Midwifery Client Handbook

Part Three

When to call your midwife

The journey of labour….

Delivering the placenta

The postpartum period

Postpartum care of the mother

Postpartum care of the baby

Breastfeeding

- How to support a breastfeeding mother
- Recommendations for breastfeeding
- Signs your baby is feeding well
- Breast Engorgement
- Sore Nipple Management: Prevention
- Sore Nipple Management: Treatment
- Treating a blocked duct
- Increasing your milk supply

WHEN TO CALL YOUR MIDWIFE PREGNANCY

To page the midwife on call: 1-778-760-2886

In Pregnancy: Situations requiring an immediate call to the midwife:

Persistent and excessive vomiting

Vaginal bleeding

Severe pelvic or abdominal pain that is unrelieved by rest or a warm bath

Episodes of dizziness, fainting or disorientation

Difficulty or burning pain with urinating

Persistent and severe mid-back pain

Swelling of hands and face

Severe headache

Blurred vision, persisting for several hours

Epigastric (mid-chest – between the ribs) pain

Initial outbreak of blisters in the perineal or anal area during first trimester

Rupture of membranes – gush or persistent leaking of clear fluid from the vagina

Regular progressively painful uterine contractions before 37 weeks

Fever: 38 degrees or more on two occasions 4 hours apart

Any other urgent situations of concern

Change in pattern of fetal movement

Contact the midwife if there is a **noticeable** change in your baby's pattern of movement. This could be a noticeable decrease; no movement over several hours or no response to stimulation. If you have concerns regarding fetal movements, have something to eat and drink, then rest and count fetal movements over a two hour period. **Six movements in a two hour period are considered normal.** Toward the end of pregnancy babies have longer sleep cycles and their movements often become slower and more rolling and stretching rather than rapid kicks.

WHEN TO CALL YOUR MIDWIFE

EARLY LABOUR

To page the midwife on call: 1-778-760-2886

Signs labour may be starting soon:

Loss of mucous plug or "Show" which is bloody-tinged mucous

Menstrual-like cramps

Frequent soft, loose bowel movements

Backache that comes and goes in a fairly regular pattern

Irregular contractions, usually non-painful

Contractions less than 45 seconds long and more than 5 minutes apart

- These are not urgent signs. One of these signs by itself may not be indicative of labour starting soon. There are usually two or three of these signs occurring at the same time. It is not necessary to call us immediately but you may notify the midwife on call during the day or the clinic midwife if you have an appointment scheduled.
- Early labour may take 24–48 hours to become "active labour". Early labour often involves periods of contractions that can become regular for a while then will decrease in frequency and strength. A hot bath or a good walk may resolve these "prelabour" contractions. This pattern may occur over several days especially if it is your second (or 3rd +) baby. It is your body's way of preparing for active labour. Some contractions may feel quite strong but if they do not get longer and stronger and continue in a regular pattern then you are not in established labour.
- Do not wear yourself out in early labour. Any rest you can get will benefit you during labour. Early labour is about the cervix becoming soft, shortened and thin. Active labour is about the cervix dilating. Be patient and do not be anxious. Babies need active, well established labour contractions to come out.

Tips for relaxing and sleeping in early labour

- If any of these occur during the night try to get some sleep, stay in bed!
- Have a warm bath, dim the lights, light some candles, have a glass of wine
- Have a glass of hot milk, a calcium magnesium supplement, calming tea
- Try Gravol: 50 – 100mg (1-2 tabs) takes the edge off and helps you drift off between contractions

- Use relaxation techniques; breathe deeply, consciously relax all your muscles and then do over again for at least seven times.
- Use a heating pad or warm pack (heat in the microwave) on your lower belly or back
- Meditate, visualize resting then waking up refreshed in labour, hypnobirthing techniques, use your own spiritual practice such as prayer
- Ask your partner for some soft, stroking massage
- Do not call people and tell them you think you are in labour
- Listen to relaxing music
- As much as possible ignore these early labour contractions – do not think about how much stronger they are going to get or how many hours of labour are ahead. Stay in the now and remember babies always come out!

Early labour during the day

- Make sure you eat and drink
- Ignore your contractions until you cannot talk through them
- Start or work on a project: bake something, crafts, scrap-booking, play scrabble, watch a funny movie,
- Have a nap
- Go for a long walk – especially out in nature

Heads up Calls:

Day: (between 9 am and 9 pm) If you are having regular contractions and think you are in labour or if your waters have broken, page the midwife on call.
A heads up call can assist us in planning our day, arranging our visits etc.

Night: (between 9pm and 9am) We do not need a heads up call during the night and we appreciate the opportunity to sleep if we are not needed immediately. You will appreciate a fresh, well-rested midwife during your labour!. If your contractions are just beginning to become established, you are able to talk through them, and they are occurring every 5 minutes or more and lasting less than 1 minute long you do not need to call us.

If your waters break….

… you have a large gush of fluid or persistent leaking AND ALL OF THE FOLLOWING APPLY:

- the fluid is clear,
- the midwife has told you the head is well down and
- your baby is active and moving normally,
- you are GBS NEGATIVE
- you are 37 weeks or over
- you are not in active labour
- it is during the night

You can put on a pad, go back to bed and call us in the morning, unless we have given you other instructions.

If your waters break….

… you have a large gush of fluid or persistent leaking AND ANY OF THE FOLLOWING APPLY: YOU NEED TO PAGE US RIGHT AWAY:

- you are GBS positive
- the fluid is brown, green or very bloody
- the fluid has a unusual or unpleasant odour
- you develop a fever (over 38 degrees) and feel unwell
- you are less than 37 weeks pregnant
- you are having regular, strong contractions
- the baby is not moving normally

INSTRUCTIONS ONCE THE WATERS HAVE BROKEN…..

- do not put anything inside the vagina: fingers, tampon etc
- do not have intercourse
- change any pad you are wearing every two hours
- do not have a bath until you are in active labour, showers are OK
- take your temperature every two hours while you are awake, page the midwife immediately if it is over 38 degrees celsius or 100.4 fahrenheit

If you feel something in the vagina, see something at the entrance of the vagina, or something is hanging outside of the vagina: get in a knee chest position on the floor and page the midwife immediately. If you are sure it is the umbilical cord, call 911 then page the midwife.

WHEN TO CALL YOUR MIDWIFE

ACTIVE LABOUR

To page the midwife on call: 1-778-760-2886

Ensure your number is correct and keep your line free for the return call. If you do not receive a call back within 10-15 minutes, please page again. If you do not receive a call back within 10 minutes on the second page, please page one more time and then call your nearest hospital maternity unit.

FIRST BABY: Use the **4 – 2 – 1 rule.** When you are having regular strong contractions occurring every 4 minutes, for over 2 hours that are lasting over 1 minute long, then call the midwife.

SECOND (or more) BABY: Use the **5 -1 -1 rule** unless your midwife has instructed you otherwise. When you are having regular, strong contractions every 5 minutes, for 1 hour that are 1 minute long, page the midwife.

If you are worried about something, or think the labour is progressing rapidly, even if it doesn't follow the 4-2-1 or 5-1-1- rules –please page the midwife.

Timing Contractions:

Contractions are timed from beginning of one to the beginning of the next, noting the duration of the contraction. This will give you the frequency. For example:
These contractions are approximately 6 minutes apart;

START	[CONTRACTION]	BREAK
4.31	[……45 seconds……..]	5 minutes
4.37	[……55 seconds……..]	5 minutes
4.43	[……50 seconds…….]	5 minutes 10 seconds

Write down the start time of each contraction and the length of it.
Time about 5 -10 contractions when there is a noticeable change in the pattern or strength of the contractions, or every few hours.

Do not start timing early labour contractions that you can talk through or do not have to breathe through.

…The Journey of Labour….

Labour is a microcosm of life. It brings pleasure and pain, joy and sadness. It is a beginning and an ending. Labour will put you in touch with both your strengths and your vulnerabilities and offer you an opportunity to learn more about yourself. Labour is one of the most challenging experiences of a woman's life, it is also one of the most rewarding.

Labour is teamwork. It is mother and a baby learning together, how to yield and how to separate from the union of pregnancy, how to push and how to be born. You are not in control nor are you out of control during labour. The best way to approach labour is with an attitude of learning, of cooperation, of harmony of mind and body. To bring optimism rather than expectations and acceptance as events unfold. Most women really do not know what they are capable of, and they have inner resources and strengths they have not encountered before. It is important that your caregiver, your support people and especially **you** do not underestimate of what you are capable.

Some labours will be short and intense some will be long and drawn out. There may be plateaus of varying lengths. Some women have an irresistible urge to push at 7 centimetres, some wait an hour after being fully dilated to begin to feel like pushing.

When you are going with the flow of your labour, as your labour progresses and you adjust to the increasing intensity of the contractions you may gradually enter a somewhat altered state – you could call it "Labourland" or being in "the Zone". This is your body releasing endorphins to help you through the process. Contractions have a particular rhythm and pattern of their own, for each woman it is different – for each baby it is different.

This is a unique journey you are about to embark on; one that has been done many times before by many, many women. Your body knows how to do this work, how to birth this baby. Even now your body is preparing itself, adjusting, changing, and getting ready to birth. It is not possible to control labour. It is, however, possible to influence labour in a positive or a negative manner. The best approach is to follow the process and meet whatever it may offer. Be confident and believe in your inner resources, your strengths and your physical ability to complete this journey in your own special way.

Letting go….

Labour requires flexibility. Labour is about yielding rather than directing. There is a major physical process happening that has an original blueprint already drawn in your body and to try and control - to redraw this blueprint may change it but not necessarily improve it.

The uterine contractions of labour have often been likened to the waves in the ocean. The waves begin slowly out in the ocean and as they come closer they begin to swell and build until they reach a peak and then they crest and continue to flow right onto the shore. The water is

also flexible in nature, molding to the contours of the land and the shoreline. Following the natural flow of contractions allows you to cooperate with the force of nature.

Give yourself permission to express yourself during labour. Whether it is breathing, yelling or singing your way through a contraction, complaining, or grunting, each woman must find her way of releasing tension. It is important to do it in a focused way as part of your breathing techniques. This release is an important goal during contractions as is the complete relaxation between contractions.

Part of the intensity of labour comes from the physiological opening of the cervix to ten centimeters, which happens only when giving birth. There is a simultaneous psychological and emotional intensity to labour that may facilitate bonding in the moments immediately giving birth.

Working through labour contractions is a little like mountain climbing. There are moments when your muscles strain and then you rest between efforts – there may be moments that you feel you cannot go further. This is a good sign of progress. Just commit to doing one more contraction, then one more, and one more and so on until you are done. You will be able to do more than you think you can. Listen to your support team. Trust in your strengths. As you meet your baby at the end of labour, you will feel this reward.

Breathing for labour…

The only breathing you will need to do during most of your labour is a natural extension of normal breathing. Slow, deliberate and steady breaths throughout each contraction ensure that you and your baby receive the necessary oxygen. Four to five breaths (seven seconds for each inhalation and exhalation) are an average number per contraction. The most important thing is to keep oxygen moving through you.

As the labour progresses and the contractions require more of your attention you will naturally adjust your breathing. You may begin to breathe faster ans shallower. It is important to keep your breathing as slow and even as possible to avoid hyper-ventilation. It is also useful to greet and release each contraction with a deep breath and then resume normal breathing. This is helpful to let your partner and support people know when the contractions begin and end. Welcome the deep rest that is possible between contractions.

Vocalization during active labour is a natural extension of breathing and serves to release tension caused by pain. You can use the sound of your breath as a focal point to help you during contractions and to ensure you are not holding your breath. Many people cease breathing as an instinctive response to pain. You can overcome this response simply by listening to your breathing sounds throughout each contraction. Some women hold their breath to avoid making noise or try to hide their response to pain. This may be because they are conditioned not to express themselves, or they are trying to avoid upsetting others. This is not a useful coping mechanism. It is very important to keep breathing throughout each contraction;

let whatever sound needs to come out - come out. Remember this is your labour. Do what works for you and let others take care of themselves.
Focus on achieving as much relaxation as possible. Think about yielding to and releasing the pain**.** Do not worry if you are not totally relaxed during the peak of a contraction. Often moving and rocking during contractions can be helpful in moving through the contractions. Some women think of it as a labour dance.

Second Stage Breathing….

When the cervix is fully dilated you enter the second stage of labour. For many women this is a relief as they can take a more active role in their labour process. This second stage is the real work of labour and the most exciting. Some women begin pushing involuntarily, responding to an overwhelming urge, others will begin pushing after they are told they are ready.

Breathing for second stage follows a similar pattern to first stage. You need to adjust your breathing so you are working in harmony with the contractions and this will be the most effective way to push your baby out. Increased vocalization is common during second stage however, ensure that you are keeping your voice low and slow. Yelling or screaming is not effective and will waste your energy. Keep your chin toward your chest and resist the urge to arch away from the contraction.

Let the contraction build, take one or two greeting breaths, bear down strongly and slowly let your breath out. You may make a grunting sound – this is good. It is a natural sound with pushing. It often takes several contractions to get into the rhythm and work with the sensations. Let your bottom relax and open. Sometimes pushing on the toilet can be a really good place to let go.

Sometimes it is necessary to hold your breath for a few seconds as you are bearing down during second stage contractions. Your midwife will give you feedback about what is effective pushing. If too many people are telling you what to do, request that only one person directs you.

Crowning and Birth

As the baby descends the head will become visible and then slide back between contractions. This back and forth movement helps to stretch the perineal tissues. Finally, you will reach a point when the widest part of the baby's head is coming through the vaginal opening. This is referred to as crowning and you will feel a burning sensation in your perineal tissues. At this time it is important that you not push in an uncontrolled manner. Your midwife will tell you when to stop pushing. Instead, lessen the pressure by using short, panting or blowing breaths. Think of breathing your baby out slowly and gently.

Once the head is crowned your baby will turn its head and shoulders and will be born with the next contraction. This is usually an easier push. The placenta will follow soon after – requiring a gentle push to complete your birth.

DELIVERING THE PLACENTA

MANAGEMENT OF THIRD STAGE OF LABOUR

The third stage of labour is the period from the birth of the baby until delivery of the placenta. After the baby is born, contractions generally resume after a few minutes, but at a much lesser intensity. These contractions cause the placenta to peel away from the wall of the uterus and drop down into the bottom of your uterus. The placenta, with the membranes (of the empty bag of waters) attached, will pass down and out of your vagina, assisted by maternal effort. You may just feel the contraction rather than an urge to push. There is generally no discomfort felt while delivering the placenta. The uterine muscles then continue to contract to stop maternal blood loss once the placenta has delivered.

Your midwife will carefully examine the placenta and membranes to make sure that nothing has been left behind. She, or your nurse, will feel your tummy to check that your uterus is contracting hard in order to stop the bleeding from the site where the placenta was attached. You may like to have a look at this organ that has supported your baby throughout the pregnancy

Delivering the placenta usually takes from five to 15 minutes, but it can take up to an hour. It depends on whether you have a managed or expectant third stage.

Active or Physiological Management

There are two approaches to delivering the placenta and completing the third stage. These are active management and physiological or expectant management.

Active management of the third stage of labour consists of interventions designed to facilitate the delivery of the placenta. This means you will have an injection of oxytocin in your thigh within one minute of your baby being born. This causes the uterus to contract strongly and separate the placenta off the uterine wall within about three minutes. The umbilical cord can be clamped at any time, often after it has stopped pulsating. Once the uterus is contracted and the placenta is separated the midwife will instruct the mother to push and she will assist the delivery of the placenta by gentle traction. This procedure involves placing one hand against the lower abdomen and applying gentle, controlled traction to the umbilical cord with the other hand to guide the placenta out as the mother pushes. This process allows the placenta to be delivered fairly quickly although sometimes it may take a few contractions.

Physiological or Expectant management involves allowing the placenta to separate and deliver spontaneously. In essence it means waiting for oxytocin to be released through your body's own physiological processes and the placenta to be delivered naturally. The process occurs in the same way in that contractions squeeze the placenta off the wall of the uterus and expel it out through the vagina. This may take from a few minutes to up to an hour to happen. Skin-to-

skin contact and breastfeeding your baby will often help the uterus to start contracting. You need to actively help the delivery of the placenta by pushing and perhaps by changing position into a more upright or squatting position.

Discussion

The main concern if the process of the third stage does not work efficiently is hemorrhage (PPH). This may impact on the mother's health and well-being in the postpartum period. Several studies over the last ten years have shown that active management of the third stage of labour reduces blood loss after birth. There is some controversy regarding the studies comparing having a natural third stage with having active management, largely because there are several different inter-dependent components of these practices, and different women have different levels of risk. There are several trials currently in progress to try to produce more evidence about how the third stage of labour should be managed.

Despite any disagreement regarding the research, the current thinking in obstetrical care is that active management with informed consent should be routine practice. The implication for both obstetric and midwifery practice is that active management of third stage of labour has positive outcomes for women in terms of a reduction in the amount of blood loss in PPH, the need for blood transfusions and postpartum anemia. For the woman, postpartum well-being may be improved.

Advantages of choosing a managed (active) third stage

- Research shows that women having an actively managed third stage have a smaller amount of blood loss (6.8% chance of a significant blood loss compared with 16.5% if you do it physiologically).
- Labour is completed more quickly.
- If you are at risk of PPH because of your medical history or because of events during labour, research shows that it is safer for you to have an actively managed third stage.
- Some women like to have the placenta delivered so they can then focus on the baby, concentrate on breastfeeding and relaxing with their new baby.
- If suturing is required it is good to have the placenta delivered so this can be completed and the mother settled with the baby.

Considerations of choosing a managed third stage

- Some women have noted there may be a feeling of being rushed, focusing on the placental delivery soon after the birth.
- With some oxytocic medications there may be a higher risk of having a retained placenta, which may then need to be removed under anaesthetic.
- There can be a risk if there is an undiagnosed twin (although this is rare due to the extensive use of ultrasound scans in pregnancy).
- If the cord is clamped **early** the baby does not continue to receive blood through the cord. However, it is possible to delay cord clamping with a managed third stage, which

significantly increases the amount of the baby's blood volume and allows for some extra oxygen.

- There may be some risks with controlled cord traction such as snapping of the cord making it more difficult to deliver the placenta quickly, the risk of pulling out an incompletely separated placenta, and the very small risk of causing the uterus to invert, which may require surgery to reverse. However your midwives are very skilled and patient in delivering the placenta this way and do not pull excessively on the cord.

Advantages of choosing a physiological third stage

- Physiological management can be seen as the logical ending to a normal physiological labour (RCM 1997).
- There are no immediate time constraints to deliver the placenta so you can relax after your baby is born, being calm and quiet.
- Your baby will stay attached to you for longer, giving you some time to get to know each other without anyone taking your baby away from you for routine procedures.
- Your baby continues to receive extra blood volume and some oxygen through the pulsating cord for a while.

Considerations if you choose a physiological third stage

- Physiological management is only appropriate for women with low risk of post-partum hemorrhage and who have had a normal physiological labour.
- Understand that the natural process may not happen properly if your labour has involved medical interventions such as augmentation with oxytocin, induction, several doses of narcotics, an epidural, or a forceps or vacuum assisted delivery. In these circumstances it is generally safer to have a managed third stage.
- Be particularly aware if you are at risk of PPH, because of your medical history. It is recommended to have a managed third stage. Your midwife will act quickly if she thinks there is a risk of PPH after your baby has been born.
- If after some time (usually one hour) your placenta fails to separate or you are bleeding significantly you will need to be given drugs (uterotonics) to contract the uterus and deliver the placenta. In rare instances women need to have the placenta manually removed.

Discuss the options with your midwife, and make your wishes known.

THE POSTPARTUM PERIOD

The postpartum period is a time to rest, recover and get to know your baby. The most important tasks are to take care of yourself, establish breastfeeding and adjust to the changes in your family**. When we call to see how you are doing please ensure you call us back promptly if you do not answer your phone.**

Rest and Sleep

Make rest a priority. You will not get enough sleep at night so you must plan to nap at least once each day. Or, as the saying goes "sleep when the baby sleeps". A new mother often has very high energy and does not feel tired after a birth. This is because of all the hormones your body has released to provide you with enough energy for the hard work of childbirth. During the 24 – 48 hours following birth these hormones pass from your system and then you can feel very tired, and exceptionally so if you have not taken the time to rest. Remember sleep deprivation is cumulative and it may be several weeks if not months before you sleep longer than a four hour stretch. Do not expect one good stretch of sleep to shift things back to "normal". Normal has changed; your life, your routine, and the way you arranged your activities is different now. Arrange for help with meals, household chores and the care of other children. The more rest you get in the first weeks, the sooner you will be able to resume your normal routine. Limit the number of visitors and the time they spend visiting in the first week. You will be surprised how tiring a few visitors can be. Accept any offers and ask visitors for help, don't wait on them! Your job is to get to know and care for your baby.

Activities

Resumption of normal activity is mostly a matter of common sense. Work into activity slowly, stopping if you tire. Do not rush your postpartum recovery. Take at least ten days to nest and have a "babymoon". Moderate exercise, such as walking, is beneficial and a good way to begin.

Good nutrition and adequate fluids

These are essential to successful breastfeeding and a speedy recovery. Always have a glass of water beside you when you nurse. You will likely feel quite thirsty anyway. You need to drink about 1.5 - 2 litres of water per day and eat about 2000 calories. If you find it hard to get to meals, ask for help and ensure you have nutritious snacks, fruits and vegetables on hand.

Emotions

It is not unusual to feel tired, a little letdown or weepy a day or two after giving birth. This is mostly due to the hormonal shifts taking place not to mention a little sleep deprivation. Relax, have a quiet day, and let the feelings flow; they will likely pass within 24 hours. However, if you feel overwhelmed, depressed, or unable to cope, call your midwife right away.

POSTPARTUM CARE OF THE MOTHER

FLOW

Your Flow (Lochia) should be similar to a heavy menstrual period. It will be heaviest in the first 24 hours after giving birth, and will lessen over the next few days. Over the first few days it will change from bright red to browny-red, then over the next few weeks to pink, then yellow. Normal lochia may last from one to six weeks. Occasionally large clots are passed (size of an egg or even a small apple) in the first few postpartum days. If flow is normal and uterus is firm following, this is no cause for alarm. Check your uterus for firmness at least twice a day for the first few days. If your flow reappears, increases or becomes red again after the first week or so you are probably doing too much!

KEY POINTS

- **If you soak one pad completely in less than 20 minutes, page the midwife immediately, then**
- **Check the fundus to see if it is firm, if not, massage until it feels firm, like a grapefruit, and**
- **Check to see if you need to empty your bladder.**
- **Call the midwife if your flow develops a strong/bad odour and**
- **if your flow increases and continues at an increased rate, soaking whole pads call the midwife**

UTERUS

In the first few days after birth your uterus should feel firm, about the size of a grapefruit, with the fundus (top edge) at or below the level of your navel. It will shrink down (involute) about a finger breadth each day and by the end of the second week you will not be able to feel it from the outside by pressing on your abdomen. Most women who have given birth previously will experience "after pains," contractions of the involuting uterus, especially when the baby nurses. These afterpains usually do not last more than 2-3 days and often cease when the milk comes in.

KEY POINTS:

- **If your uterus feels tender or painful, call the midwife.**
- **Check your uterus for firmness and position; if it is high or off to one side - is your bladder full?**
- **Take Ibruprofen and or Tylenol Extra Strength or for after-pains.**

INFECTION PREVENTION

Infection prevention is important. Hand washing is important it is the best way to prevent transmission of bacteria. Do it often! Remind other family members or visitors to wash their hands before holding the baby. Report to us any rise in your temperature above 100 F or 37.8 C. Occasionally there is a temporary rise in temperature when the milk comes in but this should fall within 12 hours.

KEY POINTS:

- **Handwashing is the best way to prevent infection.**
- **If you feel unwell, take your temperature.**
- **If temperature is above 37.8 C (100 F), call the midwife.**

PERINEUM

Your perineum may be tender for a few days. Use your plastic peri bottle every time you go to the bathroom. Fill with warm water and spray over your perineum after urinating then just dab with toilet paper. In the initial days spray before you pass urine as well. If you have had stitches or have a small tear, take at least 1 sitz bath a day. Make time for this! Soak in a clean tub filled with several inches of warm water, or use a portable sitz bath. You may add calendula or comfrey tinctures to this bath, since these herbs are known to promote wound healing. Some women like to use Epsom Salts. After your sitz bath, expose your perineum to the air, lie down on a towel without a pad or underwear for half an hour or try a hand-held hair dryer on a warm setting for a few minutes. The normal healing process for stitches will progress from feeling tender to slightly itchy.

*In the initial week following the birth try to limit sitting to nursing and mealtimes. Sitting puts pressure on the perineum so at other times lie down and put your feet up. When you get out of bed or out of a car keep your knees together and move your legs as a unit. Also minimize the amount of stair climbing and do not sit cross-legged. If your perineum is aching, you have probably been on your feet too long at one time and need to rest.

KEY POINTS:

- **Remember to use the peri bottle all the time**
- **Open labia and spray all around**
- **Dab with toilet tissue, don't wipe**
- **Change pads frequently, especially in hot weather**
- **Expose your perineum to air twice a day if possible**
- **Sitz baths are available for the toilet, otherwise, use the bathtub**
- **Initially, in the first 24 hours, ice packs may help**
- **If you are on your feet or sitting too much, your perineum may become swollen and more tender.**
- **If your perineum becomes painful, call the midwife.**
- **Start Kegel exercises as soon as possible and do them often**

BOWELS & BLADDER

Urinating may sting for a couple of days even if you do not have stitches. Try pouring warm water over your pubis and perineum with the peri bottle prior to beginning to void. If you are unable to empty your bladder at any time, call us.

Bowel movements often do not resume until 2-3 days after birth. To help keep bowels moving and stools soft, eat plenty of high roughage foods such as raw fruits and vegetables and whole grains or a big raisin bran muffin!. Prune juice can be helpful. Drink 8-10 glasses of water each day. Witch Hazel is a good remedy for hemorrhoids. Soak gauze pads with it and apply directly to the affected area, under your sanitary pad. You can buy pre-moistened pads (Tucks) at the drugstore.

KEY POINTS:

- **If you cannot empty your bladder or if you have pain after urinating, call the midwife.**
- **Drink plenty of water.**
- **Increase Fibre in your diet or try a glass of prune juice each day.**
- **Witch Hazel compresses for hemorrhoids.**
- **If you haven't had a bowel movement after 3 days, ensure the midwife knows.**

BREASTS

Most nipple soreness is due to incorrect positioning of the baby at the breast. Take your time to get comfortable, ensure you have enough pillows, good back support, maybe a footstool. Ensure that the baby is well positioned with his/her cheek resting on the breast. Wait until baby turns to the nipple and baby's mouth is wide open so they can grasp the entire nipple and a good portion of the areola, especially at the bottom. Hold the baby close to your body, bring the baby to the breast and let the baby 'take the breast'. Don't be too directive and try to stuff the breast in the baby's mouth. Do not continue to nurse if the nipple feels "pinched".

Air-dry your nipples often and rub a little breast milk onto your nipples after each nursing. It is not necessary to wash your nipples with anything but warm water.

Check your breasts once a day to identify any tender areas or lumps.

Be sure to call us with any breastfeeding questions or problems. If you are having difficulties do not try to tough it out, we can likely make it easier. See breastfeeding handouts for more breastfeeding information.

KEY POINTS:

- **Take time to get in a good, comfortable position for nursing**
- **Be patient about getting a good latch, let baby "take the breast"**
- **Do not nurse with an uncomfortable latch, or on very sore nipples**
- **If you have a hot, red, tender area or a tender lump on your breast, call the midwife**
- **Call us early with breastfeeding difficulties**

POSTPARTUM INSTRUCTIONS

CARE OF THE BABY

Respirations

These should not be laboured, but may be irregular. Normal rate is 40-60 breaths per minute on the first day, 30-40 thereafter. A few random readings outside of these numbers is not a problem. At times a baby may have periods of rapid breathing; this is normal. Call if you see flaring of the baby's nostrils, grunting with breaths or any episodes when the baby turns blue. Remember that babies are mandatory nose breathers. If the baby is sucking well, he/she is probably having no difficulty breathing. In the first 24–36 hours the baby may sound congested, or have noisy breathing. If the baby's lungs are clear this is left over mucous, at the back of the throat and nose, not cleared out at the time of the birth and is not a problem. It usually sounds worse than it is and the baby will cough and sneeze it out over the next couple of days.

Temperature

Newborns have an inefficient heat regulating system. Overdressing can be as much a problem as under-dressing. If the baby's hands and feet are cool and the chest is warm, the baby is a good temperature. Normal newborn temperature, taken under the arm is 36.4 – 37.5 C. or 97.5 – 98.6 F

The Umbilical Cord

The cord clamp should remain on about 24 hours. We will remove it at the first or second postpartum visit. The cord does not need any particular care in the first few days, just let it dry and shrivel up. It is normal for it to become a dark colour. As it dries out and decomposes it may become sticky and a little smelly at the base. If necessary you may clean it occasionally with hydrogen peroxide. It will fall off in 5-7 days. Your midwife will check on it and advise you if anything else needs to be done. If there is substantial bleeding or redness on the skin of the abdomen around the base of the cord, call us.

Bowels and Bladder

Urine and stool should be passed within the first 24 hours after birth, though you should not expect very wet diapers until the baby is getting milk – usually by the third day. Thereafter the number of wet diapers usually corresponds to the number of days of life, e.g. 2 wet diapers on day 2, 3 wet diapers on day 3 and so on until day 6. Urine should be pale and odourless. Occasionally there will be salmon coloured deposits on the diaper. This is of no concern as these are urate crystals, which are normal during the first 2-3 days of life.

Baby's first bowel movement will be black and tar-like, it is called **meconium**. Oiling the baby's bottom with a natural oil when you change diapers will make the meconium easier to clean off the skin. After all the meconium is passed, normal breastmilk stool changes in colour to become brownish/greenish and then to mustard yellow. The consistency ranges from curd-like to very runny. Your baby should have 3-4 bowel movements per day during the first 6 weeks once your

milk is in, and 6-8 wet diapers per day. Babies over 6 weeks of age may pass less frequent bowel movements and this is normal.

Feeding

Feed your baby on demand! The more frequently your baby sucks, the sooner your milk will come in and the less likely that you will become uncomfortably engorged. It is normal for breastfed newborns to sometimes nurse every hour and a half to two hours, or they may nurse frequently in clusters. It is also normal for them to not nurse for up to 4 hours during a 24 hour period. If your baby has been nursing regularly and then stops, or, if your baby becomes disinterested in nursing or hard to wake for feedings, **call your midwife**. Generally, your baby should nurse at least 8 times, for about 20 minutes, in a 24 hour period.

In the first few days while they are getting colostrum, offer both breasts to the baby at each feed, even 2-3 times a feed. The purpose of this is to stimulate milk production. After your milk comes in many babies will be satisfied with one breast per feed. Let your baby nurse for as long as they like on one breast, until they stop sucking or doze off. If the baby seems unsatisfied offer the second breast, some babies want a little "top up". Remember there is a wide variation in breastfeeding patterns, each baby will develop their own over time. Your midwife is available to help you get well established with breastfeeding. Do not hesitate to call with any difficulties.

Jaundice

One of the things we will be checking on during the home visits following birth is the baby's colour. Some babies become slightly yellow a day or two after birth and this colour recedes on its own after a few days. This is called "physiologic jaundice" and is normal. Babies are born with extra hemoglobin that is thought to provide extra oxygen for the birth process. After the birth these extra red blood cells need to be broken down and eliminated. The accumulation or slow elimination of the by-product of broken down red blood cells, called bilirubin, is what causes jaundice. Early frequent breastfeeding stimulates digestive peristalsis and promotes the elimination of bilirubin in meconium. It is important to continue to breastfeed and not to offer any glucose water or plain water to your baby. Glucose water may interfere with the elimination of bilirubin that in turn may prolong the jaundice. In a few babies this jaundice becomes extreme and requires treatment. If we are concerned with the baby's colour we will order a bilirubin level. This is a blood test and involves a heel prick on the baby.

"Sticky eyes"

Babies will often have a whitish/yellowish discharge from their eyes n the first few weeks after birth. This is usually a blocked tear duct and not an infection. Treatment is massage and wiping the discharge with warm water or a black tea solution. See the section on Newborn Eye Treatment.

POSTPARTUM CARE OF THE BABY

KEY POINTS:

Call the midwife:

Respirations:

they seem laboured, the nostrils flare,
they are fast, > 60 breaths per minute
the baby is grunting with each breath,
the baby is blue around the mouth

Temperature:

the baby is appropriately dressed and
the temp is < 36.4 or > 37.8

Umbilical Cord:

there is substantial bleeding
there is redness or swelling at the base

Feeding:

the baby who has been feeding well, stops
the baby is hard to wake for feeds and is sleepy
the baby does not suck well
do not give formula without consulting with the midwife

Elimination:

the baby does not void within the first 24 hours
the baby has been voiding then stops
the baby does not pass meconium in the first 24 hours
any other unusual occurrence with bowel movements

Colour and skin:

the baby develops a yellow colour within the first 24 hours
the baby who is slightly jaundiced becomes very yellow
the baby develops any rash within the first few days

This list is a guideline only – if you have any other concerns regarding your baby's well being do not hesitate to call.

"WHAT CAN I DO TO HELP A MOTHER BREASTFEED?"

Suggestions for Family Members and Friends

Feeding is not the only form of loving attention young babies need and understand. Love and comfort can come from others besides mother. Attention from others helps baby learn that people have different smells, sounds, shapes, and sizes.

- Support her decision (even if you have personal doubts about breastfeeding).
- Allow the new mother privacy when breastfeeding if she wants it.
- Do not question her milk supply. There is no surer way to make a new mother doubt her natural ability. She will have enough milk if she feeds the baby frequently because milk is produced on a supply and demand principle. The more she breastfeeds, the more milk she will make.
- Do not question how often she feeds the new baby. Breastmilk is absorbed more quickly and completely than artificial milk. Breastfed babies can have empty tummies in 90 minutes. Breastfed babies often "cluster feed" where they will nurse frequently for a few hours then settle to a longer sleep.
- Support the new father by encouraging him to find ways other than feeding to get to know his baby. Changing, bathing, holding, rocking, talking or singing to the baby can help the two become bonded.
- Increase your understanding of breastfeeding by reading or watching videos and share useful tips with her.
- Cook the mother a nutritious meal.
- Relieve her for a few hours by caring for her older children.
- Do the laundry, cleaning, grocery shopping, or other housework.
- Hold, cuddle, rock, walk, bathe, change, and play with baby. Give the new mother an opportunity to rest.
- Be understanding – taking care of a baby is time-consuming. She may not be able to spend as much time with you as she used to, but your support/friendship counts nonetheless.

RECOMMENDATIONS FOR BREASTFEEDING

Points for achieving a good latch

MOTHER'S POSTURE

- Sit comfortably with a well-supported back
- Trunk facing forwards, lap flat

BABY'S POSITION BEFORE FEED BEGINS

- Using a soft pillow can be helpful, manufactured nursing pillows are often the wrong shape and size – talk to your midwife
- Nipple points to the baby's upper lip or nostril
- Breast may be resting on baby's cheek

BABY'S BODY

- Placed tummy to tummy at a slight diagonal, so that the baby comes up to the breast from below and baby's eyes make contact with mother's
- Keep baby close to your body

SUPPORT BREAST

- If you have large, soft breasts you may need to make it easier for baby to latch
- Firm inner breast tissue by raising breast slightly with palm placed on chest wall with fingers and thumb either side of breast pointing up; like a U

HOLD BABY'S FACE CLOSE TO BREAST

- Head tilted back slightly, supporting the shoulders so chin and lower jaw make first contact (not nose)
- While mouth wide open, guide nipple into mouth if necessary
- Let baby take the nipple so baby's tongue draws in maximum amount of breast tissue

CAUTIONS – MOTHER NEEDS TO AVOID

- pushing her breast across her body or chasing the baby with her breast
- holding breast with scissor grip
- not supporting breast
- twisting her body towards the baby instead of slightly away
- aiming nipple toward center of mouth
- pulling the baby's chin down to open mouth
- flexing baby's head when bringing to breast (use instinctive position)
- moving breast into baby's mouth instead of bringing baby to breast
- moving baby onto breast without a proper gape (wide open mouth)

- holding breast away from baby's nose (not usually necessary as when the baby is properly latched, they can breathe).

Breast Engorgement

Engorgement usually begins on the third to fifth day after delivery. It can also occur when feedings are missed or weaning occurs too abruptly. Engorgement should be treated quickly to prevent feeding problems such as sore nipples, plugged ducts or mastitis. If treated promptly, engorgement should decrease within 12 to 48 hours. *Please call your midwife if you have a lump or tender spot in the breast that is accompanied by fever.*

What to Do:

- Apply warm compresses or have a warm breast soak for five to ten minutes before feeding and as necessary for comfort.
- Hand express or pump a little to help relieve pressure. This will not bring in more milk.
- Wear a comfortable (not too tight bra) for support.
- A warm shower or a gentle hand held shower spray can be helpful.
- Massage breasts and hand express to soften nipple and surrounding breast tissue before nursing. Also, continue to massage breasts gently while feeding or pumping.
- Allow baby to nurse frequently, every 2 to 3 hours, and more often if he wants.
- Baby should nurse effectively on one side, for at least 15 to 20 minutes, and go on to the other side if she/he desires.
- If baby nurses on only one side, allow the other side to flow freely. If the breast is still uncomfortable, hand express or pump until softer and more comfortable.
- After nursing, apply fresh, cool (from the fridge), green cabbage leaves around breasts inside bra. Cut out the thick core in the middle of the leaf and apply directly. Change as necessary (approximately every two hours or after feeds) so they are always crisp and cool. Use for 12 to 24 hours.
- Ice packs or cool compresses can be alternated with heat. Use a small bag of frozen peas or a place a clean wet disposable diaper in the freezer until cold.
- Don’t avoid drinking fluids as it doesn’t reduce engorgement. Drink to thirst.
- Avoid giving your baby bottles.

SIGNS THAT YOUR BABY IS BREASTFEEDING WELL IN THE FIRST 3 WEEKS

By 4 or 5 days of age, your baby:

- Has at least 4 –5 wet diapers (looks or feels wet) in twenty-four hours (pale and odourless urine).
- Has at least 2 – 3 bowel movements in twenty-four hours (colour progressing from brownish to seedy mustard yellow and at least the size of a loonie).
- Breastfeeds at least eight times in twenty-four hours.
- Is waking to feed on own
- Is content after most feedings.
- Weight loss is less than 10% of birth weight

If any one of these signs is *not* present after your baby is 3 or 4 days old, or if you are having problems, *please call your midwife.*

Other signs that suggest your baby is breastfeeding well are:

- You can hear your baby swallowing during feeding.
- Your breasts are full before feedings and soft after feedings.
- Your baby is only drinking breast milk.
- Baby has regained birth weight by 2 weeks of age
- Average weight gain is about 6 ounces (170 grams per week)
- Baby's skin is soft and moist and baby's mouth is moist and pink

Sore Nipple Management: Prevention

Breastfeeding is meant to be a comfortable, pleasant experience. Most of us have heard stories of sore, tender nipples. You can avoid this problem most of the time however many new mothers may find their nipples are tender for the first few days when the baby starts nursing. This usually disappears by 1 – 2 weeks.
To prevent nipple tenderness, start with correct positioning and ensure a correct latch.

Breastfeed for appropriate length and frequency:

Demand feeding usually works out to baby nursing every 2 - 3 hours (8 – 12 feedings per 24 hours). Before the milk comes in offer both breasts at each feed, for 10 minutes each side, repeat each side as baby wants. A maximum of 20 minutes each side is plenty for each feed. After the milk comes in baby may be satisfied with 20 minutes on one breast. Allow your baby to end the feed.

Release the suction before removing baby from the breast: Do this by placing a clean finger in the side of your baby's mouth between his jaws. Don't take him/her off the breast until you feel the suction break.

Identify sucking behaviour:

Ensure baby is "sucking for food" (nutritive sucking) and not "sucking for love". Babies love to suck – they are in "bubby heaven" and if they have a strong need to suck you may need to use a clean pinky finger (pad to the roof of baby's mouth) or a soother).

Vary nursing positions: as needed for comfort. We do not routinely recommend the use of nursing pillows as they may not put Mom and Baby in the best position for a correct latch.

Care of nipples:

Before and after nursing your baby, express a little breastmilk and massage it into your nipples and areola. Leave nipples open to the air regularly.

- **Lanolin cream** (such as Lansinoh) may be helpful.
- **All purpose Nipple Cream** is a compounded nipple cream for damaged nipples that can be prescribed by your midwife.
- **Breast pads:** change breast pads frequently especially when they become wet.
- **Water and a gentle, pure soap** is all that is needed to clean your breasts when you shower or bathe.

Sore Nipple Management: Treatment

If your nipples become sore:

1. First try to determine the cause – good position, correct latch. If you are not sure ask for help.
2. Use deep breathing, soft music or other relaxation techniques before and during breastfeeding.
3. Ensure you are in a comfortable position, shoulders relaxed, back supported.
4. Expressing a little milk by hand or pump helps to stimulate let down and make the areola softer, nipple more erect and latch-on easier.
5. Nurse on the least sore side first.
6. Limit the nursing time on the sore nipple for a short period. Express by hand or pump to empty the breast. Discuss this with your midwife.
7. Massage your breasts while nursing. This helps stimulate the milk to flow.
8. Use non-plastic lined bras and/or bra pads. Change the pads frequently to keep the nipple dry.
9. If your nipples become cracked or bleeding, call your midwife.
10. The following remedies are known to be helpful in healing sore nipples.

    - Black tea bags – soak the tea bags with hot water and apply warm tea bags to sore nipples. Leave on till next feed. Repeat as necessary.
    - All purpose nipple ointment – ask your midwife
    - Carrot poultice – grate raw carrot and place on a piece of cotton gauze and apply directly to the affected nipple. Change every 2- 4 hours
    - Lanolin cream **(Lansinoh)**
    - Lemon – rub a cut lemon on the sore nipple four times a day. If the nipple is noticeably cracked it may sting, however women report it is momentary and healing is rapid. You may want to wait a day until the crack has started to resolve.
    - Calendula tincture – bathe nipples with ten drops of tincture diluted in warm water, four times a day.

11. Wear multiple holed breast shells for sore nipples between feedings. This allows air to circulate and protects them from further rubbing by your bra.
12. There are some effective homeopathic remedies for sore nipples, ask your midwife.

Caution: blisters, cracking, bleeding and/or pain that continues during or in between feedings is not normal. Check with your midwife or a lactation consultant if you have any of these problems.

Treating a Blocked Duct

When there is a decreased flow of milk from one area of the breast, it can cause milk to build up in a milk duct. This causes a stasis of the milk solids which blocks further milk flow. A blocked milk duct is usually sore and swollen and is usually felt as a lump under the skin. It may come on gradually. Sometimes a small white blister or plug may be seen on the tip of the nipple. Some mothers feel a shooting pain in the breast to the nipple. A plugged duct must be treated IMMEDIATELY to avoid a breast infection. If treated aggressively, it will clear quickly.

What to Do:

- Apply hot compresses to the area. Use a hot facecloth/towel, or pour hot water into a disposable newborn diaper and wring out the excess. This hot compress can be re-heated in the microwave. Be careful it is not too hot.
- Stand in a hot shower and hand express to promote drainage.
- Massage the breast firmly using warm oil, from behind the lump toward the nipple area with the fingertips and then the flat of the hand.
- Encourage the baby to nurse longer and more frequently, particularly on the affected breast.
- Change the baby's nursing position to encourage proper drainage. Check for proper positioning and any finger pressure on milk ducts.
- Support breast from underneath if heavy.
- Avoid tight or restricting clothing. Check that your bra is fitting properly.
- A raw potato poultice will draw out the heat of inflammation, localize the infection and unblock plugged ducts. Apply directly to the affected area, cover with a clean cloth and change when dry.
- There are some effective homeopathic remedies for plugged ducts.
- Call your midwife if the lump persists.

If you start feeling unwell, develop a fever, the lump feels hot to touch, or you notice red streaks on the breast please call your midwife immediately.

Reference: Breastfeeding Guidelines for Health Care Providers. Canadian Institute of Child Health, 1993.

Increasing Your Milk Supply

To make enough milk, you need breast stimulation, rest, minimal stress and proper nutrition. Most women have a plentiful milk supply. Very few women are unable to produce enough milk for their babies.

1. Nurse baby frequently and on demand. Approximately every 2 to 3 hours during the day and every 4 to 5 hours at night, but more often if baby wants. Babies may cluster feed, especially in the evening (e.g nurses every 20min to 1 ½ hours – maybe 4 -5 times within a 3 hour period).

2. Completely empty at least one breast at a feeding.

3. Avoid using bottles.

4. Make sure you get adequate rest, try to sleep when baby does.

5. Nurse in bed at night.

6. Drink at least one to two litres of water per day as well as juices, herbal teas or low-sodium, caffeine-free and sugar-free drinks. Drink enough to keep urine pale in colour and not strong smelling. One to two cups of tea or coffee is fine.

7. Ensure adequate nutrition. Eat when hungry. Make sure you snack during the day and possibly at night, and don't go for long periods without eating.

8. There are some homeopathic and herbal remedies that are effective in increasing your milk supply. Talk to your midwife. Fennel tea, fenugreek and blessed thistle capsules or tinctures are known to be very helpful.

9. Hand express or use pump for about 5 to 10 minutes per side after each feeding.

10. Try to avoid things that cause you stress and where possible resolve stressful situations present in your life.

11. Avoid large amounts of caffeine or nicotine.

12. Avoid feeding infant solid foods until at least 6 months.

13. Don't be afraid to ask for help. Join a support group to see other's ideas, (e.g., Mom's Groups at Public Health Units, La Leche League, Facebook page in your community).