

WEIGHT LOSS (DAY 4-6) GREATER THAN 10% OF BIRTH WEIGHT IN BREASTFED FULL TERM (\geq 37 WEEKS GESTATION) NEONATES

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- Ensure a full term infant who has lost greater than 10% of birth weight is supported and followed up with the appropriate management plan.
- Awareness of risk factors and medical history can contribute to a Delayed Onset of Lactogenesis II.

2. PATIENT

- Woman who decide to breastfeed, and whose baby have lost greater than 10% of birth weight

3. STAFF

- Medical, Midwifery and Nursing Staff
- Clinical Midwifery Consultant (CMC) Lactation

4. EQUIPMENT

- Neonatal Scales

5. CLINICAL PRACTICE

- Weigh all full term neonates on day 4-6 (bare weight)
- Obtain medical, birth and feeding history
- Take into account the hours since birth and not just the day
- Calculate weight loss from birth weight, not from a previous weight and document in appropriate Clinical Pathway
- To calculate the percentage of weight loss:
$$\frac{\text{Weight loss in grams}}{\text{Birth Weight in grams}} \times 100 = \% \text{ weight loss}$$
- Inform the Senior midwife on the ward or the CMC Lactation,

Weight loss greater than 10%:

- Refer to CMC-Lactation Consultant
- Observe, supervise and document a full breastfeed.
- Check positioning, attachment, sucking pattern and milk transfer. (Utilise the Breastfeeding Assessment Tool on Postnatal Clinical Pathway)
- Review baby's feed chart since birth
- Document Sucking Code for each feed(refer to Baby's Feeding Chart)
- Assess and document baby's physical condition, full oral assessment, age appropriate urine and stools, signs of dehydration and jaundice
- Examine woman's breasts and document observations of breast changes, milk supply, nipple damage, breast surgery or birthing history that may have delayed/interfered with Lactogenesis II.
- Write a feeding plan in consultation with woman +/- CMC Lactation Consultant
- Provide the woman the written plan, place copy in baby's feeding chart and document in clinical notes

CLINICAL POLICIES, PROCEDURES & GUIDELINES

Approved by Quality & Patient Care Committee
3 March 2016

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- Notify Paediatric team (RMO for public neonates, and Consultant Paediatrician for private neonates) of follow up plan
- Review 24 hours of feeds and accurate assessment of infants' output.
- Notify Paediatric team member and Lactation Consultant if no weight gain after 24 hours
- Refer to the Breastfeeding Support Unit (BSU), Child and Family Health Centres or Paediatric Team and Midwifery Support Program to follow up.

Weight loss greater than 12%:

- Refer to Paediatric Team member and CMC Lactation Consultant.
- Observe, supervise and assess a full breastfeed. Maternal breast/ lactation assessment.
- Infant assessment includes an oral facial motor assessment to be attended by Paediatric Team or CMC Lactation
- Identify 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
- Educate woman on hand expressing and use of electric breast pump and provide written information(SESLHD Leaflets on Expressing and Storage of Breast milk and Increasing Supply)
- Initiate supplementary feeding with expressed breastmilk after offering both breasts at each feed. Formula supplementation may be required. Consent needs to be obtained, permission, signature and Acceptable Medical Reason documented.
- Provide woman with written breastfeeding plan. Place copy in Baby's Feeding chart and document. Educate the woman on signs of optimal milk transfer and baby having adequate hydration and calories and document in Breastfeeding Assessment Tool
- Refer woman to the Breastfeeding Support Unit (for follow up reassessment including reweight of baby in 48hours)
- Provide written information for ongoing community support (e.g. Child and Family Health Clinic, Breastfeeding Drop in Clinics, Peer to Peer Support of the Australian Breastfeeding Association, General Practitioner.).
- Discourage use of galactogues. Initiate non pharmacological/ conservative management to increase breast milk supply.
- Domperidone (Motilium) may be used only if woman's breast milk supply is not responding to conservative management and has an identified low milk supply because of maternal complications (e.g. PPH, Breast surgery, Hypoplastic breasts (See Domperidone - NSW Health Policy Directive).

6. DOCUMENTATION

- Clinical Pathway
- Baby's Feeding Chart
- Integrated clinical notes
- Breastfeeding plan

7. EDUCATIONAL NOTES

- Newborn infants adapt to the small amounts of colostrum available in the first few days of life (1, 2, 3).
- 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 normal (4, 5)

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- In a systematic review by Thuiler (2016) reports that 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 birth (6)
- Infant feeding patterns are 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 intake (1).
- Between 4 and 7 days of age, infants should stabilise weight loss and regain weight between 10 to 14 days (2, 4).
- The ABM protocol reinforces that when weight loss is of concern the appropriate response is to investigate and address the cause, rather than to supplement with formula (7)
- Healthy term infants should not require any immediate cause for alarm in regards to minor fluctuations in weight (3,7)
- 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 newborn (3, 6)
- Large quantities of maternal intrapartum intravenous fluids can potentially lead to maternal breast engorgement, affect birth weight and neonatal weight loss (5)
- Optimal attachment to the breast is vital to prevent the incidence of slow removal of colostrum and Delayed Onset of Lactogenesis II (3, 6, 7))
- Breast milk supply can diminish after several days if it is not frequently removed from the breast (3,7)
- Early recognition of the problem, with the appropriate breastfeeding plan, may minimise excessive weight loss in the newborn (3, 6)
- Instrumental births, caesarean section, obstetric risk factors (such as pre-eclampsia, diabetes, postpartum haemorrhage, separation of mother and baby) can lead to a higher risk of difficulty with breastfeeding initiation and delayed onset of Lactogenesis II (3, 5, 6, 7, 8)
- Early preventative management should include (6, 7, 8):
 - Skin to skin contact
 - Unrestricted breastfeeding
 - Post feed expression of breast milk

8. RELATED POLICIES/PROCEDURES/LOPs

- Supplementary Feeding Of Breastfed Babies In Postnatal Wards
- Domperidone – NSW Health Policy Directive
- Breastfeeding – Risks of Delayed Onset of Lactogenesis II, Early Intervention and Management
- Breastfeeding Support Unit (BSU)
- Breastfeeding-Protection, Promotion and Support

9. RISK RATING

- Medium

10. NATIONAL STANDARD

- Standard RH – Reducing Harm

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11. REFERENCES

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