People caring for people

RAMSAY HEALTH CARE

Pregnancy, Birth & Parenting Information

Maternity Services

KAREENA PRIVATE HOSPITAL

Congratulations on choosing Kareena Private Hospital for the birth of your baby. We pride ourselves on providing the highest standard of care that includes amongst its services:

- A comprehensive birth and parenting education program
- In- patient and Breastfeeding and Settling Sessions
- Physiotherapy services
- Lactation Services
- Special Care Nursery
- In- patient Massage Services
- Pathology Services
- Photography Services
- Specialist Social Workers
- Ultrasound
- Deluxe Parenting Suites

We look forward to being involved with your childbirth experience and providing our expert care during this special time.

Kareena Private Hospital Telephone Contact Numbers

Main Hospital Switchboard:	**(02) 9717 0000**
Delivery Suite:	**(02) 9717 0118**
Postnatal Ward:	**(02) 9717 0140**
Parent Education Bookings:	**(02) 9717 0140- Office hours**

Please do not give the Delivery Suite telephone number to your friends or family as it is for patients and doctors only.

Maternity Visiting Hours

Strictly 2pm- 4pm and 7pm- 8pm daily. Partners are welcome anytime.

Following the birth of your child, rest is very important, for this reason we have a rest period between 12md -2pm.

No visitors are permitted during rest period and no phone calls will be put through to your room.

First printed, 2006

Reviewed and amended in 2011 by

Tracey Rayner RN, CM, C&FHN

All information contained in this booklet is correct at the time of printing.

Contents

About the Maternity Unit

Health Fund Coverage

We recommend that you contact your medical insurance provider prior to the birth of your baby, to confirm or upgrade your private health insurance to cover your newborn should they require a stay in our Special Care Nursery.

Health Concerns

If you have any concerns regarding your health or your baby, or you think you may be going into labour, our Midwives are available to talk to you 24 hours a day, every day of the year. Phone: (02) 9717 0118 .

Arriving at the Hospital

When you arrive at the hospital during business hours please see main reception, after hours please go directly to level 1 Birth Suite. If you should arrive at night and have not previously phoned to tell staff of your arrival, ring doorbell which is located at the entrance, this will alert hospital staff of your presence.

Videotaping the Birth

Devices that record both film and sound are not allowed in Operating Theatres or Birth Suites. Film and sound may be recorded in the privacy of a patient's room providing the privacy of other parents and staff members is not compromised.

Support People during Labour

Please advise your friends and family that no visiting is allowed whilst you are in the Birth Suite. You may elect to have up to two support people with you during labour (your partner and one other). Visitors are encouraged to wait until the next session of visiting hours.

Support People during a Caesarean Section

If you are having an elective (planned) Caesarean section with an epidural, you will most likely be able to have one support person. However, this decision is dependent on your doctor and the Anaesthetist. It is important for you to ask when you are planning your caesarean section. Should you require an emergency caesarean section your support person may not be allowed to attend.

Partners Staying Overnight

During labour: When you are in labour we encourage your partner to be with you at all times. To help this process we provide meals for your partner until you have delivered your baby.

After the birth: As part of our rooming in policy fathers may stay overnight when a single room is available. This will incur a separate charge for both the bed and meals, please check with your health fund re coverage.

Accommodation

Kareena Private Hospital has 13 single rooms with private ensuites, 3 deluxe parenting suites with private ensuites, and 1 shared room with ensuite.

Allocation of deluxe parenting suites may be based on request or mothers clinical wellness.

Length of Stay

Women having a vaginal birth may stay up to five days, whilst women having their baby by Caesarean section may stay up to six days. Length of stay is also determined by clinical need. We do ask that you make arrangements to go home before 10.00am on your day of discharge.

Security / Valuables

Please leave all valuables at home, as Kareena Private Hospital is unable to take responsibility for any loss. If you intend to bring videos or cameras please use the complimentary in-room safes provided.

Birth & Parenting Education

Kareena Private hospital provides an array of birth & parenting education options to suit all needs, all sessions are run by accredited Midwives. Sessions are popular and it is recommended that you book your sessions by 14 weeks of pregnancy. Some health funds cover the total cost of classes, others provide some rebate. Please ask your individual health fund for information on your personal circumstances. Please see further information on birth and parenting sessions provided with this book.

Dates for classes are available contacting the Bookings Co-ordinator on 9717 0226, Tuesday to Friday 0900-1400 hours

Newborn Hearing Screening

NSW Health provides hearing screening for all newborns. This service is provided to all babies prior to discharge. Please see further information later in this book.

Discharge Information

Discharge time is 10 am. Please organise for your partner / friend or family member to collect you and your baby on discharge and transport you home. Please ensure you do not leave anything behind, and check with your Midwife regarding any discharge instructions from your Doctor.

Please note that it is a legal requirement that all babies travelling in a car are transported in an Australian standard car-seat or capsule at all times. For more information on car restraints please contact the Roads and Traffic Authority, NSW on 132 213 or www.rta.nsw.gov.au.

Birth Registration Statement Form

This form must be filled in to register, or apply to register your baby's birth with NSW Births, Deaths and Marriages Registry. This must be done within 60 days. www.bdm.nsw.gov.au.

Newborn child claim for paid parental leave, family assistance and medicare

Your claim must be lodged within 52 weeks of your baby's birth. www.familyassist.gov.au.

If claim form is lost, please find details at the website above for replacement.

What to Bring to Hospital

(It is advisable to have your bag packed by 34 weeks)

For Mum

- Sleepwear (front opening) & light weight dressing gown
- Favourite music (Ipod dock with speakers available)
- Toiletries, hair tie, massage oil, lip balm, glucose lollies etc
- Crop top / nursing bras & breast pads
- Oversized T-shirt / nightie to wear in labour
- Comfortable casual clothing for daywear
- Hairdryer
- 3 packs of sanitary pads
- A black pen, wristwatch or clock
- Any current medication
- Enough money for incidentals
- List of phone numbers
- Camera (check batteries)

For the baby

- Baby clothes- We suggest 6 singlets and 6 outfits for frequent nappy changes
- If you have decided to bottle feed your baby prior to delivery you will need to bring in formula, bottles and a microwave steriliser. If you start to bottle feed prior to discharge we are able to provide formula only until you are able to organise a supply of your own.
- Shawl/ wrap

For the Partner/Support person

- Swimmers(for use in the shower/bath)
- Change of clothes

Remember to leave unnecessary valuables at home.

Visiting Times

Visiting times are strictly 2pm – 4pm and 7pm – 8pm. We ask that you inform friends and family of this prior to the birth of your baby. Partners may visit at any time. The ward is closed between 12md and 2pm for Rest Period. To allow new mothers time to rest, we do not allow visitors or phone calls during this time.

A Healthy Pregnancy

The first 12 weeks of pregnancy is very important to your baby's development. Your baby's heart, the brain and the nervous system are all being formed. Have a general check up at your General Practitioner, and ensure you eat a healthy well balanced diet, with proportional amounts from the 5 food groups: Grains, fruit & vegetables, dairy, meat, followed by fats, sugars and salt kept to a minimum.

Folate (Folic Acid)

Lack of folate is thought to affect the baby's development, causing serious brain and spine problems. Women planning a pregnancy should eat foods high in folate, such as:

- Asparagus
- Brussel Sprouts
- Cauliflower
- Cabbage
- Potatoes
- Vegemite / Marmite
- Broccoli
- Green Beans
- Oranges & Orange Juice
- Whole Grain Breakfast Cereals
- Bananas
- Cashews / Hazelnuts
- Strawberries
- Wholegrain Breads

For most women it is also recommended to take a 0.5mg folic acid tablet daily for at least one month before pregnancy, and for the first three months of pregnancy. These tablets are safe to take during pregnancy, and are available from pharmacies and health food stores. Always check the label to make sure that the tablets contain the right amount of folic acid. Women taking medication to prevent epilepsy or seizures need to be on a much higher dose of folic acid in order to prevent birth defects such as spina bifida and cardiac abnormalities. They should consult their Obstetrician as soon as possible.

(Food Standards Australia and New Zealand, 2010)

Listeria

Listeria infection is an illness usually caused by eating food contaminated with bacteria known as Listeria monocytogenes. Healthy people may develop few or no symptoms. However, for some people, the infection can be serious enough to require hospitalisation and be a threat to life. People who are at particular risk of infection include pregnant women and their unborn babies. Listeria bacteria are widespread and commonly found in soil, silage and sewage. They have also been found in a variety of foods, including raw meat, raw vegetables and some processed foods.

To Reduce Your Risk of Listeria Infection:

1. Avoid high risk foods, including:
   - Ready-to-eat seafood such as smoked fish and smoked mussels, oysters or raw seafood such as sashimi or sushi
   - Pre-prepared or stored salads, including coleslaw and fresh fruit salad
   - Drinks made from fresh fruit and/or vegetables where washing procedures are unknown (excluding pasteurised or canned juices)
   - Pre-cooked meat products which are eaten without further cooking or heating, such as pâté, sliced deli meat, including ham, salami, and cooked diced chicken (as used in sandwich shops)
   - Any unpasteurised milk or foods made from unpastuerised milk
   - Soft serve ice-creams
   - Soft cheeses, such as brie, camembert, ricotta and feta (these are safe if cooked and served hot)
   - Ready-to-eat foods, including leftover meats, which have been refrigerated for more than one day
   - Dips and salad dressings in which vegetables may have been dipped
   - Raw vegetable garnishes

2. Always handle food safely
   - Wash your hands before preparing food and between handling raw and ready-to-eat foods
   - Keep all food covered
   - Place all cooked food in the refrigerator within one hour of cooking
   - Keep your refrigerator clean and the temperature below 5°C
   - Strictly observe use-by or best-before dates on refrigerated foods
   - Do not handle cooked foods with the same utensils (tongs, knives, cutting boards) used on raw foods, unless they have been thoroughly washed with hot soapy water between uses
   - All raw vegetables, salads and fruits should be well washed before eating or juicing, and consumed fresh
   - Thoroughly cook all food of animal origin, including eggs
   - Keep hot foods hot (above 60°C) and cold foods cold (at or below 5°C)
   - Reheat food until the internal temperature of the food reaches at least 70°C (piping hot)

(Food Standards Australia and New Zealand, 2010)

Mercury in Fish

Fish is a highly nutritious food and an excellent source of high quality protein, and vitamins and minerals however some fish contain high levels of mercury, by being aware and limiting certain fish in your diet you can prevent any harm to your unborn baby and still enjoy the health benefits of eating fish. Be aware that all fish contain a small amount of mercury with some fish having higher levels than others. Eating those fish with higher levels or eating fish everyday could have harmful effects.

Fish Containing More Mercury than Others

- Shark
- Ray
- Swordfish
- Ling
- Barramundi
- Gemfish
- Orange roughy
- Southern bluefin tuna

www.foodauthority.nsw.gov/consumers/life-events-and-food/pregnancy

www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/mercury_in_fish?open

(NSW Food Authority, 2011)

Caffeine

Some studies have found links between very large doses of caffeine and miscarriage, premature birth and stillbirth. Doctors recommend pregnant women have no more than 200mg of caffeine a day.

Type of Food / Drink (amount of caffeine depends on the strength of the brew or product)	Amount of Caffeine
Brewed fresh coffee	80 – 350mg per cup
Instant coffee	60 – 100mg per cup
Decaffeinated coffee	2 – 4mg per cup
Tea	30 – 90mg per cup
Cola drinks	35mg per 250ml
Cocoa / Hot chocolate	10 – 70mg per cup
Chocolate bars	20 -60mg per 200gm

Alcohol

There are no clear guidelines regarding exactly how much alcohol is safe to consume during pregnancy, it is known that the more you drink the greater the risk to your unborn baby. During pregnancy, alcohol passes through the placenta to the baby and may cause serious health and development problems such as bleeding, miscarriage, premature birth and fetal alcohol syndrome (FAS). Because the baby's brain continues to develop throughout the whole pregnancy, there is no safe time to drink alcohol.

Smoking

Smoking increases the risk of miscarriage or stillbirth, premature birth, problems during the birth and the baby having a smaller brain and body. Babies whose mothers smoke are more likely to find it harder to fight infections and survive, have learning problems later in life, be restless and irritable and be at an increased risk of cot death. The child whose parents smoke are more likely to suffer from more coughs and colds, sore throats and sinus problems. They are also more likely to suffer lung problems, such as asthma, bronchitis and pneumonias, grow more slowly and suffer from sore, bloodshot eyes.

If you stop smoking now you have done the best you can to have a healthy baby and child, you'll stop possible damage to your baby and family, feel healthier and stop further damage to yourself. You will also save the cost of cigarettes.

Many people have given up smoking. You can too! You may just need a little help to do it. For sympathetic encouragement, help and support contact the Quit line phone 131 848, weekdays 7am -1030 pm; weekend hours 9am -5pm

Medications & Other Drugs during Pregnancy

It is ideal if women avoid all drugs before becoming pregnant, unless prescribed by a doctor. However, if you take any medications regularly, see your doctor before becoming pregnant, and check if the medication should be changed. For further information on the use of medications and other drugs during pregnancy contact Mothersafe at the Royal Hospital for Women Sydney. Phone: (02) 9382 6539.

Toxoplasmosis

Toxoplasmosis is a disease caused by a parasite called Toxoplasmosis gondii which is usually found in cats and other mammals and birds. Infection in pregnancy may lead to infection of the fetus in the womb. Early in the pregnancy, this can cause multiple problems including brain damage, damage to the eyes, fever, enlargement of the liver and spleen, jaundice, rash, and even death of the fetus. Later in the pregnancy, toxoplasmosis can cause mild disease and delayed reactions such as eye problems. Toxoplasmosis is a very severe infection for unborn babies and for people with lowered immunity.

Pregnant women should be particularly careful to avoid contact with cat faeces and soil, and to avoid eating undercooked meats and vegetables. Cook meats until well done. Wash fruit and vegetables well before eating. Eliminate cross-contamination from raw foods to cooked foods by thoroughly washing hands, cutting boards, knives and other utensils.

RH D Immunoglobulin (Anti D)

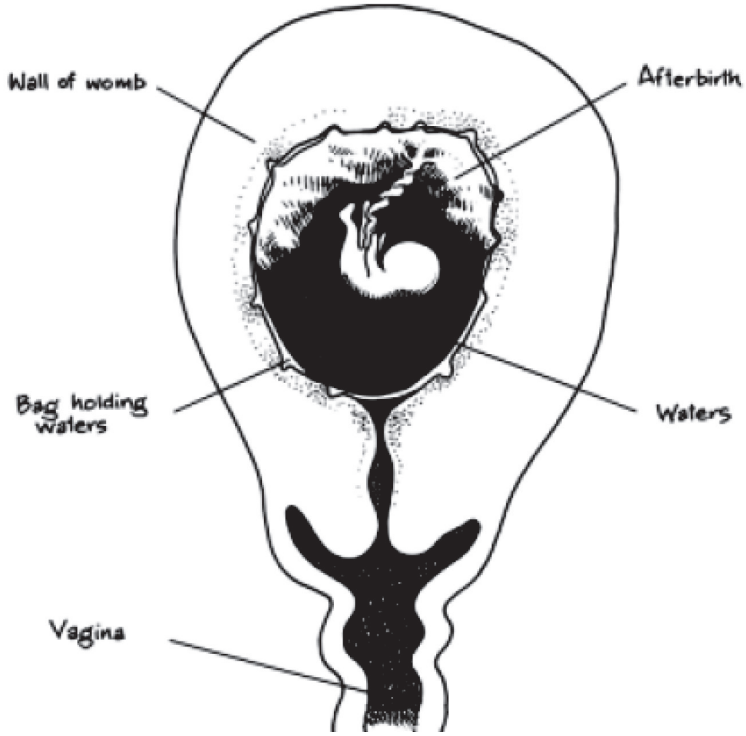
Rh D immunoglobulin is used to protect against Hemolytic Disease of the newborn, which has the potential to occur in children born to women with Rh D negative blood. All pregnant women will have their blood group and antibodies checked in early pregnancy, this will be repeated at 28 weeks for mothers with a negative blood group. A preventative immunoglobulin is then given at 28 and 34 weeks, to mothers who are Rh negative and have no preformed anti-D antibodies. A third dose may be given following the birth of baby, if the baby's blood group is found to be positive. It may be required at any time if there is concern about foetal- maternal transfusion.

(RANZCOG, 2007)

Stages of Pregnancy

By 6 Weeks: Your baby is about 5mm long, from its head to its bottom. Its brain, stomach and intestines are developing and the heart is starting to beat.

By 12 Weeks: Your baby is now about 5cm long, from its head to its bottom and weighs approximately 8 gms. It has a nose and a neck and all its organs and parts have been formed, including ovaries or testicles.



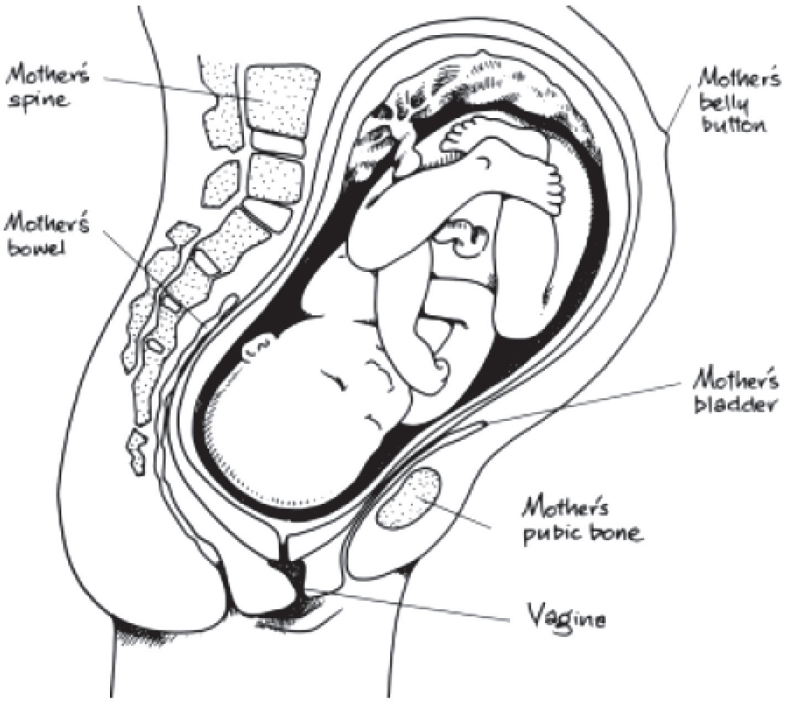
(NSW Health, 2006)

By 20 Weeks: Between 16 and 20 weeks, you may feel the baby move. The first movements are felt as flutters. They are slight at first and may be mistaken for wind, but increases in strength as the baby grows.

By 24 Weeks: Your baby is about 21cm long, from its head to its bottom and weighs approximately 600gm.

By 32 Weeks: Your baby is about 25cm long, from its head to its bottom and weighs approximately 1.7kg.

By 40 Weeks: The average Australian baby weighs between 2800 to 4500 gms. With an average length of between 46 cm to 56 cm.



(NSW Health, 2006)

Understanding Your Antenatal Card

Terms and Definitions

This is used to record the health and growth of you and your baby throughout your pregnancy and should be kept with you at all times in case you need medical attention. We have prepared the following list of terms and definitions to help you understand the information on your antenatal card.

Parity

Number of previous pregnancies and births, eg: G2P1 this woman has had two pregnancies and one birth.

LNMP

Date of last normal menstrual period

EDD

Expected date of delivery

Genital HSV

The Genital Herpes Simplex Virus. A lesion at the time of birth would require a Caesarean birth to prevent the baby coming into contact with the lesion.

Gestation

Refers to the number of weeks into the pregnancy.

Mode of Delivery

Type of birth – Normal, Vaginal, Forceps, Vacuum, Caesarean

Puerperium

Refers to the six week recovery period after birth.

Blood Group

Type of blood group – A, B, AB or O

Rhesus Factor

You will be Rhesus positive (+ve) or Negative (-ve).

Hemoglobin

Is an Oxygen carrying substance found in red blood cells. Normal levels are 110 – 150 (11-15g/dl). If the level falls below 110 your doctor may discuss with you the need to increase the iron intake in your diet, and below 105 you may need iron supplements to prevent anemia. Please discuss with your doctor prior to commencing any medications.

Hepatitis B

May be transmitted at birth. Management is to vaccinate your baby on day one to prevent them becoming a carrier.

Rubella (German Measles)

Your blood will be tested for your level of antibodies to Rubella. If you are not immune to Rubella, infection in pregnancy can lead to deafness and other abnormalities in your baby. If you are not immune, you will be vaccinated after birth on the day you are discharged from the hospital. It is very important to avoid contact with anyone who has rubella while you are pregnant: unless you are sure you are immune.

VDRL/RPR

Test for Syphilis. Early testing will allow for a woman to be treated in order to prevent infection of the baby.

Prenatal screening for Down Syndrome or other chromosome abnormality

First trimester screening tests may be offered between 10-13 weeks gestation which can provide your doctor with an estimate of the risk (or chance) that your baby has certain birth defects. A combination of maternal age, ultrasound nucal translucency measurement (NTS) and serum screening tests are utilised

Microurine

A test to detect urinary tract infections.

Ultrasound

Ultrasound can estimate your baby's age, locate the position of the placenta, determine whether or not you are carrying twins, and can also detect some physical abnormalities. Sound waves pass into the uterus, then bounce off the baby. These sound waves are translated by a computer into a picture.

BSL
Blood sugar level.

GTT
Glucose Tolerance Test – blood test to check on the way your body metabolises sugar. Abnormal results may indicate Gestational Diabetes (Diabetes in Pregnancy).

Strep B
Found in the vagina of a small percentage of all women. Causes no symptoms or problems for the woman but can be passed on to your baby at birth. The baby may develop an infection in the blood, lungs, brain or spinal cord which will need medical treatment.

If risk factors are present (eg. Preterm labour, prolonged rupture of membranes or maternal fever) you will be prescribed and given antibiotics during labour to protect your baby.

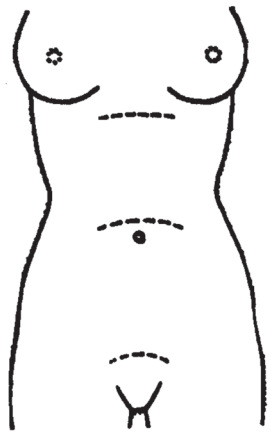
HIV (Human Immunodeficiency Virus)
HIV damages the immune system so that your body can't fight off other infections and illnesses. For HIV positive women, it is possible that the baby could become infected with HIV during the pregnancy or birth. HIV mothers are strongly advised not to breastfeed because of the risk of HIV infection to the baby.

Understanding your antenatal card.
Always ask your doctor or Midwife about anything on your card which you would like to have explained.

1 2 3 4 5 6 7 8 9 10 11

DATE	WEEKS	WEIGHT	URINE	B.P.	HEIGHT FUNDUS	PRESENTATION & POSITION	RELATION OF P.P. TO BRIM	F.H	OEDEMA	Hb	NEXT VISIT	SIG	NOTES
15/6/00	13	58 kg	Nil	110/60	15	—		—	—	12.0	20/7		arranged for 17/7 to check maternity.
20/7/00	18	59.2kg	Nil	125/60	18-20	—		FHF	—		20/8		
20/8/00	22+	61 kg	Nil	135/65	20-22	Ceph		FHF	—		17/9		taking iron
17/9/00	26+	64kg	Nil	125/75	24-26	Ceph		H	—	11.2	17/10		

1. **Date:** The date of your antenatal visit.
2. **Weeks:** The length of your pregnancy in weeks from the date of your last monthly period.
3. **Weight:** Record of your weight
4. **Urine:** These are the results of your urine tests for protein and sugar. '+' or 'Tr' means a quantity (or trace) has been found. 'Alb' stands for 'albumen', a protein detected in urine. 'Nil', 'NAD' or a tick mean the same thing – 'nothing abnormal detected'.
5. **Blood Pressure (BP):** This is carefully monitored throughout pregnancy because high blood pressure can be associated with reduced blood supply to the baby and serious effects on the kidneys, liver and brain of the mothers.
6. **Height of Fundus:** By gently pressing on your abdomen the doctor can feel your uterus. The height of the fundus is a guide to how many weeks pregnant you are. The figure recorded in this column should be roughly the same as the figure in the 'weeks' column, if there is a big difference (more than two weeks) ask your doctor about it. Sometimes the height of the fundus may be measured with a tape measure and the results entered on your card in centimetres.



7. **Presentation:** Refers to which way up your baby is. Up to about 30 weeks, your baby moves about a lot. After this point he/she usually settles into the head downwards position ready to be born. This is recorded as 'Vx' (vertex), 'C' or 'ceph' (cephalic). All three terms refer to the top of the head.

   If your baby stays with his/her bottom downwards this is a breech presentation.

   'PP' means presenting part – the part of your baby that is coming first.

L.O.L or L.O.T **R.O.A** **L.O.A** **R.O.P** **L.O.P**

Position: abbreviations are used to describe the way your baby is laying, eg: which side the baby's spine and head (occiput) are facing.

e.g **L.O.L. or L.O.T.** Left Occipitolateral or Left Occipitotransverse.

R.O.A. Right occipitoanterior.

L.O.A. Left occipitoanterior.

R.O.P. Right occipitoposterior

L.O.P. Left occipitoposterior

8. **Relation to brim:** This is where your baby's head is positioned in relation to the brim of your pelvis. It may be described in how many fifths of the head can be felt above the brim. 'E' or 'eng' means 'engaged' that is your baby's head has moved down into the pelvis ready for birth. This may happen a few weeks before birth, or not until you are in labour. 'NE' means 'not engaged'.
9. **Fetal heart:** 'FHH' or just 'H' means 'fetal heart heard'. 'FHNH' is 'fetal heart not heard'. 'FMF' means 'fetal movement felt'.
10. **Oedema:** This is another word for swelling, most often of the hands and feet. Usually it is nothing to worry about, but if it becomes uncomfortable or excessive, your doctor needs to be informed.
11. **Hb:** (haemoglobin) a complex protein-iron compound in the blood that carries Oxygen around the body. This is tested in your blood sample to check that you are not anaemic.

Exercises in Pregnancy

It is important that you continue to exercise regularly in pregnancy (unless advised otherwise by your doctor) to maintain muscle tone and general fitness, and prevent excessive weight gain. If you attend an exercise class let the instructor know that you are pregnant so that your program can be adjusted as your pregnancy progresses. If you do not usually follow an exercise program you could start walking or swimming regularly, or join a yoga class.

Pelvic Floor Exercises

A woman's pelvic floor supports the bladder, uterus and the bowel. Not only do the pelvic floor muscles play an important role in bladder and bowel control, they also affect sexual function and sensation. The pelvic floor muscles can be weakened by pregnancy and childbirth and therefore it is recommended for women to do regular pelvic floor exercises during pregnancy and following birth. Please speak with your Obstetrician.

How to Identify the Pelvic floor Muscles

1. Sit comfortably with the muscles of your thighs, bottom and stomach relaxed
2. Tighten the ring of muscle around the back passage (anus) as if you are trying to control diarrhoea or wind. Relax it.

   Try not to squeeze your bottom
3. When you are passing urine, try to stop the flow midstream, and then restart it. Only do this to learn which muscles are the correct ones. Doing this more than once a week to check your progress may interfere with normal bladder emptying.

Doing Pelvic Floor Exercises

1. Tightening and drawing in around the anus, the vagina and the urethra all at once, lifting them UP inside. Try and hold this contraction strongly as you count to five, then release and relax. You should have a definite feeling of "letting go".
2. Repeat (squeeze and lift) and relax. It is important to rest for about 10 seconds in between each contraction (tightening of the muscles). If you find it easy to hold for a count of 5, try to hold for longer – up to 10 seconds.
3. Repeat this as many times as you are able, up to a maximum of 8 – 10 squeezes
4. Now do 5 – 10 short, fast but strong contractions
5. Do this whole exercise routine at least 4 – 5 times every day while sitting, standing or lying

While doing the exercises

- Do NOT hold your breath
- Do NOT push down instead of squeezing and lifting up
- Do NOT tighten your buttocks or thighs

Good results take time, if you feel you need further assistance ask your doctor about a referral to a physiotherapist or continence advisor who will design an individual exercise program for you.

Common Discomforts of Pregnancy

Breast & Nipple Changes: Milk ducts are growing making them larger, there is also an increased blood supply making the veins under the skin more noticeable. They may feel tender and fuller, and possibly tingle. Nipples may become more prominent and may feel sensitive. Breasts may need extra support during pregnancy: you will probably need a maternity bra by about the third month of pregnancy.

Passing Urine More Frequently: This is due to increased blood flow to the kidneys and base of the bladder, making them produce more urine. This peaks by 9 – 16 weeks and then may settle down.

Increased Temperature: Metabolism increases creating more body heat and slightly raising your temperature. You may notice you sweat more.

Constipation: Hormones slow the digestive processes, by relaxing smooth muscle resulting in slower gastric emptying and peristalsis in order to maximize absorption of nutrients. To prevent constipation try regular exercise, plenty of fluids and fibre rich foods such as wholegrain bread and cereals, unprocessed bran, vegetables, fresh fruit and dried fruit and nuts.

Aches & Pains: Mild cramps, bloating, and backache are common as the uterus starts to grow. These aches can also be caused by the softening of the ligaments of the lower back and pelvis in preparation for childbirth. This may also be caused by the extra weight of the uterus.

Dizziness & Fainting: Pregnancy hormones make blood vessels relax and dilate, lowering your blood pressure, which can in-turn make you feel dizzy and faint. Avoid standing for too long. Lie or sit down at the first signs of feeling dizzy, put your head between your legs until you feel better.

Tiredness: This is due to your body adjusting to the metabolic changes necessary to grow your baby, the tiredness usually subsides by approx 12 – 14 weeks, during the last weeks of pregnancy you may also notice increased tiredness. Try resting whenever possible.

Headaches: Headaches may be due to the increased blood flow to the brain, or tension and stress. Rest and relaxation techniques often help. Contact your doctor if the headache becomes severe or frequent. Avoid Aspirin and Codeine.

Nausea & Vomiting: Typically continues until approx 12 – 14 wks of pregnancy. Usually striking when your stomach is either very empty or very full, so try to eat small frequent meals. If stress and anxiety are contributing to the intensity, deep breathing, yoga, meditation, massage and relaxation techniques may help. Some women have found acupressure, acupuncture, or homeopathy treatments useful. Most anti-nausea medications are not proven to be completely safe during pregnancy and are therefore only prescribed in severe cases.

If nothing works and you feel exhausted, or you are vomiting a lot and losing weight, see your doctor.

Heartburn: A burning feeling in your chest, sometimes accompanied by a taste of bitter fluid in your mouth is common in the second half of pregnancy. Remedies include: Sitting up for a while, try a glass of milk to neutralise the acid. To prevent heartburn, try eating slowly, frequent small meals, drink separately to the meal, and avoid foods which make the problem worse (often fatty or spicy foods). Heart burn may be relieved with antacids but please speak to your Obstetrician before taking.

Cramps: Muscle cramps in the foot, leg or thigh are common during pregnancy, they can usually be relieved by rubbing the muscle or walking around on it for a while. To relieve a foot cramp try bending your foot upwards with your hand.

Haemorrhoids: These are varicose veins in the rectum and anus which cause soreness, itching and slight bleeding. They can be triggered by constipation and / or pressure from the baby's head. Avoid straining when passing a bowel motion: follow all the recommendations to prevent constipation.

Swelling: This is caused by extra fluid in the tissues of your body during pregnancy and some of it collects in your legs. This is often more noticeable towards the end of the day. Although this swelling is common, tell your doctor, especially if the swelling is more than slight, if it presents early in the day and doesn't go down at night or if you notice it in other parts of your body such as your hands and fingers. Avoid standing for long periods, especially in hot weather, wear comfortable shoes and put your feet up as often as possible.

Common Tests during Pregnancy

Blood Tests

Blood Group: Determines what blood group the mother is.

Rhesus factor (Identified as + or -): If any antibodies or Agglutinins are present.

Hemoglobin level: Indicates red blood cell count.

Platelets: Which relate to blood clotting.

Rubella titre: Checks immunity to the rubella virus.

VDRL / RPR / TPHA – Routine tests for Syphilis which often has no physical signs and can be carried or years.

Hepatitis B, C & HIV status

Glucose tolerance test: Done at approx 28 weeks, detects the temporary condition of gestational diabetes.

Urine Tests

Are performed to exclude abnormalities such as blood, ketones or protein present, which may indicate such things as infection.

Ultrasound

Can assess such things as gestational age, locate the position of the placenta, and diagnose fetal abnormality.

Chorionic Villus Sampling (CVS)

If choosing to have this test, it must be done between the 10th and 12th week of pregnancy. CVS can be done through the cervix, or with a needle inserted through the abdomen into the uterus. By testing cells from tissues surrounding the baby, CVS can detect chromosomal abnormalities such as Down Syndrome and inherited abnormalities such as Cystic Fibrosis and Thalassaemia. Results are usually available in 2 – 3 weeks.

Amniocentesis

Amniocentesis can be done in the 14th – 18th week of pregnancy. It can detect chromosomal abnormalities, inherited disorders and neural tube defects such as spina bifida. Ultrasound guides the insertion of a needle through the abdomen into the uterus, to obtain fluid which is surrounding the baby. Results are usually available in 14 – 21 days.

Alpha Fetoprotein Test (or Maternal Serum Test)

This blood test can be done in the 16th to 18th week of pregnancy and can provide an estimate of the risk that your baby has certain birth defects. It checks the level of hormone called alpha fetoprotein (AFP) in the mother's blood. Too much AFP in the blood may mean the baby has a neural tube defect, such as spina bifida. However, there can be other causes such as twins, or your pregnancy is further along than you thought.

Nuchal Translucency ultrasound (NTS)

This is a screening test that estimates the risk of Down Syndrome or risk of other chromosomal disorders.

Ultrasound is used to measure the depth of fluid inside the back of the baby's neck. A blood test may also be done which improves the likelihood of detecting a baby with a risk of Down syndrome. It is usually performed between 11.5 and 13.5 weeks gestation.

Electronic Fetal Monitoring

This involves two belts being attached to the mother's abdomen. These belts are attached to a machine that gives a print out of the baby's heartbeat and any contractions the mother may be having. This is often used to monitor a baby's condition, and may be used regularly during the late stages of pregnancy as well as during labour.

Sometimes during labour internal fetal monitoring may be required. This provides the same information; instead via an electrode attached to the baby's scalp, however it can be more accurate as it gives direct contact with the baby.

What to Buy for Baby?

Many new parents are unsure what to buy for their new baby, often buying too much or forgetting those important little items. We have devised a basic list to help you. Experience has shown us that new parents receive many gifts, a lot of which are clothes and toys.

- Cot or bassinette
- Cot / bassinette mattress and protector
- 2 sets of cot / bassinette sheets
- 1-3 medium weight blankets
- Change table and change mat
- Capsule or car seat
- Bath
- Nappies:
- Cloth: 2-3 dozen
- Disposable: 1-2 boxes of newborn size nappies:
- Mild baby soap or soap free baby wash
- Baby wipes
- Clothing
- 6 singlets
- 6 body suits/nighties
- Pram - Australian standard AS/NZ 2088
- 4 muslin / cotton baby wraps (125cm X 125cm ideally)
- Sun hat or beanie depending on the season

How Does Labour Begin?

Labour can start days or even weeks before your estimated due date (term is anytime from 37 weeks). It can begin in many ways – contractions, a "show" or waters may break, these can occur in any order.

Show

A "show": Is a plug of mucous which during pregnancy seals the cervix. Before or during labour this becomes loose and passes out through the vagina. If this happens before labour a woman may notice it in the toilet or on her underwear as a small amount of pinkish mucous. However it may be several hours or days before contractions and real labour begin.

If unsure or concerned contact your Obstetrician or the midwives in delivery suite.

Ruptured Membranes (waters breaking)

The membrane that holds the baby and the fluid may rupture at anytime prior to the commencement of labour or anytime during labour. When this occurs, fluid may gush or leak from the vagina. Place a pad on, noting the colour of the fluid.

The water may appear clear or straw coloured, if it is green or blood stained it may indicate a problem.

Always contact the hospital as soon as the waters break.

If the waters break but there are no contractions within a certain time frame (determined by your Obstetrician) the labour may need to be induced as now that the membranes have broken there is a risk of infection.

Contractions

Labour contractions:

During labour these contractions become more regular, get longer, stronger and closer together. Early labour contractions are often likened to period cramps with or without backache.

Braxton Hicks contractions:

You may be feeling these contractions already, as tightening of the uterus, which disappears quickly. These contractions often increase in regularity and strength towards the end of pregnancy preparing your uterus for the birth. Sometimes it is difficult to distinguish between these Braxton Hicks contractions and labour contractions. Below are the common differences between the two.

Braxton Hicks contractions	Labour contractions
Usually irregular	May be irregular at first
Do not get closer together	Usually become more regular
Do not get stronger	Becomes stronger
Walking does not make them stronger	Walking makes them stronger
Lying down may make them go away	Lying down does not make them go away

When to Come to Hospital

Always call the hospital and speak to a Midwife in Delivery Suite before leaving for the hospital.

Ask your Obstetrician if they have any special recommendations for you for when to come to hospital.

If this is your first baby with a healthy pregnancy and no other complications you will usually be advised as a guide to come to hospital when the contractions are at regular 5 minute intervals and lasting approximately 45 seconds. If you live some distance from the hospital, or are finding it difficult to cope with the contractions phone the midwives at the hospital and they can advise you.

If your waters break, even if you are not in labour, you will need to contact delivery suite and come into hospital at that time

Do not hesitate to call the Midwives in Delivery Suite, available 24 hours a day, every day of the year. Delivery Suite: (02) 9717 0118

CONTACT THE HOSPITAL OR YOUR DOCTOR IMMEDIATELY

If You Have Any of the Following:

- Vaginal bleeding
- Reduced fetal movements
- Frontal or recurring headaches
- Sudden swelling
- Rupture of the membranes (waters break)
- Premature onset of contractions (before 37 weeks)

Phone: (02) 9717 0118

Please do not give the Delivery Suite telephone number to your friends or family as it is for patients and doctors only.

Emergency Birth at Home

If it becomes obvious that your baby is coming – strong uncontrolled pushing or your baby's head is visible at the vagina.

DO NOT TRY TO GET TO THE HOSPITAL DIAL 000

Ask for an ambulance. Give your address and nearest cross street clearly. The ambulance officer will give you instructions over the phone and talk you through until help arrives. Leave the front door open and turn on all the lights if it is dark so that the house is easy to find. Call out to a neighbour or passer by if you see one and ask them to wait outside to direct the ambulance.

DO NOT LEAVE THE MOTHER ALONE TO GO FOR HELP

Stages of Labour

Stage	What is Happening	What the Labouring Woman May be Feeling	Non Medicated Pain Relief Strategies	What May Happen When in Hospital
Pre-labour (Braxton Hicks Contractions)	• Painless irregular contractions "practising" for labour. • Baby's head moving into the pelvis. • The cervix may thin and dilate (open) slightly. • The mucous plug (show) may come away.	• Excited • Braxton-Hicks contractions • A burst of energy • Urge to nest • Baby may seem quieter • Diarrhoea • Backache.	• Rest • Eat light, nourishing meals.	• A Midwife can answer any questions you may have while you are in labour, 24 hours a day. Don't hesitate to call. Phone (02) 9717 0118
1st Stage Early Labour	• Uterus contracts rhythmically. • Cervix thins and begins to dilate (open). • Baby's head flexes onto the chest.	• Mild contractions that may be like menstrual cramps. • The membranes (waters) may rupture any time during labour. • Contractions gradually getting stronger, longer and closer together.	• Stay upright, rest between contractions. • Warm bath. • Empty bladder frequently. • Long slow, deep breaths. • Massage.	• During this part of labour it is usually safe to remain at home unless there are complications. However, keep in contact with the hospital and call prior to your arrival.
1st Stage Accelerated Phase (active labour)	• Contractions establish a pattern. • Cervix dilates from 4cm to 8cm.	• Contractions become noticeable. Lasting up to 60 seconds and may be 3 - 4 minutes apart. • The abdomen feels tense during contractions. • Back pain. • May start to feel quite tired, needing support to stay upright. • May find distractions quite annoying.	• Supported positions, try to remain upright e.g.: Sitting, kneeling, or pelvic rocking. • Massage. • Breathe with long slow deep breathes. • Relaxation techniques / Visualisation. • Hot packs.	• Blood pressure, temperature, pulse. • Timing of contractions and baby's heart rate will be checked regularly. • Abdominal palpation. • Vaginal examination to assess the progress of labour (will always be done prior to pain relief being given).
1st Stage Advanced labour (Transition)	• Cervix dilates from 7 cm to 10cm (fully dilated). • The baby's head is flexed and deep in the pelvis.	• Very strong contractions lasting up to 90 seconds (all encompassing and powerful). • Irritable. • May have urge to push at the height of each contraction and you may have anal pressure. • Nausea and vomiting are common at this stage.	• Listen to advice from the Midwife regarding the best position to aid the descent of your baby – all fours or upright leaning forward.	• Regular listening to baby's heartbeat. • The Midwife will stay with you during pushing and encourage you both.
2nd Stage Pushing	• Cervix is fully dilated (10cm). • Baby rotates in the pelvis, trying to find the easiest way out. • Gradually more of the baby's head becomes visible. The head crowns and is born. • With the next contraction the shoulders and body are born.	• Urge to push. • May feel a burning sensation as the perineum stretches. • A sense of relief is generally felt when the birth of your baby is complete.	• Get into a comfortable pushing position. • Work with the urges, relax all parts of your body not directly involved with pushing, particularly the pelvic floor, mouth and throat. • Push only with contractions.	• The Midwife will stay with you. • The doctor will ease your baby's head out, and check that the cord isn't around his/her neck. • The doctor will then support the baby's shoulders and the rest of your baby will be born and placed on the mother's chest.
3rd Stage Delivery of the Placenta	• Placenta separates from the wall of the uterus.	• Milder uterine contractions • An intense interest in your baby.	• Push if asked to.	• The cord is then clamped and cut, often by the father or support person. • An injection of oxytocin is given to the mother to help the uterus contract and separate the placenta.

Induction of Labour

Induction means starting labour artificially. This is usually done when there is believed to be some risk to the health of mother or baby and sometimes both, e.g.: mother has high blood pressure, and the baby appears to have stopped growing. Induction is usually planned ahead, so you will be able to discuss the reasons with your Obstetrician.

To induce labour, a small amount of gel containing a hormone may be placed in the upper vagina to help the cervix soften and start to open. Additionally / alternatively an amnihook may be inserted through the cervix to break the bag of waters, and a drip(IV) may be placed in the mothers arm and an infusion containing the hormone oxytocin commenced to start the contractions.

Working with & managing pain in Labour

As labour progresses, most women find contractions become painful. The way a labouring woman perceives and reacts to this is affected by many different factors such as fear and anxiety, personality, fatigue, cultural and social factors, as well as your expectations.

During pregnancy it is important to think about your preferences when you experience pain and what makes you feel relaxed. Discuss this with your partner, any other support people you may use, and your Doctor.

Pain experienced during labour is caused by uterine contractions, the dilatation of the cervix and, in the late first stage and the second stage, by the stretching of the vagina and pelvic floor to allow the baby's head through.

During labour the body in the presence of pain produces opiate-like substances called endorphins, which act as a natural pain relief. Endorphins prevent some pain messages from reaching the brain. Endorphins also encourage the labouring woman to withdraw to a safe private place, creates a sense of well being and positive feelings. As well as altering a woman's memory of the birth, creating an amnesic effect.

Everyone is different and so everyone feels a different level of pain in labour and childbirth.

Non Medicated Pain Relief

There are things you can do to reduce the pain of labour, such as:

Positioning: Keep active, walk around in your room or the corridors of the Delivery Suite. Change positions regularly - sitting, lying on your side, rocking, all fours, standing, squatting, walking.

Relaxation: plays a large part in managing pain in labour. Fear leads to tension, tension leads to pain, and pain leads to more fear, creating a vicious circle. There is little doubt that relaxation can do much to relieve the physical and mental strain of labour and it is possible to achieve a state of physical and mental tranquility during labour but you will need to practice and prepare for labour if you wish to achieve this.

START NOW! There are many relaxation tapes, music, yoga and books available. Try different techniques and practice your favourites often, in both relaxing and stressful situations.

Breathing Techniques: In the past, women have been taught specific breathing patterns for use during labour. While some women find these useful, in many cases trying to follow a set pattern becomes stressful. If you focus on what your body is demanding of you, you will probably find that you slip into a comfortable pattern of breathing, if this does not occur there are simple principles to remember.

Try to keep your breathing: Slow, Deep and Even.

Heat: Heat, particularly moist heat, helps increase the blood flow to the body, bringing essential Oxygen and endorphins to particular areas. A warm shower, bath or spa with the jets directed over painful areas decreases pain considerably and is very relaxing for many women. A hot pack applied to the lower back in pregnancy or labour eases the discomfort significantly. Hot packs applied to the back or lower belly during labour are an excellent form of pain relief.

When using hot packs, be sure to test the hot pack on your support person's wrist before applying it because your endorphin levels may be so high that you do not realise it is too hot and you may burn yourself. Hot packs can not be used if you have an epidural as you may be not be able to feel the intensity of the heat.

Visualisation: Visualisation is a technique where you concentrate on a specific area of your body and try to picture in your mind what it is doing. In labour you could try to visualise the uterus as it tilts forward and contracts or visualise the cervix as it thins and opens to allow your baby to move through your pelvis. Visualisation allows you to focus on the activity rather than on the pain.

Chanting: Chanting in labour is common in many cultures. It encourages you to concentrate on words that positively affirm your ability to give birth to your baby. An example of this might be:

Pain leads to power, power is progress, and progress leads to birth. I can do this, my body was designed to do this, my baby and I can do this together.

Chanting is also thought to increase endorphin levels through repetitive noise making.

Massage: Massage is not new. We have always used touch to express affection for one another: touch can provide relief from aches, pains and muscle tension. It is a skill that you can develop through experimentation and practice. There are many massage devices available on the market – a tennis ball is a cheap effective massage tool.

Face, hand and foot massages are all very relaxing and enjoyable. Find a good book on massage, experiment on each other and ENJOY.

TENS Machine (Transcutaneous Electrical Nerve Stimulation): A TENS machine consists of a small box and electrode pads which attach to your back: it delivers small electrical pulses to the body via the skin, which feel like 'pins and needles'. The TENS machine affects the way pain signals are sent to the brain. For more information please consult a Physiotherapist.

Role of the Support Person

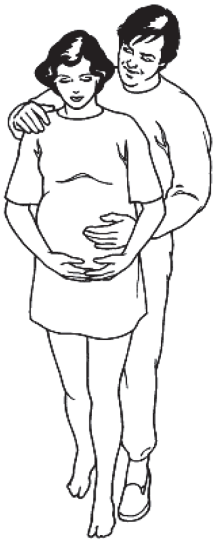
The role of the support person can not be emphasised enough. At times you may feel that you aren't helping, or don't know what to do, but just being there is often all that is required. You play a vital role in helping your partner cope with labour. Below is a short list of possible ways you can help support a labouring woman, be creative and support in any way which feels right.

- Keep calm yourself.
- Give her something to eat during early labour, to keep her strength up.
- Encourage relaxation between contractions.
- Remind her to empty her bladder every hour.
- Time contractions.
- Help distract her from the pain – TV, go for a walk.
- Encourage her to do whatever her body tells her i.e.: vocalise, groan.
- Help her into or to maintain positions.
- Massage.
- Give fluids.
- Give encouraging comments – 'you're doing great', 'keep going', the baby is nearly here'.
- Remain positive at all times.
- Help her maintain her privacy, by making sure curtains are pulled, doors are closed as desired.
- Create a relaxed atmosphere – relaxing music, dimmed lighting.
- Keep her focused on why she is doing this – 'think of our baby" 'soon we'll be holding our baby".
- Encourage her to change positions.
- Be an advocate for your partner and liaise between hospital staff and your partner.
- Support her decisions.

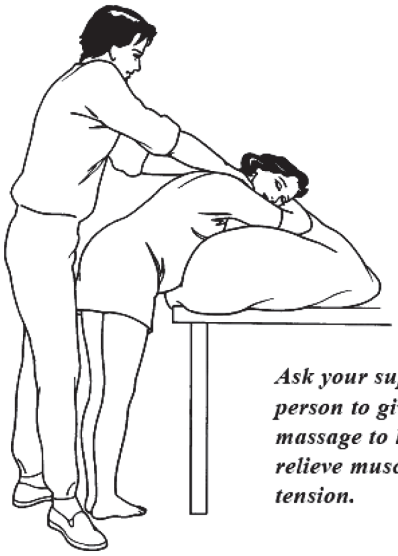
Positions for Labour

The uterus tilts forward at the start of a contraction and remains so throughout the contraction. In a lying or leaning backwards position your uterus has to work against the force of gravity, which can use up extra energy and slow the process of your labour. Your baby is travelling downwards and forwards as s/he makes his/her way through the pelvis, so for these reasons it makes sense to adopt a 'leaning forward, upright' position to reduce resistance and allow gravity to assist the progress of your labour.

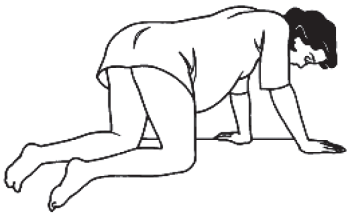
A hot bath or shower may help to reduce pain and ease backache in labour. Some hospitals provide these facilities.



Moving around during the first stage of labour can distract you from the pain and keep your circulation going.



Ask your support person to give you a massage to help relieve muscle tension.



Kneeling on all fours during the first stage of labour can help with pain relief because it takes the pressure off your back.

Lie down or lean forward into a bean bag to rest between contractions.

Medicated Pain Relief

Nitrous Oxide: Commonly called 'laughing gas'. The gas is breathed in deeply through a mouthpiece from the start of a contraction and will take 5 - 20 seconds to start working. The effect lasts the duration of the contraction and a few seconds afterward: it is not used between contractions. The mix will be controlled by the Midwife, do not alter it yourself. It does not remove the pain, but it stops you caring about it so much.

Advantages

- The mother is in control of the mouthpiece and can remove it if she does not like the effect.
- The dosage may be increased or decreased to a desired level by the Midwife as needed.
- Helps a labouring woman focus on her breathing rather than the pain.
- There are no known side effects for the baby and extra oxygen may be beneficial to both mother and baby

Disadvantages

- May not provide enough pain relief
- May cause drowsiness, confusion and a feeling of light-headedness.
- May cause nausea and vomiting

Pethidine: Pethidine is a narcotic similar to morphine and is used as a common form of pain relief during labour. It is administered by injection into the buttock or thigh, by the Midwife. A vaginal examination is performed prior to giving the injection to ensure the birth is not imminent. It will take 10 - 30 mins for the full effect to be felt and will last 2 - 4 hours. A repeat dose may be given after 4 hours, depending on your doctor's preferences. Pethidine can also be useful during a prolonged first stage to allow you to get some sleep during contractions. It won't take the pain away, but it will dull the pain.

Advantages

- Allows a labouring woman to rest or sleep between contractions
- Promotes relaxation and may expedite labour
- Decreases anxiety & discomfort

Disadvantages

- May cause drowsiness and a lack of concentration, which can make focusing on breathing techniques difficult.
- May cause nausea and / or vomiting. For this reason an anti nausea drug is usually given at the same time.
- Pethidine also depresses the respiratory centre in the brain and while this is not usually a problem for the mother, it can cause breathing difficulties at birth for your baby, particularly if it is born 1 - 3 hours after the injection is given. If this does occur it may be necessary for her / him to be given an antidote (Narcan) injection and be admitted to the Special Care Nursery for observation.
- If your baby is born within 4 hours of administration of Pethidine it may be required to go to the Special Care Nursery for a period of observation.

Epidural: An epidural may be recommended when other forms of pain relief are inadequate: it is not used routinely in all labours but is available on consultation with your Obstetrician and the Anaesthetist on call. For medical reasons, such as premature labour, delivery of twins or high blood pressure in pregnancy, an epidural may be recommended. The procedure will be explained to you and your informed consent sought before the epidural is inserted. A vaginal examination will be performed prior to an epidural to ensure birth is not imminent.

An intravenous drip will be commenced prior to the insertion of the epidural. The epidural is inserted by an Anaesthetist (available 24 hours) who will firstly use a small amount of local anaesthetic to numb the relevant area in the lower back. Then, using a special needle a soft thin plastic catheter will be inserted through the spinal ligaments of the lower back. The catheter is positioned so that it is in the epidural space, a local anaesthetic is injected through the catheter, the needle is removed and the catheter is taped to the woman's back. Pain relief should be achieved after approximately 10 minutes.

The mother's blood pressure will be monitored frequently during this time. The initial dose usually lasts for 2 - 4 hours and if additional doses are required they are given via the epidural catheter by the anaesthetist or a Midwife. Alternatively, a continuous infusion may also be connected to the epidural catheter and administered until you deliver if requested by the Anaesthetist. The catheter is then usually removed after the birth.

Precaution: As the Epidural does effect sensation and your ability to weight bear, it is imperative that your midwife is with you when you stand for the first time.

EPIDURAL

Possible side effects & complications

- The mother is unable to feel bladder sensation sufficiently to pass urine and will therefore need a catheter inserted to drain the bladder
- A decrease in blood pressure can also occur following the insertion of the epidural that can be corrected by infusing fluids rapidly via the drip
- Shivering, nausea, and vomiting may occur
- Backache is common after pregnancy and labour, whether or not an epidural has been given
- In approximately 1 in every 100 women, the dura may be punctured by the needle, and cerebrospinal fluid may leak into the epidural space, causing a moderate to severe headache. This usually responds to simple treatment

Serious Complications

Serious side effects and complications are uncommon. Although there is always a risk with any medical procedure.

- The site of puncture and the region surrounding the spinal cord can become infected.
- The local anaesthetic solution may be injected inadvertently into a blood vessel, causing dizziness, a metallic taste in the mouth, and in extreme cases, convulsions and heart problems
- Medical journals have linked permanent paralysis and death to epidurals, but cases are so rare in modern practice that the precise risks are not known
- Temporary damage to nerves outside of the spinal cord may occur in about 1 in 3000 women. This may actually be caused by labour rather than by the epidural itself. Virtually all of these cases heal within 12 weeks
- If labour becomes prolonged or blood pressure falls, the baby may become distressed, possibly leading to medical intervention such as forceps / vacuum delivery or caesarean section

Advantages

- An epidural provides a pain free or almost painless interval in your labour
- Does not cause sedation
- May help reduce blood pressure
- The resulting pain relief enables some mothers to relax, allowing the cervix to dilate more easily, and it allows rest or sleep for a while
- It also allows the experience of birth not to be missed by the mother if a Caesarean Section is needed

Disadvantages

- The mother will feel numb from the waist to mid thigh or below, and will therefore be unable to mobilise
- The mother will be placed on a fetal monitor continuously to record baby's response to contractions
- Possibility of pressure area sores if positions are not changed often, ask your support person to rub your feet to encourage blood circulation. Change positions regularly
- Occasionally there is an area that the anaesthetic does not reach, which can leave a patch of pain: this can usually (although not always) be corrected by the Anaesthetist
- If the epidural is inserted or topped up close to delivery, the mother may not be able to feel the urge to push and may not push effectively

Common difficulties during labour

Slow Progress

May be due to anxiety, an anxious mother produces adrenaline, which suppresses the production of oxytocin. Oxytocin is needed to make the uterus contract and adrenaline can slow labour until anxiety levels fall and oxytocin production returns to normal.

Helpful management can include:

- Massage
- Reduced noise levels
- Darkened room and soothing music
- Practiced breathing and relaxation techniques
- Full explanation of any procedures to be performed
- Supportive attitudes
- 'Allow' labour to happen rather than fight it

Poor Positioning of the mother:

During labour, it is recommended to stay as active and mobile as possible. This will aid the downward force of gravity.

This force is needed to assist your baby to move down onto the cervix and stimulate more contractions. If this does not happen, then labour is slowed.

Helpful management can include

- Encourage upright, open body positions, leaning forward if possible and change positions regularly.
- Use pillows, chairs, and beanbags as necessary to support the labouring woman in upright positions.
- Ask your Midwife for suggestions

Poor positioning of the baby:

If the baby is in a poor position, e.g.: a posterior position where his head is next to your spine, it will take longer for your baby to reposition himself to move through the pelvis.

Helpful management can include

- Use positions that allow gravity to aid baby in repositioning him / herself e.g. all fours.
- Warm shower
- Massage
- Heat packs

Disproportion

Sometimes the baby may be larger than the female pelvis can manage comfortably:

making birth more difficult and this can sometimes slow down the labour.

Helpful management can include

- Position the mother so that gravity aids the progress of the baby through the pelvis
- Lots of positive encouragement
- Intravenous oxytocin can make contractions more efficient
- An instrumental delivery or caesarean may be needed if no progress is made.

Abnormal fetal Heart Trace

Babies may suffer a shortage of oxygen during labour, which may show itself by a faster or slower heart rate or the baby may pass a bowel motion, making the colour of the amniotic waters look green. For this reason your baby's heart rate will be monitored during labour. There can be many reasons for fetal distress including:

Poor maternal positioning: (Mother lying on her back) causing the weight of the baby and uterus to compress the uterine artery reducing the flow of Oxygen to the baby.

Placental insufficiency: Where the placenta is not working properly.

Cord compression: The umbilical cord can sometimes become wrapped around the baby's neck, body or arms causing compression which reduces blood flow to the baby.

Head compression: As the baby's head moves through the pelvis during birth his / her skull bones override each other. This is called moulding. This process can cause the baby's heart rate to drop during contractions.

Episiotomy

An episiotomy is a cut made in the perineum just as the baby's head appears. This may be done to speed up the birth, for an assisted birth such as vacuum or to prevent perineal tearing. A local anaesthetic is usually given prior. Following birth, the episiotomy will be repaired by your doctor with stitches that dissolve. Extra care should be given to keeping these stitches clean and dry.

Forceps

Sometimes forceps need to be used to help a baby out of the vagina during the second stage of labour. These reasons include:

- Fetal distress during birth
- Slow progress during birth.
- Pelvis a tight fit for baby
- Mother unable to push, is too tired or is unable to feel contractions
- Severe high blood pressure in mother (to save her pushing)

The cervix must be fully dilated and the mothers bladder empty. A catheter may be used to drain the bladder. The mother's legs may be put into stirrups and a local anaesthetic injected to numb the lower third of the vagina and perineum. Forceps are applied, one at a time around the baby's head. They are then locked into position and the baby is rotated if necessary. Once in the correct position, some babies may deliver without further assistance, provided they are not distressed. If the baby does not deliver easily, traction is applied during contractions to assist the baby onto and over the perineum while the mother pushes. Once the baby's head is delivered, the forceps are removed and the body is delivered as normal. The placenta and membranes are then delivered following an injection of oxytocin. If an episiotomy was performed, it will be sutured.

Issues to Consider

The vagina, bladder or perineum may be bruised and become swollen, and an episiotomy is common during a forceps delivery. The degree of traction required may be considerable, which can occasionally cause bruising or temporary marks on your baby's head or face, and cause a headache which may make your baby irritable and unsettled during the first few days of life.

Vacuum

The vacuum may be used for many of the same reasons forceps are used, however it usually cannot be used to rotate the baby into a better position. A vacuum birth is done during the second stage of labour by an Obstetrician, with a suction cap which is attached to the baby's head and then applies traction to assist the baby out as the mother pushes during a contraction. Once the baby's head is born, the cap is removed and the body delivers as normal

Issues to Consider

Vacuum is not always suitable, e.g. if the baby needs to be rotated. It will create temporary swelling on your baby's head and the traction used during birth may cause discomfort for the baby.

Vacuum and Forceps can save a baby's life if s/he is distressed, and may be the only way to achieve a vaginal birth. It allows a baby to be born with less physical effort if the mother is exhausted or has high blood pressure.

Retained Placenta

In a very small number of mothers, the placenta becomes retained and is unable to be delivered. If this occurs, the mother will generally need to be transferred to the operating theatre where the placenta is removed under anaesthetic.

Caesarean Section

A caesarean section (LUSCS or LSCS) is an operation performed by an Obstetrician under anaesthetic (epidural, spinal or general) where the baby is delivered via an incision made into the mother's lower abdomen.

Some Caesareans are planned ahead due to risk factors occurring in pregnancy (elective caesarean), and others are performed in response to emergency situation that may arise during labour to hopefully save the baby's life. (emergency caesarean).

These reasons include:

- Severe fetal distress
- Severe high blood pressure
- Cephalo-Pelvic Disproportion (CPD), baby too large or pelvis too small
- Failed induction of labour
- Breech presentation
- Placenta praevia, where the placenta grows low and may cover the outlet of the cervix
- Placental Abruption, where the placenta breaks away from the uterine wall before birth
- Previous LSCS (depending on reason for last caesarean)
- Unstable diabetes in mother causing baby to grow too large
- Cord prolapse
- Multiple pregnancy

Planned caesarean section:

Do not shave prior to surgery as this will increase the risk of infection. They will clip pubic hair on admission as required.

Wax only 3-5 days prior to admission date as there is an increased risk of infection if done any later.

Ensure you arrive at the hospital at the time allocated as you will need to speak to an Anaesthetist and be prepared for surgery.

Caesarean Section: The mother must sign a consent form. A small amount of pubic hair may be clipped from just above the pubic bone and the mother will be given an antacid premedication to drink. An intravenous drip will be inserted (which will usually stay in until the following morning) and an anaesthetist will administer an anaesthetic, usually an epidural or spinal. If an epidural is already in place it is topped up with a stronger anaeshetic as long as the anaethetist is happy with the positioning.

A general anaesthetic is used in an emergency situation e.g. cord prolapse or placental abruption. In these circumstances the support person is not usually permitted to be present so that caregivers can fully focus on the mother, baby and the emergency at hand.

A catheter is passed into the bladder to empty it and will generally stay in until removal the following morning. An oxygen mask may be used to increase flow of oxygen to the baby. Once the anaesthetic is effective, an abdominal incision of about 15cms wide is made at the bikini line. The bladder is moved over and the uterus opened. Amniotic fluid is suctioned out (you may hear gurgling sounds).

The baby is delivered through the incision. Forceps may be used if the baby's head is tight in the pelvis. The mother may often feel some pressure over her upper abdomen at this time and may be aware of some pulling and tugging. The baby is lifted up for the parents to see and is then taken over to the open care cot to be assessed by the midwife and paediatrician. If there are no health concerns for baby, the mother will be given an opportunity to cuddle her baby at this time. The baby will then usually be wrapped up and given to the partner to hold for a few minutes. As theatre is very cold and the baby is adapting to life in the outside world the partner, baby and midwife usually return to the ward a short time later, where baby is weighed and examined. The mother's incision is sutured in layers, with the skin sutures being either dissolvable or non dissolvable (depending on the obstetrician's preference.)She will then spend some time in recovery (usually 30 mins to an hour) before returning to the postnatal ward.

In the meantime, the partner has the opportunity to spend time with the baby alone and bond.

Advantages

- May be lifesaving to mother or baby
- The scar usually heals very well
- Can be performed under epidural so the birth experience is not missed
- May be less traumatic than a difficult vaginal birth

Possible risks

Although considered to be a safe operation, a caesarean does have risks despite the highest standards of surgical practice. While your obstetrician makes every attempt to minimize risks, complications may still occasionally occur.

These may include:

- Wound infection
- Blood clot may form in a deep vein
- "Keloid" (raised) scarring may form on the scar from the incision

- Blood transfusion
- Damage to other organs eg bladder, ureters (tubes draining urine from the kidneys) bowel
- Decreased bowel function
- Increased bleeding
- Area of numbness or altered sensation near the caesarean scar
- Increased risk of placenta praevia in future pregnancies
- Emotional and psychological effects- some women experience a sense of failure or disappointment after caesarean

Other issues to consider

- Longer hospital stay and recovery
- Pain during recovery
- Less able to move and care for baby initially
- More difficult to find a comfortable breastfeeding position initially due to wound
- Limitations during recovery period, e.g. no lifting or driving etc
- Occasional reduced fertility
- Possible admission of baby to the Special Care Nursery for observation or treatment and consequent separation from mother
- Possibility of pressure area sores if positions are not changed often, ask your support person to rub your feet to encourage blood circulation. Ask for assistance to change positions so that you are not always lying on your back, alternate from side to side

Cord Blood Collection

Private Cord Blood Collection

If you want to privately collect cord blood you will need to organise this with the provider prior to admission to hospital and discuss this with your obstetrician.

Recovering from Birth

If the mother has had an episiotomy or a tear, your Obstetrician will suture these under local anaesthetic. The Midwife will check regularly that the mother's uterus is well contracted: blood loss is normal and blood pressure stable.

If the mother is planning to breastfeed, baby should be given the opportunity to feed as soon as possible after birth, preferably within the first hour when s/he is in a quiet and alert state. This can be encouraged by keeping him/her in close skin to skin contact with the mother's chest and asking the Midwife for help to start the feed when s/he begins mouthing around in search of the breast.

This quiet time immediately following birth is an important bonding opportunity for your new family. Use it to discover your baby top to toe and marvel at the miracle you have created.

Please be aware that general visiting is not permitted in the Delivery Suite. We therefore ask that you inform friends and family to come at the next scheduled visiting hours

Your baby will then be checked over and towel dried to remove any blood from delivery. He/she will then have their weight and length measured and given the Vitamin K (with your consent). We do not bath babies during the first 24 hours after birth as they are still adapting to maintaining their temperature.

If all is normal the mother may have a shower. If she had an epidural and has not yet regained full sensation in her legs she may have a sponge bath. The mother will be offered refreshments, although it is not uncommon for some women to experience nausea or vomiting after birth.

When the Midwife is satisfied that all is well, mother and baby will be transferred to the postnatal ward and left to rest and recover. If both mother and baby are healthy, you will have your baby room in with you 24 hours a day to promote breastfeeding and practice sleep & settling strategies, prior to being discharged.

Postnatal Care

Each day both mother and baby will have the following checks

Mother

- Temperature and pulse checked (Blood pressure checked where required)
- Fundus(top of uterus) felt at or below the umbilicus
- Moderate red blood loss (lochia) decreasing each day
- May pass small blood clots during the first 24 hours
- Breasts soft- may have leaking colostrum, breasts becoming fuller with transitional milk day 3-4

Vaginal Birth

- Perineum checked – should be clean and dry, given ice packs to prevent swelling and bruising
- Passing urine normally
- May experience mild after birth pains
- Pain relief as required

Caesarean section

- Bed rest for the first few hours
- Assisted to the shower on the evening of or morning after your operation
- IV drip generally removed the following morning or after you have passed flatus
- Free fluids on return to the ward until you have passed flatus and then you will be allowed to eat a normal diet(this may vary according to your doctors preference)
- Pain relief as required (generally a combination of rectal(suppository) and oral medication
- Urinary catheter in place to drain the bladder and generally removed on the following morning
- Dressing dry and intact(may be removed the following day or remain insitu for a few days depending on your Obstetrician preference)
- May have a drain at the caesarean site which is generally removed the following morning

Baby

- Two identification name tags
- Full check by midwife
- Umbilical cord clamped with no ooze
- Baby demand feeding as per neonatal pathway for day of birth
- Bowel action and urine output checked
- Jaundice(yellow) level monitored
- Checked by Paediatrician within the first 24 hours of birth

Days 2 to 4

- Your confidence with feeding and caring for your baby will be increasing
- Breast changes will occur to signal that your milk is "coming in"
- Your baby may be quite unsettled
- Your baby will be weighed on Day 4 and will have a small weight loss. The next weigh will usually be on the day you go home and most babies will be starting to gain weight at this stage
- Hormonal changes may result in 'Baby Blues'
- Baby's healthy hearing test is completed prior to discharge
- On day 4 your baby will have a heel prick test (Newborn Screen test) to screen your baby for some rare congenital disorders which benefit from early intervention and treatment. Your doctors and midwives will be able to provide further explanation and answers to questions that arise during your stay.
- Hepatitis B immunization is commenced (with your consent).

The Infant Health Record (Blue Book)

You will be given your Baby's Infant Health Record book after you deliver. This book is to remain with your baby while in hospital so that the immunisation information, hearing test and discharge weight can be recorded in it.

On discharge you will need to take this book home with you. It is for parents, doctors, Child and Family Health Nurses and other health workers to record details of your child's health from birth to the teenage years. Take this book with you each time you take your child to the Early Childhood Centre, Paediatrician, GP or hospital. The Blue Book also contains reminders about important health checks and immunisations.

Vitamin K for Newborn Babies

Vitamin K helps the blood to clot. It is produced by our bodies and is essential to prevent serious bleeding. Vitamin K prevents a rare, but often-fatal bleeding disorder call Haemorrhagic Disease of the Newborn (HDN). This disease can cause bleeding into the brain, which can result in brain damage: babies do not get enough of their own vitamin K until they are a few months old and do not receive very much from breast milk. For this reason they need to be given extra until they build up their own supplies.

Babies can get enough vitamin K to protect them for months from one injection. This has been given to most Australian babies just after birth for many years. Vitamin K has been used routinely in Australia for about 25 years and has almost eradicated HDN without apparent problems.

As with any preventive measure, this is your choice. However, medical authorities in Australia are united in strongly recommending that babies be given vitamin K by injection.

It can also be given in an oral preparation at birth, day 4 and again in 6 weeks. The absorption of this form of vitamin K is not as reliable. You will need to speak to your obstetrician well prior to delivery to organise this mode of administration. It will then need to be documented clearly on your antenatal card.

A doctor or Midwife will give the injection of vitamin K just after birth. Vitamin K doses given to your baby are recorded in the personal health record book ("blue book")

Hepatitis B Immunisation

Hepatitis B is a serious disease that can be contracted throughout life. It is caused by a virus that affects the liver. The Hepatitis B virus is found in infected body fluids including blood, saliva and semen. Hepatitis B can be prevented: the most effective way is by Hepatitis B immunisation. This vaccination can be safely given to babies' shortly after birth and through infancy. It is given by injection during your hospital stay. Serious side effects of Hepatitis B vaccination are rare. The most common side effects are minor and disappear quickly. These include soreness at the injection site, mild fever and joint pain. Your baby may also be irritable for a short time. If you are concerned regarding your baby's health after vaccination consult a doctor.

Newborn Screening Test

This free test is recommended for all babies in NSW. With parental consent it is performed 48-72 hours after birth. A few drops of blood are taken from the baby's heel and collected onto a special absorbent card. The dried sample is sent to the NSW Newborn Screening Laboratory for testing. Over thirty different congenital disorders can now be detected. The main disorders the test is checking for are congenital hypothyroidism, phenylketonuria, cystic fibrosis, galactosaemia and other disorders of protein and fat metabolism.

Early diagnosis means treatment can be started quickly, before the baby becomes sick.

Your Paediatrician will contact you usually within the first 2 weeks of your baby's life if there are any concerns with this test.

Hearing Test (SWISH)

About 1 to 2 in every 1000 babies has a problem with hearing that needs help. The NSW State-wide Infant Screening – Hearing (SWISH) Program aims to make sure these babies are identified. This test will usually occur whilst mother and baby are in hospital: the test takes about 10 – 20 minutes and is done when your baby is asleep or resting quietly. You can stay with the baby while the test is being done. You will get the results as soon as the test is completed. These results will also be recorded in your baby's Health Record book.

Special Care Nursery

If your baby has had a more difficult entry into the world, s/he may be taken to our Special Care Nursery for observation and treatment. The staff will keep you informed of her/his progress and encourage both you and your partner to be with her/him whenever you can. S/he is your baby and s/he needs your touch and voice to comfort her/him.

Baby Blues & Postnatal Depression

Baby Blues

The baby blues is a period of mood swings which mothers experience soon after the birth of their baby. Up to 70% of women experience the baby blues, this lasts from only a few days to a couple of weeks. The 'blues' may be caused by sudden changes in hormone levels around the time of baby's birth.

Signs of ' baby blues':

- Emotional
- Tears for no particular reason
- May feel tense or anxious
- Generally unwell
- Excessively tired

What is the difference between 'the blues' and Postnatal depression?

The 'blues' occurs during the first week or so after birth and lasts for a short while. Postnatal depression can last from several weeks to months.

Postnatal depression

Postnatal depression (PND) is the name given to the mood disorder that occurs in women in the months following childbirth, Onset may occur at any time during the first year after birth. It affects approximately 20 – 30% of women and can last from several weeks to several months.

Signs of Postnatal Depression:

- Loss of control when usually competent
- Poor self-image
- Low self-worth
- Inability to do household tasks
- Inability to think clearly or find the right words
- Tearfulness for no apparent reason
- Exhaustion and over concern about lack of sleep
- Overwhelming feelings of anxiety or depressed mood
- Poor appetite or overeating
- Loss of sexual interest
- Fear of being alone
- Fear of social contact
- Obsessional thoughts or activities
- Exaggerated fears about health and safety of self, baby or partner
- Suicidal thoughts, plans or actions

What should I do if I think I have postnatal depression?

Discuss your feelings with your partner, and your Early Childhood Nurse or doctor. They may refer you for further support and assistance as required. Treatment may include counselling, a support group, or medication.

Please refer to the useful telephone numbers and websites for further resources later in the book.

www.beyondblue.org.au.

Exercises Following Birth

It is possible to do these exercises all the way through pregnancy and following birth, as long as you feel comfortable. If in doubt always discuss with your doctor. Be aware of your breathing patterns during these exercises. Don't hold your breath – breathe normally. The number of repetitions you do of each exercise will depend very much on how you are feeling. It is better to do fewer exercises properly and with total awareness than to aim for a higher number of exercises. Eight to twelve repetitions are recommended if you are feeling comfortable. If you experience any pain or strain, especially from your back, abdomen or pelvic regions either modify the exercise or avoid it altogether.

Abdominal Exercises (Tummy Tucking)

You can do these exercises (A) standing or (B) on hands and knees.

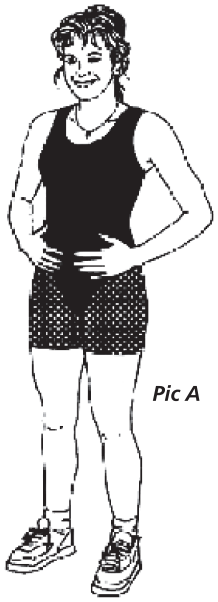
Do these exercises frequently during the day, for example, while doing housework or whilst bathing the baby. Try tummy tucking whenever you move, and this will help you support your back.

REMEMBER: DO NOT HOLD YOUR BREATH WHILE DOING THE EXERCISES

Stand with feet apart and knees slightly bent (Pic A)

Put your fingers on the widest part of your stomach, below your navel.

Pull your tummy in away from your fingers – hold for a few seconds and then let go.



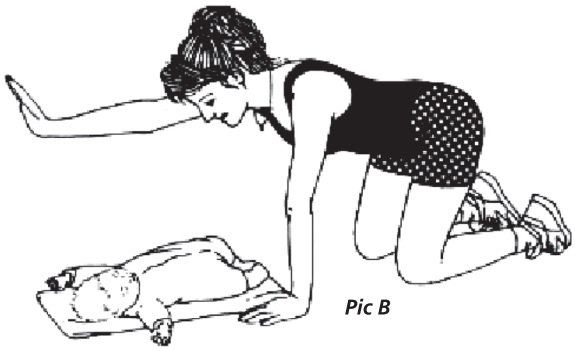
Pic A

On all fours – hands and knees

Put your hands on the floor (keep them shoulder distance apart) with your knees bent under your hips (Pic B).

Pull your tummy in without holding your breath – hold for a few seconds and then let go.

To progress this exercise on hands and knees, tummy tuck, then holding your body as still as possible, lift one arm up level with your shoulder.



Pic B

Hold for a few seconds and then lower your arm gently.

Repeat with the other arm.

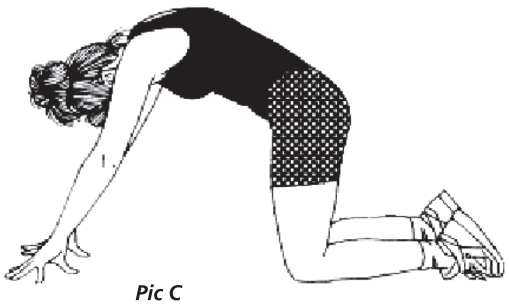
Back Stretches: To help relieve back ache and maintain mobility.

Starting position: kneel on all fours (Pic C)

Tuck in your tummy and round your back upwards, with tail bone tucked in and head gently lowered between the arms.

Hold for a few seconds, and then relax.

These exercises will help keep mobility in your spine.



Pic C

Pelvic Rotation

Starting position: stand with your feet comfortably apart.

Bend your knees slightly. Place your hands on your hips. (Pic D)

Rotate your pelvis clockwise (as in belly dancing).

Repeat in an anti-clockwise direction.

Pelvic Tilting: also assists in relieving back ache

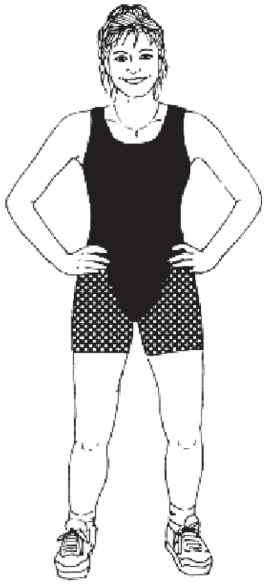
Starting position: stand with your feet comfortably apart.

Bend your knees slightly.

Place one hand on your abdomen and the other on your lower back.

Imagine your pelvis is a basin and tip it slowly backwards and forwards.

Repeat this exercise on all fours (on hands and knees).



Pic D

Breastfeeding

Why breastfeed?

Breastfeeding is the normal and most beneficial way of feeding your baby. Breastfeeding provides all your baby's essential needs for growth, development and protection from illness and disease.

Advantages for baby:

- Breast milk meets all your baby's nutritional needs for the first six months.
- Breast milk changes during the feed, as well as over months and years, to meet your baby's changing nutritional, immunological and developmental needs.
- Regular skin-to-skin contact and close interaction during breastfeeds encourages mutual responsiveness and attachment.
- Breast milk contains many anti-infective factors that help protect your baby from illnesses such as gastroenteritis and infections.
- Breastfeeding may lower the risk of being overweight, obesity and diabetes in childhood and adulthood.
- Babies who are breastfed have higher IQ scores and better jaw development.
- Breast milk is more easily digested than other milks and nappies smell less offensive.

Advantages for mother:

- Early suckling minimises bleeding after birth and helps the mother's uterus return to its pre-pregnant state.
- Breastfeeding aids a faster return to pre-pregnancy body weight as it uses kilojoules to make the milk.
- Full breastfeeding delays the return of fertility.
- Breastfeeding may reduce the risk of pre-menopausal breast, ovarian and endometrial cancers.

Advantages for the family:

- A healthier baby means reduced costs in doctor's visits and medicine.
- Breastfeeding is cheap compared to artificially feeding.
- Breastfeeding is safe and convenient

How long to breastfeed?

It is recommended that you exclusively breastfeed your baby, with no other milks, food or drinks, until about six months. At six months it is further recommended that you begin to offer solid foods while continuing to breastfeed until twelve months or longer.

Preparing to breastfeed

The shape and size of a woman's breasts are unlikely to affect the ability to successfully breastfeed. Many women notice during pregnancy that their breasts become larger and nipples more prominent. All women can benefit from becoming familiar and comfortable in handling their breasts in preparation for breastfeeding. If you have any concerns regarding inverted nipples, previous breast surgery or previous breastfeeding problems you may find it beneficial to talk with a lactation consultant before the birth of your baby.

Many practices previously recommended nipple preparation: however these have now been shown to be ineffective and even harmful.

If you have any questions regarding Breastfeeding, it is recommended that you contact the lactation consultant at Kareena Private Hospital , Monday to Friday between the hours of 6.30am and 3.00pm (also available on call)

How breastfeeding works

During pregnancy the breasts grow and change to prepare for the birth of your baby and commencing breastfeeding. At birth the mother will have a rich, thick, concentrated first milk, called 'colostrum'. Colostrum is nutritionally rich and provides an immunological boost for baby's start to life. With the delivery of the placenta a hormone is released which signals the breasts to commence making milk. The change from colostrum to mature milk begins around 30 – 40 hours after birth, however mothers don't usually notice their "milk coming in" until around the third day after birth. During this time the breasts may become noticeably fuller and heavier.

When the baby starts suckling another hormone releases the milk into the milk ducts, which then flows towards the nipple as the baby suckles. This is called the 'let-down' reflex. The key to continued milk production is demand feeding and adequate removal of milk from the breast. Once the milk has "come in" the breasts decide how much milk needs to be made for baby according to how much has been removed, so supply equals demand. We recommend that your baby has unlimited access to breastfeeds right from birth according to their individual needs. This will help to establish a good milk supply.

The First Breastfeed

Babies if placed skin to skin with their mothers show they are ready to feed by searching for the breast or they may bring their hands to their mouth. This happens soon after birth – usually within the first hour. Your Midwife will assist by ensuring both mother and baby are comfortable and supported during this time.

This first breastfeed will occur as soon as the mother returns to the postnatal ward if baby is born by caesarean. In the case of you having a caesarian section your partner will be encouraged to provide skin to skin contact whilst waiting for your return to the ward.

Learning to breastfeed

Learning to breastfeed can take time, patience and practice, however it's worth it. Breastfeeding is the natural way to feed your baby but natural doesn't always mean easy! Breastfeeding can be a challenge at first as both mother and baby learn the ropes, but as breastfeeding becomes more established it becomes much easier, takes less time and both mother and baby will begin to enjoy this unique relationship.

Individual breastfeeding education is given to mothers whilst in hospital and free outpatient consultations are available post discharge.

Positioning & Attachment

Correct positioning and attachment of the baby at the breast is the key to the prevention of most breastfeeding problems. Occasionally some babies do not feed well for a couple of days after the birth. This can be frustrating for the new mother, but it is a valuable time for learning positioning skills.

During the first weeks you may notice some tenderness or discomfort when your baby first attaches to the breast. It is normal for your nipples to feel sensitive during this time. This sensation should fade during the first few minutes of each feed, but if it continues to hurt it probably means your baby is not attached properly.

Steps to correct Attachment

1. Position yourself comfortably, sitting as upright as possible. You may require a footstool to achieve this position.
2. Take your time. Rushing only causes stress for you and your baby.
3. Maximize skin to skin contact, ensuring your breast is free of clothing and your baby is unwrapped.
4. Hold your baby close with his/her chest facing your chest. Turn your baby's body towards you. He/she should NOT have to turn their head to grasp the breast.
5. Hold your baby with the opposite arm. If you are offering the right breast, hold your baby with your left arm. Use your forearm to hold baby close to you, taking your outstretched hand behind baby's shoulder and neck to help support the head, and guide him/her towards the nipple.
6. It may be necessary to support your breast with your thumb and fingers on either side of the breast well back from the areola
7. Bring you baby to the breast
8. Tease your baby with the nipple until the mouth is wide open like a yawn, direct the nipple toward the roof of the mouth and then guide him/her toward the nipple.
9. If correct attachment is achieved, you should not feel undue discomfort. Initial attachment may cause transient discomfort (due to nipple stretch) but this should cease after 10-15 seconds of sucking. Detach baby immediately and seek lactation assistance if the pain persists
10. Check that your baby's mouth is wide open at the breast. When your baby sucks you will notice jaw movement and perhaps hear swallowing. Sucking pattern changes from short sucks to long sucks with pauses during the feed

11. Your baby's chin should be against the breast and nose free. You should not have to press down on your breast to provide the baby with nose clearance. If the nose is not clear, try tilting your baby's head so the chin moves closer into your breast
12. If you are unsure if you have achieved correct attachment, ask a midwife for assistance
13. Allow sucking to continue until your baby detaches him/herself
14. If it becomes necessary to remove your baby from the breast , slip your little finger into the corner of your baby's mouth or pull down gently on baby's jaw to break the suction.

Which breast to start with?

Your milk supply is signaled by your baby's sucking and each breast makes different amounts of milk. It is suggested to begin each feed on the alternate breast. This means start with the right breast for one feed, then the left breast for the next feed. This will ensure each breast is stimulated and drained at regular intervals.

How long should each feed last?

During the first few weeks, feeds can be enjoyed as long and as often as your baby wants. Allowing your baby's appetite to regulate your milk supply establishes a basis for the rest of your breastfeeding, so it is best to respond to your baby's needs. As long as your nipples are comfortable and your baby is sucking, then the time is unimportant. Babies get more efficient at breastfeeding as they grow and the time of each breastfeed will shorten.

One breast or both?

Each mother and baby has individual differences so there are no rules. It helps if you allow your baby to stay on the first breast while sucking well and the feed is comfortable for you.

When your baby comes off, consider either the first breast again or the second breast – depending on the fullness of your breast. Throughout the first weeks this may change at each feed as your milk volume is changing in response to your baby's needs. Your breast should be softer and less lumpy at the end of a feed.

How often will my baby feed?

For the first few days your baby may sleep long periods or may be very wakeful and need lots of feeds. The frequency of feeds will depend on your baby. We recommend baby receives a minimum of 6 feeds in 24 hours, however most breastfed babies feed on average around 8 times in a 24 hour period, once the milk is in.

Your baby will not have a feeding routine in the first weeks. He/she may want to feed every two hours at some stage and then may not feed for a five hour period. This variation between breastfeeds is normal.

How do I know when my baby has had enough?

It is not necessary to time feeds at the breast. All babies have individual needs. A general guide is if your baby:

- Is feeding at least six to eight feeds in 24 hours.
- Has six to eight pale, wet nappies in 24 hours.
- Does soft poos.
- Is looking bright, alert and contented.
- Is sleeping between most feeds in the 24 hour period, and is gaining weight satisfactorily.

Rooming in

At Kareena Private Hospital we encourage 24 hour rooming-in with your new baby from birth. Newborn babies need close maternal contact after having spent the last 9 months growing inside their mother. Separation, even just to the cot, may cause some babies to become very unsettled. Rooming-in allows you to get to know your baby and develop the breastfeeding and parenting skills you will need when you return home. Rooming-in promotes bonding, enables breastfeeding on demand and allows closer contact with the father and siblings.

Night feeds

Night feeds have many advantages:

- Earlier onset of lactation
- Engorgement is reduced and this therefore helps prevent nipple damage
- Promotes quality sleep for mother, due to the hormones released whilst breastfeeding
- Breasts will feel more comfortable and mother will therefore sleep better
- An adequate milk supply will be maintained for baby
- The milk making hormone Prolactin is highest at night

The father's role in breastfeeding

The key to successful breastfeeding is motivation and support. This is the partner's major role in breastfeeding. Your partner will need both your practical and emotional support.

Suggestions as to how you can best provide support:

- Breastfeeding does not mean that you will have less time with your baby. There are many ways to interact and care for your baby - bathing, playing, settling or going for walks.
- Encourage mum along the way, assist her when possible by ensuring that she is comfortable, that she gets the appropriate help if having difficulties, and that she gets some rest and time to herself.
- Voice your support for the breastfeeding mother and baby, to well meaning people who make statements like "are you sure she has enough milk?"
- Fix your partner a snack or a drink while she is breastfeeding.
- Let her know you support her breastfeeding and that you love her.

Breastfeeding Problems

Tender or Damaged Nipples

During the first weeks you may notice some tenderness or discomfort when your baby first attaches to the breast. It is normal for your nipples to feel sensitive during this time. This sensation should fade during the first few minutes of each feed, but if it continues to hurt it probably means your baby is not attached properly. Prevention is better than cure, but is sometimes difficult while you are both learning. Pain is an indication that something is wrong. The cure is getting positioning and attachment right. Ask for assistance from your Midwife, or you may be referred to the lactation consultant. If at home contact your local Early Childhood Centre or the Australian Breastfeeding Association.

If your nipples become damaged (grazed or cracked)

We recommend that you

- Express and rub a drop or two of breastmilk over the nipple after each feed
- Air nipples for 5 minutes (at least) after feeds
- Consider trying a different feeding position. Ask your midwife or lactation consultant for suggestions and get them to observe you attaching the baby at the breast.
- If you have grazed or cracked nipples, a purified lanolin ointment may be recommended to assist healing by granulation without a scab formation.

Dummies

Unrestricted access to the breast is necessary for your baby to learn to suckle at the breast effectively, and for your breasts to establish and maintain an adequate milk supply. The use of dummies may interfere with successful breastfeeding. When babies suck on a dummy they use a very different action than when suckling at the breast. This may lead to ineffective breastfeeding if the baby is trying to suckle at the breast in the same way they suck on a dummy. Also, replacing suckling time at the breast with a dummy may lead to a drop in milk supply.

Should you wish to introduce a dummy it is best to wait until you have established a good milk supply and your baby has learnt to attach and suckle effectively at the breast. If your baby experiences difficulty attaching to the breast, or your milk supply drops, dummy use should be removed or restricted. A dummy should never be given to delay or replace a breastfeed.

Nipple Shields

Nipple shields are made of a pliable silicone and have previously been used to assist mothers continue breastfeeding with cracked, flat or inverted nipples.

Recent research has shown however, that in the majority of situations the use of shields is largely unsuccessful.

They often cause friction between the shield and the nipple, actually causing further nipple damage

They decrease the amount of stimulation to the breast thereby decreasing mothers milk supply

They can confuse baby's sucking action thereby making it difficult to get baby to suck directly on the breast in the future.

Accordingly we discourage the use of nipple shields. If in rare circumstances the use of a shield becomes necessary, it should only be used on a short term basis with the full assistance of a midwife or lactation consultant.

Engorged Breasts

If your breasts become too full and uncomfortable:

- Try expressing a little milk before the feed to soften the breast around the areola, thus making it easier for the baby to attach correctly to the breast.
- Ensure the first side is well drained before offering the second. Most babies will only take one side when the milk first comes in and this helps to settle the supply to baby's needs
- Apply ice to the breasts for 15 minutes after feeds (ensuring the skin is protected)

Thrush

Occasionally it is possible to get thrush on the nipple causing pain, itching, redness or dryness of the nipple. Please contact a doctor or lactation consultant if concerned.

Mastitis

Mastitis can result from an unresolved blocked duct or from a bacterial infection. The risk of developing mastitis in the early weeks of breastfeeding is about 10-20%. With immediate and appropriate management, mastitis can often be resolved quickly. Below are some tips to help prevent/identify and manage this problem should it occur.

Identification

Gently check your breasts after feeds, especially the late night feed, or if baby drops a feed. You are looking for tender spots, lumps, firm areas not drained by the baby which may develop into a problem between feeds. Prompt treatment will prevent this temporary blockage/ pooling from developing into a problem.

Signs and Symptoms

You may feel unwell and flu like with a mild temperature or suddenly very sick with a high temperature. A tender or red, hot painful area may be noticed on the breast

Causes

The factors that may contribute to Mastitis are

- Nipple damage (grazes, cracks)
- Oversupply in the early weeks while your milk supply is adjusting to baby's needs. (Reduced movement of milk through the breast may lead to stasis and blocked ducts)
- Sudden changes in feeding pattern- leaving the breasts to overfill
- Being overtired, skipping meals or not caring for yourself

Prevention

Correct Attachment.

When the baby comes off the breast the shape of the nipple should look healthy and not distorted. Early nipple tenderness should be improving. If your nipples appear to be worsening, please seek professional help as soon as possible. Maintain good hygiene (wash your hands) after each nappy change and before you handle your breasts.

Breast Drainage

By the second week your baby may be feeding from both breasts more regularly as your milk supply settles. It is still important not to offer the second breast until baby's sucking slows down and swallowing occurs only occasionally. A sudden change in feeding pattern (changing the length of time the baby feeds at the breast) can cause a temporary pooling of milk, which could develop mastitis. Avoid tight bras or undergarments that my cause localized obstruction to the breast.

Management

Massage gently towards the nipple to try to clear the blocked area. Use the flats of your fingers to massage down the breast with gently vibrating motion; or use an electric body massager or the back of an electric toothbrush.

- Soften breast as much as possible
- Wake baby for a feed, or hand express under the shower as soon as you can
- Feed baby in a position that directs baby's chin to the affected area if possible
- Feed baby on the affected breast first for at least the next two feeds- do not limit sucking time on this breast. Express the second breast for comfort if necessary

THIS IS NOT THE TIME TO WEAN

Continuing breastfeeding will resolve the problem quickly. If wanting to wean, it is important to try and delay it until Mastitis is resolved. Then gradually reduce the number of feeds you give the baby balancing this with your breast comfort.

- Moist heat (shower, soak, hot pack) if the breast is not engorged- prior to a feed
- Ice for 15 mins after a feed (ensuring the skin is protected)
- Rest
- Increase your fluids
- Eat healthy food
- If your temperature becomes significantly elevated and you feel unwell you will need to see your family GP or emergency department

Breastfeeding Assistance

Australian Breastfeeding Association	1800 6862 686
	www.breastfeeding.asn.au
Tresillian	(02) 9787 0855
	www.tresillian.net
Karitane	(02) 9794 2300
	www.karitane.com.au
Mothersafe	(02) 9382 6539
	(Medications in Pregnancy and Lactation Service)
Local Early Childhood Centre	_____
Private Lactation Consultants	_____

Formula Feeding

Should you wish to use infant formula, we will respect and support your decision. Our staff will assist you with correct preparation and bottle feeding techniques. In readiness, please bring your choice of formula and two bottles, with newborn / slow teats into the hospital.

Sterilising

All utensils that come into contact with the baby's feeds or mouth need sterilising. This includes bottles, teats, caps, knife, breast expressing equipment and dummies.

Equipment can be immersed in a chemical sterilising solution (active ingredient sodium hypochlorite), steamer sterilizers or boiling in water can also be used. Please follow manufacturer's instructions carefully. Please note steam sterilising should not be used for some breast pumps as it may cause equipment to perish.

Most utensils can be boiled: Refer to products details first.

- You will need a pot large enough to take all the utensils.
- Wash hands before cleaning and preparation.
- All used feeding / expressing equipment should be rinsed with cold water.
- Turn teats inside out if possible and scrub with a brush.
- Turn teat back again and squirt hot soapy water through the hole several times.
- Repeat with hot water.
- Scrub bottles, caps, and tops, pumps, cups, and milk containers with hot soapy water and bottle brush. Rinse with hot water and drain.
- Place in boiling water for 5 minutes.
- After boiling, drain and store equipment in container in the fridge.

Preparation for Discharge

Discharge time from the ward is 10am. You will need to have a baby capsule or car seat correctly fitted in your car before you go home. The baby will need to be weighed prior to discharge.

On the morning of discharge a nurse will sign off your discharge notes and give you your discharge letter. You may take the baby's cot card and any remaining nappies home with you. Remember to take your birth registration and family payment form home with you. Before discharge you are invited to fill out the hospital questionnaire and comments card located in your room.

When you are ready to leave the ward please come to the Maternity desk. You will be advised if you need to settle any outstanding payment with the accounts department prior to discharge.

Postnatal Follow-up and Support

It is recommended that you attend your local child health clinic on a regular basis for ongoing monitoring of the growth and development of your baby. After your baby is born you will be given your baby's Personal Health Record Book and information with the phone number of your local child and family health clinic. A home visit by an Early Childhood Centre nurse will be arranged for you.

Please take the Personal Health Record Book with you when returning to your Paediatrician, family doctor, child health clinic or hospital.

You will also need appointments made with your obstetrician and Paediatrician or local doctor for a six week check up for both you and your baby.

If you are concerned about your baby's health in the first few weeks of life, please contact your paediatrician, local doctor or the Emergency department. If you have any lactation problems please ring Kareena for follow-up – you can contact a LC on 97170140 Monday to Friday 6.30am to 3.00pm.

Settling in at home

The following information is provided to assist you during your first weeks at home with a new baby. However, we recognise that all families are unique and have individual needs. Please let us know if we can assist you with any specific concerns or queries.

It is quite normal for a new family to take a few days to settle in at home. There may be periods of time when your baby is unsettled due to different noises, a new environment and parents adjusting to a new life. Take advantage of any offers to help from family and friends

Rest

It is important for you to get adequate rest. Try to rest or sleep whenever the baby sleeps

Diet

A well balanced diet is good for the health of a new mother. If breastfeeding, the recommendation is everything in moderation ie average sized servings or portions. In particular, intake of caffeine, nicotine and alcohol should be avoided as these can be a stimulant to the baby and are a SIDs risk.

Exercise

You may resume light exercises as desired and/or tolerated. Walking is an excellent form of exercise. It is important to continue postnatal exercises as set out in this booklet. If you have any difficulties passing urine, constipation or swollen hemorrhoids please let your health professional know

If you have a caesarean you should not be doing any heavy lifting vacuuming etc for at least 6 weeks

Perineal wound

If you have had stitches following a vaginal delivery these will dissolve. If the wound is still causing discomfort you may take Panadol at home. Keep the wound as clean and dry as possible to promote healing.

Abdominal wound

If you have had a caesarean no special treatment of the wound area is required. Contact your doctor if your wound is reddened with a raised firm area or if there is any pus or discharge from the wound. The numbness around the incision site is normal and sensation will eventually return

Vaginal Discharge

Vaginal loss may be heavier during the first few days at home due to increased ambulation and should settle around 4 weeks post delivery although vaginal loss in a woman having her first baby may continue for up to 4-6 weeks. Contact your doctor if you have any heavy bright bleeding large clots or offensive loss as this may indicate infection and require treatment

When to expect Menstruation

If you are not breastfeeding then ovulation/ menstruation may occur as early as 3 weeks post delivery but usually within 6-8 weeks. Menstruation is usually delayed in the fully breast feeding mother for an average of six months.

Sexuality and resumption of intercourse

There is a wide range of 'normal' sexuality. If you enjoyed sex before you will enjoy it again once early parenting pressures ease. However, if you had sexual or relationship difficulties before having a baby, these may be exacerbated. You may need to seek help from a doctor, counsellor or therapist.

Male sexuality is relatively unchanged by birth, but women's desire is tempered by her strong nurturing need. This is especially obvious in the early weeks of parenting when women find it difficult to become aroused as they always have one ear open listening for the baby to wake.

Another factor that can influence sexuality after childbirth is something sex psychologists term 'touch overload'. Mothers who have been in physical contact with their babies all day through feeding and cuddling, sometimes feel all 'touched out' by the end of the day and don't welcome any more physical contact. Unfortunately fathers have not had the same overload and need physical contact, whether loving or sexual. It will help if you can discuss these feelings together and express your needs so that a compromise can be reached.

Helpful suggestions for partners

Women who have just given birth sometimes feel unattractive as they struggle to regain their pre-pregnant shape and need to know that you still love them and find them beautiful. Constant reassurance and encouragement for her to do things that make her feel attractive may be necessary.

Breasts may leak when a woman is aroused or if they are overfull, so feed the baby first or have a towel handy.

Be creative and loving. Non-penetrative sex may be appropriate to start with and it may take several weeks or even longer for you both to become fully sexually active again. Loving communication and a sense of humour is essential during this time.

Contraception must be used if a further pregnancy is not desired as a woman ovulates (and can therefore become pregnant) before menstruation returns. Breastfeeding frequently reduces fertility but will not always prevent pregnancy and therefore should NOT be relied upon as a sole method of contraception. Note that the combined pill that contains both oestrogen and progesterone is not recommended if you are breastfeeding.

Emotions

Some mothers will notice times of tearfulness and swinging emotions. This is quite normal for new mothers adjusting to a new role. Sometimes feelings of love for your baby have to grow on you. Baby blues can still appear up to 2-3 weeks post delivery. If you are feeling tearful and sad all day it is important to speak to a health professional as you may have Postnatal depression and require some help and support.

Even though motherhood is a 24 hour job it is important you take time out to nurture yourself as often as is practical. Also time alone with your partner is important not only to develop your relationship but also to adjust to parenthood. Try to involve your partner as much as practical with baby care as they can often feel left out. Remember motherhood is one of the biggest challenges that you will have to face but well worth the effort.

Toddlers/Siblings

If you have other children it is normal to expect at some time feelings of resentment disruption to behavior or regression of milestones as a form of jealousy towards a newborn.

Initially feeding times of the newborn are usually the most difficult to manage with a toddler. Organize activities/food/drink beforehand or let the child sit with you at feed times. Encourage the older child to be involved with the care of the baby. Quality time alone with an older child is important for adjustment as is maintaining their usual routine. Remember that normal behavior will return with time patience and understanding.

Parenting

Sharing parenting from the beginning, by attending antenatal visits and sessions will help you get off to a good start with your parenting skills. Your presence and participation in your baby's birth can help consolidate your protective instincts towards your partner and your baby and can strengthen the bonds between you. Partners are naturally protective and nurturing with enormous capacity for loving. Parenting allows those feelings to come to the fore and psychologists believe if partners spend time in the early days caring for their children it can prevent difficulties in the relationship later with understanding needs and with discipline issues.

Your partner may rely on you quite heavily for physical and emotional support and you will need to share some of the physical care of your baby to give your partner a break, taking it in turns so that you both get time out for rest and other activities. Your partner may need you to protect her (and yourself at times) from well meaning advice or unwanted assistance and she may need your shoulder to cry on when she is feeling over wrought or inadequate and you may need hers too.

Babies and children love their partner's deep voice and different ways of playing and looking at the world. There are as many different ways of partnering, as there are different partners. Enjoy developing your own unique and important role in your baby's life.

You may be able to reflect on the sort of partnering experience you had yourself and build on the positive aspects while learning from any negative ones to give you a framework of how to plan to parent your child. Discuss your ideas with your partner and share your parenting experiences so that you start thinking about what is important to you both in the way you raise your children.

Community Support for New Parents

As new parents you may often feel confused and unsure of what you should do. It is important that as new parents you get out and meet other parents with babies of a similar age, that way you will find that everyone goes through the same thing. You may decide to maintain the friendship with the other members of your Birth & Parenting sessions. There are also many organisations available within the community to support new parents. You may also like to check your local phone book or ask your Early Childhood Centre for further information.

The Normal Newborn

Your baby will be assigned a Paediatrician who will perform a full examination and be contacted if there are any health concerns for your baby during its hospital stay, please note that a separate charge will apply.

Each and every baby is an individual and must be regarded as such: however there are some characteristics that most have in common. Below is an outline of some of these characteristics.

Sight: Babies can see 20-30 cms (8-12 inches).

Hearing: Normal

Taste: Develops within a few days of birth and is more sensitive than ours.

Weight: Babies lose up to 10% of their birth weight in the first week but regain this weight between 7-10 days. They then average gains of 150 – 250g per week.

Responses: Purposeful smiles occur between 4 - 6 weeks. Babies' reacts to their parents voices and smells within a few days.

Temperature: Babies can become cold quickly when wet, or overheat and dehydrate rapidly. Your baby's chest should feel comfortably warm even if the hands and feet are cold. As a rule of thumb, your baby should be wearing similar clothing to you plus a wrap. Overheating can be dangerous. The normal temperature for a baby is 36.5 -37.2°C. It is a good idea to have an easy to read thermometer in the house for emergencies and peace of mind. If your baby has a fever of 37.5°C remove excess wraps or clothing, offer a breastfeed (or boiled water if bottle feeding) and check in one hour. If the temperature is not lower contact your doctor.

Wind: Breastfed babies are less likely to have problems with wind if correctly latched on to the breast, as they seal their lips around the breast while feeding and excessive swallowing on air is avoided. Bottle fed babies swallow more air during a feed as there is an exchange of milk and air during the feed. Provided your baby is kept upright s/he should be able to burp within 2-5 minutes if s/he needs to. It may help to rock, pat or rub your baby gently during this time.

Nappies: In the first few days you can expect only a few wet nappies if you are breastfeeding as your baby is taking in low volume colostrum. During this time the urine may be quite concentrated and pinkish in colour. As the baby demands extra feeds to establish the mother's milk: the urine will become paler and more frequent. Once milk supply is established you should expect at least 6 good wet nappies in 24 hours. Less may indicate that your baby needs more frequent feeds.

Bowel Motions: In the first couple of days these will be black and sticky. Over the next few days they will change to greenish brown, then brown then yellow. Babies may grunt and strain to pass even a soft stool and can have frequent explosive wind.

A breastfed baby's stools can be from pale yellow to bright orange in colour and with seedy particles. It can even be greenish and curdy at times but not offensive to smell. It should be very soft – between liquid and toothpaste consistency. Some breastfed babies pass a stool at every feed, others once or twice a day and others much less frequently.

A formula fed baby's stools are usually paler and more bulky and may have an offensive smell and a greenish discharge. They are also slightly firmer – from paste to semi formed consistency. If stools are hard, dry or infrequent your baby may need cooled boiled water to drink. Consult with your Child and Family Health Nurse.

If stools are hard, dry or infrequent, check your formula preparation is correct. Consult with your Child and Family Health Nurse or Paediatrician.

Hiccoughs: Are common in babies who will usually feed and sleep through them and they need no treatment.

Skin Colour: Mostly pink but may have blue or purple hands and/or feet at times that may also feel cold.

Skin Texture: It is common for your baby's skin to be dry and sometimes to peel initially, particularly if overdue. Avoid using drying soaps on your baby's skin during this time. Simple moisturisers such as Sorbolene can be applied.

Jaundice: Occurs in many newborn babies, where the baby's skin appears slightly yellow in the first few days of life. This isn't usually serious but in some cases a test may be required to measure the level of bilirubin in the baby's blood. If the bilirubin is considered higher than normal then the baby will be encouraged to feed more, and maybe placed under phototherapy lights in the Special Care Nursery for a period of time until the jaundice has subsided.

Rashes: Blotchy red areas with pale centres sometimes appear on the skin of newborn babies, is thought to be a hormonal reaction, and needs no treatment. Your doctor or Child and Family Health Nurse should see other rashes.

Milia: Sometimes called milk spots, they are tiny white spots over the nose and face caused by a build up of oil under the skin. As the pores open up they will disappear and no treatment will be needed.

Birth Marks: May be seen on the eyelids, forehead, and bridge of the nose or neck. They are often referred to as 'stork marks' and disappear by age two. Mongolian Blue spots – bluish/black marks that look like bruises, are sometimes seen on the back and buttocks of darker skinned babies and usually fade by age two. A doctor should examine other birthmarks.

Eyes: May be puffy at first, following the squeeze through the birth canal. They may look squinty (cross eyed) at times due to undeveloped eye muscles and co-ordination. This will improve with time. When bathing clean the eye using a washer from the inside corner to the outside in one action, using the other corner of the washer for the other eye.

Head: May be misshapen during the birth process due to the skull bones overriding each other (moulding) and is only a temporary condition. There may also be a soft round area due to fluid build up in the scalp (Caput) which resolves on its own over the next few days.

Your baby's head may also have a cone shape, especially if it was a vacuum assisted birth, which will return to normal in a couple of days. There may occasionally be a hard swelling over one skull bone due to bruising on the bone (cephalhematoma) which can take up to six weeks to resolve.

Sometimes before birth or in the first 6-8 weeks after birth, a baby will develop a flattened spot on the back or side of her head rather than having a rounded shape. This is called Plagiocephaly (play-gi-o-cef-a-ly). Plagiocephaly does not affect growth of the baby's brain but it can cause uneven growth of the baby's face as well as their head.

A baby's head position needs to be varied during the times she is asleep and awake, particularly in the first 6 weeks

- Babies should always sleep on their backs. This makes them less likely to die from SIDS
- Place your baby at the other end of the cot for some sleeps or move the cot around its room. Babies like looking at windows or bright objects or toward the door as they know this is where you come from, and by moving the cot you will encourage him to turn his head in different ways to look at them
- Put your baby on their tummy and on their side for some of the time while they are awake
- Move toys that he / she likes to look at from side to side

If after your baby is about 6 weeks old, you are concerned about the shape of his / her head or you notice that your baby only turns his head to one side talk to your doctor or child health nurse

Tummy Time: It is particularly important to introduce your baby to tummy time as soon as possible, even in the first week. Initially tummy time will be quite short – perhaps just while drying your baby's back after the bath but s/he will progressively be happy to stay longer. Tummy time assists with development of the head, neck and trunk muscles. It is done when the baby is awake and happy. Now that it is recommended for babies to sleep on their backs, they have fewer opportunities to lift their heads as they used to so it is important to give them the chance to do so.

THE NSW SIDS ASSOCIATION RECOMMENDS BABIES SLEEP ON THEIR BACK.

Nose: Frequent sneezing is common in newborns as they react for the first time to dust and pollen in the air. They may also have a clear runny nose or snuffles as they rid themselves of any debris swept into the nostrils during birth. If the snuffles become thick, yellow or interfere with feeding, see your doctor.

Mouth: A baby's mouth and tongue should be pink. It may have a slight white coating after a feed that should clear by the next feed. If there is a thick white coating or patches before a feed, see your doctor, as it may be thrush. You may also notice a white lump on either side of your baby's mouth at the back of the hard palate. These are completely normal and thought to be used to stabilise the nipple during feeds. A baby's tongue is anchored to the floor of the mouth by the frenulum, which keeps the tongue down during breastfeeding. Very rarely the frenulum comes so far forward that the baby cannot bring the tongue forward onto the lower gum and may interfere with feeding. This is quite rare but may need attention by your doctor. A blister may form on your baby's top lip during breastfeeds if s/he is allowed to slip backwards and forwards over the areola during feeds. Check your baby's attachment and keep the chin close to the breast during the feed.

Breasts: Both boys and girls may develop swollen breasts around day 3-5 as the mothers milk producing hormones also affect them. This is normal and resolves spontaneously.

Umbilical Cord: At birth the cord will be clamped. The cord will become hard and dry after a few days, usually separating and falling off within 2 weeks. It may ooze a little old blood as it dries and separates and should be cleaned daily with a cotton bud and kept as dry as possible by keeping the cord out of the nappy. If the area becomes red, swollen or smelly inform your doctor, Midwife or Early Childhood Nurse.

Genitalia: Both sexes may seem to have disproportionately large genitalia. This is partly due to extra fluid build up in the tissues and needs no treatment. Baby girls may bleed a little from the vagina in the first week as her body responds to the hormones the mother produces. You may also notice a thick white coating around the vagina: this is a protective coating and does not need to be removed.

The foreskin of a newborn boy is adherent to the tip of the penis and gradually separates as the child grows and does not need to be pulled back. Normal washing with soap and thorough rinsing while showering or bathing is all that is required to care for the area. Commonly the scrotum of a baby boy may be swollen due to extra fluid (hydrocele) and usually resolves spontaneously and needs no treatment. One or both of the testes may not have descended into the scrotal sac by birth and it can take up to 8 weeks for them to descend. If this does not occur, a small operation may be required before two years of age.

Circumcision: The purpose of the foreskin is to protect the glans of the penis. In Australia, circumcision is now not routinely performed on newborns due to the risk of infection and haemorrhage.

Hands and Feet: These may be cool and blue at times due to physiological adaptation. Nails may be quite long, especially if your baby was overdue.

Baby's communication, sleep & settling

Crying is normal in all babies. Crying is their only form of communication: they are trying to let you know that something is upsetting them and that they need you. Many parents worry that they are going to spoil their babies by holding them too much. This is unlikely in those first 6 – 8 weeks, as it provides an opportunity for you to watch and bond with your baby and aid in getting to know them, their cues for hunger and being tired. In a few weeks you will be able to identify the reason they are crying a lot quicker than initially.

It is normal for babies to do a lot of crying in the first 6 – 8 weeks, as they get used to their new environment and body functions. Parents often find that the frequency and duration of crying decreases at approximately 8 weeks of age. Most babies have one unsettled period lasting 2 – 3 hours a day, most commonly occurring in the evening, whilst in hospital this occurs usually just after visiting hours end. Also expect one unsettled day per week, as well as a longer period during "stormy periods". Stormy periods may be associated with growth or developmental changes, such as increased stimulation when a baby begins to smile, and everyone stimulates the baby to make it smile, and therefore they often get overtired.

Reasons baby's cry

Babies cry because they are trying to communicate with you, unfortunately during the early days you may not understand the language your baby is speaking. It is often trial and error, trying to find what settles your baby best, as you and your baby get to know each other better, you will find it easier to differentiate between the different cries, such as the tired cry and the hungry cry.

Some common reasons are:

- Hunger
- Too hot / cold Wind
- Reassurance
- Sick
- Tired
- Change in environment
- Wet / dirty nappy
- "Wind"

A sick baby is usually the most unlikely reason your baby is crying, however if you are concerned, **ALWAYS HAVE YOUR BABY CHECKED BY A DOCTOR.** Out of normal business hours, go to your nearest emergency department.

Sleep

Generally, new babies will sleep for between 1-5 hours at a time. During this time your baby will pass through very active and quiet sleep and display different behaviors during these stages. In active sleep your baby will move and make noises. This can often be misinterpreted as waking up. In quiet sleep babies are quite different. There is very little movement and no noise. Their hands may look pale and feel cold if exposed. Their breathing pattern is regular with very little movement of the chest.

Each sleep cycle will last for approximately 50 minutes. If undisturbed, babies like adults can pass through several sleep cycles before fully waking up.

Sleep Associations

Babies may initially learn to go to sleep following a feed, or after being rocked, patted or cuddled to sleep. This relationship between feeding or rocking and falling asleep is learnt by the baby and is called a sleep association or cue. During the night it is normal for babies, children and adults to wake several times as we pass through the stages of each sleep cycle. Most people put themselves back to sleep without ever being aware they have been awake. If babies are unable to fall asleep by themselves they may have problems with frequent wakening during the night. At some stage it is helpful for babies to learn to initiate sleep on their own. This means putting the baby in their cot partially awake and them settling and calming them so they can drift off to sleep themselves. In general babies who are able to initiate sleep on their own will develop good sleeping habits as a toddler.

Developing Daytime Patterns

You and your baby may find it helpful to develop a rhythm or regular order in doing things during the day. This may make it easier for both of you to predict what comes next.

You will gradually learn to recognize the signs that mean your baby is ready for sleep, feeding or a playtime. Babies grow rapidly so their signals and patterns do change over time.

- After the first couple of weeks babies do not need to sleep all the time between feeds. You may find you are spending a lot of effort getting them to sleep when they really need some awake time.
- Babies are often awake and alert after a feed (though they may doze a few minutes first if they've fallen asleep while feeding). This is good time to get to know your baby or for playtime
  - Talk to and smile at your baby
  - Copy the expressions on her/his face and her noises and watch for them to copy yours
  - Walk around and show them the house and surroundings
  - Put them on the floor for a kick without their nappy or hang some toys in front of them. Watch for their early effort to hit them
  - Give some tummy time each day. It is quite safe to do this when s/he is awake and it is good for their development. Make sure you are close by and don't leave them on their tummy if they fall asleep
- When your baby has been awake for about an hour or so and show signs they are getting tired(frowning, grizzling, clenched fists, jerky movements) you can settle them in their bed for sleep
- Average times for babies to stay awake (including the feed) are about an hour for newborns, one and a half hours by 6 weeks and 2 hours from 3 months. After 6 months it may be 3 hours or more
- Day sleeps can last from 1-2 hours and some babies need to be resettled once or twice to get a good sleep. You will gradually work out when are the best play and sleep times for your baby. Some babies are sleepier in the mornings and more wakeful in the afternoons.
- When the baby wakes it may be time to feed again , followed by playtime and sleep as above
- Some babies prefer to play first then feed before going to sleep which is fine. Other babies or as they get older may switch from the first type of pattern to the second.
- With these sorts of patterns, babies tend to feed about every 2.5 to 4 hours during the day with breastfeeding babies feeding a bit more often than bottle feeders on the whole. Breast milk is digested more quickly than formula.

- If it suits you and your baby you can breastfeed more often by feeding when the baby first wakes then giving a short top up feed at the breast after the playtime before settling you baby to sleep. This is a great way to boost your supply if you feel it is a bit low, or to get through the fussiness that many babies have at the end of the day.
- Bottle fed babies may like extra feeds at times too, but don't reoffer a bottle more than an hour after the baby has first fed from it(as germs may grow and cause illness). Use a new bottle of formula.

Settling to Sleep

It is a great feeling to know you can actually put your baby to sleep when they are tired rather than just having to wait for them to fall asleep in your arms.

1. Look for tired signs

   Babies will generally begin to frown, look unhappy move their arms and legs in a tense and jerky way, clench their fists and become grizzly when tired

2. Settle your baby where they are going to sleep (Babies often cry and grizzle when put down and may need a bit of help to drop off to sleep)

- Wrap your baby so they feel more secure
- Place your baby on their back to sleep, head uncovered and with their feet at the end of the basinette or cot
- Use a repetitive soothing motion to calm your baby.
  - Try patting the baby on their side near the hip at heart beat rate. Do this over the nappy area with a cupped hand.
  - Steady the baby's shoulder with your hand if they are wriggling around and pat their bottom or stroke their head gently
  - sing to your baby softly or make 'shushing' noise
  - rock the cot or basinet gently or pat the mattress above the baby's head
  - Play a tape of relaxing music or sounds

3. Once the baby is quiet, try to leave them to settle on their own, re calming them as necessary until they go to sleep.
4. Listen to their cry. Is it a fussing whinge? Or do you need to promptly attend to them? This is known as responsive settling.
5. If your baby wakes in under an hour and is unable to resettle after a couple of minutes try helping them to resettle in their cots first by using the above methods to see if they are still tired and need some more sleep. If unable to resettle in 10-15 minutes, get your baby up. Your baby may have other needs- a nappy change a cuddle or a feed.

Unsettled evenings

It is normal for a large number of babies to have an unsettled period for up to 3 hours each day. This is commonly in the evening. It is helpful to plan ahead for these times preparing the evening meal ahead of time and getting a rest during the day when the baby sleeps

This unsettled behavior will reach a peak at around 6-8 weeks of age and will usually subside by around 12 weeks of age. During this time the baby may cry, go red in the face, screw up their fists, arch their backs and stiffen their legs.

They may need some extra help to calm down.

Remember, a baby may cry for more than one reason at a time, and just because you have changed their nappy, doesn't mean the crying will stop, as they can still have wind, be tired, or just need a cuddle. Be open to the fact that your baby can be crying for many reasons.

Strategies may include:

Remain Calm – Your baby will pick up on how you are feeling, and your feelings may affect their settling.

Hold Your Baby – Babies particularly respond to being put near to their Mother or partner's heartbeat, especially with skin to skin contact.

Feed – In the early months hunger is usually one of the main reasons babies cry. Breastfed babies will feed according to need, over the first few weeks you will become accustomed to your babies hunger signs, such as "rooting", sucking on their hands, eyes wide and looking for food, and therefore be able to respond

to your babies cues accordingly. Although you may have been through this checklist once, do not skip this step because if your baby has been crying for a while it may now be thirsty. It is difficult to settle a hungry baby, you may soothe your baby, but it will not settle for any length of time without being fed.

Change the Nappy

Burp

Wrap – Wrapping can become a baby's cue to go to sleep. It contains them like they were in the uterus, makes them feel like they are being held, and stops them from startling (where they throw their arms out).

Reduce Stimulation – Visitors, television, noise, & lighting.

Movement – May consist of holding the baby wrapped in your arms facing in towards you, with some gentle rocking and patting. You may also like to try the pram or baby sling.

Soothing Sounds – Your voice, talking, or singing, there are also music CDs available for settling babies. Some babies respond to white noise such as washing machines and dishwashers, do not place your baby on top of these appliances, and babies should not be left in these rooms unattended.

Relaxation Bath – No soap required, as the baby just floats and relaxes. The water should be warm. This can be done at anytime during the day or night. Make sure you have all the items necessary such as clothes, nappy, and towel. Take the phone off the hook. Allow 20 minutes, your baby's crying will increase because you have undressed them and placed them in water. Gently turn the baby over onto its stomach, supporting its chin with your fingers out of the water. Allow the baby to float comfortably, occasionally pouring water over its back to keep it warm. After 5 – 10 minutes your baby's fingers will start to relax and open, and your baby may close its eyes and even go to sleep.

NEVER TAKE YOUR HANDS OFF THE BABY DURING THE BATH & NEVER LEAVE THE BABY UNATTENDED.

Do not take your baby out as soon as it looks relaxed. Allow another 5 minutes, before gently lifting baby out, drying then dressing quickly. Your baby will begin to cry, but you will not undo all your good work. Following the bath, you might offer a feed to your baby, as it will be very difficult for you baby not to sleep if it is warm, relaxed, and full.

Give the Baby to Someone Else – Sharing the load is always recommended.

Change the Environment – Go for a walk with baby in the pram: reduce lighting or television sounds within the room. Think about the type of environment you like when you sleep. If there are many visitors around it makes sleeping difficult for babies.

Offer a Dummy – Dummies are not recommended whilst breastfeeding, especially in those early weeks, or if you are having any breastfeeding problems, as your baby requires unrestricted access to the breast for it to learn how to suckle at the breast effectively, as well as to establish and maintain an adequate milk supply. However if you feel it necessary, it is best to wait until the baby has learned to attach and suckle effectively. Most importantly, always offer a feed before offering a dummy.

*Please note sometimes a dummy may be recommended for your baby for a particular medical reason, such as prematurity, if a dummy is required, staff will explain these reasons to you.

Time Out – If changing the environment, or giving the baby to someone else, is not an option, you may need to put the baby in its cot for a short period. Please note that a newborn baby is not going to cry itself to sleep. The only reason you are putting the baby down is to calm yourself. You will need to walk away and calm yourself, maybe try a shower or a cup of tea at the end of the garden. Then return to your baby and begin the strategies again

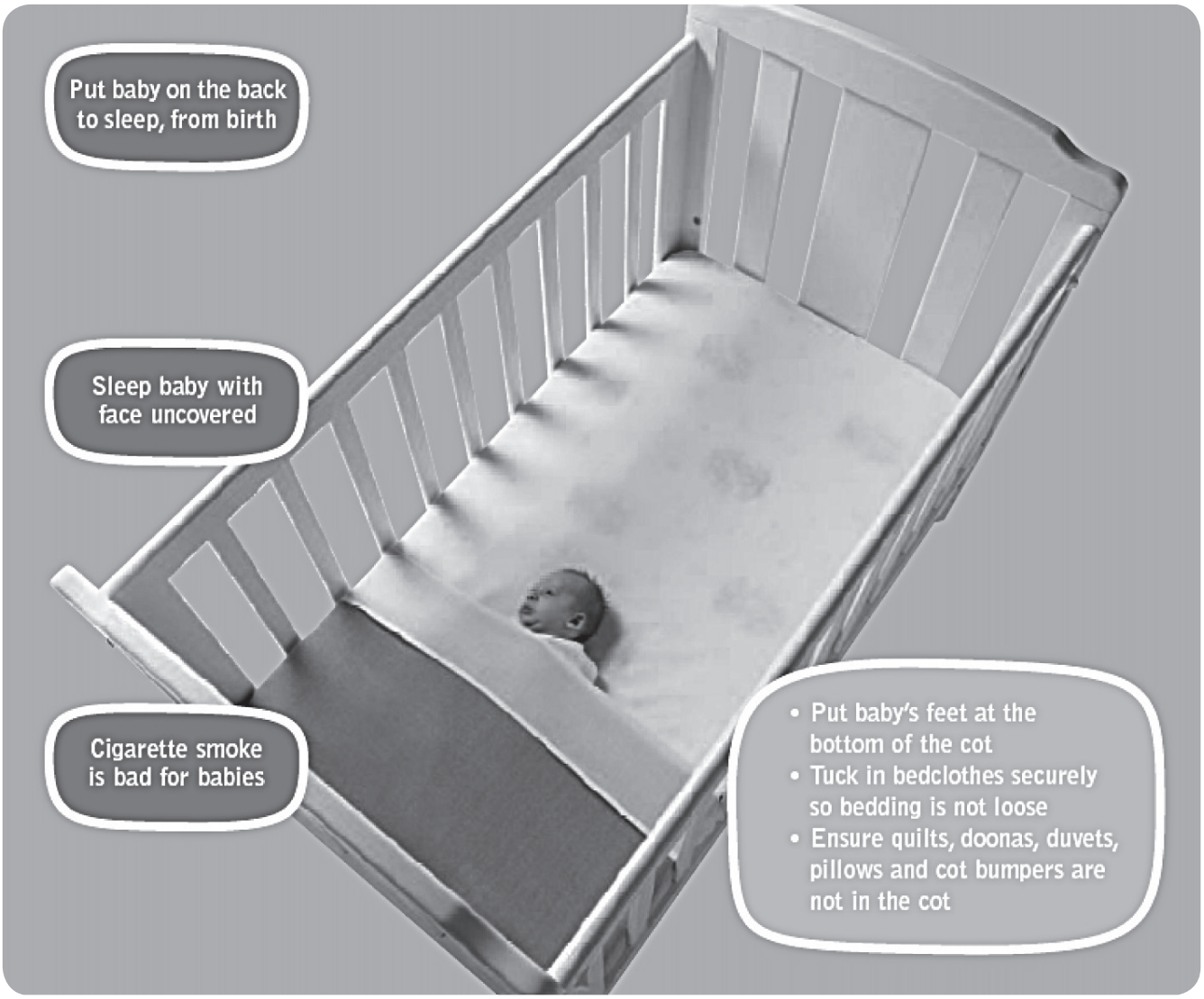
Call for Advice – You can call your Early Childhood Centre (Mon – Fri), or the Tresillian and Karitane Care Lines are available 24 hours for any settling or parenting concerns you have. If you are concerned about your baby's health contact your local Doctor or attend the Emergency department of your closest hospital.

KARITANE 24 HOUR CARELINE	**1300 CARING (1300 227 464)**
TRESILLIAN 24 HOUR HELPLINE	**9787 0855**

SIDS (Sudden Infant Death Syndrome)

The following guidelines recommended by the SIDS & Kids Association, will greatly reduce the risk for your baby:

- Use a firm, clean, well fitting mattress
- Position your baby's feet at the bottom of the cot / bassinet
- Put your baby on its back to sleep
- Tuck in your baby's bedclothes securely
- Make sure your baby's head remains uncovered during sleep
- Do not put your baby on a waterbed or bean bag
- No quilts, doonas, pillows, soft toys, snugglebeds, wedges, cot bumpers, sheepskins in the bed
- Keep your baby in a smoke free environment
- Keep your baby's cot flat



(SIDS & Kids NSW, 2009).

Parenting

Becoming a parent for the first time, is a lot like becoming a wife or husband. There is all the preparation and anticipation of the wedding followed by the big day itself. Following the honeymoon period we need to adjust to day to day living within the relationship. Similarly with birth and parenting there is the preparation and anticipation of the big day of birth, followed by the honeymoon period in hospital, the transition period of trying to get to know your baby and interpreting her/his needs and adjusting your lifestyle to accommodate her/him. At least after a wedding there are no stitches to recover from, you already have a good idea of what your partner is like and you do not have to manage on marginal sleep!

To help in the transition to parenthood consider the following:

- Can your partner take some time off work to help in the first week or so?
- If your partner can't be around is there someone else who can help?
- Who will look after other children while you're in hospital?
- Talk to your partner about how you will share household responsibilities once the baby is born
- Find out what practical support is available from family and friends
- Can someone help with babysitting or housework?
- Get to know other parents in your area

If possible, don't go making any big life changes (like moving house, renovations, or changing jobs), in the first few months after baby is born

Going Home with Baby

The stresses of early parenting can sometimes be overwhelming. You are starting a new 24 hour a day job after a few days training with no holidays or days off, while recovering from birth and suffering sleep deprivation. It is no wonder that we don't feel or look our best, or enjoy parenting as much as we had anticipated. This phase does not last forever (although it seems that way on bad days) so try to take each day as it comes and savour small moments of pleasure and small achievements – that first successful feed, a few hours of uninterrupted sleep, managing to sit down to dinner together for once, a walk in the park as a family. In no time, we look around and our tiny babies have grown and the chance to enjoy those early moments has passed.

In society today there are very few of us lucky enough to have extended family close by to help out and even those of us who have, may find that they are at work or have other commitments that prevent them helping out as much as they would have done in past generations. Therefore, the burden of parenting falls heavily on the mother and father to share as best they can. The more they can share, the more time is left for other interests and for each other. Early parenting can be stressful, particularly if communication is poor. So try to find time ever day to share some enjoyable time talking together. Putting your relationship first at times is not selfish. It is vital that your relationship is stable to enable your child to feel secure, loved and loving.

How to make life easier with a Baby

Before the baby arrives

- Have clothing and equipment ready well in advance (by 35 weeks) and avoid buying anything that can't be machine washed and tumble dried
- Buy bulk food that is easy to prepare and store
- Cook double portions to freeze, to use in the first few weeks
- Organise help at home if possible – friends, relatives, paid help for ironing and cleaning if you can afford it
- If dad can take paternity leave or a holiday, use some for when you first get home from hospital and save some for later. You will need help around the house and with the baby to start with, but would probably appreciate spending some time together as a family a few weeks later when you are fit and rested enough to enjoy it

In Hospital

- Learn as much as you can during your stay, get along to the breastfeeding and settling sessions.
- Take advantage of rest periods during the day and sleep if you can.
- Aim to become progressively independent in the care of your baby so that you will feel reasonably confident taking him/her home.
- Watch the in-house educational DVDS

At Home

- Ask friends and family to phone before visiting so that visits don't coincide with rest periods for you and the baby.
- Put a sign up near the front door to let callers know when you are feeding or sleeping.
- If you are feeling fit enough, it is sometimes easier to pop in and see friends for a short visit rather than have them visit you. That way they are responsible for catering and you can leave when you or the baby have had enough.
- If you are not feeling up to visitors or visiting keep in touch with friends, relatives by phone or email.
- Use an answering machine to screen calls.
- Snack and nap whenever you can to boost your energy levels.
- Get to know other mothers in the area. Ask if your Child and Family Health Centre has a mothers group, Early Bird Group or Transition to Parenting course for you to attend with your baby.
- Try not to have unrealistic expectations of yourself or your baby. If you are tempted to compare yourself unfavourably with other parents remember their circumstances may be very different to yours.

Housework

- Cut it down to a minimum at first and prioritise the workload.
- Try to get meals prepared and major tasks done in the morning when your baby is most likely to have a longer sleep and then nap or rest in the afternoons if you can
- Keep a 'must do' list on the fridge and if help is offered, take it and let them choose a job from the list.
- Hygiene in the kitchen and bathroom areas is important but tidiness isn't. Keep one room tidy for comfort and sanity purposes and close the door on the rest.
- Remember there is no such thing as the perfect parent. We can all just be the best we can with a loving heart and know that no one could ask any more.

Useful Phone Numbers

Australian Breastfeeding Association	1800 686 2 686
Australian Multiple Birth Association	1300 88 64 99
Dial a Mum	9477 6777
Domestic Violence – Advice & Information	1800 656 463
Down's Syndrome Association of NSW	02 9841 4444
Immunise Australia	1800 671 811
Karitane Mothercraft Society 24Hrs	9794 2300
Kidsafe	9845 0890
Lifeline	13 11 14
Men's Line Australia	1300 789 978
Poisons Information Service	13 11 26
Possum Cottage	9540 7321
SIDS NSW	1800 651 186
St John of God (Postnatal Depression)	02 9715 9200
Tresillian Family Care Centres Parent Helpline 24Hrs	9787 0855
Whispers Cottage	9525 5955
Beyond Blue	1300 2246 36

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- NSW Health (2006). Having a Baby.
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- Ramsay Health Care (2004). Breastfeeding Handbook.
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- SIDS & Kids (2009). Sids & Kids Safe Sleeping Brochure.
- Stevens ,S, & Davenport C (2008), Safe Sleep Space.

Recommended Reading

There are many publications on pregnancy, childbirth and parenting available. Try and find Australian publications where possible. Following are a number of suggested titles:

100 Ways to Calm the Crying	McKay, Pinky
Baby Love	Barker, Robin
Birth – Conceiving, Nurturing and Giving Birth to Your Baby	Price & Robinson.
Breastfeeding Naturally	Day, Jill
Exercises in Pregnancy and Childbirth	Brayshaw, Eileen
Having a Baby	Fallows, Carol
How to stay Sane in your Baby's First Year	C. Fowler & P. Gornall
Kidwrangling	K. Cooke
Men at Birth	D. Vernon
New Active Birth	Balaskas, Janet
Real Dads	Holland, Angus
Sleeping Like a Baby	McKay, Pinky
So You're Going to Be a Dad	P. Downey
Up the Duff	Cooke, Kaz
Baby on Board	Howard Chilton

Recommended Websites

Australian Breastfeeding Association:	http://www.breastfeeding.asn.au/
Australian Multiple Birth Association:	http://www.amba.org.au/content/
Birth:	http://www.birth.com.au/
Karitane:	http://www.karitane.com.au
Raising Children:	http://raisingchildren.net.au/
SIDS & KIDS:	http://www.sidsandkids.org/
The Children's Hospital Westmead:	http://www.chw.edu.au/
Tresillian:	http://www.tresillian.net/

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