GUIDELINE

Breastfeeding

Scope (Staff):	Nursing and Medical Staff
Scope (Area):	NICU KEMH, NICU PCH, NETS WA

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this disclaimer

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Aim

The aim of this policy is to protect, support and promote breastfeeding in the preterm and/or vulnerable infant. This includes supporting mothers to achieve their breastfeeding goals.

Risk

Lack of adherence to this policy may lead to decreased rates of breastfeeding, and the resulting increased use of Pasteurised Donor Human Milk (PDHM) and artificial formula. This includes mothers not meeting their breastfeeding goals at discharge.

Principles

- Breast milk is specifically designed for human infants with both the mother and infant gaining physically and emotionally from the breastfeeding experience.
- Breast milk has the correct biochemical constituents necessary for optimal growth and development and assists in the prevention of respiratory and intestinal infections and the onset of allergies.
- Premature and some surgical infants may require individually tailored fortification of human milk to reach recommended intakes and acceptable growth rates.

Health Benefits for the Infant

- Greater enteral feeding tolerance and more rapid achievement of full enteral feeds.
- Reduced risk and severity of infection both short and long term.
- Reduced risk and severity of necrotising enterocolitis.
- Reduced risk of atopic disease for infants with family risk histories.
- Enhanced retinal maturation and visual acuity.
- Enhanced developmental and neurocognitive outcomes.
- Greater physiological stability during breastfeeding compared to bottle feeding.

Health Benefits for the Mother

- Breastfeeding stimulates the uterus to contract, thus aiding the involution process and reducing the risk of postpartum haemorrhage.
- Breastfeeding reduces the risk of breast cancer and epithelial ovarian cancer.
- Psychological significance of making a unique contribution to the care of their preterm or sick infant by expressing and breastfeeding.

Breastfeeding the Preterm Infant

The following information refers predominately to breastfeeding of preterm infants. For information on establishing lactation, breastfeeding the well term infant, breastfeeding challenges or suppression of lactation refer to KEMH Obstetric Newborn Feeding and Maternal Lactation guideline.
Refer to Breastfeeding Surgical Neonates Post Abdominal Surgery guideline for neonates undergoing or have underwent abdominal surgery and Transition to Oral Feeding for High-Risk Infants in the Neonatal Intensive Care Unit guideline for high risk infants at NICU PCH 3B.

Key Points

- Any mother planning to breastfeed who is separated from her infant needs to start expressing to establish lactation.
- The first expression should be in the first hour after delivery of her infant and then around every 3-4 hours, culminating in 7–8 times each day including at least once overnight.
- Ensure that prior to the mother's discharge from hospital, she is provided with information regarding expressing, labelling, transporting and storage of breastmilk, loan/purchase of breast pumps and related equipment, and access to expressing facilities within the nursery, and of the community-based breastfeeding support and information services available.
- Vitamin D supplementation is recommended for preterm infants <35 weeks' gestation and for all term infants receiving unfortified breast milk exclusively. Refer to Vitamin D (Colecalciferol) Supplementation in the Neonate and Colecalciferol (Vitamin D) Neonatal medication monograph.
- Use the FICare Communication Board for the infant to ensure that communication between staff and parents is facilitated.
- Mothers are to be provided with continuing access to support and information about the establishment and maintenance of lactation, breast and nipple care, and positioning and attachment. Breastfeeding is to be introduced at a pace that matches the infant's energy reserves and ability to suck.
- Infants and their mothers are individuals and therefore these are guidelines only. Advice should be sought from the Lactation Consultants if breastfeeding challenges are evident.
- Introductory suck feeds are to be breast feeds; early breastfeeding is less physiologically stressful than is early bottle feeding. The infant has a greater ability to control the flow of milk during breastfeeding and has more stable patterns of oxygenation.
- Breast experiences with skin to skin can begin from 28 – 30 weeks in all infants who are medically stable including those on CPAP and HHF.

  - Increasing suck strength may occur from 30 – 32 weeks. From 34 weeks gestation onwards, the ability to co-ordinate sucking, swallowing and breathing improve as the infant matures.
  - Breast experiences can occur as often as the mother is available and are not limited to once per day. Be guided by the infant's state and cues e.g. If awake can offer a chance to breastfeed. If the infant shows signs of tiredness, then allow the baby to rest and complete the feed with the gastric tube.

- Encourage the mother to have skin to skin contact with her infant, preferably for at least 30 minutes before a breastfeed (the infant may be tube fed in this position if required).
  - Infants in skin-to-skin contact make rooting and mouthing movements and move toward the nipple, while mothers frequently report feelings of milk ejection, leaking, and expression of larger milk volumes following skin to skin cuddling.
- Initial introductions to the breast often involve non-nutritive sucking (ideally just after the mother has expressed), with a gradual transition to nutritive sucking.
- It is preferable that orogastric inserted tubes be replaced with nasogastric inserted tubes when the infant shows increased readiness to suck as this facilitates the correct sucking action.
  - Where this is not possible, it is preferable that the OGT is taped to the top lip.

Signs of readiness to suck may include

- Sucking on a feeding tube or pacifier.
- Rooting reflex.
- Swallowing own saliva.
- Putting their fist in their mouth.
- Resisting gavage feeds.

Positioning and Attachment

Positioning relates to the way in which the infant is held in relation to the mother's body whilst breastfeeding.

Attachment refers to whether the infant has enough areola and breast tissue in their mouth.

- There needs to be sufficient breast tissue in the infant's mouth for effective sucking and milk transfer to take place.
- This initiates effective sucking and swallowing.

- After the feed, the mother's nipple should look as it did before - not compressed, elongated or misshapen.

Assisting mothers to consistently achieve correct positioning and attachment of their infant at the breast results in greater success at breastfeeding.

Positioning at the breast is a learned skill acquired from instruction and/or observation of correct technique.

- Mothers should be shown positioning and attachment using a "hands off" approach so that they develop confidence and skill in their ability to independently position and attach the infant.

Recommended Positions for the Mother

- Assist the mother to find a feeding position she finds comfortable. This position should support her back and shoulders.
- Ensure the mother's feet are supported i.e. her lap is flat. A footstool may be beneficial particularly for shorter women.
- Facilitate privacy. Position chair away from the room and/or use privacy screens if required by the mother.
- Ask the mother if she has a preference for which breast she would like to begin with.

Position of the Infant

- Preterm infants should be breast fed in a position that gives support to the head and neck such as, across the lap (transitional hold), or the underarm (football) hold. As the head of the preterm infant is heavy in relation to the musculature of the neck, the base of the head needs to be supported. Undirected head movements can easily collapse the airway resulting in apnoea and bradycardia.
- Consider the use of a thin, firm pillow to help support the positioning of the infant at the breast and/or protect a tender abdomen post LUSCS. Check with the mother to determine if the pillow is required.
- If the mother's breasts are full, the mother may need to express in order to offer her infant a softer breast with a smaller amount of available milk. This aids attachment to the breast and can help reduce the fast flow with the initial milk ejection of her milk. As the infant learns to breast feed, more milk can be left in the breast.
- To help the infant attach to the breast, the mother can shape her breast using her thumb and fingers ('C' hold).

Correct attachment will usually take more than one attempt.

Signs of Correct Positioning and Attachment

1. Infant's chest in close contact with mother's chest.

2. Head is slightly extended, with the chin pressed into the breast.
3. The nose is free without the mother holding back her breast.
4. Mouth sealed around the breast.
5. Absence of clicking sounds.
6. Absence of dimpling in infants' cheeks.
7. Movement of whole jaw with muscular movement visible around ears.
8. Once infant is attached and sucking effectively there is **no nipple pain or trauma.**

Signs of Poor Attachment

- During breastfeeding nipple pain is not normal and indicates tissue damage is occurring.
    - Correct positioning and attachment minimise the risk of nipple trauma.
- Any nipple trauma should be documented in the mother's clinical pathway, by Lactation Consultant.
- There are many causes of nipple trauma, incorrect positioning and attachment is the most common cause. Other causative factors include high arched palate, ankyloglossia (tongue-tie) and dermatological conditions.
- Nipple trauma increases pain and predisposes the mother to other complications.

For further information refer to KEMH Obstetric guideline Breastfeeding Challenges - Nipple Trauma

Using Nipple Shields for Preterm Infants

Until recently it was believed that nipple shields contributed to a reduction in milk transfer and possibly a reduction in supply. Recent research however has shown that the use of nipple shields for preterm or small infants, who are unable to maintain attachment, can reduce infant fatigue and increase milk transfer and duration of breastfeeding.

Not all mothers of preterm infants will benefit from the use of a nipple shield.

- If the use of a nipple shield is being considered, refer to the Lactation Consultant / Midwife and discuss the problem prior to implementation.
- The mother's milk supply and corrected gestational age of the infant needs to be considered.

Recommended Use

Nipple shields can facilitate attachment of the infant to the breast in:

- Preterm infants who are unable to sustain correct attachment at the breast (constantly slip off the breast).

- Preterm infants who fall asleep as soon as they are attached and are unable to maintain regular nutritive sucking.
- Flat or inverted nipples with repeated failure to achieve attachment with an alert infant.

Key Points

- Ensure mother has an adequate milk supply.
- Ensure mother is aware of and agrees to the use of a nipple shield.
- Choose appropriate size shield for the infant's mouth.
- At KEMH place nipple shield referral in Lactation Consultants book in SCN2 or 2West.

Nipple Shield Sizing Guide	
Small	< 2Kg
Medium	2 – 3Kg
Large	> 3Kg

- To fit shield, ask the mother to express a few drops of milk into the shield and around the areola. The shield should be applied centrally over the nipple, the cut-out area being placed where the infant's nose will be positioned. Stretch the shield to allow the nipple to be drawn in.
- The nipple shield should be washed in hot soapy water, rinsed and dried after each use and stored in a clean container under the infant's cot.
- Document indication for use and its effectiveness in the infant's notes; review the need to continue daily.

Preterm infants will require the nipple shield until they are able to maintain attachment for adequate milk transfer for the whole feed. This may be until approximately term corrected age or longer.

Try to give direct contact with breast before and after nipple shield use.

If nipple shields are used at discharge ensure appropriate follow-up is arranged e.g. Neonatal Home Visiting Nurse (for follow-up program/special needs babies), KEMH Breastfeeding Centre or Child Health Nurse.

Further information on the use of nipple shields can be found in WNHS Newborn Feeding and Maternal Lactation Guideline.

Increasing the Number of Breastfeeds

It is important to increase breastfeeding opportunities as the infant demonstrates increasing energy reserves. Increase at a pace that matches the infant's ability to attach and suckle at the breast. The infant will demonstrate increased interest in sucking by eliciting signs of readiness to suck.

Signs of readiness to suck may occur as early as 28- 30 weeks gestation but generally occurs from 34 weeks gestation onwards as the ability to coordinate sucking, swallowing and breathing improves around this time.

Discuss with the mother the need to increase the number of breastfeeds. Explain semi-demand feeding and the need for her to be available as her infant may be interested in feeding again less than 3 hours following a breastfeed. Ensure the mother is aware of the hospital crèche facilities, parent lounge, and dining room meals.

To facilitate discharge, it may be appropriate to give bottle feeds of expressed breast milk to the infant if the mother is unavailable to breastfeed when her infant is awake and demanding a suck feed e.g. at night.

- Generally, this may occur from 34 weeks **only after consent from the mother.** The choice of teat for a breastfeeding infant is one that allows the infant to coordinate their suck/swallow/breathe at a pace that ensures respiratory stability. See Nutrition: Bottle Feeding a Breastfeeding Infant.

Always negotiate and review the feeding plan with the mother and document in the medical records and on the FICare Communication Board. If a breastfeeding plan has been developed, review changes in this plan with the Lactation Consultant.

Breastfeeding Challenges

For the following breastfeeding challenges, such as blocked ducts, breast engorgement, oversupply, and flat or inverted nipples refer to KEMH Obstetric Newborn Feeding and Maternal Lactation Guideline.

Refer mothers and infants experiencing breastfeeding challenges to the NICU Lactation Consultant/Lactation Advisor (KEMH), Lactation Consultant/Advisor or Midwife (3B) together with members of the nursing staff experienced with breastfeeding.

It is expected that mothers will be expressing up to 7 times in 24 hours and obtaining 500-800 mL/day by the end of the 2nd week in order to establish and maintain their supply. If they have a low supply, refer to lactation consultant.

The use of a Supply Line maybe considered as an adjunct support for breastfeeding mothers in specific circumstances. Refer to the Lactation Consultant guideline.

For management of mastitis refer to: KEMH Obstetric guideline Mastitis and breast abscess management

A breastfeeding care-plan is to be used for long term infants and those with special needs.

Include the following:

- The timing of breastfeeds.

- Specific requirements for positioning and attachment e.g. transitional hold, use of a footstool, nipple shield, chair selection
- The need for top-up feeds following breastfeeds.

Preparation for Discharge

Prior to discharge home ensure that the mother has the skills and knowledge to enable her to continue breastfeeding her infant at home.

Ask the Mother the Following Questions:

1. Do you understand the transition process to all breast feeds at home?
2. Can you breastfeed your infant independently preferably 3 hourly / to demand and demonstrate correct positioning and attachment?
3. Do you understand the need to express for comfort after breastfeeding, until supply = demand?
4. Can you recognise the effective nutritive sucking pattern of your infant and the signs that he/she is getting enough breast milk?
5. Do you understand the concepts of milk ejection reflex, infant led feeding, supply = demand?
6. Have you developed realistic expectations of your infant's needs and feeding behaviours in the home environment and understands that he/she will feed frequently at home i.e. eight times in a 24-hour period?
7. Are you aware of effective settling techniques?
8. Have you had the option to room in with your infant for a minimum period of 24 hours prior to discharge?
9. Can you competently bottle feed your infant, if required?
10. Do you have a pumping equipment organised for home?

Ensure contact details are given for community-based breastfeeding supports such as

- KEMH Breastfeeding Centre (for infants born at KEMH)
- SCN Home Visiting Nurse (infants <35 weeks or <1800g, or exceptional referrals)
- Local Child Health Nurse
- Australian Breastfeeding Association.

NICU Lactation Clinic - KEMH

- The Lactation clinic runs on Wednesdays by appointment from 8-4pm for any mothers and their babies who have been admitted to KEMH NICU.

- Appointments are made by LCs only.
- In clinic/Telehealth/phone call or text support available.
- Pamphlets are given to mothers prior to discharge by the LC or discharge coordinator and are available on 2West.

Mothers with a supply in excess of her infant's needs, will need to wean expressing to avoid blocked ducts and possible mastitis. They may need to hire a breast pump for home use. Discuss with lactation consultant, milk room nurse (KEMH) or discharge coordinator to consider pump hiring options.

Related CAHS internal policies, procedures and guidelines

Neonatology Clinical Guidelines

- Breastfeeding Surgical Neonates Post Abdominal Surgery
- Lactation Consultant
- Nutrition: Bottle Feeding a Breastfeeding Infant
- Transition to Oral Feeding for High-Risk Infants in the Neonatal Intensive Care Unit (NICU)
- Vitamin D (Colecalciferol) Supplementation in the Neonate
- Colecalciferol (Vitamin D) Neonatal

WNHS Obstetric Guidelines

- Newborn Feeding and Maternal Lactation
- Mastitis and Breast Abscess Management

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Useful resources
Breastfeeding Education Tools
Consumer Information – Domperidone to increase milk supply

This document can be made available in alternative formats on request.

Document Owner:	Neonatology		
Reviewer / Team:	Neonatology Coordinating Group / Neonatology Lactation Consultants		
Date First Issued:	June 2006	Last Reviewed:	October 2025
Amendment Dates:	May 2025- Supply line link added. October 2026 – Vitamin D supplementation and medication monograph links	Next Review Date:	October 2028
Approved by:	Neonatology Coordinating Group	Date:	28th October 2025
Endorsed by:	Neonatology Coordinating Group	Date:	
Standards Applicable:	NSQHS Standards: Child Safe Standards: 1,10		
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