Weighing of Well Term Babies

University Hospitals of Leicester NHS Trust

Trust ref: C21/2011

"Currently UHL utilises the terms 'woman' and 'women' within their obstetric and maternity guidelines but these recommendations will also apply to people who do not identify as women but are pregnant or have given birth."

1. Introduction and who the guideline applies to:

This guideline applies to all maternity staff in both hospital and community settings caring for well term babies. For pre-term babies please refer to the relevant neonatal guidance.

Contents

Related UHL documents:

- Breast Feeding Support UHL Obstetric Guideline
- Bottle Feeding UHL Obstetric Guideline
- Infant Feeding Policy UHL LLR and Childrens Centre Services
- Feeding Babies of Less than 30 Weeks Gestation UHL Neonatal Guideline
- Faltering Growth UHL Childrens Hospital Guideline
- Postnatal Ward Handbook UHL Neonatal Guideline

2. Weighing of well term infants

Weight should not be the only measure of health. It should be a part of the holistic assessment of the baby and of feeding. If a baby presents with significant weight loss, consider other causes (see table 1 in appendix).

Infant weight loss is a late indicator of poor breastfeeding

Table 1: Background and considerations

Research/Evidence	Conclusions/actions
Neonatal weight loss in the first few days of life is part of a normal physiological and usually stops after about 3 or 4 days of life	Normal loss of 3-5% formula fed baby, 5-7% breastfed babies (Macdonald et al 2003, NICE, 2017)
Recent evidence suggests that intrapartum fluid administration may result in greater fluid loss after birth and consequently a larger weight loss (Chantry et al 2011)	Take a comprehensive birth history
A small group of babies may be vulnerable to greater weight loss.	See risk factors below
The time taken to regain the birth weight and establish a pattern of positive weight gain is also important in the first weeks of life.	Weight loss greater than 8 % or which persists longer than 7 days is a reliable sign of insufficient milk transfer
Weight Loss is an early indicator for hypernatraemic dehydration which can cause significant morbidity	Seizures, acute renal injury, cerebral thrombosis, and haemorrhage (Bischoff et al 2017). Hypernatraemic dehydration (serum sodium ≥ 150 mmol/L) is associated with inadequate fluid intake in term infants.
The first response to the detection of a problem with weight (where there are no other indicators of illness) should be an evaluation of the feeding to ensure it is effective	Use the breastfeeding assessment tool and include the observation of a full feed.

Table 2: Prevention of excessive weight loss:

Action	Reasoning
Uninterrupted skin contact at birth or as soon as possible.	Supports the early initiation and establishment of breastfeeding. Maintains blood glucose levels. (Moore et al 2016; Ying L et al 2017)
Prior to discharge home (or as soon as possible after a home birth) please have a conversation about feeding and caring for a baby using: "Feeding and Caring for Your Breastfed Baby" and/or "Feeding and Caring for Your Bottle-fed Baby" laminated conversation sheets (see appendix 5). These laminated conversation sheets are available in maternity areas.	**This will ensure mothers have information about effective feeding, expected frequency of feeds, and know how to access help and support with any concerns once discharged from hospital.**
At the primary visit (or the next day following a home birth): All mothers need the above information reiterated to ensure they know how to feed effectively. **Community midwife** to use the "Feeding and Caring for your Breastfed Baby" and/or **"**Feeding and Caring for your Bottle Fed Baby" laminated conversation sheet (see appendix 5). Each Community Midwife should be supplied with both sheets.	To ensure mothers have another conversation about feeding and caring for their baby so that they have the information to enable them to feed their baby effectively.
The Breastfeeding Assessment tool to be completed where a baby is breastfeeding or the Bottle Feeding Check List if the baby is being bottle fed This tool should be used at *least twice* in the *first week* after birth to document assessment of breastfeeding or bottle feeding. One assessment should be carried out before leaving hospital, if admitted to the postnatal ward and another in the community and on discharge to the Public Health Nurse (Health Visitors) Service; the latter recorded in the Red Book. If the mother is breastfeeding and is discharged from hospital before 24 hours all 3 breastfeeding assessments may be carried out in the Community.	To identify concerns with feeding which may be due to issues for the mother, baby or both. To ensure mothers have the information they need to confidently manage feeding their baby and so reduce the risk of ineffective feeding. To hand over information about feeding to the Public Health Nurse(Health Visitor)

Action	Reasoning
All babies should be weighed on the 5th day following birth	Babies tend to lose most weight up to day 4 after which they tend to start gaining weight. (Macdonald et al 2003, NICE, 2017)
Babies are to be weighed at other times whenever: There are any deviations from normal noted during the baby examination which raises a clinical concern. The parent's voice concern with regards to poor infant feeding and midwife/health care professional assesses this to be an appropriate response to those concerns.	May help to prevent or reduce significant weight loss.
At every contact: Assess feeding and ensure mothers are responding appropriately to feeding cues. If there are on-going difficulties and/or weight loss is above 8% a feeding management plan should be commenced. The infant feeding team are available for support and should be contacted for all weight loss above 12% (see weight loss flowchart)	To monitor baby's feeding progress. To ensure babies are successfully feeding at the breast. Ineffective feeding or lethargy may be due to an underlying illness or medical condition.

Table 3: Step 1 - Risk Factors

Infant	Maternal: Medical	Maternal: Obstetric
Gestation / small for gestational age	Diabetes, thyroid disease, PCOS or Illness of any description	Consider maternal administration of IV fluids at less than 2 hours prior to delivery as a contributory factor
Circumstances of the delivery and condition at birth/birth injury	Breast surgery / conditions	Traumatic delivery/PPH
Supplementation, use of dummy or nipple shields	Mother's general health and lifestyle	Possible retained placenta
Breastfeeding Assessment tool highlights concern with effective feeding or out put	Smoking	Opiates in labour
Known medical/surgical condition	Medication Substance misuse	Use of artificial oxytocin in labour
Jaundice: Refer to UHL Guideline "Jaundice in Term Infants".		Caesarean Section

Difficult to rouse, sleepy or breast refusal		
Infection / sepsis in Congenital abnormality affecting feeding e.g. cleft palate Neurological abnormality affecting feeding e.g. hypotonic (floppy baby)		

Family and social situation

a. Any safeguarding concerns. Neglect (see below) Parenting - not understanding normal newborn behavior etc. Mental Health issues

b. Important Factors
It is important for midwives to consider if faltering growth, (formally known as failure to thrive) could be a symptom of neglect. Infants who are showing signs of faltering growth require an assessment which includes observing a full feed so as to assess the quality, quantity, and effectiveness of the feed (NICE, 2017). Any evidence of neglect a referral to the UHL Safe-guarding Team must be made in parallel to the referral for a clinical assessment by Children's A & E. A forms to be sent to maternity.safeguarding@uhl-tr.nhs.uk and calls for advice to 0116 258 6432

Step 2: Calculating Percentage Weight Loss for All Term Babies

When calculating weight loss as a percentage of the birth weight, always use a calculator and round to the first decimal place.

Standard formula for calculating weight loss:

$$\frac{\text{Weight Loss}}{\text{Birth Weight}} \times 100$$

Example 1

Birth weight: 3570g
Latest weight: 3385g

Weight loss: 185g

$$\frac{185 \times 100}{3570} = 5.2\%$$

Example 2

Birth weight: 2800g
Latest weight: 2505g

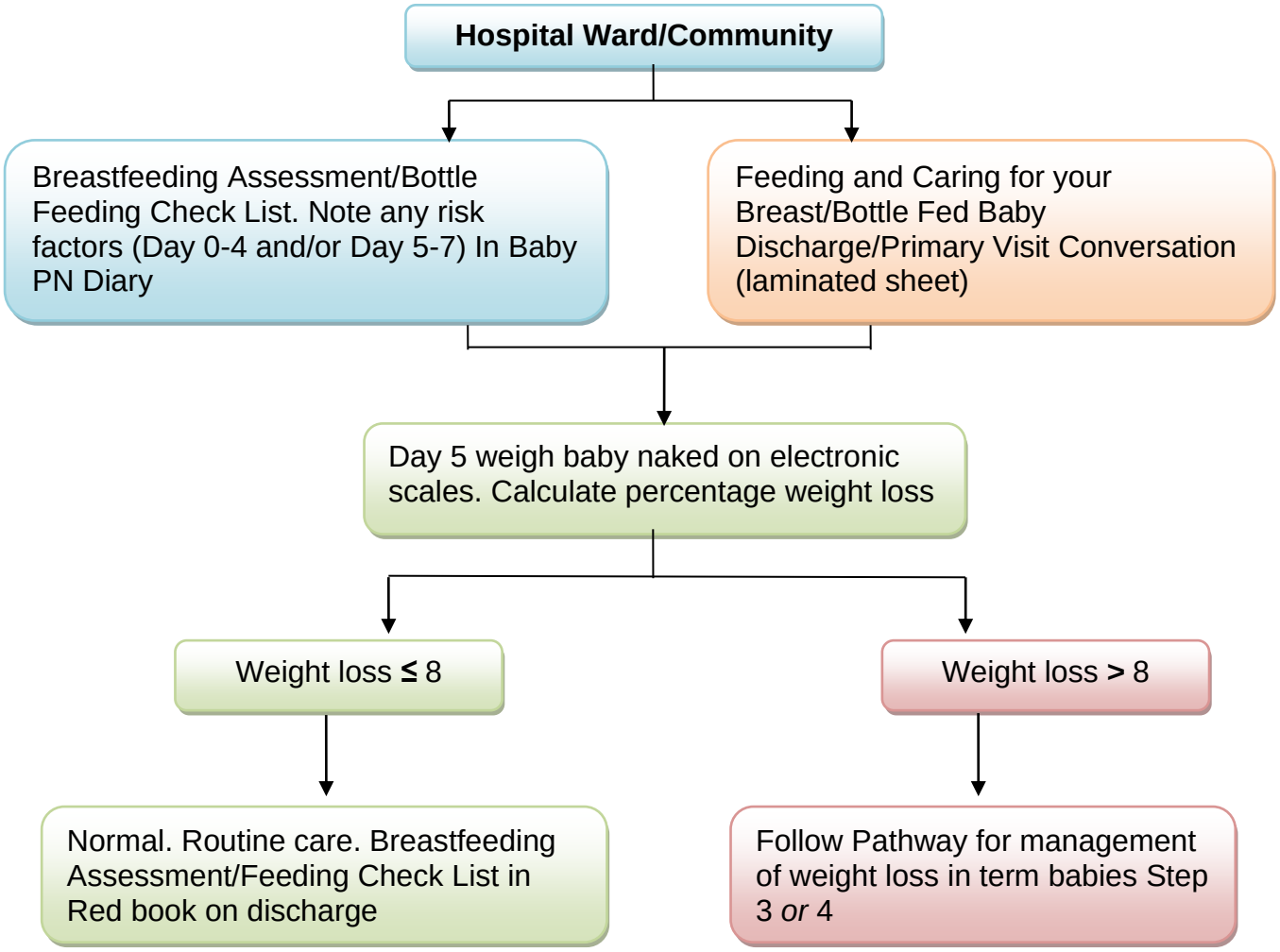
Weight loss: 295g

$$\frac{295 \times 100}{2800} = 10.5\%$$

Document the weight in both the baby postnatal record and in the child health record. (Red book) The weight calculation, any subsequent referral, advice and plan of care should be documented in the baby postnatal record.

The earliest and most reliable sign that a baby is not receiving enough milk or gaining weight is lack of stooling. Relying on urine output alone can give false reassurance. Babies should be back to their birth weight by two weeks of age. Babies should be weighed as a minimum at birth, at five days and at around two weeks to monitor growth and wellbeing. The 2 week weight may be carried out by the Public Health Nurse (Health Visitor).

Actions to Reduce Risk of Excessive Weight Loss for All Term Babies



Step 3: Pathway for Managing Weight Loss in Term Breastfed Babies.
Assess in conjunction with Breastfeeding assessment tool. Re-check calculations of weight loss and percentage as it is easy to make mistakes.

Plans for weight loss in <u>breastfeeding</u> babies

Amount of weight loss	**Follow appropriate management plan**
Weight loss 8.1% to 10%	**Plan 1**
Weight loss 10.1% to 12.4%	**Plan 1 & Plan 2**
Weight loss 12.5% to 14.9%	**Plan 1, Plan 2 & Plan 3**
Weight loss 15% or above	**Plan 1, Plan 2, Plan 3, Plan 4**

If baby appears unwell do a full set of observations and refer to Paediatrician as appropriate.

<u>Plan 1</u> Weight loss 8.1% to 10%

Normal range: Temp 36.5c - 37.5c. Resp 40-60/min Pulse 90-150/b/min. Good tone colour normal for that baby	Carry out a **Breastfeeding Assessment** and **observe full feed**. Assess baby's colour, tone, alertness, heart rate, respiration rate, temperature, urine and stool output. **1.** Act on any issues that arise from this. **2.** Encourage skin contact and frequent access by the baby to the breast. **3.** Encourage use of semi recumbent position of the mother to elicit natural feeding reflexes and breast seeking behavior. This can improve attachment. **4.** Ensure the mother has been taught hand expression. **5.** Feed at least 8 times in 24 hours from both breasts including night feeds. **Always *offer* second breast at every feed**. If breast remains full after a feed or baby does not feed from second breast, express until comfortable. **6.** Encourage a breastfeed to continue until there is a period of slow shallow/flutter sucking at the end of the feed. Cluster feeding will help the baby to receive the higher calorie milk. **7.** Consider teaching how to do 'Breast Compressions'* or 'Switch Feeding'* If feeding effectively continue responsive feeding. If any concerns with breastfeeding effectiveness consider cup-feeding EBM **8.** Avoid the use of dummies, teats or nipple shields as these will affect milk production due to reduced stimulation. If nipple shields are being used ensure correct placement and advise to hand express following feeds to maintain milk supply. **9.** Encourage the mother to keep a feeding diary / log. **10.** Consider the use of peer support and other breastfeeding support groups. **11.** Reassess via phone or visit in 24 hours. Re-weigh in 48 hours If weight gain is more than 20g a day and no further concerns return to routine care. If weight gain less than 20g per day, baby continuing to lose weight or static weight - move to **Plan 2**
Document advice and care given	

<u>Plan 2</u> Weight loss 10.1% to 12.4%

Document advice and care given	**Manage as Plan 1 plus:** **1.** Review, reassess and discuss any previous advice with parents. **2.** Implement a feeding plan: If not doing so already encourage at least 8 feeds in 24 hours. If baby **is** feeding **effectively** encourage hand expressing and/or using a breast pump to express and supplement with EBM or formula at half 24 hour volume (half of 150ml/kg/day) **3.** If the baby is ***not*** feeding effectively first breastfeed and then ideally within 30mins of breastfeed encourage expressing and if possible double pumping (i.e. pumping from both breasts simultaneously as this increases prolactin levels) at least 8 times in 24 hours to stimulate more breastmilk production. **If little EBM** is obtained it may be necessary to offer supplementary feeds of formula milk via a sterile cup or bottle until breastmilk production increases. *Consider* supplementing with full 24 hour volume (150mls/kg/day) **4.** Re-assess in 24 hours and re-weigh in 24-48 hours **Recognising improved milk intake:** • Increased urinary output. Changes in stools: amount, frequency, colour and consistency • Feeding pattern and baby's behavior indicates improved milk transfer • Mother experiencing a greater feeling of fullness before a feed with more effective drainage of the breast evident afterwards **5.** If the baby is gaining weight, (20-30g per day) reassure parents and continue to monitor until clear trend towards birth weight. If giving large amounts of supplement parents will need support to return to full breastfeeding. Consider referral to the Specialist Feeding Clinic on Friday mornings at the LGH. Mothers should be referred to this clinic by contacting Maternity Reception at the LGH on ext 14830. **6.** If baby's weight is static and otherwise well or there still issues with feeding, review feeding plan and re-assess again in 48 hours. **7.** Re-weigh baby by day 9-10. If baby is gaining weight, reassure parents and no further action required and can referred to the Health Visitor. If the baby's weight static or the baby has lost weight go to **Plan 3**

Plan 3 weight loss 12.5% - 14.9%

Document advice and care given	**Manage as Plan 1 & 2 plus** **1.**Contact on call paediatric registrar via switchboard 0300 303 1573 **2.**Parents need to take the baby to children's ED at LRI for review by a Paediatrician: U&Es may be required if the baby is unwell **3.**Inform Infant Feeding Team 07765 787279 (leave message out of hours) **4.**Consider referral to the Specialist Feeding Clinic on Friday mornings at the LGH, Mothers should be referred to this clinic by contacting Maternity Reception at the LGH on ext. 14830

Plan 4 Weight loss 15% of above

Document advice and care given	***Note any weight loss over 14.9% is significant and needs re-admission, fluid replacement and breast feeding support.** **Manage as plan 3 plus:** 1. Re-check weight and calculations 2. U&E's may be needed 3. IV fluids if the baby is unwell 4. Most of these babies are hungry and will re-hydrate safely on milk **Complete an incident form (Datix) for all babies who are referred to Children's A&E with a weight loss of 15% or more.**

Step 4: Management Plan for Exclusively Bottle/Formula Fed Babies from Birth:

A weight loss of 8% to10% in bottle fed babies needs a full assessment and a documented feeding plan put in place. Go through the Bottle Feeding check list.
Refer to: Bottle Feeding: Guideline to Support Successful Feeding of Health Term Babies to ensure correct information on the sterilisation of the equipment and preparation of infant formula has been given and followed and also that appropriate volumes of formula have been offered. If mother using a 'Preparation Machine' check correct use.
Day 5 feeding requirements for a bottle feeding baby = 150ml/kg/day of **BIRTH WEIGHT.**

Example 1 : Birth weight: 3.60 kg x150 = 540 ml in 24 hrs. ÷ number of feeds
(540 ÷ 8 = 67.5 mls)

Example 2 : Birth weight: 2.80 kg x 150 = 420 ml in 24 hrs. ÷ number of feeds
(420 ÷ 8 = 52.5 mls)

Management plan bottle/formula feeding baby

Management Plan A	**Management Plan A & B**
8% to 10% weight loss and baby well	**Over 10% weight loss**
1. Feeding Responsively? Assess number of feeds and suggest at least 8 times in 24 hours of the appropriate volume for that baby **2.** Complete Bottle Feeding Check list **3.** Observe output, urine and stool **4.** Observe baby's condition, colour, tone, alertness, HR, RR and temperature **5.** Avoid dummy use (expect to put down to sleep if already using) **6.** Re-assess in 24 hours **7.** Re-weigh in 48 hours	1. Contact on call Paediatric Registrar via switch board 0300 303 1573 2. Parents should take baby to Childrens A&E at LRI for review by a paediatrician **3. Inform Infant Feeding Team** 07765 787279 **(leave message out of hours)** **4. Complete an Incident Form (Datix) for all babies who are referred to Children's A&E.**

3. Education and Training:

One or more of the following:

Newsletter, team meetings, unit meetings, band 7 meetings, teaching sessions on mandatory training days, face to face as appropriate, communication boards and Emails

4. Monitoring

This will be monitored by prospective review of health records of babies re-admitted before 28 days of age. The admissions will be identified from the re-admission list sent to the infant feeding co-coordinators by the Clinical Team Lead in the Children's Admissions Unit. The findings will be reported the Maternity Service Governance Group

5. Supporting References:

1. National Institute for Health and Clinical Excellence (2017) Faltering Growth: recognition and management of faltering growth in children London: NG75
2. Macdonald PD, Ross SR, Grant L et al. (2003) Neonatal weight loss in breast and formula fed babies. Arch Dis Child Fetal Neonatal Ed: 88; F472-F476
3. Paul IM, Schaefer EW, Miller JR et al Weight Change (2016) Nomograms for the First Month After Birth. *Pediatrics. 2016;138(6):e20162625*
4. C M Wright, K N Parkinson (2003) Postnatal weight loss in term infants: what is ‘‘normal’’ and do growth charts allow for it? Arch Dis Child Fetal Neonatal Ed 2004;89:F254–F257. doi: 10.1136/adc.2003.026906
5. United Lincolnshire Hospitals NHS Trust (92018) Weighing and Weight Loss in Babies Guideline ULHT/G/2018/074 (V8)
6. Northampton General Hospital NHS Trust (2017) Effective Feeding Guideline NGH-GU PN13

6. Keywords:

BFI ; Responsive feeding ; Hand expression ; Double pumping ; EBM; UNICEF; Cluster feeding; Baby weight ; Bottle feeding; Breast feeding;

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) A Raja – Infant feeding specialist Midwife			**Executive Lead** Chief Nurse
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
June 2022	**4**	**A Raja**	**Specified parameters for plan 3 - Plan 3 Weight Loss 12.5% -14.9%** **Added plan 4 for weight loss >15%**

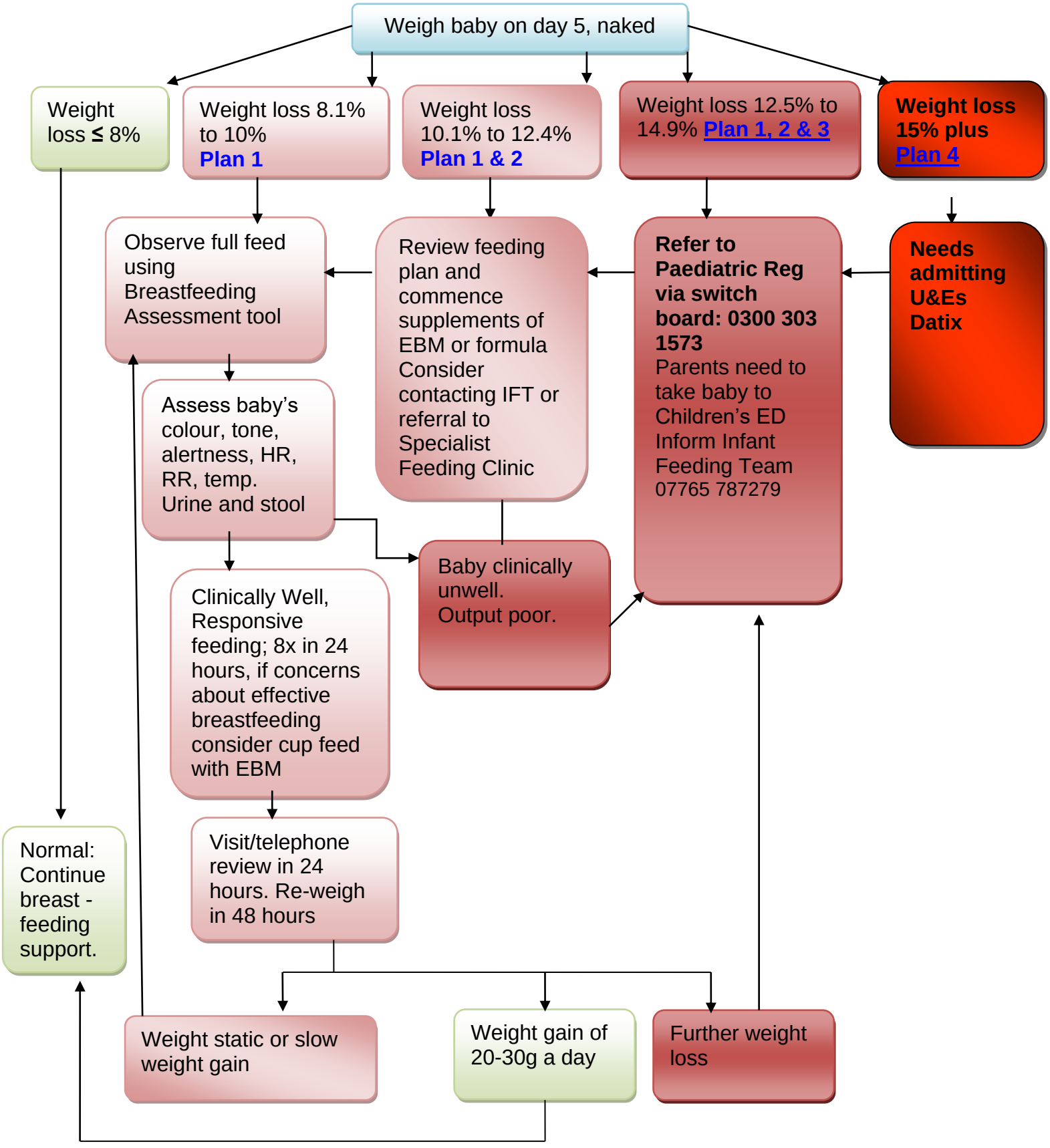
Appendix 1: Glossary

BFI	Baby Friendly Initiative
Responsive Feeding	A relationship between baby and care giver which is reciprocal, sensitive and acknowledges that feeding is about more than nutrition. It is responding to a child's need for love, reassurance and care
Hand expression	Removal of breastmilk from the breast by hand
Double pumping	Using an electric breast pump to remove milk from both breast at the same time to increase milk supply
Output	The amount and type of urine and stools passed
P & A	Positioning and attachment (at the breast)
EBM	Expressed Breast Milk
WHO	World Health Organisation
UNICEF	United Nations International Children's Emergency Fund
Semi recumbent position	A laid back feeding position that helps mothers and babies improve attachment at the breast
Cluster feeding	Normal behaviour when babies space feeding closer together at certain times of the day and go longer between feedings at other times

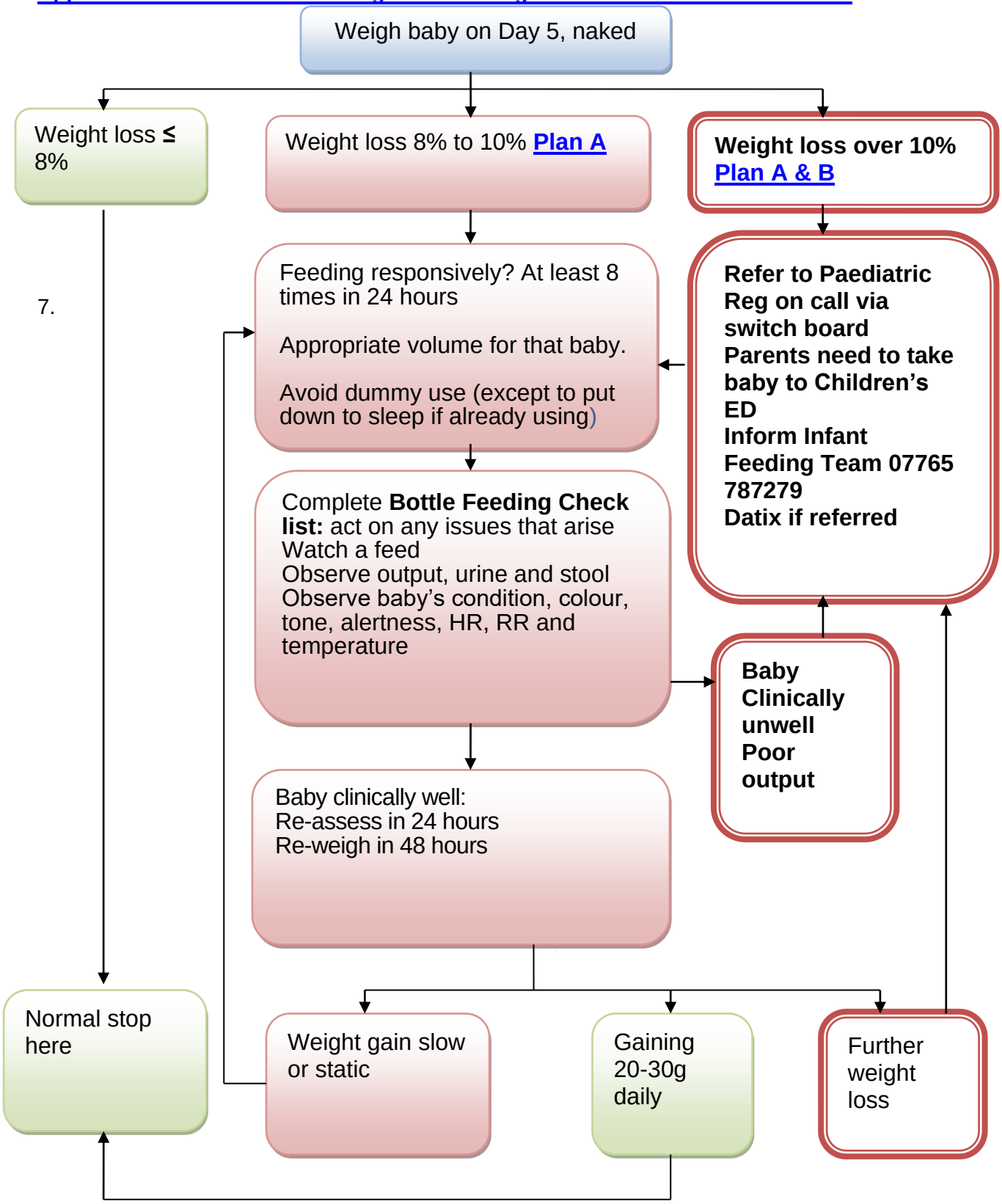
Appendix 2: Medical conditions (and investigations) that may present with faltering growth

Investigation	Indication	Condition being sought
Full blood count	Persistent weight faltering	Anaemia, Leukaemia
Ferritin	Persistent weight faltering	Iron deficiency
Urea & electrolytes	Persistent weight faltering	Renal failure, electrolyte abnormalities
Thyroid function tests	Persistent weight faltering	Thyroid disorders
Coeliac blood tests	Persistent weight faltering	Coeliac disease
Midstream urine	Persistent weight faltering	Urinary tract infection
Chromosome analysis	Girls	Turner's syndrome
Chest radiograph	<3 months; history of respiratory infection	Cardiac anomalies, cystic fibrosis
Sweat test	History of respiratory infection	Cystic fibrosis
Vitamin D levels	Solid diet is limited, dark skin colour	Rickets

Appendix 3: Flow chart for management of weight loss in term breastfed babies



Appendix 4: Flow chart for management of weight loss in term bottle fed babies



7.

Feeding and Caring for Your Breastfed Baby

Information to give to ALL breastfeeding mothers before they go home.

(ONLY mothers who *intend* to 'mix feed' also need the bottle-feeding talk)

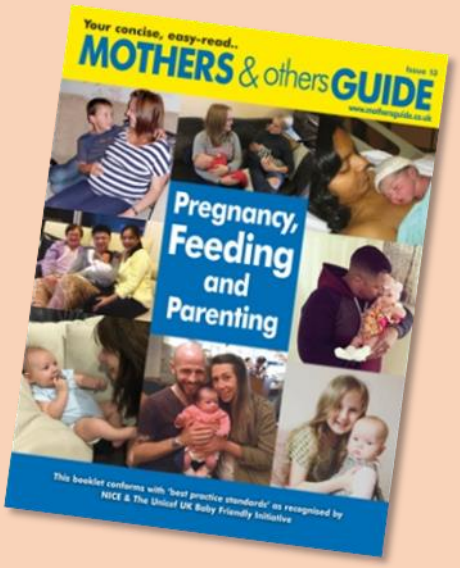
Before you start make sure she has a breastfeeding log and Mothers & Others Guide.
You may find a knitted breast useful.

Say:

"Before you go home today may I give you some information on feeding and caring for your baby?"

"When you cuddle, comfort and pick up your baby when they cry, they feel more secure and happy. It even helps their brains to fully develop. You can never spoil a baby with cuddles, skin contact, singing, or offering them your breast when they want it.

"So long as you feed your baby whenever they ask for it and they are well attached, you can be confident you will make plenty of milk for your baby."



Describe Position and Attachment (pages 8-11)

- You can use **C.H.I.N** to describe position (Close, Head free, In line, Nose to Nipple)
- Use the Mothers & Others Guide phrases

Discuss signs that the baby is feeding well (pages 10 & 15)

Say: "You'll know your baby is feeding well when

- Baby has a large mouthful of breast
- Chin is firmly touching the breast
- It doesn't hurt (first few sucks may feel strong)
- If visible, more of the areola above the top lip than the bottom lip
- Cheeks stay rounded when sucking

Appendix 5: Key conversation sheet

(Adapted with kind permission of Northampton General Hospital)

Continued overleaf

Title: Weighing of well term babies
V: 4 Approved by: Maternity Governance Group: August 2022 Next Review: August 2025
Trust Ref No: C21/2011
NB: Paper copies of this document may not be most recent version. The definitive version is held on InSite in the Policies and Guidelines Library

Continued

- Rhythmic sucking
- Baby finishes feed and comes off on their own
- Once the mature breastmilk has "come in" around Day 3 you may notice your breast feel softer after a feed"

Talk about how to know your baby is getting enough milk (page 16)

Say: "after the first day baby should feed at least 8 times in 24 hours"

- Talk about normal wees and poos (colours and amounts)
- Show parents the breastfeeding assessment sheets and explain that this shows that feeding is going well

Also Important

Say: "Feed when baby seems hungry **(explain feeding cues page 15)**

or when baby needs comforting or breasts feel full

- **Breastfed babies cannot be over fed**
- Avoid dummies and giving formula milk at least until breastfeeding is really well established (about 4-6 weeks)"

Hand Expressing (page 19 + knitted breast)

Go over reasons why hand expression can be useful:

- To encourage baby to breastfeed
- To remove some milk if breast feels too full

Demonstrate Technique

- Massage
- 2-3cm back from nipple
- Fingers in a C shape
- Compress and release
- Rotate fingers

(Adapted with kind permission of Northampton General Hospital)

Breastfeeding Support

- Useful numbers and websites on the back of the Mothers and & Others magazine
- Specialist Feeding Clinic that Community Midwife can refer to if needed
- Local support groups in Children's Centres (Health Visitor will have information about these)

University Hospitals of Leicester NHS Trust

Feeding and Caring for Your Bottle-fed Baby

Information to give to ALL bottle-feeding mothers before going home.

(Mothers who have chosen to 'mix feed' will need this talk PLUS the breastfeeding talk)

Before you start, make sure she has a bottle-feeding log which contains information about sterilising, making up a formula feed and responsive feeding, as you will be referring to these. There are leaflets in other languages if needed.

Say: "Before you go home today can I give you some information on feeding and caring for your baby?"

What you'll need to bottle feed (refer to the WHAT INFANT FORMULA TO USE and making up a feed leaflet in the bottle-feeding log)

- Any first infant formula is advised for the first year then cow's milk (unless told otherwise by Health Visitor or doctor)

(DON'T recommend a particular brand or imply that any brand is better than another – because it's not!)

- Bottles (with teats & lids)
- A bottle brush
- Sterilising equipment – There are several ways to sterilise but you must ALWAYS clean and rinse everything thoroughly FIRST

How to make up a powdered feed (Sterilising leaflet)

- Empty the kettle then refill with at least one litre of cold water
- Boil the kettle
- WASH YOUR HANDS then put sterilised bottle on a clean surface
- Within 30 min. of kettle boiling follow the instructions on the tin and add the suggested amount of hot water to bottle.

Continued overleaf

(Adapted with kind permission of Northampton General Hospital)

Continued

- It's important that the water is still hot enough to kill any bacteria that might be in the powdered milk
- Use scoop that came with the powdered milk to add the correct amount for the amount of hot water you used
- Screw on the teat and lid and shake the bottle to mix
- Cool by putting in cold water /running under cold tap till the milk feels warm or cool (but never hot) on your wrist
- Throw away any milk you don't use or that baby doesn't finish in one hour

How to hold a baby to bottle feed

Say:

- "Hold baby close with lots of eye contact so he feels safe and loved
- Hold baby fairly upright for feeds
- Offer teat to baby but avoid forcing into his mouth
- Allow baby to pause when he's feeding
- Stop when he shows signs that he's had enough (pushing the teat out with his tongue or turning his head away)
- Never try to make your baby to take more than he wants"

When to feed baby

Say:

- "Keep baby in the same room as you day and night. This helps you to know when to feed him
- Offer a feed when baby looks hungry but don't wait till he's crying it's less stressful for both of you
- Baby will feed 'little & often' and amounts will increase over time
- After the first day, baby should feed at least 8 times in 24 hours including overnight – this is normal"
- Talk about normal wee & poo (colours and amounts)

Say:

"Your baby will really enjoy being fed by just you and your partner rather than by lots of different people."

"When you cuddle and comfort your baby and don't leave them to cry, they feel more secure and happy, which helps their brains to develop. You can never spoil your baby with cuddles, skin contact, talking/singing and responding to what they want."

(Adapted with kind permission of Northampton General Hospital)

Appendix 6: Breastfeeding assessment form

How you and your midwife can recognise that your baby is feeding well			This assessment tool was developed for use in babies 0-3 days old
What to look for and discuss	Yes	No	**Information to give:**
Hold/position: CHIN **□ Close – The baby's body close against mother so the baby feels secure** **□ Head free – to tilt back so the baby can take a big mouthful of breast** **□ In line – ear, shoulder and hip in line so the baby is not twisted** **□ Nose to nipple –the baby approaches nose to nipple**			**Wet and dirty nappies: Infrequent stooling or no change in colour is an early sign of ineffective feeding** **□ First 24 hour 1 wet and 1 meconium poo/stool** **□ 1-2 days old – 2 or more wet per day and 1 or more per day black/green meconium** **□ 3 days old – 3 or more wet per day (nappies feel heavier) and 2 or more per day green/brown changing stool**
How the baby Attaches to the breast **□ The baby approaches nose to nipple with chin leading, wide open mouth, chin makes contact with breast first** **□ Nipple then slips under top lip** **□ Bottom lip comes to rest deep under areola** **□ Attachment is comfortable**			**Point out to mother:** **□ Feeding is pain-free** **□ Chin indenting breast** **□ Mouth wide open** **□ Cheeks full and rounded** **□ More areola may be visible above top lip** **□ Rhythmic suck/swallow**
Your baby: **□ Has at least 4 feeds in first 24 hours** **□ Has at least 8 feeds in 24 hours after this, often with more frequent feeds on day 2-3** **□ Is generally calm and relaxed whilst feeding** **□ Will take deep rhythmic sucks and you will see/hear swallowing. (Swallows may be less audible until milk comes in day 3-4)** **□ 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** **□ Is offered both breasts** **Your breasts:** **□Breasts and nipples are comfortable** **□Nipples are the same shape at the end of a feed as at the start**			**Feed Frequency:** **□ Skin to skin and responding to your baby encourages high levels of oxytocin and low levels of stress hormones which encourages optimal brain development.** **□ 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.** **□ Keep your baby close and feed your baby as soon as they signal they are ready to feed. These may include signs such as becoming restless, rooting/sucking fingers ,licking lips and eyes flickering** **□ You can offer a feed when your breasts feel full – remember you cannot overfeed a breastfed baby.** **□ Night feeds are important to ensure a good milk production- discuss 'safer sleeping' with your midwife, health visitor or breastfeeding support worker**
Dummies:			**Staff: if any responses not ticked: watch a full breastfeed, develop a**

May miss feeding cues and the baby will learn to suck in a different way to breastfeeding. Wait until breastfeeding is established before using a dummy. **Nipple shields: May not help before milk has 'come in'.**			**care plan including revisiting positioning and attachment and/or refer for additional support. Consider specialist support if needed.** **Care plan commenced: yes/no**
Nappies **□ 1-2 days 1-2 wet (may have urates) at least 1** **□ 3 days >3 wet, >2 changing stool** **Please see Mothers and Others Guide for further information**			**Date:** **:A signature:**

Appendix 7: Bottle Feeding Checklist

How you and your midwife can ensure that bottle feeding is done as safely as possible and help you have a close and loving feeding experience			**This checklist was developed for use in bottle feeding babies from Day 0-4**
what to look for and discuss	Yes	No	**Important Information**
Safe Preparation □ Parents shown or discussed how to make up feeds safely and how to sterilise equipment □ Parents confident with making up feeds and sterilising equipment			**Key points:** □ Infant formula powder is **NOT STERILE**. Powered infant formula can contain some dangerous bacteria that need to be killed with hot water at a temperature of at least 70°C □ You should follow carefully the instructions to make up bottles safely. Formula milk can also become contaminated from equipment or because it is not used or stored safely
Type of formula □ Discussion about which type of formula to use □ Discussion about how long parents need to use formula			**Key points:** □ It is advisable to use a **First Infant Formula (whey based)** as this is easier for the baby to digest □ It does not matter which brand you use, they are all very similar □ There is no need to move on to follow-on formula at 6 months □ At one year most babies can move onto full fat cow's milk as their main milk

			drink
Responsive Bottle feeding □ Feeding cues discussed □ A full feed observed □ Responsive feeding explained □ The value of skin to skin explained □ The importance of the baby being fed by the main carers explained □ The risk of bed sharing and managing night feeds discussed □ Keeping baby close day and night explained □ Finishing the feed: Parents recognise signs when baby has had enough milk (turning away, splaying hands, spitting out milk) □ The dangers of bottle propping, or prop feeding discussed			**Key points:** □ Feed your baby when they show signs of being hungry: look out for cues(moving head and mouth around, sucking on fingers) □ Hold baby close to you in a slightly upright position so they can see your face and reassure them by looking into their eyes and talking to them during a feed □ Begin by inviting baby to open their mouth: gently rub the teat against their top lip □ Gently insert the teat into the baby's mouth keeping the bottle just slightly tipped to prevent milk flowing too fast □ Follow baby's cues for when they need a break and gently remove the teat or bring the bottle downwards to cut off the flow of milk □ Never force baby to take a whole feed if they don't want it □ Discard any leftover milk □ Chocking during prop feeding can be silent, and your baby can choke without you noticing. Never prop feed and never leave your baby unsupervised when feeding.

General health and wellbeing of the baby □ Around six heavy, wet nappies a day by day five □ At least one soft stool a day □ Has lost no more than 8% of birth weight □ Is generally calm and relaxed when feeding and is content after most feeds □ Has a normal skin colour and is alert and waking for feeds **If any concerns make a feeding plan** □ **Feeding plan started: Date**_____			**More information** □ a simple up to date guide on infant milks can be downloaded at **www.firststepsnutrition.org** □ Unicef UK provides a guide on different milks, available to down load at **www.babyfriendly.org.uk** □Start4life Guide to bottle feeding: https://www.nhs.uk/start4life/baby/feeding-your-baby/bottle-feeding/ **Date:** _____ **Staff Signature:**_____ **Role:**_____

Appendix 8: Useful contact numbers

National Breastfeeding Support Contacts

National Breast Feeding Helpline	0300 100 0212
Association of Breastfeeding Mothers	0300 330 5443
La Leche League	0345 120 2918
National Childbirth Trust	0300 330 0700
Breastfeeding Network-Supporter line	0300 100 0210
BfN Supporter line in Bengali / Sylheti	0300 456 2421

Infant Feeding Co-ordinator – UHL

Ann Raja	07765 787279
Donna Brownless	07717 694387

Infant Feeding Co-ordinators – LPT

Team Lead	07717 803188
Team member	07500952363
Angie Bell	07500952403

email lpt.fypcinfantfeedingteam@nhs.net and our cloud number **0116 2153277**

International Board Certified Lactation Consultants:

Sally – 07580159278

Isobel - 07906040476

Breastpump hire:

Sally	07850159278
Ardo Medical	01823 336362
Medela	01617760400
Express Yourself Mums	08703895576

Or Children's Centers may have free or subsidised rental schemes

Appendix 9: Safe Storage of Expressed Breast Milk

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

In hospital:

This information applies to mothers of babies in hospital and all babies who have been born prematurely or compromised in any other way.

Freezer	3 months
Refrigerator at 2-4°C	48 hours

Thawed milk can be refrigerated for up to 24 hours.

At home:

This information applies only to mothers who:

- Have healthy full term babies;
- Are storing their milk for home use (as opposed to hospital use);
- Wash their hands before expressing and
- Use containers that have been washed in hot, soapy water and rinsed.

All milk should be dated and time expressed stated before storing.

Storage guidelines (37)

Freezer	6 months
Ice compartment	1 week
Refrigerator at 2-4°C	5 days

Thawed milk can be refrigerated and kept for up to 24 hours