Alberta Pregnancy Pathways

Adopted from Perinatal Services BC, 2015.

While every attempt has been made to ensure that the information contained herein is clinically accurate and current, AHS acknowledges that many issues remain controversial, and, therefore, may be subject to practice interpretation.

Developed by the Maternal Newborn Child & Youth Strategic Clinical Network™ – Version 4.2 September 2020

Revision Control

Version	Revision Date	Summary of Revisions	Author
V-1.0	September 2016	Original Document	MNCY SCN™ Postpartum Newborn Working Group
V-2.0	April 2017	Refer to Summary of Revisions – separate document	Ursula Szulczewski, Manager, MNCY SCN™
V-2.1	September 2017	Revisions based on provincial chart audit and staff evaluation	Debbie Leitch, Executive Director, MNCY SCN™
V-2.2	March 2018	Revisions to pathway forms	Debbie Leitch, Executive Director, MNCY SCN™
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V-4.0	January 2019	Addition of safe swaddling to comfort or soothe and link to Healthy Families, Healthy Children video. Addition of supplementation volumes for breast fed infants.	Debbie Leitch, Executive Director, MNCY SCN™
V-4.1	March 2019	Pg 86 Supplementation volumes to refer to term babies only (not late preterm). Pg 90 Formula volume (for baby not breastfeeding) returned to previous 30ml/kg/24 hours – follow hunger cues. Pg 108 Newborn stools 48-72 hours: 3 or more transitional stools/day; 72 hours – 4-6 weeks: 3 or more stools/day Pg 104 Lab bilirubin or transcutaneous bilirubin measured on all infants within 24 hours of birth and prior to discharge.	Debbie Leitch, Executive Director, MNCY SCN™
V-4.2	September 2020	Updated Appendix 1 and 2 – Strategies for Teaching Obstetrics to Rural and Urban Caregivers (STORC).	Jolene Willoughby, Coordinator, Education and Consultation, APHP

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INTRODUCTION TO ALBERTA POSTPARTUM AND NEWBORN CLINICAL PATHWAYS

Currently, 50 hospitals in Alberta provide obstetrical service. There are variances in practices related to assessment, management (for both normal and complex conditions), documentation, healthcare provider skills, patient expectations, and education provided between facilities and communities. As a result, the need for provincial, evidenced-based pregnancy clinical pathways has been identified as a provincial priority by the Maternal Newborn Child & Youth (MNCY) Strategic Clinical Network™ (SCN™), as well as the Provincial Community and Rural Maternal Services Steering Committee.

Pregnancy clinical pathways fall into 5 categories:

1. Birth: Ready or Not
2. Pregnancy
3. Labor and Birth
4. Postpartum and Newborn Care
5. Community Postpartum Resources and Care

The AHS **Normal Postpartum and Newborn** nursing pathways were adapted to the Alberta context with permission from Perinatal Services, BC. The pathways have been trialed, implemented, evaluated and will continue to be as required.

The pathways support continuity of care between care providers by promoting consistencies in assessment and documentation, thereby reducing the variation in practice. It provides the nurse, caring for the mother and newborn from 0-72 hours of age, with evidenced-based knowledge and references related to expected normal assessment findings and care practices that signal mother/baby readiness for discharge. Variances from the expected normal serve as key decision points for the nurse related to care options and interventions.

The pathways will continue to be reviewed, updated, and revised annually (or as required) so health care providers may have the most current evidenced-based information readily available to support them in their practice.

Unlike the original rollout of the pathway in September of 2016, a "paper" document will not be part of subsequent versions however, the most current and up-to-date documents, tools, and resources may be accessed the MNCY SCN™ webpage https://www.albertahealthservices.ca/scns/Page13655.aspx.

Questions or commentary about the pregnancy pathways may be directed to: maternalnewbornchildyouth.scn@ahs.ca.

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While every attempt has been made to ensure that the information contained herein is clinically accurate and current, AHS acknowledges that many issues remain controversial, and, therefore, may be subject to practice interpretation.
Note: Where current Zone or Site protocols exist, adherence to those specific protocols would supercede this document; Physician judgment would also take precedence. Where required, patient education is tailored to the patient's specific needs.

Postpartum Clinical Pathway

Introduction

Completion of the **STORC (Strategies for Teaching Obstetrics to Rural and Urban Communities)** educational modules, developed and maintained by the Alberta Perinatal Health Program, are a recommended pre-requisite to successful implementation of the Alberta Pregnancy Pathways.

About the Postpartum Nursing Care Pathway:

The Postpartum Nursing Care Pathway identifies the goals and needs of postpartum women. It is the foundation for documentation on the Postpartum Clinical Path (for Vaginal and Caesarean Delivery). To ensure all of the assessment criteria are captured, they have been organized in alphabetical order into these main sections:

- Physiological Health
- Infant Feeding
- Lifestyle
- Psychosocial Health
- Communicable Diseases

While the maternal assessment criteria are presented as discrete topic entities, it is not intended that they be viewed as separate from one another. For example, the maternal physiological changes affect her psychosocial health. To assist with this, cross-referencing is used throughout the document (will be seen as "Refer to…"). This is also evident when referencing to newborn criteria in the Newborn Nursing Care Pathway. The mother and newborn are considered to be an inseparable dyad, with the care of one influencing the care of the other. An example of this is with breastfeeding as it affects the mother, her newborn, bonding and attachment.

In this document, assessments are entered into specific periods; from immediately after birth to 7 days postpartum and beyond. These are guidelines and are used to ensure that all assessment criteria have been captured. Once the woman is in her own surroundings, assessments will be performed based on individual nursing judgment in consultation with the mother.

Underlying Principles:

- Patient and Family centered care empowers and prepares women for motherhood.
- Clinical practice is based on research and best evidence and supported through knowledge translation strategies.
- Pregnancy is considered normal, but dynamic, and risk assessment and management is integral to each phase.
- Health Care Providers have access to knowledge, tools, and resources and are prepared to support the woman and family through both normal and variant pathways.

- Collaborative relationships between all members of the health care team across the continuum, locally and provincially, support access to required levels of care or support.
- Trauma informed care supports all pregnancy pathways.

Statement of Women-Centered Care:

The Postpartum Nursing Care Pathway assumes that informed decision making is used when care is offered. As stated by the Canadian Nurses Association Code of Ethics for Registered Nurses, "Informed consent is based on both a legal doctrine and an ethical principle of respect for an individual's right to sufficient information to make decisions about care, treatment and involvement in research."

The United Nations states that gender is a primary determinant of health. Health Canada recognizes the potential biases women experience in health care where "women's health is determined not only by their reproductive functions, but also by biological characteristics that differ from those of men (sex), and by socially determined roles and relationships (gender)".

The framework of Women-Centered Care is used which respects women's diversity, supports the way women provide for their health needs in the social, cultural and spiritual context of their experience, addresses the barriers to access services, and places the women and her newborn at the center of care that was used. It also assures that women, their partners and families are treated with kindness, respect and dignity, even if they differ from the caregiver's recommendations. In certain circumstances (such as maternal mental health or child maltreatment) nursing judgment and/or reporting requirements may override a woman's decision.

Referring to a Primary Health Care Provider (PHCP):

Prior to referring to a Primary Health Care Provider (PHCP) an appropriate postpartum nursing assessment will be performed. This may need to be specific or global (physical, emotional, & psychosocial health, learning needs for self-care and care of her infant) in nature. In the intervention sections the nursing process will be referred to as Nursing Assessment.

Resources:

A list of key resources for both health care professionals and parents is listed at the end of this document.

Timeframes:

The first 2 hours following the third stage of birth (delivery of placenta) is the Period of Stability. The consensus symposium defined 'The Period of Stability' as "maternal stability is generally attained within two hours following birth." Other important timeframes identified by the development committee are: >2–24 hours, >24–72 hours, and >72 hours–7 days and beyond and are the reference points used in this document.

NOTE: In order to capture key parent teaching/anticipatory guidance concepts, these concepts will be located in the >2–24 hour timeframe. It is at the individual nurse's discretion to provide this information and or support earlier or later.

Maternal Physiological Stability:

The Postpartum Nursing Care Pathway recommends that the five (5) following criteria define postpartum physiologic stability for a delivery at term.

- Vital signs stable (T, P, R, BP)
- Perineum intact or repaired as needed or abdominal dressing dry and intact
- No postpartum complications requiring ongoing observation (e.g. hemorrhage)
- Bladder function adequate (e.g. has voided/Foley catheter draining)
- Skin-to-skin contact with baby

Postpartum Pain and the Visual/Verbal Analogue Scale (VAS):

Acute post-partum pain is a strong predictor of persistent depression after childbirth. Severity of acute postpartum pain, **not** mode of delivery, is independently related to postpartum pain (2.5 fold increased risk) and depression (3.0 fold increased risk). In order to assess postpartum pain and to improve maternal outcomes, the standardized method of using the Visual/Verbal Analogue Scale (VAS) is recommended. The pain assessment incorporates a visual or verbal pain plus 4 pain assessment questions.

For the purpose of these guidelines a verbal pain assessment will be incorporated.

The following questions should be part of the maternal path assessment.

1. **Location:** Where is the pain?
2. **Quality:** What does the pain feel like?
3. **Onset:** When did your pain start?
4. **Intensity:** On a scale of 0 to 10 (with 0=no pain and 10= worst pain possible) where would your pain be? (Pain Scale is used on Postpartum Clinical Care Path)
5. What makes the pain better?
6. What makes the pain worse?

Physiological Health: Vital Signs

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
VITAL SIGNS:				
Assess: • Vital signs • History and risks • How patient feels related to vital signs **Suggested frequency for vital signs:** **Vaginal Birth:** • q15 x 4 (delivery room) • q30 x 2 • q4h x 2 • q shift until discharge **Suggested frequency of vital signs for Cesarean Birth with Spinal Anesthesia:** • q15 x 4 (recovery room) • On arrival to unit • q30 x 2 • q4h x 24 hours • q shift until discharge **Cesarean Birth (General Anesthesia):** • q15 x 4 (recovery room) • On arrival to unit • q30 x 2 • q1h x 2 • q4h x 24 hours • q shift until discharge ***Variances, history, or risk factors may dictate more frequent observations.*** **Assess woman's understanding of:** • Her vital signs	**NORM AND NORMAL VARIATIONS:** • Asymptomatic • Temp: 36.7°C–37.9°C • BP: Systolic: 90–140 • BP: Diastolic: 50-90 • Resps: 12 -24, unlabored • Pulse: 55 – 100 bpm • SpO_2: 92-100% **Client Education/ Anticipatory Guidance:** • To notify nurse if feeling unwell **Variance:** • Chills, headache, blurred vision, light headedness, palpitations • febrile, labored/depressed respirations, variant vital signs **Intervention:** • Nursing Assessment • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** ○ Refer to PERIOD OF STABILITY **Client Education/Anticipatory Guidance:** ○ Refer to PERIOD OF STABILITY **Variance:** ○ Refer to PERIOD OF STABILITY **Intervention:** ○ Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** ○ Refer to PERIOD OF STABILITY **Client Education/Anticipatory Guidance:** ○ Refer to PERIOD OF STABILITY ○ Variances that may require follow-up **Variance:** • Refer to 0–24 hours • Temperature: >38°C **Intervention:** ○ Refer to PERIOD OF STABILITY ○ Fever management	**NORM AND NORMAL VARIATIONS:** ○ Variances that may require follow-up **Client Education/ Anticipatory Guidance:** • Refer to 0–72 hours • May experience increase in temperature with milk coming down, engorgement **Variance:** • Refer to 0–72 hours **Intervention:** • Refer to 0-72 hours

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
VITAL SIGNS:				
Assess woman's capacity to: • Identify variances and report if she requires further medical assessment(s) • **Refer to:** Pain				
HISTORY OR RISK FACTORS THAT MAY IMPACT VITAL SIGNS:	***The following are in addition to the Norm and Normal Variations, Variances, and Interventions for Vital Signs as above.**			
FREQUENCY: **In addition to vital sign measurement, assess for adequacy of ventilation when neuraxial analgesia is administered and there are not specific Anesthesia Orders:** Respiratory rate, depth, oxygenation (SpO2 when appropriate) • q1h X12 hours, • then q2h X 12 hours **NOTE:** Adequacy of ventilation assessment may be done without disturbing a sleeping patient, unless concerns.	**NORM AND NORMAL VARIATIONS:** • Resps: 12 -24, regular rhythm, unlabored, normal depth • SpO_2: 92-100% **Client Education/ Anticipatory Guidance:** • Neuraxial opioids may cause respiratory depression • To notify nurse if having difficulty with breathing **Variance:** • Labored/depressed respirations, tachypnea, bradypnea • SpO_2 <92% **Intervention:** • Nursing Assessment, increased monitoring • Supplemental oxygen administration (if indicated) • Elevate head of bed	**NORM AND NORMAL VARIATIONS:** ○ Refer to PERIOD OF STABILITY **Client Education/Anticipatory Guidance:** ○ Refer to PERIOD OF STABILITY **Variance:** ○ Refer to PERIOD OF STABILITY **Intervention:** ○ Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** ○ Refer to PERIOD OF STABILITY **Client Education/Anticipatory Guidance:** ○ Refer to PERIOD OF STABILITY **Variance:** ○ Refer to PERIOD OF STABILITY **Intervention:** ○ Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** ○ Refer to PERIOD OF STABILITY **Client Education/Anticipatory Guidance:** ○ Refer to PERIOD OF STABILITY **Variance:** ○ Refer to PERIOD OF STABILITY **Intervention:** ○ Refer to PERIOD OF STABILITY

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
VITAL SIGNS:				
	• Do not administer other Opioids • Refer to appropriate PHCP, as required			
Assess the Sedation Score when general anesthesia or neuraxial anesthesia/analgesia is administered: • q1h X 12 hours, • then q2h X 12 hours **Sedation Score** 0 = Alert 1 = Sometimes drowsy 2 = Frequently drowsy, easy to arouse 3 = Somnolent, difficult to arouse S = Normal sleep, easy to arouse	**NORM AND NORMAL VARIATIONS:** • Sedation Score - 0, 1 or S **Client Education/Anticipatory Guidance:** • Neuraxial opioids may cause drowsiness, sedation and respiratory depression • Sedation precedes opioid induced respiratory depression; therefore assessing the sedation score can prevent excessive sedation or respiratory depression from developing. **Variance:** • Altered level of consciousness, increasing level of sedation (Sedation Score – 2, 3) **Intervention:** • Nursing Assessment • Refer to appropriate PHCP	**NORM AND NORMAL VARIATIONS:** ○ Refer to PERIOD OF STABILITY **Client Education/Anticipatory Guidance:** ○ Refer to PERIOD OF STABILITY **Variance:** ○ Refer to PERIOD OF STABILITY **Intervention:** Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** ○ Refer to PERIOD OF STABILITY **Client Education/Anticipatory Guidance:** ○ Refer to PERIOD OF STABILITY **Variance:** ○ Refer to PERIOD OF STABILITY **Intervention:** ○ Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** ○ Refer to PERIOD OF STABILITY **Client Education/Anticipatory Guidance:** ○ Refer to PERIOD OF STABILITY **Variance:** ○ Refer to PERIOD OF STABILITY **Intervention:** ○ Refer to PERIOD OF STABILITY

Physiological Health: Pain

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
PAIN:				
Assess: • Pain using a visual/verbal analogue pain scale (VAS) and pain assessment questions: ○ **Location:** Where is your pain? ○ **Quality:** What does your pain feel like? ○ **Onset:** When did your pain start? ○ **Intensity:** On a scale of 0 (no pain) to 10 (worst pain possible) how would you rate your pain? ○ What makes pain better? ○ What makes pain worse? • Effectiveness of comfort measures/analgesia **Assess woman's awareness of:** • Comfort measures and/or analgesia (including doses, frequency and effectiveness) • Increased pain may increase risk of developing chronic pain and/or depression **Refer to:** • Newborn Nursing Care Pathway: Vital Signs • Newborn Nursing Care Pathway: Behavior • Breastfeeding • Abdomen/Fundus	**NORM AND NORMAL VARIATIONS:** • Pain is tolerable with/without analgesia and/or non-pharmacological pain relief measures • Pain does not impact daily living, such as walking, mood, sleep, interactions with others and ability to concentrate • After pains **Client Education/Anticipatory Guidance:** • When and how to report pain level • Importance of pain management • Current recommendation re: cautious use of Codeine when breastfeeding • After pains are normal and a sign of uterine involution **Variance:** • Pain impacts daily living, such as walking, mood, sleep, interactions with others and ability to concentrate • Pain scale >4 for vaginal birth and >5 for cesarean birth that is not relieved by current analgesia and/or non-pharmacological pain relief measures **Intervention:** • Pain scale >4 for vaginal birth and >5 for Cesarean section requires further evaluation and management of pain • Nursing Assessment • Follow specific Zone guidelines for pain management, as required • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** ○ Refer to PERIOD OF STABILITY **Client Education/Anticipatory Guidance:** ○ Refer to PERIOD OF STABILITY **Variance:** ○ Refer to PERIOD OF STABILITY **Intervention:** ○ Refer to PERIOD OF STABILITY **Variance – Spinal Headache:** • Postdural (Spinal) headache (headache worsens when positioned upright and improves when supine) **Intervention – Spinal Headache:** • Further evaluation and management of spinal headache • Follow specific Zone guidelines for pain management, as required • Refer to Anesthesiologist	**NORM AND NORMAL VARIATIONS:** • Level of pain is diminishing **Client Education/ Anticipatory Guidance:** • Refer to PERIOD OF STABILITY • Confer with PHCP re: pain management after hospital discharge **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Follow specific Zone guidelines for pain management, as required • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • Refer to 0–72 hours **Client Education/ Anticipatory Guidance:** • Refer to 0–72 hours • After pains begin to subside after about 3-5 days **Variance:** • Refer to 0–72 hours **Intervention** • Refer to 0–72 hours

Physiological Health: Abdomen/Fundus

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
ABDOMEN/FUNDUS:				
Assess: • Fundus for involution ○ Palpate fundus with 2nd hand supporting uterus just above symphysis (woman in supine position, knees flexed, and empty bladder) **Assess woman's understanding of:** • Normal involution progression **Assess woman's capacity to:** • Self-check for involution progression • Identify variances that may require further medical assessment **Refer to:** • Lochia • Pain • Elimination - Urinary Function • Vital Signs	**NORM AND NORMAL VARIATIONS:** • Fundus firm, central +/- 1 finger above/below umbilicus • Use minimum pressure to assess fundal height for Cesarean Birth • Absence of S & S of infection **Client Education/Anticipatory Guidance:** • Importance of emptying her bladder frequently • Woman able to demonstrate palpation (if she desires) **Variance – Fundus:** • Uterus – boggy, soft, deviated to one side (due to retained products, distended bladder, uterine atony, bleeding) • Elevated > 1 finger above umbilicus **Intervention – Fundus:** • Massage uterus (if boggy) • Ensure empty bladder • May require further interventions – e.g. intravenous, uterotonic medication(s), catheterization of bladder • Nursing Assessment • Refer to appropriate PHCP, as required **Variance – Infection:** • Infection S & S: T>38°C, elevated pulse, chills, anorexia, nausea, fatigue, lethargy, pelvic pain, foul smelling	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY • Rectus muscle intact **Client Education/ Anticipatory Guidance:** • Refer to PERIOD OF STABILITY • S & S of infection **Variance – Fundus and Infection:** • Refer to PERIOD OF STABILITY • Elevated beyond previous assessments **Intervention – Fundus and Infection:** • Refer to PERIOD OF STABILITY **Variance – Diastasis Recti Abdominis:** • Evidenced by bulging or gaping in the midline of abdomen **Intervention – Diastasis Recti Abdominis:**	**NORM AND NORMAL VARIATIONS:** • Fundus firm, central, 1–2 fingers below umbilicus - goes down by 1 finger (1cm) breadth/day **Client Education/ Anticipatory Guidance:** • Refer to 0–24 hours **Variance:** • Elevated beyond previous assessments • Refer to 0–24 hours **Intervention:** • Refer to 0–24 hours	**NORM AND NORMAL VARIATIONS:** • Fundus central, firm and 2–3 fingers below umbilicus • Involuting and descending ~ 1 finger breadth (1 cm)/day. Fundus is not palpable at 7–10 days postpartum, returns to pre-pregnant state at 6 weeks postpartum **Client Education/ Anticipatory Guidance:** • Refer to 0–24 hours **Variance:** • Refer to 0–24 hours **Intervention:** • Refer to 0–24 hours

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
ABDOMEN/FUNDUS:				
	and/or profuse lochia, excessive uterine tenderness **Intervention – Infection:** • Nursing Assessment • Refer to appropriate PHCP, as required	• Educate that this will become less apparent with time		

Physiological Health: Lochia

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
LOCHIA:				

Assess:
• Amount
• Clots
• Colour
• Odour
 	
Assess woman's:
• Understanding of normal lochia progression
• Capacity to self-check
• Capacity to identify variances that may require further medical assessment
 	
Refer to:
• Abdomen/Fundus
• Lifestyle: Activity/Rest
• Elimination (Urinary Function)
• Vital Signs
	NORM AND NORMAL VARIATIONS:
	• Fleshy smelling
	• Rubra color
	• No trickling
	• Absence of or small clots (<size of a loonie)
	
	Amount on Peri-pad:
	• **Small:** ½ pad in 3 hours
	• **Moderate:** ½ pad in 1 hour
	• **Heavy:** saturates > 1 pad in 1 hour
	
	Client Education/Anticipatory Guidance:
	• Normal pattern and amount/clots
	
	Variance – Postpartum Hemorrhage (PPH):
	• Saturated pad within 1 hour
	• Large clots
	
	Intervention – PPH:
	• Nursing Assessment
	• Weigh peri-pad (1g=1mL)
	  ○ Check for presence of tissue/membrane
	  ○ Frequency of clots
	  ○ Increased amount (trickling)
	• Empty bladder
	• Refer to appropriate PHCP, as required
	
	Variance – Infection:
	• Foul smell (even with frequent peri-pad changes)
	• Increased temperature
	• Pain
	• S & S of infection
	
	Intervention – Infection:
	• Nursing Assessment
	• Refer to appropriate PHCP, as required
		NORM AND NORMAL VARIATIONS:
		• Refer to PERIOD OF STABILITY
		• Increased flow on standing, activity or breastfeeding
		• Should not exceed moderate amount
		
		Client Education/Anticipatory Guidance:
		• Refer to PERIOD OF STABILITY
		• Change pads at least q 4h
		• Hygiene: shower daily, keep perineum clean (wipe front to back, use of peri bottle)
		
		Variance:
		• Refer to PERIOD OF STABILITY
		• Amount of lochia increasing
		
		Intervention:
		• Refer to PERIOD OF STABILITY
		• Decrease activity as needed
			NORM AND NORMAL VARIATIONS:
			• Fleshy smelling, rubra
			• Amount decreases daily
			
			Client Education/ Anticipatory Guidance:
			• Refer to 0–24 hours
			• Discourage tampon use
			
			Variance
			• Refer to 0–24 hours
			
			Intervention
			• Refer to 0–24 hours
				NORM AND NORMAL VARIATIONS:
				• Days 4–10: Lochia serosa (pink/brown)
				• Days 10–6 weeks: Lochia alba
				
				Client Education/Anticipatory Guidance:
				• Refer to >0–72 hours
				
				Variance
				• Refer to 0–24 hours
				• Reoccurrence of continuous fresh bleeding
				• Soaking 1 sanitary pad in 1 hour or less
				• Lochia rubra >4 days
				• Lochia >6 weeks
				
				Intervention:
				• Refer to 0–24 hours
				• 9-1-1
				• Healthlink at 8-1-1

Physiological Health: Perineum

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
PERINEUM:				
Assess: • Progression of healing • Effectiveness of comfort measures • ***NOTE:*** *3rd and 4th degree tears are not considered normal – separate approach/orders are required – refer to Zone specific guidelines* **Suggested frequency:** • q15 x 4 • q30 x 2 • q4h x 2 • q shift until discharge **Assess woman's understanding of:** • Normal perineal healing **Assess woman's capacity to:** • Self-check for perineal healing • Identify variances that may require further medical assessment • Use a visual/verbal analogue pain scale (VAS and pain assessment questions) **Refer to:** • Pain • Lochia • Vital Signs	**NORM AND NORMAL VARIATIONS:** • Mild to moderate discomfort • Perineum intact or episiotomy/tear well approximated with minimal swelling or bruising • Small tear may be present and not be sutured **Client Education/Anticipatory Guidance:** • Use of comfort measures and analgesics • Pericare – peri bottle, fresh pads, pat dry - front to back • When to report pain **Variance:** • Perineal pain >4 – due to episiotomy, tear, instrumental delivery (forceps/ vacuum), internal bleeding, prolonged pushing in 2nd stage, or hematoma • *3rd and 4th degree tears require a separate approach/orders are required – refer to Zone specific guidelines* • Excessive swelling • Hematoma • Gaping perineal incision/tear **Intervention:** • Nursing Assessment • Further evaluation and management of pain • Use of ice packs to decrease swelling • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY • Discomfort decreasing • No S & S of infection **Client Education/Anticipatory Guidance:** • Refer to PERIOD OF STABILITY • Teach how to inspect self with mirror • Perineal sutures are dissolvable • S & S of perineal infection **Variance:** • Refer to PERIOD OF STABILITY • S & S of infection **Intervention:** • Refer to PERIOD OF STABILITY • Use of ice packs to decrease swelling	**NORM AND NORMAL VARIATIONS:** • Refer to 0–24 hours **Client Education/ Anticipatory Guidance:** • Warm water sitz bath for comfort (2 per day for ≤20 minutes) longer periods may interfere with suture integrity **Variance:** • Refer to 0–24 hours **Intervention:** • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • Refer to 0–24 hours • Discomfort decreasing • Decreased use of analgesics (if on narcotic switch to non-narcotic) **Client Education/ Anticipatory Guidance:** • Refer to 0–24 hours • Discuss pain relief options **Variance:** • Refer to 0-24 hours • Pain not decreasing **Intervention:** • Refer to 0-24 hours • Refer to appropriate PHCP, as required

Physiological Health: Abdominal Incision

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
ABDOMINAL INCISION:				
Assess: • Progression of healing **Assess woman's understanding of:** • Normal healing of abdominal incision from Caesarean birth **Refer to:** • Vital Signs • Abdomen/Fundus • Pain • Lifestyle: Activities/Rest	**NORM AND NORMAL VARIATIONS:** • Abdominal incision dressing dry and intact with minimal oozing • Pain is <5 on pain scale **Client Education/Anticipatory Guidance:** • Encourage to splint abdomen with pillow when coughing, moving or feeding • Marked areas of oozing on dressing **Variance:** • Increased bleeding on dressing • Pain >5 and not relieved by current analgesia/non-pharmacological measures **Intervention:** • Apply pressure dressing (refer to Zone-specific protocols or decision documents) • *Note: Patients requiring specific types of dressings (ie: High BMI – Aquacel dressings) will be managed according to specific unit protocol or manufacturer recommendations* • Provide appropriate analgesia • Nursing Assessment • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Dressing dry and intact or no fresh oozing • No S & S of infection **Client Education/Anticipatory Guidance:** • Refer to PERIOD OF STABILITY • Use of good body mechanics when changing positions (getting up from bed/chair) • S & S of infection **Variance:** • Refer to PERIOD OF STABILITY • Incision gaping, inflammation, purulent discharge • S & S such as T>38^{0}C, increased pulse, chills, anorexia, nausea, fatigue, lethargy **Intervention:** • Refer to PERIOD OF STABILITY • Monitor for increased uterine tenderness and further S & S of infection	**NORM AND NORMAL VARIATIONS:** • Refer to 0–24 hours • Incision well approximated, free of inflammation, little or no bruising, little or no drainage, staples/sutures insitu (may have subcuticular sutures) **Client Education/Anticipatory Guidance:** • Refer to 0–24 hours • Remove dressing as per PCHP • Steri-strips to come off on own (if applied) • Ensure arrangements made for removal of staples/sutures or dressing as per hospital PHCP preference • Advise to use good body mechanics and avoid Valsalva when lifting • Avoid lifting anything heavier than baby for 6 weeks postop • Follow Zone-specific guidelines if dressing is to remain on **Variance:** • Refer to 0–24 hours **Intervention:** • Refer to 0–24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to 0–72 hours • May experience numbness around incision • Incision healing with little or no drainage **Client Education/ Anticipatory Guidance:** • Refer to 0–72 hours **Variance:** • Refer to 0–72 hours **Intervention:** • Refer to 0–24 hours

Physiological Health: Rh Factor

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
Rh FACTOR:				
Assess: • Rh factor and immune globulin eligibility	**NORM AND NORMAL VARIATIONS:** • Woman is Rh positive • Woman is Rh negative with Rh negative infant **Client Education/Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Rh negative woman with Rh positive infant **Intervention:** • Refer to >2 -24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Client Education/Anticipatory Guidance:** • Aware of need for testing infant and administration of Rh immune globulin • Implications for future pregnancies **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Aware of woman's eligibility of Rh immune globulin • Obtain Immune globulin from blood bank • Obtain Rh immune globulin from Blood Bank and administer as per PHCP orders • Refer to AHS Policy related to blood-related products (Transfusion of Blood Components and Products: Policies, Procedures, Protocols, Guidelines & Standards)	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Parent Education/ Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to >2–24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Parent Education/ Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to >2–24 hours

Physiological Health: Breasts

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
BREASTS:				
Assess: • Breasts and nipples • Breast comfort and function • Conditions that may affect milk supply: ○ Lack of breast enlargement during pregnancy ○ Some breast traumas or malformations ○ Breast augmentation or reduction surgery ○ Some medical conditions ○ Postpartum hemorrhage **Assess woman's capacity to:** • Identify variances that may require further medical assessment **Refer to:** • Newborn Nursing Care Pathway: Breastfeeding • Infant Feeding – Breastfeeding • Lifestyle: Healthy Eating • Pain	**NORM AND NORMAL VARIATIONS:** • Breasts soft, colostrum may be expressed • Nipples are intact, may appear flat or inverted but protrude with baby's feeding attempt and are minimally tender **Client Education/ Anticipatory Guidance:** • Effective latch is the most important factor in decreasing the incidence of nipple pain • Colostrum expressed should be rubbed onto the nipple and let air dry **Variance – Nipple(s):** • Nipple inversion - nipples that invert with gentle compression or do not evert with stimulation sufficient for baby to latch • Nipple trauma (beginning signs of skin breakdown – blistered, bleeding, or cracked) • Refer >2–24hours **Intervention – Nipple(s):** • Refer to >2–24hours • **Nursing Assessment**	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Client Education/ Anticipatory Guidance:** • Refer to PERIOD OF STABILITY • Comfortable bra without underwire • Use cotton breast pads without a liner to absorb leaks • Use of nipple shield require close follow-up and should not be used without consultation with an appropriate health professional **Variance – Nipple(s):** • Refer to PERIOD OF STABILITY • Nipple pain • Nipple damage – (bleeding/cracked, bruised nipples) • Nipple distortion after feeds **Intervention – Nipple(s):** • Refer to Period of Stability >24–7 days and beyond	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY • Breasts may be beginning to fill, become firmer and colostrum is more easily expressed **Client Education/ Anticipatory Guidance:** • Refer to 0–24 hours • Frequent breastfeeding helps to prevent engorgement • Look at nipple as baby releases to determine latch effectiveness - nipple should be rounded rather than creased or flattened, not bleeding, blistered or cracked **Variance:** • Refer to 0–24 hours >72 hours and beyond **Intervention:** • Refer to 0–24 hours >72 hours and beyond **Variance – Nipple(s):** • Refer to 0–24 hours (POS) **Intervention – Nipple(s):** • Assess infant feeding • Ask mother to rate her nipple pain	**NORM AND NORMAL VARIATIONS:** • After about 72 hours, breasts may be softer after feedings • Breast fullness • Extra breast tissue in the axilla **Client Education/Anticipatory Guidance:** • Refer to 0–72 hours • May have some nipple tenderness which usually peaks on days 3–6 postpartum • Increased risk of yeast infection following antibiotic therapy or if infant has signs of Candida • Variances require follow-up **Variance – Nipple(s):** • Refer to 0–72hours • If nipples were previously damaged – pain that does not subside after initial latch **Intervention – Nipple(s):** • Refer to 0–72hours **Variance – Engorgement:** • Tenderness, warmth, throbbing (may extend to armpits in severe circumstances) • Skin on breast may be taut, shiny, and transparent (with visible veins) • Nipples flat, (with areola firmness) usually bilateral • Breast(s) hot, hard, swollen, reddened and painful areas **Intervention – Engorgement:** • Massage breast gently and manually express breast milk to soften the areola

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
BREASTS:				
		• Assess infant feeding - especially for position and latch • Rub colostrum expressed onto the nipple • If nipple pain, start feeding with least affected nipple • Assist woman with hand expression if nipple pain is intolerable	• Refer to individual knowledgeable in current breastfeeding practices or lactation consultant (LC)	before breastfeeding, facilitating infant latch • Anti-inflammatory agents • Application of warm compresses, shower or breast soak before breastfeeding • Application of cold compresses post breastfeeding **Variance – Obstructive Mastitis - Plugged Duct:** • Usually 1 breast • Localized, tender spot • May be a palpable lump **Intervention –Obstructive Mastitis - Plugged Duct:** • Shower or warm compress to breast before breastfeeding • Frequent feeding, beginning on side with plugged duct • Massage behind the plug toward the nipple, prior to and during feeding • Vary positions for feeding – point baby's chin to tender area • Comfort measures which may include cold compress, and anti-inflammatory agents as directed by physician • Avoid missing feedings **Variance – Mastitis:** • Usually in 1 breast (may be both) • Breast may feel hot, painful, reddened within area over the plugged duct or have red streaks, and/or be swollen • Women may experience flu like symptoms, fever of 38.5^{o}C or greater **Intervention – Mastitis:** • Support, Rest

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
BREASTS:				
				• Continue frequent breastfeeding – milk from affected breast is safe for infant (offer affected breast first) • Check for position and latch • Express if too painful to breastfeed to manage over supply or infant unable to latch • Adequate fluids and healthy eating • If there is a firm area, gently massage affected area throughout feed • Shower or warm compresses to affected area prior to feeds After feeds – cool compress • Antibiotics may be indicated • Refer to appropriate PCHP, as required **Variance – Nipple Candida (Fungal Infection):** • Red, sore, cracked, itchy, burning painful nipples that may have white patches • Red, swollen, flaky/scaly or shiny areola • Sharp, shooting or burning pain in the breast, or severe nipple pain throughout and after feeding • Nipple variance that doesn't heal despite good positioning and latch **Intervention – Nipple Candida (Fungal** • Differentiate from poor latch • Effective, frequent hand washing • Wash breasts and nipples with water at the end of each feed and air dry (do not apply expressed breastmilk) • Antifungal treatment for both mother and infant may be prescribed • If using breast pads, change when they become wet- use cotton breast pads (not plastic)

Physiological Health: Breasts (Non-Breastfeeding Women)

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
BREASTS (NON-BREASTFEEDING WOMAN):				
Assess: • Breast Comfort **Refer to:** • Breasts • Pain • Family Planning /Sexuality • Infant Feeding – Breast Milk Substitutes (Formula) Only	**NORM AND NORMAL VARIATIONS:** • Breasts soft, colostrum may be present **Client Education/ Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to >2 - >72 hours and beyond **Intervention:** • Refer to >2 – >72 hours and beyond	**NORM AND NORMAL VARIATIONS:** • Breasts soft, colostrum may be present **Client Education/Anticipatory Guidance:** • Wear supportive bra continuously until lactation is suppressed (about 5-10 days) • Use of anti-inflammatory agents as prescribed • Application of cold treatments such as gel packs or cold packs for comfort • Avoid stimulation of the breasts such as heat, pumping, and sexual breast contact until lactation is suppressed • Small amounts of milk may be produced for up to a month postpartum • Resumption of menstrual periods (as soon as 6–8 weeks) ○ Contraception use **Intervention:** • Nursing assessment • Wear supportive, well-fitting bra within 6 hours of birth • Anti-inflammatory agents • Cold treatments, such as gel packs, cold packs for comfort for 20 minutes every 1–4 hours • Medication to suppress breastmilk is rarely prescribed	**NORM AND NORMAL VARIATIONS:** • Breasts beginning to fill, become firm and warm **Client Education/ Anticipatory Guidance:** • Refer to >2–24hours **Variance – Engorgement:** • Engorgement **Intervention – Engorgement:** • Nursing assessment • Express small amounts for comfort • Anti-inflammatory agents • Cold treatments, such as gel packs or cold packs for comfort for 20 minutes every 1–4 hours	**NORM AND NORMAL VARIATIONS:** • Breasts will become softer as lactation is suppressed • Small amounts of milk can continue to be produced for up to one month postpartum **Client Education/ Anticipatory Guidance:** • Refer to >2–72 hours **Intervention:** • Refer to >2–72hours **Variance – Mastitis:** • Mastitis **Intervention – Mastitis:** • Nursing assessment • Apply cold compresses • Analgesics • Refer to appropriate PHCP, as required

Physiological Health: Elimination (Bowel Function)

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
ELIMINATION (BOWEL FUNCTION):				
Assess: • Bowel movement pattern • Bowel sounds (Cesarean birth only) • GI history that could interfere with bowel function **Assess woman's understanding of:** • Normal bowel functions **Assess woman's capacity to:** • Identify variances that may require further medical assessment **Refer to:** • Lifestyle: Healthy Eating • Pain • Lifestyle: Activity/Rest	**NORM AND NORMAL VARIATIONS:** • Refer to >2–24 hours **Client Education/ Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to >2–24 hours **Intervention:** • Refer to >2–72 hours	**NORM AND NORMAL VARIATIONS:** • May or not have a bowel movement • Small, non-painful hemorrhoids **Norm and Normal Variations (Cesarean Birth Only):** • Evidence of increasing GI motility (impairment more likely following general anesthetic) **Client Education/Anticipatory Guidance:** • Hemorrhoid care • Prevention of constipation (fluid intake, high fiber diet, appropriate stool softeners and laxatives) • Discuss meds that may constipate - encourage use of nonnarcotic analgesics once the period of severe pain has subsided • Normal bowel habits (1st bowel movement expected within 3 days after birth) • Measures to promote passing of flatus – ambulation and position changes • Avoid gas producing foods, ice, and carbonated beverages **Variance – Hemorrhoids:** • Large, painful hemorrhoids • Rectal bleeding **Intervention – Hemorrhoids:** • Nursing Assessment • Comfort measures • Refer to appropriate PHCP, as required **Variance –Perineal Trauma** • Perineal Trauma (3rd – 4th degree tear that may affect bowel function)	**NORM AND NORMAL VARIATIONS:** • Refer to >2–24 hours **Norm and Normal Variations (Cesarean Birth Only):** • Minimal abdominal distention • Active bowel sounds present • Flatus passed **Client Education/ Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to >2–24 hours • Incontinent of stool **Intervention:** • Nursing Assessment • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Normal bowel movement pattern resumed • Refer to >2-24 hours **Client Education/ Anticipatory Guidance:** • Refer to >2 -24 hours **Variance:** • Refer to >2–72 hours • Normal bowel movement pattern not resumed within 3 days after birth **Intervention:** • Refer to >2–72 hours • Nursing assessment • May require laxatives • Refer to appropriate PHCP, as required

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
ELIMINATION (BOWEL FUNCTION):				
		Intervention – Episiotomy: • Nursing assessment • Prevention of constipation • Refer to Perineal Clinic (where available); ensure proper follow-up post discharge **Variance – Decreased GI Motility (Cesarean Birth Only):** • Bowel sounds absent • Not passing flatus • Abdominal distention • Abdominal pain **Intervention – Decreased GI Motility (Cesarean Birth Only):** • Nursing assessment • Refer to appropriate PHCP, as required • Restrict oral intake, if ordered • Comfort measures • Position changes and ambulation		

Physiological Health: Elimination (Urinary Function)

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
ELIMINATION (URINARY FUNCTION):				
Assess: • Urinary output • Foley catheter **Assess woman's understanding of:** • Normal urinary function **Assess woman's capacity to:** • Identify variances that may require further medical assessment	**NORM AND NORMAL VARIATIONS:** • Refer to >2–24 hours • Some extremity edema **Client Education/ Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to >2–24 hours **Intervention:** • Refer to >2–24 hours	**NORM AND NORMAL VARIATIONS:** • Voids comfortably • Voids sufficient quantity • Able to empty bladder • No feelings of pressure or fullness • Postpartum diuresis and diaphoresis • Indwelling Foley (draining clear yellow urine greater than 30 mL/hour) • Dysuria following catheter removal **Client Education/Anticipatory Guidance:** • Hygiene • Encourage to void approximately every 2-4 hours • Use of warm water – pour over perineum prior to/during voiding • Sitz baths • Encourage pelvic floor exercises to reestablish bladder control (refer to Healthy Parent, Healthy Children Guide for pelvic floor exercises) **Variance:** • Unable to void • Frequent voiding, small amounts • Pressure/fullness after voiding • Urgency • Loss of or difficulty controlling bladder function • Dysuria **Intervention:** • Nursing assessment • Differentiate cause of variance (UTI, not emptying bladder, superficial tears, trauma) • Use measures to help void - ambulation, oral analgesia, peri-care bottle with warm water, running water, hands in water, blow bubbles through a straw, sitz bath, shower, teach contraction and relaxation of pelvic floor • Refer to appropriate PHCP as required and/or community resources as appropriate	**NORM AND NORMAL VARIATIONS:** • Refer to >2–24 hours • Some extremity edema **Client Education/ Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to >2–24 hours • Foley catheter insitu **Intervention:** • Refer to >2–24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to >2–24 hours • Postpartum diuresis and diaphoresis common until the end of the first week PP • Extremity edema decreasing **Client Education/ Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to >2–24 hours **Intervention:** • Refer to >2–24 hours

Physiological Health: Epidural/Spinal Site

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
EPIDURAL/SPINAL SITE:				
Assess: • Puncture site on the patient's back for signs of leakage of CSF (clear, thick fluid), infection, bruising, or bleeding • Q1 h till confident no leakage • Discomfort around the puncture site(s)	**NORM AND NORMAL VARIATIONS:** • No signs of CSF leakage or infection • Minimal bruising/bleeding • Mild discomfort/tenderness around the puncture site(s) • None or minimal serosanguinous drainage at the puncture site **Client Education/ Anticipatory Guidance:** • Soreness around the puncture site should subside within 1-2 days **Variance:** • CSF leakage • Signs of infection around the site (localized redness/tenderness over puncture site) • Active bleeding from puncture site • Hematoma formation (severe, localized back pain) **Intervention:** • Analgesic may be considered for back discomfort (as ordered) • Nursing assessment • Refer to PHCP as required	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Client Education/ Anticipatory Guidance:** • Refer to PERIOD OF STABILITY **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Client Education/ Anticipatory Guidance:** • Refer to PERIOD OF STABILITY **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Client Education/ Anticipatory Guidance:** • Refer to PERIOD OF STABILITY **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY

Physiological Health: Sensory/Motor Blockade (Post Neuraxial Anesthesia/Analgesia only)

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
SENSORY/MOTOR BLOCKADE:				
Assess (post Neuraxial Anesthesia/Analgesia only): • Assess motor function/degree of motor control using either Modified (6 point) Bromage Scale or the (4 point) Bromage Scale q 1 hour until blockade has resolved and prior to initial ambulation **Modified Bromage Score- 6 point** • 1 – Complete block (unable to move feet/knees) • 2 – Almost complete block (able to move feet only) • 3 – Partial block (just able to move knees) • 4 – Detectable weakness of hip flexion (between scores 3 & 5) • 5 – No detectable weakness of hip flexion while supine (full flexion of knees against resistive force) • 6 – Able to perform knee bend while standing **Bromage 4 Point** 0- Full movement= no block 1- Flex knees with full movement of feet= partial block 2- Unable to flex knees bot full movement **of**	**NORM AND NORMAL VARIATIONS:** • Decreasing motor blockade (increased Modified Bromage Score) • Decreasing sensory blockade **Client Education/ Anticipatory Guidance:** • Anesthetic effects usually wear off in 1-6 hours after the infusion has been stopped/bolus administered • Bladder function may be impaired following • Patients are unable to ambulate until return of motor and sensory function • Notify nurse prior to initial independent ambulation to ensure full motor function • As sensation returns, they will detect light touch and pressure before temperature and pain **Variance:** • Increasing motor blockade • Increasing sensory blockade **Intervention:** • Nursing assessment • Refer to PHCP as required	**NORM AND NORMAL VARIATIONS:** • Full motor function/control should be resumed by 6 hours post Neuraxial anesthesia/analgesia (Modified Bromage Score of 6) • Full sensation should be resumed by 6 hours post Neuraxial anesthesia/analgesia **Client Education/ Anticipatory Guidance:** • Refer to PERIOD OF STABILITY **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • Refer to >2–24 hours **Client Education/ Anticipatory Guidance:** • Refer to PERIOD OF STABILITY **Variance:** • Any degree of motor/sensory blockade **Intervention:** • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • Refer to >2–24 hours **Client Education/ Anticipatory Guidance:** • Refer to PERIOD OF STABILITY **Variance:** • Refer to > 24 – 72 Hours **Intervention:** • Refer to PERIOD OF STABILITY

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
SENSORY/MOTOR BLOCKADE:				
feet=almost complete 3- Unable to move legs or feet=complete • Sensory level using ice to determine the level at which cold is felt q 1 hour until resolution of blockade/return of full sensation (movement and sensation to touch are not adequate assessment of nerve function). Use a dermatone chart to identify the level **Refer to:** • Elimination (Urinary Function)				

A description of the Bromage (4 point) and modified Bromage scale(6 pont scale) Anesthesia UK (2017). http://www.frca.co.uk/article.aspx?articleid=100316

Graham, C.. McClure, J. (2008). Quantitative assessment of motor block in labouring women receiving epidural analgesia. Anesthesia. Vol 56. 5.

Riley, E. (2003) Measuring Motor Block. Department of Anesthesia Stanford University School of Medicin Stanford CA https://soap.org/media/newsletters/spring2003/research_column.htm

Physiological Health: Healthy Eating

Family Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
HEALTHY EATING:				

Assess:
• Fluid and nutrient intake
Assess woman's understanding of:
• Healthy eating and fluid needs
Assess woman's capacity to:
• Access adequate, nutritious foods for self and household
Refer to:
• Elimination – Bowel Function
• Support Systems/Resources
	NORM AND NORMAL VARIATIONS:
	• Refer to >2–72 hours
	Client Education/ Anticipatory Guidance:
	• Refer to >2–72 hours
	Variance:
	• Refer to >2–72 hours
	Intervention:
	• Refer to >2–72 hours
		NORM AND NORMAL VARIATIONS:
		• Adequate fluid and nutritious food intake
		• No nausea or vomiting
		Client Education/Anticipatory Guidance:
		• Encourage regular meals and snacks
		• Canada's Food Guide for healthy eating
		• Women who are recovering well and do not have complications after Cesarean birth can eat and drink when they feel hungry or thirsty
		• Women who had general anesthetic may return to regular diet within 24 hours after surgery
		Variance:
		• Inadequate fluid and nutritious food intake
		• Nausea and/or vomiting
		• Pre-existing malnutrition or eating disorder
		Intervention:
		• Nursing assessment
		• Discontinue IV as ordered
		• Refer to appropriate PHCP, as required
		• Refer to Registered Dietician, as needed
		• Refer to site-specific resources (processes)
			NORM AND NORMAL VARIATIONS:
			• Refer to >2–24 hours
			Client Education/Anticipatory Guidance:
			• Encourage a fiber rich diet (whole grains, beans, lentils, high fiber cereals)
			• Encourage an iron rich diet - especially with low Hgb (liver, red meat, deep green leafy vegetables, legumes, dried fruit, and iron enriched foods).
			• May require iron supplements
			  ○ Taking vitamin C with iron enhances absorption
			  ○ Iron may be constipating
			• Return to pre-pregnancy weight takes time – quick or strict weight loss diets are not recommended
			Variance:
			• Refer to >2–24 hours
			• Inadequate financial resources to purchase foods required for a healthy or specialized diet
			Intervention:
			• Refer to >2-24 hours
			• Refer to appropriate social supports and agencies that provide assistance
				NORM AND NORMAL VARIATIONS:
				• Refer to >2–24 hours
				Client Education/ Anticipatory Guidance:
				• Refer to >2–72 hours
				Variance:
				• Refer to >2–72 hours
				Intervention:
				• Refer to >2–72 hours

Physiological Health: Activities/Rest

Family Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
ACTIVITIES/REST:				
All obstetrical patients are at risk for falls **Assess:** • Ability to safely manage activities of daily living • Ability to rest/sleep • Risk for falls (patient history, physiological status, analgesia/anesthesia, environmental factors – (refer to the *SAFE* acronym) • Risk factors for VTE (coagulopathy, increased platelet adhesiveness, traumatic vaginal or operative delivery, smoking, obesity, age >35 years, inactivity, medical history) **Assess woman's understanding of:** • Night time needs of baby • Normal activity and rest requirements **Assess woman's capacity to:** • Identify variances that may require further medical assessment **Refer to:** • Pain • Emotional Status and Mental Health • Vital Signs • Sensory/motor blockade	**NORM AND NORMAL VARIATIONS:** • Refer to >2–72 hours • Vaginal birth – ambulates with minimal assistance **Client Education/ Anticipatory Guidance:** • Refer to >2–72 hours • Initial ambulation should be with assistance **Variance:** • Refer to >2–72 hours • Impaired mobility (unable to ambulate with minimal assistance) **Intervention:** • Refer to >2–72 hours • Nursing assessment • Use of appropriate mobility aids or defer ambulation **Intervention - Impaired Ambulation and At Risk for Falls:** • Consider use of sequential	**NORM AND NORMAL VARIATIONS:** • Vaginal birth: ambulates independently • Caesarean birth: early ambulation with assistance • Able to rest • Pain does not impact normal ADL such as walking, mood, sleep, interactions with others and ability to concentrate • Absence of signs or symptoms of venous thromboembolism (VTE) **Client Education/Anticipatory Guidance:** • Normal postpartum and postop resumption of activities of daily living • Importance of early ambulation and safe body mechanics • Rest when baby sleeping, managing visitors (rest leads to recovery) • Factors that may increase risk for falls • Measures to reduce risk of falling – initial ambulation with assistance and subsequent times if dizzy, faint or impaired sensory or motor function • Aware of comfort measures and/or analgesia including dose, frequency and effectiveness • Importance of deep breathing and coughing following general anesthetic • Importance of early ambulation to prevent VTE • Signs and symptoms of VTE (calf discomfort, redness, swelling) • Supports at home and in community to assist with ADL and infant care **Variance - Impaired Ambulation and At Risk for Falls:** • Unable to ambulate independently due to uncontrolled pain, excessive blood loss, hemodynamic instability, fatigue, adverse medication effects, and/or symphysis pubis dysfunction • Unable to safely ambulate due to decreased sensory and/or motor power to the lower extremities longer than 2–5 hours after a block (depending on the agent used)	**NORM AND NORMAL VARIATIONS:** • Ambulates independently • Refer to >2–24 hours **Variance:** • Refer to >2–24 hours **Intervention:** • Refer to >2–24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to >2–72 hours **Client Education/ Anticipatory Guidance:** • Relationship between healthy eating and activity • Balance between activity and rest • Caring for self and baby • Gradual resumption of physical activity • Knowing limits • Organizing household to minimize stair climbing, reaching, lifting

Family Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
ACTIVITIES/REST:				
• Newborn Nursing Care Pathway – Health Follow-Up: Safety and Injury Prevention	compression devices to prevent DVT for patients unable to ambulate • Follow site-specific DVT prophylaxis protocol	• Environmental hazards (clutter, poor lighting, wet floor, equipment, cords, and/or lines/tubing) **Intervention - Impaired Ambulation and At Risk for Falls:** • Refer to PERIOD OF STABILITY • Nursing assessment • Assess comfort level and need for analgesia • Address environmental factors that contribute to fall risk (fall risk reduction) • Encourage and facilitate adequate rest • Refer to appropriate PHCP, as required • Refer to Physiotherapy as appropriate		

Infant Feeding: Breastfeeding

Family Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
INFANT FEEDING (BREASTFEEDING):				
Assess : • Contraindications for breastfeeding - HIV, drug use, certain medications • Decision to breastfeed • Psychological, social and/or environmental factors that may affect breastfeeding • Knowledge of breastfeeding and previous experience • Feed – minimally once per nursing shift **Assess woman's understanding of:** • Feeding options (informed decision) • Benefits of breastfeeding • The importance of exclusive breastfeeding • Breast stimulation and lactogenesis **Assess woman's capacity to:** • Determine how well her baby is feeding (include feeding cues and responses) • Feed and calm her baby • Access resources- lactation consultant, PH, peer support groups	**NORM AND NORMAL VARIATIONS:** • Uninterrupted skin to skin contact until completion of the first feeding • Initial, active feed - at breast or EBM **Client Education/ Anticipatory Guidance:** • Proper skin to skin technique - not wrapped, chest to chest with mother, blanket over mom and baby, mother awake • Benefits of skin to skin • Uninterrupted skin-to-skin contact until completion of the first feeding or longer - increases likelihood of breastfeeding exclusively • Importance of colostrum • Support mother to respond to newborn's breast searching behaviours • Proper positioning and latch, and signs of an active feed • If baby is separated from mother or does not actively feed within 1-2	**NORM AND NORMAL VARIATIONS:** • Offered breast 4 to 5 times • Able to latch baby to breast with minimal assistance or provides EBM to meet newborn requirements • Able to perform effective hand expression as required • Sensitively responds to newborn feeding cues **Client Education/Anticipatory Guidance:** • Refer to PERIOD OF STABILITY • Refer to AHS Healthy Parents, Healthy children • Refer to STORC breastfeeding modules • Review benefits of exclusive breast feeding • Ensure understanding of what constitutes an active feed (several bursts of sustained sucking at each feed) • Consistent feeding information to enable family to determine if baby is feeding well- position, latch, feeding cues, and effective suck and swallow • Review position and latch • Link intake with output • Mother comfortable- cradle, modified cradle or football hold, lying bring infant to breast, use of pillows, position of hands • Encourage skin to skin, tummy to tummy, • Ensure the mother is not leaning forward, comfortable and well-supported (use pillows and foot stools as needed) • Comfortable positioning for breastfeeding is unique for each mother and infant. A mother may need to try several positions before she finds one that works for her and her infant. • Break suction with finger before removing from breast, if necessary • Methods of burping • Encourage hand expression or pumping techniques as appropriate (ie: prems)	**NORM AND NORMAL VARIATIONS:** • Refer to >2–24 hours • Baby actively feeds ≥ 8 times per 24 hours • Frequent cluster feeds - more at night • Breasts filling **Client Education/ Anticipatory Guidance:** • Refer to 0–24 hours • Feeding frequency- ≥ 8 times per 24 hours • Strategies to meet baby's nighttime feeds (without needing to supplement unless medically necessary) **Variance:** • Refer to 0–24 hours • Delayed lactogenesis	**NORM AND NORMAL VARIATIONS:** • Increased maternal confidence • Breasts soften with feeding, free from infection, tenderness decreasing **Client Education/ Anticipatory Guidance:** • Breasts are full before feeding and soften following (this will change over time) • After several weeks it is normal to have soft breasts all the time and still have sufficient milk • Importance of human milk; exclusive breastfeeding until 6 months followed by introduction of nutritious solids • Breast milk is the most important

Family Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
INFANT FEEDING (BREASTFEEDING):				
• Identify variances that may require further medical assessment **Refer to:** • Breasts • Pain • Lifestyle: Activities/Rest • Lifestyle: Substance Use • Newborn Nursing Care Pathway – Infant Feeding: Breastfeeding • Newborn Nursing Care Pathway – Infant Feeding: Breastmilk Substitute • Newborn Nursing Care Pathway – Safety	hours, teach hand expression **Variance** • Baby not placed skin to skin • Baby not latching • Mother and baby separated • No active feeding **Intervention** • Nursing assessment • When dyad stable, place skin to skin • If unable to do skin to skin with mother - alternate support person may be utilized • Assist with latch and positioning • Support hand expression if baby separated from mother	• Mother and partner aware of the benefits of exclusive breastfeeding (no supplements or use of artificial teats) and risks of breast milk substitutes (formula), if not exclusively breastfeeding • Supplementation – medical and non-medical indications • Alternative nutrition options – breast milk substitutes • Alternative feeding methods - cup, spoon, lactation aid, bottle, syringe • Teach pumping techniques • Body's ability to meet baby's nutritional needs **Variance:** • Not exclusively breastfeeding **Intervention:** • Clarify concerns (to support informed decision) • Refer to formula feeding re: preparation and storage • Refer to healthyparentshealthychildren.ca • Provide information on alternative nutrition (EBM, pasteurized and screened human donor milk, commercial infant formula • Provide information on alternative feeding methods (cup, lactation aid, syringe, bottle, dropper, spoon) • Support breastfeeding and hand expression and pumping **Variance:** • Baby separated from mother **Intervention:** • Teach hand expression and pumping techniques as appropriate • Mother to NICU - encourage skin to skin as soon as possible	**Intervention:** • Refer to 0-24 hours • Refer to Lactation Consultant if available • Refer to appropriate PHCP, as required	food in the first year

Infant Feeding: Breast Milk Substitute, Formula Only

Family Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
INFANT FEEDING (BREASTMILK SUBSTITUTE, FORMULA ONLY):				
Assess : • Decision to formula feed • Psychological, social and/or financial factors that may affect formula feeding • Knowledge of formula feeding and previous experience • Feed – minimally once per nursing shift **Assess woman's understanding of:** • Feeding options (informed decision) **Assess woman's capacity to:** • Feed and calm her baby • Determine how well her baby is feeding (include feeding cues and responses) • Access resources – Public Health (PH), peer support groups • Identify variances that may require further medical assessment **Refer to:** • Breasts (Non-Breastfeeding Woman) • Newborn Nursing Care Pathway – Infant Feeding: Breast milk Substitute • Newborn Nursing Care Pathway – Safety	**NORM AND NORMAL VARIATIONS:** • Skin-to-skin immediately after birth • Formula offered when baby shows signs of readiness to feed **Client Education/Anticipatory Guidance:** • Proper skin-to-skin technique - not wrapped, chest to chest with mother, blanket over mom and baby, mother awake • Benefits of skin to skin • Feeding requirements, feeding cues, positioning, prevention of overfeeding • Methods and importance of burping • Appropriate formulas and preparation (refer to www.healthyparentshealthychildren.ca – Early Years (Book 2) **Variance:** • Baby not placed skin to skin • Mother and baby separated • No active feeding **Intervention:** • Nursing assessment • If unable to do skin to skin with mother - alternate support person may be utilized • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY • Feeds baby when cueing • Feeds baby appropriate formula volume • Appropriately positions baby for feeds • Responds/stops feeding when baby shows signs of satiation **Client Education/Anticipatory Guidance:** • Refer to PERIOD OF STABILITY • Review formula preparation and storage **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • Refer to 0-24 hours • Breasts filling, may become engorged **Client Education/ Anticipatory Guidance:** • Refer to 0–24 hours • Management of engorged breasts **Variance:** • Refer to 0–24 hours **Intervention:** • Refer to 0–24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to 0-72 hours **Client Education/ Anticipatory Guidance:** • Refer to 0–72 hours **Variance:** • Refer to 0–24 hours **Intervention:** • Refer to 0–24 hours

Psychosocial Health: Bonding and Attachment

Psychosocial Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
BONDING AND ATTACHMENT:				
Assess: • Maternal supports • Maternal responses to infant feeding and behaviour cues • Maternal response to infant crying • Maternal, family and baby interaction • Risk factors for poor bonding and attachment **Assess woman's understanding of:** • Infant attachment behaviours • Responses to infant feeding and behaviour cues **Assess woman's capacity to:** • Identify factors that enhance or interfere with attachment and the resources for support **Refer to:** • Pain • Infant Feeding (Breast and Breast Milk Substitutes) • Lifestyle: Healthy Eating • Lifestyle: Activities/Rest • Emotional Status and Mental Health	**NORM AND NORMAL VARIATIONS:** • Skin-to-skin contact immediately after birth until completion of the first feed or longer • Mother responds to infant cues • Maternal interactions with newborn - holding (face-to-face), talking, cuddling, making eye contact • Partner/significant person - presence and involvement **Client Education/Anticipatory Guidance:** • Refer to >2–24 hours • Bonding is a gradual process that may develop over the first month **Variance:** • Maternal - newborn separation • Limited maternal interaction with newborn • Little interest in the newborn – consider labour medication(s), exhaustion, pain, intervention(s) during labour and birth and personal expectations • Minimal or absent support(s) • Partner/significant other – limited interaction or absent • Inappropriate or abusive interactions with infant • Family history of trauma and/or lack of positive relationships • Excessive conflict and history of violent intimate partner relationships	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY • Effective consoling techniques (skin-to-skin showing face to infant, talking to infant in a steady voice, soft voice, holding, rocking, feeding, snuggling) • Responds to early infant feeding cues - restlessness, beginning to wake, hand to mouth, rooting • Affectionate towards newborn – sensitive response to infant's needs • Partner/significant other/family interacts positively with newborn and mother **Client Education/Anticipatory Guidance:** • Refer to PERIOD OF STABILITY • Mother to be involved in all decision making • Activities that enhance attachment –feeding, skin to skin, involvement in assessment and infant care, massage, talking, singing to baby ○ If formula feeding, limit the number of people who feed the baby • Involve partner • Response to infant crying • Settling techniques • Self-care enhances bonding • Available community resources **Variance:** • Refer to PERIOD OF STABILITY • Lack of or inconsistent responses to newborn feeding or other cues • Lack of response to infant discomfort or distress - mother may believe baby is crying for no reason, is spoiled or is manipulating her	**NORM AND NORMAL VARIATIONS:** • Refer to 0–24 hours **Client Education/ Anticipatory Guidance:** • Refer to 0–24 hours **Variance:** • Refer to 0-24 hours **Intervention:** • Refer to 0–24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to 0–24 hours **Client Education/ Anticipatory Guidance:** • Refer to 0–24 hours **Variance:** • Refer to 0-24 hours **Intervention:** • Refer to 0–24 hours

Psychosocial Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
BONDING AND ATTACHMENT:				
• Newborn Nursing Care Pathway: Crying • Newborn Nursing Care Pathway – Infant Feeding • Newborn Nursing Care Pathway – Behavioural Assessment	**Intervention:** • Nursing assessment • Encourage visiting and skin to skin contact as soon as able if separated from newborn • Refer to appropriate PHCP, as required • Refer to Social Worker if available and/or community resources	• Minimal or no planning for taking baby home (diapers, baby clothes, car seat) **Intervention:** • Refer to PERIOD OF STABILITY • Provide positive reinforcement when appropriate interactions are displayed – build on strengths		

Psychosocial Health: Emotional Status and Mental Health

Psychosocial Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
EMOTIONAL STATUS AND MENTAL HEALTH:				
Assess: • Emotional state • Emotional response to delivery and postpartum period (current & past) • Emotional status of partner • History – physical, social and mental health, substance use • Predisposing risk factors for postpartum depression (PPD such as previous episodes of depression, family history of depression, previous use of anti-depressants, significant obstetrical or medical challenges • Signs of PPD **Assess woman's understanding of:** • Normal postpartum emotional response and adjustment to parenthood • Personal mental health **Assess woman's capacity to:** • Identify variances that may require support and/or further medical assessment • Access support and/or medical assessment and care **Refer to:** • Bonding and Attachment • Lifestyle: Healthy Eating • Lifestyle: Activities/Rest	**NORM AND NORMAL VARIATIONS:** • Emotional stability • Emotional support(s) available • Appropriate emotional response to birth experience **Client Education/ Anticipatory Guidance:** • Refer to >2-24 hours **Variance:** • Limited or no emotional support(s) • Current symptoms of mental illness or emotional instability including: depression, anxiety, eating disorders, personality disorders or suicidal ideation **Intervention:** • Nursing assessment • Ensure maternal and newborn safety • Provide emotional support and reassurance • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY • Indicates she feels supported • Increasing confidence and competence in providing newborn care • Increasing partner confidence and competence in providing newborn care **Client Education/Anticipatory Guidance:** • Encourage verbalization of feelings and needs – extreme emotions can impact ability to care for self and newborn • Explore feelings and expectations of partner and ways to promote support • May experience a wide range of emotions – understands postpartum adjustment and postpartum blues • Importance of self-care • Realistic expectations as a new parent • Discuss risk factors and signs of PPD ***Note:*** In the "Taking in" psychological stage: experiences physical and/or emotional dependence, elation, excitement and or anxiety/confusion. Often verbally and mentally relives the labour and birth experience. Provide opportunity to review birth experience **Variance:** • Continued dissatisfaction with birth experience • Indicates lack of emotional support • Lack of confidence and competence in providing newborn care (mother and/or partner) • Negative perception of infant	**NORM AND NORMAL VARIATIONS:** • Refer to 0-24 hours **Client Education/ Anticipatory Guidance:** • Refer to 0-24 hours ***Note:*** Moving to "Taking Hold" psychological stage: actively seeks help with self-care, connects with and cares for newborn, willing to learn, expresses anxiety with mothering abilities **Variance** • Refer to 0-24 hours **Intervention** • Refer to 0-24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to 0–24 hours • More knowledgeable about caring for infant and eager to learn • Assimilating infant into family life **Client Education/ Anticipatory Guidance:** • Refer to 0-24 hours • Encourage connection with peers, new families and community resources ***Note:*** About 2-6 weeks postpartum "Letting Go" psychological state: begins to see infant as an individual, starts to focus on issues greater than those associated directly with self or infant. **Variance:** • Refer to 0-24 hours **Intervention:** • Refer to 0-24 hours • Postpartum Depression assessment and use of

Psychosocial Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
EMOTIONAL STATUS AND MENTAL HEALTH:				
• Support Systems/Resources • Family Function • Lifestyle: Tobacco Use, Drug, Substance Use • Infant Feeding (Breast and Breast Milk Substitutes) • Newborn Nursing Care Pathway – Behavioural Assessment • Newborn Nursing Care Pathway – Crying • Newborn Nursing Care Pathway – Safety		**Intervention :** • Refer to appropriate community resources/supports as required **Variance:** • Maternal conditions that may affect newborn feeding ○ Acute psychiatric condition* ○ Emotional stress* ○ Substance use* *may affect ability to care for baby and make informed decisions • Refer to Breast Assessment – conditions that may affect milk supply **Intervention:** • Careful observation of infant including breastfeeding behavior with support to maximize breast stimulation		the Edinburgh Postpartum Depression Scale for screening and education at the first immunization appointment (typically when the infant is 2 months of age) by public health in AHS

Psychosocial Health: Support Systems/Resources

Psychosocial Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
SUPPORT SYSTEMS/RESOURCES:				
Assess: • Presence of supports - partner, family, friends and/or community **Assess woman's understanding of:** • Available family and community resources **Assess woman's capacity to:** • Access family and community resources • Identify variances that may require further assessment **Refer to:** • Bonding and Attachment • Emotional Status and Mental Health • Family Function	**NORM AND NORMAL VARIATIONS:** • Maternal support system evident **Client Education/Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Absence of support system **Intervention:** • Nursing assessment • Provide nursing support	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Client Education/Anticipatory Guidance:** • Importance of utilizing or accessing supports during the postpartum adjustment period **Variance:** • Lack of support and resources to meet needs- isolation, cultural barriers, language • Unaware of supports or resources **Intervention:** • Refer to PERIOD OF STABILITY • Review community resources • Refer to Social Worker if available • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Client Education/Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to 0–24 hours **Intervention:** • Refer to 0–24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Client Education/ Anticipatory Guidance** • Refer to >2–24 hours **Variance** • Refer to 0–24 hours **Intervention:** • Postpartum Depression assessment and use of the Edinburgh Postpartum Depression Scale for screening and education at the first immunization appointment (typically when the infant is 2 months of age) by public health in AHS

Lifestyle: Family Function

Family Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
FAMILY FUNCTION:				
Assess: • Screen for domestic violence at each health encounter • Interactions between family members • Positive/effective family coping strategies • Strategies for coping with a crying infant • History, maternal perception and signs of family violence, abuse or neglect **Assess understanding of:** • Family dynamics and interrelationships **Assess capacity to:** • Identify positive coping strategies • Identify variances that may require further assessment and support **Refer to:** • Bonding and Attachment • Emotional Status and Mental Health • Support Systems/Resources • Lifestyle: Healthy Eating • Lifestyle: Activities/Rest • Communicable diseases • Newborn Nursing Care Pathway – Crying • Newborn Nursing Care Pathway – Behavioural Assessment	**NORM AND NORMAL VARIATIONS:** • Refer to >2-24 hours **Client Education/ Anticipatory Guidance:** • Refer to >2-24 hours **Variance:** • Refer to > 2-24 hours **Intervention:** • Refer to >2-24 hours	**NORM AND NORMAL VARIATIONS:** • Positive interactions between family members • Positive/effective coping strategies and conflict management • Absence of family violence, abuse, or neglect **Client Education/Anticipatory Guidance:** • Include partner/significant other in care to learn ways to support mother – parenting is a partnership • Stress reduction, time management, importance of rest, and healthy diet • Siblings have many different reactions to a new baby – include them and be patient as they adjust • Importance of communication with partner/significant other – a new baby can be a source of stress **Variance:** • Family identified as being vulnerable or at risk- increased family stress, increased risk for family breakdown, violence in family, lack of strategies and supports to deal with changing family dynamics **Intervention:** • Nursing Assessment • Provide individualized support • Review community resources • Refer to Social Worker if available • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Refer to >2–24 hours **Parent Education/ Anticipatory Guidance:** • Refer to >2- 24 hours **Variance:** • Refer to >2–24 hour **Intervention:** • Refer to >2–24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to >2–24 hours **Parent Education/ Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to >2–24 hour **Intervention:** • Refer to >2–24 hours

Lifestyle: Family Planning/Sexuality

Family Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
FAMILY PLANNING / SEXUALITY:				

Assess understanding of:
• Birth control methods
• Resumption of intercourse
 	
Assess capacity to:
• Access/obtain contraception
 	
Refer to:
• Communicable Diseases
• Emotional Status and Mental Health
• Support Systems/Resources
• Family Function
• Lochia
• Perineum
• Abdominal Incision
• Breasts
	NORM AND NORMAL VARIATIONS:
	• May have had tubal ligation with Caesarean section
	
	Client Education/ Anticipatory Guidance:
	• Refer to >72 hours
	
	Variance:
	• Refer to >72 hours
	
	Intervention:
	• Refer to >72 hours
		NORM AND NORMAL VARIATIONS:
		• Refer to PERIOD OF STABILITY
		
		Client Education/ Anticipatory Guidance:
		• Refer to >72 hours
		
		Variance:
		• Refer to >72 hours
		
		Intervention:
		• Refer to >72 hours
			NORM AND NORMAL VARIATIONS:
			• Refer to PERIOD OF STABILITY
			
			Client Education/ Anticipatory Guidance:
			• Refer to >72 hours
			
			Variance:
			• Refer to >72 hours
			
			Intervention:
			• Refer to >72 hours
				NORM AND NORMAL VARIATIONS:
				• Refer to PERIOD OF STABILITY
				
				Client Education/Anticipatory Guidance:
				• Talk to your healthcare provider regarding all of the methods of birth control
				• Refer to healthyparentshealthychildren.ca and search for birth control options
				• Many have decreased libido due to role overload, psychological and social changes, lack of sleep and hormonal changes
				• Ovulation may occur before menses begin
				  o Lactating women - start of menses may be affected by exclusive breastfeeding
				• Non-lactating women, menses may start in 6-8 weeks
				• Resumption of vaginal intercourse:
				  o Woman's sense of control (mutually agreeable)
				  o May have vaginal discomfort due to decreased hormonal levels, thinning of vaginal walls, decreased lubrication, sutures
				  o Lochia no longer red
				  o Perineum healed
				  o Incision healing
				  o Comfort measures- lubricant, positions
				• Review normal sexuality, postpartum effects of breast feeding, potential milk ejection reflex, sensual response to suckling infant
				• Awareness of contraception choices – impact of some choices on breast milk supply – discuss with PHCP at postpartum visit
				• Protection against STIs and communicable diseases, if applicable

Family Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
FAMILY PLANNING / SEXUALITY:				
				Variance: • Expectation of intercourse prior to healing of perineum/mutual agreement • Unaware of contraception choices **Intervention:** • Nursing Assessment • Refer to appropriate PHCP, as required • Refer to community resources

Lifestyle: Health Follow-Up in Community

Family Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
HEALTH FOLLOW-UP IN COMMUNITY:				
Assess: • Availability of PHCP for follow up care after hospital discharge **Assess woman's capacity to:** • Identify variances that may require medical assessment • Access resources for follow-up with PHCP **Refer to:** • Support Systems/Resources	**NORM AND NORMAL VARIATIONS:** • Refer to >2–24 hours **Client Education/Anticipatory Guidance:** • Refer to >2-24 hours **Variance:** • Refer to >2-24 hours **Intervention:** • Refer to >2-24 hours	**NORM AND NORMAL VARIATIONS:** • Prior to discharge appropriate arrangements are made for ongoing care • Communication with Public Health for post discharge evaluation **Client Education/Anticipatory Guidance (if required):** • How/when to contact Public Health • How/when to contact Health Link (8-1-1) • How/when to contact emergency services (9-1-1) • How/when to contact PCHP for follow up care **Variance:** • No PHCP identified for follow-up care **Intervention:** • Assist in identifying a PHCP to provide postpartum care	**NORM AND NORMAL VARIATIONS:** • Refer to >2–24 hours **Client Education/Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to >2–24 hours **Intervention:** • Refer to >2–24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to >2–24 hours **Client Education/Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to >2–24 hours **Intervention:** • Refer to >2–24 hours

Lifestyle: Substance Use

Family Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
LIFESTYLE - SUBSTANCE USE:				

Assess:
• Current and past use of:
  ○ Tobacco/tobacco-like products
  ○ Alcohol
  ○ Illicit drugs
• Household members' current use of:
  ○ Tobacco/tobacco-like products
  ○ Alcohol
  ○ Illicit drugs
Substance Users (current and past)
• Motivation, confidence and readiness to become and/or remain substance free
• Social situation (partner, family, friends) that may affect her ability to become/remain substance free
Assess woman's understanding of:
• The effects of alcohol, tobacco, (including second and third hand smoke), vapor from electronic smoking devices, as well as effects of prescription and illicit drugs
• Relationship between substance use and breastfeeding
Refer to:
• Support Systems/Resources
• Family Function
	NORM AND NORMAL VARIATIONS:
	• Refer to >2-24 hours
	Client Education/Anticipatory Guidance:
	• Refer to >2-24 hours
	Variance – Tobacco/Tobacco-like Product Use or Exposure:
	• Refer to >2-24 hours
	Intervention – Tobacco/Tobacco-like Product Use or Exposure:
	• Refer to >2-24 hours
	Variance – Alcohol:
	• Refer to >2-24 hours
	Intervention – Alcohol:
	• Refer to >2-24 hours
	Variance – Illicit Drug Use:
	• Refer to >2-24 hours
	Intervention – Illicit Drug Use:
	• Refer to >2-24 hours
		NORM AND NORMAL VARIATIONS:
		• Substance free
		• Home environment free of substance use
		Client Education/ Anticipatory Guidance:
		• **Tobacco/tobacco-like products:**
		  ○ Importance of becoming or remaining tobacco free for the health of the mother as the first priority
		  ○ Second hand smoke exposure is harmful (particularly to children) – make home and vehicle smoke free
		  ○ Third hand smoke stays on the clothes and body – wash face and hands and change clothing before handling baby
		  ○ Nicotine enters breast milk and may decrease milk supply, make baby irritable, slow newborn weight gain
		  ○ Importance of timing breastfeeding to reduce nicotine exposure for the newborn
		  ○ Tobacco exposure increases risk of SIDS
		  ○ Baby at risk for Neonatal Abstinence Syndrome
		• **Alcohol use:**
		  ○ Importance of becoming/remaining alcohol free
		  ○ May interfere with supervision and care of newborn
		  ○ Passes into breast milk – safe amount unknown, may decrease milk supply
		  ○ Baby at risk for Neonatal Abstinence Syndrome
		• **Illicit Drug Use:**
			NORM AND NORMAL VARIATIONS:
			• Refer to >2-24 hours
			Client Education/ Anticipatory Guidance:
			• Refer to >2-24 hours
			Variance
			• Refer to >2-24 hours
			Intervention
			• Refer to >2-24 hours
				NORM AND NORMAL VARIATIONS:
				• Refer to >2-24 hours
				Client Education/ Anticipatory Guidance:
				• Refer to >2-24 hours
				Variance:
				• Refer to >2-24 hours
				Intervention:
				• Refer to >2-24 hours

Family Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
LIFESTYLE - SUBSTANCE USE:				
• Newborn Nursing Care Pathway – Behavioural Assessment • Newborn Nursing Care Pathway – Crying • Newborn Nursing Care Pathway – Safety		○ Importance of becoming/remaining illicit drug free ○ May interfere with supervision and care of newborn ○ Passes into breast milk and may: affect infants developing brain, poor feeding, slow weight gain, increased risk of SIDS ○ Second hand smoke from illicit drugs exposes baby to drugs ○ Baby at risk for Neonatal Abstinence Syndrome **Variance – Tobacco/Tobacco-like Product Use or Exposure:** • Currently using tobacco/tobacco-like products • Exposure to second or third hand smoke **Intervention – Tobacco/Tobacco-like Product Use or Exposure:** • Nursing assessment • Monitor newborn for signs of withdrawal • Contact PHCP for nicotine replacement therapy as applicable • Include partner in teaching and interventions whenever possible • Ensure safety • Ask, advise, assess, assist, arrange: ○ Ask about tobacco use and exposure to second and third hand smoke ○ Advise re importance of remaining tobacco free for the woman's health and indicate you are open to supporting the woman's current stage and needs		

Family Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
LIFESTYLE - SUBSTANCE USE:				
		○ Assess woman's motivation, confidence and readiness to become and remain tobacco free to prevent relapse ○ Ask for permission to provide assistance/further information ○ Assist mother in planning action ○ Arrange referrals as necessary ▪ Refer to Alberta Quits Helpline ▪ Refer to appropriate PHCP, as required **Variance – Alcohol:** • Currently using alcohol • Alcohol abuse by partner/family members **Intervention – Alcohol:** • Nursing assessment • Monitor newborn for signs of withdrawal • Ensure safety • Refer to appropriate PHCP, as required • Refer to AHS Addiction Services Help Line • Review community resources **Variance – Illicit Drug Use:** • Currently using illicit drugs • Illicit drug abuse by partner/family members **Intervention – Illicit Drug Use:** • Nursing assessment • Monitor newborn for signs of withdrawal • Ensure safety • Refer to PHCP • Refer to AHS Addiction Services Help Line or Narcotics Anonymous • Review community resources		

Communicable Diseases: Hepatitis B

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
HEPATITIS B:				
Assess: • Hepatitis B status **Assess woman's understanding of:** • Hepatitis B and the risks involved **Assess woman's capacity to:** • identify variances that may require further assessments and/or treatments **Refer to:** • Breasts • Infant Feeding – Breastfeeding • Newborn Nursing Care Pathway - Breastfeeding	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention:** • Refer to >2 – 24 hours	**NORM AND NORMAL VARIATIONS:** • HBsAg (Hepatitis B Surface Antigen) negative • Woman and/or household member(s) not from an area where Hepatitis B is endemic • No risk factors for Hepatitis B infections (such as IV drug use, sex trade worker) **Client Education/ Anticipatory Guidance:** • For HBsAg positive women or a household contact with HBsAg: ▪ Disease transmission ▪ Breastfeeding not contraindicated ▪ Early identification of infant risk for exposure and need for infant prophylaxis **Variance:** • HBsAg positive • Risk factors present or HBsAg status unknown • Woman and/or household member(s) from an area where HBsAg is endemic • Primary household caregiver other than the birth mother is a known or self-reported carrier **Intervention:** • Refer to PERIOD OF STABILITY • HBsAg screen if mother's status unknown • Recommend household member(s) are screened in the community	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/ Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention:** • Refer to >2 – 24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/ Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention:** • Refer to >2 – 24 hours

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
HEPATITIS B:				
		• Refer to facility Hepatitis B Prophylaxis for Eligible Newborns Guideline • Support breastfeeding • www.phac-aspc.gc.ca/im/vpd-mev/ • www.who.int/mediacentre/factsheets/fs204/en/		

Communicable Diseases: Hepatitis C

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
HEPATITIS C (HCV):				
Assess: • Hepatitis C status **Assess woman's understanding of:** • Hepatitis C and the risks involved **Assess woman's capacity to:** • Identify variances that may require further assessments and/or treatments **Refer to:** • Breasts • Infant Feeding – Breastfeeding • Newborn Nursing Care Pathway - Breastfeeding	**NORM AND NORMAL VARIATIONS:** **Client Education/Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention:** • Refer to >2 – 24 hours	**NORM AND NORMAL VARIATIONS:** • HCV (Hepatitis C Virus) negative • No maternal risk factors for HCV are evident **Client Education/Anticipatory Guidance:** • HCV RNA and anti-HCV antibodies have been detected in colostrum and breast milk. • In multiple studies no case of transmission through breastfeeding has been documented • Support breastfeeding (breastfeeding is not contraindicated) • If nipples are cracked or bleeding, discard breast milk during this time as HCV is transmitted through blood • HCV is a blood borne pathogen and is not transmitted by urine or stool • Basic hygiene and the proper disposal of potentially infected material • Normal child care routines - the use of gloves, masks or extra sterilization is unnecessary	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention:** • Refer to >2 – 24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention:** • Refer to >2 – 24 hours

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
HEPATITIS C (HCV):				
		Variance: • HCV positive **Intervention:** • Refer to PHCP for testing and follow-up • www.phac-aspc.gc.ca/hepc/pubs/gdwmn-dcfmms/viii-pregnant-eng.php		

Communicable Diseases: Herpes Simplex

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
HERPES SIMPLEX IN PREGNANCY (HSV):				

Assess:
• Presence of Herpes Simplex Virus (HSV) lesions
 	
Assess woman's understanding of:
• HSV and the risks involved
 	
Assess woman's capacity to:
• Identify variances that may require further assessments and/or treatments
 	
Refer to:
• Breasts
• Family Planning/Sexuality
• Infant Feeding – Breastfeeding
• Newborn Nursing Care Pathway - Breastfeeding
	NORM AND NORMAL VARIATIONS:
	• Refer to >2 – 24 hours
	
	Client Education/Anticipatory Guidance:
	• Refer to >2 – 24 hours
	
	Variance:
	• Refer to >2 – 24 hours
	
	Intervention:
	• Refer to >2 – 24 hours
		NORM AND NORMAL VARIATIONS:
		• No HSV lesions
		
		Client Education/Anticipatory Guidance:
		• For woman with HSV
		  ○ Support with breastfeeding
		  ○ Breastfeeding is contraindicated **only** when there are open lesions on the breast – may provide EBM
		  ○ Importance of proper hand hygiene
		• Importance of reporting any new lesions that appear
		
		Variance:
		• HSV lesions present
		
		Intervention:
		• Nursing assessment
		• May require culture of lesions
		• May use antiviral drugs
		• Refer to appropriate PHCP, as required
		• Refer to facility infection control manual for appropriate isolation precautions
			NORM AND NORMAL VARIATIONS:
			• Refer to >2 – 24 hours
			
			Client Education/Anticipatory Guidance:
			• Refer to >2 – 24 hours
			
			Variance:
			• Refer to >2 – 24 hours
			
			Intervention:
			• Refer to >2 – 24 hours
				NORM AND NORMAL VARIATIONS:
				• Refer to >2 – 24 hours
				
				Client Education/Anticipatory Guidance:
				• Refer to >2 – 24 hours
				• Sexual activity
				  ○ Avoid intercourse if lesion(s) present
				  ○ Avoid oral sex if partner has cold sore
				  ○ Condoms help but not guaranteed to prevent transmission
				
				Variance:
				• Refer to >2 – 24 hours
				
				Intervention:
				• Refer to >2 – 24 hours

Communicable Diseases: HIV

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
COMMUNICABLE DISEASES (INFECTIONS) – HUMAN IMMUNODEFICIENCY VIRUS (HIV):				
Assess: • Presence of Human Immuno-Deficiency Virus (HIV) **Assess woman's understanding of:** • HIV and the risks involved **Assess woman's capacity to:** • Identify variances that may require further assessments and/or treatments • Follow through with any current treatment **Refer to:** • Breasts (Non Breastfeeding Woman) • Infant Feeding – Breast Milk Substitutes • Abdominal Incision	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention :** • Refer to >2 – 24 hours	**NORM AND NORMAL VARIATIONS:** • No HIV present **Client Education/Anticipatory Guidance:** • For women who are HIV positive: ▪ Advise not to breastfeed ▪ Virus may be transferred in breastmilk ▪ Higher risk for postpartum infections (wound, endometritis) • Basic hygiene and the proper disposal of potentially infected material **Variance:** • HIV present • Risk factors present or HIV status unknown **Intervention:** • Follow-up with PHCP • Refer to facility guideline • HIV screen if mother's status unknown	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention:** • Refer to >2 – 24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention:** • Refer to >2 – 24 hours

Communicable Diseases: Rubella

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
COMMUNICABLE DISEASES (INFECTIONS) – RUBELLA (GERMAN MEASLES):				
Assess: • Antenatal Rubella titre **Assess woman's understanding of:** • Rubella and the risks involved **Assess woman's capacity to:** • Identify variances that may require further assessments and/or treatments	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to >2–24 hours **Intervention:** • Refer to >2–24 hours	**NORM AND NORMAL VARIATIONS:** • Immune to Rubella IgG, antibody titre >15 IU/ml **Client Education/Anticipatory Guidance:** • For women who are non-immune or status unknown: ○ Disease transmission ○ Immunization **Variance:** • Non-immune • Immune status unknown **Intervention:** • Follow-up with Public Health	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2–24 hours **Variance:** • Refer to >2–24 hours **Intervention:** • Refer to >2 – 24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2–24 hours • If MMR is given concurrently with RhIg, Rubella status needs to be checked at 2 months postpartum **Variance:** • Refer to >2–24 hours • When MMR and Rh immune globulin are given concurrently, Rubella status at 2 months is negative – need to be revaccinated with MMR vaccine ○ No serologic testing required after the second dose of MMR vaccine **Intervention:** • Refer to >2 – 24 hours

Communicable Diseases: Varicella Zoster

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
COMMUNICABLE DISEASES (INFECTIONS) – VARICELLA ZOSTER (CHICKEN POX):				
Assess: • Antenatal Varicella status **Assess woman's understanding of:** • Varicella and the risks involved **Assess woman's capacity to:** • Identify variances that may require further assessments and/or treatments **Refer to:** • Infant Feeding – Breastfeeding • Newborn Nursing Care Pathway - Breastfeeding	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention:** • Refer to >2 – 24 hours	**NORM AND NORMAL VARIATIONS:** • Varicella immune **Client Education/Anticipatory Guidance:** • Support breastfeeding - breastfeeding is not contraindicated • Importance of proper hand hygiene • Disease transmission • Recommend immunization if non immune **Variance:** • Varicella present • Not immune to Varicella **Intervention:** • Nursing assessment • Refer to facility infection control manual for isolation precautions • Recommend woman follow-up with Public Health • Discuss immunization – refer to varicella (immunization guide) • www.phac-aspc.gc.ca/im/vpd-mev/varicella-eng.php	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention:** • Refer to >2 – 24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention** • Refer to >2 – 24 hours

Communicable Diseases: Influenza and ILI

Physiological Assessment	0 - 2 Hours PERIOD OF STABILITY (POS)	> 2 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
INFLUENZA AND INFLUENZA LIKE ILLNESS (ILI):				
Assess: • Presence of Influenza and Influenza-like Illness (ILI) symptoms **Assess woman's understanding of:** • Influenza and the risks involved **Assess woman's capacity to:** • Identify variances that may require further assessments and/or treatments **Refer to:** • Infant Feeding – Breastfeeding • Newborn Nursing Care Pathway - Breastfeeding	**NORM AND NORMAL VARIATIONS:** **Client Education/Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention:** • Refer to >2 – 24 hours	**NORM AND NORMAL VARIATIONS:** • No signs or symptoms of Influenza and ILI **Client Education/Anticipatory Guidance:** For women with flu or influenza-like symptoms: • Wash hands thoroughly with soap and water, especially after coughing or sneezing and before eating • Cover nose and mouth with tissue when coughing or sneezing – discard tissue in trash • Cough and sneeze into sleeve • Avoid touching eyes, nose or mouth (infection spreads that way) • Importance of influenza vaccination **Variance:** • Signs and symptoms of influenza- fever, respiratory tract infection **Intervention:** • Nursing assessment • Refer to facility infection control manual for isolation precautions Refer to appropriate PHCP, as required **Refer to** • https://www.canada.ca/en/public-health/services/diseases/flu-influenza.html?utm_source=canada-ca-flu-en&utm_medium=vurl&utm_campaign=flu • Avian Flu www.cdc.gov/flu/avian/	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention:** • Refer to >2 – 24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to >2 – 24 hours **Client Education/Anticipatory Guidance:** • Refer to >2 – 24 hours **Variance:** • Refer to >2 – 24 hours **Intervention:** • Refer to >2 – 24 hours

Key References

Health Canada's National Guidelines (2000)
http://www.phac-aspc.gc.ca/hp-ps/dca-dea/publications/fcm-smp/index-eng.php

As indicated by Health Canada in the document Family-Centered Maternity and Newborn Care: National Guidelines, the postpartum period is a significant time for the mother, baby, and family as there are vast maternal and newborn physiological adjustments and important psychosocial and emotional adaptations for all family members or support people.

The following are the goals, fundamental needs, and basic services for postpartum women adapted from Health Canada's National Guidelines which are to:

- Assess the physiological, psychosocial and emotional adaptations of the mother and baby
- Promote the physical well-being of both mother and baby
- Promote maternal rest and recovery from the physical demands of pregnancy and the birth experience
- Support the developing relationship between the baby and his or her mother, and support(s)/family
- Support the development of infant feeding skills
- Support the development of parenting skills
- Encourage support of the mother, baby, and family during the period of adjustment (support may be from other family members, social contacts, and/or the community)
- Provide education resources and services to the mother and support(s) in aspects relative to personal and baby care
- Support and strengthen the mother's knowledge, as well as her confidence in herself and in her baby's health and well-being, thus enabling her to fulfill her mothering role within her particular family and cultural beliefs
- Support the completion of specific prophylactic or screening procedures organized though the different programs of maternal and newborn care, such as: Vitamin K administration and eye prophylaxis, immunization (Rh, Rubella, Hepatitis B), prevention of Rh iso-immunization and newborn screening (Newborn Blood Spot and Hearing)
- Assess the safety and security of postpartum women and their newborns (families) (e.g. child safety seats, safe infant sleep, family violence, substance use)
- Identify and participate in implementing appropriate interventions for newborn variances/problems
- Assist the woman in the prevention of newborn variances/problems

World Health Organization (WHO) (2013)
http://apps.who.int/iris/bitstream/10665/97603/1/9789241506649_eng.pdf

The WHO states that "postpartum care should respond to the special needs of the mother and baby during this special phase and should include the prevention and early detection and treatment of complications and disease, the provision of advice and services on breastfeeding, birth spacing, immunization and maternal nutrition."

The eight specific WHO maternal postpartum needs are identified as:

- Information and counseling on care of the baby and breastfeeding, what happens with and in their bodies, self-care, sexual life, contraception and nutrition
- Support from health care providers and family/partner
- Health care for suspect or manifest complications
- Time to care for the baby
- Help with domestic tasks
- Maternity leave
- Social integration into her family and community
- Protection from abuse/violence

Resources for Both Health Care Professionals and Families

- Alberta Health Services' "*Healthy Parents, Healthy Children:* Pregnancy and Birth"
  - www.healthyparentshealthychildren.ca
- Health Link Alberta: (24/7 nurse advice and health information)
  - Call 811 (Toll free)
- My Health Alberta (online health information)
  - www.myhealth.alberta.ca
- 211 Alberta (community health government and social services)
  - Dial 211 in many places in Alberta or go to ab.211.ca
  - Connects people to a full range of community, health, government, and social services information

Resources for Health Care Professionals

"*Healthy Parents, Healthy Children*: Pregnancy and Birth" and "*Healthy Parents, Healthy Children*: The Early Years"

- Healthcare providers can order print copies to distribute to parents by visiting dol.datacm.com
  - **User ID**: healthypublic
  - **Password**: healthy2013
- Available online at healthyparentshealthychildren.ca

Breastfeeding

- Strategies for teaching obstetric to rural and urban caregivers (STORC) model on breastfeeding, see Appendix 2

Nutrition Guidelines for Healthy Infants and Young Children

- www.albertahealthservices.ca/info/Page8567.aspx
- Post-discharge Preterm Formula
- Safe Preparation and Handling of Infant Formula
- Homemade Formula
- Infant Formulas for Healthy Term Infants – Compendium
- Infant Formulas for Healthy Term Infants – Summary Sheet
- Introduction of Complementary Foods
- Introduction of Complementary Foods in Preterm Infants
- Vitamin D
- Allergy Prevention
- Weight Velocity
- Nutrition Education Resources
  - www.albertahealthservices.ca/nutrition/Page11115.aspx

Positioning

- Safe Infant Sleep Module, see Apprendix 2

Infection

- www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm
- https://www.canada.ca/en/public-health/services/diseases/flu-influenza.html?utm_source=canada-ca-flu-en&utm_medium=vurl&utm_campaign=flu

Teaching

- Strategies for Teaching Obstetrics to Rural and Urban Caregivers (STORC), see Appendix 2

Resources for Parents

- Health Link Alberta: (24/7 nurse advice and health information)
  - Call 811 (Toll free)
- My Health Alberta (online health information)
  - www.myhealth.alberta.ca
- 211 Alberta (community health government and social services)
  - Dial 211 in many places in Alberta or go to ab.211.ca
  - Connects people to a full range of community, health, government, and social services information
- Alberta Health Services' "*Healthy Parents, Healthy Children:* Pregnancy and Birth" and "*Healthy Parents, Healthy Children:* The Early Years"
  - www.healthyparentshealthychildren.ca
- Safe Infant Sleep Policy and Prevention of SIDS and/or safe infant sleep
  - insite.albertahealthservices.ca/9537.asp
- Ready or Not Alberta (preconception advice for men and women)
  - www.readyornotalberta.ca
- For information on feeding your baby commercial infant formula:
  - www.healthyparentshealthychildren.ca/feeding-your-baby/formula-feeding-your-baby/guidelines
  - www.albertahealthservices.ca/assets/info/nutrition/if-nfs-how-much-infant-formula-to-prepare-for-baby.pdf
- Newborn Metabolic Screening Program ("Why Does My Baby Need to be Screened?")
  - Available on Insite, AHS' staff intranet

Appendix 1: Abbreviation Definitions

ABBREVIATION DEFINITIONS			
AHS	Alberta Health Services	**PH**	Public Health
CSS	Cerebral spinal fluid	**PHCP**	Primary Health Care Provider
DVT	Deep Vein Thrombosis	**POS**	Period of Stability – the first 2 hours following the third stage of birth (delivery of placenta)
DHM	Donor Human Milk	**Q**	Every
EBM	Expressed Breast Milk	**$Sp0_2$**	Oxygen Saturation
GI	Gastrointestinal	**S&S**	Signs and Symptoms
HBsAg	Hepatitis B Surface Antigen	**SIDS**	Sudden Infant Death Syndrome
HCV	Hepatitis C Virus	**STI**	Sexually Transmitted Disease
Hgb	Hemoglobin	**UTI**	Urinary Tract Infection
HIV	Human Immuno-Deficiency Virus	**VAS**	Visual/Verbal Analogue Scale
ILI	Influenza-like Illness	**Vital Signs**	**BP** – Blood Pressure **R** – Respiratory Rate
IV	Intravenous		**P** – Pulse
NICU	Neonatal Intensive Care		**T** – Temperature
PPD	Postpartum Depression	**VTE**	Venous Thromboembolism

Appendix 2a: STORC e-Learning Modules – AHS

Strategies for Teaching Obstetrics to Rural and Urban Caregivers (STORC)		

Postpartum Shelf		
Module 09 – Postpartum Assessment MyLearningLink – Obstetrics 101	**Module 32** – Perinatal Bereavement MyLearningLink – Obstetrics 101	**Module 52** – Breastfeeding Foundations MyLearningLink – Breastfeeding Foundations
Module 19 – Intimate Partner Violence moreOB Chapter – Family Violence	**Module 34** – Safe Infant Sleep MyLearningLink – Safe Infant Sleep	**Module 53** – Managing Breastfeeding Challenges and Supplementation MyLearningLink – Managing Breastfeeding Challenges and Supplementation
Module 31 – Postpartum Hemorrhage moreOB Chapter – Postpartum Hemorrhage	**Module 38** – Skin-to-Skin Contact MyLearningLink – Obstetrics 101	

Newborn Shelf		
Module 08 – Newborn Assessment MyLearningLink – Obstetrics 101	**Module 39** – Vitamin K Administration in Term Infant MyLearningLink – Obstetrics 101	**Module 44** – Giving Protection MyLearningLink – HPHC – Giving Protection – release date TBA
Module 34 – Safe Infant Sleep MyLearningLink – Safe Infant Sleep	**Module 40** – Recognizing Newborn Illness MyLearningLink – Obstetrics 101	**Module 45** –Avoiding Exposure MyLearningLink – HPHC – Avoiding Exposure – release date TBA
Module 36 – Late Preterm Infant MyLearningLink – Obstetrics 101	**Module 41** – Car Seat Safety MyLearningLink – Obstetrics 101	**Module 46** – Promoting Healthy Mind & Body MyLearningLink – HPHC – Promoting Healthy Mind & Body – release date TBA
Module 37 – Hyperbilirubinemia MyLearningLink – Assess and Manage Newborn Hyperbilirubinemia	**Module 42** – T-Piece Resuscitator MyLearningLink – Obstetrics 101	**Module 52** – Breastfeeding Foundations MyLearningLink – Breastfeeding Foundations
Module 38 – Skin-to-Skin Contact MyLearningLink – Obstetrics 101	**Module 43** – Introduction to Preconception Health MyLearningLink – HPHC – Introduction to Preconception Health – release date TBA	**Module 53** – Managing Breastfeeding Challenges and Supplementation MyLearningLink – Managing Breastfeeding Challenges and Supplementation

Antepartum Shelf		
Module 01 – Communication and Documentation moreOB Chapters – Communication & Documentation	**Module 14** – Diabetes in Pregnancy MyLearningLink – Obstetrics 101	**Module 18** – Multifetal Gestation moreOB Chapter – Twins
Module 02 – Abdominal Palpation and Assessment MyLearningLink – Obstetrics 101	**Module 15** – Pre-Labour Rupture of Membranes moreOB Chapter – Prelabor Rupture of Membranes	**Module 19** – Intimate Partner Violence moreOB Chapter – Family Violence

Module 12 – Antenatal Tests for Fetal Well-Being MyLearningLink – Obstetrics 101	**Module 16** – Preterm Labour moreOB Chapter – Preterm Labor and Birth	**Module 21** – Group B Streptococcal Infections moreOB Chapter – Group B Streptococcus Disease Prevention
Module 13 – Hypertensive Disorders of Pregnancy moreOB Chapter – Hypertensive Disorder in Pregnancy	**Module 17** – Antepartum Hemorrhage moreOB Chapter – Antepartum & Intrapartum Hemorrhage	**Module 33** – Healthy Pregnancy Weight Gain moreOB Chapters – Weight, Obesity in Pregnancy, Weight Diet During Pregnancy & Physical Activity During Pregnancy

Intrapartum Shelf		
Module 01 – Communication and Documentation moreOB Chapters – Communication & Documentation	**Module 13** – Hypertensive Disorders in Pregnancy moreOB Chapter – Hypertensive Disorder in Pregnancy	**Module 25** – Assisted Vaginal Birth moreOB Chapter – Assisted Vaginal Birth
Module 03 – Intrapartum Fetal Assessment Fundamentals of FHS Self-Learning Online Manual https://ubccpd.ca/fhs-online-manual	**Module 14** – Diabetes in Pregnancy MyLearningLink – Obstetrics 101	**Module 26** – Shoulder Dystocia moreOB Chapter – Should Dystocia
Module 04 – Vaginal Examination MyLearningLink – Obstetrics 101	**Module 19** – Intimate Partner Violence moreOB Chapter – Family Violence	**Module 27** – Caesarean Birth MyLearningLink – Obstetrics 10
Module 05 – Assessment and Care of the Labouring Woman moreOB Chapter – Management of labour	**Module 20** – Obesity in Pregnancy moreOB Chapter – Weight, Obesity in Pregnancy	**Module 28** – Vaginal Birth After Caesarean (VBAC) moreOB – Chapter – Trial of Labor after Cesarean Section
Module 06 – Pain Management in Labour moreOB Chapter – Management of Labour	**Module 22** – Intra-Amniotic Infection MyLearningLink – Obstetrics 101	**Module 29** – Cord Prolapse moreOB Chapter – Cord Prolapse
Module 07 – Birth in Absence of a Primary Caregiver moreOB Chapter – Vaginal Birth	**Module 23** – Labour Dystocia moreOB Chapter – Management of Labor	**Module 30** – Amniotic Fluid Embolus moreOB Chapter – Venous Thromboembolism and Amniotic Fluid Embolus
Module 11 – Maternal Transport Guideline – Clinical Assessment of 'At Risk' or Actual Preterm Labour For Triage	**Module 24** - Induction and Augmentation moreOB Chapter – Induction of Labor	**Module 35** – Delayed Cord Clamping for Preterm & Term Babies Guideline – Umbilical Cord Clamping

Preconception Shelf	
Module 19 - Intimate Partner Violence moreOB Chapter – Family Violence	

Appendix 2b: STORC e-Learning Modules – Covenant Health

Strategies for Teaching Obstetrics to Rural and Urban Caregivers (STORC) – all courses are available on CLiC		
Abdominal Assessment and Palpations	**Antenatal Test for Fetal Well Being**	**Care of the Late Preterm**
C-Sections	**Diabetes**	**Intra-Amniotic Infection**
Newborn Assessment	**New Car Seat**	**New t-Piece**
Postpartum Assessment	**Recognizing Newborn Illness**	**Skin-to-Skin**
Vaginal Exam	**Vitamin K**	

Postpartum Clinical Path

Alberta Health Services

Postpartum Clinical Path

Affix patient label within this box

** see multidisciplinary notes*

Birth Summary			
Allergies *(specify)* ☐ NKA		Delivery Date *(yyyy-Mon-dd)*	Time *(hhmm)*
G _____ T _____ P _____ A _____ L _____		Foley catheter removed *(yyyy-Mon-dd)*	
Vaginal Delivery ☐ SVD ☐ Vacuum ☐ Forceps		Initial Void ☐ Yes ☐ No	
Cesarean Section ☐ Emergent ☐ Elective		If epidural or spinal, Time of catheter removal *(hh:mm)*	
Sedation ☐ Epidural ☐ Spinal ☐ General Anesthetic			
Perineum ☐ Intact ☐ Laceration Degree _____ ☐ Episiotomy			
Blood Loss ☐ less than 500 mL ☐ 500 - 1000 mL ☐ greater than 1000 mL			
Printed Name	Initials	Date *(yyyy-Mon-dd)*	Time *(hhmm)*

Clinical Observation							
Date *(yyyy-Mon-dd)*							
Time *(hhmm)*							
Temperature							
Pulse							
Respiratory Rate							
SpO_2							
Blood Pressure							
Sedation Score							
Pain Scale/ Intervention							
Fundal Tone							
Fundal Height							
Lochia amount/ colour							
Perineum/ Abdominal Incision							
Edema							
Initials							

Printed Name	Initial	Printed Name	Initial	Printed Name	Initial

Sample

18921 (Rev2018-03)

Page 1 of 2

Alberta Health Services

Affix patient label within this box

Postpartum Clinical Path

** see multidisciplinary notes*
Put a check mark (✓) in the appropriate column or 'X' if not assessed and N/A if not applicable
N= Normal, V= Variance, E= Education
Record variances/concerns/interventions on multidisciplinary notes.

Maternal Assessment																				
Date *(yyyy-Mon-dd)*																				
Time *(hhmm)*																				
Hours postpartum																				
Maternal Physiological	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E
Breasts																				
Bowel Funtion																				
Urinary Function																				
Abdomen/Fundus																				
Lochia																				
Perineum/Incision																				
Epidural/Spinal Site																				
Sensory/Motor																				
Healthy Eating																				
Activity/Rest																				
Feeding	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E
Breastfeeding/Feeding																				
Hand expression/pumping																				
Mothering	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E
Bonding/Attachment																				
Skin to Skin																				
Responds to feeding cues																				
Emotional & Mental Health																				
Family Function																				
Other	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E
Nicotine Use																				
Alcohol																				
Substance Use																				
Initial																				

Sample

Printed Name	Initial	Printed Name	Initial	Printed Name	Initial

Postpartum Clinical Path:

A Guide to Completion

Adopted from Perinatal Services BC, 2011.

While every attempt has been made to ensure that the information contained herein is clinically accurate and current, AHS acknowledges that many issues remain controversial, and, therefore, may be subject to practice interpretation.

5/8/2016

Postpartum Clinical Documentation

About the Postpartum Nursing Care Pathway:

The Postpartum Nursing Care Pathway has been developed to facilitate the assessment and documentation of pertinent information of mothers in a structured, logical, and standardized manner. It is a form to facilitate consistent and complete documentation, communication, and continuity of care among health care providers and provides a guide for evidence-based postpartum care.

Guiding Principles:

Several key principles guided the design and development:

- Be applicable for all maternity hospitals providing postpartum care
- Incorporate relevant information from the birth
- Be adaptable to charting by exception or variance charting
- Minimize double charting or need for narrative notes on several forms
- Utilize standardized terminology and abbreviations
- Facilitate early recognition, timely communication and intervention for changes in maternal wellbeing
- Seamless integration of other provincial records such as the Labour Partogram, Birth Summary, Maternal Record and Postpartum Clinical Path as much as possible
- Facilitate data collection
- Enable electronic archiving or formatting

General Guidelines:

Specific guidelines are relevant to all sections of the Postpartum Clinical Path.

- To determine the specifics of the normal and normal variations, variances, interventions, parent education and anticipatory guidance, and frequency of assessments, the Postpartum Care Pathway is used as the foundation documentation
- To obtain pertinent information
    - Confirm assessment data with parents/caregivers
    - Review Antenatal and Triage Assessment Records, Partogram, Labour & Birth Summary and any other significant health records
    - Perform a maternal physical and psychosocial assessment referred to as a Nursing Assessment
- For any identified variances
    - Document in the multidisciplinary notes

- Communicate with the Primary Health Care Provider (PHCP) or designate as required:
  - Exact time of notification
  - Nature of communication
  - Responses of PHCP
  - Plan of action
  - Response or evaluation of outcomes
- A blank space or 'x' indicates that the action or assessment was not performed

The following sections provide descriptive information about the items on the Postpartum Clinical Path:

- The term "Document" instructs one to write out the requested information in the space provided
- The term "Indicate" instructs one to check (✓) the box provided

1.0 Birth Summary - Refer to Delivery Record and other pertinent documents to assist with completion	
Item	**Description**
Addressograph/label area	See label
Allergies	Specify any allergies (and reaction/s) or check (✓) if NKA (no known allergies)
Delivery Date & Time	Document the newborn's birth information as date of birth (yyyy-Mon-dd) and time of birth (hhmm)
Gravida (G)	The total number of prior and present pregnancies regardless of gestation age, type, time or method of termination/outcome. Twins or multiples are counted as one pregnancy. A blighted ovum and hydatidiform mole are classified as a gravida.
Term (T)	The total number of previous pregnancies with birth occurring at greater than 37+0 weeks gestation.
Preterm (P)	The total number of previous pregnancies with birth occurring between 20-36+^{6} weeks gestation.
Abortion (A)	*Spontaneous:* The total number of previous spontaneous terminations of pregnancies ending prior to 20 completed weeks gestation and weighing less than 500 gm. Ectopic pregnancies, missed abortions, blighted ova and hydatidiform moles are classified as spontaneous abortions. *Induced*: The total number of previous induced terminations of pregnancies ending prior to 20 completed weeks gestation and weighing less than 500 gm.
Living (L)	The total number of children that women have given birth to, who are presently living. Does not include current pregnancy.
Foley catheter removed	Indicate date (yyyy-Mon-dd) of Foley catheter removal
Vaginal Delivery	Check (✓) if delivery was a spontaneous vaginal delivery (SVD), then check (✓) either vacuum or forceps
Initial void	Check (✓) Yes or No if there was an initial void

Cesarean Section	Check (✓) if the cesarean section was emergency or elective
Sedation	Check (✓) if sedation was epidural, spinal or general anesthetic

Perineum	Check (✓) the condition of the perineum as
	• Intact
	• Laceration – document degree:
	  ○ First – extends through the skin and structures superficial to muscles
	  ○ Second – extends through muscles of the perineal body
	  ○ Third – continues through the anal sphincter muscle
	  ○ Fourth – also involves the anterior rectal wall
	• Episiotomy

Blood Loss	Check (✓) the estimated volume of blood loss in the intrapartum episode of care as: less than 500 mL, 500–1000 mL, greater than 1000mL
Printed Name	Provide legible printed name
Initials	Provide legible initials
Date and Time	Document the date (yyyy-Mon-dd) and time (hhmm) the Birth Summary was completed

2.0 Clinical Observation

Suggested Frequency of Vital Signs

Assess: vital signs, history and risk, how she feels related to vital signs and her understanding of her vital signs

Vaginal Birth	Caesarean Birth (Spinal/Epidural)	Caesarean Birth (General Anesthesia)
• q15 x 4 (delivery room) • q30 x 2 • q4h x 2 • q shift until discharge	• q15 x 4 (recovery room) • On arrival to unit • q30 x 2 • q4h x 24 hours • q shift until discharge	• q15x4 (recovery room) • On arrival to unit • q30x2 • q1hx2 • q4hx24 hrs • q shift until discharge

NOTE: Above assessments to be done without disturbing a sleeping patient

Frequency of vital signs with Neuraxial Anesthesia (Epimorphine) in absence of specific anesthesia orders:

- Respiratory rate, depth, oxygenation ($Sp0_2$ when appropriate), sedation score q1h x 12 hours post administration, then q2h x 12 hours

Variances may require more frequent observations

- Describe any variances in the multidisciplinary notes (including focus, information on the variance, nursing actions and responses to interventions/care)

Item	Description	
Date	Document the date (yyyy-Mon-dd) the clinical observations/assessments were performed	
Time	Document the time (hhmm) the clinical observations/assessments were performed	
Temperature	Document patient temperature in ^{0}C	
Pulse	Document the pulse rate	
Respiratory Rate	Document the respiratory rate (counted for one minute, if relevant).	
$Sp0_2$	Document oxygen saturation (if relevant)	
Blood Pressure	Enter data. Blood pressures normal limits = 140 systolic and 90 diastolic	
Sedation Score	As per legend, on back of page 1, document sedation score: • S = Normal sleep, easy to arouse • 0 = Alert • 1 = Sometimes drowsy • 2 = Frequently drowsy, easy to arouse • 3 = Somnolent, difficult to arouse	

Pain Scale /Intervention	As per legend, document in the top pain section the:
	• Pain Scale from 0-10
	  ○ 0 = No pain
	  ○ 10 = Worst pain possible
		As per legend, document in the bottom pain section if analgesic was given (Intervention) or refused:
		• AG = Analgesic Given
		• RA = Refused Analgesic
		• N/A = Not applicable

Fundal Tone	As per legend, indicate the tone of the fundus as: **F** = Firm, **M** = Firm with massage or **B** = Boggy	
Fundal Height	As per legend, indicate the height of the fundus as: **u** = At umbilicus, **/u** = Above the umbilicus (specify), **u/** = Below the umbilicus (specify)	
Lochia Amount/Colour	As per legend, indicate the amount of the lochia as: **Sc** = Scant, **S** = Small, **M** = Moderate, **H** = Heavy or **CL** = Clots	As per legend, indicate the color of the lochia as: **R** = Rubra, **S** = Serosa or **A** = Alba
Perineum/Abdominal Incision	As per legend, indicate the condition of the perineum as: **A** = Approximated, **B** = Bruised, **S** = Swollen, **H** = Hemorrhoids, **I** = Intact, **C** = Cold (Ice)	As per legend, indicate the condition of the abdominal incision as: **A** = Approximated, **DI** = Dressing dry and intact, **Oz** = Dressing oozing, **B** = Bruised, **DR** = Dressing removed, **S/R** = Sutures/staples removed, **N/A** = Not applicable
Edema	As per legend, indicate the amount of the Edema as: **+1** = trace; indentation disappears rapidly	

	+2 = moderate; indentation disappears in 10-15 seconds **+3** = deep; indentation disappears in 1-2 minutes **+4** = very deep; indentation lasts more than 5 minutes (*see multidisciplinary notes)
Initials	Provide legible initials
Printed Name	Provide legible printed first and last name
Initial	Provide legible initials

3.0 Maternal Assessment

Refer to the timeframe in the Postpartum Nursing Care Pathway for a description of the normal/normal variations, client education and anticipatory guidance, variances and interventions for each of the assessed items. Variances may require more frequent assessments. Describe any variances/concerns in the multidisciplinary notes (including focus, information on the variance, nursing actions and responses to interventions/care)

Item	Description
Date	Document the date (yyyy-Mon-dd) the clinical observations/assessments were performed
Time	Document the time (hhmm) the clinical observations/assessments were performed
Hours postpartum	Document the postpartum time in hours. Once the woman is 72 hours postpartum (3 days) document the timeframe in days

Normal/Variance/Education Columns	Indicate **N**ormal, **V**ariance, **E**ducation or ***** (see multidisciplinary notes) for each of the areas relating to the maternal postpartum assessment as per the Postpartum Nursing Care Pathway
	
	Place a checkmark (✓) in the:
	• **N** = column indicating the assessment fits the normal or normal variations for the time period as described in the Postpartum Nursing Care Pathway
	  ○ (✓) = normal
	  ○ N/A = not applicable
	  ○ X = not addressed
	• **V** = column indicating there is a variance for the time period as described in the Postpartum Nursing Care Pathway
	• **E =** column indicating there was education given to the patient/family
	• ***indicates entry in multidisciplinary notes
	
	Indicate N, V, E as appropriate a minimum of 1 time per shift.

Maternal Physiological	• Breasts • Bowel function

	• Urinary function • Abdomen/Fundus • Lochia • Perineum/Incision • Epidural/Spinal Site • Sensory/Motor • Health Eating • Activity/Rest
Feeding	• Breastfeeding/Feeding • Hand expression/pumping
Mothering	• Bonding/Attachment • Skin-to-Skin • Responds to feeding cues • Emotional and Mental Health • Family Function
Other	• Nicotine Use • Alcohol • Substance Use
Initial	Provide legible initials
Printed Name	Provide legible first and last name
Initial	Provide legible initials

Newborn Clinical Pathway

Newborn Clinical Pathway

Completion of the **STORC (Strategies for Teaching Obstetrics to Rural and Urban Communities)** educational modules, developed and maintained by the Alberta Perinatal Health Program, are a recommended pre-requisite to successful implementation of the Alberta Pregnancy Pathways.

About the Newborn Nursing Care Pathway:

The Newborn Nursing Care Pathway identifies the needs for care of **healthy** term or late preterm newborns. It is the foundation for documentation on the Newborn Clinical Path. To ensure all of the assessment criteria are captured, they have been organized into five main sections:

- Infant Feeding
- Screening/Other
- Physiological Health (organized from head to toe)
- Behavioural
- Health Follow-up

While the newborn assessment criteria are presented as discrete topic entities, it is not intended that they be viewed as separate from one another. For example, the newborn physiological changes affect her/his feeding behaviour. To assist with this, cross-referencing is used throughout the document (will be seen as "Refer to…"). This is also evident when referencing to the Postpartum Nursing Care Pathway. The mother and newborn are considered to be an inseparable dyad, with the care of one influencing the care of the other. An example of this is with breastfeeding as it affects the mother, her newborn, bonding and attachment.

In this document, assessments performed while in hospital are entered into specific periods; from immediately after birth to 7 days postpartum and beyond. These are guidelines and are used to ensure that all assessment criteria have been captured.

Underlying Principles:

- Patient and Family centered care empowers and prepares women for motherhood.
- Clinical practice is based on research and best evidence and supported through knowledge translation strategies.
- Pregnancy is considered normal, but dynamic, and risk assessment and management is integral to each phase.
- Health Care Providers have access to knowledge, tools, and resources and are prepared to support the woman and family through both normal and variant pathways.
- Collaborative relationships between all members of the health care team across the continuum, locally and provincially, support access to required levels of care or support.

- Trauma informed care underlies all components of pregnancy pathways.

Statement of Family Centered Care:

In conjunction with Women Centered Care, Patient and Family Centered Care is an attitude/philosophy rather than a policy and is based on guiding principles. Key principles have been adapted and are reflected in the Newborn Nursing Care Pathway.

- Women and families have diverse birthing experiences (philosophies, knowledge, experience, culture, social, spiritual, family backgrounds, and beliefs); thus approaches to care need to be adapted to meet each family's unique needs.
- Relationships between women, their families, and the variety of health care providers are based on mutual respect and trust.
- In order to make knowledgeable and responsible decisions in providing newborn care, women and their families require support and information.
- Parents are provided with information about newborn screening/treatments (e.g. eye prophylaxis, Vitamin K and newborn blood spot and hearing) including why the treatment is recommended, advantages, side effects, and risks if not performed – if parents decline screening/treatment, a documented informed refusal is required.
- The family (Using Women Centered care principles and as defined by the woman) is encouraged to support and participate in all aspects of newborn care.
- While in hospital (whenever possible), assessments and procedures should be performed in the mother's room. The woman/her family are included in the planning and implementation of the newborn's care.
- Prior to, during, and following procedures that may cause newborn discomfort/pain, mothers are encouraged to comfort their newborns through breastfeeding or skin-to-skin contact.

Resources:

A list of key resources for both health care professionals and parents is listed at the end of this document.

Timeframes:

The first 12 hours are considered to be the period of transition where the normal newborn adapts to extra-uterine life. Thus, the guidelines determine the first 12 hours following the third stage of birth as the Period of Stability (POS) followed by >12-24 hours, >24-72 hours, and >72 hours – 7 days and beyond. These are the reference points used in this document.

NOTE: In order to capture key parent teaching/anticipatory guidance concepts, these concepts will be located in the >12-24 hour timeframe. It is at the individual nurse's discretion to provide this information/support earlier or later.

Newborn Physiological Stability:

The Newborn Nursing Care Pathway recommends that the six (6) following criteria define infant physiologic stability:

- Respiratory rate between 30-60/minute
- Axillary temperature of 36.3 – 37.2 °C and stable heart rate (100 – 160 bpm when sleeping) – *as per ACORN*
- Suckling/rooting efforts and evidence of readiness to feed
- Physical examination reveals no significant congenital anomalies
- No evidence of sepsis
- No jaundice developing <24 hours

Newborn Pain:

Newborn pain is generally alleviated by interventions such as holding the baby skin-to-skin, breastfeeding/feeding, cuddling, rocking and/or swaddling for the duration of the procedure.

Clinical Observations

Clinical Observations	0 - 12 Hours PERIOD OF STABILITY (POS)	> 12 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
VITAL SIGNS:				
Assessment Frequency: **If stable:** • Within 15 minutes of birth • At 1 and 2 hours of age • At 6 hours of age • Once per shift until hospital discharge ***Variances, history, or risk factors may dictate more frequent observations.*** **Assess:** • Temperature • Respiratory rate and effort • Heart rate and sounds • Circulation • Colour • Tone **Assess mother/family/ support's understanding of:** • Newborn physiology and capacity to identify variances that may require further assessments	**NORM AND NORMAL VARIATIONS:** **Temperature:** • Axilla - 36.3-37.2˚C **Respirations:** • Effortless - 30–60/min [1] • Clear sounds • May be irregular • Some mucous • Easy respirations when mouth closed • Sneezing common (<3–4 times/ interval) • May have slightly wet sounding lungs for the first 15–30 min and is improving **Circulation:** • Heart rate: 100–160 bpm • Healthy term newborns may have a slower resting heart rate in the range of 80-100 bpm (as per ACoRN) • SpO2 monitoring: normal range: 88-95% (as per ACoRN) • No murmur **Colour:** • Centrally pink • Acrocyanosis **Tone:** • Flexion of extremities at rest **Variance:** • Temperature instability • Heart murmur • Persistent tachycardia > 160 or bradycardia ≤ 100 bpm • Mucousy/noisy respirations that are not improving • Signs of respiratory distress ○ In-drawing	**NORM AND NORMAL VARIATIONS:** ○ Presents with normal newborn examination and no major CNS concerns ○ Refer to PERIOD OF STABILITY **Parent Education/Anticipatory Guidance:** ○ How and when to assess temperature and respirations (including normal values) ○ How to clear mucous ○ Prone, head lowered, and stroke back ○ Avoid the use of mechanical aids in nose e.g. cotton tipped applicators & bulb aspirators ○ Heat control in infants ○ Skin-to-skin with blanket over infant and mother ○ To prevent overheating, avoid use of heavy blankets. Light blankets, if used should be firmly tucked in under the mattress, reaching only to the infant's chest.	**NORM AND NORMAL VARIATIONS:** • Refer to >12–24 hours **Parent Education/ Anticipatory Guidance:** • Refer to >12–24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to >12–24 hours **Parent Education/ Anticipatory Guidance:** • Refer to >12–24 hour

Clinical Observations	0 - 12 Hours PERIOD OF STABILITY (POS)	> 12 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
VITAL SIGNS:				
	○ Grunting ○ Nasal flaring • Apneic episodes >15 sec • Respiratory Rate<30 per minute • Respiratory Rate>60 per minute • Diaphoresis • Poor colour ○ Dusky/Ruddy ○ Mottled skin • Decreased or increased tone **Intervention:** • Nursing Assessment (include SpO2) • Refer to appropriate PHCP, as required • Refer to ACORN **Parent Education/Anticipatory Guidance:** • Nursing – hands on physical assessment with parent(s) in attendance • Use of toque/head covering until thermal regulation obtained • Encourage skin to skin care • Refer to >12–24 hours	(*A hat may be used to cover the infant's head until their temperature is stabilized.*) ○ Baby may be too warm if hot to touch ○ Environmental factors can influence thermal regulation (e.g. room temperature, clothing)		
HISTORY OR RISK FACTORS THAT MAY IMPACT VITAL SIGNS:	**The following are in addition to the Norm and Normal Variations, Variances, and Interventions for Vital Signs as above.*			
GBS+ and/or prophylaxis protocol not adequate: • VS q4h x 24 hours **ROM >18 hours and/or maternal fever during labour:** • VS q4h x 24 hours	If GBS+ and prophylaxis protocol not adequate or rupture of membranes >18 hours: VS q4h x 24 hours Definition of adequate prophylaxis: Penicillin or Cefazolin given at least 4 hours before birth. Anything other than this is considered inadequate and requires increased vital VS q4h x 24 hours. (CPS Guideline)			

Clinical Observations	0 - 12 Hours PERIOD OF STABILITY (POS)	> 12 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
VITAL SIGNS:				
For Assisted Birth (AB): *use of vacuum or forceps*: • Monitor VS and head circumference: • Vital Signs Suggested Frequency (MORE^{OB}) ○ At 1 and 2 hours of age ○ Then, every 4 hours until 24 hours of age	**NORM AND NORMAL VARIATIONS:** • Head circumference measurement increases < 1 cm from previous assessment • Normal VS **Variance:** • Head circumference measurement increases ≥ 1 cm from previous assessment • Heart rate > 170 bpm • Palpable boggy scalp • Lethargy • Colour	**Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	**Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	
Maternal Use of Codeine and Other Opioids, SSRIs or sedating medications during pregnancy or postpartum period. **Postpartum:** • Monitor for respiratory depression	**Normal and Normal Variations:** Absence of signs or symptoms of adverse maternal medication effects of withdrawal such as CNS depression or disorganization. **Variance:** ○ CNS depression – exhibited as not feeding well, not waking up to be fed, or lethargy ○ S&S of a disorganized infant: ○ Metabolic/vasomotor/respiratory (CNS, crying, tremors, muscle tone, sucking, swallowing. ○ Refer to Behavior ○ GI (feeding, vomiting, stooling, excoriation) ○ If baby has signs of CNS depression or disorganized behavior- refer to PHCP **Intervention:** • Complete Neonatal Abstinence Syndrome scoring assessment and follow facility protocol for care and treatment of the newborn who is experiencing withdrawal symptoms ○ Consider having baby examined by PHCP if mother shows excessive symptoms of CNS depression	**Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	**Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	

Clinical Observations	0 - 12 Hours PERIOD OF STABILITY (POS)	> 12 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
VITAL SIGNS:				
	○ Safe swaddling as needed to calm, soothe and console. https://www.healthyparentshealthychildren.ca/resources/videos-injury-prevention-and-staying-healthy			
CRITICAL CONGENITAL HEART DEFECT SCREENING (CCHD): • Preductal (Right hand or Right. wrist) and post ductal (either foot)	***To be performed after 24 hours of age, if ordered.***	***To be performed after 24 hours of age, if ordered.**	**NORM AND NORMAL VARIATIONS:** • Negative Screen (pass) SPO_2 ≥95% in hand or foot and the preductal to post ductal difference is ≤3% **Variance:** • Positive Screen **Intervention:** • Refer to appropriate PHCP, as required	
HYPOGLYCEMIA: **Assess:** • Signs and symptoms of hypoglycemia in the newborn • Review history and risks for hypoglycemia • Blood glucose (POCT) when clinically indicated as per Facility and/or Zone guideline	**NORM AND NORMAL VARIATIONS:** • Blood Glucose levels ≥2.6 mmol/L after 2 hours of age **Variance:** • Symptomatic hypoglycemia • Blood glucose levels <2.6 mmol/L after 2hours of age **Intervention:** • As per Facility and/or Zone guideline	**NORMAL AND NORMAL VARIATIONS** • Refer to PERIOD OF STABILITY **Variance:** • Blood glucose < 2.6 mmol/l **Intervention:** As per Facility and/or Zone guideline	**Variance:** • Refer to > 12-24 hours **Intervention:** • Refer to PERIOD OF STABILITY	**Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY
WEIGHT, LENGTH, AND HEAD CIRCUMFERENCE **Assess:**	**NORM AND NORMAL VARIATIONS:** • Refer to >72 hours – 7 days and beyond • Normal birth weight for term infants is 2500–4000 gm **Parent Education/Anticipatory Guidance:**	**NORM AND NORMAL VARIATIONS:** • Refer to >72 hours – 7 days and beyond	**NORM AND NORMAL VARIATIONS:** • Refer to >12–24 hours	**Parent Education/ Anticipatory Guidance:**

Clinical Observations	0 - 12 Hours PERIOD OF STABILITY (POS)	> 12 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
VITAL SIGNS:				
• Weight, length, and head circumference at birth • Weight gain/loss appropriate for age • Discharge weight, as required **Refer to:** • Childhood Growth Monitoring, Protocol, AHS	• Refer to >12–24 hours **Variance:** • Refer to >12–24 hours **Intervention:** • Refer to >12–24 hours	**Parent Education/Anticipatory Guidance:** • Weight is only one component of a newborn's feeding assessment and well being • Hydration & elimination affect weight (intake and output) • Infants lose weight during the first few days after birth • Most infants have an overall trend of weight gain upwards towards birth weight after day 5 **Variance:** • Newborns at risk for excessive weight loss may require daily weights e.g., small gestational age, preterm, newborns under phototherapy, breastfeeding concerns. **Intervention:** • Nursing assessment • Ongoing feeding assessment • Teaching and support • Refer to appropriate, PHCP as required	**Variance:** • Refer to >12–24 hours • Excessive weight loss may be due to ○ Poor feeding (inadequate milk transfer), poor latch, poor suck, infrequent feeds ○ Low maternal milk production ○ Illness **Intervention:** • Refer to >12–24 hours	• Refer to >12–24 hours • Signs of adequate hydration • After discharge, the newborn will be weighed by public health or PHCP • Infants should return to birth weight by 2 weeks of age **Variance:** • Refer to >24–72 hours • No weight gain by day 5 • Has not returned to birth weight by about 2 weeks **Intervention:** • Refer to >24–72 hours • Assess feeding and develop a feeding plan with mother • Have a follow-up plan

Clinical Observations	0 - 12 Hours PERIOD OF STABILITY (POS)	> 12 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
VITAL SIGNS:				
				• Refer to appropriate PHCP, as required

End Notes

[1]Tveiten, L., Diep, L. M., Halvorsen, T., & Markestad, T. (2016). Respiratory Rate During the First 24 Hours of Life in Health Term Infants. Pediatrics, 137(4). doi: 10.1542/peds.2015-2326

Infant Feeding: Breastfeeding

Infant Feeding Assessment	0 - 12 Hours PERIOD OF STABILITY (POS)	> 12 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
BREASTFEEDING:				

Assess feeding effectiveness:
• Positioning
• Latch
• Hydration
• Frequency
• Duration
• Sucking
• Swallowing
• Voiding
• Stooling
 	
Assess mother's ability to initiate & complete feeds:
• Refer to STORC module on breastfeeding
 	
Observe (at least once per shift):
• Feeding
• Mother's response to feeding
 	
Observe and document ≥ 2 successful feeds prior to discharge
 	
Refer to:
• Elimination
• Weight
• Skin
• Behaviour
	NORM AND NORMAL VARIATIONS:
	• Skin-to-skin immediately after birth
	• An infant will self-latch with skin-to-skin in the first hour or so after birth (see Breast Feeding STORC Module)
	• Prior to initial latch, may lick, nuzzle or root for nipple
	• Baby latches and begins to suck
	• Actively feeds
	• Tolerates feeds
	• After initial feed baby may not be interested in further feeding during this period
	• May have small emesis of mucous or undigested milk following feeds (10 mL or less)
	
	Parent Education/Anticipatory Guidance
	• Importance of early and frequent active breastfeeding (provides antibodies)
	• Duration of breastfeeding
	• The benefits of skin-to-skin during the establishment of breastfeeding
	• Effective positioning
	  ○ Mother is comfortable and well-supported
	  ○ Infant is positioned to facilitate an effective latch
	  ○ Breast support is provided, if required
	• Effective latch
	• Show all mothers how to hand express, especially if newborn is at
		NORM AND NORMAL VARIATIONS:
		• Attempts to feeds ≥ 5 times in the first 24 hours and may cluster feed
		• Variable frequency and duration (different for each mother-infant dyad)
		• Wakes to feed
		
		Parent Education/ Anticipatory Guidance:
		• Refer to PERIOD OF STABILITY
		• Assist mother to watch/look for feeding cues
		• Early
		• Stirring
		• Mouth opening
		• Rooting/turning head
		• Mid cues
		• Increased physical activity
		• Hands to mouth
		• Late
		• Crying
		• Agitated movements
		• Colour turning red
			NORM AND NORMAL VARIATIONS:
			• Feeds 8-12 times or more in 24 hours and frequently during the night (not necessarily at regular intervals)
			• Swallowing is regular and audible throughout the feed after the first 24 hours
			• Shows signs of adequate hydration
			• Content and satisfied after feeding
			
			Parent Education/Anticipatory Guidance:
			• Refer to >12–24 hours
			• Assess satiation cues
			  ○ Slowing of swallows
			  ○ Bursts of non-nutritive suckling
			  ○ Relaxed limbs
			  ○ Content
			  ○ Sleeping
			  ○ Spontaneous release of the nipple
			  ○ Lack of further feeding cues right after the feed
			• Aware that frequent feedings assists in milk production
			• Breastfeeding throughout the night (stimulates milk production, relieves breast fullness discomfort, helps prevent engorgement)
			• Signs of effective feeding
			  ○ Feeds 8 or more times/24 hours
			  ○ Hear a "ca" sound during feeding
			  ○ Coordinated suck and swallow
			  ○ Refer to elimination re: numbers of wet diapers and bowel movements
			  ○ Evidence of milk transfer
			• Infants are to receive Vitamin D 400-800 IU/day as prescribed by PHCP (breast and formula fed)
			• For maternal Vitamin D supplementation – Refer to Postpartum Nursing Care Pathway: Healthy Eating
				NORM AND NORMAL VARIATIONS:
				• Refer to >24–72 hours
				• Feedings are shorter or baby may be satisfied for longer stretches
				• Baby may cluster feed during alert periods (often in the late evening)
				• Baby gaining weight regularly
				• Content after most feedings
				• Pattern of breast usage may change (e.g. one or both breasts per feed)
				• Changes in feeding patterns where infants feeds more frequently for several days (commonly called growth spurts)

Infant Feeding Assessment	0 - 12 Hours PERIOD OF STABILITY (POS)	> 12 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
BREASTFEEDING:				
• Postpartum Nursing Care Pathway: Breasts and Infant Feeding **Assess mother/family support's understanding of:** • Breastfeeding • Need for vitamin D supplement for both breastfeeding and non-breastfeeding infants **Assess mother's capacity to:** • Identify variances that may require further assessments and/or intervention	risk of hypoglycemia (LGA, SGA, infant of diabetic mother) **Variance:** • Infant shows no signs of interest in feeding • Poor/absent latch • Does not latch • Uncoordinated suck/ swallow/ breathing pattern • Coughing, choking • Respiratory distress with feeding • Does not settle following feeds • Congenital anomalies (e.g. tongue tie, cleft palate) • If baby is unable to breast feed then consider supplementation • If Mother has a supply of pre-delivery milk expression, this milk could be used • Mother makes an informed decision to provide supplementation (Expressed Breast Milk [EBM]) or use a breast milk substitute when no medical indications for supplementation **Intervention:** • Normal newborns eat 2-10 mLs/feed of colostrum in the first 24 hours; 5-15 mLs/feed of colostrum in 24 -48 hrs ○ Stomach capacity and amount of each individual feeding are unknown • Assess reason for variance • Ensure proper positioning	• Infants aroused from deep sleep will not feed • Duration varies for each feeding and mother-infant dyad (may last 20–50 min) • Discuss that a satisfied infant is relaxed, sleepy & disengages from breast **Variance:** • Refer to PERIOD OF STABILITY • Dimpling of cheeks • Smacking sounds while feeding • Not feeding effectively **Intervention:** • Refer to PERIOD OF STABILITY • Nursing Assessment • Refer to appropriate PHCP, as required	**Variance:** • Refer to 0–24 hours **Intervention:** • Refer to 0–24 hours **Variance – Ineffective Feeding:** • Baby not getting enough milk based on clinical assessment **Intervention – Ineffective Feeding:** • Nursing Assessment • Assist with position and latch • Hand expression with breast compression • Implement techniques for waking sleepy baby (stimulating baby, skin-to-skin, not over dressing) • May require feeding alternatives if there is evidence that baby needs more milk than he/she is getting ○ Educate and obtain informed consent ○ Provide Expressed Breast Milk (EBM), pasteurized and screened Human Donor Milk or breast milk substitute as appropriate ○ Provide by spoon, cup, dropper, bottle Suggested amoungs to offer for **supplementation** of healthy term breast fed newborns. • minimum of 8 feeds per 24 hours • 24-48 hours 5-15 mL/feed • 48-72 hours 15-30 mL/feed • 72-96 hours 30-60 mL/feed • Implement applicable feeding plan: ○ Latch challenges/tongue tie ○ SGA/IUGR	**Variance:** • Refer to 0–72 hours **Intervention:** • Refer to 0–72 hours Supplementation amounts for the term breastfed baby based on average range amounts of colostrum or breastmilk consumed per feed. **1-2 weeks** •Minimum of 8 feeds per 24 hours •72-96 hours 30-60 mL/feed •Day 5-7 30-60 mL/feed (this amount is based on a mother's production versus average newborn intake) •Day 8-21 60-90 mL/feed •Day 22 and older 90-150 mL/feed

Infant Feeding Assessment	0 - 12 Hours PERIOD OF STABILITY (POS)	> 12 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
BREASTFEEDING:				
	• Assess feeding to reassure mother that infant's needs are met by breastfeeding • Ensure that concerns about feeding are addressed • Provide teaching as needed • Refer to appropriate PHCP, as required		○ Hypoglycemia ○ Breast surgery/scars ○ Jaundice/phototherapy ○ Sleepy baby ○ Late Preterm • Refer to appropriate PHCP, as required	

End Note: Alberta Health Services Public Health Nursing- Maternal/Newborn Practice Manual (0-2 months) Section 3: Newborn Feeding- Appendix B- supplementation fo the breastfed newborn. (July 2018).

Active Feeding – Breast – several bursts of sustained sucking at each feed including effective positioning, latch, and evidence of milk transfer

Positioning – chest to chest, skin to skin, nipple to nose

Effective Latch – chest to chest, nipple to nose, wide open mouth, flanged lips, no dimpling of cheeks, may hear audible swallow, rhythmic sucking, baby doesn't easily slide off the breast, no nipple damage or distortion after feed

Adequate Hydration – moist mucous membranes, elastic and responsive skin turgor

Evidence of Milk Transfer – audible swallowing, rhythmical sucking, adequate output (refer to Elimination), appropriate weight loss for age (refer to Weight)

Infant Feeding: Breast Milk Substitute

Infant Feeding Assessment	0 - 12 Hours PERIOD OF STABILITY (POS)	> 12 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
BREAST MILK SUBSTITUTE (FORMULA):				
• Provide information as necessary for informed decision making • Explore feeding options- address mother's specific concerns about infant feeding **Assess:** • Coordinated suck and swallow (active feeding) • Hydration • Frequency • Duration • Able to consume appropriate volume for age/ weight **Assess mothers/family/ support's awareness of:** • Importance of breast milk and breastfeeding • Understanding of normal newborn feeding • Knowledge of: ○ Appropriate formula ○ Safe formula preparation ○ Safe formula storage ○ Cost ○ Potential health concerns with formula	**NORM AND NORMAL VARIATIONS:** • Skin-to-skin for all babies regardless of feeding method • Tolerates feed **Parent Education/ Anticipatory Guidance:** • Information about maternal and infant benefits of breastfeeding • Address maternal specific concerns regarding feeding issues • Refer to >12–24 hour **Variance:** • Babies at high risk for allergies **Intervention:** • Partially hydrolyzed 100% whey protein or extensively hydrolyzed casein formula	**NORM AND NORMAL VARIATIONS:** • Cue based feeding • Every 2–4 hours • Commercial formula fed newborns may feed less often (8-10 feedings in 24 hours) • Signs of fullness **Parent Education/Anticipatory Guidance:** • Choice of formula (ready-to-feed and concentrated formula are sterile until opened; powdered formula is not sterile) • Equipment ○ Equipment needed ○ Cleaning of equipment • Preparation, storage and warming formula • Formula at room temperature for no more than 2 hours • Positioning: ○ Hold baby close during feeding ○ Have baby's head higher than body, supporting baby's head ○ Never prop the bottle • Early feeding cues • Infants aroused from deep sleep will not feed • Follow baby's cues re amount to give – newborns may drink small amounts at a feeding • Burping positions • Stop feeding (don't coax to finish the bottle) when baby shows signs of fullness – closing mouth, turning away, pushing away, falling asleep ○ Discard any breast milk/commercial left over formula **Variance:** • Inappropriate formula preparation or type	**NORM AND NORMAL VARIATIONS:** • Refer to >12–24 hours **Parent Education/ Anticipatory Guidance:** • Refer to >12–24 hours • For lactation suppression – Refer to **Postpartum Nursing Care Pathway: Breasts** **Variance:** • Refer to >0–24 hour **Intervention:** • Refer to >0–24 hour **Formula Volume First 24-96 Hours:** 24–48 hours: 60mL/kg/24 hours (varies widely, follow hunger cues) 48–72 hours: 90mL/kg/24 hours (varies widely, follow hunger cues)	**NORM AND NORMAL VARIATIONS:** **Total Formula Volume:** • Baby is content between feedings • Formula is prepared safely **Parent Education/ Anticipatory Guidance:** • Formula feeding • Refer to >12–24 hours • Cue based feeding • Signs of fullness **Variance:** • Refer to >0–24 hour • Inappropriate formula • Incorrect preparation and storage • Overfeeding **Intervention:** • Refer to >0–24 hours • Introduction of complementary solids at about 6 months

Infant Feeding Assessment	0 - 12 Hours PERIOD OF STABILITY (POS)	> 12 - 24 Hours	> 24 - 72 Hours	> 72 Hours - 7 Days (and beyond)
BREAST MILK SUBSTITUTE (FORMULA):				

• Ability to initiate & complete feeds
 	
Observe:
• Newborn feeding
• Mother's response to feeding
 	
Refer to:
• Elimination
• Weight
• Skin
• Behaviour
• Postpartum Nursing Care Pathway: Infant Feeding
		Intervention:
		• Provide parent education
		• Refer to Dietitian/PHCP/other resources, as required
		
		Variance - Vomiting or Frequent Large Regurgitation:
		• Fussy
		• Irritable
		• Crying
		• Arching
		• Gassy
		• Loose stool
		
		Intervention - Vomiting or Frequent Large Regurgitation:
		• Nursing assessment, including:
		  ○ Assess feeding and burping techniques
		  ○ Assess hunger cues vs. satisfied cues to avoid overfeeding
		  ○ Inquire re: food intolerance/allergies in family
		• Refer to Dietitian/PHCP/other resources as required
		
		Formula Volume First 24 hours:
		• 30 ml/kg/24 hours(varies widely, follow hunger cues
		• Baby to receive 400 IU/day of Vitamin D (breast and formula fed)		

Screening/Other: Newborn Metabolic Screening

Screening Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
NEWBORN METABOLIC SCREENING:				
	NORM AND NORMAL VARIATIONS: • Refer to >12–24 hours **Parent Education/Anticipatory Guidance:** • Refer to >12–24 hours **Variance:** • Refer to >12–24 hours **Intervention:** • Refer to >12–24 hours	**NORM AND NORMAL VARIATIONS:** • Newborns screened between 24 and 72 hours of age • The Registered Midwife or Public Health nurse (as applicable) may be able to collect the blood spot specimen in the home setting or alternately refer patient to nearest lab **Parent Education/Anticipatory Guidance:** • Parent adequately informed and provides verbal consent • Resource "Why Does My Baby Need to be Screened?" ○ Available on Insite, AHS' staff intranet **Variance – Discharge Before 24 Hours of Age:** • Discharge less than 24 hours or transfer to another health care facility before 24 hours of age • Low Birth Weight babies to have repeat screen done between 21-28 days of birth **Intervention – Discharge Before 24 Hours of Age:** • Follow-up plan arranged for specimen collection **Variance – Refusal/Deferral:** • Parental informed refusal or request for deferral **Intervention – Refusal/Deferral:** • Discuss & address refusal • Refer to: www.albertahealthservices.ca/assets/info/hp/nms/if-hp-nms-talk4-parent-refusal.pdf • Complete Release of Responsibility Form • Documentation of Parent(s) Informed Refusal • Refer to NMS Protocol for Newborn Metabolic Screening: **https://extranet.ahsnet.ca/teams/policydocuments/1/clp-newborn-metabolic-screening-program-policy.pdf**	**NORM AND NORMAL VARIATIONS:** • Refer to >12–24 hours **Parent Education/Anticipatory Guidance:** • Refer to >12–24 hours **Variance:** • Refer to >12–24 hours **Intervention:** • Refer to >12–24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to >12–24 hours **Parent Education/ Anticipatory Guidance:** • Refer to >12–24 hours **Variance:** • Refer to >12–24 hours **Intervention:** • Refer to >12–24 hours

Screening/Other: Vitamin K

Screening Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
VITAMIN K:				
• Baby to receive Vitamin K **Refer to:** • www.cps.ca/en/documents/position/vitamin-K-prophylaxis-in-newborns	**NORM AND NORMAL VARIATIONS:** • Vitamin K given IM based on birth weight • Administer within the first 6 hours of birth following initial stabilization of the baby and on appropriate opportunity for maternal – baby interaction while skin-to-skin **Parent Education/Anticipatory Guidance** • Vitamin K administration – prevention of hemorrhagic disease of the newborn **Variance:** • Parents refused IM injection – complete "Release of Responsibility" form **Intervention:** • Vitamin K - 2mg orally at time of first feeding, repeat at 2-4 weeks and at 6-8 weeks • Parents should be advised of the importance of the baby receiving follow-up doses and be cautioned that their infants remain at an increased risk of late HDNB (including the potential for intracranial hemorrhage) using this regimen • Parents to sign "Release of Responsibility" form	**NORM AND NORMAL VARIATIONS:** • Refer to 0–12 hours	N/A	N/A

Physiological Health: Head

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
HEAD:				
Assess: • Shape • Size • Fontanelles • Circumference (see Vital Signs) **Assess mother/family/support's understanding of:** • Newborn physiology and capacity to identify variances that may require further assessments **Refer to:** • Behaviour • Vital Signs - Assisted Vaginal Birth • Safety and Injury Prevention • Postpartum Nursing Care Pathway: Bonding & Attachment	**NORM AND NORMAL VARIATIONS:** • Head round, symmetrical • May have molding, some overlapping of sutures • Anterior & posterior fontanelles flat and soft • Full range of motion **Parent Education/Anticipatory Guidance:** • Place baby skin-to-skin • Care when handling infant's head • Discuss variances and when they should resolve (caput succedaneum, Cephalohematoma, etc. - Refer to variance >12–24 hours) • Refer to >12–24 hours **Variance:** • Caput succedaneum crosses suture lines • Cephalohematoma - does not cross suture line • Bruising, excoriation, lacerations • Bulging or sunken fontanelles • Neck webbing, limited range of motion • Masses • Hydrocephaly • Microcephaly **Intervention:** • Nursing Assessment • Refer to appropriate PHCP, as required **Variance – Assisted Vaginal Birth:** • Infant is at risk for increased head circumference, variant vital signs, and CNS (behavioural changes) **Intervention – Assisted Vaginal Birth:** • Nursing Assessment • Refer to Vital Signs – Assisted Vaginal Birth • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Parent Education/Anticipatory Guidance:** • Average size 3-4cm wide (may be as small as 0.6cm); *appears slightly smaller than actual size for the first 24 hours then returns to actual size*[3] • Anterior Fontanelle: 2–4 cm long, diamond shape, may close as early as 6 months up to 18–24 months • Posterior fontanelle: smaller than anterior, triangular in shape • Supine (back) sleep position • Prevent Plagiocephaly (flat spots on head) and strengthen neck muscles by placing baby on abdomen when awake (tummy time) for several short periods each day • Carrying infant in arms (vs. in infant seat) assists with prevention of flat head and promotes bonding **Variance:** • Refer to PERIOD OF STABILITY • Caput succedaneum disappears spontaneously within a number of days • Infants who birth with assistance of vacuum extraction/forceps may have caput and bruising • Cephalohematoma occurs after 24-48 hours after birth, disappears in 2-3 weeks and may affect the bilirubin level (usually occurs within 24 hours)	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Parent Education/ Anticipatory Guidance:** • Refer to >12–24 hours **Variance:** • Refer to 0–24 hours **Intervention:** • Refer to 0–24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY • Molding decreases over the first few weeks of life • Normal head circumference of 32–37cm for boys and 32-36cm for girls once molding disappears (refer to Childhood Growth Monitoring Protocol, AHS) **Parent Education/Anticipatory Guidance"** • Refer to > 12–24 hours **Variance – Cradle Cap:** **Intervention – Cradle Cap:** • Apply non-perfumed oil, use mild non-perfumed shampoo to remove oil **Variance – Plagiocephaly:** (flattening of 1 side of the skull) **Intervention – Plagiocephaly:** • Supervised tummy time when awake **Variance – Enlarged Fontanelles:** • Remarkably enlarged fontanelles/splayed suture lines • Head appears abnormally large & looks 'heavy' – signs of hydrocephalus **Intervention – Enlarged Fontanelles:** • Nursing assessment

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
HEAD:				
		• Risk of jaundice if head trauma and/or bruising **Intervention:** • Refer to PERIOD OF STABILITY		• Refer to PHCP as required

Physiological Health: Nares

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
NARES:				
Assess: • Symmetry (air entry in both nares) **Assess mother/family/support's understanding of:** • Newborn physiology and capacity to identify variances that may require further assessments **Refer to:** • Vital Signs	**NORM AND NORMAL VARIATIONS:** • Nose breather • Symmetrical, no nasal flaring • Thin, clear nasal discharge, sneezing common • Nares patent • Milia present on nose **Parent Education/Anticipatory Guidance:** • Sneezing common **Variance:** • Nasal congestion **Intervention:** • Nursing assessment • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Parent Education/Anticipatory Guidance:** • Refer to PERIOD OF STABILITY **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Parent Education/Anticipatory Guidance:** • Refer to PERIOD OF STABILITY **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Parent Education /Anticipatory Guidance** • Refer to PERIOD OF STABILITY **Variance** • Refer to PERIOD OF STABILITY **Intervention** • Refer to PERIOD OF STABILITY

Physiological Health: Eyes

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
EYES:				
Assess: • Symmetry • Placement • Clarity • Risks for eye/vision problems (family history) **Assess mother/family/support's understanding of:** • Newborn physiology and capacity to identify variances that may require further assessments **Refer to:** • Skin • Postpartum Nursing Pathway: Bonding and Attachment	**NORM AND NORMAL VARIATIONS:** • Outer canthus aligned with upper ear. • Dark or slate blue colour • Blink reflex present • Edematous lids • Sclera clear • Pupils equal and reactive to light • May have sub conjunctival hemorrhage • Administer eye prophylaxis (after completion of initial feeding or by 1 hour after birth) • Smooth coordinated movements • May see chemical conjunctivitis due to eye ointment **Parent Education/Anticipatory Guidance:** • Eye prophylaxis – prevention of ophthalmia neonatorum • Maternal/infant eye contact enhances bonding and attachment • Refer to >12-24 hours **Variance:** • Hazy, dull cornea • Pupils unequal, dilated, constricted • Parents refusing eye prophylaxis should complete a "Release of Responsibility" form **Intervention:** • Nursing Assessment • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Parent Education/Anticipatory Guidance:** • Eye care ○ Clean from inner canthus to outer edge with warm water • Newborn's vision ○ Nearsighted – see most clearly when objects 20-25cms from face ○ Shows attention by looking, lifting upper eyelids, 'brightening' ○ Attracted to human face ○ Display visual abilities most consistently in quiet alert state	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY • Resolving or decreasing edema of eyelids and chemical conjunctivitis • May have slight jaundice of sclera **Parent Education/Anticipatory Guidance:** • Refer to >12-24 hours • Jaundice progression/ treatment **Variance:** • Refer to PERIOD OF STABILITY • Conjunctivitis **Intervention:** • Teach eye care • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Refer to 0-72 hours • Transient strabismus or nystagmus until 3-4 months • May have blocked tear duct(s) **Parent Education/ Anticipatory Guidance:** • Refer to >12-72 hours • May have intermittent/transient strabismus or nystagmus before 4 months • Plugged tear ducts: ○ Tear ducts are not patent until approximately 5–7 months ○ If discharge present (redness, pus drainage, or crusting over) follow-up with PCHP **Variance:** • Refer to PERIOD OF STABILITY • Refer to >24-72 hours **Intervention:** • Refer to 0-72 hours

Physiological Health: Ears

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
EARS:				
Assess: • Cartilage formation • Ear placement **Assess mother/family/support's understanding of:** • Newborn physiology and capacity to identify variances that may require further assessments	**NORM AND NORMAL VARIATIONS:** • Well-formed cartilage • Ears level with eyes (top of pinna on horizontal plane with outer canthus of eye) • May have temporary asymmetry from unequal intrauterine pressure on the sides of the head • Startles/reacts to loud noises • Ear canal may contain vernix (short external auditory ear canal) **Parent Education/Anticipatory Guidance:** • Refer to >12-24 hours **Variance:** • Unresponsive to noise • Ear tags, ear pits – could indicate a brachial cleft duct or cyst (risk for infection and may need surgical intervention) • Low set ears • Drainage present • Family history of childhood sensory hearing loss • Craniofacial anomalies of pinna or ear canal **Intervention:** • Nursing Assessment • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Parent Education/ Anticipatory Guidance:** • Cleaning of ears (do not use a cotton tipped swab) • Higher-pitched sounds generally gain the infant's attention rather than lower pitched sounds • Provincial Hearing Screening Program **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Parent Education/ Anticipatory Guidance:** • Refer to >12-24 hour **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Parent Education/Anticipatory Guidance:** • Refer to >12-24 hour • Able to distinguish mother's and father's voice within 2 weeks and responds with distinct reaction pattern to each • Monitor for normal hearing and speech patterns • Exposure to second hand smoke increases risk of ear infection • Review factors associated with increased risk of hearing loss: ○ Family history ○ Low birth weight ○ Jaundice – requiring transfusion ○ Infections **Variance:** • Refer to PERIOD OF STABILITY • Exposure to ototoxic medications especially aminoglycosides: ○ Gentamycin ○ Kanamycin ○ Streptomycin ○ Tobramycin • Bacterial meningitis **Intervention:** • Nursing assessment • Refer to appropriate PHCP, as required

Physiological Health: Mouth

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
MOUTH:				

Assess:
• Lips
• Tongue
• Frenulum
• Palate
• Reflexes
• Oral health
 	
Assess mother/family/ support's understanding of:
• Newborn physiology and capacity to identify variances that may require further assessments
 	
Refer to:
• Feeding
• Elimination – Urine
• Postpartum Pathway: Breasts
• Genitalia
• Refer to Zone Clinical Practice Guideline (as applicable)
	NORM AND NORMAL VARIATIONS:
	• Mucosa moist, smooth and pink
	• May have Epstein pearls
	• Tongue midline and can extend out to edge of lower lip
	• May have noticeable sublingual frenulum
	• Lips: intact and pink
	• Jaw symmetrical
	• Intact palate (soft, hard)
	• Reflexes
	  ○ Rooting
	  ○ Sucking
	
	Parent Education/ Anticipatory Guidance:
	• Refer to >12-24 hours
	
	Variance:
	• Tight frenulum (tongue tie) or heart shaped tongue
	• Short or protruding tongue
	• Large tongue (macroglossia)
	• Cleft lip/palate
	• Small receding chin (micrognathia)
	• Dry mucosa (may be dry after crying)
	• Mouth drooping or opens asymmetrically (may be facial palsy)
	
	Intervention:
	• Assess baby's ability to latch without causing pain and damage to nipple
	• Adjustments to feeding may be indicated when variances are present
	• Dry mucosa: assess hydration status
	• Refer to appropriate PHCP, as required
		NORM AND NORMAL VARIATIONS:
		• Refer to PERIOD OF STABILITY
		• May have sucking blister on lips
		• Tongue may be coated white from feeding
		
		Parent Education/ Anticipatory Guidance:
		• Mucous membranes should be moist and pink
		• Tongue should extend out to edge of lower lip
		• May have sucking blister on lips
		• Tongue may be coated white from feeding
		
		Variance:
		• Refer to PERIOD OF STABILITY
		
		Intervention:
		• Refer to PERIOD OF STABILITY
			NORM AND NORMAL VARIATIONS:
			• Refer to 0–24 hours
			
			Parent Education/ Anticipatory Guidance:
			• Refer to >12–24 hours
			Variance;
			• Refer to PERIOD OF STABILITY
			
			Intervention:
			• Refer to PERIOD OF STABILITY
			• If latching difficulty persists due to tight frenulum or tongue, refer to appropriate PHCP, as required
				NORM AND NORMAL VARIATIONS:
				• Refer to PERIOD OF STABILITY
				
				Parent Education/Anticipatory Guidance:
				• Refer to >12–24 hours
				• Oral hygiene
				  ○ Inspect baby's mouth regularly
				  ○ Wipe gums with soft, clean damp cloth twice per day prior to the eruption of the first teeth
				  ○ Prevention of tooth decay
				
				Variance:
				• Refer to PERIOD OF STABILITY
				
				Intervention:
				• Refer to PERIOD OF STABILITY
				• Refer to >24–72 hours
				
				Variance – Thrush Candida (Fungus):
				• White, cheesy patches on the tongue, gums or mucous membranes that won't rub off
				• Diaper area – red rash (dots/bumps)
				• May affect baby's feeding
				
				Intervention - Thrush Candida (Fungus):
				• Discuss signs, symptoms & treatment
				• Assess mother's nipples for thrush (red, itchy, persistent sore nipples, burning, shooting pain)
				• Avoid use of soother (can contribute to overgrowth of yeast)
				• Refer to Postpartum Pathway: Breasts
				• Refer to PHCP for antifungal treatment of both mother and baby

Physiological Health: Chest

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
CHEST:				

Assess:
• Symmetry
• Shape
• Cardiovascular function
• Breasts (including nipples)
 	
Assess mother/family/support's understanding of:
• Newborn physiology and capacity to identify variances that may require further assessments
 	
Refer to:
• Vital Signs
	NORM AND NORMAL VARIATIONS:
	• Cardiovascular stability
	• Round, symmetrical
	• Protruding xiphoid process
	• Intact clavicles
	• Clear chest sounds
	• Air entry equal bilaterally
	• Hiccoughs and sneezing common
	• Breasts may be swollen with clear/milky discharge
	• Mucous (more common in Cesarean birth)
	  ○ Dark brown mucous (mucous/blood swallowed during birth)
	
	Parent Education/Anticipatory Guidance:
	• Refer to >12-24 hours
	
	Variance:
	• Mucousy/noisy respirations
	• Signs of respiratory distress
	  ○ Retractions
	  ○ Grunting
	  ○ Nasal flaring
	  ○ Tachypnea
	• Deviation in chest shape
	• Fractured clavicle
	• Asymmetrical movement
	• Breasts inflamed
	• Supernumerary nipples
	• Coughing
	
	Intervention:
	• Nursing Assessment
	• Refer to appropriate PHCP, as required
		NORM AND NORMAL VARIATIONS:
		• Refer to PERIOD OF STABILITY
		
		Parent Education/ Anticipatory Guidance:
		• Normal newborn breathing
		• Hiccoughs resolve on own
		• Occasional sneezing is infant's mechanism to clear nasal passages
		• Do not squeeze swollen breasts (they are due to maternal hormones)
		
		Variance:
		• Refer to PERIOD OF STABILITY
		
		Intervention:
		• Refer to PERIOD OF STABILITY
			NORM AND NORMAL VARIATIONS:
			• Refer to PERIOD OF STABILITY
			
			Parent Education/ Anticipatory Guidance:
			• Refer to >12-24 hours
			
			Variance:
			• Refer to PERIOD OF STABILITY
			
			Intervention:
			• Refer to PERIOD OF STABILITY
				NORM AND NORMAL VARIATIONS:
				• Refer to PERIOD OF STABILITY
				• Breast enlargement usually resolves by the second week of life
				
				Parent Education/ Anticipatory Guidance:
				• Refer to >12-24 hours
				
				Variance:
				• Refer to PERIOD OF STABILITY
				
				Intervention:
				• Refer to PERIOD OF STABILITY

Physiological Health: Abdomen/Umbilicus

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
ABDOMEN/UMBILICUS				

Assess:
• Symmetry
• Bowel sounds
• Cord
• Umbilical area
 	
Assess mother/family/ support's understanding of:
• Newborn physiology and capacity to identify variances that may require further assessments
	NORM AND NORMAL VARIATIONS:
	
	Abdomen:
	• Slightly rounded, soft and symmetrical
	• Bowel sounds present
	• Skin: pink, smooth, opaque
	• A few large blood vessels may be visible
	
	Cord:
	• Two arteries and one vein
	• Cord clamp secure
	
	Parent Education/Anticipatory Guidance:
	• Refer to >12-24 hours
	
	Variance - Abdomen:
	• Masses
	• Absent bowel sounds
	• Sensitive with palpation
	• Flat, or concave shape
	• Green emesis &/or feeding intolerance
	• Bright red emesis
	
	Variance – Cord:
	• One artery
	• Umbilical hernia
	• Bleeding
	
	Intervention:
	• Nursing assessment
	• Apply pressure to bleeding cord
	• Refer to appropriate PCHP, as required
		NORM AND NORMAL VARIATIONS:
		
		Cord:
		• Clean and dry or slightly moist
		• Cord clamp secure
		
		Parent Education/Anticipatory Guidance:
		• Wash hands with soap & water before and after contact with umbilical area
		• Review/demonstrate cord care
		  ○ Keep the area around the cord dry to help it heal
		  ○ Clean and dry any discharge from around the cord with water
		  ○ Clean around the base of the cord after bathing and at diaper changes
		  ○ Fold diaper below the cord to prevent irritation and to keep it dry and exposed to air
		  ○ Avoid buttons, coins, bandages or binders over naval
		  ○ Encourage skin-to-skin
		  ○ A small amount of oozing or bleeding is normal when the cord starts to fall off
		  ○ S & S of infection – redness or swelling >5mm from umbilicus, fever, lethargy, and/or poor feeding
		
		Variance:
		• Refer to PERIOD OF STABILITY
		• Cord - Foul odour, redness or swelling >5mm from umbilicus
		• S & S of systemic infection – fever, lethargy, and/or poor feeding
		
		Intervention:
		• Refer to PERIOD OF STABILITY
		• Urgent care if S & S of systemic infection
			NORM AND NORMAL VARIATIONS:
			• Refer to 0-24 hours
			• Cord clamp is NOT to be routinely removed. The clamp will fall off when the naturally dried stump sloughs off
			
			Parent Education/ Anticipatory Guidance:
			• Refer to >12-24 hours
			
			Variance:
			• Refer to 0-24 hours
			
			Intervention:
			• Refer to 0-24 hours
				NORM AND NORMAL VARIATIONS:
				• Refer to 0-24 hours
				• Cord separates within 1–3 weeks
				• Slight bleeding may occur with separation
				
				Parent Education/ Anticipatory Guidance:
				• Refer to >12-24 hours
				• Normal cord separation
				
				Variance:
				• Refer to 0-24 hours
				
				Intervention:
				• Refer to 0-24 hours

Physiological Health: Skeletal/Extremities

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
SKELETAL/EXTREMITIES:				

Assess:
• Spine
• Range of motion
• Skeletal structure
 	
Assess mother/family/ support's understanding of:
• Newborn physiology and capacity to identify variances that may require further assessments
	NORM AND NORMAL VARIATIONS:
	• Symmetrical in size and shape
	• Clavicles intact
	• Bow-legged, flat-footed
	• Equal gluteal folds
	• Equal leg length
	• 10 fingers, 10 toes
	• Intact, straight spine
	• Full range of motion and flexion
	
	Parent Education/Anticipatory Guidance:
	• Refer to >12-24 hours
	Variance:
	• Spine
	  ○ Curvature of spine
	  ○ Non-intact spine
	  ○ Tufts of hair
	  ○ Coccygeal dimple
	• Range of motion
	  ○ Impaired range of motion
	  ○ Hypertonia/ contractures of extremities
	  ○ Hypotonic of extremities
	• Skeletal abnormalities
	  ○ Talipes equinovarus (club foot)
	  ○ Congenital hip dislocation
	  ○ Asymmetrical extremities
	  ○ Fractures
	  ○ Polydactyly, syndactyly, adactyly
	  ○ Webbing of fingers or toes
	Intervention:
	• Nursing Assessment
	• Ultrasound may be required to rule out spina bifida
	• Refer to appropriate PHCP, as required
		NORM AND NORMAL VARIATIONS:
		• Refer to PERIOD OF STABILITY
		
		Parent Education/ Anticipatory Guidance:
		• Follow up plan for any identified skeletal variance
		
		Variance:
		• Refer to PERIOD OF STABILITY
		
		Intervention:
		• Refer to PERIOD OF STABILITY
			NORM AND NORMAL VARIATIONS:
			• Refer to PERIOD OF STABILITY
			
			Parent Education/ Anticipatory Guidance:
			• Refer to >12-24 hours
			Variance:
			• Refer to PERIOD OF STABILITY
			
			Intervention:
			• Refer to PERIOD OF STABILITY
				NORM AND NORMAL VARIATIONS:
				• Refer to PERIOD OF STABILITY
				
				Parent Education/ Anticipatory Guidance:
				• Refer to >12-24 hours
				Variance:
				• Refer to PERIOD OF STABILITY
				
				Intervention:
				• Refer to PERIOD OF STABILITY

Physiological Health: Skin

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
SKIN:				
Assess (in natural light): • Skin colour • Turgor • Integrity **Jaundice - Assess:** • Factors that increase risk for newborn jaundice • Newborns should be clinically assessed for jaundice in the first 24 hours of life and then every 24 hours until hospital discharge. • Lab bilirubin or transcutaneous bilirubin -	**NORM AND NORMAL VARIATIONS:** • Centrally pink • Acrocyanosis • Intact skin (may be dry with some peeling, lanugo on back, vernix in the creases) • Normal skin turgor • Skin is sensitive to touch **Parent Education/ Anticipatory Guidance:** • Skin-to-skin care **Variance:** • Pallor (may be genetic) • Generalized cyanosis or increased cyanosis with activity • Skin rashes/ lacerations/breaks in skin • Hemangiomas • Petechia • Bruising (ecchymosis) • Mottling • Decreased skin turgor **Intervention:** • Nursing Assessment • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY • Acrocyanosis resolved **Parent Education/Anticipatory Guidance:** • Refer to PERIOD OF STABILITY • Normal skin variations: ○ Milia ○ Cracks ○ Peeling ○ Mongolian spots (frequently in darkly pigmented infants such as Asian, First Nation, and African-American. Most often found in the lumbosacral region, but can be found anywhere on the body) • Skin care – avoidance of perfumed products **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY **Variance – Jaundice:** • Refer to PERIOD OF STABILITY **Intervention – Jaundice:** • Refer to PERIOD OF STABILITY • Assess feeding effectiveness and output • The newborn who is clinically jaundiced or has risk factors for	**NORM AND NORMAL VARIATIONS:** • Refer to 0-24 hours • About 60% of all infants have some jaundice; it generally clears up without any medical treatment. Refer to facility guideline for normal values **Parent Education/ Anticipatory Guidance:** • Refer to 0–24 hours • Bathing: ○ Delay first bath until baby stable (minimally 6 hours of age, ideally 24 hours of age) ○ Universal precautions until bathed ○ Parents are encouraged to do the first bath with nursing support ○ Refer to vital signs re: stability ○ Tub bathing is preferable to sponge bath ○ Water – amount and temperature, soap can be irritating, use unscented lotions • Jaundice ○ Relationship between poor feeding, hydration and jaundice and the need to monitor ○ Management of jaundice – feeding, waking sleepy baby, monitoring output **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • Jaundice usually peaks by day 3-4, resolves in 1-2 weeks **Parent Education/ Anticipatory Guidance:** • Refer to 0-72 hour **Variance:** • Refer to PERIOD OF STABILITY • New, unresolved or unexplained rashes **Intervention:** • Refer to PERIOD OF STABILITY **Variance – Jaundice:** • Refer to 0-72 hours **Intervention – Jaundice:** • Refer to 0-72 hours

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
SKIN:				
measured on all infants within 24 hours of birth and prior to discharge **Assess mother/family/ support's understanding of:** • Newborn physiology and capacity to identify variances that may require further assessments **Refer to:** • Feeding • Elimination • Vital Signs • Behavioural Assessment	**Variance – Jaundice:** • Any Jaundice in the first 24 hours • Risk factors present for jaundice **Intervention – Jaundice:** • Nursing assessment • Refer to appropriate PHCP, as required-request order for Total Serum Bilirubin (TSB). • Refer to provincial guideline for the assessment and management of the newborn at risk for developing hyperbilirubinemia.	hyperbilirubinemia should have TSB/TcB levels measured in the first 24 hours of life along with a structured plan for follow-up and management.	**Variance – Jaundice:** • Refer to PERIOD OF STABILITY • Infant difficult to rouse • Feeding poorly • Parent does not demonstrate ability to monitor feeding, output, behaviour or colour **Intervention – Jaundice:** • Nursing assessment • Bilirubin level as per provinicial guidelines or PHCP orders • Support and educate parents regarding newborn jaundice and establish a follow up plan for after discharge • Assess feeding effectiveness • Refer to appropriate PHCP, as required	

Physiological Health: Neuromuscular

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
NEUROMUSCULAR:				

Assess:
• Muscle tone and movement
• Reflexes
 	
Assess mother/family/support's understanding of:
• Newborn physiology and capacity to identify variances that may require further assessments
 	
Refer to:
• Skeletal/Extremities
• Vital Signs
• Behaviour
• Crying
• Feeding
• Postpartum Nursing Pathway – Lifestyle: Tobacco use, Drug Substance use
	NORM AND NORMAL VARIATIONS:
	• APGAR scores between 7-10 at 5 minutes
	• Extremities symmetrical, full range of motion, flexed, good muscle tone
	• Able to console independently or with assistance
	• Infant reflexes present:
	  ○ Moro (startle)
	  ○ Palmar (grasping)
	  ○ Rooting
	  ○ Sucking
	
	Parent Education/Anticipatory Guidelines:
	• Refer to >12-24 hours
	
	Variance:
	• Asymmetrical facial/limb movement
	• Abnormal foot posture
	• Facial palsy
	• Brachial palsy
	• Unable to console independently or with assistance
	• Abnormal or absent reflexes
	• Limbs not flexed
	• Hypotonicity or hypertinicity
	• Seizure activity
	• Jitteriness – rule out low blood sugar
	• Arching
	
	Intervention:
	• Nursing assessment (including maternal medication/drug use)
	• Jitteriness differentiated between hypoglycemia and seizure activity
	• Refer to appropriate PHCP, as required
		NORM AND NORMAL VARIATIONS:
		• Refer to PERIOD OF STABILITY
		
		Parent Education/ Anticipatory Guidelines:
		• Encourage skin-to-skin and feeding
		• Baby's alertness and readiness to feed
		• Positioning, movement, reflexes, muscle tone
		• Jitteriness vs. seizure activity (jittery movements stop when infant is held)
		
		Variance:
		• Refer to PERIOD OF STABILITY
		
		Intervention:
		• Refer to PERIOD OF STABILITY
			NORM AND NORMAL VARIATIONS:
			• Refer to PERIOD OF STABILITY
			
			Parent Education/ Anticipatory Guidelines:
			• Refer to >12-24 hours
			
			Variance:
			• Refer to PERIOD OF STABILITY
			
			Intervention:
			• Refer to PERIOD OF STABILITY
				NORM AND NORMAL VARIATIONS:
				• Refer to PERIOD OF STABILITY
				
				Parent Education/ Anticipatory Guidelines:
				• Refer to >12-24 hours
				
				Variance:
				• Refer to PERIOD OF STABILITY
				
				Intervention:
				• Refer to PERIOD OF STABILITY

Physiological Health: Genitalia

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
GENITALIA:				
Assess: • Anus • Genitalia **Assess mother/family/ support's understanding of:** • Newborn physiology and capacity to identify variances that may require further assessments **Refer to:** • Elimination • Skin • Mouth	**NORM AND NORMAL VARIATIONS:** • Patency of anus may not be apparent until baby has stooled. • **Females:** ○ Labia swollen ○ Labia majora formed bilaterally ○ Urethral open between clitoris and vaginal opening ○ Clitoris may be enlarged ○ Vaginal skin tag (hymeneal) ○ Vernix caseosa present between labia ○ Whitish mucous or pseudo-menses • **Males:** ○ Scrotum present (with rugae) ○ Testes descended (palpable bilaterally) ○ Central urethral opening ○ Complete foreskin ○ Epithelial pearls may be present on penile shaft ○ Erections common **Parent Education/Anticipatory Guidance:** • Refer to >12-24 hours **Variance:** • Undifferentiated gender • **Female:** ○ Fusion of labia • **Male:** ○ Urethral opening below/above tip of penis (hypospadias) ○ Unequal scrotal size ○ Testes palpable in inguinal canal or not palpable ○ Incomplete foreskin ○ Hydrocele **Intervention:** • Nursing assessment • Refer to appropriate PCHP, as required	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY **Parent Education/ Anticipatory Guidance:** • Keep genital area clean and dry • **Females:** ○ Do not remove vernix ○ Clean from front to back • **Males:** ○ Do not retract foreskin ○ Provide information to support informed decision re: circumcision ○ Circumcision fees are not covered under Alberta Health Care **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	**Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • Refer to PERIOD OF STABILITY • Swelling of labia and scrotum resolves about days 3–4 • Whitish mucous or pseudo-menses subsides by end of first week **Parent Education/ Anticipatory Guidance:** • Refer to >12-24 hours • If circumcised, teach care and S & S of complications ○ Bleeding ○ Infection ○ Edema • Diaper rash ○ Frequent diaper changes ○ Keep clean and dry ○ Exposure to air ○ Use zinc based barrier cream, as required **Variance:** • Refer to PERIOD OF STABILITY • Rash that does not clear after several days **Intervention** • Refer to PERIOD OF STABILITY

Physiological Health: Elimination – Urine

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
ELIMINATION – URINE:				
Assess: • Bladder output • Colour of urine • Hydration/elimination **Assess mother/family/ support's understanding of:** • Newborn physiology and capacity to identify variances that may require further assessments **Refer to:** • Feeding • Vital Signs • Skin • Genitalia	**NORM AND NORMAL VARIATIONS:** • May or may not void in this period **Parent Education/Anticipatory Guidance:** • Refer to >12–24 hours **Variance:** • Refer to >12–24 hours **Intervention:** • Refer to >12–24 hours	**NORM AND NORMAL VARIATIONS:** • Voids within 24 hours • At least ≥ 1 small void • One clear void with possible uric acid crystals (orange/ brownish colour) • Urine clear pale yellow and odourless **Parent Education/Anticipatory Guidance:** • Relationship between feeding and output (elimination is a component of feeding assessment) • Assessing for adequate hydration • Encourage use of output record **Variance:** • No voiding in 24 hours **Intervention:** • Nursing Assessment • Ensure effective feeding • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • 24–48 hours: at least 2 small voids/day • 48–72 hours: at least 3 voids/day • Uric acid crystals in the first 72 hours **Parent Education/Anticipatory Guidance:** • Refer to >12–24 hours **Variance:** • Less than 1–3 voids/day • Inadequate hydration and elimination (poor skin turgor, sunken fontanelles, dry mucous membranes, lethargy, irritability) • Jaundice **Intervention:** • Refer to >12–24 hours	**NORM AND NORMAL VARIATIONS:** • Day 3–4: at least 4-6 large, clear, pale yellow voids/24 hours • Day 5–7 onward : at least 6 large voids, clear, pale yellow voids/24 hours **Parent Education/Anticipatory Guidance:** • Refer to >12–24 hours **Variance:** • Refer to >24–72 hours • Uric acid crystals may indicate dehydration after 72 hours • Urine concentrated • Inadequate number of voids/day **Intervention:** • Refer to >12–24 hours

Physiological Health: Elimination – Stool

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
ELIMINATION – STOOL:				
Assess: • Stools **Assess mother/family/support's understanding of:** • Newborn physiology and capacity to identify variances that may require further assessments **Refer to:** • Feeding • Vital Signs • Abdomen/Umbilicus • Genitalia • Skin	**NORM AND NORMAL VARIATIONS:** • May not have active bowel sounds during this period • May not pass meconium in this period **Parent Education/ Anticipatory Guidance:** • Refer to >12 – 72 hours **Variance:** • Abdominal distension • Absence of bowel sounds **Intervention:** • Check if meconium passed at birth • Nursing Assessment • Refer to appropriate PHCP, as required	**NORM AND NORMAL VARIATIONS:** • Active bowel sounds • ≥ 1 meconium passed **Parent Education/ Anticipatory Guidance:** • Assess feeding/oral intake • Relationship between feeding and output (elimination is a component of feeding assessment) • Expected stool pattern - colour, consistency, amount, changes • **Breastfed - Encourage:** ○ Breastfeeding ○ Skin-to-skin ○ Hand expression of colostrum ○ Intake of colostrum (acts like a laxative) • **Formula Fed:** ○ Ensure appropriate formula preparation and amounts ○ Encourage skin-to-skin **Variance:** • No stools passed within 24 hours **Intervention:** • Refer to PERIOD OF STABILITY	**NORM AND NORMAL VARIATIONS:** • **Breastfed:** ○ 24–48 hours: 1-3 meconium stools/day ○ 48-72 hours: 3 or more transitional stools/day • Formula Fed: ○ 24–48 hours: 1-2 large meconium stools/day ○ 48-72 hours: 1-2 large transitional stools/day **Parent Education/ Anticipatory Guidance:** • Refer to >12–24 hours • Changes in bowel pattern • Frequent effective feeding **Variance:** • ≤ 1 stool passed within 48 hour • Diarrhea • Green, foul smelling, mucousy stool **Intervention:** • Refer to 0-24 hours • Assess feeding and assist family in developing plan to monitor output and report ongoing variance	**NORM AND NORMAL VARIATIONS:** • Jaundiced baby (may have increased frequency of stools which may be loose, green, and explosive) • **Breastfed:** ○ 72 hours – 4-6 weeks: 3 or more stools/day ○ Stool colours vary – may be yellow/mustard or brown with mustard seed consistency or occasionally green (may reflect mother's diet) • **Formula Fed:** ○ 1-2 pale yellow/pale green stools/day for the first few weeks (may vary) ○ May be dark green with iron fortified formula **Parent Education/Anticipatory Guidance:** • Refer to >12–72 hours • Variation in stools with jaundice **Variance:** • ≤4 stools/day by day 4 with full breasts • Diarrhea (very loose, foul smelling) • Constipation – stools dry, hard, difficulty to pass (rare in exclusively breastfed infants) • Bloody stool • White clay-coloured or very light yellow stools **Intervention:** • Refer to 0 72 hours

Behavioural Assessment

Behavioural Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
BEHAVIOUR:				
Assess: • Behaviour states • Behaviour cues • Response to consoling **Assess mother/family/support's:** • Understanding of normal newborn behaviour • Response to newborn cues/ needs • Capacity to identify variances that may require further assessments **Refer to:** • Vital Signs • Crying • Elimination • Feeding • Head • Safety & Injury Prevention • Neuromuscular • Postpartum Pathway – Lifestyle: Tobacco use, Drug substance use	**NORM AND NORMAL VARIATIONS:** • Alert for the first 1–2 hours after birth • Sleeps much of the remaining PERIOD OF STABILITY (transition to extra-uterine life) • May be sleepy or unsettled due to delivery • Responds to consoling efforts • Cry is strong and robust **Parent Education/Anticipatory Guidance:** • Expect baby to become more wakeful after PERIOD OF STABILITY • Feeding cues: ○ **Early feeding cues:** rooting, fingers or hands to mouth, increased physical movement ○ **Late feeding cues**: crying, agitated body movements, colour turning red • Supine position for sleep • Safe infant sleep environment • Responds to consoling • Potential effects on the newborn from maternal use of tobacco, medications, or substances	**NORM AND NORMAL VARIATIONS:** • Feeds ≥ 5 times in the first 24 hours • Demonstrates: ○ **Early feeding cues:** stirring, mouth opening, rooting, fingers or hands to mouth ○ **Mid-feeding cues:** increased physical movement and hands to mouth ○ **Late feeding cues:** crying, agitated body movements, colour turning red ○ Organized state movement from quiet alert to crying ○ Minimal crying but is strong and robust (if occurs) ○ Responds to consoling efforts **Parent Education/Anticipatory Guidance:** • Refer to PERIOD OF STABILITY • Behaviour states: ○ Deep sleep (if aroused, will not feed) ○ Quiet sleep ○ Drowsy ○ Quiet alert (optimal state for feeding and infant-parent interactions) ○ Active alert (time for feeding)	**NORM AND NORMAL VARIATIONS:** • Refer to >12–24 hours • Feeds 8 or more times in 24 hours **Parent Education/Anticipatory Guidance:** • Refer to >12- 24 hours **Variance:** • Refer to 0–24 hour **Intervention:** • Refer to 0–24 hours	**NORM AND NORMAL VARIATIONS:** • Refer to >24–72 hours **Parent Education/Anticipatory Guidance:** • Refer to >12–24 hours **Variance:** • Refer to 0–24 hour **Intervention:** • Refer to 0–24 hours

Behavioural Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
BEHAVIOUR:				
	Variance: • Weak or high pitched cry • Irritable • Does not respond to consoling efforts • In utero exposure to SSRIs/SNRIs • Exposure to codeine in breast milk • Exposure to tobacco and/or drug substances **Intervention:** • Nursing assessment • Refer to appropriate PHCP, as required	○ Crying (late feeding cues) • Satiety cues: ○ Sucking ceases ○ Muscles relax ○ Infant sleeps/removes self from breast • Infant attachment behaviour (any behaviour infant uses to seek and maintain contact with and elicit a response from mother/caregiver) **Variance:** • Refer to PERIOD OF STABILITY • Symptoms of withdrawal from maternal use of tobacco, medications, or substances **Intervention:** • Refer to PERIOD OF STABILITY • Assess factors which may influence behaviours ○ Environmental stimuli ○ Correct sleeping position ○ Gestational age ○ Medicated labour ○ Pregnancy substance use • Refer to appropriate PHCP, as required • Provide parent education/anticipatory guidance • Complete neonatal abstinence scoring, as required		

Behavioural Assessment: Crying

Behavioural Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
CRYING:				

Assess:
• Crying:
  ○ Patterns
  ○ Quality
  ○ Duration
• Fussy periods
• Parental response to crying
 	
Assess mother/family/support's understanding of:
• Normal newborn crying and capacity to identify variances that require further assessments
• Consoling techniques
 	
Refer to:
• Behaviour
• Feeding
• Maternal Postpartum Nursing Care Pathway: Bonding & Attachment
• Vital Signs
• Elimination
• Safety and Injury Prevention
	NORM AND NORMAL VARIATIONS:
	• Minimal crying, but cry is strong and robust
	• Responds to consoling (includes feeding)
	
	Parent Education/Anticipatory Guidance:
	• Refer to >12–24 hours
	
	Variance:
	• Infant does not respond to consoling techniques
	• Unusual, high-pitched crying (neurological)
	• Weak irritable cry
	• No cry (alone with other symptoms may reflect illness, e.g., sepsis)
	• Inappropriate parental/caregiver response to baby's crying
	  ○ Not responding to infant crying
	  ○ Making negative comments about infant's behaviour
	Intervention:
	• Refer to Parent Education/ Anticipatory Guidance >12–24 hours
	• Nursing Assessment
	• Refer to appropriate PHCP, as required
		NORM AND NORMAL VARIATIONS:
		• Refer to PERIOD OF STABILITY
		
		Parent Education/Anticipatory Guidance:
		• Infant behaviour states
		• Breastfeeding/skin-to-skin during painful procedures
		• Crying:
		  ○ Is a late feeding cue
		  ○ Is an expression of need
		  ○ May be a sign of illness
		• Soothing and consoling techniques to establish trust/bonding
		  ○ Skin-to-skin care
		  ○ Feeding
		  ○ Showing mother's face
		  ○ Talking in a steady, soft voice
		  ○ Holding/carrying
		  ○ Movement: swaying, rocking, walking
		  ○ Safe swaddling as needed
		https://www.healthyparentshealthychildren.ca/resources/videos-injury-prevention-and-staying-healthy
		
		• Discuss:
		  ○ That infants cry
			NORM AND NORMAL VARIATIONS:
			• Refer to PERIOD OF STABILITY
			
			Parent Education/ Anticipatory Guidance:
			• Refer to >12-24 hours
			
			Variance:
			• Refer to PERIOD OF STABILITY
			
			Intervention:
			• Refer to PERIOD OF STABILITY
				NORM AND NORMAL VARIATIONS:
				• Refer to PERIOD OF STABILITY
				
				Parent Education/Anticipatory Guidance:
				• Refer to >12–24 hour
				• Crying is a late signal from infant
				• Family strategies to respond to crying
				• Review and discuss normal crying patterns and soothing techniques
				• If consoling techniques do not work and parents feel frustrated:
				  ○ Ensure baby is in a safe environment and leave the room
				  ○ Call Health Link at 8-1-1
				• Infant may continue to cry despite soothing efforts (is not related to parenting capability)
				• Healthy infants can look like they are in pain when crying (even when they are not)
				• Care for the caregivers:
				  ○ Breaks
				  ○ Support system(s)
				  ○ Exercise
				  ○ Web reference for parents on prevention of shaken baby syndrome/ infant crying: (http://www.healthyparentshealthychildren.ca and search for shaken baby syndrome and infant crying)

Behavioural Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
CRYING:				
		○ Importance of responding to infant crying, but that infant may continue to cry despite soothing efforts ○ Refer to >72 hours **Variance:** • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY		**Variance:** • Inconsolable constant crying • Refer to PERIOD OF STABILITY **Intervention:** • Refer to PERIOD OF STABILITY • Rule out medical concerns – ensure baby is thriving i.e. not crying due to hunger • Educate and support parents • Ensure presence of appropriate supports **Variance – Baby at Risk for Harm:** • Shaking an infant **Intervention – Baby at Risk for Harm:** • Nursing Assessment • Encourage use of family/support network for support • Consider consulting social services/ child protection services • Refer to appropriate PHCP, as required

Health Follow-Up: Safety

Health Follow-up	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
HEATH FOLLOW-UP - SAFETY AND INJURY PREVENTION:				

Assess mother/ family/ support's:
• Knowledge of common safety risks and ability to access support when needed
• Education is tailored to the patient's needs
 	
Refer to:
• Postpartum Nursing Care Pathway: Lifestyle – Tobacco Use
• Crying
• Head
	NORM AND NORMAL VARIATIONS:
	• Newborn identified as per Zone guideline
	• Refer to >12–24 hours
	
	Parent Education/ Anticipatory Guidance:
	• Refer to >12-24 hours
	
	Variance:
	• Refer to >12-24 hours
	
	Intervention:
	• Refer to >12-24 hours
		NORM AND NORMAL VARIATIONS:
		• Parents able to provide a safe environment for newborn
		
		Parent Education/Anticipatory Guidance:
		• SIDS prevention/Safe Sleep environment
		  ○ Supine (back lying) position for sleep; no prone or side sleeping
		  ○ Prevent overheating, keep baby warm, not hot
		  ○ Safe sleeping environment:
		  ▪ Smoke free environment – second hand and third hand
		  ▪ Sleeping in close proximity in the same room for the first six months (on a separate safe sleep surface)
		• Shaken Baby Syndrome
		• Supporting head and neck
		• Risk of falls- activities to keep awake when holding/feeding baby such as chewing sugarless gum or sipping ice cubes
		• Pets, siblings
		• Safety of baby products such as:
		  ○ Child safety seats (YES Test), cribs, cradles, bassinettes, stroller, change table, soothers, powders, wipes
		• Community Resources
		
		Variance:
		• Parents unable to provide a safe environment for newborn
		
		Intervention:
		• Nursing assessment
		• Identify barriers and support family with solutions:
		  ○ Alternative medical/ health care follow-up
		  ○ Consult social workers/services
		  ○ Ministry of Children and Family Development
		  ○ Childcare resource and referral
		  ○ Alberta Health Services "Healthy Parents, Health Children: Pregnancy and Birth"
			NORM AND NORMAL VARIATIONS:
			• Refer to >12 – 24 hours
			
			Parent Education/ Anticipatory Guidance:
			• Refer to >12 – 24 hours
			
			Variance:
			• Refer to >12 – 24 hours
			
			Intervention:
			• Refer to >12 – 24 hours
				NORM AND NORMAL VARIATIONS:
				• Refer to >12–24 hours
				
				Parent Education/ Anticipatory Guidance:
				• Refer to >12–24 hours
				• Need to reassess safety risks as infant's development changes
				• Encourage to read safety labels
				• Refer to "Healthy Parent Healthy Children - Early Years"
				• www.healthyparentshealthychildren.ca
				
				Variance:
				• Refer to >12–24 hours
				
				Intervention:
				• Refer to >12–24 hours

Health Follow-Up: Newborn Care

Health Follow-up	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days (and beyond)
HEALTH FOLLOW-UP - NEWBORN CARE:				

Assess mother/family/support's:
• Understanding of appropriate health care follow-up
• Capacity to identify variances that may require further assessments, and access to health care
	NORM AND NORMAL VARIATIONS:
	• Refer to >12 –72 hours
	
	Variance:
	• Refer to >12-24 hours
	
	Intervention:
	• Refer to >12–24 hours
		NORM AND NORMAL VARIATIONS:
		• Parents/caregiver have a plan for follow-up with PHCP
		• Newborn ready to be cared for by parent (caregiver)
		  ○ Normal newborn exam
		  ○ Caregiver recognition of normal newborn changes and informs PHCP of abnormal findings
		  ○ Newborn feedings are successfully initiated and completed
		  ○ Parent/caregiver responds to newborn cues and needs
		  ○ Support system in place
		
		Parent Education/Anticipatory Guidance:
		• Parents aware of the need for a newborn physical and feeding assessment following discharge
		• Growth and development of newborn
		• When to seek help from PHCP
		
		Variance:
		• Parents do not have a PHCP or a plan for follow-up with PHCP
		• Parents do not have knowledge or capacity to identify variances in newborn
		
		Intervention:
		• Nursing assessment
		• Identify barriers and support family with solutions
		• Alternative medical/health care follow-up
		• Consult social workers/services
		• Childcare resources and referrals
			NORM AND NORMAL VARIATIONS:
			• Refer to >12 –24 hours
			
			Parent Education/ Anticipatory Guidance:
			• Aware of need for Public Health follow-up after discharge
			• Aware of need for further follow-up appointment with PHCP within first 6 weeks of newborn's life or as indicated by the PHCP
			• Complete discharge teaching
			
			Variance
			• Refer to >12–24 hours
			
			Intervention
			• Refer to >12–24 hours
				NORM AND NORMAL VARIATIONS:
				• Refer to >12–72 hours
				
				Parent Education/ Anticipatory Guidance:
				• Refer to >12–72 hours
				
				Variance:
				• Refer to >12–72 hours
				
				Intervention:
				• Refer to >12–72 hours

References for Health Care Professionals and Parents

Health Canada's National Guidelines (2000)
https://www.canada.ca/en/public-health/services/maternity-newborn-care-guidelines.html

As indicated by Health Canada in the document Family-Centered Maternity and Newborn Care: National Guidelines, the postpartum period is a significant time for the mother, baby, and family as there are vast maternal and newborn physiological adjustments and important psychosocial and emotional adaptations for all family members or support people.

The following are the goals, fundamental needs and basic services for postpartum women and their newborns, adapted from Health Canada's National Guidelines which are to:

- Assess the physiological, psychosocial and emotional adaptations of the mother and baby
- Promote the physical well-being of both mother and baby
- Promote maternal rest and recovery from the physical demands of pregnancy and the birth experience
- Support the developing relationship between the baby and his or her mother, and support(s)/family
- Support the development of infant feeding skills
- Support the development of parenting skills
- Encourage support of the mother, baby, and family during the period of adjustment (support may be from other family members, social contacts, and/or the community)
- Provide education resources and services to the mother and support(s) in aspects relative to personal and baby care
- Support and strengthen the mother's knowledge, as well as her confidence in herself and in her baby's health and well-being, thus enabling her to fulfill her mothering role within her particular family and cultural beliefs
- Support the completion of specific prophylactic or screening procedures organized though the different programs of maternal and newborn care, such as: Vitamin K administration and eye prophylaxis, immunization (Rh, Rubella, Hepatitis B), prevention of Rh iso-immunization and newborn screening (Newborn Blood Spot and Hearing)
- Assess the safety and security of postpartum women and their newborns (families) (e.g. child safety seats, safe infant sleep, family violence, substance use)
- Identify and participate in implementing appropriate interventions for newborn variances/problems
- Assist the woman in the prevention of newborn variances/problems

World Health Organization (WHO) (2013)
http://apps.who.int/iris/bitstream/10665/97603/1/9789241506649_eng.pdf

The WHO stated that "postpartum care should respond to the special needs of the mother and baby during this special phase and should include: the prevention and early detection and treatment of complications and disease, and the provision of advice and services on breastfeeding, birth spacing, immunization and maternal nutrition."

The twelve specific WHO newborn needs continue to be:

- Easy access to the mother
- Appropriate feeding
- Adequate environmental temperature
- A safe environment (including safe infant sleep environment)
- Parental care
- Cleanliness
- Observation of body signs by a caregiver who can take action if necessary
- Access to health care for suspected or manifest complications
- Nurturing, cuddling, stimulation
- Protection from disease, harmful practices, abuse/violence
- Acceptance of sex, appearance, size
- Recognition by the province or government (vital registration system)

Resources for Health Care Professionals

"Healthy Parents, Healthy Children: Pregnancy and Birth" and "Healthy Parents, Healthy Children: The Early Years":

- Healthcare providers can order print copies to distribute to parents by visiting dol.datacm.com
  - **User ID**: healthypublic
  - **Password**: healthy2013
- Available online at healthyparentshealthychildren.ca
- Available on the Alberta Perinatal Health Program's STORC platform (MyLearningLink and an Interactive PDF in process)

Breastfeeding:

- Strategies for teaching obstetric to rural and urban caregivers (STORC) model on breastfeeding, see Appendix 2

Nutrition Guidelines for Healthy Infants and Young Children:

- www.albertahealthservices.ca/info/Page8567.aspx
- Post-discharge Preterm Formula
- Safe Preparation and Handling of Infant Formula
- Homemade Infant Formula
- Infant Formulas for Healthy Term Infants – Compendium
- Infant Formulas for Healthy Term Infants – Summary Sheet
- Introduction of Complementary Foods
- Introduction of Complementary Foods in Preterm Infants
- Vitamin D
- Allergy Prevention
- Iron
- Water
- Plant-based Beverages
- Weight Velocity and Weight Velocity for Public Health Nursing
- Nutrition Education Resources
    - www.albertahealthservices.ca/nutrition/Page11115.aspx
- Nutrition Guidelines for Primary Care: Healthy Eating and Active Living, Calcium and Vitamin D
    - www.albertahealthservices.ca/assets/Infofor/hp/if-hp-ed-cdm-ns-3-2-1-calcium-and-vitamin-d.pdf

Positioning:

- Safe Infant Sleep Module, see Appendix 2

Childhood Growth Monitoring Protocol:

- www.albertahealthservices.ca/info/cgm.aspx

Resources for Parents

- Health Link Alberta: (24/7 nurse advice and health information)
  - Call 811 (Toll free)
- My Health Alberta (online health information)
  - www.myhealth.alberta.ca
- 211 Alberta (community health government and social services)
  - Dial 211 in many places in Alberta or go to ab.211.ca
  - Connects people to a full range of community, health, government, and social services information
- Alberta Health Services' "*Healthy Parents, Healthy Children:* Pregnancy and Birth"
  - www.healthyparentshealthychildren.ca
- Safe Infant Sleep Policy and Prevention of SIDS and/or safe infant sleep
  - Available on Insite, AHS' staff intranet
- Ready or Not Alberta (preconception advice for men and women)
  - www.readyornotalberta.ca
- For information on feeding your baby commercial infant formula:
  - healthyparentshealthychildren.ca/feeding-your-baby/formula-feeding-your-baby/guidelines
  - www.albertahealthservices.ca/assets/info/nutrition/if-nfs-how-much-infant-formula-to-prepare-for-baby.pdf
- Newborn Metabolic Screening Program ("Why Does My Baby Need to be Screened?")
  - Available on Insite, AHS' staff intranet

Appendix 1: Abbreviation Definitions

ABBREVIATION DEFINITIONS			
AHS	Alberta Health Services	**LGA**	Large Gestational Age
ACoRN	Acute Care of the at Risk Newborn	**PHCP**	Primary Health Care Provider
APGAR	Birth score that rates: appearance, pulse, grimace, activity and respiratory effort	**POS**	Period of Stability
BPM	Beats per Minute	**POCT**	Point of Care Testing
CNS	Central Nervous System	**ROM**	Rupture of Membranes
EBM	Expressed Breast Milk	**$Sp0_2$**	Oxygen Saturation
GBS+	Group B Streptococcus	**S&S**	Signs and Symptoms
GI	Gastrointestinal	**SGA**	Small for Gestational Age
IM	Intramuscular	**STORC**	Strategies for teaching obstetrics to rural and urban communities
IUGR	Intrauterine Growth Restriction	**VS**	Vital Signs

Appendix 2a: STORC e-Learning Modules – AHS

Strategies for Teaching Obstetrics to Rural and Urban Caregivers (STORC)		

Postpartum Shelf		
Module 09 – Postpartum Assessment MyLearningLink – Obstetrics 101	**Module 32** – Perinatal Bereavement MyLearningLink – Obstetrics 101	**Module 52** – Breastfeeding Foundations MyLearningLink – Breastfeeding Foundations
Module 19 – Intimate Partner Violence moreOB Chapter – Family Violence	**Module 34** – Safe Infant Sleep MyLearningLink – Safe Infant Sleep	**Module 53** – Managing Breastfeeding Challenges and Supplementation MyLearningLink – Managing Breastfeeding Challenges and Supplementation
Module 31 – Postpartum Hemorrhage moreOB Chapter – Postpartum Hemorrhage	**Module 38** – Skin-to-Skin Contact MyLearningLink – Obstetrics 101	

Newborn Shelf		
Module 08 – Newborn Assessment MyLearningLink – Obstetrics 101	**Module 39** – Vitamin K Administration in Term Infant MyLearningLink – Obstetrics 101	**Module 44** – Giving Protection MyLearningLink – HPHC – Giving Protection – release date TBA
Module 34 – Safe Infant Sleep MyLearningLink – Safe Infant Sleep	**Module 40** – Recognizing Newborn Illness MyLearningLink – Obstetrics 101	**Module 45** –Avoiding Exposure MyLearningLink – HPHC – Avoiding Exposure – release date TBA
Module 36 – Late Preterm Infant MyLearningLink – Obstetrics 101	**Module 41** – Car Seat Safety MyLearningLink – Obstetrics 101	**Module 46** – Promoting Healthy Mind & Body MyLearningLink – HPHC – Promoting Healthy Mind & Body – release date TBA
Module 37 – Hyperbilirubinemia MyLearningLink – Assess and Manage Newborn Hyperbilirubinemia	**Module 42** – T-Piece Resuscitator MyLearningLink – Obstetrics 101	**Module 52** – Breastfeeding Foundations MyLearningLink – Breastfeeding Foundations
Module 38 – Skin-to-Skin Contact MyLearningLink – Obstetrics 101	**Module 43** – Introduction to Preconception Health MyLearningLink – HPHC – Introduction to Preconception Health – release date TBA	**Module 53** – Managing Breastfeeding Challenges and Supplementation MyLearningLink – Managing Breastfeeding Challenges and Supplementation

Antepartum Shelf		
Module 01 – Communication and Documentation moreOB Chapters – Communication & Documentation	**Module 14** – Diabetes in Pregnancy MyLearningLink – Obstetrics 101	**Module 18** – Multifetal Gestation moreOB Chapter – Twins
Module 02 – Abdominal Palpation and Assessment MyLearningLink – Obstetrics 101	**Module 15** – Pre-Labour Rupture of Membranes moreOB Chapter – Prelabor Rupture of Membranes	**Module 19** – Intimate Partner Violence moreOB Chapter – Family Violence

Module 12 – Antenatal Tests for Fetal Well-Being MyLearningLink – Obstetrics 101	**Module 16** – Preterm Labour moreOB Chapter – Preterm Labor and Birth	**Module 21** – Group B Streptococcal Infections moreOB Chapter – Group B Streptococcus Disease Prevention
Module 13 – Hypertensive Disorders of Pregnancy moreOB Chapter – Hypertensive Disorder in Pregnancy	**Module 17** – Antepartum Hemorrhage moreOB Chapter – Antepartum & Intrapartum Hemorrhage	**Module 33** – Healthy Pregnancy Weight Gain moreOB Chapters – Weight, Obesity in Pregnancy, Weight Diet During Pregnancy & Physical Activity During Pregnancy

Intrapartum Shelf		
Module 01 – Communication and Documentation moreOB Chapters – Communication & Documentation	**Module 13** – Hypertensive Disorders in Pregnancy moreOB Chapter – Hypertensive Disorder in Pregnancy	**Module 25** – Assisted Vaginal Birth moreOB Chapter – Assisted Vaginal Birth
Module 03 – Intrapartum Fetal Assessment Fundamentals of FHS Self-Learning Online Manual https://ubccpd.ca/fhs-online-manual	**Module 14** – Diabetes in Pregnancy MyLearningLink – Obstetrics 101	**Module 26** – Shoulder Dystocia moreOB Chapter – Should Dystocia
Module 04 – Vaginal Examination MyLearningLink – Obstetrics 101	**Module 19** – Intimate Partner Violence moreOB Chapter – Family Violence	**Module 27** – Caesarean Birth MyLearningLink – Obstetrics 10
Module 05 – Assessment and Care of the Labouring Woman moreOB Chapter – Management of labour	**Module 20** – Obesity in Pregnancy moreOB Chapter – Weight, Obesity in Pregnancy	**Module 28** – Vaginal Birth After Caesarean (VBAC) moreOB – Chapter – Trial of Labor after Cesarean Section
Module 06 – Pain Management in Labour moreOB Chapter – Management of Labour	**Module 22** – Intra-Amniotic Infection MyLearningLink – Obstetrics 101	**Module 29** – Cord Prolapse moreOB Chapter – Cord Prolapse
Module 07 – Birth in Absence of a Primary Caregiver moreOB Chapter – Vaginal Birth	**Module 23** – Labour Dystocia moreOB Chapter – Management of Labor	**Module 30** – Amniotic Fluid Embolus moreOB Chapter – Venous Thromboembolism and Amniotic Fluid Embolus
Module 11 – Maternal Transport Guideline – Clinical Assessment of 'At Risk' or Actual Preterm Labour For Triage	**Module 24** - Induction and Augmentation moreOB Chapter – Induction of Labor	**Module 35** – Delayed Cord Clamping for Preterm & Term Babies Guideline – Umbilical Cord Clamping

Preconception Shelf	
Module 19 - Intimate Partner Violence moreOB Chapter – Family Violence	

Appendix 2b: STORC e-Learning Modules – Covenant Health

Strategies for Teaching Obstetrics to Rural and Urban Caregivers (STORC) – all courses are available on CLiC		
Abdominal Assessment and Palpations	**Antenatal Test for Fetal Well Being**	**Care of the Late Preterm**
C-Sections	**Diabetes**	**Intra-Amniotic Infection**
Newborn Assessment	**New Car Seat**	**New t-Piece**
Postpartum Assessment	**Recognizing Newborn Illness**	**Skin-to-Skin**
Vaginal Exam	**Vitamin K**	

INITIAL NEWBORN ASSESSMENT RECORD

Alberta Health Services

Initial Newborn Assessment Record

Affix patient label within this box

Date of Birth (yyyy-Mon-dd)	Time of Birth (hhmm)	Weight grams	Length cm	Head Circumference cm	APGAR Score ____ /____ /____

Vital Signs *(suggested frequency for the "stable" newborn - within 15 minutes of birth, then at 1 and 2 hours of age)*

Time (hhmm)	Temperature	Heart Rate	Respirations	SpO_2 (%)	Printed Name	Initials
	°C					
	°C					
	°C					
	°C					

Head Circumference for AVB only: 1hour of age _____cm 2 hours of age _____cm

Medication	Dose	Site	Date	Time	Signature(s)
Vitamin K (IM) ☐ Declined	☐ 0.5 mg *Wt less than 1500 gm* ☐ 1.0 mg *Wt equal to/greater than 1500 gm*		(yyyy-Mon-dd)	(hhmm)	Cosign (if applicable)
Erythromycin Eye Ointment		Each eye	(yyyy-Mon-dd)	(hhmm)	

Physical Observations *(check all that apply)*

	Normal	Variance *requires an entry in Multidisciplinary Notes *Report all variances at transfer of care
Head		
Scalp/Skull	☐ Moulding	☐ Caput ☐ Vacuum/forcep marks ☐ Cephalohematoma ☐ Other _____
Facial Appearance	☐ Symmetrical	☐ Other _____
Anterior Fontanelle	☐ Open ☐ Soft/flat	☐ Closed ☐ Bulging ☐ Sunken
Posterior Fontanelle	☐ Open	☐ Closed
Eyes	☐ Symmetrical ☐ Edematous lids	☐ Discharge ☐ Other _____ ☐ Subconjunctival hemorrhage
Ears	☐ Aligned with outer canthus ☐ Well-formed cartilage	☐ Ear tag ☐ Low set ☐ Other _____
Nose	☐ Symmetrical ☐ Patent nares	☐ Other _____
Mouth	☐ Intact lips ☐ Intact palate	☐ Tight frenulum ☐ Other _____
Neck		
	☐ Full range of motion	☐ Limited range of motion ☐ Other _____
Chest		
Shape	☐ Symmetrical ☐ Round ☐ Intact clavicles	☐ Other _____
Breasts	☐ Breast tissue	☐ Other _____
Cardiovascular		
Rate	☐ 100 – 160 bpm	☐ Tachycardia ☐ Bradycardia
Rhythm	☐ Regular	☐ Irregular ☐ Murmur

Sample

20117 (Rev2017-12) Side A

Alberta Health Services | Covenant Health

Alberta Health Services

Initial Newborn Assessment Record

Affix patient label within this box

	Normal	Variance
Respiratory		
Air Entry	☐ Equal bilaterally	☐ Decreased: ☐ Left ☐ Right
Breath Sounds	☐ Clear	☐ Crackles ☐ Other _____
Rate	☐ 30 - 60 per minute	☐ Tachypnea ☐ Bradypnea ☐ Apneic episodes more than 15 seconds
Effort	☐ Effortless	☐ Laboured ☐ Indrawing/retractions ☐ Nasal flaring ☐ Grunting
Abdomen		
Shape/Contour	☐ Soft ☐ Round	☐ Distended ☐ Flat/concave ☐ Hernia ☐ Other _____
Bowel Sounds	☐ Bowel sounds present	☐ Bowel sounds absent
Umbilical Cord	☐ 3 Vessels	☐ 2 Vessels
Skeletal/Extremities		
Extremities	☐ 10 fingers ☐ 10 toes ☐ Equal arm lengths ☐ Equal leg lengths ☐ Equal gluteal folds ☐ Full range of motion	☐ Polydactyly ☐ Webbing of toes/fingers ☐ Asymmetrical extremities ☐ Unequal gluteal folds ☐ Impaired range of motion ☐ Other
Spine	☐ Intact ☐ Straight ☐ Midline	☐ Spina Bifida ☐ Curvature ☐ Tuft of hair ☐ Coccygeal dimple ☐ Other _____
Genitalia		
	☐ Gender specific genitalia	☐ Undifferentiated gender
☐ Male	☐ Anus visualized ☐ Scrotum present ☐ Testes descended ☐ Central urethral opening	☐ No anal opening ☐ Hydrocele ☐ Undescended teste(s)/not palpable ☐ Hypospadias ☐ Other _____
☐ Female	☐ Anus visualized ☐ Urethra visualized ☐ Labia majora formed ☐ Vaginal skin tag	☐ No anal opening ☐ Urethra not visible ☐ Fusion of labia ☐ Other
Skin		
Integrity	☐ Intact ☐ Slight peeling ☐ Dry ☐ Mongolian spots ☐ Sole creases	☐ Laceration/broken skin ☐ Rash ☐ Bruising ☐ Petechia ☐ Birth mark/stork bite ☐ Absent sole creases ☐ Other _____
Turgor	☐ Elastic	☐ Decreased
Color	☐ Centrally pink ☐ Acrocyanosis	☐ Pallor ☐ Central cyanosis ☐ Plethora ☐ Mottling ☐ Other _____
Neuromuscular		
Tone	☐ Active tone ☐ Flexed limbs	☐ Hypertonia ☐ Hypotonia ☐ Jittery ☐ Other _____
Reflexes	☐ Moro reflex *(startle)* ☐ Palmar reflex *(grasp)* ☐ Sucking reflex ☐ Rooting	☐ Absent reflexes *(specify)* _____
Cry	☐ Lusty	☐ Weak ☐ High pitched ☐ Inconsolable
Completed by *(print name)*	**Initials**	**Date** *(yyyy-Mon-dd)* / **Time** *(hh:mm)*

Sample

20117 (Rev2017-12)

Side B

Initial Newborn Assessment Record: A Guide to Completion

Introduction

About the Initial Newborn Assessment Record

The Initial Newborn Assessment Record has been developed to facilitate the assessment and documentation of pertinent information of newborns in a structured, logical, and standardized manner. It is a form to facilitate consistent and complete documentation, communication, and continuity of care among health care providers and provides a guide for evidence-based newborn care.

Guiding Principles

Several key principles guided the design and development:

- Be applicable for all maternity hospitals providing initial newborn assessments
- Incorporate relevant information from the birth
- Be adaptable to charting by exception or variance charting
- Minimize double charting or need for narrative notes on several forms
- Utilize standardized terminology and abbreviations
- Facilitate early recognition, timely communication and intervention for changes in newborn wellbeing
- Seamless integration of other provincial records such as the Newborn Clinical Path as much as possible
- Facilitate data collection
- Enable electronic archiving or formatting

General Guidelines

Specific guidelines are relevant to all sections of the Initial Newborn Assessment Record

- To determine the specifics of the normal and normal variations, variances in correlation with initial newborn assessment.
- For any identified variances
    - Document in the multidisciplinary notes
    - Communicate with the Primary Health Care Provider (PHC) or designate as required:
        - Exact time of notification
        - Nature of communication
        - Responses of PHCP
        - Plan of action
        - Response or evaluation of outcome
    - Report all variances at transfer of care

The following sections provide descriptive information about the items on the Initial Newborn Assessment Record:

- The term "Document" instructs one to write out the requested information in the space provided
- The term "Indicate" instructs one to check (✓) in the box/es provided

1.0 Birth Information

Item	Description
Date of Birth	Document the newborn's birth date as yyyy-Mon-dd
Time of Birth	Document the newborn's birth time as hhmm
Weight	Document the newborn's weight in grams
Length	Document the newborn's length in cm
Head Circumference	Document the newborn's head circumference in cm
APGAR Scores	Document the infant's Apgar Score for 1, 5 min and for 10 min (if applicable)

2.0 Vital Signs

Suggested frequency for the "stable" newborn:

- within 15 minutes of birth
- at 1 hour of age
- at 2 hours of age

Item	Description
Date of Birth	Document the time (hhmm) the clinical observations/assessments were performed
In the appropriate time column on the appropriate line document the infant's:	
Temperature	Document axilla temperature (in degrees Celsius)
Heart Rate	Document heart rate (count for a full minute)
Respirations	Document respiratory rate (count for a full minute)
$Sp0_2$	Pre-ductal oxygen saturation level (as required – document in percentage [%])
Printed Name	Print legible first and last name
Initial	Document legible initials
Head Circumference for AVB Only	Document the infant's head circumference in cm at 1 hour of age and at 2 hours of age

3.0 Medication

Item	Description
Vitamin K (IM)	Indicate with a check mark (✓) if Vitamin K (IM) was declined
Dose	Indicate with a check mark (✓) which dose was given: • 0.5 mg (if weight is less than 1500 grams) OR • 1.0 mg (if weight is equal to or greater than 1500 grams)
Site	Document the site IM was given
Date	Document the date in the format yyyy-Mon-dd
Time	Document the time in the format hhmm
Signature(s)	Document a legible signature
Erythromycin Eye Ointment – Each Eye	Indicate with a check mark (✓) if Erythromycin was declined.
Erythromycin Eye Ointment – Each Eye	Document the date (yyyy-Mon-dd) and time (hhmm) Erythromycin eye ointment was given to each eye OR document if Erythromycin Eye Ointment was declined

4.0 Physical Observations

Indicate with a checkmark (✓) all boxes that apply:

- **Normal**

  AND/OR
- **Variance:**
  - variance requires entry in Multidisciplinary Notes
  - report all variances at transfer of care

Item	Description
Head – Scalp/Skull	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Moulding) • **Variance** (☐ Caput, ☐ Vacuum/forcep marks, ☐ Cephalohematoma, ☐ Other – please describe)
Head – Facial Appearance	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Symmetrical) • **Variance** (☐ Other – please describe)
Head – Anterior Fontanelle	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Open, ☐ Soft/flat) • **Variance** (☐ Closed, ☐ Bulging, ☐ Sunken)

Head – Posterior Fontanelle	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Open) • **Variance** (☐ Closed)
Eyes	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Symmetrical, ☐ Edematous lids) • **Variance** (☐ Discharge, ☐ Sub-conjunctival hemorrhage, ☐ Other – please describe)
Ears	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Aligned with outer canthus, ☐ Well-formed cartilage) • **Variance** (☐ Ear tag, ☐ Low set, ☐ Other – please describe)
Nose	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Symmetrical, ☐ Patient nares *[nostrils are open]*) • **Variance** (☐ Other – please describe)
Mouth	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Intact lips, ☐ Intact palate) Palette should be both palpated and visually assessed using a flashlight or other light source. • **Variance** (☐ Tight frenulum, ☐ Other – please describe)
Neck	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Full range of motion) • **Variance** (☐ Limited range of motion, ☐ Other – please describe)
Chest – Shape	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Symmetrical, ☐ Round, ☐ Intact clavicles) • **Variance** (☐ Other – please describe)
Chest – Breasts	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Breast tissue) • **Variance** (☐ Other – please describe)
Cardiovascular – Rate	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ 100–160 bpm [not required to document exact rate]) • **Variance** (☐ Tachycardia, ☐ Bradycardia)
Cardiovascular - Rhythm	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Regular) • **Variance** (☐ Irregular, ☐ Murmur)

Respiratory – Air Entry	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Equal bilaterally) • **Variance** (☐ Decreased: indicate ☐ left OR ☐ right)
Respiratory – Breath Sounds	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Clear) • **Variance** (☐ Crackles, ☐ Other – please describe)
Respiratory – Rate	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ 30-60 per minute) • **Variance** (☐ Tachypnea, ☐ Bradypnea, ☐ Apneic)
Respiratory – Effort	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Effortless) • **Variance** (☐ Laboured, ☐ Indrawing/retractions, ☐ Nasal flaring, ☐ Grunting)
Abdomen – Shape/Colour	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Soft, ☐ Round) • **Variance** (☐ Distended, ☐ Flat/concave, ☐ Hernia, ☐ Other – please describe)
Abdomen – Bowel Sounds	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Bowel sounds present) • **Variance** (☐ Bowel sounds absent)
Abdomen – Umbilical Cord	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ 3 vessels) • **Variance** (☐ 2 vessels)
Skeletal – Extremities	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ 10 fingers, ☐ 10 toes, ☐ Equal arm lengths on general observation, ☐ Equal leg lengths, ☐ Equal gluteal folds, ☐ Full range of motion) • **Variance** (☐ Polydactyly, ☐ Webbing of toes/fingers, ☐ Asymmetrical extremities, ☐ Unequal gluteal folds, ☐ Impaired range of motion, ☐ Other – please describe)
Skeletal – Spine	Indicate with a checkmark ☐ (✓) all boxes that apply: • **Normal** (☐ Intact, ☐ Straight, ☐ Midline) • **Variance** (☐ Spina Bifida, ☐ Curvature, ☐ Tuft of hair, ☐ Coccygeal dimple, ☐ Other – please describe)
Genitalia	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Gender specific genitalia) • **Variance** (☐ Undifferentiated gender)

Genitalia – Male	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Anus visualized, ☐ Scrotum present, ☐ Testes descended, ☐ Central urethral opening) • **Variance** (☐ No anal opening, ☐ Hydrocele, ☐ Undescended test(s)/not palpable, ☐ Hypospadias, ☐ Other – please describe)
Genitalia – Female	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Anus visualized, ☐ Urethra visualized [if unable to visualize without manipulation- note on integrated notes], ☐ Labia majora formed, ☐ Vaginal skin tag) • **Variance** (☐ No anal opening, ☐ Urethra not visible, ☐ Fusion of labia, ☐ Other – please describe)
Skin – Integrity	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Intact, ☐ Slight peeling, ☐ Dry, ☐ Mongolian spots, ☐ Sole creases) • **Variance** (☐ Laceration/broken skin, ☐ Rash, ☐ Bruising, ☐ Petechial, birth mark/stork bite, ☐ Absent sole creases, ☐ Other – please describe)
Skin – Turgor	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Elastic) • **Variance** (☐ Decreased)
Skin – Colour	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Centrally pink, ☐ Acrocyanosis) • **Variance** (☐ Pallor, ☐ Central cyanosis, ☐ Plethora, ☐ Mottling, ☐ Other – please describe)
Neuromuscular – Tone	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Active tone, ☐ Flexed limbs) • **Variance** (☐ Hypertonia, ☐ Hypotonia, ☐ Jittery, ☐ Other – please describe)
Neuromuscular – Reflexes	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Moro reflex *[startle]*, ☐ Palmar reflex *[grasp]* , ☐ Sucking reflex, ☐ Rooting) • **Variance** (☐ Absent reflexes – please describe)
Neuromuscular – Cry	Indicate with a checkmark (✓) all boxes that apply: • **Normal** (☐ Lusty) • **Variance** (☐ Weak, ☐ High pitched, ☐ Inconsolable)

5.0 Completion	
Item	**Description**
Completed by	Print legible first and last name
Initials	Document legible initials
Date	Document date in format yyyy-Mon-dd
Time	Document time in format hhmm

NEWBORN CLINICAL PATH

Alberta Health Services

Affix patient label within this box

Newborn Clinical Path

*see multidisciplinary notes

Birth Summary

Date of Birth *(yyyy-Mon-dd)*	Time *(hhmm)*	GA	APGARS / /	Birth Weight *(grams)*	Initial Head Circumference

Type of Birth	Passed Meconium *(following delivery)*	Initial Void	Skin to Skin for the first hour
☐ SVD ☐ Vacuum ☐ Forceps ☐ C/S	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No*

Group B Strep Positive Mother?	Newborn at Risk of Hepatitis B Transmission?
☐ No ☐ Yes → Adequate Prophylaxis? ☐ No ☐ Yes Newborn at Risk of Sepsis? ☐ No ☐ Yes	☐ No ☐ Yes → Vaccine Given? ☐ No ☐ Yes → Immune Globulin Given? ☐ No ☐ Yes

Printed Name	Initial	Date *(yyyy-Mon-dd)*	Time *(hhmm)*

Date NMS Consent Received *(yyyy-Mon-dd)*	Date *(yyyy-Mon-dd)* and Time *(hhmm)* Drawn *(if known)*	Initial

Clinical Observation

Date *(yyyy-Mon-dd)*														
Time *(hhmm)*														
Temperature														
Respiratory Rate														
SpO_2														
Heart Rate														
Weight														
Head Circumference														
JMI/Serum Bilirubin Δ														
Blood Glucose Result Δ *(if indicated)*														
	N	V	N	V	N	V	N	V	N	V	N	V	N	V
Respiratory Effort														
Circulation														
Colour														
Tone														
Skin-to-Skin														
Breast Feeding														
Bottle Feeding														
Effective Latch														
Active Feeding														
Initials														

Sample

Printed Name	Initial	Printed Name	Initial	Printed Name	Initial

Alberta Health Services

Affix patient label within this box

Newborn Clinical Path

*see multidisciplinary notes

Intake and Output Summary					
Hours of Age	0 - 2 hours	2 - 24 hours	24 - 48 hours	48 - 72 hours	72 hours +
Method of feeding					
# of active feedings					
# of attempts only					
Amount of EBM (mL)					
Amount of breast milk substitute (mL)					
# of voids					
# of stools					
Other *(e.g. emesis)*					
Initials					

Newborn Assessment

Refer to Newborn pathway for normal, variance and education indicators
Put a check mark (✓) in the appropriate column or 'X' if not assessed and N/A if not applicable
N= Normal, V= Variance, E= Education *See multidisciplinary notes
Record variances/concerns/interventions on multidisciplinary notes

Date *(yyyy-Mon-dd)*																				
Time *(hhmm)*																				
Hours of Age																				
	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E
Head																				
Nares																				
Eyes																				
Ears																				
Mouth																				
Chest																				
Abdomen/Umbilicus																				
Skeletal/Extremeties																				
Skin																				
Neuromuscular																				
Genitalia																				
Elimination - urine																				
Elimination - stool																				
Behaviour (states/cues)																				
Crying																				
Safety																				
Newborn Care																				
Feeding *(includes skin to skin and hand expression)*																				
Initials																				

Printed Name	Initial	Printed Name	Initial	Printed Name	Initial

Sample

INFANT FEEDING RECORD

Alberta Health Services

Infant Feeding Record
Newborn Clinical Path

Affix patient label within this box

Date of Birth *(yyyy-Mon-dd)*							Time of Birth *(hhmm)*				
Date & Time Feed Started	Baby's Age *(hours)*	Blood Glucose Result *(ac/pc if indicated)*	Method *(see Legend)*	Active Feed (✓)	Attempt to Feed Only (✓)	Type *(see Legend)*	Amount mL (if not Br)	If EBM: Label & Baby's ID Match *(Parent and Nurse Initial)*	Feed Observed *(Nurse or Parent Initial)*	Urine (pee) (✓)	Stool (poop) (✓)

Sample

Legend

Method	Active Feed	Type
Br - Breast **Sp** - Spoon **B** - Bottle **O** - Other **C** - Cup **S** - Syringe	**At Breast** - effective positioning and latch with several bursts of sustained sucking at each feed, evidence of milk transfer **Not at Breast** - coordinated suck, swallow and appropriate amount	**EBM** - Expressed Breast Milk **BMS** - Breast Milk Substitute *(Formula)* **O** - Other

Printed Name	Initial	Printed Name	Initial	Printed Name	Initial

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Page 1 of 2

Newborn Clinical Path & Infant Feeding Record:
A Guide to Completion

Introduction

About the Newborn Nursing Care Pathway

The Newborn Nursing Care Pathway has been developed to facilitate the assessment and documentation of pertinent information of newborns in a structured, logical, and standardized manner. It is a form to facilitate consistent and complete documentation, communication, and continuity of care among health care providers and provides a guide for evidence-based newborn care.

Guiding Principles

Several key principles guided the design and development:

- Be applicable for all maternity hospitals providing healthy newborn care
- Incorporate relevant information from the birth
- Be adaptable to charting by exception or variance charting
- Minimize double charting or need for narrative notes on several forms
- Utilize standardized terminology and abbreviations
- Facilitate early recognition, timely communication and intervention for changes in newborn wellbeing
- Seamless integration of other provincial records such as the Labour Partogram, Birth Summary and Postpartum Clinical Path as much as possible
- Facilitate data collection
- Enable electronic archiving or formatting

General Guidelines

Specific guidelines are relevant to all sections of the Newborn Clinical Path

- To determine the specifics of the normal and normal variations, variances, interventions, parent education and anticipatory guidance, and frequency of assessments, the Newborn Care Pathway is used as the foundation documentation
- To obtain pertinent information
    - Confirm assessment data with parents/caregivers
    - Review Antenatal Record, Partogram, Labour & Birth Summary and the Newborn Record and any other significant health records
    - Perform a newborn physical, feeding, and behavioral assessment referred to as a Nursing Assessment
- For any identified variances
    - Document in the multidisciplinary notes
    - Communicate with the Primary Health Care Provider (PHCP) or designate as required:
        - Exact time of notification
        - Nature of communication

  - Responses of PHCP
  - Plan of action
  - Response or evaluation of outcomes
- A blank space or 'x' indicates that the action or assessment was not performed

The following sections provide descriptive information about the items on the Newborn Clinical Path:

- The term "Document" instructs one to write out the requested information in the space provided
- The term "Indicate" instructs one to check (✓) the box provided

1.0 Birth Summary – Refer to Newborn Initial Assessment, Delivery Record, and other pertinent document to assist with completion	
Item	**Description**
Addressograph/label area	See label
Birth	Document the newborn's birth information as: date of birth (yyyy-Mon-dd), and time of birth (hhmm)
GA (Gestational Age)	Document the newborn's gestational age
Apgar Score	Document the newborn's Apgar Score for 1, 5 minutes and for 10 minutes (if applicable)
Birth Weight	Document the newborn's birth weight in grams
Initial Head Circumference	Document the newborn's initial head circumference
Type of birth	Indicate with a checkmark (✓) the type of birth as: • SVD (Spontaneous Vaginal Delivery) • Forceps (Assisted Birth) • Vacuum (Assisted Birth) • C/S (Cesarean Section)
Passed Meconium (following delivery)	Indicate if the newborn passed their first meconium following delivery: Yes or No
First Void	Indicate if the newborn had their first void following delivery: Yes or No
Skin-to-Skin for the first hour	Indicate if the newborn was placed skin-to-skin following birth for the first hour of life: • Yes • No – (Variance) Document the reason on the multidisciplinary notes
Group B Strep Positive Mother Adequate Prophylaxis Newborn at Risk of Sepsis	Indicate if mother is positive for Group B strep: No or Yes • If yes, indicate if adequate prophylaxis given: No or Yes Indicate if newborn is at risk of sepsis: No or Yes

Newborn at Risk of Hepatitis B Transmission	Indicate if the newborn is at risk of Hepatitis B transmission (at risk includes: mother tests positive for HbsAg, the mother is in a high-risk category and HBsAg results are unavailable/unknown, or a primary caregiver other than the mother is a known carrier). Refer to Interim Guideline CC-XIII-115: No or Yes • If yes, indicate if vaccine was given (as applicable): No or Yes • If yes, indicate if Immune Globulin was given (as applicable): No or Yes • If yes, and Immune Globulin and/or vaccine was not given as applicable, document variance in multidisciplinary notes
Printed Name/Initial/Date/Time	Provide legible first and last name, initial and date (yyyy-Mon-dd) and time (hhmm) assessment completed
Date NMS Consent Received	Document date Newborn Metabolic Screen verbal consent received, time drawn, if known (hhmm), and provide legible initials

2.0 Clinical Observation

Suggested frequency:
If stable:
- Within 15 minutes of birth
- At 1 and 2 hours of age
- At 6 hours of age
- Once per shift until hospital discharge

Item	Description
Date and Time	Document the date (yyyy-Mon-dd) and time (hhmm) the clinical observations/assessments were performed
In the appropriate date and time column on the appropriate line document the newborn's:	
Temperature	Axilla temperature (in degrees Celsius)
Respiratory Rate	Respiratory rate (count for a full minute)
SpO_2	Pre-ductal oxygen saturation level (as required – reported in %) • Indicate the CCHD screening was done by placing * in this box and document results in the multidisciplinary notes
Heart Rate	Heart rate (count beats for a full minute)
Head Circumference	Document the newborn's head circumference in cm
Weight	Document the newborn's weight in grams
JMI/Serum Bilirubin△	Jaundice Meter Index (JMI) reading (as required) reported in umol/L, △ indicates Lab Value
Blood Glucose △	Document newborn's blood glucose if indicated
Respiratory Effort	Indicate in the appropriate date and time column: N = Normal or V = Variance
Circulation	Indicate in the appropriate date and time column: N = Normal or V = Variance

Colour	Indicate in the appropriate date and time column: N = Normal or V = Variance
Tone	Indicate in the appropriate date and time column: N = Normal or V = Variance
Skin-to-Skin	Indicate if the newborn has had the opportunity to be placed skin-to-skin with mother or significant other. Review the benefits of skin-to-skin with the parents
Breast Feeding	Indicate if the newborn is breast feeding: • N = Normal – e.g., mom demonstrates effective breastfeeding • V = Variance – e.g., mom demonstrates difficulty with breastfeeding (unable to latch, etc.)
Bottle Feeding	Indicate if the newborn is receiving breast milk substitute (formula) in a bottle: • N = Normal – e.g., baby sucking, swallowing, feeding well • V = Variance – document issue if variance identified
Effective Latch	Indicate if the newborn is demonstrating an effective latch • Definition: ○ Effective Latch = Chest to chest, nose to nipple, wide open mouth, flanged lips, no dimpling of cheeks, may hear audible swallow, rhythmic sucking, newborn doesn't easily slide off the breast, no nipple damage or distortion after feed
Active Feeding	Indicate if the newborn is demonstrating active feeding • Definition: ○ Breast = Several bursts of sustained sucking at each feed, including effective positioning, latch and evidence of milk transfer ○ Breast milk substitute = Coordinated suck, swallow and appropriate amount
Printed Name	Provide printed first and last name
Initial	Provide legible initials

3.0 Intake and Output Summary

Document in the appropriate newborn age timeframe column.

- Summary to be completed at (hhmm) hours (use infant 0-2 hrs of age to figure out time to document summary entries)

Item	Description
Method of Feeding	Document the method of newborn feeding: • Br = Breast • B = Bottle • C = Cup • S = Syringe

	• Sp = Spoon • O = Other
# of active feedings	Document the number of active feedings
# of attempts only	Document the number of feeding attempts only (tries but does not actively feed)
Amount of EBM (mL)	If using expressed breast milk, document the amount in mL
Amount of breast milk substitute (mL)	If using breast milk substitute, (such as formula), document the amount in mL
# of voids	Document the number of voids (overall N/V also assessed in Section 5 of the clinical path)
# of stools	Document the number of stools (overall N/V also assessed in Section 5 of the clinical path)
Other (e.g., emesis)	Document other (such as emesis), as a variance, on the multidisciplinary notes
Initials	Provide legible initials

4.0 Newborn Assessment

Refer to the timelines in the Newborn Nursing Care Pathway for a description of the normal/normal variations, client education and anticipatory guidance, variances and interventions for each of the assessed items.

Variances may require:

- More frequent assessments
- Describe any variances/concerns in the multidisciplinary notes (including focus, information on the variance, nursing actions and responses to interventions/care) is required

Item	Description
Date/Time	Document the date (yyyy-Mon-dd) and time (hhmm) the clinical observations/assessments were performed
Hours of Age (up to 72 hrs then # of days)	Document the age in hours. Once the newborn is 72 hours of age (3 days), document the timeframe in days

Normal/Variance/Education Columns	Indicate **N**ormal, **V**ariance, **E**ducation or ***see multidisciplinary notes for each of the areas relating to the newborn assessment as per the Newborn Care Pathway
	
	Place a checkmark (✓) in the:
	• **N** column indicating the assessment fits the normal or normal variations for the time period as described in the Newborn Nursing Care Pathway
	  ○ (✓) = normal
	  ○ N/A = not applicable
	  ○ X = not addressed

	• **V** column indicating there is a variance for the time period as described in the Newborn Care Pathway • **E** column indicating there was education given to the patient/family • ***Indicating entry in multidisciplinary notes **Indicate N, V, E, or * as appropriate a minimum of one (1) time per shift** The newborn comprehensive assessment includes: • Head • Nares • Eyes • Ears • Mouth • Chest • Abdomen/Umbilicus • Skeletal/Extremities • Skin • Neuromuscular • Genitalia • Elimination – urine • Elimination – stool • Behaviour (states/cues) • Crying • Safety – includes: safe sleeping, shaken baby syndrome prevention, injury prevention • Newborn Care – includes: overall baby care, bathing, follow-up plan with PHCP, community resources/support • Feeding – includes: skin-to-skin, hand expression, breastfeeding cues and active feeding, breastfeeding substitutes – formula preparation and storage, feeding and positioning, feeding plans
Initials	Provide legible initials
Printed Name	Provide legible printed first and last name
Initial	Provide legible initials

5.0 Infant Feeding Record

The Infant Feeding Record is to be completed at the bedside by the mother and/or nurse to document feeding during each shift. Refer to this document to complete the Intake/Output Summary on the newborn clinical path form.

Item	Description
Date and Time of Birth	Document the newborn's date of birth (yyyy-Mon-dd) and time of birth (hhmm)
Date & Time Feed Started	Document the date (yyyy-Mon-dd) and time (hhmm) feed started
Baby's Age	Document the newborn's age in hours
Blood Glucose Results (ac/pc) if indicated	Document the newborn's blood glucose results either before (ac) or after feed (pc) if indicated
Method	Document feeding method using the Legend at bottom of the page: • Br = Breast • B = Bottle • C = Cup • S = Syringe • Sp = Spoon • O = Other
Active Feed	Indicate (✓) if the newborn is demonstrating active feeding using the Legend at the bottom of the page: • At Breast = effective positioning and latch with several bursts of sustained sucking at each feed, evidence of milk transfer • Not at Breast = coordinated suck, swallow and appropriate amount
Attempt to Feed Only	Indicate (✓) if the feed was an attempt only
Type	Document Type of feeding using the Legend at the bottom of the page: • EBM = Expressed Breast Milk • BMS = Breast Milk Substitute (Formula) • Other = Other
Amount (mL)	Document amount in mL if not breast feeding (Br)
Parent/Nurse Initials: EBM Label & Baby's ID	If expressed breast milk is used, nurse and parent to initial when EBM label and baby's ID have been confirmed
Parent/Nurse Initials: Observed Feeds	Nurse or parent to initial observed feed (nurse to observe at least one feed per shift)
Urine (pee)	Indicate (✓) if diaper is wet. Additional comments can be entered in multidisciplinary notes should there be variances noted
Stool (poop)	Indicate (✓) if diaper is soiled. Additional comments can be entered in multidisciplinary notes should there be variances noted
Signature and Initials	Provide legible signature and initials

Maternal Postpartum and Newborn Clinical Paths

Case Scenario #1

Baby Michael:

- Born at 1300 today to Leah Jones – SVD
- Baby Michael's VS were done at 1310 (on Mom's chest) – T: 36, 8°C, HR: 146 bpm, R: 48
- U/S and dates confirmed Leah's EDB, making baby 40+1 weeks gestation today
- Apgar's 8/9
- Weight 3500gm
- Leah was GBS negative and her HBsAG result was negative
- Michael was skin-to-skin immediately after birth for 30 minutes, then went to breast at 1335 and fed eagerly with an effective latch on both breasts. He fed for 40 minutes with audible swallows
- Vitamin K was given while Michael was at breast (1350) & Erythromycin eye ointment at 1355
- No meconium passed following delivery, no initial void
- Written information was given and reviewed with Leah about Newborn Metabolic Screening and verbal, informed consent was obtained for the lab sample to be taken from baby Michael after he is 24 hours of age
- VS 1400 – T: 36 9°C, HR: 138 bpm, R: 50
- The initial newborn assessment was completed @ 1430 – No variances were noted, except only 1 teste was descended & a loonie sized storkbite noted at the nape of his neck
- Head 34 cm, Length 51 cm
- VS @ 1500 – T: 36, 8°C, HR: 142 bpm, R: 46
- At 1500 you transfer Leah and Michael to their postpartum room and transfer care to Nurse Jane Doe

Leah Jones:

- G1 T0 P0 A0 L0
- SVD at 1300 today
- Leah had a 2˚tear which was repaired
- The blood loss from the delivery was < 500ml
- Leah has no known allergies
- She has not voided since 1200 despite two attempts since delivery

Nurse Jane does an assessment on Leah:

- Vital signs at 1510 are:
  - T: 37, 0°C, P: 72, R: 18, BP: 118/68
- Leah rated her pain as 4 and would like some analgesia. She is given 400mg Ibuprofen PO
- Her fundus is firm with massage, 2 above umbilicus. Lochia is heavy rubra.
- Perineum is slightly bruised and swollen and an ice pad was given
- Breasts are soft, nipples intact
- You show Leah how to check her fundus and ask her to notify you if her flow increases or if she passes a clot
- You encourage her to void approximately every 2-4 hours
- Based on this assessment, Nurse Jane encourages Leah to try and void and assists her to the bathroom.
- She voids 300ml without difficulty. Leah does pericare as instructed, puts on clean pads and settles back to bed

At 1530 Leah is reassessed:

- Fundus is firm and 1 below umbilicus
- Lochia is small rubra

Leah responds to Michael who is rooting - he goes to breast at 1545 for 20 minutes - Leah states that baby had a good latch and she could hear him swallowing.

Following the feed, you teach the parents how to change baby's diaper and do cord care.

Michael has passed meconium and voided.

You do an assessment on Michael at 1910:

- T: 36, 7°C
- R: 48, effortless
- HR: 130 bpm, no murmur
- He is centrally pink, with normal tone
- You talk with Leah about recognizing feeding cues, how to console her baby when he is crying, and positioning Michael on his back to sleep

At 1930 you assess Leah:

- VS - T: 36, 9°C, P: 75, R: 20, BP: 115/70
- Pain scale is 3
- Leah does not need analgesic at this time
- Her fundus is firm, 1 below umbilicus
- Lochia is small rubra
- Trace of edema to lower legs and feet
- Perineum remains slightly bruised and swollen
- No variances are noted on assessment
- She was up to void, without difficulty
- Leah does not use illegal substances or smoke, and only drinks occasionally when not pregnant
- Discuss healthy eating and getting adequate rest

Michael was put skin to skin at 2000:

- After 30 minutes of skin to skin, Leah and the nurse try to get the baby to breast
    - He was sleepy and they were unable to get him to latch or suck
- You teach Leah about hand expression and she then expresses 2 mL and feeds it to Michael with a syringe

A set of vitals and an assessment of Leah was done at 0015:

- T: 37, 0°C, P: 80, R: 18, BP: 118/70
- Her fundus was firm, 1 below umbilicus
- Lochia was small rubra
- Trace of edema to lower limbs
- Pain scale is 4. Ibuprofen 400 mg given at Leah's request for her sore perineum
- Her perineum remains swollen and tender and ice was given
- You discover that Leah has been unable to void since 1930 despite attempts
    - She requires I&O catheterization for 400ml
    - Fundus and flow were normal

Jump ahead in time… You return the next day to care for Leah and Michael:

- 0730 - You enter Leah's room and she says her pad feels wet and she has not voided since the catheterization
- On palpation her bladder feels full with the fundus firm at 2 above umbilicus and deviated to the right
- Moderate rubra flow
- Her perineum appears swollen, but decreased swelling
- Leah's vital signs are - T: 37, 0°C, P:72, R: 18, BP: 112/64
- Pain 2/10 - no analgesic required

0735 Leah is up to the bathroom:

- After using measures to assist Leah with voiding (warm water over perineum and running water), Leah voids 450 mL, performs pericare & gets back into bed

0745 while Leah is up to the bathroom, you assess Michael:

- Michael's T is 36, 2°C, R: 55, HR: 150 bpm (He was unwrapped and in the cot beside Leah's bed while she was eating breakfast)
- No head to toe variances noted
- You encourage Edward to put Michael skin-to-skin with him

0800 you assess Leah:

- Her fundus is firm, 1 below umbilicus
- Lochia is small rubra

0845 Michael is assessed:

- T: 36, 8°C, R: 46, HR: 144 bpm

0945: You check his temp – 36, 9°C and at 1045 - 36, 9°C

1030: You have witnessed 1 successful breast feed - active feed with effective latch

1050: Leah voids following the feed, fundus and flow – normal

1100: Discharge planning/teaching completed with Leah and Edward (Further education about urinary function and when to follow up also provided)

- Discharge JMI – 55 (jaundice education provided)
- Leah is given Rh Immune globulin as ordered

1300: You complete Michael's Intake and Output record with the information taken from the Infant feeding record that Leah has been using at the bedside (because we fast forwarded in time in this scenario all feeds were not necessarily noted)

Baby Michael fed 6 times in 24 hours actively, 1 attempt only, 2ml EBM, no other types of feeding, method breast, and syringe, 2 voids, 2 meconium stools

1330: Leah, Michael, and Edward are discharged home together with Michael safely in his car seat, following his NMS being completed

Sample Completed Case Scenario: Postpartum Patient

Alberta Health Services

JONES, Leah

Affix patient label within this box

Female

Postpartum Clinical Path

** see multidisciplinary notes*

Birth Summary

Allergies *(specify)* ☑ NKA

Delivery Date *(yyyy-Mon-dd)* 2016-Aug-19 Time *(hhmm)* 1300

G 1 T 0 P 0 A 0 L 0

Foley catheter removed *(yyyy-Mon-dd)* 2016-Aug-19 1500

Vaginal Delivery ☑ SVD ☐ Vacuum ☐ Forceps

Initial Void ☐ Yes ☑ No

Cesarean Section ☐ Emergent ☐ Elective

If epidural or spinal, Time of catheter removal *(hh:mm)*

Sedation ☐ Epidural ☐ Spinal ☐ General Anesthetic

Perineum ☐ Intact ☑ Laceration Degree 2° ☐ Episiotomy

Blood Loss ☑ less than 500 mL ☐ 500 - 1000 mL ☐ greater than 1000 mL

Printed Name	Initials	Date *(yyyy-Mon-dd)*	Time *(hhmm)*
Jane Doe	JD	2016-Aug-19	1500

Clinical Observation

Date *(yyyy-Mon-dd)*	2016-Aug-19	2016-Aug-19	2016-Aug-19	2016-Aug-20	2016-Aug-20	2016-Aug-20	
Time *(hhmm)*	1510	1530	1930	0015	0730	0800	
Temperature	37°		36.9	37°	37°		
Pulse	72		75	80	72		
Respiratory Rate	18		20	18	18		
SpO_2							
Blood Pressure	118/68		115/75	118/70	112/64		
Sedation Score	0	0	0	0	0	0	
Pain Scale/ Intervention	4 AG		3 RA	4 AG	2 RA		
Fundal Tone	M*	F	F	F	F	F	
Fundal Height	2/U*	U/1	U/1	U/1	2/U*	U/1	
Lochia amount/ colour	H R*	S R	S R	S R	M R	S R	
Perineum/ Abdominal Incision	S/B/C N/A		B/S N/A	S/C N/A	S N/A		
Edema			+1	+1			
Initials	JD	JD	JD	JD	JD	JD	

Printed Name	Initial	Printed Name	Initial	Printed Name	Initial
Jane Doe	JD				

Sample

8921 (Rev2018-03)

Page 1 of 2

Alberta Health Services

JONES, Leah

Affix patient label within this box

Female

Postpartum Clinical Path

* *see multidisciplinary notes*

Put a check mark (✓) in the appropriate column or 'X' if not assessed and N/A if not applicable
N= Normal, V= Variance, E= Education
Record variances/concerns/interventions on multidisciplinary notes.

Maternal Assessment																				
Date *(yyyy-Mon-dd)*	2016-Aug-19			2016-Aug-19			2016-Aug-20			2016-Aug-20			2016-Aug-20							
Time *(hhmm)*	1510			1930			0015			0730			1050							
Hours postpartum	2			6			11			18			21							
Maternal Physiological	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**
Breasts	✓			✓			X			X			X								
Bowel Funtion	X			X			X			X			X								
Urinary Function	✓		✓	✓				✓	✓		✓		✓								
Abdomen/Fundus		✓	✓	✓			✓			✓			✓								
Lochia		✓	✓	✓			✓			✓			✓								
Perineum/Incision	✓		✓	✓			✓			✓											
Epidural/Spinal Site	X			X			X			X			X								
Sensory/Motor																					
Healthy Eating	✓			✓			✓			X			X								
Activity/Rest	✓			✓			✓			X			X								
Feeding	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**
Breastfeeding/Feeding	X		X	✓			X			X			X								
Hand expression/pumping	X			X			X			X			X								
Mothering	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**
Bonding/Attachment	X			✓			✓			X			X								
Skin to Skin	X			✓			X			X			X								
Responds to feeding cues	X			✓			✓			X			X								
Emotional & Mental Health	X			✓			✓			X			X								
Family Function	X			✓			X			X			X								
Other	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**	**N**	**V**	**E**
Nicotine Use	X			✓			X			X			X								
Alcohol				✓																	
Substance Use	X			✓			X			X			X								
Initial	JD			JD			JD			JD			JD								

Sample

Printed Name	Initial	Printed Name	Initial	Printed Name	Initial
Jane Doe	JD				

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Alberta Health Services | Covenant Health

Alberta Health Services

Multidisciplinary Notes

Disciplines			
Aboriginal Hospital Liaison	- AHL	Nursing	- Nsg
Addiction Counselor	- AC	Occupational Therapist	- OT
Audiologist	- AUD	Pharmacist	- Pharm
CardiologyTechnician	- RCT	Physical Therapist	- PT
Dentist	- DMD	Primary Care Provider	- PCP
Dietician	- RD	Psychology	- Psych
Early Intervention Program	- EIP	Recreation Therapist	- RecT
Electroneurophysiology	- ENP	Respiratory Therapist	- RT
Infection Control Professional	- ICP	Social Work	- SW
Medical Radiation Technologist	- MRT	Speech-Language Pathologist	- SLP

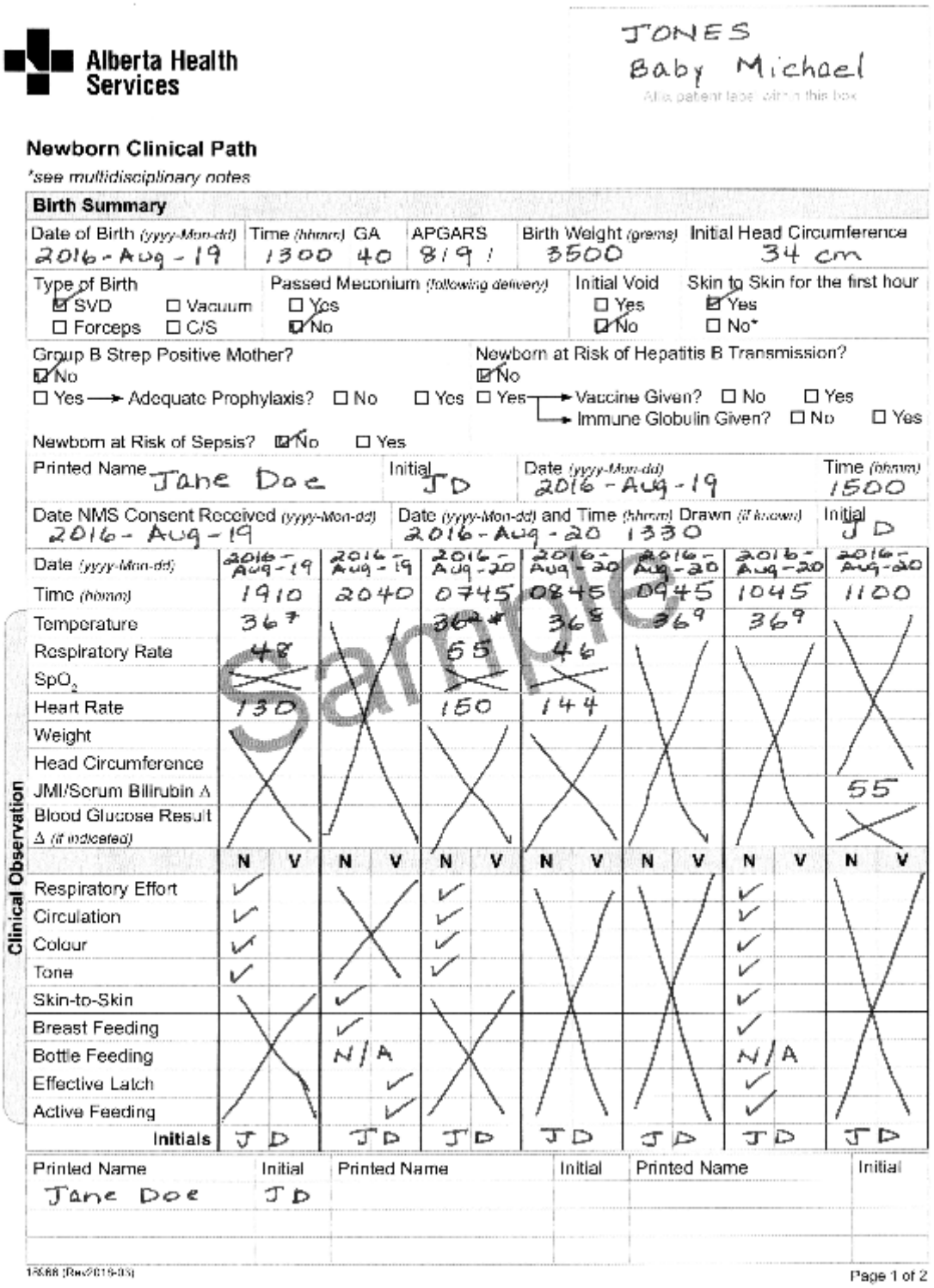
Name (last, first)	
Jones, Leah	
Birthdate (yyyy-Mon-dd)	Sex ☐ M ☑ F
PHN#	Offender#

Date (yyyy-Mon-dd)	Time	Discipline	Notes
2016 - Aug-19	1510	Nsg	• Variances identified (fundal height, tone, amount of lochia) the interventions, patient response, and applicable communication * Void information would be included in intervention details. • Reason for analgesic
2016 - Aug-20	0015	Nsg	• Reason for analgesic • Variance for urinary function, interventions, patient response and applicable communicator
2016 - Aug-20	0730	Nsg	Variances for Fundus and Urinary function, the interventions, patient response, and applicable communication

SAMPLE

05588(Rev2014-07)

Sample Completed Case Scenario: Newborn Patient



Alberta Health Services

JONES
Baby Michael
Affix patient label within this box

Newborn Clinical Path

*see multidisciplinary notes

Birth Summary

Date of Birth (yyyy-Mon-dd)	Time (hhmm)	GA	APGARS	Birth Weight (grams)	Initial Head Circumference
2016-Aug-19	1300	40	8 / 9	3500	34 cm

Type of Birth: ☑ SVD ☐ Vacuum ☐ Forceps ☐ C/S
Passed Meconium (following delivery): ☐ Yes ☑ No
Initial Void: ☐ Yes ☑ No
Skin to Skin for the first hour: ☑ Yes ☐ No*
Group B Strep Positive Mother? ☑ No ☐ Yes → Adequate Prophylaxis? ☐ No ☐ Yes
Newborn at Risk of Hepatitis B Transmission? ☑ No ☐ Yes → Vaccine Given? ☐ No ☐ Yes; Immune Globulin Given? ☐ No ☐ Yes
Newborn at Risk of Sepsis? ☑ No ☐ Yes

Printed Name	Initial	Date (yyyy-Mon-dd)	Time (hhmm)
Jane Doe	JD	2016-Aug-19	1500

Date NMS Consent Received (yyyy-Mon-dd)	Date (yyyy-Mon-dd) and Time (hhmm) Drawn (if known)	Initial
2016-Aug-19	2016-Aug-20 1330	JD

Clinical Observation

	2016-Aug-19 1910	2016-Aug-19 2040	2016-Aug-20 0745	2016-Aug-20 0845	2016-Aug-20 0945	2016-Aug-20 1045	2016-Aug-20 1100
Temperature	36.7		36.4	36.8	36.9	36.9	
Respiratory Rate	48		65	46			
SpO_2							
Heart Rate	130		150	144			
Weight							
Head Circumference							
JMI/Serum Bilirubin Δ							55
Blood Glucose Result Δ (if indicated)							
	N V	N V	N V	N V	N V	N V	N V
Respiratory Effort	✓	✓	✓			✓	
Circulation	✓		✓			✓	
Colour	✓		✓			✓	
Tone	✓	✓	✓			✓	
Skin-to-Skin		✓				✓	
Breast Feeding		✓				✓	
Bottle Feeding		N/A				N/A	
Effective Latch		✓				✓	
Active Feeding		✓				✓	
Initials	JD	JD	JD	JD	JD	JD	JD

Printed Name	Initial	Printed Name	Initial	Printed Name	Initial
Jane Doe	JD				

Sample

18688 (Rev2015-03)

Page 1 of 2

Alberta Health Services

JONES

Affix patient label within this box

Baby Michael

Newborn Clinical Path

*see multidisciplinary notes

Intake and Output Summary					
Hours of Age	0 - 2 hours	2 - 24 hours	24 - 48 hours	48 - 72 hours	72 hours +
Method of feeding	BR	BR|S			
# of active feedings	1	6			
# of attempts only	0	1			
Amount of EBM (mL)	0	2			
Amount of breast milk substitute (mL)	0	0			
# of voids	0	2			
# of stools	0	2			
Other (e.g. emesis)	0	0			
Initials	JD	JD			

Newborn Assessment

Refer to Newborn pathway for normal, variance and education indicators
Put a check mark (✓) in the appropriate column or 'X' if not assessed and N/A if not applicable
N= Normal, V= Variance, E= Education *See multidisciplinary notes
Record variances/concerns/interventions on multidisciplinary notes

	Date (yyyy-Mon-dd)			2016-Aug-19			2016-Aug-19			2016-Aug-20											
	Time (hhmm)			1610			1910			0745			1300								
	Hours of Age			3			6			18			24								
		N	V	E	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E	N	V	E
Head			X		✓			✓				X									
Nares			X		✓			✓				X									
Eyes			X		✓			✓				X									
Ears			X		✓			✓				X									
Mouth			X		✓			✓				X									
Chest			X		✓			✓				X									
Abdomen/Umbilicus				✓	✓			✓				X									
Skeletal/Extremeties		X			✓			✓				X									
Skin		X			✓			✓			✓		✓								
Neuromuscular		X			✓			✓				X									
Genitalia		X			✓			✓				X									
Elimination - urine		✓			✓			✓			✓										
Elimination - stool		✓			✓			✓			✓										
Behaviour (states/cues)			X		✓	✓		✓				X									
Crying			X		✓	✓		✓				X									
Safety			X		✓	✓		✓					✓								
Newborn Care				✓	✓			✓		✓		X									
Feeding (includes skin to skin and hand expression)		✓			✓	✓		✓		✓	✓										
Initials		JD			JD			JD			JD										

Printed Name	Initial	Printed Name	Initial	Printed Name	Initial
Jane Doe	JD				

Sample

18066 (Rev2018-03)

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Alberta Health Services | Covenant Health

Alberta Health Services

Multidisciplinary Notes

Disciplines			
Aboriginal Hospital Liaison	- AHL	Nursing	- Nsg
Addiction Counselor	- AC	Occupational Therapist	- OT
Audiologist	- AUD	Pharmacist	- Pharm
CardiologyTechnician	- RCT	Physical Therapist	- PT
Dentist	- DMD	Primary Care Provider	- PCP
Dietician	- RD	Psychology	- Psych
Early Intervention Program	- EIP	Recreation Therapist	- RecT
Electroneurophysiology	- ENP	Respiratory Therapist	- RT
Infection Control Professional	- ICP	Social Work	- SW
Medical Radiation Technologist	- MRT	Speech-Language Pathologist	- SLP

Name (last, first)	
Jones, Michael	
Birthdate (yyyy-Mon-dd) 2016-Aug-19	Sex ☑ M ☐ F
PHN#	Offender#

Date (yyyy-Mon-dd)	Time	Discipline	Notes
2016-Aug-19	2040	Nsg	•Feeding variances, interventions, patient response to interventions, and applicable communication. Include education provided as an intervention if applicable.
2016-Aug-20	0745	Nsg	Temperature variance, interventions, patient response to interventions, and applicable communication.

SAMPLE

05666(Rev2014-07)

Infant Feeding Record
Newborn Clinical Path

JONES

Affix patient label within this box

Baby Michael

Date of Birth *(yyyy-Mon-dd)* 2016 - Aug - 19 Time of Birth *(hhmm)* 1300

Date & Time Feed Started	Baby's Age (hours)	Blood Glucose Result (acips if indicated)	Method (see Legend)	Active Feed (✓)	Attempt to Feed Only (✓)	Type (see Legend)	Amount mL (if not Br)	If EBM: Label & Baby's ID Match (Parent and Nurse initial)	Feed Observed (Nurse or Parent Initial)	Urine (pee) (✓)	Stool (poop) (✓)
2016 Aug-19 1335	0.5			✓					JD		
2016 Aug-19 1545	2			✓					JD	✓	✓
2016 Aug-19 2015			S		✓	EBM	2	JD LJ	JD		
2016 Aug-20 1030	21			✓					LJ		

Sample

Legend

Method
Br - Breast
B - Bottle
C - Cup
S - Syringe
Sp - Spoon
O - Other

Active Feed
At Breast - effective positioning and latch with several bursts of sustained sucking at each feed, evidence of milk transfer
Not at Breast - coordinated suck, swallow and appropriate amount

Type
EBM - Expressed Breast Milk
BMS - Breast Milk Substitute *(Formula)*
O - Other

Printed Name	Initial	Printed Name	Initial	Printed Name	Initial
Jane Doe	JD				
Leah Jones	LJ				

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