

Position Paper—Professional Lactation Support Staffing in the Hospital Setting

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Updated lactation support hospital staffing and post-birth recommendations for FTE and per 1,000.

Keywords: hospital staffing; lactation consultant; lactation; staffing ratios

International Board Certified Lactation Consultants (IBCLCs) are uniquely positioned to provide high-acuity lactation care within the hospital setting (International Board of Lactation Consultant Examiners, 2018; United States Lactation Consultant Association, 2020a). An IBCLC is the appropriate professional to lead all clinical lactation care duties and does not require additional licensure or credentials (United States Lactation Consultant Association, 2020b). Lactation care providers can provide education and direct support for newborn feeding at the breast/chest or expressed human milk provided in an alternative format. All dyads should have access to an IBCLC upon request or a referral made to an IBCLC for more complex feeding, anatomy, or neurological impairment that affects nutritive intake at the breast/chest.

In 2006, Mannel and Mannel published staffing guidelines for tertiary care facilities based on the lactation program at the Oklahoma University Medical Center Women's/Newborn Services in 2003–2004. The IBCLC staffing ratios that came from this study considered factors such as parental and newborn health conditions, birthing practices, patient population, provider support, availability of community support, and lactation education.

Mannel and Mannel (2006) developed robust staffing ratios (Table 1).

Since the publication of this research, many hospitals have adopted these staffing recommendations with positive outcomes (Mannel & Mannel, 2006). While the authors' staffing model was based on one hospital's

delivery structure rather than a national survey of various care frameworks, it does provide adequate guidance for hospital leaders to establish lactation staffing ratios. In calculating the appropriate IBCLC staffing ratio, a facility should incorporate the variables of average daily census and acuity across a variety of settings. For instance, if the unit approximates 80% well infants and 20% NICU infants, the combined ratios of 1.3 FTEs per 1,000 well-baby dyads and 4.3 FTEs per 1,000 dyads with babies admitted to the NICU will suggest 1.9 FTE per 1,000 total dyads. If the unit approximates 95% well infants and 5% NICU, the combined ratios of 1.3 FTEs and 4.3 FTEs will suggest 1.5 FTEs per 1,000 dyads.

In 2011, Mannel developed lactation acuity levels built on the foundation of the U.S. Institute of Medicine standards to ensure patient safety. Paternal and infant characteristics determine which of three acuity levels is appropriate for a dyad (Mannel, 2011). Aligning acuity levels to IBCLC staffing will support optimal staff utilization and patient outcomes (Mannel, 2011). A flexible staffing model is indicated to accommodate lactation acuity and demographic variability. An investigation to understand the interaction between acuity and IBCLC staffing is needed to fully understand and operationalize these principles.

As the Affordable Care Act calls for breastfeeding/chestfeeding support and equipment for the duration of breastfeeding/chestfeeding (United States, 2010), postpartum units should be staffed sufficiently enough to make lactation support accessible to every breastfeeding/chestfeeding dyad that may request it. Lactation education and counseling should be available within the first 24 hours with access to an IBCLC prior to hospital discharge. Lactation care and support may be necessary under a variety of settings with basic support being available from counselors/educators and complex clinical care being available from an IBCLC.

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TABLE 1. IBCLC Staffing Ratios

Service	FTE	Adjusted to per 1000
Inpatient dyads in postpartum NICU	1:783 breastfeeding dyads	1.3:1,000 dyads
Postdischarge care		
Discharged from postpartum: In-person appointments	1:1,292 dyads	0.8:1,000 dyads
Discharged from postpartum: Telephone follow-up	1:3,915 dyads	0.3:1,000 dyads
Discharge from NICU: In-person appointments	1:818 breastfeeding infants	1.2:1,000 infants
Discharge from NICU: Telephone follow-up	1:3,915 breastfeeding infants	0.3:1,000 infants
Education	0.1:1,000 deliveries	0.1:1,000 deliveries
Program development/administration	0.1:1,000 deliveries	0.1:1,000 deliveries
Research	0.1–0.2 FTE total	

Note. FTE = full-time equivalent; NICU = neonatal intensive care unit.

Source: Adapted from Mannel and Mannel (2006).

Appropriate IBCLC staffing ratios are vital to providing the highest quality care to breastfeeding dyads of all acuity levels. An exploration of national hospital IBCLC FTEs and breastfeeding/chestfeeding outcomes will help confirm staffing ratios remain accurate.

Specific Lactation Support Recommendations for Staffing and Post-Birth Care

A lactation care provider (e.g., IBCLC or counselor/educator (United States Lactation Consultant Association, 2020c) is available, by request, to every dyad within the first 24-hours post birth.

An IBCLC is on staff to be available, by request, to each dyad prior to discharge.

Every medical/birth professional (nurses, nurse practitioners, physicians, midwives, etc.) complete at least one college-level lactation course.

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Disclosure. The authors have no relevant financial interest or affiliations with any commercial interests related to the subjects discussed within this article.

Funding. The author(s) received no specific grant or financial support for the research, authorship, and/or publication of this article.