GUIDANCE

Infant Feeding Guidance

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<td>RELATED SOP</td>
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<td>12/10/17</td>
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<tr>
<td>AUTHOR</td>
<td>Infant Feeding Team LCFT and Baby Friendly Team ELHT</td>
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1. **PARENT POLICY**

The Infant Feeding guidance Links to the Infant Feeding policy CL047. The Infant Feeding guidance supports clinical staff to implement their roles and responsibilities around the Management of complex breastfeeding challenges.

2. **GUIDANCE – contents**

1. Antenatal Colostrum Harvesting.
4. Prevention and management of excessive weight loss in the neonate
5. Insufficient milk supply
6. Use of Galactogues (domperidone)
7. Prematurity, feeding and relationship building
8. Formula Supplementation – possible medical reasons for
10. The use of nipple shields.
11. Hyperlactation
12. Thrush
13. Mastitis
15. Expressing and storage of breast milk
16. Alcohol, Smoking and medication – implication when breastfeeding.
17. Returning to work and study when breastfeeding.
18. Safer Sleep – Co Sleeping
19. Introducing Solid Foods
20. Appendix – Tongue Tie referral Forms

3. **COMMUNICATION**

LCFT clinical CFHS (other relevant services supporting lactating women) staff are to be orientated to the Infant Feeding Guidance document within one week of employment with the trust.

4. **REVIEW**

Reviewed in accordance with change in evidence, updating of Baby Friendly Initiative Standards or 3 yearly.

5. **FURTHER GUIDANCE/RELATED SOPS**

Standard Operating Procedure for the delivery of the Healthy Child Programme 0 - 4 years.
1. ANTENATAL (AN) HAND EXPRESSING TO HARVEST COLOSTRUM

RATIONALE: There are benefits of having colostrum ready at the point of birth. We know that colostrum is very protective, not only does it regulate blood sugar levels, but also protects babies from infection, optimizes bowel movement, and is easy to digest.

ELHT are now teaching diabetic mums to hand express at the consultant AN clinic—and provide equipment to do so

VALUE OF ANTENATAL HAND EXPRESSING:

- Teaching mothers the technique of hand expression can give the mother visible reassurance that she is producing colostrum. Though production of colostrum may reassure a woman that her breasts are working - it is not always possible to express colostrum in the AN period, so reassurance should be given that this does not influence milk production after birth
- Learning about AN hand expression encourages women to become familiar with their breasts and aware of what the breast tissue feels like. She can identify the position of the bundles of lactiferous ducts, which may help her appreciate where the baby’s mouth needs to be for effective attachment
- Practising a new skill means that you get better at it – this is good preparation for the postnatal period
- Any colostrum expressed can be stored for use in the PN period. This may be particularly useful for infants of diabetic mothers. This should be discussed with women in the diabetic antenatal clinic with an offer to demonstrate the skill and discuss storage of colostrum
- AN colostrum harvesting can be useful for any mother whose baby may be predisposed to low blood sugars post birth i.e. mothers who are taking beta-blockers, mothers whose babies are expected to be low birth weight.

BENEFITS OF ANTENATAL EXPRESSING FOR DIABETIC WOMEN:

- Diabetic women are more likely needed to hand express post birth to maintain healthy blood sugar levels – practising expressing pre-birth raises confidence in this skill
- Any colostrum collected can be brought into the unit at the time of birth and be used to assist in keeping blood sugar levels normal. This can prevent formula milk being used (which in turn can be a trigger for juvenile diabetes)

CONTRAINDICATIONS:

Threatened/actual premature labour, cervical incompetence / suture, multiple pregnancy

TEACHING THE SKILL (TAUGHT BY ELHT STAFF IN DIABETIC CLINIC):

- Hand expression can be taught at any time during pregnancy; however, mothers are advised not to commence this before 37 weeks gestation. Teaching the skill is most effective in the few weeks before 37 weeks gestation – to aide memory
- Midwives should use the “3 stage” method when teaching hand expression – wash hands, prepare / stimulate and the expressing technique. Clear instructions are important, and the agreed resources can be used as an aide memoire for the mother.
- Suggest for women to express for short periods of time and only a couple of times a day – plus collect any that is naturally leaking. Encourage women to be gentle, in order to avoid nipple / breast trauma. Breast pumps should not be used during pregnancy
- Remember to explain amounts expressed will vary from none at all to a few drops to a teaspoon full
- AN expressing may stimulate Braxton-Hicks contractions – this is normal. The mother should stop expressing if these start to feel like mild labour contractions (though this would be rare or
coincidental). NB. Braxton Hicks contractions are also stimulated by other oxytocin releasing activities other than hand expressing.

- Give ELHT mother information regarding AN hand expressing at the same time as teaching the skill for further reference

**STORAGE OF COLOSTRUM (UNTIL THE COLOSTRUM IS NEEDED):**

- Colostrum must be stored in purple feeding syringes capped with a sterile white cap – these are provided by the midwife teaching the skill. The diabetic midwife or nominated/trained support staff will teach this. The diabetes midwife will ensure there is a mechanism for a small stock of syringes, caps and labels in the clinics
- All syringes must be clearly labelled with name, RXR number, date/time expressed
- Colostrum can be stored in a fridge at 0-4 degrees Celsius for up to 5 days at home (ideal if mother knows she is being induced the next day). Storing inside a zip lock freezer bag is best.
- Colostrum can be stored at home in the freezer (-18 degrees Celsius) for 6 months. Any frozen colostrum can be brought into the unit in freezer packs – to prevent defrosting. Frozen colostrum will be kept in the freezer space on the antenatal ward in a freezer bag and labelled effectively – staff will be aware of safe storage guidelines
- Hospital storage times differ from home storage – guidelines should be followed
- Once in the unit at the birth time – frozen colostrum will need to be stored in a freezer until the colostrum needed (it should defrost quickly at room temperature or near to mothers skin)

**DEFROSTING COLOSTRUM:** This is done quickly at room temperature – and should not be re-frozen

**TRAINING:** Midwives and nominated support staff will be trained to be able to effectively teach mothers the skill of hand expressing and give information regarding safe storage of breast milk

**MONITORING:** Sample audit of mothers who antenatal express and postnatal outcomes will be conducted annually by the diabetes specialist midwife

**REFERENCES:**

- Cairnhs Health Service District (2008) Protocol - Antenatal expression of colostrum for mothers with diabetes and other mothers whose babies are likely to have feeding difficulties.
- Journal of Diabetes Nursing, ‘Colostrum harvesting and type 1 diabetes’, March 2005
- Riordan, J. (2009), *Breastfeeding and human lactation* (3rd Ed.). Jones and Bartlett: Boston
Drugs in Breastmilk

Information Sources

Ante natal/postnatal mum wants more information about prescribed or holistic medication and its impact/safety in relation to breastfeeding.

For up to date fact sheets and evidence on drugs in breastmilk go to

(LacMed drugs in breastmilk data base)

If you are unable to find the information specific to a certain drug/condition on either of these sights then you have the option of emailing or ringing one of the below information sources.

Ensure you have age of baby, gestation at birth, drug name, dose and frequency, how long mum been taking it for and is she or baby on any other medications.

North West Medicines Information Centre
Tel. 01517948206 Email pwmedinfo@nhs.net

Breastfeeding network drug information line
Tel. 0844 412 4665 Email druginformation@breastfeedingnetwork.org.uk

Medicine management LCFT
Tel. 01254 226219
3. BREAST ABSCESS IN LACTATING MOTHERS
PATHWAY FOR EARLY ACCESS TO SURGICAL TRIAGE TEAM AND SPECIALIST INFANT FEEDING SERVICES FOR MOTHERS WITH SUSPECTED BREAST ABSCESS

Definition:-

A breast abscess is a localized collection of pus within the breast that occurs in around 3% of women, secondary to mastitis that has not been effectively managed.

A breast abscess should be suspected if the woman has:

• A history of recent mastitis
• A painful, swollen lump in the breast with redness, heat, and swelling of the overlying skin
• Fever and malaise.

Any woman with a suspected breast abscess should be referred urgently to a general surgeon for confirmation of the diagnosis (by ultrasound), and for drainage of the abscess (by ultrasound-guided needle aspiration or surgical drainage) NICE 2014

For other localities contact HV, GP or midwife,
4. PREVENTION AND MANAGEMENT OF EXCESSIVE WEIGHT LOSS IN THE NEONATE

The following guidelines are to support professionals working within the community across Lancashire Care NHS Foundation Trust

Excessive weight loss is often due to ineffective breastfeeding (failure to establish lactation), inappropriate formula feeding or neonatal illness.

HOW MUCH WEIGHT LOSS IS NORMAL? Some weight loss in the first few days of life is normal. 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 first three days of life, although studies have indicated that, in the majority of babies, it is more likely to be between 5 and 7%.

Excessive weight loss results when there is ineffective milk transfer to the baby. The most likely reason for this is poor positioning / attachment or infrequent feeds. Rarely, it may be due to a medical condition or physical abnormality in either mother or baby. However, in all but a very small minority of cases, the problem can be overcome with an effective care plan/management. If the problem is not corrected, suppression of milk production will result.

HOW SERIOUS IS THE PROBLEM? There has been much discussion around weight loss, with increasing concern about babies with raised blood sodium levels (hypernatraemia). Hypernatremic dehydration can be difficult to diagnose clinically until it is very severe. Significant dehydration can result in serious sequelae such as stroke and thrombosis.

IS WEIGHING THE ANSWER? Some health professionals are concerned that weighing undermines a mother’s confidence. This can be minimised, provided that appropriate explanation of the purpose of weighing and ‘normal weight losses’ are given, and staff skills in supporting breastfeeding are effective. Reluctance to weigh babies can result in problems which are more difficult to resolve and, ultimately, more damaging to confidence in breastfeeding. A robust system of accurate, routine weighing is therefore vital to ensure that problems are detected early enough to avoid putting babies at risk. Of course, weighing the baby only identifies the problem, it does not resolve it. So any system for detecting ineffective breastfeeding must also enable it to be remedied. It is worth noting that babies should have re-gained their birthweight by 2nd or 3rd week of life.
**REASONS WHY BABY MAY NOT GET ENOUGH MILK:**
(NB: there may be several factors contributing in any one scenario)

<table>
<thead>
<tr>
<th>Breastfeeding factors</th>
<th>Factors occasionally associated with breast milk insufficiency</th>
<th>Factors rarely associated with breast milk insufficiency</th>
<th>Factors that can effect formula feed babies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed start in breastfeeding</td>
<td>Dislike of breastfeeding (indirectly)</td>
<td>Retained products of conception, post-partum haemorrhage.</td>
<td>Oral abnormalities e.g. tongue Tie</td>
</tr>
<tr>
<td>Inefficient suckling</td>
<td>Medication(e.g. contraceptive pill, diuretics)</td>
<td>Severe malnutrition</td>
<td>Unwell baby</td>
</tr>
<tr>
<td>Infrequent feeds</td>
<td>Pregnancy</td>
<td>Inadequate breast development.</td>
<td>Incorrect preparation of feed.</td>
</tr>
<tr>
<td>Scheduled feeds</td>
<td>Alcohol / smoking</td>
<td>Pain</td>
<td>Incorrect milk</td>
</tr>
<tr>
<td>Short feeds</td>
<td>Prematurity, illness / abnormality in baby e.g. tongue tie</td>
<td></td>
<td>Poor parental feeding technique</td>
</tr>
<tr>
<td>Supplementary feeds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of a teat or dummy</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Maternal confidence, tiredness, stress and emotional wellbeing.</td>
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**AIM:** Assess and rapidly determine any possible feeding difficulties, and manage any weight loss early and effectively.

**ADDITIONAL / CLOSE BREASTFEEDING SUPPORT IS NEEDED FOR THESE MOTHERS:**

- After C/Section
- After narcotic analgesia or general anaesthesia
- Following a period of separation
- For mothers with inverted nipples
- Preterm babies
- Primigravida mothers
- Mothers with Diabetes
**ASSESSMENT OF BREASTFEEDING:** A breastfeed should be observed and the agreed breastfeeding assessment tool (ECR Breastfeeding assessment tool and Mothers Breastfeeding assessment form) should be used at the primary visit and subsequent visits.

At each contact it is important to assess how feeding is going. Any abnormal findings trigger development of a care plan with the mother, and follow-up will be agreed.

**ASSESSMENT OF OUTPUT** - at each contact, together with on-going monitoring by the mother. Inadequate output (i.e. less than that specified - see table below) triggers weight assessment and implementation of appropriate plan.

The following findings are ‘reassuring’ in a breastfed baby. Any deviation from this should trigger further assessment.

<table>
<thead>
<tr>
<th>AGE</th>
<th>DAY 1-2</th>
<th>DAY 3-4</th>
<th>DAY 5-6</th>
<th>DAY 7-28+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urine:</strong> number of wet nappies per day</td>
<td>1-2 or more; urates may be present*</td>
<td>3 or more; nappies feel heavier</td>
<td>5 or more</td>
<td>6 or more, heavy</td>
</tr>
<tr>
<td><strong>Stools:</strong> number per day, colour, consistency</td>
<td>1 or more, dark green / black ‘tar-like’ (meconium)</td>
<td>2 or more, changing in colour and consistency - brown/green/yellow, becoming looser ('changing stool')</td>
<td>2 or more, yellow; may be quite watery</td>
<td>2 or more, at least size of £2 coin, yellow and watery, ‘seedy’ appearance</td>
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* Urates are normal bladder discharges in the first few days but persistent urates may indicate insufficient milk intake.

**NB:** After 28 days, baby may establish own frequency of passing stools - may pass several per day or have several days’ gap between stooling. Therefore, continued vigilance around feeding and growth assessments is essential.

**WEIGHT** – will be recorded at the New Birth Visit and as per Healthy Child Programme and LCFT’s Childhood Growth Policy.

**MATHMATICAL FORMULA FOR CALCULATING PERCENTAGE WEIGHT LOSS:**

1. Subtract the current weight from the birth weight.
2. Multiply the resultant figure of weight loss by 100.
3. Divide this figure by birth weight which will give you the percentage of weight lost.

**Example:** 3000gr. - 2800gr. = 200 gr. X 100 = 20000 divided by 3000gr. = 6.7% weight loss
Weight loss of 8% or more triggers further action.

<table>
<thead>
<tr>
<th>AMOUNT OF WEIGHT LOSS</th>
<th>MANAGEMENT PLAN INDICATED</th>
</tr>
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<tbody>
<tr>
<td>8% - under 10% of birth weight</td>
<td>1</td>
</tr>
<tr>
<td>10% - 12.5% of birth weight</td>
<td>1 &amp; 2</td>
</tr>
<tr>
<td>More than 12.5% of birth weight</td>
<td>1 &amp; 2 &amp; 3</td>
</tr>
</tbody>
</table>

**MANAGEMENT PLANS**

<table>
<thead>
<tr>
<th>PLAN</th>
<th>% LOSS</th>
<th>MANAGEMENT</th>
</tr>
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</table>
| 1    | 8% - 10 | - Liaise with midwife and assess existing care plans and outcome via the handheld maternity records and Child Health Record (The Red Book).  
- Review effectiveness of feeding care plan and consider reweigh after 24-48 hours - if weight increasing, monitor closely and offer support. **IF NO OR MINIMAL WEIGHT INCREASE, MOVE TO MANAGEMENT PLAN 2** |
| 2    | 10% - 12.5 | Plan 1 plus:  
- Refer to breastfeeding assessment tool and implement feeding plan accordingly.  
- For sleepy babies, consider ‘switch feeding’  
- Consider implementing an expressing care plan to protect lactation.  
- **Formula supplementation is not required at this stage unless baby unwell and mother unable to breastfeed or supply EBM**  
- Refer to medical practitioner if infection or other illness suspected  
- Review effectiveness of feeding care plan and consider re weighing again in 24-48 hours – according to the history and your assessment.  
- Ensure extra support is in place and continue to assess progress until weight is increasing. **IF NO OR MINIMAL WEIGHT INCREASE, MOVE TO MANAGEMENT PLAN 3** |
| 3    | > 12.5 | Plan 2 plus:  
- Refer to hospital for review by neonatal/paediatric team (see flow chart) & infant feeding team or trained, experienced health professional  
- In hospital the mother can expect:  
Frequent breastfeeds & expressing from admission, with hospital-grade breast pump (double-pump)  
  Carry out investigations* to determine ongoing care. Care plans may include formula feeds by cup or occasionally IV fluids if breastfeeding is ineffective or EBM unavailable  
- Reduce formula offered as breast milk supply increases. Review effectiveness of care plan within 24 hrs and consider re weighing. Upon
discharge continue to monitor weight x 2 weekly until clear trend towards birth weight demonstrated

*Investigations include urea and electrolytes along with other clinically relevant tests as indicated. In order to ensure safety, a serum sodium level in excess of 150 mmol/L, when found together with a clinical picture of weight loss in excess of 12.5% and diminished urine and stool output - with or without jaundice – indicates a need for supplementation. May be necessary to calculate amount of supplementation for those infants that are unwell.

**HEALTH VISITOR WEIGHT ASSESSMENT AT HOME AT NEW BIRTH VISIT AND SUBSEQUENT VISITS**

**MANAGEMENT OF BABIES WITH WEIGHT LOSS IDENTIFIED AT HOME**

**WEIGHT LOSS**
- Between 8% - 10%
- Between 10% - 12.5%
- Over 12.5%

**Weight loss 0 – 10%**
Follow plan 1

**Weight loss 10 – 12.5% with no clinical signs of ill health or dehydration**

**UNDER 10 DAYS:**
- Weight loss 12.5% and baby is clinically well (may be jaundiced)
  - ELHT Admit: Refer to Neonatal Registrar on 01262 804645/bleep 150
  - LTH: 01772 516565 & Southport and Ormskirk 01695 577111 ring and bleep Paediatrician on call
  - Review / assessment by Neonatal medical team and infant feeding team or experienced midwife
  - Appropriate support / investigations
  - Review in 24 hours
  - Ward staff to follow plan 3

**UNDER 10 DAYS:**
- Weight loss over 12.5% and baby is UNWELL
  - ELHT: Ring 01254 739999 and ask for Paediatric Assessment
  - LTH: Ring 01772 516565 (switchboard) to bleep Paediatric Registrar on call

**OVER 10 DAYS:**
- Any other problems? ELHT: Ring 01254 739999 and ask for Paediatric Assessment
- LTH: Ring 01772 516565 (switchboard) to bleep Paediatric Registrar on call

**REFERENCES / INFORMATION:**


Postnatal Care NICE Guidelines 2014


Supporting Health and Wellbeing
Please visit the Trustnet Policy site for the latest version of this document
5. **INSUFFICIENT MILK SUPPLY**

To ensure mothers are supported to maximise their milk supply and confidence when her supply is reduced and / or growth of her baby is faltering. These guidelines are to be used in conjunction with the Infant Feeding Policy and in consultation with the mother, in order for to make a fully informed choice.

**Ways in which breast milk production could be compromised**

**Breastfeeding causes:**
- A delayed start in breastfeeding: breastfeeding should start soon after birth
- Ineffective suckling / poor attachment at the breast: good suckling and good attachment means babies can remove the milk from the breast and stimulate a good milk supply
- Scheduled feeds: responsive feeding means that babies access all the milk they need, when they need it, including during the night.
- Short feeds: allowing the baby to finish the feed means he / she will access high fat milk and will provide full stimulation for future requirements
- Supplementary feeds: babies who exclusively breastfeed will not fill up from other supplements and consequently will feed more eagerly at the breast and stimulate a good milk supply. Also, the mother’s confidence will not be affected.
- Introducing teats and dummies: babies who haven’t been introduced to teats and dummies will often respond to the breast better and achieve optimal attachment. Dummies are often associated with a shorter duration of breastfeeding, probably because they often hide feeding cues and this could result in infrequent feeding.

**Psychological factors:**
- Lack of confidence: raising a mother’s confidence will reduce the possibility of the mother giving a formula supplement or introducing a dummy.
- Stress: reducing these will result in improved oxytocin reflex and milk transfer.
- Tiredness: encouraging a tired mother to rest and demand feed will prevent her from schedules feeding and shortening feeds, which could affect her milk supply.
- Dislike of breastfeeding: may result in infrequent feeding, dummy use, and shortened feeds – all affecting milk supply.

**Physical factors in the mother:**
- Medication: certain drugs may affect milk supply i.e.
  - The ‘combined’ contraceptive pill – containing oestrogen
  - Depo-Provera appears to have a similar effect especially if administered within 6 weeks of birth
  - Diuretic therapy may reduce milk supply
- Pregnancy: may cause a decrease in milk supply, possibly later in the pregnancy
- Alcohol and smoking: can affect the amount of milk a baby takes
- Severe malnutrition: this is very rare in developed countries. Even mothers having poor diets can produce plenty of milk for their babies.
- Retained products of conception: the level of oestrogen maintained in the body inhibits prolactin action. Placental tissue produces oestrogen –so even a small piece left in utero can delay milk production or prevent supply increasing.
- Inadequate breast development: occasionally a woman’s breasts do not undergo the normal changes of pregnancy and do not produce much milk. This is very rare and is likely to be accompanied by other evidence of hormonal dysfunction

Physical factors in the baby:
- Pre-term babies: are less able to attach and suckle effectively. Even term babies sometimes take a few days to develop their suckling ability.
- Illness: suckling may be affected and sleepiness may affect demand feeding.
- Other physical problems in the baby i.e. congenital problems, neurological problems, cleft palate, heart problems, jaundice. These babies may tire easily or find it physically hard to attach and feed effectively.

Assessing milk intake
- After the first 4 – 6 weeks baby may not pass a stool every day and may go several days without passing a stool – this can be normal as long as the stool, when passed, remains soft and the baby is growing well
- Urinates in the nappy –pink / orange salts – may be a sign that the baby is taking enough milk. Most babies will pass them once only.

How to help a mother increase her milk supply

Find the cause of the milk insufficiency:
(Most causes of low milk supply is due to ineffective attachment or infrequent feeding – or both)
- Observe and assess a breastfeed (use agreed assessment tool)
  o Check positioning and attachment
- Take a breastfeeding history
o Note frequency of feeding – should be having 8 – 12 feeds in a 24 hour period
o Note any restrictions on feeding
o Note any practises which could effect milk supply

- Examine the baby – note if there are any of the above physical factors

- Examine the mother and her breasts
  o Note if there are any of the above physical or psychological factors
  o Ask the mother what she thinks and feels

**Give support and information to increase the milk supply:**

- Build the mothers confidence by having a positive, enabling approach, and ensuring clarity about your information to increase her supply

- Ensure that the mother has frequent access to help by a trained breastfeeding

- Support her, face to face and by telephone. Refer the mother to a local support group also

- If necessary, show the mother again how to position and attach her baby for optimal milk transfer and stimulation – try new positions. Show the mother how to recognise that the baby is well attached. Help the mother to calm the bay before breastfeeding. Sometimes a little expressed milk given first can help this

  - Massaging the breast while the baby is feeding can also help to transfer more milk as can breast compressions – see a trained supporter for information

  - Observe and give information about breastfeeding practises including finishing the first breast before offering the second; responsive feeding; close and frequent skin contact; avoiding teats and dummies; avoiding supplementation; encouraging night feeds

  - Give information on maximising the milk ejection reflex including warm bathing or warm shower before feeding; breast massage; nipple stimulation; relaxation; quiet room; nice thoughts; music and closeness to baby

  - If the baby is not attaching and feeding well for whatever reason, teach the mother how to stimulate her breasts, express her milk and how to give this to her baby – avoiding bottles and teats
  
  - Suggest the mother eats and drinks as her thirst and hunger indicate - eating and drinking more than this will not increase the milk supply

  - Work with the mother to see how she can best manage the demands on her time and so enabling her to spend more time feeding her baby. Anything that helps the mother to look after herself and relax will be helpful

  - Galactogogues are sometimes prescribed to increase the milk supply (see galactogogues guidelines). These may help in difficult situations but should not be used routinely. Using drugs does not replace the need to ensure effective and frequent breast stimulation by the baby or by expressing
• Treat any underlying illness if necessary, or address any other causes found
• Ensure all staff work together to give consistent information and support
• Use agreed written / visual resources to support your discussions.

The need for formula supplements:
• Formula milk should only be suggested if there is a clear medical reason and this should be explained in full to the mother.

• If supplements are needed for a short while because the breast milk supply is very low, a breastfeeding supplemental system could be used. This will allow the baby to stimulate the breast while he / she is receiving the supplement. A supplementer can also be used to give the baby breast milk that has been expressed in between feeds.

• Careful support is needed to withdraw the formula supplements as the breast milk supply increases and return to exclusive breastfeeding.

• Discuss with Mum that she can purchase a feeding supplementer to support feeding by stimulating the breast giving all top ups, breast and formula at the breast [https://www.laleche.org.uk/nursing-supplementers/]. Supplementer can be purchased from Medela.

Monitoring progress of increasing the milk supply:
• The length of time it takes for supply to increase varies from mother to mother and will depend on:
  o The severity of the situation
  o The willingness and ability of the baby to suckle
  o The motivation and confidence of the mother
  o The support and confidence of those around her – hence it is good to include family / friends in your information giving
  o The mother’s previous success with breastfeeding.

• Monitoring means more than weighing frequently
  o Look for other signs of improvement i.e. increased alertness, reduced crying, improvement in stool and urine output
  o Observe the mother’s commitment to whatever plans you have made together and help her to maintain her belief that they will work
  o When re weighing baby try to use the same calibrated electronic scales on a hard surface, with the baby naked.

• In cases where adequate stimulation was given to the breasts in the first few weeks and the mothers supply began to diminish after this, a fairly rapid reversal of the situation can be expected. However, if stimulation was poor at the onset, and was not remedied for some weeks, it is possible that the supply will not rise to meet the baby’s needs. The baby’s wellbeing therefore relies on monitoring his progress and an accurate history taking in the first place
• Record any information / supporting the appropriate records and liaise with other colleagues
6. THE USE OF A GALACTOGOGUE (DOMPERIDONE) DURING BREASTFEEDING OR EXPRESSING BREASTMILK

Domperidone as a galactogogue aids the initiation and maintenance of breast milk supply to meet the needs of a baby receiving breast milk, when non-drug methods have failed. A health professional should be involved in any decision to use domperidone. Domperidone is most likely to be needed for mothers whose babies are on the neonatal unit.

KEY OBJECTIVE: To provide information regarding the use of a galactogogue, domperidone, in appropriate situations for mothers who need to establish / increase their milk supply.

EXAMPLES OF WHEN DOMPERIDONE MAY BE USED:

1. To aid milk supply to a baby unable to actively breastfeed due to prematurity / illness.*
2. A mother wishing to re-lactate after ceasing breastfeeding
3. A mother wishing to increase her milk supply as she is not meeting the total needs of her baby by breast milk alone
4. A mother wishing to induce lactation who has never breastfed i.e. a surrogate mother.

* In this group of sick babies the use of breast milk is essential in reducing morbidity and allowing enteral feeding to be established. This constitutes a medical need.

MILK PRODUCTION:

It is important to remember that the hormone prolactin is needed to ensure good milk production, which is released from the pituitary gland. Sensory stimulation controls prolactin i.e. baby feeding, breast or nipple stimulation, and / or regular expression of milk. When considering a low milk supply, it is also important to understand the causes of low milk supply. Firstly, ascertain is this ‘perceived’ low supply or ‘actual’ low supply. In some cases there is little to worry about, and the mother needs help to improve her confidence in breastfeeding her baby / proving breast milk. It is very rare to find an ‘actual’ poor milk supply, which is usually due to ineffective and / or infrequent attachment or expressing.

IDENTIFYING THE REASONS FOR MILK INSUFFICIENCY AND OFFERING OPTIMAL SUPPORT TO IMPROVE SUPPLY:

Where there is ‘actual’ poor milk supply, the reasons for this need to be considered and support offered to improve the situation:

1. Close attention to effective expressing techniques and frequency of expressing, considering double-pumping with a hospital grade breast pump.
2. Close attention to improving positioning and attachment if the baby is breastfeeding. Observe and assess a full breastfeed.
3. Ensuring the breasts are kept ‘well drained’ / soft (full breasts will slow down milk production as the feedback inhibitor of lactation increases)
4. Ensuring unrestricted, frequent responsive feeding and / or expressing
5. Smoking is known to be associated with a decreased milk supply and could affect the milk ejection reflex (oxytocin). Consider if this could be a reason for this mother’s low supply. Support may be needed to stop / reduce smoking.
6. Support with early (soon after birth), frequent and effective expressing after a preterm delivery
7. Consider possible prolactin deficiency. Possible causes are Sheehan syndrome and some
medications (e.g. cabergoline, bromocriptine).

8. Encourage plenty of skin to skin contact / kangaroo care which helps hormone release.
9. Emotional support for the mother. A relaxed, comfortable, well informed mother will be able to express better with optimal oxytocin release.
10. Social support – consider how social activity may be hindering breastfeeding responsiveness or expressing.

DOMPERIDONE SHOULD ONLY BE RECOMMENDED WHERE ADDITIONAL SUPPORT IS ALREADY IN PLACE. ASSESSMENT OF EXPRESSING AND/OR BREASTFEEDING, SHOULD ALWAYS BE A PRIORITY.

If you feel Domperidone could help the mother’s milk supply, you should liaise with the mother’s medical practitioner / obstetric Dr to prescribe it.

GALACTOGOGUES:
No drugs are licensed in the UK specifically as galactogogues. Domperidone is licensed only for management of nausea and vomiting. However, it does have the effect of increasing prolactin levels, thus stimulating milk production.

DOMPERIDONE DOSE:

- 10MG orally three times a day for one week.
- Domperidone is an unlicensed drug for the purpose of increasing milk supply and prescribers should consider the benefits and risks for the individual patient.

FOLLOWING A REVIEW BY THE EMA/MHRA IN APRIL 2014, due to the risk of cardiac adverse effects, advice on the use of domperidone has been updated [Link]. The use of domperidone to enhance lactation is not specifically covered by the review as it is an unlicensed (off-label) indication. However, the recommendations from the review apply to its use as a galactagogue. As there are limited alternative options for the stimulation of lactation, the use of domperidone can be considered, provided non-pharmacological options have been unsuccessful. A maternal dose of 30mg daily for a maximum of 1 week should not be exceeded.

DOMPERIDONE SHOULD NOT BE USED IF THE MOTHER OR INFANT:

- has any evidence of cardiac abnormalities and specifically arrhythmia
- is receiving other medications known to prolong QT interval or potent CYP3A4 inhibitors e.g. quinolone antibiotics, ketoconazole (fluconazole may also be considered a risk), macrolide antibiotics, SSRI antidepressants, tricyclic antidepressants, salbutamol
- have severe hepatic impairment
- have high or low levels of potassium, or low levels of magnesium

SIDE EFFECTS:

- Central Nervous System side effects are rare as the drug does not pass into the brain, making the drug favourable from the breastfeeding mother/infant perspective. However, there is epidemiological data to suggest that use of domperidone in people at risk of cardiac arrhythmia may increase cardiac risks. For this reason the daily dose should be restricted to 30mg if possible, and the drug should be avoided in people with known
cardiac disorder as described above

- Patients should be advised to seek prompt medical attention if symptoms such as syncope or tachyarrhythmia appear during treatment.

**SUPPORTING REFERENCES / INFORMATION:**

1. The UK Drugs in Lactation Advisory Service (UKDILAS) has prepared an evidence summary for the use of domperidone as a galactagogue which is available on their website
   http://www.midlandsmedicines.nhs.uk/content.asp?section=6&subsection=17&pageIdx=1
2. Drug Induced QT interval
3. MHRA information -
7. Help, Support and Establishing Breastfeeding and Relationship Building on the Neonatal Unit from a Community Perspective

http://www.bliss.org.uk/publications-for-health-professionals

Key Objective:

1. **Support parents to have a close and loving relationship with their baby.**

   Empower parents to feel they are vital part of their baby’s wellbeing and development. Share information on the science that underpins this, thereby preparing parents to nurture their baby while in NICU and in future.

   Have a sensitive approach to giving this information. Some parents may distance themselves from their very ill baby, who may have poor long term health outcomes, in order to protect their own emotional well-being.

   Skin to skin contact has many emotional and physiological benefits for parents and babies. Encourage parents to take the lead on initiating prolonged and frequent skin to skin contact and recognising their baby’s behavioural cues. Prolonged skin contact is often referred to as **Kangaroo Mother Care (KMC)** on the NICU. Encourage the view that skin contact is important not just in all areas of the NICU environment but also beyond into the community on discharge. The nurses are able to explain to parents when their baby is well/stable enough for skin to skin contact (KMC).

   Parents are enabled to recognise baby’s behavioural cues and tolerance for stimulus, and are supported to build close relationships via touch, talking, comforting etc. as appropriate.

   Encourage the view that skin contact is important, not just in a high dependency environment, but throughout their stay and beyond into the community on discharge.


2. **Enable babies to receive breastmilk and breastfeed when possible.**

   Ensure mothers have information and are being supported to express effectively by hand and pump and there is a formal review in place to ensure maximising the amount of breastmilk they are able to express. NICU nurses will be assessing expressing especially in the early weeks. Community staff may also be able to support this.


   Discuss skin contact to induce instinctive pre feeding behaviours. When mothers and babies spend lots of time together in this way with baby’s head close to mother’s breast, instinctive pre-feeding behaviours are encouraged. This enables baby to root, lick and familiarise themselves with their mother’s breast providing the perfect introduction to breastfeeding and should be seen by as important
to the transition to breastfeeding

Support mothers with the principles of positioning long before the baby is ready to feed.

Parents whose babies are bottle feeding are supported to do this responsively, recognising the baby’s cues and need for comfort and closeness during feeding.

3. **Value parents as partners in care.**

NICU would like all parents to feel true partners in care and aim to make the environment as welcoming and as comfortable as possible. Parents will be updated about their baby’s condition and involved in informed decision making. Encourage parents to carry out much of the care for their baby. The nurses on NICU will guide and support the parents with increasing care. Support parents with practical difficulties that may prevent parents being with their baby and recognise the emotional difficulties that parents face when they are separated from their baby.

Some mothers who find they have more than enough milk for their own baby may wish to donate so other vulnerable babies may benefit from receiving breast milk. Information about donating milk for parents and health professionals can be obtained via the link.

[http://www.northwesthmb.org.uk](http://www.northwesthmb.org.uk)
8. POSSIBLE MEDICAL REASONS FOR FORMULA SUPPLEMENTATION

A few medical indications in a hospital facility may require that individual infants be given food or drink in addition to, or in place of, breast milk. Each baby and situation will be individually assessed. Some examples of these situations may include:

- Low birth weight babies below 1500 grams
- Metabolic disorders such as galactosaemia, maple syrup urine disease, PKU
- Very pre term i.e. below 32 weeks
- Infants at risk of hypoglycaemia such as preterm, small for gestational age, intrapartum stress, illness or maternal diabetes – if their blood sugar fails to respond to optimal breastfeeding in spite of frequent effective suckling
- Persistent faltering growth / significant weight loss / hypernatraemia
- H.I.V. positive mother
- Cytotoxic chemotherapy
- Certain medications e.g. iodine, and drugs which may cause drowsiness
- Active herpes on breast
- Breast abscess where there is pus seen coming from the nipple

Staff should take note of the supporting ‘guidelines for breastfeeding with substance and alcohol use, and drugs misuse’.

Where mothers may take occasional illegal drugs, or non–prescribed drugs, she should be supported in making an informed choice with regard to breastfeeding, and in relation to the drug taken. She should be encouraged to stop taking the drug or reduce the intake of the drug. The benefits of breastfeeding should be considered against the risks of taking the drug. For one off drug misuse, it may be safer to express and discard the milk following the drug use.

When breastfeeding has to be temporarily delayed or interrupted, mothers should be helped to establish or maintain lactation, for example, through manual or hand pump expression of milk, in preparation for when breastfeeding can begin or be resumed.
9. Tongue Tie Assessment and Referral

- **Feeding Assessment** - Is Feeding affected by the tongue tie? – unable to sustain an effective latch after professional support and further review, nipple pain or trauma, slow weight gain, feeding for a long time/continuously, not settled after feeds, clicking sound whilst feeding? If bottle feeding is baby feeding are feeds taking longer than 45 mins, is baby dribbling a lot, gaining weight slowly? Use feeding assessment tool for full assessment.

- **Oral Examination**, can baby elevate tongue to the roof of mouth, extend it over the lower lip, is there a slight cleft in the tip of the tongue or is the tongue tip heart shaped. Can baby lateralise tongue from left to right? If you can see the frenulum where is it positioned –posterior/anterior?

- Would you like to discuss this with the specialist Infant Feeding Team first?

- **Refer** – Obtain informed consent from parents and refer via local pathway, see appendix

- **Inform** - the medical team re the referral as a ‘courtesy’ – neonatal team if in-patient / GP if in community (you do not have to ‘seek their permission’ to refer – this is purely sharing information)

- **Plan of care PRE frenotomy**– Assess need for mum to protect lactation by frequent expressing (drain breast at least 8 times per day), Skin to Skin, laid back/biological breastfeeding, if baby is able to remove milk from the breast and it is comfortable for mum advise open access to feed from the breast. It’s important mums understand the importance of maintaining their milk supply pre frenotomy. Refer to peer support agency.

- **POST frenotomy Care**– it is important to monitor feeding after the procedure, arrange to contact/visit mum within 48hrs of procedure to assess feeding. Continued skin to skin, optimise attachment assess milk supply and milk transfer Mums may notice slow progress and may need to continue to express initially; it can take up to 2 weeks for feeding to be fully established post frenotomy. If feeding has not been improved consider contacting the Infant Feeding teams for further support.

**Contacting the Specialist Infant Feeding Team**
- ELHT / BwD Community (IBCLCs) – Sue Henry 07590245753
- BwD Community (IBCLCs) – Donna Butler 07595099819
- Preston - 01772524512
- Lancaster - 01539 732288
- East, Central and North Community Infant Feeding Team 01254 612582 infant.feeding@lancashirecare.nhs.uk
10. THE USE OF NIPPLE SHIELDS

AIM: Nipple shields should not be recommended except where a clinical need is identified, and then as a short term measure. The potential consequences of their use will be explained, and the mothers will receive the support of an appropriate skilled practitioner throughout, enabling the mother to resume breastfeeding without a nipple shield as soon as possible”. The aim of this guidance is to assist the health professional to discuss nipple shields only when appropriate, and enable a fully informed choice with appropriate support.

TYPE OF SHIELDS:
- Latex shields should be avoided due to possible latex allergy
- Rubber shields are not easily available and should be avoided
- Silicone shields are extremely thin and flexible with a firmer ‘nipple part’. As the part of the shield that sits on the breast is thinner the areola is better stimulated which means milk supply is not seriously depleted when compared with other types. Thin silicone shields can be bought in different sizes and care should be taken to purchase an optimal fit.

WHAT MAY SHIELDS DO?

<table>
<thead>
<tr>
<th>WHAT MAY SHIELDS DO?</th>
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<tbody>
<tr>
<td>Form a nipple shape in baby’s mouth that is stable during pauses in sucking bursts</td>
</tr>
<tr>
<td>Provide therapeutic oral stimulation, that is not provided by mother’s nipples</td>
</tr>
<tr>
<td>Help compensate for a weak suck</td>
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<tr>
<td>Maintain nipple in an everted position</td>
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<tr>
<td>Raise the rate of milk flow</td>
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<tr>
<td>Allows milk transfer with minimal suction and negative pressure (may be useful for preterm babies)</td>
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WHAT DO SHIELDS NOT DO?

<table>
<thead>
<tr>
<th>WHAT DO SHIELDS NOT DO?</th>
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<tbody>
<tr>
<td>Correct milk transfer problems or weight gain if the mother has inadequate milk volume</td>
</tr>
<tr>
<td>Heal damage nipples if the cause is not found and rectified</td>
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<tr>
<td>Replace skilled intervention and follow up support</td>
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INFORMED CHOICE / DOCUMENTATION: Be sure to discuss with the mother the advantages and disadvantages of nipple shield use, and document the conversation including rationale for use and follow up support plan.

<table>
<thead>
<tr>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
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<tbody>
<tr>
<td>Encourages feeding at the breast – has physiological and psychological benefits for the mother. Keeps baby close to mothers’ skin during feeds.</td>
<td>Used as substitute for skilled breastfeeding support</td>
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</tbody>
</table>
POSSIBLE INDICATIONS FOR USING A SHIELD

It is essential to always try breastfeeding without a shield first

Attachment difficulty:
- flat, inverted, fibrous, inelastic, damaged nipples
- birth trauma (instrumental delivery) – baby traumatized – can affect feeding reflexes
- preference already made for teats / dummies
- transition from bottle to breast
- weak or disorganized sucking pattern (preterm, slips of nipple, neurological problems)
- baby with high or low muscle tone
- delay in putting baby to the breast
- Oral cavity problem:
  - cleft palate (seek advice from cleft nurses)
  - lack of fat pads in cheeks (preterm, small for gestational age)
  - micrognathia (recessed jaw)
  - poor central tongue grooving i.e. due to tongue tie (consider frenulotomy)
- Upper airway problems:
  - tracheomalacia
  - laryngomalacia
- When all else fails and mother is about to give up breastfeeding

INSTRUCTION FOR USE:
There is little evidence re how to use / choose a shield. These points will help:
The height (length) of the shield should not be longer than the distance from the baby’s lips to
the junction of the hard / soft palate – what you will see is the baby suckling on the shaft of
the shield and not over the breast.
Better results are seen with smallest height and smallest width possible

SUGGESTIONS THAT MAY HELP:
- Apply the shield by turning it almost inside out
- Moisten the edges to help it adhere to the breast better
- Drip expressed breast milk on the outside of the shield teat to encourage the baby to
  attach and feed
- Hand express a little milk into the teat if needed
- Use massage to help drain the breast
- The baby’s mouth must not be on the teat of the shield – needs still to attach on the
  breast – check attachment closely

IMPORTANT
- Nipple shields should only be suggested after careful skilled assessment of breastfeeding,
  and must be only suggested by a health professionals.
- Intent should be for short term use only
- Regular weighing of baby until milk supply is sufficient and baby gaining weight is
  important, as well as monitoring wet and dirty nappies to assess milk transfer
• If mothers milk supply not optimal suggest expressing after nipple shield feeds – a robust plan is essential
• Ask mother to check breasts for possible blocked ducts or any areas not draining well
• Ensure a follow up plan – and liaise with colleagues who will be assisting with the plan
• Discuss with the specialist infant feeding team for support if necessary.

CLEANING THE SHIELD: After use, the shield should be washed in warm soapy water, rinsed well and dried thoroughly. These should then be stored dry in a covered container. In the hospital setting uses 1ml of Hospec detergent to 1 litre of warm water. Also, washing of shields must take place at the ‘designated sink area’ only, and not at the sinks in the side rooms or bed bays, which are intended for hand washing.

If the mother has surface skin yeast infection, or the baby has oral yeast infection, the nipple shield should be sterilized. If at home – the mother can boil the shield (for at least 10 minutes). If in hospital they should be thoroughly washed and rinsed, as above and should be disinfected with sterilizing fluid as per instructions of the packaging. The solution should be shaken off vigorously before use. If rinsing fluid off, then cool boiled water should be used.

The shields should be replaced on a regular basis as the material will degrade and harbour micro-organisms

WITHDRAWING THE SHIELD:
• No set time – though aim for short as possible use of shield – extended use of an ultra-thin shield has not been shown to be detrimental
• Try skin to skin next to nipple / breast – start feed with shield and withdraw during feed – gradually trying feeds without it
• NEVER cut the shield back

HEALTH PROFESSIONAL RESPONSIBILITIES:
• Ensure the shield is not a ‘quick fix’ – give the baby time to learn to breastfeed (too early use of shield can equal poor breastfeeding outcome) – assess the feeding carefully seeking skilled help if needed
• Understand the advantages and disadvantages
• Fully document re nipple shield use / informed choice / plans of support - ensure close follow up whilst shield being used i.e. if discharged form hospital with a shield it should be clear to the community staff what the rationale / plan is.
• Provide detailed clear instruction on their use and cleaning the shield

REFERENCES / INFORMATION:
Auerbach, KG. The effect of nipple shields on maternal milk volume. JOGNN. 1990;19:419-427
Riordan J, Wamback K. Breastfeeding and Human Lactation. 4th edition. Jones and Bartlett, LLC. 2010

NICE Guidance Division of ankyloglossia (tongue-tie) for breastfeeding,
https://www.nice.org.uk/guidance/ipg149
HYPERLACTATION – OVER ABUNDANT MILK SUPPLY

Too much milk or milk that flows too quickly

Definition
Hyperlactation or breast milk oversupply is often described as milk production in the excess of the needs for normal growth of the Infant (Trimot and Spencer 2015).

Possible Reasons for hyperlactation
Breastfeeding mismanagement including excessive pumping, over use of galactogues, and overstimulation by baby.

Predisposition.
Underlying disorder (rare) – GP referral for thyroid function tests

Impact on Mum/Baby
Baby may be reluctance to go to the breast, startled during fast and abundant milk ejection reflex, often coming off the breast, coughing.
Babies may develop a disordered latch and move the tongue to the tip of the nipple to avoid being choked by an aggressive milk ejection reflex.
Babies may present with symptoms suggesting colic, milk protein allergies, or gastroesophageal reflux, or may present with unusually rapid or slow growth.
Mothers may present with tender leaking breasts, sore infected nipples, blocked ducts or mastitis, or even the perception of insufficient milk supply.
Mothers experiencing oversupply often report feelings of frustration and loneliness as breastfeeding can become very difficult and excessive leaking and breast pain make socialising difficult.

Having too much milk is often viewed as desirable, which can lead to inadequate support from friends and family, as well as professionals.
Babies can develop the habit of passively suckling at a breast that will give milk without any effort by the infant itself. This has the potential to lead to supply problems after 4–6 weeks

Assessment
Full feeding history and observe / assess a full breastfeed, assessing latch, baby’s behaviour during a feed and mums breasts and nipples.
Full assessment of expressing if this is what the mother is doing on a regular basis ie NICU mother

Treatment options
- Optimal position and attachment, often laid back breastfeeding works well.
- Express - If the infant is unable to attach effectively to the breast because of an overabundant milk supply/ forceful milk ejection, it may be helpful to express a little milk until the flow slows and then attach the infant to the breast. It is important to express only a small amount or the oversupply will continue. (NICE 2014)
- Block feeding – feed exclusively from one breast for a set period of time (suggested 3 hrs) this approach works on the principle that milk production will reduce due to the accumulation of the feedback inhibitor of lactation (FIL), important to observe for blocked ducts.
- Full drainage and Block feeding (FDBF) initially completely drain of both breasts. It is impossible to really empty an active, lactating breast completely, because the production of milk is an ongoing process. Emptying the breast is a major trigger for
renewed production activity. Hand expression is a possibility, but in most cases using an electric breast pump will work more efficiently and rapidly, especially if a double pump is used. Baby will latch on immediately after drainage and will be offered both “empty” breasts until satisfied. Many babies will fall asleep fully satisfied with high fat hind milk. Subsequently the rest of the day is divided into equal time blocks starting with about three hours, initially. Every time baby shows feeding cues or wanting the breast for comfort the same breast will be offered without any restriction in either frequency or duration of feeds. At the end of the block, or after 3 or more hours of sleep, baby will be offered the other breast for all feeds within the next time block. It is important that the best possible positioning and attachment techniques are used starting right from the very first feeding after pumping, for the sake of both the baby's improved suckling habits and the mother's comfort and future production. Depending on the seriousness of the symptoms time blocks may gradually be increased to 4, 6, 8 or even 12 hours. For less complex situations one-time breast pump drainage will be enough; for others occasional repetition may be necessary. Intervals between drainage will gradually increase as the symptoms lessen. Mums must be cautioned not to drain the breasts too often in order to avoid extra stimulation for milk production. Only if engorgement is becoming severe again should drainage be carried out. In using FDBF the mother will need to be instructed, cautioned and monitored for temporarily recurring over-fullness and blocked ducts or mastitis. After the first full drainage, in some women the breasts will initially continue to produce more than asked for and thus refill. In many others just a single full drainage will suffice to decrease milk production to acceptable levels.

**Review**

When hyperlactation/oversupply is diagnosed and the correct treatment plan is established it can resolve quickly, mums will require frequent support to achieve effective attachment and therapeutic treatment regimens until baby is breastfeeding comfortably and the feeding assessment is satisfactory.

**References**

Over abundant milk supply: full an alternative way to intervene by full drainage or block feeding, International Journal of Breastfeeding 2007 2:11


Breastfeeding and Human lactiaon 5th Ed, K Wambach & J Riordan 2016, Jones and Bartlet Learning, USA

Diagnosis and Management of Breast Milk Oversupply, 2015, L Trimeloni, & J Spencer, J Am Board Fam Med 2016;29:139 –142.)
## 12-18. Links to Infant Feeding Information – For Professionals

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<thead>
<tr>
<th>Topic</th>
<th>Source</th>
<th>Link</th>
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<td>First Steps Nutrition</td>
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<td>BUILDING A HAPPY BABY</td>
<td>UNICEF</td>
<td><a href="http://www.unicef.org.uk/BabyFriendly/Parents/Resources/Resources-for-parents/Building-a-happy-baby/">http://www.unicef.org.uk/BabyFriendly/Parents/Resources/Resources-for-parents/Building-a-happy-baby/</a></td>
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<tr>
<td>Relevant NICE Guidance</td>
<td>NICE</td>
<td>Postnatal Care up to 8 weeks after birth</td>
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<td><a href="https://www.nice.org.uk/guidance/cg37/chapter/1-Recommendations#infant-feeding">https://www.nice.org.uk/guidance/cg37/chapter/1-Recommendations#infant-feeding</a></td>
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<td>Maternal and Child Nutrition</td>
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<td>Vitamin D: increasing supplement use in at-risk groups</td>
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<td><a href="https://www.nice.org.uk/guidance/ph56">https://www.nice.org.uk/guidance/ph56</a></td>
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19 APPENDIX

Frenulotmy Referral forms

RLI Frenotomy Referral.docx
Preston Hosp Frenotomy Referral Frenotomy Referral.docx
Morcambe Frenotomy Referral Frenotomy Referral.docx

REFERRAL FORM FOR DIVISION OF TONGUE

Breastfeeding Care Plans

BREAST ABSCESS ENGORGEMENT care plan. JUNE 17. V1.docx
ENGORGEMENT care plan. JUNE 17. V1.docx
ENGORGEMENT care plan. JUNE 17. V1.docx
ENGORGEMENT care plan. JUNE 17. V1.docx

MASTITIS care plan. JUNE 17. V1.docx
SORE NIPPLES care plan. JUNE 17. V1.docx
SUBOPTIMAL WEIGHT GAIN care plan. JUNE 17. V1.docx

THRUSH care plan. JUNE 17. V1.docx

TONGUE TIE PRE-OP care plan. JUNE 17. V1.docx