National Neonatal Network Guideline

Managing breastmilk (Mothers own and donor) within maternity, neonatal and hospital based children's services

Document Control Sheet

Title	Manging breastmilk (Mothers own and donor) within neonatal, maternity and hospital based children's services
Lead Author(s)	Gillian Bowker, Infant Feeding Advisor, NHS Greater Glasgow & Clyde Debbie Barnett, coordinator Milk Bank Scotland Neonatal Scottish Infant Feeding Advisors Network
Date Published/ Issued	28.01.2025
Date Effective From	28.01.2025
Version/Issue Number	1.1
Document Type	Guideline
Document Status	Final
Owner	National Neonatal Network (NNN)
Approver	NNN Guideline Oversight Group
Approval Date	06.01.2025
Contact	nss.perinatalnetwork@nhs.scot
File Location	K:\09 PCF\NSD\Strategic Networks\Perinatal\Workstreams\Neo Gdlns_Drg Monos

Revision History

Version	Date	Summary of Changes	Name	Changes Marked
1.0	January 2025	None - original version	Gillian Bowker	
1.1	February 2025	Amendment p.3, removal of wording: "All staff are expected to comply with this policy."	Gillian Bowker	

National Neonatal Network Guideline: Managing breastmilk (maternal and donor) within maternity, neonatal and children's hospital settings

Aim

This guideline is intended to ensure that all staff within Scotland understand their role and responsibilities in supporting parents to feed their baby expressed breast milk (EBM) and/or donor human milk (DHM) in ways which support optimum health and wellbeing.

This guidance should be used in conjunction with local infant feeding policies and guidelines.

Summary

The safe feeding of hospitalised infants and children is paramount in enhancing their clinical outcome. Quality assurance is essential at all stages of handling, storing, transporting and administration of feeds containing EBM/DHM.
This document provides the guidelines for all health care facilities to adopt locally and from which to devise their own internal monitoring and audit trail. These guidelines are based on current research and scientific evidence where available together with best practice from experienced practitioners.
The desired outcome is that all infants and children within a health care setting receive optimal nutrition in a safe manner and that all the staff working within the health care facility have guidelines to support this.
This document will be reviewed in 3 years or as new evidence emerges.

This guideline uses the terms "woman" or "mother" throughout. These should be taken to include people who do not identify as women but who are pregnant. Similarly, where the term "parents" is used, this should be taken to include anyone who has main responsibility for caring for a baby.

Disclaimer

The recommendations in this guideline represent the view of the expert, multi-disciplinary 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.

Contributors

This document has been supported by the Neonatal Scottish Infant Feeding Advisors network (NeoSIFAN).

Key contributors:

Gillian Bowker (neonatal Infant feeding lead NHS GGC/Breastfeeding Leadership Team)

Debbie Barnett (Milk Bank Scotland coordinator NHS GGC)

Karen Read (UNICEF UK Baby Friendly Initiative neonatal lead)

Amy Boyd (neonatal infant feeding advisor, NHS Lanarkshire)

Diane Forbes (neonatal infant feeding advisor NHS Grampian)

Abby Smyth (neonatal infant feeding advisor, NHS Fife)

Eithne Clark (infant feeding coordinator, NHS Dumfries and Galloway)

Julia Maxwell (neonatal infant feeding advisor, NHS Lothian)

Janet Dalzell (Professional Lead for Scotland UNICEF UK Baby Friendly Initiative)

Definitions

Fresh breastmilk (EBM)-expressed breastmilk which has been expressed and stored in a refrigerator at ≤4°C for no longer than 48 hours (24 h if expressed at home)

Frozen breast milk – expressed breast milk which has been frozen at a temperature of -18°C or lower.

Donor human milk (DHM)-breastmilk expressed by a mother that is then processed by a donor milk bank for use by a recipient that is not the mother's own baby.

Contents

1. Introduction

Breastfeeding is the recommended method of feeding infants including the preterm and hospitalised infant. Breastmilk provides a balance of macro and micronutrients, vitamins, minerals, and living properties including transferring immune factors to protect the infant in early life optimising health outcomes in the short and longer term for mothers and babies.[1, 15] Where a mother's breastmilk (EBM) is not available in sufficient volumes or can't be used due to maternal medication, donor human milk (DHM) may be offered. Whilst DHM is not a replacement for EBM it provides easily digested nutrition as well as many anti-infective and other active components that help to optimise early newborn health. For sick or preterm infants DHM should be made discussed as an alternative to formula milk.[2] DHM can also be used as a bridge to be breastfeeding whilst women are building their milk supply. If it is not possible for an infant to breastfeed in hospital due to prematurity, infant or maternal ill health or maternal wishes, the mother should be supported to express her breast milk.[16]

2. Expressing breastmilk

To ensure a good milk supply, it is vital for mothers to start to express early, ideally within two hours after birth. Expressing frequently and effectively optimises milk supply and establishment of lactation.

Where a woman's milk supply doesn't meet the needs of her baby in the early days donor human milk should be considered as the first alternative to infant formula.

- A discussion with the family about the importance of breastmilk and how to optimise milk supply should ideally take place antenatally or at the earliest opportunity post birth.[3]
- Mothers should be supported to initiate breastmilk expression ideally within two hours of birth unless maternal health issues prevent this happening19. If this is unable to occur for practical reasons, then expression should commence as soon as possible.[3]
- Breast massage including nipple rolling increases milk production hormones and should be encouraged before every expressing session.
- Hand expression should be used to remove colostrum followed by double pumping using a hospital grade breast pump.
- Expression to remove colostrum should occur as frequently as possible aiming for 8-10 times in 24 hours. It is important that this is done flexibly to suit the needs of the woman and that she is supported to achieve this. Information around not leaving big gaps and expressing once overnight is important.[3]
- Skin to skin contact or kangaroo care (KC), will increase hormone levels involved in milk production and should be encouraged as soon as possible after birth ideally starting with a labour ward cuddle.
- Effective expressing is easier when mothers and babies are close to each other. Mothers should be encouraged to be with their babies for as long and as often as they wish. This should be supported through practical measures such as comfortable chairs, adequate cot side expressing facilities and equipment and a screen for privacy.[3]
- Using breast pump equipment near baby where possible and expressing both breasts simultaneously can increase milk yield. Breast compressions and/or hand expression towards the end of the pumping session may also help.[4]

- Lactation should be frequently assessed in the early days using UNICEF BFI Assessment of breastmilk expression or similar. Once within 24 hours of birth and another three times within the first 14 days. This should cover frequency, technique including shield fit, milk volumes and breast condition/comfort.
- A low milk supply requires prompt attention including a review of technique, frequency of expression, general support and encouragement. This may require referral to the NHS Board Infant Feeding team.[5]
- When production reaches at least 750-900mls per day the milk cells are likely to have been sufficiently primed and lactation will become established. This is usually achieved between day 14 and day 21. Some mothers may then with support safely reduce frequency of expressing to 6-8 times per day. This may happen earlier in women who have previously had a baby.

The aim is not to meet the baby's needs but to ensure future sufficient lactation. Within a few days many mothers of small babies will be producing much more than the baby initially needs.

3. Collection of breastmilk and cleaning of equipment

Premature and ill babies are much more vulnerable to common bacteria and viruses.

These would not normally cause severe illness. Therefore, attention to hygiene is essential:

- Any staff or mothers involved in milk collection or breast pump use need to be very particular about hand washing before handling equipment or milk containers.
- Ensure parents understand the importance of good hygiene. This conversation should include the importance of good hand hygiene as well as personal hygiene. The mother may need to wash more frequently if she is leaking milk or has increased perspiration (common when prolactin levels are high). Bath towels and bra may need to be changed more frequently than normal. Fresh breast pads should be used 4 – 6 hourly or sooner if damp. Support should be given where this is not possible due to challenges with living conditions.
- Staff and mothers need to ensure thorough cleaning of work surfaces and breastfeeding equipment.

Hand expressing

- Initially when hand expressing, mothers should use a single use sterile enteral syringe, spoon or galipot to collect colostrum. If colostrum is stored in an enteral syringe it needs to be clearly labelled with baby's name, CHI, date and time expressed.
- All colostrum collected should be labelled with date, time expressed and baby's name, unit/CHI number.
- Colostrum should be stored in the fridge and used within 48 hours of expressing. Freezing destroys some of the bioavailable components therefore fresh colostrum is preferable.

Electric breast pumps

Breast pumps for communal use in ward areas should be regularly serviced and checked for faults. A schedule for this should be available for inspection and audited at least annually. This is available at **HACCAP**.

- Communal breast pumps should be thoroughly cleaned by a member of staff each day and checked for wear and tear. This should be recorded daily and audited on a regular basis, at least annually.
- Mothers should also be instructed to clean the breast pump before and after they have expressed their milk. Ensure there are suitable cleansing wipes available for this.
- Sterile bottles will be provided through the hospital and a new sterile bottle will be used each time.
- Bottles should not be overfilled as this may lead to wastage, especially when a baby is receiving small volumes. Milk also expands when frozen which can cause leakage.

Hand pumps

- Mothers' own hand pumps should be cleaned and stored in the same way as pump sets and the pump surface cleaned and dried.
- When using a hand pump use a new sterile bottle each time. These will be provided by the hospital.

For babies who are being cared for in hospital including neonatal, maternity and hospital-based children's services children's wards:

Following breast pump expression of breastmilk the milk collection kits should be thoroughly cleaned in hot soapy water, dried and stored in an airtight container see optimal decontamination of breast pump equipment in hospital best practice statement hospital. [6]

For babies who have been discharged home:

Option 1. Clean the sets with hot soapy water ensuring all milk debris is removed. The sets should then be rinsed and thoroughly dried with fresh paper towel and dry stored away from sinks to avoid contamination by splashes.

Option 2. Sets may be cleaned in a dishwasher on the top shelf. Ideally, a large plastic container and lid, which is washed and dried each time with the pump set, should be used to store the equipment.

Pump sets do not need to be changed if being appropriately cleaned and stored unless damaged. There is no need to wash the tubing that connects to the breast pump.

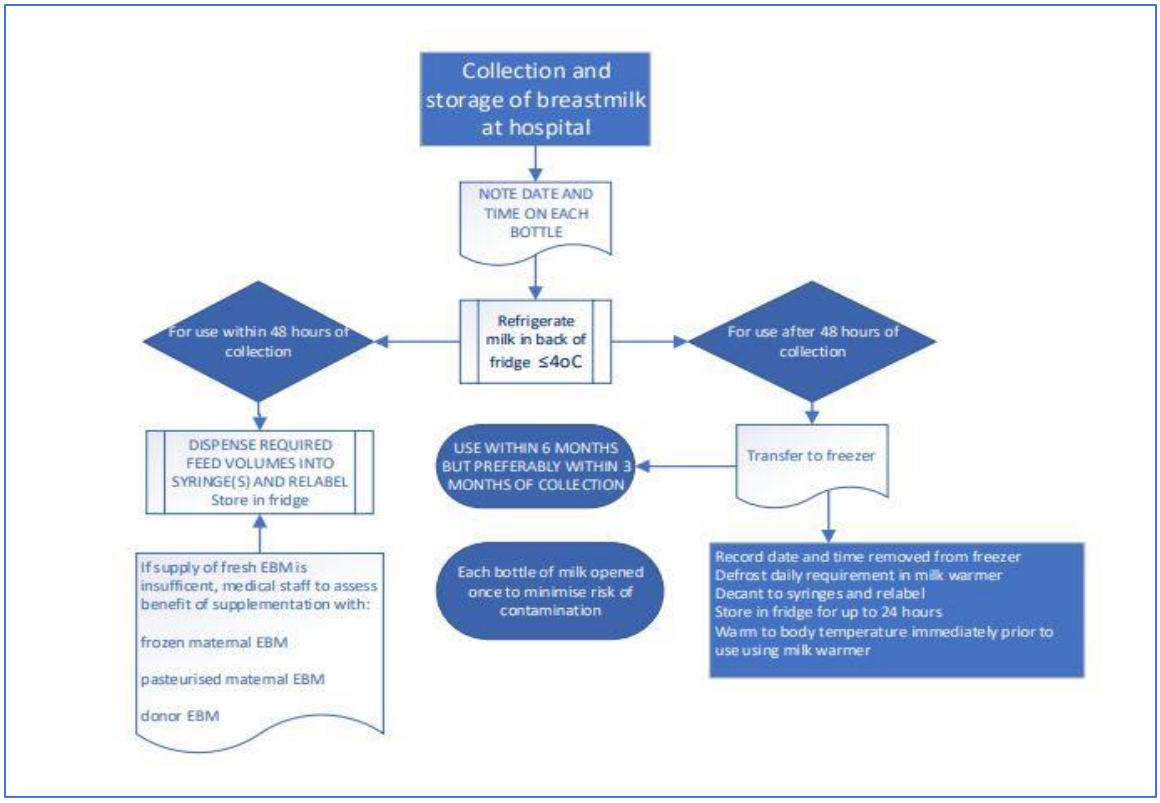
4. Storage and transporting breastmilk

Storage of expressed breastmilk results in a variety of changes to the nutritional and immunological components of human milk that can have an impact on growth and disease

protection. Expressed breastmilk should always be used fresh where possible to maximise protective properties. [20]

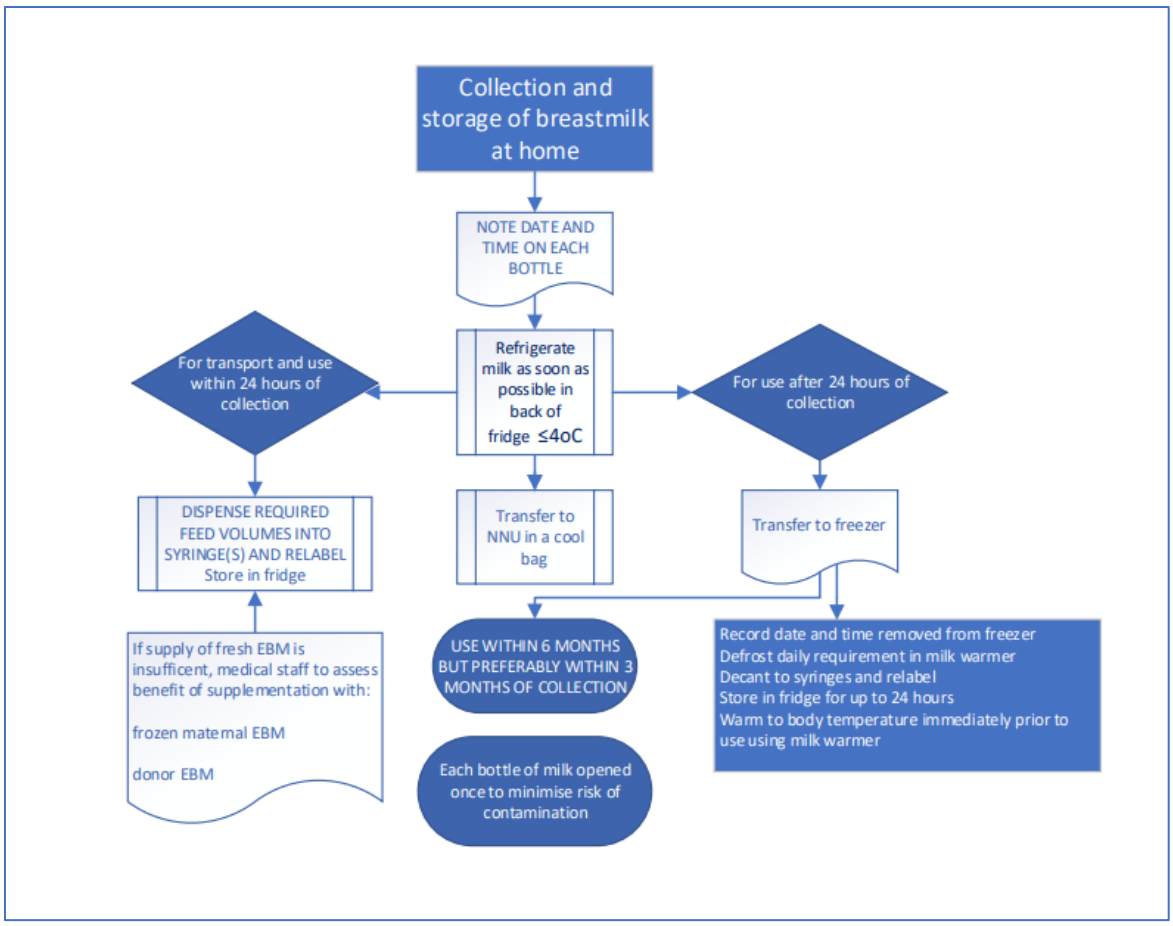
Storage for breastmilk expressed in hospital

- Expressed breast milk should be refrigerated immediately.
- Within the neonatal unit or ward fresh EBM should be stored in the fridge designated for this purpose at temperatures recorded ≤4 °C. It should be used within 48 hours of expressing. If not for use within 48 hours, it should be frozen in a freezer at a temperature of at least -18°C.
- If breastmilk is not going to be used within 48 hours of expressing, then it should be frozen as soon as possible to maintain the nutritional and microbiological quality of the milk.
- EBM can be stored for a maximum of 6 months in a freezer with the temperature set to 18°C or below. It should be used within 3 months while the baby is in the neonatal unit as antibody and fat quality will be better. [7]
- Where women living with HIV, have an undetectable viral load, are receiving antiretroviral therapy (ART) and wish to express their breastmilk, consideration should be given to the safe labelling, storage and administration of their milk. [2]



Storage and transporting for breastmilk expressed at home.

At home expressed breast milk should be stored at the back of the fridge and ideally transported to the unit or ward within 24 hours of expressing in a cool bag. If there is a delay in getting to the unit then EBM should be frozen and transported as quickly as possible in a cool bag with freezer blocks or packed in ice.



Storage and transporting breastmilk post discharge

Breastmilk can be safely transported longer distances by road and plane provided it is packed effectively.

Road travel

- Frozen breastmilk can safely be transported by car if stored in a tightly packed cool bag or box where any free space is filled with either bubble wrap or towels.
- Avoid opening storage container once packed.
- When packed effectively it will remain frozen for up to 12 hours. [20]
- If milk is partially defrosted it can be refrozen. Milk is not considered defrosted until it is in liquid state with no ice crystals. [20]
- When the milk arrives if it is fully defrosted it needs to be used within 24 hours and the rest discarded.

Plane travel

- Frozen breastmilk needs to travel in the hold and will be transported free of charge. LOGANAIR contact details.
- It should be stored in a tightly packed cool bag or box where any free space is filled with either bubble wrap or towels.
- The bag/box should be sealed with tape or locked with a padlock to ensure it remains closed until arriving at the destination.

- If milk is partially defrosted it can be refrozen. Milk is not considered defrosted until it is in liquid state with no ice crystals. [20]
- When the milk arrives if it is fully defrosted it needs to be used within 24 hours and the rest discarded.
- Small volumes of fresh/thawed breastmilk can be taken on board for use during the flight.

Check with the airline before travelling.

5. Defrosting and decanting breastmilk

Defrosting

The Health Protection Scotland document *"Guidance for neonatal units (NNUs) (levels 1, 2 & 3), adult and paediatric intensive care units (ICUs) in Scotland to minimise the risk of Pseudomonas aeruginosa infections from water* [7]*"* has indicated that it is no longer acceptable to defrost breast milk using water from a tap.
The following are methods of defrosting EBM/DHM which are permitted:

- Defrost in a designated milk fridge.
- Defrost using a thawing/warming device designed to ensure there is no direct contact with the bottle / syringe with non-sterile water.
- DO NOT DEFROST FROZEN BREAST MILK BY PLACING THE CONTAINER IN WARM TAP WATER OR RUNNING UNCER WARM TAP WATER. Label with the date and time that the milk is removed from the freezer and ensure the baby's name and CHI number is still present.
- **Discard any unused milk that has been warmed to room temperature.**

Dividing and decanting breastmilk (EBM/DHM)

Bottles containing breastmilk/DHM should be opened only once and decanted at that time.

For feeds of 20mls or less:

Option One:
Draw up into sterile enteral syringes, cap and identify with baby's name, unit/CHI number, date and time decanted (to ensure milk is used within an appropriate period). Filled syringes must be returned to the fridge immediately. Local processes to be followed regarding checking and labelling of milk.

Option two:
Use a suitable access port applied to the bottle and required amounts removed for each feed and labelled as above.

Consideration should be given to appropriate storage that enables breastmilk to be used for mouthcare and during painful procedures as a first choice over sucrose.[19]

Warming breastmilk

- Breastmilk is best used as soon as possible after reaching room/body temperature to prevent bacteria multiplying.

- Bolus milk feeds may be warmed to body temperature using a milk warmer. Only warm the volume of milk required for a single feed. Use the device to warm the milk to the required temperature and use straight away. Any residue should be discarded. **Breastmilk should not be warmed in the baby's incubator.**

- Where a baby is receiving continuous feeds, the syringe should be changed 4 hourly. As continuous feeds are used over a longer time frame, they should not be warmed before use.

6. Administering Breastmilk

Buccal colostrum administration

The provision of early colostrum to a baby is dependent on getting expressed colostrum to the neonatal unit and administered to the baby. It is reliant on all staff recognising the importance and urgency of early colostrum and understanding the enablers and barriers throughout the service that may affect this process. Based on the available evidence [8,9,10] neonatal teams should value and prioritise colostrum to be given early as the first feed.[5]

- Administer a maximum of 0.15 ml of colostrum slowly in each buccal pouch and massage into the cheeks with a gloved finger.
- **Do not use a swab as this will absorb colostrum leaving little to be absorbed by the baby.**
- Avoid oral suction for 30 min.
- Monitor the vital signs of the infant throughout the procedure.
- Repeat every 3 hours for 72 hours or until milk supply increases.
- After the initial 72 hours, colostrum can continue to be used for routine mouthcare.
- If there is excess colostrum this can be given via the nasogastric tube (NG) alongside the administration of buccal colostrum and recorded as enteral feed volumes on Badgernet.
- Record the procedure on the infant feeding record chart or relevant local documentation.
- If feeds are commenced, oral colostrum should be given first and then the NG feed. Oral volumes should be recorded separately and not included as part of the feed volume.

It is important to use colostrum in the order it was expressed. This may be made easier by numbering the syringes as they are filled.

Maternal Expressed Breastmilk

Paper tracking

Breastmilk should be checked by 2 members of staff (or one member of staff and a parent) at the baby's bedside prior to administering and documented with the 2 checkers signatures. The CHI number, name, date and time expressed should be checked against the baby's name band.

Paperless tracking

All maternal breastmilk feeds should be checked by scanning the bottles barcode label and baby's cot label immediately prior to feeding at the cot side. This will automatically be recorded via Maternal Milk Checking (MMC). This does not require a two person check and can be done by either a member of staff or the parent.

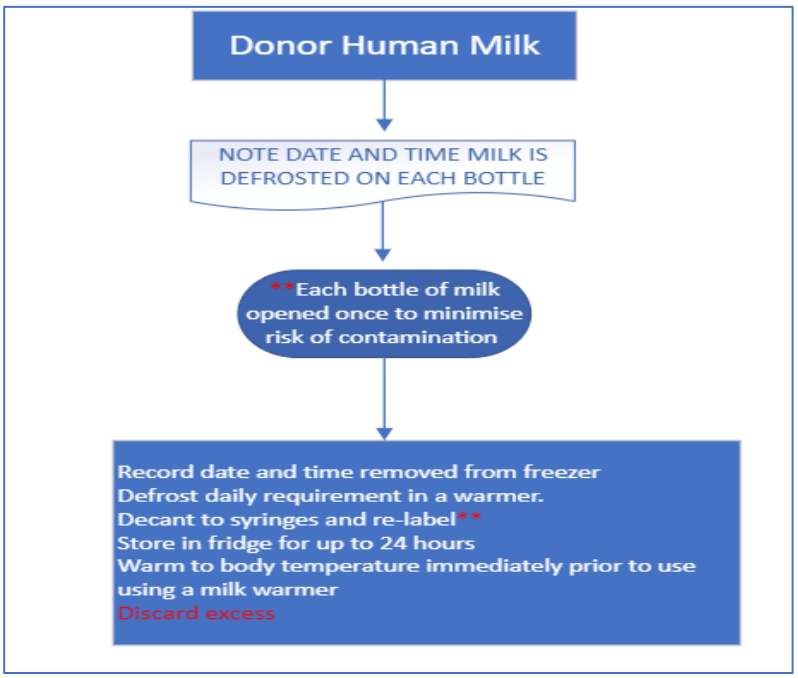
Donor Human Milk

Donor human milk is available for use within Neonatal Units across Scotland. Milk is also available for supporting lactation in the first few days after birth where there is a clinical indication. The expanded criteria can be adapted by individual boards depending on local use in the healthy term population.

The expanded criteria, recipient consent form and decision making tools can he found in the following Donor Human Milk Recommendation and Guidance for Use Document.

Recipient consent

Where possible an online consent form for the administration of donor milk should be fully completed. A copy will automatically be sent to the milk bank email. A second copy should be printed and signed by the person giving consent then inserted into case notes. Where paper consent is used, this must be completed in full. A copy must be scanned and emailed to the milk bank. The original should be inserted into the case notes.



Paper tracking

A Donor Milk Record Sheet should be inserted into the notes and used to record all donor milk received using one tear off label from each bottle of milk. The second tear off label must be attached to the batch sheet with the baby's CHI number and address label and returned to the Milk Bank Coordinator when completed. There is a legal requirement to record end fate the of all donor milk.

Paperless tracking

All DEBM feeds should be checked immediately prior to feeding at the cot side by scanning the barcode label and baby's cot label. This will automatically be recorded via Maternal Milk checking system (MMC) when the feed is confirmed. A tear off label from the bottle of EBM, should be recorded in the Donor Milk Record Sheet in the case notes.

Milk Kinship

Milk kinship is a cultural belief within Islamic religion that when two infants consume milk from the same parent they are siblings, whether the infant is genetically related or not. [17]

Whilst the milk bank will do it's best to support the tracking of milk from donor to recipient, this is challenging. Families of Muslim faith, where this is a concern, should discuss with their local Imam, prior to consent.

7. Guidance for administration of the wrong breast milk to the wrong baby

When a baby receives expressed breastmilk (EBM) in error from a woman other than their biological mother, the major risk usually relates to parental concern about possible transmission of infection. In practice the risk of infection is extremely low. Only HIV, CMV, and HTLV viruses are known to transmit via breastmilk, and HTLV is extremely uncommon in our population. Women living with HIV are encouraged to formula feed. Where the viral load is undetectable and the mother is on ART, she may choose to express and breastfeed. The risk of transmission in this instance is extremely low. [11] If breastmilk that has been given in error was frozen the risk will be even less as low temperatures and components present in breastmilk destroys HIV.

CMV commonly transmits via breastmilk, although the act of freezing EBM destroys many of the viral particles, which significantly reduces the risk of infection. Should CMV be contracted in this way, it may cause acute infection but is very unlikely to have any long term detrimental effects in contrast to prenatal infection. Infants contracting CMV postnatally are not offered any antiviral medication, except in the rare instance of a significant systemic infection.

In addition to viruses, transmission of Group B Streptococcus and Listeria monocytogenes in mothers' breastmilk may cause neonatal disease but the risk of bacterial transmission when an infant is briefly exposed to another mother's breastmilk is likely to be extremely low.

Key principles

- When a baby receives breastmilk from a mother other than their own, the incident is treated as a significant body fluid exposure. There is a tiny but possible risk of transmission of bloodborne viruses and bacteria.
- Both families need to receive consistent information and guidance from the consultant and nurse in charge
- A Datix must be completed containing details of the incident and contributing factors, both mothers' details and the subsequent management including any Duty of Candour discussions that have occurred since. Information required:
    - Name and CHI number of exposed baby and mother.
    - Name and CHI number of source baby and mother.
    - Volume of milk administered.
    - Volume of milk aspirated if applicable.
    - Type of milk- fresh, frozen.
    - Date of expression of source mother's EBM.
    - Details of all staff involved in the error and those informed subsequently.
    - How the error came about including details of the checking procedure.
    - Any contributing factors to the error.
    - Details of communication with parents including names of staff involved.

The incident must also be recorded in the Badger record of the exposed baby, including the details above and those of the risk assessment below, but omitting any identifiable information about the source mother.

Immediate response-management of baby

- If feeding was given by a gastric tube, aspirate the stomach contents but only if the gastric tube is still in place. A gastric tube must NOT be reinserted for the purpose of aspirating the incorrect EBM.
- Report the incident immediately to the nursing in charge and the neonatal middle. grade tier so that a management plan may be formalised as soon as possible and so staff involved in the error can be supported.
- Provide the baby with the appropriate feed.
- Proceed to risk assessment of the source mother.
- The consultant should be made aware as soon as possible during working hours.

Risk assessment

The neonatal Middle Grade doctor/ANNP and/or Consultant should perform and document a risk assessment at the time of the error in relation to:

The source mother

- General wellbeing, medications, recent blood transfusions and whether there is a history of taking illegal drugs.
- Antenatal serology including HCV, HBV, HIV antibodies and history of HBV vaccination.
- History of Group B streptococcus in this pregnancy.
- CMV if tested for.

The mother of the exposed baby

- Antenatal serology including HCV, HBV, HIV antibodies and history of HBV vaccination.

A. If all serology is negative and the source mother is well without relevant lifestyle factors, then the exposure is of minimal risk to the baby.
B. If serology is positive for blood borne viruses in this pregnancy, then the exposure is of low but potential risk for the baby.

a. If the source mother is HIV positive: The exposed baby's parents should be counselled that the risk to the exposed baby is extremely small. The baby should have baseline viral titres taken and managed as per the relevant guideline. The baby should be discussed with the Paediatric Infectious Diseases consultant.
b. If the source mother is HBsAg or hepatitis DNA positive: The exposed baby's parents should be counselled that the risk to the exposed baby is extremely small. Take baseline viral titres and offer hepatitis B immunoglobulin preferably within 24 hours of exposure and HBV vaccine if dose at birth has not already been administered.

B. If it is discovered that serology for HIV, HBV, HCV has not been performed during pregnancy then the risk to the exposed baby cannot be classified. Importantly the source mother's own baby may also be at risk from an unidentified bloodborne virus infection. Informed consent should be sought urgently from the source mother for testing of her blood.

a. If the mother consents to testing and is found to be positive for HIV, HBV or HCV during the screening process, they must be referred to an adult physician with relevant experience for counselling and future management. Her baby and the exposed baby should have viral titres sent and managed as per the relevant guidelines.
b. If consent is not provided, then the source mother's baby must be screened to inform further management for her baby and the exposed baby.

Counselling the exposed baby's parents

- This should be undertaken by a Consultant and Senior Nurse.
- The source mother must NOT be identified to the birth mother/parents.
- There must be open disclosure to the birth parents regarding the incident and an apology offered on the behalf of the service.
- The parents should be made aware that a review will be undertaken to understand the reasons leading to the error and systems strengthened to prevent it occurring again.
- The parents of the exposed baby should be reassured as to the very low risk of transmission of pathogens and supported at the time and thereafter as they process this information. It may be appropriate to share the source mother's viral status without identifying her.
- Parents of the exposed baby should not be routinely offered the possibility of viral testing of the exposed mother if her viral status was known to be negative at booking.
- Document the discussion in the Badger record of the exposed baby.
- It desirable to meet with parents of the exposed baby in the subsequent 24hours to address any further questions or concerns.

Key points in counselling

- The duration of exposure is limited to one feed, in contrast to the hundreds of feeds that occur over the first months of life on which most risk is documented.

- The dose (volume) of exposure is usually small.
- There have been no reports of HIV, HBV, HBC transmission with this level of exposure in the literature.
- Breastmilk stored in the neonatal unit may have been frozen, reducing the chance further.
- Women at booking have universal screening for HIV, hepatitis B, hepatitis C and syphilis and exposure to HIV positive breast milk is unlikely to occur due to counselling against breastfeeding in this group of women.

Some parents of exposed babies may insist on further reassurance including further virological testing of the source mother, although this will require consent. The exposed baby's blood should not be tested, unless the source mother refuses consent for further testing and this test is requested by the exposed baby's parents. If this is the case, then the exposed baby's blood should not be tested at the time of exposure, but arrangement made for this to be tested in three months' time to allow time for viral seroconversion.

Do not routinely offer testing of the exposed baby for CMV unless they shows signs or symptoms of acute CMV infection (incubation period 28-60 days). If a postnatal infection with CMV were to occur it is more likely that the infection would have originated from the exposed baby's own mother rather than from a small aliquot of milk from the source mother.

Counselling the source parents

- This should be undertaken by a Consultant and Senior Nurse.
- The exposed baby/family must NOT be identified to the source mother/family.
- There must be open disclosure to the source parents regarding the incident and an apology offered on the behalf of the service.
- The source parents should be made aware that a review will be undertaken to understand the reasons leading to the error and systems strengthened to prevent it occurring again.
- Document the discussion in the Badger record of the baby of the source mothers.

The above guidance has been taken with thanks from NHS Lothian-Administration of Incorrect breastmilk to a baby, Julie-Clare Becher.

8. Audit of adherence to guideline standards

Consideration should be given to tracking data for the below fields separately for babies born <34/40 to fulfil NNA requirements.

- **Number of women supported to express by hand/breast pump within 2 hours/6 hours of birth.**
- **Number of babies receiving maternal breastmilk within 48 hours of birth (all babies born / babies Born <34/40).**
- **Number of babies receiving maternal breastmilk feeds at day 14 EBM born <34/40.**
- **Number of babies discharged receiving breastmilk at discharge (all babies/babies**

born <34/40).

- **Episodes of inadvertent administration of the wrong milk.**

9. References

1. Lancet breastfeeding series 2023 https://doi.org/10.1016/S0140-6736(23)00118-6

2. The Use of Donor Human Milk in Neonates A BAPM Framework for Practice April 2023

3. UNICEF UK Baby Friendly Initiative - Guide to the Neonatal Standards

4. Acuña-Muga J, Ureta-Velasco N, de la Cruz-Bértolo J, et al. Volume of milk obtained in relation to location and circumstances of expression in mothers of very low birth weight infants. J Hum Lact. 2014;30(1):41-46. doi:10.1177/0890334413509140

5. Optimising Maternal Breast Milk for Preterm Infants: A two-part Quality Improvement Toolkit BAPM 2020

6. Optimal method of decontamination of breast pump equipment in hospital including neonatal units, postnatal wards and children's hospital settings: A best practice statement. Perinatal Network 2023

7. Guidelines for the Preparation and Handling of Expressed and Donor Breast Milk and Specialist Feeds for Infants and Children in Neonatal and Paediatric Health Care Settings BDA 2019

8. Abd-Elgawad M, Eldegla H, Khashaba M, Nasef N. Oropharyngeal Administration of Mother's Milk Prior to Gavage Feeding in Preterm Infants: A Pilot Randomized Control Trial. JPEN J Parenter Enteral Nutr. 2020;44(1):92-104. doi:10.1002/jpen.1601

9. Tao J, Mao J, Yang J, Su Y. Effects of oropharyngeal administration of colostrum on the incidence of necrotizing enterocolitis, late-onset sepsis, and death in preterm infants: a meta-analysis of RCTs. Eur J Clin Nutr. 2020;74(8):1122-1131. doi:10.1038/s41430-019-0552-4

10. Ma A, Yang J, Li Y, Zhang X, Kang Y. Oropharyngeal colostrum therapy reduces the incidence of ventilator associated pneumonia in very low birth weight infants: a systematic review and meta-analysis. Pediatr Res. Published online March 2020:1-9. doi:10.1038/s41390-020-0854-1

11. BHIVA guidelines for the management of HIV in pregnancy and postpartum 2018 (2020 third interim update)

12. Islamic Beliefs About Milk Kinship and Donor Human Milk in the United States https://doi.org/10.1542/peds.2020-0441

13.Centres for disease control and prevention (2023) What to do if and infant or child is mistakenly fed another woman's expressed breastmilk

14. HMBANA (2024) Best practice for expressing, storing and handling human milk in hospitals, homes and child care settings

15. World Health Organisation (2022) WHO recommendations for care of the preterm or low birth weight infant

16. Taylor, S.N. (2021) Empowering mothers to realize their choice for infant feeding. Seminars in perinatology, 45(2), 151379

17. Subudhi, S.,Sriraman,N. (2021) Islamic beliefs about milk kinship and donor milk in the united states Paediatrics, 147 (2)

18. Zhang. S., Su,F,.Li,J.,Chen, W. (2018) The analgesic effects of maternal milk odour on newborns: A mtea analysis. Breastfeeding Medicine, 13 (5), 327-334

19. Parker, L.A., Sullivan, S., Kreugar,C,. Mueller,M. (2020) Timing of milk expression in others delivering preterm very low birthweight infants: A randomized trial. Lornal of perinatology, 40(8), 1236-1245

20. Human Milk Banking association of North America (2024) Best practice for expressing, storing and handling human milk

Appendix 1: Authors

Gillian Bowker Neonatal Infant Feeding Team Lead NHS GGC

Debbie Barnett Donor Milk Bank Coordinator NHS GGC

Appendix 2: Guideline Development Group Membership

Chair, Gillian Bowker, Neonatal Infant Feeding Team Lead, NHS Greater Glasgow & Clyde

Debbie Barnett, Milk Bank Scotland coordinator, NHS Greater Glasgow & Clyde

Amy Boyd, Neonatal Infant Feeding Advisor, NHS Lanarkshire

Diane Forbes, Neonatal Infant Feeding Advisor NHS Grampian

Abby Smyth, Neonatal Infant Feeding Advisor, NHS Fife

Eithne Clark, Infant Feeding Coordinator, NHS Dumfries and Galloway

Julia Maxwell, Neonatal Infant Feeding Advisor, NHS Lothian

Janet Dalzell, Professional Lead for Scotland UNICEF UK Baby Friendly Initiative