Summary For the Use of Donor Human Milk for Infants on the Neonatal Unit

Reference No: CG-PAEDS/4385/24

Mother's own milk (MOM) is the optimal milk for all infants. In the first few days after birth, the infant is often ready to feed but MOM may not be available in sufficient volumes to meet the infant's needs. In such or other similar circumstances where MOM is not available or cannot be given, appropriately processed donor human milk (DHM) or specialised preterm infant formula milk can be used as alternatives.

The aim of using any such alternative is to fill the gap until MOM is available in sufficient volumes and the infant can be exclusively MOM fed.

Purpose

1. To achieve safer and quicker transition from parenteral nutrition to enteral milk feeds in preterm or sick infants.
2. To reduce the risk of NEC in at risk infants.
3. To improve the rates of MOM feeding in the neonatal unit and at discharge.

Which infants may be offered DHM?

- All infants born <32 weeks' gestational age
- All infants with birth weight <1500 grams
- All infants born at <34 weeks' gestational age with birth weight <10th centile for gestational age and sex AND have evidence of reversed end-diastolic flow on antenatal maternal Doppler ultrasound.
- Infants ≥32 weeks' gestational age who had hypoxia-ischaemia or significant hemodynamic instability requiring inotropic support.
- All infants recovering from NEC.
- Other extraordinary circumstances (requires agreement of the neonatal consultant).

If supplies are limited, clinical discretion, in discussion with the neonatal consultant, will be used to allocate DHM among eligible infants.

Informed consent for use of DHM

A neonatal nurse, midwife, nurse practitioner or doctor must discuss the rational for suggesting use of DHM to the infant's parents. Parents should be provided written information about the use of DHM and asked for consent for use of DHM for their infant.

Informed consent or oral assent should be obtained from the mother and documented in the notes. The consent form should be filed in the infant's clinical notes. If parents are not on site, oral assent can be obtained from the mother, over the phone, documented in the clinical notes, and written consent completed as soon as the mother is available.

For what purpose and how long should DHM be given?

If there is limited supply of MOM after the infant has established full enteral feeding (150ml/kg/day), feeding should be gradually transitioned to MOM supplemented with infant formula milk as given below, while giving as much of MOM as available throughout.

- Replace ¼ of DHM volume with formula milk for 24 hours.
- Increase to replacing ½ of DHM volume with infant formula milk for the next 24 hours.
- Increase to replacing ¾ of DHM volume with infant formula milk for the next 24 hours.
- Feed MOM supplemented with infant formula milk.
- Reassess process if infant shows signs of feed intolerance.

In exceptional circumstances, DHM may be given for longer. This will be decided on an individual basis in discussion with the parents and the neonatal consultant.

When DHM supply arrives from the HMB - see page 4 & Appendix 1 of main guideline.

Storage of DHM on the neonatal unit - see page 4 & Appendix 2 of main guideline.

Taking DHM bottle for use - see page 5 & Appendix 3 of main guideline.

When DHM is required for an infant - see page 5 & Appendix 4 of main guideline.

Discarding DHM - see page 6 & Appendix 5 Record of each bottle of DHM discarded.