Mackenzie Health

Mother & Baby Education Guide: Having Your Baby

ARRIVING AT MACKENZIE HEALTH

PRIOR TO COMING TO THE LABOUR & DELIVERY UNIT FOR DELIVERY OF YOUR BABY:

Please phone ahead before coming to the hospital at 905-883-1212 ext. 2125

Ensure child care arrangements are made in advance for small children so that you can concentrate on your birth experience

REGISTERING AT C5 LABOUR & DELIVERY PURPLE, 5th FLOOR, C-WING

Depending on the time you arrive at the hospital, the front doors are locked between 10:30pm and 6:00pm. Please enter the hospital through the Emergency doors after 10:30pm. From the Main Lobby, take the elevators to the C5 Labour & Delivery Purple on the 5th Floor, C-Wing. The department is locked after hours. Please press the intercom button to inform staff of your arrival.

After you register with the Secretary, you will be greeted by a nurse and assessed in our Triage Unit. If you are with a midwife, she will usually do the assessment; otherwise, a doctor will assess you and either treat your problem or admit you to the hospital. If you are in labour, you will be admitted to a private birthing suite. Here you may use the TV, jacuzzi and shower at your convenience. There is also a pull out bed for your support person to rest while you are in labour.
If there is a need for a caesarean section, this will be done in the Labour & Delivery Operating Rooms (OR).

Cameras and recording devices will be restricted during your delivery or caesarean section. No devices will be permitted at the time of delivery. Your nurse and physician will direct you or your family members to take pictures of the baby after delivery. You are encouraged to take photos and videos before and after your delivery to document the welcoming of your baby into the world. Your nursing team is happy to answer any questions you have around when it is okay to take pictures or record video.

If indicated, your doctor may order compression stockings for you following your caesarean section. There is a charge for these stockings and your doctor will discuss this with you. If you know you are having a caesarean section, you may find it easier to purchase the stockings prior to your surgery. Please discuss this with your doctor.

SIGNS OF LABOUR AND WHAT TO EXPECT

Do you know the typical signs of labour?
Understand the changes your body will go through as you prepare to give birth.

Bloody Show: Loss of mucous plug

During pregnancy, a thick plug of mucous blocks the cervical opening to prevent bacteria from entering the uterus. When your cervix begins to thin and open, this plug may fall out. You might notice stringy mucous or a thick discharge. It is typically brown and sometimes tinged with blood.

Loosing the mucous plug is a sign of labour, but it is not a guarantee. Labour may still be days or weeks away.

Rupture of Membranes: Your water breaks

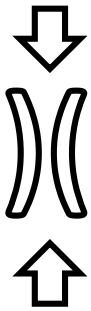
A fluid-filled sac cushions your baby in the uterus. Sometimes the sac leaks or breaks before labour beings. If this happens, you might notice a slow trickle of fluid or a more obvious gush. If your water breaks at home, or if you are uncertain whether the fluid is from the sac, urine or something else, put on a sanitary pad and continue with your daily activity for one hour. If the pad is dry after one hour, it is unlikely that the sac of water is broken. If the pad is wet, please call the Family Birthing Centre at 905-883-1212 ext. 2125. You will be asked to come to the hospital for an evaluation.

Contractions: When labour pains begin

During the last few months of pregnancy, you might experience occasional, sometimes painful contractions. This is due to your uterus tightening and relaxing. These are called Braxton Hicks (false) contractions. They are your body's way of getting ready for labour. Eventually, Braxton Hicks contractions will be replaced by true contractions. To tell the difference, consider these questions:

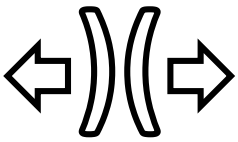
1) **Are the contractions regular?** Time your contractions from the beginning of one to the beginning of the next. Look for a regular pattern of contractions that get progressively stronger and closer together. True labour contractions come very 3 to 5 minutes. False labour contractions will remain irregular.
2) **How long do they last?** True contractions last more than 30 seconds at first and get progressively longer up to 90 seconds. The contractions of false labour vary in length.
3) **Can you stop the contractions?** True contractions continue regardless of your activity level or position. In fact, they often grown strong with increased activity, such as walking. With false labour, you might be able to stop the contractions by changing your activity or position, lying down or taking a walk.

Effacement: Thinning of the cervix



One of the first signs of labour is your cervix softening and thinning. This mostly happens in the last week before delivery and you would not feel this preparation for labour happening. Instead, your health care provider might check for signs of cervical change with vaginal exams. Thinning of the cervix is often expressed in percentages. The cervix starts out about 4 centimetres (cm) long. When the cervix is 50 percent thinned out, it is half its original thickness, or 2cm. Your cervix must be 100 percent, or completely thinned out, before a vaginal delivery.

Dilation: Opening of the cervix



Another of the early signs of labour is your cervix beginning to open or dilate. For most women, some dilation occurs before labour. Your health care provider will measure the dilation in centimetres from zero to ten.

At first, these cervical changes can be very slow. In fact, some women are dilated 2 to 3cm for days or even weeks before labour actually beings. Dilation is not a good indicator of when labour will begin, but rather a general sign that you are getting ready for labour. Once you are in active labour, expect to dilate more quickly.

False Alarms

Expect false alarms: The difference between your body's preparation for labour and the actual process of labour is not always clear. Some women have painful contractions for days with no cervical changes, while others might feel only a backache or nothing at all.

Remember, no one knows for sure what triggers labor and every woman's experience is unique. Sometimes it's hard to tell when labor begins. Don't hesitate to call your health care provider if you're confused about whether you're in labor. If you have any signs of labor before 36 weeks, especially if you also experience vaginal spotting, consult your health care provider.

At term, labour will nearly always make itself apparent. If you arrive at the hospital in false labour, do not feel embarrassed or frustrated. Think of it as a practice run. The real thing is sure to be on its way.

You can also manage your pain without the use of medication through other techniques including:

Breathing

During contractions, use the breathing technique you learned in your prenatal class. Breathe through your nose and blow out through your mouth. Your nurse or midwife can help you with this.

Positioning/Walking

If you can, walking is helpful. It may speed up your labour and helps to relieve backache. Other positions like standing, sitting, kneeling and leaning forward and/or sitting upright also help to relieve backache and speed up labour. Some people find rhythmic movement helpful and will rock back and forth, rub their abdomen, or even tap their fingers during a contraction.

Music

Music is a way of relaxing and providing distraction through your labour. Some people like soft quiet music, others prefer quick paced and more energetic music. You may want to bring a variety of music that is familiar.

Massage

Massage is another option for pain relief. This can be done with light strokes over your abdomen or more firm pressure over the back, hips, legs, buttocks and arms. It is helpful to use a lotion to help the hands glide over the skin.

Hydrotherapy

Immersing your body in warm water during labour also provider comfort and support relaxation. This is a safe and effect pain relief strategy that also promotes your body to progress through the physiological birthing process.

Imagery

Some people like to use imagery to help them relax and distract them from the pain. This is something you likely already do when you are in a stressful situation or are having difficulty sleeping. Some people bring in pictures to focus on and other people picture images in their mind.

Heat and Cold

Heat can be used to relax muscles and to distract from pain. You can apply heat by having a bath or shower. Warming gel packs may also be used. We ask that you do not use a heating pad in the hospital. Ice can also be placed on areas over the back, hips, neck or forehead to provide pain relief.

PAIN MANAGEMENT IN LABOUR

As you have chosen to deliver your baby at Mackenzie Health, we wish to take this opportunity to familiarize you with options for pain management.

Women experience labour in different ways and some will find it more painful than others. There are many comfort measures available to manage labour pain. These include the use of head/cold massage, showering, breathing/relaxation techniques, walking and position changes. Some women find these techniques very effective for part or all the labour, while others find that comfort measure alone are inadequate to manage the pain of labour.

You may CHOOSE medication at some point during the labour process as your preferred method of relieving pain or, in some cases; you may REQUIRE medication for medical reasons. Your options at Mackenzie Health are: narcotic injection (e.g. Morphine), neuraxial (e.g. epidural or spinal block). There are local anaesthetics available for episiotomy, repair of the perineum or instrumental delivery (e.g. forceps or vacuum).

Narcotic Analgesics, or painkillers, are often given in the form of a needle. You will usually feel relief from pain within 20 to 30 minutes. Pain relief will last 2 to 4 hours. Although your pain will not be eliminated, narcotic analgesics can provide good pain relief with low risk of serious side effects. The disadvantages of using these narcotic medications are that pain is not completely gone, they can cause dizziness, drowsiness, hallucinations, nausea and vomiting.
If you take narcotic analgesics, you will have to stay in bed as your may not be able to walk safetly. These medications can cause your newborn baby to be sleepy. The drowsy effects can be corrected with an injection of a medication called Narcan®.
Although the disadvantages may sound upsetting, narcotic pain relievers are considered safe for both mother and baby. The side effects are usually easy to correct.

Epidural Block is the injection of an anaesthetic through a catheter into the epidural space surrounding the spinal cord. It is usually administered once active labour is fully established. The anaesthetic causes a marked decrease in the sensation of pain associated with uterine contractions. It does not remove all discomfort associated with contractions or the sensation of pressure at the time of delivery. An epidural block utilizing more potent anesthetic solutions can also be used for Caesarean births or forceps delivery. The advantages and risks of epidurals are discussed in detail later on this information page.

A **Spinal Block** is the injection of an anaesthetic into the fluid-filled spinal space (just beyond the epidural space). It is more intense than an epidural block and is used for a Caesarean birth. It usually takes more than two hours to wear off. Potential side effects and complications of a spinal block are similar to those of an epidural block.

General Anaesthesia is reserved for operative vaginal delivery and caesarean birth. The woman is asleep for the delivery, and her support person is unable to participate in the birth experience. The baby may be sleepy and less responsive.

CONSENT FOR EPIDURAL BLOCK

Written consent will be required just prior to your epidural/spinal block by the attending Anaesthesiologist.

HOW SAFE IS THE EPIDURAL?

An epidural is generally very safe with your cooperation and the help of our trained nurses/midwives. There are some risks associated with epidurals, but we do everything possible to minimize them. The anaesthetists and nurses/midwives have been trained to anticipate and prevent complications, and to manage any which may occur despite all precautions being taken.

You must know about the potential risks before signing the epidural consent. For this reason, we want you to read and understand the following information. When considering the potential risks of epidurals, you may also wish to consider the possible benefits.

HOW IS THE EPIDURAL BLOCK ADMINISTERED?

The procedure involves placement of a thin plastic tube or catheter into the epidural space, and is performed by and Anaesthesiologist.

A hollow epidural needle is inserted in the lumbar area of the back, after freezing the skin with a local anaesthetic. The catheter is threaded through the needle, and the needle is then removed. The catheter is securely taped along the woman's back.

Throughout the procedure, it is important that you remain still; a nurse will assist you with this and to maintain proper position.

The Anaesthetist injects local anaesthetic through the catheter. Relief is generally felt within 30 minutes after the injection. A bag of anaesthetic solution is attached to the epidural catheter to administer a continuous dose throughout the remaining labour.

Note: The support person may be asked to leave the birthing room while the anaesthetist inserts the epidural.

PATIENT CONTROL EPIDURAL ANAESTHESIA (PCEA)

PCEA consists of a control button that allows you to deliver a fixed amount of additional medication if you are experiencing pain. This is a safe method of pain relief and you cannot overdose yourself. Your nurse will monitor you very closely and assess your level of pain and motor block.

POTENTIAL SIDE EFFECTS OF AN EPIDURAL

Shivering:

This is the most common side effect. It is likely a direct effect of the local anaesthetic. It generally subsides after a short time.

Low Blood Pressure:

The epidural block causes the veins to dilate and therefore to hold more blood. This means less blood returns to your heart. This may cause your blood pressure to fall and gives you a dizzy or nauseous feeling. To counteract this effect, an intravenous is started prior to inserting the epidural to provide extra fluid. In addition, a wedge is placed under your right hip to tilt your uterus slightly to the left side. This reduces the pressure on the large veins that return blood from the lower extremities to the heart. Occasionally, medications may be required to raise the blood pressure.

Temporary Reduction in Blood Flow to Baby::

This may occur if your blood pressure drops and is corrected by giving you oxygen by mask and intravenous fluid.

Inability to Move Your Legs:

The nerves that control the leg muscles may be blocked so that you are unable to move them. The movement will return gradually as the medication wears off.

Less Effective Pushing During Second Stage:

This is due to loss of sensation in the perineum and is alleviated by reducing the dose administered by continuous infusion when necessary.

Inability to Empty Bladder:

A catheter may be required to drain the bladder.

Fever:

This is due to the effect of the epidural on the body's temperature regulating system.

POTENTIAL COMPLICATIONS OF AN EPIDURAL

NOTE: The following complications are rare

IMMEDIATE COMPLICATIONS

Local anaesthetic enters a blood vessel in the epidural space, causing light-headedness or dizziness, ringing in the ears, a metallic taste, and tingling around the mouth:

This condition could progress to seizures and unconsciousness. However, immediate recognition and treatment followed by full recovery is usual.

Local anaesthetic enters the spinal space and travels too far upwards:

This could progress to breathing difficulties or unconsciousness. Again, immediate recognition and treatment followed by fully recovery is usual.

NOTE: The Anaesthetist and nurse/midwife do not leave the room until they are sure you are safe.

LATER COMPLICATIONS

Total or partial paralysis of the legs and lower body or a chronic nerve problem called "arachnoiditis'"

We do not know how or why these complications arise nor can we predict who they will affect. This occurs in only 1 in 100,000 to 1 in 200,000 cases.

Blood vessels in the epidural space bleed, forming a large collection of blood which would potentially press on the spinal cord:

A spinal operation may be required. This would not normally occur unless a bleeding disorder was present.

LESS SERIOUS COMPLICATIONS

Backache at the site of the epidural (10 – 15%):

This is due to bruising of the tissues during placement of the catheter. It may last a couple of weeks to a couple of months, but usually requires no treatment and will improve steadily. Backache can occur following labour even without an epidural.

A spinal tap (0.5 – 1.0%):

The epidural needle punctures the fine membrane between the epidural and spinal space and spinal fluid leaks out of the spinal canal. This is NOT dangerous; however, it can cause a severe headache lasting for several days or weeks. If the woman lies flat for 24 to 48 hours, this headache will be minimized and may be prevented. There are procedures available to treat the headache and full recovery is expected.

Infection:

Infection at the site of the needle is a potential risk and is treated with antibiotics. An epidural abscess that requires a spinal operation is very rare.

MORE INFORMATION ON EPIDURALS

DOES THE EPIDURAL ALWAYS WORK?

Occasionally there may be a poor anaesthetic response. The epidural may either not work or work on one side only. Trying a stronger anaesthetic solution may help. Repositioning the catheter may also correct the problem. Sometimes, repeating the whole procedure may be required. If all else fails, a general anaesthetic may be necessary for either caesarean birth or instrumental delivery (e.g. mid-forcep delivery) .

AM I GUARANTEED AN EPIDURAL BLOCK IF I WANT ONE?

Some women may not have an epidural. This includes women with a history of serious back injury or surgery, chronic back pain or abnormal anatomy of the back, bleeding disorders, local or generalized infection and allergy to local anaesthetics. The anaesthetist will review the completed anaesthetic questionnaire to identify risk factors and advise you accordingly.

If your baby shows signs of fetal distress during labour, and must be delivered quickly, there may not be sufficient time to administer the epidural/spinal block. In this case you may require a general anaesthetic.

WHAT ARE THE BENEFITS OF AN EPIDURAL BLOCK?

- It provides relief from pain while allowing you to remain alert during the birth experience.
- It provides rest/sleep for women experiencing long and difficult labour.
- It may be in place for the entire labour process including the 2nd stage of labour (pushing).
- It may improve the process of labour in the case of maternal exhaustion or ineffective uterine contractions.

WHAT IF I HAVE QUESTIONS/CONCERNS ABOUT THE EPIDURAL BLOCK?

If you have any questions or concerns about the epidural block, risk factors, or the consent for this procedure, please notify your primary care provider. He/she will arrange a consultation with an anaesthetist before your due date.

SKIN-TO-SKIN CONTACT

The first hour of birth is a crucial time for your baby's transition to life outside the womb. To help with this adjustment, we believe that all healthy, stable babies and mothers should be given the opportunity to practice Skin to Skin Contact practice immediately after delivery.

Skin to Skin Contact (SSC) is placing a naked newborn prone on mother's bare chest immediately after birth. This practice based on intimate contact within the first hours of life will facilitate mother-infant behaviour and interactions through sensory stimuli such as touch, warmth and odour. All stable babies and mother could benefit from SSC immediately after birth, including those that do not intend to breastfeed. Babies who are not stable immediately after birth can receive skin to skin contact later when they are stable. In situation where the mother is not stable or able to respond to her baby, the baby can be put skin to skin with the father or partner.

With your consent to this practice, after delivery, including after caesarean section, your health care providers will ensure that there is uninterrupted skin to skin contact between you and your baby. Skin to skin contact may continue for at least one hour after birth or until completion of the first feeding, or as long as you wish. A longer period of SSC is recommended if your baby has not suckled by one hour after birth.

Benefits

- Calms the mother and the baby
- Helps stabilize the baby's heartbeat and breathing
- Keeps the baby warm with heat from the mother's body
- Enables colonization of the baby's gut with the mother's normal body bacteria gut, provided that she is the first person that holds the baby and not the nurse or others
- Reduces infant crying, thus reducing stress and energy
- Facilitates bonding between the mother and baby, as the baby is alert in the first one to two hours
- Allows the baby to find the breast and self-attach, which is more likely to result in effective suckling than when the baby is separated from his/her mother in the first few hours
- Reduces the need for analgesia during the invasive procedures, for example, vitamin K injection
- Baby will lose less weight
- Enhances mother and infant interaction
- Extends duration of successful breastfeeding
- Hormonal interaction reduces risk of postnatal depression for the mother

For more information on SSC practice, please ask your nurse.