Perinatal Services BC
Obstetrics Guideline 20
Postpartum Nursing Care Pathway

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

Introduction

About the Maternal Postpartum Nursing Care Pathway

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

- Physiological Health
- Psychosocial Health
- Changes: Family Strengths and Challenges

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. 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; for example breastfeeding 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.

Who updated the Maternal Postpartum Nursing Care Pathway

Perinatal Services BC (formerly BC Perinatal Health Program)[1] coordinated the updating of this document. It represents a consensus opinion, based on best evidence, of an interdisciplinary team of health care professionals. The team included nurses from acute care and public health nursing representing each of the Health Authorities as well as rural and urban practice areas. Clinical consultation was provided by family physicians, pediatricians, obstetricians, and other clinical experts as required.

Statement of Women-Centred Care

The Postpartum Nursing Care Pathway assumes that informed decision making is used when care is offered. As stated by CRNBC[2] “nurses provide information that a reasonable person would require in order to make an informed decision about the proposed care, treatment or research. This includes information about the condition for which the care, treatment or research is proposed, the nature of the care, treatment or research, and its risks and benefits as well as any alternatives. Nurses provide sufficient, specific, evidence-based information in a timely and appropriate manner, advocating for clients to acquire desired information from others and assisting clients to understand the information provided.”[3]

The United Nations[4] states that gender is a primary determinant of health. Health Canada[5] 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)”.[6]

The BC Provincial Women’s Health Strategy[7] uses the framework of Women-Centred Care 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 woman and her newborn at the centre of care. It also assures that women, their partners and families are treated with kindness, respect and dignity. Services are planned and provided to meet their needs, respecting the woman’s preferences and decisions, even if they differ from the caregiver’s recommendations.[8,9] 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 as well as care of her infant)[10] in nature. In the intervention sections the nursing process will be referred to as Nursing Assessment.

Referrals to Other Resources

To support nursing practice the following resources are available. Links for many specific resources are included throughout the document. Key resources for parents are:

- **Best Chance Website** – This website is filled with up-to-date and practical information, useful tools and resources for women, expectant parents, and families with babies and toddlers up to 3 years of age. **http://www.bestchance.gov.bc.ca/**
- ***Baby's Best Chance Parents' Handbook of Pregnancy and Baby Care*** (second revision sixth edition) **www.bestchance.gov.bc.ca** In Key Resources Tab
- ***Baby Best Chance* Video** **www.bestchance.gov.bc.ca** In Key Resources Tab
- **HealthLink BC** – **www.healthlinkbc.ca/kbaltindex.asp**
- **HealthLink BC** – Telephone number accessed by dialing 8-1-1 (Services available – health services representatives, nurses pharmacists, dietitians, translation services and hearing impaired services)

Goals and Needs - Health Canada's National Guidelines

As indicated by Health Canada in the document *Family-Centred Maternity and Newborn Care: National Guidelines*,[11] 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.

From the National Guidelines, the BCPHP has adapted the goals, fundamental needs, and basic services for postpartum women 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
- Encourage and assist the completion of specific prophylactic or screening procedures organized through the different programs of maternal and newborn care, such as: Vitamin K administration and eye prophylaxis,

immunization (rubella, Hepatitis B), prevention of Rh isoimmunization and newborn screening (blood spot screening, newborn hearing screening)

- Assess the safety and security of postpartum women and their newborns (families) (e.g. potentially violent home situations, substance use, car seats)
- Identify and participate in implementing appropriate interventions for postpartum maternal and variances/concerns
- Assist the woman in the prevention of postpartum variances/concerns

Needs – World Health Organization (WHO)

The WHO[12] 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."[13]

The eight specific WHO maternal postpartum needs are identified as:

- Information and counselling 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

Timeframes

The first 2 hours following the third stage of birth (delivery of placenta) is the Period of Stability. The Consensus Symposium[14] defined 'The Period of Stability' as "maternal stability is generally attained within two hours following birth".[15] 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, they will be located in the >2 – 24 hour timeframe. It is the at the individual nurse's discretion to provide this information and or support earlier or later.

Maternal Physiological Stability

The Postpartum Nursing Care Pathway has adapted Consensus Statement #1, in the BC Postpartum Consensus Symposium[16] and recommends that the 5 following criteria define postpartum **physiologic stability** for vaginal delivery at term.

- Vital signs stable (T, P, R, BP)
- Perineum intact or repaired as needed
- No postpartum complications requiring ongoing observation (e.g.: hemorrhage)
- Bladder function adequate (e.g.: has voided)
- Skin-to-skin (STS) contact with baby

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

Acute post partum pain is a strong predictor of persistent pain and depression after childbirth.[17] Severity of acute post partum pain, **not** mode of delivery, is independently related to the risk of postpartum pain (2.5 fold increased risk) and depression (3.0 fold increased risk).[18] In order to assess post partum pain and to improve maternal outcomes, the standardized method of using the Visual/Verbal Analogue Scale (VAS) is recommended.[19] The pain assessment incorporates a visual or verbal pain scale 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 pain 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?

Sedation Scale

To investigate the effects of differing degrees of intraoperative sedation during regional anesthesia on intra and postoperative outcomes, a reliable and valid system for measuring the level of sedation is required.[20] The Wilson Sedation Scale is a simple, evidence-based sedation scale and will be used to assess sedation in women experiencing a regional anesthetic.

The following parameters are used for the sedation scale assessment

1. Fully awake and oriented
2. Drowsy
3. Eyes closed but rousable to command
4. Eyes closed but rousable to mild physical stimulation (earlobe tug)
5. Eyes closed but unrousable to mild physical stimulation

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 normal involution • Frequency of assessment following organization's policy: Suggested frequency for vaginal birth: • q 15 min for 1 hour • at 2 hours • once per shift until discharge from hospital • then as required by nursing judgment and/or self report Assess woman's understanding of: • Normal involution progression Assess woman's capacity to: • Self check her involution progression • Identify variances that may require further medical assessment **Refer to:** • Lochia	**Norm and Normal Variations** • Fundus firm, central +/- 1 finger above/below umbilicus **Client Education/ Anticipatory Guidance** • Palpate fundus with 2nd hand supporting uterus just above symphysis (woman in supine position with knees flexed).[21] • Advise to empty bladder and aware of need to empty 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) **Intervention – Fundus** • Massage uterus (if boggy) – advise to empty bladder • May require further interventions – e.g. intravenous, oxytocin (or other uterotonic medications), in and out catheterization of bladder • Nursing Assessment • Refer to appropriate PHCP prn **Variance – Infection** • Infection S & S: T>38, ↑P, chills, anorexia, nausea, fatigue, lethargy, pelvic pain, foul smelling and/or profuse lochia **Intervention-Infection** • Monitor for increased uterine tenderness and • Monitor S & S of infection • Refer to Lochia • Refer to PHCP	**Norm and Normal Variations** • Refer to POS • Rectus muscle intact **Client Education/ Anticipatory Guidance** • Refer to POS **Variance – Fundus and Infection** • Refer to POS **Intervention – Fundus and Infection** • Refer to POS **Variance – Diastasis recti abdominis** • Diastasis recti abdominis as evidenced by bulging or gaping in the midline of abdomen **Intervention – Diastasis recti abdominis** • Educate that this will become less apparent with time	**Norm and Normal Variations** • Fundus firm, central, 1 – 2 fingers below umbilicus-goes down ~ 1 finger (1cm) breadth/day **Client Education/ Anticipatory Guidance** • Refer to 0 – 24 hr **Variance** • Refer to 0 – 24 hr **Intervention** • Refer to 0 – 24 hr	**Norm and Normal Variations** • Fundus central, firm and 2 – 3 fingers below umbilicus • Involuting and descending ~1 finger-breadth 1cm/day (not palpable at 7 – 10 days postpartum, pre pregnant state at 6 wks) **Client Education/ Anticipatory Guidance** • Refer to 0 – 24 hr **Variance** • Refer to 0 – 24 hr **Intervention** • Refer to 0 – 24 hr

Refer to: *Baby's Best Chance*

Best Chance Website – **www.bestchance.gov.bc.ca**

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 Use of a visual/verbal analogue pain scale (VAS) and pain assessment questions 1. Location: Where is the pain? 2. Quality: What does your pain feel like? 3. Onset: When did your pain start? 4. **Intensity: Using the scale 0 (no pain) and 10 (worst pain possible) where would your pain be?** 5. What makes the pain better? 6. What makes the pain worse? Effectiveness of comfort measures/analgesia Assess woman's awareness of comfort measures and/or analgesia – include doses, frequency and effectiveness • Women with increased pain are more apt to develop chronic pain and/or depression	**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[22] **Client Education/ Anticipatory Guidance** • Using VAS questions to assess pain level and when to consult PHCP • Women aware of recommendation for nursing mothers to take precautions with the use of Codeine (test not available in Canada to identify ultra rapid metabolizers of Codeine[23] and the narcotic effects on the newborn. Refer to breastfeeding) ▪ Confer with PHCP re use of alternate medication. **Variance** • Pain does impact daily living, such as walking, mood, sleep, interactions with others and ability to concentrate • Pain scale >4 for vaginal birth (VB) and >5 for Cesarean birth (CB)[24] and not relieved by current analgesia and/or non pharmacological pain relief measures **Intervention** • Pain scale >4 for VB and >5 for CB requires further evaluation and management of pain • Nursing Assessment including pain assessment • Refer to appropriate PHCP prn	**Norm and Normal Variations** • Refer to POS • Afterpains may be more severe in multiparous women when breastfeeding **Client Education/ Anticipatory Guidance** • Refer to POS • Effect of breastfeeding on involution of uterus **Variance** • Refer to POS **Intervention** • Refer to POS	**Norm and Normal Variations** • Refer to 0 – 24 hr **Client Education/ Anticipatory Guidance** • Refer to POS **Variance** • Refer to POS **Intervention** • Refer to POS	**Norm and Normal Variations** • Refer to 0 – 24 hr **Client Education/ Anticipatory Guidance** • Refer to 0 – 24 hr • Afterpains begin to subside after about 72 hr **Variance** • Refer to POS **Intervention** • Refer to POS

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

Physiological Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
ABDOMINAL INCISION • Abdominal incision – progression of healing Assess woman's understanding of • Normal healing from caesarean birth abdominal incision Suggested assessment frequency for caesarean birth: • q 15 min for 1 hour • at 2 hours • q 4 h X 24 hours • once per shift until d/c from hospital • then as required by nursing judgment and/or self report	• Abdominal incision dressing dry and intact with minimal oozing **Client Education/Anticipatory Guidance** • Marked areas of oozing • Encourage to splint abdomen with pillow when coughing, moving or feeding • Use of good body mechanics when changing positions, (getting up from bed/chair) **Variance** • Increased bleeding on dressing, incision gaping, swelling and bruising **Intervention** • Apply pressure dressing • Nursing Assessment • Refer to PHCP prn **Variance – Infection** • S & S such as T>38, increased pulse, chills, anorexia, nausea, fatigue, lethargy, pelvic pain, foul smelling and/or profuse lochia **Intervention – Infection** • Nursing Assessment • Monitor for increased uterine tenderness and further signs and symptoms of infection • Refer to PHCP prn	**Norm and Normal Variations** • Well approximated and free of inflammation, little or no drainage, dressing dry and intact, staples present, may have subcuticular suture covered with steri-strip pressure dressing **Client Education/ Anticipatory Guidance** • Refer to POS **Variance** • Refer to POS • Incision gaping, edema, inflamed, ecchymosis, discharge **Intervention** • Refer to POS	**Norm and Normal Variations** • Fundus may be tender but improving • Incision swelling decreasing **Client Education/ Anticipatory Guidance** • Traditional dressing removed – may shower, cover incision • Steristrips to come off on own • For sterstrip pressure dressing leave intact until removed by PHCP • Ensure arrangements for removal of staples/sutures or Steri Strip pressure dressing (as per hospital/ agency policy/ PHCP preference) • Advise of correct lifting technique – abdominal tightening with exhalation when lifting, lift within the woman's comfort zone (e.g. baby, toddler) ▪ Advise to use good body mechanics and avoiding the Valsalva when lifting • Recommend refraining from tub bath until dressings, sutures, staples removed **Variance** • Refer to POS • Drainage/infection **Intervention** • Refer to POS	**Norm and Normal Variations** • Refer to 0 – 24 hr • May experience numbness surrounding incision • Incision healing with little or no drainage **Client Education/Anticipatory Guidance** • Refer to >24 hr – 72 hr **Variance** • Refer to 0 – 72 hr **Intervention** • Refer to POS

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 understanding of • Adequate breast stimulation Assess woman's • breastfeeding confidence to produce adequate milk supply for her baby Assess woman's capacity to hand express	**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** • Uninterrupted skin-to-skin contact until completion of the first feeding or longer • Mothers with more than one hour of skin-to-skin contact during the first three hours following birth, increased likelihood of breastfeeding exclusively[26]	**Norm and Normal Variations** • Refer to POS • Breast soft, minimal nipple tenderness **Client Education/ Anticipatory Guidance** • Hand expression – if colostrum or milk expressed feed to baby or rub drops into nipple tissue[27] • Support the woman/ infant to work together in achieving an effective latch - most important factor in decreasing incidence of nipple pain[28] • Refer to Infant Feeding Section • Healthy Eating (Refer to Lifestyle-Nutrition) • PSBC (2011) Guideline Breastfeeding the Healthy Term Infant	**Norm and Normal Variations** • Refer to >2 – 24h • Breasts may be beginning to fill, firmer and colostrum more easily expressed • May have some nipple tenderness • Breast fullness **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr • Frequent breastfeeding helps to prevent engorgement[29] • If bra used it should fit comfortably and not restrict breast	**Norm and Normal Variations** • After about 72 hours, breasts may be softer after feedings • Breast fullness **Client Education/ Anticipatory Guidance** • Refer to >2 – 72 hr **Variance** • Refer to 0 – 72 hr • If nipples were previously damaged – pain that does not subside after initial latch **Intervention** • Refer to 0 – 72 hr **Variance – Engorgement** • Tenderness, warmth, throbbing (may extend to armpits) • Skin on breast may be taut, shiny, and transparent • Nipples flat, usually bilateral • Breast(s) hard, swollen, painful **Intervention – Engorgement** • Massage breast gently and manually express breast milk to soften the areola before breastfeeding, facilitating infant latch • Anti-inflammatory agents • Application of warm compresses, shower or breast soak before breastfeeding • Application of cold treatments, such as gel packs, cold packs or some cold cabbage leaves after breastfeeding (women report the use of cold cabbage leaves as helpful although not evidenced based)[30]

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

Physiological Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
BREASTS ***(Continued)***	**Variance** • Nipple inversion, nipples that invert with gentle compression or do not evert with stimulation sufficient for baby to latch • Baby not latching • Baby separate from mother • Refer to >2 – 24 hr **Intervention** • Refer to >2 – 24 hr • Hand expression if baby separated from mother • Nursing Assessment • Refer to PSBC (2011) Guideline Breastfeeding the Healthy Term Infant	**Variance – Nipple(s)** • Refer to POS • Nipple pain • Nipple damage – (bleeding/ cracked, bruised nipples) • Nipple distortion after feeds • Inadequate breast stimulation • Not initiating hand expression within six hours if baby separated • Baby is unable to latch (flat or inverted nipple) **Intervention – Nipple(s)** • Refer to POS and > 24 – 72 hours and beyond • Assess infant feeding (especially for position and latch) • Assess and support strategies for infant feeding • If baby unable to feed effectively, initiate regular hand expression in the first 24hours and expression and pumping thereafter (refer to Newborn Nursing Care Pathway) • Apply expressed breast milk to nipple • Start feeding with least affected nipple (if nipple pain) • Only interrupt breastfeeding if feeding intolerable – assist woman with hand expression • Teach hand expression by 6 hours[31] • Information on managing engorgement (refer to 72 hr – 7 days and beyond – Engorgement) • Comfortable bra – if required • Refer to breastfeeding (variance not exclusively breastfeeding)	**Variance** • Refer to 0 – 24 hr and >72 hr and beyond **Intervention** • Refer to 0 – 24 hr and >72 hr and beyond **Variance – Nipple trauma** • Nipple trauma (beginning signs of skin breakdown) **Intervention – Nipple trauma** • Assess infant feeding • Ask mother to rate her nipple pain (using VAS-see Pain) • Encourage mother to look at nipple as baby releases it, if nipple looks rounded rather than creased or flattened the pain is probably related to previous damage. This 'reference feeding' can help determine latch effectiveness • Refer to individual knowledgeable in current breastfeeding practices or lactation consultant (LC) • After 24 hours use a combination of hand and pump expression • Refer to PSBC (2011) Breastfeeding the Healthy Term Infant	**Variance – Lump in Axilla** • Extra breast tissue in the axilla • Normal variation, medical intervention not required **Intervention – Engorgement of Lumps in Axilla** • Anti-inflammatory agents • Comfort Measure – application of cold **Variance – Plugged Duct** • Usually 1 breast • Localized hot, tender spot • May be white spot on nipple • May be a palpable lump (plugged duct) **Intervention – Plugged Duct** • Shower or warm compress to breast before breastfeeding • Frequent feeding • Massage behind the plug toward the nipple, prior to and during feeding • Vary positions for feeding[25] • Comfort measures may include ice and anti-inflammatory agents • Avoid missing feedings

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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 ***(Continued)***		**Variance – Maternal conditions** • Maternal conditions that may affect newborn feeding ▪ Acute psychiatric condition* ▪ Emotional stress* ▪ Substance use*[32] *may affect ability to care for baby and make informed decisions • Refer to Breast Assessment – conditions that may affect milk supply **Intervention – Maternal Conditions** • Careful observation of infant including feeding behavior with support to maximize breast stimulation		**Variance – Mastitis** • Sudden onset of intense pain • Usually in 1 breast (may be both) • Breast may feel hot, appear red or have red streaks and/or be swollen • Woman may experience flu like symptoms, fever of 38.5 °C **Intervention – Mastitis** • Support • Continue frequent breastfeeding – milk from affected breast is safe for infant • Rest • Express if too painful to breastfeed • Adequate fluids and healthy eating (refer to Lifestyle – Healthy Eating) • If there is a firm area, gently massage affected area (massage through feed) • Shower or warm compresses to affected area prior to feeds based on woman's preference • After feeds – cool compresses • Analgesic • If symptoms do not resolve >24hr refer to PHCP • Antibiotics may be indicated if not resolved in 24 hours[33]

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Physiological Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
BREASTS ***(Continued)***				**Variance – Nipple Candida (Fungus Infection) Yeast** • Sore burning nipples • Sore all the time but worse when feeding • Deep burning/shooting pain • Itchy, flaky nipples • Tiny blisters • Deep pink/bright red nipples/areola • Mother may have recently been on antibiotics or has a yeast infection (infant may have signs of Candida in mouth or perineal area)[34] **Intervention – Nipple Candida (Fungus Infection) Yeast** • Differentiate from poor latch • Frequent hand washing and washing of all items that touch breast and infants mouth • Antifungal treatment for both mother and infant may be prescribed • If using breast pads change when they become wet[35] • Avoid use of soother[36] **Interventions for all Variances** • Assess infant feeding • Refer to individual knowledgeable in current breastfeeding practices or lactation consultant LC)

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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 **The Non-breastfeeding Woman** Focus of Assessment: Breast comfort	**Norm and Normal Variations** • Breasts soft, colostrum may be present	**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 • Application of cold treatments, such as gel packs, cold packs or cold cabbage leaves for comfort • Avoid stimulation of the breasts such as heat, pumping, and sexual breast contact until lacation 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 **Interventions** • Wear supportive, well-fitting bra within 6 hours of birth • Anti-inflammatory agents • Cold treatments, such as gel packs, cold packs or cold cabbage leaves for comfort • PHCP may prescribe medication to aid suppression	**Norm and Normal Variations** • Breasts beginning to fill, become firm and warm **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr **Intervention** • Refer to >2 – 24 hr • Supportive bra • Anti-inflammatory agents • Cold treatments such as gel packs, cold packs or cold cabbage leaves for comfort for 20 minutes q 1 – 4 hr **Variance** • Engorgement **Intervention – Engorgement in non-breastfeeding women** • Express small amounts for comfort • Anti-inflammatory agents • Cold treatments as above	**Norm and Normal Variations** • Breasts will start to 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 – 24 hr **Intervention** • Refer to >24 – 72 hr **Variance** • Mastitis **Intervention** • Apply cool compresses • Analgesics • Refer to PHCP

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Physiological Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
COMMUNICABLE DISEASES (INFECTIONS) **Hepatitis B** Assess status at initial assessment Review status (from Antenatal Record) Assess woman's • Understanding of Hepatitis B and the risks involved • Capacity to identify variances that may require further assessments and/or treatments	**Norm and Normal Variations** • HbsAg (Hepatitis B Surface Antigen) negative • Woman and/or household member(s) not from an area when Hepatitis B is endemic • No risk factors for Hepatitis B infections (such as IV drug use, sex trade worker) • Knowledge of woman's Hep B status **Client Education/Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Hep B status is documented on the Antenatal Record Part 2 and Newborn Record Part 2 • HbsAg (Hepatitis B Surface Antigen) positive • Risk factors present or infectious status unknown • Woman and/or household member(s) from an area where HbsAg is endemic **Intervention** • Follow-up as per BCCDC policy • Recommend woman to see PHCP for testing and follow-up • Recommend household member(s) for testing and immunizations	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • For women with Hep B/ household contact with Hep B: ▪ Disease transmission ▪ Breastfeeding not contraindicated ▪ Early identification of infant risk for exposure and infant prophylaxis **Variance** • Refer to POS **Intervention** • Support breastfeeding • Early identification of risks for early intervention **www.healthlinkbc.ca/kbase/topic/major/hw40968/descrip.htm** **www.bccdc.org/downloads/pdf/epid/reports/CDC_HepBControl_June04.pdf** **www.phac-aspc.gc.ca/im/vpd-mev/hepatitis-b-eng.php** **www.who.int/mediacentre/factsheets/fs204/en/**	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • >2 – 24 hr **Variance** • Refer to POS **Intervention** • Refer to 0 – 24 hr	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • >2 – 24 hr **Variance** • Refer to POS **Intervention** • Refer to 0 – 24 hr

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

Physiological Health: 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
COMMUNICABLE DISEASES (INFECTIONS) **Hepatitis C (HCV)** Assess status at initial assessment Review status (from Antenatal Record) • Assess woman's Understanding of Hepatitis C and the risks involved • Capacity to identify variances that may require further assessments and/or treatments	**Norm and Normal Variations** • No maternal risk factors for HCV are evident **Client Education/Anticipatory Guidance** For women with Hep C: • 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[37,38] • Support breastfeeding (breastfeeding is not contraindicated) • If nipples are cracked or bleeding, discard breast milk during this time as HCV transmitted through blood • HCV is a blood borne pathogen and is not transmitted by urine or stool **Variance** • HCV evident or risk factors present (between 4 – 7 women out of 100 who have HCV might pass it to their babies at the time of birth. The risk of transmission from mother to child may reach 36 percent in mothers who have a larger quantity of the hepatitis C virus in their blood and in those who are also infected with HIV).[39] **Intervention** • Refer to >2 – 24 hrs	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • Refer to POS • **www.phac-aspc.gc.ca/hepc/pubs/gdwmn-dcfmms/viii-pregnant-eng.php** **Variance** • Refer to POS **Intervention** • Basic hygiene and the disposal of potentially infected material should be discussed with the patient. • No need for the mother to alter normal child care routines and the use of gloves, masks or extra sterilization is unnecessary • Follow-up as per BCCDC policy • Refer to PSBC Guideline for Hepatitis C **www.perinatalservicesbc.ca** • Refer to SOGC Guideline **www.sogc.org/guidelines/public/96E-CPG-October2000.pdf** • Recommend woman to see PHCP for testing	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • >0 – 24 hr **Variance** • Refer to POS **Intervention** • Refer to 0 – 24 hr	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • >0 – 24 hr **Variance** • Refer to POS **Intervention** • Refer to 0 – 24 hr

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Physiological Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
COMMUNICABLE DISEASES (INFECTIONS) **Herpes Simplex in Pregnancy (HSV)** Assess status at initial assessment Review status (from Antenatal Record) Assess woman's • Understanding of HSV and the risks involved • Capacity to identify variances that may require further assessments and/or treatments	**Norm and Normal Variations** • No HSV lesions **Client Education/Anticipatory Guidance** • Refer to 2 – 24 hrs **Variance** • Lesions present and/or history of HSV • HSV lesions not detected when there is an infection • Woman may not know she is carrying the virus **Intervention** • May require culture of lesions • Refer to 2 – 24 hrs	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • For women with HSV: ▪ Support breastfeeding ▪ Breastfeeding is contraindicated **only** when there are open lesions on the breast[40] **Variance** • Refer to POS **Intervention** • SOGC Guidelines • **www.sogc.org/guidelines/documents/gui208CPG0806.pdf** ...Any HSV lesions that appear in the mother post partum should be managed with proper hand washing and contact precautions[41] • May use antiviral drugs • Refer to PHCP	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • >2 – 24 hr **Variance** • Refer to POS **Intervention** • Refer to 0 – 24 hr	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • Refer to >2 – 24 hrs • Sexual Activity ▪ Avoid intercourse if lesion present ▪ Avoid oral sex if partner has cold sore ▪ Condoms help but not guaranteed to prevent transmission **Variance** • Refer to POS **Intervention** • Refer to 0 – 24 hrs

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Physiological Health: 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 status at initial assessment • Review status (from Antenatal Record) Assess woman's • Understanding of HIV and the risks involved • Capacity to follow through with any current treatment • Capacity to identify variances that may require further assessments and/or treatments	**Norm and Normal Variations** • No HIV present **Client Education/Anticipatory Guidance** • For women who are HIV positive: ▪ Advise not to breastfeed (in Canada) ▪ Virus may be transferred in breastmilk ▪ Higher rate for postpartum infections (wound, endometritis) **Variance** • HIV present • Risk factors present or infectious status unknown **Intervention** • Follow-up as per PSBC and Oak Tree Clinic Guidelines for HIV **www.perinatalservicesbc.ca**	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • Refer to POS • Oak Tree Clinic **www.bcwomens.ca/Services/HealthServices/OakTreeClinic/default.htm** **Variance** • Refer to POS **Intervention** • Refer to POS	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • >0 – 24 hr **Variance** • Refer to POS **Intervention** • Refer to POS	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • Refer to 0 – 24 hr **Variance** • Refer to POS **Intervention** • Refer to POS

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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 immune status at initial assessment Assess woman's • Understanding of Rubella and the risks involved • Capacity to identify variances that may require further assessments and/or treatments	**Norm and Normal Variations** • Immune (refer to Antenatal Record) **Client Education/Anticipatory Guidance** • Refer to 2 – 24 hr **Variance** • Refer to 2 – 24 hr **Intervention** • Refer to 2 – 24 hr	**Norm and Normal Variations** • Refer to POS • Immune to Rubella IgG antibody titre >10 IU[42] **Client Education/Anticipatory Guidance** • For women who are non-immune or status unknown: ▪ Disease transmission ▪ Immunization • **www.healthlinkbc.ca/kbase/list/msindex/search.asp?searchterm=rubella&filter=all** **Variance** • Non-immune • Immune status unknown **Intervention** • Counsel re rubella vaccine • Confer with PHCP re immunization prior to discharge • Give rubella vaccine upon care provider's order • If mother requires RhIg and rubella vaccine, they may be given concurrently • **www.who.int/topics/rubella/entopic.php?item=90** • **www.phac-aspc.gc.ca/im/vpd-mev/rubella-eng.php**	**Norm and Normal Variations** • Refer to >2 – 24 hr **Client Education/Anticipatory Guidance** • Refer to >2 – 24 h **Variance** • Refer to >2 – 24 hr **Intervention** • Refer to >2 – 24 h	**Norm and Normal Variations** • Refer to >2 – 24 hr **Client Education/Anticipatory Guidance** • Refer to >2 – 24 hr • If MMR is given concurrently with RhIg, rubella status needs to be checked at 2 months **Variance** • Refer to >2 – 24 hr • When MMR and Rh immune globulin given concurrently, rubella status at 2 months is negative – need to be revaccinated with MMR ▪ No serologic testing required after the second dose of MMR vaccine[43] **Intervention** • Refer to >2 – 24 hr • Refer to adult immunization clinic prn

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Physiological Health: 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 status at initial assessment Assess woman's • Understanding of Varicella and the risks involved • Capacity to identify variances that may require further assessments and/or treatments	**Norm and Normal Variations** • Immune **Client Education/Anticipatory Guidance** • Support breastfeeding (breastfeeding is not contraindicated) **Variance** • Not immune to Varicella or is not immunized • Varicella present – indicates newborn to be at high risk **Intervention** • Refer to agency infection control manual for isolation (respiratory isolation)	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • Refer to POS • Disease transmission • Recommend immunization if **non immune** **Variance** • Refer to POS **Intervention** • Discuss immunization – refer to varicella (Immunization guide) • Recommend woman follow-up with PHCP for testing and results **www.bccdc.ca/NR/rdonlyres/0065F4AD-0EEC-430F-B1B5-9634115528D4/0/Epid_GF_VaricellaZoster_July04.pdf** **www.phac-aspc.gc.ca/im/vpd-mev/varicella-eng.php**	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • Refer to 0 – 24 hrs **Variance** • Refer to POS **Intervention** • Refer to 0 – 24 hrs	**Norm and Normal Variations** • Refer to POS **Client Education/Anticipatory Guidance** • Refer to 0 – 24 hrs **Variance** • Refer to POS **Intervention** • Refer to 0 – 24 hrs

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Physiological Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
COMMUNICABLE DISEASES (INFECTIONS) **Influenza and Influenza Like Illness (ILI)** Assess status at initial assessment Assess woman's • Understanding of Influenza and the risks involved • Capacity to identify variances that may require further assessments and/ or treatments	**Norm and Normal Variations** • No signs and symptoms of influenza and ILI **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Signs and symptoms of influenza • Fever, respiratory tract infection **Intervention** • May require isolation, refer to infection control • Refer to > 2 – 24 hr	**Norm and Normal Variations** • Refer to POS **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 cough or sneezing – discard tissue in trash • Cough and sneeze into sleeve • Avoid touching eyes, nose or mouth (infection spreads that way) • Review flu vaccine availability during fall/winter months **Variance** • Refer to POS **Intervention** • Refer to PHCP prn • Seasonal Flu/ H1N1 – respiratory hygiene/cough etiquette in health care settings • **www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm** **Nursing assessment** • Refer to PHCP re follow-up vaccine orders prn **H1N1:** **www.perinatalservicesbc.ca** **www.fightflu.ca** **Avian flu** **www.cdc.gov/flu/avian/**	**Norm and Normal Variations** • Refer to POS **Client Education/ Anticipatory Guidance** • Refer to > 2 – 24 hrs **Variance** • Refer to 0 – 24 hrs **Intervention** • Refer to 0 – 24 hrs	**Norm and Normal Variations** • Refer to POS **Client Education/ Anticipatory Guidance** • Refer to 2 – 24 hrs **Variance** • Refer to 0 – 24 hrs **Intervention** • Refer to 0 – 24 hrs

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Physiological Health: Communicable Diseases – Influenza and ILI

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 • Return to normal bowel movement pattern • Bowel sounds after a Cesarean Birth Assess woman's • Understanding of normal bowel functions • Capacity to self check her bowel functions • Capacity to identify variances that may require further medical assessment	**Norm and Normal Variations** • Refer to >2 – 24 hr **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Refer to >2 – 72 hr **Intervention** • Refer to >2 – 72 hr	**Norm and Normal Variations** • May or may not have a bowel movement • Hemorrhoids **For Cesarean Birth** • Bowel sounds present • Women who are recovering well and who do not have complications after cesarean birth can eat and drink when they feel hungry or thirsty.[44] **Client Education/ Anticipatory Guidance** • Hemorrhoid care • Prevention of constipation • Discuss meds that may constipate • Return of normal bowel habits • Nutrition, fluids, ambulation, stool softeners, laxatives • Refer to Lifestyle – Healthy Eating **For Cesarean Birth** • Start with fluids, hunger present • Ensure no nausea or vomiting present **Variance - Hemorrhoids** • Large, painful hemorrhoids **Intervention - Hemorrhoids** • Nursing Assessment • Comfort measures • Pain control – (Refer to Pain) • Refer to appropriate PHCP	**Norm and Normal Variations** • Refer to >2 – 24 hr **For Caesarean Birth** • Minimal abdominal distention • Active bowel sounds present • Flatus passed **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Refer to >2 – 24 hr • Incontinent of stool **Intervention** • Nursing Assessment • Refer to appropriate PHCP	**Norm and Normal Variations** • Normal bowel movement pattern resumed **For Caesarean Birth** • Refer to >2 – 72 hr **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr **For Caesarean Birth** • Refer to >2 – 72 hr **Variance** • Refer to >2 – 72 hr • Normal bowel movement pattern not resumed **For Caesarean Birth** • Refer to >2 – 72 hr **Intervention** • Refer to >2 – 72 hr • Nursing Assessment • May require laxatives, stool softeners etc • Refer to appropriate PHCP **For Caesarean Birth** • Refer to >2 – 72 hr

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Physiological Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
ELIMINATION **BOWEL FUNCTION** ***(Continued)***		**Variance – Episiotomy** • Episiotomy/3rd – 4th° tear that may affect bowel movement **Intervention – Episiotomy** • Nursing Assessment • Prevention of constipation • Advise against use of enemas or suppositories **<u>For Cesarean Birth</u>** • Variance – Bowel Sounds Absent • Bowel sounds absent after Cesarean Birth **and** if woman has had previous GI history that could interfere with bowel function **Intervention – Bowel Sounds Absent** • Nursing Assessment • Refer to appropriate PHCP		

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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 • Voiding comfortably prn Assess woman's • Understanding of normal urinary function • Capacity to self check her urinary functions • Capacity to identify variances that may require further medical assessment	**Norm and Normal Variations** • Refer to >2 – 24 hr • Some extremity edema **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Refer to >2 – 24 hr **Intervention** • Refer to >2 – 24 hr	**Norm and Normal Variations** • Voids comfortably – voiding qs • Able to empty bladder • No feelings of pressure or fullness • Dysuria following catheter removal • Postpartum diuresis and diaphoresis **Client Education/ Anticipatory Guidance** • Hygiene • Encourage to void approximately every 4 hours • Use of warm water – pour over perineum prior to/during voiding • Sitz baths • Kegel exercises to reestablish bladder control **Variance** • Unable to void • Frequent voiding, small amounts • Burning on urination • Urinary tract infection (UTI) • Pressure/fullness after voiding • Elevated temperature • 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: such as ambulation, oral analgesia, squeeze bottle with warm water, running water, hands in water, blow bubbles through a straw, sitz bath, shower, teach contraction and relaxation of pelvic floor[45] • Refer to physiotherapy • Refer to appropriate PHCP prn	**Norm and Normal Variations** • Refer to >2 – 24 hr • Some extremity edema **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 h4 **Variance** • Refer to >2 – 24 hr **Intervention** • Refer to >2 – 24 hr	**Norm and Normal Variations** • Refer to >2 – 24 hr • Postpartum diuresis and diaphoresis common until the end of first week PP • Extremity edema decreasing **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr • Variance • Refer to >2 – 24 hr **Intervention** • Refer to >2 – 24 hr • Information re: future incontinence problems • Refer to physiotherapy prn

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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 • Stage of involution **Frequency of assessments to follow organization's policy:** Suggested frequency for vaginal birth: • q 15 min for 1 hour • at 2 hours • once per shift until d/c from hospital • then as required by nursing judgment and/or self report Suggested frequency for caesarean birth: • q 15 min for 1 hour • at 2 hours • q 4 h X 24 hours • once per shift until d/c from hospital ▪ then as required by nursing judgment and/or self report Assess woman's • Understanding of normal lochia progression • Capacity to self check • Capacity to identify variances that may require further medical assessment **** Refer to Fundus**	**Norm and Normal Variations** • Fleshy smelling • Rubra colour • No trickling • Absence of or small clots(< size of a loonie) **Range on peripad** • Scant < 1 inch stain • Light < 4 inch stain • Moderate < 6 inch stain **Client Education/ Anticipatory Guidance** • Normal pattern and amount/clots **Variance – Postpartum Hemorrhage (PPH)** • Saturated pad within one hour • Numerous, large clots (>2 large clots >loonie size per 24 hours) **Intervention – PPH** • Refer to Decision Support Tool No. 7 PPH (BCPHP, 2009) • Nursing Assessment • Weigh peripad (1g=1ml) ▪ Check presence of ▪ Tissue/membrane ▪ Frequency of clots ▪ Increased amount (trickling) • Refer to appropriate PHCP prn **Variance – Infection** • Foul smell • Increased temperature • Pain • Flu like signs and symptoms • Refer to Variance – Infection in Fundus section **Intervention – Infection** • Nursing assessment • Refer to Intervention – Infection in Fundus section	**Norm and Normal Variations** • Refer to POS • Increased flow on standing, activity or breastfeeding • Should not exceed moderate range **Client Education/ Anticipatory Guidance** • Refer to POS • Change pads q 4 h • Hygiene: shower daily, keep perineum clean (peri care, wipe front to back, use of peri bottle) • Refer to Lifestyle/Activity/ Rest • Refer to Fundus and Elimination – Urinary function **Variance – PPH, Infection** • Refer to POS • Lochia volume increasing **Intervention – PPH, Infection** • Refer to POS • Decrease activity prn • Nursing Assessment • Refer to appropriate PHCP prn	**Norm and Normal Variations** • Fleshy smelling, rubra-serosa • Amount decreases daily **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr • Discourage tampon use **Variance – PPH, Infection** • Refer to 0 – 24 hr (PPH, Infection) **Intervention – PPH, Infection** • Refer to 0 – 24 hr (PPH, Infection)	**Norm and Normal Variations** • Day 3 – 5: Lochia serosa (pink/brown) • Day 7 – 10: Temporary increasing dark red discharge (shedding of old placenta site) • Day 10 – 6 weeks: Lochia alba • Gradually decreasing – usually subsides by 4 weeks **Client Education/ Anticipatory Guidance** • Refer to >0 – 72 hr **Variance– PPH, Infection** • Refer to 0 – 24 hr (PPH, Infection) • Reoccurrence of continuous fresh bleeding • Lochia rubra >4 days • Discharge >6 weeks **Intervention – PPH, Infection** • Refer to 0 – 24 hr (PPH, Infection) • Nursing Assessment • If bleeding not decreased in 6 – 8 hours call PHCP and/or go to emergency • Refer to PHCP prn

Physiological Health: Lochia

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 • Integrity and progression of healing • Effectiveness of comfort measures **Frequency of assessments to follow organization's policy:** Suggested frequency for vaginal birth: • q 15 min for 1 hour • at 2 hours • once per shift until d/c from hospital • then as required by nursing judgment and/or self report Suggested frequency for caesarean birth: • q 15 min for 1 hour • at 2 hours • q 4 h X 24 hours • once per shift until d/c from hospital • then as required by nursing judgment and/or self report 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 of a visual/verbal analogue pain scale (VAS) and pain assessment questions **Refer to:** • **Pain**	• Refer to appropriate PHCP prn **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 sutured **Client Education/ Anticipatory Guidance** • Use of comfort measures and analgesics • Use of ice packs to decrease swelling • Pericare – peri bottle, fresh pads, wipe front to back • Using VAS questions to assess pain level and when to consult PHCP **Variance** • > 4 for VB or > 5 for CS on pain scale (may be increased with episiotomy, tear, instrumental delivery (cesarean section, forceps, vacuum), internal bleeding, hematoma) **Intervention** • Nursing Assessment • Further evaluation and management of pain • Refer to appropriate PHCP prn	**Norm and Normal Variations** • Refer to POS • Discomfort decreasing **Client Education/Anticipatory Guidance** • Offer to show how to inspect self with mirror • Refer to POS • Warm water sitz baths for comfort (for example 2 – 3 per day for short periods), longer periods may interfere with suture adherence • Discontinue ice packs >24 hr to decrease swelling (some women may choose to continue using for comfort) **Variance – Infection** • Refer to Infection **Intervention – Infection** • Refer to Infection • Refer to POS	**Norm and Normal Variations** • Refer to >0 – 24 hr **Client Education/ Anticipatory Guidance** • Refer to >0 – 24 hr **Variance** • Refer to >0 – 24 hr **Intervention** • Refer to >0 – 24 hr	**Norm and Normal Variations** • Refer to 0 - 24 hr • Discomfort decreasing • Decreased use of analgesics (if on narcotic switch to non narcotic) **Client Education/ Anticipatory Guidance** • Refer to 0 – 24 hr • Discuss pain relief options **Variance** • Refer to 0 – 24 hr • Pain not decreasing **Intervention** • Refer to 0 – 24 hr • Refer to appropriate PHCP

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 from documentation on the Antenatal Record	**Norm and Normal Variations** • Woman is Rh positive • Woman is Rh negative with Rh negative infant **Client Education / Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Rh negative woman with Rh positive infant **Intervention** • Refer to >2 – 24 hr	**Norm and Normal Variations** • Refer to POS **Client Education / Anticipatory Guidance** • Aware of need for testing infant and administration of Rh-immune globulin • Implications for future pregnancy **Variance** • Refer to POS **Intervention** • Aware of infant's Rh factor • Administer Rh immune globulin IM as per PHCP orders • If mother has non-immune rubella status and MMR vaccine is ordered by the PHCP RhIg and MMR vaccine may be administered concurrently	**Norm and Normal Variations** • Refer to POS **Client Education / Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Refer to POS **Intervention** • Aware of infant's Rh factor • Refer to >2 – 24 hr	**Norm and Normal Variations** • Refer to POS **Client Education / Anticipatory Guidance** • Refer to >2 – 24 hr • If RhIg given concurrently, rubella status to be checked at 2 months **Variance** • Refer to POS • When Rh immune globulin and MMR given concurrently and rubella status is negative at 2 months check,, need to be revaccinated with MMR ▪ No serologic testing required after the second dose of MMR vaccine[46] **Intervention** • Refer to >2 – 24 hr

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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 and include history and risks • Self report-how woman is feeling related to vital signs • Frequency of assessment to follow organization's policy **Suggested frequency for vaginal birth:** • q 15 min for 1 hour • temp x 1 in 1st hour • at 2 hours • once per shift until discharge from hospital • then as required by nursing judgment and/or self report **Suggested frequency for caesarean birth:** • q 15 min for 1 hour • temp: x 1 in 1st hour • resp rate: q 1 h x 12 hours[47] (refer to anesthesia orders) • at 2 hours • q 4 h X 24 hours • once per shift until discharge from hospital • then as required by nursing judgment and/or self report May want to use a separate graphic chart to document maternal vital signs as per the Maternal Early Obstetrical Warning System (MEOWS).[48] Use of a visual verbal analogue pain scale (VAS) and pain assessment questions Assess woman's understanding of her normal vitals signs Assess woman's capacity to • Check self • Identify variances and report if she requires further medical assessment(s) **Refer to:** • Pain	**Norm and Normal Variations** • Asymptomatic ▪ PO Temp: 36.7°C – 37.9°C ▪ BP: S= 90 – 140 D= 50 – 90 ▪ Resp: 12 – 24, unlabored ▪ Pulse: 55 – 100 bpm **Client Education/ Anticipatory Guidance** • Normal vital signs and who to contact if variances **Variance** • Chills, febrile, headache, blurred vision, labored respirations, light headedness, palpitations, edema, vital signs outside the norm **Intervention** • Nursing assessment • Refer to appropriate PHCP prn	**Norm and Normal Variations** • Refer to POS **Client Education / Anticipatory Guidance** • Refer to POS **Variance – Vital Signs** • Refer to POS • Decreased sensory and/or motor power to the lower extremities after the epidural block (from 2 – 5 hours depending on the epidural agent)[49] • ≥ 5 on the Sedation Scale • Epidural headache **Intervention – Vital Signs** • Nursing assessment • Refer to appropriate PHCP prn **Variance – Impairment of daily living such as** • Walking • Mood • Sleep • Interactions with others • Ability to concentrate[50] **Intervention – Impairment** • Nursing assessment including ▪ VAS and questions • Further evaluation and management of pain – refer to anesthesiologist	**Norm and Normal Variations** • Refer to POS **Client Education / Anticipatory Guidance** • Able to self report • Refer to POS **Variance** • Refer to 0 – 24 hr • T >38°C on any 2 days • T >39°C any time **Intervention** • Refer to 0 – 24 hr	**Norm and Normal Variations** • Normal vital signs as reported by woman **Client Education/ Anticipatory Guidance** • Refer to 0 – 72 hr • May experience increase in temperature with milk coming down, engorgement **Variance** • Refer to 0 – 72 hr **Intervention** • Refer to 0 – 24 hr

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

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 behavior 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 behaviors • Responses to infant feeding and behavior cues Assess woman's capacity to • identify factors that enhance or interfere with attachment and the resources for support **Refer to:** • **Newborn Nursing Care Pathway: Crying**	**Norm and Normal Variations** • Maternal-newborn skin-to-skin contact immediately after birth until completion of the first feed or longer • Mother responds to infant cues • Maternal interactions with newborn by holding (face-to-face), talking, cuddling, making eye contact • Partner/ significant person presence and involvement **Client Education/ Anticipatory Guidance** • Bonding is a gradual process that may develop over the first month • Refer to >2 – 24 hr **Variance** • Maternal newborn separation • Limited maternal interaction with newborn • Some mothers may appear to have less interest in the newborn in the first 24 hours – consider labor medication(s), exhaustion, pain, intervention(s) during labor and birth and personal expectations – requires further assessment • Minimal or support(s) not available • Limited interaction with newborn from support(s) • Minimal or no planning for taking baby home (diapers, baby clothes, car seat) • Inappropriate or abusive interactions with infant • Family history of trauma and/or lack of positive relationships • Conflictual, violent intimate partner relationships	**Norm and Normal Variations** • Refer to POS • Sensitive response to newborn's needs and behavior cues (feeding, settling, diapering) • Effective consoling techniques (skin-to-skin, showing face to infant, talking to infant in a steady voice, soft voice, holding, rocking, feeding) • Responds to early infant feeding cues (restlessness, beginning to wake, hand to mouth, searching for nipples) • Responds to infant's needs in a warm, loving, sensitive way, emotionally and physically available, demonstrates affection toward newborn, appears to enjoy interacting with newborn • Partner/significant other/ family interactions with newborn and mother • Positive relation with others (partner, support(s), family members) • Refer to crying section in Newborn Nursing Care Pathway	**Norm and Normal Variations** • Refer to 0 – 24 hr **Client Education/ Anticipatory Guidance** • Refer to 0 – 24 hr **Variance** • Refer to 0 – 24 hr • Feeding difficulties • Adjusting to new person in the family **Intervention** • Refer to 0 – 24 hr	**Norm and Normal Variations** • Refer to 0 – 24 hr **Client Education/Anticipatory Guidance** • Refer to 0 – 24 hr • Signs of later attachment behaviors **Variance** • Refer to 0 – 72 hr • Lack of or inconsistent responses to newborn feeding and behavior cues • Lack of response to discomfort and distress (with crying, mother may believe baby is crying for no reason, is just spoiled or is manipulating her) • Inappropriate or abusive interactions with infant • Eye contact minimal or lacking when infant awake **Intervention** • Refer to 0 – 24 hr • Ways to increase parental positive responses • Position infant so mother and infant can see each other • Make eye contact • Imitate the baby • Resource kit on infant attachment – First Connections • **www.phac-aspc.gc.ca/mh-sm/mhp-psm/pub/fc-pc/index-eng.php** • Refer to community supports/ agencies as appropriate and available, such as family resources, parenting programs, peer support, public health programs • Maintain open relationship with family

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 ***(Continued)***	**Intervention** • Refer to Client Education >2 – 24 hr • Assist mother to hand express colostrum if separated from newborn • Encourage visiting and skin-to-skin contact as soon as able if separated from newborn • Refer to appropriate PHCP prn	**Client Education/ Anticipatory Guidance** • Mother involved in all decision making (refer to Statement of Women-Centred Care) • Activities that enhance attachment (breastfeeding, skin-to-skin, involved in assessment, care, bathing, infant massage, talking, singing to newborn) • Positive reinforcement re parenting skills; there is growing evidence that role of parent as attachment figure is most influential in first few years of infant's life[51] • Involve partner/significant other as appropriate • Review methods of dealing with infant crying (Review resource Period of PURPLE crying) • See Lifestyle-Activity and Rest, (the importance of rest and night time needs of baby) **Variance** • Minimal or no interaction with baby • Lack of or inconsistent responses to newborn feeding and behavior cues • Lack of response for discomfort or distress (with infant crying mother may believe baby is crying for no reason, is just spoiled or is manipulating her) **Intervention** • Find a parenting strength to build on as a way to reassure parents that they are doing something right when trying to comfort baby (even if baby doesn't always calm down) • Ways to increase parents sensitivity (cue based interaction, discuss normal newborn growth and development) • Ask mother about what she thinks the baby is feeling and why • Suggest specific comfort measures such as snuggling, rocking, soft talking, walking, singing • Refer to appropriate PHCP, counselor, or social worker prn		

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

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 response to delivery and postpartum period (current and past) • Adjustment to parenthood and emotional status of partner/significant other • Medication use for mental health concerns • Predisposing/risk factors to postpartum depression (PPD) such as previous prenatal, postpartum or other episodes of depression, family history of depression, previous use of antidepressants, significant medical or obstetrical challenges • For current signs of PPD • For other mental health conditions such as: postpartum psychosis, schizophrenia, anxiety disorders, personality disorders or suicidal ideation ***Refer to Antenatal Record (in hospital) – EPDS Score** Assess woman's understanding of • Normal postpartum emotional responses • Adjustment to parenthood • Mental health conditions (see above) Assess woman's capacity to • Identify variances that may require support and/or further medical assessment • Access support and/or medical assessment and care	**Norm and Normal Variations** • Support(s) present • No personal history of PPD or other mental illness **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Excessive anxiety, fear, depression, exhaustion • Minimal or no maternal interaction with baby, separation of mother and baby • Limited/ no support(s) • Current symptoms or history of mental illness including: depression, anxiety disorders, eating disorders, personality disorders or suicidal ideation **Intervention** • Assist in recognizing problems • Refer to Bonding and Attachment section • Refer to appropriate PHCP prn **Variance** • Perinatal Loss **Intervention** • Nursing assessment and emotional support • Refer to appropriate PHCP prn	**Norm and Normal Variations** • Woman indicates she feels supported • Increasing maternal confidence and competence in providing infant care • Increasing partner/ significant other confidence and competence in providing infant care **Client Education/ Anticipatory Guidance** • Encourage verbalization of feelings and needs • Explore feelings and expectations of partner/ significant other and ways of promoting support • Discuss normal postpartum adjustments and challenges (appetite, sleep, energy, body image, emotional state) • Discuss mood swings, some are normal • Explore ways to maximize rest – refer to Lifestyle – Rest Activity Section • Discuss risk factors and signs of PPD with woman and families	**Norm and Normal Variations** • Refer to 0 – 24 hr • Responds to newborn's needs and behavior/cues for feeding, crying, settling, cuddling, diapering • Verbalizes understanding of PP adjustment – PP blues • Moving to 'Taking Hold' psychological stage; actively seeking help with self care; connecting with and cares for newborn and willing to learn; expresses anxiety with mothering abilities	**Norm and Normal Variations** • Refer to 0 – 72 hr • More knowledgeable about caring for infant and eager to learn • Assimilating infant into family life • Feels supported by partner/ significant other/ family friends • Tearful moments and mood swings up to about 2 weeks postpartum • May feel 'blue' • **NB:** about 2 – 6 weeks PP 'Letting Go' psychological state – begins to see infant as an individual, starts to focus on issues greater than those associated directly with self/infant **Client Education/ Anticipatory Guidance** • Refer to 0 – 72 hr • Provide opportunity to verbalize feelings (parenting, self esteem) • Encourage connecting with peers, new families and community resources such as Reproductive Mental Health, Pacific Post Partum Support Society **www.postpartum.org** • Discuss risk factors and signs and symptoms of postpartum depression and importance of talking to someone

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

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 ***(Continued)***		**www.bcwomens.ca (Search – Reproductive Mental Health)** **Note:** In the 'Taking-In' psychological stage; experiences physical and/or emotional dependence, elation, excitement and/or anxiety/confusion. Often relive, verbally and mentally, the labour and birth experience • Provide opportunity to review birth experience **Variance** • As for POS • Continued dissatisfaction with birth experience • Negative perception of infant **Intervention** • Refer to Bonding and Attachment section • Nursing Assessment • Refer to appropriate PHCP prn		**Variance** • Refer to 0 – 24 hr • Excessive anxiety, fear, depression, infanticide ideation **Intervention** • Refer to 0 – 24 hr • PPD assessment and use of a tool for screening and education such as the Edinburgh Postpartum Screening Tool between 6 – 8 weeks (by physician, midwife, PHN as per local protocol)

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

Family Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
SUPPORT SYSTEMS/ RESOURCES Assess • Mother's support(s) – partner, family, friends and community • Woman's understanding of the available family and community resources Assess woman's capacity to: • Access family and community resources • Identify variances that may require further assessment	**Norm and Normal Variations** • Refer to >2 – 24 hr **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Refer to >2 – 24 hr **Intervention** • Refer to >2 – 24 hr	**Norm and Normal Variations** • Maternal support system evident **Client Education/ Anticipatory Guidance** • BC Association of Family Resource Programs **www.frpbc.ca** **Variance** • Lack of support and resources (social determinants of health) to meet needs (isolation, cultural, language) • Woman/support(s) not aware of community resources and follow up **Intervention** • Nursing Assessment • Review community resources with woman and her partner/ significant other • Refer to social worker or available community resources • Refer to appropriate PHCP prn	**Norm and Normal Variations** • Refer to >2 – 24 hr **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Refer to >2 – 24 hr **Intervention** • Refer to >2 – 24 hr	**Norm and Normal Variations** • Refer to >2 – 24 hr **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Refer to >2 – 24 hr **Intervention** • Refer to >2 – 24 hr

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

Changes: Family Strengths and Challenges – 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 • Interactions between family members • Positive/effective family coping strategies • Strategies for coping with crying infant • Maternal perception of personal safety, such as "Is your home safe for you and your baby?" • For history and/or signs of intimate partner violence/abuse Assess woman's understanding of family dynamics and interrelationships Assess woman's capacity to: • Identify positive/effective coping strategies (for family and crying infant) • Identify variances that may require further assessment and support Follow agency policy for identification of high risk clients (E.g. Nursing Priority Screening Tool)	**Norm and Normal Variations** • Refer to >2 – 24 hr **Client Education/ Anticipatory Guidance** • Refer to >2 – 48 hr **Variance** • Refer to >2 – 48 hr **Intervention** • Refer to >2 – 48 hr	**Norm and Normal Variations** • Wide-ranging changes in family dynamics and interrelationships **Client Education/ Anticipatory Guidance** • Include partner/ significant other in care to learn ways to support mother • Provide individualized support, information and resources as needed • Discuss stress, time management • Refer to Emotional Status – Mental Health Section • Refer to Lifestyle–Activity and Rest Section • Refer to Support Systems/ Resources • Period of PURPLE crying resources **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 • Refer to appropriate resources and/or PHCP	**Norm and Normal Variations** • Refer to >2 – 24 hr • Family exhibits positive coping skills – able to express concerns and ways to resolve conflict • Some siblings may have difficulty adjusting to the birth of a new baby **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr • Sibling rivalry – ways to include siblings into activities **Variance** • Refer to >2 – 24 hr **Intervention** • Refer to >2 – 24 hr	**Norm and Normal Variations** • Refer to >2 – 72 hr **Client Education/ Anticipatory Guidance** • Refer to >2 – 72 hr • Family gradually adjusts to new infant • Review ▪ Changes that occur to relationships ▪ Expectations re child development, infant crying, behavior ▪ Infant care and feeding ▪ Domestic tasks ▪ Social integration into community ▪ Available supports and resources ▪ Healthfile resources – – *Play and Your Baby* #92c – *Time Out for Parents* #92h – *Bringing Home the Second Baby* #92f **Variance** • Refer to >2 – 72 hr • Family does not adjust well to new infant (see above) **Intervention** • Refer to >2 – 72 hr

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

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 woman's understanding of: • Family planning methods • Resumption of intercourse Assess for mothers capacity to access / obtain contraception prn	**Norm and Normal Variations** • May have had tubal ligation (TL) with C-section **Client Education/ Anticipatory Guidance** • Refer to >72 hr – 7 days and beyond (discussion may not be appropriate at this time) **Variance** • Refer to >72 hr – 7 days and beyond (discussion may not be appropriate at this time) **Intervention** • Refer to >72 hr – 7 days and beyond (discussion may not be appropriate at this time)	**Norm and Normal Variations** • Refer to >72 hr – 7 days and beyond (discussion may not be appropriate at this time) **Client Education/ Anticipatory Guidance** • Refer to >72 hr – 7 days and beyond (discussion may not be appropriate at this time) **Variance** • Refer to >72 hr – 7 days and beyond (discussion may not be appropriate at this time) **Intervention** • Refer to >72 hr – 7 days and beyond (discussion may not be appropriate at this time)	**Norm and Normal Variations** • Refer to >72 hr – 7 days and beyond (discussion may not be appropriate at this time) **Client Education/ Anticipatory Guidance** • Refer to >72 hr – 7 days and beyond (discussion may not be appropriate at this time) **Variance** • Refer to >72 hr – 7 days and beyond (discussion may not be appropriate at this time) **Intervention** • Refer to >72 hr – 7 days and beyond (discussion may not be appropriate at this time)	**Norm and Normal Variations** • Resumption of sexual activity is variable and is when woman is ready/comfortable (Refer to Statement of Woman-Centred Care) • May have vaginal discomfort due to decreased hormonal levels, thinning of vaginal walls, decreased lubrication, sutures • May have decreased libido due to role overload, psychological, social changes, lack of sleep, hormonal changes **Ovulation may occur before menses begins:** • **Lactating Women** – Breastfeeding exclusively regularly throughout the 24-hour period. Affected by frequency of breastfeeding, use of formula, other fluids, weaning, pacifier use • **Non Lactating Women** – Menses may start in 6 – 8 weeks

Refer to: *Baby's Best Chance*

Best Chance Website – **www.bestchance.gov.bc.ca**

Changes: Family Strengths and Challenges – 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 ***(Continued)***				**Client Education/ Anticipatory Guidance** • Review Lactational Amenorrhea Method for Birth Control as per client choice – all conditions must be met 1. Infant under 6 months 2. Mother has *not* had menstruation return 3. Infant exclusively breastfeeding 4. No prolonged period when infant does NOT nurse >4 hr during the day and 6 hr at night • Resumption of vaginal intercourse: ▪ Woman's sense of control and comfort (Mutually agreeable) ▪ Lochia no longer red ▪ Perineum healed – ongoing pelvic floor problems (follow-up with PHCP) ▪ Incision (from C/B) healing and comfortable ▪ Comfort measures – lubricant, positions • Review normal sexuality PP – effects of breast feeding (potential milk ejection reflex, sensual responses to suckling infant) • Awareness of contraception choices • SOGC resource site **www.sexualityandu.ca/adults/index.aspx** • Options for Sexual Health site (birth control options) **www.optionsforsexualhealth.org** **Variance** • Pain with vaginal intercourse after perineum healed • Voiced partner expectations of intercourse prior to healing of perineum/ mutual agreement • STI risk if more than one partner or partner has multiple sex partners • Unaware of contraception choices **Intervention** • Nursing Assessment • Refer to Client Education above • Refer to appropriate PHCP prn

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

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 Services accessible 7 days per week Assess woman's • Readiness for discharge • Ability to breastfeed her infant – position, latch, milk transfer • Ability to formula feed her infant (if not exclusively breast feeding) **Refer to:** • **Newborn Nursing Care Pathway** Assess woman's understanding of • Self care • Newborn feeding including feeding cues • Newborn care • Reporting Assess woman's capacity to: • Self report • Breastfeed her infant, identify and respond to infant feeding cues (position, latch, milk transfer) • Formula feed her infant (if not exclusively breast feeding) • Identify variances that may require further medical assessment • Access resources or follow-up with primary care provider or alternate medical care.	**Norm and Normal Variations** • Refer to >2 – 24 hr **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Refer to >2 – 24 hr **Intervention** • Refer to >2 – 24 hr	**Norm and Normal Variations** • Prior to discharge appropriate arrangements are made for ongoing care • If discharged <48 hr of birth, arrangements made for evaluation within 48 hours of discharge by a Health Care Professional[52] **Client Education/ Anticipatory Guidance** • Knowledge of self care[53] ▪ Mobile with adequate food / fluid intake ▪ Recognizes normal postpartum changes ▪ (physical, psychosocial) and informs PHCP of abnormal findings ▪ Responds to newborn's needs ▪ Support system in place • Provision of community resources in writing • Use of Pregnancy Passport, common care paths, feeding guidelines • Discussion and mutual decision making about ongoing contact **Variance – *no PHCP*** • Family doesn't have a PHCP **Intervention– *no PHCP*** • Nursing Assessment • Care Provider who provides ongoing care is identified	**Norm and Normal Variations** • If discharged <48 hr of birth: ▪ Refer to >2 – 24 hrs **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Refer to >2 – 24 hr **Intervention** • Refer to >2 – 24 hr	**Norm and Normal Variations** • Care provider responsible for continuing care is identified with arrangements made by mother for follow-up within 7 days of discharge[54] **Client Education/Anticipatory Guidance** • Refer to >2 – 24 hr **Variance** • Refer to >2 – 24 hr • Woman does not have PHCP **Intervention** • Refer to >2 – 24 hr • Assist in finding appropriate PHCP

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

Changes: Family Strengths and Challenges – Follow-up in Community

Changes: Family Strengths and Challenges – 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 ***(Continued)***		**Variance – *Follow-up*** • Family does not seek follow-up as needed (woman cannot be contacted or woman declines PHN services when contact/visit is recommended) • No discussion and or mutual decision making about ongoing contact **Intervention – *Follow-up*** • Notify PHCP or social services prn **Variance – *Infant Care*** • Mother not able to provide newborn care due to maternal illness, death, or infant placed in care or for adoption • Intervention – Infant Care • Support mother prn and refer to appropriate HCP prn • Support the infant's caregiver prn		**Variance** • Community resources (PHN, Early Maternity Discharge) unavailable 7 days per week at community level • Family does not seek follow-up as needed • Woman cannot be contacted or declines a visit (when vulnerabilities/needs identified by care providers) **Intervention** • Assist in obtaining supports • Family may require further assessment and referrals, such as a social worker

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

Family Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
BREASTFEEDING Assess: Woman's understanding of: • Breastfeeding recommendations[55, 56, 57, 58, 59, 60] – importance of exclusive breastfeeding for 6 months followed by the introduction of nutritious solids at about 6 months with continued breastfeeding for up to 2 years and beyond • Informed decision making re infant feeding • Infant feeding frequency over the 24 hour period • Appropriate position and latch • The importance of having support with feeding • Psychological and environmental factors affecting relaxation • Contraindications for breastfeeding – HIV, drug use, certain medications	**Norm and Normal Variations** • Skin-to-skin contact, not wrapped in blanket, baby to abdomen/chest right after birth • Maintain skin-to-skin contact until completion of the first feeding or longer • Warm blanket over mother and infant **Client Education/ Anticipatory Guidance** • Support mother to respond to newborn's breast searching behaviors • Assist mother with initial feed – baby's attempt to latch and suckle at breast as soon as possible or within 1 – 2 hours **Variance** • Baby not placed skin-to- skin on abdomen/chest right after birth • Baby not latching • Baby separated from mother	**Norm and Normal Variations** • Breast offered 5 or more times in this 24 hour period[61] • Able to latch baby to breast with minimal assistance • Sensitively responds to newborn feeding cues • Mother and partner/ significant other aware of the benefits of exclusive breastfeeding (no supplements or use of artificial teats) and risks of breastmilk substitutes (formula) • Within 24 hours of birth, 2 independent assessments of effectively latching at breast are observed[62] • 2 effective feeds achieved (without assistance) prior to moving to self care[63]	**Norm and Normal Variations** • Frequent cluster feeding (more at night) • Feeds 8 or more times/day • Signs of breasts filling • Aware of various newborn feeding positions • Refer to >2 – 24 hr **Client Education/ Anticipatory Guidance** • Refer to >2 – 24 hr • Offer both breasts each feed • Correct position, latch, nipple shape post feed • Methods of burping • Strategies to meet baby's nighttime feeds (without needing to supplement unless medically necessary) **Variance** • Refer to 0 – 24 hr • Delayed lactogenesis ▪ Explore underlying cause such as SSRI, SNRI use[67] **Intervention** • Refer to 0 – 24 hr	**Norm and Normal Variations** • Increase maternal confidence • Breasts soften with feeding, free from infection, tenderness decreases • Nipples: intact, tenderness decreases • Breastfeeding assessments: 3 – 4 days postpartum and at 7 – 10 days postpartum[68,69] • Refer to >2 – 72 hr **Client Education/Anticipatory Guidance** • Refer to 0 – 72 hr • Breasts are full before feeding and softer after feeding • After several weeks it is normal to have soft breasts all the time and still have sufficient milk • Importance of human milk: exclusive breastfeeding for 6 months followed by the introduction of nutritious solids at about 6 months with continued breastfeeding for up to 2 years and beyond • Breastmilk is the most important food in the first year **Variance** • Refer to 0 – 24 hr **Intervention** • Refer to 0 – 24 hr

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

Changes: Family Strengths and Challenges: Infant Feeding – Breastfeeding

Changes: Family Strengths and Challenges: Infant Feeding – Breastfeeding

Family Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
BREASTFEEDING ***(Continued)*** Assess woman's capacity to • Determine how well her baby is feeding (includes feeding cues and baby's response) • Feed and calm her baby • Identify common feeding issues and concerns/ variances that may require further support and assessment • Access resources (e.g.- breastfeeding clinics, peer support programs, drop-in groups), • Follow-up with primary care provider or alternate care. **Refer to:** • **Newborn Nursing Care Guidelines: Feeding**	**Intervention** • When baby stable place skin-to-skin on abdomen/ chest • Assist with latch – refer to >2 – 12 hr Client Education/ Anticipatory Guidance • Discuss importance of breast milk and support hand expression if baby separated from mother	**Client Education/ Anticipatory Guidance** • Refer to POS • Refer to Baby's Best Chance • BCPHP (2010) Breast Feeding Guidelines • Ensure the woman understands what constitutes an effective feed • Provide support ▪ written, verbal, visuals ▪ consistent feeding information to enable family to determine if baby is feeding well – position, latch, feeding cues, ▪ linking intake with output • Both breasts offered at each feed • Review position and latch ▪ Mother comfortable – cradle, modified cradle, or football hold, lying - bring infant to breast, use of pillows, position of hands[64] ▪ Encourage skin-to-skin, tummy to tummy ▪ Hand holds and supports the upper back and shoulders, cradling the neck/base of the skull ▪ If breast large, support breast (fingers back from areola) ▪ Touch baby's lips with nipple, wait until mouth open wide ▪ Aim nipple towards the roof of infant's mouth – the bottom lip/jaw on the lower areola under breast ▪ Baby begins to actively suck and cannot be easily pulled off the breast[65] • If necessary, break suction with finger before removing from breast • Methods of burping		

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

Family Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond

BREASTFEEDING *(Continued)*		**Variance – Not exclusively breast feeding**
		
		Intervention – Not exclusively breast feeding
		• Makes informed decision to exclusively feed with breastmilk substitutes (refer to breastmlk substitute)
		• Provision of supplemental feedings for medical indications
		  ▪ Provide information on alternative nutrition (EBM, human donor milk, breastmilk substitutes)
		  ▪ Provide information on alternative feeding methods (cup, syringe, bottle, dropper, spoon)
		  ▪ Support breastfeeding and hand expression and pumping
		• Provision of supplemental feedings for non-medical indications
		  ▪ Clarify concerns (to support informed decision)
		  ▪ Provide information as above
		• Refer to formula feeding re: preparation and storage
		• Refer woman to **www.healthlinkbc.ca** (search – *Formula Feeding Your Baby Getting Started; Formula Feeding Your Baby: Safely Preparing and Storing Formula*)
		HealthLinkBC telephone: dial 8-1-1
		
		Variance – Baby separated from mother
		
		Intervention – Baby separated from mother
		• Begin hand expression by 6 hr
		• Teach pumping techniques[66]
		  ▪ Combine hand expression with pump
		• Mother to NICU (encourage skin-to-skin if possible)		

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

Changes: Family Strengths and Challenges: Infant Feeding – Breastfeeding

Changes: Family Strengths and Challenges: Infant Feeding – Breast Milk Substitutes (Formula) Only

Family Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
BREAST MILK SUBSTITUTES (FORMULA) ONLY **Refer to:** • **Newborn Nursing Care Pathway** Assess woman's understanding of: • Informed decision making re: infant feeding WHO, CPS Guidelines (ask yourself – has the woman had sufficient information and opportunity to discuss her concerns about infant feeding in order to make an informed decision?) • The importance of having support with feeding • Psychological and environmental factors affecting relaxation Assess woman's capacity to • Tell how well her baby is feeding (infant's feeding cues and baby's response) • Feed and calm her baby • Identify common feeding issues and concerns/ variances that may require further support and assessment • Access resources (clinics, peer support programs, drop-in groups), • Follow-up with primary care provider or alternate care provider	**Norm and Normal Variations** • Skin-to-skin immediately after birth • Begin offering formula when baby shows signs of readiness to feed **Client Education/ Anticipatory Guidance** • Provide small amounts of formula (note: ready to use bottles of 120 ml (4 ounces) could contribute to overfeeding) • Provide information regarding amount to feed, feeding cues, positioning, prevention of overfeeding **Variance** • Lack of formula feeding knowledge **Intervention** • Nursing assessment • Use of appropriate formulas	**Norm and Normal Variations** • Feeds baby when baby shows signs of hunger • Aware of newborn feeding positions • Responds (stops feeding) when baby shows signs of satiation **Client Education/ Anticipatory Guidance** • Refer to POS • Review formula preparation and storage with the parents prior to discharge • Refer to 0 – 2 hours **Variance** • Refer to POS **Intervention** • Refer to POS	**Norm and Normal Variations** • Refer to >2 – 24 hours **Client Education/ Anticipatory Guidance** • Refer to 0 – 24 hr **Variance** • Refer to POS **Intervention** • Refer to >2 – 24 hours	**Norm and Normal Variations** • Refer to >2 – 72 hours **Client Education/ Anticipatory Guidance** • Refer to 0 – 72 hr • Careful preparation, storage and use of commercial formula • Introduction of appropriate solids at about 6 months **Variance** • Refer to POS **Intervention** • Refer to POS

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

Family Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
LIFESTYLE – ACTIVITIES / REST Assess • Ability to manage activities for daily living (ADL) • Ability to rest/sleep • Safe resumption of physical activity program Assess woman's understanding of • Night time needs of baby • Her normal activity and rest requirements Assess woman's capacity to identify • Night time needs of baby • Her rest requirements as sleep interrupted during the night • Variances that may require further medical assessment Use of visual verbal analogue pain scale (VAS) and pain assessment questions **Refer to:** • **Pain**	**Norm and Normal Variations** • Refer to >2 – 24 hr **Client Education/ Anticipatory Guidance** • Refer >2 – 24 hr **Variance** • Refer >2 – 24 hr **Intervention** • Refer >2 – 24 hr	**Norm and Normal Variations** • Vaginal birth: Ambulates independently and able to rest • Caesarean birth: Dangles and ambulates with assistance **Client Education/ Anticipatory Guidance** • Rest – when baby sleeping, managing visitors • Early ambulation, safe body mechanics • Normal postpartum recovery including body mechanics • Support(s) at home and in community **www.healthypregnancybc.ca** **Variance – Sleep** • Unable to sleep, not ambulating • Uncontrolled pain **Intervention – Sleep** • Assess comfort level and need for analgesia or relaxation exercises • Nursing Assessment • Refer to PHCP prn **Variance – Calf Discomfort** • Calf discomfort, redness, swelling, decreased mobility – possible deep vein thrombosis (DVT) **Intervention – Calf Discomfort** • Screening for DVT via Homan's sign not recommended as is not reliable • Risk of thrombosis due to activation of blood clotting factors, increased platelet adhesiveness, traumatic/ operative delivery, smoking, inactivity, medical history • Refer to PHCP prn	**Norm and Normal Variations** • Refer to >2 – 24 hr • Caesarean birth, ambulates independently **Client Education/ Anticipatory Guidance** • Refer >2 – 24 hr **Variance** • Refer >2 – 24 hr • Unable to perform activities of daily living (ADL) due to pain, fatigue **Intervention** • Refer >2 – 24 hr • Nursing Assessment • Discuss options for support • Refer to PHCP prn	**Norm and Normal Variations** • Refer to >2 – 72 hr • Fatigue gradually improving **Client Education/ Anticipatory Guidance** • Refer to >2 – 72 hr • Relationship between healthy eating and activity level – especially iron requirements, refer to Healthy Eating • Balance between activity and rest • Care for self and meeting needs of baby • Gradual resumption of physical activity (safe & appropriate exercises) • Problem solving re coping with visitors and tending to tasks • Organizing household to minimize stair climbing, reaching, lifting **Variance** • Refer to >2 – 48 hr • Intervention • Refer to >2 – 48 hr

Changes: Family Strengths and Challenges: Lifestyle – Activities/Rest

Changes: Family Strengths and Challenges: Lifestyle – Activities/Rest

Family Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
LIFESTYLE – ACTIVITIES / REST ***(Continued)***		**Variance – Separated Symphysis Pubis** **Intervention – Separated Symphysis Pubis** • Nursing Assessment • Refer to Physiotherapy or PHCP • Assist client to identify additional supports to assist with ADL and infant care • Support family • Refer to community agencies prn **Pain affecting ADL** • VAS and questions **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[70] **Client Education/ Anticipatory Guidance** • Using VAS questions to assess pain level and when to consult PHCP • Woman aware of comfort measures and/or analgesia including dose, frequency and effectiveness • Women with increased pain are more apt to develop chronic pain and/ or depression **Variance** • Pain **does** impact daily living such as walking, mood, sleep, interactions with others and ability to concentrate • Pain scale >4 for vaginal birth (VB) and >5 for Cesarean birth (CB)[71] and not relieved by current analgesia and/or non pharmacological pain relief measures • Back pain (if post epidural), localized redness/ tenderness over epidural insertion site **Intervention** • Pain scale >4 for VB and >5 for CB requires further evaluation and management of pain • Nursing Assessment • Refer to appropriate PHCP prn		

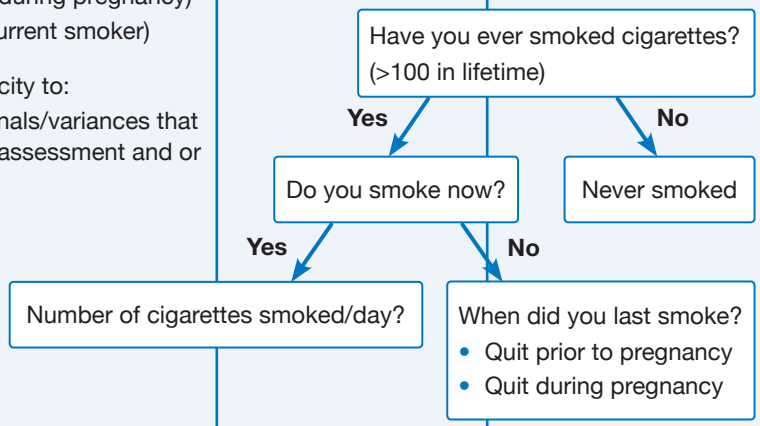
Family Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
LIFESTYLE – HEALTHY EATING Assess • Adequate fluid and nutrient intake • Ability to consume nutritious food/ adequate intake of vitamins with emphasis on Vitamin D and folate Assess woman's • Understanding of adequate and healthy eating including vitamins and folate • Capacity to access nutritious foods (with support)	**Norm and Normal Variations** • Refer to >2 – 24 hr **Client Education/ Anticipatory Guidance** • Refer to >2 – 48 hr **Variance** • Refer to >2 – 24 hr **Intervention** • Refer to >2 – 48 hr	**Norm and Normal Variations** • Adequate fluid and nutritious food intake including vitamins and folate **Client Education/ Anticipatory Guidance** • Encourage small, frequent, nutritious meals • Encourage to continue with prenatal vitamins and folate • Encourage to continue vitamins with attention to Vitamin D to maintain stores during breastfeeding and folate (both to optimize health for any future pregnancies)[72, 73] **Variance** • Inadequate fluid, food, vitamins and/or folic acid intake due to lack of knowledge, physical, emotional or socio-economic factors • Low Hgb **Intervention** • Nursing Assessment • If low Hgb consult with PHCP re potential need for iron supplement, recommend iron rich foods (taking Vitamin C with iron enhances absorption) • Refer to appropriate PHCP prn	**Norm and Normal Variations** • Refer to >2 – 24 hr **Client Education/Anticipatory Guidance** • Access to and ability to consume nutritious foods, vitamins, and folic acid to meet needs • Sources of fibre include whole grain bread, beans, lentils, whole grain bread, high fibre cereals (100% bran) • Sources of iron include liver, red meat, deep green leafy vegetables, legumes, dried fruit and iron enriched foods (taking Vitamin C with iron enhnces absorption) • If on iron may be constipated (refer to Elimination – Bowel Function) • Continue with prenatal supplements • Not a time for dieting • Impact of fatigue on appetite • May be on special diet, such as Diabetic diet • Canada's Food Guide For Healthy Eating **www.healthypregnancybc.ca** **Variance** • Refer to >2 – 24 hr **Intervention** • May require iron supplements • If on iron may be constipated, refer to Elimination – Bowel Function • Refer to nutritionist or PHCP	**Norm and Normal Variations** • Refer to >2 – 24 hr • May require iron supplement, especially if Hgb is low **Client Education/Anticipatory Guidance** • Refer to >2 – 48 hr **Variance** • Refer to >2 – 24 hr • Not able to maintain adequate fluid and nutritious food intake, may be unwell or lacking financial resources **Intervention** • Refer to >2 – 72 hr • Refer to appropriate PHCP • Refer to community nutritionist • Refer to social services and other community agencies providing assistance with food security

Refer to: *Baby's Best Chance*

Best Chance Website – **www.bestchance.gov.bc.ca**

Changes: Family Strengths and Challenges: Lifestyle – Healthy Eating

Changes: Family Strengths and Challenges: Lifestyle – Tobacco Use, Drug/Substance Use

Family Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
LIFESTYLE: **TOBACCO USE** **DRUG/SUBSTANCE USE** Assess woman and household members previous and current • Smoking history (smoking status) • Use of drugs or substances Assess woman's understanding of: • The effects of alcohol, tobacco, (including second hand smoke and exposure to residual nictoine from tobacco smoke (tobacco smoke reside on indoor surfaces including clothing and human skin of smokers), prescription and non prescription drugs Assess the woman's readiness to • Stay quit after pregnancy (if stopped smoking prior to or during pregnancy) • Quit smoking (if a current smoker) Assess woman's capacity to: • Identify warning signals/variances that may require further assessment and or action • Access support	**Norm and Normal Variations** • Refer to >24 – 72 hr **Client Education/ Anticipatory Guidance** • Refer to >24 – 72 hr and smoking history and current status **Variance** • Refer to >24 – 72 hr **Intervention** • Refer to >24 – 72 hr	**Norm and Normal Variations** • Refer to >24 – 72 hr **Client Education/ Anticipatory Guidance** • Refer to >24 – 72 hr **Variance** • Refer to >24 – 72 hr **Intervention** • Refer to >24 – 72 hr **Smoking History/ Status:**[74]  (Adapted from PSBC Guideline: Tobacco Use in the Perinatal Period. 2006)	**Norm and Normal Variations** • Non smoker (as per smoking history)[75] • Mother stays quit after pregnancy (if stopped smoking prior to/during pregnancy) • Home environment free of tobacco smoke- including second hand smoke **Client Education/Anticipatory Guidance** • Refer to smoking history and current status • Emphasize the importance of ▪ Remaining smoke free (or quitting) for her own health and that of her children ▪ Remaining drug/substance free **www.quitnow.ca** **Variance – Use of Tobacco** • Mother is currently smoking • Mother reduced smoking during pregnancy • Family is exposed to second hand tobacco smoke • Exposure to residual nicotine from tobacco smoke, also called third hand smoke (tobacco smoke residue on indoor surfaces, including clothing and human skin of smokers) presents a health hazard via dermal exposure, dust inhalation, ingestion[76]	**Norm and Normal Variations** • Refer to >24 – 72hr **Client Education/ Anticipatory Guidance** • Refer to smoking history/ status • Refer to >24 – 72hr **Variance** • Refer to >24 – 72hr **Intervention** • Refer to >24 – 72hr

Family Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
LIFESTYLE: TOBACCO USE DRUG/ SUBSTANCE USE ***(Continued)***			**Intervention – Use of Tobacco** Nursing Assessment **www.perinatalservicesbc.ca –** Guidelines on Tobacco • ASK: about smoking history/status and exposure to second hand • ADVISE: re importance of remaining smoke free (if quit before/during pregnancy) for her own health and that of her children. • If a smoker, provide brief, clear personalized and respectful message re stopping.[77] ▪ Smokes outside after breastfeeding • Discuss importance of keeping baby and self free from exposure to second hand smoke • Discuss the potential harm particularly to infants (and toddlers) from the residue of second hand smoke nicotine that lingers on surfaces that can react with another chemical in the air to form carcinogens – chemicals linked to various cancers[78] • ASSESS: assess woman's readiness to stay quit after pregnancy (to prevent relapse).[79] If a current smoker – readiness to quit and knowledge of smoking and health • For women who have quit before/during pregnancy encourage to recognize and take action on the warning signals that may precede relapse, such as stress, depression, drinking alcohol/using other drugs, flagging motivation/ feeling deprived, lack of support for cessation, weight gain • ASSIST mother in planning actions prn • ARRANGE refer to appropriate follow-up prn • Include partner/ significant other and family in interventions whenever possible **Variance – Use of substances/drugs (excluding tobacco)** • Mother is currently using drugs/substances, • Family is exposed to harmful substances, such as alcohol, drugs **Intervention – Use of substances/drugs (excluding tobacco)** • Nursing Assessment • Use Ask/ Advise/ Assess/ Assist/ Arrange principles • Refer to appropriate resources (such as addiction services/ appropriate services) and social services or PHCP prn	

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

Changes: Family Strengths and Challenges: Lifestyle – Safe Home Environment

Family Assessment	0 – 2 hours Period of Stability (POS)	>2 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
SAFE HOME ENVIRONMENT Assess the woman's knowledge of • A safe home environment • Safety hazards in the environment Assess the woman's capacity to • Identify variances that may require action • Address solution(s) prn	**Norm and Normal Variations** • Refer to >24 – 72 hr **Client Education/ Anticipatory Guidance** • Refer to >24 – 72 hr **Variance** • Refer to >24 – 72 hr **Intervention** • Refer to >24 – 72 hr	**Norm and Normal Variations** • Refer to >24 – 72 hr **Client Education/Anticipatory Guidance** • Refer to >24 – 72 hr **Variance** • Refer to >24 – 72 hr **Intervention** • Refer to >24 – 72 hr	**Norm and Normal Variations** • Home environment is free of environmental or safety hazards **Variance** • Home contains safety hazards **Intervention** • Nursing assessment • Discuss alleviating safety hazards and refer prn	**Norm and Normal Variations** • Refer to >24 – 72 hr **Client Education/Anticipatory Guidance** • Refer to >24 – 72 hr **Variance** • Refer to >24 – 72 hr **Intervention** • Refer to >24 – 72 hr

Refer to: *Baby's Best Chance* Best Chance Website – **www.bestchance.gov.bc.ca**

Glossary of Abbreviations

ADL	Activities of Daily Living
BCCH	British Columbia Children's Hospital
Bpm	Beats per minute
BCCDC	BC Centre for Disease Control
BP	Blood Pressure
CB	Caesarean Birth
Cm	Centimetres
CNS	Central Nervous System
CPS	Canadian Paediatric Society
D/C	Discontinue
E.g.	For example
EBM	Expressed Breast milk
GI	Gastrointestinal
Gm	Gram(s)
>	Greater than
≥	Greater than or equal to
HbsAg	Hepatitis B Surface Antigen
HIV	Human Immunodeficiency Virus
HCV	Hepatitis C
HSV	Herpes Simplex Virus
HBIG	Hepatitis B Immune Globulin
HR	Heart Rate
Hr	Hours
i.e.	That is
IV	Intravenous
LC	Lactation Consultant
<	Less than
≤	Less than or equal to
Min	Minute
Ml	Millilitre(s)
Mm	Millimetres
PO	By Mouth
POS	Period of Stability
PHCP	Primary Health Care Provider
PHN	Public Health Nurse
PCR / RNA	The best approach to confirm the diagnosis of hepatitis C is to test for HCV RNA (Ribonucleic acid) using a sensitive assay such as polymerase chain reaction (PCR)
PSBC	Perinatal Services BC
PP	Postpartum
PPD	Postpartum Depression
PPH	PPostpartum Haemorrhage
prn	As needed
P	Pulse
RR	Respiratory Rate
ROM	Rupture of Membranes
SOGC	Society of Obstetricians and Gynaecologists of Canada
SSRI	Selective Serotonin Reuptake Inhibitors
SNRI	Selective Norepenephrine Reuptake Inhibitors
S&S	Signs and Symptoms
T	Temperature
TL	Tubal Ligation
UTI	Urinary Tract Infection
VAS	Visual/ Verbal Analogue Scale
VB	Vaginal Birth
vs	Versus
WHO	World Health Organization

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Revision Committee

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