Babies do come with instructions.
We dedicate this book in loving memory of
Mary L. Dickson and Linda Brenneis for their years of caring
and educating new families at Lourdes; and to all those who dedicate
their lives to the nurturing of healthy and happy babies.
Caring for Mom

Perineal Care

After you have a baby, your perineum (the area surrounding your vagina) may be sore due to an episiotomy, tears, or hemorrhoids. Correct perineal care will keep this area clean and help you feel more comfortable and heal faster.

To keep the area clean after urinating, spray warm water onto the area with your peribottle from front to back. Then pat dry with toilet paper from front to back. Clean yourself this way for as long as you have any vaginal discharge. Change your maxipad after using the bathroom or whenever needed.

Any stitches will be absorbed in about two weeks. Your doctor/midwife does not need to take them out.

After Vaginal Birth

Ice packs are used during the first 24 hours after birth to reduce swelling and pain. After 12-24 hours, a sitz bath is recommended for 15 minutes, 3-4 times a day. (See Sitz Bath Instructions.) You can use a portable sitz bath (which may be ordered by your doctor or midwife before you leave the hospital) or sit in a clean tub filled with 4-6 inches of clean, warm water. You also can use an analgesic/antiseptic spray such as Dermoplast. You can buy this at any pharmacy without a prescription. Spray this onto your perineum after you have cleaned it. The ingredients in the spray bother some women. If you feel any burning after using the spray, stop using it. Tucks pads are used for hemorrhoids and stitches. After cleaning your perineum and using the Dermoplast spray, put one Tucks pad on the stitched area and leave it there until you visit the bathroom again.

To ease hemorrhoid pain, place a Tucks pad on your rectal area. When you return home from the hospital, try keeping your Tucks pads in the refrigerator. A cold pad gives you more comfort. You can also use ProctoCream HC to reduce hemorrhoid pain. Use as directed on the package.

After Cesarean Birth/Incision Care

If you have a cesarean birth, follow the guidelines above for perineal care. This will help you prevent infection to your uterus. Once your bandage has been removed and you can shower, gently wash your incision every day using non-perfumed soap. Be sure to dry the incision completely by gently patting with a clean towel. Most doctors use stitches that dissolve in about two weeks. If your stitches need to be taken out, or if you have staples, your doctor will take these out before you leave the hospital. If steri-strips were used on your incision, let them fall off on their own. They peel off easily and may start to come off in the shower. They usually fall off completely within a week.

Vaginal Bleeding

Vaginal bleeding (called lochia) begins after the birth of your baby. It continues until the placental site in your uterus heals. The bleeding varies among women and
gradually decreases over 2-4 weeks. At first, bleeding is dark red, looks like menstrual bleeding, and lasts 2-3 days. Your flow should be moderate, using 4-8 maxi-pads a day. If you are doing too much, your bleeding might increase. If this happens, reduce your activity and see if the bleeding decreases. Soaking one pad an hour is excessive. You should call your doctor/midwife if this happens. Passing a few clots is normal as long as they are smaller than a walnut and dark in color. The bleeding will gradually become a pinkish color that will last about 10 days. For 1-2 more weeks, until healing is complete, you may notice a little creamy or whitish discharge.

Like menstrual bleeding, lochia has a musty, stale odor that is not unpleasant. A foul odor can mean you have an infection, especially if you also have a fever. If this happens, call your doctor/midwife.

During this time you can use maxi-pads or pads, not tampons.

Your Uterus

Once the placenta is delivered, your uterus will contract, or close up, and become the size of a large grapefruit. Your fundus (the upper ridge of your uterus), should feel round and firm. This firmness or tightening controls bleeding and prevents hemorrhage. Your nurse will check this frequently during your hospital stay and can help you check it, too. It is usually located at or below your belly button. It will decrease by about one finger-width every day until, at two weeks postpartum, you cannot feel it through your abdomen.

If your fundus feels soft, massage it for a few moments until it gets firm. Breastfeeding can also help keep the uterus contracted. This is because oxytocin, a hormone that triggers period-like cramps and milk discharge, is released into your body as your baby breastfeeds. Some women feel afterbirth pains due to these cramps which are normal and healthy during the early days of breastfeeding.

Afterbirth Pains

Afterbirth pains are caused by sporadic contractions of your uterus. They feel like menstrual cramps and usually last for 2-3 days after birth. If you have been pregnant before, you are more likely to feel afterbirth pains. If you breastfeed, you may feel these pains when your baby sucks. This is due to the release of oxytocin into your system, which causes your uterus to contract. To help with the pain, you may take a mild analgesic (acetaminophen or ibuprofen) 30 minutes before breastfeeding or at bedtime if the pains make it hard for you to sleep. Placing a warm pack on your abdomen may also reduce the pain.

Kegel Exercise

We suggest you do “Kegel” exercises several times a day to encourage healing and tightening of your perineal muscles. When doing the Kegel exercise you are tightening the muscles of your pelvic floor. In a sitting position, lean forward to make it easier to tighten the muscles that surround the vagina. Hold these muscles tight, as if you are trying not to urinate. Hold for a slow count of five and then release. Repeat this several times a day.
Sitz Bath Instructions

Sitz baths keep your perineum clean and help you heal faster. We recommend you take a sitz bath for 15-20 minutes, 3-4 times a day. Most women begin taking these baths the day after the birth. During a sitz bath, your perineum is constantly immersed in warm water. This widens the blood vessels around your perineum and improves blood circulation to the area, helping you heal.

If given a portable sitz bath to use at home, follow these instructions:

• Urinate.
• Fill the basin with 3 inches of lukewarm water.
• Lift the toilet seat up and place the basin on the rim of the toilet seat. Leave the toilet seat up. You will sit on the basin.
• Fill the bag with very warm tap water and hang it on something in your bathroom that will keep the bag above the basin. Make sure the clamp on the tubing is closed.
• Put the tubing through the hole in the front of the basin and secure it in the groove on the floor of the basin.
• Sit on the basin and get comfortable. Release the clamp on the tubing and allow some of the hot water to flow into the basin. When the water you are sitting in becomes warm, (the warmer the better), close the clamp. Stay seated. As you feel the warm water become cool, open the clamp and let more water flow into the basin. As that water gets warm again, close the clamp. Keep repeating this for about 20 minutes.

Remember to take a sitz bath three times a day for about one week or until your stitches no longer feel sore.

Urination

Drink 6-8 glasses of liquid a day to help keep your urinary tract healthy. Try to urinate every 2-4 hours. Do your pericare after each visit to the bathroom. Contact your doctor/midwife if:

• you feel any burning or pain when urinating
• you are urinating more than usual
• you feel like you cannot completely empty your bladder
• you urinate only a few tablespoons at a time

Your Bowels

It is common for your bowels to move slowly after the birth. This may happen because your hormone levels have dropped, there is less muscle tone in your intestines, and there is less pressure in your abdomen. Pain from an episiotomy, tears, or hemorrhoids and the fear of tearing stitches may make you not want to have a bowel movement. By doing this, you will make your constipation worse and have more pain when you finally go to the bathroom.
Prevent constipation by:

- drinking 6-8 glasses of fluid each day
- eating fiber-rich foods like fresh fruits, vegetables and whole grains
- increasing your activity.

If you become constipated and are uncomfortable, you may take an over-the-counter stool softener as directed by your doctor or midwife. A stool softener will increase the bulk and moisture in your stools.

Once you are home and comfortable in your own bathroom, having a bowel movement should be easier. If you have not had a bowel movement within 4 days, contact your doctor or midwife.

**Rest**

You should rest while your baby sleeps. Do not use this time to do household chores. Getting enough rest will make it easier for you to adjust to all the changes your new baby will bring. If you are well rested, all the unknown and unexpected issues that come up will be easier for you to handle.

Your doctor/midwife will give you directions about driving and other activities before you leave the hospital. Avoid heavy lifting and exercise until your doctor/midwife approves it. If your legs or ankles swell (called edema), you may be spending too much time on your feet. To reduce the swelling, elevate your legs. You can prop them on a pillow while lying down or prop them on a foot stool while sitting.

If your friends or family offer to help, let them. It is a good idea to give them specific jobs like fixing dinner, running errands, doing laundry, etc.

**Breast Care for the Non-Nursing Mother**

If you are not breastfeeding your baby, your breasts will still fill with milk. To reverse the process, wear a light bra or sports bra, day and night, as long as necessary for comfort. Try not to stimulate your breasts. When you shower, be sure to keep your back to the water spray since the stream of warm water will cause stimulation.

When your breasts fill with milk (called engorgement), place an ice pack or bag of frozen peas or corn on your breasts. This will reduce the pressure and make you more comfortable. When the milk is absorbed into your body after a day or two, the discomfort will go away. If you want, you can take acetaminophen or ibuprofen as directed on the package to relieve some of the discomfort.

**Emotional Changes**

The birth of a baby radically changes your life and your responsibilities. It is a time of physical and emotional stress. You will probably feel overworked, overtired, and overwhelmed.

Postpartum blues is a temporary period of mild depression that affects 50 percent of new mothers. The blues usually begin on the third or fourth day after the birth. During this time you may have mood swings, feel like crying, have trouble sleeping, or feel let down. Many mothers feel guilty having these feelings because they think they should be thrilled about caring for their new baby. These feelings are normal. It
may help you to have a good cry. Don’t be afraid to talk about these feelings with a supportive person (spouse, significant other, family member, etc.).

During the first few weeks after birth, a few new moms (about 15%) experience postpartum depression. Signs include mood swings, lethargy, feelings of inadequacy, and anxiety. For most women, this depression is temporary, resolving within six months. However, for some mothers a more lasting type of depression occurs. These women may have more severe depression that interferes with their ability to function. Lack of sleep, caring for the new baby, medical complications of childbirth, and other pressures associated with a new baby can worsen the depression. It should be discussed with a doctor/midwife if it interferes with daily activity or lasts more than a few weeks. Hormonal changes are thought to be the major cause of postpartum blues although lack of sleep and discomfort also play a part. The exact cause is not known but there are many things you can do to help yourself feel better.

Here are some ideas to help you manage postpartum depression or blues:

- Admit your feelings and talk about them with someone close to you.
- Cry if you feel like it.
- Get help with chores.
- Get out of the house and spend time with other people. Do not cut yourself off from others.
- Rest.

Take care of yourself by getting enough rest. If friends or family offer help, take it. Try to give them specific jobs to do so you can devote your energies to yourself.

You should feel better when your hormonal levels go back to normal. This happens at about the same time you begin to develop routines and get a sense of control over your life. Please call your doctor or midwife if you still do not feel like yourself after 2-3 weeks. Call them immediately if you have any feelings of harming yourself or your baby.

Fathers can also suffer from baby blues. Although it is usually a much milder condition, it is important for them to talk about their feelings also.

Post Partum Depression (PPD)

Post Partum Depression is similar to “Baby Blues,” but considered to be a more severe and longer lasting disorder within the first year of childbirth. Extreme feelings of guilt, sadness, depression, suicidal thoughts, thoughts of harming oneself or the baby and not feeling the pleasure in things once enjoyed are symptoms of Post Partum Depression (PPD). “Baby Blues” are natural feelings caused by hormonal changes in new mothers. Transient feelings of moodiness, sadness, weepiness, loss of appetite and sleeping problems and feeling irritable, restless, anxious and lonely are expected soon after birth and the week following. Symptoms are not severe and treatment is not needed. Sleep patterns and appetite disturbances are also symptoms of PPD, but should not be confused with adapting your schedule to your new baby. PPD often affects a woman’s well-being and prevents her from functioning well for a longer period of time while “Baby Blues” does not. PPD needs to be treated by a doctor, with help from support groups, counseling and medicines.

The exact cause of PPD is still determined likely to be chemical imbalances and is different for everyone. There are some predisposing factors of PPD that have been
found including a history of depression or anxiety, poor marital/relationship satisfaction, family history of mental illness, problems with a previous pregnancy or birth, lack of support, history of abuse or substance abuse, and young age of the mother. Some new studies show that smoking may pose a higher risk of PPD.

It is important for PPD to be treated as it has been shown to adversely affect the mother and the rest of the family. Two common ways PPD is treated is with talk therapy and medication. Talk therapy involves talking through emotions with a therapist, psychologist or social worker and learning how to cope with the depression. Counseling with your partner can also be helpful.

Medication can be prescribed to help relieve the symptoms. Women who are breastfeeding should talk to their physician about taking anti-depressants, as some medications are available for new mothers.

**Breast Self Exam (BSE)**

Monthly breast self-exam (BSE) is helpful in detecting breast cancer early. Along with a yearly exam by your health care provider and a mammogram after age 40, BSE can save your life. Even if you are breastfeeding, it is still important to continue your monthly BSE routine. Choose the same time each month; write it on your calendar so you remember. Do BSE after you feed your baby. After feeding, your breasts are not as full so you can get a more accurate exam. No one knows your body as well as you. If you need help or a demonstration on how to perform BSE, ask your nurse or health care provider.

**Nutrition**

New mothers often ignore their own needs so they can concentrate on their baby’s needs. Remember, if you take care of yourself, you will be able to care for your baby better. Taking care of you includes eating a healthy diet and getting enough fluids to help you heal, provide milk for your baby when you are breastfeeding, and for your good health.

It is important that you drink at least 6-8 glasses of liquid every day to meet your body’s needs. Good choices are water, milk, juice, and decaffeinated tea or coffee. If you are getting enough fluids, your mucous membranes (mouth, nose) will be moist, you will urinate regularly in good amounts, and your urine will be pale yellow.

Good nutrition means eating foods from all five food groups in the Choose MyPlate guide. Each of these food groups provides some, but not all, of the nutrients you need. Foods in one group cannot replace those in another. No one food group is more important than another — you need all of them for good health.

Getting enough calcium is important to prevent osteoporosis. Low calcium intake is associated with low bone mass, rapid bone loss, and high fracture rates. To find out how much calcium you need, ask your doctor or midwife.

The amount of food that counts as one serving varies. Listed on the following page are examples of what counts as a serving for different food groups. For example, a slice of bread is one serving in the Bread, Cereal, Rice and Pasta group. So, a sandwich equals two servings since you use two slices of bread.
Grains - 6 oz equivalent per day
Make at least half your grains whole grains.
The following counts as one ounce: ? cup cooked rice, 1 cup corn flakes, 7 saltine crackers, ? English muffin, 3 cups popcorn, ? cup oatmeal, ? cup cooked pasta, 1 6 inch tortilla

Vegetables – 2 ? cups per day
Make half your plate fruits and vegetables
The following counts as 1 cup: 1 large sweet potato, 1 cup green beans, 1 cup zucchini, 1 cup tomato juice, 1 medium baked potato, 1 cup cooked spinach, 2 cups raw spinach, 2 cups lettuce

Fruits – 1 ? - 2 cups per day
Make half your plate fruits and vegetables
The following counts as 1 cup: ? large apple, 1 large orange, 32 seedless grapes, 1 one inch wedge of watermelon, ? cup dried fruit (apricots, cherries, raisins) 1 banana, 8 oz. 100% fruit juice

www.Choosemyplate.gov contains helpful information and online calculators to help you eat healthy. Click on the Pregnancy and Breastfeeding link and the Daily Food Plan for Moms to get a customized diet plan.
Dairy – 3 cups per day
Switch to fat-free or low-fat (1%) milk.
The following counts as 1 cup of dairy: 1 cup frozen yogurt, 1 cup (8 oz.) milk, 1/3 cup shredded cheese, 1 8 oz. container of yogurt, 2 cups cottage cheese

Protein – 5 – 5 ? ounces per day
Choose lean or low-fat meat and poultry.
The following equals 1 ounce: 1 egg, 1 sandwich slice of turkey, ? cup kidney beans, 1 tablespoon peanut butter, ? cup tofu, 2 tablespoons hummus, 1 ounce cooked lean beef or chicken.

Enjoy your food, but eat less.
Avoid oversized portions.
Drink water instead of sugary drinks.

Call Your Doctor or Midwife If:

1. You have a temperature over 101 degrees. This can be a sign of infection. When your milk comes in you may get a temperature as high as 100.4 degrees, which can be normal.
2. You feel burning or pain when you urinate, or you are urinating more than usual or only a few tablespoons at a time. These can be signs of a urinary tract infection.
3. You have vaginal bleeding that has a foul odor. This can signal an infection in your uterus.
4. Your bleeding is heavy (you are soaking one pad per hour) or you are passing blood clots larger than a walnut.
5. There is a small area on one of your breasts that is red, hot, and tender. This may be a sign of mastitis (an infection in the breast gland). This can occur in the glands located under the arm or anywhere around the breast. If you develop mastitis, you do not need to stop nursing your baby. The infection is in your breast tissue and will not get into the milk.
6. You have pains in your chest, shortness of breath, or are coughing up blood.
7. You have a headache along with any visual problems, changes (blurring or spots), or discomfort.
8. You have any hot/warm, red, or tender/painful areas on your legs. Unlike muscle soreness or a muscle cramp, this problem will remain constant and may be caused by a blocked blood vessel.
9. You have an incision that is red, hot, separated, or oozes a yellow/green foul-smelling drainage.
10. You haven’t had a bowel movement within 4 days after discharge.
11. You still don’t feel “like yourself” after 2-3 weeks. Call immediately if you have any feelings of harming yourself or the baby.
Caring for Baby

Physical Appearance

Newborn babies do not always look like what we expect them to. You may have imagined your baby would look more like a “Gerber baby.” Although your baby probably does not look like that, their physical appearance is normal for a newborn.

Below are some normal characteristics of a newborn baby.

Head

Your baby’s head might look too big for its body, since the human head is already 60 percent of its adult size at birth. It may also look a little misshapen due to pressure placed on it during birth. This is called molding. It will slowly disappear with time. There are also two soft spots on the baby’s skull called fontanelles. The largest is on top of the head and the smaller is on the back. These openings are covered by a membrane that protects the baby’s brain until their skull bones are fully formed. This usually happens by about 18-24 months. Since the membrane is tough, do not be afraid to handle the baby’s head using a normal, gentle touch.

Your baby’s face will probably have pudgy cheeks; a broad, flat nose; and a receding chin. If your baby was birthed using forceps, he/she might have a forceps mark. This is usually temporary and will quickly fade. You may see some raised white spots across the bridge of the baby’s nose or face. These are called milia and are plugged sweat glands. These will go away in 1-2 weeks. You may also notice small red marks on the back of the neck, the eyelids, or the forehead. These are called “stork bites” or “angel kisses”. They are due to blood capillaries in the skin and usually fade by the first birthday.

Eyes

At first, your newborn’s eyes will appear dark blue or gray. You may not be able to determine the baby’s permanent eye color for 6-12 months. There may be bloodshot areas in the eye due to pressure from the birth. This does not hurt the eye and will slowly disappear. The eyelids will be puffy at first, but this will go away in a few days. Eye crossing is very common and is due to undeveloped eye muscles. As these muscles grow stronger, usually by 2-3 months, the eyes should no longer cross. Newborns can see, but not clearly. Hold objects 8-12 inches from the baby’s face for best visibility. Babies can see shapes and patterns. They prefer human faces as well as designs that have a lot of contrast like black and white geometric patterns.

If your baby has a constantly watery or teary eye, their tear duct may be blocked. This is common. Your baby’s doctor will tell you how to care for it. If your baby gets a yellowish or greenish drainage from one or both eyes, call the doctor since this may be a sign of infection.
Ears/Hearing

New York State law requires all babies receive a hearing screening within one month of birth, preferably before they are discharged from the hospital. Early detection and intervention are crucial in preventing or minimizing development and educational delays when hearing loss is present. Babies do not speak but learn how to communicate by listening to their environment. As a result, by the first birthday a baby is already figuring out what words mean.

Undetected hearing loss can lead to slow development of speech and language, problems with family communication as well as school problems, both academic and social.

Things that put a baby at risk for hearing loss:

• You had German measles, a viral infection or the flu during pregnancy
• Alcohol and drug use during pregnancy
• Your newborn weighed less than 3 1/2 pounds at birth
• Your newborn’s face or ears have an unusual appearance
• Newborn jaundice or an exchange blood transfusion
• Antibiotic administration through an IV
• History of meningitis
• Presence of a neurological disorder

As a newborn (birth to 6 months), suspect hearing loss if your baby:

• Does not startle, move, cry or react in any way to unexpected loud noises
• Does not awaken to loud noises
• Does not freely imitate sound
• Cannot be soothed by voice alone
• Does not turn their head in the direction of your voice

As a young infant (6 – 13 months), suspect hearing loss if your baby:

• Does not point to familiar objects or people when asked
• Does not babble or babbling has stopped
• By 12 months is not understanding simple phrases as "wave goodbye" or "clap hands"

As an infant (13 – 24 months), suspect hearing loss if your child:

• Does not accurately turn in direction of a soft voice on the first call
• Is not alert to environmental sounds
• Does not respond to sound or does not locate where sound is coming from
• Does not begin to imitate using simple words
• Does not like sound or use speech like children of same age
• Does not listen to TV at a normal volume
• Does not show consistent growth in the understanding and the use of words to communicate

If you notice any of the above, be sure to mention them to your baby’s pediatrician during check-ups.
Breast Swelling

Both male and female babies may have swollen or red breasts when they are born. Most people believe this is due to an increase in mom’s pre-birth hormones. It will usually go away in 2-3 months. If the redness spreads or if the breasts look inflamed, tender, or have a yellowish or greenish discharge, call your baby’s doctor.

Genitals

The genitals or sexual organs of baby boys and girls will temporarily look large and swollen. On males, the scrotum will be swollen and red/dark. On females, you will notice the labia are red/dark and enlarged. You may notice some whitish secretions in the folds. The white, pasty secretions (called vernix) helped protect your baby’s skin before birth. You can clean this by gently wiping from front to back. You do not have to remove all the vernix. You may also see some vaginal mucus or blood. This is due to the sudden decrease in the mom’s hormones. It is temporary and no cause for alarm.

Extremities (Arms and Legs)

Your baby will probably hold their arms and legs curled up next to the body in a pre-birth position. Also, babies often clench their fists. Blue-tinted hands and feet are normal during the first several days to a week. This is called acrocyanosis. It is due to the baby’s undeveloped circulatory system and can also happen when the baby is cold. When warmed, the hands and feet return to a normal pink color.

Nails

During the first days of life, babies’ nails may stick to the skin on their fingers. Do not cut the nails at this time. Within a week, the nails will separate from the skin and frequently break off. If you notice your baby scratching their face, put mittens or socks over the hands. You can also file the baby’s nails using the soft side of an emery board. After a few weeks, you can trim the nails with cuticle scissors or a clipper. Check baby’s fingernails once or twice a week and trim as needed. Check baby’s toenails once or twice a month and trim as needed. It is best to trim babies’ nails when they are sleeping and their hands are still.

Skin

A newborn’s skin is usually pink or rosy red in color and warm to touch. Some babies have bluish hands and feet. This is called acrocyanosis. It is due to the baby’s undeveloped circulatory system, and is more noticeable if the baby is cold. Acrocyanosis is normal and should disappear in about a week. A mottled, red, “lacy” look to the skin is also normal. This often happens when the baby’s skin is exposed during bathing or dressing. Vernix, a whitish cheese-like substance, protects the baby skin while in mom’s uterus. You may notice this on your baby, especially if their birth was premature. A full-term baby’s skin is usually dry and peeling, mostly on the hands and feet. Newborns go through a process similar to molting. Their skin becomes very dry and flaky, and then peels. Once this happens, soft baby skin is exposed. You can use a little non-perfumed lotion, but it will not prevent peeling.

Erythema neonatorum toxicum is the medical term for newborn rash. It looks like a reddened splotch that sometimes has a whitehead-type pimple. It occurs in 30-70
percent of full-term babies. The rash may appear suddenly, usually over the torso and diaper area. It is best left alone and will disappear in 1-2 weeks.

Mongolian spots are bluish-black areas that can appear on the skin in the lumbar region or on the buttocks. This is common in dark-skinned babies. These may fade during the first year or two, or may be permanent.

### Reflexes

Babies will have many reflexes at birth to help them survive.

- The rooting reflex causes the baby to turn their head when anything touches their cheek. It helps the baby locate the nipple for feeding.
- The sucking reflex causes the baby to make sucking movements when anything touches their lips.
- The grasp reflex exists in hands and feet. A baby will grasp anything put into their hands.
- The moro reflex or startle reflex is a reaction to sudden, strong stimuli. You will see this reflex if the baby experiences a sudden loud noise, jolt, or loss of support. When this happens the baby will suddenly throw their arms out and then slowly bring them back into the flexed (curled) position.
- The gag reflex helps prevent choking.
- The walking reflex makes it look like the baby is trying to walk when he/she is held upright with their feet on a firm surface.

### Urination

Babies may urinate when they are born, or their first urination may be delayed 12-24 hours. Normal urine during early infancy is straw-colored and almost odorless. But the urine may have an odor if the baby is on medication or has an infection. Pink spots called brick dust spots will sometimes appear on the baby’s diaper. If these occur in the first 2-3 days of life, they are of no concern.

The number of wet diapers your baby has tells you if your baby is getting enough to drink by bottle or breast. By the second day of life, your baby should have 2-3 wet diapers during a 24-hour period. Each day after that, you should see an additional wet diaper. This means that by a week of life, your baby should be wetting 4-6 disposable (8-10 cloth) diapers a day.

### Stooling

The baby’s first bowel movement, called Meconium, is sticky, black, and odorless. Over the next 1-2 days, the stools will change to a greenish-black, and then to a greenish-brown, and finally to a brownish-yellow.

Breastfed babies have yellow stools that are loose and seedy. They may have several stools a day or even after every feeding. Babies who are formula-fed have different-looking stools from those who are breastfed. Stools of a formula-fed baby are seedy yellow and more solid. One or more a day is normal. At about the second month, the number of stools may slow down a lot. In fact, a breastfed baby may sometimes go seven days between stools.
Many babies will strain and grunt when having bowel movements. This does not mean they are constipated. A stool that is a hard-formed ball is a constipated stool. The frequency and consistency of a baby’s stool can vary from day to day. Changes in color or hardness/softness do not mean anything serious. Babies can become dehydrated quickly. Call the doctor if your baby develops diarrhea or explosive, very watery stools.

**Cord Care**

Right after birth, your baby’s umbilical cord will be white and jelly-like in appearance. The clamp is usually removed before you leave the hospital. The American Academy of Pediatrics recommends allowing your baby’s cord to dry naturally. Do not use alcohol or other items on the cord. Fold your baby’s diaper down below the cord and turn the baby’s shirt up so the cord can get plenty of air. This will help it dry. The cord usually falls off by itself between 7-10 days. Do not pull or try to remove the cord. A small amount of blood or yellow discharge is normal after the cord falls off. If any oozing continues for several days, call your baby’s doctor. The umbilical area is a likely source of infection. It is important that you call the doctor if you smell a foul odor or see oozing or redness on the skin near the cord.

**Diapering/Diaper Rash**

It is normal for a newborn to use 8-12 diapers a day. Change diapers when they are wet or soiled. Use warm water to clean the baby’s bottom after urination or mild soap and water after a bowel movement. If using wipes, use alcohol-free, unscented ones during the first few months. Some wipes contain ingredients that bother babies’ skin. Remember to clean in all the creases and folds. Diaper rash is caused by irritation from urine and stool. Some babies get a diaper rash as a reaction to new foods or, if breastfeeding, to food the mother has eaten. Since prevention is the best cure, follow some of these suggestions to reduce the chance of diaper rash.

- Keep the diaper area clean and dry.
- After each diaper change, wash the baby’s bottom with warm water and a mild soap. Rinse and dry the area well, making sure to get all the folds and creases. For baby girls, wipe from front to back.
- Do not use lotions, oils, or powders.
- If you use cloth diapers, soak dirty diapers in a pail of water with 1/2 cup of liquid chlorine bleach before washing them with a mild detergent. Add 1/4 cup of vinegar to the rinse cycle. This will help break down any leftover ammonia in the diapers, which can cause diaper rash. Drying diapers in the sun also helps.
- Keep the diaper fairly loose to allow air to circulate.

If diaper rash develops anyway, also follow these suggestions:

- Leave the diaper off as much as possible to expose the skin to air. If you do, remember to keep the room warm so the baby does not get cold.
• Do not use wipes since they can irritate the sensitive, reddened skin.
• Use a thin layer of an over-the-counter diaper cream or petroleum jelly to help protect the baby’s skin from excess moisture.
• If the rash does not improve after you have tried these remedies, call your baby’s doctor.

**Suctioning with a Bulb Syringe**

All newborns breathe through their noses and keep their air passages open by coughing or sneezing. During the first few days of life, the baby has mucous that may need to be gently suctioned using a bulb syringe. You will find a bulb syringe in your baby’s crib at the hospital. Remember to keep it with the baby while in the hospital and to take it home with you when you leave.

How to use the bulb syringe to remove mucous from the baby’s mouth:

• Squeeze the bulb and place the tip in the baby’s mouth along the tongue and cheek.
• As you release the bulb, the mucous will collect in the bulb.
• Remove the bulb from the baby’s mouth and squeeze the contents onto a tissue.

You may need to repeat this several times to get rid of all the mucous. Do not place the tip of the bulb syringe on the baby’s tongue or squeeze it forcefully in the back of the baby’s mouth since this may make the baby gag.

You can also use the bulb syringe to remove nasal drainage. To do this, squeeze the bulb and place only a small amount of the tip in the baby’s nostril. Release the bulb and remove it from the nostril. Empty the contents of the bulb onto a tissue. Try not to suction the baby’s nasal passages often, since that will irritate the inside lining of the nose and cause swelling.

Occasionally wash and rinse the bulb syringe with warm, soapy water.

**Positioning (also see page 51)**

One of the most important things you can do to help reduce the risk of Sudden Baby Death Syndrome (SIDS) is to put your healthy baby on their back to sleep. Research has shown that positioning your healthy baby this way for naps and bedtime sleeping will not increase the risk of choking, as once thought by our parents and grandparents.

It is **not recommended** to place babies on their tummy during sleep, unless they have a medical condition that requires them to sleep this way. Your baby’s doctor will let you know if your baby falls into this group. Tummy time, while your baby is awake and with you, is important to strengthen upper body muscles.

**Handling**

A newborn’s neck muscles are weak, so you must support the baby’s head when handling the baby.

The **cradle or Madonna hold** is frequently used with babies, especially during feedings. It permits eye contact; frees one of the mother’s hands; and provides a sense of closeness, security, and warmth since the mother’s arm protects the baby’s body.
The upright position is ideal for burping and also provides a sense of closeness. Many babies are comforted by this position when placed on the left side of the mother’s chest. This provides warmth, closeness, and the sound of the mother’s heartbeat. Always remember to support the baby’s head in this position.

The football hold frees one of the mother’s hands and permits eye contact. Although some bodily closeness is decreased, it is ideal for breastfeeding or shampooing the baby’s head. For a mom who has had a cesarean section, it keeps the baby off her sore tummy. Always remember to protect your baby from falling. Never leave your baby alone on an unguarded surface.

Bathing

Until your baby’s umbilical cord falls off, it is important to keep this area dry. Give your baby a sponge bath rather than a tub bath. Once the cord has fallen off, you may give the baby a tub bath. You do not need to bathe your baby every day since this can cause excessive drying and remove protective body oils. A bath every three days is adequate. If stool leaks beyond your baby’s diaper, you may need to bathe the baby more than once a day. Use your judgment.

When you bathe your baby, be sure the room is warm, there are no drafts, and the water temperature is about 85 degrees. Before you begin the bath, make sure you have all the equipment you will need. This includes mild soap, shampoo, warm water, a clean towel and washcloth, a change of clothing, a clean diaper, and a soft-bristled brush for shampooing.

During a sponge bath, you expose only a small portion of the baby’s body at a time. This will keep the baby from getting too cold. You bathe a baby from the cleanest area to the dirtiest one. Start with the eyes. Use clean water only and wipe with a soft washcloth from the inside corner of the eye to the outside corner. To clean the other eye, use a different clean area of the washcloth to prevent spreading any infections from one eye to the other. Clean the rest of the face using water; soap is used only on the rest of the body. When cleaning the ears, wash only the outer ear. Never place anything inside the ear for cleaning. Wash the scalp using a mild soap or shampoo. Lather the scalp and then clean with a soft-bristled brush to loosen any scaling. Brushing or massaging the scalp helps prevent cradle cap (see Common Concerns, page 42). Do not be afraid to include the soft spot in your shampooing. Rinse the scalp well, especially behind the ears. Dry it well. Continue with the bath, giving special care to the creases. If the baby still has some vernix, you do not need to clean it all off since it protects the skin.

Cleaning the baby’s genitals should be the last part of the bath. In female babies, separate the labia and wash from front to back (from the vaginal area to the rectum). You do not need to remove extra vernix in the labial folds since it helps protect the skin. A small amount of white vaginal mucus is normal. You do not need to wipe it all away. A little vaginal blood may also be seen in baby girls due to the hormones from mom during birth. This is called pseudo-menstruation. It usually lasts only one or two diaper changes. In males, make sure to lift and wash under the scrotum as well as in all the folds and wrinkles.

Dry the baby thoroughly (see Cord Care, page 13). Unscented lotion can be applied, but is not necessary. Baby powder is not recommended. If you wish to use it anyway, be sure to sprinkle it on your hand first and then apply it to the baby’s skin. Never shake powder onto a baby since the baby might inhale it and choke on the small particles in the powder. Do not use lotion and powder together because they will form a paste.
Temperature Taking

Unless your baby’s doctor tells you to, you do not need to take your baby’s temperature every day. If your baby feels too warm or cold, you should check their temperature.

There are many types of thermometers available. Digital or electronic thermometers are inexpensive and can be purchased at many stores. Ear thermometers and plastic forehead bands are not recommended for newborns. Glass thermometers are not recommended since they break easily and can leak mercury.

Rectal

Either lay the baby on their back and grasp the feet firmly in one hand or lay the baby on their stomach across your lap. Lubricate the end of the thermometer with K-Y Jelly or Vaseline. Spread the buttocks until you can see the anus. Insert the tip of the thermometer just until the tip disappears (approximately 1/2 inch). Hold it in place until the temperature has been detected. Remove the thermometer and read the baby’s temperature. A normal rectal temperature is 98-100.3 degrees. A rectal temperature of 101 degrees and above usually indicates a fever and you should call your baby’s doctor.

Axillary

Place the thermometer in your baby’s dry, unclothed armpit. Hold the baby’s arm down next to the body to keep the thermometer securely in place. Hold the thermometer in place until it indicates the temperature has been read. Remove the thermometer and read the temperature. A normal axillary temperature is 97.6-99.3 degrees. If you get a reading above 99.4 degrees, recheck it using the rectal method.

Environment

In the uterus, the baby’s temperature is approximately the same or slightly higher than the mother’s. Following birth, the baby must adapt to their new environment. Babies are susceptible to heat loss because their temperature-regulating mechanisms are undeveloped. Smaller babies are especially at risk since they do not have as much fat. Fat acts as an insulator.

Extreme heat can increase your baby’s temperature and cause excessive sweating and fluid loss. A room that is too cold can cause excessive heat loss for your baby, which may interfere with weight gain and general health. For your baby’s comfort and health, it is best to keep the temperature in your home at 65-75 degrees. In rooms kept below 68 degrees, you may want to put another layer of clothing and a hat on your baby.

If your doctor recommends it, use a cool mist vaporizer to keep moisture in the air. This is especially important during the winter months when household heating systems can dry the air. To keep from putting too much moisture in the air, turn the humidifier on only when your baby sleeps (unless otherwise instructed).

Exposure to cigarette smoke causes respiratory infections in newborns. It has also been linked to a higher risk of SIDS (crib death) in babies. For these reasons, avoid exposing your baby to tobacco smoke of any kind.

Babies are more susceptible to infections. Limit your baby’s exposure to large numbers of children (other than your own) and adults until he/she is 2-3 months of age. Anyone who touches your baby should wash their hands first.
Dressing

In the hospital, your baby was dressed in a T-shirt, diaper, hat and wrapped with a blanket. The temperature in your house should guide how much clothing you put on your baby at home. A good guideline is to dress the baby in one more layer of clothing than what is comfortable for you. Whenever the baby is in an environment less than 68 degrees, he/she should wear a hat to prevent heat loss.

Most babies may be taken outdoors unless the weather is severe. Do not overdress or under dress your baby, and be sure to protect him/her from the sun or extreme cold. A newborn’s skin is sensitive and can burn within 20 minutes of sun exposure. Keep your baby out of the sun and use sunscreen made for babies once your child is 6 months old, under the direction of your doctor.

Circumcision

Circumcision is an optional surgical procedure where the foreskin of the penis is separated and removed. Care of the circumcision depends on the technique used to remove the foreskin. There are several methods. The three most popular are the Plastibell, Gomco, and Mogan. The method used is determined by the physician performing the circumcision.

When the Plastibell is used, a plastic ring is left on after the circumcision. The plastic ring remains in place until it falls off in 5-6 days. Do not attempt to pull the ring off even if it is almost separated. No special dressing is required. When changing a diaper, use a little warm water over the penis to rinse away any urine.

When a Gomco or Mogan methods are used, a clean cut area is left around the head of the penis. An antibiotic ointment with or without a gauze pad will be put on your baby’s penis with every diaper change for the first 24 hours after circumcision. There is no need to use the ointment after 24 hours.

If the gauze appears to be stuck, do not pull on it. Dribble warm water over the gauze and gently pull away as it loosens. If an area starts to bleed, put pressure on it for five minutes using a clean gauze pad. If the penis continues to ooze blood more than the size of a quarter, call your baby’s doctor.

Your baby may be fussy for a few hours after the procedure. Once the circumcision is done, he may want to be fed or just to be cuddled. If there is a lot of bleeding (an area larger than a quarter), greenish discharge, swelling of the tip of the penis, or decreased urination, contact the doctor who performed the circumcision. A pain reliever can be recommended by the doctor if needed.

The Uncircumcised Penis

A baby boy with an uncircumcised penis will have fairly tight foreskin that cannot be pulled back over the glans of the penis. The baby will have spontaneous erections that will eventually cause stretching and retraction of the foreskin. It will naturally retract by about age 4.

When changing the baby’s diaper during infancy, wash the diaper area from front to back. Gently wash the end of the penis, but do not try to retract the foreskin.

Your baby’s physician will instruct you on the care of the penis as your child grows.
What is MRSA (methicillin-resistant staphylococcus aureus)?

Staphylococcus aureus or “staph” is a type of bacteria. It is common for healthy people to have staph on their skin and in their nose. In the U.S., staph bacteria are one of the most common causes of skin infections. The skin infections caused by staph bacteria, including MRSA, look like a pimple or boil and can be red, swollen, painful, or have pus or other drainage.

Some staph bacteria are resistant to certain antibiotics. MRSA is a staphylococcus aureus that is resistant to the antibiotic methicillin. It can also be resistant to amoxicillin, penicillin, and oxacillin. MRSA infections are more difficult to treat because they are resistant to some antibiotics.

Staph infections and MRSA infections occur frequently in people with weakened immune systems, such as patients in a hospital, nursing home and patients undergoing dialysis treatment. Staph and MRSA can also affect people outside of hospitals and nursing homes. Typically these are skin infections and occur in otherwise healthy people.

Most staph and MRSA skin infections are minor and easily treated. Treatment may include being prescribed an antibiotic, or having the skin “boil” drained, which may not require antibiotic treatment.

If you are prescribed an antibiotic, you must take all of the doses, even if the infection is getting better, unless the physician advises that you may stop taking the antibiotic. Do not let anyone else take your antibiotic and do not save the antibiotic to be used at a later time. There are times when staph bacteria cause more serious infections, such as infections in the blood, in a surgical incision, or pneumonia.

A person can also be colonized with staph aureus and MRSA. This means that the person has the bacteria on their body, but they are not ill due to infection with the bacteria. It is still possible to give staph or MRSA to another person if you are colonized.

Preventing staph or MRSA skin infections

1. Practice good hygiene.
2. Keep your hands clean by washing thoroughly with soap and water or using an alcohol-based hand sanitizer. Your family and close contacts should wash their hands frequently with soap and water or use an alcohol-based hand sanitizer.
3. Keep cuts and scratches clean and covered with a bandage until healed.
4. Avoid contact with other people’s wounds or bandages.
5. Avoid sharing personal items such as, clothing, towels or razors.
6. Talk to your doctor. Let your healthcare provider knows you have or had a staph or MRSA skin infection.
7. Maintain a clean environment. Clean the frequently touched surfaces such as kitchen counter, doorknobs, bathrooms, lavatory surfaces, bed rails, etc.
8. No children visitors.
9. Keep newborn in the room at all times.
What should you do when you have MRSA?
- Alert your provider that you have MRSA.
- Provide a copy of your test results to all your health care providers (OB/GYN, primary care provider).

Protecting your newborn from staph infections and MRSA
A mother who has a staph or MRSA infection, or is colonized with staph or MRSA, should keep her baby in the hospital room with her at all times. If the baby is not in the mother’s hospital room, the baby must be placed in an isolation nursery, away from other babies. Hospital staff and visitors must follow contact precautions while in the hospital, which involves wearing a gown and gloves when in the hospital room with a mother who is colonized or infected with staph or MRSA.

Circumcision and MRSA
A circumcised baby boy has an open wound on his penis, through which staph may enter. A circumcised baby boy may be infected after he comes home. You can prevent staph infection by washing your hands before and after changing diapers and when changing the circumcision dressing.

Breastfeeding and MRSA
Breastfeeding is recommended for women who have had a known exposure to MRSA or are experiencing a current infection. It is very important to remember good handwashing before feeding the baby, after changing diapers and before and after care of open wounds/rashes. While learning how to breastfeed, care should be taken to avoid any damage to your nipples as this is a way for active infection to happen. If you are experiencing a current infection, the baby’s provider may order an antibiotic for the baby, too.

References

When to Call the Baby’s Doctor
Call Your Baby’s Doctor If:
1. Your baby has a rectal temperature of 100.4 degrees or above.
2. The baby has rapid breathing, difficulty breathing, or grunts and has flaring of the nostrils while trying to breathe.
3. There is any foul odor, redness, or drainage from the umbilical cord.
4. The baby has yellowish or greenish drainage from the eyes or nose.
5. Your baby has persistent or forceful projectile vomiting. Projectile vomiting means the vomit shoots out of the baby’s mouth at a distance of 6 inches to 2 feet. This is not a wet burp.
6. The baby seems unusually fussy and will not calm down.
7. The baby becomes sluggish, difficult to wake up, will not feed, or is listless.
8. Your baby has jaundice or a yellowish tint to the skin or whites of the eyes.
9. The baby has diarrhea; loose, watery stools; or any stools that contain blood.

10. You see any unusual rash.

11. The baby has been exposed to any known communicable disease (for example, chicken pox, measles, etc.).

**On Demand Virtual Visits**

Lourdes offers OnDemand Virtual Care in partnership with Carena, Inc. You can be seen by a board certified physician or nurse practitioner from your smartphone, tablet or computer 24/7/365 by visiting lourdesondemand.anytime.org. Conditions such as congestion, cough, sore throats, fevers, skin rashes, bites and stings and much more can be treated using this service.

At the end of your visit, you will receive a treatment summary and, if required, a prescription or referral for additional follow up. If you have a Lourdes primary care provider, they will receive documentation about your visit and your health record will be updated. If you do not have a Lourdes primary care provider, the provider you identify will receive the summary.

The fee for this service is $49. Lourdes does not submit claims for virtual visits to health insurance plans. You may wish to contact your insurance carrier for coverage or submit the visit receipt to your health plan, Flexible Spending Account (FSA) or Health Savings Account (HSA). Unfortunately, due to Federal regulations, Medicare and Medicaid patients are not eligible for these virtual visit services at this time.

**Walk-In Care**

If your baby’s doctor is not available, Lourdes offers several Walk-In locations for sudden illness or injuries.

**Hours & Locations**

Open 8AM - 8PM Daily (Check website for holiday hours)

- 276 Robinson Street, Binghamton  607-771-7234
- 415 East Main Street, Endicott  607-786-1801
- 500 5th Avenue, Owego  607-972-2335

**Pediatric Walk-In Hours:**

The Lourdes Pediatric Walk-In is located within our Pediatric Practice at 161 Riverside Drive, Suite 206, Binghamton, NY 13905

Walk-In care is available Monday - Friday from 5:00 PM to 8:00 PM. No appointments are necessary to be seen by one of our pediatric providers.

**X-Ray and Lab Services** are available at all walk-in locations. Visit www.lourdes.com for days and times.

**Emergency Department**

169 Riverside Drive, Binghamton, NY  607-798-5231

Our team of emergency care specialists provide care 24 hours a day, every day.
Fathers and Grandparents

For Fathers

In the past, fathers did not usually help much with pregnancy, birth, and newborn care. It is important that you be involved in caring for your new baby. The baby does not know you did not give birth, but they will know if you are not there when they need you.

Many fathers may feel nervous about helping care for the baby because they have never taken care of a child before. Some dads want to wait until the baby is older before they get involved in the baby’s life. Do not let this fear keep you from caring for your child. Waiting means you will lose valuable time getting to know your baby.

Fathers can and should share in all the joys, expectations, and challenges of being a parent. Daily loving contact with your baby is important. Bathing, changing diapers or clothes, cuddling, singing lullabies, and feeding are all ways you can spend time with the baby. By helping with child care and household chores, you let your baby know you think your child and your home are as important as your work outside the home. It also makes it easier for mom while she heals from birth.

If mom breastfeeds, you can still share in the feeding process. At night, you can bring the baby to mom from their crib, burp the baby, change the diaper if needed, and return the baby to the crib after feeding. You can also help by staying awake with mom during the feeding, offering your loving support and even getting her a glass of water and a quick snack if she wants one.

If your baby is being formula fed, you can help make the formula and feed the baby. This will give you time to cuddle and bond with your child.

You can also offer to give mom some time for herself at the end of the day. This is a great time for a bath, feeding, or just cuddling and reading to your baby.

For Grandparents

Many things have changed since your child was born. Ideas come and go about the correct way to care for babies.

Be involved in caring for your new grandchild and the new mother during the early weeks when they are learning about each other. Ask what you can do to help with household tasks. Bring a simple meal for the new parents. The new mom is encouraged to rest as much as possible the first few weeks, so anything you can do to help will be appreciated. Even if you cannot be at the parents’ home, something as simple making a phone call and listening to their worries can be very helpful.

If your new grandchild is being breastfed, support this decision. Many items regarding how often to feed, how long to feed, supplemental bottles, and when to start solid foods have changed a lot over the years. If the new mom needs to go back to the hospital for help with breastfeeding, offer to drive her or watch any other children.

Give the new parents time to adjust to the changes in their lives. Most of all, encourage the new parents to make most of the decisions themselves regarding the baby’s care. Be supportive of their decisions.
Sibling Rivalry

Even though you have prepared older children for a new brother or sister, the actual arrival can be hard for everyone. Visiting you and the new baby at the hospital can help. If siblings visit, give them most of your attention. If you are in pain (especially if you gave birth by cesarean section), wait until you are comfortable enough to enjoy a visit. It may scare your children to see you in pain.

Young children often have behavior changes or act up more when they are stressed by changes in their lives. The arrival of your new baby will probably be one of the most stressful events that will happen to your older children. The personality of an older child may change so quickly that you do not recognize them. Common behaviors in older children could include becoming demanding, a return to babyish behavior, wetting their pants, thumb sucking, and even attempting to hurt the new baby.

Here are some ideas to help let your older children know you love them just as much as you did before you had the new baby.

- Get out their baby books and show them pictures of themselves being bathed, fed, and diapered. Talk to them about how much time it takes to care for a baby.
- When you come home from the hospital, have someone else carry the baby into the house. This way, you can greet your older children with open arms.
- A small gift from the new baby can make older children feel better.
- Ask visitors to greet older children first when they visit.
- Make sure you tell older children how lucky the new baby is to have them for big brothers or sisters.
- Since visitors often bring a gift for the new baby, have some small gifts on hand to give to your older children so they do not feel left out.
- Older children sometimes feel left out when you feed the baby. Try giving older children a snack at the same time. You might also feed the baby while sitting on the couch so the older children can sit beside you and you can read or cuddle together.
- Some older children enjoy having a baby doll to diaper and feed. Little boys and girls benefit from pretending to be a mom or dad.
- Jealousy and anger are normal. Help your children talk about their feelings and see that you love them even if they get angry at the baby. Tell them it is okay not to like the baby, but it is not okay to hurt the baby. Remind them that you would not let anyone hurt them. Do not punish your children for this jealousy or anger. Given them extra love and comfort and the behavior will slowly go away.
Breastfeeding

Getting Starting

Babies are amazing! After birth, they show you they want to eat by sucking on their hands, turning their head toward their mom’s breast, and opening their mouth. Even if you had a long labor and birth, our staff can help you get comfortable so you can take advantage of this special time to snuggle with your baby and introduce him/her to the breast. But if for some reason your baby does not feed right away, do not worry. Begin as soon as you can and ask for help if you need it. Remember, breastfeeding is a learning process for both of you.

One of the best things you can do or your baby after birth is hold her skin to skin. This will allow her time to adjust to her new surroundings and show you when she is ready to latch on. The American Academy of Pediatrics and others recommend exclusive breast feeding for the first six months of life, then continued breastfeeding while solid foods are introduced in the second half of your baby’s life.

The World Health Organization recommends two years and beyond. Your milk is the perfect food for your baby. Here are some reasons why:

• As a baby feeds, the mom’s brain releases oxytocin. This hormone helps the mother’s uterus return to its pre-pregnant state. It also helps prevent excessive vaginal bleeding.
• Breastfeeding stimulates the production of prolactin, known as the mothering hormone. Prolactin is responsible for making colostrum (mom’s first milk, see below) and milk available to the baby. It also helps mom relax.
• Breastfeeding helps mom’s body use calories better. This can help her return to her pre-pregnant weight faster.
• Breastfeeding can lower a woman’s risk of ovarian and breast cancers.
• Breastfeeding improves development of the baby’s immune system. This can lower the risk to or severity of respiratory and gastrointestinal infections.
• Breast milk contains fatty acids that are important for brain development.

Breast milk and formula are not the same. Breast milk is an ever-changing fluid designed to meet the growing needs of your baby. Formula cannot do this. Breast milk contains living cells, infection fighters, enzymes, and hormones. It is also a perfect balance of fat, proteins, and carbohydrates.

Colostrum: Your First Milk

• Colostrum is a thick fluid that can vary in color, from clear to very dark yellow or orange.
• It is a high-protein fluid that helps stabilize the baby’s blood sugar.
• It is full of antibodies to protect the baby against infection.
• It has a laxative effect to help the baby pass meconium. This is important in preventing jaundice.
• It helps the baby coordinate sucking, swallowing, and breathing while learning to feed.
• It meets all your baby’s needs in the first days of their life.
**Mature Milk**

- Mature milk follows colostrum, usually 2-4 days after birth.
- It gives complete nutrition for your baby by itself during the baby’s first six months. After that it remains an important part of the baby’s diet as other foods are introduced during the second half of the first year.
- Babies who are feeding well and gaining weight do not need water or formula along with mature milk. These can cause problems with breastfeeding.
- It is always ready at the right temperature.
- It is free.

**Getting Ready To Breastfeed**

During your pregnancy changes have been taking place inside your breasts to get them ready to make milk. Most women can make enough milk for their babies. Breast size is not a factor in being able to produce breast milk.

**How Does My Baby Get Milk?**

When your baby suckles, your milk ejection (or let down) reflex reacts. This signals hormones that then cause your breast milk to flow down the ducts to the sinuses under your areola (pink-brown area around your nipples). Your baby can then feed with correct latch-on and suckling.

When the milk comes down, you may notice a warm sensation or tingling across your chest area or in the opposite breast from where your baby is suckling. Milk may begin to drip or spray from the opposite breast. Some women, especially moms breastfeeding for the first time, may not feel this until lactation is well established. So the best way to tell if your baby is getting milk is to listen for swallowing.

**Latching On**

Latch-on is how the baby’s mouth is placed on the breast. Correct latch-on is important for stimulating the breast to produce milk, transferring milk to the baby, and preventing sore nipples. Once latched, the baby’s mouth should suckle on the areola, not on the nipple. This prevents cracked, bleeding nipples and allows the milk to flow to the baby.

**Correct Latch-On**

Be comfortable and relax. Hold your baby with their body facing yours with the baby’s body wrapped around you.

- Support your breast using a C-hold. To do this, place your thumb on top of your breast with your other four fingers cupping the breast from underneath. Your fingers should be well away from the nipple and areola. This will let the baby grasp a good mouthful of breast from the bottom side, not just the nipple.
- Tilt your nipple up slightly so it is pointing toward the roof of the baby’s mouth.
- Stroke the nipple to the baby’s top lip. Wait until the baby’s mouth opens wide and the tongue is down and forward. Bring the baby in to you; do not lean into the baby.
- The baby’s lips should be flanged outward like a fish. When suckling, the cheeks will be round and full. The angle where the lips meet is very wide. The lips should
not be pursed (like a kiss). The only sounds you should hear are breathing and swallowing. Swallowing sounds like a small puff of air being exhaled. This will happen after four or five suckles during the first few days and then more frequently as milk flow increases.

• Tugs and pulls are normal. Pinching or pain throughout the feeding is not normal. If this happens, call our Lactation Consultants at (607)798-5423 or the Women’s and Children’s Unit at (607)798-5522 for help.

• The shape of your nipple should look the same when the baby stops feeding as it did when he/she latched on.

Common Positions

Cradle Hold

You can sit in bed or in a chair. Use pillows on your lap or under your arms for support. Your forearm supports the baby’s back and your hand is on the baby’s bottom. The baby is turned to face your breast. Your free hand supports your breast.

Football Hold

Put a pillow at your side. Hold the baby at your side so their body is in a flexed (curled) position. Your hand supports the back of your baby’s head and neck in the space between your thumb and index finger. This gives you good control of their head. Your free hand supports your breast. Bring the baby in to you for latch-on. Do not lean into the baby.

This position is helpful if:
• You have had a cesarean section
• You have large breasts
• You need more visibility to get the baby to latch-on
• You have a small, sleepy or pre-term baby
• Your baby keeps their tongue on the roof of their mouth

Side Lying Hold

You and your baby lie on your sides, tummy to tummy. Place your fingers underneath your breast and lift up. Bring your baby in close when he/she roots and opens their mouth wide. Use pillows to support your back and to place behind your baby if needed.

This position is helpful if:
• You have had a cesarean section
• You are feeding the baby when you are tired

Cross Cradle Hold

This is like the cradle hold, except you use the opposite hand for positioning. This can be a good learning position for you and your baby. For example, if you are going to feed from your right breast, place your baby next to you with your baby’s tummy toward your chest and hold your baby with your left arm. Your left hand supports the
baby’s head, neck, and back. Cup your breast with your right hand. Once the baby
latches on, you can let go of your breast and bring your right arm around your baby.
Remember, no matter what position you choose, the basics of correct latch-on are
the same.

Natural Breastfeeding/Laid Back Breastfeeding

Sometimes it’s better just to let the baby do it. Lie back in a semi-reclined position,
having your head, back and arms well supported. Lie back, bringing your hips forward
so you are comfortable like you are relaxing to watch TV or listen to music. Use pillows
for support wherever you need it. Your baby will move along your body, find the breast
and latch on. All you have to do is keep your baby calm and offer help, if needed.

Burping

Babies may swallow air when crying. Breastfed babies swallow no air while feeding,
unless there is a poor seal.

Spitting

All babies sometimes spit up small amounts. Since breastfed babys don’t swallow air
during feeding but may have during crying, you can burp your baby if you think
it’s needed.

If you think your baby is spitting up too much, try to keep him/her upright for 30
minutes to 1 hour after feeding. You can do this using a baby seat or by slightly
lifting the head of the bed. To elevate the head of the bed, place blocks
under the legs of the crib or put a rolled blanket under the mattress. Do not use a
pillow under the baby’s head. If the spitting continues in spite of this, or if it seems
excessive or projectile, call your baby’s doctor.

Is My Baby Getting Enough?

Feeding the baby enough is a common concern for new parents and family members.
Most people know very little about breastfeeding.

Breastfed babies need to eat frequently — 8-12 times in a 24-hour period. Feeding
your baby whenever he wants to or “on demand” makes sure you will have enough
milk. Babies may also bunch a lot of feedings together. This is normal as long as the
baby is latched on and suckling well. Breast milk is specifically made for your
newborn baby’s immature system, helping it to develop and protecting it from illness.
This makes it more easily, quickly, and completely digested by your baby. That is why
the baby wants to eat more often.

Your baby’s urine and stool output will increase over the course of the first week.
Since colostrum is low volume, do not expect the baby to urinate often until the
colostrum changes to milk and the baby is drinking more. You will notice how much
more your baby swallows as your milk production increases. Frequent bowel
movements are expected when your baby gets colostrum and then milk. The passage
of meconium is important to prevent or minimize jaundice. Stools will change in color
as the days go by — tarry, black meconium stools will change to green, brown, and
then yellow seedy stools. The stools will be loose and resemble brown mustard and
cottage cheese.
Once babies are getting milk, they should have at least 4-6 soaking wet disposable diapers or 6-8 wet cloth diapers and/or three bowel movements in 24 hours. Bowel movements might also happen after every feeding.

Common Challenges

Sore Nipples

Sore or cracked nipples are not a normal part of breastfeeding. They are mainly due to incorrect positioning of the baby at the breast or from a disorganized sucking pattern used by the baby. You may feel some discomfort at first as the baby is latching on and positioning the nipple toward the back of their mouth. As rhythmic sucking takes place, this should go away.

Treatment for Sore Nipples

Make sure your baby is latched on properly. If you need help, ask the lactation consultant or nursing staff. Other suggestions are:

- Try an alternate breastfeeding position (side-lying, cradle, football, cross-cradle).
- Express colostrum and massage it onto the nipple. Allow to air dry.
- Do not use soaps or lotions on the nipple.
- Rub a very small amount of olive oil onto the nipple after feeding. You do not need to take it off before the next feeding.
- A warm water compress might soothe the tender skin.

Breast Fullness Versus Engorgement

Breast Fullness — You will notice a feeling of fullness in your breasts 2-5 days after birth. Your breasts may feel heavy, fuller, and appear larger. These are normal changes that occur with increased milk production and the increasing blood and lymph fluid that help nourish the milk-producing cells. Your breasts may feel firmer before feeding and softer after. You will hear your baby swallow with increased frequency and the number of wet and soiled diapers will increase. Wearing a bra that fits well and provides good support is important for your comfort. Support is also important because it helps reduce the stretching of the ligaments that hold up your breasts.

Engorgement — If the breasts are not emptied regularly they can become engorged. This might happen if the baby is too sleepy to feed, if you try to schedule their feedings or if there is a long time between feedings. If the breasts are not emptied, the milk builds up and strong pressure is created inside the breast. This makes them hard, hot, and painful. Engorgement may make it hard for your baby to latch on because the breast is full right down to the nipple. Unless taken care of, engorgement can lead to a reduced milk supply and mastitis.

Treatment for Engorgement

Allow your baby to feed as often and for as long as he/she wants. Babies are good at regulating their feedings. Other suggestions are:

- Get help with positioning and latch-on.
- Use warm compresses on the breasts before feedings if they are leaking and use gentle massaging action to stimulate milk flow.
• Take a warm shower and massage your breasts. Let the water fall on your back and shoulders.
• Use ice packs for comfort after feedings.
• Hand express milk to release pressure around the areola so that the baby can latch on.
• Short-term use of a hospital-grade breast pump might be helpful.
• Feed the baby every 1-1/2 to 2 hours. If necessary, wake the baby (try undressing or unwrapping the baby, changing the diaper, or swaying side to side).
• Feed the baby for at least 10-15 minutes per side.
• Use cabbage leaves (see following).

Use of Cabbage Leaf Compresses

Cabbage leaves are a great, natural way to reduce breast swelling. When you are engorged, they can help take away some of the over-full feeling you have. Be sure to follow the directions carefully and do not use cabbage leaves too often since they can reduce your milk supply.
• Buy a large head of green cabbage.
• Cut the cabbage in half and remove the outer leaves. Throw these away.
• Remove the rest of the leaves layer by layer. Rinse and drain the leaves.
• Place the leaves in a bowl and put them in the refrigerator to cool.
• Crumple the leaves you will use so the veins are broken.
• Cover each breast with a single layer of leaves. You can put them under your arm if that area is swollen.
• Lay a towel over your breasts. Rest for 20-30 minutes.
• As the cabbage warms, it will begin to wilt and smell like cabbage. Remove the leaves and throw them away.
• Massage your breasts and then feed the baby or express the milk.
• You can use cabbage leaf compresses 2-3 times a day during the engorgement period.
* REMEMBER - If engorgement lasts longer than 12-24 hours with no relief from the suggestions above, call the Women’s and Children’s Unit at (607) 798-5522.

Mastitis
With mastitis, or inflammation of the breast, an area of the breast may become red, hot, and painful. A woman with mastitis may also have a fever, chills, and other flu-like symptoms. These may start suddenly. Mastitis often occurs as a result of poor breastfeeding technique, especially early on due to scheduled feedings, cracked nipples or poor breast drainage. It can also occur because of fatigue and missed feedings. It can become an infection or a breast abscess if not treated.

To Prevent Mastitis, Try the Following:
• Feed the baby often.
• Use different positions.
• Be sure the baby is latched on correctly to avoid damaged nipples.
• Get enough rest.
• Do not use pacifiers, especially in the early weeks after birth.
If You Think You Have Mastitis:

- Rest.
- Continue to breastfeed often. The milk is not infected. Your breasts need to be emptied and your baby needs your milk.
- Use warm compresses on the affected area and gently massage it while the baby feeds.
- Position the baby with their chin pointed in the direction of the affected area. This will help with drainage of that area.
- Drink plenty of fluids.
- Call your doctor/midwife. You may need an antibiotic. Most are safe to take while breastfeeding. Be sure to take all the medication, even after you feel better.

Many prescription medications can be taken while breastfeeding. If your doctor/midwife tells you to stop breastfeeding because of a medication, call the Women’s and Children’s Unit at (607) 798-5931 for more information.

Important Considerations For the First Two Weeks

- You may need to wake the baby to feed during the first few days. Babies can also tell us they are ready to eat by giving us feeding cues. These include hand-to-mouth movements, mouth and tongue movements, body movements, small sounds, and rapid eye movements under the eyelids. Keep your baby close so you can see these behaviors. Remember, babies may not necessarily be ready to eat because the clock says so.
- Babies who are positioned well at the breast do not need to be timed at the breast. Watch for deep jaw movements and listen for swallowing or gulping. Babies suck in bursts and may pause for a short time between these bursts.
- Babies may not always take both breasts at a feeding. The baby can get a complete meal from one side. Milk changes from the beginning of the feeding to the end, with milk higher in protein at the start to milk higher in fat at the end. Your baby has had everything from an appetizer to dessert all from one side! Burp the baby, change the diaper, and offer the second side. If the baby is not interested, keep him/her close. The baby may wake shortly and want to eat again. If not, you can just offer that side first at the beginning of the next feeding.
- Feedings are timed from the beginning of one to the beginning of the next.
- Breasts will feel full before a feeding and softer after a feeding.
- Breast fed babies gain between 1/2 to 1 ounce per day once your milk has come in. Breastfed babies need no extra water or formula if feedings are going well. If they are not, ask for help.
- Eat whatever you want and drink to satisfy your thirst. Water is great.
- Be good to yourself and get enough rest.
- Do not delay feedings or schedule feedings.

Call Your Health Care Provider or Lactation Consultant if:

- Your baby is excessively sleepy and difficult to wake for feedings (eats fewer than eight times in 24 hours) or is fussy and always seems hungry.
• Your milk has not come in by day four or five.
• Your nipples are sore all the time or the soreness will not go away.
• You have difficulty with latching on or you think feedings are not going well.
• Your baby has fewer than six wet diapers and/or three bowel movements in 24 hours.
• You do not hear your baby swallowing the milk.
• You cannot reduce breast engorgement.
• You are going back to work and want to pump/store milk or wean your baby.
• You have symptoms of mastitis.
• You have any questions related to breastfeeding (no matter how old your baby is).

Working and Breastfeeding

Insurance companies including Medicaid now provide breast pumps to their subscribers. Give them a call to find out what they need from you. In many cases, they just require a prescription for the pump from your OB provider and a call from you. In some cases, they have many pumps for you to choose from, others, just one. Remember if you are working full time, a double electric pump will be best.

Introduction

Just as you and your baby need to learn about breastfeeding, you also need to learn how to express breast milk. You can do this by hand or using a manual, battery-operated, or electric pump. You should decide for yourself which method is best for you.

The next section talks about the different ways you can express milk and what types of breast pumps are available. There are also tips on working and breastfeeding. Guidelines for storing expressed breast milk are also given. Since breast milk is a dynamic fluid that constantly changes to meet your baby’s growing needs, the longer you can provide it, the better it is for you and your baby.

Reasons to Express Breast Milk
• To help establish milk supply
• To relieve engorgement
• To increase milk supply
• To provide breastmilk for baby when mom goes out
• To provide breastmilk for baby when mom is back at work or school
• To provide milk for a sick or premature baby
• To maintain milk supply if mom is hospitalized or must take medication that is not compatible with breastfeeding

Hand Expression of Breast Milk

Before you buy a breast pump, you should know how to express milk by hand. Here is why.
• It is easy to learn.
• It can be more efficient than a pump.
It does not cost anything and can be done anywhere. (You do not need an outlet or battery.)

There are no pieces or parts to clean.

Skin-to-skin contact makes it easier to bring out the milk ejection or let down response that causes milk to flow.

As with any new skill, hand expression may be awkward at first. Take your time, practice, and soon you will be quite efficient and confident. Since you are learning something new, do not worry if you get only a little milk at first. This will increase as you get better at the technique.

**Helpful hints to make hand expression easier:**

1. Begin practicing in the morning when your breasts are the fullest or while the baby is feeding from the other side.
2. Encourage the milk to let down (begin flowing) by:
   - taking a hot shower
   - use warm compresses on the breasts before beginning
   - massaging the breast
   - have something to drink
   - getting comfortable and using deep breathing to relax
   - thinking about your baby

**How to Hand Express Breast Milk**

Get a clean container (cup, bowl, or bottle) to express milk into. It helps if it has a wide opening, since the milk will spray from the nipple when let down occurs.

Begin by washing your hands. Next, massage the breast to encourage the milk to flow down the ducts to the sinuses under the areola.

Starting at the top of the breast, firmly press with the pads of your fingers in a circular motion. Stay in one spot for a few seconds then move to the next. Continue this around the breast, moving toward the areola.

You might need to support your breast while massaging, depending on breast size and comfort. Next, gently stroke the breasts with a light touch of the fingertips. Place a small towel under your breast to catch any dripping or spraying milk.

Hold your breast with your thumb on the top and your index and middle fingers underneath about 1-1 1/2 inches behind the nipple. Your hand will form a “C” around the breast. This is where the collecting sinuses are located.

Push your fingers straight back toward your chest wall and gently squeeze your fingers together, rolling your fingers forward. The milk will drip at first, and then begin to spray. Repeat this in a rhythmic motion until milk flow begins to slow. Rotate your fingers around the areola to empty the other areas of the breast. After about 5-7 minutes, move to the other breast and repeat the same motions. Since milk lets down several times during a feeding, you will want to move back and forth between your breasts two or three times.

Be sure not to pinch or squeeze the nipple itself or slide your hands along the surface of your breast. All the motions are gentle and need practice before you will properly
know how to express breast milk. Once you have some practice, the whole process should take 20-30 minutes.

**Breast Pumps**

A mom who does not have much time to express milk at work or school, or finds hand expression difficult may wish to buy a breast pump. There are several types available today: manual, battery operated, and automatic. Just as with hand expression, your body must be conditioned to respond to the pump like it does to your baby. Remember, no pump can get the quantity of milk from your breasts that your baby does.

Do not buy or use pumps that have a bulb to squeeze for milk expression. There is no way to completely clean the pump, and suction can be very hard to achieve and maintain.

**Questions to Consider When Choosing a Breastpump**

1. Are the directions easy to understand?
2. What is the cost?
3. Is it easy to clean?
4. Is it easy to use and effective for getting milk?
5. Do I know anyone else who has used the same type of pump?
6. Can I pump both breasts at the same time if needed?
7. Can I get replacement parts if necessary?
8. How often do I plan to use the breast pump?

**Manual or Hand-Operated Pumps**

These models are easy to take with you, inexpensive, and fairly simple to use. They can be perfect for the mom who does not plan to pump often. A drawback is that your arm muscles may get tired since you will need to use your hands to move some of the parts. Brand names include: Medela Spring Express Breast Pump, Avent Hand Pump, and Comfort Plus (Kaneson) Breast Pump.

**Battery Operated Pumps**

These pumps use batteries; some also have electric adaptors. Suction takes place automatically with most models, but you will need to press a button to release the pressure. These pumps have several drawbacks. It may take a few seconds for the pump to build up to its maximum suction before being released. The pump cycles 4-6 times a minute, but normal newborns have a suck-and-release cycle of 40-60 times a minute. That makes this type of pump less than ideal for a mom who will be pumping daily. Inadequate cycling may also cause pain and nipple trauma due to the increased suction pressure inside the pump and the low milk volume expressed.

One battery-operated pump closely matches a baby’s ability. This is the Medela Mini Electric Breast Pump. It has an auto-cycling feature.

**Fully Automatic Pumps**

These pumps create a suck-and-release pattern that very closely matches the sucking pattern of a baby. They encourage an efficient let down and are comfortable to use.
You will find them in hospitals and can usually rent them through hospital supply stores and breast pump rental stations. If you need to build or increase your milk supply or will be pumping a few times a day every day, you will find this pump ideal. It is not as easily portable as smaller, hand-held models.

When you choose a breast pump, read the directions carefully so you know how to use it most effectively. And remember that with practice, you will get better at using the pump. Also keep in mind two other things: your baby does the best job of expressing breast milk and pumping should never be painful or cause nipple damage.

**Tips to Make Pumping Easier**

- Wash your hands and get comfortable, just as you would when breastfeeding.
- Stimulate your milk ejection or let down reflex by massaging your breast. If you are using a battery/electric model, you will have one hand free for massaging while using the pump.
- Have something to eat or drink before you start
- Pump on one side while the baby is feeding from the other.
- Pump during morning feedings since milk supply is usually greatest at that time.
- If you are away from home, have a picture of the baby with you to focus on while pumping.
- Listen to your favorite music, think about the baby or tape the baby’s sounds.
- If possible, have someone massage your shoulders and between your shoulder blades. This can help you relax.
- Use a pump that can express both breasts at the same time. This will save time (15 minutes for both sides) and energy. It will also increase the level of prolactin (the hormone that makes breast milk) in your body.

**Considerations Before Returning to Work**

- Will I be working full-time or part-time?
- How long will I be away from my baby?
- Is job sharing possible with another nursing mom or employee?
- Will I have time to pump 2-3 times during work?
- Where will I pump?
- Can I leave at lunch to breastfeeding the baby?
- What are the childcare arrangements? Can the baby come to me for feedings?
- If pumping is not possible, what will I feed my baby and how do I wean those times of breastfeeding?

One of the many decisions new parents face is when or if the new mother will return to work. For some, this is not an easy decision. For others, there is no choice. Many women are hesitant to give up their working role outside the home; yet, they want to provide the best nutrition for their babies. It is possible to do both. Working and breastfeeding can be accomplished with careful planning, commitment on the mother’s part, and the support of those at home and in the workplace.

You can begin to give a bottle to your baby once he/she is feeding well, usually at 3-4 weeks. If you plan to go back to work six weeks after birth, it is especially important
to start at this time. Some babies have a hard time taking a bottle at first because it is different and they need to learn how to use it. It is best if someone other than mom can do these bottle feedings at first.

Try different nipples to find the one your baby likes the most and will affect breastfeeding the least. Most bottle nipples are narrow and the baby will need to adjust their mouth position. This can make the change from breast to bottle back to breast hard for some babies. One nipple that allows the baby to keep a wide open mouth while being bottle fed is the Munchkin nipple.

Feedings do not always have to be given by bottle, depending on the baby’s age and the comfort level of the person doing these feedings. You can also use medicine droppers, medicine spoons, or cups. If pumping at work is not possible or desired, the baby can be given formula or baby food, depending on the baby’s age. Some babies may sleep during the day while mom is away and breastfeed in the evening and at night. This is called reverse cycle nursing.

**Guidelines For Returning To Work**

- Get breastfeeding well established so that you have a good supply to start with.
- Nurse the baby when you wake up in the morning and again just before you leave the house.
- Bring an extra bra, pads, and a shirt with you so you can be prepared for any leaking.
- Pack healthy snacks and lunch. Drink plenty of fluids.
- Plan on returning to work on a Thursday or Friday. This will let you test your new routine then rest and build your milk supply on the weekend.
- If weaning during work time is necessary, begin offering the baby supplements of breast milk or formula when feeding. At first, hand expression or pumping just enough to relieve discomfort from fullness may be necessary. Your body will adjust to the reduced stimulation in time, making it possible to continue to breastfeed when you and your baby are together again.

No matter how prepared to return to work you think you are, be ready to go through a period of adjustment. You might feel worried, guilty, happy, excited, or any/all of these. Working outside the home and taking care of your family will be tiring, so try to get enough rest.

Whatever choices you make, know that breastfeeding will probably be the best part of the day for you and your baby. The breastfeeding relationship is special, but it takes commitment and support from the mom and those around her. Breastfeeding is the best choice for babies. With knowledge, preparation, and planning it can be fun and satisfying for all.

**Storing Breast Milk**

- Milk can be stored in any clean glass or plastic bottle or container. Be sure to wash the container in hot, soapy water or run it through the dishwasher.
- Plastic bottle bags may be used to store breast milk. Fold the top several times and put a twist tie around it. If you are freezing the milk, leave enough room for expansion and place the bottle bags inside a freezer bag for extra protection. There are bags specifically made for storing breast milk (for example, Medela).
* Label bottles with the date and time of pumping using a piece of tape and a pen. Use breast milk in the order pumped.

* If pumping for a premature baby, follow the directions your doctor, midwife, or hospital gives you.

* Start by storing small quantities (2-4 ounces) of milk until you know how much the baby will drink. This will prevent waste. You can always warm or defrost more milk if the baby is still hungry.

* You can safely leave pumped milk at room temperature for 6-10 hours.

* You can keep pumped milk in the refrigerator for eight days. Do not keep it in the door because the temperature changes every time the door is opened.

* You can keep frozen, pumped milk in a freezer compartment inside the refrigerator for two weeks, in a separate freezer for 3-6 months, or in a storage freezer for 6-12 months. Be sure to keep the milk in the back of the freezer and not by or on the door.

* Pumped milk should be chilled before freezing. Milk can be layered from several pumpings, but they should all be chilled first, then combined and frozen. Warm milk should not be poured on top of chilled or frozen milk.

**Defrosting Breast Milk**

Frozen breast milk can be defrosted in the refrigerator or in a bowl of warm water. You can run warm water from the faucet over the bottle to defrost the milk.

Do not heat breast milk on the stove or in the microwave. Uneven heating makes microwaving unsafe for use and heating of any kind destroys the anti-infective properties and Vitamin C in the milk.

Breast milk that has been defrosted can be kept in the refrigerator for 24 hours. If warmed in a bowl of water or under the faucet, it can be kept for four hours. Leftover milk should be thrown away. Do not save it for later use.

Breast milk will separate after thawing or standing. You will notice the fat or cream will rise to the top. Gently shake or swirl the bottle to mix it.

Milk sometimes develops an odor from freezing. This is thought to be from the breakdown of fats in the milk during freezing. The milk is not spoiled. You may need to freeze your milk for shorter periods of time. You can save the milk by heating it on the stove and taking the “skin” off the top. Cool it before giving it to the baby. You might lose some nutrient value during heating, but you will not have to throw the milk away and your baby can still drink it.

**Recommended Reading**

* The Womanly Art of Breastfeeding by La Leche League International

* The Ultimate Book of Breastfeeding Answers by Jack Newman MD

* Breastfeeding Made Simple by Nancy Mohrbacher

* Sweet Sleep, Nighttime and Naptime Strategies for the Breastfeeding Family by La Leche League International, Diane Wiessinger, Diana West, Linda J. Smith and Teresa Pitman

**Recommended Websites:**

* www.lalecheleague.org

* www.kellymom.com
Breastfeeding After Reduction. This website is invaluable for women who have had a breast procedure done from lumpectomy and implants and most especially breast reduction surgery.

http://www.health.ny.gov
- For general information – see section menu
- Going back to work
- Your rights as a breastfeeding mother
- and much more

Baby’s Second Night

You’ve made it through your first 24 hours as a new mom. Maybe you have other children, but you are a new mom all over again....and now its your baby’s second night. All of a sudden, your little one discovers that he’s no longer back in the warmth and comfort – albeit a bit crowded – womb where he has spent the last 8 1/2 or 9 months – and it is SCARY out here! He isn’t hearing your familiar heartbeat, the swooshing of the placental arteries, the soothing sound of your lungs or the comforting gurgling of your intestines. Instead, he’s in a crib, swaddled in a diaper, a tee-shirt, a hat and a blanket. All sorts of people have been handling him, and he’s not yet become accustomed to the new noises, lights, sounds and smells. He has found one thing though, and that’s his voice....and you find that each time you take him off the breast where he comfortably drifted off to sleep, and put him in the bassinet – he protests, loudly!

In fact, each time you put him back on the breast he nurses for a little bit and then goes to sleep. As you take him off and put him back to bed – he cries again.....and starts rooting around, looking for you. This goes on – seemingly for hours. A lot of moms are convinced it is because their milk isn’t “in” yet, and the baby is starving. However, it isn’t that, but the baby’s sudden awakening to the fact that the most comforting and comfortable place for him to be is at the breast. It’s the closest to “home” he can get. It seems that this is pretty universal among babies – lactation consultants all over the world have noticed the same thing.

So, what do you do? When he drifts off to sleep at the breast after a good feed, break the suction and slide your nipple gently out of his mouth. Don’t move him except to pillow his head more comfortably on your breast. Don’t try and burp him – just snuggle with him until he falls into a deep sleep where he won’t be disturbed by being moved.

Babies go into a light sleep state (REM) first, and then cycle in and out of REM and deep sleep about every 1/2 hour or so. If he starts to root and act as though he wants to go back to breast, that’s fine...this is his way of settling and comforting. During deep sleep, the baby’s breathing is very quiet and regular, and there is no movement beneath his eyelids.

Another helpful hint... his hands were his best friends in utero... he could suck on his thumb or his fingers anytime he was the slightest bit disturbed or uncomfortable. And all of a sudden he’s had them taken away from him and someone has put mittens on him! He has no way of soothing himself with those mittens on. Babies need to touch – to feel – and even his touch on your breast will increase your oxytocin levels which will help boost your milk supply! So take the mittens off and loosen his blanket so he can get to his hands. He might scratch himself, but it will heal very rapidly – after all, he had fingernails when he was inside you, and no one put mittens on him then!

By the way – this might happen every once in a while at home too, particularly if you’ve changed his environment such as going to the doctor’s, to church, to the mall, or to the grandparents! Don’t let it throw you – sometimes babies just need some extra snuggling at the breast, because for the baby, the breast is “home.”
Breastfeeding Log for the First Week

Circle the hour when your baby breastfeeds. Circle the W when your baby has a wet diaper. Circle the S when your baby has a soiled diaper.

During the first week, you will use more diapers each day. If you are using disposable diapers and cannot tell if they are wet, put a tissue in the diaper at each changing. It will easily show when your baby is wet. It is okay for your baby to have more wet diapers or more soiled diapers.

Call your baby’s doctor and breastfeeding helper if your baby has fewer than the minimum number of wet or soiled diapers listed in the log.

Birth Date ________________________________ Time ____________ AM / PM

### Day One: Goal – at least 6-8

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Formula Feeding

Formula Preparation

If you have decided to feed your baby formula, you need to do this for the first year of the baby’s life. The American Academy of Pediatrics recommends you use only baby formula that has iron in it. You should not use cow’s milk during the first year. Once you start your baby on one brand of formula, do not change it unless your baby’s doctor tells you to. Changes in bowel movements, spitting up, or occasional fussiness do not mean you need to change your baby’s formula.

Formula is available in three forms: powder, concentrate, and ready-to-feed. If you pick powder or concentrate, it is very important that you dilute it with the right amount of water. Your baby could get very sick if you feed him/her formula that has not been diluted properly. Always read the can and follow the directions carefully.

There are lots of brands of formula. At the hospital your baby will be started on a common brand of formula. If there is a family history of milk allergy or if your baby does not stomach the milk-based formula very well, the baby’s doctor will choose another type of formula.

On one end of the formula can you will find a “use before” date. Be sure you use the formula before this date. Never buy formula if the can is damaged. Never buy formula if it is already past the date on the can. Store unopened cans of formula in a clean, dry place that is not too hot or too cold.

Some doctors want you to sterilize all the equipment and water you need to make formula. Other doctors want you to do this only if your water comes from a well. There are also doctors who think if you have city water or use bottled water that you do not need to sterilize the water. Check with your baby’s doctor to find out what he/she thinks is best.

Getting Started

**Sterilizing Equipment:**

- Wash all bottles, nipples, and other equipment in hot soapy water. Rinse well.
- Put the clean bottles, nipples, rings, measuring cups, and spoons into a large pot. Fill the pot with water until all the items are covered.
- Cover the pot and let the water boil for 5 minutes. Do not open the lid until it is cool enough to touch.
- Take the items out using tongs and put them in a clean place to dry.
- You can also use a dishwasher to sterilize formula-making equipment.

**Sterilizing Water:**

Do not boil the water longer than 5-10 minutes. Boiling water too long concentrates any impurities. Do not boil water more than once. Let the water cool before you mix it with formula powder or concentrate. If you are worried about lead or other harmful substances in your water, check with your local or state health department.

**What if I do not have access to boiling water?**

- The safest way to prepare a feed is using water that has been boiled and cooled to no less than 70°C.
- If you do not have access to boiling water, you may wish to use sterile liquid infant formula.
• Alternatively, you can prepare feeds using fresh, safe water at room temperature and consume immediately.
• Feeds prepared with water cooler than 70°C should not be stored for use later.
• Throw away any left-over feed after two hours.

Types of Formula

Powder:

Take the plastic lid off the can. Next, lift and pull the metal tab, taking the entire metal lid off the can. Pour the proper amount of water into the bottle. Use the scoop that comes in the can of formula to measure the right amount of powder and add that to the water in the bottle. Mix by gently stirring or shaking. Be sure to cover the rest of the powdered formula with the plastic lid. Use the entire can within one month.

Example: To make a 6-ounce bottle, put 6 ounces of water in the bottle and then add 3 level scoops of formula. This will make slightly more than 6 ounces, but gives the proper dilution.

Concentrate:

Shake the can well. Wash the top of the can with hot, soapy water and rinse well. Use a clean, punch-type can opener. Pour even amounts of formula and water into the bottle. Mix by gently stirring or shaking. Store the rest of the concentrate in the refrigerator, covered with aluminum foil or a plastic cap. Use the refrigerated formula within 48 hours.

Example: To make a 6-ounce bottle, pour 3 ounces of water and 3 ounces of formula into the bottle.

Ready-To-Feed:

Shake the can well. Wash the top of the can with hot, soapy water and rinse well. Use a clean, punch-type can opener. Pour the desired amount of formula into the bottle. Do not add water. Store the rest of the formula in the refrigerator, covered with aluminum foil or a plastic cap. Use refrigerated formula within 48 hours.

Example: To make a 6-ounce bottle, pour 6 ounces of formula into the bottle.

Do not freeze formula either before or after mixing. Freezing it may cause it to get grainy or may make the fat separate.

Use the amount of formula your baby has been drinking during the last few feedings as a guide for how much formula to make in new bottles. This will reduce waste. If the baby does not drink all the formula in a bottle during a feeding, you must throw the rest of the formula away. This is because the saliva from the baby’s mouth gets into the bottle when he/she drinks. It then mixes with the formula. The saliva has bacteria in it that can grow in the formula after about an hour. These bacteria will make your baby sick.

Heating Formula

To warm a bottle, place it in a bowl of hot water for a few minutes. You can also hold the bottle under hot running tap water. Do not reheat bottles. Only warm what the baby will need for that feeding.

Shake the bottle well and test the temperature by shaking a few drops of formula on your wrist. It should feel lukewarm.
Never microwave a bottle! Microwaves do not heat evenly, and you could badly burn your baby. Some bottle bags explode when microwaved — even after being taken out of the microwave.

When to Feed

Babies tell us they are ready to eat by giving us cues. These include the rooting reflex, hand-to-mouth movements, mouth and tongue movements, body movements, small sounds, and being quietly awake. Feed your baby when he/she seems hungry and not by the clock. Most babies will fall into a pattern of 6-8 feedings a day, about 3-5 hours apart.

Babies do not usually follow time schedules. So do not put off a feeding because “it is not time yet.” Some babies feed a couple of times and then settle down for a few hours of sleep. The best way to be sure you get enough sleep at night is to wake the baby during the day for feedings, but let nighttime feedings be on demand.

At first, your baby may take only $\frac{1}{4} - \frac{1}{2}$ ounce of formula at a feeding. This will increase over the next few days. Your baby’s stomach is about the size of a golf ball at 10 days of age, so it does not hold much but likes to be filled often. As your baby grows so will the amount of formula they drink at each feeding. It is easy to overfeed a bottle-fed baby. Fat babies are not necessarily healthy babies. Your baby is the best judge of how much he needs to eat. Never force your baby to finish their bottle.

Babies have growth spurts at certain times. When this happens, they may need either more feedings or more formula at feedings. These spurts usually happen at 10-14 days, 5-6 weeks, and about 3 months.

Positioning

Hold your baby close to you in your arms using a cradle hold. The baby’s head should be slightly higher than their stomach. Never feed your baby by propping a bottle in their mouth so you can do other things. This robs the baby of your love and touch, and it can cause the baby to choke.

Touch the nipple next to the baby’s mouth. The baby will grasp the nipple. Insert the nipple until most of it is in the baby’s mouth. Hold the bottle so it is at a right angle to the baby. You should see formula fill the nipple. This keeps the baby from getting air and reduces spitting up. Stop halfway through the feeding to burp the baby. Burp him/her again when the feeding is done. This is a guide. Your baby may need to be burped more often.

When the baby has had enough, they will stop sucking, turn away from the nipple, or fall asleep. Do not put cereal or other foods in your baby’s bottle. The baby does not need solid food at this age. Although it may seem like your baby sleeps better, early solid foods do not digest well and can cause a lifetime of food allergies and obesity. The baby’s doctor will let you know when cereal and solid food can be introduced.

Common Questions About Formula and Bottlefeeding

Q: What type of bottles or nipples should be used?
A: There are many types and styles of bottles available. Use whichever you prefer or ask your baby’s doctor if he/she recommends a particular style. Here is how to check if a nipple has the right size opening. Turn a filled bottle (with the nipple on) upside down. If formula
drips from the nipple slowly for a few seconds and then stops, the nipple opening is the right size. If formula comes out in a steady stream, the opening is too big and the nipple should be replaced. Check each nipple after cleaning for any tears or cracks. If you notice any, throw the nipple away.

Q: How do I know if the formula is making my baby constipated?
A: Many babies grunt and strain when they have bowel movements. This does not mean the baby is constipated. Check with the doctor if the bowel movements look like formed, hard balls or if the baby cries when having a bowel movement.

Q: Does formula need to be heated?
A: If the formula has been refrigerated, some babies like it to be warmed. Others do not. If you heat the formula, make sure it is not too hot. (See Heating Formula on page 39)

Q: Does the baby need water between feedings?
A: If your baby is getting enough at each feeding, no extra water is needed. Water just fills up the baby’s stomach and does not give any nutritional value.

Q: How do I know the baby is getting enough to eat?
A: Your baby is probably getting enough if he/she is taking a bottle 6-8 times and wetting 6-10 diapers in 24 hours (by about day 4). Your baby will also be weighed and measured at each well-baby visit.

Q: Why does the formula need to contain iron?
A: Everyone needs iron. But it is especially important that babies get iron since they are growing so fast. Our brains develop the most during our first two years of life. Not having enough iron is known to cause long-lasting developmental delays.

Burping

Babies may swallow air when feeding or crying. Burping the baby will remove air bubbles from the baby’s stomach that can cause discomfort or a feeling of fullness. Burp your baby halfway through a feeding and again at the end of the feeding. If the baby needs to burp, usually he/she will do so in about five minutes.

There are three common positions to use for burping your baby:
- Hold your baby upright over your shoulder and gently pat the baby’s back
- Hold your baby in a sitting position on your lap. Support the baby’s head and chest with one hand and gently pat the baby’s back
- Place the baby down on your lap and gently rub the baby’s back

Spitting

All babies sometimes spit up small amounts. You can help prevent this by burping your baby often during feedings.

If you think your baby is spitting up too much, try to keep him/her upright for 30 minutes to one hour after feeding. You can do this using a baby seat or by slightly elevating the head of the baby’s bed. To elevate the head of the bed, place blocks under the legs of the crib or put a rolled blanket under the mattress. Do not use a pillow under the baby’s head. If the spitting continues in spite of this, or if it seems excessive or projectile, call your baby’s doctor.
Common Concerns About Baby

Breathing

All newborn babies make strange sounds when they breathe. Breathing may be a little irregular, fast, or noisy. It is normal for a newborn to switch between periods of harsh, deep breaths and periods of shallow, quiet breaths.

All newborns breathe through their noses, so you need to keep your baby’s nose clean of mucous. Sometimes your baby will sound stuffy. This is only the air trying to get through the baby’s narrow nasal passages. Sneezing is the baby’s way of keeping the nasal passages clear and does not mean the baby has a cold.

Cradle Cap

Cradle cap is a common with newborns. Crusty yellow patches form on the scalp and usually flake. To loosen the scales, brush the baby’s scalp every day with a soft-bristled brush. If the patches will not come off, try rubbing a little baby oil into the scalp and leave on for a few hours. Shampoo thoroughly using a soft-bristled brush. If the flaking is heavy or patches still will not come off, call your baby’s doctor.

Hiccups

Hiccups are very common in newborns, especially after feedings. Although they often worry parents, they usually do not bother the baby at all. You can try to stop hiccups by offering breastfed babies a little more or offering formula fed babies a few more sips. Most of the time, hiccups usually go away on their own.

Colic

Colic is a repeated pattern of unsettled behavior and crying. It usually begins in the first three weeks and sometimes lasts until the baby is 3 months old. Colicky babies look upset, in pain, and are extremely hard to comfort. No one knows why colic occurs or how to treat it. Try the suggestions listed under Crying, below. If the behavior worries you, call your baby’s doctor. If you can, take turns trying to calm the baby with your support person. This can ease your frustration.

Activity

Most newborns are wide awake and alert during the first two hours after birth. This is a great time to begin breastfeeding or other bonding with your baby. At about three hours after birth, the activity decreases and the baby goes into a sleep phase. Your baby’s first 24 hours are a time of recovery and transition.

Crying

Crying is your baby’s way of communicating with you. As you and your baby get to know one another, you will learn that there are different cries for different reasons. At first, hunger seems to be reason for your baby’s crying. Hunger is a new and unpleasant sensation for the baby. They will cry angrily until this need is met. Sometimes your baby will continue crying even after being picked up. The baby will calm down when the first few drops of milk/formula are in their mouth.
When your baby cries, talk quietly and pick them up. When hearing your voice your baby is already comforted a little and seems to understand you are close. Picking babies up frequently at this age will not spoil them.

There are other reasons babies cry. Unfortunately, we cannot always figure out why. Some babies cry every day at the same time. Often this is during the early evening hours. Unfortunately, this fussy time usually occurs at the hardest part of your day. Other children are coming home from school and want attention, dinner needs to be started, and a partner may be coming home from work.

Just as you are tired and feel tension building up when over stimulated, so does your baby. Sometimes babies just need to let off steam before they can settle down.

At times, parents and caregivers also need to let off steam. It is natural when angry to want to shake your baby or small child to stop them from crying. As parents and caregivers we need to control that response. Shaking a baby even once or twice can cause learning disabilities, brain damage, blindness or death. A one time episode of shaking can result in permanent damage. Three seconds – three shakes is all it takes, most shaking episodes last up to 15 seconds and involve as many as 50 shakes. A baby’s head and neck are especially vulnerable to injury because the head is so large and the neck muscles are still weak. The younger the child, the greater the chance for serious the injury or death from shaking. Head trauma is the most frequent cause of permanent damage or death among abused infants and children and Shaken Baby Syndrome accounts for a significant number of those cases.

If your baby is crying, here are a few things you can do:

• Check the baby’s diaper and change it if needed.
• If the baby is also pulling their knees up to their chest, this can be a sign of gas pain. Try burping the baby or putting a little pressure on their tummy. You can do this by laying the baby, stomach down, across your knees and patting the back or rubbing the tummy in a clockwise motion.
• Is anything hurting the baby? Clothes, a diaper that is too tight or an open diaper pin can bother the baby.
• Swaddle the baby in a receiving blanket. This helps the baby feel secure.
• Some babies are very sensitive to the environment. Does the baby startle at loud noises? If so, try turning the lights down, reducing noise, and speaking softly.
• Try rocking or walking with the baby.
• Sing or play music.
• If nothing else works, try putting the baby down in a safe place then give yourself some time out (have a cup of tea, listen to some music, etc.). Sometimes babies get over handled and over stimulated as they adjust to their new world.
Newborn Pulse Oximetry Screening For Critical Congenital Heart Disease (CCHD)

What is Newborn Screening?
Most babies are born healthy with no serious problems. Newborn screening is a way to find babies who have serious medical conditions that need urgent treatment. Newborn screening pulse oximetry can help find critical heart conditions in newborns.

What is Critical Congenital Heart Disease?
Critical Congenital Heart Disease (CCHD) is a medical problem that occurs when a baby’s heart or major blood vessels near the heart are not formed properly. The heart may not work well and there may not be enough oxygen in the blood.

Why is it important to screen babies for CCHD?
Some babies with a heart defect can appear healthy at first. If these babies are sent home before their problem is found, they are at risk for serious illness or death.

How is screening for CCHD done?
Pulse oximetry, sometimes called pulse ox, is a test to determine the amount of oxygen in the baby’s blood and pulse rate. Pulse oximetry is fast, easy, and does not hurt. A small soft sensor is wrapped around the baby’s hand and foot to measure the heart rate and oxygen level in the blood. As part of universal newborn screening, every baby born in New York State will have a pulse oximetry screening after 24 hours of life to see if there are signs of CCHD. Waiting for 24 hours allows the baby’s heart and lungs to fully adjust to life outside his or her mother.

What happens if the pulse oximetry reading is low?
Some babies will have a low oxygen level reading. Your doctor will determine if further testing is needed to look for CCHD, such as an ultrasound of the heart (also called echocardiogram or heart echo). A low oxygen reading does not always mean that the baby has CCHD. Some healthy babies can have a low pulse oximetry reading while their heart and lungs are adjusting after birth. There could be other conditions that can cause your baby to have a low oximetry test result.

What do parents need to know?
Most babies who pass the pulse oximetry screening will not have CCHD. Warning signs that all parents should watch for are: bluish color to the lips or skin, grunting sounds with breathing, fast breathing, poor feeding, extreme sleepiness, and poor weight gain. If you notice any of these signs in your baby please contact your baby’s health care provider right away.

Who can I contact if I have additional questions about newborn screening for CCHD?
Ask your baby’s doctor about newborn screening or visit the CDC’s website at: www.cdc.gov/ncbddd/pediatricgenetics/pulse.html
Jaundice Alert: What Every Parent Needs to Know

What is jaundice?

Jaundice is the yellow color seen in the skin of many newborns. It happens when a chemical called bilirubin builds up in the baby’s blood. Jaundice can occur in babies of any race or ethnicity, regardless of skin color. Low levels of bilirubin are not a problem, but a few babies have too much jaundice. If not treated, high levels of bilirubin can cause brain damage and a life-long condition called kernicterus.

Yet, early detection and management of jaundice can prevent kernicterus. At a minimum, babies should be assessed for jaundice every 8 to 12 hours in the first 48 hours of life and again before 5 days of age.

What causes jaundice?

Jaundice can develop when red blood cells break down and bilirubin is left. It is normal for some red blood cells to die every day. In the womb, the mother’s liver removes bilirubin for the baby, but after birth the baby’s liver must remove the bilirubin. In some babies, the liver might not be developed enough to efficiently get rid of bilirubin. When too much bilirubin builds up in a new baby’s body, the skin and whites of the eyes might look yellow. The yellow coloring is called jaundice.

What are some of the signs of jaundice?

Jaundice usually appears first on the face and then moves to the chest, belly, arms, and legs as bilirubin levels get higher. The whites of the eyes can also look yellow. Jaundice can be harder to see in babies with darker skin color. Your baby’s doctor or nurse can and should test how much bilirubin is in your baby’s blood.

Can jaundice be treated?

Yes, it can. When being treated for high bilirubin levels, your baby will be undressed and put under special lights. The lights will not hurt the baby. This can be done in the hospital or even at home. The baby’s milk intake may also need to be increased. In some cases, if the baby has very high bilirubin levels, the doctor will do an exchange transfusion of the baby’s blood. Jaundice is generally treated before brain damage is a concern. Putting your baby in sunlight is not recommended as a safe way of treating jaundice.

What can I do to make sure my baby’s jaundice does not cause brain damage?

A-C-T

• Ask your doctor or nurse about a bilirubin test.
• Create a follow-up plan before leaving the birth hospital. All babies 3 to 5 days of age should be checked by a nurse or doctor, because this is usually when a baby’s bilirubin level is highest. The timing of the follow-up visit will depend on how old your baby is when you leave the birth hospital and any other risk factors. Babies with jaundice in the first 24 hours of life or with high bilirubin levels before hospital discharge should have an early follow-up plan.
• Treat jaundice seriously.
Ask your pediatrician to see your baby the day you call, if your baby
• is very yellow or orange (skin color changes start from the head and spread to the toes)
• is hard to wake up or will not sleep at all
• is not breastfeeding or sucking from a bottle well
• is very fussy, or
• does not have enough wet or dirty diapers

Get emergency medical help if your baby
• is crying uncontrollably or with a high pitch
• is arched like a bow (the head or neck and heels are bent backward and the body forward)
• has a stiff, limp or floppy body, or
• has strange eye movements

Will my baby become jaundiced?
About 60% of all babies have jaundice. Some babies are more likely to have severe jaundice and higher bilirubin levels than others. Babies with any of the following risk factors need close monitoring and early jaundice management.

Preterm babies – Babies born before 37 weeks, or 8 1/2 months, of pregnancy might have jaundice because their liver is not fully developed. The young liver might not be able to get rid of so much bilirubin.

Babies with darker skin color – Jaundice may be missed or not recognized in a baby with darker skin color. Checking the gums and inner lips may detect jaundice. If there is any doubt, a bilirubin test should be done.

Heredity – A baby born to an East Asian or Mediterranean family is at a higher risk of becoming jaundiced. Also, some families inherit conditions (such as G6PD deficiency), and their babies are more likely to get jaundice.

Feeding difficulties – A baby who is not eating, wetting, or stooling well in the first few days of life is more likely to get jaundice.

Sibling with jaundice – A baby with a sister or brother that had jaundice is more likely to develop jaundice.

Bruising – A baby with bruises at birth is more likely to get jaundice. A bruise forms when blood leaks out of a blood vessel and causes the skin to look black and blue. The healing of large bruises can cause high levels of bilirubin and your baby might get jaundice.

Blood type – Women with an O blood type or Rh negative blood factor might have babies with higher bilirubin levels. A mother with Rh incompatibility should be given Rhogam.

What Parents of Near-Term Infants Need to Know
A near-term infant is a baby born three to six weeks early, or between 34 and 36 completed weeks of gestation (almost 37 weeks). This population of babies is also referred to as late preterm. In the last six weeks of pregnancy, the baby usually gains
about one half pound per week, so babies born a few weeks early are somewhat smaller than full-term newborns. Although near-term infants are usually significantly larger than very premature newborns, they are still premature and have their own, unique health considerations.

Recent studies show that babies born just three to six weeks early are at greater risk for potentially serious health problems than full-term newborns. It is important for parents to be alert for the special situations or needs that may arise because their baby is just a few weeks early.

Five things parents of a near-term infant should know and watch for:

1. **Feeding** – Near-term infants tend to feed slower and may need to be fed more often that full-term babies. In addition, a near-term infant may not be able to take as much breastmilk or formula as a full-term infant. It is essential these infants feed often for the first several days to help prevent jaundice. As with all infants, if a baby begins to refuse feedings, even for less than a day, the parents or caregiver should contact the baby’s nurse practitioner or pediatrician. Some near-term infants may have problems initiating or maintaining breastfeeding; so a mother who chooses to breastfeed may need to ask for support from a nurse, physician or lactation consultant.

2. **Sleeping** – Near-term infants may be sleepier than most full-term infants and may sleep through needed feedings, in which case she or he should be awakened to eat after three or four hours. All infants, including near-term infants, should always be placed on their backs to sleep.

3. **Breathing** - Near-term infants may be at greater risk for respiratory distress. If a baby seems to be having trouble breathing, parents or a caregiver should contact the baby’s nurse practitioner or pediatrician immediately or call 911.

4. **Temperature** - Near-term infants, like all preemies, have less body fat and may be less able to regulate their own body temperature than full-term infants. Like all newborns, near-term infants should be kept away from drafts. Room temperatures should be warm enough to maintain the baby’s normal temperature. A good rule of thumb is to dress your baby in one more layer than you are wearing.

5. **Jaundice and Infections** - Near-term infants may be more more likely to develop jaundice, a symptom of a condition called hyperbilirubinemia that can lead to severe nervous system damage if not identified and treated early. Parents should make sure that their infant is screened for jaundice prior to discharge. Infants should be seen by their nurse practitioner or pediatrician within 24 or 48 hours of discharge; and should be seen at any time if their skin becomes yellow or if they are not feeding well. Near-term infants have immature immune systems and may be more likely to develop infections and, like all babies, should always be watched for signs of illness or infection such as high fever or difficulty breathing.

Near-term infant information courtesy of: AWHONN

Promoting the health of women and newborns.
Safety

Burns
Hot tap water can badly burn a baby’s delicate skin. The American Academy of Pediatrics recommends that the temperature of your hot water heater be set between 100 and 120 degrees. Always test bath water before putting your baby in it. Do not hold any part of your baby’s body under running tap water. The water temperature might get hot very quickly and burn the baby’s skin. Be sure your baby does not touch or lean against a hot faucet.

Do not carry your baby while holding a hot drink. Accidental spills can burn your baby’s skin. Burns can also happen when breast milk or formula is heated in the microwave.

Sunburns
Babies can sunburn easily since they have delicate skin. Fair-skinned babies are even more likely to burn. Keep your baby covered in hot, sunny weather. Do this by using an umbrella to block the sun or by dressing him/her in light clothing that covers the skin. The baby should wear a hat to protect their face and head. Be aware that sunlight reflected off water, sand, or snow is four or five times stronger than direct sunlight.

Check with your baby’s doctor before using sunscreen on a baby younger than 6 months old. Use sunscreen with a sun protection factor (SPF) of at least 30 on babies older than 6 months old. Remember that the baby’s skin can burn in 20 minutes of sun exposure.

Fire
If you do not have a smoke detector, now is a good time to get one. You should have a smoke detector on each level of your home and in each bedroom. If you have smoke detectors in your home, be sure to check the batteries every month and replace them when needed.

Falls
Never leave your baby alone on an unguarded surface, even for a moment. Babies wiggle, squirm, and can quickly fall off a bed or changing table. If you need to take your eyes off your baby, keep a hand on them or take the baby with you. Do not rely on changing table safety straps to keep your baby from falling.

Choking
Choking is one of the most common dangers for young children. They can choke on any small object — a toy, a piece of a toy, food, a button, or string. Government regulations state that toys for children under age 3 cannot have small parts. A general guide is to give your child nothing that can fit through a toilet paper roll. Be careful if you have older children who have toys with small parts. They may want to share these with the new baby.

Never hang anything around your baby’s neck, such as a pacifier on a string or jewelry. If these catch on something, the baby would not be able to free himself/herself.
Remove mobiles or anything hanging in the crib once your baby learns to sit up or pull up. Keep drapes and venetian blind cords away from the crib.

Baby powder is not recommended. If you wish to use it, be sure to sprinkle it on your hand first and then apply it to the baby’s skin. Never shake powder onto a baby since the baby might inhale it and choke on the small particles in the powder.

**Smoking**

Do not smoke around your baby. Secondhand smoke is dangerous for your baby because it irritates the lungs and increases the risk for colds, ear infections and crib death. If you or visitors must smoke, do it outside your home and car.

**Sleeping**

**Bedding for Baby:**
- Use a firm mattress in the crib or bassinet so the baby does not sink in.
- Use bedding that is tight fitting to the mattress.
- Do not use fluffy blankets, thick quilts, comforters, or a sheepskin under or over the baby.
- Remove any soft stuffed toys or pillows from the crib.

**Positioning for Baby:**
- Always put a healthy baby to sleep on the baby’s back. Remember Back to Sleep! To keep a newborn on the back, swaddle the newborn in a blanket with hands centered over the chest.
- It is dangerous to put a healthy baby to sleep on the stomach, especially after a baby is used to sleeping on the back or side. The baby may not be able to lift and hold their head up to breathe.

**Temperature:**
- Avoid too much heat in the baby’s room. Keep the temperature at a level that feels comfortable to you.
- Don’t overdress your baby, especially at nighttime.

**Co-Sleeping:**
- The safest place for an infant to sleep is in a safety approved separate crib or bassinet in your room.
- If parents smoke or have ingested drugs or alcohol, they should not sleep with their babies. These drugs include some prescription and over the counter medications (such as allergy, sleep or cold medicine) that may make the person fall into a deep sleep and may make it difficult for the person to wake up.

It is not recommended that infants sleep in adult beds, however, if you must place your infant in an adult bed, follow these guidelines:
- The mattress should be tight fitting to the headboard of the bed.
- There should not be any space between the bed and adjoining wall where the baby could roll and become trapped.
- The baby should not be placed on their stomach.
SIDS – A Parents Guide To Safe Sleep

SIDS or Sudden Infant Death Syndrome is the sudden and unexplained death of an apparently healthy infant younger than one year of age.

Did you know? SIDS is:
- Most common among infants that are 2-4 months old
- More common in male babies
- More common during the winter months
- The leading cause of death for infants between 1 month and 12 months of age

Know the truth… SIDS is not caused by:
- Immunizations
- Vomiting or choking

What can I do before my baby is born to reduce the risk of SIDS?
Take care of yourself during pregnancy and after the birth of your baby. Things that increase your risk of having a baby die from SIDS can be reduced during pregnancy, before you even give birth! Don’t smoke or expose yourself to others’ smoke while you are pregnant and after the baby is born. Be sure to visit a physician for regular prenatal checkups to reduce your risk of having a low birth weight or premature baby. Breastfeed your baby, if possible, at least through the first year of life.

Where is the safest place for my baby to sleep?
The safest place for your baby to sleep is in the room where you sleep. Place the baby’s crib or bassinet near your bed (within an arm’s reach) to ease breastfeeding and to bond with your baby.

Why are there so many mixed messages about how and where my baby sleeps? Doctors and others have been studying why babies die for more than 80 years. The best research now says babies should be put to sleep on their back and sleep safest in their own bed.

I like to sleep with my baby – why is this a problem? Adult beds, recliners, and couches are not safe places for babies to sleep. Pillows, blankets, backs of couches, recliners, and other people sharing the same space can get pushed up against his face causing him to not be able to breathe. A baby can also get trapped between the mattress and headboard or wall. In some cases, an adult has rolled over on the baby during sleep, and the baby has died. A baby is safest when he is in the same room as his parents, but not in the same bed.

Safe sleep practices.
- Always put babies to sleep on their backs during naps and at nighttime.
- Don’t cover the heads of babies with a blanket or over bundle them in clothing and blankets.
- Avoid letting the baby get too hot. The baby could be too hot if you notice sweating, damp hair, flushed cheeks, heat rash, and rapid breathing. Dress the baby lightly for sleep. Adjust the temperature in a range that is comfortable for a lightly clothed adult.
- Will my baby choke if she spits up when sleeping on her back? Healthy babies will turn their head when they spit up or vomit. Babies lying on their back can turn away from the spit up; while babies on their tummies can’t always turn away.
- My baby sleeps better on his tummy; isn’t this more comfortable for him? Babies get used to sleeping on their backs quickly. Back sleeping helps them breathe better and take in more fresh air. A baby doesn’t fall into extremely deep stages of sleep when on his back which is a good thing for young babies. Once your baby can roll over on his own, you don’t have to worry about turning him back over.
Safe sleep environment.
• Place your baby in a safety-approved crib with a firm mattress and a well-fitting sheet (cradles and bassinets may be used, but choose those that are JPMA (Juvenile Products Manufacturers Association) certified for safety).
• Place the crib in an area that is always smoke free.
• Don’t put babies to sleep on chairs, sofas, waterbeds, or cushions.
• Toys and other soft bedding, including fluffy blankets, comforters, pillows, stuffed animals, and wedges should not be placed in the crib with the baby. These items can impair the infant’s ability to breathe if they cover his face. If bumper pads are used in cribs, they should be thin, firm, well-secured, and not “pillow-like.”
• I love the bumper pads and cute blankets for the crib – why is this a problem? Babies might push their face up against bumpers, blankets or stuffed animals in the crib and not be able to breathe. If you put your baby to sleep in a sleep sack, you don’t need blankets to keep them warm and they’re much safer!

Is it ever safe to have babies on their tummies?
Yes! You should talk to your child care provider about making tummy time a part of your baby’s daily activities. Your baby needs plenty of tummy time while supervised and awake to help build strong neck and shoulder muscles.

Remember: Tummy to play and back to sleep.
• “Tummy time” is playtime when infants are awake and placed on their tummies while someone is watching them. Have tummy time to allow babies to develop normally.
• Place babies to sleep on their backs to reduce the risk of SIDS. Side sleeping is not as safe as back sleeping and is not advised. Babies sleep comfortably on their backs, and no special equipment or extra money is needed.

Talk about safe sleep practices with everyone who cares for your baby!
• About one in five sudden infant death syndrome (SIDS) deaths occur while an infant is in the care of someone other than a parent. Many of these deaths occur when babies who are used to sleeping on their backs at home are then put to sleep on their tummies by another caregiver. We sometimes call this “unaccustomed tummy sleeping.”
• Unaccustomed tummy sleeping increases the risk of SIDS. Babies who are used to sleeping on their backs and are put to sleep on their tummies are 6-9 times more likely to die from SIDS.
• When looking for someone to take care of your baby, including a child care provider, a family member, or a friend, make sure that you talk with this person about safe sleep practices. Bring this book along to help, if needed. If a caregiver does not know the best safe sleep practices, respectfully try to teach the caregiver what you have learned about safe sleep practices and the importance of following these rules when caring for infants. Before leaving your baby with anyone, be sure that person agrees that the safe sleep practices explained in this book will be followed all of the time.

If you have questions about safe sleep practices please contact the Healthy Child Care America Back to Sleep campaign at the American Academy of Pediatrics at childcare@aap.org or 888/227-5409. Remember, if you have a question about the health and safety of your child, talk to your baby’s doctor.

SIDS information courtesy of
Car Seats

Motor vehicle injuries are the leading cause of death among children in the United States. Car seats, when properly used, can help reduce injuries. By law, children who are younger than 4 years old must be in a federally approved car seat that is attached to a vehicle by a safety belt or universal child restraint anchorage (LATCH) system.

Never use a child safety seat in the front passenger seat if the car has a frontal air bag. When the air bag inflates, it can hurt babies, small children and even small adults sitting in the front seat. The force of the air bag will thrust a baby seat into the back of the vehicle seat, causing injury. The safest place for a baby or small child is in the middle of the back seat.

Parents are responsible for making sure the baby is properly fastened in the car seat and the car seat is properly fastened in the car. We suggest someone bring the car seat to the hospital during your stay. This will give parents time to adjust straps and buckles and practice placing the baby securely in the car seat. This is much easier than trying to do this at the car for the first time in the heat, rain, wind, and/or cold!

Important car seat tips:

- Never use a child safety seat in the front passenger seat if the car has a frontal air bag.
- Never use a car seat with unknown history (garage sale, from a friend).
- Never use a car seat that has ever been in a car crash, no matter how minor.
- The American Academy of Pediatrics (AAP) recommends children remain rear-facing until age 2, or until they reach their maximum height and weight for their car seat.
- Be careful when using neck rolls, padding, toys, mirrors or any other items not originally made for that car seat. These items could decrease the safety of your car seat. Toys or mirrors could injure your baby in a car crash.
- Properly installed car seats should not be moveable more than 1 inch from front to back or side to side.
- Plan to have your car seat checked by a Certified Child Passenger Safety Technician.
Car Seat Recommendations for Children

Select a car seat based on your child’s age and size, and choose a seat that fits in your vehicle and use it every time.

Always refer to your specific car seat manufacturer’s instructions; read the vehicle owner’s manual on how to install the car seat using the seat belt or LATCH system; and check height and weight limits.

To maximize safety, keep your child in the car seat for as long as possible, as long as the child fits within the manufacturer’s height and weight requirements.

*Keep your child in the back seat at least through age 12.*

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Instructions</th>
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<tbody>
<tr>
<td>Birth - 12 Months</td>
<td>Your child under age 1 should always ride in a rear-facing car seat. There are different types of rear-facing car seats: Infant-only seats can only be used rear-facing. Convertible and 3-in-1 car seats typically have higher height and weight limits for the rear-facing position, allowing you to keep your child rear-facing for a longer period of time.</td>
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<tr>
<td>1 - 3 Years</td>
<td>Keep your child rear-facing as long as possible. It’s the best way to keep him or her safe. Your child should remain in a rear-facing car seat until he or she reaches the top height or weight limit allowed by your car seat’s manufacturer. Once your child outgrows the rear-facing car seat, your child is ready to travel in a forward-facing car seat with a harness.</td>
</tr>
<tr>
<td>4 - 7 Years</td>
<td>Keep your child in a forward-facing car seat with a harness until he or she reaches the top height or weight limit allowed by your car seat’s manufacturer. Once your child outgrows the forward-facing car seat with a harness, it’s time to travel in a booster seat, but still in the back seat.</td>
</tr>
<tr>
<td>8 - 12 Years</td>
<td>Keep your child in a booster seat until he or she is big enough to fit in a seat belt properly. For a seat belt to fit properly the lap belt must lie snugly across the upper thighs, not the stomach. The shoulder belt should lie snug across the shoulder and chest and not cross the neck or face. Remember: your child should still ride in the back seat because it’s safer there.</td>
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Types of Child Restraints

**A REAR-FACING CAR SEAT** is the best seat for your young child to use. It has a harness and in a crash, cradles and moves with your child to reduce the stress to the child’s fragile neck and spinal cord.

**A FORWARD-FACING CAR SEAT** has a harness and tether that limits your child’s forward movement during a crash.

**A BOOSTER SEAT** positions the seat belt so that it fits properly over the stronger parts of your child’s body.

**A SEAT BELT** should lie across the upper thighs and be snug across the shoulder and chest to restrain the child safety in a crash. It should not rest on the stomach area or across the neck.

Please visit [www.nhtsa.gov](http://www.nhtsa.gov) for more information.
Abduction Prevention at Home

- At some point after the birth of your baby, but before discharge from the facility, request a set of written guidelines about procedures for any follow-up care extended by the facility that will be scheduled to take place in your home. Do not allow anyone in your home who says he/she is affiliated with the facility without properly verified identification as issued by the facility. Find out what additional or special identification is being worn to further identify those staff members who have authority to enter your home. The Lourdes Maternity staff DOES NOT make home visits. If any home visits are scheduled, you will be informed of that before you go home. Potential home visitors may include: Lourdes at Home Staff, Lourdes Health Support Staff (in cases where your baby may need additional equipment at home, for instance, a bilirubin blanket, etc.), or a member of your county’s public health maternal-child health team.

- The use of outdoor announcements such as signs, balloons, large floral wreaths, and other lawn ornaments are not recommended to announce a birth because they call attention to the presence of a new infant in the home.

- Consider the risk you may be taking when permitting your infant’s birth announcement to be published in the newspaper or online. Birth announcements should never include the family’s home address and be limited to the parents’ first names. In general, birth announcements in the newspaper are not endorsed by most experts.

- At Lourdes, a baby’s photograph and information are not posted to the website until after mother and baby have been discharged. Only baby’s and parents’ first names are used. This decreases the chance a potential abductor has to “pick out a baby” online. Consider sending your own personalized birth announcement to your friends and family – the people who you want to know about your baby.

- Only allow persons into your home who are well known by the mother. It is ill-advised to allow anyone into your home who is just a mere or recent acquaintance, especially if met briefly since you became pregnant or gave birth to your infant. There have been several cases where an abductor has made initial contact with a mother and infant in the healthcare–facility setting and subsequently abducted the infant from the family home. If anyone should arrive at the home claiming to be affiliated with the healthcare facility where the infant was born or other healthcare provider, remember to follow the procedures outlined above. A high degree of diligence should be exercised by family members when home with the infant. All family members should be sensitive to any suspicious visitors. If you must take your infant out, whenever possible, take a trusted friend or family member with you as an extra set of hands and eyes to protect and constantly observe the infant. Never leave a child alone in a motor vehicle. Always take the child with you. Never let someone you don’t know pick up or hold your child.

These tips are excerpted from For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions, National Center for Missing & Exploited Children.
Vaccinations

What are vaccinations?
Vaccinations (vaccines) protect your child against serious diseases by stimulating the immune system to create antibodies against certain bacteria or viruses. Most vaccinations are given as injections.

What diseases do vaccines protect against?
Vaccines protect against measles, mumps, rubella, influenza, hepatitis B, hepatitis A, polio, diphtheria, tetanus, pertussis (whooping cough), chickenpox, and pneumococcal disease. Vaccines can’t protect children from minor illnesses like colds, but they can keep children safe from many serious diseases.

Isn’t all this talk about diseases just a way to scare parents so they’ll bring their children in for shots?
No. These diseases can still injure and kill children in the U.S. For example, during 1989–91, more than 55,000 measles cases and 123 related deaths (mostly children) were reported. Other children suffered such serious side effects as brain damage and blindness. Pertussis is another dangerous disease for infants. During 1997–2000, nearly 30,000 pertussis cases were reported and 62 related deaths. In 2003 alone, 11,647 cases and 18 deaths from pertussis were reported. Finally, during the 2003–04 influenza season, 40 states reported 152 influenza-related deaths among children younger than 18 years of age.

I don’t know anybody who has had measles or rubella. Why does my baby need these shots?
You might not think that measles and rubella are a threat today because you don’t see or hear much about them, but they are still around. These diseases are common in other parts of the world and are just a plane ride away. If we stop vaccinating against these diseases, many more people will become infected. Vaccinating your child will keep him or her safe.

Isn’t there some way besides vaccination to protect my child against these diseases?
No. Breastfeeding offers temporary immunity against some minor infections like colds, but it is not an effective means of protecting a child from the specific diseases preventable by vaccines. Likewise, vitamins don’t protect against the specific bacteria and viruses that cause these serious diseases. Of course, infection usually results in immunity, and some parents think that getting the “natural” disease is preferable to “artificial” vaccination. Some even arrange chickenpox “parties” to ensure their child is infected. However, the price paid for natural disease can include paralysis, retardation, liver cancer, deafness, blindness, pneumonia, and even death. Vaccination is definitely safer!
Are vaccinations safe?

Vaccines are safe, and researchers continually work to make sure they become even safer. Every vaccine undergoes many tests before being licensed, and its safety continues to be monitored as long as the vaccine is in use. Most side effects from vaccination are minor, such as soreness where the injection was given or a low-grade fever. These side effects do not last long and are treatable. Serious reactions are very rare. The tiny risk of a serious vaccine reaction has to be weighed against the very real risk of getting a dangerous vaccine-preventable disease. If you have concerns or questions, talk to your child’s healthcare provider.

What if my child has a cold or fever, or is taking antibiotics? Can he or she still get vaccinated?

Yes. Your child can still be vaccinated if he or she has a mild illness, a low-grade fever, or is taking antibiotics. Ask your child’s healthcare provider if you have questions.

How many times do I need to bring my baby in for vaccinations?

At least four visits are needed before age two, but the visits can be timed to coincide with well-child check-ups. Your baby should get the first vaccine (hepatitis B) shortly after birth, while still in the hospital. Multiple visits during the first two years are necessary because there are thirteen diseases your baby can be protected against, and most require several doses of vaccine for optimal protection.

How do I know when to take my baby in for shots?

Your healthcare provider should give you a reminder when the next doses are due. If you are not sure, call your clinic or healthcare provider to find out when you should bring your child back. Doses cannot be given too close together or immunity doesn’t have time to build up. On the other hand, you don’t want to delay your child’s shots and get behind schedule. It takes time to catch up and during this time, your child remains unprotected against these diseases.

What if I miss an appointment? Does my baby have to get the shots all over again?

No. If your baby misses some doses, it’s not necessary to start over. Your provider will continue from where he or she left off.

How do I keep track of my baby’s shots?

Your healthcare provider should give you a personal record card for your child’s vaccinations. If you don’t receive one, ask! Bring the card to all medical appointments. Whenever your child receives a vaccine, make sure the card gets updated. Your child will benefit by retaining an accurate vaccination record throughout his or her life.
What if my child isn’t a baby anymore? Is it too late to get him or her vaccinated?

No. Although it’s best to have your child begin vaccination as an infant, it’s never too late to start. If your child has not received any, or all, of his/her shots, now is the time to start.

What if I can’t afford to get my child vaccinated?

Vaccinations are usually free or low cost for children when families can’t afford them. You can call (800) 232-2522 or your local health department to find out where to go for affordable vaccinations. Your child’s health depends on it!

Hepatitis B Vaccination is Recommended for All Newborns

The American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention recommend that every newborn be vaccinated against hepatitis B at birth, before hospital discharge.

What is hepatitis B?

Hepatitis B is a serious disease caused by the hepatitis B virus. The virus can get in the blood and attack the liver. When infants and young children are infected, the virus often stays in the body for many years. This life-long (chronic) infection can cause liver damage, even liver cancer.

Most newborns who become infected with hepatitis B virus do not get sick at first, but they have a 90% chance of developing lifelong infection. If your child gets infected, he or she can develop serious liver damage and might get liver cancer later in life. Hepatitis B is preventable and your child can be protected by making sure he or she is vaccinated at birth.

How can my child get hepatitis B?

Hepatitis B virus is spread by contact with blood or body fluids from an infected person. Children can get infected by:

• Contact with a mother’s blood and body fluids at the time of birth.

• Contact with blood and body fluids through breaks in the skin such as bites, cuts, or sores.

• Contact with objects that could have blood or body fluids on them such as toothbrushes, washcloths or razors.
Why does my baby need hepatitis B shots now?
This vaccine protects babies from an infection that they might come in contact with at any time in life. Studies show the vaccine offers protection that lasts more than 20 years.

How many shots are needed to protect my baby?
Three or four, depending on the vaccine your healthcare provider chooses. The first shot is recommended at birth, before your baby leaves the hospital. The second shot is given one to two months later, and the third is usually given at six months of age. Four shots may be needed if your baby’s healthcare provider uses combination vaccines. If your child misses a shot, continue where you left off — you don’t need to start over!

What about my older children?
It’s best to start vaccination in infancy so your children are protected as soon as possible. If your older children missed this important vaccination in infancy, ask your healthcare provider to vaccinate them now. Hepatitis B vaccination is recommended for all children and teens ages 0–18 years. The earlier your children and teenagers are vaccinated, the sooner they are protected from this serious disease.

Is this vaccine safe?
Yes. Hepatitis B vaccine has been shown to be very safe when given to infants, children, teens, and adults. The most common side effects from hepatitis B vaccination are soreness at the injection site and mild to moderate fever. Serious side effects are rare. In the U.S. more than 100 million persons, including infants, children, and adults have received hepatitis B vaccine.

Protect Your Infant from Whooping Cough

What is whooping cough (or pertussis)?
Pertussis, or commonly known as Whooping Cough, is a highly contagious bacterial infection that causes coughing spasms so severe that in infants it makes it difficult to eat, drink and even breathe. Pertussis can cause serious sometimes life-threatening complications in infants especially within the first 6 months of life. It can lead to pneumonia, seizures, brain damage and even death.

In infants younger than one year old who get pertussis, more than half must be hospitalized.

Of those who are hospitalized with pertussis about 1 in 5 will get pneumonia and 1 in 100 will die. The majority of pertussis cases, hospitalizations, and deaths occur in infants under 2 months of age.

It is also one of the most common vaccine-preventable childhood diseases.
When should my child be vaccinated?

The CDC’s Advisory Committee for Immunization Practices (ACIP) recommends a five-shot series of DTaP vaccinations for all infants at two months, four months, six months, fifteen-eighteen months and another between the ages of four and six years. Because the maximum benefit for protection against pertussis is not achieved until an infant has received at least three doses of DTaP, infants under the age of six months who have not yet begun the vaccination series are most vulnerable to pertussis.

How can I prevent my infant from getting pertussis?

• Expectant mothers who have not been previously vaccinated, should get a Tdap vaccination during the second or third trimester. By getting Tdap during pregnancy, maternal pertussis antibodies transfer to the newborn, likely providing protection against pertussis in early life, before the baby starts getting DTaP vaccines. Tdap will also protect the mother at time of delivery, making her less likely to transmit pertussis to her infant. If a woman is not vaccinated during pregnancy, it is recommended that she gets vaccinated immediately post-partum before leaving the birthing center or hospital.

• Research has shown that infants most often contract pertussis from family members. So, it is very important that the other parent, siblings, grandparents (including those over 65 years of age) and other family members as well as babysitters and nannies are encouraged to get the appropriate vaccine at least two weeks before coming in contact with the infant.

• Because vaccine protection fades over time, adults who will be around the infant all the time, should to be revaccinated to protect against pertussis.

• Ask your nurse with help in getting caregivers vaccinated.

Immunization for Babies

These are the vaccinations your baby needs!

<table>
<thead>
<tr>
<th>At birth</th>
<th>HepB</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>2 months</th>
<th>HepB</th>
<th>DTaP</th>
<th>PCV</th>
<th>Hib</th>
<th>Polio</th>
<th>Rota</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 doses</td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>4 months</th>
<th>HepB^</th>
<th>DTaP</th>
<th>PCV</th>
<th>Hib</th>
<th>Polio</th>
<th>Rota</th>
<th>Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-11 mos</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6-18 mos</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6 months</th>
<th>HepB^</th>
<th>DTaP</th>
<th>PCV</th>
<th>Hib</th>
<th>Polio</th>
<th>Rota</th>
<th>Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-11 mos</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>6-18 mos</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12 months</th>
<th>MMR</th>
<th>DTaP</th>
<th>PCV</th>
<th>Hib</th>
<th>Chickenpox</th>
<th>HepA</th>
<th>Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-15 mos</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>18-24 mos</td>
</tr>
</tbody>
</table>

Check with your doctor or nurse to make sure your baby is receiving all vaccinations on schedule. Many times vaccines are combined to reduce the number of injections. Be sure you ask for a record card with the dates of your baby’s vaccinations; bring this with you to every visit.

Here’s a list of the diseases your baby will be protected against:

- **HepB**: Hepatitis B, a serious liver disease
- **DTaP**: Diphtheria, tetanus, and pertussis (whooping cough)
- **PCV**: Pneumococcal conjugate vaccine protects against a serious blood, lung, and brain infection
- **Hib**: Haemophilus influenzae type b, a serious brain, throat, and blood infection
- **Polio**: Polio, a serious paralyzing disease
- **Rota**: Rotavirus infection, a serious diarrheal disease
- **Influenza**: A serious lung infection
- **MMR**: Measles, mumps, and rubella
- **HepA**: Hepatitis A, a serious liver disease
- **Chickenpox**: Also called varicella

*Footnotes to above chart:
1. This is the age range in which this vaccine should be given.
2. Your infant may not need a dose of HepB vaccine at age 4 months, depending on the vaccine used. Check with your doctor or nurse.
3. Your infant may not need a dose of Hib vaccine at age 6 mos, depending on the vaccine used. Check with your doctor or nurse.

This information was adapted from The Immunization Action Coalition. www.immunize.org
Community Resources
(all telephone numbers are in the 607 area code unless noted)

- Birthright of Binghamton
  (607)798-7661 or 1(800)550-4900
  Services include: free pregnancy tests, newborn layettes, maternity and baby clothes.
  Breast Care Center at Lourdes (mammography)
  798-6161

- Broome County Department of Social Services
  778-8850
  Day care programs, child protective services, food stamps, and more

- Car Seat Safety
  Broome County Health Department
  778-2807

- Catholic Social Services
  729-9166
  Parenting classes, foster care program, adoption services, counseling and emergency, limited financial aid and/or food and clothing

- Community Hunger Outreach Warehouse (CHOW)
  724-9130
  Emergency food assistance

- Danielle House
  724-1540

- Early Childhood Direction Center (STIC)
  724-2111
  Information and referral for parents of children from birth to age 5 with special needs of any kind

- Expressly for Moms, lactation support service at Lourdes
  798-5423
  Inpatient and outpatient consultations, education and support, medical grade breast pump rentals

- Family Enrichment Network
  Broome 723-8313
  Tioga 687-6721
  Programs for singles, couples, teens and fathers, Headstart & Early Headstart, Childcare Resource & Referral, Kinship Care

- Family and Children’s Society
  Binghamton – 729-6206
  Owego – 687-3540
  Parenting programs, counseling, domestic violence services

- Family Violence Prevention Council
  778-2153

- First Call for Help
  Broome County 211 or 1-800-901-2180
Chenango County 1-800-227-5353
Tioga County 211 or 1-800-901-2180
An information and referral system

- Lourdes Women’s and Children’s Services Unit
  798-5522
  Call for questions regarding mother or baby care

- Maternal Child Health & Development
  778-2851

- Mom’s House
  644-9972
  Free all-day child care for those enrolled in a full-time educational program

- Mothers and Babies Perinatal Network
  772-0517
  Health insurance information and assistance

- Parents and Children Together (PACT) – Lourdes Youth Services
  584-4550
  Information on parenting infants and toddlers

- Public Health Department
  Broome County 778-2851
  Tioga County 687-8600
  Chenango County 335-4606
  Delaware County Public Health Maternal Child Program 832-5200

- SOS Shelter
  Hotline – 24 hours/day, 7 days/week – 1-877-754-4340
  754-4340
  Gives help to battered women

- Systematic Training for Effective Parenting (STEP)
  772-8953
  Call for information and program scheduling

- Women, Infants, and Children Program (WIC)
  Broome County 778-2881
  Tioga County 687-3147
  Chenango County 334-7114
  Delaware County 746-1600
  Northern Pennsylvania (570) 853-3300
  Provides supplemental food and nutrition education to eligible families

- YMCA
  772-0560
  Drop-in child care for maximum of three hours for children under age 5, teen resident program, support groups, clothing for infants and children, and more
Support Groups:

- Cleft Lip / Cleft Palate
  692-4353
  723-5187

- Breastfeeding
  La Leche League Binghamton
  Tracy Adams, adams.tracy@gmail.com, 607-341-2436
  Lauren Hickey, proudmomma441@gmail.com, 607-427-3059
  http://111binghamtonny.weebly.com (LaLeche League of Binghamton)
  Also find on Facebook

- Down’s Syndrome
  High Risk Birth Clinic, 729-1295

- Craniofacial Care Team
  762-3273
  Offers patients with craniofacial defects a multidisciplinary team approach to management of their specific disorder

Internet Resources:

- www.binghamtonmoms.com
- http://parenting.ivillage.com
- www.family.com (Great ideas, practical advice and fun stuff to do)
- www.nhtsa.dot.gov (National Highway Transportation Safety Administration) for car seat safety information
- www.kellymom.com (breastfeeding information, support & advocacy)
- www.aap.org (American Academy of Pediatrics)
- www.cdc.gov/vaccines
- http://bfmedneo.com/resources/videos/ (reference Maya Bolman – breast massage and hand expression)
Lourdes Commitment to a Healthier Community

If you smoke:

Four crucial factors:

• Make the decision to quit
• Consider obtaining assistance through coaching and medication – see resources below
• Set a quitting date
• Stay smoke-free

Refer to Smoking Cessation Information – “No Ifs Ands or Butts” in the Lourdes Information Guide.

What Can I do?

For help to quit smoking or to stay smoke-free, the following resources are available:

• NYS Department of Health Smokers Quitline:
  1-866-NYQUITS (697-8487) Free cessation coaching and screening for eligibility for nicotine replacement therapy
  www.nysmokefree.com

• Mothers and Babies Perinatal Network:
  772-0517 or 1-800-231-0744
  Free quit smoking kit and weekly follow-up

• Broome County Health Department:
  778-3068
  Fact sheets with helpful information for smoking cessation, referrals

• American Cancer Society:
  1-800-ACS-2345
  www.cancer.org

• American Lung Association:
  1-800-586-4872
  www.lungusa.org

• Tobacco Free Broome and Tioga: www.tobaccofreebt.org

• National Cancer Institute, www.smokefree.gov
If you have pneumonia:
Take all prescribed medications prescribed by your health care provider.
If an antibiotic is ordered, be sure to finish all of the medication even if you are feeling better.
What Can I do?
Vaccine(s): If you have not already had the Pneumonia Vaccine or Influenza Vaccine, talk to your health care provider.
Smoke: If you smoke, you should stop. Refer to the smoking cessation information – “No If Ands or Butts” beginning on page 99 of the Lourdes Information Guide.

If you have heart failure:
Take all prescribed medications prescribed by your health care provider.
What Can I do?
Weight: Weigh yourself daily before breakfast. If you suddenly gain 3 pounds in a day of normal eating, it is probably fluid rather than fat. Notify your health care provider.
Discharge weight____________________.
Vaccine(s): If you have not already had the Pneumonia Vaccine or Influenza Vaccine, talk to your health care provider.
Smoke: If you smoke, you should stop. Refer to the smoking cessation information – “No If Ands or Butts” beginning on page 99 of the Lourdes Information Guide.

If you have MI/Angina:
Take all prescribed medications as ordered by your health care provider.
What Can I do?
Weight: Weigh yourself daily before breakfast. If you suddenly gain 3 pounds in a day of normal eating, it is probably fluid rather than fat. Notify your health care provider.
Discharge weight____________________.
Vaccine(s): If you have not already had the Pneumonia Vaccine or Influenza Vaccine, talk to your health care provider.
Smoke: If you smoke, you should stop. Refer to the smoking cessation information – “No If Ands or Butts” beginning on page 99 of the Lourdes Information Guide.
Glossary of Terms

**Acrocyanosis:** A circulatory disorder in which the hands, and less commonly the feet, are persistently cold, blue, and sweaty.

**Axillary:** Armpit

**Baby Blues:** See post-partum

**Bilirubin:** The result of the natural breakdown of red blood cells in the baby’s bloodstream. It is an orange-yellow pigment and excess amounts in the blood produce the yellow appearance observed in jaundice.

**Birth ball:** A large rubber ball, similar to those used in physical therapy or exercise classes, which can be useful during labor. Leaning or sitting on the ball can decrease the discomfort of contractions, relieve the pain of back labor, and aid in the baby’s descent into the birth canal.

**Cesarean:** Birth of the baby via an incision made in the mother’s abdomen and uterus.

**Circumcision:** Circumcision is an optional surgical procedure where the foreskin of the penis is separated and removed.

**Colostrum:** The mother’s first breast milk which meets all your baby’s needs in the first days of their life.

**Constipation:** Irregular and infrequent or difficult evacuation of the bowels.

**Contraction:** The contracting of the muscles of the uterus during labor. The uterus contracts in an effort to expel the fetus into and out of the birth canal. Contractions are usually a sign of labor, although they can occur before labor.

**Edema:** Swelling from excessive accumulation of serous fluid in tissue.

**Engorgement:** Swelling and tenderness of the breasts resulting from excess fullness with milk. Usually this occurs about 3-5 days after birth.

**Episiotomy:** Incision of the perineum during childbirth to ease delivery.

**Erythema neonatorum toxicum:** The medical term for newborn rash. It looks like a reddened splotch that sometimes has a whitehead-type pimple.

**Fontanelles:** Soft spots on the baby’s skull where the bones have not yet formed together.

**Foreskin:** The loose fold of skin that covers the glans of the penis.

**Fundus:** The upper ridge of your uterus

**Gestation:** The period of fetal development in the uterus from conception until birth; pregnancy.

**Hemorrhage:** A heavy or uncontrollable loss of blood.

**Hemorrhoid:** An enlargement of the veins around the anus. It is very common to experience hemorrhoids or worsening of hemorrhoids during pregnancy due to increased blood flow to the uterus and slowed venous drainage from the pelvic region due to the enlarging uterus. Treatment includes stool softeners (to avoid constipation, which can be especially painful), warm baths, ice packs, and suppositories.
**Incision:** A cut into a body tissue or organ, especially one made during surgery.

**Jaundice:** A condition caused by an increased amount of bilirubin in the baby’s body.

**Labia:** The folds of tissue on the external genitalia of the female.

**Lactation:** The secretion or formation of milk by the breast.

**Lochia:** Fluid that seeps from the uterus and ultimately from the vagina during the weeks following childbirth.

**Mastitis:** Inflammation of the breast gland usually caused by infection.

**Meconium:** The baby’s first bowel movement.

**Milia:** Plugged sweat glands that form raised white spots across the bridge of the baby’s nose or face.

**Mongolian spots:** Bluish-black areas that can appear on the skin in the lumbar region or on the buttocks. This is common in dark-skinned babies.

**Oxytocin:** A hormone that triggers period-like cramps and milk discharge.

**Perinatal:** Refers to the time period after the 28th week of gestation and ending the first week after birth. Some sources extend this period until the fourth week after birth.

**Perineum:** The area surrounding your vagina.

**Placenta:** The organ that nourishes the baby.

**Post-partum depression (Baby blues):** During the first few weeks after birth, about 15% of new moms experience postpartum depression. Signs include mood swings, lethargy, feelings of inadequacy, and anxiety. Women at greater risk of postpartum depression are those with depression following a previous pregnancy (about 70% risk), adolescent mothers (30% risk), and women with a history of depression in the past not associated with pregnancy (30%). For most women, this depression is temporary, resolving within six months.

**Prolactin:** The hormone responsible for making colostrum and milk available to the baby.

**Pseudo-menstruation:** A small amount of vaginal blood that baby girls may discharge due to hormones from mom during birth. It usually lasts only one or two diaper changes.

**Shaken Baby Syndrome:** Shaken baby syndrome is caused by vigorous shaking of an infant or young child by the arms, legs, chest or shoulders. Forceful shaking can result in brain damage leading to mental retardation, speech and learning disabilities, paralysis, seizures, hearing loss and even death.

**Scrotum:** The external sac of skin on males that enclose the testes.

**Uterus:** The uterus is the organ that houses and protects the fetus during pregnancy. The uterus grows and expands with your baby’s growth. Your doctor will measure this growth during prenatal visits.

**Vagina:** The genital canal in the female, leading from the opening of the vulva to the cervix of the uterus.

**Vaginal birth:** Birth of a baby through the vagina (birth canal).
Questions You Should Ask Before You Leave the Hospital

These are some important questions parents should ask their nurse, nurse practitioner or pediatrician before leaving the hospital with their infant.

How often should I bring my baby in for examinations?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

When should my baby have a blood test for jaundice?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What is the minimum number of times I should feed my baby each day?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What is the longest period of time I should let my baby go without eating?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What sorts of things should I be watching out for in terms of behavior or appearance?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How will I know if I should call you and how do I reach you?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Contact Information:
A special thank you to Neil Matterson for allowing us to use his wonderful breastfeeding illustrations.

Thank you to the Immunization Action Coalition for providing the Child Vaccination schedule.

Thank you to the American Academy of Pediatrics for allowing us the use of their One-Minute Car Safety Seat Check-Up.