Preparing for childbirth and parenting

A workbook for parent education

Hospitality | Compassion | Respect | Justice | Excellence

ST JOHN OF GOD Health Care

St John of God Health Care – Introduction

St John of God Health Care is a leading provider of Catholic hospitals and outreach services, basing its care on the values of Hospitality, Compassion, Respect, Justice and Excellence.

Welcome to St John of God Health Care

We wish you a healthy pregnancy, a wonderful birth experience, and all the joy and delight of having a new baby. We would also like you to have a comfortable and safe stay at our St John of God Hospital Maternity units.

Disclaimer

All the information provided in this workbook is a guide only. We cannot include everything about your labour, birth and postnatal recovery as each woman, baby and pregnancy is different. We have included as much as possible, for you to understand the principles applied and procedures you may experience.

"We wish you a healthy pregnancy, a wonderful birth experience, and all the joy and delight of having a new baby."

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Section 1:

Preparing for labour and birth

This booklet is designed to reassure you of what to expect as you near your due date and move into the labour and birth phase. It is a guide to help you feel confident, to recognise impending signs of labour and to feel comfortable with your stay at a St John of God Private Hospital.

A checklist for what to bring has been included in this section – you can tick each item off as you pack them.

It is also useful for checking you have all your belongings on discharge.

A comparison table between true and false labour has been provided for you.

If you are still not sure, please contact the SJGHC Hospital that you have booked to have your baby at.

IMPORTANT INFORMATION

Importance of Fetal Movements

As your pregnancy progresses you will learn about the usual pattern of your baby's movements. Should you notice any decrease in these movements (including in early labour at home) it is important that you contact the SJGHC Hospital where you are planning to have your baby.

See the following website for more information:

www.movementsmatter.org.au

Maternal Sleep positions in the third trimester of pregnancy.

There is now new research that identifies the optimal sleeping position for women in the final 12 weeks of pregnancy.

Please see the video link on the home page.

Important phone numbers

Victorian SJGHC Private Birth Suites / Maternity Ward:

Ballarat	(03) 5320 2110
Bendigo	(03) 5434 3423
	(03) 5434 3269
Berwick	(03) 8784 5300
Geelong	(03) 5226 8876

Western Australian SJGHC Private Birth Suite / Maternity Ward:

Bunbury	(08) 9722 1934 (A/H) (08) 9722 1947 (8am-3pm)
Geraldton	(08) 9965 8859
Mt Lawley	(08) 9370 9420
Murdoch	(08) 9438 9700
Subiaco	(08) 9382 6259
	(08) 9382 6260

When to call your SJGHC Hospital Birth Suite / Maternity Hospital

- **You notice a reduction in your baby's movements**
- **Vaginal Bleeding**
- **You are experiencing contractions and are less than 37 weeks pregnant**
- **Sudden swelling of your face/ hands, headaches, dizziness or blurred vision, upper abdominal pain**
- **Any concerns related to your pregnancy**

1.1

When to come into Hospital for birth

Most women will recognise the changes taking place in their body when labour starts. If you need to discuss this with a midwife there is one available 24 hours at your SJGHC hospital.

Labour is different for everyone – your time is unique. Your labour may begin when one or more of these occur: – **Your waters break** (membranes rupture).

You may experience a sudden gush or a slow trickle. Contact your SJGHC Birth suite / Maternity unit on the provided phone number as soon as this happens, with or without contractions.

Contractions

The uterus has been practicing with Braxton Hicks, which are mild, cramp-like, irregular and variable.

These tightening's will gradually increase, with true labour, becoming stronger, regular and consistent.

Constant minor backache with regular bouts of stronger back pain can also be a sign of true labour.

Go to the hospital when the contractions become 5-7 minutes apart, last longer than 30 seconds or when they are causing you pain which requires you to have assistance or reassurance.

1.2

What to bring for your hospital stay

- Comfortable clothing to wear in labour – Oversized shirt, crop top, (we are also able to provide a hospital gown to wear as well).
- Casual clothes to wear during the day (T-shirt, shoes, loose pants).
- Nighties, dressing gown and slippers (front opening for breast feeding).
- Underwear – approximately six (6) pairs of 'old favorite's'.
- Maternity bras – at least three (3) pairs.
- Maternity Pads - four (4) packets of large or maternity size.
- Nursing pads – toweling or disposable. No plastic lining.
- Clothes for your baby to wear *Note: Always wash clothes before use.*
- Toiletries – bag, soap, shampoo, deodorant, toothpaste, make-up.
- Tissues.
- Phone chargers.

1.3

Signs of impending labour

You may notice some of the following, signaling that your body and/or the baby are getting ready for labour:

- The baby's head moves into the pelvis (engagement). This is also known as 'lightening' due to less pressure on your diaphragm and lungs from the baby.
- Backache either intermittently or continuous.
- Braxton Hicks become stronger and more frequent.
- Increased mucous discharge from your vagina.
- Spurt of energy (nesting).
- Slight diarrhoea.
- A "show" of pinky mucous discharge from the vagina, perhaps streaked with blood not more than 20mls. (mucus plug).

Group B Streptococcus

Group B streptococcus (GBS) is a common bacterium generally found in the gastrointestinal tract, vagina and urethra of both pregnant and non-pregnant women. It is not a sexually transmitted disease and is often transient (comes and goes). The bacteria can be passed from mother to newborn during labour and potentially lead to infection in the first week of life (early onset GBS infection). The administration of intravenous antibiotics in labour to mothers who have screened positive to GBS during pregnancy provides a level of protection to the newborn.

Screening

Your obstetrician / GP obstetrician / Midwife will provide information in relation to swab tests that generally take place between 35-37 weeks of pregnancy. You should be advised by your care provider in relation to the positive / negative results 10-12 days after testing.

On admission to the maternity unit (GBS positive):

In LABOUR: Your midwife will arrange for the insertion of an intravenous (IV) cannula and administration of antibiotics at regular intervals (usually 4 hourly). The IV will be securely taped to ensure that you are free to be active.

Booked Caesarean: If labour has not started and your waters have not broken, you may not require these antibiotics specifically for GBS.

1.4

True labour versus false labour

True labour	False labour
Pains regular and rhythmic- each one gradually building to a peak and then fading.	Pains irregular and erratic in nature.
Rest period between contractions (intervals) gradually shorten.	No change in intervals.
Duration and severity increase – developing a pattern of increasing intensity.	No change in intensity.
Pain starts in back and moves to front.	Pain mainly in front.
Walking increases strength of the contraction.	Walking decreases intensity or stops spasms.
Tightening of the uterus can be felt by placing your hand on top of your abdomen.	Usually can't be felt.
You will require more concentration to cope with the contraction and will not want to talk or do anything while you have a contraction.	You probably won't have to stop what you are doing for most of the time.
Bloody show often present.	No show evident.

NB: Sometimes labour is felt as constant minor backache with bouts of stronger back pain.

Section 2:

2.1

Admission into hospital

When you arrive at your St John of God Hospital you will be taken to the Birthing Suite / assessment area and basic observations will be taken: blood pressure, pulse, urine check, temperature, plus obstetric history and pregnancy history. The midwife will listen to the baby's heartbeat and feel its position in the abdomen.

An internal examination may be done to determine progress.

Monitoring of the baby's heart rate may occur through either a hand held device or an electronic system called a Cardiotocograph. (CTG). Your midwife will explain to you the process and the information that we are obtaining (see 3.1 Fetal monitoring).

When these admission procedures are completed you will be shown your labour room facilities, explained the hospital policies and helped to feel as comfortable as possible.

Please have your obstetric history card from your doctor with you at all times as you will be asked for this record when you come to the hospital.

2.2

How long is labour?

It is very difficult to reassure mothers on the length of labour as every pregnancy and every woman is different. Giving birth to your first baby usually takes longer than for subsequent children, but each labour will still vary, and keeping an open mind will help you prepare for all eventualities.

The length of your labour will depend on the position of the baby, the strength of your contractions and your individual pelvic structure.

2.3

Coping with your labour

You will cope more effectively if you feel safe and secure. These hints may help:

- Have close, continuous support from your partner.
- Make the birthing room cosy and homely i.e. dim the lights, use mats, fit ball, chairs etc.
- You may want to have a shower to help you relax.
- Speak to your midwife about accessing a bath for pain management*.
- Find a position you feel comfortable with.
- Have regular drinks and eat light snacks (unless your doctor has advised you to fast).
- Stay focused on what you are doing and trust your instincts.
- Ask your midwife for anything which you feel may help: cool washcloth, hot packs, ice chips.
- Bring with you anything which you know gives you comfort or security.
- You may want to download your favourite music.

Normal labour and birth process

This section relates to the normal processes of labour and birth. Presenting methods for managing pain, coping with the different experiences of childbirth and making informed decisions about your labour and birth.

Information will be provided to help you and your support person, cope with and understand the labour and the birth experience.

Sometimes it is difficult to say if labour has started. There may be long periods in which some early warning signs are present, but no consistent labour pains.

**please note that not all SJGHC Hospitals have access to a bath to be used for pain relief in labour. There are a number of medical and labour conditions (including continuous fetal monitoring) which mean that you may be unable to access the bath. SJGHC do not perform waterbirths.*

2.4

Normal childbirth

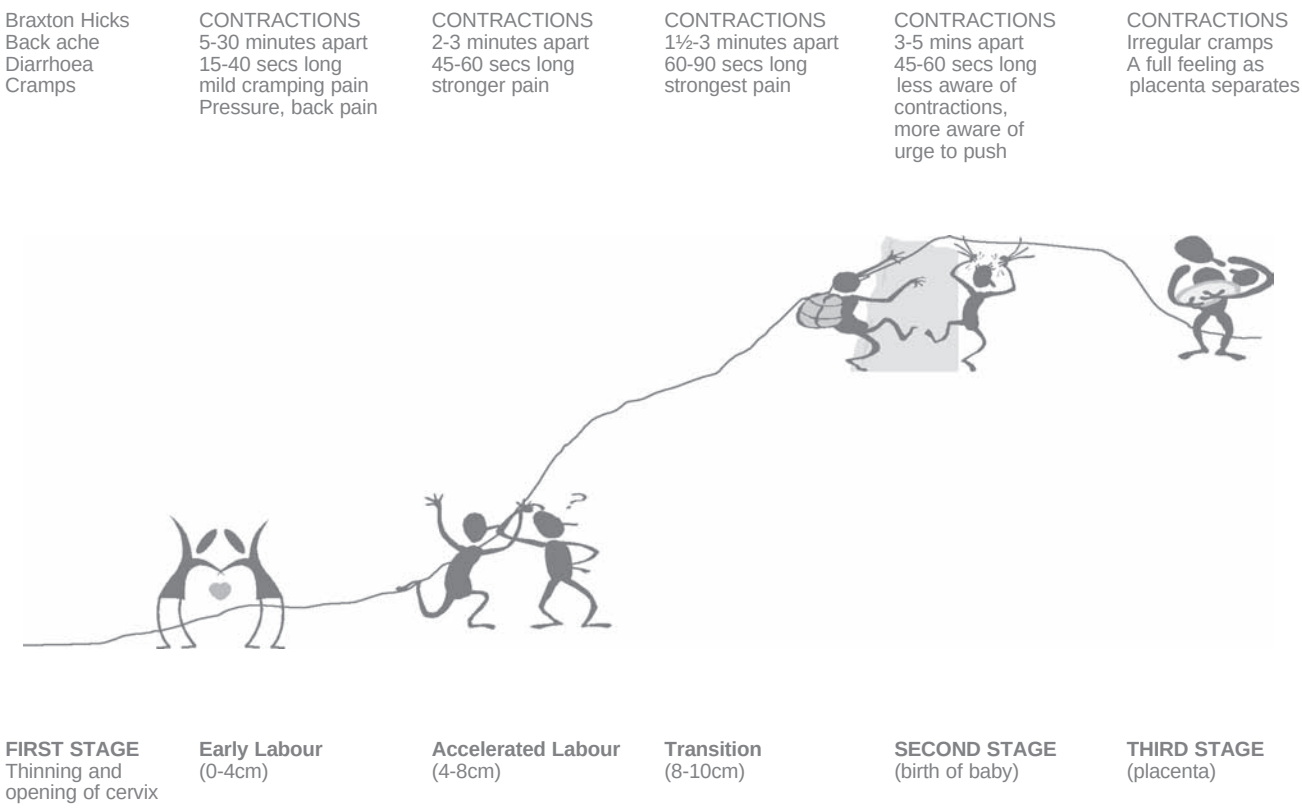
Labour is divided into three stages – First stage, Second stage and Third stage – each of these stages presents differently and requires different management for you, your support person/s and your midwife / obstetrician.

First stage is the thinning out of the cervix to full dilatation. It is divided into three separate stages:

1. Early Labour
2. Active Labour
3. Transition

Second stage – starts once your cervix is fully dilated (10cm) until the birth of your baby.

Third stage – starts after the baby has been born and involves the delivery of the placenta.



A: Early labour

This is the first phase of first stage. During this part of labour the cervix softens and shortens (effaces) and begins to dilate (0 - 4cms).

If your waters break note the colour of the fluid.

It should be clear or milky white, not yellow / brown / green (as this could be a sign of fetal distress). Contact the hospital and prepare yourself to come into hospital as soon as possible.

Self help:

- Continue eating as long as you feel like it.
- Have regular drinks of juice or water. Go to the toilet regularly.
- Shower to help you relax.
- Breathe evenly with each contraction. and rest in between.
- Move around until you find a comfortable position.
- Stay relaxed, light activities are fine as long as you feel able.
- Listen to your body and find ways of making its work easier and more comfortably.
- Paracetamol may assist with discomfort (dosage on the box)

Your support person can:

- Help provide physical support when you have a contraction.
- Provide emotional support and encouragement.
- Provide sips of water or ice between contractions.
- Use massage or relaxation therapy to soothe you.

Your midwife will:

- Monitor you and your baby's vital signs.
- Notify your doctor of your admission.
- Perform a vaginal examination to determine progress.
- Perform an external abdominal palpation to determine baby's position.
- Complete a history of your pregnancy and previous medical / obstetric history if not already completed.

Positions and coping strategies:

- Standing / sitting or kneeling, fully supported using pillows, beanbags or furniture.
- Once in a comfortable position stay there until no longer effective and then try something else.
- Relaxation and deep slow breathing during contractions.

B: Active labour

This is the second phase of first stage. During this phase your cervix will open (dilate) from 2-3cm up to 8cm. Contractions will be stronger and closer together. You will feel the need to rest more between contractions.

You may feel more introverted and focused on the labour.

Self help:

- Conserve energy by finding positions where you can relax during and between contractions.
- Keep drinking fluids, or if feeling nauseous, have sips of water or suck on ice chips.
- A shower or bath* at this time may help you to stay relaxed.
- If you are considering pain medication discuss this with your midwife.
- If you wish to have an epidural we can contact an anaesthetist for you.

Your support person can:

- Provide hot or cold packs or anything else you need to stay relaxed.
- Provide back rubs during contractions or whenever you need them.
- Give you a general massage between contractions.
- Offer sips of water / fluid between contractions
- Hold shower hose over your back or abdomen while in shower or bath*.
- Offer washcloths and lip balm as necessary.
- Offer words of reassurance, encouragement and support.

Your midwife will:

- Increase frequency of your observations.
- Monitor your contractions.
- Monitor your baby's heartbeat using either a handheld device or a via a CTG (see section 3.1 Fetal Monitoring).
- Perform a vaginal examination if you request pain analgesia or an epidural, or as necessary.
- Provide suggestions for your support person, to help you.

It is recommended you practice these positions prior to labour to see which ones you find more comfortable.

- Provide a quiet, safe environment for you.
- Reassure you about you and your baby's progression and wellbeing.
- Provide information and explanations about care and any changes you may experience.

Positions and coping strategies:

- Same as early labour only you may find it harder to stay in any one position for long.
- Breathing requires more concentration and focus.
- Water therapy – shower or bath*.
- Nitrous gas / Narcotics / Epidural.

C: Transition

This is the final phase of first stage. Your cervix will dilate from 8cm until you are fully dilated at 10cms.

Transition is the hardest part of labour, as your body changes from the opening up phase to the bearing down phase.

The contractions are usually longer and closer together. It can be a little overwhelming and is often evident by sudden emotional change and feelings of being 'out of control'. Transition can last from a few contractions to around one hour to two hours.

If the membranes haven't ruptured earlier this will probably happen during transition.

There may be an urge to push before the cervix is fully dilated.

Your midwife will be able to help you breathe through this phase or assist you to change your position until the cervix is fully dilated.

If you are not fully dilated and you push too early the cervix may become oedematous (swollen) and result in the process taking longer.

Symptoms of transition are shivering, cramps, nausea, vomiting, hiccups and you may feel pressure on your bowel as the baby's head moves deeper into the birth canal. Many mothers feel an overwhelming urge to open their bowels at this time due to the pressure from the babies head.

Self help:

- Try to remain focused – self-meditation and relaxation will help.
- Request silence or assistance as you need them.
- Close your eyes and concentrate on breathing as deeply as you can.
- A shower or bath* at this time may give you relief.
- Nitrous oxide gas can be helpful during this phase.

Your support person can:

- Keep the environment quiet so you can focus without interruption.
- Provide the reassurance, encouragement and love.
- Provide ice / sponges / pillows etc.
- Liaise with extended family members so their labouring partner is not disturbed.

Your midwife will:

- Help you find a comfortable position to promote cervical dilation.
- Assist you with using the Nitrous gas if you have requested this method of pain relief.
- Perform a vaginal examination to confirm full dilation.
- Control and monitor visitors and activity around you and your room.

Positions and coping strategies:

- Same as active labour.

2.4.2

Second stage of labour

The second stage begins when the cervix is fully dilated (10cm).

Second stage can last up to two hours with a first birth. Subsequent births are much shorter and stronger, usually lasting no more than an hour

Contractions in second stage are usually shorter than in transition, and more spaced apart, with time to rest in between.

The urge to bear down is usually irresistible. With each pushing action, the baby moves down the birth canal. Pressure will be felt on the bowel as the head presses on the rectum.

As the head presses on the perineum and the vaginal tissues open, a burning sensation may develop as the skin stretches to its maximum. As the baby's head crowns, you will be asked to pant quickly to allow a gradual stretching and easing of the skin over the baby's face.

Once the head is born, the baby turns to one side to line up with the shoulders. The shoulders are born one at a time, and the baby's body then follows. The baby is usually birthed onto your abdomen (and waiting arms).

Self help:

Once the second stage begins the feelings of transition pass and you may have a 'second wind'. Working with your body by pushing feels more satisfying and contractions seem easier to cope with. You will feel excited and anxious as you get closer to the arrival of your baby.

- The uterus will dictate when and how much to push – wait for the urge to push and concentrate on letting your body open up.
- You will feel a burning sensation as the head crowns, pant to control the urge to push hard and follow the directions of your midwife or obstetrician. The burning sensation lasts until the birth of your baby.
- Find a comfortable position for pushing with your body upright.
- You can feel the top of the baby's head with your hands to help encourage you with your pushes.
- In between contractions rest completely and keep sipping water.
- Using a mirror may assist effective pushing and enable you to watch the birth of your baby.

Your support person can:

- Help support you during pushing.

- Massage your legs / thighs after each period of pushes, to ease cramping.
- Coach you with your pushing and breathing.
- Provide water / ice / washcloth to refresh you between pushes.

Positions and coping strategies:

- Sitting-up with back support.
- All fours / squatting / kneeling. Please note that when an epidural is used in labour the opportunity for women to adopt weight bearing positions can be difficult. Your midwife will guide you into positions that are comfortable.
- Try to put all your energy and strength into the push.

Your midwife will:

- Monitor your baby's heart rate throughout your contractions.
- Prepare the neonatal resuscitation cot. (this cot is used for each birth and is not an indicator of a need for resuscitation).
- Help you to change position when pushing.
- Direct you by helping to work with your body on when, where and how to push (especially if you have an epidural and urge to push is not strong).
- Notify your obstetrician that you are fully dilated and pushing.
- Work collaboratively with your obstetrician to support you through the pushing and birth phase.
- Note and record time baby was born.

Your obstetrician (or midwife) will:

- Protect the perineum as the baby's head is delivered.
- Coach you when to start panting and stop pushing (crowning).
- Place the baby on your abdomen for you to discover the sex/ meet your newborn.

Once the baby is born, the cord is then clamped and cut. Please advise your midwife if your partner would like to participate in cutting the cord (or not).

- Check the baby is breathing without any problem and responding well to birth. This is when the Apgar score is done at 1 and 5 minutes.

2.4.3

Third stage of labour

Delivering the placenta.

As you are birthing your baby the midwife will administer an oxytocin injection in your thigh or through an intravenous drip if you have one in situ. This medication assists with the contraction of the uterus which ensures that the placenta detaches from the uterine wall and that bleeding is minimised. **SJGHC recommend that all women are administered oxytocics for the third stage of labour. Please consult with your obstetrician if you require further information.**

The uterus will contract and the placenta will come away from the uterine wall and slide into the vagina. With gentle traction on the cord and possibly a few pushes from the mother – the placenta will be expelled (usually from 5-20 minutes).

The placenta and membranes are examined to make sure they are complete and that no pieces have been trapped in the uterus.

The perineum is checked for any grazes or tears that may need a stitch. If an episiotomy has been performed, then this will be repaired.

- If you require stitches a local anaesthetic will be given to numb the area prior to repair (if there is not an epidural / pudendal block in place)

Your support person can:

- Help hold the baby close to you if you are tired and shaky.
- Keep you informed of what is happening if your baby is away from you.
- Coach you and reassure you if you require perineal repair.

Your midwife will:

- Remove any wet baby wraps and replace with warm ones.
- Observe your baby and provide any assistance necessary such as suction, oxygen (this may need to occur on the resuscitation cot).
- Assess the baby and determine the Apgar scores. (see Care of the Newborn).
- Place identity bracelets on baby's ankles after confirming with parents.
- Give the baby a Vitamin K dose, by injection, as per your written consent. (Newborn Care for further information).

- Ensure baby's weight, length and head circumference are measured.
- Attend to mother – check vital signs, blood loss, provide pain relief and/or ice packs for perineum, uterine contractions (fundus).
- Assist mother to breastfeed baby, as soon as able.
- Assist mother to get clean if unable to get out of bed, or to the shower if ambulatory.
- Check placenta to ensure that it is complete.
- Transfer mother to postnatal unit when everything satisfactory.
- Check and measure mother's urine output.

IMPORTANT INFORMATION

Precious First Moments

The first few hours after your newborn is born is an important time to get to know the new person in your life. It is important to ensure that whilst your baby is in the skin- skin position / having their first breastfeed that you observe the following:

1. Ensure that baby is positioned so that their nose is free from obstruction.
2. Monitor your baby's colour and call for assistance immediately if you notice any changes.
3. Ensure that you are not distracted from observing your baby during this important phase of transition to life outside the womb.
4. Enlist the help of your midwife to ensure that visitors do not become overwhelming.
5. Limit the number of people that hold baby to reduce the risk of infection.

The midwife may also attach a pulse oximetry probe to your baby's foot whilst they are having their first cuddles / breastfeed. This assists with identifying newborns who are having trouble transitioning to life outside of the uterus.

2.5 Relaxation and coping strategies

Pregnancy, birth and the early post partum period can be stressful for new parents. Learning some ways of reducing stress and some specific techniques that relieve symptoms will help. You can practise these techniques with your partner at any time in the pregnancy and you may find them helpful after the baby is born.

2.5.1 General relaxation

- Find a comfortable position where your body is fully supported.
- Pay attention to your legs and feet, they should be relaxed and comfortable.
- Play some soothing music that will help you relax and tune out distractions. Take several slow, deep breaths, releasing any tension from your body each time you breathe out.
- Working from your feet up through your body, imagine each part is getting heavier and loose.
- Continue until you have achieved a state of overall relaxation, allowing yourself time to enjoy the sensation of complete release for several minutes before gradually re energising by wiggling first your feet, then legs and arms, then head and body. (Practice this during the final stages of your pregnancy).
- This general relaxation can be done anywhere provided you can rest your head, and your body is well supported. It can also be useful if you are having trouble falling asleep.
- You may want to play relaxation / meditation music and use this during the final stages of your pregnancy as well.

2.5.2 Touch relaxation

Learn to relax during your massage. Your partner can concentrate the massage wherever you feel tense or uncomfortable by rubbing their hands warmly and firmly. Try circular motions or rubbing from the centre of the body out to the periphery. Let yourself go relaxed and loose so that you allow the massage to work. Usually, massaging the shoulders, back and neck offers the most comfort.

2.5.3 Massage techniques for labour

Try these types of massage to help relieve tension and pain in labour:

- **Sacral massage:** Firm, circular massage of the lower back, useful if experiencing a lot of back pain.

- **Thigh massage:** For cramps, fatigue or shaking in labour, usually during pushing stage.
- **Stroking massage:** For tense muscles, especially the upper back and shoulders.
- **Effleurage:** Fingertip massage, good on the abdomen during contractions or face.

Practice your massage regularly and work out what is helpful and relaxing for you. Baby oil / vegetable oil or aromatherapy oils (ensure not contraindicated in pregnancy) are soothing and helpful during massage. Sacral massage can be great for backache in pregnancy. Endorphins (your body's natural "pain relief" hormones) can be stimulated during back massage.

2.5.5 Breathing

Breathing deeply and rhythmically can help relieve tension and promote a sense of comfort and controlled state. You do not need to learn how to breathe during labour. Breathe at your own rate, allowing you body to determine when to breathe in and breathe out slowly and purposefully. You will breathe faster if you require more oxygen or energy, naturally. Trying to breathe to a set pattern can lead to exhaustion and tension the opposite of what you need. Follow the **slow breathing technique below**, at your own pace, and you will conserve energy and stay relaxed.

Breathing techniques are used only during a contraction, not the rest periods between contractions. Breathing enhances relaxation and helps distract during a contraction. During the rest period between contractions – concentrate on slowing your breathing and relaxing your body. These breaths between contractions should be through your nose on inhalation and out through your mouth on exhalation.

At the beginning, and at the end of a contraction, it is important to utilise a "releasing" or "cleansing" breath. This provides the woman, and the working uterus, with a good exchange of oxygen, and signals to the attendants, that the contraction has begun, and been completed. To do this, consciously draw a deep breath in through the nose, and let the air escape through the mouth in a "sigh". The breath out is longer than the breath in. Consciously release tension on each breath out – RELAX. Using the cleansing breath helps define the contraction, and makes it clear they are finite there is an end to each one - you can have a rest between each contraction.

Slow breathing:

Slow breathing enhances relaxation and provides a measure of distraction during contractions so that tension does not take over. The simplest method of breathing is known as relaxation, or slow breathing. It is easy, untiring, and individual. It ensures a steady flow of oxygen. Basic slow breathing is a big deep breath in and a long easy breath out through a slightly rounded mouth. Let your lips come together while you pause for your body to breathe in for you. When you are ready to breath out, do it as before. Keep the emphasis on the breath out. Do not consciously inhale the breath in. This breathing technique can be used throughout the whole of first stage, although as contractions become stronger it is often natural to either increase the speed or deepen the breathing. This is individual and each woman should choose for herself.

Breathing through a contraction – transitional stage:

During transition, some breathing techniques may help. One technique is "*feather blowing*". Pretend you must keep a feather suspended in the air, above your face, with a series of light blows. This stops breath holding and hard pushing, and also extends the head and prevents air pressure build up, reducing the need to push.

Another method is the "*pant blow*" sequence, pant, pant, pant, blow in 4/4 time. This does a similar thing to "*feather blowing*". It also assists the mother to focus as she concentrates more on the pattern of breathing and less on her discomfort.

If at any time the breathing causes "**hyperventilation**" where the woman blows off too much carbon dioxide, it is important to know the symptoms and treatment. Over breathing may cause dizziness, numbness of the mouth, tingling of the fingers and extremities, and perhaps a feeling of panic. The treatment is very simple, re-breathe your own air through cupped hands over the face. Once the symptoms

have passed slow down the breathing and breathe more deeply.

Breathing while pushing:

There are many different methods of controlled breathing during 2nd stage. Up until then, there is an overwhelming urge to push, the above methods should be used. As the urge to push takes over, this is one method of using your breath to assist that urge. Take a deep breath and hold it. Using the air pressure you have gathered, push down.

Imagine the baby coming around the pelvic curve. Try to get about three good pushes per contraction 15 to 20 seconds each. As the head stretches the perineum, you will be asked to pant, pant and blow to allow the skin to stretch. Large pushes at this time may increase the chance of an uncontrolled tear. Sometimes small pushes will be encouraged between contractions to help prepare the perineum.

Panting during second stage as the baby crowns is useful to control the urge to push and to slow down that final phase as the baby's face is delivered. Your obstetrician/midwife will tell you when to pant and coach you, so that we can protect your perineum during delivery.

This may seem confusing now, but your midwife will assist and coach you throughout your labour and birth. Also, the partners can help the mothers to manage their breathing throughout labour.

2.5.6

TENS for pain relief in labour

TENS, or Transcutaneous Electrical Nerve Stimulation, is an option for pain relief in labour. It is a non-invasive method and does not alter the conscious state of the mother or affect the baby.

How does TENS work?

The theory is that TENS stimulates the nerve endings sensitive to tingling. By doing this, the pathway from the nerve endings responsible for the sensation of pain is partially blocked and so the message of pain doesn't reach the brain. TENS is also thought to raise the pain threshold by increasing the production of the body's natural painkillers (endorphins).

An electric current is passed through the skin via rubber electrodes and the intensity of the impulse is controlled by the labouring woman. The tingling sensation from the TENS can also act as a distraction from pain.

How effective is TENS?

TENS has been used for years to relieve pain in many conditions such as low back pain. It has been used in the relief of labour pain for many years and has been found to be very effective and safe.

TENS does not relieve labour pains entirely but is designed to take the edge off pain and allow the labouring woman to have more control during contractions.

TENS is most effective in the first stage of labour. However, some women find it is effective through all stages of labour. TENS is most beneficial when used in conjunction with other coping mechanisms such as relaxation breathing techniques, massage etc.

What are the benefits of TENS?

- Easy to use. Non invasive.
- Safe for mother and baby.
- Controlled by labouring woman.
- Freedom of movement for an active birth.
- Can be ceased immediately if necessary.

NB. TENS machines for birth are usually available at your local physiotherapy service . It is recommended that women attend an appointment where they can be orientated to the use of the machine and the correct attachment of the pads to the back.

If you have hired a TENS machine online you should thoroughly read the instructions with your partner to ensure you understand where to place the pads prior to labour commencing.

2.5.7 Water and Heat

Warm water through the use of a shower in labour can assist with reducing the intensity of contraction pain.

Your midwife will also be able to provide heat packs during your birth suite / postnatal stay.

Section 3:

Medical care during labour and birth

- Vaginal examinations.
- Fetal heart rate monitoring.
- Induction of Labour.
- Assisted births, (i.e. vacuum or forceps).
- Caesarean birth (both elective and emergency.
- Medical pain relief – Epidurals and narcotic pain relief

Obstetric interventions can be life saving procedures for women and babies. Technological advances, improved surgical techniques and better anaesthetics have ensured that any of the women that need this kind of help receive the best possible care.

3.0

Vaginal Examinations (internal)

Your obstetrician or midwife will perform, with your permission, an internal examination to determine the condition of the cervix, progression of labour and/ or rupture of membranes.

When is it necessary?

- On admission to hospital to determine your stage of labour.
- Prior to induction to determine the condition of the cervix (readiness for labour).
- To determine whether membranes are intact or ruptured – or to rupture membranes.
- Prior to administration of narcotic pain relief, insertion or top-up of epidurals.
- To confirm second stage to ensure cervix is fully dilated.

How is it done?

The mother is asked to lie on her back with her legs open, the midwife or obstetrician wash their hands and wear sterile gloves, they will then clean the vaginal area, then gently places two fingers inside the vaginal opening, then feel the cervix to determine stage of labour and position of baby.

3.1

Fetal heart rate monitoring in labour

Fetal heart rate monitoring is a means of listening to and recording your baby's heartbeat during labour. This may be done intermittently, by using a battery operated Doppler to listen to and count the baby's heart rate; or continuously, using an electronic machine to record the heart rate on a computer screen. Continuous fetal monitoring, also called an EFM or CTG, is used to assess your baby's general well being and uterine activity.

3.1.1

Continuous electronic fetal monitoring (CTG)

An electronic method of determining the baby's heart rate, the length and strength of contractions and the reaction of the baby to those contractions.

When is it necessary?

- When there are signs of fetal distress, indicating that the baby may be experiencing difficulties.
- Any concerns about the progress of labour
- If the liquor (fluid around baby) is not clear.
- Pre-existing conditions – eg high blood pressure, gestational diabetes.
- When labour is being induced, to determine the effects of the induction on the baby.
- When requested by your obstetrician.

How is it done?

External monitoring uses two discs held onto abdomen by elastic belts. One holds an ultrasound that records the baby's heartbeat, this needs a gel to help transmit the heartbeat; the other records the length and strength of the contractions. The discs are connected up to a machine that provides a printout of both readings.

SJOG healthcare incorporates technological advances that enable all CTG monitoring to be seen remotely by your doctor in real time. This provides an additional layer of surveillance that keeps you and your baby safe and well cared for.

3.2

Induction of labour

An induction is when labour is brought on by use of hormones, which stimulate the uterus to contract. There are different methods of hormone induction – prostaglandins, cervidil and Oxytocin.

3.2.1

Prostaglandins

A hormone, in gel form or pessary, applied to the cervix in preparation for an induction.

When is it necessary?

To help soften the cervix prior to inducing labour.

How is it done?

The Prostaglandins is applied as a gel or pessary in the area around the cervix. A repeat dose of the gel may be required. Not recommended for women with ruptured membranes or contracting. A CTG will be in place before and after the gel insertion to monitor the babies heart rate.

3.2.2

Cervical Ripening Balloon

Your doctor may use a cervical ripening balloon – this is inserted into the cervix through the vagina and then water is placed in the balloon of the catheter. This gently stretches the cervix prior to the use of rupture of membranes and oxytocin infusion. The balloon may come out when the cervix dilates slightly. It may also remain in overnight and is removed with the water being taken out prior to continuation of induction.

3.2.3

The use of artificial oxytocics in labour

The body produces a natural hormone, oxytocin, which makes the uterus contract during labour. Synthetic oxytocin is a copy of natural occurring oxytocin which can be given to a mother for three main reasons:

A. To induce labour.

B. Augmentation of labour.

C. Active management of third stage.

A. Induction using an oxytocin drip

Will require a vaginal examination and the rupturing of the amniotic sac (Artifical rupture if membranes)

When is it necessary?

Concerns for the mothers health

- Blood pressure
- Heart disease
- Heart conditions
- Diabetes
- Renal disease
- Cholestasis – Liver condition in late pregnancy

Concerns for the Baby

- Slowed growth
- Large baby
- Pregnancy that has extended past the due date
- Fluid around the baby has decreased
- Concerns for fetal wellbeing

How is it done?

A drip line is attached to a vein in the back of the hand or arm, and synthetic oxytocin is steadily released into the body via the drip. The drip is attached to a device which monitors the rate of flow and this rate is gradually increased until regular contractions are established. Your baby's heart rate will be monitored using a CTG).

C. Augmentation of labour

To speed up contractions after labour starts naturally, or if labour slows down.

When is it necessary?

- If a labour that has started spontaneously slows down and there is a risk to the baby.
- If the labour slows down (Anxiety or maternal distress or epidurals can cause this).

How is it done?

A drip is set up in the same way as for an induction, but after labour has started naturally.

D. Active management of third stage (see birth)

3.3

Artificial rupture of membranes

The artificial breaking of the membranes surrounding the baby, releasing the amniotic fluid.

When is it necessary?

- To assist in the induction of labour – this will be done prior to commencement of oxytocin.
- To assist continuation of labour, which has started naturally (augmentation).

How is it done?

The mother is asked to lie on her back with legs open. A long plastic tube, called an amnihook, (similar to a crochet hook) is introduced through the vagina and cervix. A small nick is made in the membranes and the fluid is allowed to escape. Sometime a small finger glove with a small hook is placed over one finger and this is used in the same way as the amnihook, this is called an amnicot.

Women will sometimes report discomfort during the procedure. Your midwife will assist with guiding you through the process.

3.5 Episiotomy

A cut (made with scissors) in the perineal tissues at the time of birth.

When is it necessary?

- Fetal distress during second stage when it is necessary for the baby to be born quickly.
- To allow more space for assisted birth (forceps or vacuum extraction).
- If there is delay in the birth of the baby.

How is it done?

The mother is asked to lie back so that the perineum can be seen. Local anaesthetic is injected in several places close to where the tissues will be cut. When indicated, the obstetrician makes a surgical cut, using scissors, from the base of the vagina usually out to the side (lateral).

The incision is repaired with dissolving sutures that will take approximately 2 weeks to disappear.

3.6 Assisted births

Any birth that is completed with medical assistance by an Obstetrician / Medical practitioner including caesarean section.

3.6.1 Forceps birth

An assisted birth with the aid of forceps, these are two spoon like pieces designed to cradle the baby's head and traction on the handles assists the baby to be born.

When is it necessary?

Forceps are used only during second stage for these reasons:

- A delay in second stage, baby may be in an unfavourable position – the forceps can be used to rotate the baby.
- To enable the baby to be born when the mother is unable to push / pushing has become difficult.
- Fetal distress, when it is necessary to have the baby born quickly.
- To protect the head if the baby is premature or in the breech position.
- Any maternal condition where pushing would be harmful to the mother, for example a maternal heart condition or very high blood pressure.
- Forceps may be used to lift the baby out of the pelvis during a caesarean section.

How is it done?

Your midwife will assist the mother with the lithotomy position (on her back, legs in stirrups) If there is an epidural in place extra medication will be administered to ensure that there is no significant pain. If there is no epidural inplace the obstetrician will complete a pudendal block (see pain relief section). Once the forceps are in place the midwife will assist the mother with pushing at the height of a contraction to aid with the birth of the head.

3.6.2 Ventouse or Kiwi Cup (vacuum extraction)

Your Obstetrician may elect to use a vacuum when the baby requires assistance to be born and the mother is still able to push effectively.

When is it necessary?

The indications for its use are similar to those for forceps, with some differences:

- It is not used for very premature or breech births.

How is it done?

The mother is placed in the lithotomy position (on her back) with her legs in stirrups. A suction cup is applied to the baby's head and held in place with suction (either hand-held or generated from a portable suction pump). Using the handle on the vacuum tubing, the obstetrician can turn and gently assist the baby down onto the perineum and gently lift it out. The mother must assist by pushing. Once the head is born, the suction cup is removed and the baby is born normally. The 'chignon' or lump on the baby's head from the pressure of the suction, usually disappears within 24 hours.

3.6.3 Caesarean section

This is the birth of the baby through a surgical incision (approx. 10-20 cm) made in the abdominal wall and the lowest part of the uterus.

When is it necessary:

- Pre eclampsia (hypertensive disorder).
- Fetal distress.
- There is a significant delay in the opening of the cervix.
- Malpresentations, such as shoulder or brow.
- Prolapse of the umbilical cord.
- Ante-Partum haemorrhage, due to the placenta separating early.
- Placenta praevia, the placenta is located over the cervix.
- Disproportion, the baby is too big to fit through the pelvis.
- Concerns about the baby's growth (either small for gestation or growth has slowed / stopped).
- Multiple pregnancy, more than 2 babies.
- Fetal abnormality.
- Maternal medical conditions – (i.e. active vaginal herpes that could infect the baby, trauma to pelvis / spine).

Caesarean operations are also sometimes suggested for the following conditions:–

- Breech (bottom presenting)
- Previous caesarean section.
- Twins.
- History of infertility.
- Previous neonatal death.
- Maternal age.
- Maternal anxiety / concern regarding vaginal birth.

How is it done?

There are two types of caesarean births:

- Elective – a complication occurs during the pregnancy which indicates a vaginal birth is inadvisable and you are not in labour. One of the above conditions exist and you are not in labour.
- Emergency – a complication that arises during pregnancy / labour, which requires immediate action where a vaginal birth or continuing labour is not an option.

Types of anaesthesia:

- **Epidural:** the most commonly used unless there is a real emergency. The mother will be awake during the operation and can see and hold her baby straight away, unless the baby's condition requires urgent treatment. With an epidural, suction noises and changing internal pressures and tugging (but no pain) may be felt as the baby emerges. [See pain relief section for details].
- **Spinal anaesthetic:** similar to an epidural, but faster acting and of shorter duration. May be used as an alternative or in conjunction with an epidural for post operative pain relief. A spinal is only an option if no epidural already exist.
- **General anaesthetic:** used in an emergency requiring immediate birth of the baby or maternal conditions where an epidural / spinal is not advised. Should this type of analgesia be required partners will be unable to remain in the operating theatre during the birth of the baby. The midwife will provide partners with support and guidance in relation to where they can wait / first interaction with baby.

The specific procedures involved in a caesarean are as follows:

- The top pubic hair is shaved.
- You will be provided with a theatre gown and hat to wear.
- Your support person will be shown where to change and what to wear if they are to accompany you. Support people are required to wear closed in shoes (no sandals / thongs)
- Obstetricians may require you to wear anti-embolic stockings (TED), to be worn during and for at least 2-4 days after birth. An intermittent pressure device will be placed around each calf and will rhythmically stimulate muscle movements in your legs (for 12-24 hours post surgery). This reduces the risks of problems with deep vein thrombosis (DVT) in your legs.

Once you have been transferred to theatre:

- An intravenous drip line will be set up into the back of a hand.
- A Spinal / epidural will be inserted if not already in place
- A catheter is passed into the bladder to keep it empty, after the epidural has been inserted.

- A blood pressure cuff is attached to give a continuous reading. The area will be surrounded with sterile drapes, and a drape will be erected as a screen so the operating area is out of sight.
- The anaesthetist caring for you will ensure that the epidural is providing the appropriate level of cover so that the operation can proceed.
- Your obstetrician will perform an incision (approx. 10-20cm) through the lower abdominal wall usually on the 'bikini line' and then the uterus is opened.
- The amniotic fluid is sucked from around the baby after the membranes have been ruptured. The baby is lifted out, often using forceps to protect the babies head and assist birth. If an epidural or spinal has been used, the baby can be seen emerging and the first cries will be heard.
- There will most likely be a paediatrician in attendance at your caesarean birth who will ensure your baby is well before passing to you and your partner to hold.
- An injection of oxytocin is given to help the placenta to separate.
- The placenta is then lifted out, and the wound sutured.
- Where possible our SJGHC Hospitals will endeavour to keep mothers and their baby together. Should your newborn require assistance with breathing or temperature control they may need to be admitted to the special care nursery. Should this be required the partner will be requested to come with their new baby whilst your midwife / theatre team complete the post operative recovery phase.

3.7
Pain relief in labour

There are a number of drugs that may be offered to women during labour to ease the discomfort. Everyone reacts to drugs differently, if you know you have a reaction to certain medications make sure you tell your obstetrician and/or midwife.

3.7.1
Narcotics

Narcotic drugs that are given in labour may reduce the experience of the pain. It is not a pain-killing drug, (the pain doesn't go away completely) but may ease the pain as the drug takes effect. It often changes your perception of the pain as it relaxes you. These drugs do pass on to the baby and depending on when it is given during labour may affect the baby in the initial period after birth. Your baby will be monitored for any effect if this is used in labour.

When given:

During first stage, once labour is established. Usually avoided if birth is expected within the hour. (Due to effect on baby post birth – If baby is affected they may require an injection that reverses the narcotics in their system).

Given for pain relief following caesarean birth.

3.7.2
Nitrous Oxide and Oxygen (Entonox)

A combination of two gases – nitrous oxide and oxygen. Using a mouthpiece attached to a dispenser that allows the amount of the gases to be varied. Deep breathing is required to activate the dispensing machine, which can then be heard making a rattling sound. It is important to start breathing through the mouthpiece as soon as the beginning of the contraction is felt and right throughout the contraction, to obtain the maximum effect.

When given:

Can be administered when requested but research shows that it is more effective in the later part of the first stage of labour / transition.

3.7.3
Anaesthetic drugs

These can be given by injection to relieve pain during labour. An anaesthetist is required to administer an epidural or spinal anaesthetic. Obstetricians and GPs can give pudendal blocks and doctors or midwives may give local anaesthetics.

A: Epidural anaesthetic

An injection of local anaesthetic into the epidural space in the spinal column, which works on the nerve endings of the body below the injection site and relieves the pain from contractions. The epidural may not take the groin pain

with contractions away or the pressure in your bottom feeling. Both of these assist with when to push during second stage. It is the preferred anaesthetic for a woman having a caesarean section.

Route administered:

A small amount of local anaesthetic is injected into the epidural space usually between the third and fourth lumbar vertebrae. This may be done once, then topped up at regular intervals (for labouring mothers), or may be delivered continuously through a special pump. The epidural catheter remains in place and is taped securely.

Your midwife will assist the anaesthetist during the administration process and will support you with information required.

Post caesarean birth women may have a self administered epidural for pain control.

The anaesthetist will explain how to administer doses once you are in recovery.

Dosage:

If a combination drug of narcotic and anaesthetic is used then the numbness will be complete and the mother will be unable to move her lower limbs or empty her bladder. Low dose epidurals (narcotic only or low dose local anaesthetic) will work on the nerves and remove the pain of the contractions and the mother may still be able to move her legs, sit up and maybe able to pass urine.

Post caesarean epidurals only contain narcotics so that women are able to commence moving and walking once the initial numbness wears off.

When given:

- For pain relief, at any time in first stage, but usually once labour is fully established.
- Prior to a caesarean section
- To reduce high blood pressure during labour.

B: Pudendal Block

This is an injection of local anaesthetic into the pudendal nerves in the vaginal area to numb the whole perineal area.

Route administered:

The anaesthetic is injected through the walls of the vagina into the nerves on both sides of the vagina.

When given:

During second stage if instrumental delivery likely and no epidural in place.

C: Local anaesthesia of the perineum Local anaesthetic is usually injected into the perineum before an episiotomy is performed.

Route administered:

A series of small injections are made into the area where the episiotomy will be made or where the stitches will be placed – usually as the baby's head begins to crown.

Methods of pain relief

Drug	Time Lag	Duration	Route Administered	Administered by
Pethidine/ Morphine	10-20 mins	2-3 hours	Injection into thigh or buttocks	Midwife - on obstetrician's orders
Nitrous oxide	15 secs	Whilst being breathed plus 15 secs	Through a hand held mouthpiece	Yourself
Epidural anaesthetic	5-15 secs	Varies according to type of block 1-3 hrs	Epidural space	An anaesthetist inserts epidural and gives first dose. Continuous background infusion with self administered top ups. Midwife may administer extra top ups for break through pain
Pudendal block	Immediately	Usually less than an hour	Via prudential needle into pudendal nerve either side of vagina	By your obstetrician / GP obstetrician
Local anaesthesia	Immediately	Usually less than an hour	A series of small injections into perineal tissue	By obstetrician or midwife for an episiotomy or for perineal repair

Section 4:

4.1

Immediate care of the mother after birth

After your baby and placenta have been delivered, your body will start the journey back to its pre-pregnant state. The uterus will eventually contract back into a small organ and the uterine wall (where the placenta was attached) will start to repair itself. To ensure your body is adjusting to the changes and has coped with the labour and birth your midwife will check you very regularly for the first four (4) hours after your birth.

These observations will include:

- **Your vital signs** – temperature, pulse, blood pressure respiratory rate, oxygen level recordings.
- **Your fundus** – we feel the top of the uterus around your umbilicus – to make sure it is hard and contracted. Usually each day your fundus will go down (involute) until it lies below the pubic bone again (usually one (1) finger width per day).
- **Your Vaginal loss** – you will have a moderate / heavy loss for the first few days – bright red in colour – rubra. Your midwife will assist you with identifying what is normal loss in the first 24 hours.
- **Your urine output** – Your midwife will be measuring the amount of urine you are passing and will advise you of how long this will need to be assessed (usually 2-3 measures in the first 4-6 hours post birth).
- **Your bowels** – Your midwife will discuss expected bowel motions in the first few days post birth.
- **Your perineum** – if you have any bruising, tears or stitches, the midwife will check they are healing. We can provide ice pads to reduce swelling in the first 24 hours after birth. Your Obstetrician may request physiotherapy treatment to help decrease any swelling / discomfort.
- **Hemorrhoids** – Should you experience these your obstetrician may prescribe a local medication to assist with discomfort and healing.
- **Pain relief** – your midwife will ensure that you are provided with adequate pain relief so that you remain comfortable.

4.2

Care of the mother after a caesarean birth

The mother who has had a caesarean section will have the above care with some extra attention related to the surgery, these include:

- Oxygen saturations – a peg like monitor placed on your finger.
- Wound checks – for bleeding and signs of infection.
- Indwelling catheter will be emptied and measured regularly, usually removed within 24 hours.
- Any drains will be checked regularly and removed as per your doctors instructions.
- Monitor your patient controlled epidural analgesia (PCEA) and usually remove within 48 hours. If not insitu, effective alternative pain control will be offered.
- Monitor your intravenous site (IV site).
- Assist you with freshening up after you return to the ward and your sensation and movement returns, followed by a shower 8-12 hours later if you have full movement and strength in your legs.
- Administer anticoagulant injections (subcutaneously) if prescribed by you obstetrician, following the regime for approximately five (5) days.

4.3

Feeding your baby

Your midwifery / Nursing team are there to support you with feeding your newborn baby.

For comprehensive breastfeeding information please refer to the booklet back on the home page. Further information and videos can be found on the raising children website: **www.raisingchildren.net.au**

For comprehensive formula feeding information please refer to the raising children website **www.raisingchildren.net.au**

Baby care education

We will assist, support and educate you with the care of yourself and your new baby including:

- Nappy change (we use and provide disposable nappies during your stay in hospital).
- Dressing your baby (we provide singlet tops and wraps). You can bring your

own baby outfits (but ensure they are washed and labelled and make sure they don't go into the Hospital laundry).

- Breastfeeding – including care of nipples and breasts, positioning and attaching baby.
- Demonstrate formula feeding technique if this is the method of infant feeding you have chosen.
- Bathing interactive demonstration.

4.4

Ongoing post partum recovery

Following the birth of your baby, your body will gradually return to its pre pregnant state. This will take several months. In the first few weeks however, you will notice the following:

4.4.1

Vaginal loss - lochia

You will have bleeding following the birth, and it will be red at first, then turn a reddish brown, then finally, after about 2 weeks, become a clear discharge.

The lochia usually disappears after 3-4 weeks but for some women may continue until 6 weeks. The initial bleeding will be most noticeable when you breastfeed, as the uterus contracts at this time. Clots are not unusual Clots are not unusual in the first few days after giving birth but need to be checked by the midwife if larger than a 50 cent piece. Should you notice any increase in flow or changes in colour, odour or increasing pain you should let your midwife know.

If any bright bleeding persists after you leave hospital, contact your obstetrician.

If you suddenly bleed very heavily and you require immediate assistance call 000.

4.4.2

Afterbirth pains

When you breastfeed your baby your body has a hormone response that causes the uterus to contract. In the first few days these contractions can be unpleasant, especially if this is not your first baby. These pains usually become less severe and can be treated with a hot pack or some paracetamol

4.4.3

Emotions after birth

Some women feel teary and emotional after the birth. This is usually temporary as your body returns to normal hormonal levels. A long shower and a good cry may often help. You may also be very tired so reduce visitors at this time and catch up on sleep through the day.

4.4.4

Tears / episiotomies

The following hints can help with any perineal discomfort.

- Apply ice to perineum for 20 mins every 2 hours, 24-48 hours
- Physiotherapy treatment is available to help decrease swelling and pain and to promote healing throughout your hospital stay and after you have been discharged.
- Do your pelvic floor exercises as soon as you can. These will help improve circulation and speed the healing process.
- The first few times you have your bowels open, hold a pad against your perineum.
- Lie on your side to feed the baby.
- Keep the area dry and clean after passing urine. Ask for medication to make your urine more alkaline to prevent stinging when passing urine.
- Report any pain, swelling, bruising or anything you are unsure is normal to the midwives.
- Stitches should have healed by 3 weeks. If this has not occurred, see a doctor or midwife and have them checked.
- If your perineal area is still uncomfortable when you have your six week check up, tell your doctor.
- The first few times you have sexual intercourse, use a lubricating jelly. You may need to experiment with alternative positions for comfort too.

4.4.5

Routines

Routines go out the window for the first few months after having a baby but gradually

a pattern will emerge. Babies usually respond well to have a routine to help them learn to settle and adjust but sleep for the whole family is the most important factor with a new baby. Sleep patterns change all the time as your baby grows and has different sleep requirements.

Your child health nurse should help with each developmental stage you child approaches. Learning your baby's cues can take a while but soon become easier to follow and help you to settle and nurture your baby. Housework and socialising may be difficult to maintain in the first few months, remember to just do what has to be done and care for yourself as much as for your baby. You will find spending time with your baby more rewarding than having a spotless house. Don't be afraid to ask for HELP and just enjoy this time with few or no expectation.

4.4.6

Getting help

If you have a baby who cries a lot, is hard to settle or sleeps very little you might need lots of help and support. It does not mean you have done something wrong. Some babies are placid and make few demands others are more demanding and require more attention from you – they have personalities and characteristics just like everyone.

If you are finding it difficult to cope with or struggling to comfort your child, call on others for support or advice. Your local child health nurse will have names of local mothers' groups, breastfeeding support groups, or playgroups and local resources available to you. Talking to other mothers is a big help and very reassuring.

4.4.7

Fatigue

Fatigue is the biggest issue faced by new parents. Broken sleep, anxiety about baby's care and wellbeing, and hurried or skipped meals all contribute to tiredness. Tiredness can affect your enjoyment of the baby and interfere with your relationship with your partner. In the first few weeks:-

- Make time each day to have a rest, to compensate for broken sleep at night.
- Take naps after your baby has fed and has gone off to sleep.
- Try to make night feeds quicker by having everything ready (drink water, night light, spare cloth or nappy)

Resist the urge to interact with your baby at night – make feeding and changing as minimalist as possible.

- Only attend to the baby when it cries, try to ignore little whimpers or groans or short cries – your baby may settle quickly without you. If you get up to check the baby a lot you may risk disturbing them.
- Try to limit visitors, and use your "Do Not Disturb" sign when you and your baby are sleeping / napping.
- Make sure that your diet is adequate. Cook up extra servings whenever possible so you have ready made meals for busy times or lunches.
- Eat small frequent nourishing snacks, such as boiled eggs, cheese sticks, vegetable, fruit, etc especially if you find you are skipping main meals.

4.4.8

New parents' tips

Here are just some of the things that are important to keep in mind:

- Your baby can't have too much loving.
- The only way your baby can communicate to you is to cry – as time passes you will learn why your baby is crying – but always start by keeping the baby clean and dry (changing nappy) and fed and move onto comforting once these have been attended to.
- Sit down together and work out a proper budget, don't let money problems build up.
- Make time for each other.
- Find someone to look after your baby even if it's just for a few hours.
- Forget that you're parents every now and then and talk about anything but your baby.
- Share household chores and shopping.
- Don't expect too much of yourselves with cooking and housework.
- Accept offers of help from friends or family.

4.5

Care of the newborn

4.5.1

APGAR Score

Apgar is a standardised scoring system used by the midwife / doctor at 1 and 5 minutes of life to assist with defining the amount of support a newborn requires to adjust to life outside the uterus. The midwife / doctor will be evaluating

- breathing effort
- heart rate
- muscle tone
- reflexes
- skin colour

Observations

- Hourly after birth for three hours then four hourly for 24 hours or until stable or as ordered by the paediatrician. Some newborns will require more frequent observations for a longer period of time.
- Your midwife will advise you of your newborns observation schedule after the first 24 hours. Observations include colour, activity, heart rate, respiratory rate, temperature and feeding.

4.5.2

Weight

This is checked at birth day 1 and then on day 3-4, and day of discharge < 10% weight loss by day 4 is acceptable (due to meconium, excreting fluid from lung, urine output and low volume feeds). Newborns who are preterm, low birth weight or jaundiced may be weighed daily.

4.5.3

Vitamin K

The administration of Vitamin K to newborn babies is strongly recommended to prevent the rare but potentially fatal condition of haemorrhagic disease of the newborn (HDN). This disease is characterised by spontaneous bleeding and/or bruising in the first six months of life. Vitamin K is administered by a single injection shortly after birth.

Should parents consent to oral administration of Vitamin K they will need to discuss the administration guidelines with the paediatrician.

You will be provided with a consent form which you have to sign to acknowledge your permission is given, prior to Vitamin K being administered.

4.5.4

Immunisation

Parents will be provided with the relevant state immunisation schedule outlined in their Child Health Record.

The first Hepatitis B vaccination is provided during the hospital stay after completion of a parental consent form.

Information regarding this vaccination can be found on the following website:
www.health.gov.au

4.5.5

Bath

An Initial bath is performed after your newborn has maintained a stable temperature over the course of the day. An interactive demonstration bath is performed and then parent/s may bath daily to gain confidence. Some babies enjoy being bathed before a feed and others after – This will take a few practice runs to see what suits you and your baby.

4.5.6

Nappies and cord care

An initial nappy change demonstration will be done once you have recovered and supervision is available whenever requested. We use disposable nappies – which will be provided for you throughout your stay. We start by folding down the front of the nappy to expose the cord, to allow for separation and minimising infections from damp nappies. There is no special treatment for the cord stump. Clean at each bath time, not using cotton buds, and dry thoroughly with the towel.

Normal Urine and Stool motions

In the first 24 hours of life you will likely see 1-2 wet nappies and a number of bowel motions (black meconium to start) Over the next few days the frequency of urine will increase and the bowel motions will transition to a yellow paste. Once you are home you should expect to see a minimum of 6 heavily wet nappies and 3 (or more) bowel motions.

4.5.7

Congenital hip dysplasia

Your newborns hips are checked for dislocation ("Clicky hips") at birth and on discharge by your midwife and paediatrician. Your community based child health nurse will also continue to assess hip function as your baby grows and develops.

Hip dysplasia is a congenital condition, not usually associated with the birth process (however, more common in babies presenting in breech). Diagnosis is confirmed by ultrasound and treatment is a harness holding the limbs in a "frog" position as soon as possible after upon diagnosis.

4.5.8

Newborn screening (previously Guthrie Test)

This is a heel prick and is performed after 48 hrs of age of age, to collect a blood sample, which is sent to the relevant state collection agency for testing. The test is to screen for metabolic disorders. You are only notified (within 2 weeks) if there is an abnormality detected.

4.5.9

Paediatric review / discharge

Well term newborns will be reviewed by a Paediatrician / your GP Obstetrician within the first few days of life. If there are any concerns about the baby either during labour, after birth or if a caesarean section is to be done a paediatrician will be called in immediately.

The paediatrician will also admit or discharge your baby from the Special Care Nursery and/or hospital. They will answer any questions or concerns you have regarding your baby.

4.5.10

Newborn hearing test

All newborns born at SJGHC are provided a hearing test through the local provider. This test is performed during your stay at the hospital and is used to identify any potential issues with their hearing.

4.5.11

Newborn Congenital Heart screening

This is a simple test completed in the first few days of life to screen for rare forms of congenital heart disease. When your baby is in a restful state they will have a pulse oximeter (oxygen monitor) attached to one hand and one foot for a short period of time. Your midwife / nurse will be able to provide you with further information regarding this test.

4.6

Characteristics of the newborn

4.6.1

Measurements

Weight

Average = 3500gms (7.51bs) range = 2500 – 4200gms (5.5 - 9.51bs) Up to 10% may be lost in first three to four days.

Length

Average = 51 cm (20 inches) range = 46 - 56cm (18 - 22 inches).

Head circumference

Average = 35cm (13.75 inches) range = 33 - 37cm (13 - 14.5 inches).

4.6.2

Head

May be round after caesarean or breech birth, or elongated after normal, forceps or vacuum birth. This is called moulding. There may be a "chignon" (raised, soft, bruised area) if the baby was delivered by vacuum extraction.

A forcep birth may leave some redness or some bruising. These may take a few weeks to disappear completely.

4.6.3

Hair

Most babies have some hair, some have a lot. Blonde hair is not so obvious. The first hair may fall out over the first few months and be replaced by different coloured hair. Premature babies may have fine hair present over their bodies that will disappear (lanugo). Some babies of European descent may have dark hair over their bodies, which usually falls out.

4.6.4

Fontanelles

They can be felt in the middle of the head in front and back. The larger anterior fontanelle (diamond shape) closes at approx. 13-18 months old. The smaller posterior fontanelle (triangle shape) closes between 1-3 months, but you may not even be able to feel it after birth.

4.6.5

Eyes

Babies are born with dark blue eyes and change to their permanent eye colour in 1-2 weeks (colour changes can be noticeable up to 6 months). The eyelids may be swollen and a squint evident due to weak eye muscles. Tears appear about 6 weeks.

4.6.6

Ears

Shape and size is inherited. The cartilage in the ear may not be fully formed and bend over when baby is sleeping, this is normal.

4.6.7

Nose

Also inherited and can be misshapen due to delivery process. Babies sneeze and cough to clear mucus and have milia (little white spots) over bridge of nose. Milia are blocked sebaceous glands that do not require treatment.

Nostrils are usually flared to assist with breastfeeding.

4.6.8

Mouth

"Epstein's pearls" (white areas) can often be found on the roof of the mouth, they are of no significance. Tongue ties are common and only in severe cases do they interfere with sucking is treatment required.

4.6.9

Skin

Usually pink and smooth with some vernix (white cream-like substance) in creases.

A premature baby may have vernix over entire body. Post mature babies may have dry skin.

Stork marks may be present on bridge of the nose, forehead, or nape of the neck and do not require treatment.

Birth marks are normal but may need to be reviewed by paediatrician.

Mongolian spots are usually over the legs, lower back and/or buttocks. Are blue in nature and commonly noticed in babies of Asian or European descent. They do blend with skin colour over time.

Neonatal Rash (toxic erythema) is common, does not require treatment and disappears after 2 weeks.

4.6.10

Fingernails

It is advisable not to cut fingernails but they can be easily peeled.

4.6.11

Nipples / Breast tissue

Nipples/ Breast tissue in both female and male newborns may become swollen. This is related to maternal hormones through the breast milk and may secrete a little fluid. This can take up to six weeks to subside and no treatment is necessary.

4.6.12

Umbilical cord

Your midwife will be able to advise you in relation to normal cord care. Initially the cord is white / yellowish and gradually blackens and dries up. The stump will separate after 10-14 days.

You may notice some blood on the nappy when this eventually separates. This is normal.

4.6.13

Genitalia

GIRLS may have swollen labia (especially premature), but this settles after 1-2 weeks. Discharge, mucus and/or blood is normal in small amounts and it is related to the sudden withdrawal of hormones.

BOYS generally have descended testes. If not descended at birth, this should occur within first two weeks or follow up is important. They can also have swollen scrotum, which subsides, and hydoceles (fluid in scrotum. This) will be reviewed by a paediatrician but also rarely requires treatment.

4.7

Behaviour of the newborn

All normal newborns are intelligent and able to learn from birth. They can hear, feel, see, taste and smell, and by using their senses will begin to learn about their world and the people in it who are, in the beginning, their whole world. A baby has both emotional and physical needs from birth. (Breastfeeding can fulfil both of these needs simultaneously.) Frequent close physical contact is essential, particularly in the early weeks. Warm physical closeness promotes a feeling of comfort and well being, of being loved and secure. By placing the baby on the mother or father's chest, the baby will also be able to hear the heart beat, which has been a familiar sound for the past four to five months.

4.7.1

Sleeping

Babies can sleep up to 18 - 20 hours a day at first (if lucky!). They sleep heaviest after a feed and longer if they fed well and received plenty milk. Over each week the length of their awake periods will increase. Some babies startle in their sleep and may 'jump'. This is related to learning about their environment and becoming secure in a bigger "space". They should not be jittery.

4.7.2

Crying / settling

Crying is baby's only means of verbal communication. It is a signal for discomfort, hunger, pain or nothing at all. It can also be related to their emotions (i.e. frustration). Parents often don't realise how much a new baby cries, and they find it very distressing. The baby has a different cry for different needs. Gradually you will learn to recognise each one of them. 'Wind' is usually blamed, but more often the crying baby's need is for physical closeness, to be cuddled and comforted. Cuddling is reassuring. Providing love and comfort is not spoiling the baby.

Some babies can pacify themselves and others need direct attention by their parents. Rocking or "cooing" sounds may be all they need to settle. Your midwife may be able to provide you with information regarding a range of settling techniques you may find useful.

4.7.3

Feeding

New babies can be sleepy. Some of them take a while to learn to suck vigorously. Feed times can be long, and you may need practice at keeping your baby awake in the first few weeks. Some dribbling or regurgitating during or after feeds is to be expected. If you think there is too much, mention it to the doctor or nurse.

Breastfeeding gives a baby all the nutrients needed for good health. Breast milk is always available and right for your baby. It is easy to digest and means less chance of infection. Warmth and close skin contact during breastfeeding also gives your baby pleasure and satisfaction. This close physical relationship allows mother and baby to get to know one another quickly. Physical closeness with the father is of equal importance to the child's learning and to their relationship. A father can provide this in many other ways. If the choice is made not to breastfeed, the baby's emotional needs can be fulfilled at feed time in exactly the same way.

4.7.4

Sucking time

The need to suck will vary considerably among babies. Some will need to suck more frequently than others and for varying lengths of time. New parents may be confused if the baby's need to suck is misunderstood: 'If sucking means hunger, have I got enough milk?' If your baby receives no fluids other than breast milk, appears alert and has at least six to eight wet nappies in each 24 hour period, and most importantly is gaining weight, it is an indication your supply is sufficient.

4.7.5

Movements

Are generally uncoordinated and involuntary, but they have good muscle tone. This means their limbs are flexed and they can lift their head for a few moments.

4.7.6

Reflexes

They have a well-developed rooting reflex to seek for food. They also know how to suck, but may need training. They are more alert at birth than in the following 48 hours. They have a step reflex, a grasp reflex and a startle reflex. Your midwife will be able to show you these reflexes during the assessment in birth suite.

4.7.7

Jaundice

Some babies become a little jaundiced in the first few days, as their bodies eliminate excess bilirubin (a by product of breaking down extra red blood cells from being in utero) from their bloodstream. If your baby appears more yellow than normal, a blood test will be done to estimate the level of jaundice.

It may be necessary to expose the baby to extra light from a phototherapy unit.

The light source may be provided:

- over the standard cot
- over an isolette (for pre tern newborns) or
- by wrapping the newborn in a special blanket (biliblanket).

This may take a few hours or days (if severe). During this time, their eyes will be covered, and they will be sleepy.

Your paediatrician and midwife will explain the importance of fluid intake during this treatment phase and advise you on the frequency of feeding for your baby.

4.8

Special Care Nursery (SCN)

Each St John of God Hospital has a neonatal nursery / special care nursery for newborns that require extra support. Every nursery is able to provide routine support to newborns requiring:

- Regulation of temperature
- Frequent observations (including oxygen level monitoring)
- Phototherapy
- IV therapy (for antibiotics / blood sugar management)
- Nasogastric feeds
- Routine late preterm care
- Respiratory support in preparation for transfer to a larger Hospital

A number of our SJGHC Hospitals are accredited to provide a higher level of care for unwell neonates

– including ongoing respiratory support (CPAP)

– Care for premature neonates

Visiting the Special Care Nursery

Only mothers and fathers / partners are allowed into the special care environment to ensure that the risk of infection to vulnerable babies is minimized. The neonatal care team will orientate you to the strict handwashing process required prior to entry to the nursery.

Grandparents, family visitors and siblings are unable to enter the Special Care Nursery.

4.8.1

Newborn Safety

Our Hospitals are very conscious about the safety and security of your baby while you are staying with us.

- Never leave baby alone.
- Always place your baby's cot in constant view.
- Ensure only Caregivers wearing identification are permitted to handle your baby.
- **Always** transport our baby in a cot outside your room – never in your arms.
- All newborns must be identified by the midwife before being removed from the nursery. Partners will be advised of the local process for identifying that they are part of the family unit for identification purposes.

4.9

Care for the new father / partner

4.9.1

Boarding

The midwife who admits you to the hospital / Postnatal ward will be able to provide information in regards to partner boarding facilities.

4.9.2

Meals

The midwife and support caregivers will provide orientation to the meal ordering process at your Hospital.

4.9.3

Changing roles

Your role is vital and you will find much pleasure from nurturing your relationship with your baby and partner. You need to allow yourself time to spend with the baby, not just to ease the burden on your partner, but to discover for yourself the special qualities and personality of your baby.

Babies love the different 'feel' of their fathers the strong hands, deep voice and the different games they play.

Participating in the daily routine of baby care is not a waste of time or unmanly, but a special opportunity for interaction with your child.

Your partner will need time to adjust to her new role as a mother and to physically revert to her non pregnant state. If she breastfeeds, her primary focus of attention must be

the baby, but this does not mean that she doesn't want a close relationship with you too. Explore new ways of being tender and close, and accept that this is just a phase that will pass as your child grows and no longer needs her total attention.

Support and encouragement from you will be appreciated by her at this time. It is a time of learning for you both, a special time in your lives and a great opportunity for learning more about yourselves as people. Try not to rush or ignore it.

4.10

You and your emotions

4.10.1

Babies change your life in every way

Having a baby affects your individual development, the identity of your family and also your personal relationships.

Your ability to communicate effectively, maintain your relationships, and solve problems is often tested as babies and children are time consuming.

Each parent has three (3) distinct identities: as an individual, a partner and a parent. Introducing a child into your family results in a major change for you, your partner and your family, and you will find that your individual identities shift along with how you relate to each other and to others. Along with the joys of parenthood often comes a good deal of stress and fear about the changes that are happening and also the day-to-day issues that crop up.

In the early days, it is important for you, your partner and our families to understand that you don't have to be a "super mum". As with all changes, it will take time for everyone to adjust and re-establish a comfortable routine. Be patient and learn to compromise with your relationships and your routines. Do not feel guilty about accepting or asking for help. Bringing children into your relationship, including your partnership is a key emotional process. You are now not only an individual but are also learning to be a parent and a decision maker for your family.

Even with all of its challenges, this can be a very happy and rewarding time for everyone.

4.10.2

Postnatal depression / anxiety

Depression / anxiety can occur at any time throughout your pregnancy. Your changing hormones may have a lot to do with this along with any anxiety you have about being a good mother or a new mother.

The symptoms are many and varied but some of those described by mothers are:

- Overwhelming feeling of hopelessness.
- Feeling you cannot cope with things.
- Anger and rage over inconsequential things.
- Thoughts of harming your baby.
- Thoughts of harming yourself.

There are number of support networks and management options available in the community so it is important that you talk to your partner or family, your obstetrician, GP or other health professional if you are experiencing these feelings.

The important thing is not to be afraid to ask for help.

St John of God Health Care Raphael services offer support and information for parents affected by depression or anxiety during pregnancy or in the four years following birth. Please call 1800 524 484 for further information.

4.11

General information and services

4.11.1

Discharge from hospital

When you are ready to leave the hospital we request that you vacate by 10am. This will allow us to prepare for the next patient. It is important to consider any difficulties that you face upon your return home from hospital.

Your Obstetrician and ward midwives will be able to provide you with your anticipated discharge date after the birth of your baby. If both yourself and your baby are well this is usually 3 nights after a vaginal birth and 4 nights after a caesarean birth.

Should you wish to go home earlier speak to your obstetrician and midwife about Hospital "early discharge" programs that can provide postnatal support in your own home.

If you have any concerns regarding your discharge, please speak to you Obstetrician / midwife as soon as possible.

4.11.2

Pathology

Any tests that are performed during your stay and that of your baby are performed by either medical or laboratory staff. There is a separate cost to these tests that will be covered by your health fund differently. Please check with your individual health funds.

4.11.3

Visitors and visiting hours

Please speak to your Obstetrician / admitting midwife in regards to current visitor policies / times.

4.11.4

Pastoral services

Pastoral care and chaplaincy services are available for you and your family for spiritual comfort and support. If you wish to be visited by a (hospital endorsed) representative of your religious denomination, during your stay, please let our nursing staff or a member of the pastoral services team know, and this will be arranged.

4.12

Baby safety

4.12.1

Reducing the risks of SIDS

See www.rednose.org.au

For all the latest information relating to safe sleep practices

4.12.2

Home safety

www.acc.gov.au

The Australian Competition and Consumer Commission publication:

Find out More: Keeping baby safe

Includes the following information:

- Nursery furniture
- Car seats
- Baby slings
- Baby bathing items

Website also includes car seat requirements and car safety

4.12.3

Pets

www.betterhealth.vic.gov.au

Animals and Child Safety

Includes the following content

- Introducing animals to newborns / children
- Importance of direct supervision when interacting with all animals
- Recognising signs of danger.

About St John of God Health Care

St John of God Health Care, is a leading Catholic not-for-profit health care group, serving communities with hospitals, home nursing and social outreach services throughout Australia, New Zealand, and the wider Asia-Pacific region.

We strive to serve the common good by providing holistic, ethical and person-centred care and support. We aim to go beyond quality care to provide an experience for people that honours their dignity, is compassionate and affirming, and leaves them with a reason to hope.

Adapted from the St John of God Mt Lawley Parent Education Workbook.

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