# BREASTFEEDING IN THE FIRST WEEK
# LEARNING BABY'S NATURAL RHYTHMS & PATTERNS

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I. Early discharge a blessing or a curse? Should mom & baby stay 24 or 48 hours?

- A. Historical view and the effect on breastfeeding outcomes
- B. The answer is in the follow-up care
- C. A serious role for home visits! IBCLC, RN, & Doula

II. Moving toward LDRP creates best environment – Better than rooming-in

No separation of the dyad

- A. Mother resolves feelings of inadequacy (Laufer)
- B. Dyad learns to respond to each other - teach parents hunger cues
- C. Baby associates breast w/endorphin release (suckle - Smith) and pheromones of mother's smell
- D. Bonding for parents
- E. Where do you think the baby wants to be?

III. The first 24 hours

- A. Alert and ready to suckle in the first two hours
  1. Some called this the imprinting time or The Golden Hour
  2. American Academay of Pediatrics (AAP) states babies should be placed on mom at delivery and not moved for tasks till the first feed is completed.
  3. Baby will rest for 20 minutes and then move to the breast by 50 minutes.

4. If Vitamin K, heel sticks, exam need to be done before 2 hours, do them on mom early in the first hour when baby feels less pain
5. Weight, height, eye care, etc. could be done after the breastfeed. The feeding may take up to an hour.
6. Transport baby skin-to-skin to postpartum ward.

B. Infant then goes into a deep sleep for 4-6 hours

1. Parents settle in
2. This is during the period called "transition" (1st 12 hours) for the baby, and he should not be disturbed. Some hospitals delay bath & exam until after transition.
3. Where would you like to spend "transition"? Skin-to-skin in PP
    a. Mom laid-back 45° and NOT flat in the bed
    b. Safety – McKenna's work & dad or grandma to watch over her & baby while mom sleeps.
    c. AAP list of unsafe conditions for baby in parent bed
        i. Obese parent >400 pounds
        ii. Parent on drugs, alcohol or overly tired
        iii. Animals or siblings in bed also
        iv. Too small a bed/couch or crevice headboard
        v. Too soft a bedding (water bed, down bed, etc.)
    d. Do babies skin-to-skin seek the breast and graze in transition sleep?

C. Then infant wakes again after transition in 4-6 hours or longer and is eager to feed Baby is still in transition until 12 hours are up.

1. Colostrum makes sporadic swallows & long feedings. AAP says no time limits for the feeding.
    a. Feeds at 1st breast till he spits it out
    b. Burp and change the diaper
    c. Second breast until he releases the nipple asleep
    d. Nurses will come and ask how long he fed & when so they can chart it only. They are not communicating a time limit.
    e. Maternal perception of time at the breast may not match
    f. If baby nurses LONG, mom will have an oxytocin release which contracts her uterus, relaxes her and releases even more colostrum
2. No visitors till noon or ward naptime is helpful.
3. Listen for swallows and teach the sound so Mom can learn
4. Gryboski says newborns may not suckle well the first five days ( 7 days for premature babies) 35-37 week gestation suckle poorly

D. Mother is euphoric the first 24 hours & can't sleep. Ideal to nurse this night after baby's "transition". Will he get 8 feedings in?

1. First feed was in L & D
2. Subtract 2 hours alert in L & D and 4-6 hours sleep = 8 hours
3. 16 hours left and 7 more feeds to go. He can do it if he nurses every two hours this night !

E. Skin to skin keeps the blood sugar and the temperature up-Durand

F. Full term babies are born with a "backpack" Edema and fat under the skin makes them plump and "squishy"

1. This is baby's food and water for the first two days
2. Swaddling and pacifier causes him to use more energy expended than if baby is skin-to-skin
3. Baby has a small stomach so he needs frequent refills
4. Feeding frequently for long feedings is great but he needs a good suckle to remove colostrum and stimulate the system

G. Premies have a greater need for calories but take little volume of milk due to small body size.

1. Even smaller stomach
2. They have no "Back Pack"
3. Some suckle well & others do not
4. Very Low Birth Weight Babies ( < 1500 grams) food calculation:
    a. 80 cc/kg for all of day one
    b. 100 cc/kg for all of day two
    c. 120cc/kg for all of day three
    d. Full term babies should <u>NOT</u> be fed per this chart

H. Full term babies have more of a "backpack" and need less milk

1. On day one (Average 7 cc taken each feeding from breast)
2. On day two (Average 13 cc taken each feeding from breast)
3. On day three (Average 27cc taken each feeding from breast)

4. On day four (Average 46 cc taken each feeding from breast)
5. Baby does not meet the RDA for intake from the breast until day 4 BUT colostrum cannot be compared to formula. Colostrum is more concentrated.

I. From the baby's perspective, would he want his small stomach overly stretched at one feeding? His stomach can stretch to 20 cc on day one if formula fed. If he gets more this first day, he may likely throw up.

J. The earlier baby goes to the breast, the earlier the milk comes in. Textbooks say the milk comes in by 2-7 days.

K. The Joint Commission Sentinel Alert & AAP say 8-12 feeds/24 hours – but he will feed eight times this first day?

L. The moms feel they are feeding ALL THE TIME ! Reassure baby fed continuously in the womb.

1. Why not to say feed every 2-3 hours when 8-12 sounds like that?
2. Babies vary the times with a cluster of every hour feeds at one time of the day and maybe one 4 hour sleep at another time of day.
3. Get her comfortable for these long feedings
4. Help at home so she can sleep when baby sleeps (doula, grandma)
5. Babies are night feeders! They will have 5 feeds between 6pm and 6am and 3 day feeds from 6am to 6pm. Waking baby in the day does not change this pattern. It seems to be a biorythem.

M. The baby's perspective – wouldn't you want to pace your feedings?

N. What about the sleepy baby? May need to be sure he feeds often

O. No formula unless medically indicated per the AAP

1. Babies having trouble may not suckle well. Assess that
2. Remember Gryboski says that they may be developing the suckle
3. If formula ordered by the MD, use the SNS because:
    a. The flow organizes the suckle AT THE BREAST.
    b. Helps the baby build trust in the breast
    c. Corrects baby's suckle so 8-12 unlimited feeds prevent engorgement
4. If suggestions for help do not work, moms go to another LC and the 1st LC does not know it did not work

P. But, generation "Y" listens to friends, family, & internet more than the medical profession.

1. Watch they don't keep baby swaddled all the time with a pacifier rather than skin-to-skin. This may cut feedings down to 6 this first 24 hours in my observation.
2. Reassure pacifier recommended when baby 2-4 months of age to prevent SIDS

IV. The second 24 hours – remember post partum mothers learn by repetition

A. Explain to parents again:

1. Baby was continuous feeder in utero (the womb)
2. Baby had no schedule in utero (the womb)
3. To bring in the milk, he will do initial LONG feeds (maybe 1 hour ) on the first two days. Get mom comfortable for this.

4. Newborns "cluster" feed for several weeks
5. Human milk is quickly digested allowing this pattern
6. Because baby moved in the womb mostly at night, he will be feeding mostly at night for first 3 weeks. Woman's prolactin level in her blood is the highest from 1-5 a.m.
    a. Stern/Parmalee said infants capable of sleeping 6 consecutive hours by 8-12 weeks. Avoid advice to sleep train the newborn
    b. The poorly suckling infant won't sleep this 6 hours or (20% won't anyway per Stern/Parmalee)
    c. Dads are the ones who want baby to sleep more. Overheating by swaddling & hat on in the house contributes to SIDS
    d. Parents need healthy expectations of the newborn's growth and development needs.
    e. Swaddlling & shushing – how to tactfully handle it. WHY is the baby crying????
7. Therefore, parents shouldn't be given formula to use at will in the hospital or they will use it. AAP says no formula unless medically necessary.

B. 35-37 weeks The Great Pretender

1. Don't temperature regulate well so they need skin-to-skin
2. Often poor sucklers so they need feeds evaluated for swallowing
3. Don't wake to feed 8-12 times so may need to be awakened
4. Milk composition changes with age, time of day, etc.

C. Crying is his language but crying is a late sign that he needs to be fed. Feeds better when drowsy awake

D. Newborns normally loose 7-8% of their birth weight in the first week

1. 10% is too much and is a “do something” number.
2. Inductions and/or moms who had multiple IVs hung in labor will deliver edematous newborns who will pee that extra fluid out and look like they lost 10% but do not need supplements

E. Will visitors steal baby’s time? Mom too shy to nurse? The baby’s perspective: Whose arms does baby want to be in?

F. The second night ! Baby acts unfillable !!

1. Parents panic with the baby who wants to feed and feed and feed and not go back to sleep
2. Be proactive and tell them this is coming
3. Baby drives the system and is bringing in the true milk
4. She will not be engorged the next day.
5. Tell her baby is doing a great job.
6. Significant colostrum paints the baby’s gut setting up the immune system and formula given this night will change that.
7. Swaddling with a pacifier may get baby to sleep but will cut down on the number of feeds and delay the milk coming in. May contribute to a 10% weight loss.

G. How does she know the milk has come in the next morning?

1. Baby begins to swallow every 1-3 suckles

2. During the colostrums phase, baby swallowed every 4-5-or more suckles
3. During consistent swallowing, the jaw makes wider movements
4. Baby will now shorten the feedings from 1 hour to less
5. What she can express looks more white and is more liquid
6. She may feel she has slightly heavier breasts (engorgement is no longer the sign that the milk is in)
7. Baby should wet one diaper per day of age as a minimum in the first week of life….1 on day 1, 2 on day 2, 3 on day 3, etc.
8. Yellow stool by day 5 per the AAP means the milk has gone through
9. If he feeds fast and is gulping milk, he is finished. Still follow "finish the 1st breast 1st" and "2nd breast until he falls asleep"
10. Avoid telling her he is "snacking" or "using you as a pacifier" as this may be a cluster feed
11. Encourage night feedings for those who ask if someone else can feed the baby at night. Pumping is not the same stimulus as breastfeeding.
12. If a well suckling baby feeds 8-12x/24 hours for as long as he wants, then the milk will be in before 48 hours

V. The 3rd 24 hours: Following baby's normal pattern for the first 3 days (cesarean birth) in the hospital or that first few days at home

A. Pattern will be the same - initial long feeds and **frequently** at night The feeding log will show this.

1. .Frequently seen pattern is 5 feeds from 6pm to 6am and 3 feeds from 6am to 6pm.
2. Mom needs to nap in the day when baby likely to take long stretch. Help her manage visitors, phone, internet, etc.
3. Baby may be more sleepy these first days due to medications or long labor (especially if trauma to baby)
    a. Primiparas (1st time Moms) are less likely to awaken baby
    b. Overdressing/swaddling often returns baby to "womb" & they sleep even longer or don't stay awake for feedings (Franco)
    c. Cesarean birth blamed for late milk onset – Does it really? Formula given so mom can sleep delays milk coming in, can cause engorgement, & changes the gut flora. (Holt)
    d. Usually C/S recovery means < feeding opportunity by mom.
    e. Baby needs to nurse & get milk going!

B. Teach the diaper rules Urine quantity study:

a. 15-60 ml/24 hours on day 1-2

b. 50-200 ml/24 hours on days 3-10

c. 250-400 ml/24 hours on days 11 – 2months old

d. 400-500 ml/24 hours from 3 – 12 months

1. Parents will supplement if they think there are not enough diapers.
2. A tissue, cotton balls, or 4 x 4 gauze can be placed in diaper to see if baby wets paper diapers is reassuring.

3. Urate crystals (rust color on the diaper) may mean needs to nurse more
4. Watch the black meconium change to brown/green around at day 3-4 or yellow by day 3 – 5 (AAP). The milk is coming in and yellow means it came through baby's system! A well nursing newborn has 4 stools per 24 hours by day 4. (Shrago)
5. Have parents (or you) record feedings & diapers in simple format
6. Use their elaborate record keeping to point out patterns & then simplify the process especially if you are leaving.

C. The Baby's Perspective: Who does he want feeding him?

VI. The panic at home: Parents typical concerns

A. Doubt over milk supply is primary and a normal survival concern
   1. Topping off with formula will cut down on the number of feedings
   2. Formula makes baby sleep longer due to larger milk curds in the baby's stomach
   3. Breastfeeding becomes every 3 hours with one 4 hour sleep which translates to 6-7 feeds/24 hours & not the 8-12/24 hours needed.

B. Worry over baby's "non-schedule" is next – usually by Dad. May be told baby may get into a "habit" of feeding when he wants it. Smart baby.

C. Babies ARE night people – apt to want to feed and look around then.

D. Discomfort with sore nipples and engorgement is a next concern

E. Burping the baby, cord & circ care, bathing is last

F. Avoid running to lots of different advisors – narrow it down

VII. Common follow-up questions and concerns for nursery RN, IBCLC or labor doula's follow-up (hand-out)

VIII. Newborn patterns of sleeping & feeding in the first three weeks

A. Still 8-12 feedings per 24 hours

B. 10-60 minute feedings with a mean of 31 minutes

1. Nutritive suckling (1:1 suckle/swallow) dictates length of feeding
2. Babies don't do well away from Mom's body the first 8 weeks so some babies do "hang around" suckling. Is that bad? How helpful is it to hear "He is just using you as a pacifier!"
3. Babies regulate temperature, heart & respiratory rate better in arms (Bergman)
4. Adults get an endorphin release holding a baby to make us want to do it. Whose arms would baby like to be in?
5. All babies have reflux – Is this why they prefer up on the shoulder?

C. There is hope: After 3 weeks the pattern changes!

1. Night feeds become functional – less awake interactive time
2. Day feedings become more interactive
3. Night feedings still continue until 8-12 weeks as baby's job is to double the birth weight by 16 weeks or 4-6 months of age
4. Babies still feed about 8-12x/24 hours

IX. Parameters of feeding and weight loss in the first week

A. Baby can tolerate a 10% of birth weight in 1st week

1. This loss is "unpacking the back-pack" meconium, respiratory fluids,

tissue edema, using up fat under the skin, and empty the bladder.

2. The norm: breastfed babies loose7-8% or less in the first week
3. Formula fed newborns only loose 3 – 5%
4. Baby will have lost weight at the MD visit 1-3 days after discharge. Be sure family is prepared to know this is normal.

B. Baby should be back to birth weight by 10-14 days.

1. Hopefully this is explained or parents panic and feel all that nursing did nothing because of "no weight gain" Prepare the family as to what to expect on the first doctor visit and the 2 week visit
2. Needs to get praise at this point from someone.
3. Babies unsupplemented and at birth weight by two weeks can be trusted to feed on demand from then on.

C. Studies show that exclusive breastfeeding in the first two weeks showed a higher duration success rate.

D. The first 6 weeks of breastfeeding sets the milk supply. (la cuarentena)

1. Exclusive breastfeeding keeps prolactin high in her blood
2. Prolactin sets up peptide receptor sites in the breast so that the breast can operate more independent of this system later.
3. Los Dos Cosas or doing breast and bottle will not set up the milk supply this way as there is less prolactin.
4. This is most important for the working mother to set her supply before she returns to work (Berggren)

XIV. The two week visit scheduled with the primary care provider

A. Help her to make a question list for the MD/PNP/Midwife
B. Set her up with what weight to expect per age so parents are pleased at the scale if the medical provider does not praise baby's progress.
C. Take notes on what to discuss with her after the visit – not during her time with the primary care provider
D. Don't get between the primary care provider and the mother at the visit
E. Let parents undress & deal with the baby in front of you or the primary care provider. This is useful to assess how well the parents are doing.
F. The art of not undermining the relationship between the primary care provider & the parents
G. Finessing the grandparents role with you and the parents

Rev 6/2012

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