Trust Policy

University Hospitals Plymouth NHS Trust

Infant Feeding Policy

Issue Date	Review Date	Version
February 2021	February 2024	6.3

Purpose

The purpose of this policy is to ensure that all staff members at University Hospitals Plymouth NHS Trust understand their role and responsibilities in supporting expectant and new mothers and their partners to feed and care for their baby in ways which support optimum health and well-being.
In order to avoid conflicting advice it is mandatory that all staff adhere to this policy.

Who should read this document?

All staff. This policy applies to all trust employees, including locum, bank and agency staff working on behalf of the trust and involved in the direct care of patients.

Key Messages

University Hospitals Plymouth NHS Trust attaches the highest importance to ensuring a culture that values high standards of patient care exists within the organisation. This policy is intended to safeguard the position of patients and staff throughout consultation, examination, treatment and care.

ore accountabilities	
Owner	Aimee Miller, Infant Feeding Lead
Review	Maternity Assurance Group
Ratification	Director of Nursing
Dissemination	Patient safety and effectiveness manager
Compliance	Specialist Nurse

Links to other policies and procedures

This policy must be applied to all Trust policies and procedures.

Version History

1	Feb 08	Reviewed and amended by PCT Breastfeeding Coordinator
2	Sep 08	Reviewed and amended by PHNT Public Health Midwife
3	Nov 08	Reviewed and amended following Consultation and Directorate Approval
4	Aug 09	Amended Following review by the Baby Friendly Initiative at Hospital Stage 1 Assessment
5	Aug 10	Amended following review by the Baby Friendly Initiative at Community Stage 1 Assessment

6	July 2014	Document Reviewed
6.1 **6.1**	September 2014 Jan 2016	Minor Amendment Amended in line with Baby Friendly Initiative (UNICEF)
6.2	January 2019	Amended in line with Baby Friendly Initiative (UNICEF)
6.3	May 2019	Updated

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available in the Document Library. Larger text, Braille and Audio versions can be made available upon request.

Contents

1 Purpose

The purpose of this policy is to ensure that all staff members at University Hospitals Plymouth NHS Trust understand their role and responsibilities in supporting expectant and new mothers and their partners to feed and care for their baby in ways which support optimum health and well-being.

In order to avoid conflicting advice it is mandatory that all staff adhere to this policy.

2 Outcomes

This policy aims to ensure that the care provided improves outcomes for children and families, specifically to deliver[1]:

- an increase in breastfeeding initiation rates
- an increase in breastfeeding rates at 10 days
- 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 re-admissions for preventable feeding problems

3 Commitments

University Hospitals Plymouth NHS Trust is committed to:

- Providing the highest standard of care to support expectant and new mothers and their partner's 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 well-being, 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 those mothers' decisions are supported and respected.
- Working together across disciplines and organisations to improve mothers' / 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 receive training to enable them to implement the policy as appropriate to their role. New staff receive this training within six months of commencement of employment.
- The International Code of Marketing of Breast-milk Substitutes[2] is implemented throughout the service.
- All documentation fully supports the implementation of these standards.

[2] More information on the Code: http://unicef.uk/thecode

- Parents' experiences of care will be listened to through: regular audit, parents' experience surveys (e.g. Care Quality Commission survey of women's experiences of maternity services), interviews, review of complaints and compliments and the friends and family questionnaire.

4 Standards of care

This section of the policy sets out the care that University Hospitals Plymouth 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[3] and relevant NICE guidance[45].

4.1 Pregnancy

All pregnant women will have the opportunity to discuss feeding and caring for their baby with a health professional (or other suitably trained designated person). This discussion will include the following topics[6]:

- The value of connecting with their growing 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 that keeping their baby close has in supporting this
- Feeding, including :
    - 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

- Pregnant women can be signposted to online antenatal classes here
- www.inourplace.co.uk using the code TAMAR for free access to the Solihull programmes
- https://www.supportincornwall.org.uk/kb5/cornwall/directory/advice.page?id=3eUP45FLH3I

Guidance on having antenatal conversations on infant feeding can be found here:
https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2020/03/Unicef-UK-Baby-Friendly-Initiative-Guidance-Sheet-2-Antenatal-Conversations.pdf

Pregnant women who wish to breastfeed can be spoken to about expressing their breastmilk in the antenatal period. This can be done from 36 weeks gestation provided there are no medical concerns. Women can be given a kit, consisting of colostrum syringes, labels for expressed breast milk and the antenatal expressing leaflet from the ABM.

- https://abm.me.uk/wp-content/uploads/ABM-antenatal-expressing.pdf

[3] Updated Baby Friendly standards: http://unicef.uk/babyfriendlystandards

[4] NICE postnatal care guidance: http://www.nice.org.uk/cg037

[5] NICE guidance on maternal and child nutrition: http://www.nice.org.uk/ph11

4.2 Birth

- All mothers will be offered the opportunity to have uninterrupted skin contact with their baby, regardless of type of delivery, 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 an opportunity to emerge. This should not be interrupted for procedures such as measurements, weighing and transfer.
- 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 to the breast 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. The unit provides ready to use infant formula and teats. These should be used for 1 feed only and then disposed of. Once opened formula should be disposed of within 1 hour.
- 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.
- Mothers with a baby on the neonatal unit are:
  - Enabled to start expressing milk as soon as possible after birth (within two hours) using a hands off approach
  - Supported to express effectively

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

- Ensure documentation reflects whether the initial feed has taken place and if not, provide a full explanation as to why

Safety considerations

Vigilance as to the baby's well-being is a fundamental part of postnatal care in the first few hours after birth. For this reason, normal observations of the baby's temperature, breathing, colour and tone should continue throughout the period of skin contact, in the same way as would occur if the baby were in a cot. 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 on to 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.

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

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

5 Support for Breastfeeding

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

- If a baby does not feed within 2 hours of life or does not feed again within 6 hours of the first feed then the reluctant to feed pathway within this guideline should be followed (see appendix 2 for flowchart)

- 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 feeding cues.

- All feeds will be documented on a feeding chart

- A formal feeding assessment will be carried out using the Unicef (2018) assessment tool (see appendix 1) as often as required in the first week with a minimum of two assessments, one within the first 24 hours and again on day 3 to ensure effective feeding and the well-being of mother and baby. This should be documented in the handheld postnatal notes. This assessment will include a discussion with the mother to reinforce what is going well and where necessary develop an appropriate plan of care to address any issues that have been identified. This assessment tool will also be utilised for any over the phone feeding assessments such as calls in to triage.

- Mothers with a baby on the 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 support services for breastfeeding such as; additional face to face contacts by the midwifery service, health visiting service, children's centres and NCT volunteers, attendance at latch on group sessions led by peer supporters, Local La Leche league groups, digital information and maternity triage line.

- For those mothers who require additional support for more complex breastfeeding challenges an assessment using the UNICEF (2018) assessment tool will be completed and a support plan, agreed in partnership with the mother, will be put into place. Mothers will be informed of this pathway.
- Those babies with a tongue tie which is felt to affect feeding should follow the tongue tie referral pathway.

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 Unicef UK's responsive feeding infosheet: http://unicef.uk/responsivefeeding

6 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 breastmilk 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.

- If supplementation is medically indicated, expressed breast milk should be used, with formula as the last option. A syringe or feeding cup must be used to give the supplement, thus avoiding the use of teats during the establishment of breastfeeding.

- Syringe feeding is useful for giving a baby small amounts of colostrum; enteral syringes are available to facilitate this. Ensure baby is slightly upright and give small amounts allowing time for the baby to suck and swallow. Move onto cup feeding when you have >5ml to give.

- To cup feed the neonate must be held upright and be alert. Half fill a cup with EBM or formula and rest the rim of the cup on the lower lip, the cup should be tipped until the milk reaches the rim of the cup and the neonate will sip or lap from the cup. Allow the baby to rest between sips, leaving the cup in place and **do not** pour the milk into the baby's mouth.

- A full record will be made of all supplements given, including the rationale for supplementation and the discussion held with parents. One supplementation sticker to be placed in the notes and one form to be placed in the supplementation folder for infant feed lead to collect monthly. See appendix 3.

- Supplementation rates will be audited continuously with monthly interviews of women and reviewing of records.

7 Modified feeding regimes

- There are a number of clinical indications for a short term modified feeding regime in the early days after birth.
  Examples include: preterm or small for gestational age babies and those who are excessively sleepy after birth. Frequent feeding, including a minimum number of feeds in 24 hours, should be offered to ensure safety.

- Neonatal review is required if an infant appears unwell.

- Infants at risk or showing signs of hypoglycaemia must be cared for in line with the Infant hypoglycaemia policy

- Infants admitted to TCW or NICU will require a modified approach following the neonatal guidelines enteral feeding pathway**.**

- Full term, well Infants who are reluctant to feed must be cared for in line with the reluctant feeding pathway (please see appendix 2).

  Remember that full term, well infants may not feed frequently in the first 24 hours.
  They are not at risk from this infrequent feeding pattern unless they become ill. Full term, well infants are able to mobilise different fuel stores if they need to do so, such as glycogen reserves in the liver and ketone bodies from fat stores.

  We should encourage these babies to feed frequently by holding the baby in skin to skin contact and regularly hand expressing so as not to impact on establishing milk production in the first 24 hours, but we should not worry if they choose not to do so.

  Most babies will be ready for 8 – 12 feeds in 24 hours after the first 24 hours.

  Reasons why low risk babies may not ask for the milk they need:
  - not feeling hungry
  - feeling too warm or too cold- think about the environment
  - sedated from drugs given to mother in labour
  - feeling tired for example after a long labour
  - baby has an unrecognised disorder/illness
  - baby missed early opportunities to learn (the initial skin to skin contact may have been cut short or hurried)
  - early feeding cues may be being missed

  Refer to the neonatal medical team at any stage if concerns about the baby's condition arise.

8 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.

- All feeds will be documented on a feeding chart

- 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.

9 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 parenting support that is available via the bump to baby information leaflet, children's centre information, sign posted to digital resources such as the maternity breastfeeding webpage and app based resources. This will be kept up to date by the infant feeding lead.

10 Early Postnatal period: Weight guidelines

- Infants should be weighed on day 3 and day 5 for breastfed babies and babies who are combination fed breast and formula. Babies who are **exclusively** bottle fed are weighed on day 5 only if there are no concerns with formula feeding. **All** babies are weighed once again prior to discharge to the health visitor. **It is rare for formula fed infants to lose over 10% of birth weight. In this situation, the baby should be immediately referred to the neonatal team for assessment.**

- Breastfed infants who have lost over 8% and above of their birth weight should follow the management plan.

Amount of Weight loss	Management plan indicated
8-10% of birth weight	1
10-12.5% of birth weight	1 + 2
>12.5% of birth weight	1 + 2 + 3

Plan	Weight Loss	Management plan details
1	8-10%	• Perform a full examination and re-check weights and calculations • Take a full breastfeeding history from the mother • Observe a full breastfeed-ensure effective positioning &

		attachment. Observe and record the suck to swallow ratio. There should be 1-2 sucks to each swallow for effective feeding. Complete a full breastfeeding assessment. • Ensure minimum 8 feeds in 24hrs, responsive feeding cues should be followed but if baby is not waking for at least 8 feeds in 24 hours advise parents to gently wake and offer feeds every 2-3 hours • Skin to skin contact to be encouraged to stimulate breast seeking behaviour • Observe for change in frequency/amount of urine and stools. • Offer a face to face or telephone contact in 24 hours to ensure urine and stool output are improving and to offer support/reassurance. • Re-weigh in 24-48 hours, continue to closely monitor and provide support. • If at any point illness is suspected then refer to neonatal reg **If no or minimal weight increase, move to management plan 2.**
2	10-12.5%	*Follow management plan 1 plus:* • Perform a set of observations and assess and document any signs of jaundice • Consider switch feeding if baby is becoming sleepy during feeds (This is where you switch to the other breast if sucking ceases to be a nutritive pattern. This should only be used for a few days) • Monitor and record urine and stool input (including colour/consistency) • Express breast milk after each feed and consider giving it to baby by cup after the next feed • Face to face review in 24 hours to include input/output and suck to swallow ratio in 24 hours • Referral if infection or other illness suspected • Weigh again in 24-48 hours. **If no or minimal weight increase, move to management plan 3**
3	>12.5%	Refer to neonatologist/ANNP Management of on-going care dependent upon results of investigations. If medical management not indicated please follow : • Frequent breastfeeds and expressing using hospital-grade pump • If breastfeeding ineffective or EBM unavailable, management to include formula feeds by cup • Weigh again in 24 hours • Continue to monitor weight twice weekly until clear trend towards birth weight demonstrated

Readmissions

All readmissions of newborn infants must be reported via Data incident reporting system by the midwife accepting the readmission in order for a risk management review of the case to be conducted. Babies under 10 days old will be admitted to TCW and over 10 days go to the paediatric ward.

□ Call **Derriford Switchboard**: (01752) 202082 – Bleep the Neonatal Registrar on 0421

□ Call **Maternity Reception** (01752) 431499 to inform them to create labels

□ Ensure SBAR completed

□ Ask patient to **collect paperwork** from Maternity Reception prior to going to TCW

□ For babies >10 days for Paediatric Review – Bleep 0415

□Email infant feeding lead to inform her of readmission

11 Recommendations for health professionals on discussing bed-sharing with parents

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

12 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner will be responsible for agreeing the training requirements associated with the newly ratified document with the named Director and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

13 Monitoring Compliance and Effectiveness

Monitoring implementation of the standards
University Hospitals Plymouth requires that compliance with this policy is audited at least annually using the Unicef UK Baby Friendly Initiative audit tool[7]. Any Staff involved in carrying out this audit require training on the use of this tool. Audit results will be reported to the head of midwifery and an action plan will be agreed to address any areas of non-compliance that have been identified.

Monitoring outcomes
Outcomes will be monitored by:

- Monitoring breastfeeding initiation rates
- Monitoring breastfeeding rates at 10 days
- Interviewing mothers who choose to formula feed, an increase in those doing so as safely as possible, in line with nationally agreed guidance
- monitoring parents' experiences of care
- monitoring the number of re-admissions for preventable feeding problems

Outcomes will be reported to: Maternity Assurance Group

14 References and Associated Documentation

[1] More information on the Code: http://unicef.uk/thecode
[1] Updated Baby Friendly standards: http://unicef.uk/babyfriendlystandards
[1] NICE postnatal care guidance: http://www.nice.org.uk/cg037
[1] NICE guidance on maternal and child nutrition: http://www.nice.org.uk/ph11
BAPM Identification and Management of Neonatal Hypoglycaemia in the Full Term Infant https://www.bapm.org/resources/identification-and-management-neonatal-hypoglycaemia-full-term-infant-%E2%80%93-framework-practice

Breastfeeding Assessment Tool | Appendix 1

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

Full term, Well-Baby Reluctant to feed Flowchart | Appendix 2

6-8 hours following birth

- Second feed completed?
- **Fed effectively?**

YES

NO

Initiate active feeding plan **

Birth

- Dry baby/keep warm
- Initiate and maintain skin to skin contact for at least 1 hr or until after 1st feed
- Encourage responsiveness with mother.
- Discuss and support to recognize feeding cues.
- First feed in skin to skin contact preferably within 1 hour
- For babies being fed formula follow the chart but give formula milk instead of colostrum.

NO

1-2 hours following birth

- Maintain skin-to-skin contact
- Review in 1-2 hours
- Assess well-being of the baby and monitor well-being to ensure no underlying clinical cause for not feeding
- If breastfeeding encourage mother to hand express and give small amounts of colostrum to baby

NO

YES

Commence NEWTT obs and monitor well-being of baby at least 4 hourly*

- Any maternal concerns
- Colour
- Tone
- Respiratory well-being
- Temperature
- Alertness/level of consciousness
- Number and consistency of wet and dirty nappies
- Risk for sepsis

If any signs of illness refer to neonatal team. Any concerns about possible hypoglycaemia or ill-health refer to relevant guidelines

Complete breastfeeding assessment using breastfeeding assessment tool

Once the baby is feeding successfully then **responsive feeding**

Active feeding plan **

- Maintain skin contact
- Review every 2-4 hours
- Actively encourage breastfeeding
- Offer feeds according to feeding cues
- If breastfeeding hand express at least 8-10 times in 24 hours
- Continue to give ebm and actively support until successfully breastfeeding
- Avoid teats, dummies and nipple shields
- Support mother and listen to concerns raised regarding ill health
- Monitor well-being*
- Continue until feeding issue resolves- **most babies are ready for 8-12 feeds in 24 hours after the first day**

Supplementation Documentation

Appendix 3

Supplementation sticker

Supplement required clinically by infant ◯
Reason:
Supplement requested by mother ◯
Reason:
Breastfeeding assessment form completed ◯
Support given with skin contact/laid back position ◯
Support given with hand expressing ◯
Support given with positioning and attachment ◯
Discussion with parents:
Newborn feeding pattern ⓘ Responsive feeding ⓘ Signs of appropriate milk transfer ⓘ
Documented plan to support exclusive breastfeeding ⓘ
Date: ……. Time: …… Sign: ……..

Supplementation audit form

For continuous audit

Baby's name .....…….Mothers Name…….

Unit number .....…….Unit number……..

Baby's birth weight ……..……..
Gestation .....…….....……..
Age .....……..

Date of Supplementation……

Please write below why the supplement was given

Signature: .....

To be completed by auditor

Review of written records

Supplement(s) given was/were:

- ☐ Clinically indicated with optimum care given
- ☐ Clinically indicated but care could be improved
- ☐ Fully informed maternal decision
- ☐ Maternal request without fully informed decision
- ☐ Staff suggestion for non-clinical reasons

Auditor signature: .....

Date: .....

Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of three years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the Infant Feeding Lead and ratified by the MAG

Dissemination Plan and Review Checklist — Appendix 4

Dissemination Plan	
Document Title	Infant Feeding Policy
Date Finalised	February 2021
Previous Documents	
Action to retrieve old copies	Remove previous version saved/uploaded on trust folders or specific Maternity Unit Drives

Dissemination Plan

Recipient(s)	When	How	Responsibility
All Trust staff		IG StaffNet Page	Information Governance Team

Review Checklist		
Title	Is the title clear and unambiguous?	Yes
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Yes
	Does the style & format comply?	Yes
Rationale	Are reasons for development of the document stated?	Yes
Development Process	Is the method described in brief?	Yes
	Are people involved in the development identified?	Yes
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Yes
	Is there evidence of consultation with stakeholders and users?	Yes
Content	Is the objective of the document clear?	Yes
	Is the target population clear and unambiguous?	Yes
	Are the intended outcomes described?	Yes
	Are the statements clear and unambiguous?	Yes
Evidence Base	Is the type of evidence to support the document identified explicitly?	Yes
	Are key references cited and in full?	Yes
	Are supporting documents referenced?	Yes
Approval	Does the document identify which committee/group will review it?	Yes
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	
	Does the document identify which Executive Director will ratify it?	Yes
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Yes
	Does the plan include the necessary training/support to ensure compliance?	Yes
Document Control	Does the document identify where it will be held?	Yes
	Have archiving arrangements for superseded documents been addressed?	Yes
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	
	Is there a plan to review or audit compliance with the document?	Yes
Review Date	Is the review date identified?	Yes
	Is the frequency of review identified? If so is it acceptable?	Yes
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes

Equalities and Human Rights Impact Assessment	Appendix 5

Core Information	
Date	February 2021
Title	Infant Feeding Policy
What are the aims, objectives & projected outcomes?	
Scope of the assessment	
Collecting data	
Race	There is no evidence to suggest that there is an impact on race regarding this policy. Data collected from the datix incident reporting and complaints will ensure this is monitored.
Religion	There is no evidence to suggest that there is an impact on religion regarding this policy. Data collected from the datix incident reporting and complaints will ensure this is monitored.
Disability	There is no evidence to suggest that there is an impact on disability regarding this policy. Data collected from the datix incident reporting and complaints will ensure this is monitored.
Sex	There is no evidence to suggest that there is an impact on sex regarding this policy. Data collected from the datix incident reporting and complaints will ensure this is monitored.
Gender Identity	There is no evidence to suggest that there is an impact on gender identity regarding this policy. Data collected from the datix incident reporting and complaints will ensure this is monitored.
Sexual Orientation	There is no evidence to suggest that there is an impact on sexual orientation regarding this policy. Data collected from the datix incident reporting and complaints will ensure this is monitored.
Age	There is no evidence to suggest that there is an impact on age regarding this policy. Data collected from the datix incident reporting and complaints will ensure this is monitored.
Socio-Economic	There is no evidence to suggest that there is an impact on socio-economic factors regarding this policy. Data collected from the datix incident reporting and complaints will ensure this is monitored.
Human Rights	There is no evidence to suggest that there is an impact on human rights regarding this policy. Data collected from the datix incident reporting and complaints will ensure this is monitored.
What are the overall trends/patterns in the above data?	Nothing of concern
Specific issues and data gaps that may need to be addressed through consultation or further research	None
Involving and consulting stakeholders	

Internal involvement and consultation	Not required
External involvement and consultation	Not required
Impact Assessment	
Overall assessment and analysis of the evidence	Nothing of concern

Action Plan

Action	Owner	Risks	Completion Date	Progress update
None				