

Term healthy breastfeeding infant who is reluctant to feed

Key Points

- This guideline only applies to a term infant born at 37 weeks gestation or more, who has no risk factors.
- All infants should have skin-to-skin contact with the mother immediately or as soon as possible after the birth and this should be maintained for as long as the mother wishes, for at least an hour or until after the first feed
- All mothers should receive assistance / support with breastfeeding.
- All breastfed infants must have a feeding assessment.
- This guideline should be read in conjunction with FHFT guideline [Neonatal hypoglycaemia \(management on maternity wards\)](#).

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Abbreviations

EBM	Expressed Breast Milk
PROM	Prolonged Rupture of Membranes

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1. Introduction

The aim of this guideline is to ensure mother and baby get off to a good start with breastfeeding. It is recognised that breastfeeding provides the best optimal outcome of health for the infant; there are significant health gains to the baby from being breastfed^{1,2}. The majority of babies feed well at the breast from birth, however some babies need time to adjust to extra-uterine life. Providing staff and parents are being **proactive** and there are no signs of hypoglycaemia, blood sugar levels do not need monitoring in healthy term infants³.

This guideline only applies to an infant born at 37 weeks gestation or more, who has no risk factors.

This guideline should be read in conjunction with the [Neonatal hypoglycaemia \(management on maternity wards\)](#) guideline, which includes babies of diabetic mothers¹³.

2. Background

Full term healthy infants have the ability to generate ketone bodies, which are used as alternative fuels for the brain^{4,5}. Therefore, there should be few occasions when their blood glucose concentration needs to be measured.

Studies have demonstrated that asymptomatic hypoglycaemia has shown no neurodevelopmental abnormalities in term healthy infants⁵.

3. Risk factors

The following groups are at risk of clinically significant hypoglycaemia and require an alternative strategy to the term infant with no risk factors. It is important that a full maternal antenatal and intrapartum history is obtained to identify any possible risk factors^{4,5,6}.

Maternal factors:

- Diabetes requiring insulin therapy – due to hyperinsulinism
- Intrapartum administration of IV glucose (>10g/h)
- Drug treatment: betablockers or tolbutamide therapy

Neonatal factors:

- Small for gestational age infants (<2500g at term) – they have poor glycogen stores
- Preterm infants - they have reduced capacity to mobilise metabolic fuels
- Clinically wasted infants or infants of scrawny appearance, regardless of birth weight
- Infants of macrosomic appearance, even if no history of maternal diabetes
- Moderate to severe birth asphyxia (cord PH <7.1)
- Severe rhesus disease
- Hypothermia
- Infection/ PROM (>48hrs)
- Hypoxic Ischaemic Encephalopathy (HIE)

Signs of hypoglycaemia^{3,5}

- General findings – abnormal or high-pitched cry, hypothermia, temperature instability, diaphoresis, poor suck or refusal to feed.
- Neurological signs – tremors, irritability, exaggerated Moro's reflex, jitteriness*, lethargy, hypotonia, seizures, abnormal eye movements.
- Cardio respiratory symptoms: tachypnoea, apnoea, cyanosis, pallor, irregular respiratory distress, tachycardia, congestive cardiac failure.

*Jitteriness is characterised by tremulous movements of the limbs (alternating rapid, repetitive movements that are rhythmical and of equal amplitude) that should cease if limbs are held in a passive flexion. Jitteriness can be provoked by stimuli (physical, auditory or visual) but it must also be borne in mind that most new-born infants may produce some sort of transient fine movements in response to gross stimulation^{7,8}.

Jitteriness is relatively common and does not equal hypoglycaemia. If the blood glucose is normal other causes should be considered and referred to the paediatrician for review.

4. Management^{1,3,10,11}

4.1 Following birth

All infants to have skin-to-skin contact with the mother as soon as possible after the birth and this should be maintained for as long as the mother wishes, unless there is a clinical reason why this cannot be done or the mother requests not to offer skin-to-skin. If skin-to-skin is not possible at the time of birth, either because of the condition of the baby or the mother, skin-to-skin should be commenced at the earliest opportunity when this is safe for the mother and her baby¹². Please document actions on EPIC.

All mothers will be encouraged to initiate an early breastfeed as soon as the infant shows signs of readiness (feeding cues).

Mothers should be encouraged to observe for feeding cues in their baby, to promote responsive feeding whereby they respond to the needs of their baby for food and comfort¹². Examples of feeding cues are – rooting, sucking fingers, mouthing movements.

All mothers should receive assistance / support with breastfeeding for at least the first two feeds.

Ensure the infant is kept warm, make sure the baby is wearing a hat. Skin-to-skin contact is the best method of keeping infants warm.

4.2 At 6 hours after birth

All breastfed infants must be reviewed and their feeding assessed. If an infant has fed at least twice since birth then continue responsive feeding. There should be no restrictions on the frequency or duration of feeds.

The management of term healthy babies who are reluctant to feed is supported by the flow charts at the end of this guideline.

Review of the infant's well-being involves assessment of colour, tone, alertness and maintenance of normal body temperature.

If the infant has not fed again since immediately after birth, continue to offer skin-to-skin and see if the infant will breastfeed. If reluctant to feed, document the infant's well-being on EPIC. Reinforce feeding cues and reassess 2 hours later, unless the infant has fed in the meantime. Encourage the mother to continue to offer skin-to-skin.

Should the infant still be reluctant to feed, demonstrate and explain hand expressing and give colostrum by syringe/spoon or directly into the infant's mouth.

Once colostrum has been given, offer a breastfeed to the infant again (sometimes the baby will be more enthusiastic to breastfeed having been given some colostrum).

If colostrum is not available despite hand expressing, continue skin-to-skin. The mother may be reassured that this is not unusual and should be encouraged to try again later.

Continue skin-to-skin, offering assistance with breastfeeding, review the infant's well-being. Encourage hand expressing; give colostrum by syringe/spoon or directly into the infant's mouth. If no colostrum available continue with skin-to-skin. Document care given on EPIC.

Continue as above every 2-3 hours until 24 hours old or beyond 24 hours of age if the baby remains reluctant to feed. If at 24 hours the baby is not attaching at the breast, the volume of expressed breast milk (EBM) should be increased – see algorithm below for volume according to age. Once the baby is breastfeeding spontaneously there should be no restrictions on the frequency or duration of the feeds.

By encouraging the parents to observe for early feeding cues, maintaining skin-to-skin contact for long periods and ensuring mothers are taught to hand express effectively, it is likely that the majority of term healthy infants will have received a breastfeed / colostrum by 12 hours of age.

Infrequent feeding in the first 24 hours after birth is very common, and in term healthy infants not necessarily a cause for concern, providing that frequent review of the infant's well-being is made to exclude underlying illness. Reassure mother and continue to offer feeding support.

Where artificial milk is requested by the mother as a 'top-up', she should be advised about the possible effects of offering artificial milk. This should be an informed choice and must be fully documented on EPIC. Staff should continue to offer support with offering EBM, and positioning and attachment at the breast¹².

In order to initiate the milk supply, the breasts need to be stimulated either by the infant breastfeeding or expressing 8-10 times in 24 hours, and at least once at night.

If the mother is unable to express colostrum, offer support and review their technique for hand expressing and consider potential history of surgery and underlying medical conditions.

If at any time after birth, the infant's condition is a cause for concern, inform the Paediatrician in order that a careful assessment of the infant's condition can be made.

5. **Auditable standards**

- All formula supplements should be clinically indicated with optimum care given/fully informed maternal decision.
- 80% of mothers to be shown hand expressing
- All babies who are reluctant to breastfeed to be offered skin-to-skin contact

6. **Monitoring Compliance**

This guideline will be subject to a minimum of yearly audit and results presented to the Baby Friendly Initiative (BFI) working party, ward and unit meetings. Action plans will be monitored under the BFI implementation strategy.

7. **Communication**

If there are communication issues (e.g., English as a second language, learning difficulties, blindness/partial sightedness, deafness) staff will take appropriate measures to ensure the patient (and her partner, if appropriate) understand the actions and rationale behind them.

8. **Equality Impact Assessment**

This policy has been subject to an Equality Impact assessment.

9. References

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Appendix 1: Care plan for the term healthy breastfed infant who is reluctant to feed (less than 24 hours old)

For **ALL babies**, assess for:

- Colour
- Tone
- Alertness
- Maintenance of temperature
- General well-being

At birth

Initiate skin-to-skin for **ALL** babies and encourage early first feed. Discuss feeding cues, e.g., rooting, sucking fingers, mouthing.

ALL breastfeeding mothers should receive assistance with at least the first two breastfeeds.

If the baby did not feed at birth – continue skin-to-skin contact.

At 6 hours of age

ALL breastfed babies must be reviewed and feeding assessed:

- If the baby has fed spontaneously at least twice since birth, then continue responsive feeding.
- If the baby fed at birth, wake and offer assistance with breastfeeding.
- If the baby did not feed at birth, **wake and rouse the baby**, offer skin-to-skin and see if the baby will breastfeed.
- Demonstrate hand expressing, give any colostrum obtained.

If baby remains reluctant to breastfeed

Continue with guidance below at 2-3 hourly intervals

- Continue skin-to-skin.
- Give any colostrum available and then offer breastfeed to the baby again.
- Document the care given and assessment of the baby's well-being on EPIC
- Encourage the mother to respond to her baby by observing for feeding cues, and to call for help when baby shows signs of wanting to feed.

Continue to review 2-3 hourly, continue skin-to-skin, offer breastfeed and offer EBM until baby has successfully breastfed.

Remember that frequent stimulation (breastfeeding or hand expressing) is vital in order to initiate the milk supply.

If at any time you are concerned about the well-being of the baby, inform the Paediatrician immediately.

Revised by Fiona Lewis and Kirstie Wells, June 2023

Appendix 2: Care plan for term healthy breastfed infant who is reluctant to feed and more than 24 hours old

For ALL babies, assess for

- Colour
- Tone
- Alertness
- Maintenance of temperature
- General well-being

For babies 24 – 48 hours old and not breastfeeding

Continue

- Skin-to-skin and laid-back feeding
- Offer breast **2-3** hourly minimum
- If not attaching hand express 1-2 hourly
- Offer EBM, increase volume to **5-15 ml/feed** or more if available

If EBM volume <5ml despite frequent hand expression, consider offering A/F top-up, approx. 10-15 ml/feed*, by cup. **AVOID TEATS AND DUMMIES.**

For babies 48 – 72 hours old and not breastfeeding

Continue

- Skin-to-skin
- Offer breast **2-3** hourly
- Offer EBM, increase volume to **15-30ml/feed*** or more if available
- Encourage the mother to start pumping, at least 8 times over every 24 hours

If EBM volume <**15ml/feed*** despite frequent expressing, consider offering A/F top-up, approx. 20-30ml/feed*, by cup

Continue to review 2-3 hourly, continue skin-to-skin, offer breastfeed and offer EBM until baby has successfully breastfed.

Remember that frequent stimulation (breastfeeding, hand expressing or pumping) is vital in order to initiate the milk supply (**8-10 times every 24hours**).

If at any time you are concerned about the well-being of the baby, inform the Paediatrician immediately.

Always assess each individual infant and observe for clinical signs of well-being.

Monitor urinary output and frequency and colour of bowel movements and document on EPIC

*The volume suggested is an average volume – some infants will take more, some less. **Start small, we can always offer more if baby indicates hunger cues still.**

Revised by Fiona Lewis and Kirstie Wells, June 2023

Care plan for term healthy breastfed infant who is reluctant to feed and more than 72 hours old

- Continue with skin to skin
- Offer breast 2 to 3 hourly
- Offer EBM, increase volume to **150ml/kg/day**
- Continue with regular expressing

If milk has come in, consider other techniques to aid baby to remove milk, e.g., the use of nipple shields.

Make a plan for discharge home if appropriate; ensure breast feeding support will continue in the community by midwife or community support worker.

If nipple shields are used, encourage the parents to understand they should be a short time aid to get the baby to feed at the breast. The use of nipple shields can affect milk supply as the stimulation to the nipples is reduced. Ensure breastfeeding support is provided in the community.

Revised by Fiona Lewis and Kirstie Wells June 2023

Full version control record

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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date. This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version Control Sheet

Version	Date	Guideline Lead(s)	Status	Comment
1.0	23/3/2017	I Ridgers, D Sloam	Final	
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3.0	March 2024	Fiona Lewis, Lead Infant Feeding Midwife, FPH Kirstie Wells, Inpatient Midwifery Matron, FPH	Final	Approved at Cross Site Obstetric Clinical Governance meeting, 27 March 2024

Related Documents

Document Type	Document Name
Guideline	Neonatal hypoglycaemia (management on maternity wards)