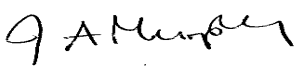
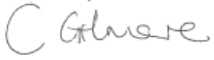
Barnsley Borough Wide
Joint Infant Feeding Policy.

We the undersigned are committed to ensuring that we and our staff will adhere to this policy:				
Authorised by:	Date Agreed	On behalf of:	Lead Director	Authors: Kay Bennett Sarah Beardsall Anne Amott Amy Booth
	2nd September 2019	Barnsley Hospital NHS Foundation Trust	Director of Nursing & Quality	
	2nd September 2019	Barnsley Metropolitan Borough Council	Director of Public Health 0-19 Service	
	29th August 2019	Barnsley Metropolitan Borough Council Family Centres	Early Start and Families Strategy and Service Manager	
Next Review Date: 2022 (3yrs)				

Please note this is a revised policy, acknowledgement to previous authors Kim Kennedy, Linda Robinson, Cathy Utley and Kay Bennett.

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1. Policy Statement

This policy has been written in line with UNICEF UK Baby Friendly Initiative Standards[44] to ensure that all staff within Barnsley Hospital Foundation Trust (BHNFT), Barnsley Metropolitan Borough Council (BMBC) understand their respective roles and responsibilities in supporting expectant and new mothers and their partners to feed and care for their baby which support optimum health and well being and very early years development.

This policy replaces the existing Joint Borough wide Breastfeeding policy (June 2014) and supports the **UNICEF Baby Friendly Standards.**

1.1: The aim of the policy is to support parents to develop healthy relationships with their baby through their chosen method of feeding (Appendix 2). It is expected that meaningful conversations staff have with parents will be client centred to enable important information to be communicated accurately.

1.2: All recommendations in this policy are evidence based with great emphasis on the infants' overall health and well-being.[18]

1.3: The policy is appropriate for all babies. Where special circumstances pertain, this will be reflected in the text, relevant pathways and guidelines.

1.4: Information and care is delivered without discrimination, regardless of, gender or transgender, race, disability, sexual orientation, age or religion or belief. Information is given to all patients and carers in a way in which they can understand that is mother or family centred and non-judgemental.

1.5: Where information is provided, it is provided in a format that is appropriate and acceptable to the parent(s). This enables support to be inclusive and accessible to all parents and their babies. A range of resources for different communication needs should be available and recommended. For example, written information available in easy read, different languages, braille etc. and non-written information available through provision of British Sign Language, interpreters etc.

1.6: It is mandatory that **all** staff adhere to this policy to deliver best practice and avoid conflicting information; any deviation from the policy must be justified and recorded in the mothers and or baby's health care records.

2. Philosophy

2.1: The foundation for lifetime health and wellbeing begins in pregnancy and infancy. Breast feeding or breast milk provides infants with all the nutrients and immune factors they need for healthy growth and development.[14,36,48.]

2.2: The aim of the policy is to ensure that parents and their babies receive evidence-based information and support. Maximising breastfeeding or breast milk, alongside the other benefits of skin to skin and responsive care, all aid attachment, optimal brain development and growth in the baby.[20]

2.3: Increased awareness of the health risks associated with NOT breastfeeding.[31] These are listed as:

Baby

- Gastroenteritis
- Respiratory infections
- Middle ear infections
- Type 1 Diabetes
- Obesity
- Atopic disease e.g.: there is evidence that breastfeeding is associated with less early childhood wheeze /eczema
- Childhood leukemia
- Coeliac disease
- Necrotising Enterocolitis in the premature baby
- Neonatal sepsis
- Reduced Sudden Infant Death
- Lowered IQ in the infant (if not breastfed)
- Dental carries [28]

Mother

- Breast cancer
- Ovarian and endometrial Cancers
- Cardio vascular disease
- Type 2 diabetes

There are another 45 conditions where there is some evidence of breastfeeding preventing illness or infection but more research is needed.

2.4: UK breastfeeding rates are among the lowest in Europe despite the acknowledged values of breastfeeding. The UK Government recommends that babies should be exclusively breastfed for 6 months of life and then on-going as part of their diet to the end of the first year and as long as the mother wishes.[28,48, 49.]

2.5: The Joint Borough Wide Infant Feeding Policy is in place to enable all organisations, including the voluntary sector, to work collaboratively, within welcoming environments, thereby, strengthening the impact of positive early relationships on wellbeing.

2.6: The policy outlines effective communication skills to acknowledge the importance of a mother centred approach to ensure that mothers and their partners are enabled to make informed decisions on their choice of infant feeding. [33,40]

2.7: Multi - agency infant feeding training will be provided to ensure that consistent clear message are given in a variety of ways to ensure the needs of the Barnsley population are met.[17] This will ensure all partners are committed to protecting, promoting and supporting children, young people and their families and the future health outcomes of the town.[27]

2.8: All partners will ensure they adopt the International Code of Marketing of Breast milk substitutes.[47] The code prohibits the advertising, display, sale or distribution of materials which promote breast milk substitutes, feeding bottles, teats or dummies to the general public. This includes free gifts to professionals, display of company logo's and use of promotional literature. Representatives of formula companies will be seen by designated staff members and by appointment only. Staff training will ensure that staff understand the rationale behind this requirement and equip them to apply this in their own practice.

3. Aims and Outcomes

3.1: The policy aims to ensure that the care provided by staff across the borough improves outcomes for children and their families, specifically:

- Uninterrupted skin to skin at birth, for all babies where possible.[5,37]
- An increase in the number of infants on the Neonatal Unit (NNU) receiving skin to skin and breast milk. Discharged home breastfeeding or human milk feeding.
- An increase in the numbers of babies initiating breastfeeding or human milk feeding.
- An increase in the initiation of breastfeeding and the numbers of babies who are on discharged home from hospital and at 10-14 days continuing to breastfeed or human milk feed.
- An increase in the number of babies' breastfeeding or human milk feeding at 6-8 weeks, this includes inpatient neonates.
- To increase exclusive breastfeeding up to 6 months and beyond alongside complementary feeds.
- Increases in the proportion of mothers or parents who chose to formula feed reporting that they have received proactive support to formula feed safely and responsively as possible, in line with nationally agreed guidance.
- Improvements in parents' experiences of care via services which promote responsive child parent relationships.
- A reduction in the number of readmissions to Child Assessment Unit and Paediatrics for infants with feeding issues e.g. weight loss.
- Increases in the proportion of parents who introduce complementary food to their baby in line with nationally agreed guidance.
- An increase in the uptake of the Healthy Start scheme[11] and vitamins for pregnant women, breastfed babies and children under 4 years of age in eligible families.

- An increase in the uptake of nationally recommended vitamin supplementation in non-eligible families.

4. Our Commitment

4.1: All partner agencies are committed to work collaboratively to:

- Provide the highest standard of care, giving clear impartial information to support pregnant women and new mothers and their partners to feed their baby, building strong, loving parent-infant relationships.[33,49.] This is in recognition of the profound importance of early relationships to future health and wellbeing and the significant contribution that breastfeeding makes to infant brain development, good physical and emotional health outcomes for children and mothers.[14,41]
- Support mothers to have a positive infant feeding experience and ensure that all care is mother and family centred, non-judgemental, supporting and respecting mothers and their partner's decisions.
- Work with families to improve and enhance parenting experiences.
- Work together across disciplines and organisations to improve mothers or families experiences of care within their communities (including the voluntary sector), developing networks and further developing the understanding of local needs, ensuring these are met according to evidence based practice.
- Clear pathways in place for additional help for mothers who require this.
- Display the policy in designated places and to make available on the respective intranet sites of each service. The parents' guide to the policy will also be accessible to **all** women and or families. The full policy will be available in each area upon request.
- Inform families about how to raise concerns about the care they receive if they feel that it was not compliant with this policy.

5 Training requirements and Implementation

5.1: **All** new staff will be orientated to the policy within 1 week of commencement of employment in order to enable them to understand the standards and how to implement these in practice.

5.2: The education programme is mandatory and reflects feedback from evaluation and audit of staff, mothers and their families and will be reviewed accordingly.

5.3: Multi-agency staff receives on-going annual mandatory Infant Feeding training (1-3 hours) to enable them to implement the policy as appropriate to their role. All respective managers have signed up to the overarching Infant Feeding training programme to ensure compliance with the Baby Friendly Initiative standards and are responsible for the monitoring of this. All new staff will receive 15 hours training within 6 months of commencement of

employment to ensure the standards are consistently maintained and aim to strengthen the mother's self-efficacy.

5.4: Training should ensure that multi-agency staff is aware of the different support needs of pregnant / new parents and their families, particularly those from diverse groups, such as:

- Black Minority and Ethnic parents
- Parents in same-sex couples
- Trans parents
- Parents with disabilities
- Teenage parents
- Parents from with different religious and/or cultural values

5.5: Multi agency staff receives education in the skills required to safely assist mothers who have chosen to formula feed at a level appropriate to their role and level of responsibility.

5.6: Medical staff have a responsibility to promote breastfeeding and provide appropriate support to breastfeeding mothers and their families. Information and or training (on-line and face to face) will be available to enable them to do this.

5.7: Clerical and ancillary staff working with mothers and their babies will receive information and guidance to enable them to refer to a suitably qualified person for relevant support in respect to all areas of infant feeding.

5.8: The International Code of Marketing of Breast milk substitute[47] is implemented throughout the Borough and embedded as part of multi-agency training.

5.9: All documentation or materials produced must fully support and reflect the implementation of these standards. (See relevant appendices on pathways and Guidelines).

5.10: Families experiences of care will be listened to and acted upon through regular audit, surveys and service user feedback to Ofsted and Care Quality Commission.

6. Care Standards. This section sets out the care that all partner agenise will provide to every pregnant woman and new mothers. It is based on UNICEF Baby Friendly Standards[14] relevant NICE guidance for maternity, neonates, health visiting (Barnsley 0 19 public health service) and the family centres.[20,21,22,24]

7. Support in Pregnancy

All services recognise the importance of human milk for babies' survival and their health.

7.1: All pregnant women will have the opportunity to have a meaningful discussion with a health professional or other suitably trained designated person. This will be a discussion that is time appropriate, unbiased and evidence based. Plans for Pregnancy and Parenthood [25] will be discussed, including: feeding, caring for their baby to support them in their decision making, taking into account their individual circumstances and needs.

7.2: This discussion will take place as part of routine antenatal care as identified in the Universal Healthy Child Programme[10] or as a targeted intervention through antenatal parent education or with an Infant feeding support worker. The discussion will be documented in the perinatal notes, in the Plans for Pregnancy and Parenting section and SystmOne. This will include:

- The value of connecting with and developing a positive relationship with their growing baby in utero.[33, 41]
- The importance of vitamin supplementation to support growth and development of the baby in utero.
- The value of uninterrupted skin contact for all mothers and babies immediately after their birth or as soon as possible and encouraged in the postnatal period for extended periods of time.[5,8]
- The importance of responding to their baby's needs, for touch, comfort, and communication and the role that keeping their baby close has in supporting this.[3,9]
- Helping prepare mothers for feeding and caring for their baby in ways that will optimise their own and their babies' wellbeing, by exploring what parents already know about breastfeeding, building on parent's knowledge and experience. This will enable them to get breastfeeding off to a good start. Understanding the value of exclusive breastfeeding and or maximising human milk that any amount of breastfeeding acts as protection, comfort and food.
- Information on formula feeding will be available on a 1-1 basis upon request in the antenatal period for women who have made an informed decision to formula feed. This will be reinforced by written material. There will be no group demonstrations of how to make up formula as this has been shown to undermine breastfeeding.[45]

7.3: Health professionals will discuss with families the evidence based recommendations on safe sleep and bed sharing to ensure that key messages are explored and understood. [1,3]

8. At Birth

8.1: All mothers should be encouraged to hold their babies in uninterrupted skin-to-skin contact immediately after birth, [4, 8, 9] this is regardless of their chosen method of feeding. All babies will be dried except for the forearms as the smell of liquor encourages the breast crawl.[34] Skin-to-skin contact should last for as long as possible[4] (a minimum of one hour or until after the first breastfeed whichever is sooner or longer in accordance with mothers wishes).

8.2: Skin to skin encourages instinctive breast seeking behaviour therefore wherever possible mother and baby should be kept in skin to skin, until after the first feed and for as long as the mother wishes if it is safe to do so.[5] Some babies need more time to achieve the first feed e.g. mothers receiving opiate analgesia through labour therefore parents may require additional support of extended skin to skin, hand expressing milk to give small amounts of colostrum to optimise their chances of exclusive breastfeeding.

8.3: Washing and dressing of infants should be delayed to enable the 9 stages of breast seeking behaviour to take place.[5] Weighing baby should be left until after the first breastfeed. Where the baby has to be weighed earlier the baby should be placed prone in the scales immediately after birth with minimal disruption to skin contact. If the 9 stages have been interrupted, support the mother and baby to start the 9 stages of skin to skin from the beginning.

8.4: All mothers who choose not to breastfeed should be offered the opportunity to formula feed their baby in skin-to-skin contact and discuss the importance of keeping baby close, therefore making baby feel secure and enabling parents to recognise feeding cues.[43]

8.5: 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. If the mothers are unable to provide skin to skin, the mother's partner should be encouraged to do so.

8.6: Staff should endeavour that skin contact is offered and maximised in all situations including at instrumental or operative births.[39] Timing, duration and reason for ending skin-to-skin contact at birth will be documented in mothers and baby's records and partogram.

8.7: Mothers with babies who require transfer to a neonatal unit are offered skin to skin wherever possible, including the use of kangaroo care. Mothers are supported and enabled to start expressing milk effectively as soon as possible after birth. [29,30,34]

8.8: 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 and that in the absence of the mother skin to skin contact will be offered to her partner or designated close family member. Skin contact will usually calm a fretful baby of any age.

8.9 Safety Considerations.

Vigilance 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 to skin contact, in the same way as would occur as 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 that the baby cannot fall 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 is not obstructed.

Many mothers can continue to hold their babies in skin to skin during perineal suturing. However adequate pain relief is required, as a mother who is in pain is unlikely to hold her baby comfortably or safely.

Mothers should be discouraged from holding their baby when receiving analgesia which cause drowsiness or alters their state of awareness (e.g. Entonox)

Where mothers who chose to formula feed in skin to skin contact particular care should be taken to ensure baby is kept warm.

9. Support for Breastfeeding, the early days

9.1: Mothers will be enabled to achieve effective breastfeeding according to their needs and empowered by staff adopting a 'hands off' approach. This will include appropriate support with positioning and attachment, hand expression, understanding signs of effective feeding. This will continue until the mother and baby are feeding confidently.

9.2: Mothers will be encouraged to respond to their babies feeding cues and respond to their desire to feed their baby. Responsive feeding recognises that feeds are not just for nutrition, it is also for comfort, love and reassurance between mother and baby.[43]

9.3: Information to be given to all mothers:

- Responsive breastfeeding means feeding their babies whenever they are hungry and as often as the baby wants, being aware there are no set rules for the number or length of feeds in a 24 hour period unless there are clinical indications. Explaining that it is normal to expect a baby to feed between 8-12 times or more in 24hrs in the early weeks.
- The importance of and management of night feeds in order to maintain their milk supply.[46]

- The benefits of keeping their baby close in the same room for at least the first 6 months.[3]
- The appropriate information about safe sleeping (see pathway).
- Whilst in hospital the practice of separating babies from their mothers has been shown to hinder attachment as well as the establishment of breast feeding.[46] All mothers and babies will be kept together for the duration of their hospital stay, unless medically indicated. [45]

9.4: 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 (PCHR and Mothers and Others guide).

9.5: All mothers who initiate breastfeeding will be contacted within 48-72hrs of discharge home or following home birth by the 0-19 Infant Feeding to support their ongoing feeding choice.

9.6: A formal feeding assessment will be carried out using the Barnsley Infant Feeding Assessment tool found in the maternal and neonatal combined notes, as a minimum of two assessments in the first week on day 3 and 5 or daily as best practice. This will ensure effective feeding and the wellbeing of the mother and baby. 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.

9.7: All breastfeeding mothers will be informed about local support services for breastfeeding e.g. health professional contact details, infant feeding support workers, voluntary peer support services and family centres breastfeeding groups. In a way that is appropriate for them.

9.8: For those mothers who require additional support for more complex breastfeeding challenges, the health professional supporting them will initially address these issues. If further support or information is required a further referral can be made to the BHNFT Infant Feeding Coordinator and or BMBC 0-19 service, Infant Feeding Coordinator, Infant Feeding Service lead, Infant Feeding team leaders (see relevant pathways).

10. Exclusive Breastfeeding

10.1: Mothers who breastfeed will be provided with information about why exclusive breastfeeding for as long as possible leads to improved outcomes for them and their baby and why it is particularly important during the establishment of breastfeeding.

10.2: Healthy term new-borns that are breastfed do not need to be screened for hypoglycaemia and do not require supplementary food or fluids.[6] The nutritional needs of a healthy term new born baby can be met through colostrum and this also has significant

immunological properties.[32] Additional fluids will not be given unless there are medical indications and or with a fully informed maternal choice, [45] where possible this will always be the mothers expressed breast milk. (See Appendix 14).

10.3: When babies require supplementary feeds in hospital whether requested by the mother or due to clinical indication, information will be provided to enable an informed decision and to maximise breastfeeding. This will include the detrimental effects supplements can have on mother's milk supply and the gut flora changes influencing the future health of the mother and baby.[45, 46] All supplements given whilst in hospital, including the rationale for supplementation and the discussion held with the parents will be documented in the mothers and baby's records and audited by the Infant Feeding Coordinator using the BFI supplementation audit tool.

10.4: When supplementary feeds are introduced parents will be encouraged that any breastfeeding is of value and supported to maximise breastfeeding to ensure their baby receives the maximum amount of breast milk possible.[14]

10.5: The introduction of dummies or teats has been shown to have an adverse effect on breastfeeding, especially when breastfeeding is not already established. Mothers should be informed of this antenataly [16, 45] with ongoing discussion in hospital and in the community to support mothers informed choice. All discussions should be documented in the mothers and baby's records.

10.6: Nipple shields are only recommended in specific circumstances and only under the care of a skilled practitioner. Mothers should be informed of the disadvantages of nipple shields and support should be provided to identify and correct the underlying problem to ensure their use is discontinued as soon as possible.[46]

11. Modified Feeding Regimes

11.1: There are a number of clinical indications for a short term modified feeding regime in the early days after birth or for a modified approach to responsive feeding in the short term. Examples include: preterm or small for gestational age babies and those who are extremely sleepy after birth, babies who have not regained their birth weight or who are gaining weight slowly. Frequent feeding, including a minimum number of feeds in 24 hours, should be offered to ensure safety.

11.2: Responsive feeding should resume when clinical indications are resolved and staff will ensure that mothers return to responsive feeding.

12. Formula Feeding

11.1: Mothers who choose to formula feed or introduce some formula feeds will have the information they need to enable them to do so as safely and responsively as possible. This information will be provided as early as possible after birth and reinforced or revisited being sensitive to mother's knowledge and previous experience. Wherever possible first feeds should be given by the mother to facilitate attachment and responsive parenting.

All staff will:

- Encourage the mother to give the first formula feed in skin to skin contact and encouraged on going skin to skin thereafter according to mums wishes or clinical indications.
- Have a discussion with mothers who formula feed about the importance of responsive feeding to enhance the relationship between mother and baby. Mothers will understand that comfort and communication are good for babies' brain and early year's developments.
- Mothers who formula feed will be encouraged to keep baby close 24 hours a day and limit the number of care givers feeding the baby in the first few days and early weeks thereby enabling mothers to recognise and respond to early feeding cues.
- Mothers who formula feed will be encouraged to cuddle and hold baby close for good eye contact, whilst inviting their baby to draw in the teat rather than forcing the teat into their baby's mouth.
- Have a discussion with mothers on pacing the feed so that their baby is not forced to feed more than they want to, this will enable them to recognise their baby's cues when they have had enough milk and avoid forcing their baby to take more milk than their baby wants, as this will inhibit the baby's appetite control mechanism.

12.2: Mothers who formula feed will be enabled to do so as safely as possible according to national guidelines. This will be facilitated through the offer of a demonstration and or discussion about how to sterilise and prepare infant formula and will be supported by written information (PCHR).

12.3: The type of formula recommended for use within the first year is stage 1 whey based protein milk unless otherwise advised by a dietician.

12.4: Health professionals will revisit and reiterate with families the evidence based recommendations on safe sleep to ensure that key messages are explored and understood (see pathway).

12.5: Parents will be provided with verbal and written information on how to access ongoing support upon discharge in a format that is appropriate and accessible to them.

13. Support for Continued Breastfeeding at Home

13.1: All decisions parents make about feeding, including decisions to formula feed, to reduce the level of breastfeeding or stop breastfeeding completely will be respected by health professionals and given appropriate support.[32] however every opportunity should be taken to maximise breastfeeding.

13.2: There will be a comprehensive handover (written and or verbal) related to the feeding history when the mothers and baby's care is passed onto the Health Visiting team to ensure effective collaborative working and a seamless transition of care for mother and baby (PCHR).

13.3: When at home all parents will be encouraged to keep their babies near them day and night so that they are able to respond promptly to feeding cues.[13, 32] The importance of close contact with their babies for safety, comfort and communication will be discussed and encouraged. Health professionals will revisit and reiterate with families the evidence based recommendations on safe sleep to ensure that key messages are explored and understood.[41]

13.4: A postnatal Safe Sleep risk assessment will be undertaken by the midwife on the first home visit and documented in the maternal and neonatal notes (Appendix 6).

13.5: The Infant Feeding Service will contact the mothers who have initiated breastfeeding between 48 and 72 hours after discharge from hospital to assess breastfeeding using the Barnsley Infant Feeding assessment tool, raising any concerns with the mother's health care professionals.

13.6: A formal breastfeeding assessment using the Barnsley Infant Feeding Assessment Tool (Appendix 10b) will be carried out by the Health Visitor at the new baby review or birth visit at approximately 10-14 days to ensure effective feeding and wellbeing of the mother and baby. This includes recognition of what is going well and identification of any problems to formulate an appropriate plan of care with mother which will be documented in the PCHR and SystmOne.

13.7: Mothers requiring additional information for more complex breastfeeding challenges will be supported by their relevant health professional in the first instance. If further additional support or information is required then a referral from the health professional to the Infant Feeding Leads will be made. Mothers will be made aware of specialist support available.

13.8: Mothers will have the opportunity for a discussion about their options for continued breastfeeding to maximise breastfeeding according to individual need.[44]

13.9: All partners will work in collaboration to provide local services in family centres or other appropriate venues to ensure that parents are “Welcomed to Breastfeed” in comfortable. Written information about local and national services will be provided on the maternity and BMBC websites, Personal Child Health Record and the Mothers and Others Guide.

14. Support for Safety, Parenting and Close Loving Relationships

14.1: Skin to skin contact will be encouraged throughout the postnatal period and beyond for all babies.

14.2: All parents will be supported to understand a new-born baby's needs including encouraging frequent touch and sensitive verbal or visual communication, keeping babies close, responsive feeding and safe sleeping practice.[21, 24]

14.3: Mothers who formula feed will be encouraged to hold their baby close during feeds and offer the majority of feeds to their baby themselves particularly in the early days to help enhance the mother, baby relationship.

14.4: Mothers will be given information about local and national parenting support that is available.

15. Introducing Complementary (solid) Foods weaning (see definition)

15.1: All parents will receive on going information regarding infant feeding and family nutrition and should know when and how to introduce food including: [2, 12,36,28,15]

- Recommendation that exclusive breastfeeding should continue until 6 months of age (26 weeks) and continued following introduction of complementary foods to at least 1year but ideally 2years and beyond.[48]
- Complementary food should be started at around six months along with breast or formula feeds.
- Information for parents on babies developmental signs and readiness for complementary foods.
- How to introduce complementary food to babies safely.
- Advice on appropriate foods for baby.
- Information on appropriate introduction of cow’s milk at one year of age.

16. Neonatal Unit

We recognise the profound importance of secure parent-infant attachment for the future health and wellbeing of the infant and the huge challenges that the experience of having a sick or premature baby can present to the development of this vital relationship. Therefore,

we are committed to care which actively supports parents to develop a close and loving bond with their baby.[40] Mothers with a baby on the neonatal unit will be:

- Enabled to have a discussion with an appropriate member of staff as soon as possible (either before or after the baby's birth) about the importance of touch, comfort and communication for their baby's health and development.

- Actively encouraged and enabled to provide touch, comfort and emotional support to their baby throughout their babies stay on the neonatal unit developing responsive care to their baby's behavioural cues thereby nurturing a close and loving attachment.

- Enabled to have frequent and prolonged skin contact with their baby as soon as possible after birth and throughout their stay on the unit as baby's clinical condition allows (Kangaroo Care guidelines).

16.1: Through enabling babies to receive human milk and to breastfeed we recognise the importance of human milk for babies' survival and health reducing morbidity and mortality.[36] Therefore, we will ensure:

16.2: A mothers own breast milk is always the first choice of feed for her baby, (donor milk may be appropriate where a baby meets the unit's criteria).

16.3: Mothers will have a discussion with relevant health professionals regarding the importance of their breast milk for their preterm or ill baby as soon as is appropriate.

16.4: A suitable accessible, environment with appropriate equipment will be provided to enable mothers to effectively express their breast milk.

16.5: Support and encouragement will be given to commence expressing milk as soon as possible after birth (ideally within 2 hours),[14] initially by hand and then by pump increasing to dual pumping to increase yield of milk.

16.6: Mothers will learn how to use pump equipment, sterilise and store milk safely (using Mothers and Others Guide, Neonatal guidance).

16.7: Mothers will encouraged and supported to express frequently, staying close to their baby when expressing where possible (at least 8 times in 24hrs including once at night) especially in the first two to three weeks following delivery in order to optimise long term milk supply (more than 750ml in 24 hours by day 10).

16.8: When baby is not tolerating oral feeds the use their mother's milk to be used for mouth care, and later to tempt their baby to breastfeed.

16.9: Mothers will be given support to recognise and respond to feeding cues in the transition to breastfeeding.[38] Using skin to skin contact to encourage instinctive feeding behaviour, [30] support with position and attachment for their baby enabling them to recognise effective feeding and overcome challenges when required (Appendix 10b).

16.10: Babies who are preterm and nursed in the neonatal unit may require alternative options for feeding and soothing which may involve using teats and dummies. This will be based on clinical need or to promote non-nutritive sucking.[26]

16.11: Mothers are provided with details of peer support for breastfeeding which they can contact or access during their baby's stay.

16.12: Mothers are supported through the transition to discharge home from hospital, including having the opportunity to stay overnight or for extended periods to support the development of mother's confidence and modified responsive feeding.

16.13: Referral to Neonatal Outreach for on-going support if appropriate.

17. Valuing Parents as Partners in Care

17.1: We recognise that parents are vital to ensuring the best possible short and long term outcomes for babies and therefore, should be considered as the primary partners in care.[29,40,] We will ensure that parents:

- Have unrestricted access to their baby unless individual restrictions can be justified for the baby's best interest.
- Are fully involved in their baby's care, with all care possible entrusted to them.
- Are listened to, including their observations, feelings and wishes regarding their baby's care.
- Have full information regarding their baby's condition and treatment to enable informed choice.
- Are made comfortable when on the unit, with the aim of enabling them to spend as much time as is possible with their baby.

18. Healthy Start and Vitamin Supplementation.

18.1: All staff will advise pregnant women and parents of children under 4 years about the need for vitamin supplementation specifically Folic acid and Vitamin D (NICE guidance) and provide information about the Healthy Start scheme.[11, 35] They should ensure all women who

may be eligible receive an application form as early as possible in pregnancy or at any relevant opportunity if circumstances change.

18.2: Health professionals should take particular care to check that women at greatest risk of deficiency are following advice to take a vitamin D supplement during pregnancy and while breastfeeding. All breastfed babies from birth should receive vitamin D supplementation. These include women: who are obese, have limited skin exposure to sunlight or who are of South Asian, African, Caribbean or Middle Eastern descent.

18.3: Health professionals will offer the maternal Healthy Start vitamin supplement to **all** pregnant women and support those who are eligible in completing the Healthy Start application form (Appendix 8).[11]

18.4: All staff will inform families where they can obtain on going supplies of Healthy Start vitamins or there equivalent if not eligible to obtain the free vitamins.[23]

18.5: Health professionals should use every opportunity they have to offer parents to be or parents, practical, tailored information, support and advice on:

- Healthy eating and increasing intake of fruit and vegetables.
- How to use Healthy Start vouchers to increase their fruit and vegetable intake.
- How to initiate and maintain breastfeeding.
- How to introduce foods in addition to milk as part of a progressively varied diet when infants are 6 months old and progressing onto consumption of well balanced, nutritional family meals.[2]

19. Alcohol.

19.1: Alcohol will be discouraged because it can inhibit the milk ejection reflex and has a mild sedative effect on the baby.[7] A discussion should be held highlighting the dangers of alcohol and its impact on the parents' ability to care for and keep their baby safe.

20. Smoking.

20.1: Smoking lowers prolactin levels. Smoking is associated with significant reduction in milk volume and milk fat concentration. However, breastfeeding is still the best choice even if mother is unable to give up smoking.[19]

20.2: Parents who smoke will be advised of the associated risks or dangers of bed sharing with their baby, as it is known to be an associated factor in Sudden Infant Death syndrome.[3]

20.3: Parents who wish to give up smoking in either the antenatal or postnatal period should be referred to the relevant stop smoking service.

21. Monitoring the Compliance and Effectiveness of this Policy

21.1: **All** organisations should be aware that by signing up to this policy, they may be audited and assessed by staff from BHNFT, BMBC and will be assessed for accreditation by a member of the Baby Friendly Initiative**.**

21.2: Compliance of the policy and information given to women in the antenatal and postnatal period will be audited annually using Baby Friendly Initiative audit tools to ensure that the policy is effective and being adhered to. Baby Friendly audit tools are nationally recognised and comply with standards of local audit departments.

21.3: Audit results will be reported to the Infant Feeding Steering Group and an action plan will be agreed to address any areas of non-compliance that have been identified. Results will be shared with senior managers and all staff to ensure adherence to the policy.

22. Monitoring Outcomes

22.1: Data relating to infant feeding showing prevalence of both exclusive and partial breastfeeding will be collected at: birth, on discharge from hospital, at the 10 to 14 days first visit from HV services, at the 6-8 weeks contact and again at 8-12 months retrospectively.

22.2: Data will be collated and reported quarterly via the Infant Feeding Steering group and associated performance teams.

22.3: Data will be utilised to effect and facilitate targeted work in improving rates at locality level.

23. Equality Impact Assessment.

23.1: All staff within the BHNFT and BMBC are committed to ensure that both current and potential service users and their families will not be discriminated against on the grounds of religion, gender, race, sexuality, age, disability, ethnic origin, social circumstance or background. The central belief to the care we provide is the principle of tolerance and understanding and respect for others.

23.2: A joint Equality Impact Assessment of this policy has been conducted by Barnsley Council.

24. Definitions

24.1: UNICEF Baby Friendly Initiative. The Baby Friendly Initiative[44] is a worldwide programme of the World Health Organisation and UNICEF. It was established in 1992 to encourage maternity hospitals to implement the 10 Steps to Successful Breastfeeding and to practice in accordance with the International Code of Marketing of Breast Milk Substitutes.[47]

The UNICEF UK Baby Friendly Initiative was launched in the UK in 1994 for hospital trusts and in 1998 for community trust and local authorities to cover the work of the community health care services and children's centres to implement the 7 Point Plan for the Promotion, Protection and Support of Breastfeeding in the community health care settings.

The Baby Friendly Initiative works with the health care system to ensure a high level standard of care for pregnant women and breastfeeding mothers and babies.[44] Baby Friendly Initiative officers provide support for health care facilities that are seeking to implement best practice and offer an assessment and accreditation process that recognises those that have achieved the required standard.

24.2: WHO (1981) International Code of Milk Marketing. The World Health Assembly adopted the **International Code of Marketing of Breast Milk Substitutes** in 1981 to protect and promote breastfeeding, through the provision of adequate information on appropriate Infant Feeding and the regulation of the marketing of breast milk substitutes, bottles, teats and dummies.

The code stipulates that there should be absolutely no promotion of breast milk substitutes, bottles and teats to the general public; that neither health facilities nor Health Professionals should have a role in promoting breast milk substitutes; and that free samples should not be provided to pregnant women, new mothers or families.[47]

24.3: Responsive Feeding.[44] Responsive feeding involves the mother responding to her baby's feeding cues as well as her own desire to feed her baby.[52] This relationship is sensitive, reciprocal, and about more than nutrition. Breastfeeding can be used to feed, comfort and calm babies; 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. A mother can also offer the breast to meet her own need i.e. if she wants to have a rest, sit down, and have a cuddle or before she goes out. It is recommended that formula fed babies should also be fed responsively according to hunger cues as it is possible to over feed a formula fed baby and this inhibits the baby's appetite control mechanism.

24.4: Exclusive Breastfeeding. The infant receives only breast milk (including breast milk that has been expressed or from a donor source) and nothing else, except hydration solutions, medicines, vitamins and minerals.

24.5: Mixed Feeding. The Infant receives breast milk (this may include breast milk that has been expressed or from a donor source) non-human milk and formula and any other food or liquid including water before 6 months of age.

24.6: Formula Feeding. Formula milk is usually made from cows milk and is treated to make it more suitable for babies and can be purchased in the powder form to mix with water or readymade.

24.7: Weaning or Complementary Feeding. Weaning is the process when breast or formula milk alone is no longer sufficient to meet the nutritional requirements of a baby; therefore other sources of nutrition are needed. The WHO recommends exclusive breast feeding until 6 months as it offers extra protection against infection and gastroenteritis and continues to protect them for as long as breastfeeding is maintained.[28,45] A baby needs no additional substance other than breast milk or infant formula for the first 6 months of life. This gives a baby's digestive system time to develop so that they cope fully with solid foods. This includes solid food made into purees and cereals added to milk.

24.8: Sudden Infant Death Syndrome (SIDS) Is the sudden and unexpected death of a baby where no cause is found. Safer sleep provides a clear message to parents or carers on how to put babies to sleep, to reduce the risk of SIDS.[1,53]

24.9: Healthy Start. The Healthy Start scheme is a statutory scheme which aims to provide a nutritional safety net to low income families by providing vouchers for free fresh milk, infant formula, fresh fruit and vegetables to young children and pregnant women, as well as free vitamin supplements.[21] The scheme also encourages earlier and closer contact with Health Professionals who can give advice on pregnancy, breastfeeding and healthy eating.[11]

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26. List of Appendices

Appendix 1 Abbreviations for Pathways

AF / BF	Artificial Feeding / Breastfeeding
AN /PN	Antenatal / Postnatal
BFAT	Breastfeeding Assessment Tool
BFI	Baby Friendly Initiative UK
BM	Breast Milk
BMBC	Barnsley Metropolitan Borough Council
BP	Breast Pump
CDP	Child Development Practitioner
EBM	Expressed Breast Milk
FC	Family Centre
HAB	Having a Baby: Parenting Programme
HCA	Health Care Assistants
HE	Hand Expression
HP	Health Professional
IFC	Infant Feeding Coordinator
IFD	Infant Feeding Discussions
IFL	Infant Feeding Lead
IFS	Infant Feeding Service
IFSW	Infant Feeding Support Worker, (BHNFT & BMBC)
MW / CMW	Midwife / Community Midwife
NNU	Neonatal Unit
RA	Risk Assessment
PCHR	Personal Child Health Record
PHN	Public Health Nurses
PHSW	Public Health Support Workers
SCPHN	Specialist Community Public Health Nurse
SSRA	Safe Sleep Risk Assessment
S1	SystmOne
UNICEF	United Nations International Children's Fund

Appendix 2

Parents' Guide to the joint Hospital / Community Infant Feeding Policy

The aim of this parents' guide is to ensure all parents receive information about the Infant Feeding Policy. All staff working with pregnant women and new mums are trained to the Baby Friendly Initiative Standards. The Guide below explains what you can expect at different stages through pregnancy, birth, early days at home and later weeks.

Please ask your Health Professional or the Infant Feeding Service if you wish to see the full policy.

PREGNANCY - What can you expect?

During this time you and your partner will begin to develop a relationship with your unborn baby.

You will have the opportunity to have a meaningful discussion with your Midwife about preparing for birth and early days with your new born baby.

A 1-1 or group discussion on Infant Feeding by a trained member of staff will be offered.

You will be provided with an awareness of the standard of care from maternity, 0-19 Public Health Nursing service and Family Centres, where to find information and support.

You will be given Information about Healthy start Scheme and vitamin supplementation.

BIRTH - Infant feeding and relationship building

Unhurried skin to skin contact as soon as possible after birth for all babies.

We encourage the first feed to be given in the first hour by mum in skin contact whatever your feeding choice is.

Continued support is available. Keeping your baby nearby /close to you at all times.

Discussions to support your preferred feeding choice will be given to meet your individual needs. Discussion on Safe Sleeping.

EARLY DAYS and BACK AT HOME – Nurturing and feeding, learning together

Getting to know your baby, through having a close loving relationship, including partners and siblings.

Getting breastfeeding of to a good start
Effective position and attachment,
Responsive feeding,
How to tell your baby is getting enough milk,
Managing night feeds.
Hand expression and safe storage of milk.
Continuing skin to skin contact.
Where to access ongoing support: peer support and social networks in Family Centres.

Formula feeding mums
Information on how to make feeds safely,
Use of first milks for the first 12 months,
How to feed baby responsively.

LATER WEEKS - Now feeding is established

Breastfeeding out and about.
Breastfeeding Welcome Scheme.
Recommend exclusive breastfeeding for the first 6 months and the importance of breastfeeding for mum and baby as long as they wish, with appropriate solid foods from around 6 months.
Importance of closeness / responding to your baby.
Support to return to work and maximising breastfeeding/breastmilk.

Special Care / Neonatal Mums

Shown how to express breastmilk and encouraged to do this frequently. Enable skin contact as soon as possible. Understand the value of breastmilk and kangaroo care for preterm babies.

All family's given information on how to access Healthy Start and vitamins supplementation up to 4 years of age.

Please remember: - this is a new skill, each mother and baby is unique. The more breastmilk you give your baby the more milk you will produce. No question is a silly question when it comes to caring for your baby.
If you have any concerns or questions please contact either your Midwife, 0-19 Public Health Nursing service including the Infant Feeding Service.

Appendix 3

Antenatal Infant Feeding Multi-Agency Pathway

6-10 weeks signpost to Maternity website for information on:	24 weeks discuss and commence Plans for Pregnancy and Parenthood, in perinatal notes:	28 weeks continue Plans for Pregnancy and Parenthood, discuss:	31 weeks continue Plans for Pregnancy and Parenthood, discuss:	32-36 weeks: 0-19 services
BMBC 0-19 IF Service. Having a Baby Programme Links to: NHS Choices. Start4life, "Off to The Best Start". Baby Friendly Initiative UK. Best Beginnings, Baby Buddy App. Healthy Start. Lullaby Trust and Basis online.	Connecting with your baby. Best Beginnings. Attended Infant feeding discussions. Having a Baby Programme. Breastfeeding workshop. Healthy Start.	Greeting your baby for the first time. Skin to skin. Healthy Start.	Responding to your baby's needs. Feeding your baby. Healthy Start.	All Health Professionals and IFS to check and revisit Plans for Pregnancy and Parenthood have been discussed and documented in perinatal green notes & S1 Provide local contact numbers for 0-19 and IFS Service. Provide PCHR.

This is a multi agency Antenatal pathway for Maternity Services, BMBC 0-19 Services and Family Centres. Always include partners at every opportunity to promote Close Loving Relationships. Pregnant women should be asked to take perinatal notes to all appointments.

At each contact on the HEALTHY CHILD PROGRAMME please discuss Healthy Start and sign post to family centres or maternity unit for vitamins: free for eligible families or on sale at reduced rate for non-eligible families.

Midwives and HCA must complete, sign and document in perinatal notes Plans for Pregnancy and Parenthood.

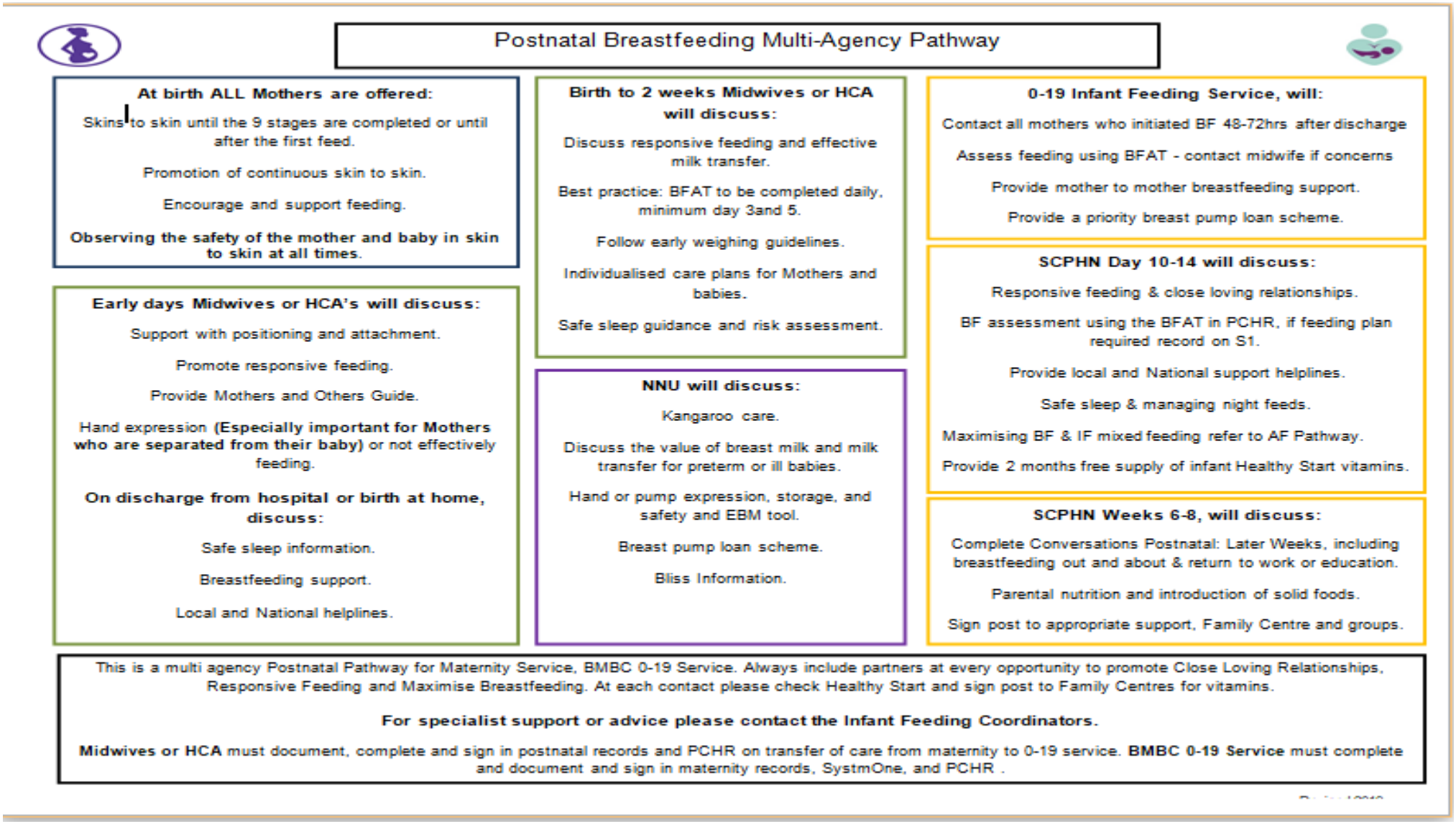
0-19 Service, SCPHNS and IFSW will sign and document in perinatal notes, PCHR and on SystmOne.

Antenatal Infant Feeding Discussions are held across the borough in local areas, please contact: 01226 775700 or IFS barnsleyinfantfeedingservice.

Some pregnant women may need additional support with Infant Feeding, please contact the lead professional to ensure infant feeding information is provided for women with more complex needs. Milk harvesting is available please contact the Infant feeding Coordinator at BHNFT for more information.

Revised 2019

Appendix 4


Postnatal Breastfeeding Multi-Agency Pathway
At birth ALL Mothers are offered:
Skin to skin until the 9 stages are completed or until after the first feed.
Promotion of continuous skin to skin.
Encourage and support feeding.
Observing the safety of the mother and baby in skin to skin at all times.
Early days Midwives or HCA's will discuss:
Support with positioning and attachment.
Promote responsive feeding.
Provide Mothers and Others Guide.
Hand expression (Especially important for Mothers who are separated from their baby) or not effectively feeding.
On discharge from hospital or birth at home, discuss:
Safe sleep information.
Breastfeeding support.
Local and National helplines.
Birth to 2 weeks Midwives or HCA will discuss:
Discuss responsive feeding and effective milk transfer.
Best practice: BFAT to be completed daily, minimum day 3and 5.
Follow early weighing guidelines.
Individualised care plans for Mothers and babies.
Safe sleep guidance and risk assessment.
NNU will discuss:
Kangaroo care.
Discuss the value of breast milk and milk transfer for preterm or ill babies.
Hand or pump expression, storage, and safety and EBM tool.
Breast pump loan scheme.
Bliss Information.
0-19 Infant Feeding Service, will:
Contact all mothers who initiated BF 48-72hrs after discharge
Assess feeding using BFAT - contact midwife if concerns
Provide mother to mother breastfeeding support.
Provide a priority breast pump loan scheme.
SCPHN Day 10-14 will discuss:
Responsive feeding & close loving relationships.
BF assessment using the BFAT in PCHR, if feeding plan required record on S1.
Provide local and National support helplines.
Safe sleep & managing night feeds.
Maximising BF & IF mixed feeding refer to AF Pathway.
Provide 2 months free supply of infant Healthy Start vitamins.
SCPHN Weeks 6-8, will discuss:
Complete Conversations Postnatal: Later Weeks, including breastfeeding out and about & return to work or education.
Parental nutrition and introduction of solid foods.
Sign post to appropriate support, Family Centre and groups.
This is a multi agency Postnatal Pathway for Maternity Service, BMBC 0-19 Service. Always include partners at every opportunity to promote Close Loving Relationships, Responsive Feeding and Maximise Breastfeeding. At each contact please check Healthy Start and sign post to Family Centres for vitamins.
For specialist support or advice please contact the Infant Feeding Coordinators.
Midwives or HCA must document, complete and sign in postnatal records and PCHR on transfer of care from maternity to 0-19 service. BMBC 0-19 Service must complete and document and sign in maternity records, SystmOne, and PCHR .

Postnatal Artificial Feeding Multi-Agency Pathway

At birth ALL Mothers are offered:

Discuss the value of colostrum.

Skin to skin until after the first feed.

First Milk for first year of life.

Promotion of continued skin to skin.

Whilst observing safety of the mother and baby.

Early days Midwives and HCA's will discuss:

Skin to skin.

Responsive feeding, keeping baby close and limiting number of people who feed baby.

Safe preparation, sterilisation and correct disposal of feeds.

First milk only (First Step Nutrition).

On discharge from hospital or following birth at home, discuss:

Safe sleep information

DOH Bottle Feeding your baby leaflet.

Refer to PCHR if available.

Birth to 2 weeks Midwives and HCA's will discuss:

Skin to skin.

Responsive feeding, keeping baby close and limiting number of people who feed baby.

Safe preparation, sterilisation and correct disposal of feeds.

First Milk for the first year of life.

Follow weighing guidelines.

Individualised care plans for Mothers and babies.

Safe sleep guidance and risk assessment.

NNU will discuss:

Kangaroo care.

The value of breast milk and milk transfer for preterm or ill babies.

Hand or pump expression, storage, and safety and EBM tool.

Responsive and safe preparation of feeds.

Bliss Information.

Day 10-14 SCPHN will discuss:

Responsive feeding, Skin – skin, keeping baby close and limiting number of people who feed baby in the early weeks

First Milk for first year of life.

Safe preparation, sterilisation and correct disposal of feeds.

Safe sleep information

Managing night feeds

Local contact numbers

Weeks 6-8, 0-19 Services, SCPHN will discuss:

Parental nutrition and introduction of solid foods around 6 months.

Invite to local sessions in Family Centres regarding introducing solid food

First milk for first year of life.

Artificial feeding out and about.

If a breastfed baby is offered a supplement of artificial formula or stops breastfeeding this pathway should be followed. This is a multi-agency Postnatal Pathway for Maternity Service, BMBC 0-19 Service. Always include partners at every opportunity to promote Close Loving Relationships, Responsive Feeding and Maximise Breastfeeding. At each contact please check Healthy Start and sign post to Family Centres for vitamins.

For specialist support or advice please contact the Infant Feeding Coordinators.

Midwives or HCA must document, complete and sign in postnatal records and PCHR on transfer of care from maternity to 0-19 service. **BMBC 0-19 Service** must complete and document and sign in maternity records, SystmOne, and PCHR.

Revised 2019

Appendix 6

Safe Sleep Multi-agency Pathway

Antenatal Midwifery contact:

At booking refer to Coni scheme if previous history of Sudden Infant Death.

At 36weeks if having a Home birth carry out Safe Sleep discussion and refer to SCPHN if any risks identified.

Midwife at Birth:

Skin to skin to regulate baby's temperature and warmth.

Safe sleep information will be given following birth in relation to the hospital environment.

Safe sleep information given prior to transfer home and document in records.

At Home Community Midwives to complete SSRA

Postnatal visit by Midwife or HCA:

First postnatal visit - complete SSRA and view where baby sleeps both day and night.

Discuss and refer to Lullaby Trust re Mother's wishes re safe sleep, bed sharing, co sleeping and the risk of sleeping with a baby on the sofa.

At each contact check where baby is sleeping and develop a plan if risk identified.

Antenatal contact 0-19 Service:

IFS to discuss Safe Sleep.

SCPHN SSRA in PCHR and document on S1, develop plan if any risks identified.

Have a meaningful conversation regarding mother's wishes re safe sleeping, bed sharing, co sleeping and the risk of sleeping with a baby on the sofa.

Discuss where baby sleeps both day and night at each subsequent contact.

Postnatal 0-19 Service 10-14 days and 6-8 wks:

Have a meaningful conversation regarding mother's wishes re safe sleeping, bed sharing, co sleeping and the risk of sleeping with a baby on the sofa.

Review and complete SSRA in PCHR develop plan if risks identified.

If risk highlighted further home visits or contacts may be required.

This is a multiagency Safe Sleep pathway for Midwives, HCA, 0-19 Service SCPHN, PHN, IFSW when discussing Safe Sleep include partners & family at every opportunity. Please have an individualised approach to care some mothers intend to sleep with their babies and some do so unintentionally; it is important to listen carefully and offer information appropriate to their needs.

Pregnant women will be advised to take perinatal notes to all appointments, 0-19 Service – SCPHNS, PHN and IFWS will sign and document in perinatal notes Plans for Pregnancy and Parenthood, PCHR and SystmOne. On transfer to 0-19 service midwife will complete handover in PCHR contact SCPHN if any risks or concerns identified.

Useful website: www.nhschoices.org.uk (DH video), www.babyfriendly.org.uk – parents & professional guide to safe sleeping, wwwbasisonline.org.uk Basisonline infant sleep App for android and apple, www.lullabytrust , www.breastfeedingnetwork.org.uk, www.bliss.org.uk **information is available in different languages**

Safe Sleep Pathway Revised 2019

Safe Sleep Pathway Revised 2019

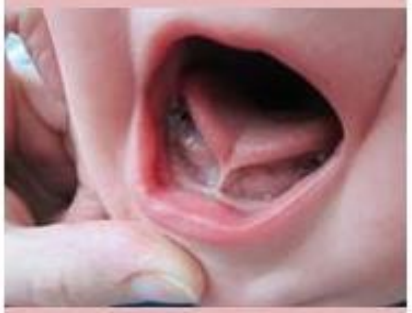
Appendix 7

Tongue Tie Referral Pathway

Tongue Tie (Anklyoglossia) identified

Definition:
Shortened frenulum restricting free movement of the tongue

Clinical indications:
Problems with feeding:
- difficulty latching on
- slipping off breast
- breast conditions i.e; sore nipples
- Poor weight gain



Child under 10 week old

HV referral to BHFNT – Dr Mohammed Ali. Copy of referral to GP
MUST BE MARKED URGENT

Dr Mohammed Ali to review and if appropriate will snip tongue tie as per SOP

Contact by phone for appointment then post /drop off formal referral letter to:

Lisa Kendrick – dental nurse clerical manager **on 01226 434337 or Angela Allsop** Secretary **Tel: 01226 431601**

Child over 10 week old

Refer to GP for assessment and referral to Sheffield hospital

Contact details:
Mr Marvin and Mr Lindley
Secretary – 0114 2267918
Fast track fax: 0114 2717461

Appendix 7

Procedure for the Referral of Babies for Assessment of Tongue-tie from Women and Children's Services.

Introduction

Standard operating procedures (SOP**)** are essential for the efficient management of wards and departments to promote safe, efficient care and optimise health outcomes. By providing a framework for staff to work with, SOPs provide clarity and uniformity of approach, whilst at the same time they help to give assurance that basic standards are being met. The main underpinning themes are risk management, cleanliness and infection control.

Aim

To assess and treat babies that are born with a shortened frenulum (ankyloglossia or tongue tie) that are struggling to feed.

Management

Patients should be assessed by the appropriate clinician (infant feeding coordinator, midwife, community midwife or paediatrician) and a diagnosis of ankyloglossia that is affecting feeding will be made.

These patients should be referred to the Maxillofacial Department at Barnsley Hospital NHS Foundation Trust using either internal or external referral e-forms if referrals are made from within Barnsley Hospital or in written form if coming from outside the Trust.

Patients can only be treated in the outpatient setting if they are less than 10 weeks old. Older patients with ankyloglossia with feeding problems may require a general anaesthetic.

We will endeavor to see patients within 2 weeks (from receiving referral) and assess and treat in the outpatient clinic by a Maxillofacial Consultant.

Please remind parents or legal guardian to bring PCHR (red book) with them on the day of the procedure.

On the day of procedure a parent or legal guardian with appropriate documentation will be required to accompany the patient.

Patients are treated in a surgical setting that is used for minor oral surgery procedures.

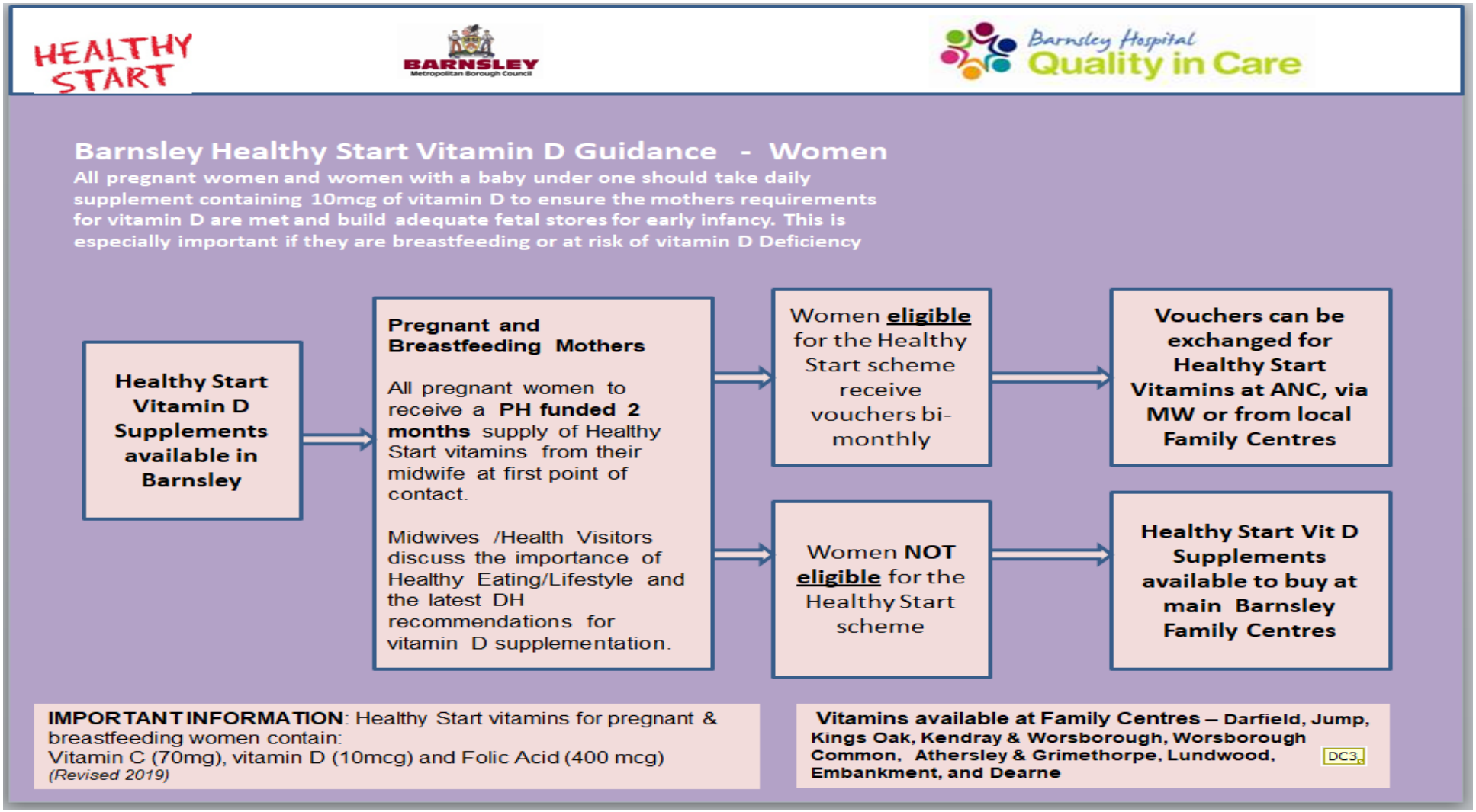
All instruments used are sterile.

No local anaesthetic is required if the patient is less than 8 weeks.

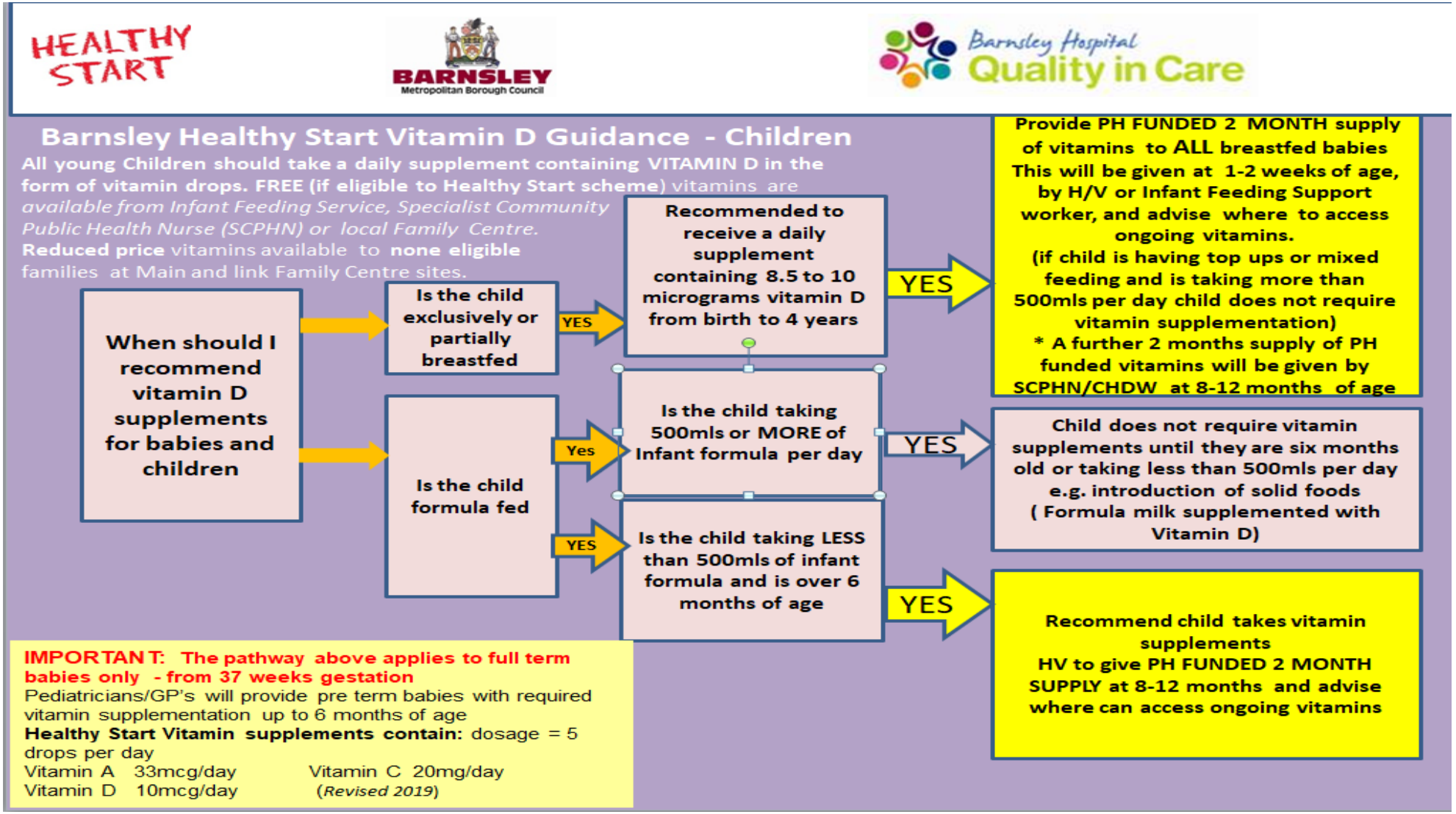
Patients are transferred to recovery after the procedure and reviewed before discharge.

Referral for release of ankyloglossia causing speech impairment should only be made to the maxillofacial department after a speech and language assessment.

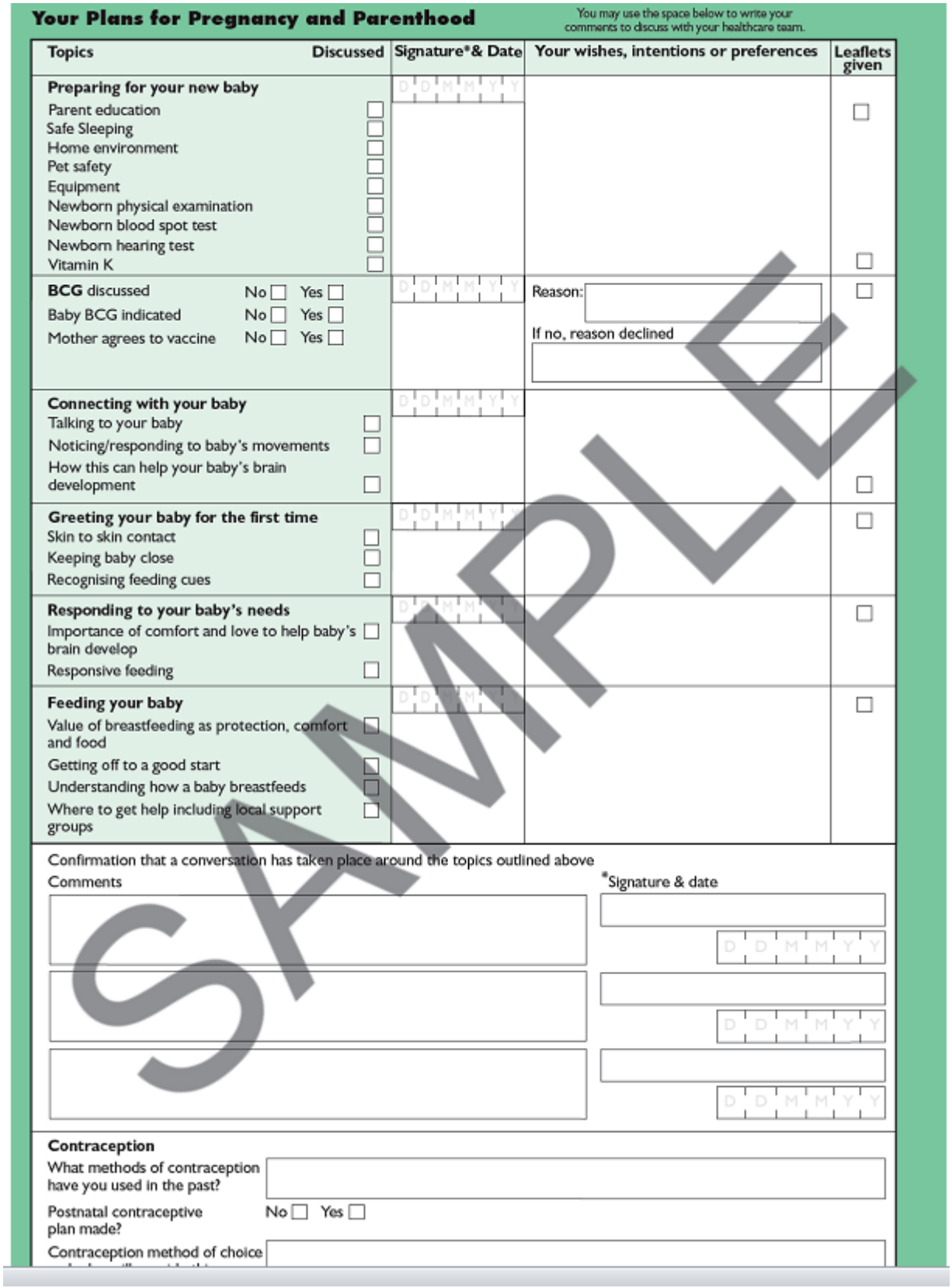
Appendix 8a


HEALTHY START
BARNSLEY
Metropolitan Borough Council
Barnsley Hospital
Quality in Care
Barnsley Healthy Start Vitamin D Guidance - Women
All pregnant women and women with a baby under one should take daily supplement containing 10mcg of vitamin D to ensure the mothers requirements for vitamin D are met and build adequate fetal stores for early infancy. This is especially important if they are breastfeeding or at risk of vitamin D Deficiency
Healthy Start Vitamin D Supplements available in Barnsley
Pregnant and Breastfeeding Mothers
All pregnant women to receive a PH funded 2 months supply of Healthy Start vitamins from their midwife at first point of contact.
Midwives /Health Visitors discuss the importance of Healthy Eating/Lifestyle and the latest DH recommendations for vitamin D supplementation.
Women eligible for the Healthy Start scheme receive vouchers bi-monthly
Vouchers can be exchanged for Healthy Start Vitamins at ANC, via MW or from local Family Centres
Women NOT eligible for the Healthy Start scheme
Healthy Start Vit D Supplements available to buy at main Barnsley Family Centres
IMPORTANT INFORMATION: Healthy Start vitamins for pregnant & breastfeeding women contain:
Vitamin C (70mg), vitamin D (10mcg) and Folic Acid (400 mcg)
(Revised 2019)
Vitamins available at Family Centres – Darfield, Jump, Kings Oak, Kendray & Worsborough, Worsborough Common, Athersley & Grimethorpe, Lundwood, Embankment, and Dearne
DC3.

Appendix 8b


HEALTHY START
BARNSLEY
Metropolitan Borough Council
Barnsley Hospital
Quality in Care
Barnsley Healthy Start Vitamin D Guidance - Children
All young Children should take a daily supplement containing VITAMIN D in the form of vitamin drops. FREE (if eligible to Healthy Start scheme) vitamins are available from Infant Feeding Service, Specialist Community Public Health Nurse (SCPHN) or local Family Centre.
Reduced price vitamins available to none eligible families at Main and link Family Centre sites.
When should I recommend vitamin D supplements for babies and children
Is the child exclusively or partially breastfed
YES
Recommended to receive a daily supplement containing 8.5 to 10 micrograms vitamin D from birth to 4 years
YES
Provide PH FUNDED 2 MONTH supply of vitamins to ALL breastfed babies This will be given at 1-2 weeks of age, by H/V or Infant Feeding Support worker, and advise where to access ongoing vitamins.
(if child is having top ups or mixed feeding and is taking more than 500mls per day child does not require vitamin supplementation)
* A further 2 months supply of PH funded vitamins will be given by SCPHN/CHDW at 8-12 months of age
Is the child formula fed
Yes
Is the child taking 500mls or MORE of Infant formula per day
YES
Child does not require vitamin supplements until they are six months old or taking less than 500mls per day e.g. introduction of solid foods
(Formula milk supplemented with Vitamin D)
YES
Is the child taking LESS than 500mls of infant formula and is over 6 months of age
YES
Recommend child takes vitamin supplements
HV to give PH FUNDED 2 MONTH SUPPLY at 8-12 months and advise where can access ongoing vitamins
IMPORTANT: The pathway above applies to full term babies only - from 37 weeks gestation
Pediatricians/GP's will provide pre term babies with required vitamin supplementation up to 6 months of age
Healthy Start Vitamin supplements contain: dosage = 5 drops per day
Vitamin A 33mcg/day
Vitamin C 20mg/day
Vitamin D 10mcg/day
(Revised 2019)

Appendix 9a



Your Plans for Pregnancy and Parenthood

You may use the space below to write your comments to discuss with your healthcare team.

Topics	Discussed	Signature*& Date	Your wishes, intentions or preferences	Leaflets given
Preparing for your new baby Parent education Safe Sleeping Home environment Pet safety Equipment Newborn physical examination Newborn blood spot test Newborn hearing test Vitamin K	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	D D M M Y Y		☐ ☐
BCG discussed No ☐ Yes ☐ Baby BCG indicated No ☐ Yes ☐ Mother agrees to vaccine No ☐ Yes ☐		D D M M Y Y	Reason: If no, reason declined	☐
Connecting with your baby Talking to your baby Noticing/responding to baby's movements How this can help your baby's brain development	☐ ☐ ☐	D D M M Y Y		☐
Greeting your baby for the first time Skin to skin contact Keeping baby close Recognising feeding cues	☐ ☐ ☐	D D M M Y Y		☐
Responding to your baby's needs Importance of comfort and love to help baby's brain develop Responsive feeding	☐ ☐	D D M M Y Y		☐
Feeding your baby Value of breastfeeding as protection, comfort and food Getting off to a good start Understanding how a baby breastfeeds Where to get help including local support groups	☐ ☐ ☐ ☐	D D M M Y Y		☐

Confirmation that a conversation has taken place around the topics outlined above

Comments

*Signature & date

D D M M Y Y

D D M M Y Y

D D M M Y Y

Contraception

What methods of contraception have you used in the past?

Postnatal contraceptive plan made? No ☐ Yes ☐

Contraception method of choice

Appendix 9b

Infant Feeding Conversations In the Early Postnatal Period.
A warm welcome –the 'Golden Hour' after birth.

All mums are offered support with:

- Unhurried/immediate skin to skin contact prioritising mum & baby stay together
- Enabling the 9 stages of skin to skin. These are: birth cry, relaxation, awakening, activity, crawling, resting, familiarisation, sucking and sleeping
- Enable mum to recognising early feeding cues
- Offering the first feed in skin to skin contact
- Transfer to postnatal ward whilst maintaining skin contact.

Print Name:	Signature:	Role:	Date:

Comments:

Infant feeding Conversations, the Early Postnatal Days

All mums are offered support to:

- Appreciate the importance of closeness loving relationships and responsiveness for mum/baby wellbeing. Explain this will not make baby demanding, but will enable responsive parenting to provide the best possible development and security. Ongoing skin to skin contact whenever possible
- Hold baby for breastfeeding & offer support for attachment.

All mums should understand what responsive feeding is:

- Recognising early feeding cues and that responsive feeding is for mum as well as baby therefore if she feels her breasts are full, put baby to the breast. If baby requires comfort, to put baby to the breast it is not good for babies to be left to cry, or feel scared this hinders their brain development
- Feed and keep baby safe at night.

All breastfeeding mums are offered support to:

- Hand express effectively with written information given
- Value exclusive breastfeeding & maximise the amount of human milk baby receives any amount of human milk is valuable
- Understand the signs that baby is getting enough milk
- Access help with feeding when at home.

All mums who formula feed or give both breast milk & formula feeds are offered information on:

- Sterilising equipment & how to safely make up feeds
- Feeding their baby **first milks** for the whole of the first year
- Limiting main feeds to be given via mum or partner
- Pacing the feed & not forcing baby to finish the whole feed if not wanted.

Print Name:	Signature:	Role:	Date:

Comments:

Mum received Mothers & Others Guide in AN period?	**Yes**		**No**	

All leaflets to be discussed with mother/parents.
Breastfeeding Discharge leaflets:- Mothers & Others Guide (if not received AN), Unicef Caring for your Baby at Night, , 'How can I tell that breastfeeding is going well', check has PCHR (Red Book).
Bottle Feeding Discharge leaflets:- DH Bottle Feeding your Baby, check has PCHR (Red Book)
N.B. Barnsley Sleep Safe Leaflet is now only available on the website.
All mums – signpost to websites: http://www.barnsleyhospital.nhs.uk/services/maternity-services/ http://www.southwestyorkshire.nhs.uk/our-services/directory/barnsley-health-visiting-service/ https:// www.barnsley.gov.uk/ift http://fsd.barnsley.gov.uk/kb5/barnsley/fisd/home.page www.unicef.org.uk/babyfriendly

Appendix 10a

Breastfeeding Assessment Tool - What to look for & ask about (Required on day 3 & 5 or best practice daily).	**Date & √**	
Your baby:		**Wet nappies:**
* has at least 8 –12 feeds or more in 24hrs*		* day 1-2 = 1-2 or more
* is generally calm & relaxed when feeding & content after most feeds		* day 3-4 = 3-4 or more, heavier
* will take deep rhythmic sucks & you will hear swallowing*		* day 5 plus = 5 or more, heavy.
* has a normal skin colour & is alert & waking for feeds		
* will generally feed for between 5 - 40 minutes & will come off the breast spontaneously		**Stools/ dirty nappies:**
* has not lost more than 7% weight on day 3 & 10% weight on day 5		* day 1-2 = 1 or more, meconium
		* day 3-4 =2 (preferably more) changing stool.
Your baby's nappies:		**Sucking pattern/ feed frequency:**
* at least 5-6 heavy, wet nappies in 24 hours - from day 5		1-2 sucks per swallow
* at least 2 dirty nappies in 24hours, at least £2 coin size, yellow & runny – from day 5		Swallows may be less audible until milk comes in day 3-4*
Your breasts:		Feed frequency: Day 1 at least 3-4 feeds*
* breasts & nipples are comfortable		After day 1 young babies will feed often & the pattern will vary, with the number of feeds increasing in the following days. Being responsive to your baby's need to breastfeed for food, drink, comfort & security will ensure you have a good milk supply & a secure happy baby
* nipples are the same shape at the end of the feed as the start		
Use of: Dummy Y / N Nipple Shield Y / N Discuss how it can effect breastfeeding / milk supply	**Infant Formula Y / N** Syringe / Cup / Teat	
Print name **Signature** **Role** **Date**		**N.B. If any responses are not ticked; observe full breastfeed, including revisiting positioning & attachment.**
Print name **Signature** **Role** **Date**		**Commence care plan & document overleaf**
Print name **Signature** **Role** **Date**		**Consider referring for additional/ specialist support if required.** Acknowledgement Baby Friendly

	Initiative: July 2015

Appendix 10b

Breastfeeding assessment tool: Neonatal

How you and your nurse/midwife can recognise that your baby is feeding well								*please see reverse of form for guidance on top-ups post-breastfeed
What to look for/ask about	✓	✓	✓	✓	✓	✓	✓	**Wet nappies:** Day 1-2 = 1-2 or more in 24 hours Day 3-4 = 3-4 or more in 24 hours, heavier Day 6 plus = 6 or more in 24 hours, heavy
Your baby: Is not interested, when offered breast, sleepy (*A)								
Is showing feeding cues but not attaching (*B)								
Attaches at the breast but quickly falls asleep (*C)								
Attaches for short bursts with long pauses (*D)								
Attaches well with long rhythmical sucking and swallowing for a short feed (requiring stimulation) (*E)								**Stools/dirty nappies:** Day 1-2 = 1 or more in 24 hours, meconium Day 3-4 = 2 (preferably more) in 24 hours changing stools By day 10-14 babies should pass frequent soft, runny stools everyday; 2 dirty nappies in 24 hours being the minimum you would expect. Exclusively breastfed babies should not have a day when they do not pass stool within the first 4-6 weeks. If they do then a full breastfeed should be observed to check for effective feeding. However, it is recognised that very preterm babies who transition to breastfeeding later may have developed their individual stooling pattern before beginning to breastfeed, and therefore this may be used as a guide to what is normal for each baby.
Attaches well for a sustained period with long rhythmical sucking and swallowing (*F)								
Normal skin colour and tone								
Gaining weight appropriately								
Your baby's nappies: At least 5-6 heavy, wet nappies in 24 hours								
At least 2 dirty nappies in 24hrs, at least £2 coin size, yellow and runny								
								Feed frequency: Babies who are born preterm/sick may not be able to feed responsively in the way a term baby does. It is important that they have 8-10 feeds in 24 hours and they may need to be wakened if they don't show feeding cues after 3 hours. During this time it is important that you protect your milk supply by continuing to express. 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.
Your breasts: Breasts and nipples are comfortable								
Nipples are the same shape at the end of the feed as at the start								
Referred for additional breastfeeding support								
Date								
Midwife/nurse initials								
Midwife/nurse: 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.								

Appendix 10c

Name: .....

D.O.B: .....

Unit No. .....

NHS Number: .....

How you, your health visitor & infant feeding support worker can recognise breastfeeding is going well

This assessment tool was developed for use in or around 10-14 days to assess breastfeeding.

What to look for & ask about	**Date & √**		
Your baby:			
• has at least 8 –12 feeds or more in 24hrs			
• is generally calm & relaxed when feeding & content after most feeds			
• will take deep rhythmic sucks & you will hear swallowing			
• has a normal skin colour & is alert & waking for feeds			
• will generally feed for between 5 & 40 minutes & will come off the breast spontaneously			
• is gaining weight steadily & to back to birth weight by 14 days			
Your baby's nappies:			
• at least 6 heavy, wet nappies in 24 hours			
• at least 2 dirty nappies in 24hours, at least £2 coin size, yellow & runny & usually more			
Your breasts:			
• breasts & nipples are comfortable			
• nipples are the same shape at the end of the feed as the start			
Use of: dummy Y N nipple shield Y N infant formula Y N			
• discuss how it can effect breastfeeding / milk supply			
Print name **Signature** **Role** **Date**			
Print name **Signature** **Role** **Date**			
Print name **Signature** **Role** **Date**			

Wet nappies:

- nappies should feel heavy. To get an idea of how this feels, take a nappy & add 2-4 tablespoons of water as this will help you know what to expect

Stools/ dirty nappies:

- by day 10-14 babies should pass frequent soft, runny, yellow stools every day with 2 stools being the minimum you would expect
- after 4-6 weeks when breastfeeding is more established this may change with some babies going a few days or more without stooling. Exclusive breastfed babies are rarely constipated & when they do pass a stool it will be soft, yellow & abundant

Feed frequency:

- young babies will feed often & the pattern & number of feeds will vary from day to day
- being responsive to your baby's need to breastfeed for food, drink, comfort & security will ensure you have a good milk supply & secure, happy baby

N.B. If any responses are not ticked; observe full breastfeed, including revisiting positioning & attachment.

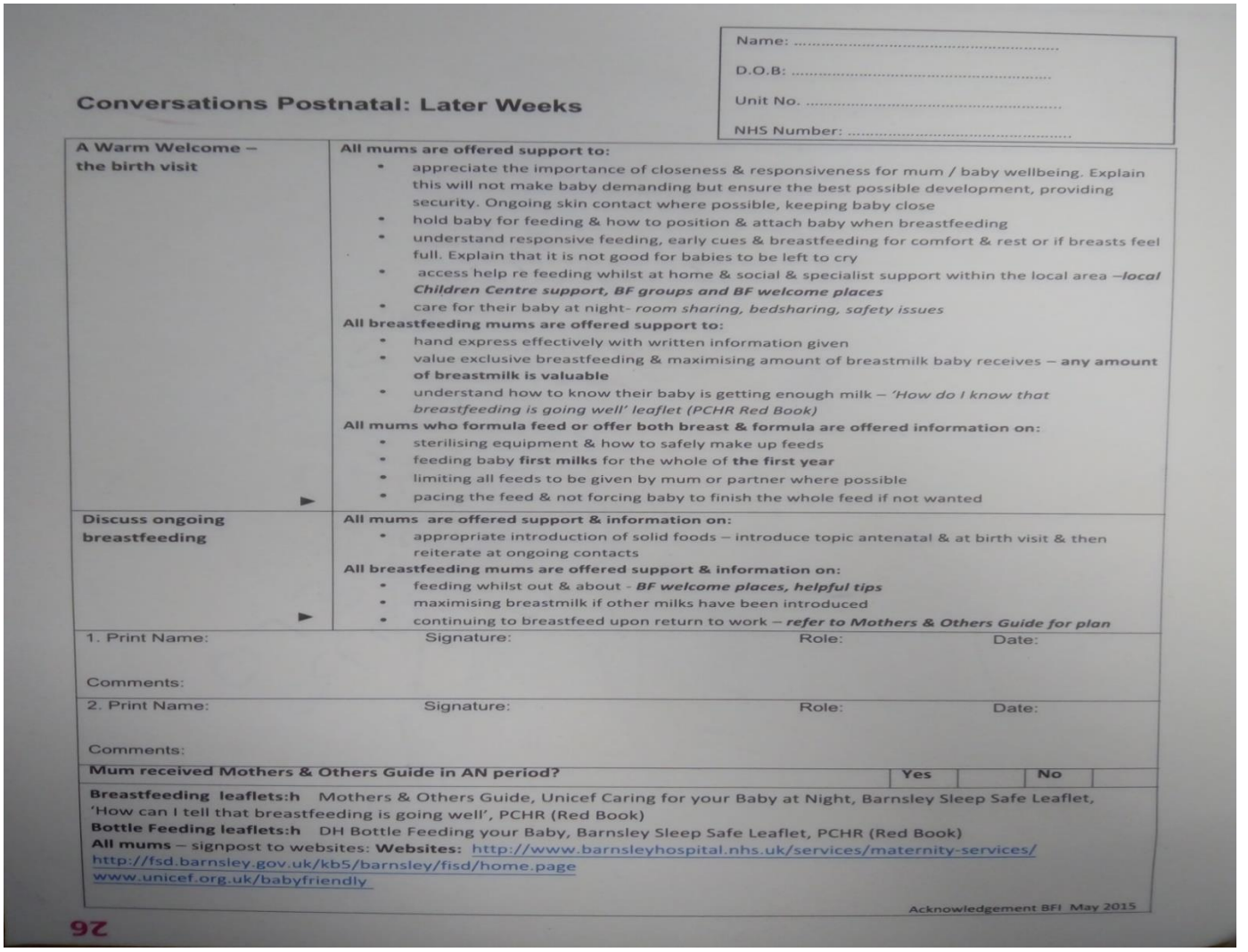
Commence care plan & document PCHR & SystmOne

Consider referring for additional/ specialist support if required.

Acknowledgement Baby Friendly Initiative: July 2015

Appendix 11

Conversations Postnatal: Later Weeks



Name: .....

D.O.B: .....

Unit No. .....

NHS Number: .....

Conversations Postnatal: Later Weeks

A Warm Welcome – the birth visit ►	**All mums are offered support to:** • appreciate the importance of closeness & responsiveness for mum / baby wellbeing. Explain this will not make baby demanding but ensure the best possible development, providing security. Ongoing skin contact where possible, keeping baby close • hold baby for feeding & how to position & attach baby when breastfeeding • understand responsive feeding, early cues & breastfeeding for comfort & rest or if breasts feel full. Explain that it is not good for babies to be left to cry • access help re feeding whilst at home & social & specialist support within the local area –***local Children Centre support, BF groups and BF welcome places*** • care for their baby at night- *room sharing, bedsharing, safety issues* **All breastfeeding mums are offered support to:** • hand express effectively with written information given • value exclusive breastfeeding & maximising amount of breastmilk baby receives – **any amount of breastmilk is valuable** • understand how to know their baby is getting enough milk – *'How do I know that breastfeeding is going well' leaflet (PCHR Red Book)* **All mums who formula feed or offer both breast & formula are offered information on:** • sterilising equipment & how to safely make up feeds • feeding baby **first milks** for the whole of **the first year** • limiting all feeds to be given by mum or partner where possible • pacing the feed & not forcing baby to finish the whole feed if not wanted
Discuss ongoing breastfeeding ►	**All mums are offered support & information on:** • appropriate introduction of solid foods – introduce topic antenatal & at birth visit & then reiterate at ongoing contacts **All breastfeeding mums are offered support & information on:** • feeding whilst out & about - ***BF welcome places, helpful tips*** • maximising breastmilk if other milks have been introduced • continuing to breastfeed upon return to work – ***refer to Mothers & Others Guide for plan***

1. Print Name: Signature: Role: Date:

Comments:

2. Print Name: Signature: Role: Date:

Comments:

Mum received Mothers & Others Guide in AN period? **Yes** ☐ **No** ☐

Breastfeeding leaflets:h Mothers & Others Guide, Unicef Caring for your Baby at Night, Barnsley Sleep Safe Leaflet, 'How can I tell that breastfeeding is going well', PCHR (Red Book)
Bottle Feeding leaflets:h DH Bottle Feeding your Baby, Barnsley Sleep Safe Leaflet, PCHR (Red Book)
All mums – signpost to websites: **Websites:** http://www.barnsleyhospital.nhs.uk/services/maternity-services/
http://fsd.barnsley.gov.uk/kb5/barnsley/fisd/home.page
www.unicef.org.uk/babyfriendly

Acknowledgement BFI May 2015

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Appendix 12

Kangaroo Mother Care and Skin to Skin Guidelines for the Neonatal and Paediatric Unit

Supportive data, background:

Kangaroo care or skin to skin cuddling is a method used for all babies regardless of feeding method to strengthen the unique mother-infant bond following the sudden separation that occurs after the birth. The baby is held wearing only a nappy and a hat, covered with a blanket, touching skin to skin held upright on the parent's chest, provided the baby is clinically stable.

This best practice standard is essential for all babies but particularly so for preterm babies, or babies who are separated from their parents.

Aims/Purpose:

Research has shown that encouraging Kangaroo care / skin to skin contact for the first hour after birth when possible, and then as often as parents are able, facilitates:-

- Observation and assistance to the baby in adaptation to extrauterine life.
- More deep sleep and quiet alertness with less crying and a calmer mum and baby.
- Avoidance of unnecessary routine procedures and fewer pain responses during cuddling when baby is undergoing painful procedures.
- Skin to skin allows the baby to be colonized by the same bacteria as the mother, resulting in less infections and allergies.
- Improved neonatal temperature regulation.
- Less episodes of apnoea and bradycardia, with improved oxygen saturations.
- Enhanced parent - infant bonding.
- Maternal release of oxytocin, which may have significance for uterine contractions, milk ejection, mother-infant interaction, and maternal stress levels.
- Early breastfeeding or hand expression of Colostrum which allows the infant to receive.
- The immunologic benefits and also helps to prevent Hypoglycaemia and Hyperbilirubinemia.
- Improved weight gain and breastfeeding duration is greater.
- Parents developing confidence in recognising and responding to baby's behavioural cues.

Contraindications:

The Medical Team in partnership with the parents will assess the baby to decide if clinically stable enough for Kangaroo care / skin to skin:

- Baby unstable e.g. prolonged/severe apnoea, indwelling chest drains.
- UAC/UVC or peripheral arterial line insitu.
- Severely jaundiced babies.
- Slow recovery of baseline vital signs after procedures.

Procedure:

If Kangaroo care/skin to skin is delayed due to medical conditions of mother or baby, the baby should be put skin-to-skin and allowed to approach the breast if Mum wishes to breastfeed, as soon as possible.

At birth, when baby's condition allows, immediately place the baby skin-to-skin on the mother's chest this promotes initial attachment between the mother and her baby.

Skin-to-skin contact prevents heat loss by conduction. Dry the baby with a warm towel, and then cover the baby with warm, dry blankets. Leave some liquor on the baby's hands/forearms this encourages the baby to initiate the breast crawl.

Promote breastfeeding of the baby within the first hour of life when stable, by supporting skin-to-skin contact and encouraging the mother to put the baby to the breast. (Preterm/IUGR babies may not be able to coordinate sucking/swallowing/breathing, so are unable to feed at the breast.) Naso-gastric tube feeding can take place at the breast in skin to skin.

Discuss with parent/parents. Some may feel reluctant or embarrassed, if so; consider kangaroo care with parent dressed/still providing skin to skin at the chest and baby's cheek areas.

Some parents may feel afraid in case they hurt the baby or make their condition worse. Give reassurance and support outlining that this is normal care and very important for baby's development providing the baby is clinically stable for Kangaroo care. Document the parental decision and outcome.

A comfortable chair, preferably with arms should be provided. Where possible the environment should be quiet and relaxed with soft lighting. Ensure their privacy at all times with a screen if desired.

Provide baby containment, flexion of the arms and legs with the knees tucked, thereby, reducing random motor activity.

Support the baby's buttocks using a rolled sheet or pillow on the parent's lap.

The head should be turned to one side and in a slightly extended position. This slightly extended head position keeps the airway open and allows eye to eye contact between the parent and their baby.

Standing transfer of the baby by the parent is preferable, the baby is laid supine on an open blanket and then swaddle loosely and contain the baby's posture. The parent stands in front of the incubator with palms upwards and underneath the blanket. The nurse supports baby's head and wires/IV's etc. While the parent lifts the baby to their chest and then is guided into the chair. Pull back the blanket for skin to skin contact. Tubing can be taped to parents clothing for security.

The parent will be assisted to standing in order to return the baby to the incubator.

Kangaroo care should last for at least 30-60 minutes or as long as the parent is able and baby remains stable.

Observations of vital signs and behavioural cues being recorded for the baby whilst in the incubator should continue whilst the baby is in Kangaroo care, and be discussed with the parents to increase their knowledge. Persistent signs of unrest from the baby not due to hunger or increased temperature and not responding to being consoled would necessitate the baby being returned to the incubator.

Baby should be in quiet/alert state or light sleep to commence Kangaroo care.

Inform parents to wear light loose clothes and no jewellery, perfume, aftershave etc. To sit quietly and not stroke or over stimulate their baby until the baby is more mature.

Kangaroo care / skin to skin sessions should be documented on the Kangaroo care audit sheet, if this practice is not being undertaken for any baby the reason why must be clearly documented.

Parents should be involved in observing their baby during kangaroo care so that they can continue monitoring for themselves when the baby is discharged.

If the baby is readmitted to the Paediatric Ward, kangaroo mother care / skin-skin can be continued for the baby to support parental/carer's choice, and promoted for breastfeeding mothers and babies to support effective attachment and recognition of early feeding cues in the baby. A risk assessment will be undertaken by staff to ensure the safety of this practice within the Paediatric Ward environment.

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Websites:

http://kangaroomothercare.com (Kangaroo care and breastfeeding)

Parent Resources

BLISS (2019) Skin to Skin with your premature baby booklet.(https://www.bliss.org.uk)

Appendix 13

Early Weighing Guidelines for the Full Term Healthy Newborn	Barnsley Hospital NHS NHS Foundation Trust
Author: :S Beardsall/J Brindley G.Dunning	Maternity Guideline Group
	Authorisation date: 31/07/2019 Reviewed:31/07/2019 Next review date:31/07/2022
Rationale	
Background	
Guideline Outline	
Staff roles and responsibilities	
Documentation	
Audit/Monitoring	
Equality Impact Assessment	
Training	
Review	
References	
Glossary of Terms	
Appendices Appendix 1 – Early weighing pathway	
Obstetric Guideline Checklist	

Rationale

To detect early warning signs of dehydration and hypernatraemia (raised serum Sodium) caused by excessive weight loss and ensure adequate hydration whilst encouraging breastfeeding in the healthy term infant.

Background Information

Healthy babies normally lose weight in the first week of life. Babies are born with excess cellular fluid which they need to shed. This weight loss is usually transient and of no significance but may be exaggerated if there is difficulty establishing feeding or if the baby is ill. Recent studies have indicated that in the majority of babies normal weight loss is likely to between 5 and 7%.

Excessive weight loss and dehydration occurs when there is ineffective milk transfer to the baby and this can lead to hypernatraemia. The most likely reason for this is either poor positioning and attachment or infrequent feeds. More rarely, it may be due to a medical condition or physical abnormality of either mother or baby. However, in all but a very small minority of cases the problem can be overcome with good management. If the problem is not corrected, suppression of milk production will occur resulting in cessation of breastfeeding.

Guideline Outline

<u>Predisposing factors of excessive weight loss – breastfed babies</u>

Ineffective milk transfer is likely to be due to:

- Poor positioning and attachment
- Infrequent feeds e.g. missed feeding cues or scheduled feeding.
- Medical or physical condition of mother or baby i.e. recognising women who may have delayed lactation
- Separation of mother and baby

<u>Signs and Symptoms of Neonatal Hypernatraemia</u>

- Poor feeding pattern
- Weight loss
- Jaundice
- Reduced urinary output
- Delayed change from meconium to transitional stools or no stools.
- Lethargy/ Irritability
- Tachycardia
- Tenting of skin
- The usual signs of acute dehydration e.g. dry mouth, sunken fontanelle may be absent

<u>Instructions for weighing babies</u>

NICE best practice suggests that as a minimum all babies regardless of breast or formula fed should be weighed naked at birth and then at 5 and10 -14 days. In addition, a breastfed

baby will be weighed on day 3. Digital scales will be used on a firm surface and must be calibrated annually and well-maintained.

(Only naked weights on correctly calibrated grade 111 electronic scales are accurate).

The health professional will explain to the parents the plan of action to be taken if there is weight loss or static weight, so that they are prepared in advance. The baby's weight and action plan will be documented in the neonatal records and in the Personal Child Health Record (if available).

N.B. The formula for calculating weight loss is:-

$$\frac{\text{Current weight - birth weight}}{\text{Birth weight}} \times 100$$

Example:

$$\frac{\text{Current weight 2.700kgs minus Birth weight 3.000 kg}}{\text{Birth weight 3kgs}} \times 100$$

= weight loss 300 grms

= 10% Weight loss

Prevention of excessive weight loss in the breastfed baby

At each postnatal check the midwife will assess that there is correct breastfeeding management with evidence of adequate milk transfer.

This is achieved by either completing the Breastfeeding Assessment Tool or by ascertaining from the mothers history:

- Quality, frequency and duration of feeds
- Adequate urine and stool output
- General wellbeing of the baby

Best practice is that the breastfeeding assessment tool should be completed at each contact, but as a minimum the Breastfeeding Assessment Tool will be completed on day 3 and day 5. Any abnormal finding will trigger further action.

<u>Management plan for excessive weight loss in the breastfed baby</u>

Baby will be weighed on day 3 and day 5	
Amount of weight loss	**Management Plan indicated**
8 -10% of birth weight	**1**
>10% of birth weight	**1 + 2**

Plan	**Weight loss**	**Management details**

1	**8-10%**	• Observe a full breastfeed- ensure effective positioning and attachment • Use Breastfeeding Assessment Tool to determine effective milk transfer and baby's well being • Teach Mother how to recognise effective feeding and signs of effective milk transfer ('What's in nappy information in 'Mothers and Others' Guide). • Responsive feeding in recognition of feeding cues • Skin contact to encourage breastfeeding • Revisit within 24hrs and reassess using the Breastfeeding Assessment Tool • Refer mother to community BMBC Infant Feeding Service for additional support • Reweigh within 48hrs. If weight increases, continue to monitor closely and provide support. If no or minimal weight increase, move to Management Plan 2
2	**>10%**	Refer CAU for review by paediatric team and implementation of management plan

Management on discharge from CAU/Ward 37

Following discharge from the paediatric department the CMW will:

- Continue management plan initiated in paediatric department
- Use Breastfeeding Assessment tool to determine milk transfer and the baby's well being
- Continue to promote and encourage breastfeeding /all breastmilk given
- If expressing the CMW will ensure the mother is aware of :
    - Hand expression
    - Correct use of breast pumps
    - How often to express
    - Safe sterilisation of equipment
    - Safe storage of milk.
    - Safe method for supplementary feeding (cup feeding is preferable but milk may be given by a bottle depending on amounts required or mother's preference
- Ensure the correct use of artificial milk if EBM unavailable by promoting:
    - Safe sterilization of equipment
    - Safe preparation of artificial milk
    - The type of artificial milk to use and for how long

    - Safe method for supplementary feeding (cup feeding is preferable but milk may be given by a bottle depending on amounts required or mother's preference
    - Outline responsive bottle feeding
    - The amount of artificial feeds will be reduced as breast milk supply increases and there is evidence of milk transfer by the baby.

- Weigh baby 24 to 48 hours and /or on day 10-14 following discharge from the paediatric department
- Continue to monitor weight weekly and/or on transfer to HV until trend towards birth weight is demonstrated.
- Continue postnatal visiting until adequate breastfeeding management in place
- Refer mother to community BMBC Infant Feeding Service

Staff roles and responsibilities

All staff involved in providing care for mothers and babies are responsible for ensuring this guideline is followed.

Documentation

Documentation relating to infant feeding will be recorded in the maternal/neonatal records and the Personal Child Health Record (Red book).

Storage of guidelines

The intranet version of this document is the only version that is maintained. Any printed copies must therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments.

Audit/Monitoring

Any adverse incidents relating to early weighing guidelines will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for the Early Weighing Guidelines for the Full Term Healthy Newborn will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

Equality Impact Assessment

Women's and Children's Services are committed to ensure that both current and potential service users and their families will not be discriminated against on the grounds of religion, gender, race, sexuality, age, disability, ethnic origin, social circumstance or background. The principles of tolerance, understanding and respect for others are central to what we believe and central to all care provided.

Training

Training will be given as documented in the Maternity Training Needs Analysis. This is updated on an annual basis.

Review

This guideline will be reviewed in three years of authorisation. It may be reviewed within this period if there are any reports, new evidence, guidelines or external standards suggesting that a guideline review is required

References

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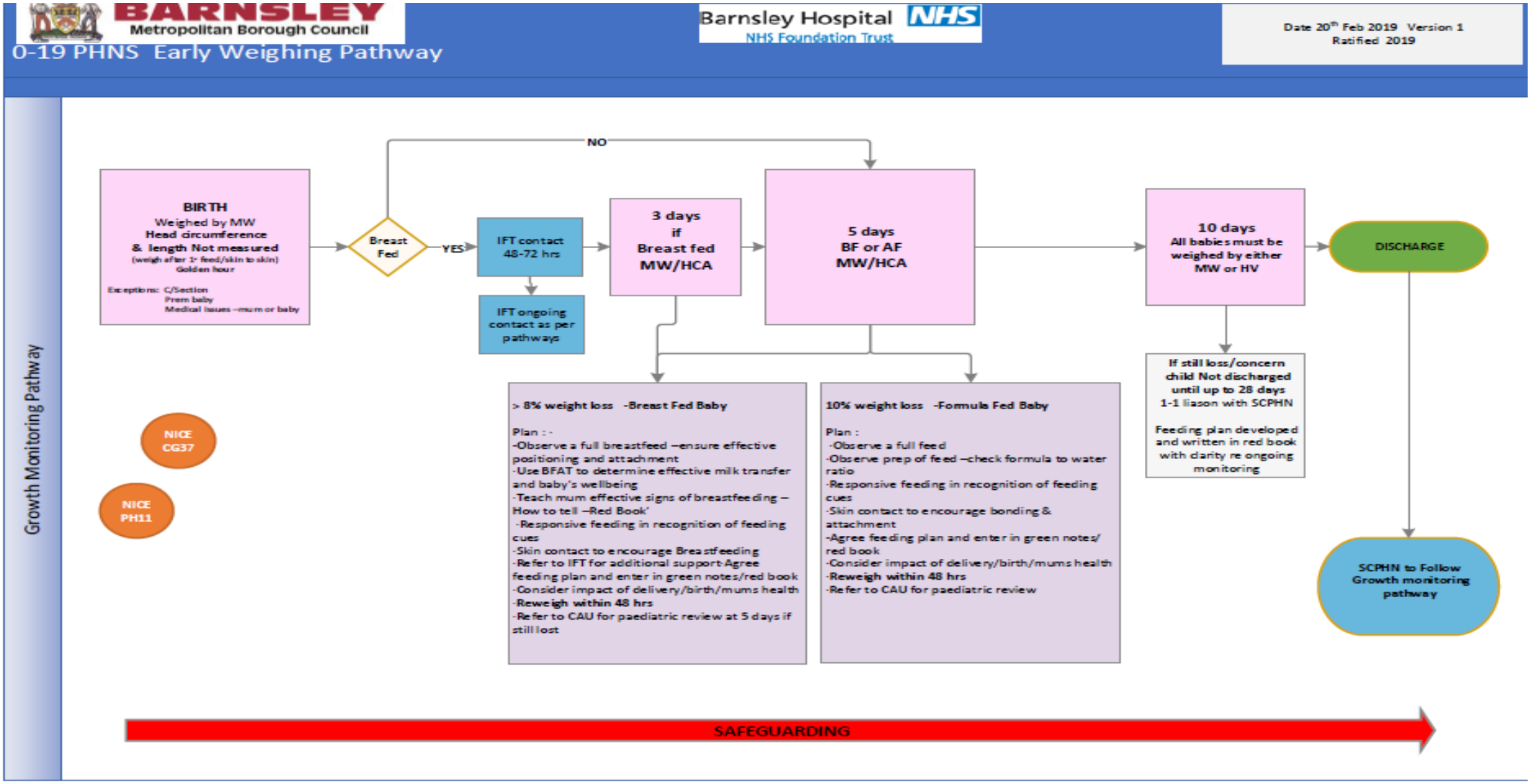
Glossary of terms

The UNICEF UK Baby Friendly Initiative (BFI) - The Baby friendly Initiative is a worldwide programme of the World Health Organisation and UNICEF. It was established in 1992 to encourage maternity hospitals to implement the 10 Steps to Successful Breastfeeding and to practice in accordance with the International Code of Marketing of Breastmilk Substitutes.

The Baby Friendly Initiative works with the health care system to ensure a high standard of care for pregnant women and breastfeeding mothers and babies.

CAU - Children’s Assessment Unit

Appendix 1 Early Weighing Pathway



Obstetric Guideline Checklist

Early Weighing Guidelines for the Full Term Healthy Newborn	**Lead Professional** S Beardsall/J Brindley G.Dunning

Formatting		
Headings included: Yes	Quality Impact Statement included: Yes	References included: Yes

Consultation Process		
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Draft presented to Women's Risk Meeting for Ratification	Date:22/07/2019	Date ratified:22/07/2019
Final draft presented to CBU 3 Overarching Governance for authorisation	Date:31/07/2019	Date Authorised:31/07/2019

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Review History	
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2.19/02/2015	19/02/2015
3.	
4.	
5.	
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10.	

Appendix 14

Prevention and Management of Impaired Metabolic Adaptation and Hypoglycaemia of the Newborn on the Postnatal Ward including Management of relucant feeding in a healthy term infants more than 37 weeks.	Barnsley Hospital NHS NHS Foundation Trust
Author: G.Dunning/J Brindley/S Beardsall	Maternity Guideline Group
	Authorisation date: 14/08/2017 Reviewed:July 2019 Next review date: July 2022
Rationale	
Background	
Guideline Outline **Management of infants at risk of Impaired Metabolic Adaptation and Hypoglycaemia** • Measuring blood glucose levels in infants • Care at birth • Care irrespective of feeding method: • Management of Breast fed babies: • Management of Formula fed babies: • Information for parents **Management of infants with Impaired Metabolic Adaptation and Persistent Hypoglycaemia**	
Staff roles and responsibilities	
Documentation	
Audit/Monitoring	
Equality Impact Assessment	
Training	
Review	
References	
Glossary of Terms	

Appendices

Appendix 1- Second centile Birth weights for boys and girls by week of gestation (BAPM)

Appendix 2 - Flow chart A – Management of term infants (≥37weeks) at risk of hypoglycaemia

Appendix 3 - Flow chart B – Pre-feed BG 1.0-1.9mmol/l and no abnormal signs

Appendix 4 - Flow chart C- Blood glucose < 1.0mmol/l and/or clinical signs consistent with hypoglycaemia

Appendix 5 – Flow chart D – Management of Reluctant Feeding in Healthy Term Infants ≥ 37 weeks

Appendix 6 - Patient information Sheet: Protecting your baby from low blood glucose

Appendix 7 - Use of dextrose gel for buccal administration

Obstetric Guideline Checklist

Rationale

The aim of this guideline is to:

- Identify those infants at risk of impaired metabolic adaptation and hypoglycaemia and ensure timely intervention and treatment
- Prevent harm caused by unrecognised or untreated hypoglycaemia
- Minimise unnecessary interventions and admissions to the Neonatal Unit

Background Information

This guideline refers babies at risk of impaired metabolic adaptation and hypoglycaemia who are deemed well enough to be cared for on the postnatal ward.

Healthy term babies often feed infrequently in the first 24–48 hours after birth. Additionally, normal healthy term babies may have low blood glucose in the first 2 to 3 postnatal days and are protected by a ketone body response. It is unlikely that they will suffer any ill effects unless feed insufficiency is prolonged and routine blood glucose monitoring is not appropriate for these babies.

However, babies with additional risk factors are less able to mount this response. Babies who are at risk need to be correctly identified and managed appropriately.

For all breastfed babies the aim should be to ensure that needs are met as far as possible by breastfeeding, or by the use of expressed colostrum / breast milk (EBM). Exclusive breastfeeding enhances the baby's ability to counter- regulate whereas large volumes of infant formula suppress this ability.

For formula fed babies the aim should be to ensure frequent effective feeding and ongoing observation of the baby's condition, this is vital as ineffective feeding may be a sign of illness.

Blood glucose measurements taken prior to 2 hours of age are not informative as readings made immediately after birth is merely indicative of the mother's blood glucose concentration. Levels may drop sharply until counter regulation is initiated.

If blood glucose levels remain lower than the acceptable minimum (see guideline outline/flow chart), the baby should be reviewed by a paediatrician with a view to further investigation and appropriate management to rule out hyperinsulinism or any another metabolic disorder characterised by neonatal hypoglycaemia.

Hyperinsulinism should be considered if the blood glucose concentration remains low (<2mmol/l on three or more occasions in the first 24 hours despite adequate energy provision and a feeding plan), or if a glucose dose more than 8mg/kg/min is required.

If at any time the baby has abnormal clinical signs there should be immediate review by paediatrician.

Guideline Outline

Management of infants at risk of Impaired Metabolic Adaptation and Hypoglycaemia

Infants with the following risk factors are at risk of neurological sequelae of neonatal hypoglycaemia and require blood glucose monitoring.

Maternal conditions:

- Diabetes
- Maternal use of beta blockers (e.g. Labetalol)

Neonatal conditions:

- Intrauterine Growth Restriction/Small for Gestational Age or Low Birth Weight (i.e.) below the 2nd centile on the gestational age and sex specific chart or (Appendix 1) or infants that are clinically wasted (infants that are clinically wasted appear starved with loose wrinkled skin, dry peeling skin, little muscle especially on the upper legs and a reduced abdominal circumference with normal head circumference and femur length)
- Preterm babies (<37 weeks gestation)
- Syndromes:
    - Midline defects
    - Beckwith- Wiedemann
    - Turner syndrome
    - Costello syndrome
    - Prader-Willi
    - Sotos
- Metabolic disorders

Blood glucose levels should also be monitored on any infant with one or more of the following clinical signs:

- Perinatal acidosis (cord arterial or infant pH <7.1 and a base deficit
- ≥12mmo/l)
- Hypothermia (<36.5°C) not attributable to environmental factors
- Suspected/confirmed early onset sepsis
- Apnoea
- Cyanosis
- Seizures
- Lethargy
- Hypotonia
- High pitched cry
- Abnormal feeding behavior (especially after a period of feeding well):
    - Not waking for feeds
    - Not sucking effectively
    - Appearing unsettled and demanding very frequent feed

NB – Jitteriness defined as excessive repetitive movements of one or more limbs which are unprovoked and not in response to stimulus is common and by itself is not an indication to measure blood glucose

NB - Babies who are developing hypoglycaemia may be asymptomatic.
The above signs are not specific to hypoglycaemia and may be an indication of another underlying cause of illness such as infection.

Measuring blood glucose levels in infants

Blood glucose levels should be measured using a ward based blood gas analyzer. This will provide an immediate and accurate blood glucose estimation prompting timely management. Hand held blood glucose analyzers are not accurate at a range of 0 - 2.0mmol/l and should not be used to guide the management of neonatal hypoglycaemia

Samples should be taken from a warm, well perfused heel by heel-prick or from a free flowing venous/arterial sample following Trust guidelines for skin asepsis. Air bubbles in the capillary tubes should be avoided.

Care at birth

Commence the care pathway for term infants at risk of hypoglycaemia **(Flow chart A – appendix 2)**

- Mothers are encouraged to have skin to skin contact to promote warmth and initiate feeding. The baby will be dried and a hat put on.
- Ensure that the ambient temperature in the room is warm
- Breastfeeding should be encouraged for babies who are at risk of hypoglycaemia as colostrum and breast milk contain metabolites which are thought to help babies cope with the physiological drop in blood glucose following birth.
- Babies will be encouraged to feed as soon as possible within one hour of birth (NB. babies who are at risk of hypoglycaemia may not display normal feeding cues).
- If the woman chooses not to breast feed the infant should be given a formula feed (10-15ml/kg) within the first hour
- Assess and document feeding cues and feeding effectiveness
- Commence a NEWTT chart and record clinical observations Review baby and manage clinical concerns promptly.

- Babies at risk of hypoglycaemia will require systematic assessment of well being using the NEWTT chart and escalation guidance outlined in the Guideline for the use of the Newborn Early Warning Trigger and Track system

- Refer for paediatric review if any deviation from normal and document findings in Baby Record

Care irrespective of feeding method:

- Continue to encourage skin to skin contact
- The baby's first blood glucose will be evaluated prior to the second feed (2-4 hours after birth)
- Offer feeds in response to feeding cues but do not allow more than 3 hours to pass between feeds until blood glucose measurements have been more than 2mmol/l on two consecutive occasion.

Based on the result of the first blood glucose measurement place the baby on one of the following pathways:

- **Flowchart B (Appendix 3)** if the first pre-feed blood glucose is 1.0- 1.9mmol/l and there are no abnormal signs

- **Flowchart C (Appendix 4)** if the first pre-feed blood glucose is < 1.0mmol/l, and or clinical signs consistent with hypoglycaemia.
- Document all care and blood results in the Baby Records and on the Blood Glucose Chart in Baby Records.

Administration of Buccal dextrose gel

Buccal dextrose can be used as a first line treatment to manage hypoglycaemia in the first 48 hours but must be used in conjunction with a feeding plan to enable the establishment of normal feeds

Can be used within the first 48hrs after birth for infants ≥ 35weeks gestation who with a blood glucose of 1.0-1.9mmol/l and no other clinical signs

Up to 6 doses can be given over a 48hr period but infants requiring more than 1 dose should be discussed with the paediatrician. Infants requiring 3 or more doses will require a paediatric review

For infants with a blood glucose level <1.0mmol/l buccal dextrose should only be used whilst arranging urgent medical review and treatment with IV glucose

See **Appendix 6** for guidance on the administration of buccal dextrose gel

Do not discharge infants who are at risk of hypoglycaemia:

- Before 24hrs of age

- Until the infant has had a blood glucose measurement of > 2mmol/l on two consecutive feeds and is feeding well

Management of Breast fed babies:

- Offer the breast in response to feeding cues as often as possible
- If the infant is not showing signs of effective feeding:
- Encourage continuous skin to skin and teach the mother to hand express
- Give the EBM to the infant immediately by 1ml syringe, cup or directly into babies mouth.
- Encourage the mother to express 8-10 times in 24 hours until the infant is feeding effectively
- Frequent small volumes of colostrum will be easily digested and absorbed by the baby
- Do not allow more than 3 hours to pass between feeds
- Supplementary feeding may be required if the mother cannot produce sufficient colostrum to achieve an acceptable rise in the infants blood glucose levels. This should only be given following discussion with the mother. Parents will be made aware of clinical indications when supplementation of formula is required and explanations documented.
- Supplementation should be offered in an appropriate volume (10- 15ml/kg per feed) by cup until colostrum is available

Management of Formula fed babies:

- Mother will be supported with bottle feeding technique until they are confident
- Offer baby frequent feeds at least 3 hourly or more frequently if baby is showing signs of willingness to feed (NB formula fed babies have limited ability to utilize ketone bodies therefore frequent feeds of sufficient volume are needed to ensure that blood glucose levels remain acceptable)
- Offer 10 - 15ml/kg per feed

Information for parents:

Parents should be given verbal and written information that describes:

- Why their baby requires extra support and blood glucose monitoring
- How to reduce the likelihood of hypoglycaemia
- Signs that their baby is becoming unwell
- How to raise concerns if they suspect their baby is unwell or not feeding

For written information see Appendix 7.

Management of infants with Impaired Metabolic Adaptation and Persistent Hypoglycaemia

Persistent or recurrent hypoglycaemia can be the first presentation of an underlying disorder of glucose metabolism. Early detection is important as investigations designed to reduce the risk of brain injury may be required

A newborn infant with the following will require urgent referral to a paediatrician:

- 2 or more blood glucose measurements <2.0mmol/l within the first 48 hours
- A blood glucose measurement of < 1.0mmol/l irrespective of age
- Signs of acute neurological dysfunction and a blood glucose of<2.5mmol/l

The infant will require investigations for:

- Blood glucose; insulin, cortisol; growth hormone; fatty acids; ketone bodies; carnitine; acylcarnitine profile; amino acids; ammonia and lactate
- Urine ketones and organic acids
- Consider investigations for early onset sepsis

Transient hypoglycaemia (i.e.) one blood glucose level of 1.0 - 1.9mmol/l in the first 24 hours with no abnormal signs who is feeding effectively does not require the above investigations.

Staff roles and responsibilities

Medical, Midwifery and Nursing Staff involved in the care of babies at risk of Hypoglycaemia will be trained to identify the symptoms of and treatment required. Staff are responsible for ensuring this guideline is followed

Documentation

Records should be written in accordance with professional, Trust and Maternity record keeping standards.

Storage of guidelines

The intranet version of this document is the only version that is maintained. Any printed copies must therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments.

Audit/Monitoring

Any adverse incidents relating to the management of babies with impaired metabolic adaptation and hypoglycaemia will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for Prevention and Management of Impaired Metabolic Adaptation and Hypoglycaemia of the Newborn on the Postnatal Ward will be audited in line with the annual audit programme, as agreed by the
CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

Equality Impact Assessment

Women's and Children's Services are committed to ensure that both current and potential service users and their families will not be discriminated against on the grounds of religion, gender, race, sexuality, age, disability, ethnic origin, social circumstance or background. The principles of tolerance, understanding and respect for others are central to what we believe and central to all care provided.

Training

Training will be given as documented in the Maternity Training Needs Analysis. This is updated on an annual basis.

Review

This guideline will be reviewed in three years of authorisation. It may be reviewed within this period if there are any reports, new evidence, guidelines or external standards suggesting that a guideline review is required

References

British Association of Perinatal Medicine (BAPM). Identification and Management of Neonatal Hypoglycaemia in the Full Term Infant – A Framework for Practice (2017) [online] www.bapm.org

Glossary of terms

BAPM – British Association of Perinatal Medicine EBM - Expressed Breast Milk
IV – Intravenous
NEWTT – Newborn Early Warning Trigger and Track

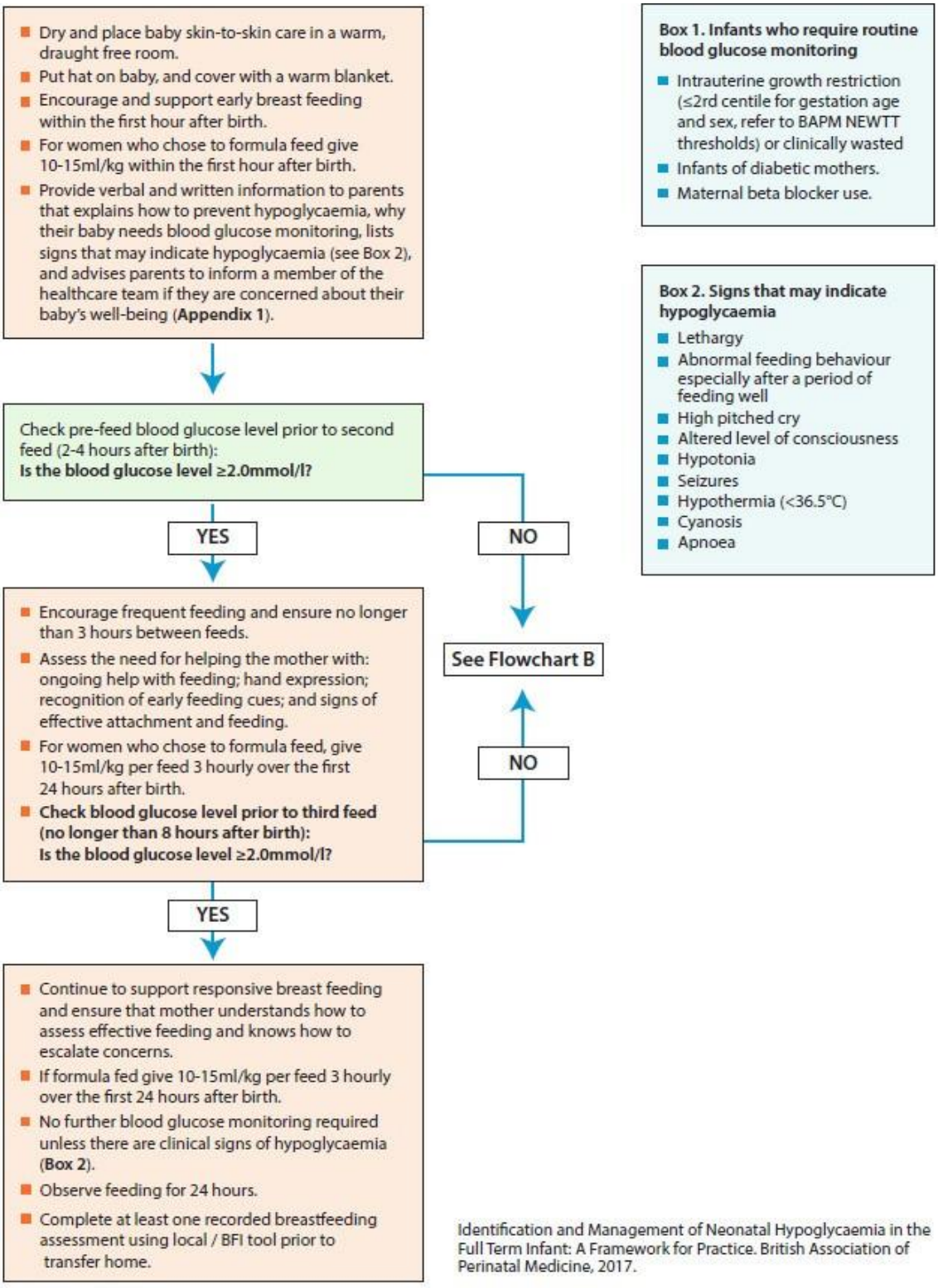
Appendix 1

Second centile Birth weights for boys and girls by week of gestation (BAPM)

Birth weight on 2nd centile/kg		
Gestational age/weeks	**Boys**	**Girls**
37	**2.10**	**2.00**
38	**2.30**	**2.20**
39	**2.50**	**2.45**
40	**2.65**	**2.60**
41	**2.80**	**2.75**
42	**2.90**	**2.85**

Appendix 2

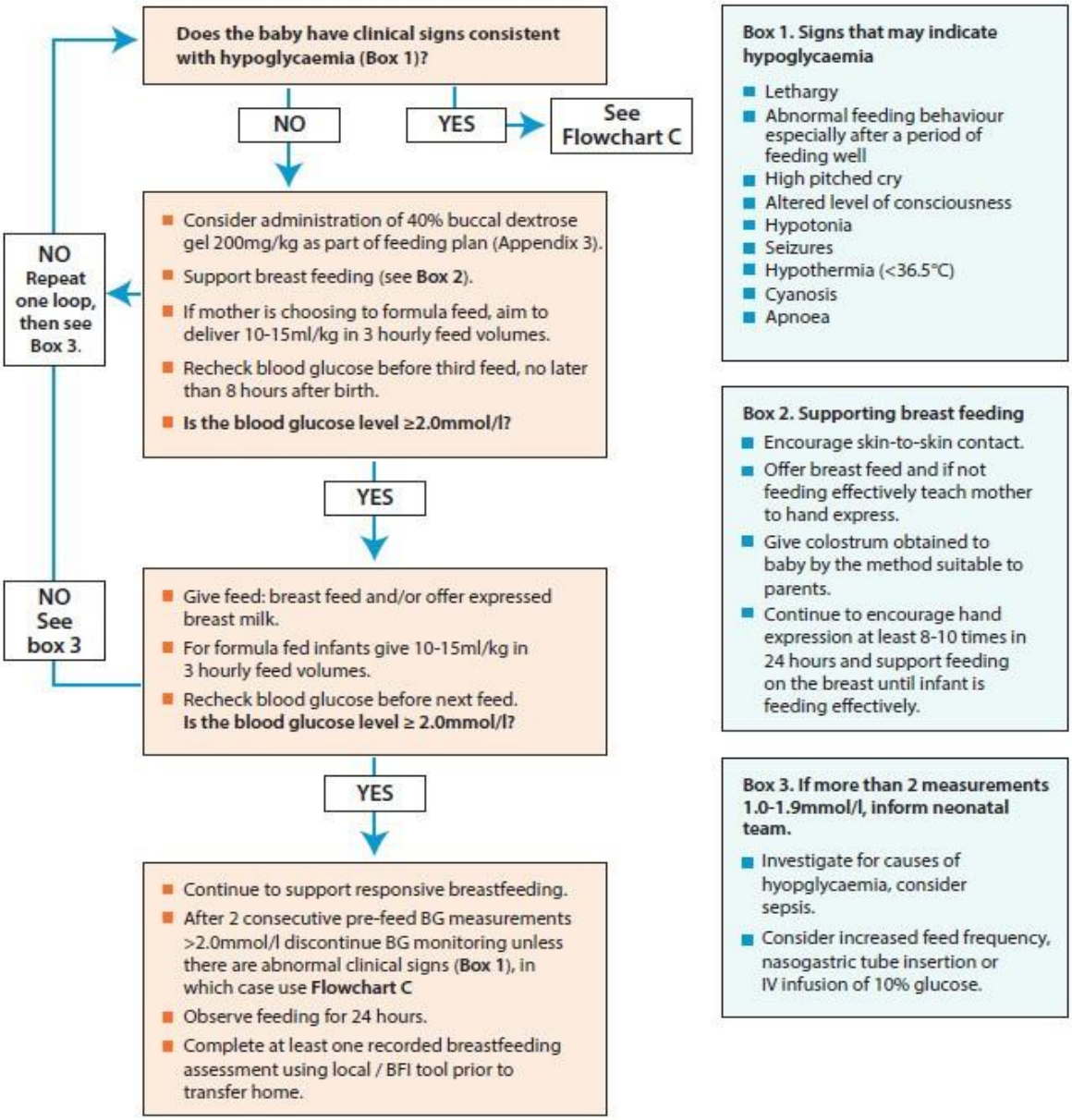
Flow chart A – Management of term infants (≥37weeks) at risk of hypoglycaemia



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

Appendix 3

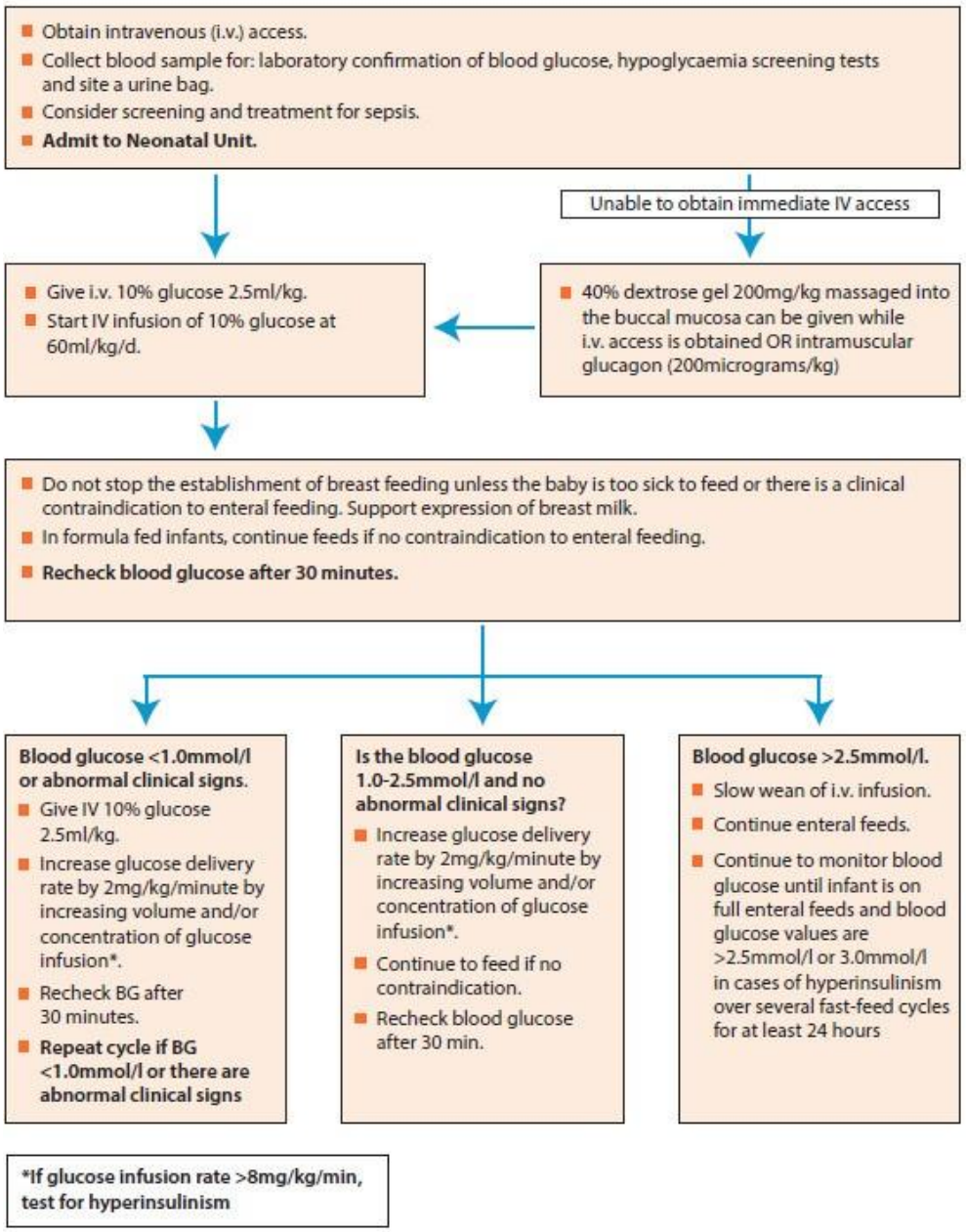
Flow chart B – Pre-feed BG 1.0-1.9mmol/l and no abnormal signs



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

Appendix 4

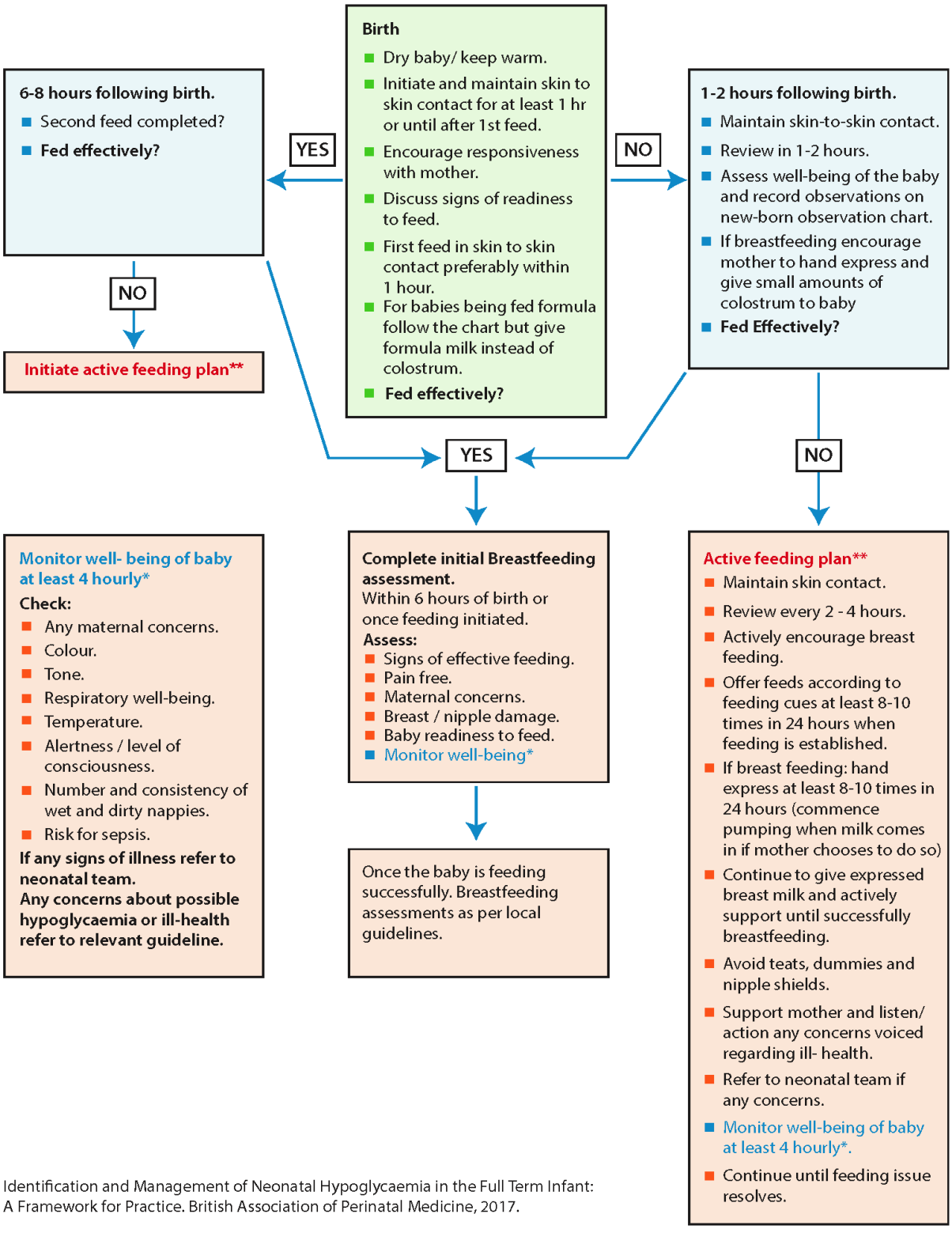
Flow chart C- Blood glucose < 1.0mmol/l and/or clinical signs consistent with hypoglycaemia



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

Appendix 5

Flowchart D. Management of reluctant feeding in healthy term infants ≥ 37 weeks



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

Appendix 6

Patient information Sheet: Protecting your Baby from Low Blood Glucose

What is low blood glucose?

You have been given this leaflet because your baby is at increased risk of having low blood glucose (also called low blood sugar or hypoglycaemia).

Babies who are small, premature, unwell at birth, or whose mothers are diabetic or have taken certain medication (beta-blockers), may have low blood glucose in the first few hours and days after birth, and it is especially important for these babies to keep warm and feed as often as possible in order to maintain normal blood glucose levels.

If your baby is in one of these “at risk” groups, it is recommended that they have some blood tests to check their blood glucose level. Extremely low blood glucose, if not treated, can cause brain injury resulting in developmental problems. If low blood glucose is identified quickly, it can be treated to avoid harm to your baby.

Blood glucose testing

Your baby’s blood glucose is tested by a heel-prick blood test. A very small amount of blood is needed and it can be done while you are holding your baby in skin-to-skin contact. The first blood test should be done before the second feed (2-4 hours after birth), and repeated until the blood glucose levels are stable.

You and your baby will need to stay in hospital for the blood tests.

How to avoid low blood glucose

- **Skin-to-skin contact**

  Skin-to-skin contact with your baby on your chest helps keep your baby calm and warm and helps establish breastfeeding. During skin-to-skin contacts your baby should wear a hat and be kept warm with a blanket or towel.

- **Keep your baby warm**

  Put a hat on your baby for the first few days while he / she is in hospital. Keep your baby in skin contact on your chest covered with a blanket and look into you babies eyes to check his / her well-being in this position, or keep warm with blankets if left in a cot.

- **Feed as soon as possible after birth**

  Ask a member of staff to support you with feeding until you are confident, and make sure you know how to tell if breastfeeding is going well, or how much formula to give your baby.

- **Feed as often as possible in the first few days**

  Whenever you notice “feeding cues” which include rapid eye movements under the eyelids, mouth and tongue movements, body movements and sounds, sucking on a fist, offer your baby a feed. Don’t wait for your baby to cry – this can be a late sign of hunger.

- **Feed for as long, or as much, as your baby wants**.

  To ensure your baby gets as much milk as possible.

- **Feed as often as baby wants, but do not leave your baby more than 3 hours between feeds.**

  If your baby is not showing any feeding cues yet, hold him/her skin-to-skin and start to offer a feed about 3 hours after the start of the previous feed.

- **Express your milk (colostrum).**

  If you are breastfeeding and your baby struggles to feed, try to give some expressed breast milk. A member of staff will show you how to hand express your milk, or watch the UNICEF hand expression video (search “UNICEF hand expression”). If possible, it is good to have a small amount of expressed milk saved in case you need it later, so try to express a little extra breast milk in between feeds. Ask your midwife how to store your expressed milk.

Don’t hesitate to tell staff if you are worried about your baby

If your baby appears to be unwell, this could be a sign that they have low blood glucose. As well as doing blood tests, staff will observe your baby to check he / she is well, but your observations are also important, as you are with your baby all the time so know your baby best. **It is important that you tell staff if you are worried** that there is something wrong with your baby, as parents’ instincts is often correct.

The following are Indications that your baby is well:

- **Is your baby feeding well?**

  In the first few days your baby should feed effectively at least every 3 hours, until blood glucose is stable, and then at least 8 times in 24 hours. Ask a member of staff how to tell if your baby is attached and feeding effectively at the breast, or how much formula he / she needs. If your baby becomes less interested in feeding than before, this may be a sign they are unwell and you should raise this with a member of staff.

- **Is your baby warm enough?**

  Your baby should feel slightly warm to touch, although hands and feet can sometimes feel a little cooler. If you use a thermometer the temperature should be between 36.5°C and 37.5°C inclusive.

- **Is your baby alert and responding to you?**

  When your baby is awake, he/she will look at you and pay attention to your voice and gestures. If you try to wake your baby, they should respond to you in some way.

- **Is your baby's muscle tone normal?**

  A sleeping baby is very relaxed, but should still have some muscle tone in their body, arms and legs and should respond to your touch. If your baby feels completely floppy, with no muscle tone when you lift their arms or legs, or if your baby is making strong repeated jerky movements, this is a sign they may be unwell. It can be normal to make brief, light, jerky movements. Ask a member of the team if you are not sure about your baby's movements.

- **Is your baby's colour normal?**

  Look at the colour of the lips and tongue – they should be pink.

- **Is your baby breathing easily?**

  Babies' breathing can be quite irregular, sometimes pausing for a few seconds and then breathing very fast for a few seconds. If you notice your baby is breathing very fast for a continuous period (more than 60 breaths per minute), or seems to be struggling to breathe with very deep chest movements, nostrils flaring or making noises with each breath out – this is not normal.

Who to call if you are worried

In hospital, inform any member of the clinical staff.

At home, call your community midwife and ask for an urgent visit or advice.

Out of hours, call NHS 111

If you are really worried, take your baby to your nearest A&E department or dial 999.

What happens if your baby's blood glucose is low?

If the blood glucose test result is low, your baby should feed as soon as possible and provide skin-to-skin contact. If the level is very low the neonatal team may advise urgent treatment to raise the blood glucose and this could require immediate transfer to the Neonatal Unit.

Another blood glucose test will be done before the next feed or within 2-4 hours.

If you are breastfeeding and your baby does not breastfeed straight away, a member of staff will review your baby to work out why. If he / she is happy that your baby is well, she/he will support you to hand express your milk and give it by oral syringe / finger / cup / spoon.

If your baby has not breastfed, and you have been unable to express any of your milk, you will be advised to offer infant formula.

In some hospitals the team may prescribe a dose of dextrose (sugar) gel as part of the feeding plan because this can be an effective way to bring your baby's glucose level up.

If you are breastfeeding and advised to give some infant formula, this is most likely to be for one or a few feeds only. You should continue to offer breastfeeds and try to express milk as often as possible to ensure your milk supply is stimulated.

Very occasionally, if babies are too sleepy or unwell to feed, or if the blood glucose is still low after feeding, he / she may need to go to the Neonatal Unit. Staff will explain any treatment that might be needed. In most cases, low blood glucose quickly improves within 24-48 hours and your baby will have no further problems.

Going home with baby

It is recommended that your baby stays in hospital for 24 hours after birth. After that, if your baby's blood glucose is stable and he / she is feeding well, you will be able to go home.

Before you go home, make sure you know how to tell if your baby is getting enough milk. A member of staff will explain the normal pattern of changes in the colour of dirty nappies and number of wet/dirty nappies. For further information, if you are breastfeeding, see 'How you and your midwife can recognise that your baby is feeding well' (Search 'UNICEF Baby Friendly assessment tool').

It is important to make sure that your baby feeds well **at least 8 times every 24 hours** and most babies feed more often than this.

There is no need to continue waking your baby to feed every 2–3 hours as long as he/she has had at least 8 feeds over 24 hours, unless this has been recommended for a particular reason. You can now start to feed your baby responsively. Your midwife will explain this.

If you are bottle feeding, make sure you are not over feeding your baby. Offer the bottle when he/she shows feeding cues and observe for signs that he/she wants a break. Don't necessarily expect your baby to finish a bottle – let him / her take as much milk as he/she wants.

Once you are home, no special care is needed. As with all newborn babies, you should continue to look for signs that your baby is well, and seek medical advice if you are worried at all about your baby.

Appendix 7

Use of dextrose gel for buccal administration

Indications

- Blood glucose 1.0-1.9mmol/l in infant with no abnormal clinical signs
- Infants ≥ 35 weeks' gestational age and younger than 48 hours after birth

Notes

- Must be used in conjunction with a feeding plan
- For babies with severe hypoglycaemia (BG <1.0mmol/l) use oral dextrose gel only as an interim measure while arranging for urgent medical review and treatment with IV glucose

Dose

- Use 200mg/kg dextrose gel (0.5 ml/kg of 40% dextrose gel), up to two doses given 30 minutes apart per episode of hypoglycaemia and a maximum of six doses of buccal dextrose gel in 48 hours.

Weight of baby (kg)	Volume of gel (ml)
1.5-1.99	1
2.0-2.99	1.5
3.0-3.99	2.0
4.0-4.99	2.5
5.0-5.99	3.0
6.0-6.99	3.5

Method of administration

- Draw up correct volume of 40% dextrose gel (Glucogel®) using a 2.5 or 5ml oral / enteral syringe
- Dry oral mucosa with gauze, gently squirt gel with syringe (no needle) onto the inner cheek and massage gel into the mucosa using latex-free gloves
- Offer a feed preferably breast milk, immediately after administering dextrose gel
- Repeat blood sugar measurement as requested
- Repeat oral dextrose gel if baby remains hypoglycaemic according to flow chart

Up to 6 doses can be given over a 48-hour period but any more than one dose should be discussed with the neonatal team and it is advisable for the baby to be examined before the 3rd dose is administered.

Obstetric Guideline Checklist

Prevention and Management of Impaired Metabolic Adaptation and Hypoglycaemia of the Newborn on the Postnatal Ward	**Lead Professional** G Dunning/J Brindley/S Beardsall

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Appendix 15

Cup Feeding Guideline

Purpose: Cup feeding can be used as an alternative method of giving a supplementary/complementary feed to healthy preterm infants, ≥ 32 weeks gestational or corrected age, while breastfeeding is being established, and the mother is unable to breastfeed.

Summary of evidence of Cup feeding:

- Provides a positive oral experience for the infant and costs very little.
- Allows the infant to pace his or her own intake so feeding is baby-led.
- Baby learns to control breathing and swallowing during a feed
- Strengthens the oral musculature and encourages coordination of the tongue and muscles of the mouth. It stimulates olfactory nerves and lingual lipases aiding digestion.
- Less fat is lost than in Naso-gastric tube feeds, so better weight gain and less oral aversion from use of invasive NG Tubes.
- It does not take a lot of energy and oxygen saturations increase during breastfeeding.
- It avoids the use of bottles and it is safe if performed correctly, providing an alternative form of feeding when mum is unavailable.
- It promotes social interaction by being held and eye contact both parents can do it.
- It increases the rate of exclusive breastfeeding at discharge.

Indications for using a cup feed: (After consulting the parents and gaining approval). Cup feeding can be given to a baby from 32 weeks gestation who:

- Is establishing breastfeeding, it encourages correct tongue placement for breastfeeding
- Cannot fully satisfy all of his/her nutritional needs at the breast.
- Has oral aversion and cannot bottle feed.
- A baby who is breastfeeding but whose mother cannot be present for all feedings.
- A baby whose mother is ill after delivery and who cannot breastfeed
- A baby who has an uncoordinated suck and swallow.

Term babies:

- A term baby, when complementary feedings are needed due to hypoglycemia, jaundice or dehydration or to give drugs orally.
- Temporary separation from the mother
- When the mother has cracked nipples and need time to heal provided the time off the breast is limited.
- Babies with neurological problems, they are often able to sip or lap milk from a cup.
- Some babies who have minor cleft lip/palate and whose mother wishes to breastfeed.

Infant Feeding Readiness cues:

Infant must be wide awake and alert and wants to suck, demonstrating hunger cues.

All staff and parents who cup feed must be thoroughly trained and competence assessed to ensure that this procedure is undertaken safely and correctly.

(Training can be obtained from the Infant Feeding Coordinator or the Infant Feeding Facilitator).

Equipment Required:

- Feeding cup with soft curved rim
- Expressed breastmilk or artificial milk if no EBM available.
- Bib (can be weighed if a lot of spillage, before and after feeds).
- Sterilising equipment - clean cup in hot soapy water, rinse and sterilise.

Learning to cup Feed:

- Wrap the baby securely, but not too tightly to allow full jaw movement.
- Support the baby in an upright position on your lap.
- Try to have the cup at least half full if possible.
- The cup should be tipped so that the milk is just touching the baby's lower lip, but never pour the milk into the baby's mouth.
- Direct the rim of the cup towards the corners of the upper lip and gums, with it gently resting on the lower lip. Do not apply pressure to the lower lip.

- Leave the cup in the correct position during feeding; do not keep removing it when the baby stops feeding, unless he requires a burp.
- If the baby demonstrates any stress cues, discontinue cup feeding, and try again at a later feed or date.
- Document the event and responses from the baby.

Contraindications to cup feed:

- If baby has a very active tongue a lot of breastmilk may be lost.
- It does not fulfil the baby's need to suck.
- It is not good for any baby who is likely to aspirate.
- Babies who have poor gag reflex or neurological defects.
- Term healthy babies can become addicted to the cup.
- Inexperienced feeders can cause tidal waves of milk.

Each baby should have an individualised assessment to determine suitability for cup feeding. This guideline should be used in conjunction with the Barnsley Breastfeeding Policy 2019.

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Appendix 16

Standard Operating Procedure For The Storage of Expressed Breast Milk And Administration.

Introduction

Standard operating procedures are essential for the efficient management of wards and departments to promote safe, effective care and optimize health outcomes. By providing a framework for staff to work with SOP's provide clarity and uniformity of approach, whilst at the same time they help to give assurance that basic standards are being met. The main underpinning themes are risk management, cleanliness and infection control.

Aim

To ensure robust systems are in place for :

- The safe storage of Expressed Breast Milk.
- The administration of expressed breast milk to the correct baby.

Process Storage of EBM:

1. The mother will express the breast milk into an appropriate sterile bottle / syringe. She will then place a hand written label onto it containing:
    a. The baby's name
    b. Date of birth
    c. The date and time the milk was expressed
2. The mother will then hand the milk to a member of staff. The member of staff will then check the details with the mother or partner prior to putting it in the fridge or freezer on Antenatal Postnatal Ward (ANPN), Neonatal Unit (NNU) and Ward 37.
3. Both the mother or partner and the member of staff will sign the check sheet to evidence that the details are correct before putting in the fridge or freezer on ANPN, or two members of staff can sign the check sheet.

Process for removing milk from the fridge or freezer and administering it to the baby.

1. On ANPN and Ward 37 two members of staff or one member of staff with the mother will check the details on the bottle or syringe with the baby wrist band and document in the notes and on the EBM Storage log which will be kept on the fridge and freezer on ANPN.
2. On NNU if the milk is taken out of the freezer it **MUST** be defrosted in the fridge – two members of staff or one member of staff with the mother, will check the details on the

3. bottle or syringe prior to administration to the baby. This will be recorded in the neonatal notes.