Document Control

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Cup Feeding Neonatal Guideline			
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Superseded Documents Guidelines for cup feeding the neonate			
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CONTENTS

1. Introduction

1.1. This document sets out Northern Devon Healthcare NHS Trust's best practice guidelines for Cup Feeding the Neonate.

1.2. Cup feeding can be used for babies whose parents wish their baby primarily to breast feed, but who on occasion need an alternative method.

1.3. Cup feeding may be considered from 35 weeks gestation onwards for the preterm baby who shows signs of wanting to suck and is not yet able to manage a full breast feed. From 35 weeks gestation, babies should be able to suck and swallow whilst coordinating their breathing (Bird, 2016). Therefore it has been deemed a safe gestation to start initiating cup feeding if needed.

1.4. Step 9 of the UNICEF UK Baby Friendly Initiative advises that when a mother is unable to breastfeed use of a teat should be avoided in order to protect breastfeeding and this in part has led to an increase in the use of cup feeding as an alternative.

1.5. Cup feeding should never be used to replace breastfeeding.

2. Purpose

2.1. The following general principles can be applied in order to provide an alternative mode of oral feeding for the neonate. It can be referred to as a resource for training purposes.

2.2. This guideline applies to all clinical staff who assist in feeding newborn babies and must be adhered to. Non-compliance with this guideline may be for valid clinical reasons only. The reason for non-compliance must be documented clearly in the patient's notes. Infant's should not be cup fed under 35 weeks gestation unless it has been discussed with the medical team and seen to be in the infants best interest to do so.

For safety reasons only trained members of staff should offer cup feeding to an infant.

3. Definitions

3.1. **Neonate**

3.2. An infant less than 28 days old

3.3. **Cup**

3.4. A sterile 60 ml measure with rounded edges is ideal to be used for cup feeding. (Hallum 1998). It should not have a lip or spout or be shaped in any way that would encourage milk to be poured into the baby's mouth.Nipple/teat' confusion is a term described by Neifert et al (1995) as occurring in term babies following bottle feeding or use of pacifiers which causes them difficulty in later latching on to the breast. However Fish and Inch (1996) argue that the feeding problem may have originated from the breast.

- 'Nipple/teat' confusion is a term described by Neifert et al (1995) as occurring in term babies following bottle feeding or use of pacifiers which causes them difficulty in later latching on to the breast. However Fish and Inch (1996) argue that the feeding problem may have originated from the breast.

4. Indications for use of Cup Feeding

- To provide a positive oral experience for the baby
- To provide an alternative method of feeding when a mother is not available to breastfeed her baby
- To top up the baby following a breast feed if there is no naso-gastric tube in situ

- To avoid 'nipple/teat' confusion, which can arise from the early and inappropriate introduction of bottles/pacifiers
- To reduce the need for nasal and oral gastric tubes

5. Advantages of Cup Feeding

- The baby paces its own intake in time and quantity
- It requires little energy expenditure
- It stimulates the suck and swallow responses
- Stimulation of saliva, lingual lipases and more efficient digestion of the milk
- It stimulates tongue and jaw movement
- Less fat is lost via a cup than with a gastric tube
- It is very easy to maintain good eye contact, the baby is held closely for the feed
- More babies are discharged exclusively breastfeeding (but there is no significant benefit that cup feeding maintains breastfeeding beyond this)

6. Disadvantages of Cup Feeding

- Milk wastage (inability to calculate how much has been taken)
- Cup addiction
- Length of time taken for feeds
- Risk of the aspiration if cup feeding is not administered properly
- Longer hospital stay (can be as much as 10 days in one study, Cochrane 2007)
- No significant difference in babies continuing to be exclusively breastfed at 3 and 6 months of age.
- **Note: Flint et al [Cochrane review] (2007) states that Cup feeding cannot be recommended over bottle feeding as a supplement to breastfeeding because it confers no significant benefit in maintaining breastfeeding beyond hospital discharge and carries the unacceptable consequence of a longer stay in hospital.**

7. General Principles of Cup Feeding

The Preterm Baby

7.1. The preterm baby has an immature uncoordinated suck, swallow and breathing pattern.

7.2. A cup feed may be safely used to feed a baby less than 35 weeks gestation if it has been discussed and deemed safe and appropriate to do so with the medical team. It may be appropriate to offer a cup when the preterm baby is:

- wide awake and restless at feed times
- not satisfied by gastric tube feeds.

- not yet able to feed directly from the breast, or has only enough energy to satisfy part of its total nutritional needs at the breast.
- Is being breast

7.3. A cup feed may be given when 2-3 hourly intermittent bolus gastric tube feeds are introduced or established.

7.4. When a baby is initially being introduced to the breast then a cup feed may be given if supplementation is required.

7.5. If a baby is successfully cup and tube feeding then the gastric tube may be removed but it needs to be replaced if there is concern over the baby's weight gain.

The Term Baby

7.6. A cup feed may be used:

- When the mother is not available to breast-feed her baby.
- To supplement breast- feeding if indicated. For example such as additional feeds required or where there are concerns of hypoglycaemia.
- To settle baby prior to a feed
- To supplement the jaundiced baby if medically indicated.
- \to give oral drugs to a breast-fed baby

The Cleft Lip/Palate Baby

7.7. Cup feeding may be used if there is a possibility that the baby will be able to breast-feed, during the period in which the establishment of breast-feeding is taking place. It can be used to supplement a feed.

The Baby Who cannot suck

7.8. If a baby is unable to suck cup feeding can be considered as an alternative to the long-term use of gastric tubes.

8. Guidance for Practice

- Give parents information and gain informed consent. (Document this)
- The baby should be awake and alert.
- Wrap the baby securely, to prevent their hands knocking the cup.
- Place a napkin under the baby's chin.
- Support the baby in an upright position on your lap, so that you are both comfortable.
- Choose a sterile 60 ml measure and check that the rim is not sharp.
- Have the sterile cup at least half full (if possible) with mother's expressed breast milk.
- Use mother's own expressed breast milk wherever possible rather than formula.

- The cup should be tipped so the milk is just touching the baby's lips. It should not be poured into the baby's mouth.
- Direct the rim of the cup towards the corners of the upper lip and gums, with it gently touching/resting on the lower lip. Do not apply pressure to the lower lip.
- Leave the cup in the correct position during the feed. Do not keep removing it when the baby stops drinking. It is important to let the baby take as much as it needs in its own time, (Hedverg Nyqvist and Stranell 1999).
- Initially a baby may only take a small amount by cup e.g.5-10mls. However a baby less than 36 weeks gestation may take varying amounts by cup (a large amount for one feed and a small amount for another). Thus the baby needs to be assessed at the end of each cup feed incase it may require topping up by tube.
- The cup should be washed and sterilized as per guidelines on sterilization of equipment.

9. Education and Training

9.1. Training will be provided during preceptorship, through formal study days and informal training on the ward where the staff member works clinically.

10. Monitoring Compliance with and the Effectiveness of the Guideline

10.1. Staff are informed of revised documentation. There is an expectation that staff are responsible to keep updated on any improvements to practice and deliver care accordingly.

10.2. Incidents including non-compliance of the guideline are reported by the Datix incident reporting system.

10.3. Non-adherence is reviewed and action plans made if required. Learning and action plans are cascaded at Paediatric Team and ward meetings and improvements implemented.

Standards/ Key Performance Indicators

10.4. Key Performance indicators on which to base care in the Special Care Unit are:

- BLISS Baby Charter Standards
- National Neonatal Audit Programme
- Nice Neonatal Quality Standards
- NHS Standard Contract for Neonatal Critical Care
- NHS Toolkit for High Quality Neonatal Services

11. Consultation, Approval, Review and Archiving Processes

11.1. The author consulted with all relevant stakeholders. Please refer to the Document Control Report.

11.2. Final approval was given by the Paediatric Specialty Team.

11.3. The guidelines will be reviewed every three years. The author will be responsible for ensuring the guidelines are reviewed and revisions approved by the Paediatric Specialty Team in accordance with the Document Control Report.

11.4. All versions of these guidelines will be archived in electronic format by the author within the Paediatric Team policy archive.

11.5. Any revisions to the final document will be recorded on the Document Control Report.

11.6. To obtain a copy of the archived guidelines, contact should be made with the Neonatal Team/ author.

12. References

- Armstrong H (1987). Breastfeeding Low Birthweight Babies: Advances in Kenya. Journal of Human Lactation. Vol 3 (2)
- Auerbach K (1990). Assisting the Employed Breastfeeding Mother. Journal of Nurse-Midwifery. Vol 35 (1) p26-34
- Cheryl Bird. 2016. Very Well. [ONLINE] Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2828611/. [Accessed 12 October 2016]
- Flint A, New K, Davies MW (2007). Cup feeding versus other forms of supplemental enteral feeding for newborn infants unable to fully breastfeed. Cochrane Database of systematic Reviews; Issue 2. Art. No.:CD005092. DOI: 10.1002/14651858.CD005092.pub2
- Egnell Ameda. Ameda Egnell Baby Cup, Cup Feeding Guidelines. Taunton.
- Fish C and Inch S (1996). Nipple Confusion- Who is confused?
- Journal of Pediatrics. 129 (1) pp174-175.
- Hallum S (1998). Nutrition in the Neonatal Unit. In ed Helen Yeo's Nursing the Neonate. Blackwell Science. Cardiff.
- Hedverg Nyqvist K and Stranell E (1999). A cup feeding protocol for neonates: Evaluation of nurses' and parents' use of two cups. Journal of Neonatal Nursing. 5 (2) p31-36.
- Lang S (1997). Breastfeeding Special Care Babies. London. Baillière Tindall
- Minchin M (1987). Premature Babies: Why Breast is Best. New Generation. P36-37.

- Muhudhia S et al (1989). Postnatal Weight Gain of Exclusively Breast Fed Preterm African Infants.
- Musoke R (1990). Breastfeeding Promotion: Feeding the Low Birth Weight Infant. Inr J. Gynecol. Obstet 31: Supplement. ! p57-59.
- Newman J (1990). Breastfeeding Problems Associated with the Early Introduction of Bottles and Pacifiers. Journal of Human Lactation. Vol 6. (2) p59-63.
- Neifert M, Lawrence R, and Seacat J. (1995). Nipple confusion: Toward a formal definition. Journal of Pediatrics. 126 (6) pp125-129.
- Richie J. (1998). Immature sucking response in premature babies: Cup feeding as a tool in increasing maintenance of breast feeding. Journal of Neonatal Nursing. 4 (2) p13-17.
- UNICEF. (2010). [on-line] Cup feeding versus other forms of supplemental feeding . http://www.unicef.org.uk/BabyFriendly/News-and-Research/Research/Miscellaneous-illnesses/Cup-feeding-versus-other-forms-of-supplemental-enteral-feeding-for-newborn-infants-unable-to-fully-breastfeed/ (accessed 16/3/13)

13. Associated Documentation

- NDDH Newborn Infant Feeding Policy and Guidelines
- NDDH Naso /orogastric tube management guidelines for the newborn (up to 28 days old)