

First week with a newborn what to expect



The first 24 hours: transition, observation, and bonding

During the first day, your newborn is completing a major cardiopulmonary and metabolic transition. Breathing, circulation, temperature regulation, glucose balance, and feeding all shift rapidly after birth. Many babies have an initial alert period soon after delivery, followed by a sleepier phase. Skin-to-skin contact can support thermoregulation, bonding, early feeding behaviors, and parental confidence.

Expect your care team to monitor feeding, urine and stool, weight, temperature, heart rate, respiratory effort, and physical exam findings. Depending on where you live and your baby's situation, newborn screening may include blood spot testing, hearing screening, congenital heart disease screening with pulse oximetry, bilirubin assessment, and prophylactic medications or immunizations. Ask your maternity or pediatric team what has been completed and what follow-up is scheduled.

At home or in hospital, a newborn's movements often look jerky or uncoordinated. The Moro or startle reflex may cause sudden arm extension. Your baby may turn toward touch near the cheek, suck on fingers, or briefly focus on a face held close. Vision is limited, but hearing is well developed enough that

many babies respond to familiar voices and startling sounds. These behaviors are usually part of normal early neurodevelopment, but persistent limpness, poor responsiveness, abnormal breathing, or seizures require urgent medical assessment.

Feeding: frequent, imperfect, and closely watched

In the first week, feeding is often the center of newborn care. Many newborns feed 8 to 12 times or more in 24 hours, and cluster feeding can make evenings feel relentless. This does not automatically mean you are doing something wrong. Colostrum is produced in small volumes but is concentrated, and mature milk often increases over the first several days. Formula-fed babies also feed frequently, though timing and volumes vary by weight, gestational age, medical history, and clinician advice.

Useful feeding signs include rooting, bringing hands to mouth, lip smacking, increased alertness, and sucking movements. Crying is a later hunger cue and can make latching or bottle coordination harder. For breast/chestfeeding, signs of effective transfer may include rhythmic sucking with audible swallows, softening of the breast after feeding, increasing diaper output, and appropriate weight trajectory. For bottle feeding, paced feeding and attention to satiety cues can help reduce overfeeding and distress.

Seek lactation or pediatric support if latching is persistently painful, feeds are consistently very short or extremely prolonged, your baby cannot stay awake to feed, or diaper output is low.

Ask your clinician before changing feeding plans for a premature baby, baby with jaundice, baby with excessive weight loss, or baby with medical complexity. If using formula, follow preparation instructions carefully and use safe water guidance recommended in your region.

It is common to need help. Feeding difficulty is not a personal failure; it is a clinical and practical problem that can often be improved with timely support.

Weight loss, diapers, and stool color

Most newborns lose some weight after birth because they diurese extra fluid and feeding volumes are still building. Clinicians interpret weight loss in

context: gestational age, delivery fluids, birth weight, feeding method, bilirubin level, urine and stool output, and physical exam. Your baby's healthcare professional should tell you when the next weight check is needed and whether supplementation or closer monitoring is appropriate.

Diapers are one of the most useful home observations. In the first day, many babies have at least one wet diaper and pass meconium, the thick black-green stool produced before birth. Over the next few days, stools typically transition from black meconium to greenish-brown and then to yellow or mustard-colored stools, especially in breastfed babies. Formula-fed stools may be tan, yellow, or brown and somewhat firmer. Exact patterns vary, but a trend toward more wet diapers and transitioning stools is reassuring.

Call your baby's clinician if your newborn has no urine for an unusually long interval, has not passed meconium within the timeframe your care team advised, has persistent vomiting, has blood in stool beyond a small amount clearly linked to a known benign cause, or seems dehydrated. Signs that can suggest dehydration include very few wet diapers, dry mouth, marked lethargy, sunken fontanelle, or poor feeding. These signs need medical review rather than watchful waiting.

Sleep, safe sleep, and day-night confusion

Newborn sleep in the first week is fragmented. Babies may sleep 14 to 17 hours in a 24-hour period, but not in long adult-like blocks. Many wake every 2 to 3 hours to feed, and some cluster feed or stay unsettled at night. Day-night rhythms are immature, so your baby may be sleepier in daylight and more alert after dark.

Safe sleep matters every time, including naps. Place your baby on their back on a firm, flat sleep surface with no pillows, loose blankets, stuffed toys, bumpers, or soft bedding. Room-sharing without bed-sharing is commonly recommended for safety. Avoid overheating; a newborn generally needs one more light layer than an adult in the same room, but sweating, hot skin, or flushed appearance may mean too much warmth.

Because exhaustion increases risk, plan before you are at your limit. If you think you might fall asleep while feeding, arrange the environment as safely as

possible and ask another alert adult to help when available. Never sleep with a baby on a sofa or armchair. If you feel so tired that you are unsafe holding your baby, place the baby in a safe sleep space and step away briefly, or call someone for help.

Crying, soothing, and overstimulation

Crying is communication, not manipulation. In the first week, crying may signal hunger, need for a diaper change, temperature discomfort, gas, overstimulation, or a need for closeness. Some crying has no obvious cause even after needs are met. Babies can become overstimulated by bright lights, many visitors, frequent handling, or noisy environments.

Soothing strategies include skin-to-skin contact, swaddling if done safely and stopped when rolling signs appear, gentle rocking, rhythmic shushing, offering a feed, burping, a clean diaper, or a calm darkened room. Holding your baby close and responding consistently helps regulation. You cannot spoil a newborn by meeting their needs.

However, certain crying patterns deserve urgent attention. A high-pitched, weak, or inconsolable cry; crying with fever or low temperature; crying with poor feeding, lethargy, breathing difficulty, vomiting, or a bulging fontanelle; or a sudden cry after possible injury should prompt immediate medical advice. If you feel overwhelmed or afraid you might shake or harm your baby, put the baby on their back in a safe sleep space and seek immediate help from another adult or crisis service. Shaking a baby can cause catastrophic brain injury.

Jaundice, skin changes, eyes, and common newborn quirks

Jaundice is yellowing of the skin or eyes caused by bilirubin accumulation. Mild jaundice is common in newborns, but significant hyperbilirubinemia can be dangerous and may require monitoring or treatment. Risk depends on age in hours, gestational age, feeding adequacy, blood group incompatibility, bruising, family history, and other factors. If your baby looks increasingly yellow, is difficult to wake, feeds poorly, has fewer wet diapers, or the yellow color spreads to the abdomen, legs, or eyes, contact your baby's clinician promptly.

Other common first-week findings include peeling skin, small white bumps called milia, newborn rash, hiccups, sneezing, brief nasal congestion, swollen genitals from maternal hormones, and mild eye crusting. Many of these are benign, but context matters. Thick pus-like eye discharge, significant eyelid swelling, fever, worsening redness around the umbilical stump, foul-smelling drainage, or spreading skin redness needs medical review.

Umbilical cord care advice varies slightly by region, but keeping the stump clean and dry is common guidance. Fold diapers below the stump if needed and avoid pulling it off. A small amount of dried blood can occur as it separates, but active bleeding, redness spreading onto the abdominal skin, or systemic illness should be assessed.

Parent recovery and mental health in the first week

The first week is not only a newborn transition; it is also postpartum recovery. After vaginal birth, cesarean birth, or complicated delivery, your body may be dealing with bleeding, uterine involution, perineal pain, incision care, breast engorgement, hormonal shifts, constipation, sleep deprivation, and emotional lability. If you are the birthing parent, follow discharge instructions closely and contact your clinician for heavy bleeding, fever, severe headache, chest pain, shortness of breath, calf pain, worsening abdominal or incision pain, visual symptoms, or blood pressure concerns if relevant.

Many parents experience tearfulness or mood swings, often called baby blues, particularly around days 3 to 5. These feelings should be monitored, especially if they intensify, last beyond two weeks, or include hopelessness, panic, intrusive thoughts, inability to sleep even when the baby sleeps, or thoughts of self-harm or harming the baby. Postpartum depression, anxiety, obsessive-compulsive symptoms, post-traumatic stress, and psychosis are medical conditions that deserve urgent, compassionate care.

Practical protection matters: limit visitors if they drain you, assign household tasks to others, keep water and food nearby during feeds, and accept help without feeling you must host. If you have a partner or support person, agree on a night plan, medication schedule if applicable, and who calls the

clinician if concerns arise.

Follow-up care and when to ask for help

Most newborns need early follow-up within the first few days after discharge, especially if they went home soon after birth, are breast/chestfeeding, have jaundice risk, were born early, lost more weight than expected, or have any medical concerns. This visit may include weight, feeding assessment, jaundice evaluation, physical exam, and review of screening results.

Prepare for the visit by tracking feeds, wet diapers, stools, temperature if measured, and any questions. You do not need a perfect chart, but concrete observations help clinicians distinguish normal transition from dehydration, inadequate intake, infection, or worsening jaundice.

Trust your pattern recognition. If your baby seems meaningfully different from earlier in the day, is unusually sleepy, has poor tone, has breathing changes, or will not feed, seek medical advice promptly. Newborns can become unwell quickly, and clinicians generally prefer early calls over delayed evaluation.