The Shrewsbury and Telford Hospital NHS Trust

Newborn Feeding,

(including Babies sharing their mothers' bed while in hospital or at home)

Version 5.2

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Care Group		Women and Children's
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Comments	:	References to SaTH Guidelines in the text pertain to the latest version of the Guideline on the intranet. This guideline needs to be read in conjunction with **Weighing the Healthy Neonate (191)**

Version	Implementation Date	History	Ratified By	Full Review Date
1	June 2010	New	MGG/ Maternity Governance	June 2013
2-2.7	5th May 2011-24th February 2014	History pages amalgamated refer to version 3.3 for full history	MGG	May 2014
3	26th January 2015	Full review for Stage 3 Baby Friendly Accreditation	MGG	January 2018
3.1	13th July 2015	Minor revision following baby friendly assessment (section 5.4.1)	MGG (30.6.15)	January 2018
3.2	28th November 2016	Updated to included recording of telephone conversations (section 5.11) following SI	MGG Maternity Governance	January 2018
3.3	21st December 2016	Updated to include the documentation for BF assessments SI action	MGG	January 2018
4	16th March 2018	Full version review ▪ Minor revisions to section 5.5 clarifications on amounts of EBM to be given via syringe. ▪ Syringe feeding restricted to hospital use parents should not be sent home with a supply of syringes only cups for cup feeding.	MGG Maternity Governance	March 2023
4.1	9th December 2020	Minor revision to sections • 5.2 Following HSIB report. When baby is in skin to skin contact with the mother, the mother should be able to see the baby's face at all times. • 5.4 Expressing for a preterm. • 5.5 Storage of EBM	GC	March 2023
5	19th May 2023	Full Review	Maternity Governance	May 2026
5.1	July 2023	Audit & Monitoring paragraph update to reflect new process		May 2026

5.2	June 2025	Added information for finger feeding	Maternity Governance	May 2026

1.0 Introduction

In this guideline we use the terms ‘woman’ or ‘mother’ throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth.

1.1 The SaTH NHS Trust Maternity Service recognises that breastfeeding confers important health benefits to both mother and baby.

1.2 All mothers have the right to receive clear and impartial information to enable them to make a fully informed choice as to how they feed and care for their babies.

1.3 Midwives and support workers will not discriminate against any woman in her chosen method of infant feeding and will fully support her when she has made that choice.

1.4 This guideline will be communicated to all healthcare staff that has any contact with pregnant women and mothers. Staff will have access to a copy of the guideline via the intranet. In order to avoid conflicting advice, it is crucial that all staff involved with the care of breastfeeding women adhere to this guideline. Any deviation from the guideline must be justified and recorded in the mother’s and/or baby’s notes.

1.5 The information within this guideline will be effectively communicated to all pregnant women with the aim of ensuring that they understand the standard of information and care expected from this Trust. This guideline will be implemented in conjunction with the parent’s guide to the Newborn Feeding Guideline in the “Mothers guide to breastfeeding”.

1.6 Experiences of care can be communicated to the Trust by parents using the Family and Friends Feedback forms.

1.7 Appendix 1 lists points to support implementation of this guideline.

2.0 Aims

- To ensure all women are given evidence-based, consistent advice about feeding their babies and supported in the decision they make on method of feeding.
- To enable Midwives, Neonatal Nurses, and support staff to create an environment where more women choose to breastfeed their babies.
- Providing the highest standard of care to support expectant and new mothers and their partners to feed their baby and build strong and loving parent – infant relationships. This is in recognition of the profound importance of early relationships to future health and well- being, and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for children and mothers.
- To ensure that the maternity service adopts the International Code of Marketing of Breast- milk Substitutes by prohibiting the display or distribution of materials which promote breastmilk substitutes, feeding bottles, teats, or dummies. Staff will receive training on the rationale behind this requirement to equip them in practice.
- Allow mothers and babies to derive the benefits of bed-sharing in hospital or at home while still ensuring the safest possible environment.
- Reduce the risk of inappropriate bed-sharing in hospital and at home.
- Provide parents with accurate information about the benefits, risk and alternatives to bed sharing.
- Increase the likelihood of appropriate and the safest possible bed sharing once mothers and babies return home.

3.0 Objectives

3.1 To give all mothers the information they need to make an informed choice of infant feeding method.

3.2 To ensure all Midwives, Neonatal Nurses and support staff follow this guideline so that advice is consistent, and evidence based.

3.3 To ensure that Midwives discuss the health benefits of breastfeeding and the potential health risks of formula feeding with all women so that they can make an informed choice about how they will feed their baby.

3.4 To give women confidence to breastfeed by explaining the physiology and providing support.

3.5 To discuss with parents who have made a fully informed choice to use Commercial Milk Formula how to prepare formula feeds correctly, in the postnatal period.

3.6 To complete documentation of all key discussions and care events.

3.7 To complete documentation when any deviations from the guideline occur, and the reasons for them.
3.8 To ensure the safest possible environment for mothers and babies.
3.9 To provide support and guidance to parents to allow them to make fully informed choices. To encourage successful breastfeeding.
3.10 To reduce the risks associated with bed-sharing where it is contra-indicated. To ensure that parents have all the information required to enable them to bed share as safely as possible with their baby in hospital and at home.

4.0 Definitions

4.1 Healthcare Staff – any clinical member of staff who has contact with pregnant women and mothers. This may include Midwives, Neonatal Nurses, Paediatricians, Neonatologists, Women's Services Assistants and Maternity Support Workers

4.2 Skin to skin contact – maternal and infant total skin contact

4.3 Rooming-in – mother and baby being close together in the same room

4.4 Artificial feeding - feeding a baby with Commercial Milk Formula.

4.5 MIS – Maternity Information System – the electronic record keeping system used in Maternity at SaTH.

4.6 EBM – Expressed Breast Milk

4.7 Lactation Consultant Midwife (LCM)
Midwives who have an additional qualification from the International Board of Lactation Consultants.

5.0 Process

Supporting all mothers

5.1 Informing pregnant women of the health benefits to mother and baby and management of breastfeeding

- At booking, women will receive digital information via the Maternity Information System from the Community Midwife to include the Start 4 Life "Off to the Best Start" in addition a hard copy of "A Mother's Guide to Breastfeeding"
- By 34 weeks of pregnancy, pregnant women presenting to SATH Maternity Service will be given an opportunity to discuss their thoughts and feelings about infant feeding and caring for their baby including the health benefits to mother and baby of breastfeeding, the value of connecting with their growing baby in utero, the value of skin contact, the importance of responding to their baby's needs for comfort, closeness and feeding after birth, and the role that keeping their baby close has in supporting this and the potential health risks of formula feeding on a one-to-one basis with a Midwife. Attendance at Trust breastfeeding workshops will reinforce this information.
- Provision of information about breastfeeding will be recorded in the Maternity Information System
- The physiological basis of breastfeeding will be clearly and simply explained to all pregnant women, together with good management practices which have been proven to protect breastfeeding and reduce common problems. The aim is to give women confidence in their ability to breastfeed.
- Pregnant women will be informed by their Midwife in the antenatal period about additional services that further support women to breastfeed. These include local breastfeeding support groups.
- For women where breastfeeding problems can be anticipated antenatally, please refer to maternity guideline - Antenatal Colostrum Collection. Any mother from to be from 36 weeks may collect her own colostrum in preparation for the birth of her baby.

5.2 Skin to skin contact and offer of help with a first breastfeed

- All mothers will be encouraged to hold their babies in skin-to-skin contact as soon as possible after delivery, for at least an hour, in an unhurried environment, regardless of their intended feeding method.
- Skin-to-skin contact must be encouraged throughout routine procedures.
- If skin-to-skin contact is interrupted for clinical indication or maternal choice it will be re-instigated as soon as mother and baby are able. Vigilance to the baby's well-being is fundamental to postnatal care in the first few hours after birth. For this reason, normal

observations of the baby's temperature, breathing, colour and tone should continue throughout the period of skin contact. Observations of the mother should also be made, with prompt removal of the baby if the health of either gives rise to concern. It is important to ensure that the baby cannot fall on the floor or become trapped in bedding or by the mother's body. Particular care should be taken with the position of the baby, ensuring the head is supported so the infant's airway does not become obstructed.

- All mothers will be encouraged to offer the first breastfeed or bottle feed in skin contact, ensuring baby is kept warm, when mother and baby are ready, preferably within the first hour of birth. Help must be available from a Midwife, MSW or WSA if needed.
- Accurate documentation of the effectiveness of the first feed is vital on the postnatal baby records.
- Mothers will be encouraged to use skin to skin contact at any time as a simple way of encouraging the baby to feed. The parent(s) are advised to observe their baby's breathing and colour. This information should be reinforced in the immediate post birth period as in the event the parent(s) are left alone (e.g. to provide privacy or complete electronic records). They

  need to be aware of what is the normal physiology immediately post birth and to summon assistance if they are concerned about their baby's breathing or colour.
- When baby is in skin to skin contact with the mother, the mother should be able to see the baby's face at all times.

5.3 Rooming-in

- Mothers will be encouraged to assume primary responsibility for the care of their babies.
- Babies will not be routinely separated from their mothers at night. This applies to babies who are being artificially fed as well as those being breastfed. Mothers recovering from caesarean section must be given appropriate care, but the policy of keeping mothers and babies together will normally apply. Separation of mother and baby will normally only occur where the health of either mother or baby prevents care being offered in the postnatal areas.
- Babies whose mothers request support with settling must be returned to the bedside as soon as possible.

5.4 Supporting breastfeeding mothers

Showing women how to breastfeed and how to maintain lactation

- Breastfeeding mothers will be offered further help with breastfeeding within 6 hours of delivery, according to their needs. A Midwife, MSW or Women's Services Assistant (WSA) will normally be available to assist a mother to breastfeed at any time she requires help during her hospital stay.
- Midwives, Student Midwives, MSW's and appropriately trained WSAs must ensure that mothers are offered the support necessary to acquire the skills of positioning and attachment. They will be able to explain the necessary techniques to a mother, thereby helping her to acquire this skill for herself. This discussion will include information on responsive feeding and feeding cues. This information should be supported by 'A Mothers Guide to Breastfeeding Booklet'.
- The term responsive feeding is used to describe a feeding relationship which is sensitive, reciprocal and about more than nutrition. Staff should ensure that mothers have the opportunity to discuss this aspect of feeding and reassure mothers that: breastfeeding can be used to feed, comfort and calm babies; breastfed babies cannot be overfed or 'spoiled' by too much feeding and breastfeeding will not, in itself, tire mothers any more than caring for a new baby without breastfeeding.
- All breastfeeding mothers will normally be shown how to hand express their milk. Written information supporting this is available in the booklet 'A Mothers Guide to Breastfeeding'.
- It is the individual Midwife's responsibility to liaise with the neonatal team and/or General Practitioner if concerns arise about the baby's health.
- When a mother and her baby are separated for medical reasons, it is the responsibility of all health professionals caring for both mother and baby to ensure that the mother is given help and encouragement to express her milk and maintain her lactation during periods of separation.
- Mothers who are separated from their babies must be encouraged to begin expressing as soon as possible (ideally within two hours) after delivery as early

initiation has long-term benefits for milk production.

- Mothers who are separated from their babies will be encouraged to express milk at least eight to ten times in a 24 hour period. They will be shown how to express breast milk both by hand and by electric breast pump.

5.5 Supporting exclusive breastfeeding

- No water or formula feed will be given to a breastfed baby except in cases of clinical indication or fully informed parental choice. The decision to offer supplementary feeds for clinical reasons must be made by a Midwife or Neonatologist. Reasons for supplementation will be fully discussed with parents, consent will be obtained, and this discussion will be recorded in the baby's care records.
- Prior to introducing artificial milk to breastfed babies, every effort must be made to encourage the mother to express her breast milk so that this supply can be given to the baby via cup or 1 ml syringe **volumes of more than 5 mls will be offered via cup**. This proactive approach will reduce the need to offer artificial feeds. **Syringe feeding will only be administered within a hospital environment.**

Finger Feeding using an oral syringe

- Wash and dry your hands thoroughly before you start, making sure your nails are not too long, and use a sterile syringe each time.
- Hold baby in an upright position.
- Gently stroke down over baby's top lip to encourage rooting and mouth opening.
- Once baby opens their mouth, place the pad of your finger to the roof of baby's mouth, taking care not to make baby gag. If this happens, pull back your finger so it is more comfortable for baby.
- Place the top part of the syringe into the baby's cheek between your finger and baby's gum.
- Push the plunger gently so that the baby suckles your finger while drinking in the milk a little at a time (0.1-2ml)
- Continue until all the milk is gone.

Continue to give the milk in this way until baby feeds reliably at the breast and consider cup feeding as milk volume increases. Finger feeding with syringe is useful for giving small amounts of colostrum (first breast milk) which is usually of a thicker consistency.
Staff can teach parents to do this.

- Following collection of expressed breast milk (EBM) the mother will complete a label with her **name, unit number and date and time of collection** of the breast milk, this will be completed in the room and attached to the bottle or syringe and the syringe capped.
- **The EBM must then be stored in the designated fridge for no longer than 48hrs at a temperature below 4 degrees; fridge temp should be checked and recorded daily. When the breast milk is required, the milk will be checked by a member of staff and the mother. If the mother is unwell and unable to, then two members of staff will check the breast milk prior to administering any feed. This will be documented on the feeding chart and/or MIS.**
- Parents who request supplementation will be made aware of the possible health implications and the detrimental impact such action may have on breastfeeding to enable them to make a fully informed choice. A full record of this discussion will be made in the baby's care records.
- When exclusive breastfeeding is not possible, the value of continuing partial breastfeeding will be emphasised and mothers will be supported to maximise the amount of breastmilk their baby receives.
- Supplementation rates will be audited using the UNICEF Audit Tool

5.6 Responsive Feeding

- Responsive feeding will be encouraged for all babies unless clinically indicated. Hospital procedures must not normally interfere with this principle. Staff must ensure that mothers

understand what is meant by responsive feeding, including the nature of feeding cues and the importance of responding to them and that they have an awareness of normal feeding patterns, including cluster feeding and “growth spurts”.

- Mothers whose babies are reluctant to feed in the first few days should encourage feeding readiness by returning their babies to skin to skin contact and offering small, frequent amounts of hand expressed colostrum (see Appendix 2)
- Mothers will be informed that it is acceptable to wake their baby for feeding if their breasts become overfull or they are concerned. The importance of nighttime feeds for milk production will be explained.
- Prior to transfer home, all breastfeeding mothers will receive information both verbally and in writing about how to recognise effective feeding to include:
  - The signs which indicate that their baby is receiving sufficient milk and what to do if they suspect this is not the case.
  - How to recognise signs that breastfeeding is not progressing normally (e.g. sore nipples, breast inflammation)
- An assessment of breastfeeding will be carried out at least twice in the first week, using the BFI breastfeeding assessment tool in the Maternity Information System (see Appendix 4) but as frequently as required to ensure effective feeding and well-being of mother and baby this will include a discussion with the mother to reinforce what is going well and, where necessary, develop a plan of care to address any issues that have been identified. Feeding assessment will be documented on the BFI tool within the Personal Child Health Record (Red Book) and the Maternity Information SystemIS.

5.7 Use of artificial teats, dummies and nipple shields

- Healthcare staff will not recommend the use of artificial teats and dummies during the establishment of breastfeeding. Parents wishing to use them must be advised of the possible detrimental effects such use may have on breastfeeding, to enable them to make a fully informed choice. A record of the discussion and parents' decision must be recorded in the baby's care records.
- Nipple shields will not be recommended unless the alternative would be to give up breastfeeding or offer formula milk. Any mother considering the use of a nipple shield must have the disadvantages fully explained to her prior to commencing use. She must remain under the care of a skilled practitioner whilst using the shield and must be helped to discontinue its use as soon as possible.

5.8 Breastfeeding support groups

- This organisation supports co-operation between health care professionals and voluntary support groups whilst recognising that health care facilities have their own responsibility to promote breastfeeding.
- Telephone numbers of Midwives, Midwife/Lactation Consultants and other professional support will be given to all breastfeeding mothers in the postnatal period.
- Contact details for voluntary breastfeeding support groups will be issued digitally or in hard copy to all mothers on the Postnatal Ward and be routinely displayed throughout the Maternity Unit. Contact details will be regularly checked and updated to ensure correct information is distributed.
- Breastfeeding support groups will be invited to contribute to further development of the policy as it relates to breastfeeding via Maternity Voices Partnership

5.9 Supporting mothers who have chosen to formula feed

- Staff should ensure that all mothers who have chosen to feed their newborn with Commercial Milk Formula are able to correctly sterilise equipment and make up a bottle of CMF during the early postnatal period and before discharge from hospital. To support this DoH leaflet “Guide to Bottle Feeding” (or suitable alternative) will be issued digitally via the Maternity Information System
- Staff should ensure that all mothers offering CMF are confident in how to hold their baby in an effective and safe position for feeding and how to offer the bottle and teat, responding to cues that their baby is hungry, inviting the baby to draw in the teat rather than forcing the teat into the baby’s mouth, pace the feed so that their baby is not forced to feed more than they want to and recognising their baby’s cues that they have had enough milk and avoid forcing their baby to take more milk than the baby wants.
- In the community, midwives should check and reinforce learning following the mothers

transfer home or following a home confinement ensure that women are able to correctly sterilise equipment and make up a feed.

- All information given will follow guidance from the Department of Health and the Foods Standards Agency. Information will be reinforced by referring to the Department of Health Bottle Feeding leaflet.
- Mothers will be given contact details of health professional support available for feeding issues once they have left hospital
- Professional and support staff will receive training in the skills needed to assist mothers who have chosen to formula feed including in the reconstitution of CMF and sterilisation techniques, at a level appropriate to their role and responsibilities within Maternity.

5.10 Weighing babies

- Babies will be weighed in accordance with the guideline - Weighing the healthy neonate.

5.11 Process if a problem with feeding is identified

- The Midwife will encourage skin to skin contact.
- Mothers whose babies are sleepy in the first few days should encourage feeding readiness by returning their babies to skin to skin contact and offering small, frequent amounts of hand expressed colostrum.
- The Midwife will consider discussing the problem with a Midwife/Lactation Consultant.
- The Midwife will make an individual plan with the mother and document this in postnatal notes.
- The Midwife will liaise with the Neonatal Team and/or General Practitioner/ Health Visitor if concerns arise about the baby's health.
- If the mother and baby are separated for medical reasons, the Midwife will ensure that the mother is given help and encouragement to express her milk and maintain her lactation during periods of separation (see section 5.4).
- Prior to introducing CMF to breastfed babies, the Midwife will make every effort to encourage the mother to express breast milk to be given to the baby via cup or 1 ml syringe. This proactive approach will reduce the need to offer artificial feeds.
- The Midwife will not recommend nipple shields unless the alternative would be to give up breastfeeding or offer CMF (see section 5.7).
- The Midwife will enable the woman to contact further support (see section 5.8).
- For weight loss problems refer to Weighing the healthy neonate.
- If a mother calls for advice with feeding her baby in the postnatal period the midwife will document any advice given ON THE Maternity Information ~System

5.12 System for reporting newborns admitted to hospital with feeding problems during the first 28 days of life

- Readmissions of babies with feeding problems up to 28 days will be identified using the maternity, neonatal, paediatric electronic information system and updates provided at least three times per year to Maternity Governance. Annual figures will be collated by a data analysis into one report. This report is presented to Maternity Governance.
- A Datix will be raised where issues relating to care and management are identified by a Ward Manager or midwife with specialist knowledge (e.g. Lactation Consultant).
- If the Infant Feeding Coordinator/Midwife Lactation Consultant is requested to review a baby on Paediatric Assessment Unit (PAU), a Ward Attendance Form is raised, and a record of these consultations will be kept.
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6.0 Babies sharing their Mothers; bed in hospital or at home

It is recognised that mothers take their baby into bed in hospital to feed and provide comfort and closeness without any intention of sleeping with their baby. While it is acknowledged that no activity is entirely without risk, in the absence of maternal sleep there is no evidence that this incurs any greater risk than the mother holding or feeding her baby elsewhere. However, in certain circumstances mothers who bed-share may fall asleep whether or not they intend to.

Individual risk assessment needs to be carried out for every mother and baby prior to bed-sharing R**efer to Appendix 3**.

It should be noted that mothers' and babies' circumstances can quickly change. Therefore, risk assessment will need to be reviewed as required.

Once the risk assessment has been carried out:

- Discuss the benefits of skin-to-skin contact with mother. Skin contact can help regulate the baby's temperature, calms the baby and encourages breastfeeding. Facilitate skin contact by undressing the baby and assisting with the mother's clothing as appropriate. **Note: babies should never be swaddled in wraps or blankets when sharing a bed with their mother.**
- Instruct the mother how to adopt the protective 'C' position whilst bed-sharing. In this position mother and baby lie facing one another, mother on her side with her arm above the baby's head and her knees drawn up under the baby's feet. Baby's movements are therefore constrained by mother's position and it is harder for them to get into dangerous positions, such as under the pillow or down the bed clothes.
- Take measures to ensure that the physical environment is as safe as possible and that the baby is protected from falling out of bed, adjust bed to lowest position. Raise upper bed rails.
- Ensure the mother has easy access to the call system in case of difficulty getting out of bed.
- Communicate at handover if a mother and baby are bed-sharing

The risk assessment can be printed and kept with the mother's records during the inpatient episode alternatively) document in Badgernet that this has been completed and whether risk assessment has indicated if mother and baby are suitable for bed sharing or bed sharing not recommended.
On discharge from hospital, staff should discuss the dangers of bed-sharing at home with parents regardless of whether the mother has shared a bed with her baby in hospital.

6.0 Training and Education

6.1 Healthcare and support staff who have direct contact with pregnant women and mothers will receive training in breastfeeding management at a level appropriate to their professional group. (See Training Needs Analysis- TNA)

6.2 New staff will receive BFI accredited training, according to their grade, within six months of taking up their posts

6.3 Training and updating in newborn feeding care management will be delivered in accordance with the SATH Maternity Services TNA.

7.0 Monitoring/Audit

Compliance with this guideline / SOP will be audited as part of the Shrewsbury and Telford Hospital NHS Trust's five-year rolling programme of NICE and local guideline audits, unless circumstances require an earlier or more frequent audit. The audit will be carried out against the auditable standards and the results of the audit will be reported and acted on in accordance with the Trust Clinical Audit Policy (CG25).

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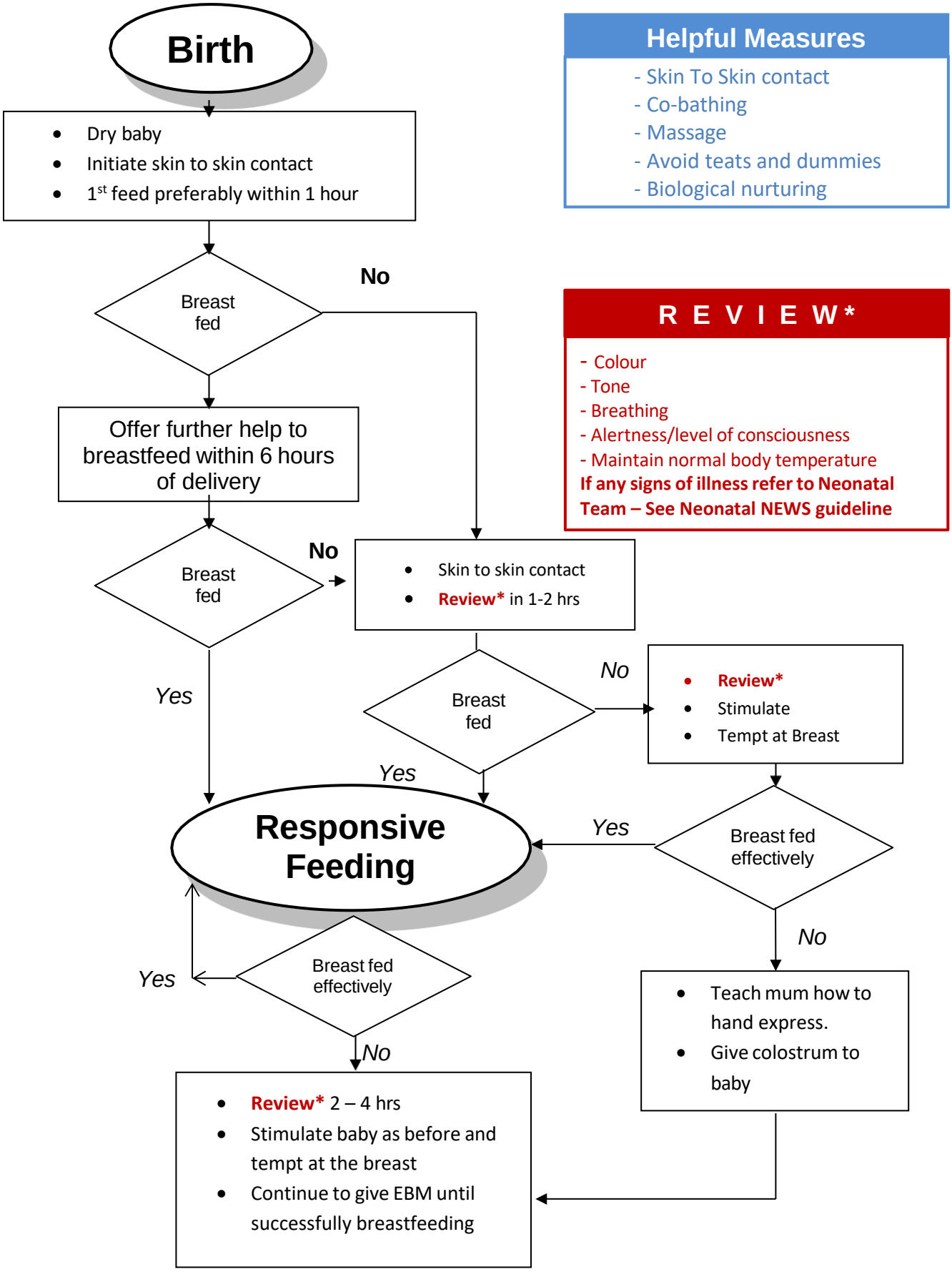
Appendix 1

Points in Support of the Guideline

- No routine group instruction on the preparation of artificial feeds will be given in the antenatal period as evidence suggests that information given at this time is less well retained and may serve to undermine confidence in breastfeeding.
- No advertising of Commercial Mil Formulas, feeding bottles, teats or dummies is permissible in any part of this organisation. The display of manufacturers' logos on items such as calendars and stationery is also prohibited.
- No literature provided by infant formula manufacturers is permitted. Educational material for distribution to women and their families must be approved by the Patient Publication Information Group.
- Women will not be asked about their intended method of feeding antenatally.

Appendix 2

Managing breast fed healthy term infants



The Shrewsbury and Telford Hospital NHS Trust

Babies sharing their mothers' bed – risk assessment

- ☐ **Has the mother or partner EVER smoked?**
- ☐ **Did the mother smoke in pregnancy?**
- ☐ **Has the mother or partner recently consumed any alcohol?**
- ☐ **Has the mother or partner taken any medications or substances that might make them sleep heavily?**
- ☐ **Is the mother excessively tired (e.g. had less than 4 hours sleep in the last 24 hours)?**
- ☐ **Is the mother bottle/formula feeding her baby?**
- ☐ **Was the baby small at birth? (Born before 37 weeks or weighing less than 2.5kg at birth)**

YES to more than ONE

YES – HIGH RISK - bed sharing not advised, re-evaluate if circumstances

NO – LOW RISK, re-evaluate if circumstances change

Contra-indications explained – High Risk

- Smoking in pregnancy or after birth and bed-sharing increases the risk of baby death. Research is on-going but it is thought that chemicals in smoke affect the baby's central nervous system and this affects their ability to respond normally to physical environment.
- Drinking alcohol, taking medications or substances which affect special awareness greatly increase the risk of baby death when bed-sharing. They are more likely to be smothered, rolled on, or placed in a dangerous position.
- Excessive tiredness affects the way you sleep, reduces your awareness and increases your baby's risk of accidental death, be careful not to fall asleep sitting up in bed or on a sofa as baby is in danger from a fall or entrapment.
- There is some evidence that small at birth babies may have an increased risk of Sudden Infant Death Syndrome (SIDS) when bed-sharing with non-smoking parents but this is dramatically increased with parents who smoke.

Safety considerations – Low Risk

- The mattress needs to be firm, clean and flat.
- In hospital have the bed at its lowest position (closest to the floor)
- Breastfeed your baby adopting the protective 'C' position whilst bed-sharing. In this position mother and baby lie facing one another, mother on her side with her arm above the baby's head and her knees drawn up under the baby's feet. Baby's movements are therefore constrained by mother's position and it is harder for them to get into dangerous positions, such as under the pillow or down the bed clothes.
- Do not use waterbeds, electric blankets or bean bags
- Make sure that baby cannot fall out of bed or get stuck between the mattress and the wall.
- Use of upper bed rails is indicated as the gap is minimal
- Room temperature of 16 – 18°C
- Babies should not be overdressed – no more than you would wear in bed yourself.
- Covers must not overheat the baby or cover baby's head.
- Baby must not be left alone in or on the bed as even very young babies can wriggle into dangerous positions.
- At home your partner should know if your baby is in the bed.
- It is not recommended that an older child also share a bed with you and your baby, but if you choose to do this then your partner should sleep between the child and the baby.
- Do not have pets or cuddly toys in the bed.

Based on the Infant Sleep and Information Service Bed-Sharing Quiz https://www.isisonline.org.uk/

Appendix 4

Breastfeeding assessment form

If any responses in the right hand column are ticked: watch a full breastfeed, develop an action plan including revisiting positioning and attachment and/or refer to specialist practitioner. Any additional concerns should be followed up as needed.

Baby's name: Baby's age: Date of birth:	Birth weight: Gestation: Current weight:		Assessment carried out by: Date:	
What to observe/ask about	**Answer indicating effective feeding**	✓	**Answer suggestive of a problem**	✓
Urine output	At least 5-6 heavy wet nappies in 24 hours*		Fewer than 5-6 wet nappies in 24 hours, or nappies that do not feel heavy*	
Appearance and frequency of stools	2 or more in 24 hours; normal appearance (i.e. at least £2 coin size, yellow, soft/runny)*		Fewer than 2 in 24 hours or abnormal appearance*	
Baby's colour, alertness and tone	Normal skin colour; alert; good tone		Jaundiced worsening or not improving; baby lethargic, not waking to feed; poor tone	
Weight (following initial post-birth loss)	If re-weighed not lost more than 10% of birth weight – see Weight Guidelines		Weight loss greater than 10%	
Number of feeds in last 24 hours	At least 8 feeds in a 24 hour period*		Fewer than 8 feeds in last 24 hours*	
Baby's behaviour during feeds	Generally calm and relaxed		Baby comes on and off the breast frequently during the feed, or refuses to breastfeed	
Sucking pattern during feed	Initial rapid sucks changing to slower sucks with pauses and soft swallowing*		No change in sucking pattern, or noisy feeding (e.g. clicking)*	
Length of feed	Baby feeds for 5 - 30 minutes at most feeds		Baby consistently feeds for less than 5 minutes or longer than 40 minutes	
End of the feed	Baby lets go spontaneously, or does so when breast is gently lifted		Baby does not release the breast spontaneously, mother removes baby	
Offer of second breast?	Second breast offered. Baby feeds from second breast or not, according to appetite		Mother restricts baby to one breast per feed, or insists on two breasts per feed	
Baby's behaviour after feeds	Baby content after most feeds		Baby unsettled after feeding	
Shape of either nipple at end of feed	Same shape as when feed began, or slightly elongated		Misshapen or pinched at the end of feeds	
Mother's report on her breasts and nipples	Breasts and nipples comfortable		Nipples sore or damaged; engorgement or mastitis	
Use of dummy / nipple shields / formula?	None used		Yes *(state which)* Ask why: Difficulty with attachment? Baby not growing? Baby unsettled?	

*This assessment tool was developed for use **on or around day 5**. If the tool is used at other times:

Wet nappies: Day 1-2 = 1-2 or more Day 3-4 = 3 or more, heavier Day 7+ = 6 or more, heavy	Stools: Day 1-2 = 1 or more, meconium Day 3-4 = 2 or more changing stools	Feed frequency: Day 1 at least 3-4 feeds Sucking pattern: Swallows may be less audible until milk comes in day 3-4

UNICEF UK Baby Friendly Initiative 2010. Adapted from checklists used in the Oxford Radcliffe NHS Trust and East Lancashire Hospitals NHS Trust