Breast feeding support of healthy term infants who are slow to feed

University Hospitals of Leicester NHS
NHS Trust

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Contents

1. Introduction and who this guideline applies to:

This guideline provides clear evidence-based information and planning which should be

followed to support women/birthing people who have chosen to breastfeed their babies
It outlines basic care from birth which encourages successful feeding and actions that should be taken if a baby is slow to initiate feeding. These actions should always ensure continued breastfeeding and if supplements are used that this is for shortest time possible and with a plan to return to full breastfeeding.
The guideline is based on UNICEF UK Baby Friendly Initiative Standards

This guideline specifically relates to babies who are more than 37 weeks gestation, weighing more than 2.5kg and are slow to feed.
Babies excluded from this Guideline are:

- Preterm and Late Preterm
- Small for gestational age
- Babies of diabetic mothers
- Those who have experienced birth trauma
- Any baby where clinical reasons indicate early and regular feeding is vital

For information about supporting these babies with feeding please see the Management of Hypoglycaemia in Neonates in the related documents below.

Purpose: To assist maternity and neonatal staff in supporting a mother and baby when the baby is slow to start feeding in the first days after birth.
This guideline applies to all UHL Trust staff, including midwifery, nursing, paediatric and support staff, involved in the care of new mothers and healthy term babies. This may be either as in patients or in community settings. This guideline should be used alongside related guidelines for all other aspects of care of the newborn, including immediate and ongoing care.

Related UHL documents:

- **Infant Feeding Policy UHL LLR and Childrens Centre Services**
- **Bottle Feeding UHL Obstetric Guideline**
- **Safer Sleeping and Reducing the Risk of Sudden Infant Death Syndrome LPT Midwifery and Neonatal Guidelines**
- **Weighing of Well Term Babies UHL Obstetric Guideline**
- **Colostrum Collection – Antenatal UHL Obstetric Guideline**
- **Breast Pump Decontamination UHL Obstetric Guideline**
- **Thermal Protection of the Newborn UHL Obstetric and Neonatal Guideline**
- **Hypoglycaemia - Neonatal UHL Neonatal Guideline**

2. Babies who are Slow to feed

Key principles:

- Many babies feed within 90 minutes of birth if kept in undisturbed skin to skin. Some babies will take longer to begin to feed effectively and will need patient, frequent help until they are reliably feeding.
- The slow to feed baby may be sleepy and not wake to feed. They may make a few attempts to breastfeed but not attach and suck effectively.
- Term babies with no risk factors are able to use fat stores for energy and so do not need routine blood glucose monitoring if they are not feeding. However, they should be encouraged to feed and the dyad assisted by staff every 2 - 3 hours with position and attachment and hand expressing until the baby has had 2 effective breastfeeds.
- Parents need to be reassured and concerns listened to. They should be helped to hand express colostrum which can then be given to the baby. Holding the baby in skin to skin in a laid-back position will encourage breastfeeding behaviours.
- Parents should be helped to understand responsive feeding as a relationship between them and their baby - recognise feeding cues and the need to keep the baby close so they can respond to signs the baby wants to feed.
- Staff should be able to recognise abnormal clinical signs in the baby and act on them appropriately.
- Staff must ensure they do not give conflicting advice and make an individual feeding plan for each slow to feed dyad.

The **flow chart** should be followed to ensure consistent breastfeeding support and information for parents.

It is important to remember that it is a warning sign if a baby who has previously been feeding well becomes a slow or reluctant feeder and they should be reviewed by a paediatrician and blood glucose measurement should be considered.

If there is concern that the baby's feeding pattern is abnormal:

- Consider the possibility of underlying illness
- Assess the baby's physical condition
- The baby should be woken and lifted from the cot to enable effective assessment of the level of consciousness.
- Observations should be recorded 4-hourly on the neonatal early warning score observation chart (NEWS)

Feeding: If the baby has not fed within 24 hours exclude signs of ill health or underlying issue. If no other concerns are present, it does not necessarily mean that formula feeding is required at this point, particularly if the parent is able to produce adequate amounts of colostrum or EBM.

- Encourage frequent hand expression (aiming for 8 times in 24 hours) and offer hand expressed EBM (colostrum) via syringe or cup. It must be stressed that expressing milk and feeding via a cup / syringe is a short-term solution. The baby should be offered the breast regularly in the meantime.
- A plan of care should be documented and implemented.
- If a formula supplement is given this must recorded with a clear explanation and rationale on the appropriate page in the Baby Postnatal Diary.

Flow Chart 1: Well term baby who is slow to feed - birth to 12 hours.

At birth the baby is placed in skin to skin on the parent's chest, dried and hat put on.

Mother and baby are left undisturbed until after the first feed. Baby attaches and feeds effectively.
Mother taught to hand express. **Document**

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Mother is offered help with second feed by 6 hours.
Baby attaches and feeds.

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Responsive feeding.
Feeding assessment completed.

At birth baby licks and tries a few sucks at the breast. Mother and baby are kept in skin to skin.
Mother is helped to hand express, and baby given any colostrum via colostrum collector, if 5mls or less. Via a cup if more than 5mls. **Document**

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Every 2-3 hrs Mother is offered help to rouse her baby and breastfeed. Does not feed. Hand express colostrum and give to baby.

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Continue to support every 2-3 hours. Encourage skin to skin and follow feeding cues. Keep hand expressing and giving colostrum.

Baby does not feed at birth. Mother and baby are kept in skin to skin.
Mother is helped to hand express. No colostrum obtained. **Document**

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Every 2-3 hrs mother is helped to rouse her baby and offer breastfeed. Hand express colostrum. No colostrum.

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Continue to support every 2-3 hours. Encourage skin to skin and follow feeding cues. Keep hand expressing. Small amounts of colostrum/no colostrum.

Most babies will start to feed by 12 hours old if kept in skin to skin and able to access the breast. Maintain milk supply by encouraging hand expressing every 2-3 hours. Reassure parents and listen to concerns.
Document every time feeding support is given. Complete 'Feeding Assessment' and make a feeding plan.

Is baby well? Colour, Tone, Alertness, Temperature. Lift baby out of cot or off of mother and assess. Has the baby passed urine and meconium? If yes continue to support every 2 hours with breastfeeding and expressing.

Any concerns do a set of observations and if abnormal inform Neonatologist. If unwell and no colostrum expressed, offer 10-15mls formula by cup with mother's consent**. Document.**

Continue to support every 2 hours. Encourage skin to skin and follow feeding cues. Keep hand expressing and giving colostrum.
Commence 4 hourly observations.

Continue to support every 2 hours. Encourage skin to skin and follow feeding cues. Keep hand expressing. Small amounts of colostrum/no colostrum.
Give 10-15mls formula in a cup with mother's consent.
Commence 4 hourly observations.

Flow Chart 2: Well term baby who is slow to feed - 12 to 24 hours.

If the baby still hasn't fed effectively (either at the breast or hand expressed colostrum) at least once within 12 hours of birth, assess the baby's condition while continuing to stimulate milk production through frequent hand expression / nipple stimulation

If not feeding by 24 hours even if observations are normal ask for a paediatric review.

24 to 48 hours; Not yet breastfeeding:

- Skin to skin, support with breastfeeding every 2 hours
- 2-3 hourly hand express, if colostrum less than 5mls also give 10-15mls formula via a cup with mother's consent - **Document**
- Consider using breast pump to increase volume of EBM
- Continue observations and how many wet and dirty nappies – 1 wet nappy first 24 hrs, 2 in next 24hrs. 1 or 2 meconium.

48 to 72 hours; Not yet breastfeeding:

- Continue to support with breastfeeding and expressing 8-10 times in 24 hours
- Offer EBM, if less than 15mls consider formula 20-30ml via cup
- Commence breast pumping, if not already done so, 8x daily with one at night
- Continue observations and how many wet and dirty nappies – 2 wet nappies 48 hrs, 3 in 72hrs, meconium x 2 each 24 hours.

Going home not breastfeeding:

- An **individual Feeding Plan** should be made with each dyad. Consider a discussion with the Infant Feeding Midwife
- The Community Midwifery team involved in the care must be informed of method of feeding and **Feeding Plan**
- Consider referral to the Specialist Infant Feeding Clinic on Fridays at LGH. Tel: 0116 258 4830

Individual Feeding Plan

Please print and attach to Baby Postnatal Diary

Mothers Name:
Baby's date of birth:
Type of birth:
Postnatal Day and Date when feeding plan made:
Breastfeeding Challenge:

- Mother:

- Baby:

- Has mother been supported with 'CHIN' principles to aid breastfeeding? **Yes** **No**

Feeding Plan:

Skin to skin contact should be encouraged at every opportunity in a laid back position on the mother's chest.

When to feed- tick correct box

- Responsive feeding following baby's feeding cues 8-10 times each 24 hours ☐
- Wake to feed every 3 hours, timing from beginning of last feed ☐

Method of supplementary feeding: tick box

Cup ☐ Bottle ☐

Have parents been shown how to Cup feed safely?	Yes	No
Have parents been shown how to pace bottle feed?	Yes	No
Have parents been shown how to sterilise equipment?	Yes	No
Have parents been shown how to make up formula?	Yes	No

How much to feed: (depends on postnatal day and if baby is managing any breastfeeds)

- ☐ mls — Every 3 hours or after each feed on PN day ☐
- ☐ mls — Every 3 hours or after each feed on PN day ☐

Expressing breast milk to maintain and increase supply and to feed the baby

Is the mother confident with hand expressing? Yes No

Does the mother have a breast pump? Yes No

The mother has had discussion about needing to express 8-10 times a day and at least once in the middle of night between 1am -4am Yes No

The mother has had a conversation about safe storage of EBM Yes No

Mother has had a conversation about wet and dirty nappies being a reliable way to tell if the baby is getting enough milk Yes No

Mother has had a conversation about lack of stool or no change in colour is a sign her baby needs more milk Yes No

Mother has been told about the numbers to ring if she is concerned about feeding Yes No

This feeding plan should be reviewed and updated with the mother every 48 hours or until the baby is feeding responsively 8 times in 24 hours.

3. Supporting successful breastfeeding

3.1 Key principles;

Initiation of a close relationship and feeding soon after birth

Vigilance as to the baby's wellbeing is a fundamental part of postnatal care in the first few hours after birth - Safety Considerations:

- Normal observations of the baby's temperature, breathing colour and tone should continue throughout the period of skin contact.

- Observations should also be made of the mother with prompt removal of the baby if the health of either gives rise to concern.
- It is important to ensure that the baby cannot fall onto the floor or 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.
- Mothers can continue to hold their baby in skin contact during perineal suturing.
- Mothers should be discouraged from holding their baby when receiving analgesia which causes drowsiness or alters their state of awareness (e.g. Entonox).
- Mothers should have access to the call buzzer when left unattended.

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3.2 All babies:

Maintaining skin contact promotes responsive feeding and Oxytocin release as the baby has access to the breast. The benefits associated with responsive feeding include:

- Higher proportion of mothers and babies still breastfeeding at four to six weeks [25, 24]
- Maintenance of release of Oxytocin which improves neurological development in the baby.
- Reduction in the release of the stress hormone Cortisol which is harmful to brain development in the baby.
- Reduction in engorged breasts and sore nipples [27]
- Decrease in weight loss from birth to day 7 [28]
- Reduced hyperbilirubinaemia on day 6 [28]
- Keeping parent and baby in the same room night and day is recommended for the first 6 months to reduce the risk of sudden infant death syndrome [34]
- One of the most commonly cited objections to keeping the baby close at night, is that it interferes with the parent's sleep. Although keeping the baby close does increase the frequency of breastfeeds at night, it has been shown not to affect the number of hours slept by the parent, or their daytime alertness [30, 31].
- Babies that are kept close to their parents sleep for longer than those cared for in a nursery [32]. Careful consideration needs to be given to the detrimental effect of separating parent and baby at any time on the postnatal ward with any advantage that may be gained.
- Any staff member removing a baby from their parent's care will then be responsible for the baby's wellbeing and needs to keep them under regular observation until they are returned to their parents' care.

3.3 Benefits associated with skin contact:

- Significantly higher axillary and skin temperatures [11]
- Higher blood glucose levels at 90 minutes [11]
- Less crying [5, 11, 12, 13]
- Reduced risk of post-partum haemorrhage by encouraging release of Oxytocin[15]
- Physiological stabilisation of neonatal observations, including reduction in the incidence and duration of neonatal tachypnoea and mucousy possetting, stabilised heart rate [38, 40, 42, 45]
- Skin contact may be used at any time to elicit breast seeking behaviour, encourage spontaneous attachment to the breast and warm the baby, not just immediately post-delivery. Skin contact and suckling are very closely linked. It also helps to avoid the baby being forced to take the breast, a practice which is ineffective at promoting breastfeeding, and is detrimental to the mother's confidence, as well as the baby's experience of breastfeeding.

3.4 Skin to skin contact for all babies at birth:

- All mothers should be offered the opportunity to hold their baby in skin contact as soon as possible after birth. This should be until after the first feed, or as long as they wish.
- The baby should be dried and protected from draughts by placing warmed towels over them and a warm hat applied. The towels should not be wrapped around the baby as this will interfere with the skin contact.
- An explanation of skin contact and how to do this safely, also recognising and responding to feeding cues should be given and the conversation document in the Baby's Postnatal Diary
- Parent and baby should not be separated at birth unless there is an unavoidable medical reason.
- Skin contact may be initiated whilst the parent is still in the operating theatre, providing the parent is well enough and feels confident to do so with the support of a midwife or MSW, and there are no medical or anaesthesia contraindications. However, operating theatres have a lower ambient room temperature than birthing rooms and special regard to thermo-protection of the newborn will be warranted.
- Skin contact will be initiated within the recovery area following caesarean section, if not already begun, providing the parent wants to do it, is well and is not left unattended. This will encourage release of Oxytocin which may often be delayed when the woman/birthing person has not laboured.
- Provided the infant is in close contact with their parent and can suckle when they show signs of readiness, there is no justification for forcing the baby to take the breast. Doing so may have an adverse effect on breastfeeding behaviour subsequently. [9]
- When helping parents to make an informed choice regarding analgesia in labour, it is important to make them aware of the fact that administration of opiates may interfere with the early development of breast seeking behaviour, delay the first breastfeed and interfere with breastfeeding long-term. [3, 14, 15, 16, 44]
- Maintaining skin contact promotes responsive feeding and Oxytocin release as the baby has access to the breast. Evidence shows that the number of hours of skin to skin contact a baby receives in the first days of life increases the parent's ability to respond to their baby appropriately
- All parents should be shown how to hand express (see Appendix 3)
- Observations to reduce the risk of Sudden Unexpected Postnatal Collapse should be

commenced while enabling parent and baby to calm and familiarise themselves with each other.

3.5 Supporting breastfeeding to get off to a good start

- Mothers will be supported to achieve effective breastfeeding according to their needs both at birth and at each postnatal contact (including appropriate support with positioning and attachment, - 'CHIN', hand expression, understanding signs of effective feeding). This should continue until the mother and baby are feeding confidently. A Breastfeeding Assessment should be completed x2 in the first 7 days postnatal. (Found in the Baby's postnatal diary) See Appendix 2
- Provided the infant is in close contact with their mother and can suckle when the baby shows signs of readiness, there is no justification for forcing the baby to take the breast. Doing so may have an adverse effect on breastfeeding behaviour subsequently. (9)
- Mothers will be offered a Breastfeeding Log and should be encouraged to use it. The feeding log is given to the mother on Delivery Suite before transfer home or to the postnatal ward. This is to enable mothers to monitor their baby's feeding and elimination and seek support / advice when required.
- When giving the Breastfeeding Log the information will be explained to the mother to ensure she is able to understand and recognise when breastfeeding is effective.
- All mothers should be shown how to hand express (see section 3.8 and Appendix 3) as soon as possible, ideally before they leave the delivery suite but before discharge home. In the case of a homebirth, before the midwives leave. If needed, colostrum collecting kits are in each delivery room.
- It is the responsibility of both Maternity and Neonatal staff to ensure mothers with a baby on the neonatal unit will be supported to express as effectively as possible by hand within 2 hours of the baby's birth and encouraged to express at least 8 times in 24 hours, including once at night. They will be shown how to express by both hand and when appropriate by pump (see Appendix 4; storage of breastmilk)
- Mothers will have the opportunity to discuss breastfeeding in the first few hours after birth as appropriate to their own needs and those of their baby. This discussion should include information about responsive feeding, feeding cues, signs of effective feeding and hand expression. This is recorded in the Baby's Postnatal Diary as part of the Postnatal Conversation.

- ***Buccal colostrum 0.2ml:**
- Boosts the immune system by stimulating immune tissue & by direct absorption of immune factors that are present in colostrum.
- Acting as a barrier, preventing bacteria attaching to the lining of the mouth.
- Increasing gut growth and development.

3.6 Responsive feeding

- Responsive feeding is used to describe a feeding relationship which is sensitive, reciprocal, and about more than nutrition. Closeness and comfort between mother and baby are shown to encourage the baby's brain development. Staff will ensure that mothers have the

opportunity to discuss this aspect of feeding and reassure mothers that: breastfeeding can be used to feed, comfort and calm babies. Breastfeeds can be long or short, breastfed babies cannot be overfed or 'spoilt' by too much feeding and breastfeeding will not tire mothers any more than caring for a new baby without breastfeeding.

Responsive feeding information should be tailored to the mother's needs and is recorded in the Postnatal Diary, 'Postnatal Conversation'.

3.7 Feeding cues

It is important that all mothers are taught to recognise the Feeding Cues that babies exhibit. These include:

- Rooting movements
- Sucking their hand or finger
- Rapid eye movements
- Body movements
- Small sounds
- Mouth and tongue movements

Mothers need to be made aware that:

- It is not possible to overfeed a breastfed baby. Crying is a late feeding cue; often the baby has been hungry for some time and may start to cry as a last resort. Crying babies need to be settled before they will feed.
- Healthy term babies often feed infrequently in the first 24-48 hours after birth.
- If feeding cues are misinterpreted there is a risk that the baby may receive fewer feeds leading to inadequate fluids and nutrition. The mother's milk supply may decrease due to reduced breast stimulation and milk removal. This can lead to early cessation of breastfeeding. (10)
- Mothers also need to be aware of the problems associated with masking these feeding cues with pacifiers/dummies.

Babies who use pacifiers/dummies will also:

- Have fewer breastfeeds (19)
- Be less likely to breastfeed at four months (20,21)
- Have a higher incidence of oral Candida infection (22, 23)
- Have a higher incidence of acute and recurrent otitis media. (24)

3.8 Why hand expression is useful:

- It helps familiarise the mother with her breasts and how to handle them correctly
- Builds the mothers' confidence and supports her initiation of lactation
- Enables immediate access to breast milk when necessary

- Aids softening of breasts and areola during engorgement/ mastitis.
- May enable direct expression of milk for pre-term/ ill/ sleepy babies
- Useful for mothers who are too uncomfortable or unable to use mechanical pump
- Hand expressed milk may have a higher sodium content and concentration than pump expressed milk which may be more advantageous to pre-term babies less than 30 weeks
- Aids healing of sore or cracked nipples.
- May be used before and after the use of a breast pump for higher milk yields and higher fat content where the mother and baby are separated, or the baby is unable to access the breast.

3.9 Support with second feed within 6 hours of birth

- All mothers should be offered support with a second feed within 6 hours of birth and this should be recorded in the baby's Postnatal Diary. If this feed is effective the mother can be encouraged to feed her baby responsively.
- All mothers should be shown how to effectively position and attach her baby for breastfeeding to ensure a comfortable and effective breastfeed. 'CHIN' can be used to help mothers understand effective positioning at the breast. (Close, Head free, In line, Nose to nipple)
- Offer breastfeeding support as needed ensuring that teats, dummies and nipple shields are avoided in these early days. Colostrum is difficult to obtain through a nipple shield. (see nipple shield guideline)
- Mothers should be encouraged to feed at least 8 times in a 24-hour period.
- Listen to the mother's concerns and take action if appropriate
- Document the care given.

3.10 Ongoing support when there has been 2 effective breastfeeds

- Most healthy term infants will feed within 12 hours of birth if skin contact is maintained. Feeding patterns vary, and the suck-swallow-breathe pattern and rate will alter during the course of a feed.
- Colostrum is produced in small quantities (typically 5-10mls / feed) but is nutritionally advanced to provide all the baby's nutrient and fluid needs and promote healthy gut colonisation and immune system development. It is therefore difficult to prescribe what constitutes a 'good feed', and professional judgement should be used.
- However, if the baby has been well attached at the breast, suckled well (rapid sucks initially followed by deep slow sucks with swallows), has finished the feed of his/her own accord and appears contented, it can be assumed that the baby has fed well.
- Further evidence of adequate feeding is the passing of meconium within 24 hours of birth and at least one wet nappy.
- This should be documented fully in the postnatal record.

Two breastfeeding assessments should be carried out with the mother in the first week. This assessment will include a discussion with the mother to reinforce what is going well and, where necessary, to develop an appropriate plan of care to address any identified challenges

On-going support:

It is unacceptable to discharge a baby from hospital care whilst the baby is not feeding effectively at the breast without having a clear plan of care in place. If the mother is expressing and giving EBM via a cup see Appendix 5.

A formal feeding assessment should be carried out using the Breastfeeding/ Infant

Feeding Assessment Tool (Appendix 2), as often as required in the first week with a minimum of two assessments to ensure effective feeding and the well-being of mother and baby (as per Weighing of Well Term Babies guideline). This assessment will include a discussion with the mother to reinforce what is going well and, where necessary, to develop an appropriate plan of care to address any identified challenges.

3.11 The use of Nipple Shields

Do not use nipple shields until there is more than 5mls of colostrum being hand expressed or until after the first 72 hours.

Staff can only recommend nipple shields if they have been trained in their correct use. This will be assessed when completing a Practical Skills Review (PSR) with the Infant Feeding Team.

A discussion with a member of the Infant Feeding before suggesting the use of nipple shields will ensure the appropriate use of nipple shields. Most breastfeeding problems involving healthy, full-term babies, and those challenging situations involving prematurity, neurological problems or birth injuries may respond to interventions that avoid using nipple shields.

What problems may arise with using nipple shields?

- The baby may struggle to transfer milk if they are ineffectively attached at the breast
- Stimulation of the breast is less effective as the mother does not feel the baby's suck in the same way as when a baby latches onto the breast directly. Under stimulation may lead to a reduced milk supply
- Without expert help the mother may attach the baby in a less effective way when using nipple shields
- Due to ineffective attachment mothers can be at increased risk of blocked ducts, engorgement and mastitis
- Many mothers want to directly breast feed and nipple shields may lead to breast refusal if then offered without a shield - it can be difficult to wean from the shields
- Incorrect size of shield can be the cause further irritation to sore nipples
- Mothers may lose confidence in their ability to breastfeed and may worry about feeding with shield when out and about

Mothers need to able to make a fully informed choice about the pro and cons of using a nipple shield and these must have been discussed with her before she decides to commence their use. She should be informed of the possible side effects the shields may have on breastfeeding (as above). All discussions and actions taken before recommending a nipple shield must be documented in her notes.

Why use a nipple shield?

While their incorrect use may mean nipple shields cause more problems than they solve, when a mother is correctly supported, they can be a useful tool to help preserve breastfeeding including these situations:

- Flat or inverted nipples.
- Baby with a restrictive frenulum
- Babies with hyper or hypotonia.
- When trying to transition an infant from bottle feeding to breastfeeding.
- When trying to transition a preterm infant to breastfeeding.
- Breast engorgement when the nipple has been flattened.

- To help a baby manage an oversupply/fast letdown of breast milk.

If the mother decides to use a nipple shield, make sure that the fit is appropriate:

- Help the mother to choose the correct size of nipple shield. Nipple shields should be the smallest size that fits the mother's nipple comfortably, and not too big for the infant's mouth.
- Measurement for nipple shield sizing should be taken at the base of the nipple. Nipple shield come in sizes small (16mm), medium (20mm) and large (24mm).
- The teat of the shield needs to be wide enough to accommodate the size of the mothers' nipple to prevent trauma.
- Nipple shields that are too small will not be able to extend deeply into the baby's mouth and so not allow for deep attachment to the breast.
- A shield that is too large may cause ineffective milk transfer and affect milk production and may be challenging for the baby.

Observation of correct attachment with a nipple shield using 'CHIN' principles:

- The baby needs to open his mouth wide with his chin touching the breast
- The baby's bottom lip is away from the base of the shield teat resting on the soft rim around the teat.
- The baby may need a slight lift up and over to allow the teat to enter the roof of the mouth.
- An asymmetric attachment should be achieved to allow the teat to extend back far enough in the baby's mouth to stimulate effective sucking.
- The baby should not just suck on the tip of the nipple shield as this leads to poor milk transfer, frustration from the baby and a slower milk flow, and the baby will have to work hard to achieve an adequate feed.
- If any part of the teat can be seen during the feed, the baby needs to be gently pulled in closer with his chin indenting the breast. If this does not improve the attachment the baby may need to be removed from the breast and repositioned.

Care of mother and baby when using nipple shields:

- To maintain her supply mothers should be encouraged to express following breastfeeds with a nipple shield.
- Show the mother how to recognise swallowing whilst the baby is feeding and why this is important.
- Milk should be seen in the teat of the nipple shield at the end of the feed.

Cleaning and storage of nipple shields in the hospital setting:

- Nipple shields need to be washed in warm soapy water after every use. Rinse with clear water.
- Nipple shields should be sterilised after every use and kept in a clean container until the next feed.

4. Education & Training:

All staff involved in supporting infant feeding should undertake regular training as detailed in the

training needs analysis.

5.Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Babies readmitted to hospital with feeding problems during the first 28 days of life should be notified to the Infant Feeding Team				

6. Supporting References

1. Righard L, Alade MO (1990) Effect of delivery room routines on success of first breastfeed *Lancet, 336(8723):* 1105-1107

2. Sosa et al. The effect of early mother-infant contact on breastfeeding, infection and growth. In *Ciba Foundation Symposium No. 45 (new series): Breastfeeding and the Mother.* Amsterdam, Netherlands, Elsevier Publishing Co. 1976: 179-193

3. De Chateau P, Wiberg B (1997a) Long-term effect on mother-infant behaviour of extra contact during the first hour post partum: II. A follow-up at three months. *Acta Paediatrica Scandinavica,* 66: 145-151

4. Thomson ME, Hartsock TG, Larson C (1979) Long-term effect of immediate postnatal contact: its effect on breastfeeding. *Canadian Family Physician,* 25:1374-137

5. Bystrova K, Ivanova V , Edhborg M, Matthiesen A, Ransjö-Arvidson A, Rifkat Mukhamedrakhimov, Kerstin Uvnäs-Moberg, MD, Ann-Marie Widströmikiel-Kostr(2009) Early Contact versus Separation: Effects on Mother–Infant Interaction One Year Later,Birth;36;97-108

6. Mikiel-kostyra K, Mazur J, Boltruszko I (2002) Effect of early skin to skin contact after delivery on duration of breastfeeding: a prospective cohort study. Acta paediatr 91(12):1301-6

7. Ali, Z, Lowry M (1981) Early maternal-child contact: effects on later behaviour. *Developmental Medicine and Child Neurology,* 23:337-345

8. *The Global Criteria for the WHO/UNICEF Baby Friendly Hospital Initiative.* In: Baby Friendly Hospital Initiative. Part II. Hospital Level Implementation. WHO/UNICEF, 1992.

9. Widstrom A-M et al, Thingstrom-Paulsson J (1993) The position of the tongue during rooting reflexes elicited in newborn infants before the first suckle. *Acta Paediatrica,* 82:281-283

10. Child Health and Development (1998) *Evidence For the Ten Steps to Successful Breastfeeding.* World Health Organisation

11. Bergstrom A Okong P Ransjo-Arvidson (2007) Immediate maternal thermal response to skin to skin care of the newborn. Acta Paediatr,96(5) page 655-658

12. Fransson A, Karlsson H, Nilsson K (2005) temperature variation in newborn babies: Importance of physical contact with the mother. arch dis child fetal neonatal Ed,90,F500-F504

13. Christensson K et al (1992) Temperature, metabolic adaptation and crying in healthy full term new- borns cared for skin-to-skin and in a cot. *Acta Paediatrica,* 81:488-493

14. Christenson K et al (1995) Separation distress call in human neonate in absence of maternal body contact. *Acta Paediatrica,* 84:468-473

15. Chua S et al (1994) Influence of breastfeeding and nipple stimulation on postpartum uterine activity. *British Journal of Obstetrics and Gynaecology,* 101:804-805

16. Nissen E et al (1997) Effects of maternal pethidine on Infants' developing breastfeeding behaviour. *Acta Paediatrica,* 84:140-145

17. Nissen et al (1997) Effects of routinely given pethidine during labour on Infants' developing breastfeeding behaviour. Effects of dose-delivery time interval and various concentrations of pethidin/norpethidine in cord plasma. *Acta Paediatrica*, 86:201-208

18. Rajan L (1994) The impact of obstetric procedures and analgesia/anaesthesia during labour and delivery on breastfeeding. *Midwifery,* 10:87-103

19. Victoria CG et al (1997) Pacifier use and short breastfeeding duration: cause, consequence or coincidence? *Paediatrics,* 95(4):497-499

20. Righard L, Alade MO (1997) Breastfeeding and the use of pacifiers. *Birth*, 24:116-120

21. Barros FC et al (1995) Use of pacifiers is associated with decreased breastfeeding duration. *Paediatrics,* 95(4):497-499

22. Manning DJ, Coughlin RP and Poskitt EME (1985) Candida in mouth or dummy? *Archives of Disease in Childhood*, 60:381-382

23. Sio JO et al (1987) Oral candida: is dummy carriage the culprit? *Archives of Disease in Childhood*, 62:406-420

24. Niemela m, Uhari M & Mottonen M (1995) A pacifier increases the risk of recurrent acute otitis media in children in day care centres. *Paediatrics,* 96(5):884-888

25. Slaven S, Harvey D (1981) Unlimited suckling time improves breast-feeding. *Lancet,* 1 (8216):392- 393

26. Yamauchi Y, Yamanouchi I (1990) Breast-feeding frequency during the first 24 hours after birth in full-term neonates. *Paediatrics*, 86(2):171-175

27. Bloom K et al (1982) II. Factors affecting the continuance of breastfeeding. *Acta Paediatrica Scandinavica,* Suppl 300:9-14

28. Elander G, Lindberg T (1984) Short mother-infant separation during first week of life influences the duration of breastfeeding. *Acta Paediatrica Scandinavica,* 73:237-240

29. Waldenstrom U, Swenson A (1991) Rooming in at night in the post partum ward. *Midwifery,* 7:82-89

30. Keefe MR (1988) The impact of infant rooming-in on maternal sleep at night. *Journal of Obstetrics, Gynaecology and Neonatal Nursing*. March-April:122-126

31. Keefe MR (1987) Comparison of neonatal night-time sleep-wake patterns in nursery versus rooming-in environments. *Nursing Research*, 36(3):140-144

32. Hopkinson JM, Schanler RJ & Garza C (1988) Milk production by mothers of premature infants. *Paediatrics*, 81(6):156-168

33. Samuel P (1988) Cup feeding: how and when to use it with term babies. *The Practising Midwife*, 1(12) pp.33-35

34. FSID (2009) *www.fsid.org.uk* accessed on 25/01/2010

35. McVea KL, Turner PD, Peppler DK. The role of breastfeeding in sudden infant death syndrome. *Journal of Human Lactation*. 2000; 16: 13-20.

36. Department of health(2009) The Pregnancy book, page 109 *http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_107685.pdf (accessed 22/01/2010)*

37. Bergman N J. Linley LL. Fawcus SR. (2004) Randomised controlled trial of skin-to-skin contact from birth versus conventional incubator for physiological stabilisation in 1200 – 2199g newborns *Acta Paediatrica,* 93(6), 779-785

38. Browne J V. (2004) Early relationship environment: Physiology of skin-to-skin contact for parents and their pre-term infants *Clinics in Perinatology,* 31(2), 287-298,vii

39. Lozoff, B, Brittenham, G M, Trause M A, Kennell, J H, & Klaus, M H (1977) The mother-newborn relationship: Limits of adaptability. *Journal of Paediatrics,* 91(1), 1-12

40. Anderson, G C, (1989) Risk in mother-infant separation post-birth *Image: Journal of Nursing Scholarship, 21(4),* 196-199

41. Moore ER, Anderson GC, Bergman N. Early skin-to-skin contact for mothers and their healthy newborn infants. *Cochrane Database of Systematic Reviews* 2007, Issue 3. Art. No.: CD003519. DOI: 10.1002/14651858.CD003519.pub2.

42. Ball, H L, Ward Platt, M P, Heslop, E, Leech S J, & Brown K A (2006) Randomised trial of infant sleep location on the post-natal ward *Archives of Disease in Childhood,* 91(8), 1005 – 1010Beilin, Y, Bodian, C A,Weiser, J, Hossain, S, Ittamar A, & Feierman, D (2005) Effect of labour epidural analgesia with and without Fentanyl on Infant breastfeeding: A prospective, randomised, double-blind study. *Anaesthesiology,* 103(6), 1211 – 1217

43. Gray, L, Watt, L, & Blass, E M (2002) Skin-to-skin contact is analgesic in healthy newborns *Paediatrics,* 105(1) e1

44. UNICEF UK (2014) Having Meaningful conversations with Mothers: A guide to the New Signature Sheets

45. *NICE*(2013) Routine postnatal care of women and their babies: quality standard 37 *http://www.nice.org.uk/nicemedia/pdf/CG37NICEguideline.pdf*

46. National Institute for Clinical Excellence (2010c) *Neonatal Jaundice Clinical Guideline 98,* May available at: www.nice.org.uk/cg98

47. Bolling K, Grant C, Hamlyn B, Thornton A. (2007) Infant Feeding Survey 2005. The Information Centre

48. www.thelancet.com/series/breastfeeding

49. Renfrew MJ, Pokhrel S, Quigley M, McCormick F, Fox-Rushby J, Dodds R, Duffy S, Trueman P, Williams T (2012a) *Preventing Disease and Saving Resources: the potential contribution of increasing rates in the UK,* UNICEF UK BFI (http://www.unicef.org.uk/Documents/Baby_Friendly/Research/Preventing_disease_saving_resourc es.pdf)

50. Uvnas-Moberg.K, Prime.D (2013), *Oxytocin effects in Mother & Infant during breastfeeding.* Infant Vol9, Issue 6, (2013)

51. Flint.A, New.K, Davies.M, (2016), *Cup Feeding versus other forms of supplemental enteral feeding for newborn infants unable to fully breastfeed.* The Cochrane Library 31 August 2016

52. Hands.A, (2003) *Safer Storage of expressed breastmilk in the home.* MIDIRS Midwifery digest vol13, no 3, Sept. 2003 ,p.378-*385*
53. file (leices tershospitals.nhs.uk) Does my breast-fed baby need formula milk?

7. Key words

Breast, feeding, cup feeding, syringe feeding, feeding cues; slow to feed, skin contact, responsive feeding, BFI, Hand expression

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) Ann Raja – Infant Feeding Midwife	**Executive Lead** Chief Nurse
Details of Changes made during review: Updated by Ann Raja October 2023 – Changed title Updated intro and purpose to clarify the aims of the guideline. Key principles added. Actions to be taken when presented with a slow to feed newborn ad=vice now in a flow chart, hours of age specific. Individual feeding plan added. Buccal colostrum section added. Use of nipple shield section added.	

Appendix 1; Overview of the Baby Friendly Initiative Standards

Building a firm foundation

1. Have written policies and guidelines to support the standards.

2. Plan an education programme that will allow staff to implement the standards according to their role.

3. Have processes for implementing, auditing and evaluating the standards.

4. Ensure that there is no promotion of breastmilk substitutes, bottles, teats or dummies in any part of the facility or by any of the staff.

An educated workforce

Educate staff to implement the standards according to their role and the service provided

Parents' experiences of maternity services	Parents' experiences of health visiting services
1. Support pregnant women to recognise the importance of breastfeeding and early relationships on the health and wellbeing of their baby. **2. Support all mothers and babies to initiate a close relationship and feeding soon after birth.** **3. Enable mothers to get breastfeeding off to a good start.** **4. Support mothers to make informed decisions regarding the introduction of food or fluids other than breastmilk** **5. Support parents to have a close and loving relationship with their baby.**	**1. Support pregnant women to recognise the importance of breastfeeding and early relationships on the health and wellbeing of their baby.** **2. Enable mothers to continue breastfeeding for as long as they wish.** **3. Support mothers to make informed decisions regarding the introduction of food or fluid other than breastmilk.** **4. Support parents to have a close and loving relationship with their baby.**
Parents' experiences of Neonatal Units	**Parents' experiences of Children's Centres**
1. Support parents to have a close and loving relationship with their baby. 2. Enable babies to receive breastmilk and to breastfeed when possible. 3. Value parents as partners in care.	1. **Support** pregnant women to recognise the importance of early relationships to the health and wellbeing of their baby. 2. Protect and support breastfeeding in all areas of the service. 3. Support parents to have a close and loving relationship with their baby.

Building on good Practice

Demonstrate innovation to achieve excellent outcomes for mothers, babies and their families.

Appendix 2: Hand expression Technique

Explain to mother why hand expression may be useful.

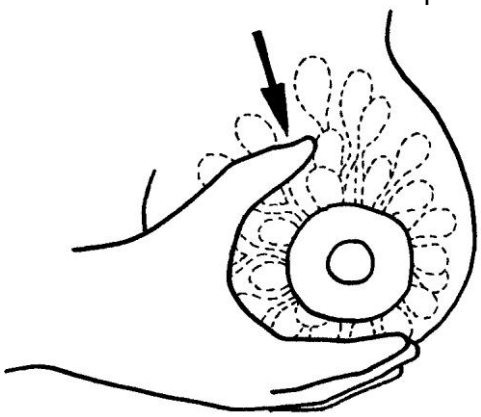
Establish the mother's knowledge base about hand expression technique.

With reference to the anatomy of the breast teach ways to stimulate the oxytocin reflex e.g.:

- Having baby close / skin contact
- Gentle breast massage
- Use of something to remind mother of baby e.g. Adapt knitted triangles

Wash hands prior to procedure

Using a demonstration breast:
Stimulate breast with massage and nipple rolling.
Place finger and thumb about 2.5 cm from the nipple in a C shape.
Using forefinger and thumb compress in a steady rhythm without sliding fingers along the skin, milk may take a few minutes to flow, if milk doesn't flow move fingers slightly up or down the breast and try again.
Rotate fingers around the breast if necessary.
When milk flow slows/ceases express the other breast.



Utilise leaflets such as NHS "Off to the Best Start" as accessed via www.leicestermaternity.nhs.uk or "Mother's Guide to Breastfeeding" to reinforce the information.

Check mother's understanding following the teaching.

Encourage expression a minimum of **8-10 sessions in 24 hours**, including once during the night, and additionally if the mother feels uncomfortable or prior to anticipated full breastfeeding.

Appendix 3: Safe Storage of Expressed Breast Milk (EBM) [56]

This is entirely dependent on the temperature at which it is kept and the gestational age of baby

Storage of expressed breastmilk

Method	Length of time
Room temperature: 19°-23° C	6 hours – covered Baby on NNU 4 hours
Refrigerator 2° - 4°	In hospital – 48hrs At home – 5 days
Freezer compartment in domestic fridge	2 weeks
Deep freeze	3 months if baby on NNU 6 months otherwise

Use of thawed breastmilk (EBM)
EBM can be thawed at room temperature and used within 12 hours or EBM can be thawed in the refrigerator and used with 24 hours
All milk should be labelled and dated before storing, and used in date order. Containers should have been washed in hot, soapy water, rinsed and disinfected

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Appendix 4: Cup feeding the term babies [46] (also suitable for preterm babies who are ready to breastfeed)

For babies who have not yet established effective breastfeeding, cup-feeding is an ideal temporary solution. Those babies who may particularly benefit are:

- Babies who are slow to feed
- Babies who are having difficulty attaching at the breast
- Babies whose suckling reflex has not fully matured

In these cases, babies will benefit greatly from hand expression and cup feeding.

There are specific stages in the maturation of the suckling baby in a baby of 37-39 weeks gestation (33):

1. Kisses the nipple
2. Licks the nipple
3. Opens mouth but not as far as gaping
4. Gapes and latches but does not maintain suction
5. Gapes, attaches and maintains suction

For a baby whose suckling reflex is not yet fully developed hand expressed colostrum directly into a cup avoids loss of the small amounts that may be obtained in the first days of breastfeeding. Samuels (1999) suggests that cup feeding speeds up the maturation process.

Cup feeding can also be used for formula milk when supplementation is necessary for clinical reasons.

How to cup feed the term baby (46)

Some staff are reluctant to cup feed, believing that it offers no advantages over bottle and that it is more time consuming. For some there may be concern about inhalation of milk. In practice inhalation is unlikely to occur, since the cup fed baby controls his/ her own intake, if the technique is done correctly. The following steps will help the practitioner or mother to develop competence and confidence in this practice.

- Hold the baby upright and swaddled. The aim is to keep the baby as still as possible to avoid losing any colostrum/EBM/Formula.
- Fill the cup with milk with the volume needed.
- Tip the cup, so that the level of milk is touching the baby's lips. The rim should be directed towards the baby's upper gum a rested gently on the baby's lower lip.
- Allow the baby time to take the milk. The way in which he/ she does this will vary between lapping and sucking
- Keep the cup in place between feeding bursts
- The baby will pace the feed and will not continue once he/she has had enough
- Involve the mother in cup feeding and encourage her to take over when practicable
- Once completed wash the cup and sterilise for future use
- Keep the cup by the cot side

Cup feeding should be used as a short-term solution. As always, the focus of care should be on supporting mother and baby to establish breastfeeding.

Going home cup feeding

In occasional situations babies do not establish direct breastfeeding for several days. This can be in situations where they are unable to latch at the breast, often due to mechanical issues such as tongue-tie.

In these situations, the mother should be supported to maintain her lactation through:

- Frequent regular expression at least 8 times in 24 hours
- Breast seeking behaviour should continue to be stimulated through frequent and extended skin contact between mother and baby and "laid back nursing" (54).
- Feeds of expressed milk should be given to the baby by cup to reduce the chance of nipple confusion developing and support attempts to establish direct breastfeeding
- If mother and baby are clinically ready for transfer home they may be supported with doing so using a cup for feeds, provided the mother is confident to do so and staff have assessed that she is competent to do so.
- Mothers will need an individual plan on how much to increase the volume of feed in each 24 hours.
- A plan should be discussed with the Infant Feeding Team and the Community Midwifery team involved in the care. This may involve referral to the Specialist Infant Feeding Clinic on Fridays at LGH. Tel: 0116 258 4830
- The cup is single patient use so can be taken home by the mother when discharged home

Appendix 5: Syringe Feeding the Term Baby

Under no circumstances should formula milk be administered to a baby via an oral syringe or colostrum collector

When initially teaching hand expression the volumes of colostrum obtained are frequently small.

Average feeds at the breast in the first 24 hrs are 5-10mls so hand expressed colostrum is likely to be anything from 0.2ml to 10-15ml. These smaller amounts have a tendency to become lost in a cup; hence, oral syringes/colostrum collector can be used to "catch" these tiny volumes to be given to the baby. This often leads to the baby showing interest in breastfeeding directly.

Caution needs to be used whenever administering colostrum via a syringe/colostrum collector as there is the possibility of aspiration taking place if done incorrectly. The syringe should be directed towards the corner of the baby's mouth and the colostrum dripped in drop by drop between the check and the gum, in tiny amounts, allowing the baby to taste it and to respond to it.

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This technique is only to be used while the volumes of colostrum or breastmilk being obtained and administered to the baby are 5mls or less.

Appendix 6: Local contacts for Leicestershire & Rutland and National Breastfeeding Support

National Breastfeeding Support

National Breast Feeding Helpline	0300 100 0212
Association of Breastfeeding Mothers	0300 330 5453
La Leche League	0845 120 2918
National Childbirth Trust (8am-Midnight)	0300 330 0700
Breastfeeding Network-Supporterline	0300 100 0210
BfN Supporterline in Bengali / Sylheti	0300 456 2421

Local Breastfeeding Support

Up-to-date details of support groups can be found on: www.healthforunder5s.co.uk

https://www.leicestermaternity.nhs.uk/

Information on postnatal support and groups –Tel: Text: WhatsApp: 07580159278 or 07402829698 for days/ times, or check website/ Facebook www.mammas.org.uk

Gujurati /Urdu Breastfeeding Helpline

07794667901 Both 9am to 9pm daily