Maternity Infant feeding Policy

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Guideline to be followed by (target staff):			
To be read in conjunction with the following documents:			
CQC Fundamental standards: Regulation 9 – person centered care Regulation 10 – dignity and respect Regulation 11 – Need for consent Regulation 12 – Safe care and treatment Regulation 13 – Safeguarding service users from abuse and improper treatment Regulation 14 – Meeting nutritional and hydration needs Regulation 15 – Premises and equipment Regulation 16 – Receiving and acting on complaints Regulation 17 – Good governance Regulation 18 – Staffing Regulation 19 – Fit and proper			

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

The purpose of this policy is to ensure all staff at Milton Keynes University Hospital (MKUH) NHS foundation Trust understand their roles and responsibilities in relation to infant feeding.

Executive Summary

This policy aims to ensure that the care provided improves outcomes for children and families, specifically to deliver:

- an increase in breastfeeding initiation rates
- an increase in exclusive breastfeeding rates at 10 days (discharge from midwifery care)
- safe and responsive bottle feeding amongst mothers who choose to artificially feed.
- improve patient experiences.
- a reduction in the number of re-admissions for feeding issues.

The maternity service's expectations in relation to Baby Friendly Initiative training must be included in the Maternity Training Needs Analysis.

Milton Keynes University Hospital NHS Foundation Trust is committed to:

- Providing the highest standard of care to support expectant and new families to feed their baby and build close and loving parent-infant relationships. This is in recognition of the profound importance of early relationships to future health and well-being.
- Breastfeeding makes a significant contribution to optimal physical and emotional health outcomes for children, mothers, and future generations.
- Ensuring that all care is mother and family-centered, non-judgmental and that mothers' decisions are supported and respected.
- Working together across disciplines and organisations to improve mothers and parents' experiences of care.

Definitions

ANNP	Advanced Neonatal Nurse Practitioner
BFI	Baby Friendly Initiative
BFO	Breast Feeding Observation
BM	Blood glucose Reading
BFI	Baby Friendly Initiative
Bung	Purple bung manufactured for use with oral syringes to hold collected breastmilk
CHINS	Acronym used for breast feeding support (**C**lose, **H**ead, **I**nline, **N**ose, **S**ustainable)
Cup Feeding	offering a feed via a sterile single use cup of breastmilk or formula.
EBM	Expressed Breast Milk
IUGR	Intra Uterine Growth Restriction
NEC	Necrotising Enterocolitis
NEWS	Neonatal Early Warning System
NNU	Neonatal Unit
SGA	Small for gestational age
Syringe Feeding	offering a feed via sterile single use oral syringe of breastmilk.
WHO	World Health Organisation

1.0 Roles and Responsibilities:

Chief Executive and Trust Board

Provision of environment – facilities, service, and systems support Links with all the other relevant risk management committees; Commitment to achieving Baby Friendly Initiative (BFI) Accreditation

Divisional Manager

To support forward planning of the service in relation to infant feeding and support the Baby Friendly Accreditation process.

Head of Midwifery/Head of Nursing Women's and Children's Health

Facilitate staff training and ensure compliance with policy to support best practice. Ensure the accurate collection of breastfeeding data.

Lead Midwife for Risk Management-To ensure that protocols and policies are adhered to. Discuss risks identified and action required to prevent risks.

Infant Feeding Lead Midwife

- To develop and deliver all infant feeding training in conjunction with the BFI maternity standards.
- To implement BFI audits of staff and service users
- To collate breastfeeding data for internal and national reporting.
- To act as positive role model and provide support and advice on more complex feeding issues. To ensure all guidelines and patient information that relate to the breastfeeding dyad are in line with the BFI Maternity Standards.
- As part of BFI commitment the service will ensure that: All new staff are orientated with this policy on commencement of employment.
- All staff receive training to enable them to implement the policy as appropriate to their role.
- New staff receive this training within six months of commencement of employment.
- The International Code of Marketing of Breast-milk Substitutes is implemented and adhered to throughout the service.
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Midwife - Responsible for providing routine postnatal care for mothers and their babies in both the hospital and community settings in line with current national guidance. They develop individualised care plans for mothers and their babies and escalates to the appropriate healthcare professional
when there are deviations from normality.

Nursery Nurse – Under the direction of the midwife provide care and infant feeding support and new parents and their babies. To perform neonatal observations and assist in the provision of transitional care, escalating deviations from normal to Midwife caring for the woman/baby.

Maternity Care Assistants – Under the direction of the midwife provide care, infant feeding support and parenting skills to support new parents and their babies. To provide basic care to new
mothers and undertake maternal observations where required, escalating deviations from normal to Midwife caring for woman.

Obstetricians – To review and recommend care pathways for women where there is a deviation.
from the normality.

Paediatricians/ANNP's – To review and recommend care pathways for babies where there has been a deviation from normality.

All Staff – It is the responsibility of all staff to familiarise themselves with and implement the infant feeding policy. In practice, this means ensuring that the care, support, and advice given is evidence-based. This should protect breastfeeding and optimise health outcomes for mothers and babies.
Staff must ensure they attend regular training, as allocated and uphold the five BFI maternity standards at all times.

2.0 Implementation and dissemination of document

This document once approved by the Maternity and Paediatric governance pathways will be accessible on the hospital intranet.

All documentation fully supports the implementation of these standards.

3.0 Processes and procedures

3.1 Care standards

This section of the policy sets out the care that the Trust is committed to giving to every expectant
and new mother. It is based on the UNICEF UK Baby Friendly Initiative standards for maternity services and the relevant NICE and BAPM guidance.

3.1.1 Pregnant women are prepared

All pregnant women will have the opportunity to discuss feeding and caring for their baby with a health professional.

This discussion will include the following topics:

- The value of developing close and loving relationships connecting with their baby whilst in utero
- The importance of brain development of the baby whilst in utero
- The value of skin-to-skin contact for all mothers and babies at birth and beyond
- The importance of responding to their baby's needs
- An exploration of what parents already know about breastfeeding
- The value of breastfeeding as protection, comfort and food
- Getting breastfeeding off to a good start

3.1.2 Skin-to-skin contact

- There will be no unnecessary separation of a mother and her baby whilst in hospital.
- All mothers are offered the opportunity to have uninterrupted skin contact with their baby and to offer the first feed in skin-to-skin contact.

- Babies should be given the opportunity to self-attach at this time (birth crawl).
- Any interventions e.g., weighing/measuring should be performed immediately after birth or after the baby has had its first feed.
- Mothers who are unable (or do not wish) to have skin-to skin contact immediately after birth are encouraged to commence this as soon as they are able.
- Mothers who formula feed are encouraged to offer the first feed in skin-to-skin contact.

Safety considerations

Vigilance as to the baby's well-being is a fundamental part of postnatal care in the first few hours after birth. For this reason, normal observations of the baby's temperature, breathing, colour and tone should continue throughout the period of skin-to-skin contact. Observations should also be made of the mother, with prompt removal of the baby if the health of either give reason for concern. It is important to ensure that the baby cannot fall onto the floor, become trapped in bedding, or by the mother's body. Particular care should be taken with the position of the baby, ensuring the head is supported so the infant's airway does not become obstructed. Parents should be educated on safe sleep at birth and on admission to Postnatal ward.

A mother can generally continue to hold her baby in skin-to-skin contact during perineal suturing. However, adequate pain relief is required, as a mother who is in pain is unlikely to be able to hold her baby comfortably or safely. Mothers should be discouraged from holding their baby when receiving analgesia which causes drowsiness or alters their state of awareness (e.g., Entonox or pethidine whilst in labour).

Where mothers choose to give a first feed of artificial milk in skin-to-skin contact, particular care should be taken to ensure the baby is kept warm.

3.1.3 Getting breastfeeding off to a good start

Mothers will be enabled to achieve effective breastfeeding according to their needs. Staff will ensure mothers are informed about:

- Principles of positioning (CHINS)
- The importance of responsive feeding and responding to feeding cues
- How to recognise effective attachment at the breast
- Understand the signs of effective feeding.
- Why effective feeding and milk transfer is important.

This discussion must be documented on the e-Care system.

A formal feeding assessment will be carried out using the Breastfeeding observation tool **(see Appendix 3**). This is required on the following days as a minimum: day 0-2 (prior to discharge), day 3, day 5 and day 10. This assessment will include a discussion with the mother to reinforce what is going well. Where necessary, develop an appropriate plan of care to address any issues that have been identified. The breastfeeding observation can be used at any time to identify ineffective feeding.

3.2 Responsive feeding

The term responsive feeding is used to describe a feeding relationship which is sensitive, reciprocal and about much more than nutrition. Staff should ensure that mothers have the opportunity to discuss this aspect of feeding covering the following:

- Recognising and responding to baby's cues
- Supporting nutritional, emotional needs and optimal brain development
- Breastfeeding can be used to feed, comfort and calm babies
- Breastfeeds can differ in length and regularity throughout a 24-hour period
- Breastfed babies cannot be overfed or spoiled by too much feeding

Responsive feeding also means responding for the mother's needs to feed e.g. to comfort or relax.

3.3 Exclusive breastfeeding

The World Health Organisation (2019) recommends exclusive breastfeeding for the first six months of life. This will ensure infants achieve optimal growth, health and development. Thereafter, it recommends that breastfeeding is continued for at least the first two years of life in conjunction with complementary and nutritionally adequate foods, from 6 months.

Mothers who breastfeed will be provided with information about why exclusive breastfeeding leads to the best outcomes. This includes why it is particularly important during the establishment of breastfeeding. The care, support and advice given to breastfeeding mothers regarding exclusive breastfeeding will be evidence-based and underpinned by knowledge of the physiology of milk production and breastfeeding. This will include:

- how breastfeeding reduces the risk of acute and chronic illness for mother and baby how the act of breastfeeding reduces the risk of certain women's health conditions
- the importance of hormonal responses in milk production and let-down
- the importance of early, frequent and effective priming of the prolactin receptor sites after birth
- the negative impact of ineffective/infrequent milk removal on milk supply

3.4 Supplementation of a breastfed baby

Supplementation describes any instance of a breastfed baby receiving artificial milk. This includes when a baby has ANY breast milk for the first feed including by syringe when hand expressing.

3.4.1 Reluctant Feeder

The **healthy, well term baby** may feed infrequently in the first 24-48 hours. In the presence of a low glucose supply, these babies utilise alternative fuels (e.g. amino acids, ketones) which are protective of neurological function. This process, known as counter regulation means that the healthy term baby is not at risk of symptomatic Hypoglycaemia i.e. neurological compromise. However, these babies require support to initiate breastfeeding and the Reluctant Feeder pathway **must** be followed **(see Appendix 1).**

3.4.2 Clinical indication

There are very few clinical reasons for an artificial milk feed e.g. babies at risk of hypoglycaemia (see Hypoglycaemia of the Newborn guideline) and those presenting with excessive weight loss (**See section 6**) In these circumstances mothers will be supported to maximise the amount of breastfeeding/breastmilk their baby receives. Feeding plans must reflect this ultimate goal.

3.4.3 Maternal request

Any decision to supplement a newborn baby at maternal request must be as a result of a fully informed choice. The person requesting the artificial feed must be asked whether the mother is breastfeeding. If the mother is breastfeeding, support must be offered to facilitate breastfeeding or give breastmilk. If the parents continue to request an artificial feed, there must be a sensitive discussion about how giving a breastfed baby this may cause:

- a decreased eagerness to breastfeed
- a reduction in milk supply
- sensitisation of the baby to cow's milk protein, increasing the risk of allergy
- a reduction in beneficial gut flora which protects the baby against infection

Whilst this information is evidence-based, it may be difficult for parents to hear. It is therefore crucial that it is offered in conjunction with intensive breastfeeding support to enable mothers to continue breastfeeding successfully/maximise the amount of breastmilk their baby receives.

Mothers who give top up feeds of artificial milk in conjunction with breastfeeding will be enabled to do so as safely as possible and with the least possible disruption to breastfeeding. Care plans must reflect the ultimate goal of maximising breastfeeding or breastmilk intake.

3.4.4 Documentation

The reason for a supplement of artificial milk **must** be clearly documented and justified. This documentation must include rationale and evidence of:

- clinical indication (if applicable) including a care plan
- an offer of breastfeeding support
- a discussion with the mother about the implications of artificial milk feed
- a fully informed maternal decision

A supplementation audit form **MUST** be completed for every feed of artificial milk. This forms part of the audit requirements from Baby Friendly.

The term mixed feeding should be replaced by BF + AF in all documentation.

5.0 Syringe and cup feeding

There are two methods for use within the hospital by trained healthcare professionals; syringe feeding andcup feeding. If a mother wishes to breastfeed and has not done so successfully, but the baby must be fed due to clinical concerns, either of these methods can be used.

Syringe feeding can be used during the first few days ,when the baby is taking small amounts of expressed colostrum (< 5 mls).

Cup feeding can be used to offer feeds of colostrum, expressed breast milk or formula to babies ≥ 34 weeks.

The World Health Organisation (2017) recommends this form of feeding a supplement to a breastfed baby. An advantage of cup feeding is that the infant is required only to lap the milk and then coordinate swallowing and breathing. Potential "nipple and teat confusion" may be avoided. Expressed breast milk (EBM) should always be used whenever possible.

For guidance for the expressing, handling and storage of breastmilk, please see:
Expressing and Handling Breast Milk (EBM) Within Milton Keynes Hospital guideline PAED/GL/56 which is available on the intranet.

5.1 Syringe Feeding

This method is appropriate for offering small quantities (< 5ml) of EBM/colostrum using a 1ml syringe to the breastfed baby.

5.1.1. Advantages of syringe feeding a baby

- Easier to give small amounts of colostrum.
- Enables a baby to feed when they have been unable to latch onto the breast and suckle successfully, but need to have a feed according to a clinical need.
- Helps to reduce the risk of causing confusion between a teat and the breast
- Easier to give to a lethargic baby in aid of treating hypoglycemia in a ward area

5.1.2 How to syringe feed a baby

- Wash and dry hands thoroughly as per trust guidelines.
- Use a new 1ml pre-sterilised syringe at each feed.
- Hold the baby slightly upright
- Encourage the baby to suckle on a gloved finger to encourage to suck/swallow reflex
- Gently and slowly syringe a small amount of EBM (no more than 0.2 mls) into the side of the baby's mouth between their gums and cheek.
- Watch the baby swallow and then gently squeeze in another 0.2 mls and repeat as necessary.
- It is important that the baby does not suck the end of the syringe nozzle as this may interfere with the breastfeeding.

5.2 Cup feeding a baby

This method is appropriate for offering quantities of EBM or formula >5ml to a breastfed baby.

This method may be used as an alternative to a bottle, ensuring there is no interference with the newborn's innate reflex to suckle with a soft nipple at the back of the mouth rather than a hard teat on the hard palate (UNICEF, 2010). It is also important for the infant to spend time at the breast attempting to latch. There is a risk of aspiration or choking if not undertaken correctly.

5.2.1 Advantages of cup feeding a baby

The baby learns to coordinate their breathing and swallowing during the feed.

- The active tongue movement required to cup feed mimics the motion needed for the baby to remove the milk from the ducts when breastfeeding.
- The baby can pace their feed, enabling them to control the flow and volume of the feed.
- Posseting is less likely during a cup feed.
- When cup feeding the baby's heart rate, respiratory rate and oxygen saturation levels are maintained. There also appears to be less risk of Broncho aspiration and apnoea compared to bottle-feeding and nasogastric feeds.
- Cup feeding may reduce the need for a nasogastric tube
- The baby needs to be held while cup feeding, promoting relationship building and stimulation rather than the passive feed via a tube.
- It can increase the rate of exclusive breastfeeding at discharge.

5.2.2 How to cup feed a baby

Wash and dry hands thoroughly as per trust guidelines

- Only specifically designed cups should be used which are pre-sterilised single use
- Ensure that baby is fully awake and alert

- Try to have the cup half full
- The cup should be tilted to allow the milk to just touch the baby's lower lip. NEVER pour the milk into the baby's mouth
- The rim of the cup should be rested on the lower lip.
- The baby will lap the milk from the cup using its tongue

The cup should be left in the correct position during the feed including when the baby stops drinking.
It is important to allow the baby to take as much as he/she wants in his/her own time. Wind the baby
during the feed if required. As cup feeding should only be used as a short-term method of feeding,
it is important to continue to help establish breastfeeding before discharge home, this includes a full breastfeeding observation documented using.

Cup feeding should only take place following staff training by Infant Feeding lead Midwife

5.3 Expressing for babies who are admitted to NNU

Babies who are admitted to NNU who do not receive their mother's own milk have a significantly higher risk of Necrotising Enterocolitis (NEC) and morbidity. Mothers must start expressing within hours of birth. The expressed breastmilk must be taken to NNU immediately. These mothers must be advised to express 8-10 times in 24 hours and at least once overnight to establish and maximize their breastmilk supply. Hand expressing packs containing syringes, milk labels (with the baby's MRN) and tamper proof seals should be given to the mother to encourage and facilitate expressing breastmilk. A picture guide on how to hand express should also be provided, alongside a demonstration using props.

5.4 Artificial milk feeding

If a mother chooses to artificially milk feed her baby, the first feed should be given in skin-to-skin contact by the mother.

Mothers who choose to artificial milk feed will be enabled to do so as safely as possible. This includes an individualised discussion regarding safe sterilising of feeding equipment and safe preparation of formula milk. This discussion needs to be documented on e-care in the newborn feeding section. Parents will be advised of the importance of only using first baby milk/stage one milk for the first year of life. No brand of milk or manufacturer will be recommended by staff members, in line with the International Code of Marketing of Breast-milk Substitutes.

5.4.1 Responsive bottle feeding

As with breastfeeding, a mother should respond to her baby's cues. All bottle-feeding mothers will be shown how to use the paced bottle feeding method:

- Hold the baby in a more upright position
- Invite the baby to draw in the teat
- Hold the bottle horizontally
- When the baby has had a few sucks and swallows, drop the bottle

- If the baby continues to suckle, bring the bottle back up
- Continue this until the baby no longer shows feeding cues.

Guide the teat gently into the baby's mouth to ensure the baby is indicating they are ready to take a feed. Similarly, the bottle is only raised if the baby starts to suckle, another indicator of readiness to feed. By pacing his intake the baby is given the opportunity to recognise when he is full. It is good practice to alternate the side a bottle fed baby is held at each feed, to ensure equal optical stimulation and skeletal balance.

5.5 Early postnatal period: support for close and loving relationships

All parents will be supported to understand their baby's needs. This includes encouraging frequent touch and sensitive verbal/visual communication, keeping babies close and responsive feeding. This approach will ensure optimal brain development by minimizing stress hormones and boosting oxytocin levels. Parents will be educated to not leave a baby to cry for prolonged periods and that it is not possible to spoil a baby. Mothers who feed their babies with a bottle will be encouraged to hold their baby close during feeds and offer the majority of feeds to their baby themselves, to help enhance the mother-baby relationship. All parents will be given information about local parenting support that is available.

Skin-to-skin contact will be encouraged throughout the postnatal period. This will boost prolactin and oxytocin levels, key in milk production and let-down.

6.0 Referral to the Infant Feeding Lead Midwife

Approximately 96% of problems regarding breastfeeding can be rectified by adjusting position and attachment. This will include carrying out a breastfeeding assessment. There are very few circumstances that go beyond the remit of the Maternity staff and require input from the Infant Feeding Lead Midwife:

- Assessment for tongue tie in Newborn infants ·
- Infants who have lost excessive weight >12%
- Breast abscess
- Infants who have a lack of sucking reflex
- Previous traumatic infant feeding experience
- Complex medical conditions that may impact on breast feeding
- Medications which may be contraindicated with breast feeding

In these situations the Infant Feeding Specialist Referral should be completed. The Infant Feeding Lead Midwife will contact the woman to formulate a care plan.

6.1 Managing neonatal weight loss

Neonatal weight loss in the first few days of life is part of normal physiology, due to excretion of extracellular fluid. This can however, cause anxiety to parents and carers. In some cases, it can lead to readmission into hospital and sometimes breastfeeding cessation.

Contributing factors:

- Ineffective milk transfer
- Maternal/neonatal separation
- Events during labour for mother and/or baby (e.g. shoulder dystocia)

Definitions

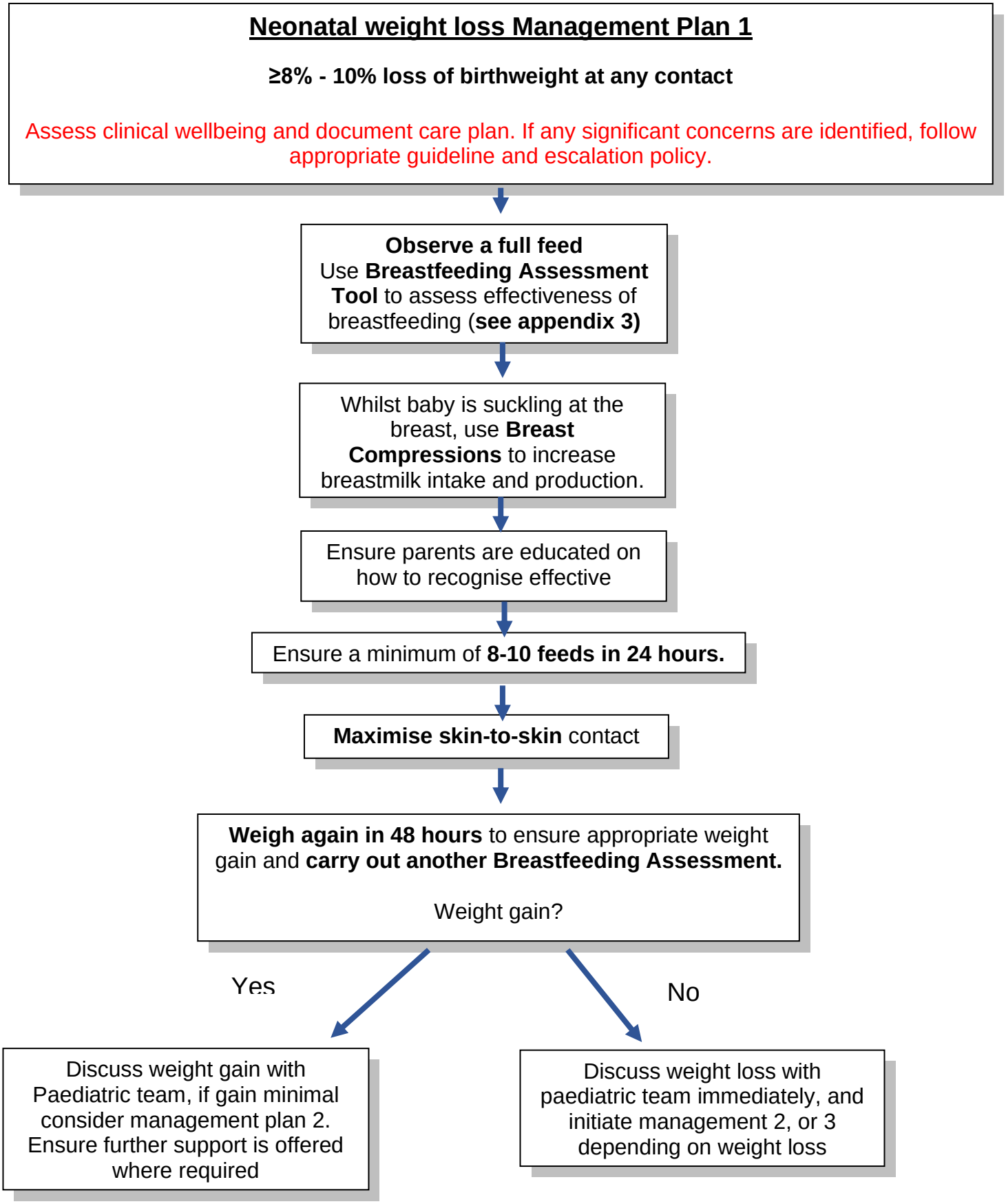
5-7 % loss of birthweight is an average weight loss in the first few days.
It generally peaks at day 3 - 4, then a steady weight gain should be seen by about day 8 (Boskabadi, et al., 2010; Macdonald, et al., 2003) and birthweight will be regained by day 14.

≥8% – 10% loss of birthweight will be the trigger for cause for concern (Marasco, et al., 2000).

>10% – 12% loss of birthweight is abnormal and warrants referral to a paediatrician/ANNP, for a care plan at home to be managed by the community midwifery team.

>12% loss of birthweight is deemed an excessive weight loss. It requires referral to a paediatrician/ANNP and readmission to the postnatal ward due to the risk of hypernatremia (Boskabadi, et al., 2010; Macdonald, et al., 2003).

6.2 Neonatal Weight loss management plan 1 - ≥8% - 10% loss of birthweight at any contact



6.3 Neonatal Weight loss management Plan 2 - > 10% - 12% loss of birthweight at any contact

Neonatal weight loss Management Plan 2

> 10% - 12% loss of birthweight at any contact

(*or no/minimal improvement following Management Plan 1)*

Assess clinical wellbeing and document care plan. If any significant concerns are identified, follow appropriate guideline and escalation policy.

Inform the paediatrician/ANNP on call of the weight loss with a view to following **Management Plan 2**.

Observe a full feed
Use **Breastfeeding Assessment Tool** to assess effectiveness of breastfeeding (**see appendix 3)**

1.Ensure a minimum of **8-10 feeds in 24 hours**
2**. Maximise skin-to-skin** contact
3. Whilst baby is suckling at the breast, use **Breast Compressions** to increase breastmilk intake and production.
4. Ensure parents are educated on how to recognise signs of effective feeding.

Express breast milk after each feed and offer this as a top up, preferably using a cup (if competent and in hospital) or a bottle. Don't force this amount - allow the baby to take what it can.

If little or no milk is expressed, it could be clinically indicated to give a top up of artificial milk, with a plan from Paediatric team. This also requires full maternal consent. A supplementation audit form **must** be completed.

Weigh again in 24 hours
Complete breastfeeding assessment and offer support
Weight gain?

Yes

If Weight gain of >20g/day **weigh again in 24 hours**

No

contact the paediatrician/ANNP immediately to establish if **Management Plan 3** should now be followed.

Document Infant Feeding Management Plan 2 / 3 in notes with next visit date and time.

6.4 Neonatal weight loss management plan 3 >12% loss of birthweight at any contact

Neonatal weight loss Management Plan 3

>12% loss of birthweight at any contact

or no/minimal improvement following Management Plans 1 and 2

Assess clinical wellbeing and document care plan. If any significant concerns are identified, follow appropriate guideline and escalation policy.

1. Refer immediately to paediatric staff – **this is mandatory**
2. Consider admission to Neonatal Unit (NNU) if baby is severely hypernatremia or clinically unwell.

On readmission:

1. take blood tests for **FBC, CRP**, **U&E's** and **SBR**. Perform sepsis screen and commence antibiotic treatment if CRP is raised.
2. Submit **RADAR** form regarding weight loss and re-admission.
3. Inform Infant feeding Lead Midwife for specialist support.
4. If artificially feeding Paediatrician will determine quantities required for 3 hourly feeds.

Observe a full feed
Use **Breastfeeding Assessment Tool** to assess effectiveness of breastfeeding **(see appendix 3**)

1.Ensure a minimum of **8-10 feeds in 24 hours**
2**. Maximise skin-to-skin** contact
3. Whilst baby is suckling at the breast, use **Breast Compressions** to increase breastmilk intake and production.
4. Ensure parents are educated on how to recognise signs of effective feeding.
5.Use an electric pump to increase milk supply (encourage **'double pumping'**) and offer this as a top up.
6. If a little or no milk is expressed, could be clinically indicated to give a top up of artificial milk with a plan from Paediatric team. This requires full maternal consent. Supplementation audit form **must** be completed. As the breastmilk supply increases, decrease the volume of formula milk.

Weigh again in 24 hours
Complete breastfeeding assessment and offer support

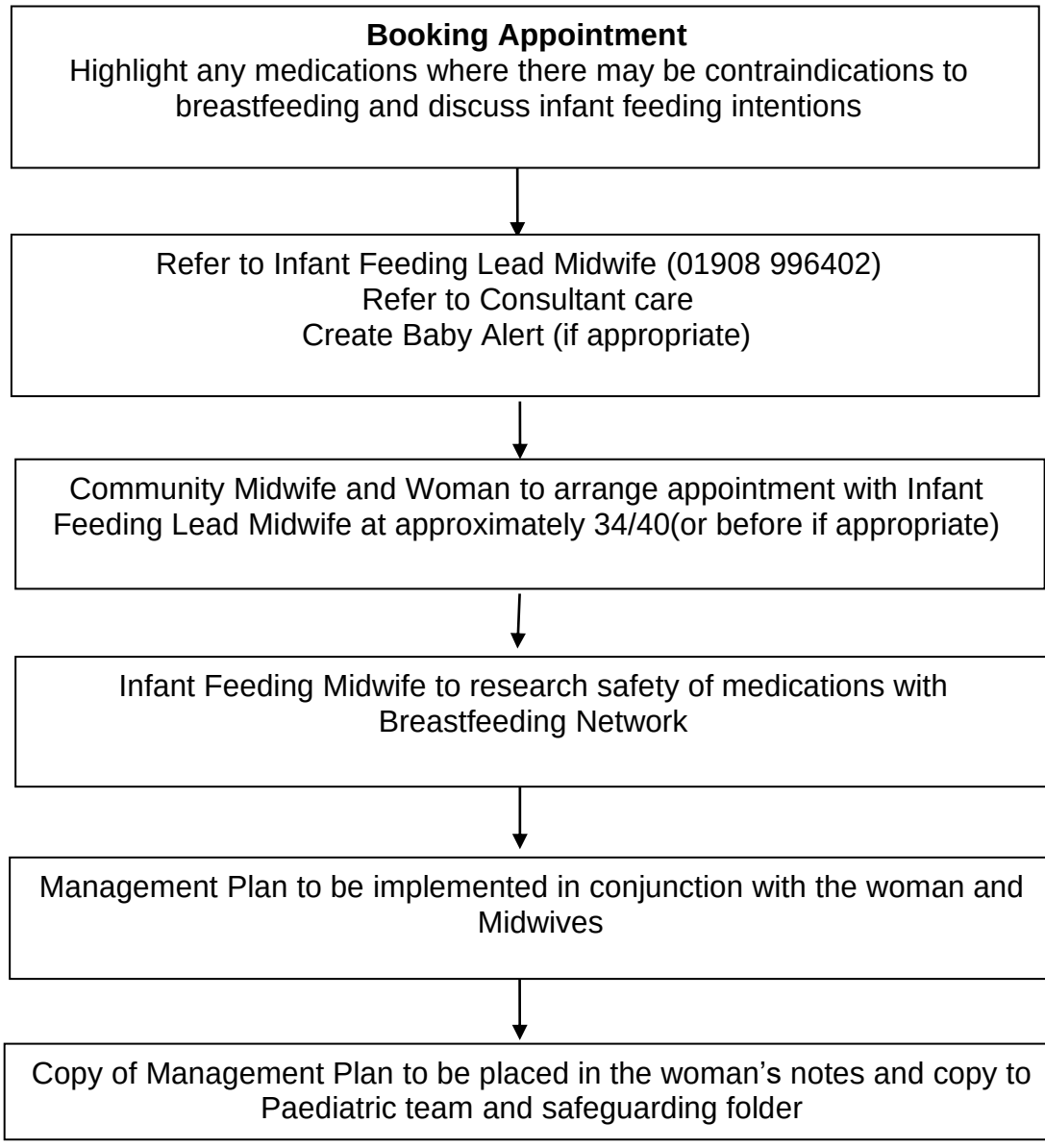
1. Carry out another Breastfeeding Assessment and ensure further support is offered where required
2. Document Infant Feeding Management Plan 3 in notes.
3. Reweigh in 24 hours, then daily weights until clear trend towards birth weight is demonstrated.

The baby can be discharged from midwifery care if consistent weight gain is shown, but the plan must be handed over to the Health Visitor by documenting in the red child health record.

7.0 Medications in Breast milk care plan

Please see medications in breastmilk care plan below for management

Medications in Breastmilk Care Plan



Personalised Breastfeeding Care Plan

Place patient sticker here	EDD: Community Midwife: GP: Prescriber: Consultant:

Medication details (including dosages and reasons for prescription):

Management Plan

Copy to: **Baby Alert file** [ ] **Safeguarding file** [ ] **Woman's notes** [ ] **EDM** [ ]

Signed ……..
Name ……
Date ……..

8.0 Statement of evidence/references

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9.0 Governance

9.1 Document review history

Version number	Review date	Reviewed by	Changes made
2.1			
3.0	Oct 2023	Michelle Hancock Gill Mallows Lila Ravel Alex Fry	Amalgamated with 'Cup feeding neonate in hospital' 'syringe feeding policy' 'neonatal weight management policy and 'expressing breast milk' policy

9.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Denise Cambell	Quality Lead Paediatrics	18/10/2023	18/10/2023	Change name to 'infant feeding in maternity' to avoid confusion as there is already an infant feeding policy within pediatrics	Yes
Gillian Mallows	ANNP	18/10/2023	18/10/2023	section 7: Medications A baby alert should be raised Page 7 needs an extra bullet point in the text. Change all datix to radar	yes
Sent to maternity staff for comment	Maternity	18/10/2023	25/10/2023	No further comments	yes

9.3 Audit and monitoring

How will compliance of this Guideline be evidenced?.

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
BFI Audit	using the UNICEF UK Baby Friendly Initiative audit tool (2019).	Michelle Hancock	3 monthly	BFI Audit

9.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

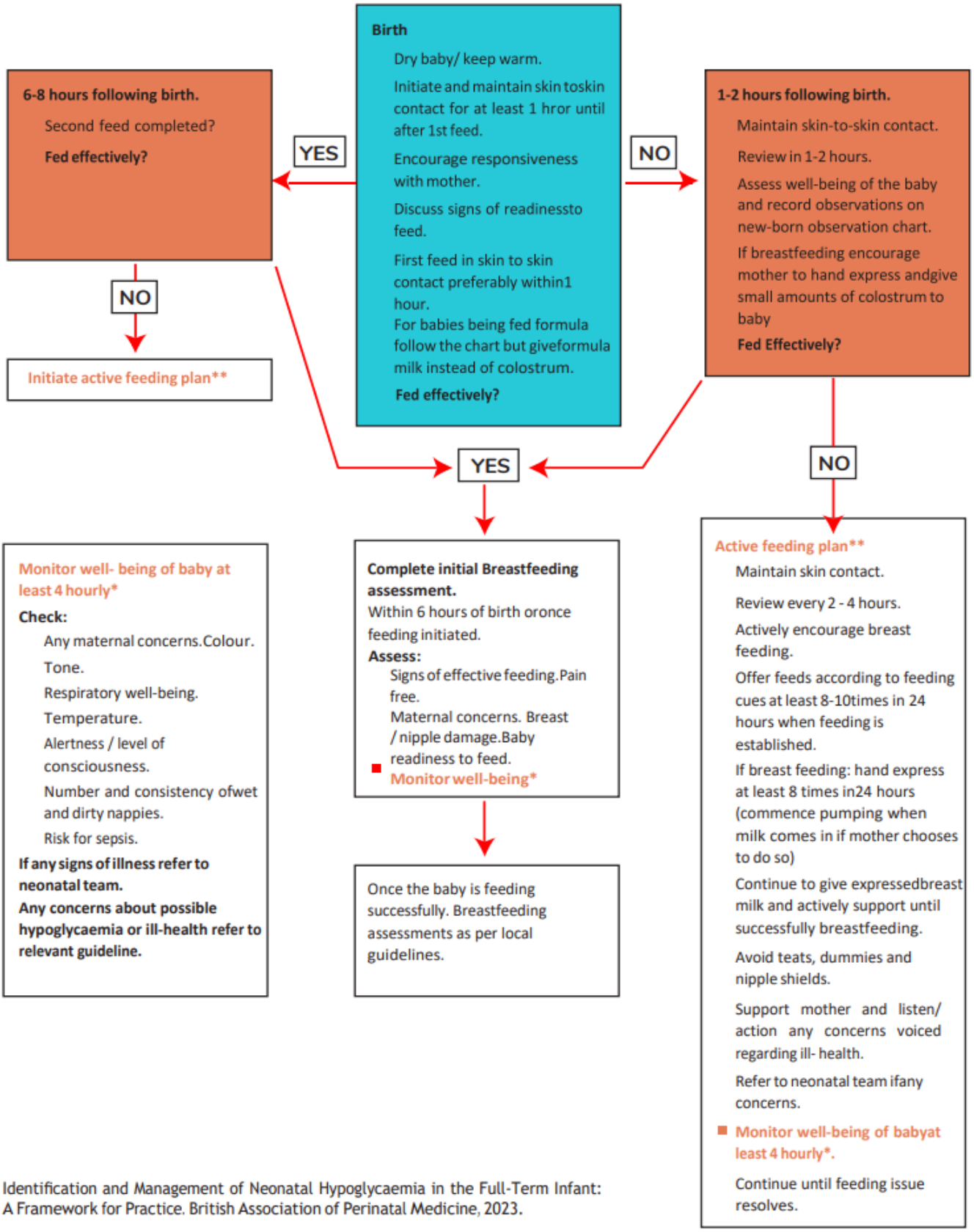
Equality Impact Assessment			
Division		Department	
Person completing the EqIA		Contact No.	
Others involved:		Date of assessment:	
Existing policy/service		New policy/service	

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*For example: community midwives, phlebotomists, all staff*

Protected characteristic	Any impact?	Comments
Age	YES NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	YES NO	
Gender reassignment	YES NO	
Marriage and civil partnership	YES NO	
Pregnancy and maternity	YES NO	
Race	YES NO	
Religion or belief	YES NO	
Sex	YES NO	
Sexual orientation	YES NO	

What consultation method(s) have you carried out?			
For example: focus groups, face-to-face meetings, PRG, etc			
How are the changes/amendments to the policies/services communicated?			
For example: email, meetings, intranet post, etc			
What future actions need to be taken to overcome any barriers or discrimination?			
What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA			

Appendix 1: Reluctant Feeder Pathway (Healthy Term Infant ≥ 37 weeks)



Identification and Management of Neonatal Hypoglycaemia in the Full-Term Infant: A Framework for Practice. British Association of Perinatal Medicine, 2023.

Appendix 2: Newborn Feeding Chart

Feeding method:

Birth weight:

Observations:

Surname:
Forename:
DOB:
Hospital no:
(or affix patient labe

Date	Time	Type of feed	Length or amount	Support	Urine	Stool

Appendix 3: Breastfeeding assessment form

How you and your midwife can recognise that your baby is feeding well						*This assessment tool was developed for use on or around day 5. If used at other times:
What to look for/ask about	√	√	√	√		**Wet nappies:** Day 1-2 = 1-2 or more in 24 hours Day 3-4 = 3-4 or more in 24 hours, heavier Day 6 plus = 6 or more in 24 hours, heavy
Your baby: has at least 8 -12 feeds in 24 hours*						
is generally calm and relaxed when feeding and content after most feeds						
will take deep rhythmic sucks and you will hear swallowing*						**Stools/dirty nappies:** Day 1-2 = 1 or more in 24 hours, meconium Day 3-4 = 2 (preferably more) in 24 hours changing stools
will generally feed for between 5 and 40 minutes and will come off the breast spontaneously						
has a normal skin colour and is alert and waking for feeds						
has not lost more than 10% weight						
Your baby's nappies: At least 5-6 heavy, wet nappies in 24 hours*						**Sucking pattern:** Swallows may be less audible until milk comes in day 3-4 Feed frequency: Day 1 at least 3-4 feeds After day 1 young babies will feed often and the pattern and number of feeds will vary from day to day. Being responsive to your baby's need to breastfeed for food, drink, comfort and security will ensure you have a good milk supply and a secure happy baby.
At least 2 dirty nappies in 24 hours, at least £2 coin size, yellow and runny and usually more*						
Your breasts:						
Breasts and nipples are comfortable						
Nipples are the same shape at the end of the feed as the start						
How using a dummy/nipple shields/infant formula can impact on breastfeeding						
Date						**Care plan commenced: Yes/No:**
Midwife's initials						
Midwife: if any responses not ticked: watch a full breastfeed, develop a care plan including revisiting positioning and attachment and/or refer for additional support. Consider specialist support if needed.						

Appendix 4: Infant Feeding Specialist Referral

Infant Feeding Specialist Referral

Place patient sticker here	DOB: Parent name: Contact number: GP: Referrer:

Type of birth:	Complications or medical issues with mother or baby:	
Gender:	Birth weight	
Current Age of baby:	Current weight:	
Method of feeding	BF	AF

Reason for referral:

Low or inadequate milk supply	Yes	No
Mastitis	Yes	No
Short feeds (all less than 5 minutes)	Yes	No
Long feeds (all longer than 45 minutes)	Yes	No
Not opening bowels appropriate to age	Yes	No
Urine output not appropriate to age	Yes	No
Suspected tongue tie:	Yes (if yes give details)	N