in in a private room during the last few days before infant discharge, the presence of specialized breastfeeding chairs, milk expression rooms, and parent beds by infants' bedsides.

NICU with better work environments, better educated nurses, and more infants who receive breastfeeding support by nurses have higher rates of infants discharged home on human milk.