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Infant Feeding Guideline

Introduction and Aim

This document outlines Cardiff and Vale University Health Board's (UHB) maternity services policy on infant feeding. It has been developed in response to Welsh Government Breastfeeding Strategy and UNICEF UK Baby Friendly Initiative (BFI) Hospital and Community standards, which endorse breastfeeding as the healthiest way for a mother to feed her baby.

This document identifies the mandatory standards and practices which maternity staff involved in the care of mothers and babies should adhere to regarding infant feeding.

Staff will not discriminate against any woman in her chosen method of infant feeding and will fully support her decision.

The aim of this policy is to ensure that all pregnant women and mothers with babies, who are cared for by Maternity Services, have information and support regarding breastfeeding in accordance with Welsh Government and UNICEF BFI (UK) standards.

Objectives

The objectives of this policy are to ensure that:-

- Arrangements are in place to ensure that all relevant employees' and new staff are familiarized with this policy on commencement of employment.
- Maternity services staff are to receive appropriate training regarding breastfeeding within 6 months of employment according to UNICEF BFI (UK) standards and safe formula feeding information -Public Health Wales standards
- Pregnant women have the opportunity to have a meaningful discussion regarding feeding and caring for their baby as well as encouraging a responsive relationship with their baby in pregnancy and following birth
- The initiation of all infant feeding is supported by encouraging uninterrupted skin to skin contact for all babies until the first feed. Frequent and repeated skin to skin contact will be encouraged for all babies.

- Mothers will be shown how to breastfeed and how to maintain lactation even if mother and baby are separated;
- Mothers will be supported to achieve effective breastfeeding by receiving support with breastfeeding and hand expressing skills as well as enabled to understand the signs of effective feeding
- Formula milk supplements will only be given to breastfed babies if there is a medical indication, or if the mother, following a discussion has been enabled to give informed consent for supplementation.
- Mothers are given support and information to maximise the amount of breast milk their baby receives.
- Exclusive breastfeeding is supported,
- Responsive feeding is encouraged for all babies.
- The use of artificial teats and dummies whilst establishing breastfeeding is discouraged.
- Information about breastfeeding support groups, and specialist infant feeding support services are provided.

Scope

This policy applies to all staff employed by the UHB Maternity, Neonatal and Acute Child Health services.

Equality Health Impact Assessment	Cardiff and Vale UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff, patients and others reflects their individual needs and does not discriminate, harass or victimize individuals or groups. These principles run throughout our work and are reflected in our core values, our staff employment policies, our service standards and our Strategic Equality Plan and Equality Objectives. The responsibility for implementing the scheme falls to all employees and UHB Board members, volunteers, agents or contractors delivering services or undertaking work on behalf of the UHB. We have undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender, maternity and pregnancy, carer status, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was positive impact to the equality groups mentioned from the health gain benefits of breast feeding.

Documents to read alongside this Procedure	*Neonatal Hypoglycaemia Guideline (All-Wales)* *Neonatal weight loss Guidance* (Maternity) *for healthy term babies In Postnatal Care Pathways, Maternity Notes*
Approved by	Maternity Professional Forum and Quality and Safety

Accountable Executive or Clinical Board Director	*Jason Roberts, Executive Nurse Director*
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Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Maternity Professional Forum.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
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The words woman and women have been used throughout this document as this is the way that the majority of those who are pregnant and having a baby will identify. We recognise maternity and gynaecological services will be accessed by women, gender diverse individuals and those whose gender identity does not align with the sex they were assigned at birth or have a non-binary identity. Therefore, we believe delivery of care must at all times be appropriate, inclusive and sensitive to the needs of everyone (RCOG 2022).

1. Responsibilities and Aims

Maternity Services have a responsibility to ensure that staff are adequately supported and provided with the training to implement these standards. They will also ensure that the environment of care is suitable for breastfeeding mothers to feed their infants where practicable and where this is not possible they will ensure that an appropriate care plan is established.

Cardiff and Vale University Health Board is committed to

1. Providing highest standard of care to support expectant and new families to feed their baby and to build close and loving parent infant relationships. This is in recognition of the profound importance of early relationships to future well-being. Breastfeeding makes a significant contribution to optimal physical, and emotional health outcomes for children, mothers, and future generations.
2. Ensuring all care provided is mother and family centred, non-judgemental and that all mothers' decisions are supported and respected.
3. Working together across disciplines and organisations to improve mother and parents' experiences of care.
4. Creating an environment where parents' are able to feel supported and gain information to enable them to feed their baby safely.
5. Recognising the challenges that the experience of having a sick or premature baby can present to the development of this relationship.

Aims

- To increase breastfeeding initiation rates,
- To increase day 10 breastfeeding rates,
- To provide safe and responsive bottle-feeding advice amongst mothers' who, through fully informed decision making, choose to bottle feed,
- To improve patient experience,
- To support a reduction in the numbers of re-admission for infant feeding related issues.

Infant feeding Coordinators (Maternity), Neonatal and ACH

The Infant Feeding Coordinators have the responsibility to audit compliance with this policy within their Directorates. They will act as a resource on infant feeding issues within the Health Board and providing appropriate training to relevant staff, as detailed in the policy.

Implementation

To ensure the implementation of this policy and the promotion of breastfeeding it will be necessary to ensure the following:-

- All staff are to receive training to enable them to implement the policy as appropriate to their role. New staff will receive this training within six months of commencement of employment.
- The International Code of Marketing of Breast-milk Substitutes is implemented throughout the service.
- All documentation fully supports the implementation of these standards.
- Parents' experiences of care will be listened to through: regular audit and parents' experience surveys.

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2. Antenatal Care

All pregnant women will have the opportunity to discuss feeding and caring for their baby with a health professional.

This discussion will include the following topics:

- The value of developing close and loving relationships connecting with their baby whilst in utero,
- The importance of brain development of the baby whilst in utero,
- The value of skin-to-skin contact for all mothers and babies at birth and beyond,
- The importance of responding to their baby's needs,
- An exploration of what parents already know about breastfeeding,
- The value of breastfeeding as protection, comfort and food,
- Getting breastfeeding off to a good start.

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3. Birth

- All mothers will be offered the opportunity to have uninterrupted skin contact with their baby at least until after the first feed and for as long as they want, so that the instinctive behaviour of breast seeking (baby) and nurturing (mother) is given an opportunity to emerge.
- All mothers will be encouraged to offer the first breastfeed in skin contact when the baby shows signs of readiness to feed. The aim is not to rush the baby to the breast but to be sensitive to the baby’s instinctive process towards self-attachment.
- When mothers choose to formula feed they will be encouraged to offer the first feed in skin contact.
- Those mothers who are unable (or do not wish) to have skin contact immediately after birth, will be encouraged to commence skin contact as soon as they are able, if they so wish.

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4. Skin-to-Skin Contact

- There will be no unnecessary separation of a mother and her baby whilst in hospital.
- All mothers are offered the opportunity to have uninterrupted skin contact with their baby and to offer the first feed in skin-to-skin contact.
- Babies should be given the opportunity to self-attach at this time (birth crawl).
- Any interventions e.g., weighing/measuring should be performed immediately after birth or after the baby has had its first feed.
- Mothers who are unable (or do not wish) to have skin-to skin contact immediately after birth are encouraged to commence this as soon as they are able. Alternatively, a birth partner could provide skin-to-skin.
- Mothers who formula feed are encouraged to offer the first feed in skin-to-skin contact.

Skin-to-Skin Safety

Routine observations of the baby's temperature, breathing, colour, and tone should continue throughout the period of skin-to-skin contact. Observations should also be made of the mother, with prompt removal of the baby if the health of either give reason for concern. It is important to ensure that the baby cannot fall onto the floor, become trapped in bed/bedding, or by the mother's body.

Particular care should be taken with the position of the baby, ensuring the head is supported so the infant's airway does not become obstructed. Parents should be educated on safe sleep. A mother can generally continue to hold her baby in skin-to-skin contact during perineal suturing. Mothers should be discouraged from holding their baby when receiving analgesia which causes drowsiness or alters their state of awareness (e.g., Entonox or pethidine whilst in labour).

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5. Parents with a Baby on the Neonatal Unit

Maternity and Neonatal with jointly ensure that:

- All parents are supported to have a close and loving relationship with their baby
- All parents will have a discussion with an appropriate member of staff as soon as possible (either before or after their baby's birth) about the importance of touch, comfort and communication for their baby's health and development including the promotion of FiCare.
- All parents will be actively encouraged and enabled to provide touch, comfort and emotional support to their baby throughout their baby's stay on the neonatal unit.
- All parents will be enabled to have frequent and prolonged skin contact (for at least one hour) with their baby as soon as possible after birth and throughout the baby's stay on the neonatal unit.
- A mother's own breastmilk is always the first choice of feed for her baby.
- Mothers have a discussion regarding the importance of their breastmilk for their preterm or ill baby.
- Use their milk for mouth care when their baby is not tolerating oral feeds, and later to tempt their baby to feed.

Expression of Milk for Babies on the Neonatal Unit

- Mothers to be informed about the importance and supported to express their breastmilk within 2 hours after birth using both hand expression and breast pump (including double electric pumping from birth) in line with national guidance:
  - (bapm.org)
  - https://www.bapm.org/pages/196-maternal-breast-milk-toolkit

- Express frequently (at least eight times in 24 hours, including once at night) especially in the first two to three weeks following delivery, in order to optimize long-term milk supply.

- Overcome expressing difficulties where necessary, particularly where milk supply is inadequate, or if less than 750mls in 24 hours is expressed by day 10 -14 (see Appendix).

Neonatal Teams will ensure that mothers receive care that supports the transition to breastfeeding, including support to:

- Recognise and respond to feeding cues and use skin-to-skin contact to encourage instinctive feeding behavior.
- Position and attach their baby for breastfeeding

- Recognise effective feeding and overcome challenges when needed
- Mothers are provided with details of voluntary support for breastfeeding which they can choose to access at any time during their stay or following discharge
- Mothers are supported through the transition to discharge home from hospital, including having the opportunity to stay overnight, for extended periods (if activity within the unit allows) to support the development of mother's confidence and modified responsive feeding

Equipment and environment:

- A suitable environment conductive to effective expression is created
- Mothers have access to effective breast pumps and equipment
- Learn how to use pump equipment and store milk safely
- Stay close to baby when expressing milk

Compliance

- A formal review of expressing is undertaken a minimum of **four** times in the first two weeks to support optimum expressing and milk supply using the UNICEF expression checklist assessment tool
- National Quality Indicators for breastfeeding eg; Periprem Cymru, National Neonatal Audit Programme (NNAP) National Neonatal Audit Programme (NNAP) | RCPCH

In order to avoid conflicting advice, it is mandatory that all staff involved with the care of breastfeeding women adhere to this policy. Any deviation from the policy must be justified and recorded in the maternal and neonatal records.

It is the individual Midwife or Nurse's responsibility to liaise with the baby's medical attendants (Neonatologist, Pediatrician, General Practitioner) should concerns arise about the baby's health. If a problem with feeding is identified the process is to refer to the above guideline/s and manage accordingly.

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6. Getting Breastfeeding off to a Good Start

Mothers will be enabled to achieve effective breastfeeding according to their needs. Staff will ensure mothers are informed about:

- Principles of positioning (CHINS),
- The importance of responsive feeding and responding to feeding cues,
- How to recognise effective attachment at the breast,
- Understand the signs of effective feeding,
- Why effective feeding and milk transfer is important.

This discussion must be documented within the patient notes or via our electronic system.

A formal feeding assessment will be carried within the first 72 hours, two mandatory feeding assessments to be carried out as a minimum by maternity services and documented on page 4 & 5 of the postnatal pathway. One prior to discharge, and as often as required to ensure effective feeding and the wellbeing of mother and baby, via community alongside health visiting service.

This assessment will include a discussion with the mother to reinforce what is going well, discuss how to know if baby is getting enough milk. Where necessary, develop an appropriate plan of care to address any issues that have been identified. The breastfeeding assessment can be used at any time to identify ineffective feeding.

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6. Responsive Feeding

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

- Recognising and responding to baby's cues,
- Supporting nutritional, emotional needs and optimal brain development,
- Breastfeeding can be used to feed, comfort and calm babies,
- Breastfeeds can differ in length and regularity throughout a 24-hour period,
- Breastfed babies cannot be overfed or spoiled by too much feeding. Responsive feeding also means responding for the mother's needs to feed e.g. to comfort or relax.

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7. Exclusive Breastfeeding

The World Health Organisation (2019) recommends exclusive breastfeeding for the first six months of life. This will ensure infants achieve optimal growth, health, and development. Thereafter, it recommends that breastfeeding is continued for at least the first two years of life in conjunction with complementary and nutritionally adequate foods, from 6 months.

Mothers who breastfeed will be provided with information about why exclusive breastfeeding leads to the best outcomes. This includes why it is particularly important during the establishment of breastfeeding. The care, support and advice given to breastfeeding mothers regarding exclusive breastfeeding will be evidence-based and underpinned by knowledge of the physiology of milk production and breastfeeding. This will include:

- how breastfeeding reduces the risk of acute and chronic illness for mother and baby how the act of breastfeeding reduces the risk of certain women's health conditions,
- the importance of hormonal responses in milk production and let-down,
- the importance of early, frequent, and effective priming of the prolactin receptor sites after birth,
- the negative impact of ineffective/infrequent milk removal on milk supply.

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8. Supplementation for Breastfeeding Babies

Supplementation describes any instance of a breastfed baby receiving artificial milk. This includes when a baby has received ANY breastfeed /milk. A **pink form** must be completed to provide evidence that the top up is medically indicated or fully informed maternal choice (see appendix).

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9. Reluctant To Feed

The healthy, well term baby may feed infrequently in the first 24-48 hours. In the presence of a low glucose supply, these babies utilise alternative fuels (e.g. amino acids, ketones) which are protective of neurological function. This process, known as counter regulation means that the healthy term baby is not at risk of symptomatic Hypoglycaemia i.e. neurological compromise. However, these babies require support to initiate breastfeeding and the Reluctant Feeder pathway must be followed (see full term >37 weeks reluctant to feed flow chart appendix).

Clinical indication

There are very few clinical reasons for an artificial milk feed e.g. babies at risk of hypoglycaemia (see Hypoglycaemia of the New-born guideline) and those presenting with excessive weight loss (see appendix) In these circumstances' mothers will be supported to maximise the amount of breastfeeding/breastmilk their baby receives. Feeding plans must reflect this ultimate goal.

Maternal request

Any decision to supplement a new-born baby at maternal request must be as a result of a fully informed choice. The person requesting the artificial feed must ask whether the mother is breastfeeding. If the mother is breastfeeding, support must be offered to facilitate breastfeeding or give breastmilk. If the parents continue to request an artificial feed, there must be a sensitive discussion about how giving a breastfed baby formula may cause:

- a decreased eagerness to breastfeed,
- a reduction in milk supply,
- sensitisation of the baby to cow's milk protein, increasing the risk of allergy,
- a reduction in beneficial gut flora which protects the baby against infection.

Whilst this information is evidence-based, it may be difficult for parents to hear. It is therefore crucial that it is offered in conjunction with intensive breastfeeding support to enable mothers to continue breastfeeding successfully/maximise the amount of breastmilk their baby receives.

Mothers who give top up feeds of artificial milk in conjunction with breastfeeding will be enabled to do so as safely as possible and with the least possible disruption to

breastfeeding. Care plans must reflect the ultimate goal of maximising breastfeeding or breastmilk intake.

Documentation

The reason for a supplement of artificial milk must be clearly documented and justified. This documentation must include rationale and evidence of:

- clinical indication (if applicable) including a care plan,
- an offer of breastfeeding support,
- a discussion with the mother about the implications of artificial milk feed,
- a fully informed maternal decision.

A pink supplementation audit form MUST be completed for every feed of artificial milk.

This forms part of the audit requirements from Baby Friendly. The term mixed feeding should be only used if the mother's intention was to combine feed from birth. i.e if the mother is breastfeeding and formula was used as a top up, this mother is still breastfeeding.

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10. Cup Feeding

Cup feeding can be used to offer feeds of colostrum, expressed breast milk or formula to babies ≥ 34 weeks.

The World Health Organisation (2017) recommends this form of feeding a supplement to a breastfed baby. An advantage of cup feeding is that the infant is required only to lap the milk and then coordinate swallowing and breathing. Potential "nipple and teat confusion" may be avoided. Expressed breast milk (EBM) should always be used whenever possible.

Cup feeding a baby

This method is appropriate for offering quantities of EBM or formula >5ml to a breastfed baby. This method may be used as an alternative to a bottle, ensuring there is no interference with the newborn's innate reflex to suckle with a soft nipple at the back of the mouth rather than a hard teat on the hard palate (UNICEF, 2010). It is also important for the infant to spend time at the breast attempting to latch. There is a risk of aspiration or choking if not undertaken correctly.

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11. Spoon Feeding

Spoon feeding, you may wish to sterilise and use a small, plastic spoon when feeding

small amounts of colostrum to your baby. You can express your milk directly onto the spoon and then offer it straight to your baby.

Plastic spoons are provided while in hospital if you would like to try this method of feeding your baby.

How to spoon feed your baby:

- Gently offer the spoon to your baby's lips and wait.
- Your baby will then sniff the milk, push their tongue forward and start to lap or drink the milk.
- Do not pour the milk into your baby's mouth.

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12. Hand Expressing

If your baby is not feeding at the breast, you may need to hand express your colostrum 8 to12 times every 24 hours (including at night) to help stimulate your breasts to produce milk. The sooner you start this after your baby's birth, the more milk you will produce. Any colostrum you collect can be given directly to your baby via a syringe or a spoon. Giving your baby colostrum will also encourage them to feed from your breast.

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13. Artificial Milk (formula) Feeding

If a mother chooses to artificially milk feed her baby, the first feed should be given in skin-to-skin contact by the mother. Mothers who choose to artificial milk feed will be enabled to do so as safely as possible. This includes an individualised discussion regarding safe sterilising of feeding equipment and safe preparation of formula milk. This discussion needs to be documented patient notes or electronically. Parents will be advised of the importance of only using first baby milk/stage one milk for the first year of life. Sign post to First Step Nutrition website for further evidence based impartial information.

No brand of milk or manufacturer will be recommended by staff members, in line with the International Code of Marketing of Breastmilk Substitutes.

Please ensure all families who choose to bottle feed have bottle feeding assessment prior to discharge. UNICEF UK Baby Friendly Initiative - Bottle Feeding Assessment

Responsive Bottle-Feeding

As with breastfeeding, a mother should respond to her baby's cues. All bottle-feeding mothers will be shown how to use the paced bottle-feeding method (whether giving

expressed breast milk or artificial milk).

- Hold the baby in a more upright position
- Invite the baby to draw in the teat
- Hold the bottle horizontally
- When the baby has had a few sucks and swallows, drop the bottle
- If the baby continues to suckle, bring the bottle back up
- Continue this until the baby no longer shows feeding cues.
- Limit the amount of people feeding baby to the two main caregivers, encourages bonding, reduces risk of overfeeding and less stress to baby.

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14. Support

- Mothers will be enabled to achieve effective breastfeeding according to their needs (including appropriate support with positioning and attachment, hand expression, and understanding signs of effective feeding). This will continue until the mother and baby are feeding confidently.
- Mothers will have the opportunity to discuss breastfeeding in the first few hours after birth as appropriate to their own needs and those of their baby. This discussion will include information on responsive feeding and feeding cues.
- Within the first 72-96 hours, two formal feeding assessments will be carried out, by maternity services using “Feeding assessment” tools in the postnatal notes. Also, further feeding assessments will be carried out as often as required to ensure effective feeding and the well-being of mother and baby, via community-based support..
- Assessments will include a dialogue / discussion with the mother to reinforce what is going well and where necessary develop an appropriate plan of care to address any issues that have been identified.
- Mothers with a baby on the neonatal unit will be supported to express as effectively as possible and encouraged to express at least 8 times in 24 hours including once during the night. They will be shown how to express as soon as is practical, within 6 hours following birth and be supported with both hand and expressing pump methods, as appropriate.
- Before discharge home, breastfeeding mothers will be given information both verbally and in writing about recognizing effective feeding and where to call for additional help if they have any concerns.
- All breastfeeding mothers will be informed about the local support services for breastfeeding.
- For those mothers who require additional support - community Maternity Care Assistant support (MCA) together with community midwifery care is available. For complex challenges the Seren (Specialist Infant Feeding Team) midwives and community-based Breastfeeding Clinics with Infant Feeding Specialists are available. Mothers will be informed at hospital discharge, how to access these support systems

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15. Modified feeding regimes

- There are a number of clinical indications for a short term modified feeding regime in the early days after birth. Examples include: preterm or small for gestational age babies and those who are excessively sleepy after birth. Frequent feeding, including a minimum number of feeds in 24 hours, should be offered to ensure safety.
- Parents of Breastfed Babies having transitional care involving temporary formula supplementation for medical indications
- should be given guidance regarding increasing breastfeeding and reducing formula supplementation- Supplementation information in Plans of Action files (see appendix)
- Early postnatal period: support for parenting and close relationships
- Skin-to-skin contact will be encouraged throughout the postnatal period.
- Mothers who bottle feed will be encouraged to hold their baby close during feeds and offer the majority of feeds to their baby themselves to help enhance the mother-baby relationship.
- Parents will be given information about local parenting support that is available including Infant Feeding support groups, Elan Team and Flying Start referrals
- Monitoring implementation of the standards
- Cardiff and Vale maternity services requires that compliance with this policy is audited at least annually using the UNICEF UK Baby Friendly Initiative audit tool (2014 edition)
- Staff involved in carrying out this audit requires training on the use of this tool. Audit results will be reported to the Head of Midwifery and an action
- Plan to be agreed by managers and Infant Feeding leads for Neonatal, Maternity and Health Visiting, to address any areas of non-compliance that have been identified.
- Monitoring outcomes
- Outcomes will be monitored by:
- Monitoring breastfeeding initiation rates
- Monitoring breastfeeding rates at 10 days postnatal in accordance with
- Public Health Wales Performance Indicators.
- Outcomes will be reported to: Heads of services and managers – Neonatal, Maternity and Health Visiting.

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16. Lactation following Baby Loss

Health professionals working with parents and families anticipating, or following a loss of a baby will provide information and guidance in supporting mothers around lactation and loss. If there is an opportunity prior to the loss it is invaluable to explore with mothers and families their wishes regarding lactation and documented clearly as part of their birth plan or advanced care plan. Palliative Care (2010) | British Association of Perinatal Medicine (bapm.org).

Lactation suppression is not some mothers preferred choice and providing support for mothers and parents to make the choices which best suit their individual circumstances, with consideration in relation to cultural and spiritual beliefs. This includes options around both cessation and continuation of lactation following the death of a baby Lactation_and_Loss_May_2022

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17. Lactation Suppression

Non-pharmacological method

- A well supporting bra should be worn day and night
- Use of breast pads within the bra can help with breast leakage
- Simple analgesia may help with the discomfort, such as paracetamol or a non-steroidal anti-inflammatory unless there are contraindications to these medications
- A cold compress may help

*For mothers who have already commenced expressing, a gradual decrease in frequency and duration is recommended to prevent breast discomfort

Pharmacological Suppression

Cabergoline is recommended (RCOG green top guidelines No 55)

Prevention of lactation

1mg to be taken as a single dose on the first day post-partum

Suppression of established lactation

250 micrograms every 12 hours for 2 days

For up to date information please see the most recent version of the British National Formulary, including contraindications

Lactation Continuation

For mothers who choose to establish lactation or continue to express milk in the longer term in memory of their baby. All mothers should be given information on their options regarding milk donation and memory making.

Milk Donation

Some mothers may take comfort from donating their milk, this should be sensitively offered and compassionately supported if this option feels right to the mother. However, mothers should be made aware that in certain circumstances milk may not be used for clinical use, but could be used for research purposes.

Donation may involve

- Health questionnaire
- Blood screening (not required for research)
- Storage and collection of milk

Best practice to contact the milk bank for eligibility criteria and further information and ongoing support, see below;

www.milkbankatchester.org.uk/

Find A Milk Bank - Milk Bank Near You, Nationwide Breast Milk (ukamb.org)

Memory Making

For babies who are receiving end of life care maternal expressed milk can be used for mouth care, and some babies may be able to suckle at the breast for comfort for both mother and baby. This option could be offered to the mother if appropriate.

Following donation, milk banks will offer gifts in memory of baby such as; certificates, pebbles and their babies name recorded on the milk tree Memory milk gift initiative (no fee involved).

Some women may wish to keep a container of milk as a memento and also be advised that there are companies that turn breast milk into mementoes such as beads and pendants for a fee.

For any further information and support contact

- Bereavement Team
- Infant feeding leads

18. Tongue-Tie

Please note this chapter replaced the archived *Guidelines for Tongue Tie Division For Breastfeeding Challenges in Neonates*.

Division of Ankyloglossia (tongue tie) for Breastfeeding Challenges in Neonates

Ankyloglossia, also known as tongue-tie, occurs when the lingual frenulum attaching the tongue to the floor of the mouth is tight, short or near the tongue tip, thereby impeding its movement. This can lead to feeding difficulties. It can vary from a simple tongue-tie in which the tongue is bound only by a thin mucus membrane to a rare form in which the tongue is completely fused to the floor of the mouth. There is a familial tendency towards tongue-tie, and it affects twice as many boys as girls.

Occasionally Tongue-tie may need intervention to solve breastfeeding problems. Some babies with tongue-tie can feed effectively without any intervention. Whilst other babies with tongue-tie may have trouble with breastfeeding and occasionally bottle-feeding.

There is no strong evidence to support performing tongue-tie division (frenulotomy) on a prophylactic basis, because of potential concerns around speech or weaning. **Cardiff and Vale University Health Board Maternity Services will only perform tongue-tie division if it is directly contributing to feeding issues** (NICE 2005).

NICE states that tongue tie division may also be used to help with bottle feeding.
NICE reports that many factors influence breastfeeding and support from someone with specialist knowledge and skills is very important.

Aims

- Early identification, assessment and plan of feeding support
- Skilled intervention to support breastfeeding skills
- Speedy referral and swift treatment where necessary
- Audit of service effectiveness

This guideline was designed to improve the breastfeeding experience of the small group of mothers and babies experiencing breastfeeding difficulties due to a sub-lingual tongue tie.

These may include:

- Sore and damaged nipples
- Very frequent feeding
- Babies with weight gain difficulties
- Mastitis

This excludes:

Babies that are feeding effectively with a visible tongue tie do not require Tongue Tie Division. Concerns about potential speech problems are not sufficient indication for Frenulotomy (NICE 2005).

Cardiff Maternity Services use the Bristol Tongue Assessment Tool (BTAT/TABBY), as a means of assessing which babies may benefit from Frenulotomy.

It is important that the mother is offered skilled help and support to achieve optimal positioning and attachment and swift referral for tongue tie division when necessary.

Evidence

NICE searched medical literature to identify studies and reviews relevant to division of tongue-ties in babies experiencing breastfeeding difficulties. The emphasis was placed on identifying good quality studies and five were selected for their report.

NICE has considered the evidence and had recommended that when healthcare professionals use this procedure for babies with tongue tie they should be sure that:

- The parents understand what is involved and consent to the treatment
- The results of the procedure are monitored and followed up.
- The Frenulotomy service will be monitored by annual audit
- Staff performing frenulotomies are trained by skilled and qualified practitioners.

The Bristol Tongue Assessment Tool (BTAT) and TABBY tongue assessment Tool are simple and effective tools for providing consistent assessment of tongue appearance and function in infants with tongue-tie.

Frenulotomy (division of tongue-tie)

Dividing the tongue tie, frenulotomy, is described as a simple procedure in the young infant which can be performed without an anesthetic and having few complications. The procedure itself must be performed by an appropriate trained practitioner and involves snipping the tissue to divide the frenulum from the bottom of the mouth. Blood loss is minimal.

Risks

In July 2004 this procedure was notified by the interventional Procedures program because of this controversy about its safety and efficacy in the treatment of babies with feeding difficulties. Therefore, it was considered important for the Interventional Procedures Advisory Committee to consider this procedure and for NICE IPG149 to issue guidance to the NHS in England, Scotland and Wales for Division of

ankyloglossia (tongue-tie) for breastfeeding.

NICE states that few problems were reported following tongue tie division.

A small amount of bleeding post division is common and to be expected. Allowing the baby to feed on the breast immediately after division is best, as feeding will compress the floor of the mouth.

Referral and Assessment Criteria prior to Frenulotomy

Referral to be made to the Infant Feeding Lead if there are breastfeeding challenges and skilled support has been provided.

- If tongue tie is causing problems despite skilled help, the mother and baby should be referred to the Infant Feeding specialist midwife for further breastfeeding assessment in a specialist (Seren) breastfeeding clinic. If it is apparent that breastfeeding cannot be improved by skilled support then the parents should be offered frenulotomy for their baby by a trained registered healthcare professional, and skilled follow up care should be offered to sustain breastfeeding.

- The Infant Feeding Specialist Midwife will be responsible for completing a referral form, including informed consent which will also be used as an audit tool

- The procedure will be fully explained to the parents using a pictorial information sheet prepared for this purpose

- Maternity services for Cardiff and Vale University Health Board provide this service for newborn babies during the postnatal period.

Risk reduction

Bleeding disorders

Prior to division ask parents/guardians about any family history of haemophilia, Von Willebrand's, platelet deficiencies, or other bleeding disorder or tendency to bleed and document this.

Vitamin K administration to the Neonatal is required in order to be suitable for this pathway. If the parents have declined Vitamin K at birth, please refer to the Paediatric ENT team.

Things to consider

- Is there a possibility of consanguineous marriage? (E.g. Some Asian families)

- Is the family Jewish? (High incidence of FXI deficiency in Ashkenazi Jews –8% of the population)
- Are there any signs of easy bleeding/bruising (e.g. Site of IM vitamin K injection, Guthrie test, cephalohematoma, bleeding from umbilicus)?
- Has the baby had Vitamin K (IM/oral)? If oral, how many doses at the point of assessment?

If in doubt don't divide and seek further advice from ENT, the haemophilia centre for your area, or the medical team looking after the family member affected by the bleeding disorder.

Management of Excessive Bleeding

If there is an unusual amount of bleeding after division, it is likely to be dark venous bleeding. Bright red arterial bleeding is very rare. Following the feed if it is still bleeding then try the following.

1. Hold the baby in an upright position. Put some gauze on the raw diamond under the tongue and hold it in place firmly with one finger, taking care not to place any pressure under baby's chin as this can obstruct the airway. Moistening the gauze with sterile water, cooled boiled water, or breastmilk will help prevent the clot sticking to the gauze and being removed when the gauze is removed. Continue to press for at least 10 timed minutes. Ensure that the airway is maintained. Keep baby warm and calm.

2. If the gauze becomes soaked while you are pressing, you are not pressing in the right place. Replace the gauze and check you are pressing under the tongue on the raw diamond, but now press with two fingers, side by side, to ensure you are pressing on the outer edges as well as the centre. Continue pressure for at least **10 timed minutes**.

3. Do not continually remove the gauze to see if the bleeding has stopped **– wait for at least 10 minutes and then look**.

4. If bleeding persists, apply pressure for a further 10 minutes using gauze and bleep the on-call ENT team, Registrar bleep 6468, ENT SHO bleep 5253, or the Consultant on their mobile via switchboard.

5. If the bleeding is very brisk or you have any concerns about the baby's breathing, call 2222 and request a "Paediatric airway call" to go out, giving clear directions to the location. This would bring an ENT SPR and Paediatric anaesthetic team to your location urgently.

6. Consider contacting Neonatal Team covering Maternity Unit if immediate assistance is required whilst waiting for ENT team to arrive.

In the unlikely event that baby requires transfer to theatre, the ENT team will contact the Paediatric Consultant to book space in ENT theatres and make the arrangements.

Baby to be transferred in either a cot or in mother/parent's arms, with mother/parent sat in a wheelchair.

Directions to Paediatric theatres:

- **Go to C3 and follow 'Star Link' corridor to Level 3 of the Children's Hospital**
- **Take the lift to Level 2, which is where the theatres are.**

Suspected Tongue-tie Referral Pathway

- Maternity and Health Visitor Professionals to check for tongue restriction, after providing breastfeeding support if mother is experiencing sore nipples and breastfeeding difficulties
- Discuss with parents, observe a feed and agree a feeding plan if necessary, including referral to Specialist Breastfeeding (Seren) Clinic. Document in mothers postnatal care pathway.

Breastfeeding challenges continue, despite good positioning and attachment skills?

YES **NO**

Support mum to express her milk/ put baby to the breast (at least x8 in 24 hours including at night) and give expressed breast milk (EBM) to baby via cup until seen by Infant Feeding Coordinator/Seren (IFC) for feeding assessment.

Continue to breastfeed baby and access breastfeeding support, including clinics/groups as required

Refer to Seren Clinic or Infant Feeding Lead (IFL) for Assessment

- **Infant Feeding Lead with appropriate experience in Tongue-tie assessment** to perform feeding assessment of breastfeeding technique and if tongue-tie suspected, to score tongue using BTAT/TABBY
- If frenulotomy indicated, IFL to discuss and offer review with tongue-tie practitioner.
- The procedure will be fully explained to the parents using Cardiff and Vale NHS UHB Tongue-tie leaflet (see appendix).
- Referral to Tongue-tie Clinic, based on Midwifery-Led Unit to be completed by Infant Feeding Lead or Tongue-tie Practitioner midwife.
- Follow-up with Seren team who will offer ongoing skilled breastfeeding support as required.
- Follow up is requested from parents 10 days- 2 weeks post procedure and audit is collated from the data collected. Three parameters are recorded, 1) Did the TTD help with breastfeeding, 2) Did the TTD heal well 3) Is baby still receiving breastmilk/breastfeeding? The audit results should be reviewed annually

  Alternatively, a referral can be arranged via the local GP to Paediatric ENT Consultant Surgeons.

Maternity services in Cardiff and the Vale are able to assess and support parents with babies having breastfeeding challenges related to tongue tie during the postnatal period (up to 28 days old). Older babies can be referred to their GP for referral to Paediatric Ears/Nose/Throat (ENT) surgery. **This pathway does not accept referrals from primary care/GPs or HV (relating to older babies).**

Bristol Tongue Tie Assessment Tool (BTTAT)

	0	1	2	Score
Tongue tip appearance	Heart shaped	Slight cleft/notched	Rounded	
Attachment of frenulum to lower gum	Attachment at top of gum ridge	Attached to inner aspect of gum	Attached to floor of mouth	
Lift of tongue, with mouth wide (crying)	Minimal tongue lift	Edges only to mid-mouth	Full tongue lift to mid-mouth	
Extension of tongue	Tip stays behind gum	Tip over gum	Tip can extend over lower lip	

Score: **0-3** = Severe restriction **4-5** = Borderline **6-8** = Not needed

Follow up and Audit

Parents should be asked to attend a Seren Clinic for a follow-up at 1-week post procedure. The following data is recorded.

Frenulotomy (TTD) Follow-up

1. Did having a frenulotomy help with breastfeeding?	YES / NO
2. Did the frenulotomy heal well?	YES / NO
3. Is baby still breastfeeding /receiving breast milk?	YES / NO

Comments from parents

……

……..

……..

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Maternity, Adoption and Paternity Guidance Notes Appendix 5 Guidelines on combining breastfeeding and returning to work

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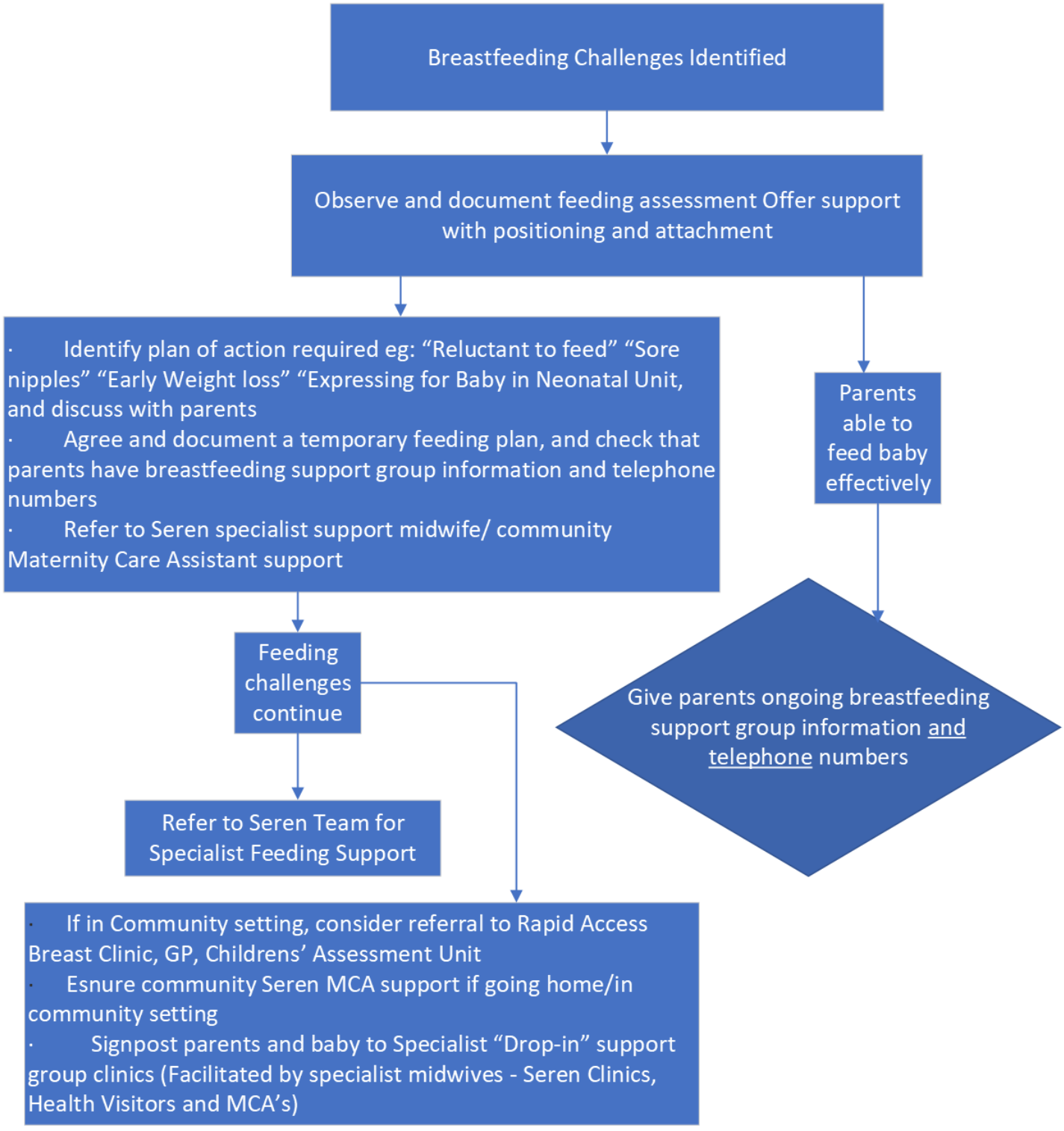
20. Appendices: Flowcharts and Patient Information Sheets



19. SUPPLEMENTARY FEED FORM

Please complete one form for every reason a supplement is given to a breastfed baby

Mother's Name: _____

Date and time of formula supplementation……
Document reason for supplementary feed: "mothers request" not enough – parents should have the information overleaf discussed to allow for "mother's ***informed*** request"

1. Did you discuss how a formula feed may affect breastfeeding? YES ☐ NO ☐
2. "Top Tips" supplementation information given

   (or information on the back of this form) YES ☐ NO ☐

3. What other action did you take to help / reassure mother?

   a. Encourage skin contact: YES ☐ NO ☐

   b. Help to hand express : YES ☐ NO ☐

   c. Explanation of how baby-led feeding works: YES ☐ NO ☐

4. How was supplement given? (please tick) syringe ☐ NG tube ☐ cup ☐ bottle ☐
5. If the supplement was given with a bottle, was nipple/teat confusion discussed?

   YES ☐ NO ☐

Name of midwife (please print)……

This section to be completed by Infant Feeding Advisor:

Supplement given was:

- *Clinically indicated with optimum care given*
- *Clinically indicated but care could be improved*
- *Fully informed maternal choice*
- *Maternal request without fully informed choice*
- Staff suggestion for non-clinical reasons

Before you give your baby a formula feed

Unless there is a medical reason, breastfed babies are advised not be given extra formula milk.

To help you make an informed choice, we would ask you to read this information sheet before you give formula milk to your baby.

Formula milk feeds may:

- Reduce your milk supply -Giving formula milk to a breastfed baby can reduce your milk supply. Your baby's eagerness to breastfeed will be less. As your baby will not want to feed as often from your breast, your milk supply is not being stimulated.

Babies need at least 8 feeds in 24 hours, including at night, (as your breastfeeding hormones are higher at night) - if your baby feeds

- Increase your baby's risks to develop gastro-intestinal infections i.e. vomiting and diarrhoea.
- Occasionally, especially if you have a family history of allergies (including eczema or asthma), giving formula milk to very young babies can increase your baby's risk to developing allergies.

20. Supplementation for Medical Reasons

This guidance includes all breastfed babies having paediatric support on thepostnatal ward e.g.; transitional care, babies having phototherapy, babies "atrisk" of hypoglycemia with BM's below 2.6mmol/l (see "Hypoglycemia Policy"for requirements)

Good practice tips:

- Feed at least every 3 hours but offer the breast whenever baby showsfeeding cues (regardless of scheduled feeding time).
- Observe the feed from beginning to end. Ensure correct attachment and ensure the baby maintains an effective suckling pattern. Listen foraudible swallowing. Monitor wet and dirty nappies/appropriate for baby's age.
- Teach a mother how to recognise effective milk transfer (smallstimulatory sucks, followed by long deep "drinking" sucks and SWALLOWING).
- Feeds should be counted from the beginning of the feed e.g. started at3pm, next feed starts at 6pm.
- Encourage the mother to stimulate baby (skin-to skin/changing thenappy etc) approx. 10 minutes before offering the breast.
- Initial attempts may only involve licking or mouthing the breast somaintain a positive attitude to the mother.
- If the baby is not feeding effectively, encourage the mother to express FREQUENTLY (at least 8-10 times in 24hrs including at night), ideallydouble pump.
- If NG tube feeds are required, they should be given while having skinto skin contact with the mother.
- Once the baby has 3 consecutive good feeds, either at the breast orwith a cup, remove the NG tube.
- **Milk Supplementation Guide**

Always use expressed breast milk in preference to formula (EBM) if available,using a cup to feed baby

Not interested / sleepy	→	full supplementary feed
Interested in breast but doesn't latch on	→	full supplementary feed
Latches on to the breast but falls asleep on the breast after little or no suckling	→	full supplementary feed
Latches on but suckling is uncoordinated with frequent long pauses	→	½ supplementary feed
Latches on, long slow rhythmical suckling & swallowing but only feeds for 5 minutes	→	½ supplementary feed
Latches on, long slow rhythmical suckling & audible swallowing, for long feed. Plenty of wet and dirty nappies appropriate for baby's age	→	NO supplementation

21. Hand Expressing Breastmilk

When should I start to express?
It is important to start expressing as soon as possible, and before baby is 6 hours old (the sooner the better). Ask staff for help and expressing syringes/equipment.

How often should I express?
You should express early and often, at least, 8-10 times in 24 hours including **at least once during the night** to make sure you make a good milk supply for your baby.

Why is it best to hand express for the first couple of days?
It is best to hand express for the first couple of days because you will be able to give every drop of colostrum to your baby rather than risk losing any of it in the pump tubing (if you use a pump)

Why do I need to express at night?
The hormone that produces milk is highest during the night. Therefore it is important that you also express **at least once during the night** to make a good milk supply.

Expressing should be pain free.

Why do I need to massage before expressing?
Massage your breasts gently for a few minutes before expressing. Massaging stimulates your "let down" or milk ejection reflex and will help to drain the breast effectively. If your baby is in the Neonatal Unit have a picture of the baby nearby as this will also stimulate your milk supply.

When can I start to use a pump?
Gradually over the next few days your milk will increase and once you are expressing on average 5-10mls per session, it may help to move on to double pumping with an electric pump.

Why "double pump"?
Using a pump to express milk from both breasts at the same time can increase the volume of milk you produce and the amount of fat in your milk. You many find that using an old bra with holes in the right places helps to hold the pump attachments in place. Made sure you are using the correct size funnels and that they are not digging into your breast and impeding the milk flow.

MORE STIMULATION = MORE MILK

The most important determining factor for your milk supply is the 24 hour volume at two weeks. You are aiming to get the volume around 750mls -1000ml/day by two weeks.

Please ask for help!

22. CHART FOR MOTHERS EXPRESSING

If you want to keep a record of how much you are expressing, please complete the chart below.

Date	Time	Volume
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	

23. Sore/Damaged Nipples

Plan of care:

- Express and rest your nipples until healed-see below.
- Cup feed expressed breast milk at least 8 times in 24 hours including at night
- Respond to baby's feeding cues

1. **Express**: **no fewer than** 8 times in 24 hours. Remember the more you express, the more milk you produce. Express from one side for **two minutes after** it stops dripping. Then express from the other side. Repeat until milk stops flowing. You can add to expressed breast milk to milk already expressed that day.

However, if no milk is flowing, express for 5 minutes on side, then5 minutes the other over a period of 20 minutes

2. **Give your expressed breast milk to your baby**: preferably witha cup to avoid nipple and teat confusion (different sucking action with a teat as to breastfeeding). Staff will teach you how to cup feed before you go home.

However, if you find this too difficult or your baby is dribbling all your expressed breast milk, then use a bottle and teat using a "breastfeeding and paced feeding method"(See You-tube for examples). This means encouraging baby to "root" for the teat by tickling babies' top lip. When baby's mouth is open wide then aim the teat towards the hard/soft palate junction. Support baby's shoulders rather than head as baby's head needs to tilt back. Teat as similar in shape as possible to the shape and feel of Mums' nipples. Never "force" feed your expressed milk in a bottle – the babies experience should be as close as possible to a breastfeed, to avoid the risk of nipple/teat confusion If no milk or minimal milk is expressed, you may need to give additional formula, just enough to settle your baby until the milk supply increases. Please read the Top Tips information before you give formula so you can make an informed choice.

3. **Demand feed your baby:** watch for feeding cues. On average new-born babies feed 8-12 times in 24 hours. If you think your baby has gone a long time (over 6 hours) without a feed, wake him up. Keep a record of the number of feeds your baby has in 24 hours. See chart overleaf.

4. **How to know the baby is getting enough**: note the number of

wet and dirty nappies.

a. By day 3: the stools should be changing colour/more wet nappies.
b. By day 5-6: on average four yellow stools and 5-6 wet nappies per day.

5. **Treatment for sore nipples:** if your nipples are cracked, it's worth applying some breast milk to the sore area. If you apply Jelonet dressings, remember to change frequently and remove before feeding. Purified lanolin is another option as long as you test to check you're not allergic to this.

6. **Once you feel ready to try again,** offer the breast. Please try and attend a breastfeeding support clinic as a skilled breastfeeding specialist can ensure your baby is latched on well (see breastfeeding support list). Remember if you have pain throughout the whole feed or your nipple is flat at the end of a feed, the baby has not latched on well, and you need to seek skilled support.

24. Neonatal Unit Admissions

EXPRESSING MILK FOR YOUR PREMATURE BABY IN THE NEONATAL UNIT

When should I start to express?

If your baby has been transferred to the Neonatal Unit (NICU) then you will need to express your milk instead. ***Start straight away*** within two hours of giving birth (ask staff to help you) You will need to hand (and or) double electric pump express at least as many times as your baby would be feeding at the breast.

*You will need to **express** at least 8-10 times in 24hours including at least once between 1-5am* (hormones are at their best in the early hours)
This is to match a baby's usual feeding pattern. Ideally you should be supported to hand (and or) double pump at least X2 by the time baby is 6 hours old.
This expressed milk should then be taken straight up to neonatal unit to be fed to your baby.

When should you start using a breast pump?

The hospital grade breast pumps have a programme which mimics a premature baby suck, and this helps stimulate your feeding hormones. You should use the "Initiate" pump programme as soon as possible following birth in combination with hand expressing. Remember that hand expressing first means your baby will receive any small amounts of colostrum available (like a first "vaccination" of antibodies). Gradually over the next few days your milk supply will increase. Once you begin expressing on average 20mls per pump session, or baby is over 5 days old, then change to using the "maintain" programme, on the electric pump.

Why "double pump"?

Using a pump to express milk from both breasts at the same time can increase the volume of milk you produce and the amount of fat in your milk. You may find that using an old bra with holes in the right places helps to hold the pump attachments in place. Made sure you are using the correct size. Expressing should be pain free.

Why do I need to massage before expressing?

Massage your breasts gently for a few minutes before expressing. Massaging stimulates your "let down" or milk ejection reflex and will help to drain the breast effectively. Having a picture of your baby nearby or expressing on the neonatal unit next to your baby will help stimulate your milk supply. You can also keep a soft cloth next to your skin as this can be put into your babies' cot so he/she can smell you. Your scent and the sound of your voice are important in helping your baby feel safe. As soon as possible ask for skin-to-skin cuddles with your baby.

How long do I need to express?

If you are using an electric pump, start the vacuum on the lowest setting and gradually increase until you feel comfortable. Be aware, too high a suction can be as bad as too little suction. Express until all your milk available is removed and then for another few minutes

MORE STIMULATION = MORE MILK

The most important determining factor for your milk supply is the 24-hour volume at two weeks. You are aiming to get the volume around 750mls -1000ml/day by two weeks.

PLEASE ASK FOR HELP!

25. Treatment of Mastitis: Guideline and Info Sheets

Mastitis means ***inflammation*** of the breast.

The first sign of mastitis is a swollen usually painful area on the breast. On darker skin tones there might be a darkening of the skin and on lighter skin tones this might be visible as a red area on the breast. However, it is important to note that there could be no visible change in skin colour at all. The inflammation and swelling is not always a sign of infection (WHO, 2000). Harmful bacteria are not always present: antibiotics may not be needed if self-help measures are started promptly. Very rarely mastitis can develop into a more serious condition which needs urgent hospital admission and IV antibiotics (RCOG, 2012). You may get mastitis when milk leaks into breast tissue from a blocked duct. The body reacts in the same way as it does to an infection – by increasing blood supply. This produces the inflammation.

The Signs of Mastitis

- A localised area in the breast which is painful to the touch, often in the outer upper area. Some mums might notice a change of colour or a red area on their breast,
- A lumpy breast which feels hot to touch,
- The whole breast aches and may appear swollen and skin may be reddened or darker, depending on skin tone,
- Flu like symptoms - aching, increased temperature, shivering, feeling tearful and tired (Jahanfar et al., 2013). This feeling can sometimes start very suddenly and get worse very quickly NB You may not have all of the above signs during mastitis.

Prevention of mastitis

- Try to avoid suddenly going longer between feeds. If you are intending to reduce breastfeeding, cutting down gradually reduces the risk of mastitis,
- Make sure your breasts don't become overfull,
- Avoid pressure on your breast from clothing and fingers,
- Start self-help measures at the first sign of any lumpy or swollen areas on your breast.

Factors which make mastitis more likely

- Difficulty with attaching your baby to the breast - this may mean that the milk is not being removed effectively and milk may leak into the breast tissue,
- Pressure from tight fitting clothing, particularly your bra, or a finger pressing into the breast during feeds,
- Engorgement or a blocked duct,
- Sudden changes in how often the baby is feeding, leaving the breasts feeling full,
- Injuries, such as bumps or knocks from toddlers.

Mastitis starts with poor milk drainage. If your baby is not effectively attached to your breast, or has difficulty feeding, it may be hard for the baby to remove the milk and some parts of your breast may not be drained during a feed. Improving the way your baby is attached at the breast will reduce the chance of you getting mastitis again. If in doubt, contact your midwife, health visitor or breastfeeding peer supporter for help with attaching your baby for feeding. You can also contact the National Breastfeeding Helpline.

Signs that the baby is well attached

- Your baby's chin is firmly touching your breast.
- Your baby's mouth is wide open
- Your baby has a large mouthful of breast.
- If you can see the darker skin around your nipple, you should see more dark skin above your baby's top lip than below your baby's bottom lip.
- It doesn't hurt you when your baby feeds (although the first few sucks may feel strong).
- No change in shape or colour of the nipple after feeds e.g. it should not be lipstick shaped or have a pressure line across the nipple
- Your baby's cheeks stay rounded during sucking.
- Your baby rhythmically takes sucks and swallows (it is normal for your baby to pause from time to time).
- Your baby finishes the feed and comes off the breast on his or her own.
- Your baby produces 6 or more heavy wet nappies every 24 hours (from 7 days old)
- Your baby produces at least two yellow poos at least the size of a £2 coin every 24 hours (from 7-28 days old). See UNICEF's breastfeeding checklist for more details. Breastfeeding assessment tool - maternity (unicef.org.uk)

If your mastitis comes back after you have taken a full course of antibiotics, or is unusually severe, it is good practice to send a sample of milk for bacteria tests. This will help the GP chose the correct antibiotic for your symptoms (Jahanfar et al., 2013).

For public health reasons doctors try to avoid antibiotics that are not essential or are unlikely to be effective. It is important that you finish the whole course of antibiotics to make sure that you recover fully and to help prevent the mastitis coming back with resistant bacteria (NICE NG15).

Self-Help measures These will also help to clear blocked ducts and engorgement. Most cases of mastitis can be improved or resolved with self-help measures.

- Keep on breastfeeding - you may feel ill, in pain, tearful or discouraged but continuing to breastfeed will help you to get better, and your breastmilk is still the best food for your baby,
- Feed your baby frequently and responsively (whenever your baby seems like they want to feed), and/or pump to your normal routine (Mitchell et al., 2022; Douglas 2022),
- Don't attempt to "empty the breast" by prolonging feeds or expressing extra milk between feeds. You may see this suggested in some places, but the current research suggests you should aim to meet your baby's needs, but avoid increasing your supply beyond that as it could make the inflammation worse. (Mitchell et al., 2022; Douglas 2022),
- Try to rest as much as you can, as this will help you recover,
- Check that your baby is effectively positioned and attached to your breast - if in doubt seek help from your midwife, health visitor or breastfeeding supporter, as even a minor tweak can make a difference,
- Try feeding with your baby in different positions,
- If necessary, soften your breast, by expressing a little milk or running warm water over it, so

that the baby finds it easier to feed well,

- Some mothers find warm compresses are soothing, and warmth on the nipple can aid let-down. However, take care using these as compresses that are too hot or used frequently could increase swelling and inflammation. Cool compresses may ease symptoms in between feeds. (Mitchell et al., 2022; Douglas 2022),
- Avoid any firm pressure or massage to the breast, or use of items such as an electric toothbrush to massage lumps or sore areas. This could cause tissue damage and increase inflammation (Mitchell et al., 2022; Douglas 2022). Any pressure you apply to your breast should be no firmer than stroking a cat,
- Check for clothing or anything else which is pressing into your breast. This includes a bra – some women find it helpful to go without. If you feel these symptoms beginning again, start self-help measures right away.

When should I contact my GP or health visitor?

If you do not begin to feel better after 24 hours despite using self-help measures, or especially if you start to feel worse, you should speak to your GP or health visitor. You may need to take antibiotics. You should contact your GP if the area becomes round and swollen or, if you can see redness or a change of colour on your skin and the pattern of the colour change/redness changes. Redness may be less visible on darker skin tones. Mastitis can develop into an abscess (a painful collection of pus). There is more information about this here: https://www.nhs.uk/conditions/breast-abscess/.

When should I seek help urgently? If you feel seriously unwell, dizzy, confused, develop nausea, vomiting or diarrhoea or slurred speech along with the symptoms of mastitis you need to seek urgent medical attention. These can be signs that mastitis is developing into sepsis. If severe, this is a medical emergency which needs urgent hospital admission and IV antibiotics. (NHS Choices: Sepsis, RCOG, 2012:6.1).

Medical treatment for Mastitis -

This information comes from the Drugs in Breastmilk Service.

- Ibuprofen reduces the inflammation, relieves pain and reduces temperature. Take 400mg three times a day after food. Ibuprofen should not be taken by women who have asthma, stomach ulcers or are allergic to aspirin. The levels of ibuprofen which pass to the baby are small. Ibuprofen is safe to take whilst breastfeeding. See https://www.breastfeedingnetwork.org.uk/analgesics/ for more information
- Paracetamol relieves pain and reduces temperature but has no anti-inflammatory action. Take two 500mg tablets four times a day.
- Aspirin should not be taken by breastfeeding mothers.
- Antibiotics may be needed if no improvement is seen with self-help measures. Most antibiotics can be safely taken whilst breastfeeding.

The World Health Organisation (WHO) recommend Flucloxacillin 500 milligrams four times a day as first line treatment with erythromycin 250-500 milligrams four times a day or cefalexin 250-500 milligrams four times a day if the mother is penicillin allergic.

Other options have been suggested by Jahanfar et al., (2013). It is essential that breastfeeding is not interrupted during mastitis. Note: Antibiotics can make the baby produce loose, runny motions and become irritable, colicky and restless. This lasts for a short time and will get better when you finish the antibiotics. BfN-Mastitis-Leaflet-December-22.pdf (breastfeedingnetwork.org.uk)

How to hand express your breast milk

1. Collect your colostrum with the sterilised syringe, and if necessary, decant to the larger sterilised container. Colostrum is very concentrated and will come out of your breast drop by drop. At first, only a few drops will come out at each session, but with practise and time, the volume will increase.

1. To collect your expressed breast milk, you will need a clean, sterilised container. If you are expressing colostrum, you will also need a clean, sterilised syringe. Make sure you have these items ready before you start.

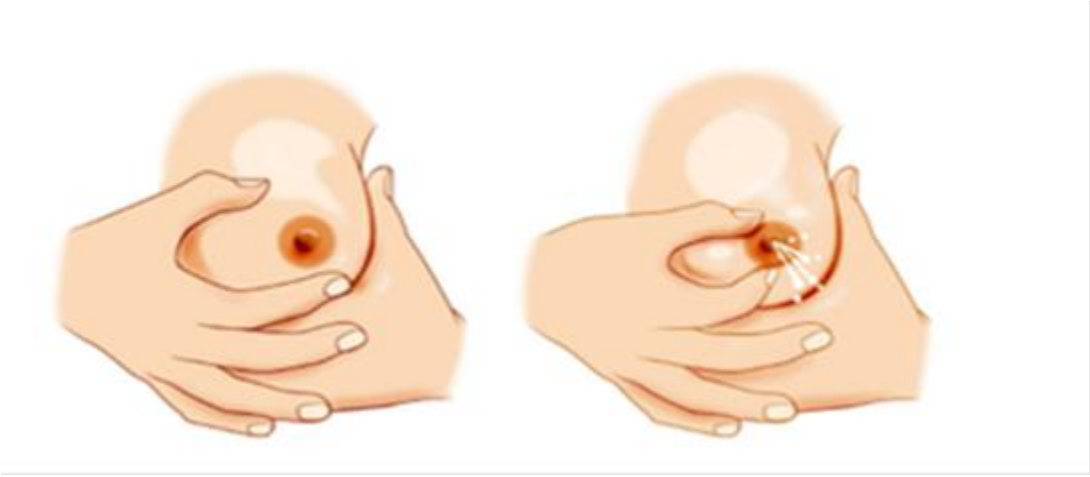
2. Make yourself comfortable and try to relax. Warmth will help, so try expressing in the shower or bath first. You can gently massage your breasts with a warm flannel.

3. Use your hand to cup one of your breasts. Your hand should be in a 'C' shape around the nipple, with four fingers under your breast and your thumb at the top. Your thumb and fingers should be about 2 to 3cm away from the areola (the darkened area of skin around your nipple).

4. Use your thumb and index finger to gently squeeze. Release the pressure and then repeat to create a rhythm. This shouldn't hurt. Avoid sliding your fingers over your skin as this may cause discomfort. If the colostrum doesn't flow, try moving your fingers slightly towards the nipple or further away, finding the spot that works best for you. You could also try gently massaging your breast.

5. When the drops slow down, move your fingers round to try a different section of your breast and repeat.

6. Repeat the process for your second breast. (Hand expression video - Baby Friendly Initiative (unicef.org.uk))



Paced Feeding

Guide the teat gently into the baby's mouth to ensure the baby is indicating they are ready to take a feed. Similarly, the bottle is only raised if the baby starts to suckle, another indicator of readiness to feed. By pacing his/her intake the baby is given the opportunity to recognise when he is full. It is good practice to alternate the side a bottle-fed baby is held at each feed, to ensure equal optical stimulation and skeletal balance. (Bing Videos)

Advantages of cup feeding a baby

- The baby learns to coordinate their breathing and swallowing during the feed,
- The active tongue movement required to cup feed mimics the motion needed for the baby to remove the milk from the ducts when breastfeeding,
- The baby can pace their feed, enabling them to control the flow and volume of the feed. Posseting is less likely during a cup feed,
- When cup feeding the baby's heart rate, respiratory rate and oxygen saturation levels are maintained. There also appears to be less risk of Broncho aspiration and apnoea compared to bottle-feeding and nasogastric feeds,
- Cup feeding may reduce the need for a nasogastric tube,
- The baby needs to be held while cup feeding, promoting relationship building and stimulation rather than the passive feed via a tube,
- It can increase the rate of exclusive breastfeeding at discharge.

(How to cup feed a baby – to be made as appendix)

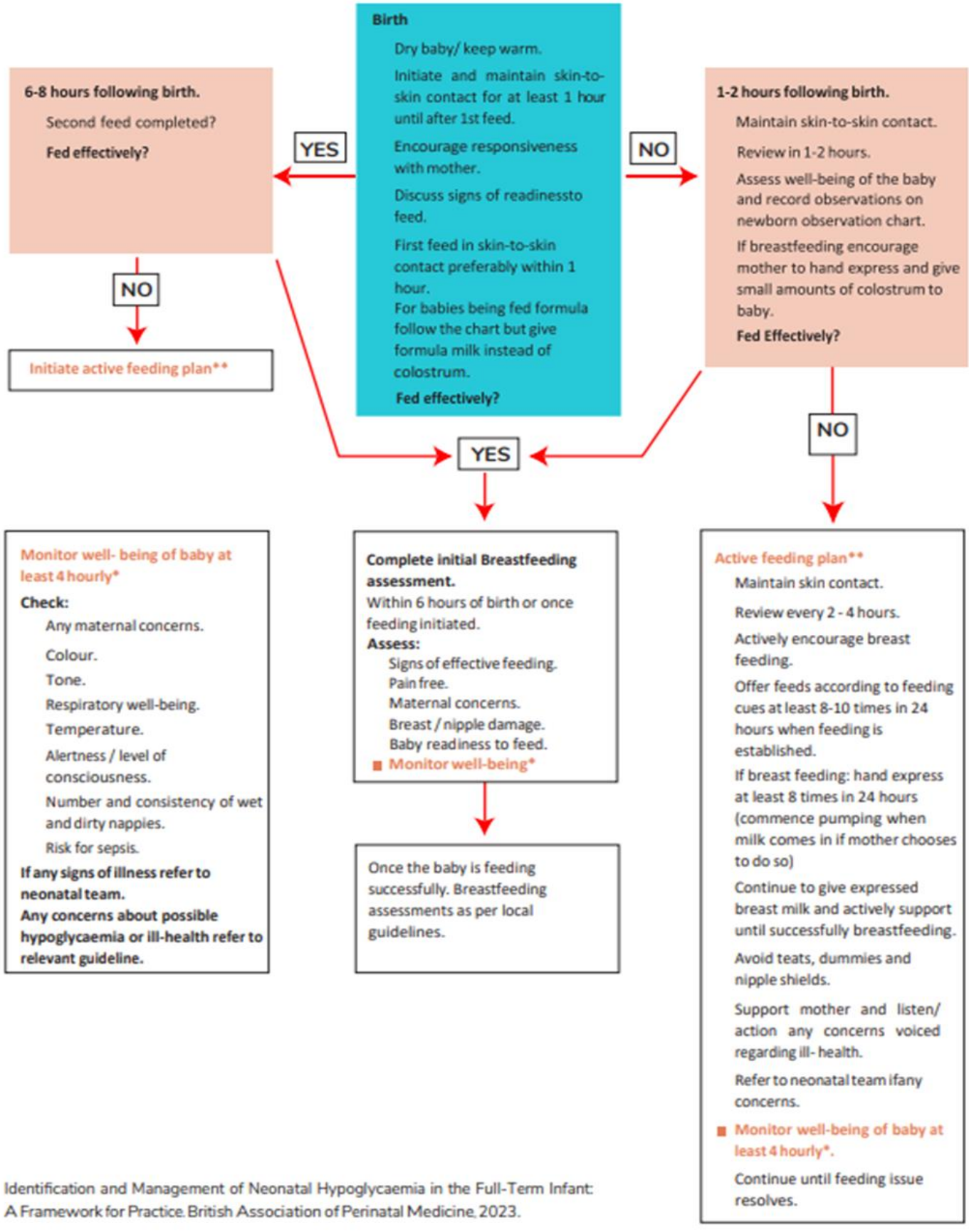
Wash and dry hands thoroughly as per trust guidelines.

- Only specifically designed cups should be used which are pre-sterilised single use,
- Ensure that baby is fully awake and alert This document is uncontrolled once printed. Please check on the Trust's Intranet site for the most up to date version,
- Try to have the cup half full,
- The cup should be tilted to allow the milk to just touch the baby's lower lip. NEVER pour the milk into the baby's mouth,
- The rim of the cup should be rested on the lower lip,
- The baby will lap the milk from the cup using its tongue.

The cup should be left in the correct position during the feed including when the baby stops drinking. It is important to allow the baby to take as much as he/she wants in his/her own time. Wind the baby during the feed if required. As cup feeding should only be used as a short-term method of feeding, it is important to continue to help establish breastfeeding before discharge home, this includes a full breastfeeding assessment documented.

26. Management of Reluctant to Feed Healthy, Term Infants

Flowchart D. Management of reluctant feeding in healthy term infants ≥ 37 weeks



Identification and Management of Neonatal Hypoglycaemia in the Full-Term Infant: A Framework for Practice. British Association of Perinatal Medicine, 2023.

Suspected Tongue-tie Referral Pathway

- Midwife suspects tongue restriction**, after providing skilled breastfeeding support if mother is experiencing sore nipples and breastfeeding difficulties**
- Discuss with parents, observe a feed and agree a feeding plan if necessary, including referral to Specialist Breastfeeding (Seren) Clinic. Document in mothers postnatal care pathway.

Breastfeeding challenges continue, **despite good positioning and attachment skills**?

YES **NO**

Support mum to express her milk/ put baby to the breast (at least x8 in 24 hours including at night) and give expressed breast milk (EBM) to baby via cup until seen by Infant Feeding Coordinator/Seren (IFC) for feeding assessment.

Continue to breastfeed baby and access breastfeeding support, including clinics/groups as required

Refer to Seren Clinic or Infant Feeding Lead (IFL) for Assessment

- **Infant Feeding Lead with appropriate experience in Tongue-tie assessment** to perform feeding assessment of breastfeeding technique and if tongue-tie suspected, to score tongue using BTAT/TABBY
- If frenulotomy indicated, IFL to discuss and offer review with tongue-tie practitioner.
- The procedure will be fully explained to the parents using Cardiff and Vale NHS UHB Tongue-tie leaflet (see appendix)
- Referral to Tongue-tie Clinic, based on Midwifery-Led Unit to be completed by Infant Feeding Lead or Tongue-tie Practitioner midwife.
- Follow-up with Seren team who will offer ongoing skilled breastfeeding support as required.
- Follow up is requested from parents 10 days- 2 weeks post procedure and audit is collated from the data collected. Three parameters are recorded, 1) Did the TTD help with breastfeeding, 2) Did the TTD heal well 3) Is baby still receiving breastmilk/breastfeeding? The audit results should be reviewed annually

  Alternatively, a referral can be arranged via the local GP to Paediatric ENT Consultant Surgeons.

Maternity Services in Cardiff and the Vale are able to assess and support parents with babies having breastfeeding challenges related to tongue tie during the postnatal period (up to 28 days old). Older babies should be referred to their GP for referral to Paediatric Ears/Nose/Throat (ENT) surgery.

This pathway does not accept referrals from primary care/GPs or HV (relating to older babies).

REFERRAL FORM FOR TONGUE TIE ASSESSMENT
TO BE COMPLETED BY INFANT FEEDING/SEREN LEAD

Mother's Name: Address: Hosp No: DOB:	Baby Hospital Number:……. Vitamin K given at birth YES / NO Family Hx of bleeding disorders? YES / NO

Date……..Tel no…….

Name of baby……..……..

Date of birth……. Age at referral……..……

Birth weight……. Weight at time of referral…….....

Referred by…….……..

History ……..……

……

……

Discussion with parents, information sheet given and parents aware of effectiveness of procedure and potential risk of infection.

Tongue-tie Practitioner (signature) …….

Consent for frenulotomy (parent signature)……..

Frenulotomy performed Yes No

Date frenulotomy performed…….by whom?.....

Breastfeeding at 1 week post procedure Yes No

Notes……

……..

……

Tongue-Tie Information for Parents

What is a "Tongue-Tie"?

The babies' tongue is tethered, or tied, to the bottom of the inside of the mouth and restricts movement. The amount of "tethering" varies. It may be mild where the tongue is bound only by a thin mucus membrane (**frenulum**), or it may be more severe where the tongue is completely attached to the floor of the mouth.

How is "Tongue-Tie" identified?

Tongue-tie is not always readily seen and may not be diagnosed until or if breastfeeding difficulties occur.

How does it cause issues?

A baby needs to make a rippling action with their tongue, pushing the nipple and areola to the roof of their mouth to release milk. If the baby is unable to do this, due to restricted tongue movement difficulties can occur

- Sore or damaged nipples
- Mastitis
- Baby may not settle following feeds
- Baby want to feed very frequently
- Baby weight gain difficulties

What can help?

- Breastfeeding should be closely monitored and skilled assistance will be offered with positioning and attachment your midwife will refer you and your baby to a Seren Clinic for further support.
- If breastfeeding cannot be improved after this assessment, the breastfeeding advisor will discuss a procedure called **frenulotomy** or tongue-tie division
- A full explanation about this procedure and the benefits/contraindications will be discussed with a breastfeeding specialist, and if necessary, an appointment arranged for the procedure to be performed

What happens at frenulotomy?

Tongue-tie division in small babies with mild tongue-tie is usually a simple, safe and virtually painless procedure. It involves dividing the tissue between the frenulum between the tongue and the bottom of the mouth and takes a matter of seconds. It does not require a general or local anaesthetic. Some babies may cry for one to two minutes after the procedure, and a couple of spots of blood may occur, but many babies will sleep through it all. Breastfeeding can restart immediately after the procedure and the breastfeeding advisor will provide ongoing technical support to enable normal breastfeeding to continue.

Neonatal Tongue Tie Division

Follow up care

Please can you attend a breastfeeding support clinic 1-2 weeks after the procedure so that a Seren Midwife can check the following

1. Did it heal well?
2. Did it help with breastfeeding?
3. Are you still breastfeeding/giving breast milk to your baby?

Alternatively, please email your follow up comments to: Seren.cav@wales.nhs.uk

Please include the baby's name and date of birth

IF YOU SUSPECT ANY PROBLEMS PLEASE CONTACT YOUR GP

Useful Contact Telephone Numbers

First Floor Maternity UHW	02920743343
Seren (Infant Feeding) Team	02920743214
Seren Mobile 1	07966697550
Seren Mobile 2	07813549510
Midwifery Led Unit UHW	02920745196
NCT (National Childbirth Trust)	0300 330 0771
Breastfeeding Network	0300 100 0212
La LECHE LEAGUE	0845 120 2918

Useful References

National Institute for of Health and Clinical Excellence 'Division of ankyloglossia (tongue tie) for breastfeeding' (2005)

Ingram J, Johnson D, Copeland M et al. The development of a tongue assessment tool Arch Dis Child Fetal Neonatal Ed 2015;100:f344-f348

Useful Websites

www.unicef.org/babyfriendly
https://www.breastfeedingnetwork.org.uk

Leaflet updated October 2025

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board