Donor Breast Milk Policy

Scope

This guideline is relevant to all medical and nursing staff involved in patient care on the neonatal intensive care unit (NICU)

Objectives

- To outline the indications for the use of donor breast milk
- To outline the transition from DBM to formula
- To outline the use, safe storage and traceability of DBM

Introduction

The World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) (1980) jointly declared that where it is not possible for the biological mother to breast feed, the use of human milk from other sources where available should be considered as the first option.

Potential benefits

Formula fed very low birth weight babies are at significantly increased risk of necrotising enterocolitis when compared with infants exclusively fed breast milk. Data suggests that donor breast milk reduces the risk of necrotising enterocolitis by as much as 79%.

Potential Risks

- Donor breast milk (DBM) is a human body fluid and, as such, carries risks of transmission of infective agents. Donors are screened and the milk is pasteurised to minimise risk. Written consent must be obtained for the use of donor breast milk
- Donor breast milk will have a variable nutrient content as seen with maternal expressed breast milk and may not contain optimum nutrients for the growth of preterm infants. Additionally it may be further compromised by heat treatment

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.

Insufficient mother's own breast milk
AND

Infant meets criteria for DBM*

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Refer mother to Breast Feeding Support Nurse for lactation support
AND
Obtain informed consent for DBM

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Make up total feed volume with DBM and any available EBM

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Increase feed volume to optimal level for baby eg 150ml/kg/d

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Feeds tolerated for 48 hours

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If infant is considere
being '**very high ris**
continue DBM/EBM

Monitor growth
Seek dietetic review

***'Very high risk'* =**
<27/40
<1000g
Recovering from NE

If no EBM available, **introduce formula**
Day 1 – ¼ formula
Day 2 – ½ formula
Day 3 – ¾ formula
Day 4 – 100% formula

Baby <2.0kg and <35 weeks use preterm formula

Baby >2.0kg and >35 weeks use term formula
Increase proportion of formula as tolerated

Indications for use of DBM - gold standard

- All babies ≤30 weeks and/or < 1500g (including multiples)
- Babies ≤35 weeks with consistently absent/reversed end diastolic flow or growth restriction below 3rd percentile
- Post necrotising enterocolitis (medically & surgically treated)
- Haemodynamically unsta**Recommendations for using donor breast milk**ble babies who have required prolonged inotropic support
- Hypoxic Ischaemic Encephalopathy (requiring total body cooling)**Recommendations for using donor breast milk**

- The best milk for a baby is its mother's own breast milk
- Nurses and doctors should 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

1. The decision to use DBM is made by the consultant in charge of the baby's care
2. Obtain consent from the parent and document in the baby's notes

3. Only DBM from authorised milk banks to be used
4. DBM is obtained on a named baby basis, and should not be used between babies
5. The milk should be stored in the NICU freezer
6. Document each use of DBM in the feeding chart
7. Keep a record of how the donor milk is used. For each bottle of donor milk, document
    - the baby's name, ID number and date of birth, and the date administered
    - the batch number and the date the donor milk was used in the patient record of each baby
    - the condition of the donor milk on arrival following transport ○ the storage conditions
8. When required for use, DBM should be left to defrost in the fridge. Once defrosted, the DBM should be used within 24 hours. DBM not used within this time will have to be discarded
9. DBM should be used to establish feeds and should rarely be used in the long term. When feeding is established (150ml/kg/day for more than 48 hours), the baby should be changed onto alternative feeds (mother's own breast milk if available or formula feeds) unless medically contra-indicated.

References

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4. Wight NE,Donor human milk for preterm infants. Journal of Perinatology; 2001; 21(4): 249-54.

5. Cristofalo EA, Schanler RJ, Blanco CL, Sullivan S, Trawoeger R, Kiechl Kohlendorfer U, et al. Randomized trial of exclusive human milk versus preterm formula diets in extremely premature infants. J Pediatr. 2013;163:1592-5.

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