

Royal Hospital for Women (RHW)
BUSINESS RULE
COVER SHEET



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EXECUTIVE SPONSOR	Helen Konowec, Co-Director Maternity Services
AUTHOR	Katy Hunt CMC Lactation Services
SUMMARY	Term neonate(s) in the postnatal setting who lose more than 10% of their birthweight can be supported and managed appropriately to preserve feeding goals. When staff are aware of risk factors for delayed onset lactogenesis II, planning and management can minimise neonatal weight loss.
Key Words	Breastfeeding, infant feeding, supplementing, weight loss greater than 10%

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in breastfed neonate (\geq 37 weeks gestation)**

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This Clinical Business Rule (CBR) is developed to guide safe clinical practice at the Royal Hospital for Women (RHW). Individual patient circumstances may mean that practice diverges

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Within this document we will use the term woman, this is not to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.

1 BACKGROUND

The aim of this CBR is to ensure a full-term neonate who has lost greater than 10% of birthweight is supported and followed up with the appropriate management plan. It also aims to assess and identify the history and risk factors contributing to a delayed onset of lactogenesis II.

Definitions:

- Term neonate: neonate born ≥ 37 weeks
- Supplementing: neonate that is breastfeeding with additional breastmilk or formula feeds
- Weight loss: normal and expected weight loss for a term neonate, primarily due to the loss of excess fluid and the passage of meconium. A weight loss of up to 10% of birthweight by days 3-5 is generally considered within normal limits

2 RESPONSIBILITIES

2.1 Medical, Midwifery and Nursing Staff

Provide support to breastfeeding women with lactation and breastfeeding challenges ensuring appropriate management of neonatal weight loss and facilitate timely referral to the CMC Lactation

2.2 Clinical Midwifery Consultant (CMC) - Lactation

Implement and review breastfeeding plan

3 PROCEDURE

3.1 Clinical Practice points

- Weigh full-term neonate on day 3-6 (bare weight)
- Obtain medical, birth and feeding history
- Consider weighing high risk woman and neonate on day 3. Refer to [RHW Breastfeeding – Risks of Delayed Onset of Lactogenesis II, Early Intervention and Management](#)

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- Calculate weight loss from birth weight and document. To calculate the percentage of weight loss:

$$\frac{\text{Weight loss in grams} \times 100}{\text{Birth Weight in grams}} = \% \text{ weight loss}$$

- Inform the senior midwife on the ward or the CMC Lactation if weight loss > 10%

Weight loss > 10%:

- Refer to CMC Lactation
- Observe, supervise, and document a full breastfeed
- Check positioning, attachment, sucking pattern and milk transfer. Refer to the Breastfeeding Assessment tool in the maternal clinical pathway
- Review neonate's feed chart since birth
- Document sucking code for each feed (see feeding chart for codes)
- Assess and document neonate's physical condition.
- Perform a full oral assessment, check urine and stools and signs of dehydration and jaundice
- Examine the woman's breasts and document observations of breast changes, milk supply, nipple damage, breast surgery, or birthing history that may have delayed or interfered with Lactogenesis II
- Write a Breastfeeding Plan in consultation with the woman +/- CMC Lactation
- Provide the woman with a written plan, place a copy in maternal notes and document in EMR
- Notify Paediatric team (RMO for public neonate or Consultant Paediatrician for private neonate) of follow up plan
- Review within 24 hours to assess feeding effectiveness and accurately evaluate the infant's output
- Notify Paediatric team member and CMC if there is no weight gain within 48 hours
- Refer to the Breastfeeding Support Unit (BSU), Child and Family Health Centres or Paediatric Team and Midwifery Support Program (MSP) to provide follow up

Weight loss > 12%:

- Notify Paediatric team member and CMC Lactation
- Instruct parents of neonate at home to return for clinical review by Paediatric RMO
- Observe, supervise, and assess a full breastfeed.
- Include an oral facial motor assessment in the neonatal assessment. (note: This is to be attended by the Paediatric team or CMC Lactation)
- Identify possible reason for weight loss and document all findings
- Assess woman's milk supply. Educate on progressing and improving her lactogenesis by frequent and unrestricted breastfeeding and post feed expressing (at least 8-10 times every 24 hours).
- Discourage use of dummies/pacifiers (refer to SESLHD Fact Sheet)
- Educate woman on hand expressing and use of electric breast pump and provide written information
- Initiate supplementary feeds with expressed breastmilk after both breasts offered; use formula if required, with informed consent documented.
- Provide and explain written Breastfeeding Plan. Place copy in Infant Feeding chart and document

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- Educate the woman on signs of optimal milk transfer and neonate having adequate hydration and calories. Document in Breastfeeding Assessment Tool
- Refer to Breastfeeding Support Unit for reassessment and reweigh in 48 hours.
- Provide written information on community support e.g. RHW Breastfeeding Support Unit, Child and Family Health Clinics, Australian Breastfeeding Association (ABA), General Practitioner (GP)
- Initiate non-pharmacological strategies to support milk supply
- Consider the use of domperidone (Motilium) if woman's breastmilk supply is not responding to conservative management and has an identified low milk supply because of maternal complications e.g. postpartum haemorrhage (PPH), breast surgery, hypoplastic breasts

3.2 Documentation

- Maternal Clinical Pathway - Breastfeeding Assessment Tool
- Neonate Feeding Chart
- EMR
- Breastfeeding Plan

3.3 Education Notes

- Newborn infants adapt to the small amounts of colostrum available in the first few days of life⁷
- Meconium and loss of excess body fluid in the form of diuresis may contribute to an initial weight loss of up to 10% of the birth weight, which is considered normal⁶
- In a systematic review by Thuiler (2016) the mean infant weight loss ranged widely among studies from 3.79% to 8.6%. The point at which most infants have lost the most amount of weight occurs 2 to 4 days after birth¹⁰
- Infant feeding patterns are a strong predictor of newborn weight loss. Specified information should be provided to all parents highlighting the prevention and management of engorgement, interpreting feeding cues and indicators for adequate output and intake⁵
- Between 4 and 7 days of age, infants should stabilise weight loss and regain weight between 10 to 14 days⁸
- The Academy of Breastfeeding Medicine (ABM) reinforces concerns for weight loss, the appropriate response is to investigate and address the cause, rather than to supplement with formula⁶
- Healthy term neonates should not require supplementation for minor fluctuations in weight⁶
- Weight fluctuations could result from stooling, urinating, feeding and maternal fluids in utero and labour. It may also be a result of inaccurate weighing procedures i.e. using different weighing scales to weigh the newborn²
- Large quantities of maternal intrapartum intravenous fluids can potentially lead to maternal breast engorgement, affect birth weight and neonatal weight loss^{2,12}
- Optimal attachment to the breast is vital to prevent the incidence of slow removal of colostrum and Delayed Onset of Lactogenesis II⁸
- Breast milk supply can diminish after several days if it is not frequently removed from the breast⁶

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- Early recognition of the problem, with the appropriate breastfeeding plan, may minimise excessive weight loss in the newborn⁸
- Conflicting evidence exists on the relationship between breast pump use and breastfeeding outcomes. The strongest correlation for positive breastfeeding outcomes was expressing behaviours^{6,15}
- Instrumental births, caesarean births, and obstetric risk factors (such as pre-eclampsia, diabetes, postpartum haemorrhage, separation of mother and baby) can lead to a higher risk of breastfeeding initiation and delayed onset of Lactogenesis II^{3,4}
- Early preventative management should include skin to skin contact, unrestricted breastfeeding, and post feed expression of breast milk⁸
- Immediate or early skin-to-skin care is one evidence-based support for breastfeeding. A non-randomized trial showed that 120 minutes of skin-to-skin (S2S) contact initiated within 30 minutes of birth (vaginal, caesarean, or instrumental) was associated with about five-fold greater odds of exclusive breastfeeding at 3 months versus no early skin-to-skin contact¹⁸
- Weight loss greater than 12% can be serious with the neonate requiring medical review. A sleepy baby with clinical signs of low urine output, dry mucous membranes and jaundice requires immediate review¹²

3.4 Related Policies/procedures

- [Domperidone - SESLHD Procedure](#)
- [RHW Breastfeeding – Risks of Delayed Onset of Lactogenesis II, Early Intervention and Management](#)
- [RHW Breastfeeding Support Unit \(BSU\)](#)
- [RHW Supplementary Feeding of Breastfed Babies In the Postnatal Period](#)

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4 ABORIGINAL HEALTH IMPACT STATEMENT DOCUMENTATION

- Considerations for culturally safe and appropriate care provision have been made in the development of this Business Rule and will be accounted for in its implementation.
- When clinical risks are identified for an Aboriginal and/or Torres Strait Islander woman or family, they may require additional supports. This may include Aboriginal health professionals such as Aboriginal Liaison Officers, health workers or other culturally specific services

5 CULTURAL SUPPORT

- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service: [NSW Ministry of Health Policy Directive PD2017 044-Interpreters Standard Procedures for Working with Health Care Interpreters.](#)

6 NATIONAL STANDARDS

- Standard 2 - Partnering with consumers
- Standard 4 - Medication safety
- Standard 5 - Comprehensive care

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7 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
02/16		Lactation Working Party
16/4/15		Quality & Patient Safety Committee
31/03/15		Maternity Services LOPs
20/06/05		Quality Council
14/6/05		Maternity Services Clinical Committee
15/4/25		Minor changes: reviewed by Lactation Services Team
24/06/25		Revisions incorporated into document.
13/10/25		RHW BRGC