University Hospitals Plymouth NHS Trust

MATERNITY GUIDELINES

Newborn Feeding Guideline and Management of weight loss

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1. Introduction

This guideline should be used within the context of best practice management of breastfeeding; i.e. the baby should be gently encouraged to feed soon after birth, helped by skin to skin contact immediately after birth and in the days following.

Further guidance on the management of breastfeeding can be found in the breastfeeding policy and related guidelines.

Inadequate feeding is recognised as the most significant cause of hypernatraemic dehydration (HND) and may have serious adverse consequences include cerebral oedema, convulsions, venous sinus thrombosis, intracranial haemorrhage, D.I.C, renal failure, permanent brain injury and death. HND arises when there is a disproportionate deficit of body water relative to body sodium. When the condition occurs in an otherwise healthy, term, breastfed infant the cause is poor milk intake.

This guideline is intended to be used in conjunction with midwifery experience and expertise. The system of weighing should be coupled with skilled breastfeeding support, including the routine use of skin to skin contact, teaching positioning and attachment and hand expression of breast milk. A formal evaluation of breastfeeding should be undertaken and fully documented, using the breastfeeding checklist, in the first 24 hours and again at 48-72 hours.

2. The Breastfeeding Infant

2.1 Management at Birth

The neonate should be dried and placed skin to skin with the mother as soon as the clinical situation allows, regardless of type of delivery. If skin to skin contact is not clinically appropriate within theatre conditions, the neonate must be placed skin to skin within 10 minutes of arrival in recovery. The period of skin contact should last for at least 1 hour or until after the first breastfeed or longer at maternal request. Skin to skin contact should not be interrupted for procedures such as measurements, weighing and transfer. Ensure the mother is given the option at birth and document mothers' wishes if it is declined

The first feed should happen on CDS or in Theatre before transfer to the postnatal ward or to community. Ensure documentation reflects whether the initial feed has taken place and if not, provide a full explanation as to why.

2.2 Responsive Feeding – baby's cues and mothers needs

Responsive breastfeeding involves a mother responding to her baby's cues, as well as her own desire to feed her baby. Crucially, feeding responsively recognises that feeds are not just for nutrition, but also for love, comfort and reassurance between baby and mother.

Baby	Mother
Rapid eye movements under the eyelids	Stop breasts filling to avoid mastitis
Mouth and tongue movements	When wanting a cuddle
Body movements and sounds	Before bed or going out
Sucking on a fist	

A healthy, term neonate should breastfeed within 4 hours of birth, then approximately 8-12 times in 24 hours in response to the feeding cues as above. In order to recognise cues within a timely manner, baby's should remain with their mother. This is known as 'rooming in'.

2.3 Discharge Home

All breastfeeding mothers must have the following information discussed prior to discharge from hospital:

- Correct positioning & attachment
- Hand expressing
- Responsive feeding
- Room & bed sharing
- The importance of exclusive breastfeeding
- Support groups/numbers
- Recognising effective feeding, to include the normal pattern of stools and urine and the normal pattern of a feed.

This discussion should be documented using the postnatal checklist in mother's notes.

3. The Formula Fed Infant

3.1 Management at Birth

The neonate should be dried and placed skin to skin with the mother as soon as the clinical situation allows, regardless of type of delivery. If skin to skin contact is not clinically appropriate within theatre conditions, the neonate must be placed skin to skin within 10 minutes of arrival in recovery. The period of skin contact should last for at least 1 hour or until after the first breastfeed or longer at maternal request. Skin to skin contact should not be interrupted for procedures such as measurements, weighing and transfer. Ensure the mother is given the option at birth and document mothers' wishes if it is declined

The *first feed should ideally happen on CDS or in Theatre* before transfer to the postnatal ward or to community. Ensure documentation reflects whether the initial feed has taken place and if not, provide a full explanation as to why.

A healthy, term neonate should artificially feed within 4 hours of birth, and then approximately 8-12 times in 24 hours in response to the feeding cues as above. Whilst in hospital the formula should be given at room temperature, warming of the feed is not necessary or advised. The formula and teat should be used for one feed only, once feed complete any unused formula should be disposed of appropriately after 1 hour.

3.2 Discharge Home

Prior to discharge home, the mother should receive the following information:

- How to clean and sterilise equipment (according to WHO recommendation)
- How to safely make up a feed (according to WHO recommendations)

4. Reluctant to Feed Infant

If the baby has not had the first feed within 4 hours or birth or second feed within 6 hours after the first, the following steps should be considered:

Step 1: Assessment of the baby, labour and environment

- Maternal analgesia during labour – consider opioids
- Maternal medication
- Temperature of baby – 36.6˚c - 37.4 ˚c
- Temperature of room - 16 ˚c - 20 ˚c
- Was resuscitation required?
- Risk factors for infection – is neonatal review necessary?
- Does the baby handle normally, is baby irritable or in pain

Step 2: Undress baby and place them skin to skin with mother

Step 3: For breastfed infants hand express and give expressed colostrum to baby

- Obtained colostrum should be given by syringe or cup – see 4.2
- If no colostrum obtained – see 4.3
- If mother declines to express, discuss option of formula supplementation

Repeat steps 1-3 every two hours until successful feeding is established, ensure documentation is contemporaneous.

If the baby appears unwell, commence neonatal observations and seek a neonatal review.

If the baby is jittery, a blood glucose sample is required. See Management of Neonatal Hypoglycaemia

4.1 Syringe Feeding

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.

4.2 Cup Feeding

Feeding cups are available to facilitate this method of feeding. 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

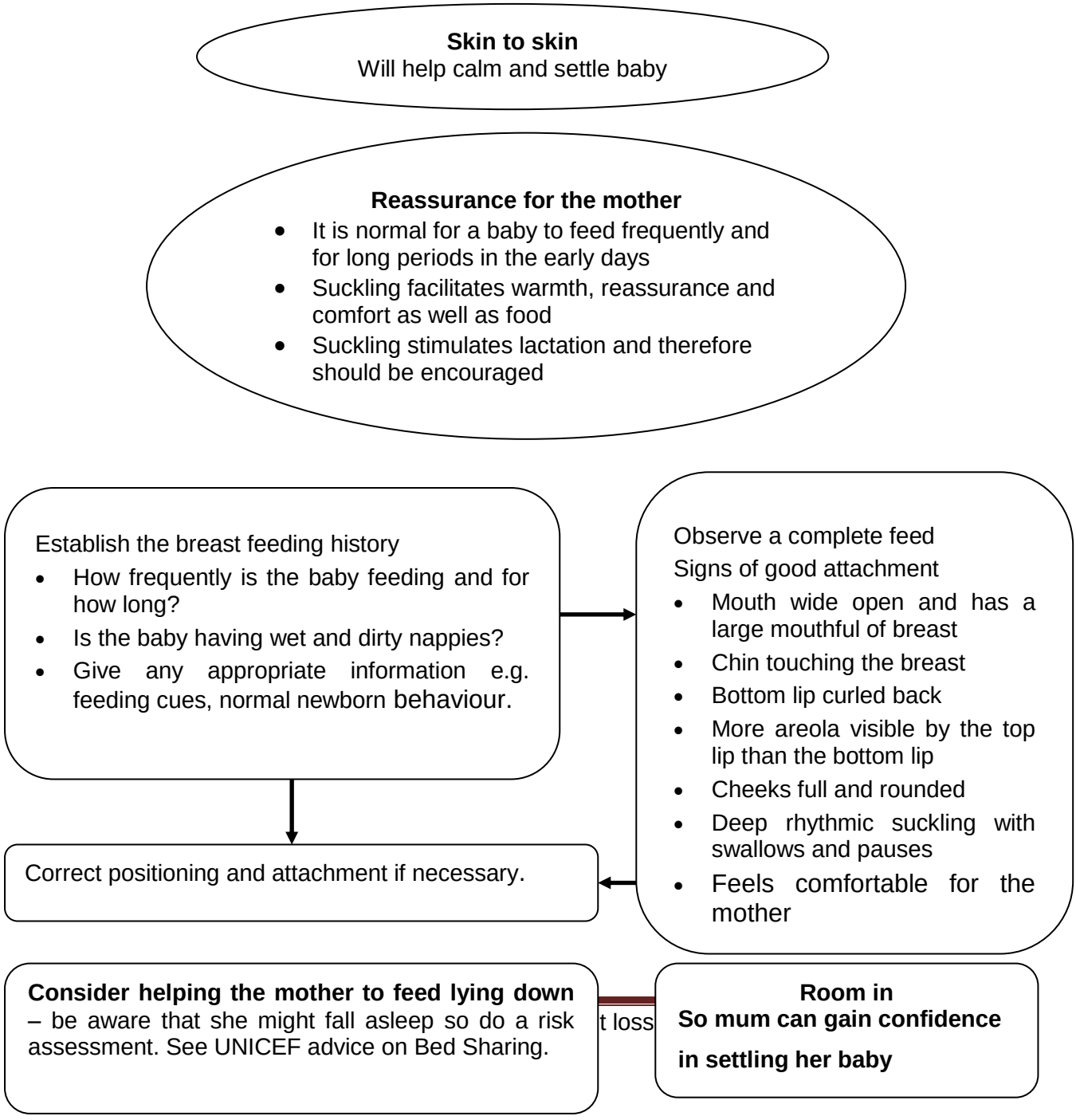
will sip or lap from the cup. Allow the baby to rest between sips, leaving the cup in place and **do not** pour the milk into the baby's mouth.

4.3 Supplementary Feeding or Complimentary

When colostrum is not present, a supplementary feed may be given with maternal consent. It is the responsibility of the accountable midwife to discuss with her the alternatives available and the disadvantages of giving formula. If it is the mother's informed choice to proceed with the supplementary feed, then the amount for each feed as follows:

Day 1: Commence milk feeds 30-60 ml/kg/day, supplemented by IV fluids if necessary
Day 2 – 7: Increase milk feeds by 30 ml/kg/day as tolerated

5. Management of the unsettled, term, healthy breastfed baby



6. Breastfeeding assessment:

The assessment tool can be used by mothers and professionals to recognise whether the baby is feeding well. Found within the purple perinatal institute postnatal notes.

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.						

*Urates are normal bladder discharges in the first few days but persistent urates may indicate insufficient milk intake.
** After 28 days, baby will establish their own pattern of bowel movement -may pass several per day or may have several days gap in between.

7. Weight Guidelines

7.1 Formula fed infants

Formula fed infants should be weighed on day 5 and once again prior to discharge to 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.**

7.2 Breastfed infants

Breastfed infants should be weighed on day 3 (72 hours) and again at day 5. Weight loss of 8% or more will trigger further action.

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 details
1	**8-10%**	• Observe a full breastfeed-ensure effective positioning & attachment. • Ensure minimum 8 feeds in 24hrs • Skin contact to encourage breastfeeding • Observe for change in frequency/amount of urine and stools. • Re-weigh day 5, continue to closely monitor and provide support. **If no or minimal weight increase, move to management plan 2.**
2	**10-12.5%**	*Follow management plan 1 plus:* • Express breast milk after each feed and consider giving it to baby by cup. If none available consider the use of a formula feed by cup • Referral if infection or other illness suspected • Weigh again in 24 hours. **If no or minimal weight increase, move to management plan 3**
3	**> 12.5%**	• Refer to neonatologist/ANNP Management of ongoing 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

7.3 Feeding Plans

A feeding plan indicates the need for appropriate supplementation. Expressed breast milk (EBM) should be used in the first instance, with formula milk only being used when EBM is not available.

7.4 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

8. Record Keeping

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.
All entries must have the **date and time** together with **signature and printed name.**

Training requirements

Audit of training needs compliance – please refer to TNA policy

Training needs analysis:
Please refer to 'Training Needs Analysis' guideline together with training attendance database for all staff

Cross references

Guideline development within the Maternity Services:
http://staffnet.plymouth.nhs.uk/Portals/1/Documents/Clinical%20Guidelines/Maternity/Guideline%20development.pdf?timestamp=1538658644196

Maternity Hand Held Notes, Hospital Records and Record Keeping:
http://staffnet.plymouth.nhs.uk/Portals/1/Documents/Clinical%20Guidelines/Maternity/Maternity%20hand%20held%20notes%20and%20hospital%20records.pdf?timestamp=1538733640084

References

Modi, N (2017) Avoiding Hypernatraemic Dehydration in healthy, term infants**,** *Arch Dis Child.* Vol 92, pp 474-47

UNICEF (2018) Baby Friendly Initiative: Resources [Available at https://www.unicef.org.uk/babyfriendly/]

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