1. Aim/Purpose of this Guideline
   1.1 This guideline aims to use available evidence alongside national and network best practice to provide optimal nutritional care to meet the needs of infants born prematurely, in conjunction with individual clinical assessment.

2. The Guidance
   2.1 Introduction
   Suboptimal nutrition commencing in the early neonatal period contributes to postnatal malnutrition, and reduces resistance to infection. Conversely over nutrition and excessive growth acceleration may lead to adverse health issues such as diabetes, obesity and cardiovascular disease in later life.

   The goals of nutritional support in the preterm include:
   - Achieving an acceptable standard of short term growth.
   - Meeting the recognised nutritional requirements of the preterm infant.
   - Preventing feeding-related morbidities, especially necrotising enterocolitis (NEC)
   - Optimising long-term outcomes.

2.2 Nutritional requirements of the preterm infant.
   Evidence based estimations form the basis of published nutritional requirements for pre-term infants. These calculated requirements are high as preterm infants are born at a time when in utero growth rates would have been 2-3 times greater than a baby born at term, however, the increased nutrient demands are not evenly spread. These variable increases are not met by a straight increase in volume of breast milk Provision and have led to the development of specialist formulas and breast milk fortifiers or use in the preterm population.

   **Pre- Term Infants Nutritional Daily Requirement**

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>Term</th>
<th>Pre-Term Infant (Tsang 2005) ELBW</th>
<th>VLBW</th>
<th>Pre-Term Infant 1000kg – 1800kg (ESPGHAN 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Energy</strong></td>
<td>95 - 115</td>
<td>130 - 150</td>
<td>110 - 130</td>
<td>110 - 135</td>
</tr>
<tr>
<td><strong>Protein</strong></td>
<td>2</td>
<td>3.8 - 4.4</td>
<td>3.4 – 4.2</td>
<td>4.0 - 4.5 (&lt;1.0 kg) 3.5 - 4.0 (1.0 -1.8kg)</td>
</tr>
<tr>
<td><strong>Sodium</strong></td>
<td>1.5</td>
<td>3.0 - 5.0</td>
<td>3.0 – 5.0</td>
<td>3.0 - 5.0</td>
</tr>
<tr>
<td><strong>Potassium</strong></td>
<td>3.4</td>
<td>2.0 - 3.0</td>
<td>2.0 - 3.0</td>
<td>2.0 - 3.5</td>
</tr>
<tr>
<td><strong>Calcium</strong></td>
<td>3.8</td>
<td>2.5 - 5.5</td>
<td>2.5 - 5.5</td>
<td>3.0 - 3.5</td>
</tr>
<tr>
<td><strong>Phosphate</strong></td>
<td>2.1</td>
<td>2.0 - 4.5</td>
<td>2.5 - 4.5</td>
<td>1.9 – 2.9</td>
</tr>
</tbody>
</table>
2.3 When to start feeding the preterm infant.

Stable non high risk preterm infants should commence feeding as close to birth as possible. There is growing evidence to support a move to earlier enteral feeding in the high risk infant. Infants considered **high risk** should include:

- <28 weeks gestation or <1000g birth weight
- Preterm SGA infants (<2nd percentile and <34 weeks gestation)
- Severe SGA infants (<0.4th percentile and >34 weeks gestation).
- Absent or reversed end diastolic flow in infants <34 weeks
- Infants re-establishing feeds after an episode of NEC
- Perinatal hypoxia-ischaemia with significant organ dysfunction.
- Infant with congenital gut malformations (e.g. gastroschisis)
- Hypotensive / unstable ventilated neonates
- Complex congenital cardiac disease
- Dexamethasone treatment
- Indomethacin or Ibuprofen treatment for PDA
- Polycythaemic infants

Caution should be taken when initiating feeding in the above subgroups. Treatment as high risk should be at individual clinical assessment.

2.4 Trophic feeding

Trophic feeds are small volumes of milk given to stimulate the bowel which are maintained for up to 7 days and not intended to contribute to nutrition. The maximum volume classed as a “trophic feed” is **1ml/kg/hour or 24ml/kg/day**. Trophic feeds should be considered in very premature or very high risk infants in order to utilize maternal colostrum and stimulate gut trophic hormones. There is no recognised consensus on duration or method of delivery. However there is general clinical consensus that:

- Trophic feeds should commence as soon as possible, where clinically indicated.
- Trophic feeds can be initiated and advanced during Indomethacin / Ibuprofen treatment.
- Trophic feeding of preterm infants with IUGR and abnormal antenatal Doppler results may not have a significant impact on incidence of NEC or feed intolerance.
- Individual infants should be assessed daily for tolerance and decisions made with regard to continuation of trophic feeding or standard advancement of feeds.

2.5 Rate of advance of feeding

Current data does not provide evidence that slow advancement of feeding in very low birth weight infants reduces the risk of NEC however available evidence and current best practice suggest the following: (until SIFT trial results awaited)

- In standard risk infants a rate of increase of 30ml/kg/day is reported safe.
- In high risk infant evidence points towards a period of trophic feeds followed by a rate of increase of 10-20ml/kg/day.
- There should be a low threshold for withholding stepped increases secondary to intolerance in the high risk infant.

2.6 Assessing feed tolerance

Careful clinical assessment is essential to prevent unnecessary limitations of enteral feeds, reliance on parenteral nutrition, delay to full feeding and poor growth. Stomach should be aspirated 4 hourly. Gastric residual volume and colour of aspirate may indicate level of gut maturity rather than gut dysfunction and as volumes vary in
the early stages of feeding significant increases should not be used in isolation when deciding to limit advancement of feeds. For the early detection of VLBW infants at risk for NEC, gastric residual volumes and bloody residuals in combination represent an early relevant marker. Use of diluted feeds is not recommended.

**Signs of intolerance:**
1. Vomiting
2. Gastric residuals >25% of previous 4 hours feed volume, persistent or increasing.
3. Abdominal distension

**Signs of Necrotising Enterocolitis (NEC) including:**
1. Bilious/ bloody aspirates
3. Grossly bloody/watery or abnormal stools
4. Clinically unstable or acute deterioration.

**Suggested interventions if signs of intolerance present:**
1. Medical review.
2. Consider septic screen and/or abdominal x-ray.
3. Consider continuing with trophic feeds rather than nil enterally (not if signs of NEC).

**Available recommendations suggest undigested milk residuals should be replaced and feeding continued if:**
1. Residual volumes <25% of previous 4 hour feed volume.
2. Residual volumes are present during low volume/trophic feeding.

### 2.7 Bolus feeding is recommended because:
- Bolus feeding may be more physiologic in the preterm infant.
- Bolus fed infants may experience less feed intolerance and have a greater rate of weight gain.
- Growth may be compromised in continuous feeding as human milk fat adheres to the tubing.
- Infants fed continuously take the same length of time to achieve full feeds as those fed bolus feeds.
- Higher behavioural stress responses in bolus fed infants have recently been reported.

Feed frequency in trophic feeding has not been evaluated and is constricted by the small volumes involved. Debate is greater with advancing feeds. Infants <32 weeks should receive 1-2 hourly feeds moving to 3 hourly as they grow. 4 hourly feeds are not supported by the Baby Friendly Initiative in babies whose mothers intend to breast feed.

### 2.8 Milks and Indications for use.

**Breast Milk**
Breast milk expressed by an infant’s own mother is the standard of care for preterm infants.
Mothers should be counselled and encouraged to breastfeed or express milk as soon after birth as possible, even if their long term intention is not to breastfeed. They should be encouraged to express 8 times in a 24 hour period, or as frequently as possible, as a minimum daily volume of 750 – 900ml by day 10-14 after birth is required in order to sustain exclusive breastfeeding.

Preterm breast milk contains higher concentrations of protein, fat, energy and sodium in the first few weeks of lactation, but these drop to the same levels as mature term milk within 2-3 weeks of birth. Eventually more protein will be required in the form of multi nutrient fortifiers, especially in those infants <1500g birth weight. The energy (but not protein) needs of a preterm infant can be met by breast milk alone if expressing techniques and milk handling are optimised.

- Feed to initial volume of 60ml/kg increasing to 180 ml/kg as indicated by weight gain and volume tolerance.
- Infants born <1000g will require 200ml/kg EBM to meet requirements for energy.
- Infants born <1000g cannot meet their higher requirement for protein without fortification of breast milk. Fortification is therefore indicated in this group in order to maintain lower feed volumes.

Preterm infants fed exclusively on breast milk should receive supplementary phosphorus which should be titrated against normal serum phosphate and Alkaline phosphatase levels. Refer to separate Neonatal Guideline for Phosphorus supplementation.

**Breast Milk Fortification**

The addition of Breast Milk Fortifiers (BMF) to maternal expressed breast milk (EBM) expressed 2 weeks post delivery should be considered for the following infants born <34 weeks once they are established on 165ml/kg of enteral feeds for at least 24 hours:

1. Infants with a birth weight <1500g
2. Infants with a birth weight >1500g but <2000g where:
   - volumes of 180-200ml/kg EBM are not likely to be tolerated or
   - Serum urea falls <2 umol/l or
   - weight gain is <18g/kg/day on maximum volumes tolerated or
   - IUGR where birth weight for gestational age is <9th centile

BMF need not be added if more than half of the feed requirement is provided by preterm formula, though it should be considered if there is associated poor growth and tolerance of volume. In practice this would depend on having adequate volumes of milk to fortify accurately. Where a combination feed is required it can be given either mixed or alternating with feeds of EBM+BMF or used once supplies have run out or until the next expression. There is no evidence to support one practice over the other, but the method that is easiest in practice and that involves the least amount of milk handling is likely to be the best for individual infants. BMF should never be added as a supplement to preterm formula.

**Preterm formulas**

Where maternal EBM is not available preterm formulas are to be used. There is no evidence to support the routine use of term or semi elemental/elemental formulas.
Indications for use of preterm formulas
- Infant’s born <34 weeks with a birth weight <2000g where EBM unavailable.
- Feed to initial volume of 150ml/kg increasing as indicated by weight gain and volume tolerance.
- Infants born >1000g will have their protein requirements met by 165ml/kg
- Infants born <1000g will have their protein requirements met by 180ml/kg
- Volumes >180ml/kg are not usually necessary and other reasons for poor growth should be sought before further volume increases are introduced.

Nutrient Enriched Post Discharge Formulas (NEPDF)
Maternal choice and the difficulties some mothers face trying to maintain breastfeeding will result in some infants requiring some or all formula milk at the time of discharge.

Infants born prior to 34 weeks and <2kg at birth who are not breastfed or who will require supplementary feeding at discharge can be transferred to NEPDF a few days before discharge, or when they have reached 2kg depending on rate of weight gain. There are two NEPDFs available in the UK, Nutriprem 2 and SMA Gold Prem 2. Only Nutriprem 2 is available in a ready to feed (RTF) format which is preferable for hospital use. European guidance recommends a RTF format for ex-preterm infants for the first few weeks post discharge. Nutriprem 2 is available on prescription for preterm infants from 35 weeks until 6 months corrected age.

There are no recommendations for infants born 34-37 weeks. As nutrient stores are better and infants are likely to establish feeding more quickly than those born more preterm a pragmatic view needs to be taken with regard to feeding. Maternal breast milk is the feed of choice.

Growth restricted term infants >37 weeks, should be offered ordinary term formula in the absence of maternal milk.

Specialised term formulas
None of the specialised term formulas are designed for use in the preterm population. Energy needs might be met by increased volumes (but are often poorly tolerated). Concentration of formulas may be tolerated but will not address the nutrient imbalance.

Specialised formulas require making up from powder within a Feed Unit/Milk Kitchen environment. They will be non sterile and have potentially inconsistent composition. All powdered feeds should be made up in accordance with the Department of Health guidelines for the Use of Powdered feeds in a Hospital Environment.

Specialised formulas should only be used where absolutely necessary and always under the direction of a Paediatric or Neonatal Dietitian.

Soya formulas are not recommended for infants under 6 months of age.
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Key changes in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Paul Munyard. Consultant Paediatrician and Neonatologist</td>
</tr>
<tr>
<td>Tool</td>
<td>Audit To be included in the Neonatal Clinical Audit Programme. Findings reported to the Directorate Audit / Governance meetings.</td>
</tr>
<tr>
<td>Frequency</td>
<td>As dictated by audit findings</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Child Health Directorate Audit and Neonatal Clinical Guideline meetings.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Paul Munyard. Consultant Paediatrician and Neonatologist Andrew Collinson. Consultant Paediatrician and Neonatologist</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 of audit. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</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 which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

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>Enteral Feeding of Pre-Term Infants – Neonatal Clinical Guidelines</th>
</tr>
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<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>30 September 2015</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>30 September 2018</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>30 September 2018</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Andrew Collinson. Consultant Paediatrician and Neonatologist</td>
</tr>
<tr>
<td>Contact details:</td>
<td>(01872) 252667</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This guideline is designed to provide guidance to neonatal staff on the feeding of pre-term infants.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Neonatal. Preterm. Enteral feeding.</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT Y PCH CFT KCCG</td>
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<tr>
<td>Executive Director responsible for Policy:</td>
<td>Executive Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td></td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>New document</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Sheena Wallace</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet Y Intranet Only</td>
</tr>
<tr>
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<td>Neonatal.</td>
</tr>
<tr>
<td>Links to key external standards</td>
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### 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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</thead>
<tbody>
<tr>
<td>30 Sept 14</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Andrew Collinson. Consultant Paediatrician and Neonatologist</td>
</tr>
<tr>
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<td></td>
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<td></td>
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</tbody>
</table>

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This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

 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 Form

| Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description): | \begin{center} Enteral feeding of the Pre-Term Infant – Neonatal Clinical Guideline \end{center} |
| Directorate and service area: | Child Health Directorate. Neonatal |
| Is this a new or existing Policy? | New |
| Name of individual completing assessment: | Andrew Collinson |
| Telephone: | (01872) 252667 |

1. Policy Aim*  
Who is the strategy / policy / proposal / service function aimed at?  
The guideline is aimed at hospital staff responsible for the nutritional care of pre-term infants in a hospital setting.

2. Policy Objectives*  
As above

3. Policy – intended Outcomes*  
Audit

4. *How will you measure the outcome?  
Audit

5. Who is intended to benefit from the policy?  
Medical, nursing and midwifery staff responsible for the care of pre-term infants. Neonatal patients

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?  
No

b) If yes, have these *groups been consulted?  

C). Please list any groups who have been consulted about this procedure.

7. The Impact  
Please complete the following table.

| Are there concerns that the policy could have differential impact on: | Yes | No | Rationale for Assessment / Existing Evidence |
| Equality Strands: | | | |
| Age | x | | |

Enteral Feeding of the Pre-Term Infant – Neonatal Clinical Guideline  
Page 11 of 18
| **Sex** (male, female, transgender / gender reassignment) | x |
| **Race / Ethnic communities /groups** | x |
| **Disability** - learning disability, physical disability, sensory impairment and mental health problems | x |
| **Religion / other beliefs** | x |
| **Marriage and civil partnership** | x |
| **Pregnancy and maternity** | x |
| **Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian** | x |

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 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.

No area indicated

Signature of policy developer / lead manager / director
Paul Manager | 30:09:2015 |

Names and signatures of members carrying out the Screening Assessment

*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*

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

Signed ______Kim Smith__________

Date _________30:09:2015_______
Appendix 3. Enteral Feeding Risk Criteria

HIGH RISK

High risk can be defined by any of the following:

- Less than 28 weeks gestation
- Less than 1000g birth weight
- Preterm Small for Gestational Age infant (less than 2<sup>nd</sup> percentile and less than 34 weeks gestation)
- Absent or reversed end diastolic flow in infants less than 34 weeks gestation
- Unstable ventilated neonates
- Hypotensive ventilated neonates
- Re-establishment of feeds following NEC
- Perinatal hypoxia-ischaemia with significant organ dysfunction
- Congenital gut malformations

MODERATE RISK

Moderate risk can be defined by any of the following:

- 28+1 – 31+6 weeks gestation
- Severe small for gestational age infants (less than 0.4<sup>th</sup> percentile and greater than 34 weeks gestation)
- Indomethicin or ibuprofen treatment for PDA
- Complex congenital heart disease
- Polycythaemic infants

STANDARD RISK

Standard risk can be defined by

- Babies greater than 32 weeks with no risk factors in any of the other groups.
Appendix 4. Enteral Feeding High Risk Criteria and Algorithm.

HIGH RISK CRITERIA

Please tick the appropriate boxes below to define the criteria with the Consultant

High risk can be defined by any of the following:
- Less than 28 weeks gestation
- Less than 1000g birth weight
- Preterm Small for Gestational Age infant (less than 2nd percentile and less than 34 weeks gestation)
- Absent or reversed end diastolic flow in infants less than 34 weeks gestation
- Unstable ventilated neonates
- Hypotensive ventilated neonates
- Re-establishment of feeds following NEC
- Perinatal hypoxia-ischaemia with significant organ dysfunction
- Congenital gut malformations

Enteral feeding HIGH Risk Algorithm

Start TPN day 0, by peripheral cannula pending central access

When clinically indicated start 10-20mls/kg/day trophic feeds 1-2 hourly

Increase by 10mls/kg/day 12hourly as 1 or 2 hourly feeds. Titrate feed volumes against IV fluids until 150mls/kg/day. Stop Lipid infusion when feeds at 120mls/kg/day

If weight gain unsatisfactory, increase by 10mls/kg/day until on 180mls/kg/day.

Is the weight gain now satisfactory?

Yes

Continue

No

If on Maternal EBM and plans on breastfeeding consider starting ¼ strength fortifier. (see Appendix) Increase strength of fortifier every 48 hours as tolerated.

If on Donor EBM or pregestimil consider starting ¼ strength Preterm Formula/Term Formula. (see Appendix) Increase strength of fortifier every 48 hours as tolerated.
Appendix 5. Enteral Feeding MODERATE Risk Criteria and Algorithm

Moderate risk can be defined by any of the following:

- Babies born between 28+1 – 31+6 weeks gestation
- Severe small for gestational age infants (less than 0.4<sup>th</sup> percentile and greater than 34 weeks gestation)
- Indomethicin or ibuprofen treatment for PDA
- Complex congenital heart disease
- Polycythaemic infants

**Enteral Feeding MODERATE Risk Algorithm**

Start TPN day 0, by peripheral cannula pending central access

When clinically indicated start 20-30 mls/kg/day trophic feeds 1-2 hourly

Increase by 10-15 mls/kg/day every 12 hours as 1 or 2 hourly feeds. Titrate feed volumes against IV fluids. Stop Lipid infusion when feeds at 120 mls/kg/day

Continue to increase by 10 mls/kg/day 12 hourly as 1 or 2 hourly feeds until on 150 mls/kg/day

If weight gain unsatisfactory, increase by 10 mls/kg/day until on 180 mls/kg/day.

Is the weight gain now satisfactory?

Yes

Continue

No

If on Maternal EBM and plans on breastfeeding consider starting ½ strength fortifier. (see Appendix 8) Increase strength of fortifier every 24 hours as tolerated.

If on Donor EBM or pregestimil consider starting ¼ strength Preterm Formula/Term Formula. (see Appendix 8 ) Increase strength of formula every 48 hours as tolerated.

Standard risk can be defined by

- Babies greater than 32 weeks with no risk factors in any of the other groups.

**STANDARD Risk Algorithm**

Is the baby on respiratory support?

- **Yes**
  - Start IV fluids at 60mls/kg/day
  - Once stable on respiratory support, commence 30mls/kg enteral feeds as 2 or 3 hourly feeds.
  - Increase as indicated by 30mls/kg/day as 2 or 3 hourly feeds.
  - Continue increasing at this rate until full enteral feeds volume achieved.

- **No**
  - Start 30-60mls/kg/day as 3 hourly feeds
  - Increase as indicated by 30mls/kg/day as 3 hourly feeds.
  - Continue increasing at this rate until full enteral feeds volume achieved.
Appendix 7 . Choice of Milk Algorithm

Expressed breast milk is the first milk of choice for these infants unless clearly contraindicated. Use this algorithm to select which milk should be used if maternal EBM supply is not yet fully established to meet the babies feed volumes or if the baby is formula feeding.

Birth Weight

- Less than 2kg
  - Less than 1.5kg
    - Establish feeds on maternal EBM. If maternal EBM supply not fully established to meet the babies feed volumes by Day 7 then ANNP/Registrar/Consultant to discuss Donor EBM (if available) with mum and obtain consent. If Donor EBM is not available or not consented for then supplement maternal EBM with Pregestimil.

- More than 1.8kg
  - Establish feeds on maternal EBM and Preterm Formula.
  - 1.5kg – 1.8kg
    - Establish feeds on maternal EBM and Preterm Formula.
Appendix 8. Fortifier Concentration to 50mls of Expressed Breast Milk

Breast Milk Fortifier Concentrations

Mix 1 sachet of breast milk fortifier with 6mls expressed breast milk (referred to as fortified EBM solution from this point forward)

For ¼ Strength Fortifier

To make a 50ml volume add 1.5mls of fortified EBM solution to 48.5mls EBM

For ½ Strength Fortifier

To make 50mls of milk up add 3mls of fortified EBM solution to 47mls EBM

For ¾ Strength Fortifier

To make 50mls of milk up, add 4.5mls of fortified EBM solution to 45.5mls EBM.

For full Strength Fortifier

To make 50mls of milk up, you can add 1 whole sachet of breast milk fortifier to 50mls of EBM, or 6mls of fortified EBM solution if you have already made some.

Please increase strength of breast milk fortifier as per guidance on the individual babies risk criteria algorithm.

Expressed breast milk with added fortifier can be safely stored in the refrigerator for 24hour as per the manufacturers guidelines, but will expire if the EBM is due to expire earlier. (e.g. after 12hours if using defrosted EBM)