



GUIDELINE

Enteral Feeding: Bolus Tube Feeds, Continuous Milk Feed (CMF), Bottle Feeds

Scope (Staff):	Nursing and Medical Staff
Scope (Area):	NICU KEMH, NICU PCH, NETS WA

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this [disclaimer](#)

Checking of Expressed Breast Milk in the NICU

- All expressed breast milk (EBM) and pasteurised donor human milk (PDHM) must be double checked by two nurses at the cot side with the infants name band and includes the UMRN, Surname and DOB. The decanted feed volume is to be labelled and have the date and time the milk was taken out of the fridge. The decanted milk must also have the initials of the nurses checking the milk out of the fridge.
- In open nursery areas the decanted milk is to be kept to the right of the infants monitor.

Intermittent Gastric Tube Feeds (Bolus)

Provide enteral nutrition to stable neonates that are:

- Too immature to suck feeds.
- Unable to take adequate nutrition to grow.
- Intermittent feeds have been shown to induce cyclical bursts of enteroinsular hormones. These hormones stimulate gut growth, mucosal development, increase gut motility, and influence pancreatic endocrine secretion and hepatic metabolism.
- Feed 2, 3 or 4 hourly depending on diagnosis, weight, gestational age. Refer to [Nutrition: Volume and Nutritional Requirements guideline](#).

Procedure

- Position yourself so the infant is facing towards you during the feed so you can act promptly in the event of vomiting or distress.
- Infants \leq 35 weeks gestation should be fed in a side-lying or prone position.
- Infants $>$ 35 weeks gestation should be fed in a side-lying position unless prone positioning is indicated for medical reasons.

Parents can hold the syringe whilst their infant is receiving a tube feed provided the following criteria is met:

1. The parent wishes to do so.
2. The infant can be in an incubator or open cot, or the parent maybe holding the infant.
3. The infant has been on full 2 hourly feeds for more than 24 hours OR has been on full 3 hourly feeds for more than 24 hours.
4. The nurse has instructed the parent on how to hold the syringe and how to kink the tube if:
 - a) The infant is vomiting or distressed, has trouble breathing or coughs excessively during the feed
 - b) Tape lifting or not securing the tube adequately.
 - c) Baby has a colour change.
 - d) Monitor alarming
 - e) The competency package is completed and signed.
5. Nurse to sign parent competency for holding syringe found [here](#).

Parents can also tube feed their infant if criteria are met. Refer to [Gastric Tube Feeding by Parents in the NICU](#).

Continuous Milk Feeds (CMF)

Provide enteral nutrition to neonates with:

- Signs of intolerance with intermittent/bolus feeds.
- Respiratory compromise exacerbated by bolus feeds.
- Persistent hypoglycaemia.
- Equipment
- Enteral system Luer lock syringe 30 mL/50 mL
- Mixing cannula
- Syringe pump
- Long extension (change daily)
- Label

Procedure

Collect **three** (3) hourly volume of milk, ensure the EBM/PDHM is double checked by two staff members and the syringe has a continuous milk sticker which is labelled and completed correctly and signed.

1. Attach syringe to long extension tubing and prime line first to prevent air being pumped into the stomach.
2. Aspirate gastric tube and test to ensure correct placement. Connect to NGT/OGT and label the extension line with the time and date to be changed.
3. Set calculated rate on pump and commence infusion. Changes and setting of rates to be double checked by nursing staff.
4. Document type of milk and volume delivered on the observation chart.

If using a **Kangaroo Pump**, see **Kangaroo Pump** instructions.

Rescheduling of Feeds

The progression towards demand feeding is achieved by increasing the time between feeds according to the neonate's size, condition and tolerance of feeds.

- Multiple changes to feeds should not be made simultaneously. Therefore, if the feed is increasing in volume, achieve this before changing time interval.
- Document and report any large residuals or vomiting, indicating feed intolerance.

CMF to 2 Hourly Feeds

Neonates being graded from hourly CMF to 2 hourly bolus feeds: turn CMF off for a period of one hour before commencing the first bolus feed.

An example of rescheduling from CMF 5 mL/hour to 10 mL/2 hourly bolus feed:

	CMF off	Start time	1hr later	1hr later	1hr later	1hr later	1hr later	1hr later	1hr later	1hr later	1hr later	1hr later	1hr later
TIME	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000
5mL/hr		5mL	5mL	4mL	6mL	3mL	7mL	2mL	8mL	1mL	9mL	0mL	10mL

2 Hourly to 3 Hourly Feeds

The slow progression from 2-3 hourly feeds may suit neonates who have had previous attempts at rescheduling of feeds and have failed to tolerate it.

Calculate the volume of a 3 hourly feed.

Feed the neonate a 2 ½ hour volume every 2 ½ hours for two feeds.

e.g. 2 hour volume + 3 hour volume, divided by 2 = 2 ½ hour volume feed.

If tolerated, continue with 3 hourly feeds.

An example of rescheduling from 2 hourly feeds (20mls) to 3 hourly feeds (30mls)

$\frac{20 + 30}{2} = 25 \text{ mL every } 2 \frac{1}{2} \text{ hours}$
--

Start time	2½ hours later	2½ hours later	3 hours later
20 mL	25 mL	25 mL	30 mL

Bottle Feeding for Infants not Breastfeeding

For breastfeeding infants refer to [Nutrition: Bottle Feeding a Breastfeeding Infant](#).

From 32-34 weeks onwards, the rooting reflex is quite active and nutritive sucking begins with a stable rhythm, to progress to full suck feeds the infant has to have sufficient neurodevelopment to regulate a rhythmic suck-swallow-breathe pattern with cardiorespiratory stability.

At 34-36 weeks most infants will have developed awake/sleep patterns and be capable of managing nutritive sucking with a coordinated pattern. Between 34-40 weeks healthy infants will maintain satisfactory growth with full oral feeding by demand.

Feeding Position

Position is important and depends on the infants muscle tone. The head must be in alignment with the trunk and all limbs must be contained (wrapped) or supported.

Preterm infants especially cannot always cope with the cradled semi-recumbent posture of the term infants and may cope better if supported in a semi-upright position. Careful attention to correct alignment is paramount.

Some infants with CLD or other complex problems benefit from an elevated side-lying position. Oxygen dependent infants may need an increase in their O₂ requirements until they develop a coordinated rhythm.

If the infant loses interest in sucking or uses a non-nutritive (chomping) action and is not showing signs of stress or fatigue, it may be helpful to support the infant's lower jaw near the base of the tongue to improve jaw stability. Excessive manipulation of the teat is likely to be distressing and over stimulating resulting in 'shut-down'.

Teat Size / Shape

Try not to switch between different teats, try for at least 24 hours to assess progress. Start with a slow-flow teat. Preterm infants initially have an uncoordinated suck-

swallow-breath technique and tend to suck vigorously and not pause long enough to breathe which can result in apnoea, desaturation and bradycardia. Pacing the feed and tilting the bottle so no milk is in the teat or removing the teat from their mouth will allow them to recover. For ongoing problems involve a feeding specialist/team.

Signs of Stress or Fatigue

Can occur before, during or after a feed and include the following:

- Limpness.
- Gagging.
- Squirming.
- Desaturation.
- Rapid / laboured or irregular breathing and bradycardia.

If any of these signs are present, stop the feed and wait for the infant to regain their stability. Try positioning the infant upright (may be wind related). If after recommencing the feed the infant shows signs of stress again, complete the feed by the gastric tube.

Related CAHS internal policies, procedures and guidelines



Neonatology guideline

- [Nutrition: Volume and Nutritional Requirements](#)
- [Nutrition: Bottle Feeding a Breastfeeding Infant](#)
- [Gastric Tube Feeding in the NICU](#)

Useful resources (including related forms)

[Kangaroo Pump Instruction](#)

This document can be made available in alternative formats on request.

Document Owner:	Neonatology		
Reviewer / Team:	Neonatology		
Date First Issued:	July 2006	Last Reviewed:	October 2021
Amendment Dates:		Next Review Date:	21 st October 2024
Approved by:	Neonatology Coordinating Group	Date:	21 st October 2021
Endorsed by:	Neonatology Coordinating Group	Date:	
Standards Applicable:	NSQHS Standards:   Child Safe Standards: 1,10		

Printed or personally saved electronic copies of this document are considered uncontrolled



Healthy kids, healthy communities

Compassion
Excellence
Collaboration
Accountability
Equity
Respect

Neonatology | Community Health | Mental Health | Perth Children's Hospital