Reluctant to Feed Management of Healthy Newborn Babies at Term Clinical Guideline

V3.0

March 2019
1. **Aim/Purpose of this Guideline**

This guideline applies to all health professionals caring for healthy, term newborn babies that are reluctant to feed. Management of these babies includes promoting and protecting breastfeeding if this is the mother’s choice, or formula feeding if not, and aims to detect and prevent any deterioration in the baby's condition.

2. **The Guidance**

2.1. Best practice guidance encourages the baby to feed soon after birth, helped by uninterrupted skin to skin contact for at least 1 hr. or until after the first feed. Most babies will seek to feed effectively within the first 1-2 hours of life, but some babies may be slightly more reluctant due to the effects of maternal analgesia or a long labour. Some babies may feed well initially but then not actively seek a further feed for many hours.

2.2. **If the baby has not had their first feed within 4 hours or the second feed within 6 hours of the first feed, THINK POSSIBLE SEPSIS**

2.2.1 Assess the baby. Record temperature, record heart rate for a full minute with a stethoscope, observe respirations for a full minute including colour, sternal recession and nasal flaring and record all observations on a NEWS chart. Take a history and assess risk factors for sepsis, history of mother’s analgesia or any other medications that may affect the baby. If the baby seems unwell/ any concerns of sedation/ alerts on NEWS chart, refer for paediatric review as soon as possible.

2.2.2 Undress baby and place ‘skin to skin’ with mother. If the baby’s temperature is below 36.6 put on a hat and ensure mum and baby are both covered with a warm, dry blanket.

2.2.3 If the baby appears well, encourage the mother to be proactive and lead the feeding until the baby has taken at least 2 effective breastfeeds, or is taking at least 10ml formula by bottle.

2.2.4 Review with the mother feeding cues (see 2.4.)

2.2.5 Encourage the mother to talk to the baby and massage baby’s hands/feet.

2.3. **If still not fed after 2 hours of the above interventions.**

2.3.1 If breastfeeding, encourage the mother to hand express colostrum into a cup. Teach the mother to finger feed or syringe feed (see 2.5.) the colostrum to the baby.

2.3.2 If formula feeding, the baby can be offered formula milk by finger or syringe if refusing to suck on a teat.

2.3.3 Keep the baby skin to skin with the mother and encourage the mother to look for changes in her baby’s condition. Advise her to inform staff of any concerns.
2.3.4 A blood glucose level is needed only if the baby is jittery. Jitteriness may be defined as excessive, symmetrical repetitive movements of limbs, which are unprovoked and usually relatively fast. It is important to be sure this movement is not simply a response to stimuli. Immediate neonatologist review is required if the baby appears unwell.

2.3.5 Keep the baby ‘skin to skin’ and repeat steps 2.2. to 2.3. in 2 hours.

2.3.6 Anticipate that the baby will become more interested in feeding and encourage the mother to offer the breast or bottle, whenever the baby begins to show feeding cues.

2.3.7 If breastfeeding, continue to encourage the mother to hand express and give her colostrum 2 hourly until the baby breastfeeds well e.g. staying attached and suckling effectively for at least 5-10 minutes.

2.3.8 If formula feeding, encourage offering small amounts of formula by bottle, finger or syringe, until baby is taking at least 10mls formula by bottle.

2.3.9 If the mother has continuing concerns regarding the baby or the feeding, repeat observations must be completed within 4 hours. If this is not possible in the community, refer in to a midwifery setting for review. If the baby is in hospital, then repeat the observations and NEWS recordings at least 4hrly until the baby is waking and feeding normally. Paediatric review is required if any of the NEWS observations are in amber or red or if the baby appears unwell (New 2016).

2.3.10 Ensure the mother has a copy and has read the Essential Guide to feeding and caring for your baby. Highlight the reluctant feeding section within the booklet.

2.3.11 Follow appendix 3. Document in the neonatal section of the handheld notes what you have done to promote feeding and any plan of care.

2.3.12 Supply the mother with a cup and 3ml syringes for hand expressing and syringe feeding. Empower the mother to independently feed her baby. Explain how to use the microwave sterilizer as the syringes and cups are all reusable.

2.4. Feeding Cues

Feeding cues indicate a state of light sleep and the beginning of feeding readiness when babies are more likely to latch on and suck. Cues include rapid eye movements under the eyelids, mouth and tongue movements, body movements and sounds, sucking on a fist. Crying is a way of indicating to the mother that the feeding cues have been ignored.

2.5. Feeding expressed breastmilk (EBM) or formula in small volumes to baby (New 2016)

Small amounts of colostrum or formula (up to 5ml max) can be fed to baby by finger feeding or syringe feeding, so that none is lost in a cup.
2.5.1 Finger feeding – Ensure the mother has clean hands and short nails, and encourage her to hold baby in her arm, with feeding cup in same hand, and use little finger of opposite hand to dip into milk and give to baby to suck, pad uppermost in baby’s mouth

2.5.2 Syringe feeding - To syringe feed safely, the baby should be held in mother’s arms slightly upright, not flat. Draw up the milk in a 3ml syringe. The syringe is put in between the gum and cheek; give approx. 0.2ml at a time. Allow the baby time to suck and enjoy the food. Move onto finger-and-syringe feeding or cup feeding once you have more than 5ml to give

2.6 Supporting a mother and baby
Teach her how to hand express her breast milk. Give her a supply of 3ml or 5ml syringes and feeding cups. Encourage ‘skin to skin’ contact especially in laid-back position and help her to recognize her baby’s feeding cues and offer her breast to her baby when he/she is ready, and to syringe feed and cup feed her baby until baby is feeding actively and effectively.

2.7 If the mother does not want to hand express
The length of labour and the type of birth may influence the mother’s feelings about hand expressing and giving her colostrum intensively for the first few hours. She may ask to give formula instead (see section 2.9.) However, if her baby is not breastfeeding, she needs to express to initiate her milk supply within 6 hours of birth.

2.8 If the mother chooses not to express colostrum
If the mother cannot, or chooses not to express her colostrum, and the baby needs a supplementary feed, it is the responsibility of the midwife to discuss the alternatives available and the disadvantages of giving formula milk. If the mother gives her informed consent for a supplementary feed of formula milk, this should be documented in her notes. The milk should be given by the mother either by finger feeding, syringe or cup, in volumes appropriate to the baby’s age i.e. first day 5-10mls per feed, second day 10-15mls per feed, third day 20mls per feed. Formula should not exceed 20mls per feed or given once lactation is established.
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>The audit will take into account record keeping by midwifery team members, and supplementation rates for babies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Infant Feeding Coordinator</td>
</tr>
<tr>
<td>Tool</td>
<td>The tool used will be the United Nations International Children’s Emergency Fund (UNICEF) supplementation audit tool, to include:</td>
</tr>
<tr>
<td></td>
<td>- Copy of Appendix 3 filed in the notes</td>
</tr>
<tr>
<td></td>
<td>- Plan of care made to promote and protect breastfeeding if this is the mother’s choice</td>
</tr>
<tr>
<td></td>
<td>- Plan clearly documented in the neonatal pages of the hand held notes</td>
</tr>
<tr>
<td></td>
<td>- Documented mother’s informed consent - If a breastfeeding baby received any formula supplements was it in appropriate quantities for the baby’s age and by a method other than by bottle</td>
</tr>
<tr>
<td>Frequency</td>
<td>Yearly</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>A report will be completed by the Infant Feeding coordinator, shared with the Infant Feeding Steering Group, and a summary sent to all members of the midwifery team</td>
</tr>
<tr>
<td></td>
<td>Patient Safety Management and Clinical Audit Forum</td>
</tr>
<tr>
<td></td>
<td>During the process of the audit if compliance is below 80% or other deficiencies identified, this will be highlighted at the next Maternity Patient Safety and Clinical Audit Forum and an action plan agreed</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Any deficiencies identified on the audit will be discussed at the Infant Feeding Steering Group and an action plan developed</td>
</tr>
<tr>
<td></td>
<td>Action leads will be identified and a time frame for the action to be completed by the Infant Feeding Coordinator, working with the Postnatal Ward Manager</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within 3 months</td>
</tr>
<tr>
<td></td>
<td>If the supplementation rate is found to be above 10% of those interviewed, training and updating of staff will be reviewed within the following 3 months</td>
</tr>
<tr>
<td></td>
<td>The results of the audits will be distributed to all staff via the Infant Feeding Newsletter</td>
</tr>
</tbody>
</table>
4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

4.2. Equality Impact Assessment
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Reluctant To Feed- Clinical Guideline For Management Of Healthy Newborn Babies At Term V3.0</th>
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<tbody>
<tr>
<td><strong>Date Issued/Approved:</strong></td>
<td>7th March 2019</td>
</tr>
<tr>
<td><strong>Date Valid From:</strong></td>
<td>20th March 2019</td>
</tr>
<tr>
<td><strong>Date Valid To:</strong></td>
<td>7th March 2022</td>
</tr>
</tbody>
</table>
| **Directorate / Department responsible (author/owner):** | Helen Shanahan  
Infant Feeding Co-ordinator  
Women and Children’s and Sexual Health Division |
| **Contact details:** | 01872 253180 |

**Brief summary of contents**

This guideline applies to all health professionals caring for healthy, term newborn babies that are reluctant to breast feed. Management of these babies includes promoting and protecting breastfeeding and aims to detect and prevent any deterioration in the baby’s condition.

**Suggested Keywords:**

Breastfeeding, reluctant, formula, expressing, breast, newborn, supplementation, colostrum, skin, feeding, jittery, glucose

**Target Audience**

<table>
<thead>
<tr>
<th>RCHT</th>
<th>CFT</th>
<th>KCCG</th>
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<tbody>
<tr>
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</table>

**Executive Director responsible for Policy:**

Medical Director

**Date revised:**

7th March 2019

**This document replaces (exact title of previous version):**

Guideline for management of babies reluctant to breastfeed V2.3

**Approval route (names of committees)/consultation:**

Maternity Guideline Group  
Obs and Gynae Directorate  
Divisional Board

**Divisional Manager confirming approval processes:**

Debra Shields, Care Group Manager

**Name and Post Title of additional signatories:**

Not Required

**Signature of Executive Director giving approval:**

{Original Copy Signed}

**Publication Location (refer to Policy)**

Internet & Intranet  
✓ Intranet Only
Related documents:

- NICE (2006) CG 37 Postnatal care: Routine postnatal care of women and their babies

Training Need Identified?

- Part of the midwives annual mandatory training - Peripartum Day 2
- Part of the initial training for all staff involved with infant feeding

## Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tr>
<td>10 Jun 08</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Helen Shanahan, Infant Feeding Co-ordinator</td>
</tr>
<tr>
<td>1 Sep 09</td>
<td>V2.0</td>
<td>Amendment of initial timing criteria</td>
<td>Helen Shanahan, Infant Feeding Co-ordinator</td>
</tr>
<tr>
<td>2nd May 13</td>
<td>V2.1</td>
<td>Addition of EIA, governance and monitoring documents</td>
<td>Helen Shanahan, Infant Feeding Co-ordinator</td>
</tr>
<tr>
<td>Date</td>
<td>Version</td>
<td>Changes</td>
<td>Author</td>
</tr>
<tr>
<td>--------------</td>
<td>---------</td>
<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>1\textsuperscript{st} May 2014</td>
<td>V2.2</td>
<td>Minor changes to reflect new UNICEF standards. Appendix 3 with definition of jitteriness and advice for staff to give to mothers</td>
<td>Helen Shanahan, Infant Feeding Coordinator</td>
</tr>
<tr>
<td>7\textsuperscript{th} April 2016</td>
<td>V2.3</td>
<td>Minor changes to update latest guidance and to include artificial feeding</td>
<td>Helen Shanahan, Infant Feeding Coordinator</td>
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<tr>
<td>5\textsuperscript{th} April 2017</td>
<td>V2.3</td>
<td>Wording changed from cold baby to temperature below 36.6</td>
<td>Sarah-Jane Pedler, Practice Development Midwife</td>
</tr>
<tr>
<td>3\textsuperscript{rd} March 2019</td>
<td>V3.0</td>
<td>Algorithm font reduced to enable single page double-sided handout</td>
<td>Helen Shanahan, Infant Feeding Coordinator</td>
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\textbf{All or part of this document can be released under the Freedom of Information Act 2000}

\textbf{This document is to be retained for 10 years from the date of expiry.}

\textbf{This document is only valid on the day of printing}

\textbf{Controlled Document}
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Screening Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed:</th>
<th>Reluctant To Breastfeed Management Of Healthy Newborn Babies At Term - Clinical Guideline V3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area:</td>
<td>Obstetrics and Gynaecology</td>
</tr>
<tr>
<td>Is this a new or existing Policy?</td>
<td>Existing</td>
</tr>
<tr>
<td>Name of individual completing assessment:</td>
<td>Helen Shanahan</td>
</tr>
<tr>
<td>Telephone:</td>
<td>01872-253180</td>
</tr>
</tbody>
</table>

1. **Policy Aim**

**Who is the strategy / policy / proposal / service function aimed at?**

This guideline applies to all health professionals caring for healthy, term newborn babies that are reluctant to breast feed. Management of these babies includes promoting and protecting breastfeeding and aims to detect and prevent any deterioration in the baby’s condition.

2. **Policy Objectives**

Safe, evidence-based management of healthy, term, new-born babies reluctant to breast feed

3. **Policy – intended Outcomes**

Promotion and protection of breastfeeding, reduction in numbers of women who stop breastfeeding within the first week.

4. **How will you measure the outcome?**

UNICEF audit tool

5. **Who is intended to benefit from the policy?**

Newborn Babies and their parents

6a **Who did you consult with?**

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

b). Please identify the groups who have been consulted about this procedure.

- Maternity Guidelines Group
- Obs and Gynae Directorate
- Policy Review Group

What was the outcome of the consultation?

Guideline agreed.
7. The Impact
Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>x</td>
<td></td>
<td>All pregnant women.</td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td></td>
<td>x</td>
<td></td>
<td>All pregnant women.</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td></td>
<td>x</td>
<td></td>
<td>All pregnant women.</td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td></td>
<td>x</td>
<td></td>
<td>All pregnant women.</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td></td>
<td>x</td>
<td></td>
<td>All pregnant women.</td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
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<td></td>
<td>All pregnant women.</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
<td>x</td>
<td></td>
<td>All pregnant women.</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
<td>x</td>
<td></td>
<td>All pregnant women.</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No | x

9. If you are not recommending a Full Impact assessment please explain why.
Not required

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen Shanahan</td>
<td>07/03/19</td>
</tr>
</tbody>
</table>

| Names and signatures of members carrying out the Screening Assessment | 1. Helen Shanahan | 2. Policy Review Group (PRG) | PRG Approved |

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust’s web site.

Signed Sarah- Jane Pedler

Date March 2019
Appendix 3:

These guidelines are for term healthy babies

These guidelines should be used within the context of best practice management of breastfeeding i.e. the baby should be gently encouraged to feed soon after birth, helped by skin to skin contact.

If the baby has not had the first feed within 4 hours of birth or second feed 6 hours after the first, think POSSIBLE SEPSIS and follow the guidelines below:

1. Assess the baby and environment

   Look at the history, including pain relief in labour, environmental temperature etc. Take a full set of observations (temp, heart rate, respirations) and plot on NEWS chart. If the baby is unwell, paediatric review should be sought.

   **Be pro-active**: this baby may not demand feed. Encourage mother led feeding until baby has **woken up and taken two** breastfeeds or formula feeds well. Explain his feeding cues to parents as overleaf

2. Undress the baby and put skin to skin with mum. If the baby’s temperature is below 36.6 put on a hat and ensure baby is skin to skin and both mum and baby are wrapped in a blanket.

   **Encourage the mother to talk to her baby and massage baby’s hands and feet.**

3. If the baby has still not fed two hours later, teach the mother to hand express colostrum onto her nipple to tempt the baby. A DVD ‘Expressing and giving breast milk’ is available to help reinforce learning.

4. Hand express and give the colostrum.

   **Obtained colostrum or small volumes of formula should be given either from the mother’s finger or by syringe or cup. (See instructions overleaf about syringe feeding safely).**

5. Keep the baby and mother skin to skin

   **REASSESS THE BABY** – the mother should be encouraged to observe for changes in her baby’s condition and inform staff if she has concerns. A blood sugar assessment is needed only if the baby is jittery*. Jitteriness may be defined as excessive, symmetrical repetitive movements of limbs, which are unprovoked and usually relatively fast. It is important to be sure this movement is not simply a response to stimuli. If in hospital NEWS observations should be done at least 4hrly and paediatric review is required if baby appears unwell.

6. **REPEAT IN TWO HOURS**

7. Continue hand expressing and giving colostrum or small volumes of formula **2 hourly** until the baby feeds well, staying attached and suckling properly for at least 5-10 minutes per feed, or bottle feeds well, taking at least 10ml. Document what has been done to promote breastfeeding.

   **Food requirements will increase when baby is more than 24 hours old (see overleaf)**

8. Keep the baby near the breast to encourage frequent breastfeeding.
Appendix 4:

Healthy term babies may feed enthusiastically at birth and then sleep for many hours. In order to prevent the baby being left for long periods, which may have a potential negative effect on stimulation of lactation follow the flow chart overleaf if the baby has not fed within the last 6 hours.

Feeding Cues
Feeding cues indicate a state of light sleep and the beginning of feeding readiness when babies are more likely to latch on and suck. Cues include rapid eye movements under the eyelids, mouth and tongue movements, body movements and sounds, sucking on a fist. Crying is a way of indicating that the feeding cues have been ignored.

Feeding expressed breastmilk (EBM) or small volumes of formula to baby
Small amounts of precious colostrum or formula (up to 5ml max) can be fed to baby by finger feeding or syringe feeding, so that every drop can be used and not lost in a cup.

- Finger feeding – Ensure the mother has clean hands and short nails, and encourage her to hold baby in her arm, with feeding cup in same hand, and use little finger of opposite hand to dip into milk and give to baby to suck, pad uppermost in baby's mouth
- Syringe feeding - To syringe feed safely, the baby should be held in mother's arms slightly upright, not flat. Draw up the milk in a 3ml syringe. The syringe is gently put in between the gum and cheek and a little colostrum gently squirted in, no more than 0.2ml at a time. Allow the baby time to suck and enjoy the food. Allow time to swallow, then give a little more. Move onto finger-and-syringe feeding or cup feeding once you have more than 5ml to give.

Boosting confidence
You can help and support the mother and boost her confidence by teaching her to hand express. Give her a supply of 3ml purple syringes and feeding cups, encourage skin contact, especially in laid-back position and help her to recognize her baby's feeding cues and offer her breast to her baby when he/she is ready, and to finger or syringe feed her baby until baby is breastfeeding actively and effectively. Mother-led feeding will empower the mother as well as saving you time.

If the mother does not want to hand express
The length of labour and the type of birth may influence the mother's feelings about hand expressing and givingcolostrum intensively for the first few hours. The mother may ask to give formula instead (see below). Remember that in order to establish a good milk supply, ideally the mother needs to start hand expressing within 6 hours of birth.

If the mother does not express colostrum
If the mother cannot, or chooses not to express her colostrum, and the baby needs a supplementary feed, it is the responsibility of the midwife to discuss the alternatives available and the disadvantages of giving formula milk. If the mother gives her informed consent for a supplementary feed of formula milk, this will be documented by the midwife in the woman's notes. The milk should be given either by finger feeding, syringe or cup, in volumes appropriate to the baby's age i.e. first day 5-10mls per feed, second day 10-15mls per feed, third day 20mls per feed. Formula should not exceed 20mls per feed or given once lactation is established.