VIRGINIA PEDIATRIC AND ADOLESCENT CENTER

Fostering the growth, health, and happiness of your children

Postpartum and Newborn Care

The information given in this handout is evidence-based and pertains to postpartum and newborn care for expecting parents and caregivers.

The hand-out should provide you with a thorough understanding of the proper care for infants age 0-3 months of age. It is meant as a guide to new parents and caregivers, but is not meant to replace the guidance and information gained at regularly scheduled well visits and the ongoing care that we provide to your child.

About our Practice

The providers of Virginia Pediatric and Adolescent Center have been caring for the children of Northern Virginia through multiple generations since the practice opened in 1963. Our goal is to foster the growth, health, and happiness of your child. We care for children from infancy through college, and we take pride in treating them with compassion in a non-hurried and nurturing environment.

We care for the whole child--meaning that we give both illness-related and preventative care--while tending to the physical, emotional and social developmental needs of each child in the context of self, family, and the broader community.

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Section 1 – The First Days Home with Your Baby

In this section we will discuss the most common newborn care issues new parents face when transitioning from hospital to home with your baby.

NEWBORN ASSESMENT – Meet the Baby!

The head-to-toe physical assessment allows caregivers to identify normal newborn appearance versus when a problem may present.

Appearance of the Fontanel

The fontanel is commonly known as the “soft spot” on the baby’s head and is comprised of membranes connecting the cranial bones. There are 2 fontanels, the anterior (front of the head) and the posterior (toward the back of the head). Typically, the posterior fontanel closes by 4 months of age and the anterior fontanel closes anywhere between 9 and 18 months of age.

Normal appearance and feel of the fontanel are flat and firm, and you may observe it pulsating.

Abnormal appearance of a fontanel indicates rare but serious issues. The pediatrician must be called when either of the following present:

- convex or “caved in” fontanel: This is a sign of dehydration
- bulging or “swollen” fontanel: This is a sign of one of the following:
    1. head trauma
    2. excessive fluid build-up around the brain
    3. infection of inflammation in the brain (encephalitis)

**It is normal for the fontanel to be temporarily bulging due to crying or forceful spitting up but should go back to a normal firm appearance when your baby is calm.*

Your Baby’s Nose, Mouth and Breathing

Because newborns nasal passages are narrow, small amounts of nasal fluid or mucus can cause them to breathe noisily or sound congested even when they don't have a cold. A bulb syringe may be used to help clear the nasal passages if necessary.

Sneezing is also common in newborns and doesn’t indicate illness or allergies.

Your baby’s mouth will be pinkish, indicating good breathing. You may observe whitish-yellow cysts on the gums and roof of the mouth. These are called “Epstein Pearls” and are present in 80% of newborns as a result of a baby’s normal growth. They are harmless, painless to babies, and resolve on their own.

If parents are concerned about Epstein Pearls, they should consult their pediatrician.

Newborn Breathing Patterns: What's normal?
While all adults and children alike have variable breathing patterns, it is easy for parents to focus on the variations in their newborns breathing and wonder what is normal and what is not. Here are some things that are normal with regard to baby breathing patterns:

40-60 breaths per minute
Assess a newborn's breathing by looking at their abdomen. An infant's abdomen rises and falls with each breath. The normal rate is 40-60 breaths per minute (bpm) in the healthy, full-term infant (counted for a full minute), and bpm will vary depending on whether she or he is sleeping, awake, active, or crying.

Apnea
A baby born preterm, or before 37 weeks gestation, is at risk for apnea. Apnea is a pause in breathing for more than 20 seconds. For any parent, this is a very long time! The good news is that pauses that are 5-10 seconds long are completely normal. These short pauses, or "periodic breathing", are commonly seen in preterm infants. Pauses in breathing for 20 seconds or greater require stimulation to resume breathing such as rubbing his or her back, arms, or legs. If this occurs, you should contact your pediatrician immediately. If your baby is prone to apnea before leaving the hospital, the hospital will monitor this closely and may prescribe an apnea monitor upon leaving the hospital to indicate if baby ever needs stimulation.

Skin Color
Another good indication that your baby is breathing well is his or her skin color.

*Pink skin = GOOD perfusion of tissues = good breathing.
*Blue hands, feet, and around the mouth are actually normal in newborn babies too. This is called acrocyanosis and is often seen the first few days of life while newborns transition to life outside the womb.
*Blue INSIDE the mouth is not normal and suggests that baby is not breathing well. 911 should be called immediately if this occurs at home.

Breathing differences will usually resolve on their own as your baby's brain and spinal cord mature and muscle tone strengthens. A caregiver can help your baby breathe best by laying your baby on his or her back on a firm, flat crib or bassinet to ensure that the airway is open.
For further reading, visit: KidsHealth.org (https://bit.ly/32caLDC)

UMBILICAL CORD CARE
The umbilical cord transmitted nutrients during pregnancy and is now a purplish-blue stump about ½ an inch to an inch long. It will take approximately 1-2 weeks before the stump dries up and falls off and needs care to avoid infection and irradiation.

Caring for the Umbilical Cord:

1. Keep the area clean. The AAP no longer recommends cleaning it with rubbing alcohol. Alcohol can irritate your baby's sensitive skin and delay the healing process.
2. Keep the area dry. Allow the area to be exposed to air as often as possible. This allows base of the cord to dry. Use newborn diapers that have a cut out for the umbilical cord or fold the baby's diaper down.
3. Only give sponge baths. Do not bathe your baby in a sink or tub until after the cord has fallen off. Do sponge baths only, avoiding the umbilical area. If the area accidentally gets wet, do not rub the umbilical area dry. This can cause irritation.

4. Let the cord heal naturally. If cord is hanging on by a thread, just let it fall off by itself. Do not pick or pull the cord off.

Umbilical Cord Infections:

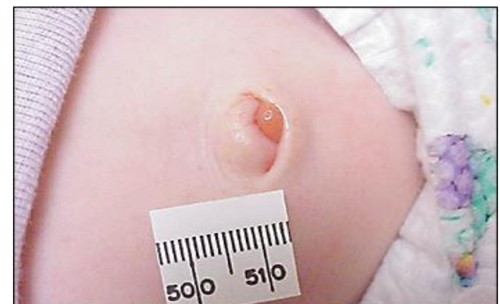
Umbilical cord infection is rare but it's helpful to know the symptoms which include:

- Red or swollen area around the base of the cord
- Continuous bleeding
- Yellow or white pus
- Foul smelling discharge
- Baby seems in pain

Signs of infection of the umbilical cord stump can result in *omphalitis*, a life-threatening infection of the umbilical cord. This is considered a serious condition and needs to be treated immediately. If there are any signs of infection, call a pediatrician right away.

Umbilical Granulomas:

An umbilical granuloma is a small nodule of firm pinkish-red tissue (similar to scar tissue) with persistent yellow-green drainage that is simply leftover scar tissue from umbilical cord removal. This is different than an infection because it is *not* accompanied by swelling, redness, warmth, tenderness, or a fever. This is most often treated by applying silver nitrate to the area, which cauterizes and dries the tissue. There are no nerve endings in the area, so it is not painful. Cauterization is simple and causes no lasting effects although it often discolors the surrounding skin for a couple of days.



While some babies and young children have "outie" belly buttons, almost all people beyond 10 years of age have "innies". Contrary to some popular belief, taping a coin or flat object over the navel does not change baby's natural form.

More sources: American Pregnancy Association: http://americanpregnancy.org/first-year-of-life/umbilical-cord/ *Umbilical Cord Care*, 07/2014 American Family Physician: http://www.aafp.org/afp/2005/0415/p1590.html, *A Newborn with An Umbilical Mass*

CIRCUMSCISION CARE

What is Circumcision?

Circumcision is the procedure in which the skin (foreskin) covering the end of the penis is removed. Parents may want their sons circumcised for religious, cultural or social reasons, and the American Academy of Pediatrics recognizes the medical benefits of circumcision. However, circumcision is not essential for a child's health, and parents should choose what is best for their child by weighing the benefits and risks. An infant must be in good health to be circumcised.

How to Care for a Circumcised Penis on a Newborn Baby?

- Use a gentle washcloth and warm water (not a baby wipe) to wipe away any bits of fecal matter at diaper changes.
- Sponge bathe only until your baby's penis is healed and his umbilical cord drops off.
- After diaper changes, squeeze petroleum jelly on the inside of clean diaper to prevent diaper from rubbing against circumcised penis until it appears well-healed. This is usually about 3-4 days, but can sometimes take as long as seven days.
- Some doctors also advise covering the area with a piece of gauze.

Problems and Infections with Circumcision (reasons to call your pediatrician):

- Your baby does not urinate within 6-8 hours after the procedure.
- Continuous bleeding or more than quarter-sized spot of blood on the diaper.
- Redness around the tip of the penis that gets worse after 3-5 days
- Yellow discharge that lasts more than a week. (Some discharge/ yellow oozing is normal.)
- Fever

NEWBORN BATHING

The American Academy of Pediatrics recommends sponge baths, rather than a tub bath until baby's umbilical cord stump falls off. There's no need to give a newborn a bath every day. In fact, bathing a baby more than several times a week can dry out skin.

Sponge Bathing

Supplies needed:

- 2 towels (preferably one that is hooded)
- Washcloth
- Basin of warm water
- Gentle baby soap/shampoo
- Diaper cream (optional)
- Clean diaper
- A warm place with a flat surface

Procedure for Giving Your Baby a Sponge Bath

1. Spread out towel (not the hooded one) over a soft surface such as a contoured changing pad. Note: Some infant bathtubs have hammock areas for sponge baths.
2. Fill a bowl with warm water and use the inside of wrist or elbow (not your hand) to test the water temperature. The water should be warm but not hot.
3. Undress your baby down to the diaper and lay your baby on his/her back on the toweled surface.
4. Be sure to **always keep one hand on the baby** throughout the whole sponge bath. Also, to keep the baby warm, expose only the parts you are cleaning, keeping the other parts wrapped in the towel.
5. Wet the washcloth and ring out any excess water.
6. Be sure to first use the washcloth to gently clean your baby's face, wiping away any crustiness around the eyes or dried milk around the mouth. Do not use any soap, no matter how gentle, on a newborn's face.
7. Use the washcloth to clean the outside of and behind the ears (do not clean inside the ears and do not stick cotton swabs or Q-tips into baby's ear canal.)
8. Re-wet the cloth to clean your baby's body except the diaper area. Be sure to gently clean inside folds and crevices. You may use a gentle baby soap/shampoo.
9. Remove the diaper and clean the diaper area by gently washing from front to back. If a baby boy has just been circumcised, unless there is stool on his penis, do not use soap or water on the area until it is completely healed.
10. Slip the washcloth underneath your baby to clean the backside.
11. Dry your baby completely with a hooded towel, apply diaper cream (if using,) and put on new diaper and clean clothes. Most newborns do not need lotion after a bath.

Infant Tub Bathing:

Supplies needed

- Infant bath tub
- Washcloth
- basin of warm water
- plastic cup (for rinsing hair)
- gentle baby soap/shampoo
- towel
- clean diaper
- diaper cream (optional
- change of clothes

Some parents choose freestanding infant bathtubs, and others may choose plastic basins or inflatable tubs that fit in the bathtub. Safety is the most important thing to remember. **Always keep one hand on the baby and never leave baby alone in the water.**

Procedure for Giving Your Baby a Tub Bath:

1. Using warm water, fill tub 2 to 3 inches.
2. Hold your baby securely in the water by supporting his or her head and torso with your arm and hand. Wrap your arm under baby's back and firmly under the armpit.
3. To keep your baby warm, use the cup to pour water over baby during the bath (still holding baby securely.)
4. First wash your baby's face, and then move to the body. Be sure to wash inside skin folds and genitals carefully.
5. When you clean your baby's back, lean him or her forward on your arm and continue to grasp baby under armpit.
6. If the baby's hair seems dirty or your baby has cradle cap (cradle cap will be explained more in the next session,) wash his or her hair.
7. Use a small amount of baby shampoo on your baby's scalp and rinse the shampoo with a damp washcloth or pouring water from the cup. Cup your hand across your baby's forehead so the soapsuds do not run on his or her face or eyes.
8. Dry your baby completely with hooded towel, diaper, and put on fresh clothes.

As babies get older, around 2 or 3 months, many parents wish to start a bedtime routine. A warm bath, followed by a change into cozy pajamas and a feeding can naturally induce sleep and can be a good anchor to the bedtime routine.

Video Demonstration: ***How to Give Your Newborn a Bath*** (https://www.youtube.com/watch?v=PLMiQoYCqpA&t=8s)

CRADLE CAP

What is Cradle Cap?

Cradle cap is a scaliness and redness on a baby's scalp. When this rash occurs on the scalp alone, it's known as cradle cap. But while it may start as scaling and redness of the scalp, it can also extend to the face and diaper area, too. When it does, pediatricians call it *seborrheic dermatitis* (because it occurs where there are the greatest number of oil-producing sebaceous glands). Seborrheic dermatitis is a noninfectious skin condition that's very common in infants, usually beginning in the first weeks of life and slowly disappearing over a period of weeks or months. It is rarely uncomfortable or itchy.

How is Cradle Cap Treated?

Cradle cap is not harmful and will typically go away on its own by your baby's first birthday. It can be treated though, by washing hair frequently with a mild baby shampoo and then using a soft brush to remove the scales. Some doctors recommend a stronger, medicated shampoo or cortisone cream. These may remove the scales quickly but can be irritating to most baby's sensitive skin. Only use them after consulting a pediatrician.
The AAP does not recommend using baby oil or mineral oil on cradle cap. Doing so allows the scales to build up on the scalp, particularly over the fontanel, or soft spot on a baby's head.

Sometimes a yeast infection may form on the crease areas of the skin. If this happens, the area will be red and itchy. Seek the care of a pediatrician who may prescribe an anti-yeast cream.

JAUNDICE

Jaundice presents as a yellowish tone to newborn's skin and sometimes whites of their eyes. This yellow pigment is a sign that your baby's liver is still immature and is common. While most jaundice

is mild and resolves on its own, some newborns may need treatment in a hospital before being discharged.

For newborns with mild jaundice, pediatricians may recommend and increase in the frequency of feeding. Increased feeding simply allows baby to increase bowel movements and urine, eliminating the yellowish pigment, called "bilirubin."

USING A BULB SYRINGE TO CLEAR YOUR BABY'S NOSE

Bulb syringes are helpful devices that allow you to remove mucus from your baby's nose if he or she is congested. Congested noses can make it hard for babies to breathe, eat, sleep and stay comfortable.

How to Properly Use a Bulb Syringe:

1. Wash your hands. Wet your hands with warm running water. Apply soap and lather for at least 20 seconds. Rinse your hands under clean, running water. Dry your hands using a clean towel, or air dry them.
2. Squeeze the air out of the bulb. Before putting the bulb syringe in your baby's nostril, squeeze all of the air out of the bulb. While keeping the bulb squeezed, gently place the tip of the syringe into your baby's nostril. Be sure not to not push the syringe in too far.
3. Release the bulb. Once the syringe is in the nostril, slowly release your thumb to let the air come back in the bulb. The suction will pull the mucus out of your baby's nose and into the bulb.
4. Squeeze the mucus out of the bulb. To discard the mucus from the bulb, squeeze the bulb onto a tissue or into the sink until all the mucus is removed.
5. Repeat as needed
6. Wipe baby's nose
7. Wash and rinse the bulb dropper using warm soapy water and let it air dry on a clean towel.
8. Wash your hands again.

Video Demonstration (Hyperlink): *How to Use a Bulb Syringe*

SECTION 2 – Feeding

This section provides common feeding issues and solutions and then an in-depth discussion of breastfeeding and bottle feeding.

How Often Should a Newborn Baby Eat?

Newborns need to eat every 2 to 3 hours. For breast fed newborns, this could mean putting a baby to breast ten to twelve times per day in the first weeks, following the baby's lead when he or she shows signs of hunger. The more a mom nurses in the first two weeks, the more plentiful her milk supply will become and the more spaced out the feeds will naturally become in the following weeks.

For formula fed and bottle-fed babies, the same recommendation of on-demand feeding applies in the early weeks. Because nipples on baby bottles may flow faster than the breast, slow feeding and stopping to burp often is recommended. Your baby may inadvertently get overfed, causing gastric discomfort or spitting up.

Your baby's stomach is the size of a cherry and then an apricot ball the first 7-10 days after birth, so while instinct may be to feed baby large amounts, smaller feeds are best for newborns.

There is no data to support the myth that large feeds will help "stretch a baby's stomach." Smaller more frequent feeds in your baby's first weeks allow him or her to be comfortable. For nursing moms, more frequent feedings stimulate breast milk production.

When does mother's milk come in?

Mom's milk will "come in" 2-5 days after baby's birth, typically in the evening hours. Until then, skin-to-skin contact is the best way to promote milk production. Small feeding sessions every two hours are the norm during this period. If the baby is crying inconsolably due to hunger, temporary supplementation with a bottle should be given.

Is my baby eating enough?

A baby who is getting enough milk will have 4 to 6 wet diapers a day by the fourth day after birth. After that, your baby will have around 8-10 wet or soiled diapers a day, but 12-15 is normal too, especially for a breastfed baby. If your baby does not regularly produce wet or dirty diapers and shows signs of dehydration, such as dark yellow colored urine, the primary care physician should be notified immediately.

Should babies be woken up to feed?

The question of whether to wake a newborn to feed or allow a baby to sleep as long as her body allows is answered by your baby's pediatrician. The doctor may recommend waking your baby every 2-3 hours to feed to encourage weight gain and/or combat jaundice.

While jaundice is usually harmless for a baby discharged from the hospital and resolves on its own, pediatricians may recommend waking to baby to feed in order to correct jaundice. Increases in frequency of feedings allow babies to eliminate the yellowish pigment, called "bilirubin," through bowel movements and urine.

How should I wake my baby to feed:

To wake a baby, first loosen swaddle and clothes. If your baby is still sleepy, undress him or her down to just the undershirt. Changing the diaper can also help wake your baby to feed.

Nurse's Tip: Shining a light on your baby will not wake him or her. In fact, it encourages newborns to close their eyes!

How long can breast milk sit out?

According to the Center for Disease Control (CDC), a covered container of human breast milk can sit out at room temperature for six hours if unused, although we usually recommend 4 hours to be on the safe side. It is best to store breast milk in the refrigerator and not to re-heat it once it has been warmed. For more information, please check the Proper Storage and Handling of Human Milk article on the CDC website. www.cdc.gov

How long can formula sit out?

After formula has been prepared, it can sit at room temperature for up to 1 hour. Once your baby has fed from a bottle, discard the remaining unused formula. Remember: when in doubt throw it out. *(See safe formula preparation guideline by World Health Organization later in this section.)*

How do I warm a bottle?

When warming a bottle containing breast milk or formula, use a bottle warmer, or heat water in a pot, and place bottle in that hot water for 30 seconds to 1 minute, or until milk is warm but not hot.

Never microwave a bottle! Microwaving does not evenly warm a bottle leaving hot spots in the milk that can burn baby.

BREASTFEEDING NEWBORNS
Please see the free publication ***Breastfeeding Instruction and Support*** *at* *Women's Health.gov.*

Link: http://www.womenshealth.gov/publications/our-publications/breastfeeding-guide/breastfeedingguide-general-english.pdf

Of specific note:
- How Breastmilk is Made: Page 8 & 9
- Learning to Breastfeed: Pages 13-17 (includes positions, latches, feeding frequencies)
- Common Challenges: Pages 18-24

Videos and Resources for Further Study:

Breastfeeding Help Videos by the International Breastfeeding Centre
Link: https://ibconline.ca/breastfeeding-videos-english/

How Much Should I Breastfeed My Baby? by Let Mommy Sleep:
Link: https://bit.ly/2Nf2TwR

"Starting Out Right," by the Int'l Breastfeeding Centre
Link: https://ibconline.ca/information-sheets/breastfeeding-starting-out-right/

Common Concerns and Solutions, by KellyMom **Link:** https://kellymom.com/category/bf/concerns
BOTTLE FEEDING BABIES
How to Hold a Baby for a Bottle Feeding:

During feedings always hold your baby, and never prop your baby with a bottle. This will decrease the risk of choking and ear infections. Hold the baby's head slightly higher than his/her body and place your baby at about a 45-degree angle, with the head and neck aligned. Hold the bottle at an angle and make sure the milk is always filling the nipple so your baby will swallow less air. The caregiver should burp the baby after every ounce during the feeding and at the end of feeding.

How Much Should You Feed a Bottle Fed Baby:
The first thing to be aware of before feeding are your baby's signs of hunger. Hunger cues include: opening mouth, lip smacking, turning head side to side "searching" for breast, hand-to-mouth, rooting, and increased alertness. Crying is a late sign of hunger, so it is important to try to pick up on the early cues before your baby starts crying.

Bottle-fed babies need to eat every 2-3 hours during the day and every 3-4 hours overnight. This is just ***a general guideline*** however; a baby's hunger cues are the most important indicator of whether or not to feed.

Week 1: give approximately 25- 45mls per feeding session, observing baby to see which amount is appropriate.
Week 2: baby will be typically be taking about 1-2 oz.
Week 3: baby will typically drink about 2-3 oz.
Week 4: approximately 3 oz, possibly 4. From week 4 on, many babies plateau at 4oz for a while, until around 3-4 months.

Video Demonstration: Proper Bottle Feeding
Link: https://bit.ly/34wQNVo

World Health Organization (WHO)'s Safe Formula and Bottle Preparation Guidelines
Infant formula is not sterile and can carry harmful bacteria. Here is how to prepare a bottle feed properly and safely according to WHO guidelines*:

Step 1: Clean & disinfect the surface on which you prepare the feedings.
Step 2: Wash your hands with soap and warm water and dry with a clean or disposable cloth.
Step 3: Boil some safe water. If using an automatic kettle, wait until the kettle switches off. If using a pan to boil water, make sure the water comes to a rolling boil.
Step 4: Read the instructions on the formula's packaging to find out how much water and how much powder you need.
Step 5: Taking care to avoid scalds, pour the correct amount of boiled water into a cleaned and sterilized feeding bottle. The water should be no cooler than 70o degrees C, so do not leave it for more than 30 minutes after boiling.
Step 6: Add the exact amount of formula to the water in the bottle.
Step 7: Mix thoroughly by gently shaking or swirling the bottle.
Step 8: Immediately cool to feeding temperature by holding the bottle under cold running tap water, or by placing in a container of cold or iced water. So that you do not contaminate the feed, make sure that the level of the cooling water is below the lid of the bottle.
Step 9: Dry the outside of the bottle with a clean or disposable cloth.
Step 10: Check the temperature of the feed by dripping a little onto the inside of your wrist. It should feel lukewarm, not hot. If it still feels hot, cool some more before feeding.
Step 11: Feed infant
Step 12: Throw away any feed that has not been consumed within one hour.

*If you are using well water, you should follow the WHO recommendations above. These guidelines are written by the WHO to safeguard against disease in all possible situations. However, in Northern Virginia, when using safe drinking water sources from either the tap or bottled water, the boiling of water is not generally felt to be necessary by the providers at Virginia Pediatric and Adolescent Center

Formula Usage and Storage:
Follow the formula package guidelines for usage guidelines on how long formula may sit out. It is safest to prepare a fresh feed each time one is needed, and to consume immediately. If you need to prepare feeds in advance for use later, they should be prepared in individual bottles, cooled quickly and placed in the refrigerator. Throw away any refrigerated feed that has not been used within 24 hours.

Offering a Bottle to a Breastfed Baby:
The following tips can help when attempting to offer a baby a bottle for the first time:

- Offer the baby a small amount of food when the baby is not too hungry and perhaps a little sleepy.
- Let someone other than mom feed the baby in a location that is not the normal nursing spot for mom and baby.
- Since the baby associates food with mom, sometimes it is best for mom to leave the house.
- Tickle the baby's lips with the nipple of the bottle to get the baby to open his mouth wide. Let him or her take the lead in drawing the nipple into the mouth.
- Hold your baby in an upright position with the bottle at a horizontal position to the mouth. This will mimic breastfeeding and allow him or her to eat at own pace without overfeeding.
- Once the baby starts drifting off and letting go of the nipple, cease feeding the baby. Follow the baby's cues and be finished when he or she is done; do not force the last bit of milk into the baby by jiggling the nipple or waking the baby.

Burping your baby:
Newborns have an immature digestive system and need help to expel air when eating. Babies naturally take in a bit of air when feeding so burping a baby every few minutes throughout feedings and afterwards eliminates the discomfort caused by air taking up space in the belly.

Babies should be burped at least halfway through feedings and upon finishing a bottle. If breastfed, a a baby should be burped in between sides. Some babies may need it more frequently: if your baby is fussing or squirming while feeding, try burping him or her. Make sure you have a burp cloth on hand because some babies spit up when burped.

Seated Burping Position:
There are several burping positions, but the seated burping position is most often instructed in hospitals. This position makes it easier to see your baby in case of distress, and it works well to eliminate extra gas.

1. When it is time to burp your baby, sit its legs on your lap in a seated position, while making sure to support its head and chest with one hand, the other hand on his or her back.
2. Lean your baby forward so that you can pat his/her back with the other hand.
3. Make sure that the airway is clear by having your supporting hand is on your baby's chin & jaw, not the neck.
4. Set burp cloth on lap to catch any spit up.
5. Pat your baby's back with strong, firm pats.
6. Use rubs and pats to work out gas.

youtube.com/LetMommySleepUSA, How to Burp My Baby

Shoulder Burping Position:
Place the burp cloth over shoulder, lift baby up so their head is on shoulder. Then pat and rub your baby's back, being sure his/her airway is clear.

Putting Your Baby to Sleep After a Feeding:
Newborns will usually fall asleep after their feeding. Try to keep your newborn baby upright for at least 10-15 minutes after its feeding to help eliminate any spit up or gastric distress that may happen during the digestive process. Then, lay your baby flat on back in crib or bassinet to practice safe sleep.

REFLUX IN BABIES:
Gastroesophageal Reflux (GER) is a backward flow of the contents of the stomach into the esophagus. Some amount of this is normal in all newborn babies and infants. Reflux is one of the most common conditions newborns face and is caused by the esophageal sphincter valve not being fully developed. This causes milk to come back up the esophagus through the throat. Because it is often mixed with stomach acid, it sometimes can cause a burning sensation. When it is associated with pain and discomfort it is referred to as **Gastroesophageal Reflux Disease (GERD).** While reflux may present without spit up because the fluid is not coming all the way up the throat ("silent reflux"), a refluxing baby usually spits up or vomits.

Your baby's esophagus may become fully mature anytime within the first year, at which point reflux naturally resolves. Pediatricians may recommend the medications to soothe the burning sensation, but time is the only "cure" for reflux.

Here are Other Tips to Help Soothe a Refluxing Baby:
1. **Keep your baby's head elevated while feeding.** Gravity helps hold contents in the belly and

reduces the amount of spit up. Do not place your baby where he/she can easily slide down. This could put pressure on the belly and force contents up.

2. **Burp frequently during feeding.** This helps keep air out of the stomach. Air bubbles can force milk back up the esophagus, causing pain and discomfort.
3. **Have smaller and more frequent feedings.** When a baby is too full, it can put pressure on the sphincter valve forcing the baby to spit up. This can cause pain and also lead to choking.
4. **Fill the bottle nipple with fluid.** If your baby is bottle-fed, make sure the entire nipple on the bottle is filled with fluid to avoid swallowing excess air.
5. **Hold your baby upright after feeding.** Holding your baby upright for 30 minutes after feeding can help keep the contents of the stomach down.

TONGUE TIE IN BABIES

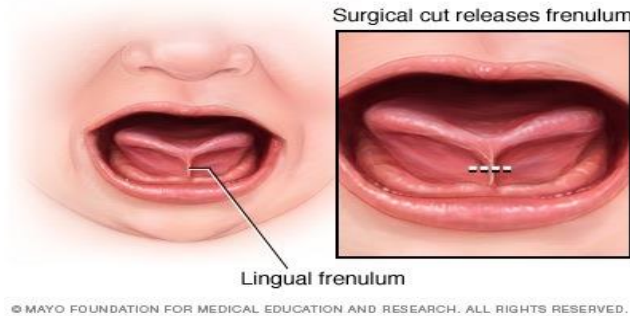
While there are four types of tongue-tie in babies, tongue-tie (being born with a slightly limited range of motion in the tongue) is *rarely* serious. And while tongue-tie is typically very easy to fix, it can lead to frustrating feeds because baby is not able to get a strong latch on breast or bottle.

Babies with tongue-tie are able to drink, but not as efficiently as they should. They are getting enough milk/formula to keep them interested in feeding but they often fall asleep before they're full because they are working so hard to get milk. Also, they may take in unnecessary air due to their limited latch, which causes them to have excess gas.

Posterior tongue-tie is the most common presentation of tongue-tie, and there are three quick ways to tell if a baby is tongue-tied. If any of the three below is present, notify your pediatric practitioner.

Ways to Tell if a Baby Has a Posterior Tongue Tie:

1. If the back of your baby's tongue goes up in a little hump when your pinky is offered, that is indicative of tongue-tie. For a proper latch, the baby's tongue will envelope your pinky, where the tongue wraps around the pinky.
2. For breastfeeding moms, examine the nipple. If a red circular spot is present on the nipple, it is indicative of your baby's tongue rubbing back and forth in that one area, and that can be an indication of a tongue tie.
3. If the frenulum under the tongue (the small band of tissue that attaches the tongue to the base of the mouth) prevents the tongue from extending forward without pulling on the tongue, your baby may have a tongue tie. **Remember that most normal tongues have a frenulum. It is a normal part of our anatomy. The presence of a frenulum does not in and of itself indicate a tongue tie. Tongue tie is a functional problem which prevents the proper movement and sucking motion of the tongue.**



SECTION 3 – Soothing Your Baby

In this section we will discuss how to comfort your baby, minimize fussiness and soothe him or her during those inevitable fussy periods, which are a normal part of development. There are many times when a baby is fed and the diaper is changed, but the baby is still crying. It is crucial to remain calm during these times. Following are techniques to soothe your baby.

Swaddling:
Swaddling means being snugly wrapped in a blanket from the bottom of the shoulders down to the feet. Sometimes called a “baby burrito” for its “wrap” look, the swaddle imitates how baby felt “wrapped up” and confined in the womb and is a comforting, familiar feeling to babies age 0-3 months.

Because newborn babies do not yet have control of their arms and legs, being swaddled also allows them to be calm.

Beyond the first 4-6 weeks, it is important when swaddling to only wrap the torso snugly but not the legs. While the legs are covered, wrapping the legs down too tightly can cause permanent hip problems**.**

There are many types of commercial swaddle blankets available. Some of the most popular and successful are:

- Aden and Anais (Muslin swaddle blanket)
- Ergo Baby Swaddler
- Miracle Blanket
- Halo Sleep Sack Swaddle

Demonstration of area on baby where the swaddle should be snugly wrapped, shoulders to bottom of torso.

Demonstrations of Swaddling:

Let Mommy Sleep: How to Swaddle a Baby Video showing 2 types of swaddles
Link: http://www.youtube.com/watch?v=Q4b_MD3e0zo&list=UUpNaTVLKwnBx14k1GSLyGBw
Baby Center: How to Swaddle a Baby
Link: http://www.babycenter.com/2_how-to-swaddle-a-baby_10347122.bc

How to Use the Halo Sleep Sack Swaddle:
Link: http://www.youtube.com/watch?v=A-zPnTFfhxU

"The 5 S's"
In addition to swaddling, there are 4 more "S" techniques that can also be used once baby is swaddled, "shushing," sucking, side-lying position and swaying.

"Shushing" White noise, the "*shhhhh*" sound, is a rhythmic monotonous whooshing sound that we assume reminds baby of being in utero. It can lull baby to sleep and even help baby stay asleep. Although there are many white noise machines on the market, some specifically marketed towards babies, there are free white noise apps available on smartphones. Caregivers can also go low-tech, making a gentle "shushing" sound near –but not into- baby's ear.

Sucking: Babies have a strong sucking reflex. Sucking either a finger or pacifier can calm a baby by making him/her feel secure. Pacifiers reduce the risk of SIDS in newborns, and it's okay (if doctor and parent permit) to let baby keep the pacifier in bed.

Side position: after baby is swaddled, holding baby so s/he is in a side lying position or on her stomach while in parent/caregiver's arms can calm baby. Hold the baby in arms in a side or tummy-down position or on lap on baby's belly. Newborns feel secure and content on their side or tummy, and while these are great positions for soothing, they are never acceptable for sleeping. **Due to safe sleeping practices and SIDS, never put baby on his/her side or stomach to sleep.** Once baby falls asleep, put him/her on his back.

Swaying/Swing: A new baby is used to being naturally rocked while in utero. Gently swaying (not shaking) from side to side, moving back and forth no more than an inch in any direction, while holding a swaddled baby can help calm baby.

Further reading: Karp, Harvey. *The Happiest Baby on the Block The New Way to Calm Crying and Help Your Newborn Baby Sleep Longer*. New York: Bantam, 2003.

Baby-Wearing:
Babies are used to literally being attached to mom in the womb and until very recently in human history, if a baby was put down unaccompanied, danger would be sure to follow. Feeling this vulnerable, it makes sense that newborns protest when being put down alone.
Baby carriers allow caregivers to be hands-free, while baby is still snug and secure. Many studies have researched the benefits of baby-wearing, including one where six-week-old babies who were worn in baby carriers cried 43% less than other children[1]. A baby cannot be spoiled by being carried or worn, but at some point, you will likely want to wean your baby from this. If you feel unsure about the timing of this, please talk with your pediatric health care provider about it.

There are many kinds of baby carriers such as wraps, slings, and buckle-based carriers. Follow the manufacturers' instructions regarding positioning of baby, weight and age requirements.
For more info, visit the non-profit, Babywearinginternational.org

Kangaroo Care:
Kangaroo care is skin-to-skin contact between parent and baby. When a baby is skin to skin with mom, they are hearing the cadence of her breathing, her heartbeat and feeling the warm of her skin. All of these combined, emulate the womb and bring comfort to a newborn that has most likely become over stimulated by his or her new environment."

Caregivers can encourage kangaroo care between new baby and parent as part of education to new parents.

Turn Down Stimuli and Blue Light
Too much stimuli caused by a seemingly normal daily dose of lights, blue light from electronics and sounds can be overwhelming for a young baby, as they still have an immature nervous system and are used to darkness in the womb. Simply turning off the TV, dimming the lights and bringing baby to calm environment is a way to stop fussiness before it starts.

Blue light, the light emitted from smartphones and other electronic devices has been proven to disrupt sleep[2] so use of a blue light blocking screen may be advised.

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1. http://www.babywearinginternational.org/what-is-babywearing/babywearing-resources/benefits-of-babywearing/
2. http://www.health.harvard.edu/staying-healthy/blue-light-has-a-dark-side

It’s important to note that even with every tip and trick to help calm baby, crying, even prolonged crying, is a normal part of development in early weeks. There will be times when baby cries for seemingly no reason and while this is completely normal, parents should always consult their child’s pediatrician if they feel something is just not right.

Section 4- Diapering & Dressing

In this section we will discuss proper procedure for changing and applying disposable and cloth diapers, identifying and treating diaper rash and appropriate clothing and temperature for baby.

DIAPERING

How Often to Change a Baby:

Change baby as soon as diaper is soiled or wet. Some disposable diapers for young babies have a wetness indicator on them – a line that turns color if the diaper is wet.

Before your baby arrives, caregivers can become familiar with what a newborn’s wet diaper feels like from the outside by taking a clean diaper and pouring about 2 tablespoons of water into it. The weight of the diaper will show the difference between a dry and wet diaper. New babies may go through 10-14 diapers a day. It may be time to go up a size when baby’s diaper leaks or becomes consistently full. The weights noted on diaper packaging are just guidelines, and baby may need a bigger size sooner.
In the first week of baby’s life, it can be hard to know “what’s normal” with wet diapers and bowel movements. This chart used with permission from WomensHealth.gov breaks it down:

Baby's Age	Number of Wet Diapers	Number of Bowels Movements	Color and texture of Bowel Movements
Day 1 (first 24 hours after birth)	1	The first one usually occurs within 8 hours after birth	Thick, tarry and black
Day 2	2	3	Thick, tarry and black
Day 3	5-6	3	Looser greenish to yellow
Day 4	6 or more	3	Yellow, soft and watery
Day 5	6 or more	3	Loose seedy, yellow color
Day 6	6 or more	3	Loose seedy, yellow color
Day 7	6 or more	3	Larger amounts of loose seedy, yellow color

Some babies will switch to less frequent but large bowel movements at about six weeks of age.

How to Wipe a Baby:

Clean your baby's front with an unscented baby wipe or damp washcloth. For female babies, wipe from front to back (toward her bottom). This helps keep bacteria from causing an infection. Apply diaper cream or petroleum jelly only when the area is completely clean and dry.

Nurse's tip: apply diaper cream/ointment directly to the diaper rather than on baby's skin, especially for recently circumcised boys to for a quick change with minimal discomfort.

Procedure for Putting on a Clean, Disposable Diaper:

Pull the front half of the clean diaper up to your baby's tummy. For a boy, be sure to point the penis down so he's less likely to pee over the top of the diaper. Apply diaper cream or petroleum jelly at pediatrician's direction. Newborns may not need diaper cream.

If your baby is a newborn, avoid covering the umbilical cord stump until it's dried and fallen off. You can buy special disposable diapers with a notch cut out for the stump or fold down the front of the diaper.

Make sure that the part of the diaper between your baby's legs is spread as wide as seems comfortable. Too much bunching in that area can cause chafing and discomfort

Fasten the diaper at both sides with the tabs. The diaper should be snug but not so tight that it pinches. Make sure the tabs aren't sticking to your baby's skin.

All changed!
Immediately Wash Hands and Use Hand Sanitizer After Diaper Changes

Video : "How to Change a Disposable Diaper" BabyCenter
Link: http://www.babycenter.com/0_how-to-change-a-disposable-diaper_3838.bc
How to Change a Cloth Diaper
Supplies:

- Clean diaper
- Clean diaper cover, in case the one your baby's wearing got dirty
- Diaper fastener (Snappi and Boingo are popular brands) or safety pins
- Cloth wipes, baby washcloths, or disposable wipes for cleaning your baby. (Dampen the cloth or washcloth with warm water or a homemade solution of warm water and a little liquid soap.)
- Dry wipe or washcloth, to dry your baby if you won't be letting your baby air-dry

Optional items:

- Rash cream, if your baby has diaper rash. Make sure to select a cream that works with cloth diapers, since standard rash creams and jellies are difficult to wash out of cloth diapers and may ruin them.
- A cloth or disposable liner. Liners wick moisture away from your baby and into the diaper. Disposable liners make it easier to dispose of poop and also help protect cloth diapers from lotions and creams. Cloth liners can be used to protect diapers, too, in which case they should be washed separately from the diapers.
- An insert or booster, sometimes called a "doubler", for added absorbency. (Some inserts are also topped with a stay-dry fabric.)

Safety note: If baby is changed on an elevated surface such as a changing table or bed, be sure to keep one hand on your baby at all times. Most changing tables have a strap you can use to secure your baby. Whether your baby is strapped in or not, don't leave baby unattended for even a second. Babies of any age can squirm off the table unexpectedly.

Procedure for a Cloth Diaper Change

1. Lay out the clean diaper. (Some types of cloth diapers need to be folded first.)
2. Unfasten the diaper cover your baby's wearing and bring down the front part of the cover
3. Unfasten the dirty diaper and pull down the front half. If your baby is a boy, you might want to cover his penis with a clean cloth or another diaper so he doesn't pee on either of you.
4. If there's poop in the diaper, use the front half of the diaper to wipe the bulk of it off your baby's bottom.
5. Fold the dirty diaper in half under your baby, clean side up. (This provides a layer of protection between the clean changing surface and your baby's unclean bottom.) To do this, lift your baby's bottom off the table by grasping both ankles with one hand and gently lifting upward.
6. Clean your baby's front with a wet cloth or wipe. If your baby's a girl, wipe from front to back (toward her bottom) to help keep bacteria from causing a urinary tract infection.
7. If your baby pooped, grab another wipe and clean his bottom. You can either lift his legs or roll him gently to one side then the other. Be sure to clean in the creases of your baby's thighs and buttocks.
8. If you have time, let your baby's skin air dry. Otherwise, pat dry with a clean cloth. If necessary, apply a rash cream that works with cloth diapers.
9. Remove the dirty diaper and, if it got soiled, the diaper cover. Set them aside.
10. Place the clean diaper underneath your baby so that the back edge is in line with your baby's waist.
11. Pull the front half up to your baby's tummy. If your child is a boy, be sure to point his penis down so he's less likely to pee over the top of the diaper.
12. For newborns, position your baby so the back of the diaper is higher than the front: You don't want the fabric to irritate the umbilical cord stump. Many newborn diapers and diaper covers have a snap- or fold-down area for the cord.
13. Make sure that the part of the diaper between your baby's legs is spread as wide as seems comfortable. Too much bunching in that area can cause chafing and discomfort.
14. Fasten the cloth diaper. Some come with built-in snaps or tabs. Pre-folded and flat diapers (which you fold yourself) require fasteners or pins. Be sure the diaper is snug but not so tight that it pinches.
15. Once the clean diaper is on, place the outer cover over it. (You'll either reuse the cover your baby was wearing before or, if it got dirty, replace it with a clean one.) Fasten the cover with its tabs or snaps
16. Dress your baby and put him in a safe place, like on the floor with a toy or in his crib.
17. Dump as much of the waste from the diaper and cloth wipes or washcloths into the toilet as you can. (Poop from formula or solids isn't water soluble and won't rinse away in the washing machine. Poop from an exclusively breastfed baby, on the other hand, is water soluble and doesn't require rinsing.) A diaper sprayer – similar to a kitchen sink sprayer that attaches to the

toilet – is a useful tool for getting as much poop into the toilet as possible. You can also swish the diaper and cloths in a clean toilet bowl. Put the dirty diaper and wipes – and dirty cover, if there is one – in your diaper pail or hanging wet bag

Video: "How to Change a Cloth Diaper" BabyCenter
Link: http://www.babycenter.com/0_how-to-change-a-cloth-diaper_3846.bc

DIAPER RASH:

What is Diaper Rash?
A diaper rash is a rash that develops inside the diaper area. In mild cases, the skin may be red, but in more severe cases, there may be painful open sores. With treatment, mild cases clear up in 3-4 days.
Causes of Diaper Rashes:

- Too much moisture
- Skin irritation from too much rubbing
- When urine, stool, or both touch the skin for long periods of time
- Bacterial infection
- Yeast infection
- Allergic reaction

"When skin stays wet for too long, it starts to break down. When wet skin is rubbed, it also damage more easily. Moisture from a soiled diaper can harm your baby's skin and make it more prone to chafing. When this happens, a diaper rash may develop." *(AAP Patient Education)*

Treatment of Diaper Rashes:
If your baby gets a diaper rash (and to prevent future diaper rashes) it's important to keep the area as clean and dry as possible. Change wet or soiled diapers right away. This helps cut down how much moisture is on the skin.

- Gently clean the diaper area with water and a soft washcloth. Disposable diaper wipes may also be used. Avoid wipes that contain alcohol and fragrance. Use soap and water only if the stool does not come off easily. If the rash is severe, use a squirt bottle of water so you can clean and rinse without rubbing.
- Pat dry; do not rub. Allow the area to air-dry fully.
- Apply a thick layer of protective ointment or cream (such as one that contains zinc oxide or petroleum jelly). These ointments are usually thick and pasty and do not have to be completely removed at the next diaper change. Remember, heavy scrubbing or rubbing will only damage the skin more.
- Do not put the diaper on too tightly, especially overnight. Keep the diaper loose so that the wet and soiled parts do not rub against the skin as much.
- Use creams with steroids only if your pediatrician recommends them. They are rarely needed and may be harmful.

- If you usually use non-disposable diapers, you may want to consider using disposable diapers until the rash resolves. While many people use non-disposable diapers for both economical and perceived ecological benefits, disposable diapers tend to wick moisture away from the baby's skin better, and can be beneficial in the setting of diaper rashes.

- **Nurse's Tip: Use Milk of Magnesia to treat a diaper rash**: Milk of Magnesia is non-toxic and safe to use in the diaper region (even if it gets into the folds on female babies.) First, clean diaper region and pour milk of magnesia over diaper rash. Then, close up diaper and wait five minutes. Afterwards, open diaper back up and apply a zinc oxide-based cream. Do not rinse or wipe off the milk of magnesia when you apply. Apply it right on top. It's okay if it looks white and cakey, that means it's working!

- At the next diaper change, use a warm washcloth to rinse and wipe the diaper region, dry, and start the process again.

When to Call the Pediatrician About a Diaper Rash:

- If a diaper rash has blisters or pus-filled sores
- does not go away within 2 to 3 days
- Gets worse
- If your baby is taking an antibiotic and has a bright red rash with red spots at its edges. This might be a yeast infection.
- If there is a fever
- The rash seems very painful.

For more info and graphics visit: AAP's Patient Education page
Link: http://patiented.aap.org/content.aspx?aid=5297

CLOTHING/DRESSING YOUR BABY:

The rule of thumb is to dress your baby in whatever an adult would be comfortable wearing plus one extra layer.

Nurse's tip: Hats can be a safety hazard while sleeping as they move around when a baby moves through the night. Hats should not be worn when adults are sleeping or otherwise unable to check on baby.

Temperature in the Home

The optimal temperature in the home for a baby is 69-71 degrees. This is the temperature in hospital nurseries and provides a comfortable temperature for babies dressed properly.

Section 5 – Safety: Safe Sleep, SIDS Prevention and Monitoring Temperatures

SAFE SLEEP AND SIDS PREVENTION

The following is a direct reproduction used with permission from the American Academy of Pediatrics Pamphlet, "A Child Provider's Guide to Safe Sleep"
http://www.healthychildcare.org/PDF/SIDSchildcaresafesleep.pdf

DID YOU KNOW?

- About one in five sudden infant syndrome (SIDS) deaths occur while an infant is being cared for by someone other than a parent. Many of these deaths occur when infants who are used to sleeping on their backs at home are then placed to sleep on their tummies by another caregiver. We call this "unaccustomed tummy sleeping."

- Unaccustomed tummy sleeping increases the risk of SIDS. Babies who are used to sleeping on their backs and placed to sleep on their tummies are 18 times more likely to die from SIDS.

WHO IS AT RISK FOR SIDS?

- SIDS is the leading cause of death for infants between 1 month and 12 months of age.
- SIDS is most common among infants that are 1-4 months old. However, babies can die from SIDS until they are 1 year old.

- Because we don't know what causes SIDS, safe sleep practices should be used to reduce the risk of SIDS in every infant under the age of 1 year.

KNOW THE TRUTH ... SIDS IS NOT CAUSED BY:

• Immunizations
• Vomiting or choking

CREATE A SAFE SLEEP POLICY

- Create and use a written safe sleep policy: Reducing the Risk of Sudden Infant Death Syndrome, Applicable Standards from Caring for Our Children National Health and Safety Performance Standards: Guidelines for Out- of-Home Child Care Programs outlines safe sleep policy guidelines. Visit http://nrckids.org/CFOC3/HTMLVersion/Chap ter03.html#3.1.4.1 to download a free copy.

A SAFE SLEEP POLICY SHOULD INCLUDE THE FOLLOWING:

- Back to sleep for every sleep. To reduce the risks of SIDS, infants should be placed for sleep in a supine position (completely on the back) for every sleep by every caregiver until 1 year of life. Side sleeping is not safe and not advised.
- Consider offering a pacifier at nap time and bedtime. The pacifier should not have cords or attaching mechanisms that might be a strangulation risk.

- Place babies on a firm sleep surface, covered by a fitted sheet that meets current safety standards. For more information about crib safety standards, visit the Consumer Product Safety Commissions' Web site at http://www.cpsc.gov.
- Keep soft objects, loose bedding, bumper pads, or any objects that could increase the risk of suffocation or strangulation from the baby's sleep area.
- Loose bedding, such as sheets and blankets, should not be used. Sleep clothing, such as sleepers, sleep sacks, and wearable blankets, are good alternatives to blankets.
- Sleep only 1 baby per crib.
- Keep the room at a temperature that is comfortable for a lightly clothed adult.
- Do not use wedges or infant positioners, since there's no evidence that they reduce the risk of SIDS, and they may increase the risk of suffocation.
- Never allow smoking in a room where babies sleep, as exposure to smoke is linked to an increased risk of SIDS.
- Have supervised, daily "tummy time" for babies who are awake. This will help babies strengthen their muscles and develop normally.
- Teach all staff, substitutes, and volunteers about safe sleep policies and practices and be sure to review these practices often.
- When a new baby is coming into the program, be sure to talk to the parents about your safe sleep policy and how their baby sleeps. If the baby sleeps in a way other than on her back, the child's parents or guardians need a note from the child's physician that explains how she should sleep, the medical reason for this position and a time frame for this position. This note should be kept on file and all staff, including substitutes and volunteers, should be informed of this special situation. It is also a good idea to put a sign on the baby's crib.
- If you are not sure how to create a safe sleep policy, work with a child care health consultant to create a policy that fits your child care center or home.
- Face up to wake up—healthy babies sleep safest on their backs.

Safe Sleep Practices

- Practice SIDS reduction by using the *Caring for Our Children* standards.
- Always place babies to sleep on their backs during naps and at nighttime.
- Avoid letting the baby get too hot. The infant could be too hot if you notice sweating, damp hair, flushed cheeks, heat rash, and/or rapid breathing. Dress the baby lightly for sleep. Set the room temperature in a range that is comfortable for a lightly clothed adult.
- Talk with families about the importance of sleep positioning and encourage them to follow these guidelines at home.

Safe Sleep Environment

- Place babies to sleep only in a safety- approved crib with a firm mattress and a well- fitting sheet. Don't place babies to sleep on chairs, sofas, waterbeds, or cushions. Adult beds are NOT safe places for babies to sleep.
- Toys and other soft bedding, including fluffy blankets, comforters, pillows, stuffed animals, bumper pads, and wedges should not be placed in the crib with the baby. These items can impair the infant's ability to breathe if they are close to their face.

- The crib should be placed in an area that is always smoke-free.
- Room sharing *without* bed-sharing is recommended. Evidence has shown this arrangement can decrease the risk of SIDS as much as 50%.
- Do not place pillows, quilts, pillow-like toys, or anything in the crib.

THE ROLE OF CHILDCARE PROVIDERS IN THE PREVENTION OF SIDS

Some childcare providers are professionals with college degrees and years of experience, but other kinds of child care providers could be grandparents, babysitters, family friends, or anyone who cares for a baby. The following guidelines apply to any kind of child care provider. If you ever care for a child who is less than 12 months of age, you should be aware of and follow the safe sleep practices discussed above.

Other Recommendations

- Support parents who want to breastfeed or feed their children breast milk.
- Encourage parents to keep up with their baby's recommended immunizations, which may provide a protective effect against SIDS.
- Talk with a child care health consultant about health and safety in child care.
- Have a plan to respond if there is an infant medical emergency.
- Be aware of bereavement/grief resources.

If you have questions about safe sleep practices, please contact Healthy Child Care America 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 an infant in your care, ask the baby's parents if you can talk to the baby's doctor.

RESOURCES:

American Academy of Pediatrics
http://www.aappolicy.org

SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment
http://pediatrics.aappublications.org/content/128/5/1030.full

Healthy Child Care America
http://www.healthychildcare.org
Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care, Third Edition.

Visit the National Resource Center for Health and Safety in Child Care and Early Education Web site at:
http://nrckids.org/CFOC3/ to download a free copy. Hard copies are available from the American Academy of Pediatrics Bookstore at **http://www.aap.org**.

National Institute for Child and Human Development Back to Sleep Campaign Order free educational materials from the Back to Sleep Campaign at **http://www.nichd.nih.gov/sids/sids.cfm**

First Candle/SIDS Alliance
http://www.firstcandle.org

Association of SIDS and Infant Mortality Programs
http://www.asip1.org/

CJ Foundation for SIDS
http://www.cjsids.com/

National SIDS and Infant Death Resource Center
http://www.sidscenter.org/

The Juvenile Products Manufacturers Association
http://www.jpma.org/
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TAKING YOUR CHILD'S TEMPERATURE

While you often can tell if your child is warmer than usual by feeling the forehead, only a thermometer can tell you the actual temperature. Even if your child feels warmer than usual, you do not necessarily need to check temperature unless there are other signs of illness.

Always use a digital thermometer to check your child's temperature (*see "Types of digital thermometers" below for more information, including guidelines on what type of thermometer to use by age*). Mercury thermometers should not be used. The American Academy of Pediatrics (AAP) encourages parents to remove mercury thermometers from their homes to prevent accidental exposure and poisoning.

Note: Temperature readings may be affected by how the temperature is measured and other factors. Your child's temperature *and* other signs of illness will help your doctor recommend treatment that is best for your child.

Types of Digital Thermometers
The following are 3 types of digital thermometers. While other methods for taking your child's temperature are available, such as pacifier thermometers or fever strips, they are not recommended at this time. Ask your child's doctor for advice.

1. Digital Multiuse Thermometers

How They Work: Digital multiuse thermometers read the body temperature when the sensor located on the tip of the thermometer touches that part of the body. Can be used rectally, orally, or axillary.

Age/Method Recommendations:
Rectal (in the bottom): Birth to 3 years.
Oral (in the mouth): 4 to 5 and older.
Axillary (under the arm): Any age. Least reliable. Useful for screening.

Notes: The 100.4 °F fever guideline is based on taking rectal reading.
Label the thermometer "oral" or "rectal".
Don't use the same thermometer in both places.
Taking an axillary temperature is less reliable; however, this method may be used in schools and child care centers to check (screen) a child's temperature when a child has other signs of illness.

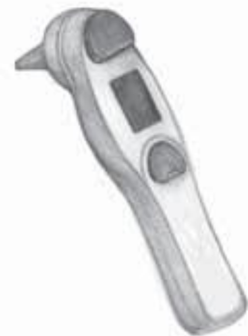
2. **Temporal Artery Thermometers**

How They Work: Temporal artery thermometers read the infrared heat waves released by the temporal artery, which runs across the forehead just below the skin.

Age/Method Recommendations: To be used for children/infants above 3 months of age by swiping the thermometer across the side of the forehead.

Notes: Temporal artery thermometers may ultimately be reliable in newborns and infants younger than 3 months according to new research. Before 3 months of age, it may be a better screening device than axillary (armpit) temperatures. At this time, follow the recommendations that come with the device.

3. Tympanic Thermometers



How They Work: Tympanic thermometers read infrared heatwaves given off by the eardrum.

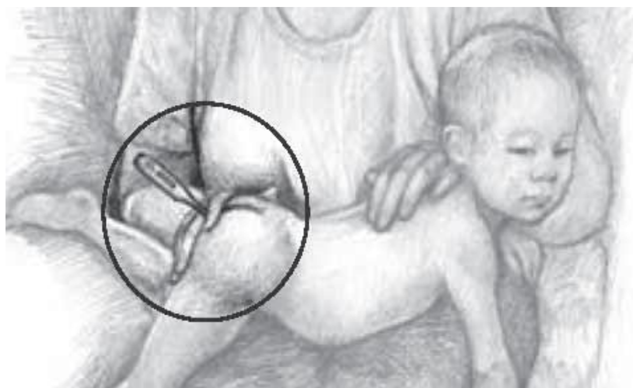
Age/Method Recommendations: To be used in infants/children 6 months of age and older in the ear.

Notes: Tympanic thermometers are not reliable for babies younger than 6 months.
When used in older children, they need to be placed correctly in the child's ear canal to be accurate.
The user must pull up GENTLY on the ear in order to straighten the ear canal and allow the thermometer to be in direct line with the eardrum.

Too much earwax can cause a reading to be incorrect.

SOME SPECIFIC INSTRUCTIONS ON THE USE OF DIGITAL MULTIUSE THERMOMETERS:

Rectal Temperatures



If your child is younger than 3 years, taking a **rectal temperature** gives the best reading. The following is how to take a rectal temperature:

- Clean the end of the thermometer with rubbing alcohol or soap and water. Rinse it with cool water. Do not rinse it with hot water.
- Put a small amount of lubricant, such as petroleum jelly, on the end.
- Place your child belly down across your lap or on a firm surface. Hold him by placing your palm against his lower back, just above his bottom. Or place your child face up and bend his legs to his chest. Rest your free hand against the back of the thighs.
- With the other hand, turn the thermometer on and insert it 1/2 inch to 1 inch into the anal opening. Do not insert it too far. Hold the thermometer in place loosely with 2 fingers, keeping your hand cupped around your child's bottom. Keep it there for about 1 minute, until you hear the "beep." Then remove and check the digital reading.

- Be sure to label the rectal thermometer so it's not accidentally used in the mouth.

Oral Temperatures

Once your child is 4 or 5 years of age, you can take his temperature by mouth. The following is how to take an oral temperature:

- Clean the thermometer with lukewarm soapy water or rubbing alcohol. Rinse with cool water.
- Turn the thermometer on and place the tip under your child's tongue toward the back of his mouth. Hold in place for about 1 minute, until you hear the "beep." Check the digital reading.
- For a correct reading, wait at least 15 minutes after your child has had a hot or cold drink before putting the thermometer in his mouth.
-

Source: Fever and Your Child (Copyright © 2007 American Academy of Pediatrics, updated 5/2012)

Section 6 – Mother Care

Postpartum Care: Physical Changes, Pain Management and What to Expect

Whether a vaginal birth or Cesarean, most women experience some degree of pain or discomfort after childbirth.

With a vaginal birth or even labor before having a c-section, the perineum (area surrounding the vaginal opening) may be bruised, or mother may have stitches to repair a tear or episiotomy (a surgical cut made at the opening of the vagina) during childbirth, to aid a difficult delivery and prevent rupture of tissues.

Cesarean birth results in pain at the incision site making it uncomfortable to move, cough, and even laugh.

Mothers may be on pain medication, but comfort techniques such as the use of ice on sore stitches or sitting and lying positions can be suggested.

Bleeding – What's Normal and What's Not?
After delivery, uterine contractions expel blood and tissue. This vaginal flow is called lochia and continues for 2 to 6 weeks after delivery.

The first several days after delivery:

- bleeding is usually heavy and bright to dark red in color.
- Some clots as large as a small tangerine are normal.

Call a healthcare professional if: there are many large clots or unusually heavy flow (soaking through a large pad in an hour or less) occurs.

Several weeks after delivery:

- Bleeding will decrease over the next few weeks
- Discharge color will turn from bright red to pink to brown to yellow and then clear.
- Discharge will have a strong fleshy smell, not a putrid odor.
-

Call a healthcare professional if: there is a return to bright red bleeding or passing of large clots once your bleeding has slowed. This usually signifies excessive activity on mother's part but may be a sign of rare complications.

Afterpains – What are they?
Afterpains, or cramping, are the contractions of the uterus occurring in the days following childbirth. They are normal, but can be uncomfortable and are usually strongest:

1. on the second and third days following delivery
2. when mom is breastfeeding or
3. after a uterus-contracting medication is prescribed.

Cramping is also most noticeable after the birth of a second or third baby.

Afterpains gradually decrease in intensity, but may last seven to ten days.

To help ease afterpains, you may recommend the following:

- ibuprofen or prescribed medication as needed.
- Relaxation and breathing techniques mom may have used during labor.
- Recommend walking soon after delivery if possible.
- Frequently emptying bladder.
- Frequent breastfeeding, starting immediately after birth, can also alleviate afterpains.

Changes in The Uterus

Immediately after delivery and for the next several days, the uterus weighs about two pounds. It can be felt just below the navel as a firm mass about the size of a grapefruit. Large blood vessels bleed into the uterine cavity where the placenta was attached to the wall of the uterus.

The following activities help the uterus contract:

- Mom, mom's partner or caregiver can massage the uterus for the first few days after delivery. This is done by placing a hand on the uterus and slowly rubbing in a circular motion. This procedure will stimulate contractions and make the uterus become firm.
- Breastfeeding also causes the uterus to contract as the hormone oxytocin is released.
- Occasionally, medication is given for several days after birth to keep the uterus firm.
- The uterus continues to decrease in size until it returns to its normal size and weight of about two ounces six weeks after delivery.

Laceration (Tear) or Episiotomy

During childbirth, the perineum stretches and occasionally tears. If the tears are small, uncomfortable swelling and stinging may occur. If the tear is large, there may still be pain upon arriving home and mom will have stitches.

Occasionally, an episiotomy (a surgical incision that enlarges the vaginal opening) is performed to facilitate the birth of the baby. The amount of pain following an episiotomy or deep tear varies among individuals. It is caused by the swelling of the tissues surrounding the vagina as well as by the incision or deep tear.

Swelling and discomfort usually peak on the second or third day after delivery, but it is difficult to predict how long the discomfort will persist. Some women experience little or no discomfort, while others experience dull, aching pain for some time.

This is all normal and eventually subsides.

Helpful Hints for Care of the Perineum:

- Always wash hands well before and after cleaning the vaginal area.

- In the first 24 hours after delivery, place ice on the perineum to reduce swelling and pain. Ice may be continued as needed.
- When sitting, mom can position herself squarely on the bed or in the chair, tightening the perineum, buttocks, and thigh muscles. (Sitting only on one hip may pull stitches.)
- After urination or bowel movements, stitches should be cleanses by squirting warm water from the top of the stitches back toward the rectum. Mom will be sent home with a peri bottle to use in cleansing, and its use should be continued as needed. Pat dry with a clean tissue, again from front to back.
- If mom reports burning over the stitches during urination, you may recommend pouring warm water over the area to dilute the urine as she goes.
- Mom should then apply a clean sanitary pad from the front to back.
- Witch hazel compresses between the pad and the stitches may be soothing.
- A sitz bath can be helpful in soothing as well. To do this, fill the bathtub with several inches of warm water. Sitz baths may be done several times a day for 20 minutes and may be continued as needed for comfort.

Cesarean Birth Recovery

Helpful Hints

- If mom needs to cough or sneeze, she may hug a pillow snugly against incision to splint it and reduce the pain and pressure over the incision.
- Constipation is common after any abdominal surgery. It is also a side effect of many pain medications. Therefore, it is important to continue to take a stool softener and to eat foods that are high in fiber.
- Mom should rest as much as possible and avoid lifting anything heavier than baby.
- To increase comfort during breastfeeding, use a pillow to position baby away from incision.
- The tape strips over mom's incision will stay in place until physician/midwife removes them at mom's postpartum check.

Call the doctor/midwife if the incision:

- opens
- becomes sore and red
- has a greenish-yellow drainage
- bleeds.

Hemorrhoids

Hemorrhoids are protruding veins in the rectum that often cause a constant dull pain or feeling of pressure around the anal area. They may become prominent during late pregnancy or labor. Hemorrhoids can become aggravated by the constipation that commonly follows delivery. They may become swollen and tender, sometimes itch, and may bleed.

Treatment for Hemorrhoids

- Apply a cold ice pack for 20 to 30 minutes, several times a day as needed for swelling and comfort.

- Take sitz bath, a bath in which only the buttocks and hips are immersed in warm or iced water. Lie down for 15 minutes after a sitz bath.
- use soothing over-the-counter medications such as Tucks, witch hazel, or hemorrhoid ointments.
- Avoid constipation by using stool softeners.
- Drink lots of water and eat fresh fruits, vegetables, and whole grains.

6.1 Postpartum Care – Mother & Partner Care

Postpartum Depression Facts - Recognizing and Alleviating Baby Blues and Postpartum Depression in Mothers

The transition to motherhood brings fluctuating hormones and reorganization of everyday responsibilities and stressors in the four-week period following childbirth. These changes have an effect on mood, causing early elation at delivery that can be followed by mild depression with tearfulness, irritability, and fatigue. These feelings peak on the fifth day postpartum, often called "the baby blues". Most women recover and adapt to these postpartum changes in a few days. However, the physiological factors that affect mood can interact with minor anxieties and stresses to result in a clinical depression. Postpartum depression (PPD) is recognized by a persistent mood of despondency and the mother's disinterest in bonding with baby. Beyond 5 days, the persistence is not expected and should be reported to a health care provider immediately.

Typical postpartum change/recovery is described in three phases:

Phase 1- Taking In -

Mother is passive and willing to let others care for her. Conversation centers on her birth experience. Mother has great interest in her infant but has little interest in learning about caring for the child, as her primary focus is on recovery from birth and her need for food, fluids, and deep restorative sleep. She is willing to let others handle the care of the child not because she is disinterested, but because she must care for herself first.

Phase 2- Taking Hold -

Mother begins to initiate action and becomes more interested in caring for her infant. She becomes critical of her "performance". She has increased concern about her body's functions and assumes responsibility for her self-care needs. This phase is ideal for teaching infant care.

Phase 3- Letting Go -:

Mothers, and often fathers, work through giving up their previous lifestyle and family arrangements to incorporate the new infant. Some mothers must give up their ideal of their birth experience and reconcile it with what actually happened.

Postpartum assessment typically includes physical valuation, and assessment of psychological bonding, but must also include evaluation for fatigue. Because today's lifestyle often has women working through most of her pregnancy, rooming-in after delivery with responsibility for newborn care, and then returning home in 48 hours or less to accept full home responsibilities, many women do not have the opportunity to rest and adapt in the postpartum phase.

In some cases, medication is necessary to help mothers with PPD. However, postpartum support can be received through social service agencies, public health nurses, parenting courses, group discussions and caregiver support.

Source: *The Brookside Associates Medical Education Division*
http://www.brooksidepress.org/Products/Obstetric_and_Newborn_Care_II/lesson_6_Section_2.htm

Postpartum Depression Facts - Recognizing and Alleviating Postpartum Depression in Fathers and Partners

Studies cited by the National Institute of Health, one in 2007 and one in 2011, recognize that Post-Partum Depression) in the first two months postpartum may range from 4 to 25 percent for new fathers. Paternal PPD has high comorbidity with maternal PPD and might also be associated with other postpartum psychiatric disorders.

Changes in hormones, including testosterone, estrogen, cortisol, vasopressin, and prolactin, during the postpartum period in fathers may be biological risk factors in paternal PPD.

Fathers who have ecological risk factors, such as excessive stress from becoming a parent, lack of social supports for parenting, and feeling excluded from mother-infant bonding, may be more likely to develop paternal PPD.

As with postpartum mothers, in some cases medication is necessary to help fathers and partners with PPD. However, postpartum support can be received through social service agencies, public health nurses, parenting courses, group discussions and caregiver support.

Sources*:* *Sad Dads: Paternal Postpartum Depression:*
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2922346/
Identifying the support needs of fathers affected by post-partum depression: a pilot study:
http://www.ncbi.nlm.nih.gov/pubmed/21214683

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