

Infant feeding - Breastfeeding the Healthy Term Baby

Key points

- Babies' normal feeding pattern is to feed frequently – usually 8-12 times in 24 hours
- All feeding should be supported by a baby-led, developmentally supportive approach
- Staff have an important role in helping parents recognise and respond to their baby's feeding cues
- All babies will be discharged home with a written feeding plan

1. Purpose

This document provides guidelines for breastfeeding of the healthy term baby at the Women's. Breast milk and breastfeeding are the optimum form of feeding for all babies. It is normal and physiologically beneficial for newborn babies to feed very frequently - usually 8-12 times in 24 hours, often 1 to 3 hourly. Cluster feeding (several feeds in a short time period) and night feeds are normal and benefit both mother and baby. [Breastfeeding Policy](#)

2. Definitions

Healthy Term Baby

- 37 completed weeks gestation or greater
- >2500gm birth weight
- no medical morbidities identified

3. Responsibilities

Midwifery, Nursing and Medical Staff:

- Provide evidence based care to breastfeeding mothers and their babies based on the Baby Friendly Health Initiative (BFHI) Ten Steps to Successful Breastfeeding.
- Give parents accurate information and advice regarding care and feeding of their baby.
- Consult with and/or refer to other healthcare team members when indicated.

Clinical educators, facilitators and preceptors

- Educate staff regarding evidence based care for breastfeeding mothers and babies

Lactation Consultants:

- Provide primary or secondary lactation consultations and recommendations to parents, midwifery and nursing staff and medical staff.

4. Guideline/Procedure

4.1 Birth room

Immediate skin-to-skin contact

- Place the baby skin-to-skin on its mother's chest and cover both mother and baby with a warm blanket
- Position the baby with the head slightly extended to enable a clear airway whilst in skin-to-skin contact
- Leave undisturbed for at least one hour or until after the first breastfeed is initiated

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- Maintain observation of the baby's breathing, colour and muscle tone whilst in skin-to-skin contact
- Routine newborn vital signs can be assessed while the baby is in skin-to-skin contact
- A support person or midwife should remain in the room at all times particularly if the mother has received narcotic analgesia during labour
- Babies born by caesarean section should be placed skin-to-skin with their mothers as soon as the mother's condition allows this, preferably in post anaesthetic care unit (PACU) or if this is not possible, soon after the mother returns to the maternity ward.

Keeping baby safe during skin-to-skin contact

If the midwife leaves the birthroom whilst baby is in skin-to-skin contact, instruct the mother and birth support persons to:

- Observe the baby's breathing and colour. The baby should be breathing easily and the lips should be pink.
- Observe the baby's muscle tone by gently lifting the baby's arm up then releasing – the baby will pull the arm back towards the body.
- If the baby's lips are not pink or the arm is limp, call the midwife immediately.

First feed

- Assist the mother to recognise early baby feeding cues such as crawling movements, mouthing, vocalising, hand-to-mouth movements, searching for the nipple
- Assist mother and baby into a comfortable position to facilitate baby-led feeding, offering help with attachment if needed
- Showering the mother and weighing the baby, as well as any other routine, non-urgent procedures should be delayed until after the first feed
- Allow the first feed to continue uninterrupted until the baby appears to have finished feeding.

4.2 Subsequent feeds – first 24 hours

- Subsequent feeds will depend on how the baby breastfeeds in the immediate post birth period. Refer to flow chart [appendix 1]
- Some babies will not be interested in feeding in the first 24 hours – this is normal if the baby is clinically well, and formula supplementation is not indicated
- If the baby is not interested in feeding, observe for signs of hypoglycaemia and sepsis as per the following RWH guidelines:
 - [Hypoglycaemia - Infant Management](#)
 - [GBS Colonisation Management of infant to prevent Early Onset Group B Streptococcus \(EOGBS\) Disease](#)
 - [Sepsis in the Neonate - Identification, Evaluation and Management](#)

4.3 After the first 24 hours

- Breastfeeding should be flexible and unrestricted 24 hours per day
- After the first twenty-four hours, most newborn babies need at least 8-12 feeds/24 hours
- During each feed:
 - Offer both breasts at each feeding, alternate the starting breast. The baby may feed from one or both breasts
 - Allow the baby to finish the first breast before offering the second. The baby may need a short break before taking the second breast
 - Observe for and educate the mother regarding effective sucking and swallowing and signs of milk transfer
 - Length of feeds may vary greatly and this does not indicate feeding effectiveness

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- Long intervals (eg > 6 hrs) between feeds should be avoided as this may negatively affect the establishment of an adequate breast milk supply and contribute to weight loss, jaundice, lethargy or unsettled baby
- Continued skin-to-skin contact during the postnatal stay can facilitate effective establishment of breastfeeding.

4.4 Supplementary feeds

- Formula supplementation is not required in the first 24 hours in the healthy term newborn [Academy of Breastfeeding Medicine Clinical Protocol #3 2009]
- Expressed breastmilk is the first choice if supplementary feeds are considered necessary
- Formula supplementation should only be given if there are acceptable medical indications AND there is insufficient expressed breastmilk available [see appendix 2]
- Supplementary feeds, if required, should be given by cup, syringe or spoon. Avoid the use of bottles, teats or pacifiers as these may negatively affect the establishment of breastfeeding
- If a mother requests artificial infant formula for her baby in the absence of medical indications, the midwife should discuss with her why this is not recommended. If the mother still wishes to give her baby artificial infant formula, she should be given a copy of the 'Infant formula information for breastfeeding mothers' prior to her baby being given the artificial infant formula.
- Refer to the RWH clinical guideline [Infant Feeding - Indications, Use and Preparation of Artificial Infant Formula](#)

4.5 Assessment of breastfeeding

Document an assessment of breastfeeding at least once each shift during the hospital stay.

Assess the following:

- condition of both breasts and nipples
- baby feeding cues
- positioning and attachment skills
- signs of effective milk transfer
- frequency of feeds
- urine and stool output – number and character
- hydration
- presence of jaundice
- mothers understanding of normal breastfeeding patterns
- assess weight loss after 48 hours

4.6 Recognition of baby feeding cues and signs of adequate milk intake

- Provide mother with a copy of the Australian Breastfeeding Association's handout 'Normal nappies: what to expect' prior to discharge
- Mothers should be taught how to identify their baby's feeding cues. These may include the following:
 - Mouthing – opening and closing mouth
 - Rooting - turning head from side to side
 - Rapid eye movements, waking from sleep and becoming restless
 - Opening mouth and making cooing or sighing noises or sucking fist or fingers
 - Nuzzling into breast. Change in facial expression
 - **Crying is a late hunger cue**

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- Provide parents with education about the signs of adequate milk intake as follows:
 - The baby is settled most times between feeds, although unsettled periods where the baby will feed very frequently are common
 - During breastfeeds rhythmic sucking and swallowing can be seen and heard once the milk is in
 - The mother's breast is fuller at the start of the feed and softer at the end of the feed, once the milk is in
 - The baby has appropriate output as follows:

Day	Hours	Urine	Stools
1	0-24h	1 wet	Meconium
2	24-48h	2 wet	Soft green black
3	48-72h	3 wet	Greenish brown- less sticky
4	72-96 h	4 wet	Greenish- brown changing to mustard yellow which can be seedy/watery
5	96h +	5 wet	Mustard yellow, soft or liquid 3-4 times per 24hrs
6		5-6 disposable 6-8 cloth	Mustard yellow, soft or liquid 3-4 times per 24hrs.
The presence of urates in the nappy is normal up to day four. Urine should be pale yellow in colour			

Normal weight loss and gains are as follows:

- Loss of less than 7% of birth weight is considered normal in the first few days of life
- Loss of 7-10% of birth weight may be normal, but assess that infant is well and feeding adequately
- Loss of >10 – 12.5% of birth weight requires infant wellness and feeding review, and discussion with the neonatal RMO and ongoing daily review until appropriate weight gain.
- Once the milk is in, the average weight gain for the first 3 months is around 20-30 gm per day or 150-200gm per week, but this can vary.
- The baby should regain their birth weight by 14 days of life.

4.7 Positioning and attachment

- Begin with the baby skin-to-skin and encourage baby-led attachment where this is reasonably practicable for mother and baby

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- Babies are more likely to attach and feed effectively when they are supported to follow their instincts and self-attach to the breast
- Ensure the mother is aware of how to correctly position and attach her baby to the breast if the baby cannot self-attach
- A 'hands off or hands over' approach is preferable when teaching these skills to mothers. Cloth dolls and breasts are available in each maternity ward to demonstrate
- In some situations, the midwife may need to fully assist the mother to position and attach her baby e.g. first 24 hours following caesarean section.

4.8 Babies who are not feeding well

- A review of mother and baby's history should be undertaken to identify any risk factors that may contribute to poor feeding
Refer to flow chart for actions to take if a baby is not feeding well.[appendix 1]

4.9 Discharge and follow up care

- A feeding plan must be in place for every baby before they are discharged home.
- Ensure the mother has contact details for where to find extra help with breastfeeding if required after discharge home.

Australian Breastfeeding Association 24 hour helpline 1800 686 2 68
MCHN helpline 13 22 29

- Print out any breastfeeding fact sheets that may be applicable to the mother's individual needs.

5. Evaluation, monitoring and reporting of compliance to this guideline or procedure

Compliance to this guideline or procedure will be monitored, evaluated and reported through the following:

- Breastfeeding Services Lactation Consultants when called to provide consultations for women and their babies within the scope of this guideline will review the documented treatment plan to determine consistency with this guideline
- Where a treatment plan does not comply with this guideline the Lactation Consultant will complete a clinical incident report (Riskman).
- The Breastfeeding Service will review all incidents of non-compliance reported through VIHMS and develop an action plan to address issues as required.

6. References

Academy of Breastfeeding Medicine (2009) Clinical Protocol #3: Hospital Guidelines for the Use of Supplementary Feedings in the Healthy Term Breastfed Neonate

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- Victorian Breastfeeding Guidelines, 2014. Department of Education and Early Childhood Development, Victoria, Australia

http://www.who.int/nutrition/publications/infantfeeding/9789241595018_s1.pdf

7. Legislation/Regulations related to this guideline or procedure

Nil

8. Appendices

[Appendix 1: Breastfeeding the Healthy Term Baby flow chart](#)

[Appendix 2: Acceptable Medical Reasons for Use of Breastmilk Substitutes](#)

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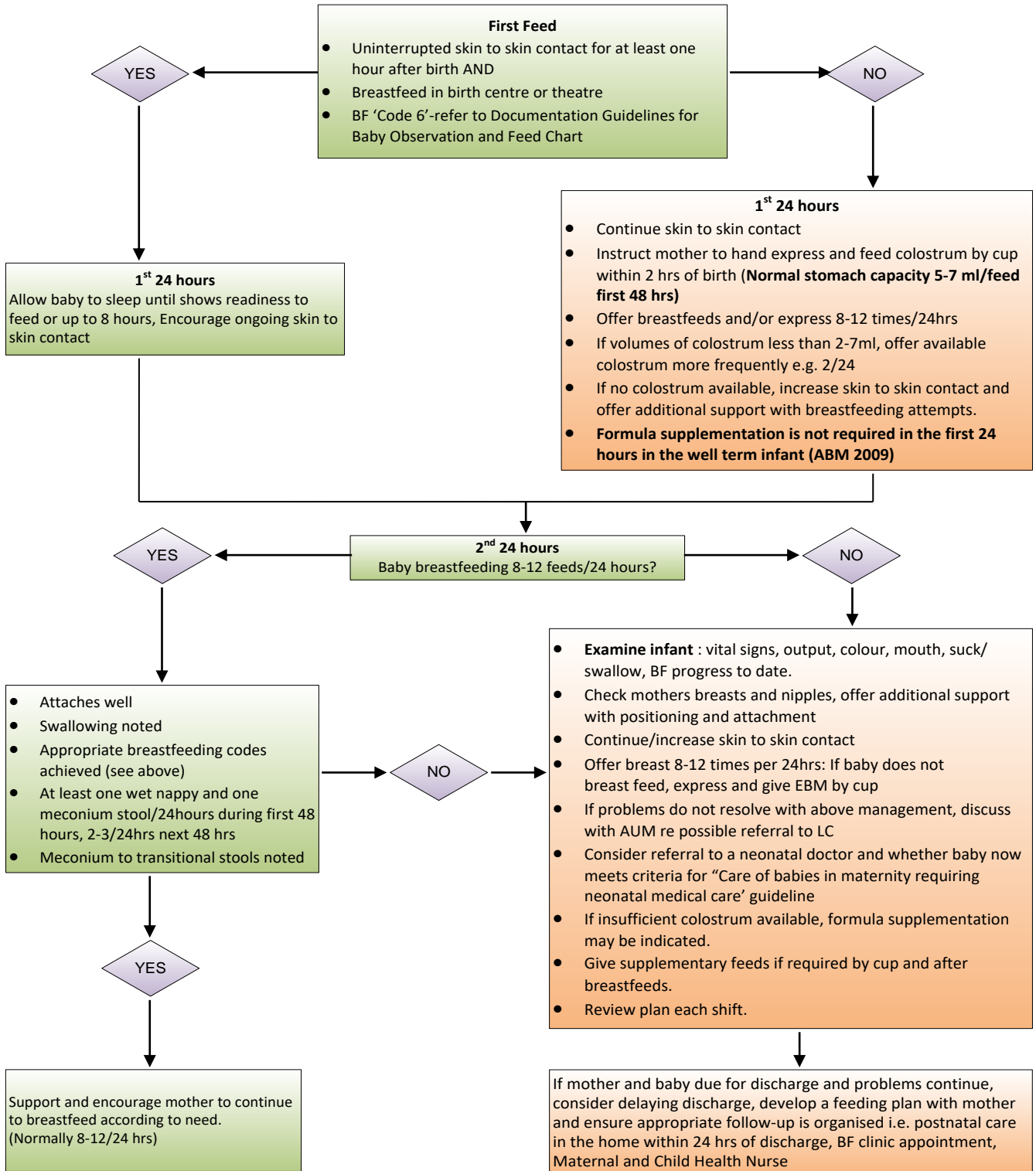
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Breastfeeding the Healthy Term Baby Flow Chart



Breastfeeding the Healthy Term Baby

- Full term healthy baby >37 completed weeks gestation
- ≥ 2500gms
- Not under neonatal medical care



Academy of Breastfeeding Medicine Protocol #3 Hospital Guidelines for the Use of Supplementary Feedings in the Healthy Term, Breastfed Neonate Revised 2009

Acceptable Medical Reasons for Use of Breastmilk Substitutes



From BFHI Australia. (2009). *Booklet 1 – The Global Criteria for Baby Friendly Hospitals in Australia. Standards for Implementation of the 10 Steps to Successful Breastfeeding.*

Introduction

Almost all mothers can breastfeed successfully, which includes initiating breastfeeding within the first hour of life, breastfeeding exclusively for the first 6 months and continuing breastfeeding (along with giving appropriate complementary foods) up to 2 years of age or beyond.

Exclusive breastfeeding in the first six months of life is particularly beneficial for mothers and infants. Positive effects of breastfeeding on the health of infants and mothers are observed in all settings. Breastfeeding reduces the risk of acute infections such as diarrhoea, pneumonia, ear infection, *Haemophilus influenza*, meningitis and urinary tract infection. It also protects against chronic conditions in the future such as type-1 diabetes, ulcerative colitis, and Crohn's disease.

Breastfeeding during infancy is associated with lower mean blood pressure and total serum cholesterol, and with lower prevalence of type-2 diabetes, overweight and obesity during adolescence and adult life. Breastfeeding delays the return of a woman's fertility and reduces the risks of post-partum haemorrhage, pre-menopausal breast cancer and ovarian cancer.

Nevertheless, a small number of health conditions of the infant or the mother may justify recommending that she does not breastfeed temporarily or permanently. These conditions, which concern very few mothers and their infants, are listed below together with some health conditions of the mother that, although serious, are not medical reasons for using breast-milk substitutes.

Whenever stopping breastfeeding is considered, the benefits of breastfeeding should be weighed against the risks posed by the presence of the specific conditions listed.

Infant Conditions

Infants who should not receive breast milk or any other milk except specialized formula

- Classic galactosemia: a special galactose-free formula is needed;
- Maple syrup urine disease: a special formula free of leucine, isoleucine and valine is needed;
- Phenylketonuria: a special phenylalanine-free formula is needed (some breastfeeding is possible, under careful monitoring).

Infants for whom breast milk remains the best feeding option but who may need other food in addition to breast milk for a limited period

- very low birth weight infants (those born weighing less than 1500g);
- very preterm infants, i.e. those born less than 32 weeks gestational age;
- newborn infants who are at risk of hypoglycaemia by virtue of impaired metabolic adaptation or increased glucose demand (such as those who are preterm, small for gestational age or who have experienced significant intrapartum hypoxic/ischaemic stress, those who are ill and those whose mothers are diabetic⁵) if their blood sugar fails to respond to optimal breastfeeding or breast milk feeding.

Maternal Conditions

Mothers who are affected by any of the conditions mentioned below should receive treatment according to standard guidelines.

Mothers who may need to avoid breastfeeding

- HIV infection: if replacement feeding is acceptable, feasible, affordable, sustainable and safe

Acceptable Medical Reasons for Use of Breastmilk Substitutes



(AFASS)

The most appropriate infant feeding option for an HIV-infected mother depends on her and her infant's individual circumstances, including her health status, but should take consideration of the health services available and the counselling and support she is likely to receive. When replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS), avoidance of all breastfeeding by HIV-infected women is recommended. Mixed feeding in the first 6 months of life (that is, breastfeeding while also giving other fluids, formula or foods) should always be avoided by HIV-infected mothers.

Mothers who may need to avoid breastfeeding temporarily

- Severe illness that prevents a mother from caring for her infant, for example sepsis;
- Herpes simplex virus type 1 (HSV-1): direct contact between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved;
- Maternal medication:
 - sedating psychotherapeutic drugs, anti-epileptic drugs and opioids and their combinations may cause side effects such as drowsiness and respiratory depression and are better avoided if a safer alternative is available
 - radioactive iodine-131 is better avoided given that safer alternatives are available - a mother can resume breastfeeding about two months after receiving this substance;
 - excessive use of topical iodine or iodophors (e.g., povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression or electrolyte abnormalities in the breastfed infant and should be avoided;
 - cytotoxic chemotherapy requires that a mother stops breastfeeding during therapy.

Mothers who can continue breastfeeding, although health problems may be of concern

- Breast abscess: breastfeeding should continue on the unaffected breast; feeding from the affected breast can resume once treatment has started;
- Hepatitis B: infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter;
- Hepatitis C;
- Mastitis: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition;
- Tuberculosis: mother and baby should be managed according to national tuberculosis guidelines;
- Substance use:
 - maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies;
 - alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby.

Mothers should be encouraged not to use these substances and given opportunities and support to abstain. Mothers who choose not to cease their use of these substances or who are unable to do so should seek individual advice on the risks and benefits of breastfeeding depending on their individual circumstances. For mothers who use these substances in short episodes, consideration may be given to avoiding breastfeeding temporarily during this time.

**Addendum for Australia ACM – BFHI Handbook for Maternity Facilities
Baby Friendly Health Initiative, Australia. Updated 2016 incorporating the revised
World Health Organisation (WHO) & UNICEF Global Standards for BFHI.**

Acceptable Medical Reasons for Use of Breastmilk Substitutes



The list above was developed by the World Health Organization for global use. There are some situations and more recent recommendations which are not included above, but are listed below that are considered by BFHI to be acceptable medical reasons for the use of breastmilk substitutes in Australia.

Primary Inadequate Breastmilk Supply

- Breast surgery: Women who have had breast surgery such as breast reduction with nipple relocation may find it necessary to use a breastmilk substitute to supplement their baby's intake and ensure adequate nutrition.
- Bilateral breast hypoplasia: Every attempt should be made to stimulate an adequate milk supply, but if unsuccessful, the baby may need a breastmilk substitute to supplement intake and ensure adequate nutrition.

HIV Infection

The World Health Organization (WHO) have released updated guidelines; Guidelines on HIV and Infant Feeding, 2010, Principles and recommendations for infant feeding in the context of HIV and a summary of Evidence, Geneva WHO; 2010. If a decision is made to use replacement feeding it must be acceptable, feasible, affordable, sustainable and safe (AFASS). An individual decision should be made in consultation with each mother, taking into account her circumstances and viral load.