Use of Donor Breast Milk on the Neonatal Unit

A Clinical Guideline

For Use in: Neonatal Intensive Care Unit (NICU) and Maternity Department

By: All Nursing, Midwifery and Medical Staff

For: Neonates

Division responsible for document: Women and Children’s Services

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Description of changes: Changes to paragraph 9 on page 4 - Informal Milk Sharing (use of donor milk outside of a registered Milk Bank)

Compliance links: (is there any NICE related to guidance) NICE clinical guidelines (2010) Donor milk banks: the operation of donor milk bank services. CG93

If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why? No
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Quick reference guide for which babies may be suitable for Donor Breast Milk

<table>
<thead>
<tr>
<th>Premature Infants</th>
<th>More mature infants who fit these criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babies &lt;30 weeks</td>
<td>Unstable ventilated babies</td>
</tr>
<tr>
<td></td>
<td>Post major abdominal surgery/recovering from necrotising enterocolitis (NEC)</td>
</tr>
<tr>
<td></td>
<td>Consistently Absent/ Reversed End Diastolic Flow on antenatal Doppler studies</td>
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<tr>
<td></td>
<td>Preterm significantly Small for Gestational Age babies (&lt; 2\textsuperscript{nd} centile and &lt; 34/40 gestation at birth.)</td>
</tr>
<tr>
<td></td>
<td>Haemodynamically unstable babies who have required prolonged inotropic support.</td>
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<tr>
<td></td>
<td>Hypoxic Ischaemic Encephalopathy (requiring total body cooling)</td>
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<tr>
<td></td>
<td>In extraordinary circumstances the Infant Feeding Coordinators may request short term use of DBM for specific reasons. They will keep under review any mother needing to supplement with DBM.</td>
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</tbody>
</table>

1. Objectives

To provide guidance as to which babies should be offered donor breast milk (DBM) on the NICU and the maternity unit and on the duration of its use.

2. Rationale

- To protect the culture of breast feeding on the NICU and the Maternity Unit and to minimise both the short and long term risks associated with giving cow's milk protein to neonates
- There are multiple advantages for the baby when using breast milk compared to formula including the reduced risk of NEC. There have been no documented cases of disease transmission from donor milk provided by a milk bank operating under standard practice (Arnold)

3. Broad recommendations

- The best milk for a baby is its mother's own breast milk.
- Nurses, midwives or neonatologists can take the lead equally in emphasising the benefit of exclusive use of human milk for all babies and the particular importance of human milk for the ‘at risk’ baby. Good joint working and communication are encouraged
- Every effort should be made to help mothers express their milk as soon as possible following birth, as their expressed breast milk (EBM) is the preferred enteral feed. The medical and nursing staff looking after the baby should ensure this is communicated to the parents and the staff on the delivery suite and/or the postnatal ward and that on-going lactation support is provided
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- The use of donor breast milk (DBM) should be considered for eligible infants (see section 4) where the mother has a short-fall in her milk supply. Full support for lactation should be on-going to enable her milk supply to be increased sufficiently to provide milk for her baby. The use of DBM should be time limited, with clinician’s discretion depending upon individual circumstances (see Section 7)

- The support of excellent expressing skills is implicit throughout the period of low milk supply. DBM should not be used in place of effective support to establish lactation, but to complement skilled help

4. Which babies MAY be eligible for donor breast milk?

- For eligibility criteria, please see Table 1

- In the event of supplies being limited for these babies, DBM will be allocated at the clinician’s discretion

5. Consent for use of donor breast milk (DBM)

- Written consent for the use of DBM should be sought from the mother and recorded together with the feeding intention in the baby’s notes – see Appendix A and B

6. Documentation and traceability

- Each bottle of donor milk is labelled with a batch number to ensure traceability

- The DBM profoma must be filled in for every baby who is given DBM. When a new bottle of DBM is removed from freezer, the batch number and baby’s details must be recorded on the list on the fridge, as well as on the DBM profoma to allow traceability

- A copy of the DBM profoma must be copied and put in DBM file (at front desk) at discharge

7. How long to use DBM

- The use of DBM must be time limited. Every effort must be made to support mother’s lactation to enable her milk supply to be increased and the use of DBM be discontinued

- In the event of persistent low milk supply despite on-going optimal lactation support, it would be reasonable to offer DBM until full enteral feeds are achieved. Longer use of DBM may be warranted in individual cases at the consultant’s discretion

- If transfer is planned to another hospital, inform the donor milk provider and recipient hospital. It may be possible to send a small supply with the baby

8. Grading on to formula on NICU

- Ideally support with DBM will coincide with lactation and growing volumes of maternal milk, allowing this to replace the need for DBM. In the event that there is an insufficient volume of maternal milk, further support with lactation must be offered

- Should the use of formula be required, the following grading plan should be used:
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- Start with ¼ formula for 24hr
- Increase by ¼ every 24hr as tolerated i.e. re-grading should take 3 days

9. Informal Milk Sharing (use of donor milk outside of a registered Milk Bank)

- In recent years, increasingly, mothers who are unable to breastfeed or supply enough of their milk for their full term, healthy babies have come to use networks developed through the internet to obtain breastmilk. These connect them with mothers who wish to share or to sell their milk. Human milk, when shared outside milk banks that follow accepted guidelines, does not provide the same safety guarantees and the possibility of serious adverse consequences cannot be ruled out

- The main risks of sharing milk are that it is contaminated with pathogenic bacteria as a result of suboptimal collection, storage and transportation or that it contains viruses as a result of the mother having unknown infections which may be transmitted via the milk. These include viral infections such as HIV, Hepatitis or HTLV (Human T Lymphotropic Virus). In addition, the shared milk may contain medications taken by the mother as well as alcohol, nicotine, drugs and other contaminants

- Harmful bacteria ingested in large quantities through breastmilk may lead to severe infections including septicaemia. Viruses such as HIV and HTLV in breastmilk can cause serious illnesses, some of them manifesting several years after contamination. Screening of donors, milk testing and appropriate pasteurization, as routinely done in human milk banks, greatly reduces the risks associated with sharing breastmilk

- If mothers choose to use human milk that is shared from an informal source, the health care professional should document in the baby’s health care record that they have had a discussion about the risks of this decision. They should discuss the points raised above and give a printed copy of this information to the parents

10. Clinical audit standards

- Number of babies who receive donor breast milk
- Indications for use of DBM
- Incident forms related to use of DBM
- Number of babies receiving at discretion of Infant Feeding Coordinators
- Rational for use by term babies

11. Summary of development and consultation process undertaken before registration and dissemination

This guideline was adapted from the Guidelines for the Use of Donor Breast Milk on the Neonatal Unit at Imperial College Healthcare NHS Trust by the authors listed above on behalf of the Neonatal Guidelines Group and Maternity Guidelines Committee has agreed the final content. During its development it has been circulated for comment to Heads of Wards and Departments, The Breastfeeding
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Core Group and the Neonatal and Midwifery Guideline Development Groups. Any comments received have been incorporated where appropriate into the document.

12. Distribution list/ dissemination method

- All NICU staff
- Trust Intranet

13. References/ source documents


Bliss Charter (2011) Alternatives to maternal breastmilk, Standard 6.3
Appendix A

Consent for Donor Breast Milk (DBM) for your baby

This form indicates that you:

1) Understand that the use of DBM is a temporary measure with the aim to top-up your own milk amounts. Its use is dependant on on-going medical need and availability of DBM.

2) Have read and understood the Information Leaflet (Donor Breast milk – Your Questions Answered)

3) Have had your questions answered

Indication/s for DBM ________________________________________________________________

_________________________________________________________________________

We ask that you sign below to give your consent to your baby receiving donor breast milk.

Baby’s name ________________________________________________________________

Hospital number______________________________________________________________

Date of Birth (ddmmyy) _________________________________________________________

Signature of parent or guardian ________________________________________________

(relationship) __________________________________________________________________

Date (ddmmyy) __________________ Staff counsellor ________________________
Appendix B

What is the best milk for my baby?
Your own breastmilk is the best milk for your baby.

What is donor breastmilk?
Donor milk is expressed by mothers who have more milk than their own babies need.

Why Donor Milk?
Breastmilk is more easily digested than formula milk and it helps protect your baby from infection.

Is it Safe?
Donor mothers will have been screened to be donors at breastmilk banks. Donated milk is tested for bacteria and heat treated for added protection.

What Screening Takes Place?
Donor mothers are screened for:
- Lifestyle
- Previous Medical History
- Infections

What is Lifestyle Screening?
A donor mother does not:
- Smoke
- Drink more than small amounts of alcohol
- Drink excessive number of drinks containing caffeine per day (coffee, tea or cola)
- Receive certain medications (traditional or herbal)
- Take drugs
What is important in the donor’s previous medical history?

A donor mother does not have a:
- Chronic or acute medical condition requiring certain medications
- Family history of TB
- History of having received growth hormone
- Recent history of vaccination
- Family history of CJD (however there is no evidence that CJD is transmitted through breastmilk)

What infection screening is carried out?

It is recommended in guidelines produced by UKAMB and endorsed by the Royal College of Paediatrics and Child Health that donor mothers are tested for:
- HIV 1 and 2 (viruses causing AIDS)
- Hepatitis B and C
- HTLV 1 and II (human T-cell Leukemia Viruses)
- Syphilis

How is milk collected?

Donor mothers will have been shown how to express and collect their milk cleanly.

Is the milk tested?

Every bottle of milk will have been tested to ensure that it has not become contaminated with undesirable bacteria during expression and handling.

Is the milk treated?

UKAMB guidelines recommend that all donor milk is heat treated.