

Welcome

to North Mississippi Medical Center's Women's Hospital!

We are pleased you have chosen us to care for you and your family. Women's Hospital is dedicated to providing a family centered approach to labor, delivery, postpartum care and, if needed, neonatal care services for your baby. We recognize this is a special time in your family's life. It is important that you know we are here to meet your needs. Our dedicated staff includes physicians, nurses, lactation consultants, respiratory therapists and pharmacists who are here to care for you and your baby. If there is something you need, please do not hesitate to ask any of your caregivers or, if you prefer, you may call me directly at (662) 377-4902.

Again, thank you for allowing us to care for you. It is our pleasure to serve the needs of mothers and babies in our region, and we strive to treat each and every one with special care and attention.

Sincerely,



Ellen Friloux, Administrator
Women and Children's Services



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Baby Care



**NORTH MISSISSIPPI
MEDICAL CENTER**

WOMEN & CHILDREN'S SERVICES



Baby Care

Nursery Information

Please read the following information about your baby's nursery stay. You may call the nursery by dialing 4937, 4938 or 4940 from your hospital room.

Admission

During admission to the nursery, your baby will receive two medications; eye ointment and a shot of Vitamin K. He/she will be weighed and his/her length and head will be measured. A nursery nurse will examine your baby and check his/her temperature, heart rate and respiratory rate every hour for four hours. Your baby will be kept in a heated incubator for three hours and during this time, he/she will be bathed. Your baby may also have glucose screening based on his/her weight, if the mother had diabetes during the pregnancy, or if the baby has symptoms that could indicate a low blood sugar. Three hours after admission to the nursery, your baby will be placed in an open crib if his/her temperature is stable. Once in a crib, a security photo will be made and then your baby will be brought to your room.

Rooming In

After the initial transition period in the nursery, we encourage you to keep your baby in the room with you as much as possible, but we are always available to help when needed. "Rooming in" provides an excellent opportunity to increase the amount of bonding time with your baby and helps you learn your baby's natural eating and sleeping routines. You will find that this makes your transition to home much easier.

Feeding Times

If you choose not to room in, after the initial visit, bottle fed babies will be brought to your room for feedings. Generally, your baby will be with you 60-90 minutes for feedings, but you may keep him/her longer. Babies who are small or slightly pre-term should be fed every three hours. Larger, full term babies may be fed every three to four hours. Because babies have small stomachs and their food moves quickly through the digestive tract, babies have to be fed day and night.

Breast fed babies should be fed following delivery if the baby is stable, and then on demand. Therefore, we strongly encourage rooming in. If you choose not to room in, after the initial visit breast fed babies will be brought to your room on demand or at least every three hours.

During feeding times, the baby's crib will remain in the room. Diapers and clean linen are in the crib drawer. Please inform the nursery person who returns your baby to the nursery if you have changed a diaper or if your baby has spit up during the feeding. If your baby is receiving formula, bottles and nipples will be in the crib. Once your baby has eaten from a bottle, the milk in the bottle may only sit out for one hour. Always get a new nipple and bottle from the baby's crib for each feeding.

Security Measures

Your baby has an I.D. number on his/her ankle bracelet which matches the number on the mother's bracelet. Each time the baby is brought to your room, these numbers are checked to verify that we are giving you the correct baby.

For the safety of your baby, please have him/her returned to the nursery if you need to take a shower or leave the room. Your baby will be brought to and from your room in his/her crib. Please place your baby in the crib when he/she is not being held. For your baby's safety, do not leave him/her lying on your bed unattended.



A member of the nursery staff will explain the security card system to you when your baby is brought to your room for his/her first visit. DO NOT give your baby to anyone unless they show you the security card and you verify your signature on the card.

All Women's Hospital staff can be identified by a photo I.D. badge. Staff members that should pick up your baby will also have small teal and pink colored footprints beside the photograph in their I.D. badge. Please look for this identification prior to giving your baby to anyone. Call the nursery immediately if someone comes to your room to pick up your baby who does not have the appropriate I.D. or looks suspicious.

Infant Photos

During your stay, you will have an opportunity to purchase infant photographs. Typically, photos will be taken the day following birth. You will be asked to sign a consent for your baby to have his/her picture taken. If you have a special outfit for baby pictures, please put that outfit in the crib drawer today.

Visitors

To prevent sickness, it is best to limit visitor contact with a newborn baby. Brothers and sisters (siblings) of the baby are permitted to visit their mother at the convenience of the family. Siblings should be free from signs of illness, such as colds, and should not have been exposed to any contagious diseases, such as chicken pox, in the past three weeks. No other children are allowed to visit the patient rooms. Three adult visitors including the father/significant other are allowed in the mother's room when the baby is present. Everyone should wash their hands before holding the baby.

Circumcision

If your baby is a boy and you want him to be circumcised, you must make arrangements with the doctor that delivered him – if you have not previously done so. The doctor may require you to pay any fees prior to the circumcision. You will be asked to sign a consent form after the arrangement has been made. Generally, circumcisions are done in the morning between 7-10 a.m. Your baby's visit and feeding will be delayed until after the circumcision.

Hearing Screen

Following recommendations from the American Academy of Pediatrics and mandate from the State of Mississippi, all infants will have a hearing screen (ABR) performed prior to discharge. You will be notified of the results of the screen and will be asked questions to determine if your baby is at risk for hearing loss. Infants with hearing loss should be identified by 3 months of age in order to optimize speech development.

Why is it important for me to know about my baby's hearing now?

Hearing impairment in infants is easy to ignore because it is invisible and infants and toddlers cannot tell us they are unable to hear. Yet, hearing impairment is the most common birth defect and the most treatable of birth defects. Six out of 1,000 babies are born with it. Because babies learn to speak by listening, the child who is unable to hear normally will not develop speech and language normally. The most critical years for the development of language are from birth to three years of age. Early identification of hearing impairments enables us to give the child the special attention needed to aid in language development as well as in social, emotional and academic development.

How can my baby's hearing be screened?

We use a procedure called Automated Auditory Brainstem Evoked Response (AABR). Soft sounds are presented to your baby's ear through earphones. Electrodes that resemble stickers pick up the response from your baby's brain and send it to the instrument where it is analyzed automatically. The instrument then gives a PASS/REFER result.



What does PASS/REFER mean?

The instrument will test each ear independently. The output is determined as PASS (indicating the tested ear is normal) or REFER (indicating additional testing is needed).

What happens if my baby is referred?

If the baby refers on either ear, the screen is performed again after 12-24 hours. If a REFER is present on the second screen, and your baby is in the well baby nursery, your baby will be scheduled as an outpatient for further testing approximately two weeks after discharge. This test will be done at the Women's Hospital. If a REFER is present on the second screen and your baby is in the Neonatal Intensive Care Unit, your baby will be scheduled for an appointment with an audiologist one month from the due date.

What if my baby has risk factors?

Infants who are identified as having risk factors will be referred to the Mississippi State Department of Health Early Hearing Detection and Intervention Program for follow-up and should be seen regularly by his/her pediatrician.

How long does the test take?

The screening time depends entirely upon how quietly your baby is resting and may be completed in 15-20 minutes.

Is this test painful to my baby?

No. The test is completely painless and most infants sleep through the testing.

Where is the test performed?

Generally, the hearing screen is performed in the nursery area of the Women's Hospital.

Who does the test?

Nursery personnel who have been trained to operate the screening equipment will perform the screening. You will be notified of the outcome prior to discharge. You will receive a card stating whether your baby passed or is being referred for further evaluation, as well as the approximate ages that your child should be doing certain tasks, to see if he/she is on target for speaking and hearing.

What can you do if a hearing impairment is present?

Intervention is dependent upon the type of hearing impairment present. Medical consultation would be appropriate. If your child requires hearing aids, it is ideal that they be fitted before 6 months of age and that hearing follow up and rehabilitation be initiated accordingly.

An undetected and untreated hearing impairment can present a great disadvantage for the child and can permanently damage speech and language. **The sooner the impairment is identified the greater the opportunity the child has to develop normal speech and language.** Hearing impaired children can and do lead normal and happy lives.



Back To Sleep

Your baby should be placed on his/her back to sleep, unless he/she has a health condition that re-quires different positioning. Please read the following information on SIDS.

What is SIDS?

SIDS stands for sudden infant death syndrome. This term describes the sudden, unexplained death of an infant younger than one year of age. Some people call SIDS “crib death” because many babies who die of SIDS are found in their cribs. But, cribs don’t cause SIDS.

What should I know about SIDS?

Health care providers don’t know exactly what causes SIDS, but they do know:

- Babies sleep safer on their backs. Babies who sleep on their stomachs are much more likely to die of SIDS than babies who sleep on their backs.
- Sleep surface matters. Babies who sleep on or under soft bedding are more likely to die of SIDS.
- Every sleep time counts. Babies who usually sleep on their backs but who are then placed on their stomachs, even for a nap, are at very high risk for SIDS. So it’s important for everyone who cares for your baby to use the back sleep position for naps and at night.

What can I do to lower my baby’s risk for SIDS?

Here are 10 ways that you and others who care for your baby can reduce the risk of SIDS.

Safe Sleep Top 10

1. Always place your baby on his or her back to sleep, for naps and at night. The back sleep position is the safest, and every sleep time counts.
2. Place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet. Never place your baby to sleep on pillows, quilts, sheepskins or other soft surfaces.
3. Keep your baby’s sleep area close to, but separate from, where you and others sleep. Your baby should not sleep in a bed or on a couch or armchair with adults or other children, but he or she can sleep in the same room as you. If you bring the baby into bed with you to breastfeed, put him or her back in a separate sleep area, such as a bassinet, crib, cradle or a bedside cosleeper (infant bed that attaches to an adult bed) when finished.
4. Do not allow smoking around your baby. Don’t smoke before or after the birth of your baby, and don’t let others smoke around your baby.
5. Keep soft objects, toys and loose bedding out of your baby’s sleep area. Don’t use pillows, blankets, quilts, sheepskins and pillow-like crib bumpers in your baby’s sleep area, and keep any other items away from your baby’s face.
6. Think about using a clean, dry pacifier when placing the infant down to sleep, but do not force the baby to take it. (If you are breastfeeding your baby, wait until your child is one month old or is used to breastfeeding before using a pacifier.)
7. Do not let your baby overheat during sleep. Dress your baby in light sleep clothing, and keep the room at a temperature that is comfortable for an adult.
8. Avoid products that claim to reduce the risk of SIDS because most have not been tested for effectiveness or safety.
9. Do not use home monitors to reduce the risk of SIDS. If you have questions about using monitors for other conditions, talk to your health care provider.
10. Reduce the chance that flat spots will develop on your baby’s head: provide “tummy time” when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers and bouncers.



Babies sleep safest on their backs.

One of the easiest ways to lower your baby's risk of SIDS is to put him or her on the back to sleep, for naps and at night. Health care providers used to think that babies should sleep on their stomachs, but research now shows that babies are less likely to die of SIDS when they sleep on their backs. Placing your baby on his or her back to sleep is the No. 1 way to reduce the risk of SIDS.

But won't my baby choke if he or she sleeps on his or her back?

No. Healthy babies automatically swallow or cough up fluids. There has been no increase in choking or other problems for babies who sleep on their backs.

Spread the word!

Make sure everyone who cares for your baby knows the Safe Sleep Top 10! Tell grandparents, babysitters, child-care providers and other caregivers to always place your baby on his or her back to sleep to reduce the risk of SIDS. Babies who usually sleep on their backs but who are then placed on their stomachs, even for a nap, are at very high risk for SIDS – so every sleep time counts!

For more information on sleep position for babies and reducing the risk of SIDS, contact the Back to Sleep campaign at:

Phone: 1-800-505-CRIB (2742)

Mail: 31 Center Drive, Room 2A32, Bethesda, MD 20892

Fax: (301) 496-7101

Web site: <http://www.nichd.nih.gov/SIDS>



Discharge Classes

Discharge classes are offered Monday-Friday at 2:30 p.m. in Classroom "C." It is very important that you attend this class to receive discharge instructions on the care of your baby and yourself. If you are unable to attend this class, these instructions will be reviewed with you prior to discharge. Please feel free to ask questions regarding your baby anytime.

Infant CPR

Infant CPR classes are offered by a certified American Heart Association instructor every Tuesday and Thursday at 4 p.m. in Classroom "C." Please call (662) 377-4940 to register.

Car Seat Testing

Babies born prior to 37 weeks gestation will be tested in their car seat prior to discharge. The nursery staff will ask you to bring your car seat so that they may do this test. The test is done in the nursery. The baby will be secured in the car seat while attached to a monitor which will show the baby's heart rate, respiratory rate and how well the baby's blood is saturated with oxygen. The baby will be monitored for 30 minutes in the car seat. If the baby does not tolerate positioning in the car seat, the baby will have to be discharged in a car bed provided by the hospital. The car bed should be used until the baby is retested in the regular car seat and can tolerate positioning in it.

Newborn Screening

Mississippi law requires all newborns to be tested for a number of genetic disorders. This test is done by taking a small sample of blood from your baby's heel, typically on the second morning in the nursery.



Hepatitis B Vaccine

Following recommendations from the American Academy of Pediatrics, we offer the first dose of Hepatitis B vaccine to newborns in the nursery. We recommend your baby receive this vaccine within the first 12 hours of life. Please review the Hepatitis B vaccine information. You will be asked to sign a consent to accept or decline the vaccine for your baby.

Hepatitis B Vaccine – What you need to know

1. *Why get vaccinated*

Hepatitis B is a serious disease. The hepatitis B virus can cause short-term (acute) illness that leads to:

Loss of appetite • Tiredness • Pain in muscles, joints and stomach • Diarrhea and vomiting • Jaundice (yellow skin or eyes)

It can also cause long-term (chronic) illness that leads to:

Liver damage (cirrhosis) • Liver cancer • Death

About 1.25 million people in the United States have chronic hepatitis B virus infection.

Each year it is estimated that:

- 200,000 people, mostly young adults, get infected with hepatitis B virus
- More than 11,000 people have to stay in the hospital because of hepatitis B
- 4,000 to 5,000 people die from chronic hepatitis B

Hepatitis B vaccine can prevent hepatitis B. It is the first anti-cancer vaccine because it can prevent a form of liver cancer.

2. *How is hepatitis B virus spread?*

Hepatitis B virus is spread through contact with the blood and body fluids of an infected person. A person can get infected in several ways, such as:

- During birth when the virus passes from an infected mother to her baby
- By having sex with an infected person
- By injecting illegal drugs
- By being stuck with a used needle on the job
- By sharing personal items, such as a razor or toothbrush, with an infected person

People can get hepatitis B virus infection without knowing how they got it. About 1/3 of hepatitis B cases in the United States have an unknown source.

3. *Who should get hepatitis B vaccine and when?*

Everyone 18 years of age and younger

Adults over 18 who are at risk

Adults at risk for hepatitis B virus infection include people who have more than one sex partner, men who have sex with other men, injection drug users, health care workers, and others who might be exposed to infected blood or body fluids.

If you are not sure whether you are at risk, ask your doctor or nurse.

People should get three doses of hepatitis B vaccine according to the following schedule. If you miss a dose or get behind schedule, get the next dose as soon as you can. There is no need to start over.

Who: Infant whose mother is infected with hepatitis B virus

First dose: Within 12 hours of birth

Second dose: 1-2 months of age

Third dose: 6 months of age



Infant whose mother is not infected with hepatitis B virus

First dose: Birth-2 months of age

Second dose: 1-4 months of age (at least 1 month after first dose)

Third dose: 6-18 months of age

Older child, adolescent or adult

First dose: Any time

Second dose: 1-2 months after first dose

Third dose: 4-6 months after first dose

The second dose must be given at least one month after the first dose.

The third dose must be given at least two months after the second dose and at least four months after the first.

The third dose should not be given to infants younger than six months of age.

All three doses are needed for full and lasting immunity.

Hepatitis B vaccine may be given at the same time as other vaccines.

4. *Some people should not get hepatitis B vaccine or should wait*

People should not get hepatitis B vaccine if they have ever had a life-threatening allergic reaction to baker's yeast (the kind used for making bread) or to a previous dose of hepatitis B vaccine.

People who are moderately or severely ill at the time the shot is scheduled should usually wait until they recover before getting hepatitis B vaccine.

Ask your doctor or nurse for more information.

5. *What are the risks from hepatitis B vaccine?*

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of hepatitis B vaccine causing serious harm or death is extremely small.

Getting hepatitis B vaccine is much safer than getting hepatitis B disease.

Most people who get hepatitis B vaccine do not have any problems with it.

Mild problems

- Soreness where the shot was given, lasting a day or two (up to one out of 11 children and adolescents, and about one out of four adults)
- Mild to moderate fever (up to one out of 14 children and adolescents and one out of 100 adults)

Severe problems

- Severe allergic reaction (very rare)

6. *What if there is a moderate or severe reaction?*

What should I look for?

Any unusual condition, such as a serious allergic reaction, high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat or dizziness. If such a reaction were to occur, it would be within a few minutes to a few hours after the shot.

What should I do?

Call a doctor or get the person to a doctor right away. Tell your doctor what happened, the date and time it happened, and when the vaccination was given.

Ask your doctor, nurse or health department to file a Vaccine Adverse Event Reporting System (VAERS) form, or call VAERS yourself at 1-800-822-7967.



7. *The National Vaccine Injury Compensation Program*

In the rare event that you or your child has a serious reaction to a vaccine, a federal program has been created to help pay for the care of those who have been harmed. For details about the National Vaccine Injury Compensation Program, call 1-800-338-2382 or visit the program's website at <http://www.hrsa.gov/bhpr/vicp>.

8. *How can I learn more?*

Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.

Call your local or state health department's immunization program.

Contact the Centers for Disease Control and Prevention (CDC):

Call 1-800-232-2522 or 1-888-443-7232 (English) • Call 1-800-232-0233 (Español)

Visit the National Immunization Program's website at

<http://www.cdc.gov/nip> or <http://www.cdc.gov/ncidod/diseases/hepatitis>.

Mother to Child HIV Infection

Transmission of HIV from mother to child is called perinatal transmission. It can occur anytime during pregnancy, during labor or delivery or by breastfeeding. Perinatal HIV transmission is the most common way children become infected with the virus.

Research has shown that pregnant women with HIV can reduce the risk of transmitting HIV to their baby by taking Zidovudine (Retrovir, AZT) throughout their pregnancy. Research has also shown that giving Zidovudine to HIV exposed babies can greatly decrease their chance of developing the disease.

If you have HIV, your baby will be started on Zidovudine syrup within a few hours of birth. Your baby will need the medicine every six hours for six weeks to decrease his/her risk of getting HIV. You will be taught how to draw up and administer the medicine.

It is very important your baby receive the medicine on time and not miss any doses. To ensure there is no interruption in your baby's medication, ask the baby's doctor to call the prescription in to your pharmacy the day before you are discharged. Calling early will give the pharmacy time to order the medication if not in stock.

Your baby's doctor will work very closely with the University of Mississippi Medical Center Pediatric Infectious Diseases Department in Jackson, Miss. The goal is to ensure your baby is treated according to the latest recommendations. Your baby will need to be tested for HIV at 2 weeks, 1 month, 3 months and 6 months at UMMC Pediatric Infectious Diseases Clinic in Jackson. Appointments for testing can be made by calling UMMC Pediatric Infectious Diseases Clinic at (601) 815-1119.



Bathing

Choose a time of day when you can bathe your baby in a relaxed manner. Wait at least 30 minutes after a feeding before bathing the baby to prevent spitting up. If your baby does not sleep well during the night, you might try giving the bath in the evening just before you are ready to put the baby down for the night. Many babies fall into a deep sleep after a bath. If the temperature in your home is between 70°F-75°F, you should not have to raise it for the bath. Avoid drafty areas when giving the bath; babies lose heat four times faster than adults.

Sponge bathe your baby until the umbilical stump and circumcision have healed. Gather all of the items you need for the bath and bring them to the bath area. Choose an area where you have a flat, firm surface to lay the baby (a bed, changing table, kitchen table, etc.) and good lighting. You will need the following supplies:

- Baby soap, bath wash or any unscented white soap
- Shampoo and baby lotion
- Two washcloths and two bath towels
- Comb and brush
- Clean clothes and diaper

*Never leave the baby unattended in the bath. A baby can drown in a few inches of water.

Breastfeeding a Healthy/Well Baby

It is your responsibility to make sure your baby will get off to a good nutritional start. With your decision to breastfeed, you have joined the majority of American women who feel this is the best and most ideal way of feeding your baby. The American Academy of Pediatrics recommends breastfeeding exclusively until your baby is at least 6 months old, then continuing until your child is at least one year of age with breastfeeding and supplemental baby food being added to their diet. Breastfeeding may continue until you and your baby are ready to wean.

Almost as important as getting your baby off to a good nutritional start is the contribution that breastfeeding makes toward the infant's emotional development. Antibodies in breastmilk promote wellness in your infant. Breastmilk is a special combination of fats, minerals, proteins, vitamins, glucose and enzymes that promotes brain and body growth for your baby. The benefits of breastmilk have been well documented to include decreased respiratory and ear infection, aids digestion therefore less incidence of digestive illnesses, enhanced immune system, reduced incidence of some childhood cancers, and reduced incidence of heart disease and diabetes as an adult.

For you, Mom, it's convenient (always ready), economical and helps the process of the uterus to return to its normal size. It decreases your risk of ovarian and breast cancer. Breastfeeding creates a beautiful and intimate bond that only you and your baby can share.

The First 24 Hours

Immediately after delivery, your baby will be in a quiet alert state and will usually be ready to feed. If your baby isn't interested in feeding at this time, try again within the next half-hour. Within the first hour the baby's sucking reflex is most intense. After the baby is dried off, while lying on your chest in a skin-to-skin position, with a blanket covering both of you, your baby will start bobbing his head and move towards one breast or the other. Gently support your baby's bottom and back and let him move in the direction that he wants. Your baby will latch if he is ready. Taking advantage of this alert state and intense reflex can get you and your baby off to a good start. Within a couple of hours your baby will become very sleepy, and drowsiness may last for several days. Keeping your baby with you during your hospital stay will help you get to know and respond immediately to your baby's feeding cues.

Feeding/Hunger Cues

- Sucking movement of mouth and tongue
- Bringing hands/fingers to mouth
- Small sucking noises
- Rapid eye movement under eyelids



- Progressing to quiet alert, looking about for food

NOTE: Crying is a late sign of hunger. Do not wait for crying during your daytime hours.

The first 24 hours of breastfeeding can be a worrisome time. Your baby may or may not have fed within that first hour, but has now gone into a deep sleep and you are unable to get your baby to feed. It is very easy to become discouraged during this time. Get comfortable, remain calm and keep your baby close. Offer the breast every two to three hours, but also watch for cues and offer then also. Continue to offer in this pattern until baby is nursing well.

Placing your baby skin to skin on your chest may entice your baby to become interested in feeding. Most babies will actually move down the mother's body until self-attaching to the breast. Express (gently squeeze) a few drops of colostrum before you offer the breast. Your baby will be encouraged to latch if colostrum is readily available. Sometimes it is after the first day that your baby will begin to nurse six or more times/day (24-hour period) progressing to eight to 12 times a day thereafter. Babies are born with a special "fat" beneath the skin at the back of the neck called "brown fat." They metabolize or break down this fat for part of their energy and nutritional needs during this sleepy phase. The combination of this fat breakdown and intake of the concentrated colostrum is ample nutrition for babies. Most all babies lose an average of 7-10 percent of their birth weight in the first week. Your goal will be for baby to gain back to birth weight by the two-week checkup.

Waking a Sleepy Baby

The following are some suggestions for waking a sleepy baby.

- Undress baby down to diaper and cap, place skin-to-skin on your chest using a blanket to cover both baby and you
- Dim the lights
- Change diaper or at least thorough diaper check
- Try football hold
- Express a small amount of colostrum/milk onto your nipple so that baby may taste and smell the colostrum
- If latched but falling asleep, compress your breast gently, to increase the amount baby gets
- Rub the bottom of baby's feet or back gently

Never use a pacifier or supplements with your newborn. Your baby does not need water. Everything that your baby needs is present in your colostrum/breastmilk. Colostrum, the first milk, is rich in nutrients that are just right for your baby. The amount your baby receives increases somewhat each day. Colostrum is not a volume fluid, but rather concentrated to be a small amount that fits into baby's small stomach.

Skin-to-Skin Contact (Kangaroo Mother Care)

A multitude of studies show that mothers and babies should be together, skin-to-skin, immediately after birth as well as later. Babies positioned skin-to-skin on Mom are more likely to latch without any help, and latch well. Skin-to-skin positioning promotes a happier baby. The baby's temperature, heart rate and breathing are more stable, as well as baby's blood sugar.

Skin-to-skin contact is achieved by the baby dressed only in a diaper and cap, placed prone on your chest, and vertical with head just under your chin. Position baby's hands up toward face so he may accomplish pushing up and pushing off for movement toward the breast when ready to suck. Make sure you are comfortable and that the head of the bed is slightly elevated. (A recliner allows for appropriate positioning at home to continue use of skin-to-skin after discharge). Both you and your baby should be covered, allowing both to rest, thus allowing infant to self-wake and self-attach to the breast. Infant alertness and movement toward the breast may be sudden or require 30-45 minutes of movements with short periods of rest until squirming has placed infant directly in front of the nipple with strong rooting to self-latch with only gentle support from Mom. This "imprinting" time helps infant use all senses to find his food at the breast. This method may be used any time feedings are not going well, for the sleepy infant, or the infant who is fussy and seems confused at the breast.



REMEMBER: Skin-to-skin has the following effects on the baby:

- Encourages breastfeeding through stimulation of all infant senses
- More likely to latch well
- Stabilization of temperature, heart rate, respiration, blood pressure
- Stable blood sugar
- Less likely to cry
- More likely to exclusively breastfeed longer

This positioning of you and your baby together may be the single most effective tool to encourage breastfeeding. Skin-to-skin contact is also useful for the small baby or premature infant who may have temperature instability in an open crib.

Positions for Feeding

There are many different positions for holding your baby while feeding. The different positions prevent the same pressure points on your nipple and help with milk removal from your breast throughout the day. The first thing to do before positioning your baby at the breast is to make yourself comfortable. Use pillows to support your back and your arms. Sit as upright as you can in bed or in chair.

Football or Clutch Hold

As the name implies, tuck your baby's body under your arm like a "football." Place a pillow behind your back for support and along the side of the breast you will use. This will help support your baby up to the level of your nipple. Use your forearm to support the baby's back and the palm of your hand at the baby's shoulder blades. Position your thumb behind one ear, your other fingers cupped behind other ear to complete the hold for this position. This will keep him from curling his head forward. Gently tilting head backward allows for wider opening of the mouth, to bring chin onto breast first, then tip of nose just at breast. With your other hand forming a cup hold of the breast, gently stroke the upper lip with your nipple to stimulate the rooting reflex, which makes the baby open his mouth wide. Bring the baby onto the breast; don't try to force your breast into the baby's mouth. The football hold is frequently the first-used position in the hospital and early breastfeeding. This position gives you most control of the infant, best view of your baby while feeding, and is associated with achieving effective feedings when compared to other positions. This position is most often recommended after C-section deliveries.



Cross-Cradle Hold

To achieve this hold, simply put infant into football hold position, then use shoulder and arm to slide baby's head in front of opposite breast. Support your baby on the arm opposite the breast you use for feeding. Turn his body to face yours, chest to chest. Palm of your hand supports baby's shoulder blades and back while fingers form a c-shaped sling to hold head at base of skull and just behind the ears on either side. Push baby's chest toward you allowing the head and neck to extend slightly back. This support lifts the baby's chin up and off the chest to encourage wide-mouth opening and deeper latch. With your other hand forming a cup hold of the breast, gently stroke the upper lip with your nipple to stimulate the rooting reflex. Bring baby onto breast quickly once a wide gape, (open mouth) is viewed.



Side-Lying

This can be a very comfortable and convenient position, but it takes a little practice to get it right. It can allow you to rest while feeding your baby. This position is most useful for the new C-section mother who may still be very drowsy and have trouble holding her baby. This position is used after spinal or epidural anesthesia when the mother is required to lie flat for a specified length of time. Lie on your side, pillow behind your back, under your head, and between your knees. Position your baby on her side, opposite your breast, head slightly extended back. Your baby should be looking more upward toward your face than facing down into breast for proper latch. Guide her mouth to your nipple, once again stimulating the rooting reflex. Support baby's back with your forearm or place a rolled blanket/towel behind the back to keep baby close. It is wise to have family members instructed in assistance with this position as well as how to observe for proper latch. Both Mom and baby may easily fall asleep, lose appropriate latch, and begin to cause nipple damage or unnecessary soreness. Soreness requires intervention; ask for help.



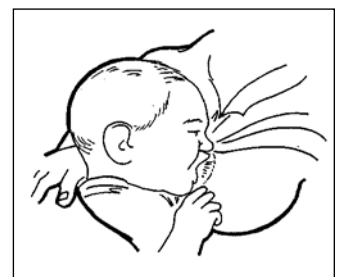
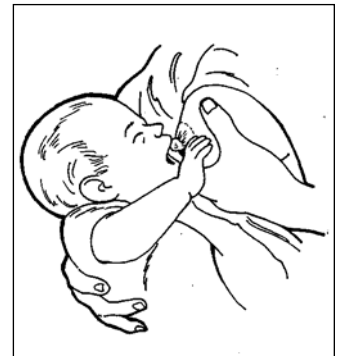
Cradle Hold

This classic hold is a commonly used position but may be the most difficult for appropriate latch and efficient feeds during the first few days in the hospital. Hold baby in your lap or on top of pillow. Extend your forearm and hand down her back to support neck, spine and buttocks. Her body from ears to knees should be in alignment facing towards you. Tuck her lower arm under your arm and breast. The nose should line up with your nipple. You may find it helpful to keep your elbow pulled snug against your side to give good support under baby's neck and to extend head slightly upward to lift chin up and off chest. Placing a pillow beside you or under this arm will provide you added support. Many moms use various forms of nursing pillows, but a folded blanket or bedspread is just as useful.



Latch

Getting the baby latched correctly is one of the most important steps in successful breastfeeding. The baby must open his mouth wide enough to get a good amount of areolar tissue into the mouth. Good positioning of baby makes for a better latch. Lightly stroke the baby's lips and chin with your nipple in a downward motion from the upper lip, keeping your nipple pointed up toward roof of baby's mouth. This is accomplished by cupping the breast, fingers underneath, thumb on top, positioned behind the areola. Tease baby with your nipple and wait for him to open his mouth wide (like a yawn, or the bird-in-a-nest look). Bring baby quickly to breast. Keep baby's head tilted back slightly. The chin and lower jaw will touch the breast first. Move the baby's body and head together, keeping baby uncurled. Slight pressure against the shoulder blade with palm of your hand keeps baby in this chin up or slightly sniffing position. When forwarded onto the breast quickly enough, the lips should flange outward (top lip rolled up and bottom lip rolled down; Dads may recognize this as "bass fish lips").



Signs of a Good Latch

- Absence of pain
- Lips flared out
- Tongue over lower gum
- Baby stays on breast
- Feel a strong pull and tug on breast
- Listen for swallows. Sounds like a soft "ca"
- Good latch usually leads to good sucks



Signs of Swallowing

Once latched correctly, listen or look for swallowing. The first few days your baby will suckle approximately three to seven times before a swallow is heard. You may also see the baby's throat move downward. In the first three days after delivery it may be difficult to hear or see swallowing. Ask your nurse to assist you in listening or evaluating for swallows. After larger volumes of milk arrive, you will hear definite suck to swallow ratio changes. It is the proper compression of the areola tissue from the baby's suck and the baby's tongue resting on top of the lower gum line that allows him to draw milk through the nipple.

Breast Compression

This technique works well in the first few days of your baby's life to help her get more colostrum. When baby is latched but not suckling, take your hand that is holding breast in a C-hold behind the areola and gently compress your thumb and fingers together. Release the pressure when the baby no longer drinks with the compression. A good rule of thumb is to compress for the count of three, let up, compress for the count of three, let up, in a slow and relaxed rhythm. Compression helps to forward colostrum to the nipple and encourage infant to feed as well as gently massages the tongue with your nipple, also encouraging baby to suck. The compression pressure should not hurt; do not squeeze hard enough to change the shape of the breast at baby's mouth or lips. You will not always need to use compressions. As breastfeeding improves, you will be able to let things happen naturally.

Taking Baby off the Breast

To take your baby off the breast, slide your finger into the corner of baby's mouth, over the gum line, to break the suction. Do not pull baby off breast while latched because pulling and stretching of the nipple can damage nipple tissue and cause undue soreness. Using your finger to break suction allows baby to bite down on your finger, not your nipple, while pulling away. Babies frequently do the big push off the breast themselves or relax enough in sleep to fall away from the nipple to detach.

Burping

Attempt to burp baby between breasts and after feeding to get rid of any swallowed air. Most air difficulties are associated with crying before feed or fussy at breast while trying to get latch. A well-latched baby does not swallow air from the breast. A diaper check between breasts is also helpful to wake baby for better feeding at the second breast.

Frequency and Duration of Feedings

How long?: Some babies will start out feeding only five to 15 minutes. Some will breastfeed for 30-45 minutes. Always leave baby on first breast as long as possible. Let your baby determine when the feeding has ended. When the baby comes off the first breast, attempt to burp him, check his diaper, and then offer second breast. Do not be concerned if your baby only nurses one side each feeding. Alternate breast when starting next feeding.

How often?: Most babies need and naturally request eight to 12 feedings in a 24-hour period after the first day of life. In the early sleepy days, the baby tends not to request feedings often enough. Offer a feeding approximately every one to two hours. This time starts from the beginning of one feeding to the beginning of the next one. Watch for feeding cues. Nursing after a baby shows cues stimulates your breast to produce plenty of milk. If you follow these steps, you will ensure proper milk removal completely and regularly, increase milk production, reduce breast engorgement and nipple tenderness, and maximize weight gain. The first sleepy week or two may prove to be a challenge for you to keep your baby interested in a feeding. Talk to your baby while nursing to keep him focused on you. Refer back to "Waking a Sleepy Baby" for waking techniques.

How to Know if Baby is Getting Enough

Unfortunately there are not ounce markers on the breast for you to see the exact amount your baby is receiving from you. This can be unnerving at times. Many clues indicate that everything is going well. Be attentive to the following:



- Your baby eats every one to two hours during the day and no more than one four-hour stretch at night.
- Wet diapers. Expect one wet diaper in first 24 hours after delivery, two on the second day, three on the third day, and five to six wet diapers of urine that are light yellow in color once milk is in greater supply.
- Your baby will pass thick black stools called meconium the first one to two days of life. This will change to green runny transitional stools and then to a runny, seedy, mustard color soft stool once milk is in greater supply. She will have four or more of these stools per day in the first month. You may also find that she will stool a little after each feeding.
- It is okay for your baby to breastfeed more than 12 times each day and to have more wet or soiled diapers. Call your baby's doctor or lactation consultant if your baby has less feedings, or fewer wet or soiled diapers.
- It is normal for a baby to lose up to 7-10 percent of his birth weight in the first few days of life. He should regain to his birth weight by two weeks of age. Thereafter, your baby should gain four to eight ounces per week.

Rest assured, the early milk, colostrum, is a perfectly balanced food for your baby's nutrition. It is very concentrated, measured in drops or teaspoons. Colostrum is a perfect amount for the baby's small stomach and kidneys that are not quite ready to handle volume fluid. Colostrum is full of antibodies, digestive enzymes, hormones, immune properties, and even a natural laxative that will help your baby pass the early stools called meconium. This form of valuable milk is not present in formula. Colostrum increases each day as the body gradually transitions to mature milk. This is what is referred to as your "milk comes in." The larger volume of milk occurs around three to five days after giving birth.

Help for Breastfeeding Mothers

Contact the Lactation Center with questions and concerns about breastfeeding and to schedule a lactation consultation. Call (662) 377-5490.



Breastfeeding Log

To help you keep track of feedings, wet diapers and soiled diapers, use the following log during the first week. Circle the hour (numbers 12-11) when your baby breastfed. Circle W when your baby has a wet diaper. Circle S when your baby has a soiled diaper (bowel movement). If you are using disposable diapers and cannot tell if they are wet, put a dry paper towel or tissue in the diaper at each changing. It will show when the baby is wet.

Birth Date: ___/___/___

Time: _____ AM PM

DAY ONE		Goal
12 1 2 3 4 5 6 7 8 9 10 11	12 1 2 3 4 5 6 7 8 9 10 11	6 to 8
Wet diaper	W	1
Black tarry soiled diaper	S	1

DAY TWO		Goal
12 1 2 3 4 5 6 7 8 9 10 11	12 1 2 3 4 5 6 7 8 9 10 11	6 to 8
Wet diaper	W W	2
Black tarry soiled diaper	S S	2

DAY THREE		Goal
12 1 2 3 4 5 6 7 8 9 10 11	12 1 2 3 4 5 6 7 8 9 10 11	8 to 12
Wet diaper	W W W	3
Brown tarry soiled diaper	S S	2

DAY FOUR		Goal
12 1 2 3 4 5 6 7 8 9 10 11	12 1 2 3 4 5 6 7 8 9 10 11	8 to 12
Wet diaper	W W W W	4
Brownish yellow or green seedy	S S S	3

DAY FIVE		Goal
12 1 2 3 4 5 6 7 8 9 10 11	12 1 2 3 4 5 6 7 8 9 10 11	8 to 12
Wet diaper	W W W W W	5
Yellow soiled diaper	S S S	3

DAY SIX		Goal
12 1 2 3 4 5 6 7 8 9 10 11	12 1 2 3 4 5 6 7 8 9 10 11	8 to 12
Wet diaper	W W W W W W	6 to 8
Yellow soiled diaper	S S S S	4

DAY SEVEN		Goal
12 1 2 3 4 5 6 7 8 9 10 11	12 1 2 3 4 5 6 7 8 9 10 11	8 to 12
Wet diaper	W W W W W W W	6 to 8
Yellow soiled diaper	S S S S	4 to 12

It's okay for your baby to nurse more than 12 times each day and to have more wet or soiled diapers. You can't nurse too often. You CAN nurse too little. Call if you have fewer than the numbers on the log.



Discharge Instructions

Building Your Milk Supply

- Feed early and often, at the earliest signs of hunger
- Eight to 12 feedings per 24 hours is expected, though these feedings may not follow a regular schedule.
- Avoid pacifiers or bottles, at least two weeks
- Frequent feeds, not formula: only use formula if there's a medical reason.
- Sleep near your baby, even at home.
- Learn to nurse lying down also.

Feed at the earliest signs of hunger

- Hands to mouth, sucking movements
- Soft cooing, sighing sounds or stretching
- Rooting mouth, licking lips
- Crying is a late sign of hunger; don't wait until then!

Watch the baby, not the clock

- Alternate which breast you start with or start with the breast that feels most full.
- Switch sides when swallowing slows or infant takes himself off.
- It's okay if baby doesn't take the second breast at every feed.
- Help baby open his mouth widely; tickle his upper lip, use nipple to stroke his chin.
- If baby is sleepy, skin-to-skin contact can encourage feeding. Remove baby's clothes and place him on your bare chest. Cover both of you with a blanket.

Look for signs of milk transfer

- You can hear baby swallowing or gulping.
- There are no clicking or smacking sounds.
- Baby no longer shows signs of hunger after feed.
- Baby's body is relaxed.
- You may feel milk letdown, tingling in breasts.
- You should feel strong tugging, NOT persistent pain.
- Proper latch prevents pain: chin to breast, chest to chest.
- Baby has adequate weight gain: at follow-up two days after discharge, and again at two weeks.

What goes in, must come out

- Look for three bowel movements every 24 hours by Day 4.
- Bowel movements change from dark black to green/brown to loose yellow at your milk comes in.
- Six to eight wet diapers/day by Day 7.

Over time

- All babies have days when they nurse more frequently; this doesn't mean you aren't making enough milk.
- Growth spurts occur at 2-3 weeks of age, at 6 weeks and at 3 months. These may occur at any time.
- Nursing more will make your milk supply catch up with baby's needs.
- Responding to feeding cues helps babies to regulate milk supply.
- Breast swelling normally lessens at about seven to 10 days and is NOT a sign of decreased milk supply.
- Your milk may look thin or bluish, but it contains plenty of nutrients.

If you have questions, persistent pain or can't hear swallowing, ask for help right away!

Call your pediatrician or lactation consultant:

North Mississippi Pediatrics: (662) 844-9885 • Lactation Office: (662) 377-5490

Baby's birth date and time: _____ % weight loss: _____
Baby will be 4 days old on: _____ (Normal loss 7-10%)
Baby's birth weight: _____ Follow-up clinic weight: _____
Baby's discharge weight: _____ Weight at 2-week check-up: _____
(Should regain to birth weight by 14 days)



Breast Engorgement

Many breastfeeding mothers experience a period of engorgement when increased blood flow to the breast and the onset of mature milk production occurs. Typically, this is the second day postpartum for the mother who has had previous children, and the third to fifth day postpartum for the first time mother. A transient, mildly uncomfortable period of breast enlargement at this time is considered normal. More severe engorgement that leads to difficulty with feedings, pain, or low-grade fever should serve as a warning flag to get assistance. Intense engorgement often suggests infrequent feedings or an inability of the infant to breastfeed well.

You may experience the following:

- Uncomfortable swelling of breasts in the first week
- Sleepy infant, difficult to rouse for feeding
- Infrequent breastfeeds, missed feeds or feeds that seem to take an hour or more
- Breasts “lumpy” in appearance, generalized swelling of both breasts often with flattening of nipples.

Management of Engorgement

- Remember that mild swelling of the breasts between Day 2 and Day 6 is referred to as physiologic engorgement, a healthy expected outcome.
- Apply heat to breasts for about five minutes before nursing. This can be done in the shower, with a warm wet towel or by leaning breasts into a bowl or sink of warm water.
- Gently massage breasts with fingertips (work around the breasts as performing a breast self-exam).
- Soften areola by hand expressing a small amount of milk. Hand expression is most effective method of milk removal at this time.
- Use both breasts for feeding as frequently as possible (every two to three hours, or more frequently if infant shows hunger).
- Between feedings, apply cold packs to breasts for 20 minutes. You can use cold gel packs, cold wet towels, chilled diapers or an ice pack. Chilled cabbage leaves are appropriate at this time, but no more than twice per day.
- Take ibuprofen or acetaminophen by directions as needed for discomfort.
- Wear a supportive bra; avoid underwires.

If engorgement is not improving after 24 hours, use of a breast pump once, draining as much milk as possible, is indicated. Remember to massage first, and continue use of hand expression if more effective. Contact a lactation consultant if engorgement is affecting latch and effective feedings.

Growth Spurts

Growth spurts commonly occur at 2-3 weeks, 6 weeks and 3 months, but may occur at any time. You will notice that your baby wants to nurse more often, usually over a 48-hour period. After several days of frequent breastfeedings your milk supply will catch up with the increased demand. Then your baby will settle down to a less frequent schedule again. You will notice after about a week that your baby has grown a lot.

Collecting Breastmilk

Breast pumps can be helpful in relieving engorgement, collecting breastmilk when you and your baby are apart, and increasing your milk supply. You may find it helpful to talk with a lactation consultant to discuss your needs and goals. Choose a pump suitable for the need. For short-term or occasional use.:

- Hand expression
- Hand pump
- Battery pump
- Inexpensive electric pump

For long-term or frequent use:

- Purchase a good quality double pumping pump
- Rent a hospital grade electric pump. Pumps are available for purchase in the Women’s Hospital Gift Shop (662) 377-4949.



- Each time you pump and before you handle the pump parts, wash your hands with soap and water.
- Place warm, wet washcloths on your breast for one to three minutes before pumping.
- Gently massage your breast.
- Roll your nipple between your finger and thumb to stimulate a letdown reflex.
- Express a few drops of colostrum or breastmilk.
- Relax and think about your baby.
- Moisten the pump breastshield (the funnel part that fits over the breast) with water. Center your nipple in the opening.
- Set the suction control to the lowest setting and pump for one to three minutes. Slowly increase the pressure as long as you are comfortable.
- If you are pumping one breast at a time, pump five to 10 minutes, switching to the opposite breast when the flow of colostrum or milk slows down. Pump each breast for a total of 15-20 minutes or until breasts are soft and the flow of milk slows to a drip.
- If double pumping (pumping both breasts at the same time), pump for a total of 15-20 minutes or until the flow of colostrum slows to a drip and the breasts are soft. You may pump for 10 minutes and rest for three to five minutes, then repeat again. You may find that one breast softens before the other. Massage and single pump to relieve fullness in the second breast.

Breastmilk Storage Guidelines

Refrigerated

Breastmilk may be stored in a refrigerator three to five days. If you do not plan to use it within that time period, freeze it. It can be stored in any clean container – plastic, glass or plastic bags designed for breastmilk collection. If you use a bottle liner it should be double bagged for the freezer. Label milk with date and time if you do not plan to use in several hours.

Frozen

Breastmilk may be stored in a freezer that will keep ice cream solid for six months. It should be placed in a part of the freezer that will not be subject to changes in temperature as the door is opened and closed. Protect breastmilk stored in plastic bags from being bumped or torn in the freezer. Freeze in small amount, two to four ounces per container. Allow space in container for breastmilk to expand as it freezes.

Thawed

Use oldest milk first. It can be thawed in a pan of lukewarm water or held under lukewarm running water. Never make breastmilk warmer than body temperature, as this can destroy some of the protective properties of the milk. Do not use microwave oven or heat on top of the stove. Any milk left in a bottle after feeding must be discarded. Thawed breastmilk must be discarded after 24 hours. Breastmilk is not homogenized and cream may rise to the top of the container. Gently shake the container to mix the layers together. It is normal for human milk to vary in odor, consistency and color depending on the mother's diet and type of storage container used.

Supplements

If you choose to supplement breastfeeding, it is advisable to wait until breastfeeding is well established, usually after two to three weeks. Offering a bottle before this time may contribute to nipple confusion and breast engorgement, and may also reduce your milk supply.



Common Problems

Sore Nipples

Some mothers experience nipple tenderness during the first few days of nursing, especially when the baby latches on to the breast. Once the baby begins nursing the pain should disappear. If the pain continues, break the suction, remove the baby from the breast and try again. If the baby is positioned incorrectly on the breast or has a poor latch, the soreness will continue and may cause nipple damage (cracked or bleeding nipples). The following are some suggestions for relieving nipple soreness:

- Apply a warm, wet washcloth and gently massage the breast to start the flow of colostrum or milk.
- Express a small amount of colostrum or milk to soften the breast.
- Begin feeding on the least sore breast.
- Position the baby correctly on the breast. Baby's nose and chin should touch the breast. Baby's lips should be flanged (top lip rolled up and bottom lip rolled down).
- Apply a small amount of colostrum or breastmilk on the nipple and areola after each feeding or small amount of modified lanolin (ex. Lansinoh or Purelan).
- Report cracked or bleeding nipples to your doctor or lactation consultant.

Plugged Ducts

A plugged duct occurs when milk is not flowing well. When feedings are delayed or missed, or when your baby breastfeeds poorly, milk can collect in the ducts and form a thick plug or small lump. You may experience it as a red, tender area or small lump in the breast. The area may or may not be painful. The following are suggestions for getting relief.

- Apply warm compresses (towel with warm water) on the plugged area before breastfeeding.
- Breastfeed more often during the day.
- Begin each feeding on the breast with the plug.
- Position the baby's mouth so that the baby's nose is pointing toward the plug.
- Massage the plugged area while the baby is nursing.
- Hand express or pump after each breastfeeding to relieve fullness or remove plug, if needed.
- Use two or three different breastfeeding positions each day to empty all the ducts.
- Avoid bras that are too tight or those with underwire.

Breast Infection (Mastitis)

Signs of a breast infection are flu-like symptoms, fever, weakness, pain, redness and swelling of the breast.

Report these symptoms to your doctor. When antibiotics are prescribed, it is important to take the medicine until it is gone. Failing to take all the medicine may increase your chances of developing another episode of breast infection. Symptoms may improve after 24-48 hours. The following are suggestions for relief:

- Start each feeding on the uninfected breast until let-down reflex occurs (milk is dripping), then switch to the infected breast.
- Apply warm compresses to the breast before feeding to encourage let-down reflex (warm washcloth, warm shower or tub bath).
- Apply cold compresses or ice packs after each feeding to reduce swelling and relieve pain.
- Breastfeed frequently, every one to three hours during the day and every two to three hours at night.
- Take acetaminophen or ibuprofen for pain.
- Drink enough water to satisfy thirst.
- Get plenty of rest.



Nutrition & Breastfeeding

What should I eat?

- There are no special foods to eat. Your milk will be nutritious for your baby. You will have more energy and be more resistant to illness if you eat wisely and well.
- Eat regular meals and at least one snack each day. Snacks should be high in protein and calcium.
- Some examples are cheese and crackers, peanut butter and crackers, sandwiches and milk.
- Eat a variety of foods from all of the food groups every day.
- Drink whenever you are thirsty. Good choices are water, fruit and vegetable juices, soup, decaffeinated beverages and milk.
- Drink milk or eat other high calcium foods. You don't have to "drink milk to make milk," but it is important to have enough calcium to protect your body.
- Other sources of calcium are cheese, yogurt, canned sardines, canned salmon with bones, broccoli, mustard, turnip or collard greens and orange juice with calcium added.
- Eat plenty of fiber from fresh fruits, raw vegetables, dried beans and peas, and whole grain breads and cereals to prevent constipation. These can be time savers for you, too.
- Avoid heavily processed foods which are often high in sugar, fat, salt or chemicals. Examples are foods from mixes, baked goods and chips.

Are there certain foods I should avoid while breastfeeding?

- There are no particular foods to avoid.
- Limit caffeine-containing beverages and chocolate to one or two servings per day.
- Gas-forming food eaten by you does not cause gas in your baby.
- Acidic foods do not make your milk acidic.
- Garlic, onion and spice flavors may pass into your milk. Some babies like the flavor.



Bulb Syringe

You may notice that your baby sounds as though the nose is stuffy or may spit-up mucus with some of the feedings. To remove the mucus from the nose or mouth, use the baby's bulb syringe. The syringe should be kept in the baby's crib. Squeeze the bulb portion of the syringe to remove all air. Insert the spout up to the baby's nostril and let go of the bulb portion to cause a suction. Suctioning may be repeated for each nostril and as needed for nasal stuffiness, cold and congestion. The bulb syringe may also be used in the mouth if the baby chokes. Using the same action as for nasal suctioning, place the spout to the side of the tongue. To cleanse the bulb syringe use a small amount of warm water and dish washing liquid. Suction the solution in and out of the syringe and follow with clear water. Squeeze excess water out before storing.

Burping

Burping your baby helps remove swallowed air. Even if fed properly, both bottle-fed and breast-fed babies usually swallow some air. The way to help your baby get rid of this is by burping. You may burp your baby by using one of the following methods:

- Hold the baby upright over your shoulder. Pat or rub the baby's back very gently until the air is released.
- Another way to burp is to place the baby's face down over your lap and gently rub the back.
- Your baby can be burped by holding him or her in a sitting position (baby leaning slightly forward) on your lap with your hand supporting the baby's weight. Then pat the baby lightly on the upper back.

If your baby doesn't burp in a minute or so, don't worry; there may not be any air bubbles. Older babies tend to need burping less.

Circumcision Care

If your baby boy is circumcised, it will probably be done the day after delivery. Occasionally, circumcision must be postponed because of prematurity or other medical problems. After the circumcision has been performed you will be given a tube of petroleum jelly to apply to the circumcised area every time you change your baby's diaper until it has healed. It is important to keep this area clean. If your baby has a stool (bowel movement) and particles of the stool get on the penis, wipe it gently with soap and water, and apply the petroleum jelly and diaper.

The circumcised area may look red for the first few days and you may notice a yellow secretion. This is an indication the area is healing normally. If the plastibell method of circumcision was used, a clear plastic ring will remain around the circumcised area. Within a week to 10 days, the redness and secretion should disappear. Once the circumcised area has healed, the plastic ring will fall off. Should the redness persist or if there is swelling or crusted yellow sores that contain cloudy fluid, there may be an infection. Report this to your baby's doctor. Remember to sponge bathe your baby until the circumcision and umbilical stump have healed.

Cord Care

Keep the diaper folded below the umbilical cord stump until it falls off and stops draining. The cord stump may take five days to two weeks before falling off. After the cord stump falls off, there may be a small amount of drainage for two to three days.

Do not put your baby in a tub for a bath until the cord stump has fallen off and stopped draining. Try to keep the stump dry while sponge bathing your baby. If the stump becomes infected, it will require medical treatment – phone the pediatrician if you notice any of the following signs:

- A bad odor from the stump or drainage
- Pus at the base of the cord
- Redness around the base of the cord
- Crying when you touch the cord or the skin next to it



Diaper Rash

The first sign of a diaper rash is usually redness or small bumps on the lower abdomen, buttocks, genitals and thigh folds. This type of rash usually clears in three or four days with good care.

The most common causes of diaper rash include:

- Leaving a wet diaper on too long. The moisture makes the skin more susceptible to chafing.
- Over time, the urine in the diaper decomposes, forming chemicals that can further irritate the skin.
- Leaving a stool-soiled diaper on too long. Digestive agents in the stool then attack the skin, making it more likely for a rash to develop.
- Regardless of how the rash begins, once the surface is damaged, it becomes even more vulnerable to further irritation by contact with urine and stool.

Most babies develop diaper rash at some point during infancy. A diaper rash is more likely to develop during the following conditions:

- If babies are not kept clean and dry
- Among babies age 8 to 10 months old
- When babies have frequent stools (especially when the stools are left in their diaper overnight)
- When a baby starts to eat solid food (probably caused by the introduction of more acidic foods and changes in the digestive process caused by the new variety of food)
- When a baby is taking antibiotics (because these drugs encourage the growth of yeast organism that can infect the skin)

If your baby should develop a diaper rash, you can apply a commercial diaper rash ointment or cream (Desitin, A&D Ointment, etc.). Apply the ointment or cream each time you change the diaper when the baby is awake. When the baby is asleep, remove any cream or ointment – let the baby's bottom air dry while asleep. This treatment should heal a diaper rash within four to seven days. If the rash lasts longer than a week or shows no signs of improvement after 48 hours, report it to the baby's doctor.

Another cause of rash in this area is yeast (fungus) infection. This rash is common on thighs, genitals and lower abdomen.



Formula Feeding

If you choose to bottle-feed, your baby's doctor will recommend a formula. The decision to bottle-feed may present questions about formula preparation. The following information may answer some of those questions:

Bottle Preparation

Sterilizing bottles, nipples and caps is recommended until your baby is able to purposely pick up things and place them in the mouth.

Sterilizing Bottles (aseptic method)

- Wash your hands with soap and water.
- Wash bottles, nipples, collars and caps with hot soapy water and rinse.
- Squeeze water through nipple holes during washing and rinsing.
- Place bottles, nipples, collars and caps in a big pot; cover with water and put lid on top of pot.
- Let the water boil for five minutes.
- After water cools, remove bottles, nipples, collars and caps from water and drain on a clean towel on the counter or table. Place bottles upside down.
- After all the parts are dry, reassemble and fill with formula.

Sterilizing Bottles (dishwasher method)

- Wash your hands with soap and water.
- Rinse bottles, nipples, collars and caps (squeeze water through nipples).
- Place items in top rack of dishwasher (a basket may be purchased to put nipples, collars and caps in to prevent items falling to bottom of dishwasher).
- Items will be sterilized at the end of the dishwashing cycle.
- Remove bottles, nipples, collars and caps and reassemble and fill with formula.

Formula Preparation

Formula is available in three forms; ready-to-feed, concentrated and powdered.

Ready-To-Feed

Directions are on each container. Ready-to-feed formula may be stored in the refrigerator for 48 hours. Once the formula is removed from the refrigerator and warmed, it must be fed to the baby within one hour or discarded. Do not return formula to the refrigerator after warming it or feeding begins.

- Wash hands and work area with soap and water and dry thoroughly.
- Check the top of the can for expiration date. Do not use cans with dents or expired dates.
- Wash the top of the can with soap and water. Rinse and shake can well.
- Punch two holes in the top with a clean can opener. This formula requires no mixing.
- Fill a sterilized bottle with enough formula for a single feeding. Cover the ready-to-feed can and store in the refrigerator until ready for use.
- The chill may be removed from the bottle by setting it in a container of warm water or holding it under running warm water. It is not necessary to warm formula, but it should not be given ice cold. Do not warm a bottle in a microwave oven. The formula in the bottle may develop hot spots, which may burn the baby's mouth.

Concentrated

This is a liquid formula that must be mixed with equal parts of water. Directions are on each container. The water should be boiled for five minutes and allowed to cool before mixing with concentrated formula. Formula prepared from concentrate may be stored in the refrigerator for 48 hours. Once the formula is removed from the refrigerator and warmed, it must be fed to the baby within one hour or discarded. Do not return formula to the refrigerator after warming it or feeding begins.

- Wash hands and work area with soap and water and dry thoroughly.
- Check top of can for expiration date. Do not use cans with dents or expired dates.



- Wash top of can with soap and water. Rinse and shake can well.
- Punch two holes in top with clean can opener.
- To prepare a single bottle with four ounces of formula, fill a sterilized bottle with two ounces of water that has been boiled for five minutes and cooled. Then add two ounces of the concentrated formula. This is a ratio of one part formula to one part water. Cover the can of concentrated formula and store in the refrigerator.
- To make a day's supply of formula; fill all bottles needed for a day with equal parts of concentrated formula and water (one part concentrated formula with one part water).
- The chill may be removed from the bottle by setting it in a container of warm water or holding it under running warm water. Do not warm a bottle in a microwave oven. The formula in the bottle may develop hot spots, which may burn the baby's mouth.

Powdered

This is a dry formula that must be mixed with water. Follow instructions on the can. Boil the water for five minutes and allow it to cool before mixing with the powder. Formula prepared from powder may be stored in the refrigerator for 24 hours. Once the formula is removed from the refrigerator and warmed it must be fed to the baby within one hour or discarded. Do not return formula to the refrigerator after warming it or feeding begins.

- Wash hands and work area with soap and water and dry thoroughly.
- Wash top of can with soap and water and rinse before opening a sealed can.
- Use the correct number of scoops.
- Put the cap on the bottle and shake to mix.
- Cover remaining powder with plastic lid and store in a cool dry place.
- Fill sterilized bottles with formula.
- Store bottles in refrigerator until ready to use.
- Remove chill from bottle by setting in a container of warm water or holding bottle under running warm water. Do not use a microwave oven to warm a bottle. The formula in the bottle may develop hot spots, which may burn the baby's mouth.

Bottle-Feeding Technique

Since babies' stomachs are small, they will need to be fed every three to four hours day and night. As they get older, they will sleep for longer stretches at night. Feedings should be enjoyable for you and your baby. Hold the baby securely by cradling the baby in your arms in an upright position. Turn the bottle upside down so that the nipple is filled with formula. This will prevent the baby from swallowing large amounts of air. Place the nipple in the baby's mouth on top of the tongue. Burp the baby frequently during the feeding (after 1/2 to 1 ounce of formula). Do not prop the bottle as this may cause choking, ear infections and tooth decay. If your baby does not finish a bottle of formula within one hour, throw away the leftover. Do not save it for later.



Genitals

Girls

To cleanse a baby girl's genital area, use a soft, wet washcloth or disposable wipe. Wipe down each side and middle of the labia (large outer folds of the vagina) from front to back using a single wiping motion. Then spread the labia apart and use the same wiping motion to cleanse in between the labia. A baby girl may have a small amount of clear, white, pinkish or slightly bloody vaginal discharge caused by the mother's hormones crossing over to the baby before birth. This will disappear in a few days.

Boys

If your baby boy has not been circumcised, do not push back the foreskin from the head of the penis to cleanse that area. Cleanse the penis and scrotum with a wet washcloth or diaper wipe. If the baby has been circumcised, clean around the circumcised area gently, and cleanse the scrotum and the area underneath it. Apply a small amount of petroleum jelly to the circumcised area after each diaper change until the plastibell (a clear ring around the circumcised area) has fallen off. If a plastibell was not used, apply the petroleum jelly for three to five days. Avoid getting the petroleum jelly on the umbilical cord. Do not use baby powder in the diaper area.

Jaundice

It is fairly common for parents to notice a yellowish color to their baby's skin the first few days of life. This yellowish color is called "jaundice" and it is normal for most newborns.

Newborns are prone to develop jaundice for two reasons: 1) a newborn has a lot of red blood cells that are broken down all at the same time and 2) a newborn's liver is immature and cannot process the bilirubin (the result of broken down red blood cells) as rapidly as it will be able to when the baby gets older.

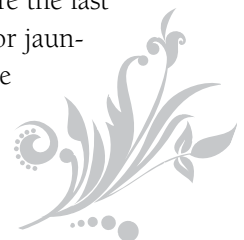
You may have heard the doctor or nurse refer to the yellowish color in your baby's skin as "physiologic jaundice," which means it is the natural process of breaking down red blood cells that cause it. Most babies with jaundice have physiologic jaundice. Occasionally, jaundice in a newborn can result if the blood type of the mother is incompatible with the blood type of the baby. Jaundice as a result of incompatible blood types in the mother and baby is Rh or ABO incompatibility. Whether your baby's jaundice is physiologic or the result of blood incompatibility, treatment is the same.

Jaundice, especially physiologic jaundice, usually disappears in a few days without any treatment. Also, it is important to remember that nothing is wrong with babies that do need treatment, it is just that the immature liver needs a little help at this point in life.

While jaundice is sometimes noticed at birth, physiologic jaundice is usually seen around the second or third day of life. If jaundice is noticed by the doctor or nurse before your baby leaves the hospital, a simple blood test can be done to check the level of bilirubin in the blood. If the bilirubin level is high enough, the doctor will recommend your baby stay in the hospital for phototherapy. (It is sometimes possible for parents to rent equipment that will allow phototherapy to be done in the home.) If the bilirubin level is borderline, the doctor will make an appointment for you to bring the baby back to the hospital or the doctor's office for a recheck of the bilirubin level. It is very important that appointments to recheck the bilirubin level be kept.

If a bilirubin level is checked and no treatment is necessary, your baby will be discharged and the doctor may or may not ask you to come back to the hospital or the doctor's office for a recheck of the bilirubin. If no treatment is necessary, you can expect the yellowish color to decrease after a week and disappear within two weeks.

If you notice jaundice in your baby after you are home from the hospital or if the jaundice gets much more noticeable to you, you will need to contact the doctor to see if you should bring the baby in for a bilirubin level check. Generally, babies become jaundiced on the head and face first, so this would be no cause for concern. If the bilirubin level continues to rise, the chest and abdomen become jaundiced. The arms and legs are the last areas to become jaundiced and would mean a doctor should be notified. A good way to check for jaundice is to press an area of the skin gently with your finger which causes the area to become white (blanche); when you remove your finger the spot will be pink if the baby is not jaundiced and yellow if the baby is jaundiced. Good places to check the baby for jaundice are the bridge of the nose, the forehead, the breastbone or over any point where you can easily feel a bone.



Newborn Channel

Twenty-four hour educational programs on mother care, newborn care, feeding, health and safety topics are available in English on Channel 58 and in Spanish on Channel 59.

Safety Tips

Back To Sleep

- Position the baby on his back for sleeping. Sleeping on the back decreases the risk of Sudden Infant Death Syndrome.

Car

- Get a federally-approved infant car seat for your baby. Always make sure your baby is properly positioned and strapped in the car seat before the car starts moving. Babies under 20 pounds should be in a semi-reclining car seat in the back seat facing the rear window. Acquire an infant car seat and become familiar with the directions before discharge.
- Do not leave your baby unattended in a car. Your baby may wiggle out of the car seat or an intruder might get into the car. You might lose your keys, leaving your baby trapped inside the car.

Nursery

- Always put crib sides up when not tending to your baby, even if you just turn your back.
- DO NOT leave your baby alone in the bathtub, or on a bed, sofa or changing table. Your baby may roll over at any time. The first time your baby does something new that you didn't anticipate or expect is when an accident is likely to happen.
- Space between the crib's rails should not be more than 2 3/8 inches. If the space is larger, your baby might be able to wiggle his body through and get his head trapped.
- Make sure the mattress fits snugly in the crib. If the gap between the mattress and crib is greater than one inch, the baby might get a leg or arm trapped between the space.
- Do not place the crib within reach of cords to window blinds or shades because the baby might get entangled in the cord. Keep crib out of direct sunlight to prevent sunburn.
- Once your baby is able to sit up, place the mattress in the lowest level of the mattress support.
- The crib should be finished with lead-free non-toxic paint or stain. Keep crib free of pillows and large or floppy toys.
- Once your baby is able to crawl, keep floor free of objects small enough for baby to put in his mouth, ear or nose. Shield electrical outlets with safety shields.
- Use safety strap in the infant carrier, swing, stroller and high chair.

Kitchen

- Do not hold your baby while cooking over a hot stove, drinking hot liquids or smoking.
- Place cabinet latches on all unsafe cabinets and drawers. Do not store dangerous items in lower cabinet (glass jars, boxes of foil and plastic wrap and cleaning supplies).
- Appliance cords (ex: electric skillet) should not dangle down from counter; because the baby might pull them down.

Toys

Select toys with smooth edges that are appropriate for your baby's developmental level and do not have removable parts.



Security Measures

With your help and cooperation, Women's Hospital and your room will provide a protected environment for you and your baby. The first time the baby is brought to your room for a visit, you will be given instructions about how you can prevent abduction of your newborn. You will be asked to sign a security card that is stamped with both your and your baby's names. Anytime anyone comes into your room to pick up your baby, ask to see the security card and then look at it carefully to ensure all the information on it, including your signature, is correct. Never give your baby to anyone unless he or she can show you the correct security card.

To help ensure you do not give your baby to an unauthorized person, you will be notified by a staff member from the nursery if your baby has to have a special test or procedure done. A staff member from the nursery will accompany your baby at all times if he or she must leave the Women's Hospital for a test or procedure.

If you are alone with your baby in the room and you become sleepy or must use the bathroom, call the nursery. A staff member will take the baby to the nursery. Do not walk the hall with your baby in your arms. Do not leave the door to your room open so people in the hallway could possibly look in and see your baby.

When you go home, do not leave balloons and yard decorations announcing the arrival of your new baby up for more than a day. If you publish a birth announcement in the paper, do not supply an address. If someone comes to your home claiming to be a home health nurse, ask for the name of the agency. Call to verify that the person is truly in their employment, then ask for identification from the visiting nurse before you allow them into your home. These are just a few tips to prevent the abduction of your baby.

Signs of Sickness In Infants

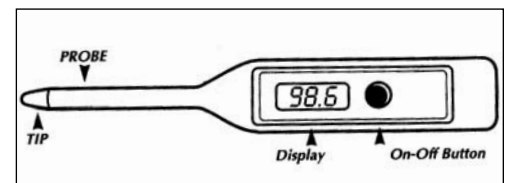
Signs of illness are sometimes difficult to detect in a newborn. Generally, fever, vomiting and diarrhea are signs that your baby is sick. Report any of these signs to your baby's doctor:

Fever

If your newborn's skin feels warm or hot, or if the skin color is flushed, check your baby's temperature. Report a skin temperature (one you take by placing the thermometer under the arm) of 100.5° or more to your baby's doctor. Report a rectal temperature of 101° or more. Do not give any medicine until advised to do so by the baby's doctor.

Taking the Temperature

If you think your baby is sick or has a fever, take the temperature. A digital thermometer should be used the first six months of life. A skin temperature may be taken by placing the thermometer under the baby's arm. This is also known as an axillary temperature. The baby's temperature may also be taken rectally.



Skin Temperature

Press the power button to turn on the thermometer. The thermometer is ready to use once a flashing °F appears on the display screen. Make sure the underarm is dry. Place the thermometer probe tip in the center of the underarm and bring that arm down and against the baby's body. Hold the thermometer in place for four minutes. Report temperature of 100.5 °F or more.

Rectal Temperature

Press the power button to turn on the thermometer. The thermometer is ready to use once a flashing °F appears on the display screen. Apply a small amount of water-soluble lubricant such as KY jelly to the tip of the probe. Insert ½ inch of the probe into the rectum. Hold your baby's legs firmly with one hand. Keep your other hand on the thermometer. Do not force the tip into the rectum if you feel resistance. Three rapid beeps is the sign that the temperature measurement is complete. Report temperature of 101°F or more. Once thermometer is used rectally it should not be used orally for sanitary reasons.

Cleaning the Thermometer

Clean the thermometer with warm soapy water before and after use. Dry thermometer thoroughly. Or you may clean the thermometer by wiping the entire length of the probe with 70% isopropyl alcohol before and after use.



Vomiting

If your baby vomits forcefully two or more times within a day, report it to the doctor. Spitting-up differs from vomiting. When a baby spits up, it is not forceful, and the spit-up material looks very much like the milk that was fed to the baby (it may be thicker or have curds or mucus in it). Vomiting, however, is often forceful and the vomited material looks partially digested and smells bad. Vomiting should be reported to the doctor to prevent the baby from dehydrating.

Diarrhea

Report four or more watery stools (bowel movements) within a day to your baby's doctor. Sometimes babies will have diarrhea stools that are not completely watery. A diarrhea stool may have a little consistency to it. A diarrhea stool may also be mushy, seedy, curdy or loose surrounded by a big water ring. Report four or more of these stools to the doctor. It is very important that a newborn does not become dehydrated.

Sleeping

Newborns may sleep 16 to 17 hours a day. Some sleep as little as 12 hours, others as much as 20 hours. All these ranges are normal. Initially, your baby doesn't know the difference between day and night. A baby's stomach will hold only enough to satisfy him for three or four hours, regardless of the time, so there is no escaping around-the-clock waking and feeding for the first few weeks. During this period, you can begin to teach your baby that nighttime is for sleeping and daytime for play. Keep nighttime feeding as quiet and calm as possible. Don't turn up the lights or prolong late-night diaper changes. Instead of playing, put the baby right back down after feeding and changing.



Mother Care



**NORTH MISSISSIPPI
MEDICAL CENTER**

WOMEN & CHILDREN'S SERVICES



Mother Care

Afterbirth Pain

Some menstrual-like cramping or afterbirth pains are common after delivery as the uterus (womb) contracts to return to its pre-pregnancy size and position in the pelvis. Afterbirth pains are more common after the birth of a second or third child and when breastfeeding. If breastfeeding, remember to empty your bladder before feeding the baby. This will decrease the intensity of that pain.

If needed, a mild analgesic such as Tylenol may be helpful. These contractions will slowly decrease in their intensity and frequency, but can last for several days in a mother not breastfeeding and as long as a couple of weeks in a breastfeeding mother.

Baby Blues or Postpartum Depression

Baby blues is a normal reaction that many new mothers experience two to three days or two to three weeks after delivery. You may experience a low feeling, lose your appetite or be unable to sleep. Some women experience it as unexplained crying episodes. Baby blues may last for several weeks. Remember that this is normal and will pass with time. Many changes are occurring in your body, role and relationships. Give yourself time to adjust to these changes. Remember to take care of yourself first, so that you can better care for your baby and family. Get plenty of rest and eat properly.

If you become so depressed that you feel as though you will not be able to care for yourself or baby, give your doctor a call. This may be postpartum depression which responds best to treatment. If you are still experiencing baby blues when you return for your six weeks check-up, let your doctor know.

Bladder & Bowel Patterns

Right after delivery you may not be able to feel when your bladder is full. Your bladder may lose some of its tone because of the pressure of your uterus (womb) against it during labor. Try to empty your bladder every three to four hours when awake. If you experience difficulty starting a stream of urine, try these following techniques:

- Lace your fingers together, press them against the lowest part of your abdomen, lean down and make a “ha” sound.
- Spray the water from your peri-bottles over your bottom to relax those muscles.
- Flush the commode; the sound of the water may help you to relax.

Do not resist the urge to have a bowel movement because you have stitches on your bottom. You will receive a stool softener or laxative while in the hospital. The first bowel movement will be soft and not place any tension on your stitches. After you get home you will need to include some fiber in your diet each day to prevent constipation. Eat whole grain breads and cereals, raw fruits and vegetables, and drink adequate amounts of water and other fluids.

If you should become constipated you may take Milk of Magnesia or a stool softener such as Colace, Dialose or Metamucil. Breastfeeding mothers may also use these stool softeners.

Breast Care

Wear a supportive, snug-fitting bra (preferably without the underwire) or a good sports bra day and night the first two weeks if you are not breastfeeding. A bra that provides good firm support is needed to prevent engorgement (breast becoming hard, swollen and painful). Avoid any stimulation to the breasts during the first two weeks. Position yourself when showering so the water falls on your back rather than directly on your breasts. Water falling directly on your breast will act as a massage and may stimulate milk production in your breasts.



Call Your Doctor

If you experience any of the following symptoms, please report them to your doctor:

- Flu-like symptoms – chills, aches and fever;
- Fever of 100.5° Fahrenheit or more on two readings during a four-hour period;
- Vaginal bleeding that becomes unusually heavy (saturating two or more pads within an hour);
- Frequency, pain or burning on urination;
- Foul smelling vaginal discharge;
- Pain or tenderness in legs with redness or swelling;
- Redness, swelling, persistent or intense pain in your episiotomy or abdominal incision.

Care After Cesarean Section

Observe your incision each day. Slight redness is normal. Any increased or unusual redness, swelling or drainage should be reported to your doctor. You will need to go to the clinic one week after delivery for staple removal. You should not lift anything heavier than approximately 10 pounds. It is very important that you do not get constipated in the first couple of weeks after delivery. We want to keep your bowel movements very soft for approximately two to three weeks. This can be done by eating green leafy vegetables, bran cereal, fruit juices or, if necessary, take Colace or Milk of Magnesia to help keep stool soft. You need to have a bowel movement at least every other day for the first three weeks. Use Dulcolax suppositories if you miss a day. Showers are recommended instead of tub baths after delivery. Be sure to keep your incision dry. Do not apply creams or lotions to incision. You should call your doctor's office if you have a fever of 100.5 degrees or more.

Characteristics of the Lochia (Vaginal Discharge)

The vaginal discharge that you are having since delivery is called lochia. The first few days it usually looks like a menstrual flow. It is a moderate amount of bright red discharge if you deliver vaginally. If you deliver by Cesarean, it is usually a small amount of bright red discharge. About the third day after delivery, the color changes to a pink to brownish color; then yellow and clear. The amount of lochia will continue to diminish. The lochia usually last two to three weeks, but may last for six weeks. As long as it does not have a bad odor, do not be concerned. It should normally smell like a menstrual flow. A bad odor is a sign of infection. Phone your doctor if you notice this.

The lochia is a good indicator of how well you are doing. If you become too active, lift something too heavy or go up and down stairs too many times, you may notice that the lochia will increase in amount. The color will become bright red again. You may experience some menstrual-like cramping. If this happens, go to bed and rest for two to three hours. This should cause a reverse in the lochial changes.

Episiotomy Care (Stitches)

Air drying your bottom (perineal area) for a few minutes each day will help it to heal. Continue to use your anesthetic foam and ointment as prescribed, three to four times a day. Change your pads frequently to keep a dry surface next to the healing perineum.

Sitting and getting up from a sitting position can be a challenge if you have stitches on your bottom. Try sitting on the padding of your bottom by squeezing your buttocks together before sitting or getting up. Avoid sitting on one side which can cause pulling and more discomfort.

You may notice that your stitches begin to pull or itch about the second or third day. This is a sign that your stitches are healing and being absorbed.

Fundal Checks

The top of the uterus (womb) is called the fundus. After delivery your uterus is about the size of a large grapefruit and the fundus can usually be felt at the level of your navel. Each day the fundus can be felt lying lower beneath the navel. By six weeks, the uterus will be back in the pelvis. Your nurse will be checking the location and firmness of your fundus frequently



Ice Packs

After delivery, an ice pack may be placed against your bottom to reduce swelling if you have stitches. You may be asked to wear it for four to six hours to get the maximum benefit. Let your nurse know if it is uncomfortable.

Menstrual Period

Your menstrual period may or may not return before your six weeks checkup. Sometimes the flow will not resume until seven to 10 weeks after delivery.

If you are breastfeeding, your menstrual period will probably not return before three months after delivery. It is normal to be delayed when breastfeeding. Some mothers will not menstruate until they stop breastfeeding, but it varies from woman to woman. It is possible to get pregnant before having a menstrual period if not using a method of family planning.

Nutrition

Most new mothers' thoughts turn to losing weight after delivery. Remember you will continue to lose weight until six weeks after delivery. You need to eat three well-balanced meals each day. Avoid foods with empty calories. These include foods with high sugar content, fried foods and soft drinks. They do not provide the nutrients required to help your body heal and repair. Some mothers are not very hungry for a few days after delivery and others are unable to get enough to eat. If you do not have much of an appetite, try dividing your meals into five smaller meals or snacks.

Drink eight glasses of fluid each day. Continue to take your prenatal vitamins until you have your six weeks checkup or as long as you breastfeed your baby.

Perineal Hygiene

For the first two weeks after delivery use your peri-bottles with the shampoo prescribed by your doctor after each time you urinate or have a bowel movement. Fill one bottle with the shampoo and warm water and the other with clear warm water. Make up a fresh solution before each use. Once you've used all of the shampoo, continue to use the bottle of clear warm water until the end of the second week.

Blot dry with bathroom tissue. Always blot from front to back, then discard the tissue. Do not blot from back to front as bacteria may be introduced from the rectum into the bladder.

Rest and Graded Exercise

For the first two weeks after delivery do not do anything other than take care of yourself and your baby. Avoid lifting anything heavier than your baby. Delegate housework during this time. Two weeks after delivery you may gradually begin doing a little light housekeeping. You may also resume driving at this time. Limit the number of times you climb stairs to a couple of times each day. Stairs are not dangerous, but tiring.

Rest is important for new mothers because of the demands of labor, birth and caring for a newborn 24 hours a day. Try to have a rest period each morning and afternoon. It is not necessary that you sleep, just relax a couple of times each day. Do this until you return for your six weeks checkup. You will find that you are going to feel tired a lot. It may take a couple of months before your normal energy level returns. Limit the time you spend sitting each day. When the weather permits, walk outside each day.



Resuming Your Sexual Relationship

The postpartum period can be a stressful time in a couple's sexual relationship. Many couples may be apprehensive that intercourse will be painful and possibly hurt the episiotomy site or cesarean incision. Intercourse may be resumed when the episiotomy site and the abdominal incision has healed and the lochia (vaginal discharge) has stopped. This could be as early as six weeks after delivery. Talk to each other and share your desires and your feelings. Resume your sexual relationship when you are both mentally and physically ready. Talk to your doctor about a method of birth control that is right for you, if you plan to use one.

Sitz Bath

A sitz bath (clear, comfortably warm water in a sitz bath basin or in the bathtub) promotes healing and comfort to stitches and hemorrhoids. Sitz baths are usually started 24 hours after delivery. This bath can be done two or three times a day for 15 to 20 minutes at a time. Continue your sitz bath until your bottom is no longer sore. Use only clear water for your sitz bath; anything else could be irritating. If you take a tub bath, change the water before taking a sitz bath.



Resources/Notes



**NORTH MISSISSIPPI
MEDICAL CENTER**

WOMEN & CHILDREN'S SERVICES



Resources & Referral Numbers

Your obstetrician: _____

NMMC Women's Hospital Lactation Services (for breastfeeding questions or assistance)	(662) 377-5490
Car Seat Safety • www.usa.safekids.org	(601) 360-0531
Child Health Insurance Programs	1-877-543-7669
El Centro (support organization for the Hispanic population)	(662) 823-7450
Family Resource Center of Northeast Mississippi	(662) 844-0013
Good Samaritan Health Services	(662) 844-3733
Mississippi State Department of Health	
Chickasaw County	
Houston	(662) 456-3737
Okolona	(662) 447-5492
Clay County	(662) 494-4514
Itawamba County	(662) 862-3710
Lafayette County	(662) 234-5231
Lee County	(662) 841-9096
Monroe County	(662) 256-5341
Pontotoc County	(662) 489-1241
Prentiss County	(662) 728-3518
Tippah County	(662) 837-3215
Union County	(662) 534-1926
Mississippi Medicaid Regional Office	(662) 844-5304
North Mississippi Pediatrics	(662) 844-9885
Nurse Link (open 7 a.m.-midnight for health questions)	1-800-882-6274
Poison Control Center	1-800-222-1222
S.A.F.E., Inc. (Domestic Violence Shelter)	(662) 841-9138 or 1-800-527-7233
WIC (Women, Infant & Children) Nutrition Program	1-800-545-6747



