Breastmilk: Safe Management

Summary This Guideline outlines the requirements to support the safe management of breastmilk in all NSW Health facilities, to reduce the risk of misadministration of breastmilk and to manage any adverse incidents.

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Distributed to Ministry of Health, Public Health System, Divisions of General Practice, Government Medical Officers, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

Audience All Clinical Staff;Midwives;Nurses;Neonatologists;Paediatricians;Maternity Units;Neonatal Intensive Care;Special Care Nursery;Paediatric Units;Emergency Department;Aboriginal Health Workers;Child and Family Health Services

NSW Health

GUIDELINE

Breastmilk: Safe Management

GUIDELINE SUMMARY

NSW Health is committed to supporting the safe management of breastmilk in all NSW Health facilities to reduce the risk of misadministration of breastmilk and to manage any adverse incidents.

KEY PRINCIPLES

NSW Health facilities are required to reduce the risk of the misadministration of breastmilk. This includes ensuring that all babies have secure identification in place and babies are not separated from their mothers without a compelling reason.

All expressed breastmilk is required to be safely managed and education is to be provided to parents and carers about this management.

If a baby is exposed to the wrong breastmilk, the relevant health professionals must conduct risk assessments, order and interpret screening, and initiate treatment as required.

All screening, management plans, results and counselling must be documented in the relevant health care record.

Local health districts and specialty health networks must ensure relevant staff:

- receive education and training to support the safe management of breastmilk, to identify risks and to manage adverse incidents
- implement strategies to reduce risk of the misadministration of breastmilk
- implement appropriate management if a baby receives the wrong breastmilk
- develop local policy and guidelines to support families who choose to intentionally feed their baby unpasteurised breastmilk from a nominated non-birth mother
- develop local policy, guidelines and procedures to:
    - implement this Guideline
    - monitor practice
    - document appropriately.

REVISION HISTORY

Version	Approved By	Amendment Notes
GL2023_021 August-2023	Deputy Secretary, Health System Strategy and Patient Experience	Provides further direction on: • strategies for health facilities to support families who intentionally utilise breastmilk from a nominated non-birth mother • clear guidance on number of times fridges must be checked in a 24-hour period.
PD2010_019 March-2010	Deputy Director-General	Replaces PD2006_088 Provides further direction on: • strategies to reduce the risk of babies receiving incorrect breastmilk • management of accidental neonatal exposure to breastmilk from a non-birth mother statements that accommodate circumstances where milk is provided to a neonate from a non-birth mother in an approved, controlled environment.
PD2006_088 November-2006	Director-General	New policy providing direction for Area Health Services on the requirements to safely manage breastmilk.

CONTENTS

1. BACKGROUND

The importance of babies receiving breastmilk is well documented [1,2]. Due to the small, but possible, risk of infectious agents from the ingestion of breastmilk, all NSW Health services are required to safely manage expressed breastmilk (EBM).

1.1. About this document

There is the potential for the misadministration of breastmilk in any clinical area where mothers and babies are separated and/or EBM is dispensed. Risks include inadequate identification processes, and the absence of systems to manage safe storage and dispensing. This Guideline outlines how NSW Health services must ensure strategies are implemented to reduce these risks (see Sections 2 and 3).

All staff working with breastmilk must receive education on safe management of breastmilk and local policy and guidelines must address the content of this Guideline (see Section 4).

When misadministration of breastmilk occurs, staff must implement appropriate management (see Section 5).

1.2. Key definitions

Aboriginal	In this Guideline, Aboriginal and Torres Strait Islander people are referred to as Aboriginal people in recognition that Aboriginal people are the original inhabitants of NSW.
Birth mother	In this Guideline, the term birth mother refers to the woman who gave birth to her baby.
Breastmilk	Human milk, including colostrum. The definition specifically includes breastmilk given directly from the breast and expressed breastmilk given by other means.
Hard frozen	Frozen in solid form.
Misadministration of breastmilk	The baby is fed with the wrong breastmilk.
Mother	This Guideline refers to mothers and is inclusive of the mother's baby or babies, the baby's father, the mother's partner and/or support people, family and is inclusive of the LGBTIQ+ community. The use of the term mother (woman) is not meant to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care. This includes mothers, fathers, parents, carers, partners.

Non-birth Mother	In this Guideline, non-birth mother refers to a woman who did not birth the baby.
Pasteurised donor human milk	Donated human breastmilk that has been through a process of pasteurisation with the required safety and quality procedures.

1.3. Related documents

This Guideline must be read in conjunction with the following documents:

Document Number	Policy Title
GL2018_013	*Work Health and Safety – Blood and Body Substances Occupational Exposure Prevention*
PD2012_069	*Health Care Records – Documentation and Management*
PD2014_028	*Open Disclosure Policy*
PD2017_010	*HIV, Hepatitis B and Hepatitis C – Management of Health Care Workers Potentially Exposed*
PD2017_036	*Neonatal Hepatitis B Prevention and Vaccination Program*
PD2018_034	*Breastfeeding in NSW – Promotion, Protection and Support*
PD2018_043	*Pasteurised Donor Human Milk For Vulnerable Infants*
PD2020_047	*Incident Management*
PD2021_033	*Patient Identification Bands*
	A guide to the Child Safe Standards
	NSW LGBTIQ+ Health Strategy 2022-2027
	Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW

2. IDENTIFICATION

2.1. Identification of babies

Babies must always have secure identification bands in place as per NSW Health Policy Directive *Patient Identification Bands* (PD2021_033).

2.2. Separation of mothers and babies

Babies must not be separated from their mothers without a compelling reason [1,3,4].

When babies must be separated from their mothers, two clinical staff, or one member of clinical staff and the mother if appropriate, must check the identification of both the mother and baby before breastfeeding or feeding expressed breastmilk (EBM) when they are reunited.

3. MANAGEMENT OF EXPRESSED BREASTMILK

3.1. Labelling

All expressed breastmilk (EBM) containers (used in hospital or brought in from home) must be clearly labelled, with the following information:

- Antenatal EBM must have mother's name and medical record number
- Postnatal EBM must have mother's name, baby's name and baby's medical record number
- Contents (such as EBM)
- Any additives (such as milk fortifier)
- Date and time expressed
- Date and time defrosted
- Date and time of expiry
- Signatures of the two people who checked the EBM.

Refer to Appendix 3 for the NSW Health Expressed breastmilk label (NH601049) for mandatory use.

Refer to appendix 4 for the NSW Health form *Consent for Pasteurised Donor Human Milk* (NH700424) and appendix 5 for the Pasteurised Donor Human Milk label (NH700602) for mandatory use.

3.2. Transporting

If EBM is to be transported (such as from the mother's home) NSW Health clinical staff will advise that:

- all feeding equipment, including pumps, must be cleaned according to the manufacturer's instructions. For further instructions refer to the Raising Children Network guide Cleaning expressing equipment.
- frozen EBM must be maintained in a hard frozen state by using appropriate equipment such as an insulated portable container and a hard frozen freezer brick.
- fresh EBM must be maintained cold by using appropriate equipment such as an insulated portable container and a hard frozen freezer brick.
- EBM must have labelling checked (see Section 3.1) by two clinical staff or one clinical staff member and one parent and placed into the milk fridge/ freezer, immediately on arrival to the clinical setting. The EBM must be checked in and out of the fridge/ freezer and the time documented in a milk register.

3.3. Storage fridge/ freezer environment

Appropriately sized fridges and freezers must be available for the storage of EBM to avoid overcrowding. Each baby must have an allocated area and a labelled storage container.

In the hospital setting, fresh EBM may be left at room temperature for a maximum of 4-hours. If saving for later use, fresh EBM must be refrigerated within 2-hours of expressing and kept in the fridge at 4°C for up to 48-hours (as bactericidal capacity declines significantly after 48 to 72-hours) or stored in the freezer for 6 to 12-months at minus 20°C or lower.

Ensure frozen EBM remains hard frozen until required to be dispensed.

Fortified or thawed EBM must be used within 24 hours [5,6,7,8].

A member of clinical staff must be allocated to check the fridge twice daily, for all the above and must record findings in a milk register and a temperature data logging system.

3.4. Thawing and warming

Thawing frozen EBM:

- For immediate use, frozen EBM can be thawed by placing in a container of warm water or in a milk warmer.
- EBM can be thawed in the fridge, additionally labelled with date and time removed from fridge and used within 24-hours.

Warming EBM:

- Place in a container of warm water or in a milk warmer.
- Once warmed EBM must be used within 1-hour.
- EBM that has been administered to the baby must be consumed and any residual EBM discarded within 1-hour.
- Hang time for continuous enteral feeding of EBM at room temperature is a maximum of 4-hours.
- **Never** use a microwave to thaw or warm EBM.
- **Never** refreeze or rewarm EBM.

3.5. Dispensing

EBM that is dispensed into a second or additional container/ syringe must be checked at that time with the original EBM container. It must be correctly labelled and signed by two clinical staff, or one clinical staff member and the mother if appropriate.

The additional containers of EBM must be labelled with two (preferably three) of the following identifiers:

- Name of the mother
- Name of the baby, and
- Baby's medical record number (MRN)
- Date of birth of the baby
- Mother's MRN.

Ensure that labelling is complete and correct for each EBM container before dispensing further EBM.

3.6. Checks prior to feeding

Two clinical staff, or one clinical staff member and the mother if appropriate, must always perform the identification process. The same clinical staff member must select, prepare, administer and record the feed or support the mother to feed their baby if they are present and able.

Ensure the following:

- Right baby: by checking the baby's identification bands.
- Right EBM: by cross checking the details from the EBM label are a match with the baby's identification bands and
- The EBM has been stored and thawed within storage time limits.
- Right time, volume and route: by checking the baby's feed chart.

If a feed is delayed, EBM must never be left at the bedside.

4. EDUCATION AND COMMUNICATION

Local health districts and specialty health networks must develop local policies and guidelines to ensure that:

- all staff working with breastmilk are aware of current policy and practice in relation to the safe management of breastmilk and receive appropriate education.
- all mothers are provided with information regarding the collection, labelling, transporting and storage of breastmilk.
- staff and mothers are aware of the potential risks if the baby receives the wrong breastmilk.

5. MANAGEMENT OF THE MISADMINISTRATION OF BREASTMILK

Several infectious agents have been identified in breastmilk but only a small number of these agents have been shown to result in infection (see Appendix 1).

The exposure of a baby to breastmilk from a non-birth mother may arise in the following circumstances:

- The provision of pasteurised donor human milk via Chief Executive approved milk banks, including the provision of pasteurised donor human milk for vulnerable infants (see NSW Health Policy Directive *Pasteurised Donor Human Milk For Vulnerable Infants* (PD2018_043)), in neonatal intensive care units (NICU).
- The intentional breastfeeding/use of expressed breastmilk (EBM) from a nominated non-birth mother (see section 5.2).

5.1. Misadministration of breastmilk

Misadministration of breastmilk may occur in the following circumstances (refer to Sections 5.4 through to 5.10):

- EBM from one mother is given to another mother's baby in error.
- A mother inadvertently breastfeeds a baby other than her own.

5.2. Intentional breastfeeding/ feeding expressed breastmilk from a nominated non-birth mother

There are circumstances when mothers choose to use unpasteurised human breastmilk from a non-birth mother. These circumstances may include surrogacy, adoption, same sex couples and where the birth mother is unable to provide enough or any breastmilk. All NSW Health organisations must develop local policies and guidelines to support these families to make an informed choice.

The risks associated with sharing unpasteurised breastmilk must be fully explained to the birth mother, as this is done at their own risk. This must be explained by an appropriate clinician as early as possible, preferably in the antenatal period.

The birth mother must be advised that the non-birth mother should be serologically tested for:

- Human immunodeficiency virus (HIV) – antigen and antibody
- Hepatitis C – antibody or hepatitis C virus by nucleic acid testing (NAT)
- Hepatitis B – surface antigen (HBsAg)
- Human T-lymphotropic Virus (HTLV) 1 & 2
- Cytomegalovirus (CMV)
- Rubella
- Syphilis.

Alcohol, nicotine, caffeine, medication use and lifestyle factors of the non-birth mother must also be considered when families choose to use unpasteurised human breastmilk.

5.3. Local operational arrangements for misadministration of breastmilk

All NSW Health organisations must develop local operational procedures to manage adverse incidents relating to the misadministration of breastmilk. This includes:

- an immediate response plan to manage the incident (see Section 5.4)
- incident management (see NSW Health Policy Directive *Incident Management* (PD2020_047)
- open disclosure to the birth mother and non-birth mother (see NSW Health Policy Directive *Open Disclosure Policy* (PD2014_028)

- an individual assessment of clinical risk factors to identify the appropriate screening and serology that must be obtained. This will include obtaining informed consent from the birth mother and non-birth mother
- consideration of risk must be discussed in terms of:
    - exposure: this is most typically via an intra gastric tube or teat rather than the breast and the volume of exposure is usually small
    - the duration of exposure: this is usually limited to one episode.
    - screening: many of the viruses of concern are part of routine antenatal screening and exposure to HIV-positive breastmilk is unlikely to occur due to screening and counselling against breastfeeding in this group of mothers.

5.4. Immediate response – management of recipient baby

Immediate aspiration of the stomach contents must be considered if the feed was via a gastric tube. The feed can be aspirated up to 30-minutes after feeding.

Nasogastric/ orogastric tubes **must not** be inserted for the purpose of aspirating EBM.

5.5. Risk assessment of the non-birth mother

Each NSW Health facility must identify designated officers who can conduct a risk assessment of the non-birth mother. The risk assessment must include:

- keeping the non-birth mother's identity confidential
- offering counselling, support and follow up to the non-birth mother with informed consent gained prior to screening (see Appendix 1)
- an assessment of the mother's clinical status at the time of expressing or feeding, including:
    - the presence of fever
    - the presence of rash (including vesicles on the breast)
- checking the antenatal screening results included syphilis, hepatitis C (HCV), hepatitis B (HBV) and human immunodeficiency virus (HIV)
- assessing risk factors of blood borne viruses, such as having a history of:
    - injecting drug use
    - tattoo or piercing
    - syphilis
    - blood transfusion
    - iatrogenic exposures to blood borne viruses
    - unprotected sex with at risk partner

- birthplace / residence / travel in a country with high prevalence of HIV[1]

- checking for a history of HBV vaccination
- checking medications prescribed.

5.6. Serological and breastmilk screening

It is recommended that both mothers are screened at the time of exposure. Testing must be expedited to allow for commencement of treatment for the baby if required.

Pre and post-test counselling must be conducted and informed consent obtained.

Table 1. Serological and breastmilk tests

Blood	Combined HIV antigen and antibody (fourth generation HIV immunoassay), HIV RNA NAT, HIV proviral DNA (if available) and HIV antibody /antigen test. However, this information is unlikely to be available in time to guide initiation of prophylactic therapy of the baby.
	HCV antibody test, HCV RNA test
	HBV surface antigen (HBsAg), HBV core antibody
Breastmilk	Cytomegalovirus (CMV) NAT (if recipient baby is less than one month of age, or has underlying immune deficiency)

Where the risk assessment of the non-birth mother identifies factors that may indicate a potential window period for HIV infection, HIV serology must be repeated on both mothers three months after the exposure of the baby.

If a result from either mother is positive or equivocal, further investigations and management will be required for the exposed baby and must be discussed with an infectious diseases physician or other appropriate consultant.

Additional testing must also be discussed with a clinical microbiologist or infectious diseases physician if the non-birth mother is clinically unwell (such as fever or breast abscess).

If post-exposure to HBV immunoglobulin, HBV vaccination, HIV post-exposure prophylaxis (PEP), direct acting antiretroviral (DAA) therapy for HCV, and/or CMV antiviral therapy is clinically appropriate or to be considered then instigation and management must be undertaken with advice from clinicians with relevant expertise [10,11,12].

5.7. Non-consent to testing

If either of the mothers decline consent for testing, then with parental consent, the baby's blood, urine or saliva must be taken for CMV testing. If parental consent is not given for the baby to have testing this must be recorded in the health care record.

The risk of the non-birth mother being infected with HIV or HBV must be assessed from epidemiological and historical information and the baby should be managed in a way

[1] Countries with population prevalence over 1% are considered to have a high prevalence of HIV. High prevalence areas include the Caribbean, sub-Saharan Africa, South East Asia, and Papua New Guinea. For the HIV seroprevalence of individual countries go to https://aidsinfo.unaids.org/

appropriate to the level of risk. This must be done in consultation with an infectious diseases physician, experienced HIV physician, or virologist.

5.8. Management and treatment for the birth and non-birth mothers

If either mother is found to have positive results for HIV, HBV or HCV during the screening process they must be referred immediately to a clinician with relevant expertise for appropriate management.

5.9. Management and treatment for the baby

If either mother is HIV positive:

- Sydney Children's Hospital, Randwick offers state-wide expertise in the management of paediatric HIV disease. An expert clinician must be consulted regarding the event and, if required, advice on antiretroviral HIV prophylaxis doses for the exposed baby.

If either mother is HBV positive:

- Commence Hepatitis B immunoglobulin, ideally within 24-hours of exposure
- Commence Hepatitis B vaccination for the baby, if the birth dose has not yet been administered see NSW Health Policy Directive *Neonatal Hepatitis B Prevention and Vaccination Program* (PD2017_036)

If testing of the non-birth mother is not possible or, there is not rapid availability of results and is assessed to be at high risk of being positive for HBsAg or by NAT, advice must be sought from an expert clinician regarding the need for administration of hepatitis B immunoglobulin to the exposed baby.

If either mother is HCV positive:

- the baby must be referred to a clinician with expertise in the management of HCV.

If either mother is CMV positive:

- the baby must be referred to a clinician with expertise in the management of CMV, for example a paediatrician.

Advice regarding these or any other infection risk (other than HIV) must be sought from the relevant tertiary children's hospital within the NSW Children's Healthcare Network (see Appendix 2).

6. DOCUMENTATION

All screening, management plans, results and counselling are to be contemporaneously documented in the relevant health care record (see Appendix 6 for the *Exposure of baby to breastmilk from a non-birth mother form* (NH606537).

7. MONITORING

An annual audit to assess compliance with this Guideline must be undertaken by local health districts and specialty health networks.

8. REFERENCES

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9. APPENDICES

1. Appendix 1: Infectious agents transmitted via breastmilk
2. Appendix 2: Contact points for specialised services
3. Appendix 3: Expressed breastmilk label
4. Appendix 4: Consent for Pasteurised Donor Human Milk form
5. Appendix 5: Pasteurised donor human milk label
6. Appendix 6: Exposure of baby to breastmilk from a non-birth mother form

9.1. Appendix 1: Infectious agents transmitted via breastmilk

Infectious agent	Description
Bacteria	Bacteria, particularly normal skin flora, may be present in breastmilk. Bacteria in breastmilk is extremely unlikely to cause infections in healthy babies. The absence of clinical features in both the birth and/or non-birth mother such as fever, mastitis, and breast abscess further reduce the risk for transmission of bacteria. Babies are monitored for signs and symptoms of sepsis as part of general routine care.
COVID-19	You can keep breastfeeding if you have COVID-19. Please refer to advice on the NSW Health website Breastfeeding with COVID-19 or flu.
Cytomegalovirus (CMV)	Transmission of CMV has been well recognised after primary or recurrent maternal CMV infection. Babies at particular risk from CMV infection include premature babies, those with very low birth weight (less than 2000 grams) and babies with T cell immune deficiency. Some of the risk from CMV transmission may be mitigated by freezing breast milk, preferably for at least 72 hours.
Hepatitis B (HBV)	HBV particles have been detected in human milk. However, there is an extremely low risk of transmission of the virus and disease in babies. Babies vaccinated for Hepatitis B are not considered at risk. Current recommendations from the Australian Immunisation Handbook advise that all babies should be vaccinated within 24-hours of birth.
Hepatitis C (HCV)	Hepatitis C RNA and antibodies have been detected in breastmilk. There is no identified association between transmission of HCV and breastfeeding.
Herpes simplex virus types I and 2 (HSV 1 and 2)	HSV 1 and 2 can be found in breastmilk. Active lesions and viral shedding have been implicated in transmission of the disease. However, national infant feeding guidelines advise against women with active infection (particularly active lesions on the breast or nipple) breastfeeding.
Human immunodeficiency virus (HIV)	HIV RNA has been identified in infected mothers' breastmilk and HIV can be transmitted by breastmilk. The risk of HIV transmission from breastmilk consumed by a baby is considered to be very low because: • women in Australia who are HIV positive are advised not to breastfeed their babies, even if they are on antiretroviral treatment and have an undetectable viral load • chemicals present in breastmilk may act, together with time and cold temperatures, to destroy the HIV RNA present in expressed breastmilk • transmission of HIV from a single breastmilk exposure has never been documented.
Human T cell leukaemia virus type I (HTLV1) and II (HTLVII)	Both HTLV I and II have been found in breastmilk and the risk of transmission increases with longer breastfeeding. HTLV I occurs in general populations in Japan, the West Indies, parts of Africa and South America, and in many Aboriginal populations in central and northern Australia. HLTV II has been identified in some Aboriginal populations and the risk of transmission is considered extremely low.

Rubella	Wild-type and vaccine rubella virus have been isolated from breastmilk, but other routes of infection are more likely. There are high rates of immunity to rubella and the mother's status should be known from antenatal screening.
Syphilis	There is no evidence that syphilis can be transmitted by breastmilk alone. The presence of clinical features of syphilis infection in the mother (particularly syphilitic lesions on the breast) has been associated with the transmission of syphilis. Breastfeeding is not recommended where a lesion is present on the breast.
Varicella zoster virus (VZV)	VZV DNA has been detected in breastmilk. However, breastfeeding is not considered to be a significant route of transmission for VZV.
West Nile virus/ Kunjin disease	There is potential for this virus to be transmitted via breastmilk, with a few documented cases globally. However, there is no evidence of recognisable illness in babies. Although it is rare, West Nile virus can be found in parts of Australia, particularly the Northern Territory and northern Western Australia.

9.2. Appendix 2: Contact points for specialised services

As per Section 5.9, advice regarding infection risk, investigations and management must be sought from the relevant tertiary children's hospital within the NSW Children's Healthcare Network domain in which the event occurred.

Appropriate contacts:

MotherSafe provides a comprehensive counselling service for women and their healthcare providers concerned about exposures during pregnancy and breastfeeding.

For HIV (State-wide):

Sydney Children's Hospital	
Head of Department, Immunology & Infectious Diseases	02 9382 1508
HIV Clinical Nurse Consultant	via switch 02 9382 1111

All other queries:

In Northern Child Health Network (Hunter New England, Mid North Coast and Northern NSW Local Health Districts)

John Hunter Children's Hospital Consultant on-call for Infectious Diseases	via switch 02 4921 3000

In Western Child Health Network (Far West, Western NSW, Nepean Blue Mountains, Central Coast, Western Sydney, South Western and Sydney Local Health Districts)

Sydney Children's Hospital Network (Westmead) Consultant on-call for Infectious Diseases	via switch 02 9845 0000

In Southern Child Health Network (South Eastern Sydney, Illawarra, Sydney South West, Sydney, Southern NSW, Murrumbidgee and Northern Sydney Local Health Districts and ACT Health):

Sydney Children's Hospital Network (Randwick) Consultant on-call for Infectious Diseases	via switch 02 9382 1111

9.3. Appendix 3: Expressed breastmilk label

EXPRESSED BREASTMILK

Baby Surname:_____ MRN:_____

Baby Given Name:_____

Baby DOB:____/____/20___ Baby Sex ☐ M ☐ F

Mother's Name:_____

EBM:_____mL Additive/s:_____

Expressed: date____/____/20____ time_____:_____

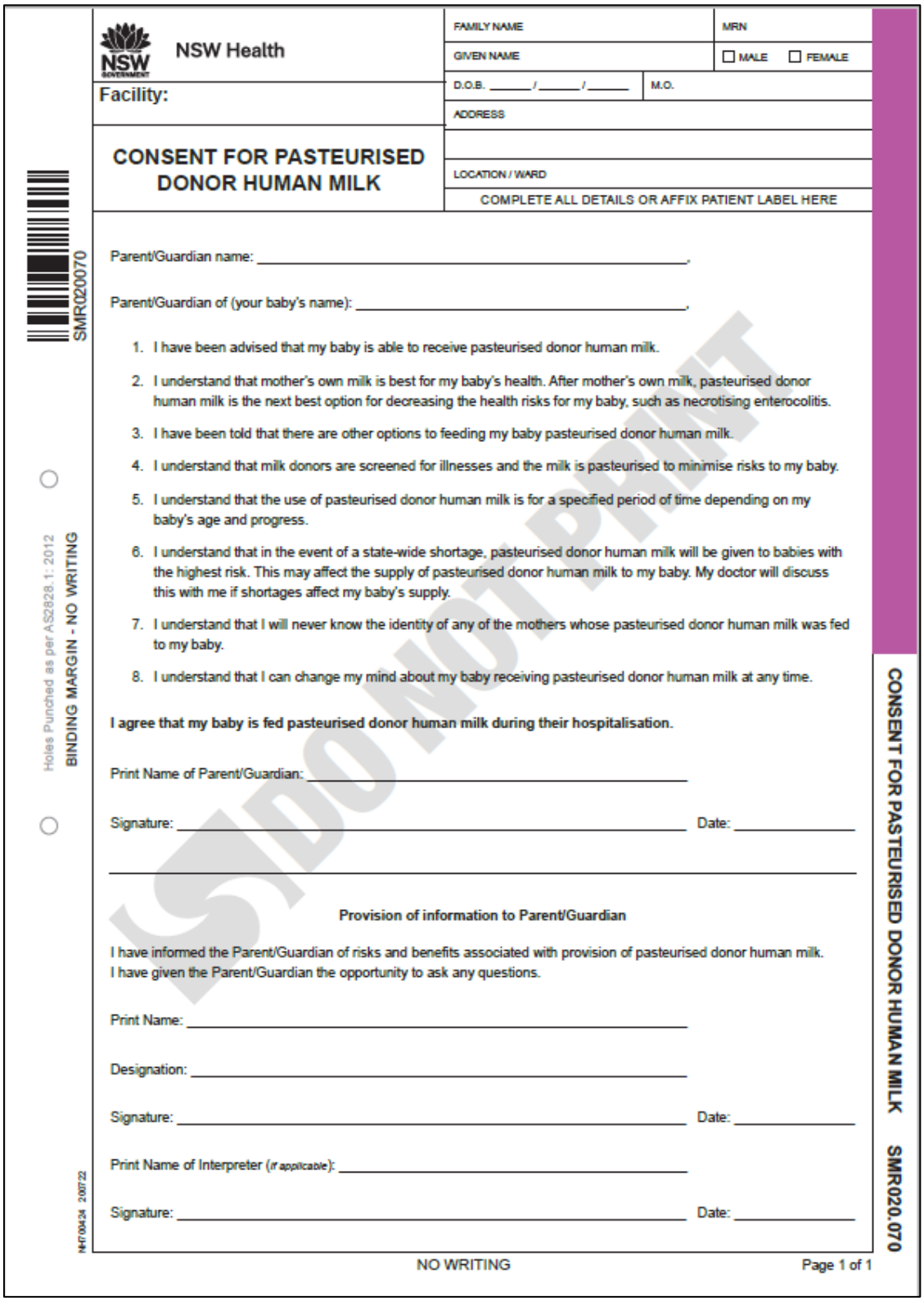
Defrosted: date____/____/20____ time_____:_____

Expires: date____/____/20____ time_____:_____

Sign:_____ Sign:_____

NH601049 17/02/15

9.4. Appendix 4: Consent for Pasteurised Donor Human Milk form



NSW Health

Facility:

CONSENT FOR PASTEURISED DONOR HUMAN MILK

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR020070

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

Parent/Guardian name: _____,

Parent/Guardian of (your baby's name): _____,

1. I have been advised that my baby is able to receive pasteurised donor human milk.
2. I understand that mother's own milk is best for my baby's health. After mother's own milk, pasteurised donor human milk is the next best option for decreasing the health risks for my baby, such as necrotising enterocolitis.
3. I have been told that there are other options to feeding my baby pasteurised donor human milk.
4. I understand that milk donors are screened for illnesses and the milk is pasteurised to minimise risks to my baby.
5. I understand that the use of pasteurised donor human milk is for a specified period of time depending on my baby's age and progress.
6. I understand that in the event of a state-wide shortage, pasteurised donor human milk will be given to babies with the highest risk. This may affect the supply of pasteurised donor human milk to my baby. My doctor will discuss this with me if shortages affect my baby's supply.
7. I understand that I will never know the identity of any of the mothers whose pasteurised donor human milk was fed to my baby.
8. I understand that I can change my mind about my baby receiving pasteurised donor human milk at any time.

I agree that my baby is fed pasteurised donor human milk during their hospitalisation.

Print Name of Parent/Guardian: _____

Signature: _____ Date: _____

Provision of information to Parent/Guardian

I have informed the Parent/Guardian of risks and benefits associated with provision of pasteurised donor human milk.
I have given the Parent/Guardian the opportunity to ask any questions.

Print Name: _____

Designation: _____

Signature: _____ Date: _____

Print Name of Interpreter (*if applicable*): _____

Signature: _____ Date: _____

NH70424 20722

CONSENT FOR PASTEURISED DONOR HUMAN MILK SMR020.070

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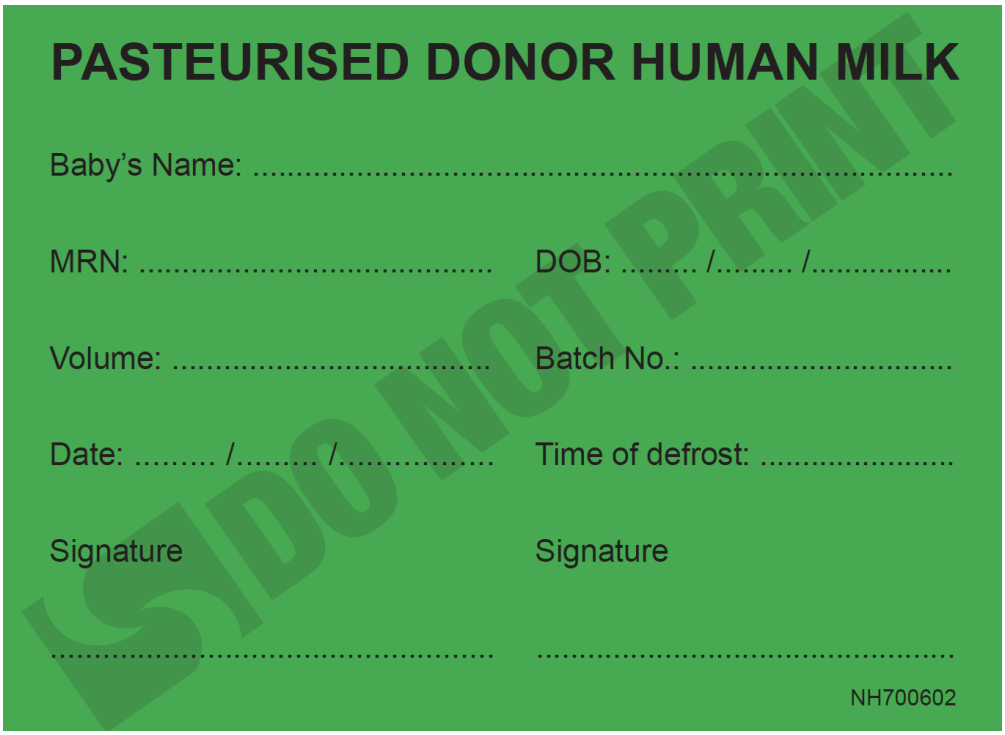
9.5. Appendix 5: Pasteurised donor human milk label



9.6. Appendix 6: Exposure of baby to breastmilk from a non-birth mother form

NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____ / _____ / _____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

EXPOSURE OF BABY TO BREAST MILK FROM A NON-BIRTH MOTHER

SMR060470

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Exposure checklist	Completed		Results/comments
1. Breast milk feeding from a non-birth mother verified	Yes	No	Date of exposure: ..... /..... /..... Time of exposure: .....hrs Time identified: .....hrs
2. Breast milk feed aspirated from infant stomach (only if nasogastric or orogastric tube is in situ at time of incident or still in situ and <30 minutes after event)	Yes	No	Date of aspiration: ..... /..... /..... Time aspiration: .....hrs
3. The birth mother/parents have been informed of the exposure and relevant information and fact sheets provided	Yes	No	Date informed: ..... /..... /..... Time informed: .....hrs Counselling provided by:
4. A clinical assessment has been performed on the source (non-birth) mother at time of breast milk collection/ expression or feeding	Yes	No	Date of assessment: ..... /..... /..... Presence of fever: Presence of rash (including vesicles on the breast): Presence of mastitis or breast abscess or bleeding nipples: Comments: .....
5. A check of the antenatal serology for previous results has been done for: a) Non-birth mother b) Birth mother	 Yes Yes	 No No	Non-birth mother: Rubella: / Syphilis: / HCV antibodies: / HBV: / HIV antibodies: / CMV: / Comments: ..... Birth mother: Rubella: / Syphilis: / HCV antibodies: / HBV: / HIV antibodies: / CMV: / Comments: .....
6. Risk factors for blood borne viruses and/or syphilis have been identified from both mothers	Yes	No	If Yes, indicate which: ☐ Injecting Drug Use: ☐ Birthplace or previous residence or travel in a country with high prevalence of HIV: ☐ Birthplace or previous residence or travel in a country with high prevalence of HBV or HCV: ☐ Tattoo or piercing ☐ History of syphilis (including date and treatment): ☐ Blood transfusion history or possible iatrogenic exposure to a blood borne virus ☐ Unprotected sex with a partner who has or is at risk of having a blood borne virus ☐ Other risk factors:
7. A check of medications prescribed to source mother has been conducted	Yes	No	List relevant medications: .....
8. Pre and post test counselling provided and consent given for relevant serological testing for: (a) Non-birth mother (b) Birth mother	 Yes Yes	 No No	 Name of counsellor: Name of counsellor:

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EXPOSURE OF BABY TO BREAST MILK FROM A NON-BIRTH MOTHER

SMR060.470

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NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

EXPOSURE OF BABY TO BREAST MILK FROM A NON-BIRTH MOTHER

9. Infectious Diseases Physician consulted	Yes	No	Date: ..... /..... /..... Time: .....hrs Name:
10. Appropriate testing for exposure performed on non-birth mother	Yes	No	Date collected: ..... /..... /..... Time collected: .....hrs Blood – HIV RNA NAT: HIV proviral DNA (if available): HIV antigen: HCV antibody: HCV RNA: HBV surface antigen: HBV core antibody: Breast milk – CMV NAT (if baby less than one month of age):
11. Appropriate testing for exposure performed on birth mother	Yes	No	Date collected: ..... /..... /..... Time collected: .....hrs Blood – HIV RNA NAT: HIV proviral DNA (if available): HIV antigen: HCV antibody: HCV RNA: HBV surface antigen: HBV core antibody: Breast milk – CMV NAT (if baby less than one month of age-corrected):
12. Arrangement for appointment to discuss results and arrangement for follow-up blood testing:			
a) Non-birth mother	Yes	No	Recommended follow up: Yes / No Appointment date: ..... /..... /.....
b) Birth mother/parent	Yes	No	Recommended follow up: Yes / No Appointment date: ..... /..... /.....
13. Results of testing for exposure reviewed:			
a) Non-birth mother	Yes	No	Date: ..... /..... /..... Time: .....hrs
b) Birth mother	Yes	No	Date: ..... /..... /..... Time: .....hrs
14. Exposed baby requires treatment	Yes	No	
Hepatitis B immunoglobulin and/or vaccine given	Yes	No	Infant hepatitis B immunoglobulin: Date: ..... /..... /..... Time: .....hrs Commence hepatitis B vaccination (in a different limb) if birth dose of HBV vaccine has not already been administered. Date: ..... /..... /..... Time: .....hrs
HIV prophylaxis given (access via Paediatric specialist hospital)	Yes	No	HIV prophylaxis commenced: Date: ..... /..... /..... Time: .....hrs Single/double/triple therapy:
15. Incident has been documented and reported appropriately:			
(a) Baby's medical record:	Yes	No	
(b) Source mother's medical record:	Yes	No	
(c) IIMS:	Yes	No	

Name & Designation: _____ Signature: _____

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