Leche League International is also a great resource for sharing breastfeeding experience and determining obstacles. And also teach some basic points for feeding success. The steps are:

1. Maternal pain, fear, stress, fatigue, and prolonged recovery
2. Complications and separation of mother and baby
3. Delayed access to baby and supplementary feedings
4. Anesthesia and analgesia (delayed lactogenesis and poorer infant suck)

Cesarean section may limit mother’s comfort in terms of positioning, but the baby’s sucking stimulate mother’s uterus contract more quickly, speeding up their healing. Researches show fewer women breastfeed their babies after having had a cesarean. Breastfeeding advocates have long promoted the idea that woman who has had a cesarean need extra support and help to establish breastfeeding.

Breastfeeding is the most suitable and unequalled method of feeding, one that ensures the healthy growth and development of the infant. At the same time, breastfeeding is a vehicle of interaction that has positive biological and emotional effects on the health of both mother and child. Some mothers who undergo a cesarean birth have difficulty at the beginning with taking their babies in their arms and breastfeeding. For this reason, babies encounter problems at the breast.

Moreover, during the mother’s stay at the hospital, the nurse should provide her with information about lactation and the mechanism involved, breastfeeding methods, baby care, problems that may be encountered and their solutions, breast care, personal care, nutrition and exercise.

Bonding is often an issue after a cesarean. Many mothers report feeling distant and detached from their cesarean babies. In part, this may be because the mother is not able to actually “see” the baby emerging from her body, and is usually one of the last people to get to hold and snuggle baby for any real time.

Lastly, starting off on a positive mother-baby relationship after a cesarean helps to instill a feeling of trust in the child and forms the foundation for the development of a healthy personality in later life. Nurses and other health professionals working with newborns have important responsibilities in helping to initiate this relationship.

Breast milk is the preferred nutritional source for all newborns and infants through the first six months of life and is widely recommended through the first year. It has significant health benefits for infants and mothers. Providing maternal support and structured antenatal and postpartum breastfeeding education are the most effective means of achieving breastfeeding success. Immediate skin-to-skin contact between mother and infant and early initiation of breastfeeding are shown to improve breastfeeding outcomes.

WHO/UNICEF were determined tens steps for increasing breastfeeding success. This steps are:

- Determining a written breastfeeding policy
- Training all health care staff for implementing this policy
- Informing all pregnant women about the benefits and management of breastfeeding
- Helping mothers initiate breastfeeding
- Showing mothers how to breastfeed and how to maintain lactation
- Giving infants only breastmilk
- Practicing rooming-in
- Encouraging breastfeeding on demand
- Giving no pacifiers or artificial nipples
- Supporting mother with foster breastfeeding groups before discharge

In this circumcussion nurses can work as lactation consultants for teaching breastfeeding to new mothers. Lactation consultants help mothers for detemining obstacles. And also teach some basic points for deciding timing of breastfeeding, using the experiences of others and being ready to start breastfeeding, some social support systems like La Leche League International is also a great resource for sharing breastfeeding experience. More supported mothers continue breastfeeding more successfully. And more breastfeed child become healthier children.

Breastfeeding and Bonding After Cesarean

The assessment and accreditation of medical education training in the United States is rapidly moving from experience-based to
problem in studies to validate triage tools is the lack of consensus of the reference standard for "true urgency". Does the MTS urgency predicts true urgency? A proxy reference standard can be a combination of vital signs, disease severity, resource use and follow-up or just hospitalization. The validity of the MTS in a large prospective study of 17600 children in the Netherlands was moderate and low for febrile children compared to the combined reference standard. Age related fever modifications were validated in a new sample and improved specificity while sensitivity remained similar. The modified MTS agreed in 37% with the reference standard of urgency and 56% were overtriage and 13% undertriage (2% by >1 category). Over and undertriage need to be balanced to have a safe triage system. Performance of the MTS in different settings and in large populations need to be studied. New modifications on flowchart or subgroup level might further improve the MTS.

Fortified HM is easily fed as long as the preterm infant has a nasogastric tube during hospitalization. After hospital discharge fortification of HM becomes a challenge, but can be established using a bottle with fortified HM as supplementation while breastfeeding.

Among "healthy" preterm infants catch-up growth can be achieved before discharge, while "sick" and small for gestational age preterm infants might not achieve catch-up growth until months or years after discharge. A gradual return to normal for all growth variables while avoiding excessive weight gain should be the goal for nutrition of very preterm infants during and after hospital discharge.

The treatment of acute pain and anxiety in children undergoing therapeutic and diagnostic procedures in the emergency department has improved dramatically over the last few years. The availability of noninvasive monitoring devices and the use of short acting sedative and analgesic medications enable physicians to conduct safe and effective sedation and analgesia treatment. In today’s practice of paediatric emergency medicine, sedation and analgesia has been considered as the standard of care for procedural pain.

This lecture will be focused on the basic principles of paediatric procedural sedation and analgesia in the paediatric ED.

Background and aims PICU admission is a major event for children and their parents. Therefore our guidelines dictate that a primary care nurse is assigned to (expected) long-stay patients in any case after two weeks. The primary care nurse coordinates nursing care, informs and supports parents, and organizes multidisciplinary meetings. Because this guideline was not always followed we organized an awareness week. This study evaluates the effectiveness of this intervention.

Methods Data were collected retrospectively over two three-month periods: before and after the awareness week. Background variables including the presence of a primary care nurse were collected for all patients admitted > 2 weeks. The two periods were compared using chi square tests, Fisher exact tests and Mann-Whitney tests.

Results The percentage of patients assigned a primary care nurse dropped statistically significantly from 56.8% to 33.3%, p=0.024. Length of stay was statistically significantly shorter in the after period.