Table S2. All topics, subtopics, and statements included in the Delphi survey, with results from rounds 2 and 3.

	Round 2			Round 3		
Topics, subtopics, and statements	**Mean (SD)**	**Range**	**N (%)**	**Mean (SD)**	**Range**	**N (%)**
Topic 1. Human milk						
1.1 Benefits of human milk						
1. Human milk should be the first-line nutrition of choice for infants with CCHD.	1.12 (0.33)	1–2	25 (100)	–	–	–
2. Human milk has advantages for the health of a child with CCHD.	1.08 (0.28)	1–2	25 (100)	–	–	–
3. Human milk leads to better growth outcomes than formula.	2.48 (1.09)	1–4	25 (100)	2.00 (0.74)	1–3	23 (100)
4. An unfortified exclusive human milk diet reduces the risk of necrotizing enterocolitis.	1.80 (0.87)	1–4	25 (100)	–	–	–
5. Defatted human milk is a safe and effective treatment for infants who develop chylothorax after cardiac surgery.	1.61 (0.72)	1–3	23 (92)	–	–	–
6. Human milk can help an infant recover more quickly from cardiac surgery.	1.92 (0.91)	1–4	25 (100)	–	–	–
7. Human milk prevents infection in infants with CCHD.	1.60 (0.71)	1–3	25 (100)	–	–	–
8. Human milk feeding of mother's own milk increases a family's ability to participate in their infant's care.	1.12 (0.44)	1–3	25 (100)	–	–	–
9. Human milk feeding of mother's own milk reduces a family's stress.	*2.16 (0.94)*	*1–4*	*25 (100)*	*2.27 (0.70)*	*1–4*	*22 (96)*[a]
10. Human milk feeding of mother's own milk increases a family's stress,	*4.20 (1.16)*	*1–3*	*25 (100)*	*4.27 (0.77)*	*1–4*	*22 (96)*
11. Human milk feeding is an important topic for consideration in all stages of care, including in the ICU.	1.08 (0.28)	1–2	25 (100)	–	–	–
12. A human milk diet can reduce the number of days that total parenteral nutrition is needed.	1.74 (0.81)	1–4	23 (92)	–	–	–
13. It is possible for infants with CCHD to gain enough weight from an exclusively human milk diet.	*2.64 (1.41)*	*1–5*	*25 (100)*	*2.83 (1.19)*	*1–6*	*23 (100)*
14. Human milk may not have adequate caloric strength to support growth in infants with CCHD.	*2.60 (1.26)*	*1–6*	*25 (100)*	*2.70 (1.15)*	*1–5*	*23 (100)*
15. Most infants will need to supplement to a higher number of calories than human milk can provide.	*2.88 (1.27)*	*1–5*	*25 (100)*	*2.70 (1.06)*	*1–5*	*23 (100)*
16. Human milk is the most cost effective nutrition.	1.40 (0.65)	1–3	25 (100)	–	–	–
17. Human milk should be considered a medication for infants with CCHD.	1.84 (1.34)	1–6	25 (100)	1.61 (0.66)	1–3	23 (100)
18. Donor human milk is a safe option for infants with CCHD.	1.44 (0.58)	1–3	25 (100)	–	–	–
19. Donor human milk is preferable to formula.	1.92 (1.15)	1–4	25 (100)	1.87 (0.82)	1–4	23 (100)
20. Performing oral cares with human milk can reduce the number of days to full enteral feeds.	1.86 (0.85)	1–4	21 (84)	–	–	–
21. Performing oral cares with human milk is safe for physiologically unstable infants.	1.56 (0.87)	1–4	25 (100)	–	–	–
22. Teaching parents and caregivers to perform oral cares with human milk is a way to support bonding and connection between a caregiver and their infant.	1.20 (0.50)	1–3	25 (100)	–	–	–
23. Performing oral cares with human milk is associated with increased rates of breastfeeding.	2.05 (0.84)	1–4	22 (88)	1.91 (0.43)	1–3	22 (96)
24. Infants with CCHD are at risk for low rates of human milk intake.	1.88 (1.12)	1–6	24 (96)	1.74 (0.54)	1–3	23 (100)
25. Infants with CCHD are typically weaned from human milk more quickly than healthy infants.	*2.57 (1.50)*	*1–6*	*21 (84)*	*2.32 (0.89)*	*1–4*	*22 (96)*

Topics, subtopics, and statements	Round 2 Mean (SD)	Round 2 Range	Round 2 N (%)	Round 3 Mean (SD)	Round 3 Range	Round 3 N (%)
26. Difficulty with pumping is often a barrier to human milk feeding,	1.96 (1.10)	1–4	25 (100)	1.91 (0.85)	1–5	23 (100)
27. Parental worry about inadequate milk supply is often a barrier to human milk feeding.	1.92 (0.81)	1–3	25 (100)	–	–	–
28. Separation between an infant and their mother is often a barrier to human milk feeding.	1.64 (0.86)	1–4	25 (100)	–	–	–
29. The high-tech, non-private environment of the intensive care unit is often a barrier to human milk feeding.	1.88 (1.01)	1–4	25 (100)	1.87 (0.46)	1–3	23 (100)
30. Structured feeding practices in the intensive care unit are often a barrier to human milk feeding.	*2.32 (1.22)*	*1–5*	*25 (100)*	*2.04 (0.56)*	*1–3*	*23 (100)*
1.2 Delivery of human milk						
31. Breastfeeding is safe for most infants with CCHD.	1.84 (1.07)	1–5	25 (100)	1.78 (0.42)	1–2	23 (100)
32. Breastfeeding is more work than bottle feeding for infants with CCHD.	*4.40 (1.61)*	*1–6*	*25 (100)*	*4.17 (1.15)*	*1–5*	*23 (100)*
33. Breastfeeding allows infants to remain more physiologically stable than bottle feeding.	*2.24 (1.01)*	*1–4*	*25 (100)*	*2.13 (0.76)*	*1–4*	*23 (100)*
34. Weighing an infant before and after a breastfeeding session provides an accurate measure of the volume of milk consumed.	*2.40 (1.38)*	*1–6*	*25 (100)*	*2.52 (0.95)*	*1–5*	*23 (100)*
35. Infants who are directly breastfeeding will need to supplement with bottle or tube feedings.	*3.50 (1.06)*	*1–5*	*24 (96)*	*3.52 (1.04)*	*1–6*	*23 (100)*
36. An infant who is being fed orally should be relied upon to determine the amount, frequency, and length of feeding.	*2.84 (1.43)*	*1–6*	*25 (100)*	*3.04 (0.83)*	*1–5*	*23 (100)*
37. Breastfeeding should not be attempted in infants who are physiologically unstable.	*2.64 (1.22)*	*1–5*	*25 (100)*	*2.70 (0.97)*	*1–5*	*23 (100)*
38. Breastfeeding should not be attempted in infants who are receiving prostaglandin infusion.	*4.17 (1.15)*	*1–6*	*23 (92)*	*4.21 (0.92)*	*1–5*	*19 (83)*
39. Breastfeeding should only be considered once adequate growth is established, with close monitoring of ongoing normal infant weight gain.	*4.80 (1.16)*	*1–6*	*25 (100)*	*4.83 (0.94)*	*1–6*	*23 (100)*
40. Breastfeeding is almost never possible for infants with single ventricle physiology.	5.09 (1.19)	1–6	22 (88)	5.15 (0.59)	1–3	20 (87)
41. Most mothers wish to breastfeed their infants.	1.92 (0.93)	1–5	24 (96)	–	–	–
42. Breastfeeding has significant benefits for the mother of an infant with CCHD.	1.40 (0.58)	1–3	25 (100)	–	–	–
43. Even the most vulnerable infants can achieve breastfeeding.	*2.00 (1.04)*	*1–5*	*25 (100)*	*2.09 (0.29)*	*1–2*	*23 (100)*
44. It is possible to increase the rates of infants with CCHD who consistently breastfeed.	1.56 (0.71)	1–3	25 (100)	–	–	–
45. Breastfeeding allows infants to be active participants in feeding.	1.56 (0.71)	1–3	25 (100)	–	–	–
46. Supporting breastfeeding should be a priority for the healthcare team.	1.32 (0.56)	1–3	25 (100)	–	–	–
47. Establishing breastfeeding or pumping is a priority in the immediate post-birth period.	1.20 (0.41)	1–2	25 (100)	–	–	–
48. Reducing the time to the first pumping session after birth is critical to the establishing of a human milk supply.	1.28 (0.61)	1–3	25 (100)	–	–	–
49. Pumping should be discussed as part of the treatment plan.	1.00 (0.00)	1–1	25 (100)	–	–	–
50. Skin-to-skin contact between a mother and their infant facilitates human milk feeding of mother's own milk.	1.04 (0.20)	1–2	25 (100)	–	–	–
51. Skin-to-skin contact between a mother and their infant should be a priority of the healthcare team.	1.00 (0.00)	1–1	25 (100)	–	–	–
52. Facilitating skin-to-skin contact between parents or caregivers and their infant is often difficult in the context of the intensive care unit.	*2.32 (1.44)*	*1–6*	*25 (100)*	*2.48 (0.95)*	*1–5*	*23 (100)*

Topics, subtopics, and statements	Round 2 Mean (SD)	Round 2 Range	Round 2 N (%)	Round 3 Mean (SD)	Round 3 Range	Round 3 N (%)
1.3 Human milk education						
53. Supporting human milk feeding should be a priority of the healthcare team.	1.12 (0.44)	1–3	25 (100)	–	–	–
54. Human milk education should be a priority before birth.	1.12 (0.33)	1–2	25 (100)	–	–	–
55. It is the responsibility of the entire healthcare team to carry out human milk education.	1.48 (0.82)	1–4	25 (100)	–	–	–
56. Ensuring parents have access to coherent and accurate knowledge about human milk supply techniques and benefits facilitates human milk feeding.	1.12 (0.33)	1–2	25 (100)	–	–	–
57. The relationship between parents and the healthcare team, in terms of consistent support and education, helps facilitate human milk feeding.	1.12 (0.33)	1–2	25 (100)	–	–	–
58. It is the responsibility of the healthcare team to provide additional support to mother-infant dyads who are not immediately able to reach their human milk feeding goals.	1.20 (0.41)	1–2	25 (100)	–	–	–
59. Healthcare providers of infants with CCHD tend to focus more on the volume of feeding, rather than the feeding experience of the infant and parent/caregiver.	1.79 (1.29)	1–6	24 (96)	1.87 (0.69)	1–4	23 (100)
60. The choice of what nutrition to feed an infant is a personal decision that is ultimately up to the family.	*2.76 (1.23)*	*1–5*	*25 (100)*	*2.96 (0.83)*	*1–5*	*23 (100)*
61. Parents can feel satisfied with a variety of methods of human milk delivery for their infant.	2.04 (0.94)	1–4	25 (100)	1.87 (0.34)	1–2	23 (100)
62. It is ultimately the parent's responsibility to achieve their breastfeeding and human milk feeding goals.	*4.24 (1.36)*	*1–6*	*25 (100)*	*4.43 (0.66)*	*1–4*	*23 (100)*
Topic 2. Oral feeding						
2.1 Feasibility of oral feeding						
63. Nearly all infants will be able to achieve full oral feeds, whether via breastfeeding or bottle feeding, by hospital discharge.	*3.75 (1.36)*	*1–6*	*24 (96)*	*3.86 (0.77)*	*1–4*	*22 (96)*
64. Infants who take at least 50% of their feeds orally prior to surgery will likely be able to reach 100% oral feeding by discharge.	*3.05 (1.13)*	*1–6*	*22 (88)*	*3.15 (0.67)*	*1–4*	*20 (87)*
65. Between 30–50% of infants will need feeding tube supplementation at hospital discharge.	*2.57 (1.17)*	*1–6*	*21 (84)*	*2.75 (0.72)*	*1–4*	*20 (87)*
66. Feeding causes physiological distress for most infants.	*4.32 (1.03)*	*2–6*	*25 (100)*	*4.13 (0.76)*	*1–4*	*23 (100)*
67. Oral feeding should not only be attempted in the physiologically stable infant.	*2.44 (1.12)*	*1–5*	*25 (100)*	*2.52 (0.99)*	*1–6*	*23 (100)*
68. Infants who are able to feed orally tend to have experienced a more stable clinical course.	*2.20 (0.96)*	*1–4*	*25 (100)*	*2.09 (0.61)*	*1–4*	*22 (96)*
69. The decision to begin oral feeding is generally made by the healthcare team through evaluating the infant's physiological stability, with little attention given to developmental cues for success.	*2.50 (1.35)*	*1–5*	*24 (96)*	*2.77 (1.07)*	*1–4*	*22 (96)*
70. Oral feeding outcomes may be vastly different for two infants that undergo the same high-risk surgery.	1.40 (0.50)	1–2	25 (100)	–	–	–
2.2 Risk factors for oral feeding problems						
71. Prolonged respiratory support (e.g. intubation, BiPAP, CPAP) is a risk factor for delay in achievement of feeding milestones.	1.52 (0.51)	1–2	25 (100)	–	–	–
72. The risk of not feeding orally at the time of discharge increases for each day of intubation.	*2.21 (0.59)*	*1–3*	*24 (96)*	*2.23 (0.53)*	*1–3*	*22 (96)*

Topics, subtopics, and statements	Round 2			Round 3		
	Mean (SD)	Range	N (%)	Mean (SD)	Range	N (%)
73. The severity of an infant's cardiac defect is related to their risk for oral feeding problems.	*2.68 (0.99)*	*1–5*	*25 (100)*	*2.36 (0.58)*	*1–3*	*22 (96)*
74. Infants with cyanotic defects are at higher risk for feeding problems with those with acyanotic defects.	*2.59 (0.80)*	*1–4*	*22 (88)*	*2.67 (0.48)*	*1–2*	*21 (91)*
75. Infants who have undergone cardiopulmonary bypass are at increased risk for delay in achieving feeding milestones.	*2.22 (0.90)*	*1–4*	*23 (92)*	*2.14 (0.57)*	*1–4*	*21 (91)*
76. The presence of a genetic defect increases the risk for needing tube feeding supplementation at hospital discharge.	2.12 (0.83)	1–4	25 (100)	1.86 (0.36)	1–2	21 (91)
77. Infants with CCHD may have neurological delays that affect the development of coordinated sucking, swallowing, and breathing.	1.92 (0.81)	1–4	25 (100)	–	–	–
78. Infants who require staged repair are at increased risk for needing tube feeding supplementation during the first year of life.	1.88 (0.53)	1–3	25 (100)	–	–	–
79. NG tubes often negatively impact the development of oral feeding skills.	*3.16 (1.43)*	*1–6*	*25 (100)*	*3.13 (1.14)*	*1–5*	*23 (100)*
80. Both baseline preoperative oral feeding skills and the rate at which those skills are regained after cardiac surgery are important in predicting prolonged feeding difficulty.	1.80 (0.71)	1–3	25 (100)	–	–	–
2.3 Developing oral feeding skills						
81. It is important for infants to experience breastfeeding as soon as possible, if desired by the parent, to help prevent swallowing disorders.	*2.39 (1.27)*	*1–6*	*23 (92)*	*2.13 (0.69)*	*1–4*	*23 (100)*
82. Encouraging infants to experience nipple feeding (breast or bottle) preoperatively, when possible, leads to increased rates of oral feeding postoperatively,	1.79 (0.66)	1–3	24 (96)	–	–	–
83. For bottle fed infants, slow-flow nipples are less physiologically taxing than standard-flow nipples.	*2.67 (1.44)*	*1–6*	*24 (96)*	*2.50 (0.67)*	*1–4*	*22 (96)*
84. The pattern of sucking, swallowing, and breathing must be assessed as part of the development of a feeding plan.	1.36 (0.57)	1–3	25 (100)	–	–	–
85. Breastfeeding prompts greater synchronization between suck, swallow, and breathing patterns than bottle feeding.	1.75 (0.94)	1–4	24 (96)	–	–	–
86. Having a clear understanding of when an infant shows a disorganized feeding pattern of sucking, swallowing, and breathing is needed for effective problem-solving.	1.32 (0.48)	1–2	25 (100)	–	–	–
87. Parents or caregivers need to make sense of their baby's pattern of sucking, swallowing, and breathing to optimize feeding.	1.32 (0.48)	1–3	25 (100)	–	–	–
88. Infants with CCHD who are working on developing oral feeding skills should be allowed to feed by nipple for a restricted period of time (e.g. 10–20 minutes), with the remaining milk volume administered via tube feedings.	*2.28 (0.84)*	*1–4*	*25 (100)*	*2.36 (0.90)*	*1–5*	*22 (96)*
89. Infants with CCHD who are working on developing oral feeding skills should be encouraged ad libitum oral feeding during the day (8–12 hours), then provided the balance of the daily nutritional needs by continuous feeding at night.	*3.61 (1.23)*	*2–6*	*23 (92)*	*3.48 (0.95)*	*1–4*	*23 (100)*
2.4 Dysphagia						
90.Most infants with CCHD will deal with some degree of dysphagia.	*2.86 (1.36)*	*1–6*	*22 (88)*	*2.65 (0.57)*	*1–3*	*23 (100)*

Topics, subtopics, and statements	Round 2			Round 3		
	Mean (SD)	Range	N (%)	Mean (SD)	Range	N (%)
91. Most infants who are intubated for more than 24 hours will experience some degree of dysphagia.	*3.04 (0.94)*	*1–5*	*25 (100)*	*3.00 (0.60)*	*1–3*	*23 (100)*
92. For infants who are intubated for more than 24 hours, an evaluation by a speech-language pathologist should be completed before oral feeding is resumed.	*2.92 (1.22)*	*1–6*	*25 (100)*	*2.43 (0.90)*	*1–4*	*23 (100)*
93. Consistent involvement by a speech-language pathologist can reduce patient morbidity, length of hospital stay, and necessity of feeding tubes.	2.00 (1.16)	1–5	25 (100)	1.78 (0.52)	1–3	23 (100)
94. An oral motor stimulation program can reduce length of hospital stay.	2.04 (0.94)	1–5	25 (100)	1.86 (0.35)	1–2	22 (96)
95. An oral motor stimulation program can help infants with CCHD achieve oral feeding more quickly.	1.96 (0.79)	1–5	25 (100)	–	–	–
96. An oral motor stimulation program can reduce the need for feeding tubes.	2.12 (0.83)	1–5	25 (100)	1.82 (0.40)	1–2	22 (96)
97. An oral motor stimulation program is feasible for parents/caregivers to learn and implement in the hospital.	1.79 (0.72)	1–4	24 (96)	–	–	–
98. For infants who experience dysphagia, bottle feeding leads to more swallowing difficulty than does breastfeeding.	*3.05 (1.33)*	*1–6*	*22 (88)*	*2.91 (1.04)*	*1–5*	*23 (100)*
Topic 3. Feeding practice						
3.1 Preoperative feeding practice						
99. Early preoperative enteral feeding (within 24 hours after birth) is well-tolerated in infants with CCHD.	*2.23 (1.07)*	*1–5*	*22 (88)*	*2.05 (0.52)*	*1–3*	*19 (83)*
100. Enteral feeding should be initiated as soon as the infant is hemodynamically stable.	1.52 (0.59)	1–3	25 (100)	–	–	–
101. Preoperative trophic feeding is associated with improved outcomes, as compared with infants who receive nothing by mouth.	1.71 (0.62)	1–3	24 (96)	–	–	–
102. Delayed initiation of enteral feeding increases the time needed to attain full enteral feeds.	1.68 (0.63)	1–3	25 (100)	–	–	–
103. Human milk is the preferred option for initiation of preoperative enteral feeds.	1.04 (0.20)	1–2	25 (100)	–	–	–
104. Preoperative enteral feeding is safe in prostaglandin-dependent infants.	*2.19 (0.87)*	*1–4*	*21 (84)*	*2.06 (0.54)*	*1–3*	*18 (78)*
105. Preoperative enteral feeding is safe in infants who have ductal-dependent physiology.	*2.36 (0.90)*	*1–4*	*22 (88)*	*2.11 (0.57)*	*1–3*	*19 (83)*
106. Preoperative enteral feeding is safe in infants who have umbilical arterial or venous catheters.	1.73 (0.70)	1–3	22 (88)	–	–	–
107. Preoperative enteral feeding is safe in infants who require vasoactive medication therapy.	*2.70 (1.13)*	*1–5*	*20 (80)*	*2.67 (0.69)*	*1–3*	*18 (78)*
108. Preoperative enteral feeding promotes bonding between the infant and the parent/caregiver.	1.29 (0.55)	1–3	24 (96)	–	–	–
109. Preoperative enteral feeding is associated with a shorter duration of mechanical ventilation.	*2.87 (1.30)*	*1–6*	*15 (60)*	*2.72 (0.46)*	*1–2*	*18 (78)*
110. Preoperative enteral feeding promotes the development of normal feeding patterns.	2.08 (0.88)	1–4	24 (96)	1.95 (0.38)	1–3	21 (91)
111. Preoperative enteral feeding promotes immunologic and gut mucosal health.	1.60 (0.71)	1–4	25 (100)	–	–	–
112. Most feeding protocols for infants with CCHD fail to identify preoperative measures that protect the intestinal barrier and mucosal and immune function in this fragile population.	*2.21 (1.25)*	*1–5*	*24 (96)*	*2.14 (0.71)*	*1–4*	*22 (96)*
113. All patients with single-ventricle physiology will require parenteral nutrition before stage 1 palliation and in the early postoperative period.	*3.19 (1.50)*	*1–6*	*21 (84)*	*3.16 (0.60)*	*1–4*	*19 (83)*

Topics, subtopics, and statements	Round 2 Mean (SD)	Round 2 Range	Round 2 N (%)	Round 3 Mean (SD)	Round 3 Range	Round 3 N (%)
3.2 Postoperative feeding practice						
114. Postoperative enteral feeding should begin as soon as safe and feasible.	1.28 (0.54)	1–3	25 (100)	–	–	–
115. Postoperatively, healthcare teams are hesitant to begin feeding infants with more complex cardiac repairs due to hemodynamic instability.	1.88 (0.85)	1–4	24 (96)	–	–	–
116. Infants with CCHD tolerate enteral feeding (e.g., trophic feeding) starting 4–6 hours after surgery.	*2.50 (1.10)*	*1–5*	*20 (80)*	*2.68 (0.95)*	*1–4*	*19 (83)*
117. Early enteral feeding (e.g., trophic feeding) starting 4–6 hours after surgery decreases infection-related morbidity following congenital heart repairs.	*2.65 (1.04)*	*1–5*	*20 (80)*	*2.53 (0.70)*	*1–4*	*19 (83)*
118. Early enteral feeding (e.g., trophic feeding) starting 4–6 hours after surgery, is associated with shorter duration of mechanical ventilation.	*2.68 (1.00)*	*1–5*	*19 (76)*	*2.74 (0.65)*	*1–4*	*19 (83)*
119. Early enteral feeding (e.g., trophic feeding) starting 4–6 hours after surgery is associated with shorter ICU length of stay.	*2.74 (0.99)*	*1–5*	*19 (76)*	*2.79 (0.71)*	*1–4*	*19 (83)*
120. Most infants with CCHD will receive nutrition via an NG tube postoperatively.	1.96 (0.62)	1–3	24 (96)	–	–	–
121. Rapid advancement to higher caloric intake (e.g., fortification of human milk) improves weight gain postoperatively.	*3.30 (1.22)*	*2–6*	*23 (92)*	*2.95 (0.50)*	*1–3*	*21 (91)*
122. Higher caloric intake (e.g., fortification of human milk) is associated with better postoperative recovery, with less chance of infection and shorter ICU stay.	*3.25 (1.02)*	*1–5*	*20 (80)*	*2.95 (0.50)*	*1–3*	*21 (91)*
123. Higher caloric intake (e.g., fortification of human milk) may not be tolerated in some infants with CCHD.	1.88 (0.67)	1–4	25 (100)	–	–	–
124. Most infants will be fluid-restricted postoperatively.	1.91 (0.95)	1–5	23 (92)	–	–	–
125. Postoperative feeding protocols improve weight gain in infants with CCHD.	1.78 (0.85)	1–4	23 (92)	–	–	–
126. Feeding protocols promote consistent communication between healthcare providers and families.	1.80 (1.04)	1–5	25 (100)	–	–	–
127. Many feeding protocols do not have clearly defined, medically sound reasons for withholding or discontinuing feeds.	*2.44 (1.00)*	*1–5*	*25 (100)*	*2.05 (0.58)*	*1–4*	*22 (96)*
128. Any standardized feeding protocol that includes clear definitions for feeding intolerance, acceptable reasons for withholding of feeds, minimization of interruptions for routine procedures, and clear caloric goals with frequent growth assessment is likely to improve care overall.	1.40 (0.50)	1–2	25 (100)	–	–	–
129. Because there are few data associating feeding practices and outcomes in infants with CCHD, healthcare providers rely on anecdotal and institution-based practices for the initiation and advancement of feeding.	1.61 (0.58)	1–3	23 (92)	–	–	–
130. There is significant variability of practice in postoperative feeding management for infants with CCHD.	1.46 (0.66)	1–3	24 (96)	–	–	–
3.3 Necrotizing enterocolitis						
131. Absence of enteral feeding does not prevent necrotizing enterocolitis.	1.63 (0.77)	1–4	24 (96)	–	–	–
132. An NPO state may put an infant at higher risk for necrotizing enterocolitis.	2.14 (1.04)	1–4	22 (88)	1.95 (0.58)	1–3	22 (96)

Topics, subtopics, and statements	Round 2 Mean (SD)	Round 2 Range	Round 2 N (%)	Round 3 Mean (SD)	Round 3 Range	Round 3 N (%)
133. Rapid advancement of enteral feedings in postoperative infants does not increase the risk of necrotizing enterocolitis.	*3.09 (1.19)*	*1–5*	*22 (88)*	*3.00 (0.80)*	*1–4*	*20 (87)*
134. Rapid advancement in caloric density may increase the risk of necrotizing enterocolitis.	*2.92 (1.14)*	*1–6*	*25 (100)*	*2.86 (0.77)*	*1–5*	*22 (96)*
135. High-volume feeding may increase the risk of necrotizing enterocolitis.	*3.43 (1.08)*	*2–5*	*23 (92)*	*3.14 (0.71)*	*1–4*	*22 (96)*
136. Very slow and cautious escalation of feeding volumes is protective against necrotizing enterocolitis.	*3.22 (1.17)*	*1–5*	*23 (92)*	*3.19 (0.87)*	*1–5*	*21 (91)*
137. There is an association between formula feeding and necrotizing enterocolitis.	*2.17 (1.23)*	*1–5*	*23 (92)*	*2.04 (0.83)*	*1–4*	*23 (100)*
3.4 Interdisciplinary healthcare team practice						
138. Enteral feeding guidelines tend to focus on hemodynamic stability and nutrition goals without regard to developmental milestones necessary to support oral feeds.	1.76 (0.66)	1–3	25 (100)	–	–	–
139. All infants should be reviewed weekly by a dietitian, as part of a multidisciplinary team process.	1.24 (0.52)	1–3	25 (100)	–	–	–
140. Parents and caregivers should be involved in discussions about nutrition and fluid goals for their infant.	1.28 (0.54)	1–3	25 (100)	–	–	–
3.5 Post-discharge and interstage feeding practice						
141. Infants with CCHD often receive fewer calories than they need after discharge	*2.55 (1.44)*	*1–6*	*22 (88)*	*2.68 (0.72)*	*1–4*	*22 (96)*
142. For infants who are interstage, adequate growth may be achieved regardless of feeding modality (e.g., by mouth or feeding tube) and therefore local comfort and complication risk should dictate feeding modality.	*2.95 (1.54)*	*1–6*	*20 (80)*	*2.95 (0.87)*	*1–4*	*21 (91)*
143. For infants who are interstage, home monitoring is key to achieving adequate growth.	1.48 (0.65)	1–3	25 (100)	–	–	–
144. A registered dietitian should be involved in assessment and management of growth at each clinic visit and when nutritional concerns arise.	1.44 (0.71)	1–3	25 (100)	–	–	–
145. Supplemental tube feeding is a safe and effective method for delivering nutrition.	1.84 (0.94)	1–5	25 (100)	–	–	–
146. A G-tube is a marker for greater severity of illness.	*3.63 (1.58)*	*1–6*	*24 (96)*	*3.43 (1.12)*	*1–5*	*23 (100)*
147. Supplementation by tube feeds does not mitigate growth failure.	*3.16 (1.55)*	*1–6*	*25 (100)*	*3.48 (0.73)*	*1–4*	*23 (100)*
148. Tube feeding facilitates catch-up growth for infants who have low weight-for-age z-scores after hospital discharge.	*2.48 (1.19)*	*1–6*	*25 (100)*	*2.22 (0.60)*	*1–4*	*23 (100)*
149. Nutritional support delivered via G-tube reduces the stress experienced by parents of infants with feeding problems.	*3.36 (1.63)*	*1–6*	*25 (100)*	*3.09 (0.87)*	*1–5*	*22 (96)*
150. Parents/caregivers experience increased stress when their infant requires a feeding tube.	*2.64 (1.52)*	*1–6*	*25 (100)*	*2.70 (0.82)*	*1–4*	*23 (100)*
151. Parents/caregivers are concerned about the time, energy, and knowledge required for feeding tubes.	*2.04 (1.10)*	*1–5*	*25 (100)*	*2.04 (0.56)*	*1–4*	*23 (100)*
152. Parents/caregivers worry about the long-term effects of tube feeding on their infants' ability to feed normally in the future.	1.64 (1.00)	1–5	25 (100)	–	–	–
Topic 4. Growth failure						
4.1 Risk factors related to growth failure						
153. Most infants who require cardiac surgery in the neonatal period struggle with gastrointestinal	*2.43 (1.04)*	*1–5*	*23 (92)*	*2.14 (0.47)*	*1–3*	*22 (96)*

Topics, subtopics, and statements	Round 2 Mean (SD)	Round 2 Range	Round 2 N (%)	Round 3 Mean (SD)	Round 3 Range	Round 3 N (%)
morbidities and growth failure during the postoperative period and throughout the first 4–8 weeks after birth.						
154. Duration of respiratory support (both invasive and noninvasive) is associated with a lower weight-for-age z-score.	*2.32 (1.00)*	*1–5*	*22 (88)*	*2.09 (0.43)*	*1–3*	*22 (96)*
155. Lower caloric intake is associated with a lower weight-for-age z-score at hospital discharge.	1.83 (0.82)	1–4	24 (96)	–	–	–
156. A shorter duration of parenteral nutrition therapy is associated with lower weight-for-age z-score at hospital discharge.	*3.58 (1.31)*	*1–5*	*19 (76)*	*3.72 (0.75)*	*1–4*	*18 (78)*
157. Weight-for-age z-score is not associated with severity of surgery.	*3.55 (0.86)*	*1–5*	*22 (88)*	*3.95 (0.39)*	*1–3*	*20 (87)*
158. A lower weight-for-age z-score is a risk factor for longer length of hospital stay.	*2.25 (0.90)*	*1–4*	*24 (96)*	*2.05 (0.38)*	*1–3*	*22 (96)*
159. Single ventricle infants are at a higher risk of growth failure and malnutrition, as compared to infants with other forms of CCHD.	1.90 (0.94)	1–4	21 (84)	–	–	–
160. Infants who are interstage are most at risk for growth failure, as compared to infants with repaired CCHD.	1.91 (0.81)	1–3	22 (88)	–	–	–
161. Infants who undergo surgeries that are considered riskier are more likely to experience growth failure postoperatively.	*2.56 (1.00)*	*1–5*	*25 (100)*	*2.59 (0.59)*	*1–3*	*22 (96)*
162. Growth failure is more common in infants who have pulmonary hypertension.	*2.59 (0.91)*	*1–4*	*22 (88)*	*2.70 (0.57)*	*1–3*	*20 (87)*
163. Growth failure is more common in infants who are formula fed, as compared to those who are fed human milk.	*4.05 (0.91)*	*2–6*	*19 (76)*	*4.18 (0.73)*	*1–4*	*22 (96)*
164. Exclusively breastfed infants will lose more weight than those who receive supplemental feeds via bottle or feeding tube.	*4.00 (1.27)*	*1–6*	*22 (88)*	*3.82 (0.85)*	*1–5*	*22 (96)*
4.2 Energy needs						
165. Infants with CCHD require more kcal/kg/day than healthy infants.	2.20 (1.04)	1–5	25 (100)	1.87 (0.46)	1–3	23 (100)
166. Infants with unrepaired CCHD have increased energy needs.	2.00 (0.82)	1–4	25 (100)	–	–	–
167. Insufficient pain control can prolong or exacerbate the catabolic response following surgery, leading to increased energy requirements.	1.96 (0.86)	1–4	24 (96)	–	–	–
168. Energy requirements for infants of CCHD quickly decline toward normal with surgical repair and normalization of cardiac physiology.	*2.46 (1.14)*	*1–5*	*24 (96)*	*2.27 (0.46)*	*1–2*	*22 (96)*
169. For infants with CCHD, caloric intake during the hospital stay is below what is recommended.	*3.13 (1.14)*	*1–5*	*23 (92)*	*2.91 (0.87)*	*1–4*	*22 (96)*
170. An infant who is exclusively breastfed can be relied on to take in a volume of human milk suited to nutritional needs.	*3.70 (1.26)*	*1–6*	*23 (92)*	*4.17 (0.65)*	*1–4*	*23 (100)*
171. Most infants will be unable to reach calorie goals of 100–120 kcal/kg/day by hospital discharge.	*3.70 (1.02)*	*1–5*	*23 (92)*	*3.62 (0.74)*	*1–3*	*21 (91)*
172. Ultimately, growth failure is linked to inadequate nutrition, both caloric and protein.	2.33 (0.96)	1–4	24 (96)	1.96 (0.48)	1–3	23 (100)
173. To establish adequate growth, the most severely affect infants may require more than 150 kcal/kg/day.	*2.64 (1.33)*	*1–6*	*22 (88)*	*2.65 (0.75)*	*1–4*	*20 (87)*
174. The infant who has undergone cardiac surgery has higher protein needs than a healthy infant; therefore, protein supplementation is a key component of a postoperative feeding protocol.	*2.71 (1.19)*	*1–6*	*21 (84)*	*2.67 (0.73)*	*1–4*	*21 (91)*

Topics, subtopics, and statements	Round 2			Round 3		
	Mean (SD)	Range	N (%)	Mean (SD)	Range	N (%)
175. A daily protein intake of 2–3 g/kg is sufficient to avoid a negative nitrogen balance and promote tissue repair.	*2.95 (0.83)*	*2–5*	*20 (80)*	*2.82 (0.39)*	*1–2*	*17 (74)*
176. Infants should be expected to gain 20 to 30 g/day for the first six months of life.	*2.40 (0.96)*	*1–5*	*25 (100)*	*2.09 (0.52)*	*1–3*	*23 (100)*
177. While increase in weight is an objective measure of energy balance, feeding success is more difficult to quantify.	*2.29 (1.27)*	*1–6*	*24 (96)*	*2.13 (0.87)*	*1–6*	*23 (100)*
178. Fluid restrictions cause the provision of sufficient energy and protein during the postoperative period to be challenging.	1.75 (0.79)	1–4	24 (96)	–	–	–
4.3 Prevention and treatment of growth failure in the hospital						
179. For infants with CCHD, aggressive parenteral and enteral nutritional therapy during the initial hospital course reduces the risk of growth failure.	*2.08 (1.08)*	*1–5*	*25 (100)*	*2.05 (0.65)*	*1–4*	*22 (96)*
180. Initiation of early postoperative nutrition improves weight-for-age z-score by hospital discharge.	1.80 (0.58)	1–3	25 (100)	–	–	–
181. Parenteral nutrition should be stopped only after achieving full volume/caloric density of feeds.	*2.79 (1.35)*	*1–6*	*24 (96)*	*2.55 (0.74)*	*1–4*	*22 (96)*
182. Parenteral nutrition is not utilized as often as it should be, in order to help infants achieve adequate nutrition.	*3.27 (1.42)*	*1–5*	*22 (88)*	*3.09 (1.02)*	*1–5*	*22 (96)*
183. Intravenous intralipids should be administered until patients are consistently receiving at least 100 kcal/kg/day.	*2.57 (1.25)*	*1–5*	*21 (84)*	*2.67 (0.77)*	*1–4*	*18 (78)*
184. Infants with CCHD should be given probiotics.	*3.78 (1.17)*	*2–6*	*18 (72)*	*4.11 (0.76)*	*1–4*	*18 (78)*
185. Growth failure is a common reason for the healthcare team to delay discharge.	2.00 (1.18)	1–5	24 (96)	1.91 (0.43)	1–3	22 (96)
4.4 Prevention and treatment of growth failure post-discharge and interstage						
186. For infants who are interstage, the majority of weight loss occurs early during the interstage period, within the first month after stage 1 surgery.	*2.68 (1.00)*	*1–5*	*19 (76)*	*2.65 (0.49)*	*1–2*	*20 (87)*
187. For infants who are interstage, the rate of weight gain will decline over time.	*3.05 (1.31)*	*1–5*	*19 (76)*	*2.90 (0.72)*	*1–4*	*20 (87)*
188. For infants who are interstage, failure to gain at least 20 g in 3 days is a red flag that should be reported to a healthcare provider.	*2.08 (0.83)*	*1–5*	*24 (96)*	*2.05 (0.22)*	*1–2*	*21 (91)*
189. For infants who are interstage, enteral intake less than 100 mL/kg/day is a red flag that should be reported to a healthcare provider.	1.78 (0.74)	1–4	23 (92)	–	–	–
190. For infants who are interstage, weight loss above 30 g/day is a red flag that should be reported to a healthcare provider.	1.75 (0.74)	1–4	24 (96)	–	–	–
191. For infants who are interstage, a lower number of nutritional interventions by cardiologists results in poorer growth.	*2.68 (1.38)*	*1–5*	*19 (76)*	*2.76 (0.70)*	*1–4*	*21 (91)*
192. Normal infant growth can be achieved with intensive multidisciplinary nutritional intervention in the setting of an interstage home monitoring program.	1.58 (0.65)	1–3	24 (96)	–	–	–
Topic 5. Parental concern						
5.1 Parental concern about feeding						

Topics, subtopics, and statements	Round 2			Round 3		
	Mean (SD)	Range	N (%)	Mean (SD)	Range	N (%)
193. For parents of infants with CCHD, timing feedings is a difficult task, as these babies may either take a long time to eat or tire easily.	1.80 (0.96)	1–5	25 (100)	–	–	–
194. Vomiting in infants with CCHD is a major source of stress for parents.	1.56 (0.71)	1–3	25 (100)	–	–	–
195. Infants with CCHD are less likely to show interest in feeding, as compared to healthy infants.	*2.46 (1.22)*	*1–5*	*24 (96)*	*2.30 (0.64)*	*1–3*	*23 (100)*
196. Parents of infants with CCHD have a more difficult time determining their infant's hunger cues, as compared to healthy infants.	*2.63 (1.28)*	*1–5*	*24 (96)*	*2.61 (0.78)*	*1–4*	*23 (100)*
197. Feeding difficulties are one of the main post-discharge concerns for parents of infants with CCHD.	1.40 (0.58)	1–3	25 (100)	–	–	–
198. For parents of infants who are receiving human milk, feeding support following discharge should include a visit with a lactation consultant.	1.44 (0.65)	1–3	25 (100)	–	–	–
199. The impact of feeding difficulties on the family an infant with CCHD can be so great as to overshadow any other cardiac concerns.	1.88 (0.95)	1–4	24 (96)	–	–	–
200. How parents interpret their baby's cues related to feeding can direct their feeding practice.	1.52 (0.65)	1–3	25 (100)	–	–	–
201. In order to develop sensitive feeding practices, it is necessary for parents and caregivers to recognize infant cues that signal hunger, stress, fatigue and satiation.	1.28 (0.46)	1–2	25 (100)	–	–	–
202. The extent to which a parent worries about feeding volume, at the expense of attention to infant cues, could interfere with sensitive feeding practices.	1.36 (0.57)	1–3	25 (100)	–	–	–
203. Parent and caregiver development of feeding competencies is a high priority before an infant is discharged from the hospital.	1.54 (1.14)	1–6	24 (96)	–	–	–
204. The healthcare team should assess how parents and caregivers think and feel about feeding their baby.	1.24 (0.52)	1–3	25 (100)	–	–	–
205. Parents and caregivers need specific guidance and support for developing feeding competencies for their infant.	1.20 (0.41)	1–2	25 (100)	–	–	–
206. Parents and caregivers may need assistance in making decisions about changing feeding practice in respect to method, type, frequency, and volume of feedings.	1.24 (0.44)	1–2	25 (100)	–	–	–

[a]Statements in which the results did not achieve consensus (mean >2 or <5; SD >1) are italicized

CCHD = complex congenital heart disease; ICU = intensive care unit; BiPAP = bilevel positive airway pressure; CPAP = continuous positive airway pressure; NG = nasogastric; NPO = *nil per os* (nothing by mouth); G-tube = gastrostomy tube