Northern Devon Healthcare NHS Trust

Document Control

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Author Infant Feeding Lead			**Author's job title** Midwife
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Main Contact Infant Feeding Coordinator Midwife Ladywell Unit North Devon District Hospital Raleigh Park Barnstaple, EX31 4JB			**Tel: Direct Dial** **Tel: Internal** **Email:**
Lead Director Lead Midwife, Public health, Community and Antenatal Services			
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1. Purpose

The purpose of this policy is to ensure that all staff at North Devon District Hospital (NDHT) understand their role and responsibilities in supporting expectant and new mothers and their partners to feed and care for their babies in ways which support optimum health and wellbeing.

All staff are expected to comply with this policy.

Outcomes

Implementation of this policy will ensure that the care provided improves outcomes for children and their families, specifically to deliver:

- an increase in breastfeeding initiation rates
- an increase in breastfeeding rates at transfer to care to health visitor
- amongst mothers who choose to formula feed, an increase in those doing so as safely as possible, in line with nationally agreed guidance
- improvements in parents' experiences of care
- a reduction in the number of readmissions for feeding problems

2. Definitions

BFI Baby Friendly Initiative (UNICEF, UK)

EBM Expressed Breast Milk

SOP Standard Operating Procedure

Reluctant feeder showing no feeding cues

3. The Trusts' Commitment

NDHT is committed to:

- Providing the highest standard of care to support expectant and new mothers and their partners to feed their baby and build strong and loving parent-infant relationships. This is in recognition of the profound importance of early relationships to future health and wellbeing, and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for children and mothers.

- Ensuring that all care is mother and family centred, non-judgemental and that all mothers' decisions are supported and respected.

- Working together across all disciplines and organisations to improve mothers' and parents' experiences of care.

As part of this commitment the service will ensure that:

- All new staff are familiarised with this policy on commencement of employment
- All staff will receive training to enable them to implement the policy as appropriate to their role. New staff receive this training within 6 months of commencement of employment
- The International Code of Marketing of Breast-Milk Substitutes is implemented throughout the service
- All documentation fully supports the implementation of these standards
- Parents' experiences of care will be listened to through: regular audit and parents' experience surveys (e.g. Friends and Family Test and the Infant Feeding Clinic Survey)

4. Care standards

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

Pregnancy

All pregnant women will be given the 'Off to the Best Start' information leaflet at the booking appointment and have the opportunity to discuss feeding and caring for their baby with a health professional (or other suitable trained designated person). This discussion will include the following topics:

- The value of connecting with their baby in utero
- The value of skin contact for all mothers and babies
- The importance of responding to their baby's needs for comfort, closeness and feeding after birth, and the role in keeping their baby close has in supporting this
- Feeding, which will include:
  - 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

Birth

- All mothers will be offered the opportunity to have uninterrupted skin contact with their baby at least until after the first feed and for as long as they want, so that the instinctive behaviour of breast seeking (baby) and nurturing (mother) is given opportunity to emerge.

- Those mothers who are unable (or do not wish) to have skin contact immediately after birth, will be encouraged to commence skin contact as soon as they are able, or so wish

- All mothers will be encouraged to offer the first breastfeed in skin contact when the baby shows signs of readiness to feed. The aim is not to rush the baby but to be sensitive to the baby's instinctive process towards self-attachment.

- When mothers choose to formula feed, they will be encouraged to offer the first feed in skin contact. This is important for the baby's transition to life outside the womb as well as the developing microbiome.

- Mothers with a baby on special care/ neonatal unit are:
  - Enabled to start expressing milk as soon as possible after birth (within six hours)
  - Supported to express effectively
  - Mothers who have decided not to breast feed are encouraged to express whilst their baby is so vulnerable. Midwives will discuss the benefits of giving EBM to their babies for the short term.

It is the joint responsibility of maternity and special care/ neonatal staff to ensure that mothers who are separated from their baby receive this information and support.

Safety considerations (Skin to Skin)

Vigilance of the baby's well-being is a fundamental part of postnatal care immediately following and 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 in the same way as would occur if the baby were in a cot (this includes calculation of the Apgar score at 1, 5 and 10 minutes following birth). Care should always be taken to ensure that the baby is kept warm. Observations should also be made of the mother, with prompt removal of the baby if the health of either gives rise to concern.

Staff should have a conversation with the mother and her companion about the importance of recognising changes in the baby's colour or tone and the need to alert staff immediately if they are concerned.

It is important to ensure that the baby cannot fall on to the floor or become trapped in bedding or by the mother's body. Mothers should be encouraged to be in a semi-recumbent position to hold and feed their baby. 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.

Notes – Mothers

- Observations of the mother's vital signs and level of consciousness should be continued throughout the period of skin to skin contact. Mothers may be very tired following birth and so may need constant support and supervision to observe changes in their baby's condition or to reposition their baby when needed

- Many mothers can continue to hold their baby in skin to skin contact during perineal suturing, providing they have adequate pain relief. However, a mother who is in pain may not be able to hold her baby safely. Babies should not be in skin to skin contact with their mothers when they are receiving Entonox or other analgesics that impact consciousness.

Notes – Babies

All babies should be routinely monitored whilst in skin to skin contact with mother or father. Observation to include:

- Checking that the baby's position is such that a clear airway is maintained– observe respiratory rate and chest movement. Listen for unusual breathing sounds or absence of noise from the baby
- Colour - the baby should be assessed by looking at the whole of the baby's body as the limbs can often be discoloured first. Subtle changes to colour indicate changes in the baby's condition
- Tone – the baby should have a good tone and not be limp or unresponsive
- Temperature – ensure the baby is kept warm during skin contact.

Always listen to parents and respond immediately to any concerns raised

5. Support for breastfeeding

- Mothers will be enabled to achieve effective breastfeeding according to their needs (including appropriate support with positioning and attachment, hand expression, understanding signs of effective feeding). This will continue until the mother and baby are feeding confidently.

- 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 will include information on responsive feeding and recognising feeding cues. Where appropriate, discuss the role of the partner in supporting breastfeeding once home.

- A formal feeding assessment will be carried out using the UNICEF UK breastfeeding assessment tool (page 14 of baby's' postnatal notes) as often as required in the first week with a minimum of two assessments to ensure effective feeding and the wellbeing of mother and baby. This assessment will include a discussion with the mother to reinforce what is going well and where necessary develop an appropriate action plan of care to address any issues that have been identified.

- Mothers with a baby on special care/ neonatal unit will be supported to express as effectively as possible and encouraged to express at least 8 times in 24 hours including once during the night. They will be shown how to express by both hand and pump.

- Before discharge home, breastfeeding mothers will be given information both verbally and in writing about recognising effective feeding and where to call for additional help if they have any concerns.

- All breastfeeding mothers will be informed about the local and national support services (see appendix one and two for further information)

- For those mothers who require additional support for more complex breastfeeding challenges, a referral to the Infant Feeding Clinic should be made: https://ndht.ndevon.swest.nhs.uk/midwifery/infant-feeding/infant-feeding-special-interest-clinic-referral-form/ (see appendix one for further information)

- For mothers with ongoing breastfeeding challenges at the time of or after discharge from midwifery care, a referral to the Specialist Health Visitor Infant Feeding Clinic should be made: https://ndht.ndevon.swest.nhs.uk/midwifery/infant-feeding/specialist-hv-infant-feeding-clinic-referral-form/ (see appendix one for further information)

Responsive Feeding

The term responsive feeding is used to describe a feeding relationship which is sensitive, reciprocal, and about more than nutrition. Staff should 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 'spoiled' by too much feeding and breastfeeding will not, in and of itself, tire mothers any more than caring for a new baby without breastfeeding. Find out more in the Unicef UK responsive feeding info sheet: http://unicef.uk/responsivefeeding

Exclusive breastfeeding

- Mothers who breastfeed will be provided with information about why exclusive breastfeeding leads to the best outcomes for their baby and why it is particularly important during the establishment of breastfeeding.

- When exclusive breastfeeding is not possible, the value of continuing partial breastfeeding will be emphasised and mothers will be supported to maximise the amount of breast milk their baby receives.

- Mothers who give other feeds in conjunction with breastfeeding will be enabled to do so as safely as possible and with the least possible disruption to breastfeeding. This will include appropriate information and a discussion regarding the potential impact of introducing a teat when a baby is learning to breastfeed.

- A full record will be made of all supplements given, including the rationale for supplementation and the discussion held with parents.

Supplementation rates will be audited continuously and supported by monthly sampling and reviews of records (see appendix three for additional guidance on supplementation).

6. Modified feeding regimes

When babies are at risk and/or sleepy following birth or when there is a concern about weight gain, it is sensible to encourage frequent feeding, including a minimum number of feeds in 24 hours, to ensure safety. It is however important that mothers do not see this as the 'norm' and any other feeding pattern a cause for concern, once their baby is no longer sleepy or at risk. Ensure normal feeding behaviour/ patterns is discussed with mothers. See below for other identified circumstances that may require modified feeding regime. All relevant guidelines can be found via this link: https://ndht.ndevon.swest.nhs.uk/midwifery/infant-feeding/policies-guidelines/

- Please refer to **Enteral Nutrition for Neonates on SCBU Guideline** for further guidance on caring for a preterm neonate and those diagnosed as small for gestational age.

- Please refer to the **Hypoglycaemia Management and Prevention in Neonates Guideline** for full guidance on caring for neonates identified as 'at risk' of hypoglycaemia and those who become symptomatic.

- Please refer to the **Jaundice Management Guidelines for Neonates** for further guidance on management and prevention of neonatal jaundice.

- Please refer to appendix four for the **Management of Reluctant Feeding in Healthy Term Infants Care Pathway** for further guidance on how to appropriately and safely care for these babies.

- Please refer to the **Tongue Tie in Infants Guideline** for management of infants with feeding related problems associated with suspected tongue tie.

7. Formula feeding

- Mothers who formula feed will be enabled to do so as safely as possible through the offer of a demonstration and / or discussion about how to prepare infant formula.

- Mothers who formula feed will have a discussion about the importance of responsive feeding and be encouraged to:
    - respond to cues that their baby is hungry
    - invite their baby to draw in the teat rather than forcing the teat into their baby's mouth
    - pace the feed so that their baby is not forced to feed more than they want to
    - recognise their baby's cues that they have had enough milk and avoid forcing their baby to take more milk than the baby wants.

Please refer to the **Safe preparation and handling of infant formula SOP** for further guidance on supporting mothers who are formula feeding to do so safely and in line with nationally agreed guidelines.

8. Early Postnatal period

Support for parenting and close relationships

- Skin to skin contact will be encouraged throughout the postnatal period
- All parents will be supported to understand a newborn baby's needs (including encouraging frequent touch and sensitive verbal/visual communication, keeping babies close, responsive feeding and safe sleeping practice)
- Mothers who bottle feed 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
- Parents will be given information about local infant feeding and parenting support that is available (please see appendix one for further information)

Recommendations for health professionals on discussing bed-sharing with parents

Simplistic messages in relation to where a baby sleeps should be avoided; neither blanket prohibitions nor blanket permissions reflect the current research evidence.

The current body of evidence overwhelmingly supports the following key messages, which should be conveyed to all parents:

• The safest place for your baby to sleep is in a cot by your bed.

• Sleeping with your baby on a sofa puts your baby at greatest risk.

• Your baby should not share a bed with anyone who:

- is a smoker
- has consumed alcohol
- has taken drugs (legal or illegal) that make them sleepy.

The incidence of SIDS (often called “cot death”) is higher in the following groups:

- parents in low socio-economic groups
- parents who currently abuse alcohol or drugs
- young mothers with more than one child
- premature infants and those with low birthweight

Parents within these groups will need more face to face discussion to ensure that these key messages are explored and understood. They may need some practical help, possibly from other agencies, to enable them to put them into practice.

9. Monitoring Compliance with and the Effectiveness of the Policy

Key performance indicators comprise:

- Increase in rates of breastfeeding initiation
- Increase in rates of breastfeeding at transfer of care to health visitor
- Reduction in rates of readmission to Caroline Thorpe for feeding related problems
- Improvements in parents' experiences of infant feeding care

10. Process for Implementation and Monitoring Compliance and Effectiveness

Outcomes will be monitored by the Lead Midwives for Infant Feeding and reported to the Lead Midwife, Community and Outpatient Services and . This will include:

- Rolling audit of the key performance indicators with a quarterly report to the Maternity Specialist Governance Group
- Formal registration of audit with the Trust's Clinical Audit Team for on-going support with data analysis and reporting
- Use of the BFI audit tools
- Bi-annual presentation at the Audit and Case Review meeting

11. Equality Impact Assessment

The author must include the Equality Impact Assessment Table and identify whether the policy has a positive or negative impact on any of the groups listed. The Author must make comment on how the policy makes this impact.

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age				
Disability				
Gender				
Gender Reassignment				
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment), marriage and civil partnership				
Pregnancy				
Maternity and Breastfeeding	x			
Race (ethnic origin)				
Religion (or belief)				
Sexual Orientation				

12. References

British Association of Perinatal Medicine, 2017. Identification and Management of Neonatal Hypoglycaemia in the Full Term Infant: A Framework for Practice.

National Childbirth Trust et al, (1997) Hypoglycaemia of the Newborn. Guidelines for appropriate blood glucose screening & treatment of breastfeeding and bottle fed babies in the UK. NCT

National Institute for Health and Clinical Excellence (NICE) (2006) *NICE Clinical Guideline 37: Routine Postnatal Care of Women and their Babies*. London: NICE. Available at: www.nice.org.uk

National Institute for Health and Clinical Excellence (NICE) (2010 [2008]) *NICE Clinical Guideline 62: Antenatal Care: Routine Care for the Healthy Pregnant Woman*. London: NICE. Available at: www.nice.org.uk

Royal College of Midwives, (2002) *Successful Breastfeeding* RCM, London: Churchill Livingstone

Scientific Advisory Committee on nutrition (2008) *Infant Feeding Survey 2005: A commentary on infant feeding practices in the UK.* London: The Stationery Office.

UNICEF: Baby Friendly Initiative (online) 2020
https://www.unicef.org.uk/babyfriendly/what-is-baby-friendly/
https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2011/11/Caring-for-your-baby-at-night_online-singles.pdf

World Health Organisation (WHO) (2007), *Evidence on the Long Term Effects of Breastfeeding*. Geneva, Switzerland: WHO.

World Health Organisation (WHO) (1981), *International Code of Marketing of Breastmilk Substitutes* Geneva, Switzerland: WHO. Available at: **www.babymilkaction.org**

13. Associated Documentation

To access the guidelines below follow this link:

http://ndht.ndevon.swest.nhs.uk/midwifery/infant-feeding/policies-guidelines/

- Care of the Newborn Immediately After Birth Guideline
- Post Natal Care Planning & Post Natal Information Guidelines
- Expressed Breast Milk handling, labelling and storage SOP
- Cup Feeding Neonatal Guideline
- Donor Breast Milk (DBM) Guidelines
- Excessive Weight Loss in the Healthy Breastfed Newborn Guideline
- Antenatal Hand Expressing of Colostrum in Pregnant Women who have Diabetes Guideline
- Hypoglycaemia Management and Prevention in Neonates Guideline
- Management and Prevention of Neonatal Jaundice
- Safe preparation and handling of infant formula SOP
- Tongue Tie in Infants Guideline

14. Appendices

Appendix 1 - Local Infant Feeding Support and Parenting Groups

- The following link will be displayed on the handheld postnatal notes folder. http://www.devon.gov.uk/positive-about-breastfeeding/support-groups/ Mothers' will be advised to follow the link to access up to date information on local breastfeeding and parenting support groups

- If you have identified a mother and baby who may benefit from more time and focused feeding support, they can be booked into the Infant Feeding Clinic via BOB and Trakcare: https://ndht.ndevon.swest.nhs.uk/midwifery/infant-feeding/infant-feeding-special-interest-clinic-referral-form/

- If you have identified a mother and baby who is having continued (at discharge or after discharge from midwife) feeding associated difficulties and require ongoing support, they can be referred to the Specialist Health Visitor Infant Feeding Clinic: https://ndht.ndevon.swest.nhs.uk/midwifery/infant-feeding/specialist-hv-infant-feeding-clinic-referral-form/

Appendix 2 - National Breastfeeding Support Services

Contact details for approved breastfeeding support services should be given to all mothers in the postnatal period and be routinely displayed in all relevant areas throughout the unit. Sources of national and local support should be identified and mothers given verbal and written information about these prior to transfer home from hospital.

National Breastfeeding Helpline
0300 100 0212
www.nationalbreastfeeedinghelpline.org.uk

Association of Breastfeeding Mothers
http://abm.me.uk/

The Breastfeeding Network
www.breastfeedingnetwork.org.uk

National Childbirth Trust
NCT Breastfeeding Line 0300 330 07771
www.nct.org.uk

La Leche League
www.laleche.org.uk Start4Life
0300 123 1021

Appendix 3 – Guidance on supplementation

Supplements are generally given for a small number of reasons including clinical concerns, cultural expectations and lack of confidence that breastfeeding can provide everything a baby needs.

It is our aim at NDHT to reduce supplementation rates over time; specifically those given without medical indication or and uninformed decision made by the mother.

Below are two tables showing how care will be analysed when formula supplementation is given to a breastfed baby for either clinical indication or maternal request (BFI, 2016). Staff should familiarise themselves with the aspects of care expected, to ensure they are providing the best possible care during an assessment of need for supplementation.

What are the risks of giving a breastfed baby formula milk when there is no clinical indication?

Increased risk of cow's milk allergy: If there is a family history of allergies, the giving of even one formula feed during the first 3 days can increase the risk of the baby developing allergies.

Increased risk of gut infections: breastfed babies have a lower gut pH level during the first 6 weeks of life. This is beneficial as it reduces harmful germs in the gut. If formula supplements are given in the first 7 days, the development of the low pH in the gut is slowed and may never fully develop.

Risk of reducing mother's milk supply: When a formula feed is given, the baby does not suckle at the breast. This reduces the mother's milk supply, as the breast is not stimulated.

Increased risk of diabetes: Early exposure of cow's milk protein increases the risk of the baby developing insulin dependent diabetes.

Risk of nipple confusion: If an artificial teat is used to give the supplement, the baby can develop 'nipple confusion' which may create difficulties in successful attachment at the breast.

Mothers should be fully informed about the potential risks associated with supplementation.

Clinical indication

Occasionally there are medical reasons to offer breastfed baby supplements of formula milk. Some of these medical reasons include hypoglycaemia, prematurity and weight loss of greater than 10% of the baby's birth weight. The healthiest supplement is the mother's expressed breast milk followed by formula milk. If a breastfed baby needs a supplement, the mother should be taught how to express. If at the time of expressing, there is not enough expressed breast milk available to meet the baby's medical need, then an infant formula may be offered.

Supplement details – Maternal request

Analysis of care	Yes (Y)	No (N)	X	Comments
Mother has had antenatal conversation about breastfeeding				
Clear documentation of mothers reason, alternative options and information given				
Optimum skin contact / support with first feed				
Responsive feeding explained/ encouraged				
Number of feeds in last 24 hours				
Support with positioning and attachment (effectively and timely)				
Use of skin contact/ laid back nursing				
Hand expression as indicated (effective and timely)				
Appropriate observations and monitoring				
* Volume of infant formula appropriate				
Formula milk given safely with least possible disruption to breastfeeding				
Plan made for future feeds (maximising breast milk/breastfeeding)				

These feed volumes refer to well babies

First day 5-10mls per feed

Second 24 hours 10-15mls per feed

Third 24 hours 15-20mls per feed

Formula supplementation should not exceed 20mls per feed and should be ceased once lactation commences.

Supplement details – Clinical Indication/ babies ‘at risk’

Analysis of care	Yes (Y)	No (N)	NA	Comments
Baby correctly identified as ‘at risk’				
Optimum skin contact/ support with first feed				
Proactive feeding - at least every 3 hours				
Supported appropriately with positioning and attachment				
Use of skin contact/ laid back nursing				
Hand expression effective and timely				
Appropriate observations and/or blood glucose monitoring				
Feeding assessment including urine output and stools				
Volume of infant formula appropriate				
Formula milk given safely and with least possible disruption to breastfeeding				
Information for mother was effective/ appropriate				
Plan made for future feeds (to support lactation)				
Documentation satisfactory				

Appendix 4 – Management of reluctant feeding in healthy, term infants

Healthy term babies may feed enthusiastically at birth and then sleep for many hours. In order to prevent a potential negative effect on a baby's wellbeing, establishment of feeding and the stimulation of lactation, some babies may need a proactive feeding plan. Infants with no risk factors and no abnormal clinical signs, but are reluctant to feed should be given an **Active Feeding Plan** (see flow chart below).

We recommend pro-active support of feeding in the immediate post-partum period which includes skin to skin, laid-back nursing and a reminder of baby's feeding cues. Healthy term babies are not at risk from infrequent feeding in the first 48 hours unless they become unwell.
Encouragement to feed frequently should be made but as long as the baby remains well, medical attention is not required.

Infrequent feeds can impact on the mother's milk supply and so frequent and effective expressing of breast milk should be encouraged if her baby is not feeding. Prolonged skin contact should also be encouraged to optimise instinctive feeding behaviours and to stimulate milk making hormones.

What are Baby's Feeding Cues?
Feeding cues indicate the beginning of feeding readiness when babies are more likely to latch on and suck. They can occur during periods of light sleep as well as when a baby is awake. Cues include rapid eye movements under the eyelids, mouth and tongue movements, body movements and sounds, sucking on a fist. Crying can be a way of indicating that the feeding cues have been missed. If this doesn't occur, support should be provided and documented until effective feeding is established. Recommend avoiding dummies whilst establishing breastfeeding to ensure feeding cues and an opportunity to go to the breast is not missed.

Assisted Feeding Methods
If breastfeeding, it may be helpful to give a baby small amounts of colostrum by finger feeding, using an oral syringe or cup. The mother should be taught and encouraged to hand express colostrum to stimulate lactation and to offer to her baby until feeding is established. Ensure she has a copy of 'Off to the best start' leaflet for visual aids and information on hand expression.
If formula feeding, the baby can be offered formula milk by the same methods if refusing to suck on a teat.

To finger feed safely, ensure the mother has clean hands and short nails and encourage her to hold baby in her arm, with finger feeding cup in same hand. Use little finger of opposite hand to dip into milk and give to baby to suck, pad uppermost in baby's mouth.

To give a syringe feed safely, the calm and alert baby should be held in the mother's arms slightly upright, not flat. The oral syringe is gently placed in between the gum and cheek and a little colostrum gently instilled, no more than 0.2ml at a time. Allow the baby time to taste and enjoy the milk. Stop if the baby starts sucking, allow time

to swallow, then give a little more. **Move onto cup feeding once you have more than 5mls to give.**

To give a cup feed safely, hold baby in an upright position, ensuring that baby's neck and shoulders are well supported. Make sure baby is fully awake, calm and alert. Half-fill the cup and hold it so that it just touches baby's mouth. It should reach the corners of her/his mouth and rest lightly on her/his bottom lip. Allow her/him just a tiny sip, to encourage drinking – do not pour the milk into her/his mouth; tip the cup just enough so that baby can lap up. Keep the cup in this tilted position and allow her/him to start again when she/he is ready. Please refer to **Cup Feeding Neonatal Guideline** for more detailed information.

Supporting a mother and baby
You can help and support the mother and boost her confidence by teaching her to hand express. Give her a supply of oral feeding syringes and feeding cups, encourage skin contact, especially in the laid-back position and help her to recognize her baby's feeding cues. Encourage the mother to offer her breast to her baby when he/she is ready, and to feed her baby expressed breast milk until he/she is breastfeeding actively and effectively.

What if the mother does not want to hand express?
The length of labour and the type of birth may influence the mother's feelings about hand expressing and giving colostrum intensively for the first few hours. The mother may ask to give formula instead (see below). If the mother cannot or chooses not to express her colostrum it is the responsibility of the midwife to ensure this is an informed decision based on awareness of the benefits of breastfeeding and the risks of formula. This will be documented by the midwife in the woman's notes.
If there is a clinical indication to provide formula supplementation or a mother makes an informed choice to provide formula this can also be given in a cup. A nasogastric tube may be required if the baby shows no cues in response to assisted feeding methods. The milk should be given by cup in volumes appropriate to the baby's age:

First day	5-10mls per feed
Second 24 hours	10-15mls per feed
Third 24 hours	15-20mls per feed

Formula supplementation should not exceed 20mls per feed and should be ceased once lactation commences. These volumes refer to healthy term infants that are reluctant to feed.

Active Feeding Plan for Reluctant Feeding in Term Infants

The baby should be encouraged to feed soon after birth, helped by uninterrupted skin to skin contact for at least the first hour. If the baby has not had a first feed by **4 hours old** or a second feed **six hours later**. Use the flowchart below:

Assess the baby and the environment.
If breastfeeding, complete initial breastfeeding assessment

Take a history, including analgesia in labour, environmental temperature etc.
- Be proactive: this baby may not demand a feed
- Encourage the mother to lead the feeding until baby has woken up and taken two consecutive effective breast feeds
- Explain feeding cues to the mother

Encourage uninterrupted skin to skin contact, ensuring both mother and baby are well covered

Encourage the mother to talk to her baby and massage baby's hands & feet. Use the laid back position to encourage instinctive feeding behaviour

If the baby has still not fed at 4 hours old, teach the mother to hand express colostrum onto the nipple to tempt the baby
Hand express and give baby collected colostrum

Obtained colostrum, should be given from the mother's breast, finger or by enteral syringe or cup.
If no colostrum is obtained and baby is **clinically well** continue with skin to skin and try again in 1-2 hours, a formula supplement is not necessary

Reassure the mother and protect her milk supply: continued skin to skin and support expressing **every 2-3 hours**

REASSESS THE BABY
The mother should be encouraged to observe for changes in her baby's condition and inform staff if she has concerns. NEWS observations should be done **4 hourly**. If clinically indicated request a paediatric review. A blood-sugar assessment is only necessary if the baby is symptomatic of hypoglycaemia

Continue with hand expressing and giving colostrum two hourly until baby is breastfeeding well (staying attached and suckling well for at least 5-10 minutes).
If formula feeding, continue giving small volumes of formula until bottle feeds well, taking at least 10mls

Milk volume requirements will increase when baby is more than 24 hours old, see above

Document what has been done to promote breastfeeding and ensure the wellbeing of mother and baby