WOMEN’S AND NEWBORN HEALTH PROGRAM
Clinical Policy/Procedure

<table>
<thead>
<tr>
<th>TITLE:</th>
<th>Nursing Assessment for the Postpartum Patient</th>
<th>NUMBER:</th>
<th>40050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsor:</td>
<td>Director, Women’s and Newborn Health Program</td>
<td>Page:</td>
<td>1 of 17</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Combined Childbirth, Family Newborn &amp; Prenatal Care Team Committee</td>
<td>Approval Date:</td>
<td>Feb. 28th, 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Effective Date:</td>
<td>June 6th, 2017</td>
</tr>
<tr>
<td>Applies To:</td>
<td>Registered Nurses and Licensed Practical Nurses in the Women’s and Newborn Health Program</td>
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</table>

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OP3PO150710
POLICY STATEMENTS

1. Patients in the postpartum period will be assessed by the Registered Nurse (RN) or Licensed Practical Nurse (LPN) to ensure that they are making the expected physiological and psychosocial adaptations. The Registered Nurse will be responsible for the initiation of the plan of care for all postpartum patients.

2. Assessments must be individualized based on identified risk factors, co-morbidities, and complications around the birth experience. These assessments will be planned in partnership with the patient and family to meet their unique postpartum needs. The minimum frequency of postpartum assessments is outlined Appendix B.

3. Internal transfers are the responsibility of the attending physician or midwife and readiness for transfer is based on meeting the criteria outlined in Appendix C.

4. Discharge is the responsibility of the patient’s attending physician or midwife and should be based on the discharge criteria outlined in Appendix D.

5. The RN/LPN will document the care provided on the patient’s permanent health record including, but not limited to: date & time of assessments, assessment findings, interventions, patient’s response and any other relevant information.

GUIDING PRINCIPLES AND VALUES

1. The care provided to the postpartum patient and their family will include ensuring that physical, emotional and learning needs are met.

2. Nursing care in the postpartum period will be undertaken with the priority of keeping the patient, family and baby together and to maximize newborn bonding, feeding and skin to skin contact whenever possible.

3. Throughout the postpartum stay the RN/LPN will provide care in a way that maximizes the patient’s readiness for discharge. This includes encouraging self-care, meeting any learning needs, and assisting with transition to community supports.

PROTOCOL

Assessment

1. Frequency of postpartum assessments should be completed as per the following guidelines and patient specific orders. See Appendix B for criteria and frequency of assessment.

2. Patients should be educated to alert nursing staff immediately if changes in status occur between assessments. Any abnormal clinical findings may require increased monitoring, further assessments and documentation.

3. Postpartum assessments must include, but are not limited to the following criteria:
   
   3.1. Vital Signs: i.e. temperature, pulse, respiration, blood pressure and/or oxygen saturation
   3.2. Symptom Management: i.e. pain, nausea and vomiting
   3.3. Neurological Assessment:

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OP3PO150710
3.3.1. Bromage Scale (If received regional anesthesia)
3.3.2. Somnolence Scale (If received general anesthesia or intravenous narcotics and are not awake and alert)

3.4. Hemodynamic Assessment:
3.4.1. Fundus
3.4.2. Lochia

3.5. Abdominal incision
3.6. Perineum
3.7. Breasts and Nipples
3.8. Bladder (See Appendix E)
3.9. Bowel

4. Other assessments should be included in postpartum assessments, though the frequency will vary based on the clinical picture and needs of the postpartum patient. Examples of additional assessments include:
4.1. Bonding/Attachment
4.2. Nutrition
4.3. Emotional/Mental Health
4.4. Learning needs (specifics around feeding decisions, family planning, healthy eating lifestyle, postpartum activity, etc.)

Transfer

1. Readiness for transfer must be based on transfer/discharge criteria for that phase, and not on a specified period of time.
2. Transfer from the Birth Unit Labour and Delivery room is the responsibility of the patient’s attending physician or midwife.
   2.1. The postpartum patient who has an operative delivery in the OR may recover outside of PACU at the discretion of the responsible anesthetist.
   2.2. Discharge or transfer from PACU is the responsibility of the anesthesia provider.

3. In addition to meeting the transfer criteria, the following items have been addressed:
   3.1. All stat orders have been implemented.
   3.2. Attending physician has provided post op orders for the patient care unit.

4. All post-op patients will remain in PACU for:
   4.1. At least 15 minutes following IV narcotic administration.
   4.2. At least 30 minutes following IM or subcutaneous narcotic administration.
   4.3. At least 30 min following the initiation of blood or blood products.
   4.4 At least 30 min following vasoactive drug administration.
   4.5. At least 45 minutes after the administration of reversal for neuromuscular paralysis.
4.6. At least 90 minutes following the administration of Narcan.

5. Internal transfers should be initiated upon meeting the criteria outlined in Appendix C, or to a higher level of care as medically required.

6. On transfer to another unit, the receiving nurse is responsible for performing a full assessment of the patient, regardless of the number of hours postpartum the patient is (See IWK Policy 1833).

**Discharge**

1. Planning for patient discharge from the health centre should begin immediately after birth and is ongoing throughout their stay. Discharge planning should be guided by the discharge criteria (See Appendix D) however it must be individualized to include the needs of the family.

2. If the postpartum patient has met all of the criteria and is ready for discharge but needs to remain in hospital to provide care for the newborn the RN/LPN should contact the primary care provider to designate patient as Alternate Level of Care (ALC).
REFERENCES

Alberta Health Services (2014). Discharge from Post Anesthesia Care Unit to Patient Care Unit. Post Anesthesia Care Unit Manual. Calgary, AB: Author


Regina Qu’Appelle Health Region (2009). PACU discharge criteria. Regina, SK: Author

Saskatoon Health Region (2012). Discharge from post anesthetie care unit. Saskatoon, SK: Author


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Vanderbilt University Medical Center (2012). Care of patients in postpartum period. Nashville, TN: Author


**RELATED DOCUMENTS**

**Policies**
- IWK Clinical Policy #40070– Bladder Assessment and Management Guidelines for the Obstetrical patient
- IWK Clinical Policy 30.40 – Diabetic Management for Obstetrical Patients
- IWK Clinical Policy 4560 - Gestational Hypertension (PIH) – Care of the Patient Post Delivery
- IWK Clinical Policy 7086 - Guidelines to Management of Patients with Moderate to Severe Gestational Hypertension or HELLP Syndrome
- IWK Clinical Policy 1155 - Insertion and Maintenance of Peripheral Intravenous Devices and Initiation and Maintenance of Peripheral Intravenous Therapy
- IWK Policy 1519 - Pain Management
- IWK Policy 80.50 - Postpartum Hemorrhage
- IWK Policy 1833 - Transferring and Receiving Patients to and from Inpatient Units within the IWK Health Centre
- IWK Clinical Policy 50030 – Women and Abuse Assessment and Intervention

**Forms**
- IWK_ALLECA Alternate Level of Care (ALC) Designation Form
- IWK_INPO Initial Postpartum/Postoperative Checks Admission to FNASU

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IWK_PONE Postpartum Analgesia Orders

IWK_VACA Postpartum Plan of Care Women’s and Newborn Health Program

IWK_ROUPO Postpartum Orders

IWK_VISIRE Vital Signs Record

IWK_WOAB Woman & Abuse Assessment & Intervention

**Brochures**

PL-0753 – Pain Relief and Tips after Having a Baby

PL-0035 – After Baby: Community Resource Information for New Families in Nova Scotia

**Appendices**

Appendix A – Definitions

Appendix B: Assessment Criteria (Period of Stability and Ongoing Assessment)

Appendix C Transfer Criteria

Appendix D: Discharge Criteria

Appendix E: Postpartum Bladder Assessment and Voiding Guidelines
APPENDIX A

Definitions

**Period of Stability:** For this policy this has been defined as the first two hours after the delivery of the placenta. Most patients will achieve this physiological state within 1 to 2 hours therefore transfer will be determined based on the physiological criteria outlined in this policy.

**Bromage Score** a tool used for the assessment of motor block in the clinical setting. The Bromage Scale is an accepted tool for the measurement of motor block. This scale assesses the intensity of motor block by the patient’s ability to move their lower extremities.

<table>
<thead>
<tr>
<th>Score</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>1</td>
<td>Complete block (unable to meet feet or knees)</td>
</tr>
<tr>
<td>2</td>
<td>Almost compete block (able to move feet only)</td>
</tr>
<tr>
<td>3</td>
<td>Partial Block (just able to move knees)</td>
</tr>
<tr>
<td>4</td>
<td>Detectable weakness of hip flexion while supine (full flexion of knees)</td>
</tr>
<tr>
<td>5</td>
<td>No detectable weakness of hip flexion while supine</td>
</tr>
<tr>
<td>6</td>
<td>Able to perform partial knee bend</td>
</tr>
</tbody>
</table>

(Adapted from Breen et al, 1993)

**Somnolence Score:** a tool used to assess somnolence or sleepiness, the state of feeling drowsy, ready to fall asleep.

1 = awake and alert, no action needed
2 = sedated but arousable, no action needed
3 = heavily sedated and difficult to arouse, drifts off during conversation, requires action/decrease dose
4 = unresponsive or somnolent, minimal or no response to physical stimulation; unacceptable, stop opioid, consider administering naloxone
SL = normal sleep

(Reference D’Arcy, 2008)
# Appendix B
Assessment Criteria and Frequency

<table>
<thead>
<tr>
<th>PHYSIOLOGICAL</th>
<th>Period of Stability</th>
<th>Ongoing Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vital Signs</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Blood pressure | Frequency for vaginal birth:  
  - q 15 min for 1 hour (temp x 1 in first hr)  
  - Then at 2 hours | Frequency for vaginal birth including temperature:  
  - Once per shift until discharge |
| Heart rate    | Frequency for caesarean birth  
  - q 15 min for 1 hour (temp x 1 in 1st hr)  
  - Hourly x 3 hours | Frequency for caesarean birth including temperature:  
  - q4h x 24 hours  
  - Then once per shift until discharge |
| **Temperature** | Temperature          |                   |
|               | at 1 hr              |                   |
| **Respiratory rate** | Resp rate Post Epimorph:  
  - q 30 min x 2 hours (refer to anesthesia orders)  
  - q1h x 15 hrs  
  - O2 Sats indicated | Frequency:  
  - Once per shift |
| O2 saturation (as indicated) |                   |                   |
| **Symptom Management** | Frequency:  
  - q 15min x 1 hr | Frequency:  
  - Once per shift |
| **Pain** | Use of a visual/verbal analogue pain scale (VAS)  
  Documentation of assessment details, interventions and effectiveness of comfort measures | |
| **Nausea/Vomiting** | Documentation of any assessment details, interventions and responses | |
| **Neurological Assessment** | Frequency:  
  - Q 15 min x 1 hr | Frequency:  
  - As required |
| **Bromage Scale** | Performed on patients who have received Regional analgesia  
  All patients prior to ambulating as required | |
<p>| <strong>Somnolence Scale</strong> | Patients who receive a general anesthetic, intravenous analgesics/sedation | |</p>
<table>
<thead>
<tr>
<th>PHYSIOLOGICAL</th>
<th>Period of Stability</th>
<th>Ongoing Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hemodynamic Assessment</strong></td>
<td>Frequency for assessment (vaginal and cesarean birth):</td>
<td>Frequency for assessment (vaginal and cesarean birth):</td>
</tr>
<tr>
<td><strong>Fundus</strong></td>
<td>• q 15 min for 1 hour</td>
<td>• Once per shift until discharge</td>
</tr>
<tr>
<td><strong>Involution</strong></td>
<td>• then q 1 hour x 1</td>
<td></td>
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<tr>
<td><strong>Lochia</strong></td>
<td>Frequency for assessment (vaginal and cesarean birth):</td>
<td></td>
</tr>
<tr>
<td>Amount, clots, and colour</td>
<td>• q 15 min for 1 hour</td>
<td></td>
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<tr>
<td></td>
<td>• then q 1 hour x 1</td>
<td></td>
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<tr>
<td><strong>Peripheral IV Therapy</strong></td>
<td>See IWK Policy 1155</td>
<td>See IWK Policy 1155</td>
</tr>
<tr>
<td><strong>Abdominal Incision</strong></td>
<td>Frequency for caesarean birth:</td>
<td>Frequency for caesarean birth:</td>
</tr>
<tr>
<td>Assess integrity and progression</td>
<td>• q 15 min for 1 hour</td>
<td>• Once per shift until discharge</td>
</tr>
<tr>
<td>of healing</td>
<td>• q 1 hour x 1</td>
<td></td>
</tr>
<tr>
<td><strong>Perineum</strong></td>
<td>Frequency for vaginal birth/operative vaginal delivery:</td>
<td>Frequency for vaginal birth/operative vaginal delivery:</td>
</tr>
<tr>
<td>Assess integrity and progression</td>
<td>• q 15 min for 1 hour</td>
<td>• Once per shift until discharge</td>
</tr>
<tr>
<td>of healing</td>
<td>• then q 1 hour x 1</td>
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<tr>
<td><strong>Breasts</strong></td>
<td>Frequency:</td>
<td>Frequency:</td>
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<tr>
<td>Breasts and nipples</td>
<td>• With feeds</td>
<td>• Minimum once per shift</td>
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<td>Breast comfort and function</td>
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<td>• With feeds as required</td>
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<tr>
<td>Woman’s understanding of</td>
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<td>adequate breast stimulation</td>
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<td>Woman’s breastfeeding confidence</td>
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<tr>
<td>to produce adequate milk supply</td>
<td></td>
<td></td>
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<tr>
<td>for her baby</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Woman’s capacity to hand express</td>
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<tr>
<td><strong>Elimination – Urinary function</strong></td>
<td>Reference to IWK Policy 40070 Bladder Management &amp; Assessment Guidelines of the Obstetrical Patient</td>
<td>Frequency:</td>
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<tr>
<td>Refer to IWK Policy 40070 Bladder</td>
<td>• q 15 min x 1 hr (relative to fundal checks)</td>
<td>• As required by policy 40070</td>
</tr>
<tr>
<td>Management &amp; Assessment Guidelines of the Obstetrical Patient</td>
<td>• As required by policy 40070</td>
<td></td>
</tr>
<tr>
<td><strong>Elimination – Bowel function</strong></td>
<td>Frequency</td>
<td>Frequency</td>
</tr>
<tr>
<td>Return to normal bowel movement</td>
<td>• As required</td>
<td>• Once per shift</td>
</tr>
<tr>
<td>pattern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Passing flatus after a Cesarean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSYCHOSOCIAL</td>
<td>Frequency:</td>
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</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
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<tr>
<td>Patient’s supports / environment</td>
<td>Assessments are ongoing from admission through discharge.</td>
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<tr>
<td>Patient's responses to infant feeding, cues, and</td>
<td>Every interaction the nurse has with patients and families is the</td>
<td></td>
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<tr>
<td>crying</td>
<td>opportunity to assess how the family is transitioning into parenthood.</td>
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<tr>
<td>Patient, family and baby interaction</td>
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<td>Risk factors for poor bonding and attachment</td>
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<tr>
<td>Adaptation to postpartum period</td>
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</tbody>
</table>
APPENDIX C

Criteria for Internal Transfer:

Spontaneous Vaginal Delivery (SVD) or Uncomplicated- Birth Unit

Transfer from Birth Unit Labour and Delivery room is the responsibility of the patient’s attending physician or midwife.

| Vital Signs          | HR and BP are within 20% of patients recent values for 2 consecutive checks
|                      | Respirations greater than or equal to 10 per minute.
|                      | Temperature greater than 35.5 and less than 38.5
|                      | O2 Saturations greater than 92% with or without supplemental O2
| Symptom Management   | Pain: Management effective – Level 4 or less on a scale of 1-10
|                      | Nausea: Management effective
| Neurological          | Bromage score 3 or higher
|                      | Documentation of receding block
|                      | Epidural removed intact (unless otherwise ordered)
|                      | Alert, oriented
|                      | Tolerating head up tilt of 45 degrees with less than 20 % change in systolic BP
| Hemodynamics          | PV flow stable
| Episiotomy/Tear       | Intact
| Skin to skin commenced| If infant present and mother/support person agreeable
| Newborn Feeding       | If newborn present and well
Surgical – Post Anesthesia Care Unit (PACU):
The postpartum patient who has an operative vaginal delivery in an OR may recover outside of a PACU at the
discretion of the responsible anesthetist.

Discharge or transfer from PACU is the responsibility of the anesthesia provider.

In addition the following items have been addressed:

- All stat orders have been implemented
- Attending physician has provided post op orders for the patient care unit

All patients will remain in PACU for:

- At least 15 minutes following IV narcotic administration
- At least 30 minutes following IM or subcutaneous narcotic administration
- At least 30 min following the initiation of blood or blood products
- At least 30 min following vasoactive drug administration
- At least 45 minutes after the administration of reversal for neuromuscular paralysis
- At least 90 minutes following the administration of Narcan

### Vital Signs

<table>
<thead>
<tr>
<th>Vital Signs</th>
<th>HR and BP are within 20% of preoperative /interoperative values x 2 consecutive checks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Respirations greater than or equal to 10/min.</td>
</tr>
<tr>
<td></td>
<td>Temperature greater than 35.5 and less than 38.5</td>
</tr>
<tr>
<td></td>
<td>O2 Saturations greater than 92% with to without supplemental O2</td>
</tr>
</tbody>
</table>

### Airway

- Maintained without assistance
- Note: Patients must remain in PACU a min. of 30 minutes post extubation

### Symptom Management

- Pain: Management effective – Achieve Level 4 or less on a scale of 1-10
- Nausea: Management effective

### Neurological

- Bromage score 3 or higher
- Documentation of receding block
- Tolerating head up tilt of 45 degrees with less than 20 % change in systolic BP
- Epidural removed intact (unless otherwise ordered)
- Alert, oriented consistent with pre-operative status
- Somnolence (sedation) score of 2 or less

### Surgical Site

- No apparent bleeding or swelling from the surgical site

### Hemodynamics

- PV flow stable

### Nausea

- Controlled

### Skin to skin commenced

- If infant present and mother/support person agreeable

### Newborn Feeding

- If newborn present and well

### Episiotomy /Tear

- Intact
Appendix D

<table>
<thead>
<tr>
<th>Discharge Criteria</th>
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**Discharge is the responsibility of the attending physician, midwife, or nurse practitioner**

### Bleeding & Vital Signs Stable

Lochia:
- **Amount**: Less than 1 pad every 2-3 hours
- **Clots**: Absent or minimal (smaller than a quarter)
- **Colour**: Up to day 3 - Rubra (Dark Red), Day 3-10 - Serosa, (pink, brown tinged blood and mucous), Day 10-14 - Alba (yellowish-white)
- **Odour**: Not foul smelling

### Vital Signs:
- **PO Temperature**: 36.7-37.9
- **Blood Pressure**: S= 90-140   D= 50-90
- **Respirations**: 12-24, unlaboured
- **Pulse**: 55-100bpm

### Eating and Passing Flatus

### Appropriate Supports in Place

### Rh Immunoglobulin provided
- If Rh- and baby Rh+, or directed by Rh program

### Vaccinations Administered
- As needed

### Voiding Normally (Self)
- At least 2 measured voids greater than 150mL
- Steady stream when voiding
- Patient feels bladder is emptying completely.
- If foley insitu, referral and follow up arrangements made with Healthy Recovery from Childbirth Clinic (HRCC)

### Pain Management via Oral Medication
### Discharge Criteria (continued)

<table>
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<tr>
<th><strong>Ambulating &amp; Caring for Self</strong></th>
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<tbody>
<tr>
<td><strong>EHV Screening Completed by Public Health</strong></td>
<td></td>
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<tr>
<td>If residing in Halifax Regional Municipality</td>
<td></td>
</tr>
<tr>
<td><strong>Episiotomy/laceration/Incision Healing</strong></td>
<td></td>
</tr>
<tr>
<td>- Sutures/staples intact</td>
<td></td>
</tr>
<tr>
<td>- No signs of infection, bleeding, or hematoma</td>
<td></td>
</tr>
<tr>
<td>- Edges approximated</td>
<td></td>
</tr>
<tr>
<td>HRCC consult sent if applicable</td>
<td></td>
</tr>
<tr>
<td><strong>Teaching Goals Met</strong></td>
<td></td>
</tr>
<tr>
<td>Refer to Maternal Learning Summary and Point of Care Resource</td>
<td></td>
</tr>
<tr>
<td><strong>Follow Up Plan Established</strong></td>
<td></td>
</tr>
<tr>
<td>Arrangements made with Postpartum Follow-up Clinic, Family Doctor, Nurse Practitioner, and/or Midwife</td>
<td></td>
</tr>
<tr>
<td><strong>Confidence in Feeding Plan</strong></td>
<td></td>
</tr>
<tr>
<td>- Capable of breast/nipple care, hand expression, and positioning</td>
<td></td>
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<tr>
<td>- If needed, appointment made with Postpartum Follow-up Clinic</td>
<td></td>
</tr>
<tr>
<td>If feeding baby with formula, teaching done re: volumes, preparation &amp; storing of formula</td>
<td></td>
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</tbody>
</table>
Appendix E:
Postpartum Bladder Management Algorithm

Postpartum Voiding

Uterus deviated from midline OR Increased PV bleeding/trickling OR Urge to void OR 4 hours since bladder empty

If algorithm is being followed for a second time and patient scans for 400mL or more, has increased bleeding, trickling, deviated uterus, urge to void, or 6 hours have elapsed and patient is unable to void, notify care provider and obtain order for foley for 24-48hr

RESTART ALGORITHM

Notify care provider
Obtain order and insert foley x 24-48hr

Measure 1st void

YES

Can patient void?

Less than 800mL

NO

Greater than 400mL OR bleeding, trickling, uterus deviated, urge to void

IN/OUT catheter and document

800 - 1000mL

1000 mL or more

NO

Assess & bladder scan

Adequate?

YES

Measure 2nd void

NO

Adequate?

YES

Routine care & monitoring

Adequate voiding:
- Measured greater than 150 mL
- Steady stream
- Completely emptying (Patient has no urge)

Less than 400mL

Assess bladder hourly x 2.

Can patient void?

Measure x 2 for voiding adequacy

Notify care provider
Obtain order for foley x 1-5-7 days. Send referral to HRCC & page Dr. Pierce or Dr. Amir for follow-up. If weekend/holiday page next working day. (If still unable to reach Dr. Pierce or Dr. Amir call attending physician attending to plan discharge and follow up.)

HRCC = Healthy Recovery from Childbirth Clinic

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OP3PO150710
District Health Authority/IWK Policies Being Replaced

(Please List)

Version History

(To Be Completed by the Policy Office)

<table>
<thead>
<tr>
<th>Major Revisions (e.g. Standard 4 year review)</th>
<th>Minor Revisions (e.g. spelling correction, wording changes, etc.)</th>
</tr>
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<tbody>
<tr>
<td>March 2017</td>
<td>March 2019</td>
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