Guidelines for the use of Donor Breast Milk on the Neonatal Unit

The best milk for babies is the mother's own breast milk.

- Every effort should be made to help mothers express their own milk as soon as possible following delivery, as this is the preferred enteral feed.
- The nurse looking after the baby should ensure this is communicated to the parents and the staff on the postnatal ward.

Which babies should be considered for donor breast milk?

- Infants <32 weeks and/or <1500g.
- More mature babies who fit the criteria below:

1. Post abdominal surgery / recovering from necrotising enterocolitis
2. Consistently absent / reversed end diastolic flow (if less than 35^{+0} weeks gestation only)

In the event of supplies being unavailable for all these babies the following should be prioritised in the order shown:

- Babies <1000g
- Post abdominal surgery/recovering from necrotising enterocolitis
- Consistently absent/reversed end diastolic flow

How to approach initiating milk feeds in this group?

- As in all preterm infants, speak to the mother (with the father if available) about the importance of mother's own breast milk, during antenatal counselling if possible, and otherwise soon after admission to the unit. After admission, also speak to them about how best to express (ask someone who is better qualified, such as a neonatal nurse if necessary).
- In the above groups, ask for consent to use donor breast milk if needed soon after admission to the unit.
- Ensure that mothers are given support in expressing MEBM, and feed the baby whatever amount is available even if it is only a few drops as soon as the baby is considered ready for enteral feeds, ideally as the first feed.
- If in the above groups, insufficient MEBM is available at 24 hours, consent for DEBM and start between 24-48 hours.
- After 48 hours in a baby receiving MEBM, any shortfall should be made up with DEBM. Ideally, MEBM and DEBM should be mixed at each feed to enable the baby to get the benefit of the lipases in unpasteurised MEBM, which will result in better fat absorption.

How long to use

- Until 30 weeks CGA, then transition to preterm formula if required.
- If started in infants 27-31+6 weeks gestation continue for 3 weeks, after which DEBM will be replaced by preterm formula unless discharge planning ongoing.
- Breast milk fortification may be required.

Grading on to formula

- Start with ¼ formula for 24hr
- Increase by ¼ every 24hr as tolerated ie, regrading should take 3 days

Authors James Boardman, Hester Blaire
Implementation date 17 6 20 Review date 17 6 30