NHS SCOTLAND

## National Neonatal Network Guideline

# Neonatal Infant Feeding Policy

Scottish Perinatal Network NEONATAL

## Document Control Sheet

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# Neonatal Infant Feeding Policy

## Aim

This policy aims to support all staff to provide care that improves outcomes for babies and their families, specifically to deliver:
a**. Improved parents' experiences of care**: parents' views should be listened to through regular audit and parents' experience surveys. Care should be family centred and non-judgmental. Parents should be enabled to contribute to decision making and to be primary care givers for their baby.
b. **Collaboration and continuity of standards** amongst staff working across disciplines. All documentation across and between services should fully support the implementation of these standards.
c. **An increase in the number of sick and premature babies receiving expressed breast milk** and an increase in the number of babies discharged home continuing to breastfeed or receive breast milk.
d. **Improved outcomes for mothers who choose to formula feed** including an increase in those doing so safely and responsively.

## Disclaimer

The recommendations in this guideline represent the view of the National Neonatal Network Guideline Development Group, arrived at after careful consideration of the evidence available. When exercising their clinical judgement, healthcare professionals are expected to take this guidance fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to follow the guideline recommendations and it remains the responsibility of the healthcare professional to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

# Contents

# 1. Introduction

The aim of this policy is to make sure that all staff understand their roles and responsibilities in supporting new parents to feed and care for their baby in ways which maximise optimum health and well-being.

This policy should be used in conjunction with:

- Improving Maternal and Infant Nutrition: A Framework for Action (2011)
- The evidence and rationale for the UNICEF UK Baby Friendly Initiative standards
- Implementing the UNICEF UK Baby friendly Neonatal Standards (2016)
- Best Start: Five Year Plan for Maternity and Neonatal Services in Scotland (2017)
- Infant Feeding Workbook (2021). The completion and signatures of training record in Appendix 4 is an essential part of this.

# 2. World Health Organisation (WHO) International Code of Marketing of Breast-milk Substitutes

Full implementation of the World Health Organisation (WHO) International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions is mandatory throughout services by all staff (see supporting document in Appendix 3: Code of Conduct for staff).

# 3. Scope of policy

This policy is mandatory and applies to all employees in all locations. All staff who provide care for pregnant women, babies and their families should be orientated to this policy and understand their role and responsibilities and support optimum infant nutrition.

# 4. Our commitment

We are committed to:

- Providing the highest standard of care to support parents with a baby admitted to the neonatal unit, to feed their baby and build strong and loving parent-infant relationships. This is in recognition of the profound importance of early relationships on future health and well-being and the significant contribution that breastfeeding makes to promoting positive physical and emotional health outcomes for babies and their families.
- Ensuring that all care is mother and family centred, non-judgemental and that parent's decisions are supported and respected.
- Working together across disciplines and organisations to improve mothers'/parents' experiences of care.

As part of this commitment services will confirm that:

- All new staff are familiarised with this policy on commencement of employment.
- All staff will receive training to enable them to implement the policy as appropriate to their role. New staff will receive this training within six months of commencement of employment.
- The International Code of Marketing of Breast-milk Substitutes is implemented throughout the service.
- All documentation fully supports the implementation of BFI neonatal standards.
- Parents' experiences of care will be listened to through: regular audit using the Baby Friendly Initiative audit tool, parents' experience surveys (e.g. Bliss Baby Charter audit tool)

# 5. Care Standards

### Supporting parents to have a close and loving relationship with their baby

This service recognises the profound importance of secure parent-infant attachment for the future health and wellbeing of the infant and the challenges that the experience of having a sick or premature baby can present to the development of this relationship. Therefore, this service is committed to care which actively supports parents to develop a close and loving bond with their baby.

All parents will:

- Have a discussion with an appropriate member of staff as soon as possible (either before or soon after their baby's birth) about the importance of touch, comfort and communication for their baby's health and development.
- Be actively encouraged and enabled to provide comfort and emotional support for their baby including comforting touch and responsiveness to their baby's behavioural cues throughout their baby's stay in the neonatal unit.
- Be enabled to have frequent and prolonged skin contact with their baby as soon as possible after birth (ideally in the labour ward) and throughout the baby's stay on the neonatal unit.

## Enabling babies to receive breastmilk and to breastfeed

This service recognises the importance of breastmilk for babies' survival and health. Therefore, this service will make sure that:

- A mother's own breastmilk is always the first choice to feed her baby and where this is not possible, donor human milk will be offered if appropriate.
- Mothers have a discussion regarding the importance of their breastmilk for their preterm or ill baby as soon as is appropriate. The aim being to provide mothers breastmilk within the first 24 hours of life through buccal colostrum.
- A suitable environment conducive to effective breastmilk expression is created.
- Mothers have access to effective breast pumps and equipment.
- Mothers are enabled to express breastmilk for their baby, including support to:
    - Express as early as possible after birth (ideally within two hours)
    - Learn how to express effectively, including by hand and by pump
    - Learn how to clean equipment and store milk safely following the best practice guidance, National Neonatal Guidance - Scottish Perinatal Network
    - Express frequently (at least eight times in 24 hours, including once at night) especially in the first two to three weeks following delivery to optimise long-term milk supply
    - Overcome common expressing difficulties with support from core staff, particularly where milk supply is inadequate (less than 750ml expressed in 24 hours by day 10). Where needed they should have access to skilled infant feeding support staff.
    - Stay close to their baby (when possible) when expressing milk
    - Use their breastmilk for mouth care for their baby and later to tempt baby to feed.

- A formal review of expressing is undertaken a minimum of four times in the first two weeks to support optimum expressing and milk supply using Assessment of breastmilk expression checklist or similar.
- Mothers receive care that supports the transition to breastfeeding, including support and information to:
    - Be close to their baby as often as possible so that they can recognise and respond to feeding cues
    - Recognise signs that their baby no longer wants to feed
    - Use skin-to-skin contact to encourage instinctive feeding behaviour
    - Position and attach their baby for breastfeeding
    - Recognise effective feeding
    - Overcome challenges when needed

## Cue based feeding

Cue Based Feeding (CBF) is an individualized, developmentally appropriate feeding method, where the baby leads how and when it will feed by displaying behavioral cues and reflexes. This supports the transition to oral feeding competence.

Cue based feeding is a meaningful behaviour where the focus changes from volume driven to an infant led approach. This is reflected in:

- The baby's behaviour as the main driver for oral feeding
- Change from a routine approach, to responding to the feeding cues or stress cues of the infant
- Improvement in long-term neurodevelopmental outcomes for the most fragile infants
- Parents building confidence and competence in establishing feeding as a pleasurable and relationship building activity
- Promoting parental attachment and decreasing parental anxiety
- Reducing length of stay and facilitating early discharge on partial tube feeding
- Improvement in weight gain.

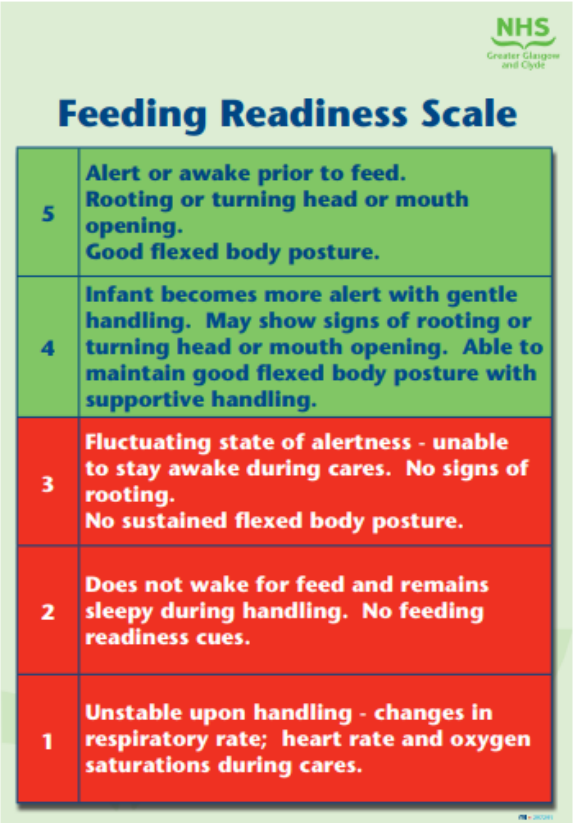
Mothers will have support to learn how to assess, respond and optimally support their baby as they learn to feed.

In baby's being bottle fed, most literature supports offering oral bottle feeds from 32 weeks' gestation, according to readiness cues. However, a baby experiencing earlier non-nutritive suckling at the breast during skin-to-skin may progress more quickly to attaching and suckling with transfer of milk. A baby suckling at the breast has more control of the flow of milk as compared to bottle feeding and may be able to co-ordinate suck/swallow with respiration safely at corrected gestational age less than 32 weeks.
When considering cue based feeding it is important to recognise:

- The introduction of early scoring of feeding readiness should begin long before the introduction of oral feeds. This supports monitoring progression and increasing parental awareness of their baby's cues
- Feeding safely and achieving adequate intake for growth requires the integration, maturation, and coordination of multiple subsystems which requires a wider understanding of the baby's overall stability and developmental readiness
- Principles of developmental supportive care are fundamental to the implementation of successful cue-based feeding practice
- The need for optimal postural stability by holding baby close for feeding, and utilise supportive swaddling and side lying as necessary
- Parents need to understand how to use pacing during the feed
- Baby's behaviour needs to be assessed from moment to moment
- Cue based feeding is based on the quality of feeding rather than the volume
- Each feeding episode should be evaluated in isolation regardless of the baby's previous assessment outcome.

Skillful feeding assessment provides a consistent approach to selecting effective feeding interventions that address the needs of the baby. Working in partnership with parents encourages individualised approach to feeding. This includes tools to assess feeding readiness cues and stop cues. See examples below.

**Feeding Readiness Cues** **Feeding Stop Cues**



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**Feeding Readiness Scale**

| | |
|---|---|
| 5 | Alert or awake prior to feed.<br>Rooting or turning head or mouth opening.<br>Good flexed body posture. |
| 4 | Infant becomes more alert with gentle handling. May show signs of rooting or turning head or mouth opening. Able to maintain good flexed body posture with supportive handling. |
| 3 | Fluctuating state of alertness - unable to stay awake during cares. No signs of rooting.<br>No sustained flexed body posture. |
| 2 | Does not wake for feed and remains sleepy during handling. No feeding readiness cues. |
| 1 | Unstable upon handling - changes in respiratory rate; heart rate and oxygen saturations during cares. |

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**When to STOP feeding me**

**STOP** the feed if any stress signs are observed and offer a rest period. If stress cues continue with further feeding attempts then give the remainder via nasogastric tube.

- When I am becoming increasingly drowsy - I may start yawning.
- When my tone changes and I become floppy.
- When I am sleeping or not actively sucking.
- When I am pausing for a long time (to recover) after only sucking for a very short time.
- When I push away – I may stretch my arms out or bring them to my face - my fingers might be splayed.
- When my suck-swallow-breath pattern changes and I am finding it more difficult and start to gulp.
- When my monitor shows that my numbers are not good.
- If my skin colour changes – it may become pale, mottled or bluish.



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The use of a systematic assessment tool for feeding readiness facilitates neonatal care units to develop a common language and supports consistent documentation of oral feeding readiness and quality.

### Assessing Effective Feeding

For all babies regardless of feeding method, the effectiveness of milk transfer and overall intake need to be monitored. Skin to skin contact should be encouraged throughout the baby's stay and beyond, to support relationship building and parental attunement to baby's cues.

### Breastfeeding Assessment

- A formal review of effective feeding is carried out at least once every 24 hours using the BFI neonatal breastfeeding assessment tool or similar.
- Mothers are supported through the transition period to discharge home from hospital, including having the opportunity to stay overnight/for extended periods to optimise confidence and recognise feeding cues to enable modified responsive feeding

Responsive feeding: The term responsive feeding is used to describe a feeding relationship which is sensitive, reciprocal, and about more than nutrition. Staff should ensure that mothers have the opportunity to discuss this aspect of feeding and reassure mothers that breastfeeding can be to feed,

comfort and calm their baby; breastfeeds can be long or short, breastfed babies cannot be overfed or 'spoiled' by too much feeding and breastfeeding will not, in and of itself, tire mothers any more than caring for a new baby without breastfeeding. Modified responsive feeding builds in safety where a baby born sick/preterm and doesn't always show feeding cues. The baby should feed a minimum of 8 times in 24hours. If the baby is sleepy the mother may need to wake her baby after 3 hours to feed. She may also need to express after some feeds to protect her milk supply until the baby is feeding responsively. It is important that mothers understand that modified responsive feeding is only a short term transition to responsive feeding – refer to transitioning to modified responsive/responsive feeding

- Mothers are provided with details of voluntary support for breastfeeding which they can choose to access at any time during their baby's stay.
- Mothers are provided with information about all available sources of support before they are transferred home see 4a for useful resources.

### Bottle Feeding Assessment

It may be helpful to use the bottle feeding assessment tool to assess parent's knowledge and skills and identify where further support may be required.

All parents who formula feed or bottle feed breastmilk should feed responsively. The term responsive feeding is used to describe a relationship which is sensitive, reciprocal and about more than nutrition. Staff should provide parents with the opportunity to discuss this aspect of feeding and reassure them that by holding their baby close during feeds and offering the majority of feeds to their baby themselves helps enhance the parent/baby relationship. This includes:

- using a safe and responsive technique:
  - holding their baby in close maintaining good eye contact
  - talking to their baby throughout the feed
  - encouraging their baby to take the teat into their mouth
  - letting their baby pace the feed by holding the bottle horizontally and offering breaks as needed according to feeding cues
- how to clean/sterilise equipment and make up a bottle of formula milk. Information is available from formula feeding - How to feed your baby safely

It is important to recognise signs of distress during feeds and not force a full feed. Parents should be encouraged to do most bottle feeds to support early relationship building and connection - see UNICEF baby friendly resources responsive bottle feeding

For some babies, there may be a need for additional feeding interventions to support the transition to bottle feeding. This may be particularly relevant for babies born extremely preterm or with complex conditions. These interventions would include external pacing of feeds and elevated side lying. Before implementing, the baby should be assessed by the Speech and Language Team where possible.

### Valuing parents are partners in care

This service recognises that parents are vital to ensuring the best possible short and long term outcomes for their babies and should be considered as the primary partners in care. The service will ensure that parents:

- Have unrestricted access to their baby unless individual restrictions can be justified in the baby's best interest. Parent's individual circumstances and needs will be considered.
- 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 decision-making.
- Are made comfortable when they are in the unit, with the aim of enabling them to spend as much time as is possible with their baby.

# 6. Reviewing and monitoring

This policy will be reviewed annually for accuracy in accordance with any policy changes and audit results. It will be fully reviewed by key stakeholders every three years.

### Monitoring

We require that compliance with this policy is audited at least annually using the UNICEF UK BFI neonatal audit tool.

**Audit tools:** Compliance is monitored using UNICEF UK BFI audit tools (2021 edition). Staff involved in carrying out audit will require appropriate training on the use of the tool. Audit should be completed at least annually for staff and six monthly for mothers. The results should be reported to the NHS Board. An action plan should be agreed to address any areas of non-compliance.

**Monitoring outcome indicators:** Outcomes will be monitored by annual breastfeeding data collection and the BFI neonatal data set. This data will cover:

- Time to first expressing-hand and pump (BFI dataset)
- Early breastmilk within 48 hours reflecting NNAP for babies >34 weeks
- Early breastmilk for all babies (BFI data set)
- breastmilk at day 14 of life
- breastmilk on discharge from NNU for babies >34 weeks
- Breastmilk on discharge from the NNU for all babies (BFI data set)

Readmission rates and parental satisfaction should also be monitored.

**Managing performance issues:** Arrangements should be made by service leads to develop action plans and interventions to improve the standards of care when issues are identified at audit or in outcome measures.

# 7. References

1. Improving Maternal and Infant Nutrition: A Framework for Action (2011) improving maternal infant nutrition framework

2. The evidence and rationale for the UNICEF UK Baby Friendly Initiative standards (2013) evidence and rationale for the baby friendly standards

3. Implementing the Neonatal UNICEF Baby Friendly Initiative Standards (2016) implementing neonatal BFI standards

4. The Best Start: Five Year plan for Maternity and Neonatal Care in Scotland (2017) best start five year forward plan maternity neonatal care Scotland

5. The International Code of Marketing of Breastmilk Substitutes (2013) international-code-marketing-breastmilk-substitutes

6. Working Within the International Code of Marketing of Breastmilk Substitutes: A Guide for Health Professionals (2020) UNICEF UK Baby Friendly Initiative working within the code health professionals guide

7. first steps nutrition trust

8. https://www.thelancet.com/series/breastfeeding-2023

# Appendix 1: Expressing Assessment

**Expressing assessment form**

If any responses in the right hand column are ticked refer to specialist practitioner. Any additional concerns should be followed up as needed. Please date and sign when you have completed the assessments.

| *Mother's name:* | *Baby's name:*<br><br>*Date of birth:* | *Date of assessment:* | | | | *Birth weight:*<br><br>*Gestation:* | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **What to observe/ask about** | **Answer indicating effective expressing** | ✔ | ✔ | ✔ | ✔ | **Answer suggestive of a problem** | ✔ | ✔ | ✔ | ✔ |
| Frequency of expression | At least 8-10 times in 24 hours including once during the night. | | | | | Fewer than 8 times. Leaving out the night expression. | | | | |
| Timings of expressions | Timings work around her lifestyle – if cluster expressing, no gaps of longer than 4 hours (daytime) and 6 hours (night time) | | | | | Frequent long gaps between expressions. Difficulty 'fitting in' 8 expressions in 24 hours. | | | | |
| Stimulating milk ejection | Uses breast massage, relaxation, skin contact and/or being close to baby. Photos or items of baby clothing to help stimulate oxytocin. | | | | | Difficulty eliciting a milk ejection reflex.<br>Stressed and anxious. | | | | |
| *Hand expression | *Confident with technique.<br>Appropriate leaflet/information provided. | | | | | *Poor technique observed. Mother not confident. | | | | |
| Using a breast pump | Access to electric pump. Effective technique including suction settings, correct breast shield fit. Double pumping (or switching breasts) to ensure good breast drainage. Uses massage and/or breast compression to increase flow. | | | | | Concern about technique. Suction setting too high/low, restricting expression length, breast shield too small/large. | | | | |
| Breast condition | Mother reports breast fullness prior to expression which softens following expression. No red areas or nipple trauma. | | | | | Breasts hard and painful to touch. Evidence of friction or trauma to nipple. | | | | |
| Milk flow | Good milk flow. Breasts feel soft after expression. | | | | | Milk flow delayed and slow. Breasts remain full after expression. | | | | |
| Milk volumes | Gradual increases in 24 hr volume at each assessment. | | | | | Milk volumes slow to increase or are decreasing at each assessment. | | | | |

***Hand expression may not need to be reviewed every time***

# Appendix 2: Breastfeeding assessment tool (neonatal)

**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:**<br>Day 1-2 = 1-2 or more in 24 hours<br>Day 3-4 = 3-4 or more in 24 hours, heavier<br>Day 6 plus = 6 or more in 24 hours, heavy |
| **Your baby:**<br>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:**<br>Day 1-2 = 1 or more in 24 hours, meconium<br>Day 3-4 = 2 (preferably more) in 24 hours changing stools<br>By day 10-14 babies should pass frequent soft, runny stools everyday; 2 dirty nappies in 24 hours being the minimum you would expect.<br><br>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:**<br>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:**<br>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.<br><br>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:**<br>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 2a: Assessing effective breastfeeding/top up form

**Breastfeeding assessment score to determine tube top ups**

adapted from Imperial College Hospitals NHS Trust

To be used in conjunction with the assessment of maternal lactation, attachment and signs of effective milk transfer

| Score | Definition | Action |
|---|---|---|
| A | Offered the breast, not showing feeding cues, sleepy | Full top up |
| B | Some interest in feeding (licking and mouth opening/head turning) but does not attach | Full top up |
| C | Attaches onto the breast but comes on and off or falls asleep | Full top up |
| D | Attaches only for a short burst of sucking, uncoordinated with breathing and swallowing and/or frequent long pauses | Half top up if the mother is available for next feed. The baby may wake early |
| E | Attaches well, long, slow, rhythmical sucking and swallowing – sustained for a short time with breasts not softened throughout | Half top up if mother is not available for next feed. If mother is available for next feed do not top up, and assess effectiveness of next feed. |
| F | Attaches well, long, slow, rhythmical sucking and swallowing – sustained for a longer time with breasts feeling soft following feed | No top up |

# Appendix 3: Code of conduct for staff relating to products covered by the World Health Organisation (WHO) International code on marketing of breast milk substitutes

## Introduction

Rationale: Formula milk feeding is associated with risk to maternal and child health. Staff who support pregnant women, their partners and new parents should ensure that only unbiased factual, evidence-based information is provided. This will enable parents to make informed decisions with regard to their feeding choice and formula milk use. Staff should avoid being used as a conduit to relay formula company messages to parents. It is inappropriate for staff to be seen to promote particular formula milk brands or associated products (bottles, teat or dummies). Parents can be signposted to First Steps Nutrition Trust for unbiased information.

The WHO Code: The World Health Organisation International Code of Marketing of Breastmilk Substitutes was adopted by a Resolution (WHA34.22) of the World Health Assembly to ensure the proper use of breast-milk substitutes. It regulates the promotion of bottle feeding and information on infant feeding. The UNICEF UK Baby Friendly Initiative advocates the complete separation of health professionals from companies at an organisational level and has provided guidance Health Professionals Guide to the Code 6The UK regulates the marketing of breast milk substitutes through the Infant Formula and Follow-on Formula Regulations. The Scottish Government's Improving Maternal and Infant Nutrition: A Framework for Action and NHS GGC fully endorses and supports the WHO Code and this operates in addition to the existing NHS GGC code of conduct of business matters. Professional codes of practice should also be considered by staff in the context of formula milk marketing.

# Appendix 4: Training record

| | | |
|---|---|---|
| Name<br>Workplace<br>Date of commencing<br>Date of infant feeding training | | |
| | Date and signature of mentor | Date and signature of staff |
| Has read infant feeding policy | | |
| Signed copy of code of conduct and sent to manager | | |
| Review of knowledge completed | | |
| Mentored practice completed | | |

I have read this code of conduct and understand that its content is mandatory for staff working within, in contract with or affiliated with NHS.

| Name of staff member | Designation | Signature | Date |
|---|---|---|---|
| Name of line manager | | | |

**This should be completed and then retained by the line manager in the employee's folder.**

# Appendix 4a: Useful resources

### Parent support organisations

https://www.unicef.org.uk/babyfriendly/support-for-parents/

BLISS

parentclub

Milk-bank-Scotland

the Breastfeeding network

nct

Lullaby Trust