# PRETERM, LATE PRETERM, LOW BIRTH WEIGHT OR SMALL FOR GESTATIONAL AGE BABY

**Keywords**: breastfeeding small baby, breastfeeding preterm, low birth weight,

## AIM

- To assist mothers and infants in achieving successful breastfeeding by providing consistent information which meets individual needs.
- To nurture a mother's knowledge and confidence in her ability to breastfeed her baby with individual challenges
- To assist midwives caring for these infants in properly managing breast feeding issues.
- To reduce the incidence of hypothermia, hypoglycaemia, hyperbilirubinaemia and excessive weight loss.

## DEFINITIONS

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| Pre-term | Less than 37 completed week's gestation at birth. |
| Late preterm | Born between 34 weeks and less than36+6 weeks. |
| Low Birth Weight | Less than 2500 g at birth |
| Small for Gestational Age | Less than the 10th percentile of birth weight for appropriate gestation at birth. |

## KEY POINTS

- These babies in postnatal settings require careful attention if management is to be effective.[1, 2]
- When admitted to a postnatal ward these babies will be in good condition and will have adapted to the extra uterine environment. If this is not the case, the baby must be transferred to the Neonatal Clinical Care Unit. Any baby requiring 28 calorie complementary feeding must be transferred to the NCCU.
- Encourage skin to skin contact as often as possible
- Generally, a small baby will require at least 8 feeds in 24 hours.[1, 2]
- These babies can appear vigorous but can tire easily and hence a maximum of handling time of 45 minutes per feed is a good guide.
- **It is vital to assist the mothers of these infants to express following feeds to ensure adequate stimulation of milk supply from the first feed.**

## MANAGEMENT[1]

1. Early feeding following birth is recommended - i.e. within 90 minutes of birth. The earlier this is done the better. **A pre second feed Plasma Glucose Level (PGL) should be performed. If the PGL is < 2.6mmol / L, inform the paediatrician and commence care as per the guideline Postnatal Ward Hypoglycaemia**
2. Discuss the frequency of feeding on the ward with the baby's mother. Document the agreed plan in the baby's chart and on the baby's observation chart. Review the plan every 24 hours or earlier if problems arise.
3. **Offer the baby a feed at least every three hours or sooner if the baby is demanding**. **If the baby does not feed within a four hour period, give EBM to the baby. The baby must be reassessed by the midwife with a view to paediatric consultation.**
4. Monitor the baby's attachment to the breast and the suck/ swallow actions to determine nutritive vs non –nutritive sucking. Breast compression may aid nutritive sucking swap sides if this is not effective. It is important to limit the time at the breast if sucking is not nutritive and commence EBM top ups. Good supervision by a midwife is vitally important. **Consult the paediatric team if you are unsure about a baby's progress.**
5. **Weigh the baby daily pre feed**, at a similar time of day, using the same scales.
6. Document the baby's urinary output and colour and frequency of bowel actions. Less than two bowel actions a day may be the first indication of poor feeding.[3]
7. These babies often have compromised sucking ability that is insufficient to initiate and maintain milk production.[4] To assist the mother in achieving an optimal milk supply and adequate weight gains for the baby, commence expressing after feeds.
8. Commence expressing after each feed if output is poor or the baby is sleepy at the breast.
9. Discuss discharge plans with the Paediatric Consultant and Lactation Consultant well prior to discharge. As a general guideline the baby must be healthy, maintaining temperature, feeding well and have had a weight gain before discharge (i.e. ≥ 30 g /day).
10. If the woman is to be discharged while expressing and giving her baby EBM feeds, discuss the loan of a breast pump and ensure there is a written plan which includes a Breastfeeding Centre appointment.

## DISCHARGE PLANNING:

1. Arrange for follow-up by Visiting Midwifery Service (VMS).
2. Ensure the mother has an appointment with the Breastfeeding Centre or Community Health Nurse for follow up

3. Visits to continue until mother and midwife are satisfied baby is feeding well and gaining weight. Prior to discharge from VMS midwife to liaise with VMS coordinator.
4. Arrange appointment with the Breastfeeding Centre if there are difficulties with breastfeeding on discharge.
5. Arrange electric breast pump loan if the baby is requiring EBM top ups after feeds.


**REFERENCES /STANDARDS**

1. Black KA H. Breastfeeding the high risk infant: Implications for midwifery management. **Journal of Midwifery & Womens Health**. 2000;45(3):238-45.
2. Walker, M. Breastfeeding the Late Preterm Infant Journal of Obstetric, Gynecologic and Neonatal Nursing, 37, 692-701. 2008
3. Brodribb W. **Breastfeeding Management in Australia**. 4th ed. NSW: Ligare Pty Ltd; 2013.
4. Lauwers, J., Swisher, A. Counselling the Nursing Mother A Lactation Consultant's Guide Sixth edition 2016


National Standards – Clinical Care is Guided by Current Best Practice
Legislation – Nil

Related Policies / Guidelines –KEMH Newborn Feeding
Other related documents – Nil

| **RESPONSIBILITY** | |
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| **Policy Sponsor** | Nursing and Midwifery Director OGCCU |
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