QUINTE HEALTHCARE CORPORATION

Disclaimer: Any printed copy of this policy is only as accurate as of the date it was printed: it may not reflect subsequent revisions. Refer to the electronic version of the policy on the Intranet under the Policy and Procedure Manual for the most current policy.

Maternal/Child − Expressed Breast Milk – Errors in Administration

Title: Maternal/Child − Expressed Breast Milk – Errors in Administration		**Policy No:**	**3.10.1**
		Original Issue Date:	February 20, 2014
Manual:	**Clinical**	**Last Review/Revision Date:**	
Department:	**Maternal/Child**	**Policy Lead:**	Director Maternal/Child Program
Approved By:	**Maternal/Child Program Advisory Committee Quality and Patient Safety**		

1. POLICY

Breast milk is the optimal feeding choice for most newborns. At the same time, breast milk is a body fluid and may contain blood-borne pathogens. It is the policy of Quinte Healthcare Corporation (QHC) to minimize the risks associated with potential exposure of an infant to a blood-borne pathogen through accidental ingestion of EBM from someone other than the infant's mother.

2. DEFINITIONS

Donor Mother: the mother who expressed the breast milk

Recipient Infant: the infant who ingests the breast milk

Recipient Mother: the mother of the infant who ingested the breast milk

3. PROCEDURE

Human milk is a body fluid capable of transmitting blood borne pathogens. In the event that an infant has inadvertently ingested EBM from another infant's mother, or it is suspected that it has occurred, the following procedure should be taken:

1. Confirm that the infant has ingested the wrong EBM.
2. Notify the responsible physician about the event.

3. Inform the recipient infant's parents/guardians of the event as soon as possible. Maintain confidentiality at all times. The names of donor and recipient parents, ethnic background and underlying medical conditions of the infants are never to be shared with each other.
4. Inform the donor infant's parents/guardians of the event as soon as possible.
5. Review donor and recipient mothers' antenatal records for HBV and HIV status.
6. Obtain consents for viral testing and document consents in the health records. If recipient and/or donor infant's mother refuses testing, document this in both infants' health records. During the consent process, the donor mother should be informed that the test results will be released to the recipient mother without disclosure of identity.
7. Send blood from both the donor and the recipient mother for the following laboratory tests:
    - Hepatitis B surface antigen (HBsAg)
    - Antibody to hepatitis C virus
    - Antibody to human immunodeficiency virus (HIV)
    - Antibody to human T-cell lymphotropic virus I and II (HTLV I/II)
    - Antibody to cytomegalovirus

    NOTE: HIV antibody and HBsAg are ordered STAT in the donor mother so that post-exposure prophylaxis can be administered in a timely manner if indicated by serology.

    For STAT HIV and HBsAg testing of the donor mother:

    - Notify the BGH Microbiology lab and advise them of the name of the source patient so they can be ready for the specimens
    - Send the labelled specimens to the Microbiology lab with fully completed Public Health Lab requisitions (General Test Requisition and HIV Serology Test Requisition) indicating this is a STAT request on the source of an exposure

8. If the donor mother refuses to consent or cannot be tested, arrange for the recipient infant to have urgent blood work drawn for HBsAg, Hepatitis C and HIV serology. This is done to establish infant's baseline status to the viral agents.
9. Discuss the results of the laboratory tests with both sets of parents independently when available. Document the results of the donor mother's laboratory tests on both infants' health records, coded to maintain confidentiality.
10. If the donor mother is known to be HIV positive, a decision needs to be made immediately regarding anti-viral prophylaxis as it should start within 1 – 2 hours after the exposure. Urgent consultation with paediatric infectious disease specialist is recommended.
11. Order prophylaxis and arrange follow-up as determined from serology testing.
12. If the HBsAg results of the exposed person or source are unavailable within 48 hours of the incident, management of the exposed person should assume possible exposure.
13. Where indicated, Hepatitis B Immune Globulin (HBIG) 0.5 mL IM (Neofax, 2011) and Hepatitis B vaccine 0.5 mL IM (Neofax, 2011) must be given within 48 hours of the incident (PIDAC, 2012). The infant will then receive the Hepatitis B vaccine series. Provide parents/guardians the patient information sheet regarding hepatitis B vaccinations (Appendix B).
    Note: Please see the Infant Hepatitis B Prophylaxis policy for further direction regarding the administration of Hepatitis B vaccine and HBIG.
14. If indicated, the scheduled vaccine regime is: 0, 1 and 6 months of age (3 doses total)
    ***If preterm infant less than 2kg at birth**: 0, 1, 2 and 6 months of age (4 doses total).

15. If indicated, post immunization serological testing within one to six months of completion of the vaccination series is recommended.
16. If further guidance is needed, contact an infectious disease specialist.
17. Document the course of action in the recipient infant's medical record once all laboratory tests are reported.
18. Complete the QHC Cares patient safety event report with details of event.

APPENDICES AND REFERENCES

Appendices: Appendix A – Hepatitis B Patient Information Sheet
Appendix B – Hepatitis B Vaccine for Newborn Babies

References:

NEOFAX. (2011). 24th Ed. Thomson Reuters

Public Health Agency of Canada. (2012). *Canadian immunization guide – Hepatitis B Vaccine.* Retrieved from www.publichealth.gc.ca

Provincial Infectious Diseases Advisory Committee (PIDAC). (2012). *Best Practices for Infection Prevention and Control in Perinatology* (ISBN: 978-1-4435-9246-8). Queen's Printer for Ontario.

The Hospital for Sick Children (2007). *Expressed breast milk – Errors in administration* [Policy]