Trust Guideline for the Prevention and Management of Excessive Weight Loss in Healthy Breastfed Newborns

A Clinical Guideline

For use in:	Maternity and Paediatric Services
By:	Midwives, Registered Nurses, Medical Staff, Maternity Care Assistants, Nursery Nurses, Student Midwives/Nurses under the direct supervision of their allocated mentor, Peer Supporter Volunteers in Maternity Services
For:	Prevention of excessive weight loss in healthy breastfed newborns over 37 weeks gestation
Division responsible for document:	Women and Children's Division
Key words:	Newborns, weight loss, breastfeeding
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Assessed and approved by the:	Chair of Maternity Guidelines Committee Chair of Clinical Guidelines Assessment Panel (CGAP) If approved by committee or Governance Lead Chair's Action; tick here ☑
Date of approval:	07/12/2021
Ratified by or reported as approved to:	Clinical Safety and Effectiveness Sub-board
To be reviewed before:	07/12/2024
To be reviewed by:	Infant Feeding Co-ordinator
Reference and / or Trust Docs ID No:	8333
Version No:	4
Compliance links:	No
If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why?	NA

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Version and Document Control:

Version Number	Date of Update	Change Description	Author
3	28/09/2018	Weight loss plans changed to reflect the change in threshold for referral to CAU from 10% weight loss to 12%	Luisa Lyons Joanna Naylor
4	30/11/2021	Minor amendments – 'cup feeding' amended to 'preferably by cup or by paced bottle feeding'	Joanna Naylor Gayle Richards

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Introduction

Excessive weight loss (>8%) in healthy breastfed newborns results when there is ineffective milk transfer to the baby. The most likely reasons for this are:

- The baby is not attaching to the breast effectively.
- The baby is not feeding frequently enough or for long enough (see appendix 1).
- More rarely, it may be due to a medical condition or physical abnormality of either mother or baby (illness, infection).

In all but a very small minority of cases the problem can be overcome with good feeding management. If the problem is not corrected, suppression of milk production will result (Neifert 2004). In the first few days of life the problem is more likely to be one of milk transfer from mother to baby rather than milk supply. An underlying illness can itself cause weight loss or may be the reason for poor feeding responses. Therefore it is important that babies with excessive weight loss are examined by a paediatrician to consider this.

The importance of observing babies at the breast cannot be over-emphasised. All babies should be observed at the breast and a full Breastfeeding assessment carried out (see appendix 1). Mothers need to know how to tell if breastfeeding is going well, how to recognise feeding cues and know what is normal and what is a cause for concern. All mothers should therefore receive information verbally, and in writing following birth, about how to recognise effective feeding (see Appendix 2). This should be pointed out and explained by maternity staff. Mothers and their families should be educated both antenatally and again following the birth, about early feeding cues and normal frequency of breastfeeding.

Responsive Feeding is recommended. There is a myth that babies develop a regular “3 hourly” pattern of feeding when in fact a baby will breastfeed for many reasons other than hunger, including thirst, protection, comfort, warmth and love. Mothers may offer a feed if their breasts feel full. Responsive feeding means responding promptly to feeding cues as well as recognising the aforementioned reasons to offer a feed. Some babies will feed infrequently in the first 24-48 hours due to a variety of peripartum factors, but many babies subsequently feed much more frequently over the next few days, weeks and months. This is normal and healthy. Cluster feeding, (where babies feed for lengthy periods often on an evening) is normal-if signs of effective milk transfer are evident).

Aims and Objectives

The aim of this guideline is to use a robust, standardised evidence based framework for the prevention and management of newborn weight loss. This will be achieved by:

- Performing a breastfeeding assessment on least four 4 occasions in the first 14 days, at key points. These are detailed on the tool (appendix 1).
- Weighing babies appropriately and accurately in a consistent manner.
- Implementing relevant weight loss management plans.

In doing so, care will be given to all breastfeeding mothers which promotes and supports ongoing breastfeeding.

Rationale

There are a significant number of newborns who are readmitted to hospital in the first 28 days of life. Weight loss in the first few days of life is normal as babies are born with excess extracellular fluid which they need to shed. This may be why early breast milk (colostrum) is in a concentrated form (UNICEF, 2005). Recent studies have indicated that, in the majority of babies, weight loss is likely to be between 5 and 7% (Dewey et al, 2005, Macdonald, 2003). Reduced length of hospital stay has also been linked to excessive neonatal weight loss (Hall 2000).

A robust system of proactive management - through several standardised feeding assessments - is vital to ensure that problems are detected early enough to prevent babies suffering significant weight loss which we regard as >8%. Weighing a baby only identifies the problem, it does not resolve it.

Broad recommendations

AS a UNICEF Baby Friendly Hospital, all staff giving direct care to mothers and babies are required to undertake training relevant to their role including being able to assess effective milk transfer. When all staff have developed their skills in breastfeeding management by completing the UNICEF standard in-house training programme, it is expected that readmissions for excessive weight loss will fall. The infant feeding co-ordinator, together with the risk management nurse for paediatrics will meet monthly to review the number of readmissions.

Guideline

The key to preventing excessive newborn weight loss is to ensure effective breastfeeding. This is achieved by both staff and mothers being able to identify the signs of effective milk transfer and by ensuring frequent, baby-led feeds.

Breastfeeding Assessment

A full breastfeeding assessment, using the standardised 'Breastfeeding Assessment Tool' (see Appendix 1) should be carried out:

- Prior to discharge from hospital (or leaving house if homebirth).
- First postnatal visit by community midwife.
- Between day 5-8 (determined by extent of weight loss at first visit – see plan A, B or C).
- Between day 10-14.
- At discharge from midwifery care, if later than day 14.

The rationale for doing this is to adequately assess breastfeeding in a standardised manner. Mothers will be given written and verbal information (See appendix 2) to help them understand effective breastfeeding.

Weight

The process for weighing newborns is:

- At birth (preferably double checked).
- At or around 72 hours of age and thereafter as clinically indicated.
- At or around day 10. Birth weight should normally have been regained by 14 days.

Babies should not be discharged from midwifery care until they have regained their birth weight. The weight measurement obviously needs to be accurate. Therefore the baby should be weighed in line with Department of Health and World Health Organisation (WHO) guidance (2009):

- On class III electronic/digital scales in metric setting.
- On a hard surface (not carpet, if using lay on scales).
- The baby should be preferably naked or in a clean dry nappy only if necessary**.** If weighing a baby in a dry nappy, the scales should be set to 'zero' with a new nappy first.
- Ideally babies should be weighed pre-feed and, to reduce distress in a prone position. The relation to feed should be documented as pre or post-feed.
- For consistency, wherever possible the same scales should be used.
- Digital scales should be serviced annually in line with medical devices standards.

Weight should then be documented in the baby records and weight loss or gain documented accordingly.

Identification of excessive weight loss

Weight loss should be calculated as a percentage using the following formula:

$$\frac{\text{Weight loss (g)}}{\text{Birth weight (g)}} \times 100 = \text{weight loss \%}$$

Weight loss **must** be documented in the baby's records.

Weight loss of 8% or more triggers further action. Weight loss of 12% or more requires a Paediatric or Neonatal medical or Advanced Nurse Practitioner review.

Action Plans:

Amount of weight loss	Management Plan indicated
8-10.0% of birth weight	PLAN A (See below)
10.1-12.0% of birth weight	PLAN A AND B (See below)
More than 12% of birth weight	PLANS A, B AND C (See below)

PLAN A: 8-10.0% weight loss

- ✓ Perform a full set of observations and document in Neonatal Record. Recheck weights and percentage calculations as mistakes are common
- ✓ Observe a full breastfeed - ensure effective positioning and attachment noting in particular the importance of **urine and stool output**
- ✓ Consider referral to Children's Assessment Unit (CAU) if illness suspected
- ✓ Teach the mother about early feeding cues; what they are and the importance of responding early to them. Ensure baby having a minimum of 8 feeds in 24 hours- rather than '3 hourly' -the 24 hour picture is more important. **Start a feed chart in the Neonatal record**
- ✓ Promote lengthy skin to skin contact to encourage pre feeding behaviour and effective breastfeeding
- ✓ Observe for effective suckling pattern during a feed- check the suck:swallow ratio which should be 1:1 or 2:1 maximum. Document the current ratio.
- ✓ Teach the mother to do breast compressions whilst baby is feeding. If you are unsure how to do this please ask your area's infant feeding key worker
- ✓ **Observe tongue movements** to rule out a restrictive lingual frenulum (tongue tie). Use the RLF assessment form and file it in the Neonatal Record. (If you do not feel able to do this ask an infant feeding key worker or appropriately trained professional).

THEN

- ➢ Observe for change in frequency/amount of urine and stools and document. Reweigh after 48 hours or sooner if stools and urine are of concern.
- ➢ If weight increasing, continue to monitor closely and provide encouragement and support.
- ➢ Telephone after 24 hours to ensure stool and urine output are improving.

After 48 hours if static weight or minimal weight increase (<25g/day), move to Management Plan B straight away

PLAN B: 10.1-12.0% weight loss

Follow Management Plan A, **plus**:

- ✓ Perform a full set of observations and document in Neonatal Record. Examine baby for signs of jaundice and document extent of jaundice.
- ✓ Liaise with Infant feeding link midwife/nurse in your own team or clinical area for feeding assessment and advice or Infant feeding Co-ordinator if concerned.
- ✓ Ensure skilled help with positioning and teach exaggerated attachment technique.
- ✓ Ensure breast compressions are being done **effectively and throughout** feed
- ✓ If babies are sleepy or weak, or have a poor suck, teach mothers 'switch nursing' technique*.
- ✓ Monitor and record urine and stool output noting frequency and colour
- ✓ Express breastmilk after each feed and offer to baby preferably by cup, or paced bottle feeding.
- ✓ If the baby is not breastfeeding effectively consider if half top ups are indicated at this point.
- ➢ Telephone at 24 hours to ensure stool and urine output are improving and breastfeeding is more effective and/or frequent.
- ➢ Weigh again in 48 hours, preferably on the same scales (or earlier if there are clinical concerns).

If no increase in weight or only minimal increase (<25g/day) or weight loss, move to Management Plan C straight away.

*Switch nursing swaps the baby from one breast to the other and back each time the sucking pattern cases to be a nutritive pattern.

PLAN C: MORE THAN 12.0% weight loss

Follow Management Plan B, plus:

- ✓ Perform a full set of observations and document in Neonatal Record. Examine baby for signs of jaundice and document extent of jaundice.
- ✓ Refer to hospital for review on CAU. Will require additional support with feeding from infant feeding link midwife/nurse or infant feeding midwife or co-ordinator.
- ✓ Carry out investigations to determine ongoing care. This will include a blood gas.
- ✓ Minimum 8 feeds in 24 hours plus supplements of EBM each feed to rehydrate. If EBM is insufficient give formula feeds preferably by cup, or paced bottle feeding (or if clinically indicated, intravenous fluids) but only if breastfeeding ineffective or EBM unavailable. Supplements should be given at **half of the calculated daily fluid requirement**.
- ✓ Expressing after and between feeds, using hand expressing, own pump or hospital-grade breast pump, whichever yields most milk.
- ✓ Reduce formula offered as breastmilk supply increases. Weigh again in 24 hours
- ✓ Continue to monitor weight alternate days until clear trend towards birth weight demonstrated.

Treatment of Babies requiring rehydration

All babies should be supplemented with expressed breastmilk in the first instance. This would be done with a plan to protect the breastfeeding relationship and preserve breastmilk supply. Formula should only be used if insufficient volumes of expressed breastmilk are available whilst encouraging breastfeeding/expressing. Any supplementation should be given preferably via a feeding cup at the mother's bedside, or if this isn't the parents' choice, by paced bottle feeding. Mothers should be offered to be taught how to cup feed by staff if possible, to empower them to feed their babies themselves (see Appendix 3). If longer term supplementation is needed, discuss with Infant feeding co-ordinator and consider a supplemental nursing system.

Volume of Supplement

A pragmatic approach would be to feed the baby with approximately one half of its fluid requirement as supplemental feeds at first (whilst continuing to support lactation and breastfeeding). This would equate to approximately 30mls of milk per feed for a 4kg baby on day 3 if feeding 3 hourly (120mls/kg). This supplement may be given as 1 feed of 60ml approximately 6 hourly along with support of lactation and feeding. Larger supplements given less frequently may be more protective for breastfeeding and lactation. All feeds should be clearly documented on the baby's feed chart. Supplemental feeds should not be more than 6 hours apart in this group of babies and breastfeeding and/or breastmilk should be given in between formula feeds as frequently as possible.

Supplementation should reduce once baby's weight has increased, blood profile has normalised and weight loss is within 12% birthweight. The baby should be reviewed daily by a paediatrician until discharged home and will usually be weighed alternate days.

Significant hypernatraemia (Na >150mmol/l) is an absolute indication for supplementation of feeding and should be discussed with a senior paediatrician.

Clinical audit standards

The Maternity Services are committed to the philosophy of clinical audit, as part of its Clinical Governance programme. The standards contained in this clinical guideline will be subject to continuous audit, with multidisciplinary review of the audit results at one of the monthly departmental Clinical Governance meetings. The results will also be summarised and a list of recommendations formed into an action plan, with a commitment to re-audit within three years, resources permitting.

The number of babies readmitted to hospital with excessive weight loss will be monitored and recorded. The system for reporting excessive newborn weight loss is via DATIX incident reporting. The Infant Feeding Policy states the healthcare professional admitting the baby into hospital should be responsible for completing the DATIX form. Admission proformas have been amended to record richer data which will enable further practice development and education. The Infant Feeding Co-ordinator/s will liaise with Clinical Governance Nurse for paediatrics on a monthly basis to analyse the data on readmissions for excessive weight loss and review each case of weight loss resulting in hypernatraemia on an individual basis.

Summary of development and consultation process undertaken before registration and dissemination

This guideline was drafted by Luisa Lyons supported by the Maternity guidelines group, the Neonatal guidelines group and in consultation with Head of Midwifery, Senior Midwifery managers, NICU, Consultant Neonatologists Consultant Paediatricians and Paediatric managers.

Distribution list

Trustdocs

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Breastfeeding Assessment Tool

Appendix 1

For the actual document see Trustdocs Id 14528

Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Breastfeeding Assessment Tool

Put a tick (✓) or a cross (X) in the relevant column

Where there are any crosses it is important to observe a full breastfeed and develop an individualised care plan including revisiting positioning and attachment. Any additional concerns should be followed up as necessary.
Refer to a breastfeeding specialist if required.

Patient Identifier Label

D

What to observe and ask about	Effective feeding? (✓)	Day 0/1 Before going home or leaving if homebirth	1st visit	Day 5-8	On transfer to Health Visitor	Ineffective feeding? (x) *Put X below if appropriate*
Baby's stools	Day 0-2 = **1** or more meconium Day 3-4 = **2** or more 'changing stools' Day 5+ = **2** or more **yellow** soft stools					Less stool output than opposite
Baby's urine output	Day 0-2 = **1-2** or more wet nappies Day 3-4 = **3** or more heavier wet nappies Day 5-6 = **5** or more heavy wet nappies Day 7+ = **6** or more heavy wet nappies					Less wet nappies than opposite
Weight	If **72 hours** old and over – not lost more than 8-10% of birth weight					If weight loss greater than 8-10% see Prevention of Excessive Newborn Weight Loss Guideline, then implement management plan A B or C.
Number of feeds in last 24 hours/or from birth	Day 1 – at least 3-4 feeds. Thereafter – at least 8 feeds in 24 hours					Less than stated opposite.
Baby's behaviour during feeds	Generally calm and relaxed					Baby comes on and off the breast during the feed or refuses to breastfeed
Sucking pattern during feeds	Initial rapid sucks followed by deeper sucks and pauses and soft swallowing					No change in sucking pattern or noise feeding (clicking)
End of feed	Baby lets go of breast spontaneously or does so when breast is gently lifted					Baby does not release breast spontaneously or mother removes the baby
Baby behaviour after feeds	Baby content after most feeds					Baby unsettled after feeding
Offer second breast?	Second breast offered. Baby may or may not feed on second breast – dependant on appetite					Mother restricts feeds to 1 breast per feed or insists on 2 breasts per feed
Length of feed	Baby feeds for 5 – 30 minutes at most feeds					Baby consistently feeds for less than 5 minutes or more than 40 minutes
Shape of nipple at end of feed	Same shape as when feed began or slightly elongated					Nipple misshapen or pinched at end of feed
Baby's colour alertness and tone	Normal skin colour, alert and good tone					Jaundice worsening or not improving. Baby lethargic and not waking for feeds. Poor tone.
Breasts and nipples	Breasts and nipples comfortable Breasts filling at appropriate time					Nipples sore or damaged, engorgement or mastitis. Breasts not filling as expected
Use of dummy, nipple shield +/- formula?	None used					Yes (state which) Ask why? e.g. Difficulty with attachment/? Baby's weight? Baby unsettled?
Mother's confidence	Feeling happy and confident					Feeling anxious or uncertain

Visit	Date *(dd/mm/yyyy)*	Print name	Signature	Designation
Day 0/1				
1st Visit				
Day 5 - 8				
On transfer to HV				

Adapted from an assessment tool in use from Bradford Hospitals NHS Foundation Trust, with kind permission from Janette Westman RM IBCLC.

- Put a **tick** (√) **or a cross (X)** in the relevant column
- **Where there are any crosses it is important to observe a full breastfeed and develop an individualised care plan** including revisiting positioning and attachment. Any additional concerns should be followed up as necessary. Refer to a breastfeeding specialist if required.

Appendix 2 (Example)

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

"How can I tell that breastfeeding is going well?" **A Checklist for Mothers.**

Breastfeeding is going well when;	**Talk to your midwife if;**
Your baby has 8 or more feeds in 24 hours	Your baby is sleepy and has had less than 6 feeds in 24 hours
Your baby is feeding for between 5 and 30 minutes at each feed	Your baby is feeding for 5 minutes or less each feed Your baby is feeding for longer than 40 minutes at each feed
Your baby has normal skin colour	Your baby appears jaundiced (yellow discolouration of the skin)
Your baby is generally calm and relaxed whilst feeding	Your baby comes on and off the breast frequently during a feed
Your baby comes off the breast naturally after a feed	Your baby has to be 'released' from the breast by you
When your baby is older than 3-4 days you can hear them swallowing frequently during a feed	You cannot tell if your baby is swallowing any milk after your baby is 3-4 days old
Your baby is having wet nappies (As disposable nappies are very absorbent it is sometimes hard to tell- to get an idea take a nappy and add 2-4 tablespoons of water. This should give you an idea what to look/feel for): 0-2 days old= **1-2** wet nappies (urates* may be present) 3-4 days old= **3** heavier wet nappies 5-6 days old= **5** or more heavy wet nappies 7 + days old= **6** or more heavy wet nappies	Your baby is having less wet nappies than described opposite *Urates are a dark pink/red substance that many babies pass in the first couple of days. They are normal in the first 1-2 days but if they are still there after day 3 it may be a sign your baby is not getting enough milk.
Your baby is having dirty nappies: 0-2 days old= **1** or more green/black tar-like (meconium) nappy 3-4 days old= **2** or more stools which are changing colour and less sticky 5-6 days old= **2** or more yellow stools which may be 'loose' 7-28 days old= **2** or more at least the size of a £2 coin, yellow & loose	Your baby is having less frequent or differently coloured stools than described opposite
Your breasts and nipples are comfortable	Your nipples or breasts are sore or damaged, very full or red in colour
You are not feeling the need to use a dummy, nipple shields or formula	You think your baby needs a dummy and / or formula milk
You are enjoying breastfeeding your baby!	You are feeling anxious or uncertain or not enjoying breastfeeding

Luisa Lyons RM IBCLC 27.10.11 Adapted from the UNICEF Mother's Checklist.

Appendix 3

Patient Information Leaflet for Cup feeding

Click here Trustdocs ID No: 15475

Appendix 4

Document Name: Infants readmitted with weight loss under 28 days old

Element to be monitored	*Lead Responsible for monitoring*	*Monitoring Tool / Method of monitoring*	*Frequency of monitoring*	*Lead Responsible for developing action plan & acting on recommendations*	*Reporting arrangements (*	*Sharing and disseminating lessons learned & recommended changes in practice as a result of monitoring compliance with this document*
1. All infants who have lost >10% birth weight will be referred to CAU	Infant Feeding Co-ordinator	A formalised audit tool with reference to CNST requirements	Tri -annually	Clinical Governance Lead	Department Clinical Governance Meeting	The Lead responsible for developing the action plans will disseminate lessons learned via the most appropriate committee e.g. Clinical Effectiveness; Clinical Governance, Patient Safety and where appropriate, the Compliance Assurance Group.
2. There will be documentation to indicate effective milk transfer had taken place whilst an inpatient.	Infant Feeding Co-ordinator	A formalised audit tool with reference to CNST requirements	Tri -annually	Clinical Governance Lead	Department Clinical Governance Meeting	
3. Breastfeeding Assessment Tool (BAT) completed whilst inpatient before discharge home including noting stool and urine output	Infant Feeding Co-ordinator	A formalised audit tool with reference to CNST requirements	Tri -annually	Clinical Governance Lead	Department Clinical Governance Meeting	
4. Breastfeeding Assessment Tool (BAT) completed at first postnatal community midwife visit including noting stool and urine output	Infant Feeding Co-ordinator	A formalised audit tool with reference to CNST requirements	Tri -annually	Clinical Governance Lead	Department Clinical Governance Meeting	

5. Breastfeeding Assessment Tool (BAT) completed at day 5-8 in community including noting stool and urine output	Infant Feeding Co-ordinator	A formalised audit tool with reference to CNST requirements	Tri -annually	Clinical Governance Lead	Department Clinical Governance Meeting	The Lead responsible for developing the action plans will disseminate lessons learned via the most appropriate committee e.g. Clinical Effectiveness; Clinical Governance, Patient Safety and where appropriate, the Compliance Assurance Group
6. Breastfeeding Assessment Tool (BAT) completed by community midwife at transfer to Health Visitor care including noting stool and urine output	Infant Feeding Co-ordinator	A formalised audit tool with reference to CNST requirements	Tri -annually	Clinical Governance Lead	Department Clinical Governance Meeting	
7. Weight loss management plan implemented appropriately and clearly including breast compressions if (>8%) and switch nursing (if >10%)	Infant Feeding Co-ordinator	A formalised audit tool with reference to CNST requirements	Tri -annually	Clinical Governance Lead	Department Clinical Governance Meeting	
8. Supplementation with formula is prescribed in volumes as per guideline (half volume requirements for breastfed babies)	Infant Feeding Co-ordinator	A formalised audit tool with reference to CNST requirements	Tri -annually	Clinical Governance Lead	Department Clinical Governance Meeting	
9. Infant feeding keyworker contacted for support with plan of care	Infant Feeding Co-ordinator	A formalised audit tool with reference to CNST requirements	Tri -annually	Clinical Governance Lead	Department Clinical Governance Meeting	