Supporting Neonatal Feeding
Standard Operating Procedure

V2.1

June 2021
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Data Protection Act 2018 (General Data Protection Regulation – GDPR) 
Legislation

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We cannot rely on opt out, it must be opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the Information Use Framework Policy or contact the Information Governance Team rch-tr.infogov@nhs.net
1. Introduction

1.1. Royal Cornwall Hospitals Trust (RCHT) is committed to providing the highest standard of care to support families to feed their baby and build strong and loving parent-infant relationships. This is in recognition of the profound importance of early relationships to future health and well-being, and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for children and breastfeeding parents.

1.2. This guideline makes some recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals.

1.3. World Health Organization (WHO)/United Nations Children’s Fund (UNICEF) definitions are:

1.3.1. Breastfeeding - The infant has received breast milk direct from the breast or expressed.

1.3.2. Exclusive Breastfeeding – The infant has received only breast milk from the mother or expressed breast milk, and no other liquids or solids with the exception of mineral supplements, or medicines.

1.4. This version supersedes any previous versions of this document.

2. Purpose of this Standard Operating Procedure

2.1. The purpose of this guideline is to ensure that all staff at Royal Cornwall Hospitals Trust understand their roles and responsibilities in supporting parents to feed and care for their baby in ways which support optimum health and well-being. This guideline works in conjunction with the Infant feeding policy and provides specific guidance for families cared for on the Neonatal or Transitional Care units.

2.2. This guideline aims to ensure that the care provided improves outcomes for children and families, specifically to deliver:

- increases in the number of babies receiving breastmilk.
- increases in breastfeeding initiation rates.
- increases in the number of babies who are discharged home breastfeeding or breastmilk feeding.
• increases in the proportion of parents who chose to formula feed reporting that they have received proactive support to formula feed as safely as possible in line with Department of Health guidance.

3. Ownership and Responsibilities

All healthcare staff working in Maternity, Obstetrics, Neonatal and Transitional Care are expected to comply with this policy. This policy applies to any person who is taking on the breastfeeding or expressing role in their baby’s life and includes, but is not limited to; cisgender and transgender women, transgender men and non-binary individuals.

Health professionals have responsibilities for the development, management and implementation of this guideline as detailed below.

3.1. Role of the Managers

The Neonatal unit manager is responsible for:

• The management of the Neonatal Infant Feeding Lead.

3.2. Role of the Infant Feeding Steering Group

The Infant Feeding Steering Group is responsible for:

• Reviewing the Infant Feeding Guideline at least every 3 years, or as often as necessary if new guidance becomes available or new training/updating needs become apparent.

• Overseeing the drive towards achieving and maintaining UNICEF BFI accreditation, as recommended in NICE guidance.

• Ensuring that the progress of the UNICEF BFI process, infant feeding rates etc. are communicated to all staff members, line managers and the Trust Board as appropriate.

3.3. Role of the Neonatal Infant Feeding Lead

The Neonatal Infant Feeding Lead is responsible for:

• Writing and updating the Infant Feeding Policy.

• Working closely with those overseeing, updating and writing of any policy or Guideline related to Infant Feeding within Neonatal and Transitional Care.

• Writing and updating the curriculum.

• Delivering or supervising the provision of training and updating as required.
• Ensuring monitoring and compliance standards are met as specified in the Policy.

• Reporting back to the Infant Feeding Steering Group 3-4 times per year.

• Liaising with the Infant Feeding co-ordinators to ensure that Baby Friendly Standards are achieved and maintained.

3.4. Role of Individual Staff

All Maternity, Obstetric, Transitional care and Neonatal staff members are responsible for:

• Attending an annual Infant Feeding update if in frontline clinical contact with new babies and their families.

• Practising in accordance with the Maternity Infant Feeding Policy and this Neonatal guidance document at all times while employed in this Trust.

• All Neonatal staff members are additionally responsible for:
   Attending initial Baby Friendly Neonatal standards training once every three years.

4. Standards and Practice

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

Parents will have a discussion with an appropriate member of Neonatal staff as soon as possible after admission about the importance of touch, comfort and communication for their baby’s health and development. Parents are actively encouraged to provide comfort and emotional support for their baby including frequent and prolonged skin contact, comforting touch and responsiveness to their baby’s behavioural cues.

4.2. Enabling babies to receive breast milk and to breastfeed.

4.2.1. The unit will enable babies to receive breast milk and to breastfeed when possible. A breastfeeding parent’s own breast milk is always the first choice of feed for their baby. Breastfeeding parents will have the opportunity for discussion about the importance of their breast milk for their preterm or ill babies as soon as is appropriate. They will be enabled to express breast milk for their baby including support to:

  • Express as early as possible after birth (ideally within two hours). Parents expecting a preterm birth or diabetic mothers should be encouraged to express antenatally; packs supporting this are available on delivery suite.
• Express eight to ten times in 24 hours including once during the night.

• Learn how to express effectively, including hand expression, use of the breast pump equipment and storing milk safely.

• Express frequently, especially in the first two to three weeks following delivery, in order to optimise long term milk supply.

• Stay close to their baby when expressing milk. Breastfeeding parents are encouraged whenever possible to express beside their baby.

• Access effective breast pump equipment.

• Use their milk as mouth care when their baby is not tolerating oral feeds, and later to tempt their baby to feed.

4.2.2. Staff will ensure that a formal review is undertaken a minimum of four times in the first two weeks to support optimum expressing and milk supply. A guide for staff is available in Appendix 3. Appropriate support will be then be offered to overcome expressing difficulties where necessary, particularly where supplies are not meeting the baby’s requirements or is less than 750mls in 24 hours by day 10. The service will also ensure that in the unit, a suitable environment is provided, which is conducive to effective expressing.

4.2.3. A pacifier may be offered in set circumstances but never in the establishment of breastfeeding and only ever with explicit parental consent. Please see separate guidance—‘Non Nutritive Sucking Neonatal Clinical Guideline’.

4.2.4. There may be circumstances where the use of nipple shields is appropriate to support successful breastfeeding. This should always be introduced alongside a referral to the Infant Feeding Team to ensure that a weaning plan is also in place. Please refer to Appendix 4 (or ABM guidance - https://abm.me.uk/breastfeeding-information/using-a-nipple-shield-with-a-breastfed-baby/) for advice on the appropriate introduction of nipple shields.

4.2.5. Parents will receive care that supports the transition to breastfeeding or responsive bottle feeding, including:

• Being able to be close to their baby as often as possible so that they can respond to feeding cues.

• Use of skin to skin contact to encourage instinctive feeding behaviour.

• Information about positioning for feeding and how to recognise effective feeding.
4.2.6. Breastfeeding parents should have additional help with breastfeeding challenges when needed. This is provided via Neonatal staff with support from Infant feeding team or Infant feeding co-ordinators as necessary. Online Peer to Peer support is also made available to inpatient and discharged neonatal families for support with breastfeeding, responsive bottle feeding and expressing. Parents are supported through the transition to discharge home from hospital particularly in relation to feeding and caring for their baby and will be offered the opportunity to stay overnight/for extended periods to support development of parent’s confidence and understanding of modified responsive feeding. Information will also be provided on how to access support in the community at discharge.

4.2.7. The term responsive feeding is used to describe a feeding relationship which is sensitive, reciprocal, and about more than nutrition. Staff should ensure that parents have the opportunity to discuss this aspect of feeding and reassure them that:

- Breastfeeding can be used to feed, comfort and calm babies.
- Breastfeeds can be long or short.
- Breastfed babies cannot be overfed or ‘spoiled’ by too much feeding.
- Breastfeeding will not tire them any more than caring for a new baby without breastfeeding.

4.3. Valuing parents as partners in care

4.3.1. All parents have unrestricted access to their baby unless individual restrictions can be justified in the baby’s best interest. The unit will make parents as comfortable, informed and involved as possible in their baby’s care during their stay. Every effort will be made to ensure effective communication between parents and the healthcare team, including full information on treatment and baby’s condition to enable informed decision making.

4.3.2. All babies should have a care plan in place for their chosen method of feeding to support information giving. Parents have free access to their baby’s patient folder and should be encouraged to contribute to care plans, individualising these for their baby as required.

4.3.3. Parents who formula feed will be enabled to do so as safely as possible through the offer of a demonstration and / or discussion about how to prepare infant formula from powder.

4.3.4. Parents who formula feed will have a discussion about the importance of responsive feeding and be encouraged to:

- Respond to early cues that their baby is hungry.
• Invite their baby to draw in the teat rather than forcing the teat into their baby’s mouth.

• Pace the feed so that their baby is not forced to feed more than they want to.

• Recognise their baby’s cues that they have had enough milk and avoid forcing their baby to take more milk than the baby wants.

4.3.5. All staff should adhere to these guidelines when supporting parents to feed their babies, unless a deviation is agreed in the medical notes by a Speech and Language therapist or consultant.

4.4. The International Code of Marketing Breastmilk Substitutes (the Code)

4.4.1. All parents should be given unbiased, evidence-based information that is free from advertising

4.4.2. The display and distribution of materials which promote the use of breastfeeding substitutes, bottles, dummies and teats etc is therefore prohibited throughout the unit, and any violations will be addressed

5. Dissemination and Implementation

5.1. This policy is to be communicated to all health care staff that have any contact with Neonatal families. All staff will receive a copy of the policy.

5.2. Neonatal Team members have the primary responsibility for supporting all parents to become confident with feeding and caring for their babies and for helping them to overcome related problems.

5.3. Once ratified this policy will be uploaded to the intranet Document Library and replace all previous versions. Older versions will be held in the legacy document library.

5.4. All new staff will be orientated to the policy as soon as their employment begins. This will occur through provision of the Staff Guide to the Policy to all staff attending induction and will be recorded through attendance records.

5.5. All professional, clerical and ancillary staff who have contact with pregnant and breastfeeding parents will receive training in infant feeding management at a level appropriate to their professional group.

5.6. New Midwifery, Neonatal and Child Health Team members will receive training consisting of a minimum eighteen hours of formal education and clinical practices within six months of taking up their posts, unless they can evidence attendance at the UNICEF 2 or 3 day training in breastfeeding management. Such staff must be orientated to local infant feeding support arrangements in their induction period. All members of these teams must
also attend an annual update of two hours duration, the content of which will be determined by audit.

5.7. Information and training will be given to Paediatricians (and other medical staff) to enable them to promote breastfeeding and to appropriately support all parents in feeding and caring for their babies.

5.8. Curricula for all staff training provided will be available and will comply with the UNICEF Baby Friendly best practice standards.

6. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Staff knowledge of the policy will be audited regularly as part of achieving Neonatal Baby Friendly Status.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Neonatal Infant feeding Lead</td>
</tr>
<tr>
<td>Tool</td>
<td>Baby Friendly Initiative Neonatal Audit tool</td>
</tr>
<tr>
<td>Frequency</td>
<td>Staff database reviewed every 6 months to ensure compliance Audit of 10 neonatal/ paediatric staff every 6 months as a minimum, Audit of 10 breastfeeding and bottle feeding parents every 6 months as a minimum. Both these audits should be done more frequently during the Baby Friendly accreditation process.</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>The completed audit report will be presented to the Neonatal Infant Feeding Steering committee at their 2 monthly meetings. The Neonatal Infant Feeding Lead will analyse the results of the audit and make a plan to correct any deficiencies.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Neonatal Infant feeding Lead will act on recommendations.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within 2 months. 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>

7. Updating and Review

7.1. Policy to be reviewed every 3 years or if new information becomes available, whichever is sooner.

7.2. Revisions can be made ahead of the review date when the procedural document requires updating. Where the revisions are significant and the overall policy is changed, the author should ensure the revised document is taken through the standard consultation, approval and dissemination processes.

7.3. Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval can be sought from the Executive Director responsible for signatory approval, and can be re-published accordingly without having gone through the full consultation and ratification process.
7.4. Any revision activity is to be recorded in the Version Control Table as part of the document control process.

8. **Equality and Diversity**

8.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the [Equality and Diversity website](#).

8.2. **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>Supporting Neonatal Feeding Standard Operating Procedure V2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Neonatal Infant Feeding Policy V2.0</td>
</tr>
<tr>
<td>Date Issued/Approved:</td>
<td>June 2021</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>June 2021</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>April 2024</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Dellen Prescott, Senior Staff Nurse. Emma Stone, Senior Staff Nurse Louise Picket, Maternity Support Worker Helen Greenhill, Neonatal and Transitional Care Matron</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252667</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>The policy describes how to ensure all staff understand their roles and responsibilities in supporting parents to feed and care for their baby in ways which support optimum health and well-being. This guideline works in conjunction with the Infant feeding guideline and provides specific guidance for the neonatal unit.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Neonatal feeding, parents as partners in care, close and loving relationships</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Approval route for consultation and ratification:</td>
<td>Neonatal Guidelines Group</td>
</tr>
<tr>
<td>General Manager confirming approval processes</td>
<td>Mary Baulch</td>
</tr>
<tr>
<td>Name of Governance Lead confirming approval by specialty and care group management meetings</td>
<td>Caroline Amukusana</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>None required</td>
</tr>
<tr>
<td>Related Documents:</td>
<td>Maternity Infant Feeding Policy Non-nutritive sucking policy</td>
</tr>
<tr>
<td>Training Need Identified?</td>
<td>No</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
</tr>
</tbody>
</table>
## 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)</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2018</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Dellen Prescott Senior Staff Nurse and Neonatal Infant feeding lead.</td>
</tr>
<tr>
<td>July 2020</td>
<td>V2.0</td>
<td>Transferred to new trust format</td>
<td>Dellen Prescott Senior Staff Nurse And Neonatal Infant feeding lead.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Addition of transitional care to scope and staff requirements. Term ‘Mother’ changed to be more inclusive and inclusivity sentence added to scope. Appendix 3 updated to reflect changes to expressing and feeding review documentation.</td>
<td></td>
</tr>
<tr>
<td>May 2021</td>
<td>V2.1</td>
<td>Updated onto Standard Operating Procedure template</td>
<td>Infant Feeding Team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Change of title of document</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Point 1.2 added by the Infant Feeding Team</td>
<td></td>
</tr>
</tbody>
</table>

**All or part of this document can be released under the Freedom of Information Act 2000**

**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 for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.
### Appendix 2. Equality Impact Assessment

#### Section 1: Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Supporting Neonatal Feeding Standard Operating Procedure V2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area:</td>
<td>Neonatal</td>
</tr>
<tr>
<td>Is this a new or existing Policy?</td>
<td>Existing</td>
</tr>
<tr>
<td>Name of individual/group completing EIA</td>
<td>Neonatal Guidelines Group</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252667</td>
</tr>
</tbody>
</table>

1. **Policy Aim**
   - **Who is the strategy / policy / proposal / service function aimed at?**
   - This guideline works in conjunction with the Infant feeding policy and provides specific guidance for the neonatal unit and transitional care.

2. **Policy Objectives**
   - **To ensure that all staff at Royal Cornwall Hospitals Trust understand their roles and responsibilities in supporting parents to feed and care for their baby in ways which support optimum health and well-being.**

3. **Policy Intended Outcomes**
   - **To enable Neonatal families to develop confidence in feeding their babies and to develop close and loving parent-infant relationships.**

4. **How will you measure the outcome?**
   - Compliance Monitoring Tool, data collection and monitoring at the Neonatal Infant feeding steering group Meeting

5. **Who is intended to benefit from the policy?**
   - Breastfeeding parents, babies and their families, through improved short and long term better health, and the Trust, by lower rates of admission with illnesses related to ineffective breastfeeding or to not breastfeeding

6a). **Who did you consult with?**
   - Workforce
   - Patients
   - Local groups
   - External organisations
   - Other
   - x

   **Please record specific names of groups:**
   - Neonatal Guidelines Group
   - Infant Feeding Guidelines Group

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

   **c). What was the outcome of the consultation?**
   - Approved- 23/06/21
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 a positive/negative impact on:

<table>
<thead>
<tr>
<th>Protected Characteristic</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></td>
</tr>
<tr>
<td>Sex (male, female non-binary, asexual etc.)</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender reassignment</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/ethnic communities /groups</td>
<td></td>
<td>X</td>
<td></td>
<td>Any information provided should be in an accessible format for the parent/carer needs – i.e. available in different languages if required/access to an interpreter if required</td>
</tr>
<tr>
<td>Disability (learning disability, physical disability, sensory impairment, mental health problems and some long term health conditions)</td>
<td></td>
<td>X</td>
<td></td>
<td>Those parent/carers with any identified additional needs will be referred for additional support as appropriate - i.e. to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family’s needs e.g. easy read, audio etc.</td>
</tr>
<tr>
<td>Religion/other beliefs</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual orientation (bisexual, gay, heterosexual, lesbian)</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If all characteristics are ticked ‘no’, and this is not a major working or service change, you can end the assessment here as long as you have a robust rationale in place.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

<table>
<thead>
<tr>
<th>Name of person confirming result of initial impact assessment:</th>
<th>Neonatal Guidelines Group</th>
</tr>
</thead>
</table>

If you have ticked ‘yes’ to any characteristic above OR this is a major working or service change, you will need to complete section 2 of the EIA form available here: [Section 2. Full Equality Analysis](#).

For guidance please refer to the Equality Impact Assessments Policy (available from the document library) or contact the Human Rights, Equality and Inclusion Lead [india.bundock@nhs.net](mailto:india.bundock@nhs.net)
Appendix 3. Guide to Expressing and feeding reviews for staff

Guide to Expressing and feeding reviews for staff

Expressing breastmilk over a long period of time can be extremely rewarding for parents but can be equally demanding. If a breastfeeding parent is to succeed they will need support from all those involved in their care.

For sick and preterm babies the importance of breastmilk cannot be overestimated:

- It supports growth and provides protection from infection.
- Evidence suggests that the use of breastmilk decreases the incidence and severity of the life threatening disease necrotising enterocolitis.
- By providing breastmilk a parent can be assured that they are uniquely contributing to the wellbeing and development of their baby also contributing significantly to emotional wellbeing.

The Baby Friendly Initiative recommends that an expressing assessment is carried out; this ensures the breastfeeding parent receives support to:

- express and address any issues or concerns within a timely matter to not negatively impact on supply.
- enable a breastfeeding parent to maximise milk production so that supply can be maintained for as long as desired.
- avoid delay in starting to express or any reduction in the frequency or effectiveness of expression will compromise long term supply.
- detect and correct problems that will help maintain confidence in ability to produce milk for baby.

Expressing should commence accordingly;

Early
Within the first 2 hours.

At least once within the first 12 hours following delivery
This is to support and encourage early expressing. Review at least four times within the first two weeks to ensure that breastfeeding parents are expressing effectively and to address any issues or concerns they may have.

Frequent
Eight to ten times in 24 hours (including once at night). Ensure expressing is effective (combining hand and pump expression). With the correct support to express, a breastfeeding parent can aim to achieve an average milk volume of approximately 750 - 900ml in 24 hours at day 14.

Reviews
Reviews should ideally be carried out on or around days 2, 5, 8 and 11. However, they are not restricted to these days and should be conducted a minimum of four times in the first two weeks and as required thereafter. Take an extra front sheet as required and add to documentation.
Completing the expressing and feeding review

For the neonate, expression forms the beginning of the breastfeeding parent’s breastfeeding journey. The review serves as a documented journey of hand and pump expressing. What is captured from the outset is incredibly valuable in providing on-going tailored support and care to enable them to successfully express and breastfeed. The review enables staff to provide tailored support by viewing the history of expressing and breastfeeding support provided.

The form is laid out for staff to easily follow. While in conversation staff can document and review how expressing and breastfeeding is progressing.

Tips to help parents succeed

- Hand expression is a good technique for obtaining small volumes of colostrum.
- Breast massage and relaxation techniques help to get milk flowing.
- Expressing close to baby or at least having a photo or piece of baby’s clothing will help milk production and flow.
- Encourage regular daily skin to skin contact and to interact and undertake care giving as all positive interactions boosts milk-producing hormones.
- When using a pump ensure the correct technique and always check the pump shield to ensure it is the correct one.
- Encourage double pumping as this both saves time and boosts supply. It may also contribute to being able to express long term.
- Help make a plan for expressing and consider using an expressing log to help— try to steer parents away from a strict 3-4 hourly routine but rather help them to avoid long gaps between expressions. Gaps should be a maximum of four-hourly in the day and six hourly at night, whilst ensuring that they get the recommended 8-10 times in 24 hours frequency.
- Emphasise the importance of the night-time expression as this is when hormone levels are highest and long term expressing most likely to succeed with these in place.
- Although it is expected that milk volumes increase daily in first two weeks, it is important that parents don’t feel pressurised to obtain a ‘specific’ amount. Refer for specialist support if you have concerns about milk volumes.
- Keep parents updated on baby’s progress and encourage them to be with baby as much as possible as this will help alleviate anxiety.
Appendix 4. Use of nipple shields while working towards successful breastfeeding.

A nipple shield is a covering usually made of silicon or plastic which permits the flow of milk when placed over the nipple and areola. It is generally a short-term remedy. It is usually recommended to mothers with flat nipples where the baby has difficulty attaching to the breast as the nipple does not provide the stimulation needed to make them gape. The use of nipple shields should not be used to replace effective breastfeeding support as it can have a negative effect on milk supply and therefore potentially an impact on the longevity of the mother's breastfeeding journey.

Appropriate indications for use:

The baby will not attach to breast for the following reasons:

- Mother has flat or inverted nipple(s).
- Baby has a tongue tie awaiting imminent treatment or review.
- Mother has soft non protruding nipples where the nipple does not become erect on stimulation.
- Sore nipples – *for short term use only* of 24-48 hours to allow moist healing. Mothers must be immediately referred to the infant feeding team and have a breastfeeding assessment prior to use.

Inappropriate indications for use

- Large nipples
- When milk supply is not established
- Sore nipples where the reasons for damage have not been addressed.

If indications for use are appropriate and mother is happy to try a shield, follow the below protocol.

Before introducing nipple shields

- Observe 2-3 feeds from the beginning to end. Aim to assess whether there is an issue with their feeding technique (Baby should be close, with their head free to tilt, their head and body of baby should be in a straight line, and they should be nose to nipple). Where an issue with positioning and attachment is identified, do not proceed to try nipple shields as this will not help them. Parents should be provided with specialist input to support breastfeeding and gaining an effective attachment.
- Perform pinch test to confirm inverted nipple. Make a ‘C’ shape using your thumb and index finger around the areola about 2-3 cms behind the nipple. Gently squeeze the thumb and index finger together. The nipple should naturally protrude; if it doesn't it can be described as ‘flat’ and if the nipple pulls inward it can be described as ‘inverted’.
- Ask the mother to try stimulating their nipple by gently rolling it with their thumb and index finger. They can also use a cold wet cloth if they prefer. Expressing with a hand pump prior to trying to feed can also help draw the nipple outwards.
- Encourage prolonged skin to skin contact and biological nurturing so that the baby’s natural instinct to attach is stimulated.
- Shields should be clean before use and can be a hassle when out and about and the shield is dropped or becomes soiled.
- Apply drops of hand expressed milk to nipple to tempt the baby to attach to the breast.
Using nipple shields

- Select appropriate size according to the nipple size. Sizes available are 16mm, 20mm and 24 mm of which 16 mm is the smallest and 24 mm is the largest.
- Use freshly sterilized nipple shield as a wet warm shield sticks to the breast easily and will form a good seal. Wash and store shields in a clean container labelled with the baby’s hospital label.
- Hand expressing immediately prior to attempting to feed can help the nipples stand out as much as possible and can help to stimulate the let down as baby may find it is more difficult to achieve with shields in place.
- Weigh baby regularly; document wet and dirty nappies to ensure baby is feeding and growing well.
- Reinforce good breastfeeding technique and observe feeds regularly to ensure the baby has an effective attachment and good milk transfer.
- Check for the presence of milk at the end of shield during feeds to ensure baby is getting breast milk from the nipple shield.
- Mother should report that her breasts feel softer after each feed.
- Nipple shields can cause reduced milk transfer, so discuss signs of mastitis and breast engorgement with parents.
- Nipple shields can further diminish milk supply if there is already an issue as the stimulation and draw on the breast is often less than during breastfeeding. Parents should be encouraged to express in addition to attempting breastfeeds to protect milk supply. Baby will also tire more quickly with the use of nipple shields as it requires more effort to achieve let down and milk transfer.
- Evaluate the need and effectiveness of the use of nipple shields daily and document in the ‘Review of Expressing and breastmilk feeding’ care plan.

Weaning from nipple shields

- Weaning from the shields should start from first use.
- Nipple shields should ideally not be used every feed as baby can develop nipple confusion and can lose the ability to root onto the breast. Attempt to use nipple shields for alternate feeds.
- Where nipple shields are being used as a short term remedy for damage to the nipple/breast, they should be used for 24-48 hours and then gradually removed.
- Start feeding with nipple shield in situ and get baby to establish let down, remove the baby from the breast quickly and remove the nipple shield. Attach baby again.
- Regularly promote skin to skin time and attempt attaching without a shield.
- When weaning the shields they should never be cut down, this practice is no longer recommended.

Parent support

If parents are going home using nipple shields (and this should not be the case), the health visitor, midwife and infant feeding team should be alerted to ensure support and continuity of care for the family at home. This should be documented in the notes and ‘Review of Expressing and breastmilk feeding’ document.