UNICEF UK BABY FRIENDLY INITIATIVE

GUIDANCE FOR PROVIDING REMOTE CARE FOR MOTHERS AND BABIES DURING THE CORONAVIRUS (COVID-19) OUTBREAK

GUIDANCE SHEET 5D (CHALLENGES): CONCERNS ABOUT BABY'S GROWTH/WEIGHT

Delivering Baby Friendly services at this time can be difficult. However, babies, their mothers and families deserve the very best care we can provide. This document on baby's growth and weight is part of a series of guidance sheets designed to help you provide care remotely.

THE MOTHER IS CONCERNED ABOUT HER BABY'S GROWTH/WEIGHT

The earliest and most reliable sign that a baby is not receiving enough milk or not gaining weight is lack of stooling. Relying on urine output alone can give false reassurance. Most babies are back to their birth weight by two weeks, with a full assessment and follow up needed if they are not. Babies should be weighed at a minimum at **birth**, at **five days** and at around **two weeks** to monitor growth and wellbeing. Once feeding is established, continue to monitor growth at around 8, 12 and 16 weeks and at one year.

PREPARING FOR THE CONVERSATION

- Plan a mutually agreed appointment with the mother and consider using video so that you can watch a feed and see the mother and baby
- Refer to Guidance Sheet 1 before you start
- Be aware that parents may be feeling vulnerable and frightened because of Covid-19, so sensitivity and active listening are important
- Take the parent's worries seriously as they can often sense when something is wrong.

USEFUL RESOURCES

- Education refresher sheet 5: minimising supplementation in the early days
- Guidance Sheet 5c: concerns about milk supply
- Breastfeeding assessment tools (midwives, health visitors, neonatal or mothers)
- Neonatal breastmilk expression tool
- Unicef UK support for parents overcoming breastfeeding problems
- Knitted breast and doll (if video call)

DURING THE CALL

Introduce yourself and confirm consent for the call

- Ask the mother to describe her feeding journey so far and carry out a full feeding assessment including urine and stool output of the baby and number of breastfeeds in 24 hours – *see table on page 2*
- Watch a whole feed via video (if possible) to ensure the baby is effectively attached and there is milk transfer – revisit positioning and attachment as needed
- Inadequate urine and particularly **stool** output in the early weeks indicate that the baby is not receiving enough breastmilk – *see table opposite.*

WET NAPPIES	STOOLS AND DIRTY NAPPIES
Day 1-2: 1-2 or more in 24hrs	**Day 1-2:** 1 or more in 24hrs with meconium
Day 3-5: Should increase by 1 daily, beginning with 3 on the third day and 5 on the fifth day (should also be heavier)	**Day 3-4:** At least 2 (preferably more) in 24hrs with changing stool
Day 6+: 6 or more heavy, wet nappies in 24hrs.	**Day 5+:** At least 2 (preferably more) soft, runny, yellow stools each day
	Weeks 4-6+: All babies under 4-6 weeks old should have a minimum of 2 stools a day. When breastfeeding is more established, some babies may go a few days without stooling. Breastfed babies are never constipated and when they do pass a stool it should be soft, yellow and abundant.

Offer appropriate strategies

- Encourage the mother to feed her baby at least eight times in 24 hours and to recognise and respond to feeding cues (mouth opening, turning head, seeking and rooting, sucking fists)
- Encourage the mother to hold her baby in skin contact to stimulate the baby to attach at the breast
- Remind the mother to offer both breasts at each feed – breast compressions whilst the baby is

feeding may also be useful
- Ensure that the mother knows how to express her breastmilk so she can give expressed breastmilk to her baby if required
- Discuss alternative methods of giving breastmilk, e.g. spoon, syringe, cup or bottle
- See table below for weight loss plan in the first 2-3 weeks and refer to local trust guidelines
- A plan of care needs to be put in place until the baby's weight is on a normal trajectory.

Plan 1 Weight loss 8-10%	▪ Re-check weights and percentage calculations as mistakes are common ▪ Observe a full breastfeed to ensure effective positioning and attachment ▪ Minimum eight feeds in 24 hours ▪ Skin-to-skin contact to encourage breastfeeding ▪ Observe for change in frequency/amount of urine and stools ▪ Re-weigh in two to three days (sooner if stools and urine are of concern) ▪ If weight is increasing, continue to monitor stools and urine closely and provide encouragement ▪ If no or minimal weight increase or further loss, see plan 2.
Plan 2 Weight loss 10.1%-12.4%	**As in plan 1, plus:** ▪ Exclude infection or illness ▪ Consider additional support from breastfeeding team or Infant Feeding Advisor and/or paediatric review (depending on local policy) ▪ For sleepy babies or those with a poor suck, consider switch feeding and breast compressions* ▪ Express breastmilk after each feed and offer to baby by cup ▪ Weigh again in 24-48 hours ▪ If no or minimal weight increase or further loss, see plan 3 and refer to local trust guidelines. *Switch feeding is a short-term option that swaps the baby from one breast to the other and back each time the sucking pattern ceases to be a nutritive pattern, i.e. with audible swallows. Breast compressions encourage the let-down reflex to stimulate a sleepy baby and encourages sucking.
Plan 3 Weight loss 12.5%-14.9%	**As in plans 1 and 2, plus:** ▪ Consider re-admission ▪ Paediatric review required to exclude and/or manage underlying illnesses ▪ U&Es may be required if baby is unwell ▪ Additional support from breastfeeding team or Infant Feeding Advisor required ▪ Ensure a minimum of eight feeds in 24 hours plus top ups after each feed, ideally with expressed breastmilk (EBM) ▪ Express using a hospital grade electric pump – if there is insufficient EBM, use donor milk if available or infant formula and then reduce this as breastmilk supply increases ▪ Weigh again in 24 hours and continue to monitor output ▪ Monitor until clear trend towards birth weight.
Plan 4 Weight loss 15%+	***Note: Weight loss in excess of 15% is significant and will require re-admission, fluid replacement and breastfeeding support.*** **Manage as in plan 3, plus:** ▪ Re-check weight and calculations as mistakes can be made ▪ Discuss with consultant paediatrician ▪ U&Es may be required ▪ IV fluids if baby is unwell ▪ Refer to your local trust guidelines for management.

Note: As the baby starts to gain weight, support the mother to maximise her breastmilk and reduce use of supplementation (expressed breastmilk or infant formula) slowly and return to full breastfeeding.

A face-to-face consultation will be required to weigh the baby and plot weight gain on the appropriate growth chart. For infants with **faltering growth from two weeks**, see table below.

FALTERING GROWTH FROM TWO WEEKS

From two weeks onward, weights should be plotted on the relevant centile chart. If there are concerns, babies should be weighed more often. However, weights measured too closely together can be misleading. For more information, see the RCPCH growth charts.

At the time of weighing

- Perform a clinical, developmental and social assessment
- Take a detailed feeding history
- Observe a feed and complete a feeding assessment.

The following thresholds should be used for concern about faltering growth in babies

- A fall across 1 or more weight centile spaces, if birthweight was below the 9th centile
- A fall across 2 or more weight centile spaces, if birthweight was between the 9th and 91st centiles
- A fall across 3 or more centile spaces, if birthweight was above the 91st centile
- When current weight is below the 2nd centile for age, whatever the birthweight
- Length or height should be measured whenever there are any worries about a child's weight gain, growth or general health.

Ongoing care

- Refer to local trust guidelines for managing faltering growth, including appropriate referral to GP/paediatrician and consideration of investigation for urinary tract infection
- Undertake further investigations only if they are indicated based on a full clinical assessment
- Offer appropriate strategies as previously described on page 1.

For more information, see NICE guidance.

CLOSING THE CONVERSATION

- Ensure the mother knows she can carry on breastfeeding
- Ask the mother how she feels and if there is anything else she would like to know
- Offer to send her a summary of the conversation (with links to resources) and plan of care by email/text
- Inform her of what happens next
- Record the conversation and make a referral as appropriate in line with trust guidelines.

ADDITIONAL INFORMATION

- Take the parent's worries seriously
- If the baby appears unwell, refer for a paediatric/GP assessment
- Report and record your findings in line with trust guidelines

IF THE MOTHER HAS COVID-19

1. Review with parents how to take precautions to limit the spread of Covid-19 to the baby:
   - Wash hands thoroughly before and after contact with the baby
   - Routinely clean and disinfect any surfaces touched
   - Clean any infant feeding equipment, including breast pumps, in hot, soapy water and sterilise thoroughly before and after use
   - Practice respiratory hygiene, e.g. avoid coughing/sneezing on the baby during feeding and wear a face mask or suitable alternative if available.
2. If a breastfeeding mother is feeling unwell, continuing to breastfeed rather than expressing may be easier and less stressful during this time. Alternatively, she may prefer for someone who is well to feed expressed breastmilk to the baby.
3. If a baby is being bottle fed with infant formula or expressed milk, wash equipment in hot, soapy water and sterilise carefully before each use.
4. If the mother is too unwell to breastfeed/express, she may be supported to when well enough. Consider using donor milk if available or applicable.

USEFUL RESOURCES

- ATAIN Avoiding Term Re-admissions and Unicef UK Baby Friendly Initiative