

BSN Learning Pathway Self-Guided Perinatal Passport – Postpartum

A tool to guide BSN students with specialized perinatal learning opportunities, with or without a formal learning pathway.

BSN students can work through this self-paced, specialized perinatal postpartum learning pathway, with or without formal postpartum placements. The booklet highlights the various learner levels, some key concepts, skills, and activities for the student to work through. The passport is best utilized during your first clinical rotation, and then to be carried through your program, optional employed student nursing position, and preceptorship. The goal is to guide the learner in establishing and achieving timely realistic knowledge and skills to become better prepared as a post-partum nurse upon graduation.

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Grounding Us

Rooted in Benner's Novice to Expert theory, this passport focuses on how you, the BSN student, move through your program with potential skills you may acquire at various times, how your thinking evolves, and what supports your learning best at each stage. Before we move into the tangible pieces, it might be helpful to clarify some key concepts, noted below.

1. **Learning Pathway:** A learning pathway is an opportunity to specialize your practice within your undergraduate program. This would include having an employed student nursing job (ESN), a preceptorship, and a new graduate experience all within the same location. This can be formal or informal.
2. **Formal Learning Pathway Student:** These are students who are formally identified through a rigorous selection process to have priority learning pathway opportunities. There are typically extra course(s) and course work provided with formal learning pathway students. Not every school or specialty area offers formal learning pathways to their students at present.
3. **Informal Learning Pathway Student:** These are students whose programs or specialty areas do not offer formal learning pathways OR who were not selected to be a formal pathway student but still follow a similar process. The difference is only some elements may be included, and not all. For example, there may not be additional extra coursework or opportunities offered. Instead, a student can gain similar experiences by self-advocacy, collaborating with their school, and with the unit of interest.

IMPORTANT NOTE: If you do not get the opportunity as a formal learning pathway student, or you are simply unsure if a postpartum specialty is for you, do not worry! In following this booklet, you can still acquire meaningful skills that will serve you very well upon graduating and working in the perinatal specialty.

Phases of Learners

Within this document, learners move through phases that align with where they are in their BSN program. There will be more information around each phase as we continue to work through this document. However, below is a brief overview.

1. *Phase 1-Early Learner:* This is when you are still very new to the BSN program, likely in your first 1-3 semesters. Your learning is very task-focused, rule-guided, and influenced by your few clinical exposures.
2. *Phase 2- Developing/Intermediate Learner:* You are further along in your program (but likely still within the first half) and are beginning to manage simple priorities and routine care, still with support.
3. *Phase 3- Senior/ Consolidating Learner:* You are now in the latter half of your program and are feeling more confident in organizing your patient care and can likely even manage some changes that come up within your day!
4. *Phase 4- Final Practicum/Transition-to-Practice Learner:* You are almost there! You are right at the end of the program and are starting to shift your focus on transitioning to becoming an RN, preparing for graduation and clarifying where you might like to further consolidate after graduation.

Before we begin looking at the individual phases, let's look at what we expect from all BSN students at BCW:



1. Assume accountability for your own learning
2. Seeking and utilizing resources, adhering to the BCCNM standards
3. Know your own role, scope and responsibilities within the team
4. Demonstrate honesty, integrity, support and respect in interpersonal relationships
5. Recognizing your limitations
6. Support families with reporting Indigenous specific racism and/or other discriminatory events

RECOMMENDATION: After reading this brief introduction to the phases, identify where you might see yourself fitting best. That is where you will probably find the most suitable resources and learning activities. However, this is designed to be flexible therefore, if it doesn't meet you where you are at in your learning, go to the previous or next phase to gain the most out of your experience and preparation to become a post-partum nurse.

Phase 1-Early Learner

In the brief introduction of this phase, it was identified that you are still early on in your BSN program if you are a phase 1 learner. Or, depending on your program structure, if you have had few clinical exposures, you might find yourself here as well.

In this phase, you are very focused on doing things, like skills or personal care. Further, you are highly focused on ensuring you are practicing and doing things the 'right way'. At this stage, you can typically collect measurable parameters like intake and output; weight; vital signs; and other objective measures. You also can follow step-by-step instructions but can only focus on a single task with appropriate time allotted to it. Within the clinical setting, you require close and consistent clinical supervision. Your clinical judgment is likely not there yet; therefore, you can't always anticipate changes or connect the theory you have learned in unpredictable situations. It can be very difficult for you to focus on multiple tasks at this stage and that's okay because you are simply trying to learn the tasks!

In this phase, your learning can be supported by very clear expectations, consistent routines, safe spaces to ask what seem like 'basic questions', clearly stating what you can/can't do, and direct supervision. At this phase, there is SO MUCH learning and doing. So, if you have a clinical placement in post-partum and/or are an ESN here but have not yet completed your postpartum rotation, where should you start with respect to your skills? Let's take a look at this guideline!

Domain	Skill/ Task
Establishes and maintains effective relationships with patient, families and care team	Identify potential unique needs of patients and families
Ensures comprehensive communication and documentation of care	Focus charting
	Using the computer apps to seek resources and data
	Ensures that relevant client care information is captured timely and effectively
	Receive and give nursing report

Organizes, plans and coordinates care effectively	Collect data from the chart, handoff tool/ nursing shift summary, results review and other records/ sources to plan care
	Communicates completion/ results of delegated tasks
Provides timely and effective teaching with patient and families	Access teaching resources such as Perinatal Services BC *Note, create an account to access resources
Maternal postpartum assessment and newborn care	Height and weight of newborn
	Ensure and assist where needed that self-hygiene has been performed
	Physical preparation of parent for various diagnostic tests and appointments ex. , changing the patient into fresh gown, ensuring privacy, warmth and comfort with blanket
	Performs newborn bath
Provides safe nursing care to parents, newborns, and families	Environmental safety assessments
	Promotion of culture of safety
	Universal precautions, infection control, isolation, hazardous drug precautions
	Emergency simulation ex. Mock Code blue/pink/neo-resus
	Performs and documents falls risk assessment (maternal and newborn)
Provides safe sleep assessment and teaching	
Pain assessment and management	Use nonpharmacological measures (distraction, relaxation)
Parenteral and Infusion therapy	IV system set-up to pump, priming, preparing basic lines *no high-risk infusions
	Site-to-source basic IV assessment (Simple IV setup with no high-risk infusions)
	Assess IV site
Respiratory Care	Apply probe for pulse oximetry to adult and newborn
Cardiovascular Care	Place pt on Phillips cardiac leads and pulse oximeter
Neurological Care	Seizure protocol and safety measures
GI/GU Care	Supports parents to record newborn feeds and/or supplementation, and output
	Urine collection via clean catch and via catheter
	Foley bag emptying and measuring
	Removes foley catheters
	Foley/straight catheter insertion and +/- sample collection
Musculoskeletal Care	Basic positioning and mobility support noting differences between types of deliveries (spontaneous vaginal delivery, assisted, surgical) and unmedicated, epidural, spinal and general anesthetic
Endocrine/ Metabolic Care	Glucometer quality assurance checks
Integumentary	ARO swabs
Mental Health Care	Supportive behavior (distraction, sitting with a patient)
	Escalate care based on safety plan (call RN, Staff Assist, Code White/Yellow)
	Practice trauma and violence informed principles in care
Provides Family Centered Care	Involve and partner with the family in plan of care
	Advocate for patient and family
	Identify resources for family support
Documentation	Document all care practices for patient in Cerner

PRO TIP: Look for these skills, and the other phases skills, in the clinical setting you are currently practicing at. Even if it is not in postpartum or perinatal, you can still gain extra exposure and practice! That can make it less daunting when doing it in a specialty area with a specialty population

Although you might not have had your perinatal clinical placement, ESN placement or preceptorship, here are some things you can begin with. The following activities will help you accomplish some of these skills and tasks wherever you are in practice to better prepare you as an early perinatal nurse learner!

1. Looking at the skills above, navigate to [SHOP](#), and in the space below, create your own library of resources. Think about the things you commonly do, or some things you want to challenge yourself with! Keep this library handy for when you are in the practice setting and continue to build it as you gain more exposure in the clinical setting! Consider reviewing with a peer, mentor, or educator for feedback! and in the space below, create your own library of resources. Think about the things you commonly do, or some things you want to challenge yourself with! Keep this library handy for when you are in the practice setting and continue to build it as you gain more exposure in the clinical setting! Consider reviewing with a peer, mentor, or educator for feedback!

2. You are working with an RN to collaboratively care for Maria. Maria is a 27-year-old woman who had her baby 12 hours ago. Maria delivered vaginally at 39+2 and is accompanied in the room by her partner, Scott. The dyad is doing well, and you are going in for your first morning assessment. When you walk in the room, you see Scott asleep on the parent cot, Maria asleep in the patient bed, and the babe asleep, cuddled up in mom’s blankets with her, supported by a couple of pillows.
 - a. Navigate to [SHOP](#) and find resources on safe sleep. What are some safety concerns you can identify in this scenario??

 - b. What actions should be taken? In what priority should you complete these actions?

 - c. When you provide education, Maria states that she is so tired at the end of her breastfeeding sessions and can’t help but fall asleep. This is her first baby, and she doesn’t know what else to do to prevent falling asleep but wants her baby to be sleeping in a safe place. What are some strategies you can offer her to help her with this goal?

3. You are working with an RN to collaboratively care for Yuki, a 32-year-old who vaginally delivered her baby 13 hours ago. She delivered at 37+6 and is the only one present in the room, aside from her baby. The report you received is that her and babe are doing well and are preparing for discharge this morning. When you enter the room, you notice baby is crying in the bassinet and Yuki is in the bathroom. When she returns to the bedside, you notice that Yuki appears exhausted and overwhelmed. She quickly grabs the baby and attempts to soothe babe by rocking, 'shh-shh'-ing. When that is unsuccessful, she hastily attempts to place babe on the breast. After only a few seconds of trying, she becomes tearful and states, "He was up all night. I haven't slept and I have no one here to help me. My husband works long hours and cannot be here right now because we didn't expect him to come this soon. I really want to breastfeed but I don't have enough milk and I just can't right now. Can you take him and feed him some formula for me so I can have a moment to calm down?"
- a. Review [Communication Tools in Escalation of Care](#) on SHOP. Practice using SBAR to communicate your immediate concerns to the RN you are collaborating with.
 - b. The nurse directs you to review [Informed Infant Feeding Decisions: Guidance for Healthcare Providers](#) on SHOP and [Informed Decision Making: Having Meaningful Conversations Regarding Infant Feeding](#). You decide to calm the baby down and re-explore Yuki's feeding plan. What are some phrases and/or approaches you plan to use during the conversation?
 - c. Within the first 24 hours, what are some important teaching topics to support a parent on their breastfeeding journey and put some of their concerns to ease?
 - d. After the conversation, Yuki is open to support with breastfeeding. What are some other supports that might be helpful to offer Yuki to navigate some of her other feelings and voiced concerns?

Phase 2-Developing/ Intermediate Learner

In phase 2, you are now a bit further along in your program- and so is your thinking and skill development! At this stage, you will begin to recognize patterns and find meaning in your previous clinical experiences. You recognize that there are still a lot of new concepts, especially in the various practice settings you have interacted with. You are learning to prioritize but still need support to do so. You might also notice that you can manage the organization of one to three routine care tasks like activities of daily living, vital signs, and more. Even though you are becoming more competent each day, you still need support in decision making and clinical supervision with most things, especially when it comes to independently prioritizing tasks and handling unexpected outcomes or changes.

At this phase, it helps when you are provided with direct clinical support for new or unexpected situations. Reflection and discussion on how to apply current situations to future experiences is very beneficial for phase 2 learners. Additionally, continued shared decision-making with your clinical supervisor/preceptor is important. For phase 2 learners, some things might feel familiar and solid, while others do not, in addition to the different contexts to consider the application of a previously learned skill. Phase 2 learners at BCW have typically had their clinical placement in postpartum thus far. Therefore, if you are a new ESN that has completed your postpartum placement, you might find this is where you fit best. For phase 2 learners, where you sit really depends on your previous experience; therefore, it is encouraged to look at the phase 1 skills first, to ensure you have accomplished those before transitioning to this phase. Let's take a look below at what we might expect for a phase 2 learner.

Domain	Skill/ Task
Establishes and maintains effective relationships with patient, families and care team	Advocates for unique needs of patient, parent(s), newborns, and families
Ensures comprehensive communication and documentation	Create and individualize care plans, documents in Powerchart
	Uses Cerner and teaching flowsheets to communicate and document care Communicates finding with supervising RN with SBAR
Provides timely and effective teaching with parents, patient, and families	Simple teaching with patients and families (oral medication listed under competency VII, postpartum self-care, newborn care, breastfeeding teaching, discharge instructions)
	Reinforcing teaching
	Documentation of teaching
Organizes, plans, and coordinates care effectively	Uses a worksheet to plan delegated care
Maternal postpartum assessment and newborn care	Individual systems assessment
	Vital sign measurement
	Calculates baby weight loss
	Admits mother and baby together in room with primary nurse following the Perinatal BC Maternal and Newborn Pathway
	Assesses newborns for signs of mild jaundice not requiring phototherapy (skin color, lethargy, poor feeding, and low outputs)
Provides safe nursing care to parents, newborns, and families	Bedside safety checks, unit checklist
	Emergency situations- CPR, Code Pink/ Blue and Neonatal Resuscitation appropriate roles

- c. Review resources on SHOP and elsewhere. Utilizing the resources, create a teaching plan to address the identified concerns.
 - i. HINT: Review the [Breastfeeding Your Baby](#) webpage on BCW Website, in addition to all the other resources available on HealthLink BC, Baby's Best Chance, perinatal services, and more!

d. What resources can you provide to Yuki to support her during this time?

2. Below, calculate the weight loss percentages. Additionally, state if this is appropriate, or concerning.

a. Newborn weight of 3.6kg at birth; at 48 hours, weight is 3.4 kg.

b. Newborn weight of 3.2 kg at birth; at discharge, weight is 3.0 kg.

c. Newborn weight of 3.8 at birth; on day 3, weight is 3.3 kg.

d. Newborn weight of 3.4 kg at birth; at 36 hours, weight is 3.2 kg.

- e. Newborn weight of 4.0 kg at birth; at 48 hours, weight is 3.5 kg.

 - f. If a baby loses too much weight (>10%), what are some things you might want to consider assessing and/or thinking about?
3. You are assisting a nurse caring for Tarandeep who delivered SVD at 38+6 and is now 30 hours post-delivery. You are assigned to assess the newborn.
- a. In addition to the physical assessment, what other information do you want to know about the newborn?

 - b. You decide to ask about feeding. Tarandeep responds, “This little one is not like any of my others. She loves to sleep! It is so cute- sometimes, I can barely wake her up to feed because she is just cuddled up, so peaceful, enjoying her rest!” When you hear this report, do you have any concerns? If so, what are they? If not, why not?

 - c. Upon assessment of the intake and output form, you notice that this baby is feeding every 4-4.5 hours. They have only had one documented wet diaper in the last 24 hours. You confirm with Tarandeep that this is correct. With all this information, what might you be worried about this baby developing?

- a. With one of the current concerns being the potential for newborn jaundice, what teaching elements are priorities to review with Tarandeep to support this baby?

Phase 3- Senior/ Consolidating Learner

In phase 3, you might start to feel like things are finally starting to come together! You can organize patient care tasks and manage some simple changes to the routine or patient condition. You can apply previously learned patterns to different situations that you might encounter because now, you have likely had a good range of experiences. When you know what care tasks need to be done, you can plan your care accordingly and begin to prioritize changing or complex patient care demands, with support and guidance from your clinical supervisor/preceptor. There are likely some routine skills that you feel confident in doing independently but will need supportive clinical supervision to run through your plan, review, and reflect on how it went. At this stage, depending on the clinical setting, you are likely taking a partial patient assignment with support and coaching, and are becoming increasingly aware of time management needs and competing priorities.

At phase 3, you are just starting to explore and practice independent prioritization, therefore you still need support to do so with new, unexpected or complex situations. At this stage, your support may vary from constant support, in the case of a quickly decompensating clinical situation; coaching and shared decision-making, as in the case of competing priorities; or some independence, as in the case for routine patient care and skills. As in any phase, it is important that you communicate exactly what type of support you need in the various situations you may encounter. BCW learners at this phase are likely those who have been an ESN for an extended time and/or are new preceptors. Before looking at mastering these skills, take a look at the previous phases to ensure this is where you best fit!

Domain	Skill/ Task
Provides timely and effective teaching with women/ families	Follow-up and review teaching strategies
	Completes postpartum liaison forms, sections 1&2 (birth summary), 3 (lifestyle) for basic discharges (no complex cases)
	Completes newborn liaison forms, sections 1&2 (birth summary)
Maternal postpartum assessment and newborn care	Comprehensive assessment (head-to-toe, systems), newborn and maternal
	Assessment of evolving jaundice requiring interventions alongside RN (monitoring feeds q3H, output, weight)
	Setting up phototherapy when baby in a crib or Joey bed
	Routine vital sign checks when baby is under phototherapy

	Discharges uncomplicated mother and baby (no variances) after confirmation with primary nurse. Primary nurse to check documentation
Provides safe nursing care to parents, newborns, and families	Emergency situations- CPR coach, runner, clear equipment
Pain assessment and management	Performs respiratory and sedation checks, mobility checks on post-operative c-section patient (Pasero, post-op VS, sensory and motor block) *interpretation always with an RN
	Post-operative vitals *interpretation must always be with RN
	Give out self-medications (initiate and restock)
Parenteral and Intravenous Infusion therapy	With RN direct supervision, connect PIV to newborn, change IV bags (with no medication), saline lock with order, and discontinue IV. *Can perform independently after consulting with RN for parent
Respiratory Care	Administration of low flow O2 or weaning of O2 with direction from RN
	Plan and implement care with RN of patients with actual or potential respiratory alteration
Cardiovascular care	Plan and implement care with RN for patients with actual or potential cardiac alterations
Neurological Care	Plan and implement care with RN for patients with actual or potential neurological alterations
Hematological	Monitor vital signs for blood products after first 15 minutes on hemodynamically stable patient that has not shown signs of transfusion reaction
GI/GU care	Plan and implement care with RN for patients with actual or potential GI alterations
	Cup feeding/ syringe feeding
Musculoskeletal care	Plan and implement care with RN for patients with actual or musculoskeletal alterations
Endocrine/ Metabolic Care	Plan and implement care with RN for patients with actual or potential metabolic or endocrine alterations
Integumentary Care	Plan and implement care with RN for patients with actual or potential integumentary alterations
	Teaching wound care to be performed at home
	Removes staples

1. Let's jump back into Tarandeep and her baby's clinical scenario!
 - a. Complete hyperbili activity: Baby girl was born on March 15 at 2000 at 38+6 weeks. A routine bilirubin test is scheduled for March 17 at 0600 (34 hours of age). Tarandeep's blood type is O+, and the infant has no known neurotoxicity risk factors. The Total Serum Bilirubin (TSB) result returns at 189 $\mu\text{mol/L}$. Use Hyperbili.com to enter the infant's information and determine the ΔTSB . Based on the results, what would your next nursing action be?

 - b. Use SBAR to communicate your findings to the primary RN and the MRP.

- c. With the increased concern of newborn jaundice, the primary RN and you prepare to initiate phototherapy. Review [Hyperbilirubinemia: Phototherapy](#) and [Hyperbilirubinemia: Phototherapy: Equipment](#) on SHOP.

 - d. How do you decide if the infant requires an incubator or Joey bed?

 - e. What are the key newborn assessments required when a patient is receiving phototherapy?

 - f. PRACTICE TIP: Next time you are in the clinical setting, go find the equipment required to set up the different variations of phototherapy. Even better, volunteer to support this set up if it comes up with your, or other patients on the floor.
2. You are working with an RN caring for Stacey who delivered via C-section 9 hours ago at 40+3. Review the [Perinatal Services BC Obstetric Guideline 20 Postpartum Nursing Care Pathway](#) and [Post-Cesarean Delivery Pain Management at BC Women's Hospital](#) on SHOP.
- a. What are some of the additional assessments required for a C-section patient?

- b. You go into Stacey's room to complete an assessment. When asked how she is doing, she reports, "Honestly, I am a bit uncomfortable but I really don't like taking medications. I am pretty sure I need to take these oral medications for 2 days, but after that, I don't think I will want to take anything!" What are some important teaching points that should be reviewed with Stacey for optimal post-section recovery?

- c. Stacey wants to get out of bed to eat her lunch. Review the [Postpartum Mobility Assessments Following Regional Anesthesia](#) and [Labour Neuraxial Analgesia: Care Assessments in Labour and Postpartum](#) on SHOP to answer the following questions:
 - i. Stacey's block is still present at L1. When will her next ice check be? When can you stop performing the sensory level testing?

 - ii. Stacey scored 1 on the OB Lower Motor Assessment. How often do you need to continue this assessment?

 - iii. What is RAMA? What information should you know about this assessment?

Phase 4- Final Practicum/ Transition-To-Practice Learner

It is time for the last phase, phase 4- you are so close to the finish line. Students in this phase are in their preceptorship and are preparing for graduation. If you have made it this far in the booklet, you likely find yourself very focused on the post-partum specialty and becoming competent in this area. Your focus is beginning to shift from a focus on attaining physical skills to focusing on what you will need to be successful

as a new graduate nurse. At this stage, you are beginning to not only recognize patterns, but anticipate various situations based on previous experiences. You likely notice your ability to start modifying plans to address the changes in practice and some independent decision making for concepts that are repeated in practice.

It is not uncommon and is quite okay and expected to still require support, coaching, and validation for decision making and responding to changes; hence why you should never be expected to oversee the patient care independently and will still work closely with a preceptor. You may find yourself proud to advance caring for 2+ stable dyads, but you still might need closer support to manage multiple complex patients. At this stage, your learning is best supported by coach-like support or at the elbow support where you have some freedom to explore but also a preceptor right there to continue guiding and overseeing your practice. You also really benefit from learning from fewer preceptors (ideally, limited to only one or two key preceptors) to further consolidate your knowledge. As mentioned, if you made it here with your skill progression, you are likely a preceptor. Like always, it will be important to ensure you have acquired the previous skills and knowledge touched in phases 1-3 to continue building a solid post-partum nurse foundation.

Domain	Skill/ Task
Provides timely and effective teaching with parents and families	Medication teaching
	Complex teaching
	Discharge teaching to mothers/parents and babies with identified variances with support
	Liaison forms for mother/parent and/or babies with complex histories and/or babies with complex histories with support
Provides safe nursing care to parents, newborns, and families	Medication administration
	Medication dose and dilution calculation
	Emergency situations- family support
Pain assessment and management	Pharmacological measures
	Opioid side effect management
Parenteral and Intravenous Infusion therapy	Administer IV medications
	Administer high concentration products
Respiratory Care	Evaluate plan of patients with actual or potential respiratory alteration
Cardiovascular care	Evaluate plan of patients with actual or potential cardiac alteration or hypertension
Neurological Care	Evaluate plan of patients with actual or potential neurological alteration
GI/GU care	Evaluate plan of care for patients with actual or potential GI alterations
	Evaluate plan of care for patients with actual or potential GU alterations
Musculoskeletal Care	Evaluate plan of care for patients with actual or potential musculoskeletal alterations
Endocrine/ Metabolic Care	Insulin administration

	Evaluate plan of care for patients with actual or potential endocrine/ metabolic alterations
	Hyper/hypoglycemia management
	Glucometer checks on baby
Integumentary	Evaluate plan of care for patients with actual or potential integumentary alterations
	Drain removal- assists team and supports patient

1. Let's jump back into Stacey's case. She is still admitted and is now 55 hours post-c-section. Her epidural has been off for some time now, and she is beginning to think about discharge. You walk in to complete her assessment and notice she is wincing while moving in bed. You ask her how things are going for her and baby, and she states: "I have been up to the bathroom. I am a bit uncomfortable, but I really don't want to take any other medication- the epidural was already outside my comfort. If I could do it over again, I would have wanted to do everything completely natural. Baby is doing good! I am not sure how much milk they are getting because they are so sleepy, but it seems like they are doing fine and just finished feeding about 45 minutes ago." As she says this, you notice her wincing in bed and bracing herself as she moves.
 - a. Review the post-operative orders for pain management below. Using SBAR, what would you communicate to the RN you are working with to care for Stacey?

OB Postpartum Cesarean Section (Multiphase), Pain and Symptom Management (Planned)
 Last updated on: 15-Dec-2021 23:39 PST by: TestMAT, OBGYN-Physician, MD
 Alerts last checked on 15-Dec-2021 23:38 PST by: TestMAT, OBGYN-Physician, MD

Admit/Transfer/Discharge
 Do not initiate this PowerPlan if Acute Pain Service (APS), Perioperative Pain Service (POPS) or Anesthesiology is following this patient

Medications

Other Medications

Self Medication Program

<input checked="" type="checkbox"/>	acetaminophen	650 mg, PO, q4h, PRN pain, drug form: tab Self Medication Program - keep medications at bedside for patient to self-administer. Maximum acetaminophen 4 g/24 h fro...
<input checked="" type="checkbox"/>	ibuprofen	400 mg, PO, q4h, PRN pain, drug form: tab Self Medication Program - keep medications at bedside for patient to self-administer. Maximum 2.4 g/24 h. To start 8 hours ...
<input checked="" type="checkbox"/>	docusate	200 mg, PO, qHS, PRN constipation, drug form: cap Self Medication Program - keep medications at bedside for patient to self-administer. For prevention of constipation.
<input checked="" type="checkbox"/>	hydrocortisone-zinc sulfate topical (ANUSOL HC EQUIV 0.5% oint)	1 application, topical, BID, PRN other (see comment), drug form: oint Self Medication Program - keep medications at bedside for patient to self-administer. PRN Reason: for hemorrhoids and also...

Select if not ordered for Self Medication

<input type="checkbox"/>	acetaminophen	650 mg, PO, q4h, PRN pain, drug form: tab Maximum acetaminophen 4 g/24 h from all sources
<input type="checkbox"/>	acetaminophen	975 mg, rectal, q6h, PRN pain, drug form: supp Maximum acetaminophen 4 g/24 h from all sources
<input type="checkbox"/>	docusate	200 mg, PO, qHS, PRN constipation, drug form: cap For prevention of constipation
<input type="checkbox"/>	hydrocortisone-zinc sulfate topical (ANUSOL HC EQUIV 0.5% oint)	1 application, topical, BID, PRN other (see comment), drug form: oint PRN Reason: for hemorrhoids and also apply after each bowel movement

Analgesics

<input checked="" type="checkbox"/>	HYDROMORPHONE (HYDROMORPHONE PRN range dose)	dose range: 1 to 2 mg, PO, q3h, PRN pain, drug form: tab Start with 1 mg dose and reassess in 60 minutes; may give second 1 mg dose if pain not improving. DILAUDID EQUIV
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- b. In discussing with the RN and Stacey to manage the post-operative pain, you decide to administer hydromorphone. After administration, Stacey asks: "Oh wait! I shouldn't have taken that. Now that I have taken that, can I still breastfeed? Oh my goodness- I can't believe

Additionally, you may want to explore these other resources on your own:

1. Perinatal Specific Resources:

- a. [Baby's Best Chance: Parents' Handbook of Pregnancy and Baby Care | HealthLink BC](#)
- b. [Perinatal Services BC](#)
- c. [Perinatal & Newborn Health Hub](#)
- d. [Pregnancy & Parent Learning Centre](#)
- e. BCIT [Perinatal Nursing Theory 1 – Healthy Childbearing Experiences & The Newborn](#)
- f. BCIT [Perinatal Nursing Specialty \(Standard Option\), Post Diploma Advanced Certificate](#)

2. Transition to Practice Resources: Transitioning from school to RN is a big transition. It can bring up a lot of emotions, some that we may not even anticipate or expect! If you have made it this far in the learning passport, your next steps are to help prepare yourself by understanding what you might experience, what supports are available to you, and more. As you work through some of this material, start to brainstorm what supports and structures you will need in place to be most successful as a new graduate, especially in a specialty area!

- a. [Nursing the Future](#)
- b. [New Grad Nursing Program](#)

3. Prepare to Meet Unit Leaders: Throughout your preceptorship, you might have the opportunity to have a meet and greet with unit leaders to explore the opportunity to work there as a new graduate. Here are some ways you can help prepare for a formal conversation:

- a. Reflect on the experiences you have had as an undergraduate student. These can be moments from clinical, preceptorship, employment opportunities, or other. Reflect on specific instances when you may have faced a challenge, experienced conflict, were successful, and other types of experiences. When reflecting, think about how you would communicate your role in these experiences.
- b. Reflect on your personal values and beliefs. Identify what you might bring to the team, work environment, patient and family dynamic, and more. Reflect on how those values and beliefs impact your care and decision to be a nurse.
- c. Reflect on the area of practice you are interested in. Explore why you are excited and what you could bring to this area that might be unique!
- d. Reflect on your dreams- what are some things you hope to accomplish as a new nurse or as you gain more experience?
- e. Reflect on your role in promoting cultural safety and humility. Explore how you integrate that into your practice.
- f. Finally, reflect on what questions you might have about the unit, health authority, or the leaders!



Appendix A- Skills Validation

Skills validations are exactly what the name says- having your skills validated by a registered nurse, or other competent professional. Before completing any of these skills in the practice setting, all students must have had the previous foundational knowledge and learning in your BSN program. **If your school has not covered the material, you cannot perform it in the clinical setting**, even though it might seem super simple!

Checking your skills in a specialty area provides you the opportunity to ask questions, use the right approach, to feel confident, and practice safely. Something like an IV assessment might seem simple, but it takes a variety of intangible skills and a tailored approach to be successful. We want you to be successful and therefore, skills validations can help you do that!

With any new skill, we recommend getting it assessed three times before you consider practicing it with a different level of support or supervision. If you have demonstrated it well three times but still want extra support, that is completely fine. We want you to feel confident and safe in your practice. Consider spacing out the validation over a couple of shifts to ensure retention of the skill and the opportunity to assess different patients.

You might also notice that not every skill we reviewed above is highlighted in the skills validations. Some of the skills listed above are quite unique to certain practice areas; therefore, only commonly practiced skills among all areas are listed below. The same process can be followed for skills not listed; however, it requires a bit of work on your end to find the appropriate documents and understand what knowledge you should have. Review it with your preceptor or whoever is supervising you for the day to help guide you!

Finally, DO NOT forget about the ‘invisible’ skills like communication, tailored approach, developmental considerations, and others that are practiced in the postpartum setting. Focusing on these invisible skills can make the psychomotor skills much easier to accomplish and are just as important in our perinatal nursing practice.

Phase 1 Skills Validation

Learning Assessment & Activities	Clinical Skill: Newborn Height and Weight	Demonstrated well X3			Needs learning & Practice
<p>Learner assessment of readiness:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous foundational education on height and weight measurement <p>Learning Activities:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Review Routine Care for the Newborn on Postpartum on SHOP 	<p>Knowledge:</p> <ul style="list-style-type: none"> – Describes the rationale for maintaining accurate height and weight measurements – Articulates the frequency for height and weight measurements <p>Skill:</p> <ul style="list-style-type: none"> – Performs height and weight 				
Learning Assessment & Activities	Clinical Skill: IV System Set-up to pump, priming, preparing basic lines	Demonstrated well X3			Needs learning & Practice
<p>Learner assessment of readiness:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous foundational education on IV set up <p>Learning Activities:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Complete Course 2007 PHSA – CW – Alaris Pump Online Training on LearningHub <input type="checkbox"/> Review Intravenous Therapy: Priming and Changing a Solution on Elsevier 	<p>Knowledge:</p> <ul style="list-style-type: none"> – Describes the rationale for patient requiring intravenous access – Demonstrates an understanding of why patient requires this infusion – Describes the differences in preparation for peripheral IV lines and central IV lines, clean technique vs sterile technique. – Articulates the steps for IV line set up and priming workflow <p>Skill:</p> <ul style="list-style-type: none"> – Performs IV set up, priming and setting up lines 				
Learning Assessment & Activities	Clinical Skill: Site-to-Source Basic IV Assessment	Demonstrated well X3			Needs learning & Practice
<p>Learner assessment of readiness:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous foundational education on IV assessment <p>Learning Activities:</p>	<p>Knowledge:</p> <ul style="list-style-type: none"> – Describes the rationale for patient requiring site-to-source checks – Describes the differences in a patent IV versus an infiltrated IV 				

<input type="checkbox"/> Review Intravenous Therapy: Extravasation Management on Elsevier	<ul style="list-style-type: none"> – Articulates the steps for site-to-source check and TLC Skill: <ul style="list-style-type: none"> – Performs PIV site-to-source check 				
Learning Assessment & Activities	Clinical Skill: Provides Safe Sleep Assessment and Teaching	Demonstrated well X3			Needs learning & Practice
Learner assessment of readiness: <ul style="list-style-type: none"> <input type="checkbox"/> Previous foundational education on teaching and safe sleep Learning Activities: <ul style="list-style-type: none"> <input type="checkbox"/> Review Safe Sleep and Falls Prevention: Inpatients on SHOP <input type="checkbox"/> Review Safe Sleep and Falls Prevention Care Plan on SHOP <input type="checkbox"/> Review Safe Sleep for Infants on SHOP <input type="checkbox"/> Review Safe Sleep for Your Baby on SHOP <input type="checkbox"/> Review Teaching About Safe Sleep Practices (Neonatal) on Elsevier 	Knowledge: <ul style="list-style-type: none"> – Describes a safe sleep environment – Describes safe sleep interventions and prevention – Identifies what resources are available to support the education of patients and families regarding safe sleep Skill: <ul style="list-style-type: none"> – Assesses if the environment is safe for sleep – Performs safe sleep teaching 				
Learning Assessment & Activities	Clinical Skill: Glucometer Quality Assurance Checks	Demonstrated well X3			Needs learning & Practice
Learner assessment of readiness: <ul style="list-style-type: none"> <input type="checkbox"/> Previous foundational education on glucometer QC checks Learning Activities: <ul style="list-style-type: none"> <input type="checkbox"/> Complete Course 22130 on LearningHub <input type="checkbox"/> <i>Optional:</i> Review Performing a QC Test on the Nova StatStrip Glucometer on SHOP 	Knowledge: <ul style="list-style-type: none"> – Describes the importance of completing a glucometer QC check – Identifies the frequency of glucometer QC checks Skill: <ul style="list-style-type: none"> – Demonstrates glucometer QC check 				

Learning Assessment & Activities	Clinical Skill: ARO Swabs	Demonstrated well X3			Needs learning & Practice
<p>Learner assessment of readiness:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous foundational education on specimen collection: swabs <p>Learning Activities:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Review Antibiotic-Resistant Organisms (ARO) Admission Screening on SHOP Review Throat Specimen Collection on Elsevier 	<p>Knowledge:</p> <ul style="list-style-type: none"> – Identifies appropriate swab sites – Describes when a patient requires ARO swabbing – Identifies infection precautions required during lab wait period <p>Skill:</p> <p>Demonstrates correct swabbing technique</p>				
Learning Assessment & Activities	Clinical Skill: Urinary Catheter Insertion and Removal	Demonstrated well X3			
<p>Learner assessment of readiness:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous foundational education on urinary catheterization <p>Learning Activities:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Review Urinary Retention Flow Diagram on SHOP <input type="checkbox"/> Review Bladder Scan on Elsevier <input type="checkbox"/> Review Urinary Catheter: Straight Insertion (Female) on Elsevier <input type="checkbox"/> Review Urinary Catheter: Indwelling Insertion (Female) on Elsevier 	<p>Knowledge:</p> <ul style="list-style-type: none"> – Describes the difference between a straight and indwelling catheter insertion – Describes the rationale for obtaining a bladder scan – Identifies the indication for both a straight and indwelling catheter insertion – Identifies the indication for catheter removal <p>Skill:</p> <ul style="list-style-type: none"> – Performs a bladder scan – Performs straight catheter insertion – Performs indwelling catheter insertion – Performs catheter removal 				

Phase 2 Skills Validation

Learning Assessment & Activities	Clinical Skill: Vital Sign Assessment	Demonstrated well X3			Needs learning & Practice
Learner assessment of readiness:	Knowledge:				

<input type="checkbox"/> Previous foundational education on vital sign assessment Learning Activities: <input type="checkbox"/> Review Routine Care for the Newborn on Postpartum on SHOP <input type="checkbox"/> Review Perinatal Services BC Newborn Guideline 13 Newborn Nursing Care Pathway on Perinatal Services BC <input type="checkbox"/> Review Perinatal Services BC Obstetrics Guideline 20 Postpartum Nursing Care Pathway on Perinatal Services BC <input type="checkbox"/> Review Pulse Oximetry and Pulse Oximetry (Neonatal) on Elsevier <input type="checkbox"/> Review Blood Pressure: Upper Extremity and Blood Pressure Measurement (Pediatric) on Elsevier <input type="checkbox"/> Review Counting a Respiratory Rate and Assessment: Respirations (Pediatric) on Elsevier <input type="checkbox"/> Review Apical Pulse and Apical Pulse (pediatric) on Elsevier	<ul style="list-style-type: none"> - Describes the appropriate technique to obtain each vital sign - Identifies the appropriate sites to obtain each vital sign - Describes the frequency of vital sign measurement Skill: <ul style="list-style-type: none"> - Selects appropriate equipment size to obtain each vital sign - Demonstrates vital sign measurement - Documents vital sign measurement - Calculates final PEWs score 				
Learning Assessment & Activities	Clinical Skill: Discontinuing a PIV			Demonstrated well X3	Needs learning & Practice
Learner assessment of readiness: <input type="checkbox"/> Previous foundational education of peripheral IV's Learning Activities <input type="checkbox"/> Review Intravenous Therapy: Discontinuation on Elsevier	Knowledge: <ul style="list-style-type: none"> - Describes when an IV can be discontinued Skill: <ul style="list-style-type: none"> - Demonstrates discontinuing a PIV 				
Learning Assessment & Activities	Clinical Skill: Assess Newborn Tone and Reflexes			Demonstrated well X3	Needs learning & Practice

<p>Learner assessment of readiness:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous foundational education of newborn tone and reflexes <p>Learning Activities:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Review Routine Care for the Newborn on Postpartum on SHOP <input type="checkbox"/> Review Perinatal Services BC Newborn Guideline 13 Newborn Nursing Care Pathway on Perinatal Services BC <input type="checkbox"/> Review Assessment: Head to Toe: Newly Born (Maternal-Newborn) on Elsevier 	<p>Knowledge:</p> <ul style="list-style-type: none"> - Identifies what newborn reflexes require an assessment - Describes the appropriate technique for assessing each reflex - Describes the expected reflex responses - Describes the expected muscle tone <p>Skill:</p> <ul style="list-style-type: none"> - Performs a newborn tone assessment - Performs newborn reflex assessments 				
<p>Learning Assessment & Activities</p>	<p>Clinical Skill: Feeding and Breastfeeding Support</p>			<p>Demonstrated well X3</p>	<p>Needs learning & Practice</p>
<p>Learner assessment of readiness:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous foundational education on feeding and breastfeeding <p>Learning Activities</p> <ul style="list-style-type: none"> <input type="checkbox"/> Review Bottle-Feeding on HealthLink BC <input type="checkbox"/> Review Burping a Baby on HealthLink BC <input type="checkbox"/> Review Spitting Up on HealthLink BC <input type="checkbox"/> Review Breastfeeding on HealthLink BC <input type="checkbox"/> Review Latching on HealthLink BC <input type="checkbox"/> Review Breastfeeding Positions on HealthLink BC <input type="checkbox"/> Review Signs That Your Baby is Getting Enough Breast Milk on HealthLink BC <input type="checkbox"/> Review Preventing Choking in Babies and Young Children: For Child Care Providers on HealthLink BC <input type="checkbox"/> Review BC Women's Breastfeeding Your Baby page 	<p>Knowledge:</p> <ul style="list-style-type: none"> - Describes the principles of safely bottle-feeding an infant - Describes the principles of safely feeding infants and children - Explains how to support a breastfeeding parent - Explains the importance of burping a baby <p>Skill:</p> <ul style="list-style-type: none"> - Demonstrates feeding an infant with a bottle - Demonstrates supporting a breastfeeding parent 				

Phase 3 Skills Validation

Learning Assessment & Activities	Clinical Skill: Set up Phototherapy	Demonstrated well X3			Needs learning & Practice
<p>Learner assessment of readiness:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous foundational education on Phototherapy <p>Learning Activities:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Review Hyperbilirubinebia: Phototherapy on SHOP <input type="checkbox"/> Review Hyperbilirubinemia: Phototherapy: Equipment on SHOP <input type="checkbox"/> Review Joey Bed Warmer on SHOP 	<p>Knowledge:</p> <ul style="list-style-type: none"> – Describe the indications for phototherapy – Identify the various levels of irradiance orders – Explains the difference in equipment use and function – Describes the various assessments required to care for a newborn receiving phototherapy – Explains how to incorporate family into the care of a newborn receiving phototherapy (skin-to-skin, comfort, feeding, etc...) <p>Skill:</p> <ul style="list-style-type: none"> - Performs set up of phototherapy 				
Learning Assessment & Activities	Clinical Skill: Performs respiratory, sedation, and mobility checks on post-operative c-section patient	Demonstrated well X3			Needs learning & Practice
<p>Learner assessment of readiness:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous foundational education on sedation monitoring <p>Learning Activities:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Review Post-Cesarean Delivery Pain Management at BC Women’s Hospital on SHOP <input type="checkbox"/> Review Postpartum Mobility Assessments Following Regional Anesthesia on SHOP <input type="checkbox"/> Review CST orders 	<p>Knowledge:</p> <ul style="list-style-type: none"> – Describes the rationale for respiratory, sedation and mobility checks – Explains the signs of deterioration for a patient receiving sedation – Describes the escalation steps of calling for help when confronted with signs of deterioration for patients receiving sedation <p>Skill:</p> <ul style="list-style-type: none"> – Performs respiratory, sedation, and mobility checks on a post-operative c-section patient 				
Learning Assessment & Activities	Clinical Skill: Give out Self-Medications	Demonstrated well X3			Needs learning & Practice
<p>Learner assessment of readiness:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous foundational knowledge of self-medications <p>Learning Activities:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Review Patient Self-Medication Program (BCWH) on SHOP 	<p>Knowledge:</p> <ul style="list-style-type: none"> – Describes the rationale for providing self-medications in this practice setting – Identifies what is required to teach the patient when administering self-medications <p>Skill:</p>				

<input type="checkbox"/> Review Postpartum Self-Medication Record on SHOP <input type="checkbox"/> Review Aches and pains after giving birth: Self Medication for Managing your pain on SHOP	<ul style="list-style-type: none"> – Performs self-medication administration 				
Learning Assessment & Activities	Clinical Skill: Monitor vital signs for blood products after first 15 minutes on hemodynamically stable patient that has not shown signs of transfusion reaction	Demonstrated well X3			Needs learning & Practice
Learner assessment of readiness: <input type="checkbox"/> Previous foundational knowledge of blood product administration Learning Activities: <input type="checkbox"/> Complete Course 6627: PHSA – BCW – Administration of Blood to Adults on LearningHub <input type="checkbox"/> Review appropriate resources on Transfusion Medicine Manual on ePOPS <input type="checkbox"/> Review Administration of Blood Components Volumetric Method (Red Cells, Platelets, Plasma, & Cryoprecipitate) on SHOP	Knowledge: <ul style="list-style-type: none"> – Describes the frequency of vital sign monitoring for blood products after the first 15 minutes – Describes the signs of a transfusion reaction – Explain the escalation steps of calling for help when signs of a transfusion reaction are present Skill: <ul style="list-style-type: none"> – Performs vital sign monitoring after the first 15 minutes of a blood product administration on a hemodynamically stable patient with no signs of transfusion reaction 				
Learning Assessment & Activities	Clinical Skill: Syringe Feeding	Demonstrated well X3			Needs learning & Practice
Learner assessment of readiness: Learning Activities: <input type="checkbox"/> Review Supplementation of Breast/Chestfeeding Infants on SHOP	Knowledge: <ul style="list-style-type: none"> – Identifies the indications for supplementation of breast/chest feeding – Explains the steps to take before providing supplementation – Describes the rationale for selecting the syringe feeding method Skill <ul style="list-style-type: none"> – Performs syringe feeding 				



Appendix B- Answer Key

Phase 1 Questions:

1. Looking at the skills above, navigate to [SHOP](#), and in the space below, create your own library of resources. Think about the things you commonly do, or some things you want to challenge yourself with! Keep this library handy for when you are in the practice setting and continue to build it as you gain more exposure in the clinical setting! Consider reviewing with a peer, mentor, or educator for feedback! and in the space below, create your own library of resources. Think about the things you commonly do, or some things you want to challenge yourself with! Keep this library handy for when you are in the practice setting and continue to build it as you gain more exposure in the clinical setting! Consider reviewing with a peer, mentor, or educator for feedback!
2. You are working with an RN to collaboratively care for Maria. Maria is a 27-year-old woman who had her baby 12 hours ago. Maria delivered vaginally at 39+2 and is accompanied in the room by her partner, Scott. The dyad is doing well, and you are going in for your first morning assessment. When you walk in the room, you see Scott asleep on the parent cot, Maria asleep in the patient bed, and the babe asleep, cuddled up in mom's blankets with her, supported by a couple of pillows.
 - a. Navigate to [SHOP](#) and find resources on safe sleep. What are some safety concerns you can identify in this scenario?
 - Baby in blankets, mom asleep holding baby, baby surrounded by pillows, no firm surface for baby, bedsharing
 - b. What actions should be taken? In what priority should you complete these actions?
 - Explore what the mom knows about safe sleep
 - Provide education on safe sleep practices
 - Place baby in a safe position/place (bassinet) as the main priority
 - c. When you provide education, Maria states that she is so tired at the end of her breastfeeding sessions and can't help but fall asleep. This is her first baby, and she doesn't know what else to do to prevent falling asleep but wants her baby to be sleeping in a safe place. What are some strategies you can offer her to help her with this goal?
 - Offer options ex. feeding in an upright chair
 - Listen to music or something stimulating while you are breastfeeding
 - Ask a partner or friend or nurse to keep you accountable while feeding
 - Set an alarm for the length of the feed to go off near the end of a feeding session
 - Many more!
3. You are working with an RN to collaboratively care for Yuki, a 32-year-old who vaginally delivered her baby 13 hours ago. She delivered at 37+6 and is the only one present in the room, aside from her baby. The report you received is that her and babe are doing well and discharge this morning. When you enter the room, you notice baby is crying in the bassinet and Yuki is in the bathroom. When she returns to the bedside, you notice that Yuki appears exhausted and overwhelmed. She quickly grabs

the baby and attempts to soothe babe by rocking, 'shh-shh'-ing. When that is unsuccessful, she hastily attempts to place babe on the breast. After only a few seconds of trying, she becomes tearful and states, "He was up all night. I haven't slept and I have no one here to help me. My husband works long hours and cannot be here right now because we didn't expect him to come this soon. I really want to breastfeed but I don't have enough milk and I just can't right now. Can you take him and feed him some formula for me so I can have a moment to calm down?"

- a. Review [Communication Tools in Escalation of Care](#) on SHOP. Practice using SBAR to communicate your immediate concerns to the RN you are collaborating with.
 - S: "Yuki appears to be very exhausted and overwhelmed with feeding"
 - B: "She doesn't have much support and is requesting formula"
 - A: "I think she might need a moment before attempting to support her breastfeeding"
 - R: "I recommend that I calm the baby down, provide her a couple minutes of space, and then explore her feeding concerns"
- b. The nurse directs you to review [Informed Infant Feeding Decisions: Guidance for Healthcare Providers](#) on SHOP and [Informed Decision Making: Having Meaningful Conversations Regarding Infant Feeding](#). You decide to calm the baby down and re-explore Yuki's feeding plan. What are some phrases and/or approaches you plan to use during the conversation?
 - Use open ended questions, listen actively, reflect back, remain unbiased
 - Refer to documents for specific phrases
- c. Within the first 24 hours, what are some important teaching topics to support a parent on their breastfeeding journey and put some of their concerns to ease?
 - No need to supplement within the first 24 hours
 - Reassure family of baby's tummy size (marble) and therefore, supplementation not needed
 - Milk will not come until 3-5 days
 - Encourage hand expression and get EBM for babe
 - Focus on skin-to-skin, bring babe to the breast to offer a feed, a sleepy babe is normal for the first 24 hours
 - -reassure that most babies will be fine without any supplementation in the first 24 hours, but if your baby needs extra milk, we will provide it safely and guide you through it
- d. After the conversation, Yuki is open to support with breastfeeding. What are some other supports that might be helpful to offer Yuki to navigate some of her other feelings and voiced concerns?
 - Lactation consultant
 - Psychology, Reproductive Mental Health
 - Spiritual Health
 - Social Work

Phase 2 Questions:

1. Let's jump back into our scenario from phase one with our patient, Yuki. The next day, you return to care for Yuki and decide to explore her feeding plan. She states: "Every time I go to feed him, it's

almost like I have missed the window and am too late. He is already crying and fussy, and by then, it is too hard to calm him down and focus on breastfeeding. On the odd occasion I catch him in a good moment, it really hurts to breastfeed. I am so worried about him getting enough milk and it all feels so overwhelming- I don't know where to start. It feels like I can never get it right."

d. How might you choose to respond to Yuki?

- Acknowledge Yuki's concerns
 - Explore Yuki's openness to breastfeeding support
 - e. Based on what Yuki is expressing, what identified concerns will you provide education and support on?
 - Feeding cue signs
 - Latch support
 - f. Review resources on SHOP and elsewhere. Utilizing the resources, create a teaching plan to address the identified concerns.
 - i. HINT: Review the [Breastfeeding Your Baby](#) webpage on BCW Website, in addition to all the other resources available on HealthLink BC, Baby's Best Chance, perinatal services, and more!
 - g. What resources can you provide to Yuki to support her during this time?
 - Provide the same ones suggested above for review, specifically ones that provide pictures around latching
2. Below, calculate the weight loss percentages. Additionally, state if this is appropriate, or concerning.
- b. Newborn weight of 3.6kg at birth; at 48 hours, weight is 3.4 kg.
 - 5.6% weight loss, expected range
 - c. Newborn weight of 3.2 kg at birth; at discharge, weight is 3.0 kg.
 - 6.25% weight loss, expected range
 - d. Newborn weight of 3.8 at birth; on day 3, weight is 3.3 kg.
 - 13.2% weight loss, abnormal range
 - e. Newborn weight of 3.4 kg at birth; at 36 hours, weight is 3.2 kg.
 - 5.9% weight loss, expected range
 - f. Newborn weight of 4.0 kg at birth; at 48 hours, weight is 3.5 kg.
 - 12.5% weight loss, abnormal range
 - g. If a baby loses too much weight (>10%), what are some things you might want to consider assessing and/or thinking about?
 - You want to think about what could be contributing to the weight loss: is the baby feeding well, mom's production
 - Create a feeding plan, support the family with feeds
 - Re-weigh baby at a later time
 - Consult MRP and/or lactation consultant
3. You are assisting a nurse caring for Tarandeep who delivered SVD at 38+6 and is now 30 hours post-delivery. You are assigned to assess the newborn.
- a. In addition to the physical assessment, what other information do you want to know about the newborn?

- Feeding patterns, routine, how it's going
- Intake and output
- Overall impression: sleepy, upset, etc...
 - b. You decide to ask about feeding. Tarandeep responds, "This little one is not like any of my others. She loves to sleep! It is so cute- sometimes, I can barely wake her up to feed because she is just cuddled up, so peaceful, enjoying her rest!" When you hear this report, do you have any concerns? If so, what are they? If not, why not?
- No urgent concerns with this immediate information
- However, it is important to ensure that despite baby not wanting to wake up, that they still wake up Q2-3H and take sufficient feeds
- Want to ensure that baby is still having good output of urine and stool
 - c. Upon assessment of the intake and output form, you notice that this baby is feeding every 4-4.5 hours. They have only had one documented wet diaper in the last 24 hours. You confirm with Tarandeep that this is correct. With all this information, what might you be worried about this baby developing?
- Low weight
- Hypoglycemia
- Jaundice
 - d. With one of the current concerns being the potential for newborn jaundice, what teaching elements are priorities to review with Tarandeep to support this baby?
- Support the parent with a feeding plan to include waking babe to feed more regularly (Q3H)
- Support Tarandeep with breastfeeding
- Explore the need for supplementation/pumping, and if required, help with topping up via bottle or other methods
- Provide reassurance and support to parents and family
- Encourage them to continue accurately documenting intake and output

Phase 3 Questions:

1. Let's jump back into Tarandeep and her baby's clinical scenario!
 - d. Complete hyperbili activity: Baby girl was born on March 15 at 2000 at 38+6 weeks. A routine bilirubin test is scheduled for March 17 at 0600 (34 hours of age). Tarandeep's blood type is O+, and the infant has no known neurotoxicity risk factors. The Total Serum Bilirubin (TSB) result returns at 189 $\mu\text{mol/L}$. Use Hyperbili.com to enter the infant's information and determine the ΔTSB . Based on the results, what would your next nursing action be?
 - Use SBAR to communicate findings to primary RN
 - Advocate for a repeat bloodwork in 12-24 hours
 - e. Use SBAR to communicate your findings to the primary RN and the MRP.
 - S: "The bloodwork for Tarandeep's baby girl came back"
 - B: "The baby has not been waking to feed and has number of wet diapers"
 - A: "When I plugged the bloodwork into Hyperbili.com, there are no current risks"

- R: “I recommend we call the MRP to repeat the TSB within 12-24 hours and to reassess the need for phototherapy like hyperbili suggests”
 - f. With the increased concern of newborn jaundice, the primary RN and you prepare to initiate phototherapy. Review [Hyperbilirubinemia: Phototherapy](#) and [Hyperbilirubinemia: Phototherapy: Equipment](#) on SHOP.
 - g. How do you decide if the infant requires an incubator or Joey bed?
 - The primary driving factor for making this decision is how well the infant can maintain their body temperature
 - h. What are the key newborn assessments required when a patient is receiving phototherapy?
 - Temperature
 - Daily weight and weight loss/gain
 - Monitoring intake of feeds, output of urine and stool
 - Teaching parents and family what to expect
 - o Increase in stools and voids, fussy baby, increased feeding
 - i. PRACTICE TIP: Next time you are in the clinical setting, go find the equipment required to set up the different variations of phototherapy. Even better, volunteer to support this set up if it comes up with your, or other patients on the floor.
2. You are working with an RN caring for Stacey who delivered via C-section 9 hours ago at 40+3. Review the [Perinatal Services BC Obstetric Guideline 20 Postpartum Nursing Care Pathway](#) and [Post-Cesarean Delivery Pain Management at BC Women’s Hospital](#) on SHOP.
- j. What are some of the additional assessments required for a C-section patient?
 - Increased respiratory assessments:
 - o High Risk: q1h X12 hours, then q2h X12 hours
 - o Low risk: q2h X 12 hours
 - Sedation and mobility assessment
 - Abdominal incision assessments: Q 15 min for 1 hour, at 2 hours, Q4H X 24 hours, once per shift until DC and PRN
 - Lochia assessments: Q15 min for 1 hour, at 2 hours, Q4 X24 hours, once per shift until DC and PRN
 - Perineum Assessments: Q15 min for 1 hour, at 2 hours, Q4 X24 hours, once per shift until DC and PRN
 - k. You go into Stacey’s room to complete an assessment. When asked how she is doing, she reports, “Honestly, I am a bit uncomfortable but I really don’t like taking medications. I am pretty sure I need to take these oral medications for 2 days, but after that, I don’t think I will want to take anything!” What are some important teaching points that should be reviewed with Stacey for optimal post-section recovery?
 - Explore medication values and beliefs
 - Provide education on pain management principles
 - Provide education on the importance of maintaining comfort for mobility and newborn care
 - l. Stacey wants to get out of bed to eat her lunch. Review the [Postpartum Mobility Assessments Following Regional Anesthesia](#) on SHOP. Answer the following questions:
 - i. Stacey’s block is still present at L1. When will her next ice check be? When can you stop performing the sensory level testing?

- Continue to assess and document Q1H until felt at L2, and then Q2h until full return of sensation (S3)
 - ii. Stacey scored 1 on the OB Lower Motor Assessment. How often do you need to continue this assessment?
- No need to continue assessing this as full return of motor function has occurred. If it had not, you would continue to assess and document Q1H
 - iii. What is RAMA? What information should you know about this assessment?
- This is the regional anesthesia mobility assessment that helps ensure a patient is safe to ambulate and prevent falls
- Must be done prior to the first time a patient ambulates post anesthesia
- If they cannot achieve each stage, they are not safe to ambulate and escalation to the MRP or anesthesiologist is required

Phase 4 Questions:

1. Let's jump back into Stacey's case. She is still admitted and is now 55 hours post-c-section. Her epidural has been off for some time now, and she is beginning to think about discharge. You walk in to complete her assessment and notice she is wincing while moving in bed. You ask her how things are going for her and baby, and she states: "I have been up to the bathroom. I am a bit uncomfortable, but I really don't want to take any other medication- the epidural was already outside my comfort. If I could do it over again, I would have wanted to do everything completely natural. Baby is doing good! I am not sure how much milk they are getting because they are so sleepy, but it seems like they are doing fine and just finished feeding about 45 minutes ago." As she says this, you notice her wincing in bed and bracing herself as she moves.
 - a. Review the post-operative orders for pain management below. Using SBAR, what would you communicate to the RN you are working with to care for Stacey?

OB Postpartum Cesarean Section (Multiphase), Pain and Symptom Management (Planned)	
Last updated on: 15-Dec-2021 23:39 PST by: TestMAT, OBGYN-Physician, MD	
Alerts last checked on 15-Dec-2021 23:38 PST by: TestMAT, OBGYN-Physician, MD	
Admit/Transfer/Discharge	
Do not initiate this PowerPlan if Acute Pain Service (APS), Perioperative Pain Service (POPS) or Anesthesiology is following this patient	
Medications	
Other Medications	
Self Medication Program	
<input checked="" type="checkbox"/>	acetaminophen 650 mg, PO, q4h, PRN pain, drug form: tab Self Medication Program - keep medications at bedside for patient to self-administer. Maximum acetaminophen 4 g/24 h from all sources
<input checked="" type="checkbox"/>	ibuprofen 400 mg, PO, q4h, PRN pain, drug form: tab Self Medication Program - keep medications at bedside for patient to self-administer. Maximum 2.4 g/24 h from all sources
<input checked="" type="checkbox"/>	docusate 200 mg, PO, qHS, PRN constipation, drug form: cap Self Medication Program - keep medications at bedside for patient to self-administer. For prevention of constipation
<input checked="" type="checkbox"/>	hydrocortisone-zinc sulfate topical (ANUSOL HC EQUIV 0.5% oint) 1 application, topical, BID, PRN other (see comment), drug form: oint Self Medication Program - keep medications at bedside for patient to self-administer. PRN Reason: for hemorrhoids
Select if not ordered for Self Medication	
<input type="checkbox"/>	acetaminophen 650 mg, PO, q4h, PRN pain, drug form: tab Maximum acetaminophen 4 g/24 h from all sources
<input type="checkbox"/>	acetaminophen 975 mg, rectal, q6h, PRN pain, drug form: supp Maximum acetaminophen 4 g/24 h from all sources
<input type="checkbox"/>	docusate 200 mg, PO, qHS, PRN constipation, drug form: cap For prevention of constipation
<input type="checkbox"/>	hydrocortisone-zinc sulfate topical (ANUSOL HC EQUIV 0.5% oint) 1 application, topical, BID, PRN other (see comment), drug form: oint PRN Reason: for hemorrhoids and also apply after each bowel movement
Analgesics	
<input checked="" type="checkbox"/>	HYDROmorphine (HYDROmorphine PRN range dose) dose range: 1 to 2 mg, PO, q3h, PRN pain, drug form: tab Start with 1 mg dose and reassess in 60 minutes; may give second 1 mg dose if pain not improving. DILAUDID

- S: Stacey is the patient that is 55 hours post-c-section
- B: Her epidural has been off for some time now and she is preparing for discharge
- A: She appears to be in pain, reports ‘being a bit uncomfortable’, and is wincing and bracing as she mobilizes in bed.
- R: I recommend we administer her some hydromorphone because she has already taken her self-medications as instructed. Can you assist me with this?
 - b. In discussing with the RN and Stacey to manage the post-operative pain, you decide to administer hydromorphone. After administration, Stacey asks: “Oh wait! I shouldn’t have taken that. Now that I have taken that, can I still breastfeed? Oh my goodness- I can’t believe I never even asked about the risks of this medication.” She appears overwhelmed. What education can you provide to Stacey in response to her concerns?
 - Hydromorphone is approved pain management and safe for breastfeeding
 - It is used for short-term break through pain at low dose
 - It is safe to use when tylenol/naproxen is not enough
 - Start with low doses
 - Discuss the importance of pain control for recovery and ability to care for and feed baby
 - c. After providing education, you plan to reassess Stacey and the baby in 45 minutes to see how the pain has changed. At the 45-minute mark, you walk in to find Stacey quietly asleep, with the baby asleep in the bassinet beside her. 4 hours later, you are about to do your final check before going home. You find Stacey and baby still sleeping. You quietly wake Stacey to let her know you are leaving. She wakes up frazzled and states: “Oh my goodness, why didn’t you wake me? It has been over 5 hours since I last fed my baby. Why didn’t I hear my baby wake up to feed? Can you please pass me my baby so I can feed now.” As you unbundle the baby, you notice they are more lethargic than when you first assessed them and appear to have jittery arms. What are your initial concerns with this baby, if any?
 - Hypoglycemia
 - d. Review [Newborn Hypoglycemia Screening and Management](#) on SHOP. You take a blood sugar and the result is 2.1. What are the next steps required to manage this episode of hypoglycemia?
 - Feed the newborn 5 ml/kg of expressed breast milk or formula
 - Contact the MRP for further management
 - e. Once this episode is managed, what steps are required to prevent this from happening again?
 - Encourage regular feeding q3h, and on demand
 - Help set up a feeding plan with mom
 - Assess effective feeding (latch, duration of feed, output)

References

1. Benner, P. (1982). From novice to expert. *The American Journal of Nursing*, 82(3), 402-407.
<https://www.jstor.org/stable/3462928?origin=JSTOR-pdf>
2. BSN LP Learning Network. (2025). *Action 61: Bachelor of science in nursing learning pathways foundational program document*.