

Prevention and management of faltering weight gain in breastfed babies.

Guidelines for Health Visitors, Family Nurses and Community Nursery Nurses.

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1. Introduction

1.1 Weight loss in the first few days of life is normal, as babies are born with excess extracellular fluid which they need to shed. Conventional wisdom has been that normal weight loss may be up to 10% of birth weight, although studies have indicated that, in the majority of babies, it is more likely to be between 5% and 7% (Dewey et al, 2005, Macdonald, 2003).

1.2 Birth weight is usually regained by 2 weeks of age (Wright 2004). A healthy baby feeding well should then continue to gain weight. Babies are weighed and their weight plotted on the growth chart in the personal child health record (red book) by a trained person (e.g. a Health Visitor, Family Nurse, Community Nurse or Community Nursery Nurse). It should be explained to parents that a baby's birth weight and subsequent growth curve can legitimately follow any of the centile lines, and that the 50th centile is an average rather than an 'ideal' weight.

1.2 Poor weight gain and faltering growth causes anxiety to parents and staff alike and may result in the use of supplements of formula milk or cessation of breastfeeding. Both health professionals and parents may assume that breastfeeding itself has led to poor weight gain or faltering growth, rather than ineffective breastfeeding management.

1.3 As poor weight gain and faltering growth can be a sign of illness, careful assessment of all babies who are not gaining weight at the expected rate should be carried out, with referral to the General Practitioner (GP) where necessary.

- **“Organic disease**

Two UK population studies showed that in infants with weight faltering, only 5–10% had a substantial organic disease.

Whilst the nature of organic disease was heterogeneous, all had clear symptoms or signs suggesting underlying disease.

A US-based study showed that in asymptomatic children, investigations did not identify new diagnoses of organic disease.

- **Socioeconomic factors**

Historically, poverty and low educational attainment were felt to be associated with poor weight gain. This is probably still true in the developing world settings but not in the UK. Three large UK population studies showed no relationship between low socioeconomic status and weight faltering.

- **Neglect**

Most children with weight faltering are not neglected. A small cohort study suggested that neglect is a contributing factor in about 5% of cases. We should think about it in the context of what we know about the family and other concerns expressed.

- **Maternal depression**

Studies show mixed results – maternal depression may have a weak association with weight faltering”. (GP-CPD, 2016)

1.4 These guidelines have been developed to help professionals support breastfeeding mothers and their partners to overcome difficulties, and to safely and successfully breastfeed their babies for as long as they wish to do so.

1.5 Where the term ‘Health Visitor’ is used, this denotes any member of the Health Visiting service, such as Family Nurses and Community Nursery Nurses, who provide breastfeeding care for Swindon Borough Council (SBC).

2. Purpose/objective of the document

To provide staff with a clear **pathway on** how to manage weight loss or faltering growth in breastfed babies in order to maintain the health and wellbeing of these infants. In order to do this, staff will be trained to:

- Identify slow weight gain.
- To manage slow weight gain proactively.
- To support breastfeeding mothers.
- To prevent premature cessation of breastfeeding.
- To prevent unnecessary formula supplementation of breastfed babies.
- To safely manage any necessary formula supplementation.

3. Responsibilities

3.1 All staff involved with supporting breastfeeding mothers are responsible for reading and following this guidance, and for accessing training and updates regarding its use.

3.2 Health Visitors delegating work to skill mix staff must ensure they have the required level of skills to support families where there are breastfeeding problems, and that they report back to the delegating Health Visitor.

4. Process or procedure

4.1 Routine weight monitoring by the health visiting team

- All babies should be weighed at the new birth visit if this has not been completed by the midwife at discharge around day 10. See link for advice around routine weighing and measurement [Early years - UK-WHO growth charts and resources | RCPCH](#) go to information for health professionals
- All babies should be weighed a week after discharge by the midwife/ new birth visit if they had not yet reached birth-weight or there are any additional concerns.
- All babies should have a feeding assessment at the primary birth visit at 10-14 days.

4.2 Assessing breastfed babies at the primary visit

A full breastfeeding assessment should be carried out to ensure correct attachment and positioning. The UNICEF UK Baby Friendly Initiative breastfeeding assessment tool, found in the personal child health record should be used as an aid memoir and for documentation, this will help to ensure early identification of breastfeeding problems and prevention of potential problems. If concerns exist about the effectiveness of breastfeeding, a plan of care will be completed with the mother. Documentation of the assessment and plan of care should also be completed in the child's CAPITA records, as per NMC guidelines [Record keeping guidance](#).

4.3 Weight monitoring after the primary visit

If no problems are identified at the initial assessment, it is acceptable for the baby to be weighed as recommended by NICE (2008), and the Royal College of Paediatrics and Child Health (2013), at 8, 12, 16 weeks and at 1 year around the time of routine immunisations.

If a baby is gaining weight slowly the baby should be weighed and assessed as described in section 4.4 below.

4.4 Weight monitoring when slow or static weight gain is identified

- Poor weight gain can be a result of ineffective milk transfer from mother to baby. This is commonly caused by poor attachment and positioning at the breast, or insufficiently frequent feeds. More rarely, it may be due to poor health of the mother, a medical condition, or physical abnormality of either mother or baby. In most cases the problem can be overcome with good management.
- If ineffective milk transfer is not corrected, suppression of milk production will result, due to the Feedback Inhibitor of Lactation (FIL), which inhibits further milk production (Neifert 2004). It is therefore extremely important that slow or static weight gain is managed proactively. Breastfeeding technique and management should be optimised to support the establishment of a good milk supply and effective milk removal.
- If there is cause for concern the baby should be moved from a routine to an individual weighing plan. As far as reasonably possible, the baby should be weighed at the same time of day, in the same relation to a feed (i.e. before/after), on the same scales which are placed on the same surface and by same person, as all these factors contribute to accuracy of weighing. (Hall, DMB; and Elliman, D. 2003)

4.5 Babies who enter Health visiting care below their birth weight

A baby who is below birth weight around day 14 needs careful monitoring.

- A breastfeeding history and assessment should be conducted, using the UNICEF UK Baby Friendly Initiative Breastfeeding Assessment Form found in the personal child health record. This may show that the baby is recovering from a large initial loss and is now gaining weight. In this case both feeding and weight monitoring should continue until birth weight is regained and the baby has established an upward weight gain trend on at least two occasions 2-4 weeks apart depending on the history and risk factors such as inter-uterine growth retardation.
- If the baby is not now gaining weight, careful monitoring and assessment should continue. Feeding should be managed using Plans A-C in the slow weight gain and faltering growth pathway for breastfed babies and a clear feeding plan should be documented in the personal child health record and the child's electronic record. If a baby has not regained birth weight by 3 weeks of age s/he should be referred to a GP and to the Specialist Infant Feeding Clinic for further assessment.
- Mothers can be signposted to additional sources of support such as Breastfeeding Counsellors and peer support groups. Breastfeeding peer supporters are not health professionals and it is not within their role to identify

health concerns or problem solve. Health professionals should be aware of the role of the Breastfeeding Peer Supporter (See HV N Drive Infant Feeding).

Specialist Infant feeding Clinic: Cathy Gale Tel. 01793 604726 (Referral form on HV N Drive Infant Feeding), email to cathy.gale@gwh.nhs.uk.

NCT Breastfeeding Counselor Elena Rossi Tel. 07733609660

Breastmates [Breastmates](#) | [Breastfeeding](#) | [Swindon Borough Council](#)

4.6 Babies who are gaining weight slowly

A baby's weight may not exactly follow one centile line and may cross a line. This is especially true in the first 9 months of life. Changes of less than one channel width (the gap between two centile lines) are quite normal. Weight loss during an illness is also common, but on recovery the baby's centile usually returns to normal within 2-3 weeks. Babies whose weight is consistently below the bottom centile, or who cross down two or more channel widths without recovery, should be assessed by a GP to exclude illness as a cause of the poor weight gain. Babies on or above the 91st centile can drop through three centiles, before referral if no other presenting concerns. Babies below the 9th centile who cross one centile should prompt concern.

5.0 Management plans for babies with static or slow weight gain: See pathway for detail.

5.1 Risk Factors; this list is a guide and is not exhaustive.

Maternal	Neonatal/ Infant
Diabetes including gestational diabetes	Intra uterine growth retardation
Thyroid disease	Prematurity
Antenatal infection including Group B Strep	Cystic Fibrosis
Substance misuse	Kidney disease
	Cardiac anomalies
	Projectile vomiting

6.0 Training requirements

Staff are required to familiarise themselves with the content of this guidance, and to undergo training, before giving guidance to parents, this will be provided within six months of working for SBC, in biennial infant feeding updates and on an individual basis from the infant feeding lead if staff identify a training need between updates.

7.0 Monitoring of compliance with the policy including frequency

Compliance with this guidance will be audited annually, as part of the UNICEF UK Baby Friendly Initiative audit.

8.0 References

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9.0 Associated documents

- SBC Infant Feeding Policy [N:\Education\ED_HV\Infant feeding policy and guidelines and referrals\Infant feeding Policy 2017.pdf](#)
- Tongue Tie Pathway and parent leaflet [N:\Education\ED_HV\Infant feeding policy and guidelines and referrals\GWH Tongue Tie Leaflet 2016.docx](#),

[N:\Education\ED_HV\Infant feeding policy and guidelines and referrals\GWH Tongue Tie Pathway 2016.docx](#)
UNICEF UK Baby Friendly Initiative Breastfeeding Assessment Tool [Breastfeeding Assessment Tools - Baby Friendly Initiative](#)

Date of approval:
Review date October 2017