The Newcastle upon Tyne Hospitals NHS Foundation Trust

Expression, Storage and Administration of Expressed Breast Milk Policy

<table>
<thead>
<tr>
<th>Version No.:</th>
<th>1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective From:</td>
<td>06 June 2017</td>
</tr>
<tr>
<td>Expiry Date:</td>
<td>06 June 2020</td>
</tr>
<tr>
<td>Date Ratified:</td>
<td>11 May 2017</td>
</tr>
<tr>
<td>Ratified By:</td>
<td>Quality and Safety Women’s Services</td>
</tr>
</tbody>
</table>

1. Introduction

Mothers who are unable to feed their babies effectively require support and information on how to express their breast milk safely and effectively in order to maintain their baby’s well-being. It is also recognised that the handling, preparation and storage of Expressed Breast Milk (EBM) in a hospital environment may present potential health risks if it is not done safely.

2. Scope

This policy sets out the procedures to be followed for mothers who are unable to feed their baby effectively or who may be separated from their babies due to prematurity or ill health. This document is designed to provide guidance for all staff that are involved in supporting mothers to express their breast milk and in the handling, storing or administration of EBM as part of their role in the maternity unit of the Newcastle Upon Tyne Hospitals NHS Foundation Trust. This document may also be useful for members of staff in other directorates.

3. Aims

This document provides guidance for staff caring for mothers and infants in the maternity unit and community setting. It may also be helpful for staff in other directorates caring for mothers and new born babies. This document aims to ensure that all women are provided with appropriate advice and care in relation to expressing their breast milk and that staff are able to provide safe and appropriate care which minimises any associated risks when storing and administering EBM.

4. Duties (Roles and Responsibilities)

Midwives, Nurses, Nursery Nurses and Health care assistants have the primary responsibility to ensure that all women are given appropriate and correct information in relation to the expression and administration of breast milk.

The Infant feeding Coordinator and Infant feeding lead for NICU have primary responsibility for the training of the staff in relation to this and the monitoring of compliance with this policy.

The Senior Midwives/Nurses for Postnatal and the Neonatal Unit have primary responsibility for the implementation of the policy.
5 Definitions

EBM refers to milk that has been expressed from a mother’s breast either manually or mechanically via an electrical or manual breast pump.

6 Clinical Policy for expressing breast milk

All mothers who are wishing to breastfeed/establish lactation will routinely be shown how to hand express as soon as possible following birth (within 6 hours). This will be documented in the expression of breast milk checklist.

Following delivery all mothers who are separated from their babies (irrespective of their feeding choice) should have an informed discussion on the benefits of expressing breast milk for premature or ill babies. To support this discussion some mothers will need communication support such as spoken language interpreting or British Sign Language interpreting. Staff will adapt the procedure to accommodate mothers who are disabled. The Learning Disability Liaison Nurse can be contacted to discuss any specific issues relating to mothers with a learning disability. This will be documented in the Postnatal Infant feeding checklist.

Mothers will be encouraged to hand express for 48 hours prior to commencing electrical expression. Electrical expression will only be introduced prior to this on a clinical need after discussion with an Infant Feeding lead or fully informed maternal choice and mothers will still be encouraged to hand express prior to using the electrical pump in order to maximise the amount of colostrum obtained.

The mother will be shown how to massage and express breast milk (both by hand and subsequently by electrical pump) from her breasts to encourage lactation and to provide mouth care and nutrition for her baby if her baby is unable to feed for any reason.

Mothers will be advised to express at least eight times per day including at least once during the night if they are unable to breastfeed their babies.

Following transfer home those women with babies in the neonatal unit will be provided with the necessary equipment to assist them with expression of breast milk.

All mothers with babies on the neonatal unit will be shown the expression of breast milk room.

On discharge initiation of breastfeeding will be documented on the Euroking E3 maternity system. The midwife should document yes to the relevant question (*Did the mother attempt to initiate breastfeeding, or did the baby (any of the babies) receive any breast milk within the first 48 hours?*) If the mother has attempted to offer a breast feed or express and provide her baby with expressed breast milk even if she has been unsuccessful at this point

The mother may require specialist support in relation to expressing and this is available from the Infant Feeding Lead for NICU, Infant Feeding Coordinator or a Nursery Nurse. A flowchart detailing the relevant steps within the process is located in Appendix 1.
6.1 Maintaining safety

All expressing equipment should be for single patient use only.

Surfaces of the breast pumps should be cleaned with a detergent wipe after each patient use in line with trust policy.

The importance of hand hygiene should be communicated to all personnel who are involved in handling and storage of breast milk, particularly to mothers prior to assembly of expressing equipment.

All mothers who are expressing breast milk will hand express for 48 hours initially and then be shown how to use an electrical pump if they wish to do so and an assessment will be undertaken to ensure they have understood the information given. They will be:

• Given support in relation to maintaining lactation
• Verbal and written instructions on how to use the expressing equipment
• How to label and store their breast milk safely
• How to maintain and clean their expressing equipment
• How to obtain an electrical pump for use at home (if required)
• How to obtain their breast milk from the EBM fridge and verify that they have been provided with the correct milk from a member of staff.

6.1.1 Identification and labelling process when storing EBM

All women should be shown how to label their EBM before they commence expression. They should be provided with the equipment and labels to be able to do this safely. See Appendix 3 for more information.

Immediately following expression the expressed milk bottle must be labelled with the baby’s:

• MRN
• Name
• Date and time of expression.

It is the parent’s responsibility to label milk and staff will offer assistance if required.

It is the nurses/midwives responsibility to check that the bottle is correctly labelled prior to putting this into the fridge or freezer.

6.1.2 Storage of EBM

EBM should be stored in exclusive fridges or freezers that are locked at all times or in clinical areas that only staff will have access to.

Once labelled correctly the milk will be stored on trays which have an addressograph label of the baby attached to it.
Any babies that are sharing a basket in the freezer should have the milk bagged and an addressograph visible on the front of the bag so that the EBM bottle is checked prior to going into the freezer to prevent any mixing of milk in the baskets.

All staff are responsible for advising mothers to give the EBM to the nurse caring for their baby. EBM should not on the bench or given to a passing nurse. This is to ensure that we have compliance with the checking process.

EBM should be stored at the following temperatures:

- Fridge 2°C - 4°C, Freezer <-20°C
- Frozen EBM can be stored in a suitable freezer at -20°C for up to 3 months.
- EBM should be stored or transported at a temperature maintained between 2°C - 4°C.
- EBM which is known to be infectious should be stored separately i.e. maternal MRSA.

Fridge temperatures should be checked and recorded daily to avoid fluctuations in temperature. Freezers should have an adequate alarm fitted to alert any temperature rise that may induce thawing of the EBM. Feeds should be disposed of if temperatures are not within the recommended range. The thermometers should be kept at the back of the fridge not in the door.

The inside of the fridge should be checked and cleaned daily, standard trust documentation will reflect that this has been achieved.

6.1.3 Frozen EBM at discharge from the Neonatal Unit

- When a baby is ready for discharge all milk in the fridge and freezer should be checked by either two nurses or a nurse and the mother into the bag in readiness for discharge. This is to ensure that the mother takes home only her EBM.
- Once the milk is checked and bagged, the nurse and second checker (mother or another nurse) should sign in the nursing notes and on the nursing chart.

6.1.4 EBM Fridge

Any EBM stored in the fridge will be checked daily using the appropriate audit sheet. This sheet will be stored in the appropriate place on the front of the fridge.

The Trust standard policy in relation to cleaning will be adhered to and the documentation completed.

Only expressed Breast milk will be stored in the designated fridge on the postnatal wards.
On the neonatal unit milk that has been prepared specifically for a baby and/or EBM can be stored in the EBM fridge

The fridge will be checked daily and the following discarded:
- Unlabelled EBM.
- EBM stored in doors-please inform the mother.
- EBM older than 48 hours- please inform the mother.
- EBM of a mother who has gone home.
- Any formula milk.

Ensure patient removes any EBM from the fridge before transfer from the ward or on discharge of the baby from the neonatal unit.

6.1.5 Preparation of EBM

Where possible infants should receive fresh EBM to maintain the breast milk quality.

EBM will always be used in date order.

Fresh EBM will only be stored within a suitable fridge for up to 48 hours and, if not used, discarded. If there is any reason why it may not be used within that time it should be frozen directly after expressing.

When defrosting frozen EBM on the neonatal unit, it should be placed in the fridge to thaw gradually, labelled, with the use by date and used within 24 hours.
- Frozen EBM should be used in date order, i.e. oldest date first.
- Microwave ovens should never be used to thaw or warm EBM.
- Fortified EBM must be discarded after 4 hours (NUTH guidance).

6.2 Safe administration of EBM on the Postnatal ward and Neonatal Unit

Parents and visitors will not have access to this fridge.

The staff member will take the milk out of the fridge for the feed when it is required and complete a visual check to ensure that it is the correct milk.

Staff will ensure that the milk is administered in date and time order

Milk will always be checked by two members of staff (that have received training in relation to this) before administering or by one member of staff and a parent (if parent is administering the feed)

The following are confirmed before administration:
- MRN number
- Name
- Date and time of expression (and defrosting if required).
Once it has been confirmed that the milk removed from the fridge is the correct milk for the baby then the amount of milk required can be decanted into which ever method of feeding is being used. Both checkers must confirm that the milk once decanted is given to the correct baby before the feed is commenced or the milk handed to a parent to administer.

The date and time of milk administration and who was involved in the checking process is documented and signed for by both checkers (on the nursing chart for the Neonatal unit or the feeding chart of the baby notes for Postnatal; in adjacent comments section).

All mothers expressing breast milk on the postnatal ward should have a Neonatal care plan to document the safe administration of EBM. This does not classify the baby as high risk unless medically indicated and the midwife should document clearly at the top of the care plan the reason why the mother is expressing and the plan of care in relation to feeding (documenting that the baby is low risk and under midwifery care if required)

Staff should be mindful that babies on the neonatal unit may have their name changed following registration of birth.

Staff will ensure that parents are competent to safely label, check and administer milk before supporting parents to do so.

A flowchart detailing the relevant steps within the process is located in Appendix 2.

**6.3 Action to be taken in the event of a baby receiving another mother’s breast milk**

Despite careful checking procedures our high usage of maternal EBM risks the possibility that the ‘wrong’ milk may be given to the ‘wrong’ baby. In the vast majority of the cases the risk to the baby is absolutely trivial but there are a number of procedures to be followed.

1. Immediately inform the nurse/midwife in charge. This is a serious matter and should be dealt with quickly and sensitively. Maternal trauma should be considered. The senior nurse/midwife should inform the neonatal registrar and together they should decide whether to inform the consultant immediately or whether (outside normal working hours) that can wait until routine medical staff handover

2. If the milk had just been given shortly prior to recognition of the inadvertent administration consider aspirating the milk via the NGT and discard

3. Inform the recipient baby’s parents at the next appropriate opportunity (generally not appropriate in the middle of the night).
Consider who is best placed to do this. This is often the senior nurse, but at times the consultant might be best placed.

4. Offer a full apology and say sorry. Explain about the risk management process, and tell the parents what is likely to happen next. Explain that in >99% of cases the risk to the baby is zero.

5. Do not breach confidentiality by disclosing the name of the donor mother, but carefully describe the low risk nature of the donor where that is appropriate. To do this, you will need to check the past history of the donor mother including the results of any antenatal viral serology. Document any relevant details in the recipient baby’s notes but omit any identifying information at this stage i.e. do not include donor mother’s name or numbers.

6. If the donor EBM was from a high-risk mother then immediately inform consultant and Infectious Diseases team.

7. If the mother has a low risk lifestyle and negative antenatal serology then further testing of the donor mother may not help. However, in routine practice we would plan to repeat serology of the donor mother. Always discuss with neonatal consultant.

8. There are currently no reports in the literature of HIV transmission via incorrect EBM administration despite this event likely occurring several thousands of times worldwide.

9. If consent allows then test the donor mother for HCV, HBV and HIV after discussion with consultant virologist. Testing for CMV is not appropriate as it is prevalent and even if positive no treatment would be offered. CMV is commonly acquired in the neonatal period and is not normally associated with symptomatic disease.

10. If donor mother declines testing discuss with consultant and virology team. Breast milk testing is not validated for the commonly used testing platforms and is NOT recommended as this would constitute testing of the mother and could not be done without consent.

11. Any blood taken from the donor mother should be sent to the lab after discussion with the on call virology consultant (via extension 21104). Donor blood may well be kept for up to 2 years in the event the baby subsequently becomes unwell. (all blood is kept for 2 years if sufficient sample)

12. **HCV**: rarely transmitted via EBM. If the mother was positive (or declines a blood test) then organise for HCV PCR at 3-6 months post-exposure.

13. **HBV**: rarely transmitted via EBM. If the mother is HBV positive immediately discuss with consultant and ID team and consider vaccination at 0,1,2 and 12 months. Organise to test HBsAg at 12 months of age. There is a case for giving HBlg if the donor mother was HBeAg positive, despite the low risks involved. This can be obtained via virology.

14. **HIV**: mothers who are known to be HIV positive are encouraged not to express EBM. In the rare situation where a HIV+ mother expresses, the milk should NEVER be stored on ward 35. If a donor mother was not known to be HIV+ but this is identified on subsequent testing immediately discuss with Infectious Diseases
team. Depending on donor viral load, post-exposure prophylaxis may be appropriate.

15. Complete a DATIX form and include both mothers' MRN numbers on form.

16. Carefully and sensitively explain and apologise to the donor mother even when no further testing is indicated.

A flow chart detailing the relevant steps in relation to what measures should be taken in the event of the wrong EBM being given to a baby is located in Appendix 4.

7 Training

All professional and support staff who have contact with pregnant women and mothers will receive training in breastfeeding management (which covers expression and storage of breast milk) at a level appropriate to their professional group. New staff will receive training within six months of taking up their posts.

Medical staff have a responsibility to promote breastfeeding (and therefore expression of breast milk) and provide appropriate information and support.

A teaching curriculum is in place which determines the content of the education that is given to all staff.

The responsibility for providing training lies with the Infant Feeding Co-ordinator.

In accordance with the training needs analysis the Infant Feeding Co-ordinator will ensure all relevant staff are allocated to attend the appropriate training, maintain records of attendance and ensure the existing process is maintained for following up non-attendees.

The Infant Feeding Coordinator will audit uptake and efficacy of the training and publish the results on an annual basis presenting findings to the audit group.

8 Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

9 Monitoring

The maternity service continually strives to achieve 100% compliance with this policy and its intended outcomes. Where this is not met an action plan will be formulated and agreed by the overseeing committee and reviewed by them until completion. Please see the table below for standards and monitoring arrangements.
<table>
<thead>
<tr>
<th>Standards</th>
<th>Monitoring and audit</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>All mothers who are wishing to breastfeed/establish lactation and are unable to breastfeed will be shown how to hand express as soon as possible after birth (within 6 hours)</td>
<td>This will be audited using the UNICEF Baby Friendly audit tool</td>
<td>Infant Feeding lead NICU/infant feeding coordinator</td>
<td>CIRG</td>
</tr>
<tr>
<td>All mothers who are separated from their babies will have an informed decision regarding the benefits of breast milk within 6 hours of delivery (unless clinical indication prevents this)</td>
<td>This will be audited using the UNICEF Baby Friendly audit tool</td>
<td>Infant Feeding lead NICU/infant feeding coordinator</td>
<td>CIRG</td>
</tr>
<tr>
<td>Mothers will be advised to hand express for 48 hours before commencing mechanical expression (unless clinically indicated /informed choice otherwise)</td>
<td>This will be audited using the UNICEF Baby Friendly audit tool</td>
<td>Infant Feeding lead NICU/infant feeding coordinator</td>
<td>CIRG</td>
</tr>
<tr>
<td>Mothers will be advised to express at least 8-10 times in 24 hours including at least once per night if they are unable to feed their baby.</td>
<td>This will be audited using the UNICEF Baby Friendly audit tool</td>
<td>Infant Feeding lead NICU/infant feeding coordinator</td>
<td>CIRG</td>
</tr>
<tr>
<td>All mothers who are expressing with an electrical breast pump will be shown how to do so effectively and safely.</td>
<td>This will be audited using the UNICEF Baby Friendly audit tool</td>
<td>Infant Feeding lead NICU/infant feeding coordinator</td>
<td>CIRG</td>
</tr>
<tr>
<td>All mothers with a baby on the neonatal unit will be shown the facilities in the expression rooms on ward 35 within 24 hours of delivery (or as soon as clinically indicated)</td>
<td>This will be audited using the UNICEF Baby Friendly audit tool</td>
<td>Infant Feeding lead NICU</td>
<td>CIRG</td>
</tr>
<tr>
<td>Initiation of breastfeeding will be documented on the Euroking E3 system on discharge of the mother</td>
<td>This will be monitored using process out into place on the E3 Maternity system</td>
<td>Infant feeding Coordinator</td>
<td>CIRG</td>
</tr>
<tr>
<td>Standards</td>
<td>Monitoring and audit</td>
<td>Method</td>
<td>By</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Following transfer home mothers with a baby on the neonatal unit will be provided with specialist equipment to assist them to express their breast milk</td>
<td>This will be monitored using internal monitoring process</td>
<td>Infant Feeding lead (NICU)</td>
<td>CIRG</td>
</tr>
<tr>
<td>Specialist support will be provided as required from the IFL (NICU), IFC or Nursery Nurse</td>
<td>This will be audited using the UNICEF Baby Friendly audit tool</td>
<td>Infant Feeding lead NICU/infant feeding coordinator</td>
<td>CIRG</td>
</tr>
<tr>
<td>All expressed breast milk will be labelled, stored and administered correctly</td>
<td>This will be audited using an internal monitoring process</td>
<td>Ward 35 – Infant Feeding Lead NICU Postnatal-Nursery Nurse/ Infant Feeding Coordinator</td>
<td>Management team</td>
</tr>
<tr>
<td>All staff will attend training according to their role in relation to Infant feeding</td>
<td>Staff training compliance report, Annual Assurance Report – overview of the delivery of the training programme</td>
<td>TNA Lead</td>
<td>CIRG</td>
</tr>
<tr>
<td>The directorate will ensure that all staff have received training according to their role in relation to infant feeding</td>
<td>&quot;Training Needs Analysis; for staff that care for women and the newborn&quot;</td>
<td>Directorate Management team</td>
<td>CIRG and Corporate Governance Committee</td>
</tr>
<tr>
<td>All babies receiving expressed breast milk will receive the correct breast milk</td>
<td>Review of all incidents where a baby was given the incorrect breast milk</td>
<td>Matron postnatal/Ward 35</td>
<td>CIRG</td>
</tr>
</tbody>
</table>

10 Consultation and review

This document was reviewed by the Infant Feeding Coordinator, Infant Feeding Lead for the Neonatal Unit, Senior Midwives for Postnatal, the management team and the Neonatal consultants. It was also reviewed by CIRG prior to ratification.
11 Implementation (including raising awareness)

This policy will be implemented following a period of awareness raising. It will be publicised in the directorate newsletter, via e-mail to all relevant staff, discussed at team meetings and via the postnatal forum. Following a period of awareness raising the guideline will be implemented.

12 References


13 Associated documentation

Review of the following guidelines may also be helpful:

- Feeding Room guidelines
- Hypoglycaemia - feeding management in vulnerable infants
- Hypoglycaemia- Flow chart
- Infant Feeding Guideline
- Management of babies at delivery and on the Postnatal ward
- Management of Babies in the Birth Centre
- Vulnerable infant-identification & management on postnatal wards
Appendix 1: Expression of Breast Milk Flow Chart

Expression of Breastmilk Flow Chart

All mothers who are wishing to breastfeed/establish lactation and are unable to breastfeed will be shown how to hand express as soon as possible after birth (within 6 hours)

All mothers who are separated from their babies will have an informed decision regarding the benefits of breastmilk within 6 hours of delivery (unless clinical indication prevents this)

Mothers will be advised to hand express for 48 hours before commencing mechanical expression (unless clinically indicated/informed choice otherwise)

Mothers will be advised to express at least 8-10 times in 24 hours including at least once per night if they are unable to feed their baby.

All mothers who are expressing with an electrical breast pump will be shown how to do so effectively and safely.

All mothers will be provided with written information on how to contact professional and lay support within 6 hours of delivery

All mothers with a baby on the neonatal unit will be shown the facilities in the expression rooms on ward 35 within 24 hours of delivery (or as soon as clinically indicated)

Initiation of breastfeeding will be documented on the Euroking E3 system on discharge of the mother

Following transfer home mothers with a baby on the neonatal unit will be provided with specialist equipment to assist them to express their breastmilk.

Specialist support will be provided as required from the IFL (NICU), IFC or Nursery Nurse
### Appendix 2: UNICEF Audit Tool

**Expression of Breast Milk checklist; complete on day 3, 10 and 21 (and at any point a problem is identified). File in baby notes.**

<table>
<thead>
<tr>
<th>What to observe/ask about</th>
<th>Answer indicating effective expressing</th>
<th>Answer suggestive of a problem</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother’s name:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baby’s name:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Date of birth:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Date of assessment:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Birth weight:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gestation:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Frequency of expression</strong></td>
<td>At least 8 times in 24 hours including once during the night</td>
<td>Fewer than 8 times. Leaving out the night expression.</td>
</tr>
<tr>
<td><strong>Timings of expressions</strong></td>
<td>Timings work around her lifestyle with no gaps of longer than 4 hours (daytime) and 8 hours (night time)</td>
<td>Frequent long gaps between expressions. Difficulty 'fitting in' 8 expressions in 24 hours.</td>
</tr>
<tr>
<td><strong>Stimulating milk ejection</strong></td>
<td>Uses breast massage, relaxation, skin contact and/or being close to baby. Photos or items of baby clothing to help stimulate oxytocin.</td>
<td>Difficulty eliciting a milk ejection reflex. Stressed and anxious.</td>
</tr>
<tr>
<td><strong>Hand expression</strong></td>
<td>Confident with technique. BLISS booklet provided</td>
<td>Mother not confident/does not wish to hand express</td>
</tr>
<tr>
<td><strong>Using a breast pump</strong></td>
<td>Access to electric pump. Effective technique including suction settings, correct breast shield fit. Switching breasts (or double pumping) to ensure good breast drainage. Uses massage and/or breast compression to increase flow</td>
<td>Concern about technique. Suction setting too high/low, restricting expression length, breast shield too small/large.</td>
</tr>
<tr>
<td><strong>Breast condition</strong></td>
<td>Mother reports breast fullness prior to expression which softens following expression. No red areas or nipple trauma.</td>
<td>Breasts hard and painful to touch. Evidence of friction or trauma to nipple.</td>
</tr>
<tr>
<td><strong>Milk flow</strong></td>
<td>Good milk flow. Breasts feel soft after expression.</td>
<td>Milk flow delayed and slow. Breasts remain full after expression.</td>
</tr>
<tr>
<td><strong>Milk volumes</strong></td>
<td>Gradual increases in 24 hr volume at each assessment.</td>
<td>Milk volumes slow to increase or are decreasing at each assessment.</td>
</tr>
</tbody>
</table>

If any responses in the right hand column are ticked refer to specialist practitioner. Any additional concerns should be followed up as needed.

"Hand expression may not need to be reviewed every time"
<table>
<thead>
<tr>
<th>Date</th>
<th>Information/support provided</th>
<th>Name/Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Within 6 hours of delivery (before transfer from delivery suite) provide information on the benefit of breast milk for all babies including those that are premature/ Vulnerable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within 6 hours of delivery (before transfer from delivery suite) provide Start for life leaflet/ Bliss leaflet and contact numbers sheet</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within 6 hours of delivery (before transfer from delivery suite) provide demonstration of hand expression and give mothers hand expression packs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Checklist completed on day 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Checklist completed on day 10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Checklist completed on day 21</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Taken from sample expression form UNICEF UK Baby Friendly Initiative 2013
Appendix 3: Labelling, Storage and Administration of Expressed Breast Milk (EBM)

Expressed Breast Milk (EBM)
Obtained from Mother

Labelling of EBM
Immediately following expression the mother labels the EBM bottle with the baby’s:

- MRN,
- Name
- Date of expression
- Staff will offer assistance if required with documentation

EBM Fridge
- Kept locked or in room only staff can access
- Maintained at temperature 2-4c
- Stored for a maximum of 48 hours
- Defrosted EBM should have date and time defrosted written on label, stored maximum of 24 hours in fridge
- All EBM bottles stored on foil tray with babies addressograph label
- Nurse/Midwife checks EBM bottle is labelled correctly before placing in appropriate tray in EBM Fridge

Administration
1. EBM is removed from fridge by member of staff when required
2. The milk is taken to the cot side in the original bottle and checked by either two staff members or a staff member and the parent
3. Confirm that the milk is the correct milk for the baby by checking:
   - MRN number
   - Name
   - Date and time of expression (and defrosting if required)
4. Both checkers must remain at cot side until this has been checked, verified, the feed commenced (or the EBM given to the mother to administer) and the relevant documentation signed.
Appendix 4: Action to be taken in the event of a baby receiving another mother’s milk

- Aspirate NGT and discard contents

- Nurse/Midwife-in-charge to inform duty registrar – see note 1

- Consultant or Senior nurse to inform recipient baby’s parents at next appropriate opportunity – see notes 4 & 5

  - High risk donor mother

  - Low risk donor mother

  - Inform Infectious Diseases team

  - Consider repeat maternal serology – see notes 6-14

  - Apologise to donor mother

  - Complete Datix form
    See note 15
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. Assessment Date: 7/2/17

2. Name of policy / strategy / service:
   Expression & Storage of breast milk policy

3. Name and designation of Author:
   Helen Smith - Infant Feeding Nurse / Lynne Mcdonald – Infant Feeding Co-ordinator

4. Names & designations of those involved in the impact analysis screening process:
   Helen Smith - Infant Feeding Nurse/ Lucy Hall Equality and Diversity Lead

5. Is this a: Policy X Strategy [ ] Service [ ]
   Is this: New [ ] Revised X
   Who is affected Employees X Service Users X Wider Community [ ]

6. What are the main aims, objectives of the policy, strategy, or service and the intended outcomes? (These can be cut and pasted from your policy)
   This document provides guidance for staff caring for mothers and infants in the maternity unit and community setting. It may also be helpful for staff in other directorates caring for mothers and new born babies. This document aims to ensure that all women are provided with appropriate advice and care in relation to expressing their breast milk and that staff are able to provide safe and appropriate care which minimises any associated risks when storing and administering EBM.

7. Does this policy, strategy, or service have any equality implications? Yes X No [ ]
   These have been taken into account in the policy.
   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

[Blank space for additional comments]
8. Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
</tr>
</thead>
</table>
| Race / Ethnic origin (including gypsies and travellers) | Mandatory EDHR Training  
Provision of Spoken Language Interpreters | Minority ethnic women may need communication support to understand EBM process. | Add to point 6  
To support this discussion some mothers will need communication support such as spoken language interpreting. |
| Sex (male/ female) | Mandatory EDHR Training | No | No |
| Religion and Belief | Mandatory EDHR Training | No | No |
| Sexual orientation including lesbian, gay and bisexual people | Mandatory EDHR Training | No | No |
| Age | Mandatory EDHR Training | No | No |
| Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section | Mandatory EDHR Training  
Provision of BSL Interpreters and support for people who are hard of hearing. Learning Disability Liaison Nurse. | Disabled mothers may need support and communication support to understand EBM process. | Add to pint 6  
To support this discussion some mothers will need communication support such as British Sign Language interpreting. Staff will adapt the procedure to accommodate mothers who are disabled. The Learning Disability Liaison Nurse can be contacted to discuss any specific issues relating to mothers with a learning disability. |
| Gender Re-assignment | Mandatory EDHR Training | No | No |
| Marriage and Civil Partnership | Mandatory EDHR Training | No | No |
9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes  No  X

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

No

PART 2

Name: Helen Smith

Date of completion: 7/2/17

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)