Newborn Feeding Policy

Classification :	Policy
Authors Name:	Michelle Hancock
Authors Job Title:	Infant Feeding Lead Midwife
Authors Division:	Women and Children's Health
Departments/Group this Document applies to:	Maternity and Paediatrics

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Guideline to be followed by (target staff):
Paediatricians, ANNP, Midwives, Nursery Nurses and maternity support staff

To be read in conjunction with the following documents:

- Hypoglycaemia of the Newborn policy
- Weight Management of the Newborn guideline
- Tongue Tie Guideline and Patient Information Leaflet
- Newborn Feeding Patient Information Leaflet

Are there any eCARE implications? No

CQC Fundamental standards:
Regulation 9 – person centred care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 19 – Fit and proper

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.
The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material lies solely with you as the medical practitioner.

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Guideline Statement

The purpose of this policy is to ensure that all staff at Milton Keynes University Hospital (MKUH) NHS Foundation Trust understand their roles and responsibilities in supporting expectant and new mothers and their partners to feed their baby. This policy supports them to care for their baby in ways that support optimum health outcomes and well-being. All staff are expected to comply with this policy at all times.

Executive Summary

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

- an increase in breastfeeding initiation rates
- an increase in exclusive breastfeeding rates at 10 days (discharge from midwifery care)
- safe and responsive bottle feeding amongst mothers who choose to artificially feed
- improve patient experiences
- a reduction in the number of re-admissions for feeding issues

The maternity service's expectations in relation to Baby Friendly Initiative training must be included in the Maternity Training Needs Analysis.

Milton Keynes University Hospital NHS Foundation Trust is committed to:

- Providing the highest standard of care to support expectant and new families to feed their baby and build close and loving parent-infant relationships. This is in recognition of the profound importance of early relationships to future health and well-being. Breastfeeding makes a significant contribution to optimal physical and emotional health outcomes for children, mothers and future generations.
- Ensuring that all care is mother and family-centred, non-judgemental and that mothers decisions are supported and respected.
- Working together across disciplines and organisations to improve mothers and parents experiences of care.

Definitions

BFI – Baby Friendly Initiative
BFA – Breast Feeding Assessment
CHINS – Acronym used for breast feeding support (**C**lose, **H**ead, **I**nline, **N**ose, **S**ustainable)
NEC – Necrotising Enterocolitis
NNU – Neonatal Unit
WHO – World Health Organisation

1.0 Roles and Responsibilities:

Chief Executive and Trust Board

Provision of environment – facilities, service and systems support
Links with all the other relevant risk management committees;
Commitment to achieving Baby Friendly Initiative (BFI) Accreditation

Divisional Manager

To support forward planning of the service in relation to infant feeding and support the Baby Friendly Accreditation process

Head of Midwifery/Head of Nursing Women's and Children's Health

Facilitate staff training and ensure compliance with policy to support best practice.
Ensure the accurate collection of breastfeeding data.

Lead Midwife for Risk Management

To ensure that protocols and policies are adhered to.
Discuss risks identified and action required to prevent risks.

Infant Feeding Lead Midwife

To develop and deliver all infant feeding training in line with BFI maternity standards.
To implement BFI audits of staff and service users
To collate breastfeeding data for internal and national reporting.
To act as positive role models and provide support and advice on more complex feeding issues.
To ensure all guidelines and patient information that relate to the breastfeeding dyad are in line with the BFI Maternity Standards.

All Staff

It is always the responsibility of all staff to familiarise themselves with and implement the policy. In practice, this means ensuring that the care, support and advice given is evidence-based. This should protect breastfeeding and optimise health outcomes for mothers and babies. Staff must ensure they attend yearly update training, as allocated and uphold the five BFI maternity standards.

2.0 Implementation and dissemination of document

This document will be highlighted in team meetings, risk management meetings and presented to Maternity and Paediatric guideline groups and Clinical Improvement Groups (CIGs). It will be accessible on the hospital intranet.

As part of this commitment the service will ensure that:

- All new staff are orientated with this policy on commencement of employment.
- All staff receive training to enable them to implement the policy as appropriate to their role.
- New staff receive this training within six months of commencement of employment.
- The International Code of Marketing of Breast-milk Substitutes is implemented and adhered to throughout the service.
- All documentation fully supports the implementation of these standards.

3.0 Processes and procedures

3.1 Care standards

This section of the policy sets out the care that the Trust is committed to giving to every expectant and new mother. It is based on the UNICEF UK Baby Friendly Initiative standards for maternity services and the relevant NICE guidance.

3.1.1 Preparing mothers in pregnancy

All pregnant women will have the opportunity to discuss feeding and caring for their baby with a health professional (or other suitably trained designated person).

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

3.1.2 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 it's 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
- Mothers who formula feed are encouraged to offer the first feed in skin-to-skin contact

Safety considerations

Vigilance as to the baby's well-being is a fundamental part of postnatal care in the first few hours after birth. For this reason, normal 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 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 at birth and on admission to Postnatal ward.

A mother can generally continue to hold her baby in skin-to-skin contact during perineal suturing. However, adequate pain relief is required, as a mother who is in pain is unlikely to be able to hold her baby comfortably or safely. Mothers should be discouraged from holding their baby when receiving analgesia which causes drowsiness or alters their state of awareness (e.g. Entonox).

Where mothers choose to give a first feed of artificial milk in skin-to-skin contact, particular care should be taken to ensure the baby is kept warm.

3.1.3 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:

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

This discussion must be documented in the newborn feeding section on e-CARE system.

A formal feeding assessment will be carried out using the Breastfeeding Assessment tool (see Appendix 1). This is required on the following days as a minimum: day 0-2, day 3, day 5 and day 10. This assessment will include a discussion with the mother to reinforce what is going well where necessary, develop an appropriate plan of care to address any issues that have been identified. The Breast feeding assessment can be used at any time to identify ineffective feeding.

3.2 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 feeding 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
- 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 her.

3.3 Exclusive breastfeeding

The World Health Organisation (2017) 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 response in milk production and let-down
- the importance of early, frequent and effective priming of the prolactin receptor sites
- the negative impact of ineffective/infrequent milk removal on milk supply

3.4 Supplementation of a breastfed baby

Supplementation describes any instance of a breastfed baby receiving artificial milk. This includes when a baby has any breast milk for the first feed.

3.4.1 Reluctant Feeder

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 Appendix 3).

3.4.2 Clinical indication

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

3.4.3 Maternal request

Any decision to supplement a newborn baby at maternal request must be as a result of a fully informed choice. The person requesting the artificial feed must be asked whether the mother is breastfeeding. If the mother is breastfeeding, support must be offered to facilitate a breastfeed or give breastmilk. If the parents continue to request an artificial feed, there must be a sensitive discussion about how giving a breastfed baby this 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.

3.5 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 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 replaced by BF + AF in all documentation.

3.6 Expressing breastmilk

All breastfeeding mothers will be taught to hand express their breastmilk before discharge from hospital. This skill may be useful:

- to express colostrum
- to help with attachment
- to relieve engorgement
- to deal with a blocked duct

If expressed breastmilk is required as part of a feeding plan (e.g. baby on the hypoglycaemia pathway, excessive weight loss, baby in Neonatal Unit, mother in ITU, a pump should be introduced at the earliest opportunity. The timing of this will differ from woman to woman. A good indicator would be that she can easily fill a 5 ml syringe with colostrum.

3.7 Expressing for babies who are admitted to NNU

Babies who are admitted to NNU who do not receive their mother's own milk have a significantly higher risk of Necrotising Enterocolitis (NEC) and morbidity. Mothers must start expressing within hours of birth. The expressed breastmilk must be taken to NNU immediately. These mothers must be advised to express 8-10 times in 24 hours and at least once overnight to establish and maximize their breastmilk supply. Hand expressing packs containing syringes , milk labels (with the baby's MRN) and tamper proof seals should be given to the mother to encourage and facilitate expressing breastmilk. A picture guide on how to hand express should also be provided, alongside a demonstration using props.

3.8 Artificial milk 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 artificial milk. This discussion needs to be documented on e-care in the newborn feeding section. Parents will be advised of the importance of only using first baby milk/stage one milk for the first year of life. No brand of milk or manufacturer will be recommended by staff members, in line with the International Code of Marketing of Breast-milk Substitutes.

3.8.1 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:

- Hold the baby in a more upright position
- Invite their 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.

Guide the teat gently into the baby's mouth, this method ensures 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 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.

3.9 Early postnatal period: support for close and loving relationships

All parents will be supported to understand their baby's needs. This includes encouraging frequent touch and sensitive verbal/visual communication, keeping babies close and responsive feeding. This approach will ensure optimal brain development by minimizing stress hormones and boosting oxytocin levels. Parents will be educated to not leave a baby to cry for prolonged periods and that it is not possible to spoil a baby. Mothers who feed their babies with a bottle 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. All parents will be given information about local parenting support that is available.

Skin-to-skin contact will be encouraged throughout the postnatal period. This will boost prolactin and oxytocin levels, key in milk production and let-down.

3.10 Referral to the Infant Feeding Lead Midwife

Approximately 96% of problems regarding breastfeeding can be rectified by adjusting position and attachment. This will include carrying out a breastfeeding assessment. There are very few circumstances that go beyond the remit of the Maternity staff and require input from the Infant Feeding Lead Midwife:

- Assessment for tongue tie in Newborn infants
- Infants who have lost excessive weight >12%
- Breast abscess
- Infants who have a lack of sucking reflex
- Previous traumatic infant feeding experience
- Complex medical conditions that may impact on breast feeding
- Medications which may be contraindicated with breast feeding

In these situations, the referral form at appendix 6, Infant Feeding Specialist Referral should be completed. The Infant Feeding Lead Midwife will contact the woman to formulate a care plan.

3.10.1 Medications in Breast milk care plan

At the booking appointment, any women who are taking medications, which could be contraindicated with breast feeding should be referred to the Infant Feeding Lead Midwife. This will enable a personalised care plan to be implemented using Appendix 5 (Medications in breast milk care plan).

3.11 Monitoring implementation of the standards

Milton Keynes University Hospital NHS Foundation Trust requires that compliance with this policy is audited at least annually using the UNICEF UK Baby Friendly Initiative audit tool (2019 edition). Staff involved in carrying out this audit require training in the use of this tool. Audit results will be reported to the Head of Midwifery and Division Manager and an action plan will be agreed by the BFI working party to address any areas of non-compliance that have been identified.

3.11.1 Monitoring outcomes

Outcomes will be monitored by:

- Monitoring breastfeeding initiation rates
- Monitoring breastfeeding rates at discharge from midwifery care

4.0 Statement of evidence/references

References:

(2006) Routine postnatal care of women and their babies. National Library of Guidelines. NICE.

World Health Organistation (WHO) (1981) *International Code for the Marketing of Breastmilk Substitutes*. Geneva. WHO.

World Health Organisation (WHO) (2017) Nutrition: *Exclusive Breastfeeding*. [Accessed on 20th October 2020] Available from: http://www.who.int/nutrition/topics/exclusive_breastfeeding/en/

External weblink references:

Please note that although Milton Keynes University Hospital NHS Foundation Trust may include links to external websites, the Trust is not responsible for the accuracy or content therein.

5.0 Governance

5.1 Document review history

Version number: 1.1		**Date:** 06/2019		
Section Number	**Amendment**	**Deletion**	**Addition**	**Reason**
3.6	Section added			Update
3.7	Section added			Update
Version 1.1	Updated the audit and monitoring criteria		Added in appendix 6 & 7	Update

5.2 Consultation History

Stakeholders Name/Board	**Area of Expertise**	**Date Sent**	**Date Received**	**Comments**	**Endorsed Yes/No**

5.3 Audit and monitoring

Audit Criteria	**Tool**	**Audit Lead**	**Frequency of Audit**	**Responsible Committee/ Board**
Bottle feeding mothers	BFI audit tool	Infant Feeding Lead Midwife	3 monthly	
Breast feeding mothers	BFI audit tool	Infant Feeding Lead Midwife	3 monthly	
NNU mothers	BFI audit tool	Infant Feeding Lead Midwife	3 monthly	
Staff interview	BFI audit tool	Infant Feeding Lead Midwife	3 monthly	
Supplementation	BFI audit tool	Infant Feeding Lead Midwife	Continuous and intermittent	

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women's and Children's	Department	Maternity
Person completing the EqIA	Michelle Hancock	Contact No.	86402
Others involved:		Date of assessment:	12/2020
Existing policy/service	Yes	New policy/service	No

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*All maternity Staff*

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	YES	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

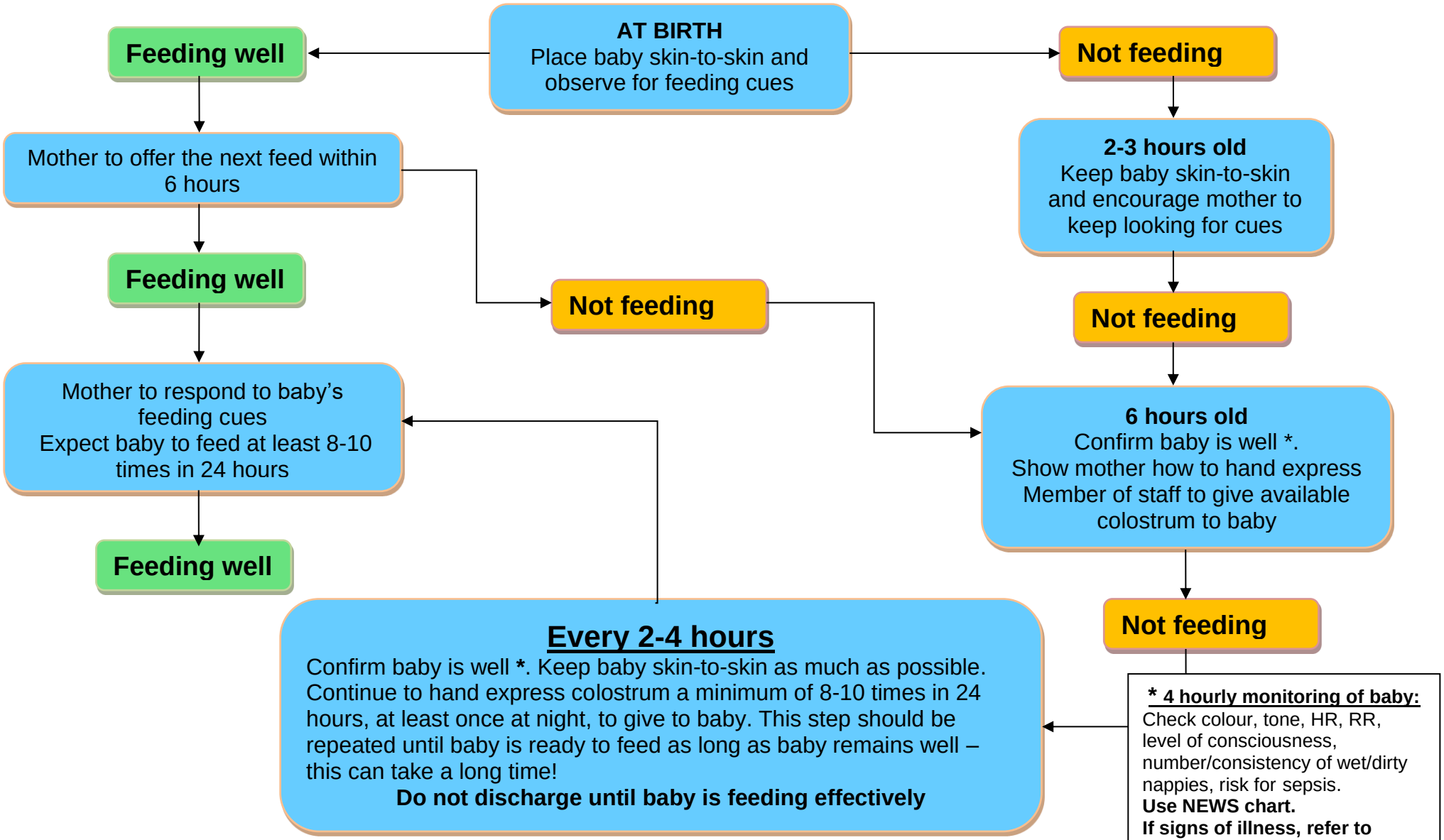
What consultation method(s) have you carried out?
Circulation to entire Women's and Children's directorate (Maternity, NNU & Paediatrics). Discussion at guidelines meetings, CIG and PIG
How are the changes/amendments to the policies/services communicated?
Email, meetings, individual face to face contact and Infant Feeding training (Mandatory)
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA	01/12/2023		

Appendix 1: Breastfeeding assessment form

Breastfeeding Assessment Tool					***Signs of effective attachment:** wide open mouth, chin indenting breast, full rounded cheeks, more areola visible above the top lip, suck:suck:swallow:breathe (less audible on the colostrum days)			
Baby Sticker:	Birth weight: Gestation:	Date:	Date:	Date:	If any responses in the YELLOW column are ticked: develop a plan to include revisiting POSITION and ATTACHMENT	Date:	Date:	Date:
	Tick the appropriate box	Initials:	Initials:	Initials:	**Tick the appropriate box**	Initials:	Initials:	Initials:
What to ask about:	**Indicates effective feeding √**	**Day 0-2**	**Day 3**	**Day 5**	**Suggestive of a problem √**	**Day 0-2**	**Day 3**	**Day 5**
Appearance and frequency of stools (in 24 hours)	Day 0-2: 1-2 or more - meconium				Fewer than indicated for the appropriate age or abnormal in appearance			
	Day 3-4: 2 or more - changing to green							
	Day 5-6: 2 or more - yellow, soft and runny							
Urine output (in 24 hours)	Day 0-2: 1-2 or more				Fewer than indicated for the appropriate age or abnormal in appearance			
	Day 3-4: 3 or more - heavier							
	Day 5-6: 5-6 or more - heavy							
Number of feeds in 24 hours	Day 0: 3-4 or more - colostrum				Fewer than 8 feeds in the last 24 hours			
	Day 1-2: 8-10 or more - colostrum							
	Day 3 onwards: 8 -10 - full milk							
Baby's colour, alertness and tone	Normal skin colour, alert, good tone				Jaundice worsening or not improving; baby lethargic, not waking to feed, poor tone			
Sucking pattern during feed	Initial rapid sucks changing to slower sucks with pauses and soft swallowing				No change in sucking pattern, or noisy feeding e.g. clicking			
Signs of effective attachment *	All present *				Any sign of poor attachment			
Length of feed	Baby feeds for 5 -30 minutes at most feeds				Baby consistently feeds for less than 5 minutes or longer than 40 minutes			
End of feed	Baby lets go spontaneously, or does so when breast is gently lifted				Baby does not release the breast spontaneously			
Offer of second breast	Baby feeds from second breast or not, according to appetite				Mother restricts baby to one breast per feed, or insists on two breasts per feed			
Baby's behaviour during feeds	Generally calm and relaxed				Baby comes on and off the breast or refuses the breast			
Baby's behaviour after feeds	Baby content after most feeds				Baby unsettled after feeding			
Shape of either nipple at end of feed	Shape the same or elongated				Misshapen or pinched at the end of feed			
How breasts feel	Breasts and nipples feel comfortable				Breasts or nipples painful			
Weight loss	Weight loss <8% of birthweight				Weight loss ≥ 8 % of birthweight			
Weight on Day 3/Day 5 as appropriate			g	g			g	g
Use of dummy/nipple shields/formula?	None used				Yes (state which)			

Appendix 2: Reluctant Feeder Pathway (Healthy Term Infant ≥ 37 weeks)



Appendix 3: Newborn Feeding Chart

Feeding method:

Birth weight:

Observations:

Surname:
Forename:
DOB:
Hospital no:
(or affix patient label)

Date	Time	Type of feed	Length or amount	Support	Urine	Stool	Initial/signature		ID check
							1st person check	2nd person check	

Appendix 4: Infant Feeding Specialist Referral

Infant Feeding Specialist Referral

Place patient sticker here	DOB: Parent name: Contact number: GP: Referrer:

Type of birth:	Complications or medical issues with mother or baby:	
Gender:	Birth weight	
Current Age of baby:	Current weight:	
Method of feeding	BF	AF

Reason for referral:

Low or inadequate milk supply	Yes	No
Mastitis	Yes	No
Short feeds (all less than 5 minutes)	Yes	No
Long feeds (all longer than 45 minutes)	Yes	No
Not opening bowels appropriate to age	Yes	No
Urine output not appropriate to age	Yes	No
Suspected tongue tie:	Yes (if yes give details)	No
Other: (give details)		

Recommendations/plan to date:

Completed Breastfeeding assessment documented in notes ☐
(if not completed, please complete prior to referral)

Skin to skin	**Yes**	**No**
Change of position	**Yes**	**No**
Breast compressions	**Yes**	**No**
CHINS	**Yes**	**No**
Expression (8-10 in 24 hours)	**Yes**	**No**
Other: (give details)		

Referrer details:

Signed: …… Name: ……

Date: …… Role: ……

Date referral received: ……..

Management Plan: **Face to face consultation** ☐ **Phone consultation** ☐

Signed …….. Name……..

Date ……..

Follow up required ☐ **Date of follow up: ……**

Appendix 5: Medications in Breastmilk Care Plan

Medications in Breastmilk Care Plan

Booking Appointment
Highlight any medications where there may be contraindications to breastfeeding and discuss infant feeding intentions

Refer to Infant Feeding Lead Midwife (01908 996402)
Refer to Consultant care
Create Baby Alert (if appropriate)

Community Midwife and Woman to arrange appointment with Infant Feeding Lead Midwife at approximately 34/40
(or before if appropriate)

Infant Feeding Midwife to research safety of medications with Breastfeeding Network

Management Plan to be implemented in conjunction with the woman and Midwives

Copy of Management Plan to be placed in the woman's notes and copy to Paediatric team and safeguarding folder

Personalised Breastfeeding Care Plan

Place patient sticker here	EDD: Community Midwife: GP: Prescriber: Consultant:

Medication details (including dosages and reasons for prescription):

Management Plan

Copy to:

Baby Alert file	**[ ]**
Safeguarding file	**[ ]**
Woman's notes	**[ ]**
EDM	**[ ]**

Signed …….. Name……..
Date ……..