Infant Feeding Policy: Standards of Care

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Monitoring Groups: Maternal and Infant Nutrition Group

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Approved by:	NHSGGC Board Clinical Governance Forum
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THE CARE STANDARDS

1. Pregnancy

The service recognises the significance of pregnancy as a time for building the foundations of future health and well-being and the potential role of Maternity, Neonatal, Paediatric, Health Visiting teams and Community Nursing, Dietetic, Medical, Support and Allied Healthcare Professionals to positively influence pregnant women and their families.

a) Antenatal Discussion: Pregnant women will have the opportunity to discuss feeding and caring for their baby with a health professional (or other suitably trained designated person). Information can also be provided at any other antenatal contact (such as visits to clinic or classes). Any opportunity should be taken to discuss breastfeeding and the importance of early relationship building, using a sensitive and flexible approach. This discussion will include the value of:

i. Connecting with their growing baby *in utero*, and skin contact for all mothers and babies immediately after birth whenever possible.
ii. 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.
iii. Feeding, including an exploration of what parents already know and feel about breastfeeding, the value of breastfeeding as protection, comfort and food and getting breastfeeding off to a good start.
iv. For women expected to deliver their baby sick or preterm a specific conversation about the benefits of breastmilk for this vulnerable group.

b) Health Visiting and Family Nurse Partnership services within GGC are committed to giving every pregnant woman and mother and baby dyad the highest standard of patient centred care in line with the The Universal Health Visiting Pathway in Scotland: Pre-birth to Pre-school (Scottish Government 2015)[1].

c) Collaborative working: Services should work collaboratively to develop or support and locally operated antenatal interventions delivered with or by partner organisations. Staff will proactively support and recommend the services provided by maternity/neonatal/health visiting services or voluntary organisations.

2. At the Birth

All mother's are offered skin to skin contact following the birth of their baby.

a) Skin to Skin Process: When the infant is relaxed and in skin-to skin contact with its mother, it will go through nine behavioural phases resulting in early optimal self regulation and feeding. Interrupting the process before the baby has completed this sequence or trying to hurry through the stages, is counterproductive and may lead to problems at subsequent breastfeeds[2,3].

Supportive Environment: Providing an environment that enables the infant to go through the phases will help to relax them both. The raised the levels of oxytocin will promoting bonding and secure attachment[4,5]. If this process happens optimally then the baby is more likely to feed effectively at the breast and the mother will have decrease anxiety and increases self-confidence in her ability to produce breast milk and succeed at breastfeeding[6,7].

b) **Normal Care:** Whenever possible all mothers will be offered the opportunity to have uninterrupted skin contact with their baby immediately after the birth at least until after the first feed and for as long as they want, so that the instinctive behaviour of infant breast seeking and maternal nurturing is given an opportunity to emerge.

c) **First Feed**: All mothers will be encouraged to offer the first breastfeed in skin contact when the baby shows signs of readiness to feed. The aim is not to rush the baby to the breast but to be sensitive to the baby's instinctive process towards self attachment. When mothers choose to formula feed they will be encouraged to offer the first feed in skin contact.

d) **Delayed Skin Contact**: Those mothers or infants who are unable (or mothers who decline) to have skin contact immediately after birth, will be encouraged to commence skin contact as soon as they are able, or wish to do so. If a baby needs to be transferred to the neonatal unit offer a labour ward cuddle/skin to skin contact where appropriate. The mother should be supported to start expressing milk as soon as possible after birth ideally within two hours. This should include hand expressing and double pumping it is the joint responsibility of Midwifery and Neonatal Unit (NNU) staff to ensure that mothers who are separated from their baby receive this information and support.

e) **Safety:** Vigilance of the baby's well-being is a fundamental part of postnatal care immediately following and 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 (this includes calculation of the Apgar scores).
   - Care should always be taken to ensure that the baby is kept warm.
   - Observations should also be made of the mother including level of consciousness with prompt removal of the baby if the health of either gives rise to concern.

Staff should have a conversation with the mother and her companion about the importance of recognising changes in the baby's colour or tone and the need to alert staff immediately if they are concerned and how to alert staff e.g. emergency buzzer use.

It is important to ensure that the baby cannot fall onto the floor or become trapped in bedding or by the mother's body. Mothers should be encouraged to be in a semi-recumbent position to hold and feed their baby. Particular care should be taken with the position of the baby ensuring their head is supported and airway protected.

Notes – Mothers

- Mothers may be very tired following birth, and so may need constant support and supervision to observe changes in their baby's condition or to reposition their baby when needed.
- Many mothers can continue to hold their baby in skin-to-skin contact during perineal suturing, providing they have adequate pain relief. However, a mother who is in pain

may not be able to hold her baby safely. Babies should not be in skin-to-skin contact with their mothers when they are receiving Entonox or other analgesics that impact consciousness.

Notes – Babies
Routine observations of the baby should include:

- Checking that the baby's position maintains an unobstructed airway.
- Observe respiratory rate and chest movement and listen for unusual breathing sounds or absence of noise from the baby.
- Colour: The baby should be assessed by looking at the whole of the baby's body, as the limbs can often be discoloured in the early days. Facial or central discolouration can be a cause for concern and should always be investigated. Subtle changes to colour indicate changes in the baby's condition.
- Tone: The baby should have a good tone and not be limp or unresponsive.
- Temperature: Ensure the baby is kept warm during skin contact.
- Where mothers chose to give a first feed of formula milk in skin contact, particular care should be taken to ensure the baby is kept warm.

More information on HSIB recommendations (2020)[8] can be found here.

3. The Postnatal Period

The delivery of postnatal care in line with NICE Guideline (2021)[9] including:

a) **Support for parenting and close relationships:** This service recognises the profound importance of secure parent-infant attachment for the future health and well-being of the infant. These care practices are important for all infants, including those who are unwell or premature and cared for in Neonatal Units.

b) **Ongoing skin-to-skin contact** will be encouraged throughout the postnatal period.

c) **Closeness and responsiveness**: All parents will be supported to understand a newborn baby's needs for food, comfort and emotional support (including encouraging frequent touch and sensitive verbal/visual communication, keeping babies close (rooming in), responsive feeding and safe sleeping practice). Mothers and babies should normally remain together to enable this close relationship and responsive feeding.

d) **Ongoing support;** Parents will be given information about the availability of local parenting support. Recommendations for health professionals on discussing bed-sharing with parents should include Safer Sleep resources[10].

4. Breastfeeding

In recognition of the profound importance of breastfeeding to good physical and emotional health outcomes for children and mothers this Board supports it as the biological norm. Mothers will be enabled to achieve effective breastfeeding according to their needs:

a) **Early support for breastfeeding** (maternity unit and at home)**:** Mothers will have the opportunity to discuss breastfeeding in the first few hours after birth as appropriate to their own needs and those of their baby. This discussion will include information on responsive feeding, feeding cues and positioning and attachment, hand expression

and understanding signs of effective feeding. This will continue until the mother and baby are feeding confidently.

b) **Responsive feeding:** The term responsive feeding (previously referred to as 'demand' feeding) is used to describe a feeding relationship which is sensitive, reciprocal, and about more than nutrition. Staff should ensure that mothers have the opportunity to discuss this aspect of feeding and reassure mothers that breastfed babies cannot be overfed or 'spoiled' by too much feeding and breastfeeding will not tire mothers any more than caring for a new baby without breastfeeding. Breastfeeding can be used to feed, comfort and calm babies; breastfeeds can be long or short, mothers can feed their babies if they instinctively feel they should, their breasts feel full, or they just want to sit and rest. There are several clinical indications for a short term modified feeding regime in the early days after birth. Modified responsive feeding builds in safety to this group of at-risk babies who don't always show feeding cues. Baby should feed a minimum of 8 times in 24hours. If the baby is sleepy then encourage the mother to wake her baby after 3 hours to feed. She may also need to express after some feeds to protect her milk supply until baby is feeding responsively. It is important that mothers understand that modified responsive feeding is only a short-term transition to responsive feeding.

   Where babies are following a modified responsive feeding approach within the neonatal unit the neonatal breastfeeding assessment tool[11] should be completed once every 24 hours to guide the need for ongoing top-up volumes.

c) **Feeding assessment**: A formal breastfeeding assessment will be carried out using the breastfeeding assessment tool[11]. The feeding assessment can be carried out as often as required, with a minimum of two assessments within the 1st 10 days to ensure effective feeding and wellbeing of mother and baby.

   This assessment will include a discussion with the mother, reinforcing what is going well and where necessary developing an appropriate plan of care to address any issues that have been identified. The conversation can be supported by the mothers breastfeeding checklist[11].

   Where mothers require additional breastfeeding support whilst in hospital, the Infant Feeding Team can review and care plan appropriately in partnership with parents.

d) **Weight**: Babies should be weighed as a minimum at **BIRTH, 60-72 HRS** and at **10 days.** Staff should use Breastfeeding Assessment Tools[11] in conjunction with Faltering Growth: Recognition and Management of Faltering Growth in Children (NICE 2017)[12].

e) **Before discharge home from the maternity unit:** Breastfeeding mothers will be given information about recognising effective feeding and where to access additional support if they have any concerns. All breastfeeding mothers will be directed to local support services for breastfeeding.

   Support for complex problems: For those mothers who require additional support for more complex breastfeeding challenges, a referral to the specialist service should be made. Staff should ensure a face to face feeding assessment has happened with a feeding plan implemented and reviewed before referral to the breastfeeding clinic is made.

Complex problems should be highlighted between MW and HV/FNP prior to discharge/ handover. Additional support for parents can be found here: iconcope.org

Midwives refer via Badgernet: New notes; Woman Notes; Referral (woman); Referral to Breastfeeding Support Referral

HV/FNP refer via Breastfeeding Clinic Referral Template NEW 1.docx to ggc.breastfeeding.clinic@nhs.scot

f) **Support for continued breastfeeding in community Services:** The service will work in collaboration with other local services to make sure that mothers have access to social (support groups, voluntary organisations, peer supporters etc) and specialist support (if required) for breastfeeding.

Ongoing Breastfeeding: care in the community focuses on enabling mothers to continue breastfeeding for as long as they wish and assists staff to encompasses the following;

- Carrying out a breastfeeding assessment at primary visit between 10-14 days using breastfeeding assessment tool found on EMIS
- Weight, length and OFC should be completed at primary visit as per HV universal pathway
- Observe a full breast feed and optimise positioning and attachment using CHINS principles (close, head free, in alignment, nose to nipple and sustainable position)
- Support responsive feeding and the understanding that you cannot over feed or spoil a breastfed baby.
- Tailor individual conversations with mothers according to their needs and past knowledge and experience.
- Plan individual care and review date according to the needs of mother and baby being mindful of breastfeeding challenges or growth concerns.

g) **Exclusive breastfeeding:** Mothers who breastfeed will be provided with information about why exclusive breastfeeding is particularly important during the establishment of breastfeeding and leads to the best outcomes for their baby. The World Health Organisation and UNICEF UK BFI recommend that mothers exclusively breastfeed infants for the first six months to achieve optimal growth, development and health.

h) **Supplemental feeding (maternity services)**: 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 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 introducing a teat when a baby is learning to breastfeed. A full record will be made of supplements given, including the rationale for supplementation and the discussion with parents.

A full record will be made of all supplements given, including the rationale for supplementation and the discussion held with parents. Supplementation rates will be audited continuously via supplementation audit and maternal telephone audit.

i) All mothers who breastfeed should take 10 micrograms of Vitamin D daily.
j) All breastfed babies should take 10 micrograms of vitamin D daily.

k) Babies who are mixed feeding and receiving less than 500mls of formula per day require a vitamin D supplementation daily (10 micrograms).

l) Babies who are formula fed do not require vitamin D supplementation until they are consuming less than 500mls of formula per day.

m) Children from 1 to 4 years of age are advised to take Vitamin D supplements. Supplies should be made available on discharge from maternity care with information about how to obtain ongoing supplies within the community.

5. Formula Feeding

All mothers who formula feed will have a conversation enabling safe and responsive formula feeding in line with:

- How to formula feed your baby safely (PH Scotland 2023)[13]
- UNICEF Bottle feeding Assessment Tool (UNICEF 2019)[14]

a) **Safety**: Mothers will be offered a demonstration and / or discussion in hospital after the baby is born on how to clean equipment, how to prepare infant formula safely and the use of appropriate whey based formula milks. This should include information regarding all first stage milks being nutritionally equivalent with varied price points.

b) **Closeness:** Mothers who bottle feed will be encouraged to hold their baby close during feeds and offer the majority of feeds to their baby themselves to help enhance the mother-baby relationship.

c) **Responsiveness**: This term describes a feeding relationship which is sensitive, reciprocal and about more than nutrition. Parents should be encouraged to hold their baby in close during their feeds and to offer majority of the feeds themselves. This will enhance parent-baby relationships. Responding to the baby's cues, inviting the baby to take the teat into their mouth, pacing a feed and not forcing a full feed ensures feeding is a pleasurable experience.

d) **Continuing feeding support**: At the Community Midwife and Health Visitors' first visits a discussion about how feeding is going will be offered. Although staff recognise that this information will have been discussed with maternity service staff, this may need revisiting or reinforcing. Being sensitive to a mother's previous experience, staff will check that mothers are aware of the key points: cleaning and sterilising equipment, making up one feed at a time, using the appropriate whey based milk and responsive feeding. They will also offer information about sources of local parenting support. NICE guidelines[9] recommend measuring weight and head circumference of babies in the first week. Health visitor primary visit would include weight, length and OFC measurements.

6. Introducing Solid Food

All parents will have a timely discussion about when and how to introduce solid food including:

a) **The benefits and rational for starting solid food at around 6 months:** Starting solids helps infants learn about textures, flavours and eating together. It is recommended that infants should start solid foods from around the age of 6 months. For the first 6 months, all the nourishment infants need comes from breast milk (or infant formula), but after around 6 months they need more nutrients than milk alone

can provide, for example, iron.

Before 6 months infants' kidneys, immune and digestive systems are still developing. Waiting until around 6 months ensures these are developed enough to cope with solid foods. Starting solids is also easier at around 6 months because mashed foods and soft finger foods can be used and there is no need to puree or sterilise feeding equipment.

b) Signs of infants' developmental readiness for solid food:

- They can stay in a sitting position and hold their head steady.
- They can reach out and grab things accurately; for example, they may look at a toy, pick it up and bring it to their mouth by themselves.
- The tongue reflex has developed to enable them to move food around their mouth with their tongue instead of pushing food out. Babies who are not ready will push their food back out of their mouth
- If your baby is around 6 months old and the signs above are there, parents can try offering a spoonful of soft food to see how the infant copes.

c) False signs of readiness for starting solids:

- Infant displaying signs of increased hunger
  If an infant seems particularly hungry at any time, they may be having a growth spurt and extra breastfeeding or infant formula will be enough to meet their needs.
- Infant not sleeping through the night (when they had been previously)
  There is no evidence to suggest that starting solids earlier will help to alleviate this issue.
- Bigger infants: There's no need to introduce solid food earlier just because the infant weighs more than other infants of their age.

d) How to introduce appropriate solid foods for infants: It is recommended parents offer a small amount of food at one meal each day, either mashed or finger food, starting with vegetables (first) ~~and~~ then fruit, gradually increasing the amounts and variety of other foods.

As soon as infants show interest, it is also a good idea to encourage them to feed themselves using their fingers, while offering a wide range of different foods and textures, including mashed-up healthy family foods where possible, without any added sugar or salt.

Free-flow cups (given out as part of the Childsmile programme) are recommended from around 6 months, with only (tap) water being offered.

By around 9-10 months, the infant should have been moved on to a more lumpy/minced texture as this helps with the development of muscles for speech and preparedness for further textures associated with family foods.

By 12 months, food rather than breast milk or infant formula should be the main part of the infants' diet. Breastfeeding can continue alongside solid food for as long as the parent and infant desire. At 12 months, formula fed babies should switch to full fat or semi-skimmed cow's milk (or fortified unsweetened plant based alternative).

Important point to remember to discuss Vitamin D[15] drops for the infant (& tablets for breastfeeding mother) with the carers.

For further, more detailed information, we'd recommend referring to the 'Starting Solids' webpage and videos Starting Solids - NHSGGC[16] - see below:

'Starting Solids' webpage includes videos by a dietitian, an oral health promoter and a community chef, showing how to make some of the Fun First Foods recipes and more. The page also contains a range of key messages and lots of helpful resources, designed to help parents get started with introducing first foods to infants as well as supporting staff with the relevant information.

7. Babies Admitted to Neonatal Units and Paediatric Wards

This service recognises the importance of breast milk for babies' survival and health. For more information see Neonatal Infant Feeding Policy[17]**.**

a) **Responsibility**: It is the joint responsibility of Midwifery and NNU/ Paediatric staff to ensure that mothers who are separated from their baby receive information and support.

b) **Value breast milk:** A mother's own breast milk is always the first choice of feed for her baby and mothers should have a discussion regarding the importance of their breast milk for their preterm or ill baby as soon as possible.

c) **Expressing**: Wherever the mother is, if the baby is unable to feed effectively the mother will be enabled to start expressing milk:

References

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[3] Crenshaw J.T, Cadwell K., Brimdyr K., Widström A.M, Svensson K., Dimmitt Champion J., Gilder R.E, Winslow EH (2012) Use of a Video-Ethnographic Intervention (PRECESS Immersion Method) to Improve Skin-to-Skin Care and Breastfeeding Rates, Breastfeeding Medicine, 7(2), pp 69-78.

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[6] Moore E.R, Anderson G.C, Bergman N., Dowswell T. (2012) Early skin-to-skin contact for mother and their healthy newborn infants (Review) The Cochrane Library, Issue 5.

[7] Uvnäs-Moberg K., Francis R. (2003) The Oxytocin Factor: Tapping the Hormone of Calm, Love and Healing. Da Capo Press.

[8] HSIB 2020. Neonatal Collapse Alongside Skin-to-Skin Contact

[9] NICE Guideline 2021. Postnatal Care Guideline 2021

[10] Scottish Government 2022. Safer sleep for babies: guide for professionals

[11] UNICEF UK Baby Friendly Initiative. Breastfeeding Assessment Tools

[12] National Institute for Health and Care Excellence (NICE) 2017. Faltering Growth: Recognition and Management of Faltering Growth in Children

[13] Public Health Scotland 2023. Formula Feeding: How to Feed Your Baby Safely

[14] UNICEF UK Baby Friendly Initiative. UNICEF Bottle feeding Assessment Tool

[15] NHSGGC. Vitamin D Free Supplements Advice

[16] NHSGGC. Starting Solids - NHSGGC

[17] Perinatal Network Scotland 2024. Neonatal Infant Feeding Policy