

Newborn care preferences in birth plan



Why newborn care preferences belong in a birth plan

Many people think of a birth plan as a document focused on labor positions, pain management, and delivery preferences. Yet the immediate postpartum period is just as worthy of planning. In the first hour, clinicians may assess neonatal transition, support thermoregulation, facilitate skin-to-skin contact, initiate feeding, and administer routine preventive treatments. A written plan helps the team understand which parts of care you hope can happen uninterrupted, which decisions you want to discuss in real time, and who should be involved if you cannot speak for yourself.

Newborn care preferences are especially helpful because maternity units often have standard workflows. These workflows are designed for safety, but there may be room for individualized timing or sequencing. For example, a stable newborn may be placed directly on the birthing parent's chest before routine measurements, while another baby may need prompt evaluation at a warmer. A birth plan can state your preference while acknowledging that neonatal assessment, resuscitation, or maternal stabilization takes priority when needed.

It is also useful to separate preferences from decisions that require medical counseling. Feeding goals, rooming-in, and support person involvement are

usually preference-driven. Vitamin K prophylaxis, ocular antibiotic prophylaxis, glucose monitoring, bilirubin checks, and other newborn interventions may be influenced by local policy, public health requirements, risk factors, and pediatric guidance. Instead of framing the plan as demands, use language such as, "If medically appropriate, we prefer..." or "Please discuss indications, benefits, and risks with us before non-urgent newborn procedures."

Skin-to-skin contact and the first hour

Immediate skin-to-skin contact is one of the most common newborn care preferences. For a vigorous term or near-term infant, many hospitals support placing the baby directly on the birthing parent's bare chest after birth, drying the baby there, covering both parent and infant with warm blankets, and delaying non-urgent measurements. This can support temperature regulation, cardiorespiratory transition, bonding, and early feeding cues.

Your birth plan can describe how strongly you value this time. You might write that you would like uninterrupted skin-to-skin contact for the first hour, or until after the first feed, as long as both parent and baby are clinically stable. If you are planning breastfeeding, you can ask for support with the first latch while keeping the baby skin-to-skin. If you are not breastfeeding, skin-to-skin can still be requested for bonding and physiologic stability.

Consider also documenting what should happen if the birthing parent is unable to do immediate skin-to-skin care. ACOG's sample birth plan includes options such as having a support person hold the baby if the mother cannot. You can name the person who should provide skin-to-skin or hold the newborn, and whether that person should accompany the baby if transfer to a warmer, nursery, or neonatal unit is necessary.

Some families also include delayed cord clamping in the newborn transition section, though it is closely tied to delivery management. If this matters to you, ask your clinician what timing is typical for vaginal and cesarean births, and how the plan may change if the newborn needs resuscitation or there is significant maternal bleeding.

Feeding preferences: breast milk, formula, combination feeding, and pacifiers

Feeding preferences deserve clear language because early feeding support can shape the postpartum experience. Your plan may state that you intend exclusive breastfeeding, exclusive formula feeding, expressed human milk, donor milk if available, or combination feeding. Each approach can be medically and emotionally valid. The goal is to help the care team provide support without assumptions.

If you plan to breastfeed or chestfeed, you can request help with early latch, positioning, hand expression, and lactation consultation. You might ask that formula, bottles, or pacifiers not be offered unless medically indicated or discussed with you first. However, it is wise to include flexibility for neonatal hypoglycemia, excessive weight loss, dehydration concern, prematurity, poor feeding, hyperbilirubinemia risk, or maternal illness. A practical phrase is: "We hope to breastfeed exclusively; if supplementation is recommended, please explain the reason and discuss available options with us."

If you plan formula feeding, state whether you prefer staff to teach paced bottle-feeding, safe preparation, and feeding-volume expectations. If you plan combination feeding, specify whether you want breastfeeding offered first, pumping support, or formula given on a schedule. ACOG's template recognizes that families may choose breastfeeding, formula feeding, or both, and may have preferences about pacifier use.

Pacifiers can be included as a separate preference. Some families prefer to delay pacifier introduction while feeding is being established; others want pacifier use allowed for soothing or painful procedures. Your hospital may use sucrose, pacifiers, swaddling, or skin-to-skin for procedural comfort. Ask your pediatric or newborn team what options are standard and what you can choose.

Rooming-in, nursery care, and who stays with the baby

Rooming-in means the newborn stays in the parent's room rather than spending routine time in a nursery. Many hospitals encourage it because it can support feeding cues, bonding, parental confidence, and education before discharge. Your birth plan can say whether you prefer the baby to remain in your room at all times, to go to the nursery only when medically necessary, or to spend selected periods in the nursery so you can rest.

This preference is personal and may change after a long labor, cesarean birth, postpartum hemorrhage, magnesium sulfate treatment, severe pain, exhaustion, or other clinical circumstances. It is acceptable to plan for rooming-in and also state that you may request nursery support if recovery is difficult. Safety matters: if you are very sleepy, sedated, or physically unable to hold the baby safely, ask staff for help placing the newborn in a bassinet or arranging supervised care.

ACOG's sample template includes detailed options for whether the baby stays in the room continuously, goes to the nursery for procedures, or returns for feedings. You can also specify whether procedures such as weight checks, routine exams, glucose monitoring, hearing screening, or blood tests should be done in your room when feasible.

Another important detail is accompaniment. If your baby needs to leave the room for evaluation or treatment, you may want your partner, doula, or another support person to go with the baby. Include the name or relationship of that person and whether you want updates before any non-urgent procedures. This is particularly helpful if the birthing parent is recovering from anesthesia or a complicated delivery.

Routine newborn medications, prophylaxis, and preventive care

Birth plans often mention antibiotic eye ointment and vitamin K injection because these are routine newborn preventive measures in many hospitals. Vitamin K prophylaxis is used to reduce the risk of vitamin K deficiency bleeding, a rare but potentially serious condition. Antibiotic eye ointment is intended to prevent certain neonatal eye infections, depending on local regulations and risk-based policies. If you have questions or hesitations, discuss them before delivery with your obstetric clinician and the baby's pediatric clinician rather than waiting until the busy immediate postpartum period.

Your plan can focus on informed consent and timing. For example, you may ask to hold or see the baby before eye ointment is placed, or request that medications be given after the first hour of skin-to-skin if there is no urgent indication and hospital policy allows. Essentia Health's birth plan guidance specifically

notes that parents may include preferences about antibiotic eye ointment, vitamin K injections, and timing of the first bath.

Other newborn preventive care may include hepatitis B vaccination, metabolic screening, congenital heart disease screening, hearing screening, bilirubin assessment, glucose monitoring for at-risk infants, and pediatric physical examination. Not every item is optional in the same way; some are governed by state law, hospital policy, or specific medical risk factors. Use your birth plan to ask for explanations, presence when possible, and clustering of care to minimize disruption.

For families planning circumcision, bloodless procedures, cultural rituals, or specific naming ceremonies, include these in the newborn section and discuss logistics with the pediatric or obstetric team. If you decline or defer a procedure, document that you want counseling on benefits, risks, alternatives, and appropriate follow-up.

Bathing, measurements, and minimizing separation

The first bath is no longer automatically done immediately in many settings. Some families prefer delayed bathing to protect thermoregulation, allow prolonged skin-to-skin contact, preserve vernix for a time, and avoid interrupting the first feed. If this matters to you, state when you prefer the first bath: after 12 hours, after 24 hours, after breastfeeding is established, or after you are able to participate. Hospital policy and infection-control considerations may affect timing in certain situations.

Routine measurements such as weight, length, and head circumference can often wait until after initial bonding in a stable infant. You can request that these assessments be delayed or performed at the bedside. Similarly, footprints, identification bands, and newborn security procedures may be necessary soon after birth but can often be integrated into skin-to-skin care.

If you want to minimize separation, be specific. Write that you prefer newborn assessments, medications, and routine procedures to be performed in your room whenever medically appropriate. Ask whether your hospital supports "couplet care," in which postpartum and newborn care are coordinated together. If your baby requires a higher level of monitoring, your team can explain whether

observation can occur in your room or whether nursery or neonatal unit care is safer.

Photography and visitors can also affect the early postpartum environment. Some parents prefer a quiet first hour with no visitors, phone calls, or nonessential interruptions. Others want a support person to take photos after birth. These are not medical choices, but they can help staff protect your bonding time and reduce overstimulation.

Writing preferences that remain safe when plans change

A newborn care plan is strongest when it combines clarity with flexibility. Birth can change quickly, and newborns sometimes need help with breathing, temperature, glucose regulation, infection evaluation, or feeding. Flexible birth preferences do not mean your wishes are unimportant; they mean your values can still guide care when medical needs arise.

Organize your document by phase: labor, delivery, and postpartum or newborn care. Essentia Health suggests beginning birth plan discussions around 28 weeks, which gives time to ask questions, understand hospital norms, and revise the plan after prenatal visits. Bring the plan to a late pregnancy appointment, ask your clinician to review it, and consider sharing a concise copy when you arrive in labor.

Use short, direct statements. A newborn section might include:

"If baby and parent are stable, we prefer immediate skin-to-skin contact and delayed routine measurements."

"If the birthing parent is unavailable, our support person should hold or accompany the baby."

"We plan to breastfeed and request lactation support; please discuss any supplementation recommendation with us."

"We prefer rooming-in, with nursery care only if medically needed or requested for recovery."

"Please explain routine newborn medications and perform them after initial bonding when safely possible."

Finally, keep the plan accessible and respectful. Nurses and clinicians may be

caring for multiple patients, and a one-page plan is more likely to be read and used. Emphasize your top priorities, invite questions, and identify who can make decisions if you are unable. The best newborn care preferences support both family-centered bonding and rapid, skilled medical care when needed.