Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

Cup feeding Guideline

Amendments			
Date	Page(s)	Comments	Approved by
July 2019		*New Document*	

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In Consultation with: Elizabeth Jennis, NICU Breastfeeding Lead Nurse

Ratified by: Women's Health Guideline group, Neonatal Guidelines Group
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Target Audience: Staff working within Women's Health
Impact Assessment carried out by: Women's Health Guideline group
Comments on this document to: Women's Health Guidelines Group

1. Introduction

1. Cup feeding is a safe, simple and effective method of feeding when an alternative to breast and gastric tube feeding is required.

2. It encourages correct tongue placement for breastfeeding and eliminates the need to give bottle feeds to breast feeding babies, reducing the risk of nipple/teat confusion.

3. It is a temporary alternative method of feeding until breast feeding can be established and it provides an option available to both parents and health professionals that has several important and beneficial uses that ensure breastfeeding is protected.

4. All staff must complete the trust cup feeding workbook Including a competency assessment.

5. All staff irrespective of grade to follow the plan of care as illustrated on the flow chart attached to this guideline(Appendix 1)

6. Cup Feeding must not replace breastfeeding without a very good reason

2. Definition

Cup feeding is a method of feeding a baby who is able to swallow when milk is in his mouth, but may not be able to effectively attach or suckle at the breast effectively for different reasons.

3. Aim

3.1 To provide a short term alternate nutritive method of feeding, until it is possible to breast feed

3.2 Babies who may require cup feeding

- Preterm babies around 34 weeks gestation, if the medical condition of the baby is stable and suck/swallow reflex has been established. They should be alert and looking for a feed but do not have the energy to complete a full breast feed (Lang 2002)
- Babies who require supplementary feeds if medically indicated of either expressed breast milk (EBM) or artificial milk (if there is not enough expressed breast milk available).
- Babies with a Cleft lip/palate (only on discussion with the neonatal team)
- Babies who's mothers are unable to breast feed their baby due to illness.

4. Advantages:

- Babies can feed at their own pace, and control the rate of milk transfer into their mouth.
- Saliva and lingual lipases are stimulated, enabling better digestion of breast milk (Smith 1986, Aurback & Riordan 1993)
- It can provide a baby with a positive oral experience (Lang 2002)
- It provides an alternative method of feeding which does not cause nipple confusion.
- Very little energy is required, so heart rate and oxygen saturation remain stable (Dowling et al 2002)
- It stimulates appropriate tongue and jaw movements.
- Less fat is lost when cup feeding as fat globules adhere to the sides of feeding tubes (Spencer & Hull 1981)
- Reduces the need for a gastric tube that some babies may find distressing.
- Positive feeding experience as good eye contact with baby.

5. Disadvantages

- Exclusive long term cup feeding can deprive the baby of suckling at the breast (Fisher & Inch 1996) as they develop a preference for the cup
- Cup feeding might be used by staff where it may be more appropriate to help the mother breastfeed.
- More likely to lose some of the milk through spillage from the cup
- There is a risk of aspiration due to poor feeding technique – with a potential that the baby may inhale, choke or aspirate on their milk. Aspiration is a danger if a poor feeding technique is used. If a baby does not wish to take more milk, staff must not pour milk into the infant's mouth.
- If a cup is held too tightly to the lip or gum, the skin can be blistered or broken. This can occur if the cup has a sharp rim or is not held in a relaxed manner between forefinger and thumb

6. ROLES & RESPONSIBILITIES

6.1 The Consultants, Midwifery team, Matrons and the Medical and Nursing team on the Children's wards, Postnatal and Neonatal Unit at Ashford and St Peters are responsible for ensuring that they are aware of the cup feeding guideline.

6.2 Cup feeding should not be carried out unless the person has been assessed and approved as competent.

6.3 If there are any concerns about an infant or they have a medical reason requiring the need to cup feed this must be discussed with the medical team prior to giving the feed.

7. HOW TO CUP FEED

7.1 Discuss and explain the reasons to cup feed and obtain verbal consent from mother

7.2 Gather equipment:

- Cup (sterile)
- Bib
- Something to wrap the baby in
- Expressed breast milk / artificial milk if clinically indicated
- Measure out the required amount of milk, no more than 20mls, which is a third of a cup

7.3 Method

- Wrap the baby securely to prevent their hands knocking the cup, and place the bib under the chin
- Support the baby in an upright position on your lap, so that you are both comfortable.
- Direct the lip of the cup towards the upper lip and gums, with it **gently** touching/resting on the lower lip. **Do not** apply pressure to the lower lip
- The cup should be tilted so that the milk is just touching the baby's lower lip (the milk should **not** be poured into the baby's mouth)
- Leave the cup in the correct position during the feed; do not remove when the baby stops drinking. Allow them to resume when ready and let them set their own pace (follow the babies cues)
- Wind the baby as you would with other feeding techniques. Continue to offer the cup until the baby completes the feed or shows signs of sleepiness
- As with any method of feeding, close observation of the baby while the cup feed is in progress
- Document in the baby's medical notes, purple hand held notes, the discussion regarding feeding, the date and time of the feed and the amount taken. Sign and print name and designation.

8 Competencies for mothers carrying out cup feeding

All Parents/carers who are involved in cup feeding should receive training and the cup feeding leaflet (Appendix 2). The Health Professional should have taught the mother/carer in line with the Trust guideline the correct procedure how to safely cup feed their infant.

9. Actions during adverse situations when cup feeding:

9.1 The baby becomes cyanosed/ apnoeic during the procedure

- Stop feeding
- Sit the baby up/forward
- Gently tap on the back
- Once the baby has recovered (this should be a short space of time) and is pink in colour reassess if the feed should continue
- If the infant is not recovering call for assistance

9.2 The baby chokes, splutters or vomits

As above stop feeding and support the infant, reassess if the baby is able to continue with the feed and call for assistance if the baby does not recover in a short space of time.

10. Discharge from hospital to the community

Unless exceptional circumstances exist, babies should not go home cup feeding. If a baby goes home cup feeding this must be agreed in advance with the mother and the community midwife, with a plan of care agreed and documented. The mother must be given the cup feeding instruction sheet. The Infant feeding team must be informed, to provide additional support. This should be documented on the breast feeding assessment /management plan as part of on-going care. This must be continually reviewed.

Babies on the Neonatal unit do not go home cup-feeding unless medically indicated and sanctioned by the neonatal consultant.

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Appendix 1

Plan of Care - Flow Chart

Discuss and explain the reasons to cup feed and obtain verbal consent from mother

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Gather equipment:

- Cup (sterile)
- Bib
- Something to wrap the baby in
- Expressed breast milk / artificial milk if clinically indicated
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Measure out the required amount of milk, do not fill the cup more than 20mls which is about a third of the cup

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Wrap the baby securely to prevent their hands knocking the cup, and place the bib under the chin

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Support the baby in an upright position on your lap, so that you are both comfortable

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Direct the lip of the cup towards the upper lip and gums, with it gently touching/ resting in the lower lip. **Do not** apply pressure to the lower lip

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The cup should be tilted so as the milk is just touching the baby's lips (the milk should **not** be poured into the baby's mouth)

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Leave the cup in the correct position during the feed; do not remove when the baby stops drinking. Allow them to resume when ready and let them set their own pace (follow the baby's cues)

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Wind the baby as you would with other feeding techniques. Continue to offer the cup until the baby completes the feed or shows signs of sleepiness

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As with any method of feeding, close observation of the baby while the cup feed is in progress

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Documentation

Document in the baby's medical and baby's' hand held notes/ Badger net the discussion regarding feeding, with a clear management plan including the date and time of the feed and the amount taken. Sign and print your name and designation. The plan should be continually reviewed. Also document if the parent/carer has been shown and observed and given written instruction on cup feeding the baby.

Appendix 2

How to cup feed safely: information for parents

A cup can be used by parents who primarily wish their baby to be breastfed, but who on occasions need an alternative method of feeding. It will be most successful when the baby is wide awake and interested.
Expressed breast milk is the ideal milk to use but artificial milk may also be given.

If you or your baby is having difficulties with feeding, another way of helping your baby to take your breast milk is by using a cup.

Expressing your breast by hand or with a pump will ensure that your milk supply is stimulated and that your baby gets breast milk.

Cup feeding is a way of avoiding giving your baby a teat while they are learning to breastfeed, as sucking on a teat requires a different action to suckling on the breast.

If your baby needs your breastmilk or formula milk by cup, a health professional will teach you to how to cup feed your baby safely.

It is important that you continue to offer plenty of opportunities for your baby to breastfeed by using skin to skin contact and offering the breast while your baby is calm or showing signs of wanting to feed.

Cup feeding helps you to work towards breastfeeding because it encourages your baby to use their tongue and lower jaw to take the milk in a similar way to when your baby is breastfeeding. They will also be able to smell and enjoy the milk. Some babies need only one or two cup feeds, some need to use a cup for longer; however this should only be short term until breastfeeding is established. Please ask for as much help as you need.

Do not attempt to cup feed a baby who is not alert or who is excessively sleepy.

How to cup feed

• Wash your hands before you start.

• Wash the cup and then sterilise it in the steam steriliser or use cold water sterilisation if you are at home. Hospital cups are disposable and for single patient use, but can be sterilised in a Milton tank at home.

• With clean hands, put the expressed breast milk into the cup about a third full (approx. 20mls).

• Wrap your baby securely in a cot sheet to keep their hands out of the way.

• Support the baby in an upright position on your lap to prevent choking. Use a cloth or a bib to catch any dribbled milk.

• Offer the cup so that it is gently resting on their lower lip but do not press down. Tilt the cup so that your milk touches the baby's lip, then wait, and your baby will smell the milk and make movements with their tongue to lap, suck or drink the milk.

• All you need to do is to keep your baby upright and keep the cup still. Do not tip the milk into the baby's mouth as they could choke if you do this. The aim is for your baby to drink at their own speed.

• Your baby will take a rest when they want by closing their lips firmly or by pulling away from the cup. When your baby has had a rest, let them start again. It is important to let the baby take as much as it needs in its own time.

Appendix 3: **EQUALITY IMPACT ASSESSMENT TOOL**

Name: Cup Feeding
Policy/Service: Women's Health

Background Description of the aims of the policy Context in which the policy operates Who was involved in the Equality Impact Assessment
Women's Health Guideline group, neonatal guidelines group
Methodology A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) The data sources and any other information used The consultation that was carried out (who, why and how?)
Policy widely circulated for comments within the Multidisciplinary Maternity Team.
Key Findings Describe the results of the assessment Identify if there is adverse or a potentially adverse impacts for any equalities groups
The policy in inclusive
Conclusion Provide a summary of the overall conclusions
. No adverse or potentially adverse impacts for any equalities groups were identified
Recommendations State recommended changes to the proposed policy as a result of the impact assessment Where it has not been possible to amend the policy, provide the detail of any actions that have been identified Describe the plans for reviewing the assessment
Policy suitable for use.

APPENDIX 4: CHECKLIST FOR THE REVIEW AND APPROVAL OF DOCUMENTS

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: Cup Feeding

Policy (document) Author: Jo Wilding-Hillcoat

		Yes/No/ Unsure/ NA	Comments
1.	**Title**		
	Is the title clear and unambiguous?	**Y**	
	Is it clear whether the document is a guideline, policy, protocol or standard?	**Y**	
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?	**Y**	
	Is the purpose of the document clear?	**Y**	
	Are the intended outcomes described?	**Y**	
	Are the statements clear and unambiguous?	**Y**	
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?	**Y**	
	Who was engaged in a review of the document (list committees/ individuals)?		**Maternity Team, Managers, neonatal team, Managers**
	Has the policy template been followed (i.e. is the format correct)?	**Y**	

		Yes/No/ Unsure/ NA	Comments
4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	**Y**	
	Are local/organisational supporting documents referenced?	**NA**	
5.	**Approval**		
	Does the document identify which committee/group will approve/ratify it?	**Y**	
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?	**Y**	
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	**Y**	
	Does the plan include the necessary training/support to ensure compliance?	**Y**	
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	**Y**	
8.	**Review Date**		
	Is the review date identified and is this acceptable?	**Y**	
9.	**Overall Responsibility for the Document**		

		Yes/No/ Unsure/ NA	Comments
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	**Y**	
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Y	

Committee Approval (insert name of Committee)			
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner			
Name of Chair	 Dr M. S. Edwards	**Date**	**July 2019**
Ratification by Management Executive (if appropriate)			
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner			
Date: n/a			