# Bottle feeding
## on the Neonatal Unit

FROM ADMISSON TO DISCHARGE AND BEYOND.

FIRST DROPS

Neonatal Intensive Care
NNUH

## Contents

This is baby Emily, who was born at 24+6 weeks gestation and weighed 706g. Emily spent 82 days on the Neonatal Unit and weighed 2.2 kg at discharge. Emily stayed with her parents in one of our bedrooms for 5 days prior to going home. Emily still had her naso-gastric tube in when she went home because she was still developing her feeding stamina. This stayed in for a further 6 weeks, during which time Emily's parents were supported by the unit's Out-Reach Team

We would like to thank her parents for allowing us to use images of Emily within this booklet

Welcome to NICU.

Congratulations on the birth of your baby. We are here to support you and provide you with the information you need to feed your baby while they are on the Neonatal Intensive Care Unit (NICU).

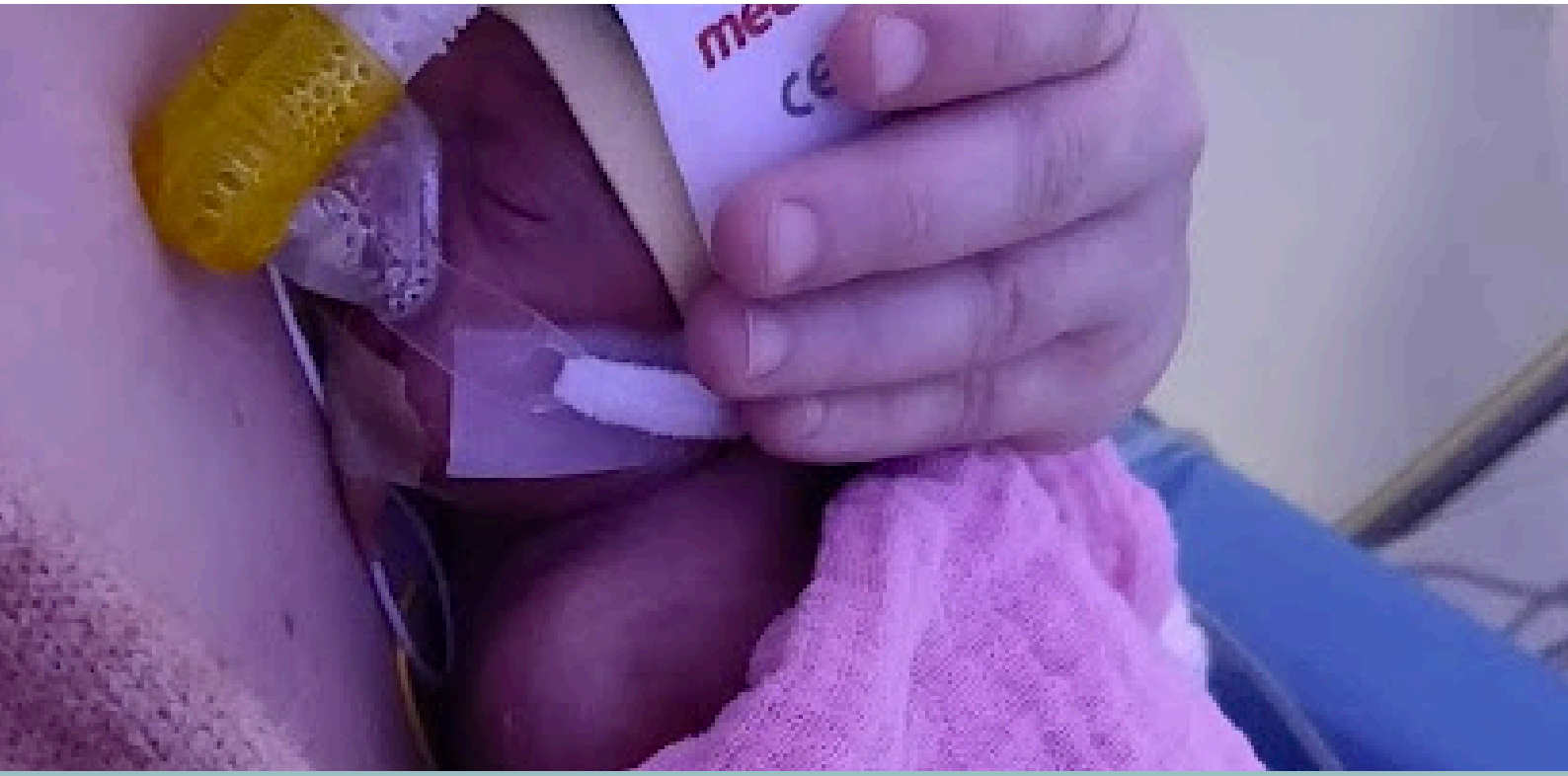
It is an exciting time at Norfolk and Norwich University Hospitals (NNUH).As of June 2023, we have made our commitment to begin the process of becoming accredited according to the United Nations International Children's Emergency Fund (UNICEF) Baby Friendly Neonatal Standards. This means that, as a unit, we are improving our practice to better support families with feeding and developing close, loving parent-infant relationships, ensuring that all families get the best possible start. We strive to provide sensitive and effective care and support for families, enabling you to make an informed choice about feeding and overcome any challenges you may face.

All nursing and medical staff have infant feeding training. We want you and your baby to enjoy a responsive, positive and rewarding feeding experience. As a unit we take pride in supporting all parents however they choose to feed their babies. We have a small specialist Infant Feeding Team to support staff and parents. They are available should any complex issues arise. Please ask your cot side nurse if you would like to see a member of this team. We work closely with Speech and Language Therapy (SALT) to ensure safe feeding and introduce oral feeds at the right time, in the right way for all within our care.

Having a baby who is born early or ill can be a very emotional time. As parents you may feel overwhelmed and unsure of what to expect or what your role is. This is all very normal. This document has been designed to support you through your feeding journey with your baby during your entire stay on the NICU and once you are home and until your baby is completely bottle feeding .

## Skin to skin

As soon as your baby is stable, staff will support you to have skin to skin care with your baby. It helps you produce hormones which can help with your milk supply, regulates baby's heart rate and breathing, keeps them warm and helps calm you both. Whilst in skin contact, your baby will sleep more deeply, this helps them grow and nurtures their growing brain. It can help to comfort your baby after blood tests or a medical procedure.



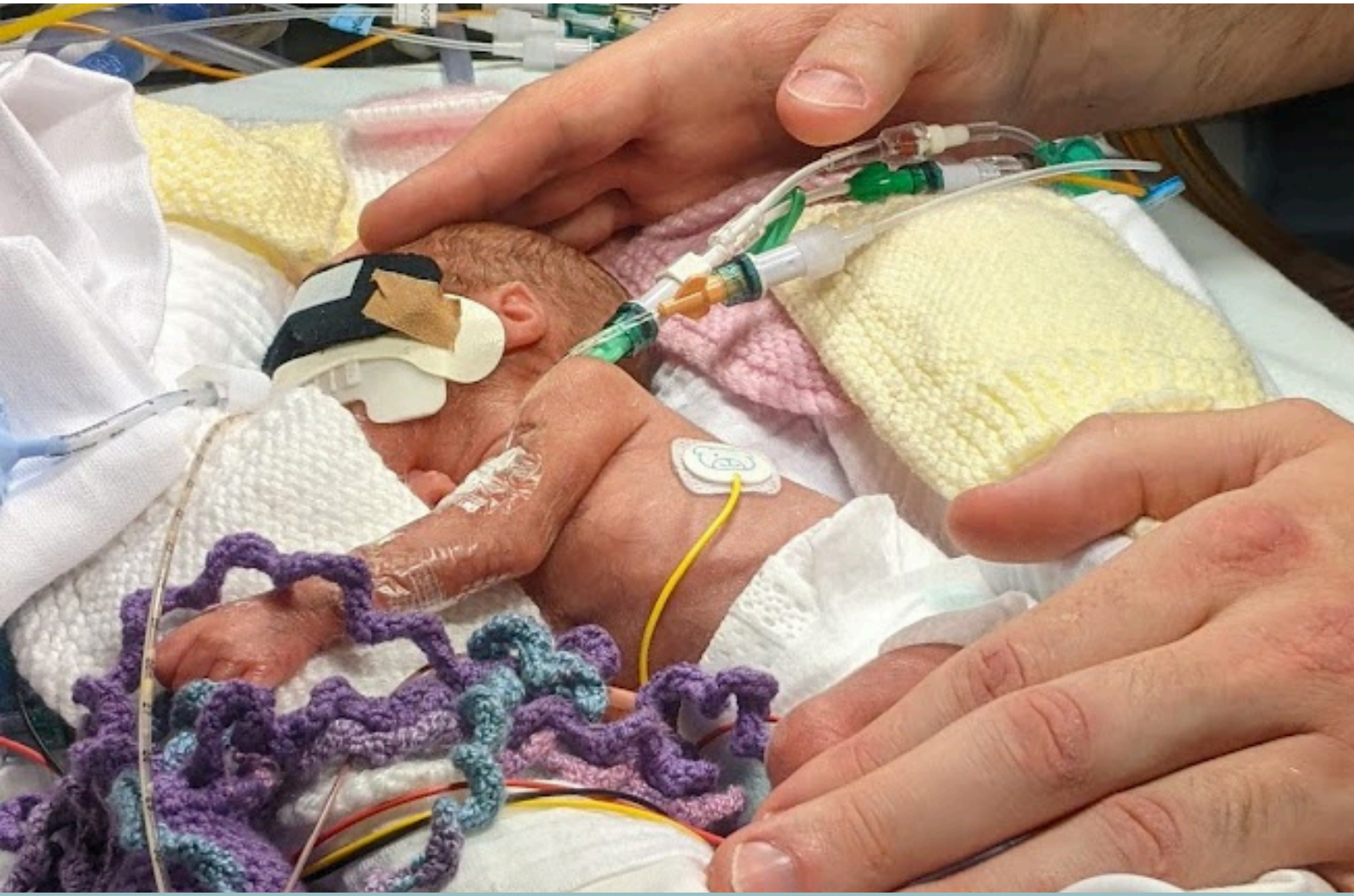
# Comfort holding

At times, your baby may be more comfortable lying in the incubator than being held. In this case, the staff may suggest that you try comfort holding if they think your baby is well enough. Comfort holding is one of many ways for you and your baby to get to know each other.
Comfort holding is ‘still touch’. Cradling your baby with still, resting hands can be more comforting than stroking or massage, which are more stimulating.

Comfort holding can:

- soothe your baby during uncomfortable procedures.
- settle your baby if they are a restless
- help your baby to get back to sleep after feeds and care.
- encourage your baby to be quietly awake and responsive.

Comfort holding is a way to experience loving touch when your baby is not ready to be held.



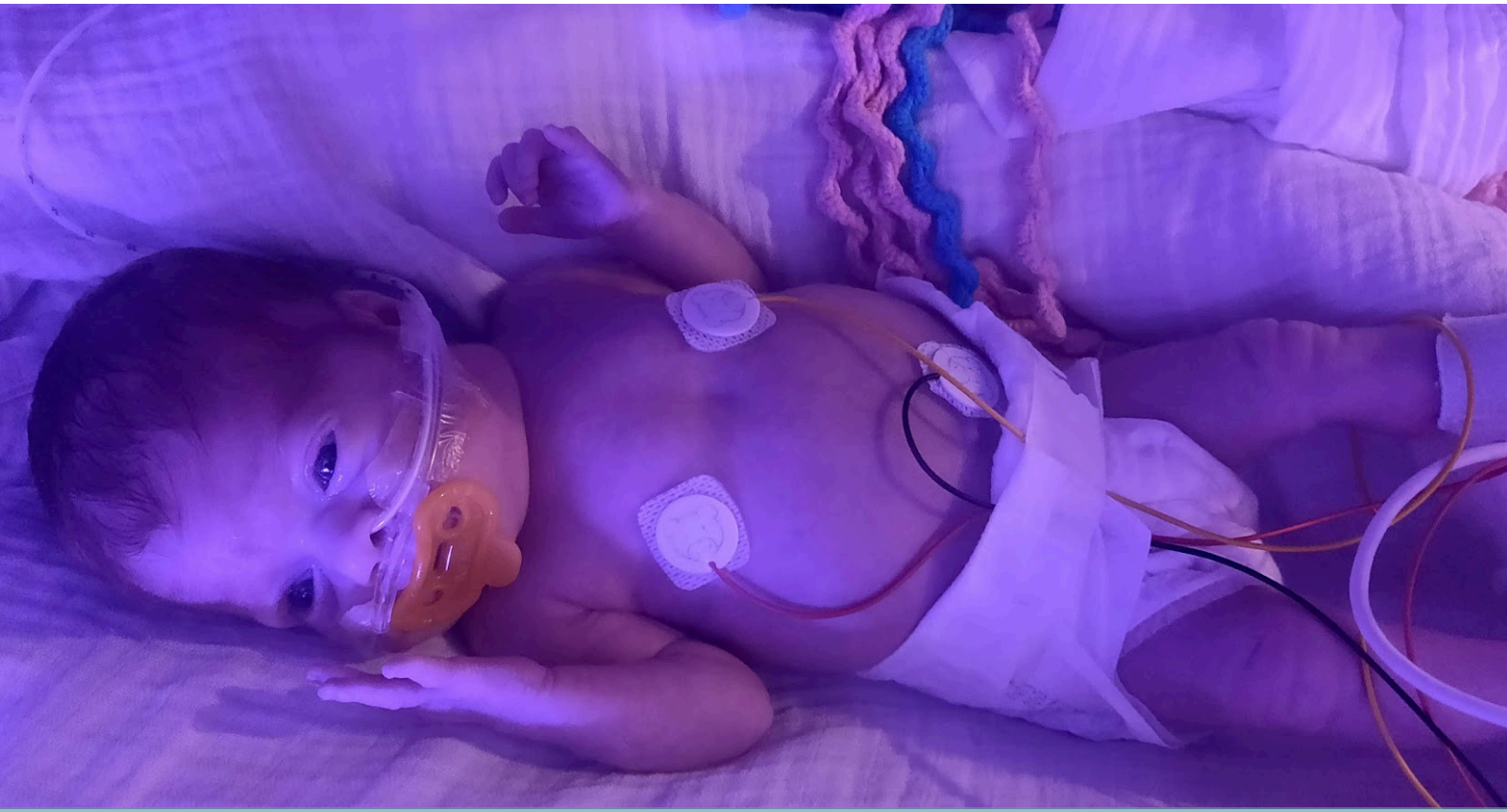
# Non-nutritive sucking

**Non-nutritive sucking is the term used for when a baby sucks on something like a dummy or finger for comfort.**
**Dummy/finger/thumb sucking is different to the suck babies use to suck a milk feed.**

## Benefits

Evidence suggests that offering a dummy for short periods of non nutritive sucking can:

- Help your baby to settle and calm themselves so they use less energy, which may help them to grow a little faster.
- Decrease the stress response if your baby has to have painful procedures e.g. blood test.
- Stimulate the stomach to make the juices that help your baby to digest and tolerate their feeds more easily so they grow faster.
- Can speed up the maturity of your baby's sucking reflex so that they move onto oral feeding more quickly.



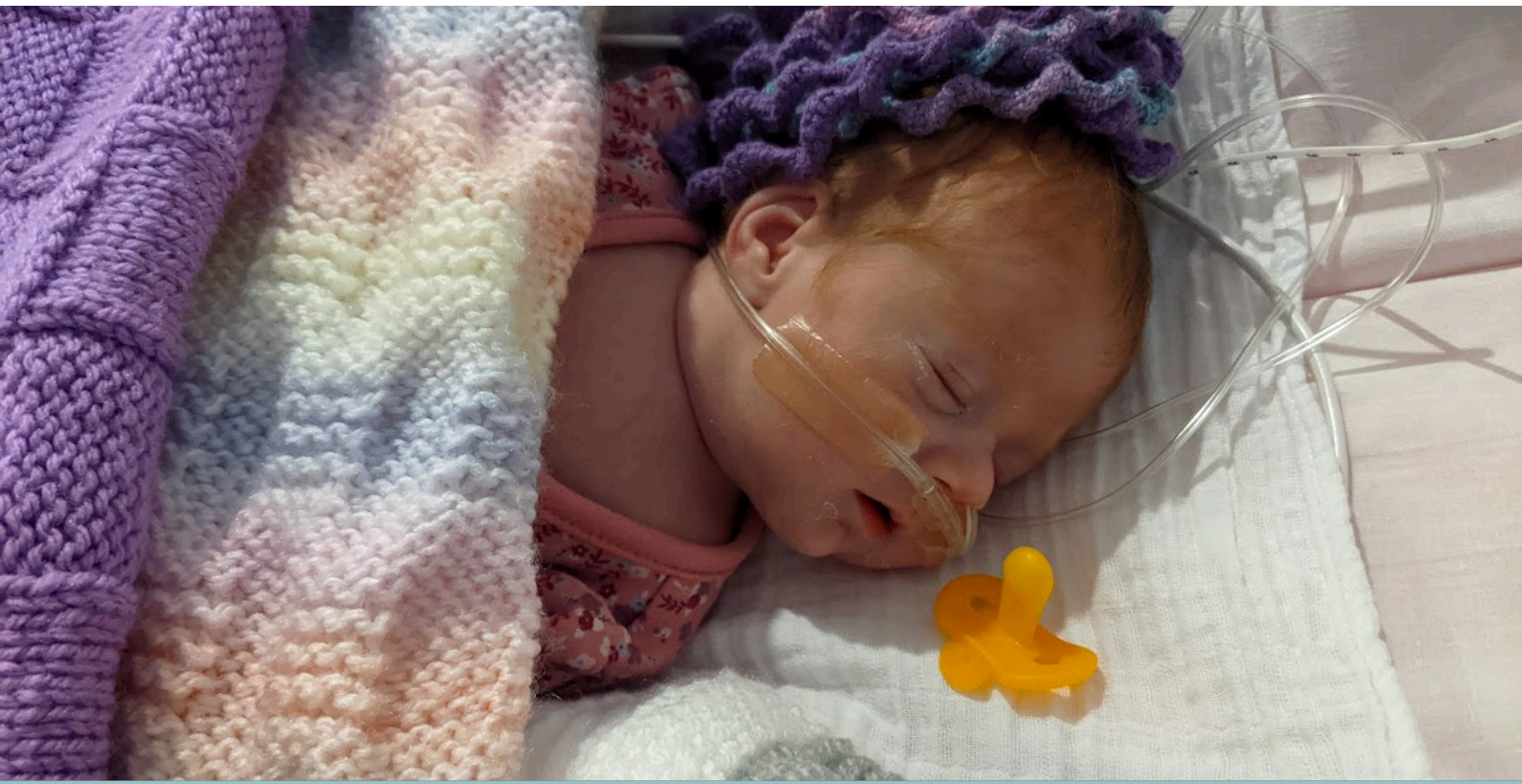
**Developmental benefits**

Sucking is vital in the early development of your baby. Speech and language therapists often recommend non-nutritive sucking programmes for tube fed preterm infants to speed up the transition to oral feeding. It may assist brain development and improve oxygen levels in infants receiving nasal ventilation e.g. vapotherm, nasal cannula oxygen and CPAP (Continuous Positive Airway Pressure).

**When to offer a dummy**

Your baby will show you if they would like to suck, you will notice them move their mouth/tongue and mimic sucking actions. Offering a dummy at the same time as giving a tube feed will help stimulate digestion and your baby will begin to associate the sucking technique with receiving milk.

Your baby will also tell you if they don't want to suck in a variety of ways for example if they spit out the dummy, pull a grimacing face, gag, close their lips and frown. Some babies prefer to suck their own fists or fingers rather than a dummy. **The key is to use your baby as the lead and respond to their actions. If you would like to offer your baby a dummy, please speak with one of the nursing team who can give you some guidance about the size of dummy you will need to buy.**



## Risks

As a parent, you may feel worried that using a dummy before oral feeding can start  may lead to your baby becoming dependent on it as they grow. The information surrounding this generally concerns healthy full term babies and does not apply to premature or unwell term babies that are not receiving oral feeds. We have got a parent information leaflet about giving your baby a dummy, if you are not offered this then please ask a nurse for a copy.

## Alternatives

Your baby may prefer to suck their fingers instead of a dummy, if they are able to get their hand to their mouth.

We can provide very tiny dummies for very tiny babies but we ask you to supply your own if your baby can manage a new born size.

# Routine use of probiotics on the NICU.

**What are probiotics?**

When a baby is born at term their bowels are full of ‘friendly’ bacteria which help to keep the bowel healthy. When infants are born prematurely, they do not have the same range or amount of ‘friendly’ bacteria. This can lead to less ‘friendly’ bacteria increasing within the bowel, which, in turn, can put them at risk of developing a disease called necrotising enterocolitis (NEC). NEC is a condition that mainly affects premature infants. It affects the bowels and, when severe, can be life threatening. There are many factors involved in the development of NEC, but we know that the type of bacteria in the bowel is one of them. Probiotics preparations contain the ’friendly‘ bacteria normally found in the bowels of babies born at term. Probiotics are given to preterm babies to grow in their own bowel and to help stop more ‘unfriendly’ bacteria from growing out of control. Research studies have shown that giving probiotics to premature babies can reduce their risk of developing NEC. They may also help prevent other infections and improve overall survival. In the UK probiotics are classed as food supplements, not medicines. However, the probiotic preparation used in NICU is produced under the same standards as medicines to ensure its safety and quality.

**How are probiotics taken?**

Probiotics are given as soon as your baby is ready to feed, at the same time as one of their milk feeds.

**How often are probiotics given to my baby?**

If your baby is born at less than 32 weeks, probiotics will be given daily until your baby reaches around 34 weeks, as this is the age the risk of NEC is thought to reduce. The probiotic is either mixed in your baby’s milk or given with a few drops of water if your baby isn't receiving milk feeds. If your baby is older than this but was started on probiotics because they were very small, the probiotics will stop as part of the discharge planning process. If, for any reason, your baby stops feeds, then the probiotics will stop as well. They will recommence once feeds are restarted.

**What are the side effects of probiotics?**
Research has shown probiotics to be safe to use in preterm babies. There is however a very small risk that probiotics may cause an infection in some preterm infants. This infection can be treated with antibiotics. The risk of infection from the use of probiotics is much smaller than the risks associated with the development of NEC. In other words, the benefits of giving probiotics outweigh the risks of not giving them.

**Can I refuse to allow my baby to have probiotics?**
Yes, you can choose not to allow your baby to receive probiotics, and you can change your mind either way at any time.

**Does formula milk contain probiotics?**
Preterm formulas do not contain probiotics.

**What if I have further questions?**
If you have any further questions, please ask a member of staff

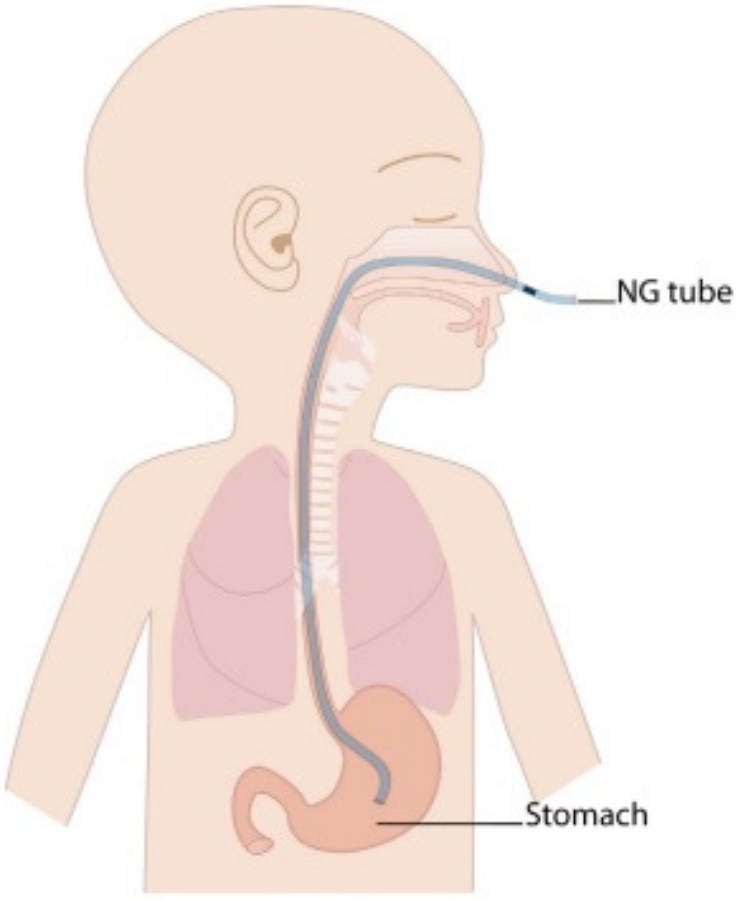
# Nasogastric tube feeding guidelines for parents

You are invited to feed your baby via the nasogastric tube providing the tube is already in place and it is considered safe for you to do so by the neonatal staff. You must have adequate instruction and complete and sign the competency statement for parents with the neonatal nurse who has taught you. You must be closely observed until you feel confident with the procedure and there must always be a member of staff in the room with you.

**You will need:**

3mL syringe for testing
pH Indicator Strip
An Appropriately sized syringe to deliver the feed (nurses will advise you)
Feed

# Procedure for NGT feeding for parents:




**1.** See the diagram to show the correct position of the tube.

**2.** Ensure your baby is in a safe and secure position.

**3**. Wash your hands, dry thoroughly and use alcohol gel.

**4**. Collect equipment - syringes, pH Indicator Strip, and the correct amount of warmed breast milk or formula milk (can be used at room temperature).

**5.** Open packets containing the syringes and put a pH Indicator Strip in/on the syringe packet to keep it clean and dry.

**6.** Do not touch the coloured area of the pH Strip with your fingers as it may affect the reading.

**7.** Test the feeding tube is in the correct place by gently withdrawing a small amount of fluid up the tube from the stomach with a 3mL syringe attached to the tube. If you are unable to obtain any fluid from the tube then you must ask for help.

**8**. Drop a small amount of the fluid onto the pH Indicator Strip, ensuring you cover the coloured area (3 squares), leave for a few seconds and check the pH colour against the scale. It must be 5.5 or less. If you are unsure of the result, please ask a nurse to help you.

**9.** When it has been confirmed that the tube is in the correct position, check the temperature of the milk and then attach the open syringe to the tube. Do not overfill the syringe because if the baby cries, it can force the milk to overflow from the syringe. With smaller feeds (less than 10mLs ) the full feed can be drawn up into an appropriately sized syringe.

**10**. When giving a feed that is already drawn up in a syringe, make sure the black plunger is at the top end of the syringe before attaching to the feeding tube. This prevents unnecessary pressure on your baby's stomach when withdrawing the plunger from the syringe.

**11**. Allow the milk to flow via gravity down the tube into the stomach at a steady rate - not too quickly. This will depend on how high or low you hold the syringe. It may be necessary to give a gentle push with the plunger just to get the feed started. If the milk still doesn't flow, then please ask for help from a nurse.

**12.** If giving a larger feed, where the syringe may need topping up during the feed, ensure that you do not let the syringe empty completely in between. This can allow air to enter the stomach via the tube causing discomfort for your baby. You must kink the tube to stop the flow into the baby whilst topping up the syringe. The nurse will show you how to do this.

**13**. Throughout the feed, observe your baby for signs of vomiting, change in colour or signs of distress. If this happens, stop the feed by kinking the tube and call a nurse immediately.

**14**. Once the feed is completed, allow the milk to run down the tube. If this does not clear the milk from the tube, gently push in 0.5mLs (or less) of air to clear the tube. Kink the tube to prevent milk flowing back up the tube. Remove the syringe and recap the end of the feeding tube.

**15**. Dispose of all equipment appropriately in a safe manner and wash your hands

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# Tube feeding my baby

## Confidence Statement for Parents

| Statements of Confidence | Parent / Carer Initial | | Nurse Signature |
|---|---|---|---|
| I have read and understood the 'Nasogastric Tube Feeding – Guidelines for Parents.' (See above.) | | | |
| I have been given a demonstration of nasogastric feeding by NICU/Transitional Care staff including<br>• Positioning – safe and secure<br>• Skincare<br>• Visual Observation of the baby | | | |
| I am aware of the Health and Safety issues around this procedure including potential aspiration of milk • It has been explained to me what to do if my baby coughs, chokes, gags, vomits, becomes unwell or changes colour whilst feeding • I also know what to do if my baby vomits and at the same time the nasogastric tube becomes dislodged | | | |
| I know how to effectively wash my hands using the correct technique before I start the procedure and, if in hospital, to use the alcohol gel after washing | | | |
| I know how to safely warm the milk if needed and not to carry hot water outside of the milk kitchen | | | |
| I know my baby must be in a safe and secure position/place before I start the feed | | | |
| I have been shown how to check the feeding tube is securely attached | | | |
| I have been shown how to check the feeding tube is in at the correct length and documented on the feed chart. | | | |

| | | | |
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| I have been shown a diagram demonstrating the correct position of a nasogastric tube (feeding tube) | | | |
| I have been taught how to check the correct position of the tube by gently aspirating immediately prior to use, then testing the aspirate on a pH Indicator Strip | | | |
| I understand the result range on the pH paper and that it must be 1~5.5. If 6 or above I must not feed my baby. If baby has taken some feed orally I will wait 10-15 minutes then retest the pH. If it remains above 6 whilst in hospital I will inform the nurse caring for my baby. If at home I will call the Children's Assessment Unit (CAU) on 01603 289774 or the Neonatal Outreach Team 01603 286838 or 07771 881389 | | | |
| I have been shown the types and sizes of syringes that I need to use and how to use them | | | |
| Before starting to feed baby, I will check the temperature of the milk is not too hot or too cold | | | |
| I know how to pull back the plunger on the syringe before I attach the syringe to the feeding tube and then remove the plunger to start the feed. When my baby requires more than 20ml then I will attach an empty syringe to the feeding tube instead and fill this from a bottle of milk. | | | |
| I know the milk must flow slowly into my baby's stomach and this depends on how high or low I hold the syringe from my baby. | | | |
| I know how to stop the feed quickly if my baby vomits, becomes unwell, or changes colour (becomes 'blue') | | | |
| I know I must call for help if I am at all worried. | | | |

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| I know how to remove the syringe at the end of a feed and then use approx. 0.5ml of air in a 3ml syringe to gently push the milk through the tube to clear it. I will replace the cap on the nasogatric tube at the end of the feed. | | | |
| I know where to dispose of milk bottles and equipment at the end of the feed. | | | |
| I know to make sure that the feed is written on the feed chart. | | | |
| I know that I should not allow anyone else to feed my baby who has not been trained to do so by NICU staff. | | | |
| I know what to do and who to contact if the nasogastric tube is pulled out, dislodged or I have any other concerns (CAU or Outreach once at home and nursing staff whilst in hospital.) | | | |

**Supervision log - Please ensure an assessment is carried out over a period of time to ensure parents are consistently competent. The amount of supervised tube insertions will be dependent on each parent/care giver's individual needs and staff need to assess this. A minimum of three supervised insertions is recommended.**

| Date (dd/mm/yyyy) | Staff signature / designation | Comments & Name of Parent / Carer |
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| Staff and parent to sign prior to completing nasogastric tube feeds without supervision | Print Name, Sign & Date |
|---|---|
| Parent/Carer: I have received training, been assessed and feel safe and able to feed my baby by nasogastric tube. I am willing to take responsibility for feeding my baby using a nasogastric tube without supervision | Parent / Carer (1):<br>Parent / Carer (2): |
| Staff: I have provided the above training to the Parent/Carer named and assessed their competence. I consider them ready to take responsibility for feeding this baby by nasogastric tube without supervision | Nursing staff: |

**x2 photocopies required:**
**x1 filed in baby's medical records**
**x1 for The Outreach Team**

# Passing a Nasogastric Tube – Guidelines for Parents

You are invited to pass a nasogastric feeding tube on your baby when it is considered safe for you to do so by the neonatal staff. You must have adequate instruction and complete and sign the competency statement for parents with the neonatal nurse who has taught you. You must be closely observed until you feel confident with the procedure and there must always be a member of staff in the room with you.

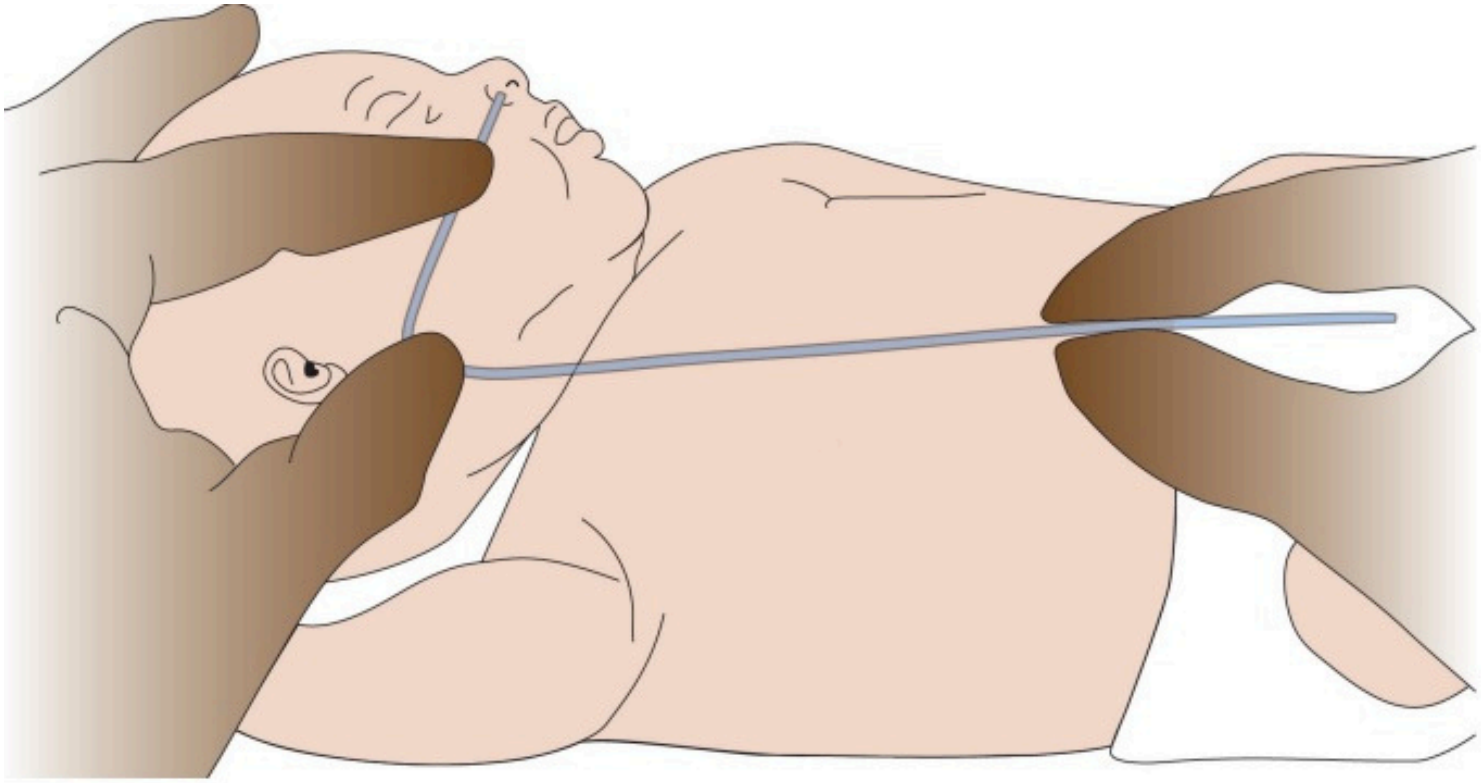
1. Collect all necessary equipment
   - Correct size feeding tube (usually a size 6)
   - Pre-cut Duoderm tape for the face
   - Clear tape cut to an identical shape to secure the tube
   - 3ml syringe to test the position of the tube once in place
   - pH strips

2. Check that all packaging is intact and date is correct for use and the feeding tube has not become kinked from folding during storage.

3. Wash hands, dry thoroughly and disinfect with alcohol gel to prevent the spread of infection.

4. Prepare equipment for use
   - Open feeding tube packet and attach 3ml syringe to the end of the tube.
   - Put a pH strip on the inside of the syringe package (remember not to touch the end of the paper that the sample is going to be placed on as the paper can be affected by the pH of your skin)
   - Stick the Duoderm on your baby's face, close to the nostril on the side to be used (Pass the tube down the alternate nostril from the previous tube if possible)
   - Keep the top layer of clear tape close by.

5. Measure the level that the tube needs to be passed to, from the nostril to the ear lobe and then down to the xiphisternum as shown below.



6. Place your baby on their back, wrap in a soft blanket to secure the arms or ask a second person to hold them to provide some comfort during the procedure. If your baby is able to suck on a dummy during this time it may help make the insertion easier.

7. Hold the tube with your dominant hand and with your other hand mark the distance to which the tube needs to be passed.

8. With the head in a slightly tilted back position so that the nose is upwards, direct the tube slowly backwards and down through the nostril. The tube should take at least 15 seconds to pass into the stomach.

9. If there is any resistance felt, stop, withdraw slightly and alter the angle you are using to pass the tube. If your baby is distressed this may also cause some resistance. Try to calm baby with a dummy or clean finger to suck on. Your baby might gag when the tube reaches the back of the throat, pause, give them time to relax and then continue they may swallow which will help the tube move down.

10. Watch your baby's colour and breathing throughout, occasionally the tube can curl up in the mouth, so check the mouth and if this happens remove and start again. Sometimes a small amount of blood may appear in the tube. If baby continues to cough and protest remove the tube. Allow a period of recovery before trying again.

11. When the tube reaches the measured length test the pH. If this is less than 5.5 secure the tube to the cheek. It is now ready for use.

12. If you cannot aspirate the tube, try to insert the tube a little further or check that it has not coiled in the mouth.

13. If the pH is too high the tube may be too far down. Try to withdraw a little, do NOT use a tube if you are unsure of the position.

14. NEVER try to pass a feeding tube when your baby has just been fed. This may cause your baby to vomit or the pH will be high as the pH of milk is 6. ALWAYS wait until the next feed is due.

15. Dispose of any rubbish and wash your hands.

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# Passing a Nasogastric Tube

## Confidence Statement for Parents

| Statements of Confidence | Parent / Carer Initial | | Nurse Signature |
|---|---|---|---|
| I have read and understood 'Nasogastric Tube Feeding – Guidelines for Parents' see above. | | | |
| I have been given a demonstration of passing a nasogastric feeding tube by NICU staff including: • Preparation of correct equipment • Positioning of baby • Skincare and use of tape • Visual Observation of the baby during and after procedure | | | |
| I am aware of the Health and Safety issues around this procedure including potential for tube displacement • I have been shown a diagram demonstrating the correct position of a nasogastric tube (feeding tube) • I have been shown a diagram demonstrating how to measure the level that the tube needs to be passed to • It has been explained to me what to do if my baby coughs, chokes, gags, vomits, becomes unwell or changes colour whilst inserting a feeding tube. | | | |
| I know how to effectively wash my hands using the correct technique before I start the procedure and to use the alcohol gel after washing. | | | |
| I know how to safely warm the milk if needed and not to carry hot water outside of the milk kitchen. | | | |
| I know my baby must be in a safe and secure position/place before I start the procedure. | | | |
| I know to ask a second person to hold my baby to provide comfort and offer baby a dummy if appropriate to help make insertion easier. | | | |
| I have been shown how to position my baby's head and pass the tube down the nostril to the level required. | | | |

| | | | |
|---|---|---|---|
| I have been taught how to check the correct position of the tube by gently aspirating immediately prior to use, then testing the aspirate on a pH Indicator Strip | | | |
| I understand the result range on the pH paper and that it must be 1~5.5. If 6 or above I must not feed my baby. If baby has taken some feed orally I will wait 10-15 minutes then retest the pH. If it remains above 6 whilst in hospital I will inform the nurse caring for my baby. If at home I will call the Children's Assessment Unit (CAU) on 01603 289774 or the Neonatal Outreach Team 01603 286838 or 07771 881389. | | | |
| I know what a normal aspirate (clear/milky) looks like and to call for help from nursing staff if green/yellow or blood stained. Contacting CAU or the Neonatal Outreach Team if at home (details as above) | | | |
| I know what to do and who to contact if I have any concerns about the nasogastric feeding tube. (Nursing staff whilst in hospital and CAU or the Neonatal Outreach Team once at home) | | | |
| I know that I should not allow anyone else to insert a feeding tube on my baby who has not been trained to do so by the NICU staff. | | | |

**Supervision log - Please ensure an assessment is carried out over a period of time to ensure parents are consistently competent. The amount of supervised tube insertions will be dependent on each parent/care giver's individual needs and staff need to assess this. A minimum of three supervised insertions is recommended**

| Date (dd/mm/yyyy) | Staff signature / designation | Comments & Name of Parent / Carer |
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| Staff and parent to sign prior to passing nasogastric tubes without supervision | Print Name, Sign & Date |
|---|---|
| Parent/Carer: I have received training, been assessed and feel safe and able to pass a nasogastric feeding tube on my baby. I am willing to take responsibility for passing a nasogastric feeding tube on my baby without supervision. | Parent / Carer (1):<br><br>Parent / Carer (2): |
| Staff: I have provided the above training to the parent/carer named and assessed their competence. I consider them ready to take responsibility for passing a nasogastric tube without supervision. | Nursing staff: |

**x2 photocopies required:**
**x1 filed in baby's medical records**
**x1 for The Outreach Team**

# Transitioning to oral feeding

**Babies don't need to be taught how to feed, their feeding skills develop over time. They need the right support, given in the right way, at the right time. Supporting your baby's feeding journey will help you and your baby develop a close and loving relationship. Try to be with your baby as often as you can, learn to recognise feeding cues & stress signs and how to respond to your baby. Take time to discuss your baby's feeding journey with their cot side nurse.**

## Step 1: Get Ready:

Baby may not yet be ready to feed orally if:
They need support with their breathing.
They are not tolerating feeds.
They are too sleepy,
it is important to allow your baby to rest when they are learning to feed.

**What you can do:**

- Skin to skin care.
- Talk to baby during feeds.
- If awake at feed times, offer a dummy, stroke around baby's lips and face.
- Learn how to provide your babies NGT feeds.
- Learn to recognise feeding cues and stress signs and how to respond.

## When is my baby ready to feed?

Babies born prematurely are not ready to bottle feed until they reach at least 34 weeks gestation. For all babies, readiness to feed is judged on several factors which tell us that they are likely to do so safely.

Feeding is an integral part of bonding with your baby. It enables you to get to know your baby and learn to communicate with each other. For your baby to develop good feeding skills, it helps to have consistent people feeding your baby and you, as their parents, are the best.

Your nurse, midwife, doctor or speech and language therapist are always available to discuss any feeding issues or concerns.

## Recognising and responding to cues

Your baby communicates with you through their movements and actions. These signs, or cues, help you to know when they are ready to try feeding and when they need to rest.

## Signs that your baby might be ready to try a bottle feed:

• Opening and closing their eyes.
• Awake and active.
• Licking and rooting, sucking on a finger or dummy.
• Rooting is a reflex that happens when a baby's cheek or lip is touched.

## Signs your baby is not ready to try a bottle feed:

• Does not root, lick or suck.
• Looks sleepy.
• Rolls their eyes.
• Yawns, opens but doesn't close their mouth.
• Continue to watch for when they are next awake, or it is time for their next feed.

The nurse supporting you and your baby will help you to recognise these signs.

## Feeding cues

| **Early**<br>**(I'm ready to feed)** | **Mild**<br>**(I'm really hungry)** | **Late**<br>**(Calm me first then feed me)** |
|---|---|---|
| Stirring, eyes open. | Stretching. | Crying. |
| Mouth opening, tongue moving. | Increased movement. | Agitated, cross. |
| Turning head, seeking, rooting. | Hand to mouth. | Turning red. |

## Step 2 :Time to Practice:

Your baby needs lots of opportunities to practice feeding.

Focus on the **quality** of the feed, rather than how much your baby takes or how long they feed for. Your baby will still need most of their feeds by their tube.

To protect your baby and to ensure they progress to taking full bottle feeds, we use a bottle feeding flow chart. This provides a step by step programme designed to ensure your baby progresses at their pace, protecting them from becoming overwhelmed and having negative feeding experiences.

## What you can do:

Be with your baby as much as possible.

Keep their cot space calm and quiet.

Learn to get your baby out of the cot by yourself.

Be skin to skin during tube feeds if possible.

With support from your cot side nurse, slowly introduce milk on a ‘dummy dip.’

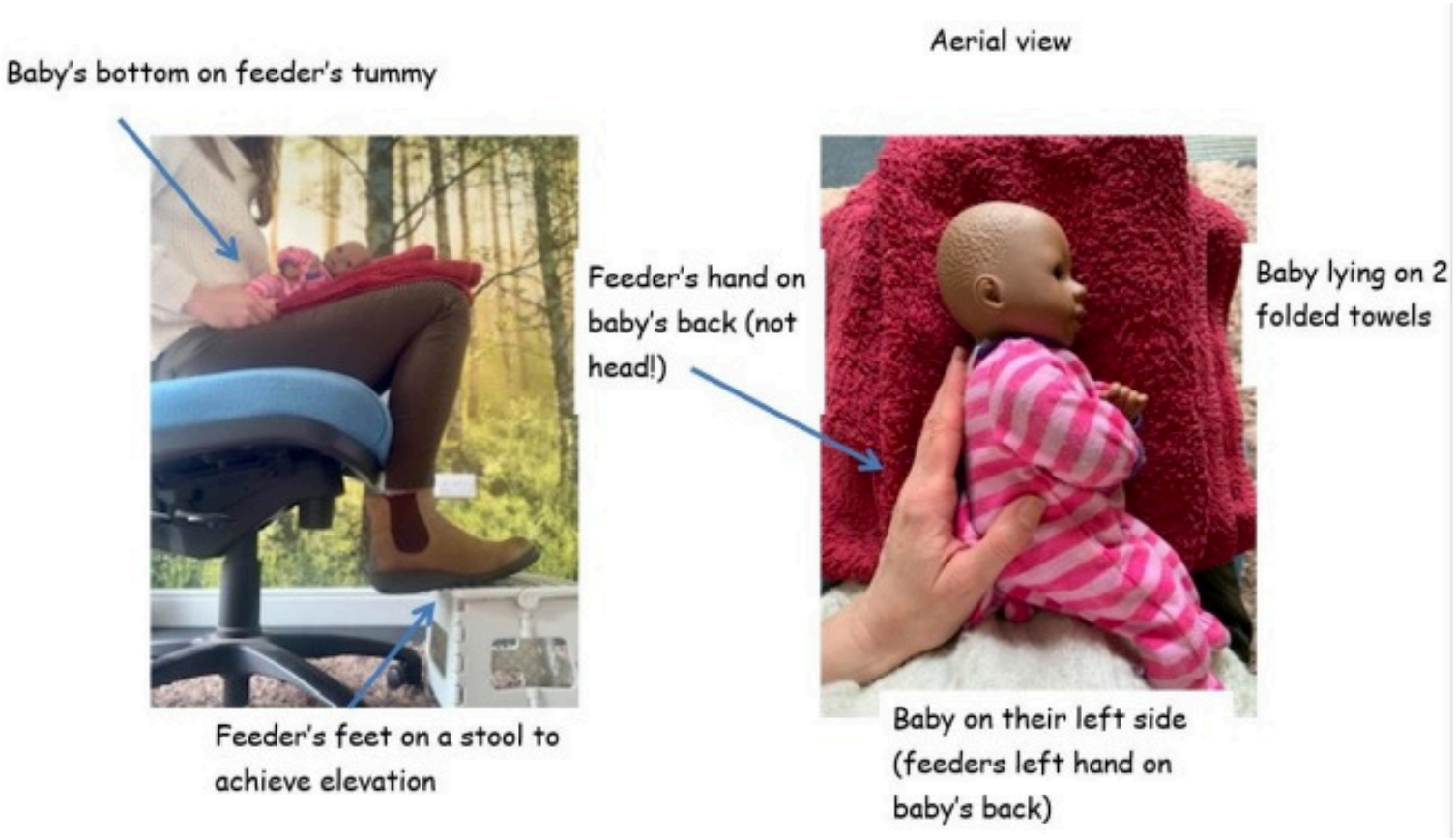
## What is  elevated side lying when bottle feeding?

This a bottle feeding position that's being used more and more for preterm babies and infants who have feeding difficulties.

This position is a natural and physiologically normal feeding position just like how a baby feeds at the breast. It means your baby does not have to do any work at all to support their  body while they  feed which makes for an easier and more relaxed feed for both you and your baby.

Your baby is supported by 2 folded towels which provides them with a stable surface to lay on. You can clearly see your baby's face and watch for signs that they may need to pause for winding or stop if the flow of milk is too fast - which it often can be at the start while your baby is mastering their suck, swallow and breathe co-ordination. This position allows the milk to safely dribble out of their  mouth instead of coughing while feeding.

This is a great position for babies who have reflux or who are prone to vomiting. If you place your baby on their left side to feed, it increases the space from the bottom of their  stomach to their oesophagus making it less likely for them to vomit or reflux.



## Starting a feed…

Offer the bottle by putting the teat on your baby's lips and watch for your baby to open their mouth to accept the teat.

Give your baby time to prepare to accept the teat – some babies need more time than others

You could try stroking your baby's lips with the teat to encourage them to open their mouth. This can be over stimulating for some babies so watch for any signs of distress. It's important not to force or push the teat into your baby's mouth.

Your baby will take the teat when they are ready.

You could try putting a drop of milk on your baby's lips to stimulate interest in sucking

## During your baby's feed….

Babies need to pace themselves during feeding. They will suck in bursts and pause to take catch-up breaths.

Allow your baby to stop and wait for them to recover and start sucking again. It is important for your baby to control their feeding and you should not jiggle, turn, twist or move the teat in and out of your baby's mouth. Still hands when feeding is best practice.

Watch for signs that your baby has had enough or needs to rest. These signs might include:

- A drop in their oxygen levels (desaturating)
- Arching their back or pushing away from the bottle
- Spreading their fingers
- Falling asleep or closing their eyes
- Hiccups or sneezes
- Dribbling, stop sucking
- Change of colour to pale or red
- Rapid breathing
- Flared nostrils – indicates increased work of breathing
- Eyebrow raising, rapid or flickering of the eyes, wide panicked eyes
- Coughing or choking
- Drooling/losing milk indicating your baby can't manage the flow or amount of milk.

If you see any of these signs, stop feeding, assess whether your baby needs winding and talk to the nurse about finishing their feed using their feeding tube. You can then have skin-to-skin, a cuddle or put them back into bed. You will know what is right for you and your baby.

**FEEDING SHOULD BE A MAXIMUM OF 20-30 MINUTES.**

Always aim for a **positive** feeding experience **NOT VOLUME** taken

## Step 3: Supported responsive feeding:

With steady progress, once waking regularly for feeds; your baby can gradually move to responsive feeding, using their feeding tube for top ups as required.

- Your baby needs to feed any time they show feeding cues.
- Your baby should not be left longer than 3 hours between feeds.
- At this stage, your baby may need waking gently, if feeding cues are not shown.
- Complete the feed by tube ("Top Up"), if needed.

## Step 4: Full Responsive Feeding:

- Respond to your baby's feeding cues
- End the feed if your baby shows stress cues.
- Often our babies are discharged home by this point under the care of the Neonatal Outreach Team with their NGT still in situ. There is no rush to remove this tube. It is there to use as a tool should you need it until you are have fully established feeding. Well done! Continue to 'top up' feeds via the NGT as needed. The Outreach Team will support you to remove the tube when the time is right for you and your baby.

# What formula to choose?

It doesn't matter which brand you use, they are all the same
It doesn't matter if you choose a cows' or goats' milk based formula, but talk to your midwife or health visitor before choosing a soya based formula.

**What about all the other milks that claim to help hungry babies, prevent colic, wind, reflux or allergies?**

There is no evidence that most of these other milks do any good, and they might not be safe for your baby. Ask your midwife or health visitor if you think your baby might need a different milk.

**How long do I need to use infant formula for?**

When your baby is one year old, they will be getting more of their energy, vitamins and minerals from food, and full fat cows' milk can be their main milk drink. If you have any concerns, or want to know about other milks, ask your health visitor.

**Want to know more?**

You can find a simple up to date guide on infant milks on firststepsnutrition.org.

UNICEF provides a guide on different types of infant milk downloadable at babyfriendly.org.uk

**UNICEF Responsive Bottle Feeding Factsheet**

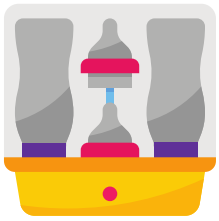
**UNICEF Guide to Bottle Feeding**

## What do you need for formula feeding?

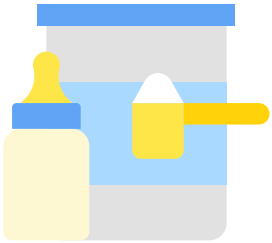
You need to make sure you **clean and sterilise all equipment** to prevent your baby from getting infections and stomach upsets. You'll need:

Bottles and teats

Bottle brush



Sterilising equipment (such as a cold-water steriliser, microwave or steam steriliser)



Infant formula powder or ready-to-feed liquid formula

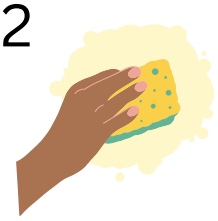
## How to sterilise feeding equipment

The following instructions apply to all feeding equipment you use for your baby, whether you are using expressed breastmilk or first infant formula.

1

Wash and dry your hands

2



Clean the work surfaces with hot, soapy water.

3

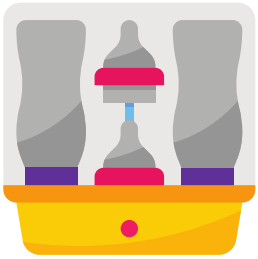
Check that the bottle and teat are not damaged, then clean the bottle and teat in hot, soapy water using a clean bottle brush

4

Rinse all your equipment in clean, cold running water before sterilising.

# Sterilising methods

## Steam sterilising – electric steriliser or microwave



It is important to closely follow manufacturer's instructions and guidance, as there are many models and pieces of equipment on the market to choose from.

## Cold-water sterilising

1 Follow the manufacturer's instructions.

2 Change the sterilising solution every 24 hours.

3 Leave feeding equipment in the sterilising solution for at least 30 minutes.

4 Make sure that there is no air trapped in the bottles or teats when putting them in the sterilising solution.

5 Keep all the equipment under the solution with a floating cover.

## Sterilising by boiling

Make sure that whatever you sterilise in this way is safe to boil.

Boil the feeding equipment in water for at least 10 minutes, making sure that all items stay under the surface of the water. You may need to use a small plate to keep the bottles under the water.

Remember that teats tend to get damaged faster with this method.

# How to make up a feed

Use fresh water from the cold tap to fill your kettle every time you make up infant formula. Do not use water that has been previously boiled or artificially softened water. Bottled water is not recommended to make up a feed as it is not sterile and may contain too much salt (sodium) or sulphate.

1

Fill the kettle with at least 1 litre of fresh tap water from the cold tap (don't use water that has been boiled before).

2

Boil the water. Then leave the water to cool in the kettle for no more than 30 minutes so that it remains at a temperature of at least 70°C.

3 Clean and disinfect the surface you are going to use. It's really important that you wash your hands to stop bacteria spreading.

4 If you are using a cold- water steriliser, shake off any excess solution from the bottle and the teat, or rinse the bottle with cooled boiled water from the kettle (not the tap).

5 Place the teat and cap on the upturned lid of the steriliser or on the cleaned work surface.

6 Follow the manufacturer's instructions and **pour the correct amount of water into the bottle first**.

7

Loosely fill the supplied scoop with the infant formula and
level it off using either the flat edge of a clean, dry knife or the leveller provided. Follow the manufacturer's instructions and only put the suggested number of scoops in the bottle.

8

Holding the edge of the retaining ring, put it on the bottle and screw it in. Cover the teat with the cap and shake the bottle until the powder is dissolved.

9

It is really important to cool the infant formula so it is not too hot to drink. Cool the formula by holding the bottom half of the bottle under cold running water. Move the bottle about under the tap to ensure even cooling.

10


Test the temperature of the infant formula on the inside of your wrist before giving it to your baby. It should be body temperature, which means it should feel warm or cool, but not hot.

11

If there is any made-up infant formula left in the bottle after a feed, throw it away.

12

To reduce the risk of infection, make up feeds as your baby needs them, one at a time. If you have no choice and need to store a feed, please speak to your health visitor about the best way to do this.

Leftover infant formula should be discarded at the end of a feed. Unused bottles of infant formula should be discarded if they have been kept at room temperature for over 2 hours.

## Ready-to-feed liquid infant formula

Ready-to-feed liquid infant formula is sterile until opened. All feeding equipment will still need to be sterilised. Once opened, any unused liquid infant formula that remains in the carton needs to be stored at the back of the fridge on the top shelf with the cut corner turned down, for no longer than 24 hours.

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