# Trust Guideline for the Management of Newborn Babies ≥37 weeks gestation who are Reluctant to Feed

## Document Control:

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|---|---|---|---|
| **For Use In:** | Maternity Services<br>by Midwives and Midwifery Support Staff | | |
| **Search Keywords** | Reluctant, feed, newborn, breastfeed, bottle, formula | | |
| **Document Author:** | Sophie Harvey. Based on an earlier guideline by:<br>Luisa Lyons, Rosemary Jackson, and Julie Mansfield. | | |
| **Document Owner:** | Midwife and Infant Feeding Coordinator | | |
| **Approved By:** | Clinical Guideline Assessment Panel | | |
| **Ratified By:** | Clinical Safety and Effectiveness Sub-Board | | |
| **Approval Date:** | NMCP Board – 12th July 2023 | **Date to be reviewed by:** This document remains current after this date but will be under review | 12/07/2026 |
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## Version History:

| Version | Date | Author | Reason/Change |
|---|---|---|---|
| V4.0 | 2018 | L Lyons | To originate document |
| V4.1 | 2021 | L Lyons | Extension granted |
| V4.2 | 2022 | L Lyons | Extension granted |

## Previous Titles for this Document:

| Previous Title/Amalgamated Titles | Date Revised |
|---|---|
| MID35, MID35v2, MID35v3, MID35v4 | 2018 |

## Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

## Consultation

The following were consulted during the development of this document:
Practice Development Midwives, Postnatal Ward Lead Midwife, Clinical Effectiveness Midwife, Midwifery Senior Matrons, Director of Midwifery, Maternity Clinical Guidelines Committee, Consultant Neonatologists.

## Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

## Relationship of this document to other procedural documents

This document is a clinical guideline applicable to Norfolk and Norwich University Hospitals; please refer to local Trust's procedural documents for further guidance, as noted in Section 5.

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## Contents Page

**Quick reference - FLOWCHART A: Management of Feeding for all Healthy term Infants ≥37 weeks and Recognition & Management of the Reluctant Feeder. 0 - 24 HOURS OLD**

**Quick Reference - FLOWCHART B: Management of Feeding for all Healthy term Infants ≥ 37 weeks and Recognition & Management of the Reluctant Feeder ≥ 24 HOURS OLD**

## 1. Introduction

### 1.1. Rationale

Reluctant feeding is common behaviour for many healthy term babies in the first 24-48 hours of life and mothers will require reassurance if they are anxious. Early, prolonged skin-to-skin contact can minimise reluctance to breastfeed (Righard and Alade, 1992).

Babies need to feed at frequent intervals and healthy, term babies will wake and feed. The term “reluctant feeder” is applied to newborn babies who are too sleepy to attach and suck at the breast or who do not wake and “demand feed” very often. If a baby has not fed within the first two hours following birth or is not effectively feeding by six to eight hours, then it should be considered to be a reluctant to feed baby.

If a baby is keen to breastfeed, but not feeding effectively, despite continued breastfeeding support, this guideline and the attached flow charts can also be applied.

If babies have any risk factors for hypoglycaemia they should be managed as per the Trust Guideline for the Management of Hypoglycaemia in Newborn Infants Trustdocs ID: 1196. Lack of interest in feeding can be the first sign of an unrecognised disorder or illness. If babies have any risk factors for infection, please ensure they are monitored closely and if they develop any “red-flags” please consult a Neonatologist

straight away. See Trust Guideline for the Management of babies at increased risk of developing neonatal infection Trustdocs ID: 9998.

### 1.2. Objective

To promote best practice in the care of newborn, healthy term babies:

- greater than 2kgs,
- above the 2nd centile,
- at or above 37 weeks gestation, and
- without risk factors for hypoglycaemia

### 1.3. Scope

This document has been developed for use by Maternity and Neonatal Staff caring for all healthy newborn babies ≥37 weeks gestation who are reluctant to feed within Maternity Services.

### 1.4. Glossary

The following terms and abbreviations have been used within this document:

| Term | Definition |
|---|---|
| EBM | Expressed Breastmilk |
| BAT | Breastfeeding Assessment Tool |
| NEWTT | Newborn Warning Trigger and Track |

## 2. Responsibilities

Sophie Harvey, Infant Feeding Coordinator. Responsible for updating guidance and auditing compliance to guidance.

## 3. Policy Principles/ Service to be delivered/Processes to be followed

Following birth, healthy term newborn babies will adapt from a constant supply of nutrients via the placenta, to extra-uterine life by the counter-regulatory response. This complex process involves the baby:

- Inhibiting the secretion of insulin to help sustain blood glucose levels
- Breaking down glycogen reserves in the liver
- Synthesizing glucose from stores in the liver
- Generating alternative fuels such as ketone bodies to provide protection for the brain and other vital organs

Therefore, healthy term newborns are designed to cope well with initial adaptation and the adjustment to intermittent feeding. They do not develop symptomatic hypoglycaemia as a result of simple under feeding. Effort should be made to encourage babies to feed frequently in the first 48 hours.

Babies may be slow to feed for a number of reasons; these include sedation, illness, birth trauma and missed opportunity for skin-to-skin contact. (UNICEF 2016). Babies

who have had an instrumental birth, long, augmented, or difficult labour can deplete their glycogen stores. Babies that become cold also deplete their glycogen stores and being too cold can depress feeding behaviour. When coupled with an opiate given to the labouring mother, the result can often be a baby that needs to feed but does not seek the breast. Thermoregulation should be monitored as per the regional guidance from the East of England regarding Thermoregulation in Neonates Trustdocs ID: 1244.

### 3.1. Feeding Cues and Helpful Measures

New mothers may not know about early, more subtle feeding cues and therefore many babies' cues are unintentionally missed. By informing the mother antenatally or early in the postnatal period about these cues she can be empowered to be proactive in feeding her baby. A baby may be reluctant to feed because of missed opportunities to learn (e.g. through skin to skin contact being cut short or interrupted), or attempts by staff to help the baby attach. This may have in fact disrupted the baby's natural steps to learn to attach to the breast.

Dimming bright lights, holding the baby up in an upright position, encouraging the mother and baby to bath together (perhaps using a pool on the birthing unit if available) and stimulating the baby with massage have all proved helpful in managing babies reluctant to feed. Mothers can be encouraged to adopt laid back positions with the baby lying prone on the mother's chest. Biological nurturing- or 'laid back' breastfeeding and has been shown to elicit babies' natural reflexes and encourage feeding (Rapley 2014).. The feed chart in the Neonatal notes should record every attempt at feeding whether successful or not.

### 3.2. Hand expressing – why and how?

Hand expressing is an ideal method of expressing milk in the first few days. Colostrum is low in volume and may get 'lost' in a pump. Also, milk expressed by hand tends to have a higher fat content than by pump. Mothers often prefer the feel of their own hand to a pump.

Empowering a mother to be able to maintain her milk supply whilst providing colostrum for her baby can help build her confidence and avoid unnecessary use of infant formula. Breastmilk flow is reliant on oxytocin, which can be inhibited by anxiety or embarrassment. Encourage the mother to hand express at least 8-10 times in 24 hours. Commence pumping when the milk comes in if the mother wishes to do so.

If the mother has attempted unsuccessfully to hand express, ask a colleague to go through the technique again. Sometimes another person explains the process in a different way, and this helps the mother understand. If the mother is still unable (or unwilling) to hand express any colostrum, she may be supported to try to use a breast pump (either her own or a hospital-grade pump). This is not the most ideal method of obtaining colostrum but is sometimes appropriate in the circumstances outlined. Keep trying to hand express as frequently as the mother is happy to until good volumes are achieved.

If the baby is well and observations are normal there is no need to give a supplementary formula feed in the first 24 hours. Close observations (at least every 4 hours) are required to ensure that the poor feeding is not because the baby is unwell and that the baby is not becoming hypoglycaemic. A medical review of the baby can be sought at 24 hours old or sooner if there are any concerns. If the baby has normal observations and there are no concerns, carry on for a further 24 hours. At 48 hours old if the baby is still reluctant to feed, refer the baby to the Neonatal team for a review, involve an infant feeding keyworker or infant feeding co-ordinator and advise on safe formula supplementation whilst supporting lactation.

#### 3.3. Syringe finger feeding

This method is used to give a baby small amounts (<5mLs) of colostrum that would otherwise get lost in a cup. To syringe finger feed safely, health care professionals should teach this skill and support parents until they are confident to syringe finger feed their baby themselves. The baby should be fully awake, calm and alert. Baby should be held in an upright position, ensuring that baby's neck and shoulders are supported. For staff, a gloved finger is placed in the baby's mouth, for parents, a clean finger with short fingernails is placed in the baby's mouth. With finger pad placed to the roof of the baby's mouth to initiate a sucking reflex. A 1ml colostrum syringe is inserted in the corner of baby's cheek and a little colostrum is gently dripped into the cheek cavity (no more than 0.2ml at a time), to allow the baby to suck and swallow the milk at their own pace. If baby is taking the milk too quickly, stop and wind the baby. Move on to cup feeding once you have more than 5mls of colostrum to give as syringe finger feeding larger quantities carries a risk of aspiration. Babies should not be discharged home if still being fed by syringe.

**Never offer formula to a baby via syringe.**

#### 3.4. Cup feeding

Cup feeding encourages the baby to practice tongue movements, enhances digestion by stimulating saliva and allows the baby to control the rate and amount of milk given. As it is generally thought of as an 'interim measure' it may not appear as "medicalised" to parents as using a syringe. It also does not risk causing nipple confusion and is therefore preferable to giving milk via a teat and bottle. Health care professionals should teach this skill and support parents until they are confident to cup feed their baby themselves. The baby should be fully awake, calm and alert. Baby should be held in an upright position, ensuring that baby's neck and shoulders are supported. The cup should be half-filled and held in a way that it just touches the baby's mouth. It should reach the corners of his/her mouth and rest lightly on the bottom lip. Allow the baby just a tiny sip, to encourage drinking – do not pour the milk into the baby's mouth; tip the cup just enough so that baby can lap up the milk. There is no limit to volume as long as small amounts are offered (5-10mLs in the cup at a time) and overall volume is documented.

#### 3.5. What if the mother does not want to express and give colostrum?

The length of labour and the type of birth may influence the mother's feelings about expressing. She may ask you to give formula instead. Obviously consider cultural / personal choices. However, remember that if her baby has not breastfed, she needs to express to initiate a good milk supply. This is because prolactin receptors should

be activated ideally within the first hour after birth but at least within 4-6 hours of birth to enhance long-term milk production. Breastfeeding or expressing within the first hour after birth and frequently thereafter is associated with long term success in breastfeeding (UNICEF 2008).

If a mother chooses not to express colostrum by hand or pump, and requests her baby receive a supplementary formula feed, the aim should be to ensure she is fully informed of the risks, benefits, and alternatives of all the choices available to her. The patient information sheet for mothers entitled "Does your baby feed too much… or too little?" Trustdocs ID: 8582 may be used to enable a meaningful discussion. To enable informed choice, the mother has a right to know:

- Formula supplements are highly likely to reduce her milk supply
- Giving formula may impair the baby's ability to utilise ketone bodies and counter-regulate (De Rooy and Hawdon, 2002).
- There is a risk of possible allergic sensitisation of the baby to cow's milk protein (Host 1998).
- It is known that, in genetically susceptible individuals, breast feeding can have a protective effect on the later development of diabetes (Virtanen & Knip 2003, Sadauskaite-Kuehne et al, 2004, Knip et al, 2010, Unicef 2016).
- When supplements are given with an artificial teat, they have been associated with breastfeeding problems such as incorrect sucking technique and breast refusal (Niefert 1995, Righard 1998, Cronenwett 1992) as well as shorter duration of breastfeeding (Kurinij and Shiono 1991). Although some babies appear to be able to breastfeed successfully after having been given a teat, there are other babies for whom early introduction of a teat leads to breastfeeding cessation. Therefore, it is advisable to avoid teats wherever possible while babies are learning to breastfeed.

The discussion should take place in an unhurried manner and the information should be given sensitively, as it may not be easy for a new mother to hear. Ensure the mother understands that these are risks, not certainties. The discussion should be documented in the baby's records. Mothers should be aware that staff will respect her wishes and choices whatever she decides. How a supplement is given is a separate issue to that of the supplement itself and should be documented as such.

### 3.6. A baby who is reluctant to bottle feed

If a baby who is bottle feeding is reluctant to feed using the responsive, paced bottle feeding technique; the recommendation is to consider using the elevated side lying position.

The elevated side lying position is associated with improved oral feeding in preterm infants by supporting physiological stability, measured by heart rate and oxygen saturation during feeding but can also improve feeding in term infants (Clark et al, 2007; Raczyńska and Gulczyńska, 2019).

The feeder should be sat comfortably, with their knees higher than the base of their lap, so that the level of baby's head is higher than their feet. A footstool can be used

to achieve this. The baby should be placed in a side-lying position on the feeder's lap, with their bottom touching the feeder's stomach and their back supported by the feeder's left hand. The baby's neck and spine should be in line and hips flexed at 90 degrees to allow their legs to curve around the feeder's stomach. The feeder should place the teat on the baby's lips and invite baby to take the bottle, watching the baby responsively and following cues that baby may need a break. Stop the feed when baby is satisfied – they do not need to drain the bottle if they do not want to (Clark et al, 2007).

## 3 Training & Competencies

Training within UNICEF BFI 2 day course and subsequent triennial updates.

Competency within 234 Breastfeeding Management.

## 4 Related Documents

Trust Guideline for the Management of Hypoglycaemia in Newborn Infants Trustdocs ID: 1196

Trust Guideline for the Management of babies at increased risk of developing neonatal infection Trustdocs ID: 9998

Regional guidance from the East of England regarding Thermoregulation in Neonates Trustdocs ID: 1244.

Does your baby feed too much…or too little? Trustdocs ID: 8582

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## 6 Monitoring Compliance

Compliance with the process will be monitored through the following:

| Key elements | Process for Monitoring | By Whom (Individual / group /committee) | Responsible Governance Committee /dept | Frequency of monitoring |
|---|---|---|---|---|
| Babies commenced on reluctant feeder guideline and managed appropriately | A formalised audit tool | Infant Feeding Team | Maternity Clinical Guidelines Committee | Three yearly |
| Babies appropriately risk assessed at birth (i.e. infants at risk of hypoglycaemia are managed on Hypoglycaemia g/l) | A formalised audit tool | Infant Feeding Team | Maternity Clinical Guidelines Committee | Three yearly |
| Babies who are reluctant to feed have clinical observations recorded as appropriate | A formalised audit tool | Infant Feeding Team | Maternity Clinical Guidelines Committee | Three yearly |
| Babies who are asymptomatic for hypoglycaemia and otherwise well do not have blood glucose performed unnecessarily | A formalised audit tool | Infant Feeding Team | Maternity Clinical Guidelines Committee | Three yearly |

The audit results are to be discussed at relevant governance meetings – Maternity Clinical Audit meetings to review the results and recommendations for further action. Then sent to Maternity Clinical Guidelines Committee who will ensure that the actions and recommendations are suitable and sufficient.

## 7 Appendices

There are no appendices for this document.

**8 Equality Impact Assessment (EIA)**

| **Type of function or policy** | New/Existing (remove which does not apply) |
|---|---|

| **Division** | Women and Children's | **Department** | Maternity |
|---|---|---|---|
| **Name of person completing form** | Sophie Harvey | **Date** | 05/12/2022 |

| **Equality Area** | **Potential Negative Impact** | **Impact Positive Impact** | **Which groups are affected** | **Full Impact Assessment Required YES/NO** |
|---|---|---|---|---|
| Race | Not Relevant | Not Relevant | Not Relevant | Not Relevant |
| Pregnancy & Maternity | Not Relevant | Not Relevant | Not Relevant | Not Relevant |
| Disability | Not Relevant | Not Relevant | Not Relevant | Not Relevant |
| Religion and beliefs | Not Relevant | Not Relevant | Not Relevant | Not Relevant |
| Sex | Not Relevant | Not Relevant | Not Relevant | Not Relevant |
| Gender reassignment | Not Relevant | Not Relevant | Not Relevant | Not Relevant |
| Sexual Orientation | Not Relevant | Not Relevant | Not Relevant | Not Relevant |
| Age | Not Relevant | Not Relevant | Not Relevant | Not Relevant |
| Marriage & Civil Partnership | Not Relevant | Not Relevant | Not Relevant | Not Relevant |
| **EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?** | Not Relevant | | | |

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

**IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED**

**The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.**