1922

Title:	**SPECIALIST COMMUNITY PUBLIC HEALTH NURSING (SCPHN) INFANT FEEDING POLICY (Health Visiting)**	Author: Health Visitor
Directorate:	**PUBLIC HEALTH OPERATIONS**	Version: 1
Responsible for review:	**SERVICE MANAGER & PROFESSIONAL LEAD FOR SPECIALIST COMMUNITY PUBLIC HEALTH NURSING**	Classification: Policy
Ratified by:	**Care and Clinical Quality Group**	
		Due for Review: 19/02/20
Applicability:	**The SCPHN Infant Feeding Policy (Health Visiting) is applicable to all families living in the Borough of Torbay**	Document Control

Contents

1. Purpose

1.1 This policy aims to ensure that all members of the Specialist Community Public Health Nursing (SCPHN) health visiting team at Torbay and South Devon NHS Foundation Trust (TSDFT) understand their role and responsibilities in supporting expectant and new mothers, and their partners, to feed and care for their baby in ways which support optimum health and well-being.

1.2 Compliance with this policy is mandatory.

2. Introduction

2.1 Torbay and South Devon NHS Foundation Trust is committed to:

i. Providing the highest standard of care to support expectant and new mothers and their partners to feed their babies and build strong and loving parent-infant relationships. This is in recognition of the profound importance of early relationships to future health and well-being, and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for children and mothers.

ii. Ensuring that all care is mother- and family-centred, and non-judgmental, and that the mother's decisions are supported and respected.

3. Roles and Responsibilities

3.1 As part of its commitment, the health visiting service will ensure that:

i. All new staff are familiarised with the policy on commencement of employment;
ii. It is mandatory that all staff receive training to enable them to implement the policy as appropriate to their role and receive this training within 6 months of commencement of employment.
iii. The International Code of Marketing of Breastmilk Substitutes is implemented throughout the service;
iv. All documentation fully supports the implementation of these standards;
v. Parents' experiences of care will be listened to through:
- TSDFT Public Health: "Your Thoughts on Our Service" feedback leaflet;
- the UNICEF UK audit tool for the Health Visiting Service.

4. Procedure to Support Responsive Feeding

4.1 **Aim of Policy:** This policy aims to ensure that the care provided improves outcomes for children and families, specifically to deliver:

i. Increases in breastfeeding rates at 6-8 weeks
ii. Amongst parents who choose to formula feed, increases in those doing so as safely as possible in line with nationally agreed guidance;
iii. Increases in the proportion of parents who introduce solid food to their baby, in line with nationally agreed guidance;
iv. Improvements in parents' experiences of care;
v. To maintain the health and wellbeing babies;
vi. To identify slow weight gain;
vii. To manage slow weight gain proactively;
viii. To support breastfeeding mothers;
ix. To prevent premature cessation of breastfeeding;
x. To prevent unnecessary formula supplementation of breastfed babies.

4.2 **Scope of the Policy:**

4.2.1 **Antenatal Contact is Part of the Commissioned Health Visiting Service:** All pregnant women will have the opportunity to discuss feeding and caring for their baby with a health visitor from 28 weeks of pregnancy. This discussion will include the following topics:

i. The value of connecting with their growing baby in utero;
ii. The value of skin contact for all mothers and babies;
iii. The importance of responding to their baby's needs for comfort, closeness and feeding after birth, and the role that keeping their baby close has in supporting this;
iv. Feeding, including:
- 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.

4.2.3 **Background:** Weight loss in the first few days of life is normal, as babies are born with excess extracellular fluid which they need to shed. This is probably why early breast milk is in concentrated form (colostrum). Conventional wisdom has been that normal weight loss may be up to 10% of birth weight. In the majority of babies, it is more likely to be between 5% and 7% (Dewey et al. 2005, Macdonald, 2003).

Birth weight is usually regained by 2 weeks (Wright 2004). A healthy baby, feeding well, should continue to gain weight. Babies are weighed and their weight plotted on the growth chart in the parent-held record by a trained member of staff. It should be explained that the 50th centile is average rather than ideal.

Poor weight gain causes anxiety in parents and staff alike, and may result in supplementation or cessation of breastfeeding. Both health professionals and parents might assume that breastfeeding itself has led to poor weight gain, rather than ineffective breastfeeding management.

4.3.5 **Assessing Breastfed Babies at the New Birth Visit:** A full breastfeeding assessment is carried out, which includes observation of a feed to ensure correct attachment and positioning.

This includes recognition of what is going well and the development, with the mother, of an appropriate plan of care to address any issues identified. If no problems are identified, then further assessments are routinely undertaken at 8, 12 and 16 weeks, and at 1 year at the time of routine immunisations, as recommended by the Royal College of Paediatrics and the Healthy Child Programme. These assessments would usually occur at the Child Health Clinics.

Staff should ensure that mothers have the opportunity to discuss responsive feeding and reassure mothers that breastfeeding can be used to feed, comfort, and calm babies. Breastfeeds can be long or short. Breastfed babies cannot be overfed or 'spoiled' by too much feeding, and breastfeeding will not, in itself, tire mothers any more than caring for a new baby without breastfeeding.

4.2.6 **Weight Monitoring when Slow or Static Weight Gain is Identified:** Poor weight gain is often a result of ineffective milk transfer. This is most frequently caused by poor attachment and positioning at the breast, or infrequent feeds. Rarely is it attributed to physical abnormality in the mother or a medical condition. In most cases the problem can be overcome with good management.

Breastfeeding technique and management should be optimised to support the establishment of a good milk supply and effective milk removal.

Percentage weight loss can be calculated as follows:

- Weight loss = difference between current weight and birth weight
- Percentage weight loss = weight loss divided by birth weight multiply by 100

For example:

A baby born at 3.500kg* who drops to 3.150kg at 5 days has lost 0.35kg**
(3.500kg - 3.150kg = 350g) or 10%, calculated as follows:

$$\frac{0.35^{**}}{3.50^{*}} \times \frac{100}{1} = 10\%$$

If concerns exist about the effectiveness of breastfeeding, an action plan is made which includes a timetable for reassessment:

- Feeding assessment after the new birth visit; and
- Effective feeding will be assessed considering:
  - Output (urine and stools)
  - Weight

ASSESSMENT OF OUTPUT		
AGE	7-28 DAYS	28 DAYS and beyond
No. of WET NAPPIES	6 or more per day, nappies feel heavy	6 or more per day, nappies feel heavy
No. of DIRTY NAPPIES	2 or more per day the stool is at least the size of a £2 coin and yellow, soft/runny	After 28 days the baby will develop its own pattern, there may be several stools per day or the baby may go several days between stools and then pass a large stool

If ineffective milk transfer is not corrected, suppression of milk production will result due to the Feedback Inhibitor of Lactation (FIL) which inhibits further milk production (Neifert 2004). It is therefore extremely important that slow or static weight gain is managed proactively. Breastfeeding technique and management should be optimised to support the establishment of a good milk supply and effective milk removal.

If there is cause for concern, the baby should be moved from a routine to an individual weighing plan. The baby should be weighed at the same time of day, in the same relation to a feed (i.e. before/after), on the same scales, which are placed on the same surface and by the same person, as all these factors contribute to accuracy of weighing. Babies are always weighed naked from birth to first birthday.

4.2.7 **Babies who enter Health Visitor Care below their Birth Weight:** A baby who is below birth weight at the initial weighing needs careful monitoring. A breastfeeding history and assessment should be conducted, using the UNICEF breastfeeding assessment tool. This may show that the baby is recovering from a large initial loss and is now gaining weight. In this case, both feeding and weight monitoring should continue until birth weight is regained and the baby has established an upward weight gain trend.

If the baby is not now gaining weight, careful monitoring and assessment should continue. Feeding should be managed using Management Plans 1, 2, 3 (as 4.2.9 below). If a baby has not regained birth weight by 3 weeks of age, s/he should be referred to a GP and/or the on-call paediatrician (contacted though switchboard at Torbay Hospital 01803 614567).

4.2.8 **Babies who are Gaining Weight Slowly:** A baby's weight may not follow one centile line and may cross a line, especially in the first 9 months. Changes of less than one channel width (the gap between two centile lines) are quite normal. Weight loss during an illness is also common. However, on recovery, the baby's centile usually returns to normal within 2-3 weeks.

For those mothers who require additional support for more complex breastfeeding challenges, a referral to the specialist service will be made by the health professional working with the mother. A member of the Responsive Feeding Team or Lactation Specialist can be contacted Monday-Friday on 07500952216.

Referrals for the tongue tie service can be made via email sdhct.tonguetie@nhs.net or telephone to 01803 656275.

Babies who lose more than 10% weight or who cross two or more centile lines within an 8 week period should be referred to the appropriate professional. Poor weight gain can be a sign of illness, therefore a careful assessment of all babies who are not gaining weight at the expected rate should be carried out, with referral to the GP and/or the on-call paediatrician (contacted though switchboard at Torbay Hospital 01803 614567).

4.2.9 **Management Plans for Babies with Static or Slow Weight Gain:**

AMOUNT OF WEIGHT GAIN	MANAGEMENT PLAN INDICATED
Baby not yet back to birth weight	Plan 1 moving to Plan 2 then Plan 3 if necessary
Moderately slow weight gain (i.e crossing one centile space downwards in one month or less)	Plan 1 moving to Plan 2 if necessary
Very slow weight gain (i.e crossing 2 centile spaces downwards in one month or less)	Plan 1 moving to plan 2 if necessary
Static or falling weight	Plan 1 moving to plan 2 and then to 3 if necessary

MANAGEMENT PLAN 1:

i. Observe a full breastfeed and check for effective attachment
ii. Observe for effective sucking pattern
iii. Ensure a minimum 8 feeds in 24 hours, including during the night
iv. Ensure that mother is aware of feeding cues / ask mother to wake baby to ensure enough feeds in 24 hours
v. Address any family barriers to frequent feeding
vi. Check dummy is not being used
vii. Recommend skin to skin contact to encourage breastfeeding
viii. Refer to a breastfeeding support group
ix. Observe for change in frequency/amount of urine and stools
x. Reweigh in one week.
xi. If the baby's weight increases, continue to monitor closely and provide support.
xii. If there is no or minimal weight gain, move to Management Plan 2.

If, at any time, the baby develops other concerning symptoms, immediately review and reassess for medical referral.

MANAGEMENT PLAN 2:

Carry out Management Plan 1, plus:

i. For sleepy babies, consider 'switch feeding' (i.e. take the baby off the breast and offer the other side to stimulate let-down)
ii. Breast compression during feed
iii. Express breast milk after each feed (or as often as the mother can manage) and offer to the baby by cup/ teaspoon/wide based teat with paced bottle feeding
iv. Massage breast before expressing
v. Consider referral to GP
vi. Review in 24-48 hours

If there is no evidence of increase in milk intake (i.e. an increase in number of wet nappies, yellow stools), move to Management Plan 3.

MANAGEMENT PLAN 3:

Carry out plans 1 and 2, plus:

i. Refer to GP
ii. Ensure frequent breastfeeds and expressing
iii. Consider introducing formula feeds if expressed breast milk is unavailable
iv. Use advice below for introducing formula feeds
v. Reduce formula offered as breast milk supply increases
vi. Weigh in 2-4 days after starting formula feeds
vii. Continue to monitor weight weekly until clear trend of increase is demonstrated

4.2.10 **Supplementing with Formula Milk:** If a mother chooses to supplement with formula, even where the health visitor does not think this is required, the health visitor should continue to offer information and support for breastfeeding. The health visitor should only consider recommending supplementation when:

i. Measures to improve milk supply and transfer have been tried for at least one week;
ii. The baby's weight gain has been static or there has been minimal increase for more than one week;
iii. The baby appears dehydrated or unwell;
iv. The baby has been checked by the GP/paediatrician to exclude underlying illness.

How to supplement: Discuss with the mother how the supplement is to be given to ensure informed choice:

i. Begin with one feed or more of expressed breast milk or formula milk;
ii. Give supplement as a separate feed (i.e. not 'top ups' after breastfeeds) at the time most convenient to the mother;
iii. Ensure appropriate sterilisation of all equipment;
iv. Active breastfeeding and support should continue alongside supplementation;
v. Weigh baby 2-4 days after introducing formula;
vi. Continue to monitor weight weekly until clear trend of increase is demonstrated;

Monitoring and assessment should continue throughout the period of supplementation, with the health visitor continuing to assess the adequacy of milk supply and the effectiveness of baby's feeding. The transition back to exclusive breastfeeding, if this is what the mother wishes, is possible in most cases. Supplements should be reduced as breast milk supply increases.

4.2.11 **Support for Parenting and Close Relationships:** All parents will be supported to understand a baby's needs (including encouraging frequent touch and sensitive verbal/visual communication, keeping babies close, responsive feeding and safe sleeping practice).

Mothers who bottle feed are 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 (recorded in Parent Held Record).

Mothers who breastfeed will be provided with information about why exclusive breastfeeding leads to the best outcomes for their baby, and why it is particularly important during the establishment of breastfeeding.

When exclusive breastfeeding is not possible, the value of continuing partial breastfeeding will be emphasised and mothers will be supported to maximise the amount of breast milk their baby receives. Mothers will have the opportunity for a discussion about their options for continued breastfeeding (including responsive feeding, expression of breast milk and feeding when out and about or going back to work), according to individual need.

Mothers who give other feeds in conjunction with breastfeeding will be enabled to do so as safely as possible and with the least possible disruption to breastfeeding. This will include appropriate information and a discussion regarding the potential impact of the use of a teat when a baby is learning to breastfeed.

4.2.12 **Modified Regime:** There are a small number of clinical indications for a modified approach to responsive feeding in the short term. Examples include pre-term or small-for-gestational-age babies, babies who have not regained their birth weight, babies who are gaining weight slowly [Ref 0434 version 9].

4.2.13 **Support for Formula Feeding:** At the new birth visit, mothers who formula feed will have a discussion about how feeding is going. Recognising that this information will have been discussed with maternity service staff, but may need revisiting or reinforcing, and being sensitive to a mother's previous experience, staff will check that:

i. Mothers who are formula feeding have the information they need to enable them to do so as safely as possible, including the recommendation that first stage milk can be used for the first year (HSC 2014). Staff may need to offer a demonstration and / or discussion about how to prepare infant formula.
ii. Mothers who formula feed understand about the importance of responsive feeding and how to:

- Respond to cues that their baby is hungry;
- Invite their baby to draw in the teat rather than forcing the teat into their baby's mouth;
- Pace the feed so that their baby is not forced to feed more than they want to;
- Recognise their baby's cues that they have had enough milk and avoid forcing them to have more milk than they want.

4.2.14 **Recommendations for Health Professionals on Discussing Bed-Sharing with Parents:** Simplistic messages in relation to where a baby sleeps should be avoided; neither blanket prohibitions nor blanket permissions reflect the current research evidence.

The current body of evidence overwhelmingly supports the following key messages, which should be conveyed to all parents:

i. The safest place for your baby to sleep is in a cot by your bed;
ii. Sleeping with your baby on a sofa puts your baby at greatest risk;
iii. Your baby should not share a bed with anyone who:

- is a smoker;
- has consumed alcohol;
- has taken drugs (legal or illegal) that make them sleepy.

4.2.15 **The Incidence of Sudden Infant Death Syndrome (SIDS):** (often called "cot death") This is higher in the following groups:

i. Parents in low socio-economic groups;
ii. Parents who currently abuse alcohol or drugs;
iii. Young mothers with more than one child;
iv. Premature infants and those with low birth weight;

Parents within these groups will need more face to face discussion to ensure that these key messages are explored and understood. They may need some practical help, possibly from other agencies, to enable them to put them into practice.

4.2.16 **Introducing Solid Food:** All parents will have a timely discussion about when and how to introduce solid food including:

- That solid food should be started at around 6 months;
- Recognising babies' signs of developmental readiness for solid food;
- How to introduce solid food to babies;
- Appropriate foods for babies.

5. Training and Supervision

5.1 All clinical staff are required to complete the UNICEF approved 2-day Breastfeeding Training facilitated by TSDFT's Infant Feeding Specialist Midwife, and members of the TSDFT Responsive Feedi

5.2 All clinical staff are required to undertake annually the ¾ hour mandatory update, facilitated by members of the Responsive Feeding team.

5.3 The UNICEF approved 2-day Breastfeeding Training is delivered in-house and is booked through TSDHCT's Horizon Centre.

5.4 This training is mandatory for all clinical staff within TSDFT's health visiting service.

5.5 Staff joining the Trust are required to evidence if/when they have attended the UNICEF approved 2-day Breastfeeding Training (which needs to be confirmed by their team leader and added to their personal staff file), In addition, they will have a practical skills assessment by a member of the Responsive Feeding team.

5.6 Date pertaining to individuals' training (name, date, type) is recorded on the department-held Breastfeeding Training spreadsheet.

6. Monitoring and Auditing

6.1 TSDFT requires that compliance with this policy is audited at least annually using the UNICEF UK Baby Friendly Initiative audit tool (2013 edition).

6.2 All staff involved in carrying out this audit requires training on the use of the UNICEF UK Baby Friendly Initiative audit tool.

6.3 Audit results will be reported to the Trust's Service Manager and Professional Lead for Specialist Community Public Health Nursing, and an action plan will be agreed by the Professional Lead to address any areas of non-compliance that have been identified.

6.4 Outcomes are monitored as follows:

- Breastfeeding initiation rates are collected by the PHR and email. The information is disseminated quarterly via the Breastfeeding Forum:
- Skills audit by Responsive Feeding team or a selection of staff;
- Use of DATIX for critical incident reporting;
- Use of "Your Thoughts on our Service" questionnaire;
- Team leader or delegated supervisor to review SCPHN HV team members' training passports at annual appraisal.

6.5 Outcomes will be reported to, the TSDFT's Service Manager and Professional Lead for Specialist Community Public Health Nursing.

7. References

7.1 Public Health Outcomes framework 2013-16: https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

7.2 Information on the Code of Marketing of Breastmilk Substitutes: http://www.unicef.org.uk/BabyFriendly/Health-Professionals/Going-Baby-Friendly/Maternity/The-International-Code-of-Marketing-of-Breastmilk-Substitutes-/

7.3 Updated Baby Friendly standards: www.unicef.org.uk/babyfriendly/standards

7.4 NICE guidance on maternal and child nutrition: http://www.nice.org.uk/ph11

7.5 Healthy Child Programme: https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

7.6 The UNICEF UK Baby Friendly Initiative audit tool (2013 edition) http://www.unicef.org.uk/BabyFriendly/Resources/Guidance-for-Health-Professionals/Audit/Audit-tools-to-monitor-breastfeeding-support/

7.7 Birth to Five Book (Health and Social Care 2014)

8. Equality and Diversity

8.1 This document complies with Torbay and South Devon NHS Foundation Trust's Equality and Diversity Statements

8.2 All information should be presented in a format that meets the needs of the client.

9.	**Further Information**
9.1	Links to Policies
	• 0434 Newborn Feeding Policy http://nww.sdhs.nhs.uk/link.php?page=dept/Clinaud/CEDept.html
	• 0905 Weight Loss Policy http://nww.sdhs.nhs.uk/link.php?page=dept/Clinaud/CEDept.html
9.2	Best Practice Information
	• unicef.org.uk/BFIevidence
9.3	Forms / Recording Documentation
	• UNICEF Breastfeeding Assessment Form (Appendix 1)

10. Appendices

Appendix 1: UNICEF Breastfeeding Assessment Form

11. Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.
Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.
If printed, this document is only valid for the day of printing.

Ref No:	1922		
Document title:	TSDFT SPECIALIST COMMUNITY PUBLIC HEALTH NURSING (SCPHN) INFANT FEEDING POLICY (Health Visiting)		
Purpose of document:	This policy aims to ensure that all TSDFT SCPHN staff understand their role and responsibilities in supporting expectant and new mothers, and their partners, to feed and care for their baby in ways which support optimum health and well-being		
Date of issue:	7 April 2017	**Next review date:**	7 April 2020
Version:	1	**Last review date:**	March 2017
Author:	Health Visitor		
Directorate:	Specialist Community Public Health Nursing Health Visiting (Public Health Operations)		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race, ethnicity, religion or belief.		
Committee(s) approving the document:	Care and Clinical Policies Group		
Date approved:	15 July 2015		
Links or overlaps with other policies:	• All TSDFT strategies, policies and procedure documents • 0434 Maternity Service Policy • 0905 Maternity Weight Loss Policy		

	Please select Yes	No
Does this document have training implications?	☒	☐
UNICEF approved 2-day Breastfeeding training facilitated by TSDHCT's Infant Feeding Specialist Midwife, and members of the TSDHCT Responsive Feeding Team.		
Does this document have financial implications?	☒	☐
The UNICEF Baby Friendly Assessment.		
Is this document a direct replacement for another?	☐	☒

Document Amendment History

Date	Version No.	Amendment Summary	Ratified by:
11/5/2015	1	New	Health Visitor
07/04/2017	1	Date change	Health Visitor/Practice Teacher
19/02/2018	1	Review date extended from 2 years to 3 years	

12. The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

> **"**The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves".

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare:
http://icare/Operations/mental_capacity_act/Pages/default.aspx .

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

13.

Quality Impact Assessment (QIA)

	Please select			
Who may be affected by this document?	Patient / Service Users	☒	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☐	Other Statutory Agencies	☐
	Others *(please state):*			

Does this document require a service redesign, or substantial amendments to an existing process? INSERT	☐
If you answer yes to this question, please complete a full Quality Impact Assessment.	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity? INSERT	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐		
If you answer yes to any of these strands, please complete a full Quality Impact Assessment.				
If applicable, what action has been taken to mitigate any concerns?				

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☒	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☒
	NHS Organisations	☒	Police	☐
	Councils	☐	Carers	☐
	Staff	☒	Other Statutory Agencies	☐
	Details *(please state):*			

APPENDIX 1:

Breastfeeding assessment form

If any responses in the right hand column are ticked: ***watch a full breastfeed, develop an action plan*** *including revisiting positioning and attachment and/or refer to specialist practitioner. Any additional concerns should be followed up as needed.*

Baby's name: Baby's age: Date of birth:	Birth weight: Gestation: Current weight:		Assessment carried out by: Date:	
What to observe/ask about	**Answer indicating effective feeding**	✓	**Answer suggestive of a problem**	✓
Urine output	At least 5-6 heavy wet nappies in 24 hours*		Fewer than 5-6 wet nappies in 24 hours, or nappies that do not feel heavy*	
Appearance and frequency of stools	2 or more in 24 hours; normal appearance (i.e. at least £2 coin size, yellow, soft/runny)*		Fewer than 2 in 24 hours or abnormal appearance*	
Baby's colour, alertness and tone	Normal skin colour; alert; good tone		Jaundiced worsening or not improving; baby lethargic, not waking to feed; poor tone	
Weight (following initial post-birth loss)	If re-weighed not lost more than 10% of birth weight – see Weight Guidelines		Weight loss greater than 10%	
Number of feeds in last 24 hours	At least 8 feeds in a 24 hour period*		Fewer than 8 feeds in last 24 hours*	
Baby's behaviour during feeds	Generally calm and relaxed		Baby comes on and off the breast frequently during the feed, or refuses to breastfeed	
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)*	
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 the feed	Baby lets go spontaneously, or does so when breast is gently lifted		Baby does not release the breast spontaneously, mother removes baby	
Offer of second breast?	Second breast offered. 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 after feeds	Baby content after most feeds		Baby unsettled after feeding	
Shape of either nipple at end of feed	Same shape as when feed began, or slightly elongated		Misshapen or pinched at the end of feeds	
Mother's report on her breasts and nipples	Breasts and nipples comfortable		Nipples sore or damaged; engorgement or mastitis	
Use of dummy / nipple shields / formula?	None used		Yes *(state which)* Ask why: Difficulty with attachment? Baby not growing? Baby unsettled?	

UNICEF UK Baby Friendly Initiative 2010. Adapted from checklists used in the Oxford Radcliffe NHS Trust and East Lancashire Hospitals NHS Trust