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

WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

Weighing Babies and Well baby clinic Pathway

Amendments			
Date	Page(s)	Comments	Approved by
12.11.14	Whole guideline		

Compiled by: Jo Wilding-Hillcoat Infant Feeding Lead Midwife

In Consultation with: Donna Winderbank-Scott, Paediatric Registrar, Women's Health Guideline Group, Obstetric Consultants, Supervisors of Midwives. ASPH Paediatric Team. Deborah Parkinson Lead Midwife.

Ratified by: Women's Health Guideline Group – Chairs Action
Date Ratified:

Date Issued:

Revised by: Dr Vennila Ponnusamy, Neonatal Consultant (amended plan 4)

Date amended: May 2017 – Ratified in Postnatal baby forum (May 2017)

Next Review Date: May 2019

Target Audience: Staff working within the maternity unit including transitional care

Impact Assessment Carried Out By: Women's Health guideline group

Comments on this document to: Jo Wilding-Hillcoat

ROUTINE WEIGHING OF BABIES

This guideline covers the Infant Feeding and Wellbeing Clinic and what to do in the event of significant neonatal weight loss.

See also:
Infant Feeding Guideline

Key Objectives

- To ensure that a robust system is in place for obtaining and recording an accurate rate of weight gain (which will be the baseline for future clinical care planning).
- To advise midwives of the clinical response for those babies identified as having a significant weight loss (greater than 10% of birth weight)
- To have clear guidelines for the Infant Feeding and Wellbeing clinic, including a Frenulotomy Service.
- To minimise the chances of the baby developing hypernatraemic dehydration, which may be associated with significant morbidity or mortality.
- To reduce the number of babies receiving unnecessary supplementation
- To ensure good communication occurs between all key professionals and parents.
- To reduce the number of babies with excessive weight loss necessitating readmission.

Weighing of babies in the postnatal period is part of monitoring the health and growth of a baby.
It is important to appreciate that weighing the baby only identifies a problem. It does not resolve it.
Parents should be included in all decisions and fully informed of plans made.
All discussions and plans should be clearly documented in the appropriate notes
All community midwives and community midwifery support workers should have a copy of the care management pathway and copies of the breastfeeding assessment tool to carry with them.

To calculate % weight loss:

Birth weight – current weight = weight loss

Weight loss ÷ birth weight x 100 = % weight loss

Background:

Some weight loss in the first few days of life is normal.
Babies are born with excess extracellular fluid which they need to shed. This is probably why early breast milk is in concentrated form (colostrum). Conventional thought has been that normal weight loss may be up to 10% of birth weight in the first three days of life, although recent studies have indicated that, in the majority of babies, it is more likely to be between 5 and 7% on average (Dewey et al. 2005, Macdonald 2005).

In the last few years there has been much discussion around weight loss, with increasing concern about babies with raised blood sodium levels (hypernatremia). Oddy et al (2001) have reported the incidence of hypernatremia as 7.1 per 10,000 breastfed babies. Although there is still little evidence that this is increasing (Sachs and Oddy, 2002), the problem still needs to be addressed. Hypernatraemic dehydration can be difficult to diagnose clinically and can result in serious sequelae such as stroke and thrombosis.

Normal neonatal weight loss is brief with few babies remaining more than 10% below their birth weight after 5 days (Wright CM, Parkinson KN, 2004).

In the first week of life weight loss greater than 10% or which persists longer than 7 days is a reliable sign of **insufficient milk** intake in an otherwise well baby.

Key Points

- Average weight loss from birth weight is 5 - 7%
- Normal weight gain following initial loss is 17 – 30 g/day.
- Ideally baby should gain his/her birth weight by 10 - 14 days.
- Weights must be accurate: weigh all babies naked and use digital scales which are well maintained and calibrated, on a firm surface.

PREVENTION OF EXCESSIVE WEIGHT LOSS IN THE NEONATE

Aims:

Are to identify and assess any potential feeding difficulties.
To manage any excessive weight loss early and effectively, whilst supporting and promoting breastfeeding and effective formula feeding.

Background:
Excessive weight loss results when there is ineffective milk transfer to the baby. The most likely reason for this in a breastfed baby is either poor positioning and attachment or infrequent feeds. Less commonly, it may be due to a medical condition or physical abnormality in either mother or baby. However, in all but a very small minority of cases, the problem can be overcome with good management. If the problem is not corrected, suppression of milk production will result (Neiferet 2004).

Reasons why a baby may not get enough breast milk

Factors relating to breast feeding	Psychological factors	Maternal medical Factors	Neonatal factors
• Delayed start in breastfeeding • Inefficient suckling with poor positioning and attachment • Infrequent, short or scheduled feeds • Inappropriate Supplementary feeds • Inappropriate use of a teat, dummy or nipple shield	• Lack of confidence • Tiredness, stress, worry • Reluctance to feed e.g. painful nipples Engorgement /mastitis **Rarer:** • Dislike of breastfeeding • Rejection of baby	• Endocrine disorders, e.g. PCOS, thyroid dysfunction, diabetes • Breast surgery, e.g. breast reduction or inadequate breast development • Medications, e.g. contraceptive pill, diuretics • Pregnancy **Rarer:** • Retained products of conception • Alcohol/smoking	• Prematurity, •Infection / sepsis in baby •Congenital abnormality affecting feeding e.g. cleft palate •Neurological abnormality affecting feeding e.g. hypotonic (floppy baby)

Maternal Additional Support:
It has been identified that women who experience the following may need extra support with feeding to increase the chances of successful breastfeeding

Pregnancy related	Delivery related	Postnatal factors
Primigravida. High maternal body mass index (BMI). Maternal pre-existing medical conditions that may affect milk supply (see above table) Medications that may impact on milk production (See BNF/Hale)	Caesarean section. Instrumental delivery. Major obstetric haemorrhage Breech birth 3rd/4th degree tears	Preterm and low birth weight infants Babies of diabetic mothers Unwell babies e.g. those with infections or jaundice requiring treatment. Tongue tie or other congenital abnormalities affecting feeding (e.g. cleft palate or floppiness in Down's Syndrome).

Management:

1. Teaching mothers skills for effective feeding and how to recognise when their baby is hungry is essential.
2. To ensure each mother knows how to recognise that her baby is/is not feeding effectively and is receiving enough/not enough milk she should be shown in the information 'How can I tell that breastfeeding is going well?' (Appendix 2), contained in the discharge pack - Postnatal Care.
3. Encourage mothers to be aware of wet nappies, bowel frequency and colour of stool.
4. Teach all breastfeeding mothers hand expressing techniques and check their understanding.
5. Reassess plan when required using Breast feeding assessment tool (Appendix 3) e.g. if breastfeeding assessment identifies concerns or baby becomes unwell, earlier weighing and more intensive support may be required.

Flow chart

- Weight is recorded in grams in baby notes, labour summary, birth notification electronic record system and in the red book
- The weight must be accurately recorded on all documentation as this is the baseline for all future weights.

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Initiation of feeding including skin to skin (regardless of feeding method)

- CHINS and COLLARS SBAR sticker commenced to record skin to skin and first discussion.
- Record initial feed volume taken for formula fed babies and discuss responsive feeding (Formally known as demand feeding)

Support effective feeding

- Teach correct positioning and attachment at the breast & hand expression.
- Highlight to mother the supportive information provided on the cot and welcome pack.

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Prior to transfer home

- All of the topics on the postnatal assessment sheet (appendix 4) should be initiated at birth and addressed with all breastfeeding mothers before they return home to the community.
- Ensure safe formula feeding discussed and bottle feeding leaflet given for babies who are formula fed. (Appendix 5)

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Use of breastfeeding assessment form

When assessing a breastfeed the assessment form (appendix 3) should be used.
This form should be completed

- On day 2 or on discharge from JB ward/ABC in community -whichever is first
- On day 5/6 visit from community midwifery team
- At any additional times where feeding is being assessed for specific reasons

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If breastfeeding is assessed as being effective a healthy term baby should be weighed on <u>day 5</u>	**Where there are concerns about baby's wellbeing, or if breastfeeding is assessed as being ineffective, a feeding plan should be made for additional weighing on <u>day 3</u>** **DEPENDANT ON % WEIGHT LOSS PLEASE SEE WEIGHT LOSS MANAGEMENT PLAN BELOW.**

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Transfer to Health Visiting service

- Weigh prior to discharge to the HV, normally day 10 – 14.
- Liaise with HV to discuss any on-going breastfeeding issues on transfer to her care using the red book for communication

Assessment of feeding adequacy:

Inadequate output of urine or stool in the baby (i.e. less than that specified in the table below), should trigger weight assessment and implementation of an appropriate Management Plan.

Age	Day 1 - 2	Day 3 - 4	Day 5 - 6	Day 7 - 28and beyond
Number of wet nappies per day	1 - 2 or more: Urates may be present*	3 or more: Nappies feel heavier	5 or more:	5 or more:
Stools:	1 or more: dark green/ 'tar-like' (meconium)	2 or more: changing in colour and consistency; brown/green/yellow becoming looser (changing stool)	2 or more: Yellow – may be quite watery	2 or more: ** At least size of £2 coin: Yellow and watery, seedy appearance

*Urates are normal bladder discharges in the first few days and appear as a pink staining in the nappy. Persistent urates may indicate insufficient milk intake if they are still present after day 3-4.

**After 28 days, a baby will establish own frequency of passing stools – he/she may pass several per day or have several days gap in between.

Weight loss assessment pathway

- **Unwell babies should be referred through A & E on a blue light if needed.**
- **At the weekend community midwives to follow assessment plans 1 – 3 within the community and assessment plan 4 refer to the neonatal postnatal SHO on 5125/Registrar on 5302**

Plan	% weight loss	Actions
1	**Up to 8% Is a normal weight loss**	If the baby has lost up to 8% of the birth weight the Mother should be reassured, breastfeeding advice reinforced and the baby weighed again as per guidelines
2	**8-9.9% weight loss**	• Midwife/ MSW to observe a full breastfeed, observe positioning, attachment and sucking pattern, complete a breastfeeding assessment form. • Take BF history. Ensure minimum of 8 feeds in 24 hrs. Implement a feed chart. • Ensure both breasts are offered at each feed – baby finishing first breast before offering second • Encourage skin to skin contact • Monitor number and colour of stools and urine Provide women with what's in a nappy leaflet and " How can I tell Breast feeding is going well hand out" • Review baby the next day and weigh baby in 48hrs unless additional concerns arise. If weight increasing continue to monitor closely. • If no weight gain after 48 hours refer to Infant Feeding coordinators and consider implementing management plan 3
3	**10% -12.4% weight loss After assessment at the Infant Feeding and Wellbeing Clinic, It is expected that the majority of these babies will be managed in the community setting.**	• Refer to infant feeding midwife for triage appointment at the Infant Feeding and Wellbeing Clinic for full review, examination and assessment on 07468701479. **Advise the mother to take Baby Care Plan into the clinic.** • The midwife must strip baby, perform a thorough examination and take a full set of observations:- Temp, Respirations, Heart rate, Capillary refill. If the baby is very jaundice take a SBR • Take a feeding history. • Midwife to observe a full breastfeed, observe positioning, attachment and sucking pattern and complete a breastfeeding assessment form. Ensure minimum of 8 feeds in 24 hrs. Implement a feed chart and monitor urine and stool output.

3	**3 Continued**	• Ensure both breasts are offered at each feed – baby finishing first breast before offering second breast. For sleepy babies consider 'super switching' feeding. (Mothers can watch the baby's sucking and switch to the other breast as soon as the sucking begins to slow down. Repeating this several times during the breastfeeding increases breast stimulation and let down.) • Encourage skin to skin contact • Monitor number and colour of stools and urine output and provide women with "How can I tell Breast feeding is going well" hand out • Express from both breasts after each feed and ensure baby receives additional feeds of EBM (Formula) at a rate of 6mls/kg per feed via a cup. • Examine baby for tongue tie. Perform Frenulotomy if required by infant feeding team midwife during this clinic. • If baby is well send home with mother, o Document a clear plan on page 3 of the lilac baby care plan. o Inform verbally or if not possible email the community team leader and named midwife about plan for next visit. o Document this in the team daily diary and update the community visit sheet. o If woman is in Topaz team please ensure that the midwife and team leader are aware. Contact telephone no Team Leader Topaz team is 07789926424 Topaz suite 4181/442. • Midwife to review baby's wellbeing within the next 24 hours. • Reassess and reweigh in 48hrs. • If adequate weight gain (20 g per day or more): continue support and reduce top ups when breastfeeding has improved and deemed to be adequate on assessment. • Weigh again prior to discharge to HV and liaise with HV to discuss plan of care. Please ensure plan is documented in the red book. • If artificially feeding observe a feed and encourage 6 – 8 feeds in 24 hours refer to infant feeding guideline to calculate amount of formula per feed. Implement a feed chart and monitor urine and stool output. • Infant feeding midwife will refer to neonatal registrar if there any concerns regarding the wellbeing of the baby (such as dehydration, reduced bowel movements or urine output, significant jaundice, lethargy, pyrexia, hypothermia, any abnormal observations) • **If no/sub-optimal weight increase, move to Feeding Plan 4**

4.	**>12.5% weight loss** **Or babies on feeding plan 3 with no optimal weight gain** **4. Continued**	It is expected that these babies will be **admitted** to an appropriate clinical area for further assessment and support. • Refer to infant feeding midwife for triage appointment at the Infant Feeding and Wellbeing Clinic for full initial review, examination and assessment on 07468 701479. **Advise the mother to take Baby Care Plan into the clinic.** • **Follow feeding management plan 3** • Warn parents regarding likelihood of admission to hospital. • Discuss care plan and obtain consent from mother for formula milk supplementation • Assess breastfeed and document in notes adequacy/frequency/technique as well as any feeding interventions so far (for neonatal review) • **Refer to Neonatal doctor** • Neonatal SHO /Registrar to review baby • Check SBR and Blood gas for electrolytes • Review SBR plot in the appropriate gestation chart with second person to ensure plotted correctly and sign • If normal electrolytes, phototherapy not indicated and baby clinically well, does not need to be admitted to TC. Liaise with Infant Feeding Team (IFT) - can be discharged home with feeding plan as advised (liaise with IFT for follow up plan) • If needs phototherapy for mild jaundice, but no top up feeds with NGT – Can be admitted in JB with mum under care of IFT • If significant jaundice or needs NGT top up, need to be admitted in TC under care of neonatal team • Liaise with Infant Feeding Team / community midwife at discharge for follow up of all readmissions **Community care after hospital discharge.** • Continue to support and assess breastfeeding • Reduce top-up feeds as breast milk supply increases • Weigh prior to discharge to Health Visitor. • Liaise with HV and document plan in red book.

*A serum sodium level in excess of 150 mmol/L, when found together with a clinical picture of weight loss in excess of 12.5%, indicates a need for urgent feeding supplementation.
Hypernatremia and dehydration above this level is associated with serious complications e.g. thrombosis and stroke. However rehydration must be carried out slowly, (as a fast reduction in serum sodium is also associated with complications), hence preference for oral top-up feeds.

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Neifert MR (2004). Breast milk transfer: positioning, latch-on and screening for problems in milk transfer. Clinical Obstetrics and Gynaecology: 85; 318-20

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Sachs M, Oddy S (2002). Breastfeeding – weighing in the balance: Reappraising the role of weighing babies in the early days. MIDIRS 12; 296-300

UNICEF workbook: Course in Breastfeeding Management: Appendix 9 (information sheet 8)

La Leche League 2006 Is it possible to breastfeed after a caesarean birth http.//www.llli.org/faq/caesarianhtml

Cecilia Jevitt CNM,PhD et al 2007 Lactation complicated by overweight and obesity: Supporting the mother and newborn http.//www.medscape.com/viewarticle/565627 3

Lisa Marasco MA,IBCLC, 2005 Polycystic ovary syndrome http.//www.llli.org/llleaderweb/iv/ivaprmay05p27.html

NICE Clinical Guidelines for Neonatal Jaundice CG98 http.//www/publications.nice.org.uk/neonataljaundice-cg98/guidance

NICE Clinical Guideline 37 Routine Postnatal care for women and their babies
http.//www/publications.nice.org.uk/postnatal-care-cg37

Monitoring:

Readmissions for Feeding/weight loss	All babies readmitted must be entered on the Datix reporting electronic system.
How and what will be monitored?	Audit of 6 sets of maternal notes and baby maternity notes using audit tool (See appendix 1)
How often will this take place?	At random every 3 months. Frequency and number of notes audited to be reviewed after 3 months dependent on findings.
Who is the lead professional co-ordinating this audit?	Jo Wilding-Hillcoat, Infant feeding lead midwife.
Where will the results be presented?	Community team leader meetings, Senior management governance meetings, Paediatric Governance meetings
Where will the results and recommendations be discussed and an action plan agreed?	Community team leader meetings, Senior management governance meetings Paediatric Governance meetings
How will learning be disseminated?	Mandatory training, baseline and team meetings.
How will this be monitored?	Divisional Clinical Governance meetings

Based upon Buckinghamshire Health care Trust Guidelines and Royal Devon and Exeter Weighing Babies management pathway.

Appendices:

1. Audit tool
2. How to tell if breastfeeding going well mothers guide
3. Breastfeeding assessment form
4. Infant feeding postnatal check list
5. Bottle feeding postnatal check list
6. CHINS and COLLARS SBAR tool

Appendix 1 **Audit Tool**

Month **Total number of readmissions for feeding/weight loss:**

Baby's name: No: NHS No:

DOB:

Reason for admission: Age of baby:

Maternal notes/infant notes	Yes	No	N/A	Comment
Place of delivery				
Identification of known medical condition in pregnancy that may affect breastfeeding/milk supply				
Birth weight recorded in delivery and infant notes				
Skin to skin contact received until the first breastfeed. If not, why not.				
'At risk' of hypoglycaemia baby identified and managed appropriately				
Help offered for the first breastfeed				
Help offered for a second feed within 6 hours of birth				
2 feeds observed before discharge				
Completion of documentation before discharge: P&A shown Signs of efficient feeding Mother taught how to hand express before discharge				
Leaflet 'How can I tell if……' given				
Breastfeeding assessment done as per standard				
Documentation of assessment of wet and dirty nappies at each visit				
Documentation of baby's wellbeing Action plans documented for feeding concerns				
Completion/review of feeding assessment Day 3. Reviewed Day 5, Day 10.				
Baby weighed Day 5				
Appropriate care plan documented correlating with weight loss management plan – see overleaf				

Appendix 2

How can I tell that breastfeeding is going well?

 **Breastfeeding is going well when:**	 **Talk to one of the midwifery team if:**
Your baby has at least 3 – 4 feeds during the first 24 hours and then 8 feeds or more each 24 hours.	**Your baby is sleepy and has had less than 3 feeds during the first 24 hours and then fewer than 6 feeds each day**
Your baby is feeding for between 5 and 40 minutes at each feed	**Your baby consistently feeds for less than 5 minutes or for longer than 40 minutes at each feed**
Your baby finishes the feed himself	**Your baby always falls asleep on the breast and/or never finishes the feed himself**
Your baby changes from initial rapid sucks to slower, quiet sucks with pauses	**Your baby doesn't change his/her sucking pattern to slower sucks and pauses and/or is noisy when feeding**
When your baby is 3 - 4 days old and beyond you should be able to hear your baby swallowing frequently during the feed	**You cannot tell if your baby is swallowing milk when your baby is 3 - 4 days old and beyond**
Your baby is generally calm and relaxed whilst feeding and is content after feeds	**Your baby comes on and off the breast frequently during the feed or refuses to breastfeed**
Breastfeeding is comfortable	**You are having pain in your breasts or nipples which doesn't disappear after your baby's first few sucks. Your nipple comes out of your baby's mouth looking pinched or flattened on one side.**
Your baby has wet and dirty nappies (see chart below)	**Your baby is not having the wet and dirty nappies explained below**
Your baby has normal skin colour	**Your baby appears jaundiced (yellow discolouration of the skin)**
	You think your baby needs a dummy and/or formula milk

Nappies

The contents of your baby's nappies will change during the first week. These changes will help you know if feeding is going well. Speak to your midwife if you have any concerns.

Baby's age	**Day 1 - 2**	**Day 3 - 4**	**Day 5 - 6**	**Day 7 - 28 and beyond**
Urine(wees): Number of wet nappies per day	1 - 2 or more: Urates may be present *	3 or more: Nappies feel heavier **	5 or more	6 or more: heavier
Stools(poos): Number per day, colour and consistency	1 or more: Dark green/black 'tar-like' (meconium)	2 or more: Changing in colour and consistency, brown/green/yellow becoming looser (changing stool)	2 or more: Yellow, may be quite watery	2 or more: At least size of £2 coin. Yellow and watery, 'seedy' appearance

** Urates are a dark pink/red substance that many babies pass in the first couple of days. At this age they are not a problem, however if they go beyond the first couple of days you should tell your midwife as that may be a sign that your baby is not getting enough milk.*

*** With new disposable nappies it is often hard to tell if they are wet, so to get an idea if there is enough urine, take a nappy and add 2 - 3 tablespoons of water. This will give you an idea of what to look/feel for.*

Appendix 3 **Breastfeeding Assessment Form** This assessment should be carried out at least **twice before the baby is 7 days old**, on day 2 or on discharge as an IP and day 5/6 in community. More may be required if breastfeeding issues are present. 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: Day	2	5	Assessment carried out by: Date: Day	2	5
What to observe/ask about	**Answer indicating effective feeding**			**Answer suggestive of a problem**		
Urine output	**At lease 5-6 heavy wet nappies in 24 hours by day 5 ***See below for other days**			**Fewer than 5-6 wet nappies in 24 hours, or nappies that do not feel heavy***		
Appearance & frequency of stools	**By day 5 - 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 & 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 24hrs	**3-4 feeds in first 24 hours. Thereafter at least 8 or more feeds in a 24 hour period**			**Less than 2-3 in first 24 hrs. Thereafter 8 feeds in the last 24 hours**		
Baby's behaviour during feeds	**Generally calm and relaxed**			**Baby comes on & off the breast frequently during feed, or refuses to breastfeed.**		
Sucking pattern during feed	**Initial rapid sucks changing to rhythmic slower sucks with pauses & soft swallowing ,ending with flutter sucks**			**No change in sucking pattern, or noisy feeding (eg clicking)***		
Length of feed	**Baby feeds for 5-30 minutes at most feeds**			**Baby consistently feeing 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 & nipples	**Breast 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?**		
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 maybe less audible until milk comes in day 3-4		

Appendix 4

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Infant Feeding – Postnatal Checklist (hospital)

Your midwife will complete this checklist to ensure that you are given all the information you need to breastfeed successfully

Checklist	Yes	No
Positioning and attachment taught	☐	☐
Mother confident with positioning and attachment	☐	☐
Hand expressing taught	☐	☐
Other useful information for successful breastfeeding	☐	☐
How to recognize effective milk transfer	☐	☐
Baby-led feeding explained	☐	☐
Room- and bed-sharing discussed	☐	☐
Problems with using teats, dummies, nipple shields	☐	☐
Importance of exclusive breastfeeding	☐	☐
Breastfeeding support details given and explained	☐	☐

Leaflets given and discussed

On and around day 2 and 5/6

Breast feeding assessment carried out ☐ ☐

Appendix 5
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Bottle Feeding – Postnatal Checklist

	YES	No	Date	Signature
Baby – feeding explained	☐	☐		
Feeding cues discussed	☐	☐		
Room and bed sharing explained	☐	☐		
Checklist for feeding a healthy term baby				
Mother shown how to hold baby and how to offer feed safely	☐	☐		
Mother confident with holding and feeding baby	☐	☐		
Full feed observed	☐	☐		
Problems with dummies discussed	☐	☐		
Mother shown or discussed how to make up feeds safy and how to sterilize equipment.	☐	☐		
Mother confident with how to make up feeds safely and how to sterilize equipment.	☐	☐		
Formula milk, feeding equipment and sterilizer ready at home.	☐	☐		

Leaflets given and discussed

Appendix 6

SBAR POSITIONING & ATTATCHMENT

Time ……..

CHINS	Discussed		**COLARS**	Discussed
Chin in first Nose free			**C**hin touching breast Nose free	
Head and body in alignment			**O**pen mouth wide	
In close to mum			**L**ower lip curled back-More	
Nose to nipple			**A**reola visible above top lip	
Sustainable position			**R**ounded full cheeks	
			Sucking rhythmically pain free	
Hand expression Skin to Skin	**Discussed/shown Y / N Discussed Y / N**		**Signed Print**	**MW / NN MCA / IFA**

EQUALITY IMPACT ASSESSMENT TOOL

Name: Weighing Babies Pathway

Policy/Service: Maternity Service

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
Provides evidence based guidance enabling staff to deliver consistent care with maternity services
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?)
Unlikely to have any negative impact as no procedure is carried out with full consent of the women involved and is based on clinical need
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
No impact identified
Conclusion • Provide a summary of the overall conclusions
No impact 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
Reconsider at next guidance review

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)

If further assessment is required please see the Integrated Single Equality Scheme.

For advice in respect of answering the above questions, please contact, HR Manager, on extension 2552.

PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name:	…… Weighing Babies Pathway ……
Name of Person completing form:	……Jo Wilding ……
Date:	……12.11.14……

Author(s)	Jo Wilding	
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Jo Wilding	
Date of final draft	12.11.14	
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency?		Yes
By whom:	Women's Health guidelines Group	
Is this a new or revised policy/guideline?	New	
Describe the development process used to generate this policy/guideline.		
Maternity guidelines disseminated to all Paediatric consultants for comment		
Who is the policy/guideline primarily for?		
Staff working in maternity services		
Is this policy/guideline relevant across the Trust or in limited areas?		
Maternity services		
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?		
Notice board, intranet, communication bulletin, newsletters		
Describe the process by which adherence to this policy/guideline will be monitored.		
See monitoring section		
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?		
Advice from UKMi regarding codeine and breastfeeding.		
What (other) information sources have been used to produce this policy/guideline?		
See reference list		
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?		
No impact identified		
Other than the authors, which other groups or individuals have been given a draft for comment?		
Women's Health guideline Group, Supervisors of Midwives, all obstetric consultants		
Which groups or individuals submitted written or verbal comments on earlier drafts?		
Comments received by email		
Who considered those comments and to what extent have they been incorporated into the final draft?		
All comments considered by Women's Health guideline group		
Have financial implications been considered? yes		