Guidelines for the Prevention, Identification and Management Weight Loss in Healthy, Term Breastfeeding Babies in the Early Postnatal Period

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The latest approved version of this document is online.
If the review date has passed, please contact the Author for advice.

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Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	May 2017
2	All Wales document not updated. Adapted Betsi Cadwaladr Weight loss policy and added amendments and updates regarding infant feeding. Title amended to include prevention	Sept 2023

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document.

Role / Designation
Infant Feeding Co-ordinator

Circulated to the following for Consultation.

Date	Role / Designation
8/6/2023	PTHB Midwifery
8/6/2023	PTHB Health Visitors
8/6/2023	Womens & Childrens Guideline Group

Groups Approved at

Date	Group
7/8/2023	Maternity guidelines Group

Evidence Base
Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area? NICE (2017) Faltering growth: recognition and management of faltering growth in children. https://www.nice.org.uk/guidance/NG75 UNICEF (2023) Baby Friendly initiative

Equality Impact Assessment Summary					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** Please remember policy documents are published to both the **intranet** and **internet.** The version on the internet must be translated to Welsh.
Age	■				
Disability	■				
Gender reassignment				■	
Pregnancy and maternity				■	
Race	■				
Religion/ Belief	■				
Sex				■	
Sexual Orientation	■				
Marriage and civil partnership	■				
Welsh Language	■				
Human Rights	■				

Risk Assessment Summary

Have you identified any risks arising from the implementation of this policy / procedure / written control document?

No

Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document?

No

Have you identified any training and / or resource implications as a result of implementing this?

No

Policy Statement / Introduction

Basic understanding of the physiology of breastfeeding shows that early, frequent, and effective breastfeeding is essential to initiate a successful milk production immediately post birth. However, Weight loss in the immediate first few days of life is a normal physiological process where the extra-cellular fluid is excreted after birth, and this should not be highlighted as pathological.

Normal new-born weight loss is expected to be up to 7- 10% of the baby's birth weight; however, this is not an evidence-based finding and is very outdated. Recent studies (Dewey et al, 2005 & Macdonald, 2003) show that a normal weight loss is more likely to be between 5-7% of birth weight.

We know that weight loss is likely to stop after 3 or 4 days of life (NICE, 2017). This is due to the commencement of lactogenesis 3 around the same time, however the evidence also suggests that factors which occur at birth and postnatally can have a negative effect on lactation and therefore is more likely to result in an excessive weight loss, please see point 6 for details.

Even though we acknowledge that it is normal for neonates to lose up to 10% of their birthweight, there may be reasons for concern about weight loss in the early days of life, which may need assessment and intervention, especially if it goes above 12% of birth weight or there is other clinical concerns (NICE, 2017).

Midwives play an important role in providing support with positioning and attachment to aid effective milk transfer and adequate milk production. Midwives also play a key role in educating parents around the importance of neonatal hunger cues, importance of regular feeding and the risks of supplementation on lactation and the neonatal microbiome.

It is known that excessive weight loss usually occurs due to:

- Ineffective milk transfer, due to ineffective positioning and attachment
- Infrequent feeding, i.e., use of supplementary feeds, use of dummies

Following Day 5 of life it is expected that babies should gain between 20-30g per day until they are over their birth weight, which usually occurs by 3 weeks of age (NICE, 2017)

2 Objective

The aim of this guidelines is to prevent, aid early identification and manage excessive new-born weight loss in the community setting. This guideline is for use by PTHB Community midwives when supporting families with their infant feeding journey.

This guideline will help to outline how to complete appropriate new-born assessments including weight and feeding assessments. It will outline how professionals can manage and implement infant feeding and lactation care

plans in a timely and appropriate manner when weight loss is identified. This guideline aims to protect lactation, support breastfeeding, and maximise human milk being given when there is a weight loss in the neonatal period.

3 Definitions

PTHB – Powys Teaching Health Board

IFC – Infant Feeding Coordinator

OTL – Operational Team Lead / Band 7 Team Lead midwife

BFI – Baby Friendly Initiative

4 Responsibilities

4.1 Head of Midwifery and Sexual Health

The Head of Midwifery and Sexual Health must:

- Ensure all staff read and understand this guideline.
- Arrange regular review to monitor compliance with this guideline.

4.2 Assistant Head of Midwifery and Sexual Health Services

The Assistant Head of Midwifery and Sexual Health Services has responsibility for:

- Ensuring dissemination of this document to all relevant staff

4.3 Band 7 operational team lead (OTL)

The OTL has responsibility for:

- Ensuring compliance with this document by the teams that they manage
- To fully understand and work within this document
- To ensure all midwives within their team are aware of this guideline and follow it within their practise.
- Highlight any additional training needs of staff surrounding infant feeding to the infant feeding coordinator.

4.4 Infant Feeding Coordinator and Infant Feeding Champions

The IFC and infant feeding champions have responsibility for:

- Ensuring promotion of the use of this guideline
- Reviewing any evidence that may lead to changes to the document.

4.5 Women and Children's Risk and Governance Lead

The Women and Children's Risk and Governance Lead has responsibility for:

- Monitoring review of incidents in relation to content of this document

5 Supporting Breastfeeding

5.1. Getting to breastfeed off to a good start.

Midwives play a key role in the prevention of excessive weight loss in the early neonatal period. This can be achieved by ensuring mothers are educated during the antenatal period through at least 3 antenatal conversations throughout their pregnancy. These conversations are documented on the AN conversations page of the All-Wales maternity handheld records and are audited as part of the annual Powys maternity notes audit. Midwives must discuss with all families:

- Benefits of colostrum and breastmilk
- Skin to skin benefits
- Responsive parenting and feeding
- Feeding Cues
- Closeness
- Normal new-born behaviour and pattern of feeding

Midwives also need to ensure that when they are providing intrapartum and immediate postnatal care to families, they must protect and support uninterrupted skin to skin for at least 1 hour or for as long as the mother wishes and until at least after the first feed has been achieved (unless there are clinical concerns). Mothers should not be asked how they wish to feed their baby prior to the moment when baby is in skin to skin, and support can be offered.

Mothers should not be discharged from the birth centre environment/ midwife should not leave the home environment until they have observed an effective feed.
All mothers must be taught to hand express prior to discharge and provided with syringes by midwives.
Mothers must be encouraged to offer the breast at least 8-10 times in 24 hours and if baby does not feed to hand express and give EBM.
Midwives must explain that the breasts produce milk in response to stimulation, so the more skin to skin, attempts to latch baby and hand expressing in the first 72 hours of life the more likely they are to successfully lactate.

5.2. Assessing effective breastfeeding

Midwives should be confident with their skills and ability to assess a breastfeed and identify any areas of concern.

To fully assess the effectiveness of a breastfeed, midwives should complete the UNICEF assessing a breastfeed tool (APPENDIX 2) within the postnatal records and use their clinical skills. A full infant feeding assessment will comprise of both an observed breastfeed and a full feeding history from parents.

Midwives should be confident in their ability to assess whether a baby is effectively or ineffectively positioned and attached at the breast (See 5.1, 5.2 & 5.3) for details. Midwives should also discuss with the parents:

- do parents have any concerns around feeding
- How often does baby feed and how long is a breastfeed
- Does baby wake for feeds
- What has babies weight loss or gain been like
- Is baby content following a feed
- Output of stools and urine
- What is the condition of the breasts?

If any causes for concern arise, midwives must ensure they document within the postnatal pathway any changes and support they have provided regarding positioning and attachment and any feeding plans they have implemented with the follow up plan clearly evidenced.

5.3. Schedule of breastfeeding assessments

Full infant feeding assessments must be carried out and documented prior to discharge from birth centre/ home (Powys Birth) or at primary birth PN visit (DGH Birth), Day 4 of life and prior to discharge to the health visitor for all babies who receive PN care.
If additional concerns are raised regarding infant feeding including painful feeding, inadequate weight gain/ excessive weight loss then Infant feeding assessments should be carried out at each PN contact.

5.4 Weighing

Method

- Neonatal weight is measured using calibrated, electronic neonatal scales.
- For consistency, wherever possible the same scales should be used.
- Ideally babies should be weighed pre-feed. The relation to feed should be documented as pre or post, especially if there are weight loss issues.
- Weighing should be carried out on a hard, even surface and the baby should be naked.
- Weight should then be documented in the postnatal records and the red book and should be acted upon accordingly.
- Newborns should be weighed in a prone position to reduce cortisol levels and reduce likelihood of initiating startle reflex.

Weighing schedule

- All babies should be weighed at birth, 3-5 days and around 10-14 days of age as part of their feeding and wellbeing assessment, unless concerns arise prior to day 5 (WHO, 2009)
- The birth weight should take place immediately following birth or following at least 1 hour of uninterrupted skin to skin and the first feed (later is preferable unless clinical concerns)

- Babies should be above birth weight prior to discharge to the HV and this should be around day 14 of life (can be up to 21 days)

5.5 Identification of weight loss

Weight loss should be calculated as a percentage using the following formula:

$$\frac{\text{Weight loss (g)}}{\text{Birth weight (g)}} \times 100 = \text{weight loss \%}$$

Weight loss must be documented in the baby's postnatal records and the red book both as grams lost and overall percentage loss.
Good practice is to double check the weight and the calculation.

5.6. Hand over to health visitors

Midwives must ensure that they do not discharge from maternity services until a neonate is above their birth weight or there is an individual care plan in place to support this.
Communication with health visitors is paramount and any issues regarding infant feeding/ weight must be verbally handed over to named health visitor and outlined on the hand over to health visitor form.

5.7 IFC and Infant Feeding Champion Role

Champions and IFC to provide additional support and guidance to clinical staff to implement individual care plans where illness is not suspected, or implementation of feeding plans have been unsuccessful.

6 Midwifery Infant Feeding Tool kit to support with Infant feeding assessments and Care plan implementation.

6.1 Effective attachment

Method

- Place baby Nose opposite nipple
- Let babies head tip back.
- The top lip of baby will brush against nipple initiating a wide gape mouth.
- When baby opens mouth wide, bring baby into breast with head back, chin leading.
- Chin will touch the breast first which will allow baby to get a large mouthful of breast tissue in their mouth, drawing the nipple onto the soft palate.

Signs

- Mother is comfortable.
- Baby has a large mouthful of breast tissue.
- Babies mouth is wide open.
- More areola visible above the top lip than below- symbolised baby latched asymmetrically.
- Baby's cheeks are rounded during feeding.

- Rhythmical suck swallow pattern with normal pauses
- Babys chin is indenting/ touching the breast.
- No change to nipple shape or colour to the nipple following the feed.
- Baby falls off the breast themselves.
- You can see/ hear/ palpate a suck swallow ratio (2:1 after day 3)
- Regular wet and dirty nappies age appropriate

6.2 Effective positioning

CHIN Principles are a useful way of supporting and teaching mothers how to get baby in a good position so baby can effectively attach at the breast.
Close: baby needs to be close to his mother so he can scoop enough breast into his mouth. Ensure both mother and baby's clothing and hands are not in the way.
Head free: when attaching to the breast, the baby will tilt his head back to allow his chin to lead as he comes onto the breast. Even a finger on the back of the baby's head will prevent this important movement.
In line: the baby's head and body should be in alignment so that he does not have to twist his neck, which would make feeding and swallowing difficult.
Nose to nipple: with mother's nipple resting below baby's nose, he will begin to root. As he tilts his head back, the nipple will slip under his top lip upwards and backwards to rest between the hard and soft palate.

Signs

- Comfortable mother, with back support and not leaning forward onto baby.
- Baby nose to nipple when rooting for feed.
- Nothing touching back of baby's head- including mothers' finger/ hand/ pillow etc.
- Babies head and body in alinement and not twisted at the neck.
- Baby free to root around at the nipple and self-attach.
- Baby closely pressed into mother, allowing the chin to indent and touch the breast first as baby latches.

6.3 Sign of effective milk transfer/ Suck pattern

Ineffective milk transfer is the main cause of excessive weight loss/ or slow to gain weight in new-borns. Signs of effective milk transfer:

- Suck Pattern- initially fast rapid sucks, then more long-drawn-out sucks with pauses
- Audible and palpable suck swallow ratio. This should be 2:1 by day 3 of life or once lactogenesis 3 has been established.
- Baby content while feeding at breast.
- Baby finishes the feed themselves and fall off breast contented.
- Babies output is age appropriate.

6.4 Switch Feeding

Switch feeding is a short-term option that swaps the baby from one breast to the other and back each time the sucking pattern ceases to be a nutritive pattern, i.e., with audible swallows. This allows multiple let downs per feeds and will stimulate the breasts to produce more milk.

6.5 Breast Compression

Breast compression can encourage the let-down reflex, stimulate a sleepy baby to feed and increase milk transfer**.** To do breast compression follow these simple steps:

1. Cup and support your breast with one hand (thumb on one side, fingers on the other).

2. Allow the baby to actively feed unaided, once their suck slows, compress the breast firmly to aid milk flow. You should be able to hear more audible sucks. Hold it squeezed while they continue nursing actively, then release your hand. Ensuring that you are not rubbing the skin of the breast.

3. Rotate your hand around the breast and repeat step 2 on different areas of the breast.

6.6 Supplementation

Caution should be used when introducing supplementation, especially with formula. It is well documented that it is likely to positively affect weight gain, but also likely to cause the cessation of breastfeeding.

Protecting and increasing milk production should always be the outcome of adding in supplementation n in the short term and a plan to withdraw supplementation should be discussed at the first available opportunity.

First line should always be to give expressed breast milk supplementation, however formula may be clinically required with excessive weight loss or prolonged static weight, where mother cannot express enough EBM.

A pragmatic approach would be to feed the baby with approximately 25% of its fluid requirement (150ml/kg/24 hours divided by 4) as supplemental feeds at first (whilst continuing to support lactation and breastfeeding). Midwives need to ensure they monitor output and weight gain for 24 hours following supplementation commencing.

Larger supplements given less frequently may be more protective for breastfeeding and lactation and mothers should be encouraged to express at the time of supplementation (if giving formula) to aid increase in supply. Supplementation should always be given after a breastfeed and not instead of one. Supplemental feeds should not be more than 6 hours apart in this group of babies and breastfeeding and/or breastmilk should

be given in between formula feeds as frequently as possible. Supplementation should reduce once baby's weight has increased and is no more than 12% below birth weight.

Example
3kg baby on day 5: 150ml/kg/24hrs = total 450ml ÷ 4 = **115mls**
115mls given as 19mls after 6 x BF OR 28mls after 4x BF.

Methods of supplementation that can be used:

- Syringe feeding
- Finger Feeding
- Cup Feeding
- Supplementing Nursing System (SNS)
- Bottle (Last preference)

If midwives are supporting a mother to supplement using a bottle, then responsive and paced bottle feeding must be discussed and a bottle-feeding assessment must be completed within the postnatal records.

7. Excessive weight loss may also be anticipated in specific instances such as:

- Primigravida, especially with a short postnatal stay or home birth
- History of infertility
- Polycystic Ovarian Syndrome (PCOS)
- Nipple abnormalities.
- Following Caesarean section – especially in absence of a labour (Preer et al 2012).
- Large ante or post-natal haemorrhage.
- Retained placenta.
- Epidural.
- Long labour
- Large volumes of intravenous fluids (I.V) >2,500 mls (Chantry et al 2011).
- Severe illness of the mother or mental health illness
- Congenital abnormalities.
- Babies born prior to 37 weeks gestation.
- Twins.
- Intra-uterine growth restriction.
- Infection in the neonate.
- Jaw/mouth abnormalities.
- Polycythemia of the neonate.
- Higher birth weight (Regnault et al 2011).
- Overweight or obese mothers (Krause et al 2011).

In these cases, it is important to reassure mothers regarding potential increase risks or excessive weight loss due to these factors and ensuring support / encouragement is given to increase milk supply and confidence in their abilities.

8. Action Plans

A table can be found in Appendix 1 and within the postnatal records for weight loss care plans.

8.1 Care Plan 1: 8-10% Weight loss

- Observe a full breastfeed – use BF assessment tool in postnatal records & ensure effective positioning & attachment.
- Observe for effective suckling & swallowing pattern = efficient milk transfer. 2:1 suck swallow ratio
- If the technique appears good, check for structural reasons for poor attachment e.g., tongue tie, raised palate, retrognathia.
- Promote regular skin contact to encourage feeding behaviors.
- Review feeding "cues" with mother.
- Ensure minimum of 8 feeds in 24 hours,
- Offer both breasts at each feed – stimulate baby in between e.g., change nappy before offering other side.
- Establish plan of care with mother & ask her to keep a daily feed/output diary (BF/PU/BO) and document in the infant feeding care pathway.

Mother & baby should be allocated to daily contacts if any feeding issues identified (virtual or face to face to assess feeding), Reweigh by day 10.

8.2 Care Plan 2: >10%-12% Weight loss

- If any concern regarding baby's condition, consider referral to GP/ pediatrician to exclude underlying illness. IF midwife notes significant P+A issues. Ineffective milk transfer is the likely causation of weight loss continue with Care plan 2.
- Ensure optimal attachment. Support mother to do Breast Compressions to increase milk transfer (see 5.5 for details)
- Consider switch feeding if baby is sleepy after short period on breast (see 5.4 for details)
- Check mother's medical & birth history: Issues that could indicate compromised/ delayed Lactation e.g., RPC, PCOS, thyroid dysfunction, previous breast/nipple surgery, breast/nipple anomalies, hypoplasia, history of infertility, traumatic birth, delayed onset of Lactation i.e., > 72hrs, LCSC, Retained placenta/ products, PPH. If so, allow a further 24-48 hours for the milk supply to establish.
- Support with expressing after feeds with hospital grade pump using double pumping or then single pumping with breast compressions.
- Support parents to 1) offer any EBM obtained via cup/syringe/finger feeding 2) Monitor output.
- Repeat weight check in 24-48 hours – If no or minimal wt. gain (<20-30g /24hrs) move to Plan 3
- *Consider* a discussion via telephone with the pediatrician in DGH.
- Consult with the infant feeding champion in your area/ infant feeding coordinator re: management plan *if* required.

8.3 Care Plan 3: >12% Weight loss

- Refer for medical review by pediatrician at DGH.
- Plan of care to be implemented for intensive breastfeeding support if not kept as inpatient.
- Continue with all aspects of care plan 2.
- Assess breast feeds & top-up required ***
- Give any EBM available + formula as needed via cup/syringe/finger feed/lactation aid.
- Support with expressing after feeds with hospital grade pump using double pumping or single pump with breast compressions.
- If clinically appropriate seek prescription Domperidone (10mg TDS): dependent on the hospital policy where baby is being reviewed.
- Weigh again in 24 hours. Monitor & support closely.
- As Lactation increases reduce formula offered – seek plan from I.F champion.
- Continue to monitor & check weight 2 x week until clear trend towards birth weight/normal weight gain demonstrated (Approx 20-30g/day)

Please ensure a DATIX is submitted for any weight loss >12% or postnatal readmissions

9 Monitoring Compliance, Audit & Review

There are a number of audits that are conducted in relation to breastfeeding and also weight loss that will support audit against this guideline. BFI Supplementation Audit will be completed in cases when supplementation is used – these will be reviewed by the IFC. Also, an antenatal conversation Audit is completed as part of BFI work – these are completed by the IFC.

DATIX submissions for excessive weight loss and neonatal readmissions are completed and are reviewed against this guideline.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

10 References / Bibliography

BREASTFEEDING NETWORK (2023) How to breastfeed. (online)
How to breastfeed - The Breastfeeding Network

NICE (2017) Faltering growth: recognition and management of faltering growth in children

NICE (2021) Postnatal Care Guideline.

UNICEF (2018) Breastfeeding assessment tool for maternity. Online.
Breastfeeding assessment tool - maternity (unicef.org.uk)

Appendix 1

Care Plan	Weight Loss	**CARE GUIDANCE** Top Tip 1: Most common reason for poor weight gain = ineffective attachment and/or infrequent feeding Top Tip 2: Always re-check weights & calculations as mistakes can be made
1	8-10%	• Observe a full breastfeed – use BF assessment tool in postnatal records & ensure effective positioning & attachment. • Observe for effective suckling & swallowing pattern = efficient milk transfer. 2:1 suck swallow ratio • If technique appears good, check for structural reason for poor attachment e.g., tongue tie, raised palate, retrognathia. • Promote regular skin contact to encourage feeding behaviours. • Review feeding "cues" with mother • Ensure minimum of 8 feeds in 24 hours, • Offer both breasts at each feed – stimulate baby in between e.g., change nappy before offering other side. • Establish plan of care with mother & ask her to keep a daily feed/output diary (BF/PU/BO) and document in the infant feeding care pathway. • Mother & baby should be allocated to daily contacts (virtual or face to face to assess feeding), Reweigh by day 10
2	10-12%	Follow Management Plan 1+ • If any concern regarding baby's condition, consider referral to GP/ paediatrician to exclude underlying illness. IF midwife notes significant P+A issues/ Input is the likely causation of weight loss continue with Care plan 2. • Ensure optimal attachment. Support mother to do Breast Compressions* to increase milk transfer. • Consider switch feeding if baby is sleepy after short period on breast** • Check mother's medical & birth history: Issues that could indicate compromised/ delayed Lactation e.g., RPC, PCOS, thyroid dysfunction, previous breast/nipple surgery, breast/nipple anomalies, hypoplasia, history of infertility, traumatic birth, delayed onset of Lactation i.e., > 72hrs, LCSC, Retained placenta/ products, PPH. If so, allow a further 24-48 hours for the milk supply to establish. • Support with expressing after feeds with hospital grade pump using double pumping or then single pumping with breast compressions. • Support parents to 1) offer any EBM obtained via cup/syringe/finger feeding 2) Monitor output. • Repeat weight check in 24-48 hours – If no or minimal wt. gain (<20-30g /24hrs) move to Plan 3 • *Consider* a discussion via telephone with the paediatrician in DGH. • Consult with the infant feeding champion in your area/ infant feeding coordinator re: management plan *if* required.
3	>12% or no/minimal weight gain after 48 hours on Care pathway 2 PLEASE SUBMIT A DATIX	• Refer for medical review by paediatrician at DGH. • Plan of care to be implemented for intensive breastfeeding support if not kept as inpatient. • Continue with all aspects of care plan 2. • Assess breast feeds & top-up required *** • Give any EBM available + formula as needed via cup/syringe/finger feed/lactation aid. • Support with expressing after feeds with hospital grade pump using double pumping or single pump with breast compressions. • If clinically appropriate seek prescription Domperidone (10mg TDS): dependent on the hospital policy where baby is being reviewed. • Weigh again in 24 hours. Monitor & support closely. • As Lactation increases reduce formula offered – seek plan from I.F champion. • Continue to monitor & check weight 2 x week until clear trend towards birth weight/normal weight gain demonstrated (Approx 20-30g/day)

*Breast Compression: Monitor baby swallowing – when swallowing slows, gently squeeze the breast whilst baby is sucking – stop squeezing when baby stops sucking. Repeat this with each sucking "burst" until sucking & swallowing slows again → switch feeding.

**Switch feeding: Monitor baby for vigorous sucking & swallowing – when sucking & swallowing slows, take baby off the breast, stimulate and attach to other breast. Repeat this process so that baby has at least "4" breasts per feed.

***Volume of supplement: A pragmatic approach is to feed baby approx. 25% of total fluid requirements as supplemental feeds at first & monitor for effectiveness - output & wt gain. E.g., 3kg baby on day 5: 150ml/kg/24hrs = total 450ml ÷ 4 = 115mls given as 19mls after 6 x BF OR 28mls after 4x BF

E.G 150ml x weight of baby / 4 = amount of top up to be given over 24 hours. (Divide it by how many BF they wish to supplement after)

Appendix 2

How you and your midwife can recognise that your baby is feeding well						*This assessment tool was developed for use on or around day 5. If used at other times:
What to look for/ask about	√	√	√	√		**Wet nappies:** Day 1-2 = 1-2 or more in 24 hours Day 3-4 = 3-4 or more in 24 hours, heavier Day 6 plus = 6 or more in 24 hours, heavy
Your baby: has at least 8 -12 feeds in 24 hours*						
is generally calm and relaxed when feeding and content after most feeds						
will take deep rhythmic sucks and you will hear swallowing*						**Stools/dirty nappies:** Day 1-2 = 1 or more in 24 hours, meconium Day 3-4 = 2 (preferably more) in 24 hours changing stools
will generally feed for between 5 and 40 minutes and will come off the breast spontaneously						
has a normal skin colour and is alert and waking for feeds						
has not lost more than 10% weight						
Your baby's nappies: At least 5-6 heavy, wet nappies in 24 hours*						**Sucking pattern:** Swallows may be less audible until milk comes in day 3-4 Feed frequency: Day 1 at least 3-4 feeds After day 1 young babies will feed often and the pattern and number of feeds will vary from day to day. Being responsive to your baby's need to breastfeed for food, drink, comfort and security will ensure you have a good milk supply and a secure happy baby.
At least 2 dirty nappies in 24 hours, at least £2 coin size, yellow and runny and usually more*						
Your breasts:						
Breasts and nipples are comfortable						
Nipples are the same shape at the end of the feed as the start						
How using a dummy/nipple shields/infant formula can impact on breastfeeding						
Date						**Care plan commenced: Yes/No:**
Midwife's initials						
Midwife: if any responses not ticked: watch a full breastfeed, develop a care plan including revisiting positioning and attachment and/or refer for additional support. Consider specialist support if needed.						