

Expression, Storage and Administration of Expressed Breast Milk Guidelines for hospital

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Foreword

NHS Highland is committed to promoting breastfeeding as the healthiest way for a mother to feed her baby. The important health benefits of breastfeeding are now known to exist for both mother and baby. NHS Highland will support the physiological and psychological function required to establish this natural maternal infant process.

Mothers who are unable to breastfeed their babies effectively during a hospital admission whether in the maternity unit, SCBU or children's ward require research based information and skilled support on expressing to achieve and maintain adequate lactation.

Within the hospital environment, the safe handling, preparation and storage of expressed breast milk (EBM) is essential in ensuring any potential health risks are minimised for both the mum and baby.

This guidance document will provide guidance for staff who are caring for a mother who is unable to breastfeed due to clinical factors or separation from her baby. It will support staff to optimise the volume of EBM a mum can produce and ensure handling, storage and administration of EBM are optimal to ensure safety at all times

EBM means any milk that has been expressed from a mother's breast either by hand or by pump.

Equality and Diversity

NHS Highland ensures that the individual needs of mothers and their babies are given due consideration. In order to understand individual need, staff need to be aware of the impact of any barriers in how we provide services.

Staff are advised to:

- Check whether mothers require any kind of communication support including an interpreter to ensure that they understand any decisions being made.
- Ensure that they are aware of any concerns a mother may have about coping with breastfeeding and any decisions made.
- Ensure that any mother who has a disability that may require individualised planning re breastfeeding practice is appropriately supported.

1. Aims and Objectives

- To ensure all maternity, neonatal and children's ward staff – midwifery and nursing - are able to offer research based advice and support to ensure optimal expressing practices.
- To ensure all maternity, neonatal and children's ward staff – midwifery and nursing - are aware of this local guidance document and can safely handle and store EBM.

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- To ensure all maternity, neonatal and children's ward staff – midwifery and nursing - are aware of the risks associated with unsafe storage, handling and preparation of EBM.
- To ensure all health professionals are confident to encourage and teach breastfeeding mothers how to express their breast milk (via hand or pump) if their babies are unable to feed effectively. Thus ensuring that all attempts are made to provide breast milk for babies requiring supplementation. This will help reduce the unnecessary use of formula and ensure adequate breast milk supply for future lactation.
- To ensure all maternity, neonatal and children's ward staff – midwifery and nursing - are aware of current documentation in relation to EBM and can use this effectively.

2. Proactive management of a woman required to Express Breast Milk

A maternal condition, separation from baby or a baby unable to effectively attach at the breast are all common reasons why expressing breast milk is recommended in hospital. **Without** the stimulation at the breast and the associated hormonal release, lactogenesis, will be inhibited leading to a reducing breast milk supply and finally cessation.

- Following delivery all mothers who are separated from their babies should have an informed discussion on the benefits of expressing breast milk for premature or sick babies – document in the post natal maternity hand held notes.
- All mothers who wish to breastfeed or express should be offered to EBM as soon as possible following delivery. The goal is within 6 hours of birth – document in post natal maternity hand held notes.
- This should be by hand in the first instance for at least the first 24 hours – unless the baby is premature where pumping via an electric double pump has shown some benefit over hand expressing.
- Hand expressing should always be encouraged prior to using an electrical pump to stimulate a good hormonal response.
- A good time to switch from hand expression to using an electric pump is when the yield from each hand expression is approximately 7 mls.
- As the mother is able, she should be offered the opportunity to EBM in SCBU either beside the cot or in the feeding room within SCBU.
- Completion of the Expressing Checklist, Appendix 1, should be encouraged for all mums who are expressing and be completed on day 1 and four times within the first two weeks.
- Following admission to the children's ward – mothers should be offered to EBM if their baby is nil by mouth, sick or unable to effectively attach to the breast – this should be documented clearly in the baby's notes.

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- Expressing should be encouraged at least 8 times in 24 hours (and if possible 10 times).
- Timings should work around the mother's lifestyle with no strict pumping regimes commenced or advised– expressing should fit around the mother's lifestyle as long as she does not leave more than 6 hours between pumping as evidence suggests that this can reduce the fat content.
- Women should not be advised how long they should pump but should be encouraged to observe volumes yielded and stop expressing when flow slows and stops.
- Double pumping is recommended for any mum who has a problem with supply, a baby in SCBU or who is planning expressing long term.
- Volumes should be charted to observe an increase gradually each 24 hours – the optimal volume for a mum who is fully EBM at 14 days is 750 mls.
- Use of an expressing log should be encouraged for use by women who are EBM long term.

3. Safety Issues with regards to Expressed Breast Milk within the Hospital Environment

- Strict hand hygiene should be encouraged for everyone involved in the handling and storage of expressed breast milk, this will include mothers/parents.
Adherence to local infection control manual:
<http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/National%20Infection%20Prevention%20and%20Control%20Manual.pdf>
- All expressing equipment should be for single patient use.
- All mothers will be:
 - Given verbal instructions and demonstration on how to use the expressing equipment following appropriate manufacturer's instructions.
 - Given information on how to label and store EBM safely.
 - Given information on how to clean and sterilise EBM equipment using cold water sterilisation.
 - Given information on how to obtain their EBM from fridge/freezer from a member of staff.
 - Given information on how to verify that they have been provided with the correct EBM from the ward staff member.
 - Given information on how to clean surfaces of breast pump with a detergent wipe after and before use.

4. Identification and Labelling of Expressed Breast Milk

- All mothers who express should be shown how to correctly label expressed breast milk before commencement of expressing.
- All mothers should be provided with labels to enable them to do this safely.

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- Labels should be completed by the mother/parent – given appropriate assistance by staff if required.
- Labels should contain the following information:
 - Baby name.
 - Baby CHI.
 - Date expressed.
 - Time expressed.
 - Date and time defrosted.
- Labels will be checked by ward staff to ensure correct labelling prior to placing in fridge or freezer.
- Fridges for storage of EBM are located in SCBU, ward 10 and the children's ward at Raigmore and in the Henderson Wing at Caithness General Hospital.

5. Safe Storage of Expressed Breast Milk while in hospital

- EBM should be stored in a fridge/freezer in clinical areas which is exclusively for this purpose.
- **Only** staff should have access to the fridge or freezer to reduce potential infection risk or misuse.
- EBM should be stored under 4°C for no more than 24 – 48 hours.
- Any EBM which is stored in the fridge and will not be used within 48 hours should be frozen.
- EBM stored in the fridge should **NEVER** be placed in the door of the fridge.
- Any EBM within the fridge which is unlabelled, stored in the fridge door, older than 48 hours or from a mother who has gone home should be discarded immediately.
- EBM should be stored in the freezer at -20°C for no more than 3 months in the hospital environment or 6 months in a domestic freezer in a home.
- Temperatures in both fridge and freezer should be checked twice daily and temperatures documented in the ward record.
- Any deviation from optimal temperatures will be reported immediately to the nurse/midwife in charge and appropriate action taken.
- Gloves should be used at all times when handling EBM.

6. Preparation of Expressed Breast Milk

- EBM should be used in chronological order with the older used first.
- If baby is in SCBU and at risk of infection then use of newer milk first is advisable to ensure immunological protection from current milk production.
- If milk is stored at room temperature – within the hospital this should be used within 2 hours of expressing or should be placed in the fridge if not.
- If milk is stored in the fridge and it is obvious that the milk will not be used within 24 – 48 hours please place in freezer.

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- Ideally frozen breast milk should be defrosted in a fridge gradually and used within 24 hours – clear documentation of time defrosting commenced should be placed on the label on the bottle.
- Defrosted frozen EBM cannot be replaced in a fridge or freezer once defrosted.
- Microwave ovens should NOT be used for defrosting.
- Within SCBU the CALESCA warming - thawing device can be used in accordance with manufacturer's instructions which are housed in SCBU.
- If EBM is taken out of the fridge the maximum time that it can be left at room temperature without consumption is 2 hours – this milk should not be replaced in fridge or frozen once taken out.
- **NEVER** use water to defrost or warm EBM in hospital due to the risk of pseudomonas contamination.

7. Safe administration of Expressed Breast Milk

- No non-staff member i.e. parents or visitors will have access to the fridge or freezer in clinical areas.
- Mothers/ parents will request EBM from a staff member as required.
- Staff member will visually check identification label on EBM with either a colleague or the mother/parent. It is **vital** that the label is checked by 2 adults.
- When EBM is identified as correct the small sticky label will be removed from the EBM bottle and either placed in the baby's notes in the maternity unit, the feeding chart in the children's ward or the HDU/ care chart in the NNU.
- The small sticky label will be signed by the 2 adults who visually checked the identification label as correct.
- Once the EBM has been confirmed as correct then it can be administered to the baby.
- Date, time and method of administration should be documented in the appropriate notes.

Baby name	EBM checked by
Baby CHI	
Date expressed	/
Time expressed	
Date and time defrosted	

8. Action to be taken if a baby is administered another mother's breast milk

- Immediately inform the nurse/midwife in charge of the error.
- Senior paediatric registrar should be notified by the charge nurse/midwife immediately.
- This matter is serious and requires careful and sensitive handling.
- Keep the parents of the recipient baby and the donor mother informed of the wrongful administration at all times – offer an apology and fully explain the risk management process.

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- If the error has been recognised early – NG aspiration of stomach needs to be performed as soon as possible and discarded.
- Do not breach confidentiality by disclosing the name of the donor mother. Check the donor mother’s clinical history including antenatal viral serology tests – this should be documented in the recipient’s baby notes ensuring that identification of the donor mother is not written anywhere in the notes. Ensure that details of both the recipient baby and donor mother are written on the DATIX form.
- If the donor mother was known to be at high risk for infection or has a positive infection screen then immediately inform the paediatric consultant, involve microbiology and notify the obstetric consultant.
- Even if the donor mother is low risk and serology testing is negative, a repeat serology of this mother is recommended.
- Re-assurance should be given to the recipient mother that there are no documented cases of HIV transmission through incorrect EBM administration.
- If the donor mother consents – please test for:
 - HCV – rarely transmitted into breast milk – if the donor mother proves positive - HCV and HCV antibody on the recipient baby should be organised at 6, 12 and 24 weeks post exposure. The recipient should also be tested for HCV antibody at 12 months of age.
 - HBV i.e. Hepatitis B Surface antigen HBsAg – rarely transmitted in breast milk. If the donor mother is HBV positive immunising of the recipient baby is required following the national guidance in the [Green Book](#). Treat the baby as if it has had a significant exposure similar to a needlestick injury.
 - HIV – mothers who are positive are encouraged NOT to express. If the donor is identified as being HIV positive immediate discussion with the health protection team, depending on the donor viral load prophylaxis may be recommended. This should be given as soon as possible, ideally within the hour, and would not normally be started 72 hours after the exposure.
 - If the donor mother’s serology is negative for HCV, HBV and/or HIV, arrange an outpatient appointment for baby at 1 year of age and check baby’s HCV, HBV and HIV serology.
- If the donor mother declines testing discuss with the consultant paediatrician and microbiologist.
- Obtain consent from the recipients parents to take 1 – 1.5 mls of blood in a clear bottle from their baby to be sent to virology and be kept in storage for at least a year.
- Testing of breast milk is not recommended.
- Completion of DATIX form - including both mothers details.
- Careful explanation and apology to the donor mother even when no further testing is required.

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Please see Appendix 2 for the pathway.

9. Alternative feeding methods

- **Oro/naso-gastric tubes**

Very pre-term babies will initially need tube feeding to enable early gut priming, gut mobility and passage of meconium.

Naso-gastric tubes may cause nasal obstruction but allow commencement of oral feeding, while oro-gastric tubes have less effect on respiratory system but can restrict tongue movement to aid sucking during oral feeding.

Long term tube feeding can lead to oral tactile hypersensitivity and may dampen oral reflexes.

The use of non-nutritive sucking (sucking a dummy) during tube feeds may help to accelerate the organisation and efficiency of sucking and may build an association of sucking and satiation. Dummies should not be used when breastfeeding is established.

- **Cup feeding**

Appropriate training is encouraged.

Cup feeding may help to improve preterm oral skills and is an appropriate method for a baby who is showing signs of wanting to suck.

Cup feeding has certain advantages for the baby over using syringes and tubes.

Gives the baby valuable experience of taking food by mouth and the pleasure of taste.

It stimulates baby's digestion.

It allows baby to practise tongue movements which will help progress to breastfeeding.

Cup feeding is particularly useful for the following babies:

- A preterm who is wide awake and restless between feeds.
- A preterm or sick baby who shows signs of wanting to lick or suck.
- A baby who is not satisfied by tube feeds and who is restless after them.
- A baby who is not yet able to feed directly from the breast, or has only enough energy to satisfy part of his total nutritional needs at the breast.
- A term baby whose mother is ill after delivery.
- A baby who is lacking energy because of a cardiac or respiratory problem.

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- A baby who cannot feed directly from the breast because of a neurological problem which interferes with sucking co-ordination.

Cup feeding has the following advantages over other feeding methods.

Allows the baby to control the amount and rate of the feed.	Does not need you to put something into the baby's mouth and may be less disruptive to breastfeeding than feeding with a bottle.
A baby has to be held when cup feeding.	Cup is easier to sterilise than a bottle.
Cup feeding is thought of as an interim clinical procedure rather than a normal feeding method – therefore carries less connotations that breastfeeding is a “failure”.	

Currently within the maternity unit there are varying practices with regards to cup feeding, the most worrying being that cup feeding is not being recommended on discharge home or encouraged as a first line of supplementation.

More recent studies have found that if a baby was cup fed they are more likely to be exclusively breastfed on discharge, with no apparent increase in hospital stay.^{1,2,3}

There are no reasons why a baby cannot be discharged home cup feeding if the skill has been demonstrated and taught to parents by a skilled health professional. All breastfed babies should be offered a supplement by a cup in the first instance if required.

Parents must be reassured that cup feeding is a short term process to enable breastfeeding. It should never be used in the longer term.

How to cup feed a baby?

All mothers whose baby requires a cup feed should be shown how to cup feed her baby via a demonstration by either the midwife, nursery nurse or infant feeding support worker on the ward. During this demonstration the following needs to be taught

- Hands should be thoroughly washed and dried before commencing a cup feed
- The baby needs to be awake and alert, if not then this should be documented and a bottle should be used instead for safety reasons
- NEVER CUP FEED A SLEEPY BABY
- The baby should be in an upright position
- Milk should NEVER be poured into the baby's mouth – cup feeding should use a lapping motion of the tongue
- Use a feeding cup either the medela or axifeed cups
- It may be useful to wrap the baby prior to placing in upright position to prevent them from knocking cup out of the providers hands
- A cloth under the baby's chin is recommended
- Baby should be facing you in an upright position
- Rest the rim of the cup of the baby's lower lip or their lower gum ridge
- Tip the cup just enough so that the milk reaches the rim of the cup
- Do not pour the milk into the mouth and do not put pressure on the lower lip of the baby
- Keep the cup tipped just enough for the milk to reach the rim of the cup

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- The baby should sip or lap the milk from this position
- Wind baby as necessary during feed

Subsequent feeds

It is the responsibility of the health professional to observe the parents cup feeding their baby until they feel that this is done safely observing for the following as a priority

- Parent only cup feeds if baby is alert and awake
- Parent feeds baby in an upright position, well supported and wrapped
- Parent is able to position cup appropriately – on the lower lip, lower gum ridge
- Parent is able to ensure milk sits at the cup ridge to enable baby to sip or lap milk
- Parent is aware to never pour milk into the baby’s mouth

Discharge home

If parent is competent at cup feeding in the ward there is absolutely no reason why they should not be encouraged to cup feed at home. Handover to community staff should include that the baby is cup feeding and parent has been observed as being competent in this skill by ward staff and is aware of the risks such as ensuring baby is awake, alert, in an upright position and not to pour milk into baby’s mouth.

¹ Han AM, [Cup-feeding versus other forms of supplemental enteral feeding for newborn infants unable to fully breastfeed](#), 2010

²Yilmaz et al, [Effect of cup feeding and bottle feeding on breastfeeding in late preterm infants: a randomized controlled study](#), 2014

³McKinney et al, [Feeding Neonates by Cup: A Systematic Review of the Literature](#), 2016

- **Bottle feeding**

In newborn babies swallowing interrupts breathing, tidal volume, minute ventilation, oxygen saturation and heart rate. In preterm babies the assessment of the suck/swallow/breathe pattern is essential when offering bottle feeds as preterm babies cannot override the reflex to suck. This may prevent them from taking a breath causing de-saturation, coughing or aspiration.

Pacing the baby by removing the teat after short sucking bursts allows respiratory recovery in the pauses and supports immature sucking patterns.

Fast flow teats should be avoided.

Behavioural cues should be responded to in order for the feed to be responsive and to prevent negative experiences.

A time limit of 30 minutes should be placed on a bottle feed since continuing after this time can be exhausting and will lead to calorific expenditure.

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Bottle feeding should only be considered for a breast fed baby when all other methods have not been successful or are contra-indicated for a clinical reason. If a baby is using a bottle when establishing breastfeeding it should not be offered routinely in this period.

- **Nipple shields**

Occasionally a nipple shield for a preterm or sick infant can be useful, especially when the baby is unable to generate sufficient suction pressure to retain the nipple in the mouth.

Shields should always be checked during a pause phase in the suck/swallow pattern to ensure that there is milk in the shield.

When the baby becomes older and stronger the mother should be encouraged to feed without a shield to promote more effective milk transfer.

Mothers who use a nipple shield should be encouraged to express following a feed to improve milk drainage.

Nipple shields are not recommended for mums who do not have sufficient milk supply or who are in the very early days of feeding prior to “milk coming in”

- **Breastfeeding supplementer**

These are designed to provide the baby with a steady flow of a supplementary feed while suckling at the breast. They also provide nipple and breast stimulation. They are useful for mums who have an insufficient milk supply and good to entice the baby to suck at the breast with a good suckling pattern to aid milk stimulation.

They are extremely useful for babies with weak or disorganised suckling patterns and can avoid the potential for nipple/teat confusion. They are useful for allowing coaxing on the breast. Through effective attachment and suckling the baby is rewarded with a milk flow. Since tubing is soft and small the flow of milk is easily controlled.

The only negative with this system appears to be that not all mothers will be keen due to the intrusive nature of attaching the tubing and potential messiness of use.

Please seek specialist advice and support prior to using this method.

- **Syringe feeding**

It is vital that only a small syringe is used – no more than a 5 ml syringe to ensure that small boluses are given to the baby. Small squirts should be administered to the baby waiting for a swallow prior to continuing. Allowing the baby to suck from the syringe continually is contra-indicated and could cause aspiration.

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Appendix 1



Assessment of breastmilk expression



For sick and preterm babies the importance of breastmilk cannot be overestimated, supporting growth and providing protection from infection. In particular, evidence suggests that the use of breastmilk decreases the incidence and severity of the life threatening disease necrotising enterocolitis. By providing her breastmilk a mother can be assured that she is uniquely contributing to the wellbeing and development of her baby. However, expressing breastmilk over a long period of time is extremely demanding and if a mother is to succeed she needs the support from those involved with caring for her and her baby.

The Baby Friendly Initiative recommends that a formal review is carried out at least once within the first 12 hours following delivery to support early expressing and **at least four times within the first two weeks** to ensure that mothers are expressing effectively and to address any issues or concerns they may have. Early (within the first 4-6 hours), frequent (at least eight times in 24 hours including once at night) and effective (combining hand and pump expression) expressing is crucial to ensuring a mother is able to maximise her milk production so that she can maintain her supply for as long as she wishes. With the correct support to express, a mother can aim to achieve an average milk volume of approximately 750–900ml in 24 hours at day 14.

Delays in starting to express or any reduction in the frequency or effectiveness of expression will compromise her long term supply. Early detection and correction of problems will help her maintain confidence in her ability to produce milk for her baby.

Tips to help mothers succeed

- Hand expression is a good technique for obtaining small volumes of colostrum.
- Breast massage and relaxation techniques help to get her milk flowing.
- Expressing close to her baby or at least having a photo or piece of baby's clothing will help milk production and flow.
- Encourage her to ask for regular skin to skin contact or, where this is not possible, to interact and undertake care giving for her baby as this boosts milk-producing hormones.
- When using a pump ensure she is taught the correct technique and always check the pump shield to ensure it is the correct one.
- Encourage double pumping as this saves time and may contribute to being able to express long term
- Help her make a plan for expressing and consider using an expressing log to help – she does not have to stick to a strict 3-4 hourly routine but help her to avoid long gaps (four-hourly in the day and six-hourly at night) between expressions.
- Emphasise the importance of the night-time expression as this is when hormone levels are highest and long term expressing most likely to succeed.
- Although it is expected that milk volumes increase daily in first two weeks, it is important that mothers don't feel pressurised to obtain a 'specific' amount. Refer for specialist support if you have concerns about milk volumes.
- Keep her updated on baby's progress and encourage her to be with her baby as much as possible as this will help alleviate anxiety.
- Value her contribution and let her know how important it is for her baby.

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Expressing assessment form

If any responses in the right hand column are ticked refer to specialist practitioner. Any additional concerns should be followed up as needed. Please date and sign when you have completed the assessments.

<i>Mother's name:</i>	<i>Baby's name:</i>	<i>Date of assessment:</i>				<i>Birth weight:</i>				
What to observe/ask about	Answer indicating effective expressing	✓	✓	✓	✓	Answer suggestive of a problem	✓	✓	✓	✓
Frequency of expression	At least 8 times in 24 hours including once during the night.					Fewer than 8 times. Leaving out the night expression.				
Timings of expressions	Timings work around her lifestyle with no gaps of longer than 4 hours (daytime) and 6 hours (night time)					Frequent long gaps between expressions. Difficulty 'fitting in' 8 expressions in 24 hours.				
Stimulating milk ejection	Uses breast massage, relaxation, skin contact and/or being close to baby. Photos or items of baby clothing to help stimulate oxytocin.					Difficulty eliciting a milk ejection reflex. Stressed and anxious.				
*Hand expression	*Confident with technique. Appropriate leaflet/DVD provided.					*Poor technique observed. Mother not confident.				
Using a breast pump	Access to electric pump. Effective technique including suction settings, correct breast shield fit. Switching breasts (or double pumping) to ensure good breast drainage. Uses massage and/or breast compression to increase flow.					Concern about technique. Suction setting too high/low, restricting expression length, breast shield too small/large.				
Breast condition	Mother reports breast fullness prior to expression which softens following expression. No red areas or nipple trauma.					Breasts hard and painful to touch. Evidence of friction or trauma to nipple.				
Milk flow	Good milk flow. Breasts feel soft after expression.					Milk flow delayed and slow. Breasts remain full after expression.				
Milk volumes	Gradual increases in 24 hr volume at each assessment.					Milk volumes slow to increase or are decreasing at each assessment.				

Hand expression may not need to be reviewed every time



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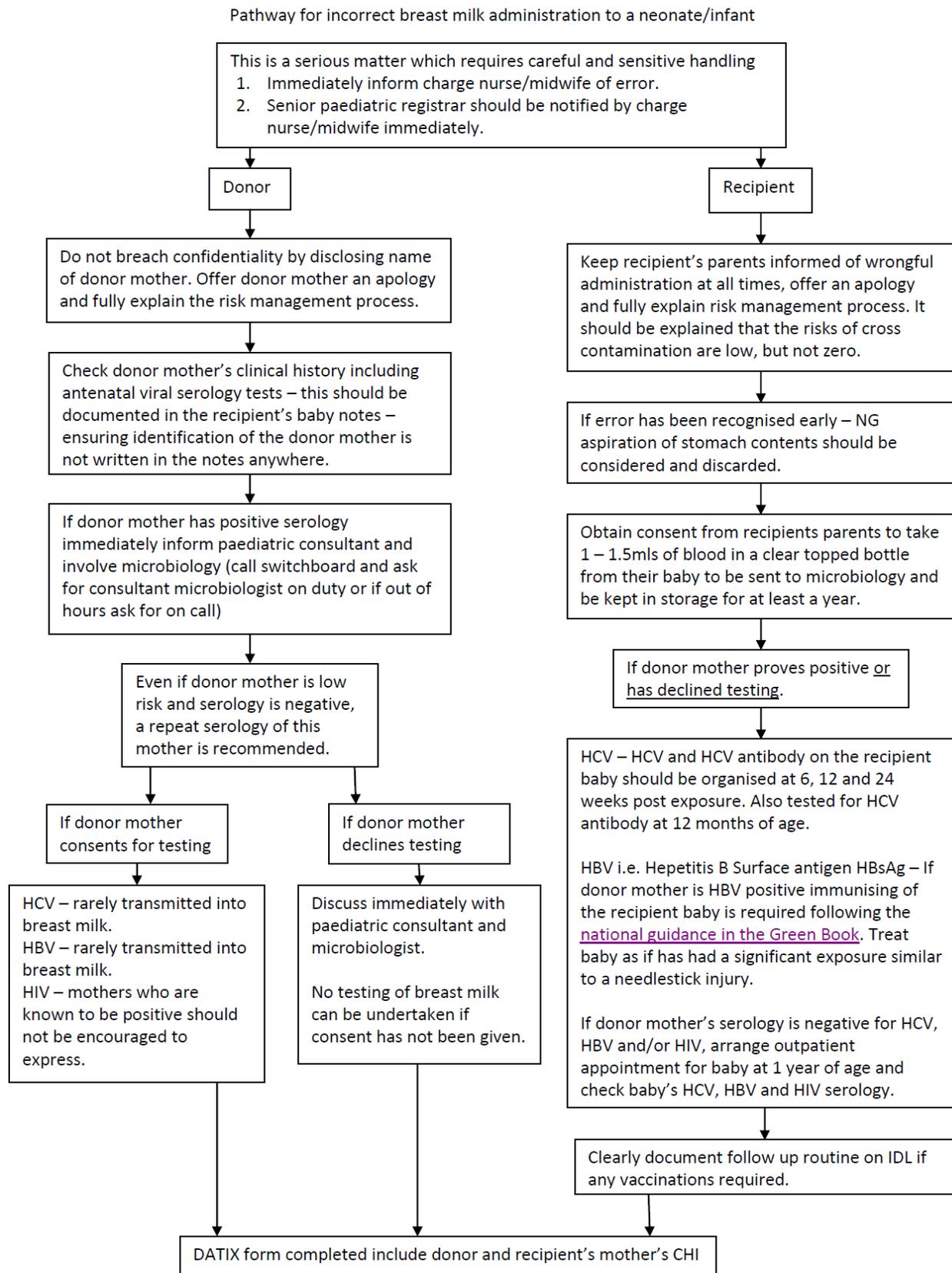
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