Breastfeeding Committee for Canada

Comité canadien pour l'allaitement

Baby-Friendly Initiative Implementation Guideline

Introduction

The Baby-Friendly Hospital Initiative (BFHI) was launched by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in 1991 to protect, promote and support breastfeeding as a means of "strengthening the contribution of health services to safe motherhood, child survival and primary health care in general" (45th World Health Assembly-WHA-1992). The minimum standard of care for newborns and their mothers/birthing parents in hospitals was embodied in the "Ten Steps to Successful Breastfeeding," and the International Code of Marketing of Breast-milk Substitutes (the Code) and subsequent relevant World Health Assembly resolutions. The BFHI was revised and updated by WHO-UNICEF in 2009 and 2018, based on current research and experience in many countries.

In 2018, an exhaustive literature review[1] led to a reinvigorated BFHI including a new guide for global BFHI implementation: *Implementation Guidance: Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services: the revised Baby-Friendly Hospital Initiative*. This new guidance document stresses "national implementation of BFHI, with an emphasis on scaling up to universal coverage and ensuring sustainability over time" (p. 6). In Canada, the BFHI includes community health services reflecting the continuum of care in our healthcare system and is called the Baby-Friendly Initiative (BFI). This Baby-Friendly Initiative Implementation Guideline describes the application of the international standards within the Canadian context and replaces the previous BCC *BFI 10 Steps and WHO Code Outcome Indicators for Hospitals and Community Health Services.*

The WHO/UNICEF Guidance (2018) core intent of protecting, promoting and supporting breastfeeding remains the same as the 1989 and 2009 versions. The following are the major changes that influenced the update of the Canadian BFI Implementation Guideline.

1. The Ten Steps are regrouped in two sections:
    - **Critical Management Procedures** (Steps 1 and 2) are institutional procedures necessary to ensure that care is delivered consistently. Step 1, Infant Feeding Policy, has been modified to: 1.a. The Code; 1.b. Written infant feeding policy; 1.c. Ongoing internal monitoring of clinical practices; Step 2. Staff competency assessment rather than a specific curriculum.
    - **Key Clinical Practices** (Steps 3–10) focus on individual care of mothers/birthing parents and infants, relevant to infant feeding.

2. Major changes and shifts:

[1] World Health Organization. *Guideline: Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services*. Geneva, CH: WHO; 2017.

- All infants, including small, sick and preterm infants, are included in the scope of BFI. See *Protecting, Promoting and Supporting Breastfeeding: the Baby-Friendly Hospital Initiative for small, sick, and preterm newborns* (WHO, 2020) for additional clinical guidance and measures for newborns, whether cared for in the NICU or in maternity units. Some of the global BFHI Standards do not apply fully to this population. For example, Step 4, skin-to- skin care at birth, is extremely important for the small, sick and preterm population, however, the 80% threshold for standards in Step 4 does not apply, as immediate and continued skin-to-skin may not be feasible for all preterm, especially very preterm, newborns. Similarly, Step 8, supporting responsive, cue-based feeding, may not apply to preterm infants, depending on their gestational age.
- Facilities assess staff competencies (knowledge, skills and attitudes) to ensure they are aligned with BFI, rather than requiring a specific curriculum or number of education hours. See *Competency Verification Toolkit: Ensuring competency of direct care providers to implement the BFHI* (WHO, 2020). For direct care providers in community health services, see the BCC competency verification guideline. [hyperlink here]
- Integration of BFI into other initiatives such as maternal and newborn health program development, healthcare quality improvement and quality assurance. All Ten Steps should be monitored to identify and address the gaps in care. Facilities are encouraged to assess practices according to the BCC's standards and implementation checklist for each step.
- Clarification of some clinical care issues based on current evidence (e.g., the use of feeding bottles, teats and pacifiers focuses on counselling mothers/parents on their risks and use, rather than on prohibiting them).
- Recognition that improving breastfeeding rates can be a key driver for achievement of the Sustainable Development Goals. For example, breastfeeding can be linked to goals 1 (end poverty in all its forms everywhere); 2 (end hunger, achieve food security and promote sustainable agriculture); 3 (ensure healthy lives and promote well-being for all at all ages); 4 (ensure inclusive and quality education for all and promote lifelong learning); 5 (achieve gender equality and empower all women and girls); 8 (promote sustained, inclusive and sustainable economic growth, employment and decent work for all); 10 (reduce inequality within and among countries); and 12 (ensure sustainable consumption and production patterns).

Facilities that seek BFI designation in Canada (outside of Quebec) will be required to meet the standards outlined. These standards focus on outcomes for pregnant persons, mothers/birthing parents and infants. Staff play a vital role in the achievement of these outcomes. For more information on the BFI Assessment process, see Process and Cost of BFI Designation. The **BFI Guideline Checklist [hyperlinks will be live in the final posted document]** provides direction on the actions that facilities need to take to attain the standards. If a facility determines that they are not meeting a standard, then the BFI Guideline Checklist should be used to determine areas needing further focus for education and care improvement. The BFI Guideline Checklist is required for BFI designation (including Certificate of Participation, Pre-Assessment and External Assessment).

Diversity and Health Equity

Using diversity and health equity approaches when implementing the Baby-Friendly Initiative helps to progressively close the unjust gaps in population health outcomes. Leadership to create an enabling environment that supports all families to meet their infant feeding goals facilitates the achievement of equity for all families. A holistic view to support breastfeeding and address the needs of diverse, vulnerable populations is imperative. Addressing the needs of priority populations requires a

population health approach. Communities, families and children who are most underserved or at major risk require special attention.

A person and family-centred approach to care includes cultural safety, as well as trauma-informed and harm-reduction measures. These approaches to care are foundational in the work and are enhanced by supportive partnerships. Placing the unique needs and strengths of the client at the centre of care ensures full client/family participation in the planning of care. Staff, volunteers, visitors and clients feel respected and safe from discrimination as they access healthcare services when there is a partnership between healthcare provider and clients, and informed decision making occurs.

In this document the terms breastfeeding, mother, woman, parent, and birthing parent may be used. We encourage all healthcare providers to inquire with families on first consultation what language they use when referring to their pregnancy, parenting and infant feeding as well as their preferred pronouns. For example, an individual may want to be referred to as a pregnant person rather than a pregnant woman; the person giving birth may want to be referred to as a birthing parent rather than a mother; the individual who is lactating may prefer the term chest feeding parent rather than breastfeeding woman or parent. Birthing parent is understood as the parent who has given birth to the child and this could include a cisgender woman, a transgender man, and a non-binary person. By using a person-centred approach, we can enable all families to be empowered to reach their personal infant feeding goals.

Some key definitions are presented in Appendix 1 to ensure common understanding of the terms used in this national guideline. Some definitions also appear as footnotes in the Standards.

The BFI Implementation Guidance document is divided into sections. The first section provides an overview of the Ten Steps to Successful Breastfeeding in Canada and is followed by a detailed table of each step with the required standards. This table includes information on targets to be achieved, with suggested monitoring modalities to verify that the standards have been met. Finally, the table can be used as a checklist for facilities to self-assess their progress in meeting each standard. The standards selected to be monitored are aligned with the WHO recommendations. Facilities may choose to add monitoring processes of the standards to assess progress toward meeting the targets.

The second section is broken down into three parts. The first part provides information on Continuous Quality Improvement (CQI), the second part provides the tools that may be used to support the facility's BFI journey and the last part provides information on implementing improvement changes.

The Ten Steps to Successful Breastfeeding in Canada

Critical Management Procedures
1.a. Comply with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly Resolutions.
1.b. Have a written Infant Feeding Policy that is routinely communicated to all staff, pregnant persons and parents.
1.c. Establish ongoing BFI monitoring and data-management systems.
2. Ensure that staff have the competencies (knowledge, attitudes and skills) necessary to support women/birthing parents to meet their infant-feeding goals.
Key Clinical Practices
3. Discuss the importance and process of breastfeeding with pregnant persons and their families.
4. Facilitate immediate and uninterrupted skin-to-skin[2] contact at birth. Support mothers/birthing parents to respond to the infant's cues to initiate breastfeeding as soon as possible after birth.
5. Support mothers/parents to initiate and maintain breastfeeding and manage common difficulties.
6. Support mothers/parents to exclusively breastfeed for the first six months, unless supplements are medically indicated.
7. Promote and support mother–infant togetherness.
8. Encourage responsive, cue-based feeding for infants. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.
9. Discuss the use and risks of feeding bottles, artificial nipples and pacifiers with parents.
10. Provide a seamless transition between the services provided by the hospital, community health services and peer-support programs.

For a comparison of BCC 2017, WHO 2018 and BCC 2020 Ten Steps visit here [hyperlink]

BFI Standards in Canada

The following table lists the standards for each of the Ten Steps. The column on the left indicates the facility to which the standard applies, the second column describes the standards and the third column identifies the required target for BFI designation. Suggestions for monitoring are found in columns four and five for the remaining steps. The bold text identifies monitoring recommended by WHO. Facilities may choose to add additional monitoring protocols for any of the standards. The last column can be used to assess progress toward meeting the standard. If a facility is not meeting the required standards, review of the BFI Guideline Checklist will assist in narrowing the areas for further improvement.

Table 1: BFI Standards and Monitoring Recommendations

The suggested monitoring column provides examples of tools that may be used to collect and verify the facility's progress toward meeting the standards. The hyperlinks to these tools are available on page [xx].

Hospital

Community Health Service

Critical Management Procedures

Facility		Baby-Friendly Initiative Standard	Target	Suggested Monitoring	Progress
1.a. Comply with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly Resolutions.					
		1a.1. All products[1] covered by the Code have been purchased in the same manner as other pharmaceuticals and food, and not received through free or subsidized supplies.	Demonstrated	Review of facility purchasing records	
		1a.2. The facility as well as independently run businesses operating on facility sites have: • no displays, promotions or free distributions of products covered by the Code. • no display of items with logos of companies that produce human-milk substitutes, feeding bottles and teats, or names of products covered by the Code.	Not displayed	Observations in the facility	
		1a.3. The facility has an Infant Feeding Policy describing adherence to the Code, including:	Exists and meets criteria	Review of infant feeding policy	

[1] Products covered by the Code include the following: breastmilk substitutes (including infant formula), feeding bottles and teats. This should be understood to include any formulas or milks (or products that could be used to replace breast milk) that are specifically marketed for feeding infants and young children up to the age of three years, including special-needs, follow-up and growing-up formulas; other foods and beverages promoted to be suitable for feeding a baby during the first six months of life when exclusive breastfeeding is recommended. This would include baby teas, juices and waters. (*The International Code of Marketing of Breast-milk Substitutes: Frequently Asked Questions* (2017). World Health Organization. http://apps.who.int/iris/bitstream/10665/254911/1/WHO-NMH-NHD-17.1-eng.pdf)

		• procurement of human milk substitutes • prohibition of support, education or gifts from producers or distributors of products covered by the Code. • prohibition of provision of samples of human milk substitutes, feeding bottles or teats to pregnant women or mothers.			
		1a.4. Care providers (direct and indirect) can describe how adherence to the Code is incorporated into their practice.	≥80%		
1.b. Have a written Infant Feeding Policy that is routinely communicated to all staff, pregnant persons and parents.					
		1b.1. The healthcare facility has a written Infant Feeding Policy that addresses the implementation of the Ten Steps.	Exists and is regularly updated and communicated to staff	Review of infant feeding policy	
		1b.2. A summary of the policy is visible to pregnant persons, parents and the public in languages most understood by the population served.	Displayed	Observation of posted policy	
		1b.3. Clinical protocols and standards related to breastfeeding and infant feeding are consistent with the BFI standards and current evidence-based guidelines.	In alignment	Review of clinical protocols and standards	
		1b.4. Staff can explain at least 2 elements of the Infant Feeding Policy that influence their role at the facility.	≥80%	Interviews with staff	
1.c. Establish ongoing BFI monitoring and data-management systems.					
		1c.1. The facility has a protocol for ongoing monitoring and data-management systems to comply with the eight key clinical practices and aligns with the BCC Monitoring Recommendations. (See Step 1c in BFI Guideline Checklist.)	Exists and is regularly updated and communicated to staff	Documentation of protocol	

		1c.2. Meetings of the facility's quality-improvement/BFI team take place regularly.	At least every six months	Documentation of meetings	
		1c.3. Staff can explain why practices are monitored, the importance of monitoring and how monitoring is done in the facility.	≥80%	Interviews or surveys with staff	
2. Ensure that staff have the competencies (knowledge, attitudes and skills) necessary to support women/birthing parents to meet their infant feeding goals.					
		2.1. Staff new to the facility are oriented to the BFI according to their role, within 6 months of their start date.	≥80%	Interviews with staff and orientation tracking tool	
		2.2. Direct care providers[2] review their BFI competencies within their role in the facility, using the international protocol WHO Competency Verification Toolkit [hyperlink] and the BCC Competency Verification for Direct Care Providers Working in Community Health Services [hyperlink] at least every 2 years.	≥80%	Interviews with direct care providers, performance appraisals	
		2.3. Indirect care providers[3] can show evidence of competency related to BFI within their role at the facility.	≥80%	Interviews with indirect care providers, continuing-education tracking tool	

[2] *Direct care provider: person who provides education, assessment, support, intervention, assistance and/or follow-up with regards to infant feeding.*

[3] *Indirect care provider: person who provides services to perinatal clients and could influence information communicated to them on topics addressed in the BFI indicators*

Key Clinical Practices

Facility		Baby-Friendly Initiative Standard	Target	Suggested Monitoring of Primary Sources	Suggested Monitoring of Additional Sources	Progress
3. Discuss the importance and process of breastfeeding with pregnant persons and their families.						
H	🌐	3.1. Pregnant persons receiving prenatal care/education through the facility receive information on breastfeeding.	≥80%	Interviews, surveys or focus groups	Clinical records, staff surveys	
H	🌐	3.2. Pregnant persons who receive prenatal care can adequately describe what was discussed about 3 topics included in the international protocol for prenatal discussion. (hyperlink)	≥80%	Interviews, surveys or focus groups	Staff surveys	
4. Facilitate immediate and uninterrupted skin-to-skin contact at birth. Support mothers/birthing parents to respond to the infant's cues to initiate breastfeeding as soon as possible after birth.						
H		4.1. Mothers/birthing parents report that their infants are placed skin-to-skin with them immediately after birth (vaginal and caesarean) unless there are justifiable medical reasons for delayed contact. **Note:** The use of terms "as soon as possible" and "up to 5 minutes" are intended to signal those attending the birth that an occasional delay may be necessary to allow them time for brief assessment of a critical medical issue. The assessment of the standard allows for a delay of up to 5 minutes under these circumstances.	≥80%	Observations, interviews or surveys	Clinical records, staff surveys	
H		4.2. Mothers/birthing parents report that their infants (born vaginally or by caesarean) remained skin-to-skin with them without interruption for at least one hour, or until completion of the first feed, unless there were documented medically justifiable reasons.	≥80%	Observations, interviews or surveys	Clinical records, staff surveys	

		4.3. SENTINEL STANDARD: Mothers/birthing parents report that they offered the breast to their baby within one hour after birth (vaginal or caesarean).	≥80%	Interviews or surveys	Clinical records, staff surveys	
		4.4. Mothers/birthing parents of unstable or sick infants report that they were supported to hold their infant skin-to-skin as soon as they were stable.	≥80%	Interviews	Clinical records, staff surveys	
		4.5. Mothers/birthing parents report they were given information during pregnancy about the importance of skin-to-skin contact with their baby at birth and how to ensure safety.	≥80%	Interviews, surveys or focus groups	Clinical records, staff surveys	
		4.6. Mothers/birthing parents report they were given information on how to safely position and monitor their babies while skin-to-skin.	≥80%	Interviews, surveys or focus groups	Staff surveys	
5. Support mothers/parents to initiate and maintain breastfeeding and manage common difficulties.						
		5.1. Breastfeeding mothers/parents can comfortably position and latch their infant.	≥80%	Interviews or surveys	Staff surveys	
		5.2. Mothers/birthing parents can describe practices that increase breastfeeding success (early frequent feeding, responding to cues, effective latch, skin-to-skin, etc.).	≥80%	Interviews, surveys or focus groups	Clinical records, staff surveys	
		5.3. Mothers/birthing parents can describe signs that the infant is feeding effectively.	≥80%	Interviews, surveys or focus groups	Staff surveys	
		5.4. Parents who are not breastfeeding or not breastfeeding exclusively report they received individualized counselling to respond to their needs.	≥80%	Interviews, surveys or focus groups	Staff surveys	
		5.5. Breastfeeding mothers/parents are offered timely assistance with breastfeeding within 6 hours after birth and as needed.	≥80%	Interviews, surveys or focus groups	Staff surveys	
		5.6. Breastfeeding mothers/parents can	≥80%	Interviews, surveys or focus groups	Staff surveys	

		demonstrate or explain how to hand express their milk.				
H		5.7. Breastfeeding mothers/parents separated from their infants are offered timely assistance to express their milk within 1 to 2 hours after birth and as needed.	≥80%	Interviews, surveys or focus groups	Clinical records, staff surveys	
H	🌐	5.8. Breastfeeding mothers/ parents separated from their infants or whose babies are not feeding effectively can describe how to express their milk to initiate and maintain milk supply.	≥80%	Interviews, surveys or focus groups	Staff surveys	
H	🌐	5.9. Breastfeeding mothers/parents are aware of how to access timely, knowledgeable assistance with breastfeeding throughout their breastfeeding experience.[4]	≥80%	Interviews, surveys or focus groups	Staff surveys	
6. Support mothers/parents to exclusively breastfeed for the first six months, unless supplements are medically indicated.						
H		**6.1. SENTINEL STANDARD: Infants (term, preterm) received only human milk throughout their stay at the birthing facility.**	≥75%	Clinical records	Interviews, surveys or focus groups. Staff surveys.	
H		6.2. Breastfed infants who received supplemental feeds have documented medical indications for supplementation.	See table under Step 1.c	Clinical records		
H	🌐	6.3. Mothers/birthing parents who supplement for medical or personal reasons or decided not to breastfeed report they were supported in their decision making[5] and plan.	≥80%	Interviews, surveys or focus groups	Staff surveys	

[4] The minimum of six breastfeeding counselling contacts may occur at the following time points: before birth (antenatal period); during and immediately after birth (perinatal period up to the first 2–3 days after birth); at 1–2 weeks after birth (neonatal period); in the first 3–4 months (early infancy); at 6 months (at the start of complementary feeding); and after 6 months (late infancy and early childhood), with additional contacts as necessary (for instance, when planning to return to school or work, or any time that concerns or challenges related to breastfeeding arise) or when opportunities for breastfeeding counselling occur (such as during child immunization visits). (*Guideline: Counselling of women to improve breastfeeding practices* (2019). *World Health Organization.* https://apps.who.int/iris/bitstream/handle/10665/280133/9789241550468-eng.pdf?ua=1)

[5] Supporting informed decision making includes the provision of:

- the opportunity for women/ birthing parents to discuss their concerns
- the importance of breastfeeding for babies, mothers/birthing parents, families and communities
- the health consequences of not breastfeeding for babies and mothers/birthing parents
- the risks and costs of human-milk substitutes
- the difficulty of reversing decisions once breastfeeding is stopped

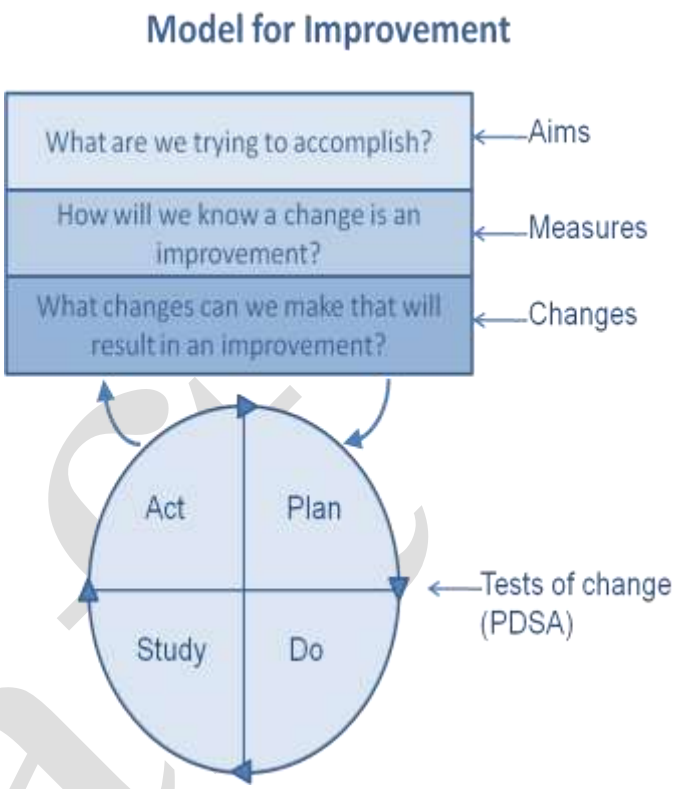
		6.4. Parents who decided not to breastfeed exclusively or not to breastfeed report that direct care providers discussed individually with them the safe preparation, feeding and storage of human-milk substitutes.	≥80%	Interviews, surveys or focus groups	Clinical records, staff surveys	
		6.5. Parents of premature or vulnerable infants who cannot be fed their mother's/parent's milk are offered individual information about the importance, availability and use of pasteurized donor human milk.	≥80%	Interviews, surveys or focus groups	Clinical records, staff surveys	
7. Promote and support mother–infant togetherness.						
		7.1. Mothers/birthing parents confirm that they were supported to stay together with their infant since birth.	≥80%	Interviews, surveys or focus groups	Clinical records, staff surveys	
		7.2. Mothers/birthing parents of infants in NICU confirm they were encouraged to stay close to their infants as much as possible, day and night.	≥80%	Interviews, surveys or focus groups	Clinical records, staff surveys	
		7.3. Parents confirm that they received information about safe sleep for infants using harm-reduction messaging about bedsharing and swaddling/tight bundling.	≥80%	Observation, interviews, surveys or focus groups; review of facility's print and online materials	Staff surveys	
		7.4. Mothers/birthing parents confirm that their infants were held skin-to-skin and/or breastfed during infants' painful procedures.	≥80%	Observation, interviews, surveys or focus groups; review of facility's print and online materials	Staff surveys	
		7.5. Mothers/birthing parents report they received information on strategies to facilitate mother-infant togetherness at home.	≥80%	Interviews, surveys or focus groups	Staff surveys	
		7.6. Breastfeeding parents confirm that they felt welcome to breastfeed in all public areas of the facility.	≥80%	Observation of parents breastfeeding in public places in the	Staff surveys	

				facility; interviews, surveys or focus groups		
		7.7. Parents confirm that they could access a private, comfortable space at the facility for breastfeeding or milk expression upon request.	≥80%	Existence of a comfortable, private space for breastfeeding or milk expression; interviews, surveys or focus groups	Staff surveys	
8. Encourage responsive, cue-based feeding for infants. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.						
		8.1. Parents report that they have been encouraged to feed responsively according to their infants' cues.	≥80%	Interviews, surveys or focus groups	Clinical records, review facility's print and online materials, staff surveys	
		8.2. Parents are aware of recommendations for breastfeeding duration and when to introduce complementary foods.	≥80%	Interviews, surveys or focus groups	Review facility's print and online materials, staff surveys	
		8.3. Parents of preterm, sick or non-cuing infants report they have received guidance in observing their infants' subtle signs and behavioural state shifts to help them determine when to feed.	≥80%	Interviews, surveys or focus groups	Staff surveys	
9. Discuss the use and risks of feeding bottles, artificial nipples and pacifiers with parents.						
		9.1. Parents report they were supported to make informed decisions about the use of bottles, artificial nipples and pacifiers for medical or non-medical reasons.	≥80%	Interviews, surveys or focus groups	Clinical records, staff surveys	
		9.2. Parents who are using bottles, artificial nipples or pacifiers confirm that they	≥80%	Interviews, surveys or focus groups	Clinical records, staff surveys	

		received information on their safe use and care.				
		9.3. Parents can describe the information they have received about calming techniques for infants other than pacifiers.	≥80%	Interviews, surveys or focus groups; review of facility's print and online materials	Staff surveys	
		9.4. Parents of infants needing supplementation can confirm that options were discussed with them (e.g., cup, spoon, feeding tube).	≥80%	Interviews, surveys or focus groups; review of facility's print and online materials	Staff surveys	
		9.5. Parents with a baby in the NICU can describe at least 1 justifiable reason for the use of pacifiers and how to minimize pacifier use during breastfeeding establishment.	≥80%	Interviews, surveys or focus groups	Staff surveys	
10. Provide a seamless transition between the services provided by the hospital, community health services and peer-support programs.						
		10.1. There is evidence of coordination of care among hospitals, community health services and peer-support groups to facilitate seamless transition.	Exists	Interviews, surveys or focus groups		
		10.2. Parents report that they have been informed how to access breastfeeding/infant feeding support in their community.	≥80%	Interviews, surveys or focus groups	Print or electronic material, clinical records, staff surveys	
		10.3. There is evidence that appropriate services are in place to support infant feeding from time of entry into service and for as long as the infant is breastfeeding.	≥80%	Interviews, surveys or focus groups		
		10.4. There is evidence that the facility uses targeted approaches to reduce inequities and universal approaches to protect, promote and support breastfeeding.	Exists	Interviews, surveys or focus group; review of facility's print and online materials		
		10.5. Parents report that community health services were	≥80%	Interviews, surveys or	Staff surveys	

		available if and when they needed support with breastfeeding/infant feeding, even during emergencies.		focus group; review of facility's print and online materials		

QUALITY-IMPROVEMENT PROCESS



This section outlines basic quality-improvement principles that facilities can utilize to assist with achieving the above standards. The World Health Organization (WHO) calls for strengthening the quality-improvement aspects already present in the Baby-Friendly Initiative. Quality Improvement is defined as "a systematic and continuous actions that lead to measurable improvement in health care services and health status of targeted patient groups" (WHO, 2018 p.29). The WHO has revised Step 1 of the Ten Steps to Successful Breastfeeding to include "Establish ongoing monitoring and data-management systems." Continuous Quality Improvement (CQI) means that quality improvement is ongoing, and in order to create lasting change in healthcare it needs to be sustained over time.

Becoming a high reliability organization [hyperlink] requires a focus on system changes that creates the conditions for success and learning from failures when they do occur. In implementing BFI, it is important to know what you want to change. Monitoring data based on the above standards will inform your area of focus for improvement. Use this information to create an aim statement of what you want to change. Then continue to monitor the data as you make improvements.

There are varying approaches for the process of CQI. Facilities are encouraged to use the methodologies they are familiar with and have proven to be successful in their setting. One suggested approach is the Model for Improvement (MFI) (Associates for Process Improvement). [Design note: This refers to the image]

MFI is a structured approach that teams use to drive improvement. MFI emphasizes the inclusion of:

- A well-focused and time-limited aim
- Process and outcome measures to track improvement and evaluate progress

Ideas for effecting changes in a system are tested and evaluated using the Plan-Do-Study-Act (PDSA) cycle. PDSAs test changes, initially on a very small scale, to quickly identify promising ideas and adapt and develop them into robust and reliable standard processes. MFI stresses prediction and measurement as critical features of change evaluation and includes a roadmap of techniques to help guide the journey.

[Image credit: © Associates for Process Improvement]

Aim Statement

An aim statement is a concise written statement that describes what the team expects to accomplish in a specific time frame.
An effective aim statement is **SMART**:

- **S**pecific
- **M**easurable
- **A**ctionable
- **R**ealistic
- **T**ime-bound

Setting quantitative goals helps to:

- Clarify the aim
- Create healthy tension for change
- Direct data measurement activities
- Identify necessary resources
- Create focus for initial changes

Example Individualized Aim Statement (with Associated Goals):

By June 30, 2022, we will improve our exclusive breastfeeding rate at discharge of the hospital stay from 40% to 75% (by 35 percentage points). We will achieve this by implementing evidence-based practices to provide better care to families and their infants who deliver at our hospital so that:

- 75% of infants are fed only breast milk from birth to discharge, unless medically indicated
- 80% of staff caring for families and infants have the competencies to support infant feeding
- 80% of pregnant persons receive prenatal information on the importance and process of breastfeeding
- 80% of stable infants go skin-to-skin for at least one hour after delivery
- 80% of mothers/breastfeeding parents receive assistance and support with breastfeeding
- 80% of stable infants room-in with mothers/birthing parent 24 hours/day
- 80% of stable infants are responsive cue-based fed

In setting your team's individualized aim statement, be sure to do the following:

Efficiently involve senior leaders in development to:

- Provide critical input into goal development
- Give final approval and ensure there is senior leader initial and ongoing buy-in and support
- Provide and approve financial and human resources needed to accomplish the aim

Base your aims on data by:

- Completing the BFI Self-Assessment [hyperlink], which will provide information on focus areas for your team. Each team should begin to tailor their aim statement based on what is reasonable and appropriate for their individual facility.

Incorporating your aim statement in your organization's strategic plan and/or quality-improvement priorities is an effective approach to create organizational awareness, obtain senior leadership commitment and demonstrate accountability. Creating a concise and aspirational aim statement will

be a key communication tool you can use as your elevator pitch, communicate to staff and partners, and use to share your progress.

1. DATA-COLLECTION TOOLS

Once you have a clear aim statement you will need to create process and outcomes measures that will help you know that the changes you are making are resulting in improvement. Collecting data is key to testing, implementing and sustaining improvement. Baseline data helps determine where the starting point is and should be collected before tests of change begin. Ideally, collection and recording three months of data will provide a median baseline data point. The BCC has created and tested several data-collection tools to help with the process of regular data collection. The BFI Standards and Monitoring table above provides the target measures and suggested verification means for Steps 1 and 2 as well as the targets and suggested primary and secondary sources to obtain the information for the clinical practices in Steps 3–10. The BFI Guideline Checklist provides the direction on the actions needed by facilities to attain the standards and is required for the Certificate of Participation, Pre-Assessment and External Assessment. Below are the recommended tools facilities may use to assist in self-assessing their progress and collecting data based on recommended indicators for monitoring measures prior to seeking BFI designation. [Hyperlink all tools below]

BFI Guideline Checklist
Hospital Patient Survey
Community Client Survey
Staff survey: Competency Verification Toolkit: Ensuring competency of direct care providers to implement the BFHI
Staff survey: Competency Verification for Direct Care Providers Working in Community Health Services
Chart Audit User Manual
Chart Audit Form (Excel) (In development)
Hospital Patient Survey Summary Forms (Excel) (In development)
Community Client Survey Form (Excel) (In development)
Run Chart templates (Excel) (In development)
Tutorial videos on these tools (In development)

Suggested timelines include BFI Guideline/Self-assessment and Staff Surveys annually, Patient Surveys quarterly, and monthly Chart Audits on specific indicators. Teams may need to assess their documentation tools in their clinical records to see if the pertinent data is being recorded related to the indicators being collected. Updating clinical documentation tools and ensuring compliance with consistent documentation are areas of focus for teams, to ensure that data is available for extraction from the clinical record.

2. IMPROVEMENT CHANGES

WHO describes the quality-improvement process as cyclical and comprised of the following steps:

i) Planning a change in the quality of care
ii) Implementing the changes (after testing change ideas)
iii) Measuring the changes in care practices and/or outcomes; and
iv) Analyzing the changed situation and taking further action to either further improve or maintain practices

These steps are known as Plan, Do, Study and Act (PDSA). Teams should plan and carry out PDSA testing for each change idea. Each change idea can have multiple PDSA cycles, which can be performed simultaneously. Increase the frequency of PDSA cycles, tweaking each test of change based on learnings acquired from the previous PDSA until the changes have been tested under several conditions

(day, nights, weekends, high and low census, times of short staffing, etc.). Once a reasonable level of confidence in the new process is reached, the ideas are ready for full implementation. Data collection should continue for some time to ensure the improvements changes are sustained over time.

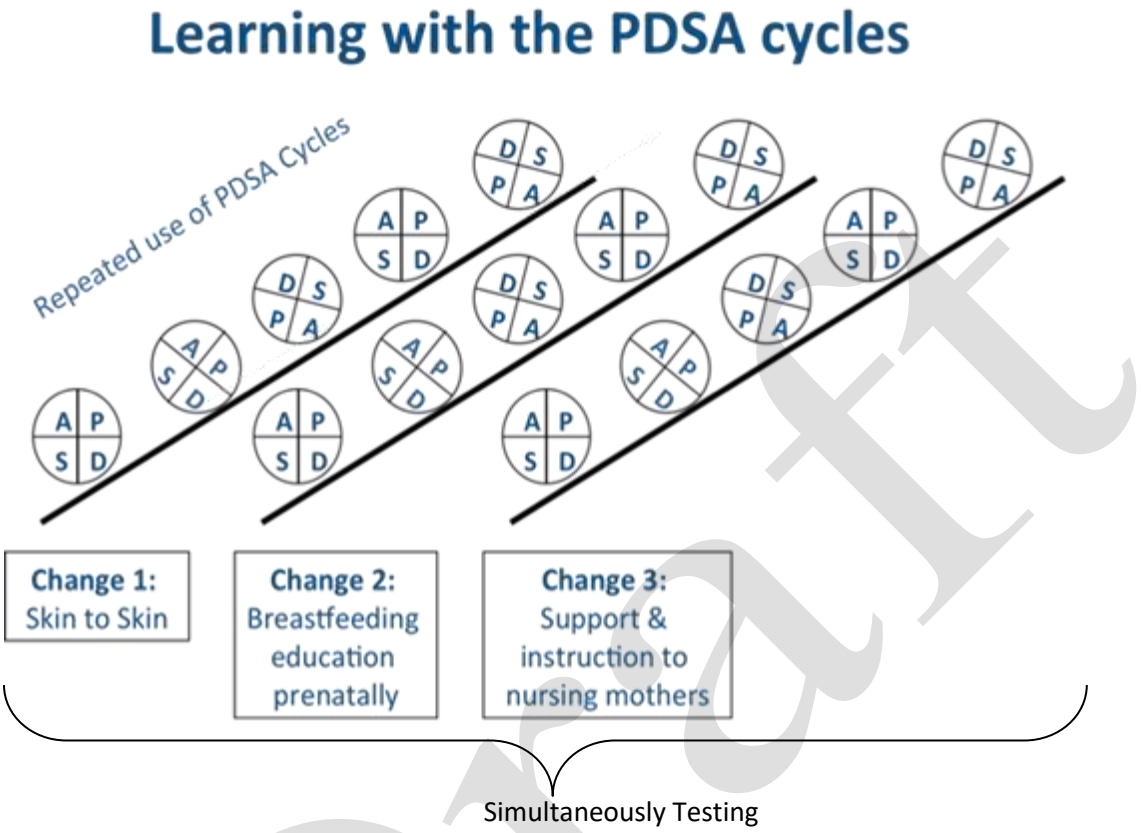


Figure A. PDSA Cycles conducted simultaneously

Key drivers and principles for effective quality-improvement initiatives include the following:

1. *Planning* for change, *implementing* improvement changes and monitoring *control* measures to ensure that change is sustained.
2. Assemble a BFI team focused on quality improvement that reflect the team that works together each day. Each team member should have an active role, with tasks and expectations that contribute to the accomplishment of the aim. The BFI team should be interprofessional and include direct care providers and people who have experienced care in the facility, within the last two years, to review care practices and provide honest and realistic feedback on planned changes and system structures. It is recommended that the team meets frequently (bi-weekly or monthly) to review data, discuss ideas and challenges, decide on the processes or actions that need to be changed, and evaluate ongoing progress.
3. Engage facility leaders (administrative and physician leaders) and champions for change who will commit to and communicate the aim statements, goals and measures to be monitored. Leaders are essential to address barriers, create accountabilities, provide system-wide communication, recognize improvements and celebrate successes. Champions for change provide the ongoing support to coordinate, monitor and report on progress.
4. Measure and analyze progress over time. Use the tools in this section to identify the areas of care that need focused improvements. Collect and analyze data regularly and report on

progress to all stakeholders.

Quality improvement tools and methods are particularly important for BFI steps that have been especially difficult, and the standards have not been achieved. Once the desired targets have been achieved the hospital team can focus on monitoring the sentinel indicators of early initiation and exclusive breastfeeding from birth to discharge and the community health services team can focus on indicators related to exclusive breastfeeding and duration of breastfeeding.

Appendix 1

Definitions

Standard: goal to be achieved "set through a rigorous and diligent development process, supportive of ongoing quality-improvement measures in health care systems, leading to higher quality health services for all." (Accreditation Canada, 2020).

- **Sentinel standard**: Overarching standard that when achieved is a proxy measure for other standards. The sentinel standards have been determined by WHO.

Monitoring: regular, timely collection and compilation of data to rigorously inform quality of care in a facility.

Competency: an integrated set of knowledge, skills, attitudes and judgements sufficient to fulfill a role.

Staff: a general term referring to all persons working for the facility, paid or non-paid, employed, contractual, or holding professional privileges.

- **Direct care providers:** those who provide education, assessment, support, intervention, assistance and/or follow-up for infant feeding.

- **Indirect care providers:** those who provide services to perinatal clients and could influence information communicated to them on topics addressed in the BFI indicators (examples: phlebotomist, immunization nurse).

- **Volunteers:** persons providing non-paid work for the facility.

- **Students:** persons involved in a practicum or training in a clinical specialty such as medicine, nursing sciences, midwifery, etc.

- **Manager:** any person in a leadership position, responsible and accountable for overseeing perinatal and child health.

Products covered by the Code include the following: breastmilk substitutes (including infant formula), feeding bottles and teats. This should be understood to include any formulas or milks (or products that could be used to replace breastmilk) that are specifically marketed for feeding infants and young children up to the age of three years, including special-needs, follow-up and growing-up formulas; other foods and beverages promoted to be suitable for feeding a baby during the first six months of life when exclusive breastfeeding is recommended. This would include baby teas, juices and waters. **World Health Organization 2017. The International Code of Marketing of Breast-milk Substitutes: Frequently Asked Questions http://apps.who.int/iris/bitstream/10665/254911/1/WHO-NMH-NHD-17.1-eng.pdf**

Breastfeeding: feeding an infant at the mother's/birthing parent's breast or feeding human milk.

- **Exclusive breastfeeding**: the infant receives human milk (including expressed milk and donor milk) and allows the infant to receive oral rehydration solution, syrups (vitamins, minerals, medicines) but does not allow the infant to receive anything else.

- **Non-exclusive breastfeeding** receiving human milk and foods or fluids other than human milk.
- **Early initiation of breastfeeding**: offering the breast to infants within one hour of birth.
- **Initiation of breastfeeding**: the onset of exclusive or non-exclusive breastfeeding.
- **Any breastfeeding:** receiving human milk, either exclusively or non-exclusively.
- **Pasteurized donor human milk (PDHM):** donor human milk that has been collected and processed according to the Human Milk Banking Association of North America (HMBANA) Standards.

Non-human milk: refers to human milk substitutes, commercial infant formula or breastmilk substitutes.

Established lactation/Lactogenesis II: the onset of copious milk secretion, which usually takes place during the first four days postpartum and involves a set of changes in milk composition and volume.

Supplement: any oral fluid (except vitamins, minerals and medications) other than human milk given to a breastfed baby.

Replacement Feeding: any feeding given to replace human milk for medical reasons.

Informed decision making: the process whereby pregnant persons and mothers/birthing parents receive evidence-informed information and support to make infant feeding decisions, which include:

- the opportunity for women/birthing parents to discuss their concerns
- the importance of breastfeeding for babies, mothers/birthing parents, families and communities
- the health consequences for babies and mothers/birthing parents of not breastfeeding
- the risks and costs of human-milk substitutes
- the difficulty of reversing decisions once breastfeeding is stopped

Skin-to-skin at birth: immediate and uninterrupted skin-to-skin contact at birth. It refers to the naked infant being placed on the mother's/birthing parent's naked chest immediately at birth, drying the infant and covering both with a warm dry blanket, and maintaining this close contact for at least one to two hours after birth.

- **Skin-to-skin care**: is skin-to-skin contact at any time after birth.
- **Kangaroo care**: is sustained skin-to-skin contact with preterm infants.

Stable infant: stability is the absence of severe apnoea, desaturation and bradycardia without reference to gestational age.

Responsive, cue-based feeding: watching for infant's cues and responding quickly when infant signals readiness to feed, the need for a break during the feeding or when hunger is satiated.

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