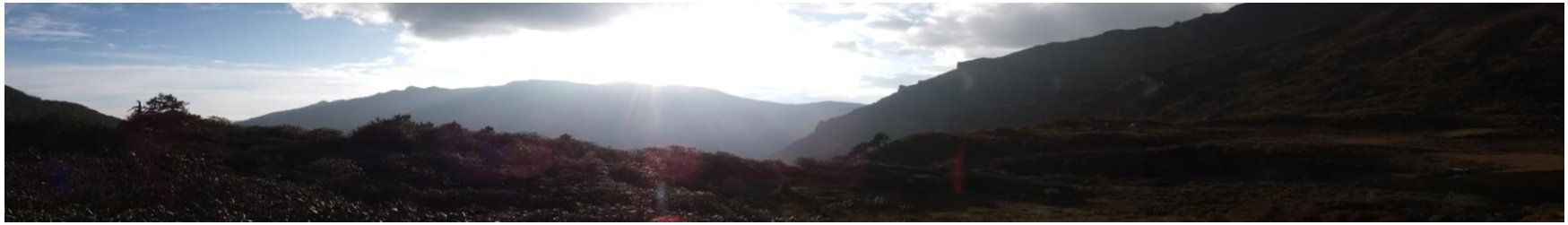


PRA-BC Orientation:

I've had the baby: Now What?
A guide to early postpartum & newborn care

Dr. Preveena Dharmaraj

With thanks to Dr. Karen Buhler and Dr. Moira de Valence

April 2025

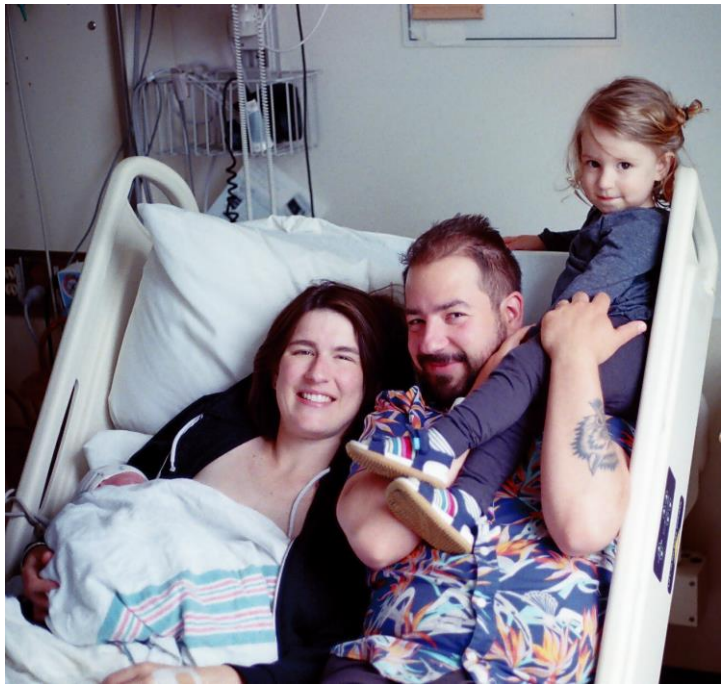
Disclosure of Commercial Support

I have no commercial interests to disclose.

Situating ourselves, territorial acknowledgement

Living and working with gratitude on the traditional unceded homelands of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and Səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations

Agenda



1. Approach to early postpartum and newborn care
2. Supporting breastfeeding / chestfeeding
3. Review workflow efficiencies, structural supports, billing tips
4. Summary and Wrap Up

Photos by Morag Hastings: www.appleblossomfamilies.com
And others generously donated by personal friends

Is ours not a strange culture that focuses so much attention on childbirth--virtually all of it based on anxiety and fear--and so little on the crucial time after birth, when patterns are established that will affect the individual and the family for decades?

Suzanne Arms

Case Studies:

1. Farah
Newborn weight and jaundice

2. Angel
Breastfeeding support

Case 1: Farah

Farah is a patient in your family practice who saw an obstetrician for her pregnancy. Farah had a spontaneous onset of labour at 41 weeks' gestation. It was a long labour with an epidural for pain management. She delivered a vigorous male infant, "Liam", by emergency caesarean section for an abnormal fetal heart rate. Farah had no obstetrical complications, and will be seen by the obstetrician at 6 weeks postpartum. She will follow up in your family practice in the meantime.

- Apgars of 8 at one minute and 9 at 5 minutes
- Birth weight was 3550g, and discharge weight at day 3 of life was 3390g
- He was assessed by the pediatrician at birth with no major concerns
- He passed urine and meconium within the first 24 hours

After discharge from the hospital, when should you see Farah and Liam for the first visit in your office? How often afterwards should you reassess?

Postpartum and Newborn Care

- **Health Assessments should routinely occur**:
  - Within 2-4 days of leaving the hospital
  - One week later (at 1 week)
  - One month after birth (at 4 weeks)
  - Two months after birth (at 8 weeks)

  - More as needed to assess wt. gain or breast feeding concerns or jaundice

Case 1: Farah

The public health nurse saw Farah and Liam the first day after discharge, at day 4 of life/postpartum. They reported that Farah's milk was just starting to come in. They helped Farah to reposition for a deep latch with breastfeeding. Weight on day 4 was 3335g.

You see Farah and Liam in your office 2 days later, on day of life/postpartum 6

You have booked 2 consecutive appointments to allow sufficient time for this visit (one for baby and one for mom). What 9 major topics must be addressed at this visit?

The first postpartum visit - 9 B's

1. Baby
2. Breasts
3. Belly
4. Bottom
5. Bowels
6. Bladder
7. Bleeding
8. Baby blues & postpartum depression
9. Birth control

Baby

Doctor's Question	Farah's response	Learning point
How is the latch? How long are the feeds? Is Liam content after feeding?	Farah says much better after help from the public health nurse. Public health nurse told her it looks like a deep latch, and after the adjustment it does not hurt during the feed.	Poor or shallow latch is one of the main causes of inadequate milk production and transfer, and can cause nipple trauma for the breast or chestfeeding parent! Stay tuned for the breastfeeding module to learn more about assessing feeding! Farah notes that Liam is quite sleepy and hard to feed.
How many wet diapers (urine) does Liam have in a day?	5-6	Expect to see the same number of wet diapers per day as the number of days of life until day 5, when the number plateaus at 5-6. Any less than this should prompt assessment for dehydration, feeding, and jaundice.
How many dirty diapers (stool) does Liam have in a day?	1	Exclusively breastfed babies can have variable stooling patterns, with some stooling frequently and others less so. The most important fact is to establish that there was no delayed passage of meconium
What colour is the stool?	Yellow, mustard seed	Transition from meconium to a yellow mustard seed appearance indicates that the baby is beginning to take in milk/formula. Generally this happens day 3-4. Delayed clearance of meconium can indicate delayed or failed lactogenesis, ineffective milk transfer, or rarely, medical complications such as intestinal obstruction associated with cystic fibrosis. This is also a good opportunity to review the stool colour card which is given to all parents in hospital and can be accessed online if they lose it: http://www.perinatalservicesbc.ca/our-services/screening-programs/biliary-atresia-home-screening-program

Template – 1st visit, well baby

Delivery: SVD at term, no complications, no resus

No complications in pregnancy

Bili:

Newborn Screening: pending

Parental concerns:

Birth Weight:

Discharge Weight:

Feeds: BF/formula xxml q2-3h

Good latch, no concerns

Output: normal - 4-5 BMs mustardy, 3-4 wet diapers

1st visit, well baby - exam

Physical examination:

- Growth (weight**, length, HC)
- Jaundice assessment**
- Complete Physical Exam including:
  - Red reflex
  - Anterior fontanelle
  - Palate
  - Clavicles
  - Resp exam and heart sounds
  - Abdo exam and umbilicus
  - Femoral pulses
  - Hips
  - GU, anus patent, sacrum

Case 1: Farah and Liam

Liam's birth weight was 3550g

His discharge weight on Day 3 was 3390g and his weight on Day 4 was 3335g.

You calculate his weight loss on day 4:

- Birth Weight 3550 g - Day 4 weight 3335 g = 215 g weight loss
- 215 g weight loss / Birth weight 3550 g = 6.0% weight loss from birth weight

Newborn weight

Key points:

- Weight loss is normal in the newborn period
- Expect up to 10% loss – this alone is not an indication for formula top ups
- Babies should by gaining by day 4-5 and regain to birth weight by DOL10
- 97.5% regain their birth weight by 21 days.
- Expect gain of 25-35g/day, minimum 20g/day

NORMAL NEWBORN STOMACH VOLUMES			
Day 1	1-1.4 tsp	5-7 mL	Size of a cherry
Day 2	0.75-1 oz	22-27 mL	Size of a walnut
1 Week	1.5 -2 oz	45-60 mL	Size of an apricot
1 Month	2.5-5 oz	80-150 mL	Size of an egg

Newborn weight

Weight loss >7%

- Watch closely, may indicate breastfeeding problems
- Assess breastfeeding and milk transfer
- Correct problems, consider referral to lactation consultant
- Consider supplementation with expressed milk or formula AFTER full assessment of feeding, if corrective measures are unsuccessful
- Review feeding and hunger cues with the family

Excessive weight loss: >10%

- Monitor closely (twice weekly minimum)
- Consider supplementing early with expressed breast milk, donor milk, or formula Always latch on the breast first, prior to offering the EBM or formula by bottle
- Consider referral to breastfeeding clinic, lactation consultant, maternity care provider, or pediatrician

Case 1: Farah and Liam

You recall that Farah noted Liam was quite sleepy and hard to feed. You are not sure on physical exam whether he appears jaundiced or not.

Q: Which infants should be screened for jaundice?

A: The Canadian Pediatric Society recommends that ALL infants be screened for jaundice with a serum bilirubin test at 24 hours of life, with follow up as needed.

Jaundice

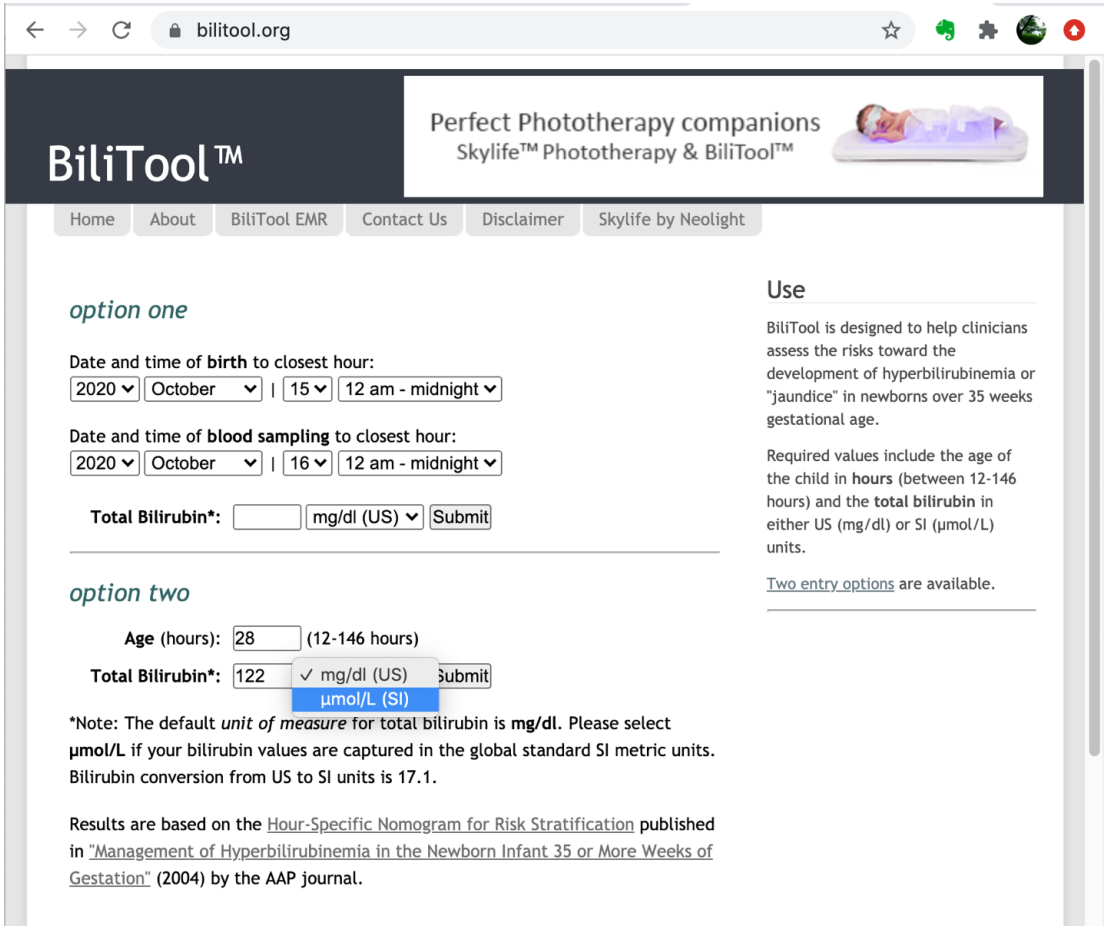
- IN 1ST week all newborns have increased bilirubin levels and ~60% have visible jaundice
- Peak bilirubin concentration occurs at day 3-5 (i.e. after discharge from hospital)
- Presence of jaundice or severity of jaundice is NOT accurately determined visually

What you need to do:

- Decide if you need to order a repeat bilirubin test
- If any visible jaundice and bilirubin not done yet – order a bilirubin
- Follow up on recommendation regarding when/if to do next one
- If in doubt, order another bilirubin level
- Ask parents about infant's stool colour (If abnormal, contact Biliary Atresia Home Screening Program)

Case 1: Farah and Liam

- You review Liam's hospital discharge and note that the newborn screen and bilirubin was done at 28 hours of age and was 122.
- The most common tool used in BC is "bilitool" and this will offer a "common language" when speaking with other practitioners
- Remembering to change the units to SI units



bilitool.org/index.php?page_id=8

BiliTool™

Home | About | BiliTool EMR | Contact Us | Disclaimer | Skylife by Neolight

Hour-Specific Nomogram for Risk Stratification

Infant age	28 hours	
Total bilirubin	122 µmol/L	
Risk zone	High Intermediate Risk	

Risk zone is one of several risk factors for developing severe hyperbilirubinemia.

Recommended Follow-up

Hyperbili Risk Level	Interval
Lower Risk (>= 38 weeks and well)	Follow-up within 48 hours and consider TcB/TSB at follow-up
Medium Risk (>=38 weeks + hyperbili risk factors **OR** 35 to 37 6/7 weeks and well)	Evaluate for phototherapy and check TcB/TSB within 24 hours
Higher Risk (35 to 37 6/7 weeks and hyperbili risk factors)	Evaluate for phototherapy and check TcB/TSB in 4-24 hours

AAP Phototherapy Guidelines (2004)

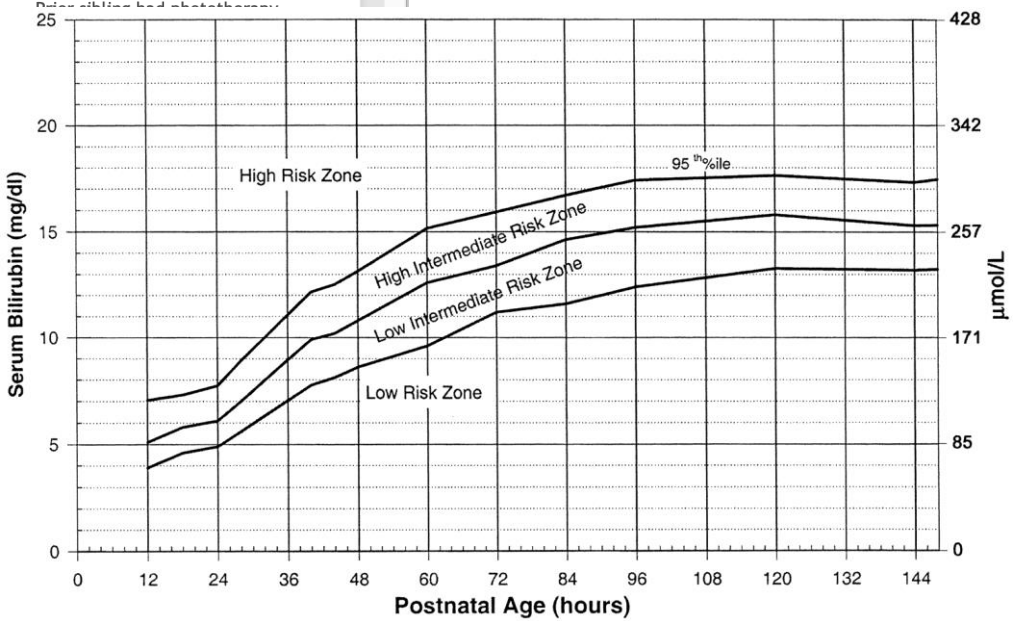
Links

Hour-specific nomogram
Phototherapy nomogram
Exchange nomogram

Hyperbilirubinemia Risk Factors

- TSB/TcB in high-risk zone
- Jaundice in first 24 hours
- ABO incompatibility with positive direct Coombs, known hemolytic disease, or elevated ETCO
- Gestational age 35-36 weeks

- Pt 1- Risk stratification



bilitool.org/index.php?page_id=8

and well)	
Higher Risk (35 to 37 6/7 weeks and hyperbili risk factors)	Evaluate for phototherapy and check TcB/TSB in 4-24 hours

AAP Phototherapy Guidelines (2004)

Neurotoxicity Risk Level	Start phototherapy?	Approximate threshold at 28 hours of age
Lower Risk (>= 38 weeks and well)	No	210.33 µmol/L
Medium Risk (>=38 weeks + neurotoxicity risk factors **OR** 35 to 37 6/7 weeks and well)	No	179.55 µmol/L
Higher Risk (35 to 37 6/7 weeks and neurotoxicity risk factors)	No	145.35 µmol/L

It is an option to provide conventional phototherapy in the hospital or at home at TSB levels 2-3 mg/dl (35-50 µmol/L) below those shown. Home phototherapy should not be used in infants with risk factors.

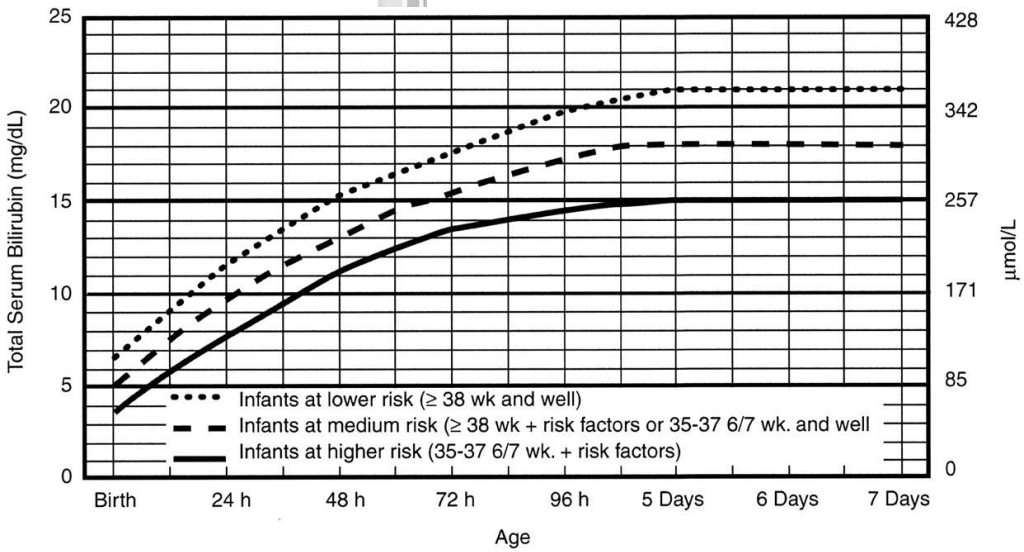
If phototherapy threshold is exceeded, please also review AAP Guidelines for Exchange Transfusion.

poor feeding or weight loss
- East Asian Race

Neurotoxicity Risk Factors

- Isoimmune Hemolytic Disease
- G6PD deficiency
- Asphyxia
- Significant lethargy
- Temperature instability
- Sepsis
- Acidosis
- Albumin < 3.0 g/dL

- Pt 2 – Phototherapy treatment threshold



- Use total bilirubin. Do not subtract direct reacting or conjugated bilirubin.
- Risk factors = isoimmune hemolytic disease, G6PD deficiency, asphyxia, significant lethargy, temperature instability, sepsis, acidosis, or albumin < 3.0g/dL (if measured)
- For well infants 35-37 6/7 wk can adjust TSB levels for intervention around the medium risk line. It is an option to intervene at lower TSB levels for infants closer to 35 wks and at higher TSB levels for those closer to 37 6/7 wk.
- It is an option to provide conventional phototherapy in hospital or at home at TSB levels 2-3 mg/dL (35-50mmol/L) below those shown but home phototherapy should not be used in any infant with risk factors.

Hour-Specific Nomogram for Risk Stratification

Infant age	28 hours
Total bilirubin	122 µmol/L
Risk zone	**High Intermediate Risk**

Risk zone is one of several risk factors for developing severe hyperbilirubinemia.

Recommended Follow-up

Hyperbili Risk Level	Interval
Lower Risk (>= 38 weeks and well)	Follow-up within 48 hours and consider TcB/TSB at follow-up
Medium Risk (>=38 weeks + hyperbili risk factors **OR** 35 to 37 6/7 weeks and well)	Evaluate for phototherapy and check TcB/TSB within 24 hours
Higher Risk (35 to 37 6/7 weeks and hyperbili risk factors)	Evaluate for phototherapy and check TcB/TSB in 4-24 hours

AAP Phototherapy Guidelines (2004)

Neurotoxicity Risk Level	Start phototherapy?	Approximate threshold at 28 hours of age
Lower Risk (>= 38 weeks and well)	No	210.33 µmol/L
Medium Risk (>=38 weeks + neurotoxicity risk factors **OR** 35 to 37 6/7 weeks	No	179.55 µmol/L

Links

Hour-specific nomogram
Phototherapy nomogram
Exchange nomogram

Hyperbilirubinemia Risk Factors

- TSB/TcB in high-risk zone
- Jaundice in first 24 hours
- ABO incompatibility with positive direct Coombs, known hemolytic disease, or elevated ETCO
- Gestational age 35-36 weeks
- Prior sibling had phototherapy
- Cephalohematoma or bruising
- Exclusive breastfeeding, esp. with poor feeding or weight loss
- East Asian Race

Neurotoxicity Risk Factors

- Isoimmune Hemolytic Disease
- G6PD deficiency
- Asphyxia
- Significant lethargy
- Temperature instability
- Sepsis
- Acidosis
- Albumin < 3.0 g/dL

Jaundice

Key points:

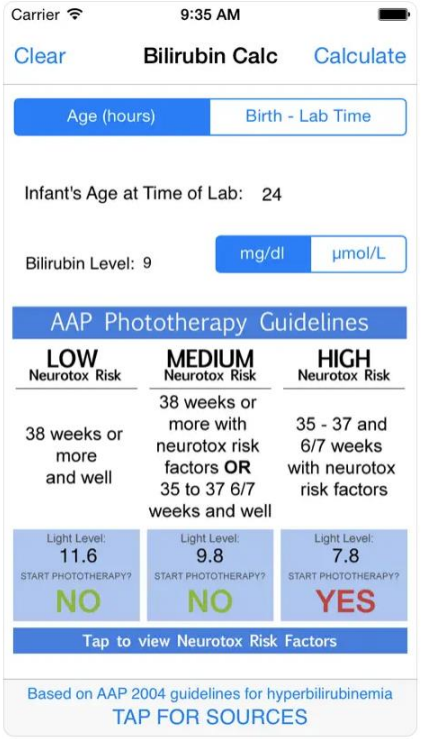
- When in doubt – call peds/newborn on call group in hospital for advice
- Know if your local hospital is using the updated 2022 guidelines or the 2004 AAP guidelines
- There are several tools online for calculation (BiliTool, PediTools, BiliCalc)

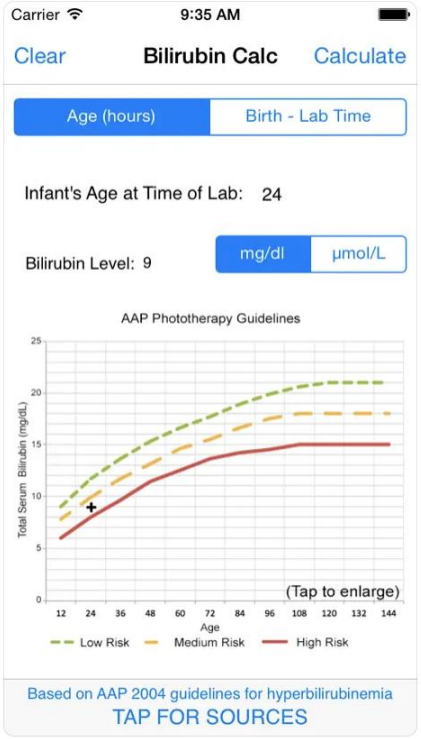
Clinical Pearls / Red flags:

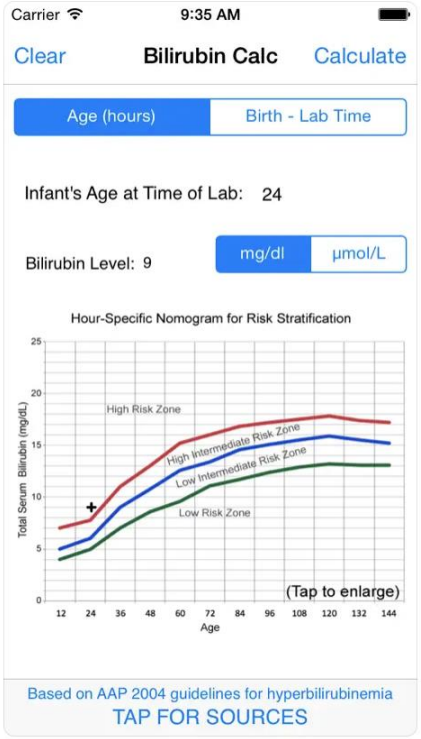
- Severe hyperbilirubinemia: total serum bili >340 at any time in first 28d of life
- Critical hyperbilirubinemia: total serum bili >425 at any time in first 28d of life
- All babies with visible jaundice within 24 hours need immediate workup. Jaundice within 24 hours is always pathologic: rule out sepsis, infections (rubella, toxoplasmosis), hemolytic disease of the newborn, etc.
- Conjugated hyperbilirubinemia should prompt further evaluation

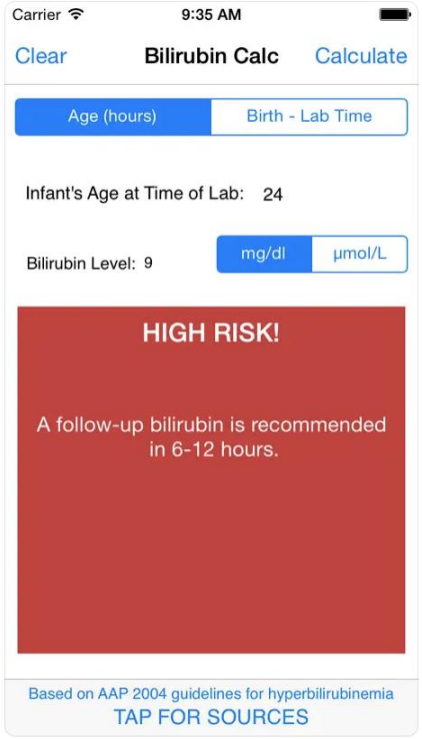
Jaundice

BiliCalc App









Template – 1st visit, birthing parent

? months PP

Delivery: SVD at ?, ?complications

Breasts: ?BF'ing, nipples ok

Urination/Stooling:

Perineum:

Lochia:

Menses:

Contraception:

Mood:

Supports:

Rest of the Bs

The rest of our 9 B's concern the birthing person:

2. **Bowels**

Prevent or treat constipation

Recommend high fiber diet, increased water intake

Consider adding PEG (osmotic laxative)

Expect resolution of stool or flatus incontinence by three months

If symptoms persist beyond 6 months, arrange endoanal U/S and refer to colorectal surgeon.

3. **Bladder**

Recommend pelvic floor exercises

Refer to a pelvic floor physiotherapist as needed to control urinary symptoms

Refer to a urogynecologist if urinary symptoms are significant beyond 3 months.

Rest of the Bs

4. Belly

Afterpains" and C-section incisional pain most often responds to Acetaminophen +/- Ibuprofen but some women require narcotic medication (Hydromorphone 1-2 mg q6h prn is safe for breastfeeding)

Codeine is contraindicated for breastfeeding as it can be life-threatening for some babies due to a ultra-rapid metabolizer genotype (up to 30% in parts of Asia and Africa)

Fundus should be firm and non-tender

Refer back to maternity care provider if an incision:

- opens,
- has significant discharge or bleeding,
- or becomes red or painful.

Rest of the Bs

5. **Bottom**

Expect perineal pain to resolve by 6 weeks

Treat haemorrhoids as per usual care

Refer back to maternity care provider if perineal wound has:

- Gaping edges
- Odorous discharge
- Unusual pain or swelling

6. **Bleeding**

Normal lochia is brown and light after two weeks and finished by 6-8 weeks

Needs urgent assessment if:

- Fever is present
- Abdominal pain and cramping are persistent
- Lochia is heavy, persistent beyond 6 weeks, frequently bright red or has a foul odour

Rest of the Bs

7. Baby blues / postpartum depression

Mild mood changes (baby blues) are common and may last 1-6 weeks.

Be aware of Postpartum Depression, which is common, frequently undiagnosed and under treated with serious morbidity for the whole family.

Enquire about mood, social adjustment, and family adjustment AT EVERY VISIT

Two best quick questions to screen for depression:

- Over the past two weeks, have you ever felt down, depressed or hopeless?
- Over the past two weeks, have you felt little interest or pleasure in doing things?

Add formal screening using Edinburgh Depression Scale (EPDS) if person at risk or has signs or symptoms.

Refer as appropriate

Rest of the Bs

8. Birth Control

Discuss by six weeks

Provide information about contraceptive options

Recommended interpregnancy interval is minimum 18 months to reduce complications

Ovulation occurs before first menses returns, so lactational amenorrhea is not recommended as is higher risk for unintended pregnancy

If contraception is desired, preferred options are barrier methods, IUD, progestin-only pill, or Depo Provera

Avoid or delay the use of combined oral contraceptives as they may decrease milk supply and increased risk VTE 1st 30 days

Progesterone generally considered not to affect milk supply, but if concerns, consider non-hormonal options

Case 2: Angel

Angel is a first time mother who you are seeing at 8 days postpartum. She had an uncomplicated vaginal delivery, and her daughter Kira was placed skin to skin and latched within the first hour of life. Kira was on the 10th percentile for weight at birth, but both Angel and her partner Danny are smaller people. Kira has started to gain approximately 15 g per day. She has 2 stools which are yellow and seedy, and 6 wet diapers per day. Angel is exclusively breastfeeding. She is tearful in your office – she is exhausted, the latch is painful, and it feels like she is always feeding.

What do you want to discuss with regards to #9 on your postpartum list (breasts)?

9th B - Breasts

Three main areas to discuss for this B:

1. BABY (weight gain)
2. MILK
3. TRANSFER (latch, pain)

Assess and treat problems or refer

Provide information on collection and storage of breast milk.

Case 2: Angel and Kira

Angel tells you that she is feeding approximately 8 times in 24 hours. She has one longer stretch of 4 hours, but also seems to feed every 1-2 hours in the middle of the night. Kira spends about 60 minutes with each feed, 30 minutes at each side. Kira is irritable with latching, and after about 5 minutes she falls asleep at the breast but will start nibbling again if Angel and Danny try to remove her.

What do you think of the frequency and duration of Angel and Kira's feeds?

Breastfeeding

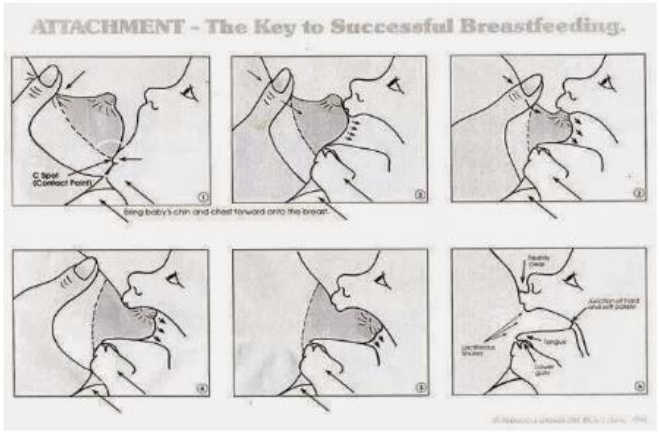
- Most common challenge in the early days is establishing feeds
- Know your local resources for support (public health RNs, hospital lactation consultants, private lactation consultants)
- Establishing supply is time sensitive so ensure to connect patients with resources early

Breastfeeding

CAUSES OF LOW SUPPLY		
Mom Factors	**Baby Factors**	**Other**
Primip, C-section, IVF, PPH, PCOS, Hypothyroid, GDM/T2DM/PCOS, Obesity, AMA, Infertility treatment, Breast surgery, Insufficient glandular tissue, Nipple trauma, retained placenta, early contraceptives, exhaustion.	Late preterm, Tongue dysfunction, Recessed chin, High palate, Hypotonia, Shallow latch, Asymmetric cheek bulk, Facial/head malposition in utero, tight neck muscles, torticollis.	Less than 8 nursing sessions/24 hours, limited skin to skin, supplementation, sleep training, stockpiling a milk stash or "feeding the freezer".

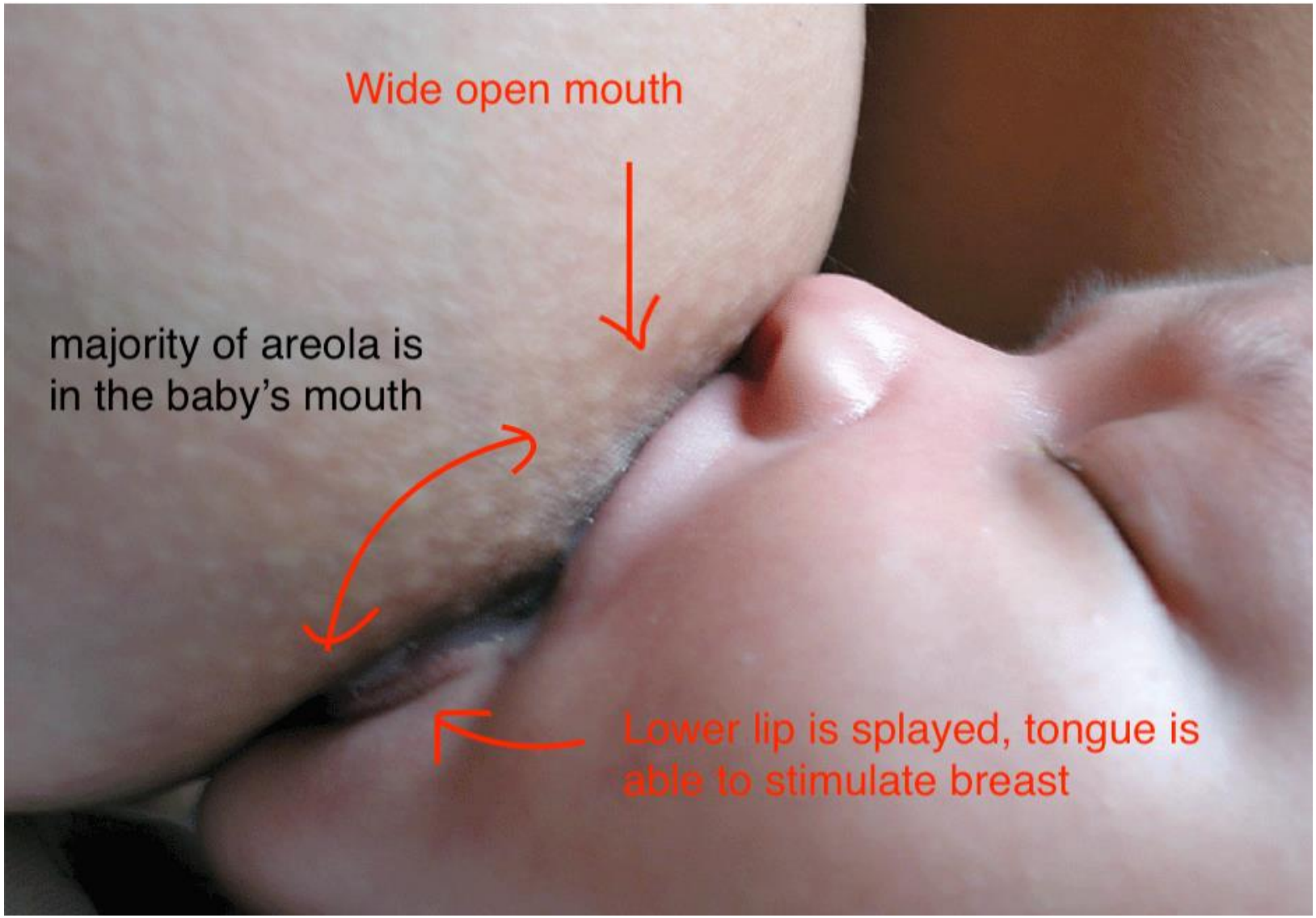
SIGNS OF A GOOD LATCH

Asymmetrical (more of areola below nipple is in baby's mouth than above)
Most of areola is inside baby's mouth
Lips are flanged outward
Nipple is in "comfort zone" at where soft palate starts
Tongue mobilizes forward and upward enough to make a seal



Breastfeeding – shallow latch

Breastfeeding – deep latch



Breastfeeding – take home pearls

- As a physician you have a significant impact on a mother's infant feeding choices
- Babies need to feed frequently in the first few weeks.
- A deep latch and correct positioning will almost always help
- Remove the milk! Use baby/hands/pump as able
- Be a good breastfeeding resource for your patients:
  - Take the UBC CPD Online 1 hour course (free): Latching On: How Family Physicians Can Support Breast Feeding Patients.
  - https://elearning.ubccpd.ca/enrol/index.php?id=148

How do we get all this done?

1. Use reference cards and checklists
2. Automate processes
3. Give the parent resources
4. Use community resources and referrals
5. EMR optimization

PSP
Practice Support Program

1. Use reference cards and checklists

Divisions of Family Practice Checklist

Post Partum and Newborn Care Summary Checklist for Family Physicians

These recommendations are based on a review of the best evidence and consensus opinion of the Vancouver Division of Family Practice Maternity Care Network Committee.

Health assessments of mother and baby should occur:

- Within 2-4 days of leaving the hospital
- One week later
- One month after birth
- Two months after birth

The 9 B's

1) BABY

Physical Examination and History:

- Gold standard for assessment and documentation is the **Rourke Baby Record** for relevant history, developmental milestones, focused physical exam, growth charts, and education topics for parents. http://ow.ly/qPBWz

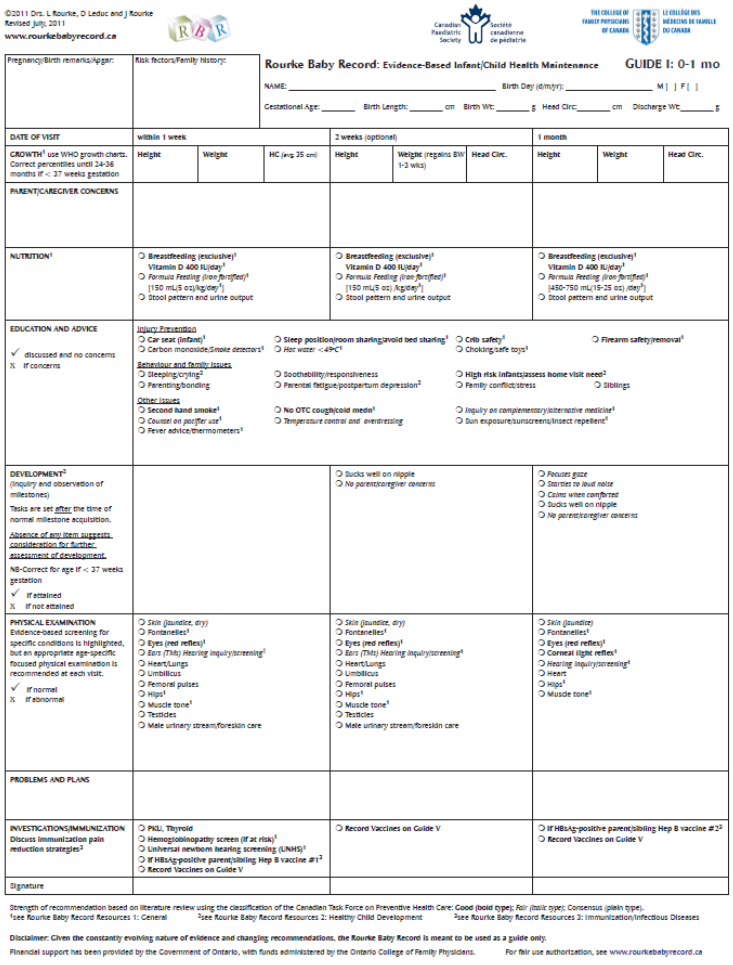
- Expect return to birth weight by 10-14 days of age.
- Monitor closely (twice weekly minimum) if weight loss is greater than 10% of birth weight.
  - Consider referral to lactation consultant, breastfeeding clinic, maternity care provider, or paediatrician.

1. Use reference cards and checklists

Rourke Baby Record

www.rourkebabyrecord.ca

- Fillable in EMR
- Automatically populate growth charts
- Detailed description of anticipatory guidance and resources on website



©2011 Drs. L Rourke, D Leduc and J Rourke
Revised July 2011
www.rourkebabyrecord.ca

Rourke Baby Record: Evidence-Based Infant/Child Health Maintenance **GUIDE I: 0-1 mo**

NAME: _____ Birth Day (d/m/yr): _____ M [ ] F [ ]

Gestational Age: _____ Birth Length: _____ cm Birth Wt: _____ g Head Circ: _____ cm Discharge Wt: _____ g

DATE OF VISIT	within 1 week			2 weeks (optional)			1 month		
GROWTH[1] use WHO growth charts. Correct percentiles until 24-36 months if < 37 weeks gestation	Height	Weight	HC (avg 35 cm)	Height	Weight (regains BW 1-3 wks)	Head Circ.	Height	Weight	Head Circ.
PARENT/CAREGIVER CONCERNS									
NUTRITION[1]	○ Breastfeeding (exclusive)[1] Vitamin D 400 IU/day[1] ○ *Formula Feeding (iron fortified)*[1] (150 mL/5 oz/kg/day[1]) ○ Stool pattern and urine output			○ Breastfeeding (exclusive)[1] Vitamin D 400 IU/day[1] ○ *Formula Feeding (iron fortified)*[1] (150 mL/5 oz/ kg/day[1]) ○ Stool pattern and urine output			○ Breastfeeding (exclusive)[1] Vitamin D 400 IU/day[1] ○ *Formula Feeding (iron fortified)*[1] (450-750 mL/15-25 oz) /day[1]) ○ Stool pattern and urine output		
EDUCATION AND ADVICE ✓ discussed and no concerns X If concerns	Injury Prevention ○ Car seat (infant)[1] ○ Carbon monoxide/*Smoke detectors*[1] ○ Sleep position/room sharing/avoid bed sharing[1] ○ *Hot water <49C*[1] ○ Crib safety[1] ○ Choking/safe toys[1] ○ Firearm safety/removal[1] Behaviour and Family Issues ○ Sleeping/crying[2] ○ Parenting/bonding ○ Soothability/responsiveness ○ Parental fatigue/postpartum depression[2] ○ High risk infants/assess home visit need[2] ○ Family conflict/stress ○ Siblings Other Issues ○ Second hand smoke[1] ○ *Counsel on pacifier use*[1] ○ Fever advice/thermometers[1] ○ No OTC cough/cold meds[1] ○ *Temperature control and overdressing* ○ *Inquiry on complementary/alternative medicine*[1] ○ Sun exposure/sunscreens/insect repellent[1]								
DEVELOPMENT[2] (Inquiry and observation of milestones) Tasks are set after the time of normal milestone acquisition. Absence of any item suggests consideration for further assessment of development. NB-Correct for age if < 37 weeks gestation ✓ If attained X If not attained				○ Sucks well on nipple ○ *No parent/caregiver concerns*			○ *Focuses gaze* ○ *Startles to loud noise* ○ *Calms when comforted* ○ Sucks well on nipple ○ *No parent/caregiver concerns*		
PHYSICAL EXAMINATION Evidence-based screening for specific conditions is highlighted, but an appropriate age-specific focused physical examination is recommended at each visit. ✓ If normal X If abnormal	○ *Skin (jaundice, dry)* ○ Fontanelles[1] ○ Eyes (red reflex)[1] ○ *Ears (TM)/ Hearing inquiry/screening*[1] ○ Heart/Lungs ○ Umbilicus ○ Femoral pulses ○ Hips[1] ○ Muscle tone[1] ○ Testicles ○ Male urinary stream/foreskin care			○ *Skin (jaundice, dry)* ○ Fontanelles[1] ○ Eyes (red reflex)[1] ○ *Ears (TM)/ Hearing inquiry/screening*[1] ○ Heart/Lungs ○ Umbilicus ○ Femoral pulses ○ Hips[1] ○ Muscle tone[1] ○ Testicles ○ Male urinary stream/foreskin care			○ *Skin (jaundice)* ○ Fontanelles[1] ○ Eyes (red reflex)[1] ○ Corneal light reflex[1] ○ *Hearing inquiry/screening*[1] ○ Heart ○ Hips[1] ○ Muscle tone[1]		
PROBLEMS AND PLANS									
INVESTIGATIONS/IMMUNIZATION Discuss immunization pain reduction strategies[3]	○ PKU, Thyroid ○ Hemoglobinopathy screen (if at risk)[1] ○ Universal newborn hearing screening (UNHS)[1] ○ If HBsAg-positive parent/sibling Hep B vaccine #1[2] ○ Record Vaccines on Guide V			○ Record Vaccines on Guide V			○ If HBsAg-positive parent/sibling Hep B vaccine #2[2] ○ Record Vaccines on Guide V		
Signature									

Strength of recommendation based on literature review using the classification of the Canadian Task Force on Preventive Health Care: Good (bold type); *Fair (italic type)*; Consensus (plain type).
[1]See Rourke Baby Record Resources 1: General [2]See Rourke Baby Record Resources 2: Healthy Child Development [3]See Rourke Baby Record Resources 3: Immunization/Infectious Diseases

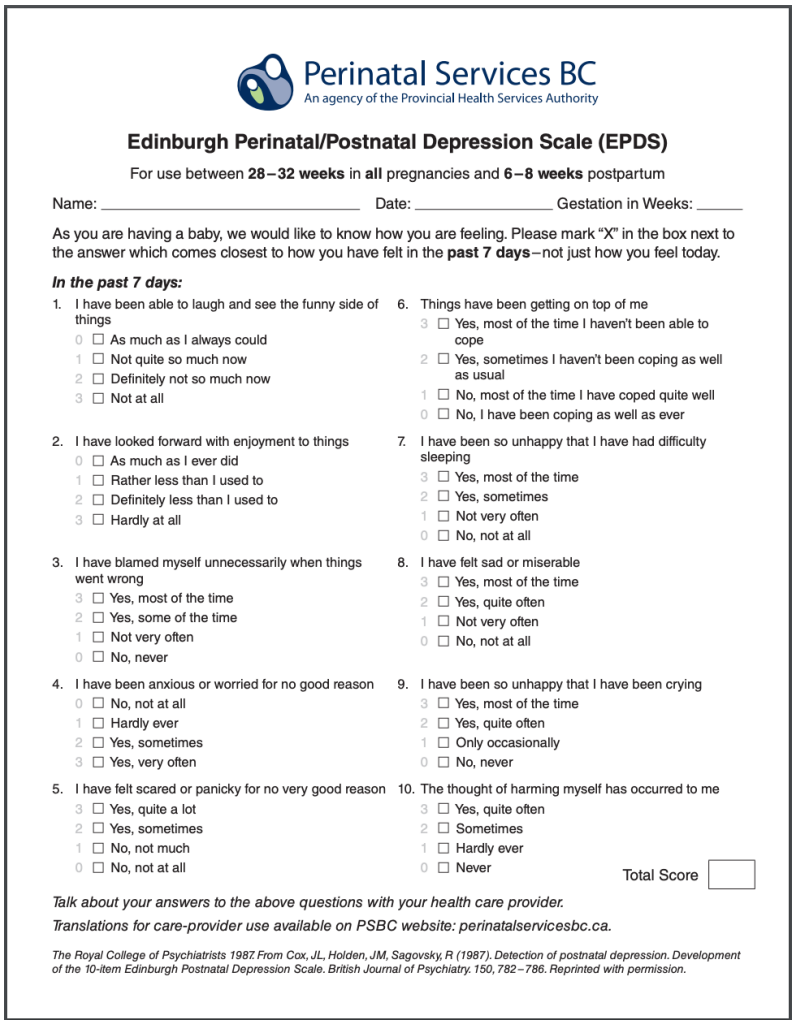
Disclaimer: Given the constantly evolving nature of evidence and changing recommendations, the Rourke Baby Record is meant to be used as a guide only.

Financial support has been provided by the Government of Ontario, with funds administered by the Ontario College of Family Physicians. For fair use authorization, see www.rourkebabyrecord.ca

1. Use reference cards and checklists

EPDS for postpartum depression

- http://www.perinatalservicesbc.ca/Documents/Resources/HealthPromotion/EPDS/EPDSQuestionnaireApril2013.pdf
- 11 languages available on PSBC website



Perinatal Services BC
An agency of the Provincial Health Services Authority

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

For use between **28–32 weeks** in **all** pregnancies and **6–8 weeks** postpartum

Name: _____ Date: _____ Gestation in Weeks: _____

As you are having a baby, we would like to know how you are feeling. Please mark "X" in the box next to the answer which comes closest to how you have felt in the **past 7 days**—not just how you feel today.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - 0 ☐ As much as I always could
   - 1 ☐ Not quite so much now
   - 2 ☐ Definitely not so much now
   - 3 ☐ Not at all
2. I have looked forward with enjoyment to things
   - 0 ☐ As much as I ever did
   - 1 ☐ Rather less than I used to
   - 2 ☐ Definitely less than I used to
   - 3 ☐ Hardly at all
3. I have blamed myself unnecessarily when things went wrong
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, some of the time
   - 1 ☐ Not very often
   - 0 ☐ No, never
4. I have been anxious or worried for no good reason
   - 0 ☐ No, not at all
   - 1 ☐ Hardly ever
   - 2 ☐ Yes, sometimes
   - 3 ☐ Yes, very often
5. I have felt scared or panicky for no very good reason
   - 3 ☐ Yes, quite a lot
   - 2 ☐ Yes, sometimes
   - 1 ☐ No, not much
   - 0 ☐ No, not at all
6. Things have been getting on top of me
   - 3 ☐ Yes, most of the time I haven't been able to cope
   - 2 ☐ Yes, sometimes I haven't been coping as well as usual
   - 1 ☐ No, most of the time I have coped quite well
   - 0 ☐ No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, sometimes
   - 1 ☐ Not very often
   - 0 ☐ No, not at all
8. I have felt sad or miserable
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, quite often
   - 1 ☐ Not very often
   - 0 ☐ No, not at all
9. I have been so unhappy that I have been crying
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, quite often
   - 1 ☐ Only occasionally
   - 0 ☐ No, never
10. The thought of harming myself has occurred to me
    - 3 ☐ Yes, quite often
    - 2 ☐ Sometimes
    - 1 ☐ Hardly ever
    - 0 ☐ Never

Total Score ☐

Talk about your answers to the above questions with your health care provider.

Translations for care-provider use available on PSBC website: perinatalservicesbc.ca.

How do we get all this done?

1. Use reference cards and checklists
2. Automate processes
3. Give the parent resources
4. Use community resources and referrals
5. EMR optimization

2. Automate Processes

Office Considerations

- Have staff teach parents how to weigh baby and measure height at beginning of each visit
  - Staff can enter in Rourke

- Have babies go to the room undressed from the scale for exam (blanket for warmth!)

- Booking guidance, always separate visit for parent and baby to ensure adequate time
  - Consider longer visits for immunizations, or having vaccines at public health

2. Automate Processes

Office Considerations

- Resource packages: consider pre-printed set of resources given at 1 week, 1 month, 2 month visit, etc

- Anticipatory guidance: give vaccine info at 1 month for parent to review prior to 2 month visit

How do we get all this done?

1. Use reference cards and checklists
2. Automate processes
3. Give the parent resources
4. Use community resources and referrals
5. EMR optimization

PSP
Practice Support Program

3. Give the parent resources

Baby's Best Chance - pdf

https://www.healthlinkbc.ca/pregnancy-parenting/babys-best-chance

3. Give the parent resources

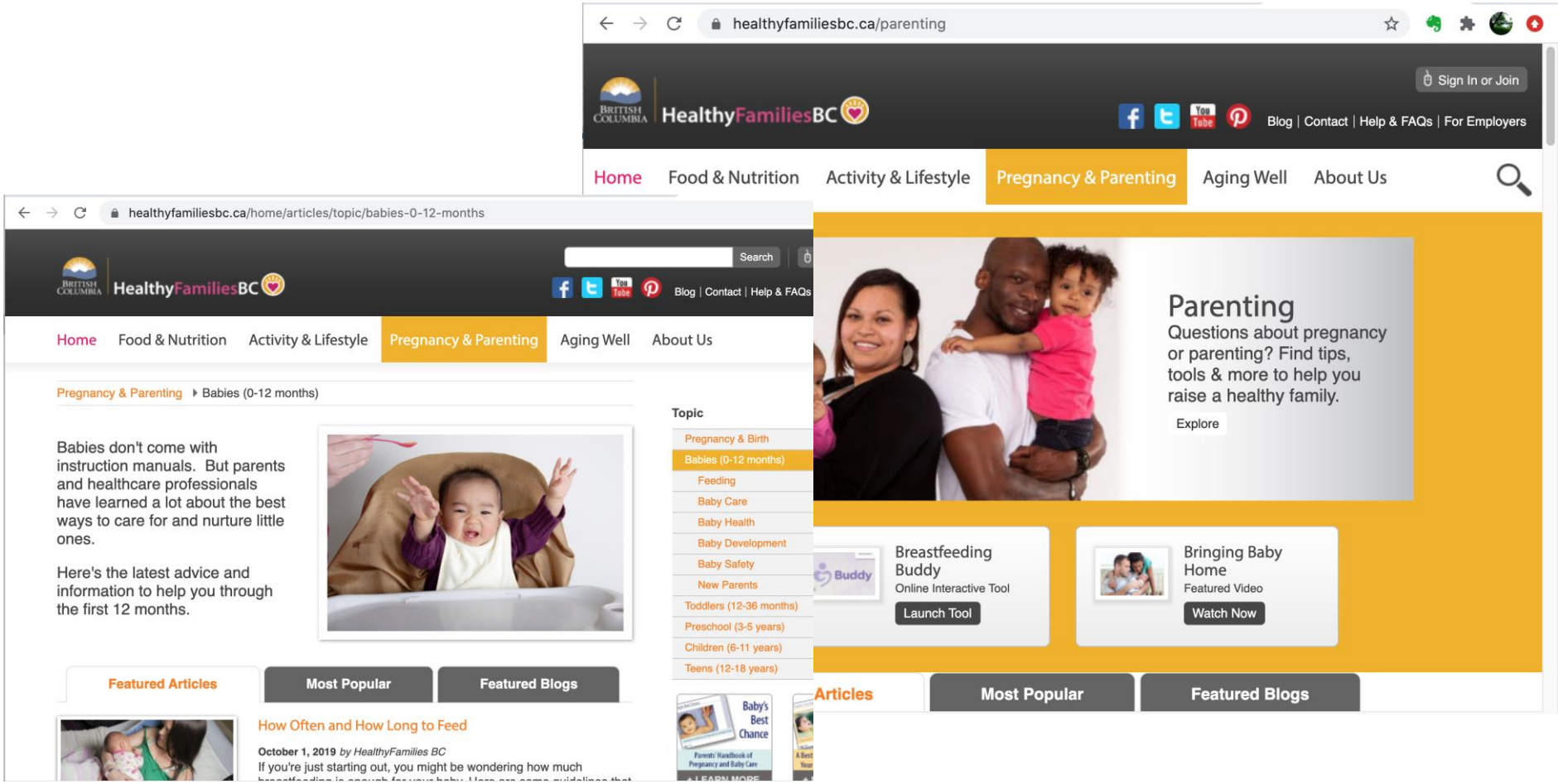
CPS Caring for Kids Website

https://www.caringforkids.cps.ca/

3. Give the parent resources

Healthy Families BC

https://www.healthyfamiliesbc.ca/parenting



3. Give the parent resources

Perinatal Services BC

http://www.perinatalservicesbc.ca/health-info/newborn-care

Provincial Health Services Authority

Alert: Health professional content is moving to the Perinatal and Newborn Health Hub. For the latest resources and guidance, visit the Hub

phsa.ca

Perinatal Services BC

Follow us

Search...

Our Services | Health Info | Research | About | Contact | Health Professionals | Careers

Menu

Health Info / Postpartum & Newborn Care

SHARE A A

Postpartum and Newborn Care

3. Give the parent resources

Safer Sleep

https://www.healthlinkbc.ca/pregnancy-parenting/parenting-babies-0-12-months/baby-safety/safer-sleep-my-baby

Safer Sleep for My Baby

Helping Parents and Caregivers Create a Safe Sleep Plan

As parents, you make many decisions every day to help keep your child healthy and safe. When it comes to sleep, your baby's sleep environment is always important – day or night. Some sleep practices are safer than others. This pamphlet shares information about how to help make your baby's sleep environment as safe as possible – so every sleep is a safer sleep.

You and your health care provider can also discuss your infant's sleep plan. For more information, see the resources at the end of this document.

Make Every Sleep a Safer Sleep

Place baby on their back to sleep

Put your baby to sleep on their back for every sleep, whether it's naptime or nighttime.

Use a firm mattress free of hazards

Use a firm mattress made for babies with no bumper pads, pillows, heavy blankets, comforters quilts or toys. This will help keep their sleep space safe.

Use a crib or bassinet

The safest place for your baby to sleep is in their own Health Canada approved crib, cradle or bassinet when at home or traveling. Plan ahead when traveling, and make sure there

3. Give the parent resources

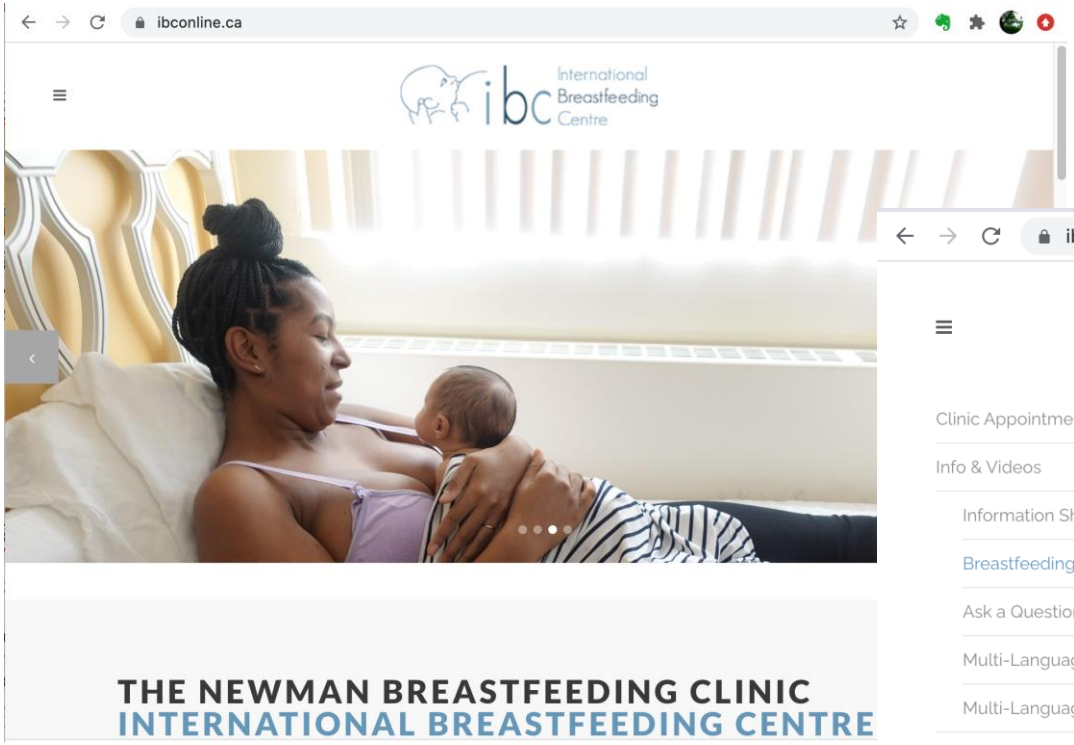
Biliary atresia stool colour card

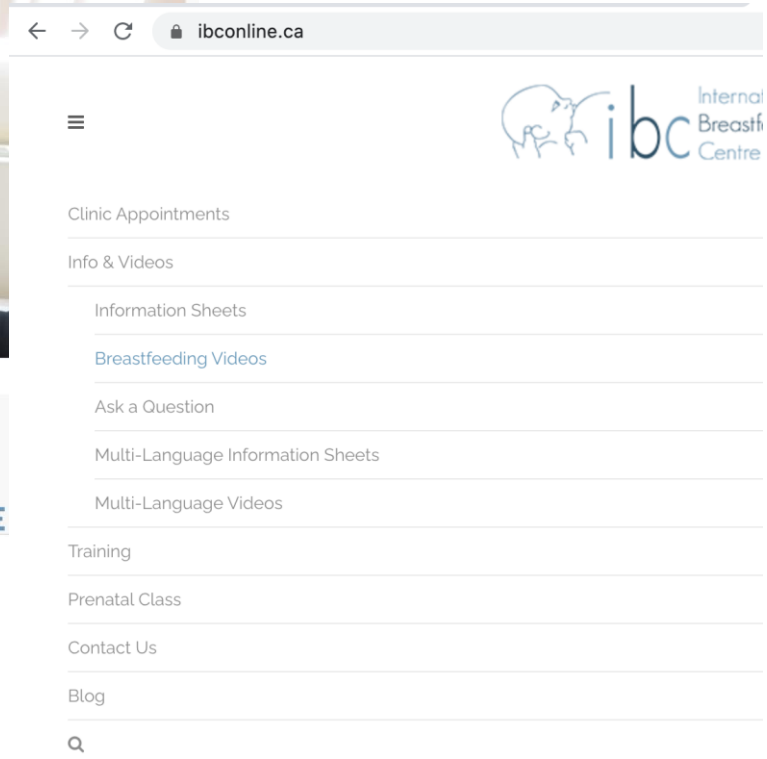
http://www.perinatalservicesbc.ca/Documents/Screening/BiliaryAtresia/StoolColourCard_English.pdf

3. Give the parent resources

International Breastfeeding Centre (Dr Newman)

https://ibconline.ca/

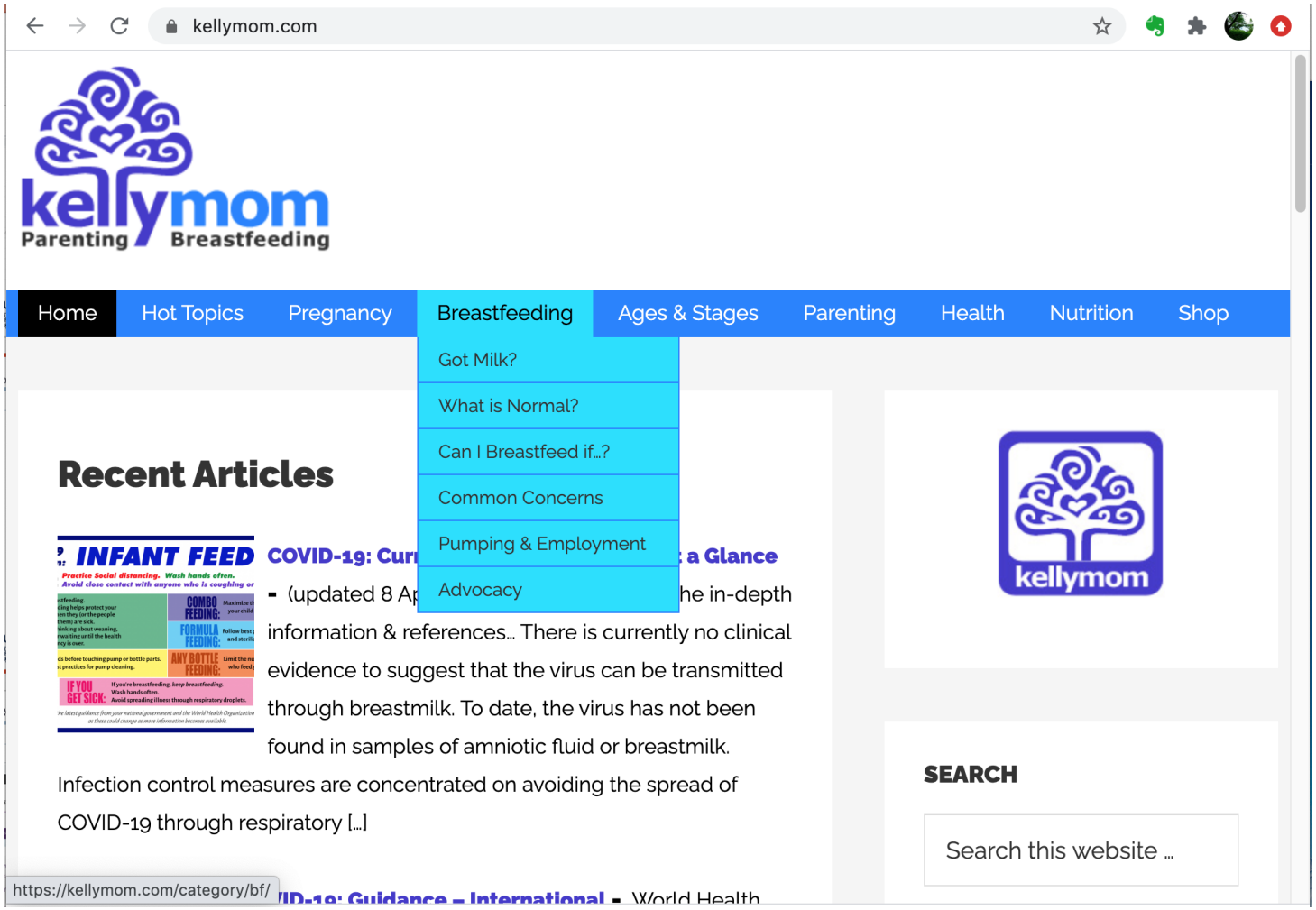




3. Give the parent resources

Kellymom

https://kellymom.com/



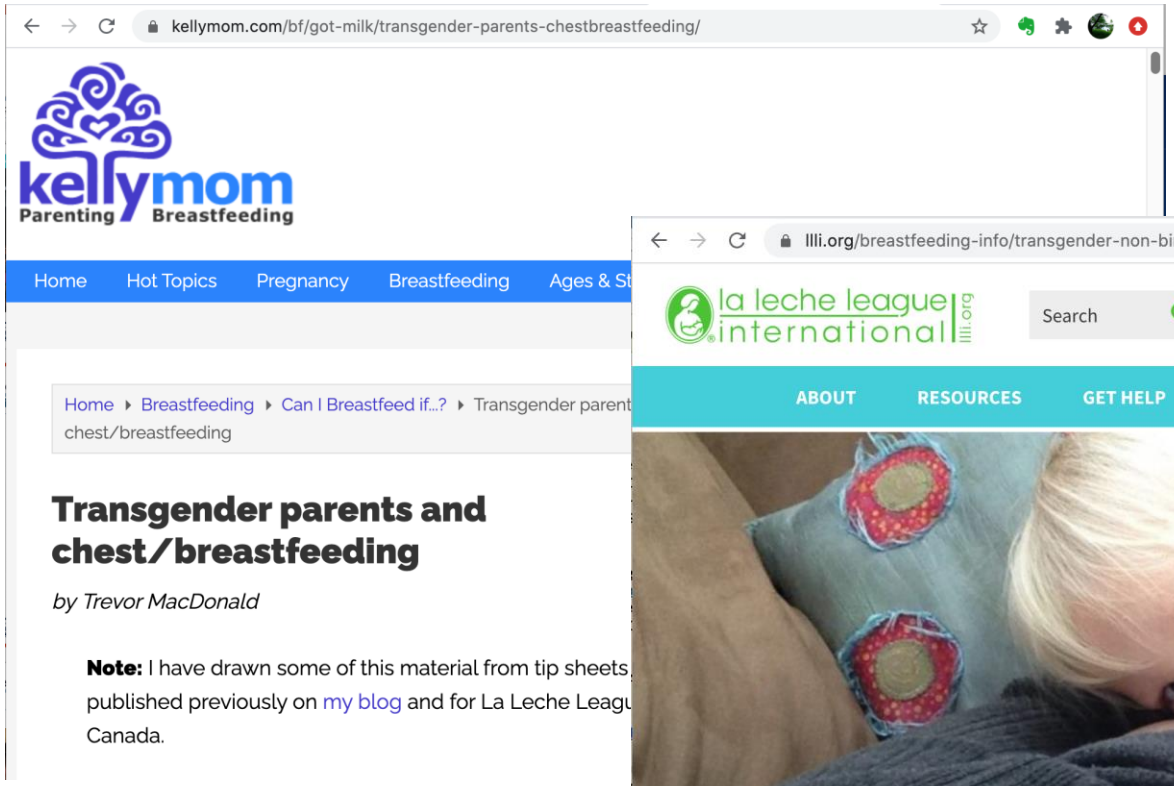
3. Give the parent resources

La Leche League

https://www.llli.org/

3. Give the parent resources

Chest- and Breastfeeding for non-binary parents



3. Give the parent resources

Plagiocephaly

Preventing and treating your baby's flat head

A family guide to Plagiocephaly

BC CHILDREN'S HOSPITAL
An agency of the Provincial Health Services Authority
4800 Oak Street, Vancouver, BC V6H 3N1

You can prevent your baby's head from shaping flat

Until about 1 year of age a baby's head shape is flexible and can become flat and uneven if a baby likes to look in one direction or is always on his or her back.

You can prevent this. The main way is to change your baby's sleep and play position often during the day and night. Here are some specific ways how to do this:

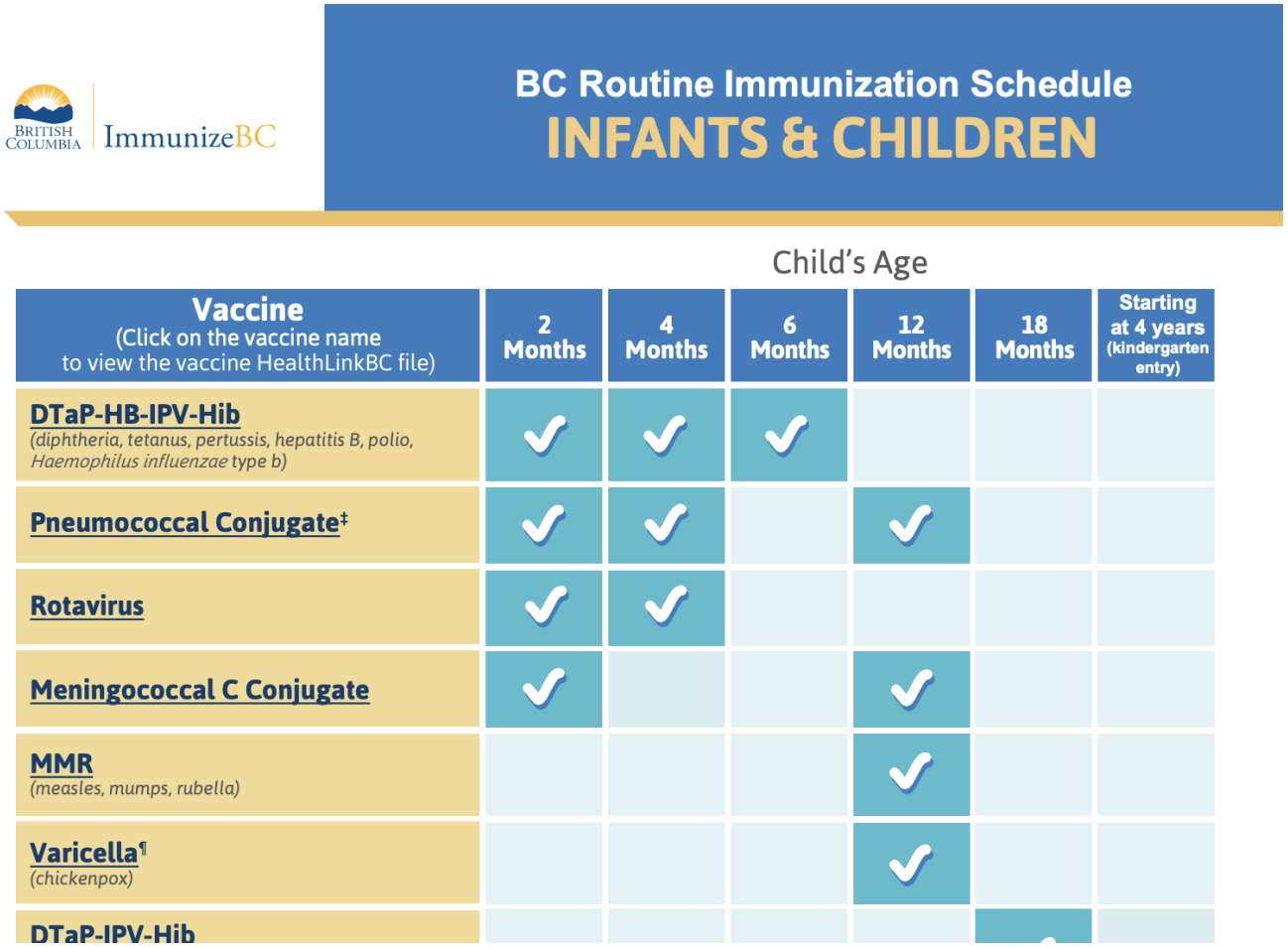
- Sleep your baby on his or her back,but make sure your baby's head is in a different position each time he or she sleeps such as the right side, straight forward, left side. TIP: you can turn a young baby's head once they are sound asleep.
- Switch the end you put your baby down in the crib each night.
- Play with your baby on his or her tummy and sides 3 to 5 times a day. Some tummy time tips are given later.
- Change toy and mobile positions every few days so that your baby does not always look in one direction.

Keep using the ideas listed above, as well as:

- Move the crib so that your baby turns his or her head away from the "flat" side when looking toward the door.
- Place toys and mobiles on the "round" side so your baby turns away from the flat side.
- Carry and hold your baby on the round side to avoid pressure on the flat area.
- If you bottle feed your baby, feed from from the round side. Breast fed babies already change sides when they feed. When introducing solid foods, spoon feed your baby from the round side rather than "face on".
- Carry your baby. Use a front or side carrier with a padded waist strap. Play with your baby in different positions. Every baby, no matter how old she or he is, needs tummy time 3 to 5 times a day. Some tummy time tips are given later.
- Here are some play ideas for babies of different ages.
  - ***For babies under 3 to 4 months:*** Your baby will

3. Give the parent resources

Vaccine schedules – immunizebc.ca



BRITISH COLUMBIA | ImmunizeBC

BC Routine Immunization Schedule

INFANTS & CHILDREN

Vaccine (Click on the vaccine name to view the vaccine HealthLinkBC file)	Child's Age: 2 Months	4 Months	6 Months	12 Months	18 Months	Starting at 4 years (kindergarten entry)
DTaP-HB-IPV-Hib (*diphtheria, tetanus, pertussis, hepatitis B, polio, Haemophilus influenzae type b*)	✓	✓	✓			
Pneumococcal Conjugate‡	✓	✓		✓		
Rotavirus	✓	✓				
Meningococcal C Conjugate	✓			✓		
MMR (*measles, mumps, rubella*)				✓		
Varicella¶ (*chickenpox*)				✓		
DTaP-IPV-Hib						

How do we get all this done?

1. Use reference cards and checklists
2. Automate processes
3. Give the parent resources
4. Use community resources and referrals
5. EMR optimization

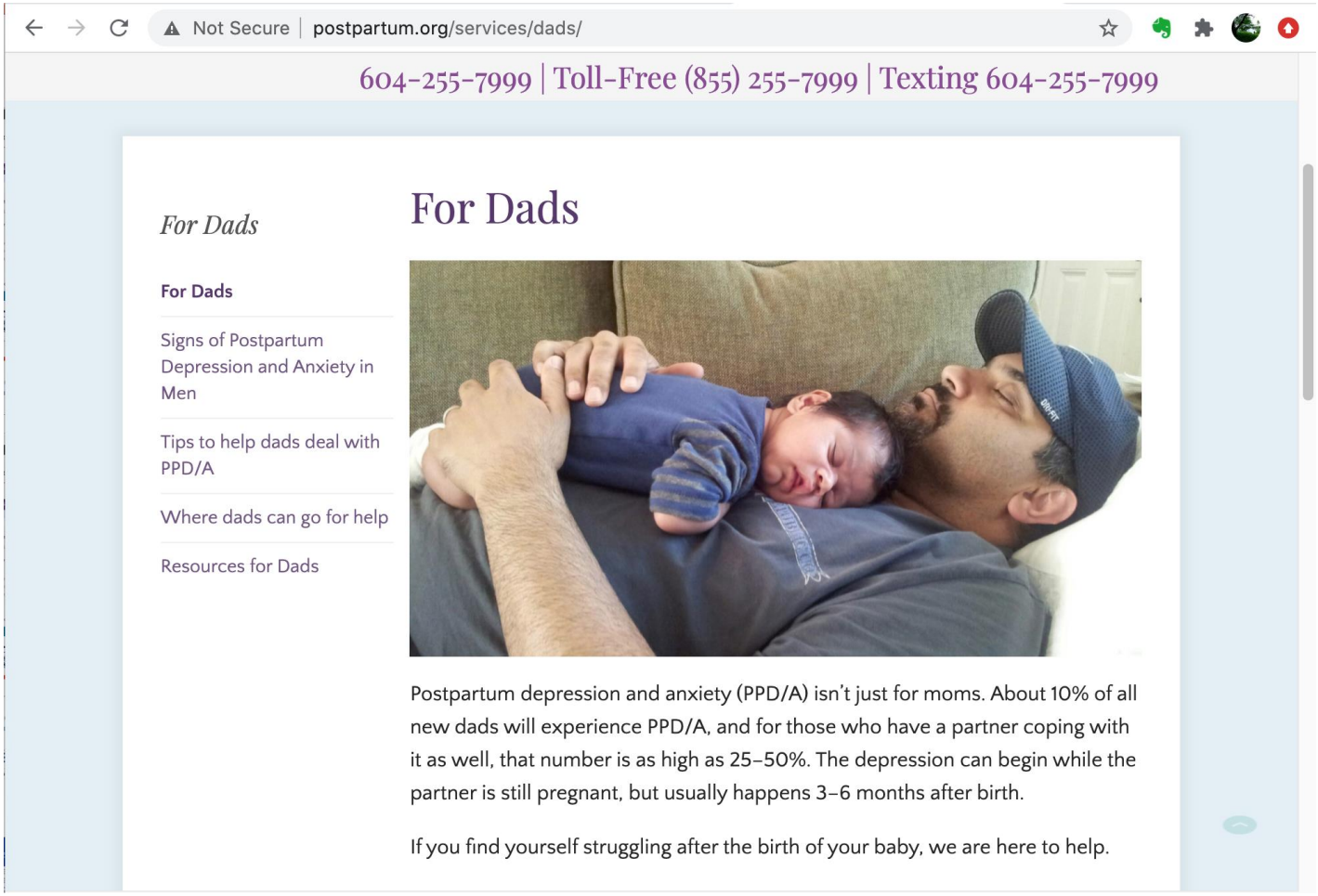
PSP
Practice Support Program

4. Use community resources and referrals

Pacific Postpartum Support Society

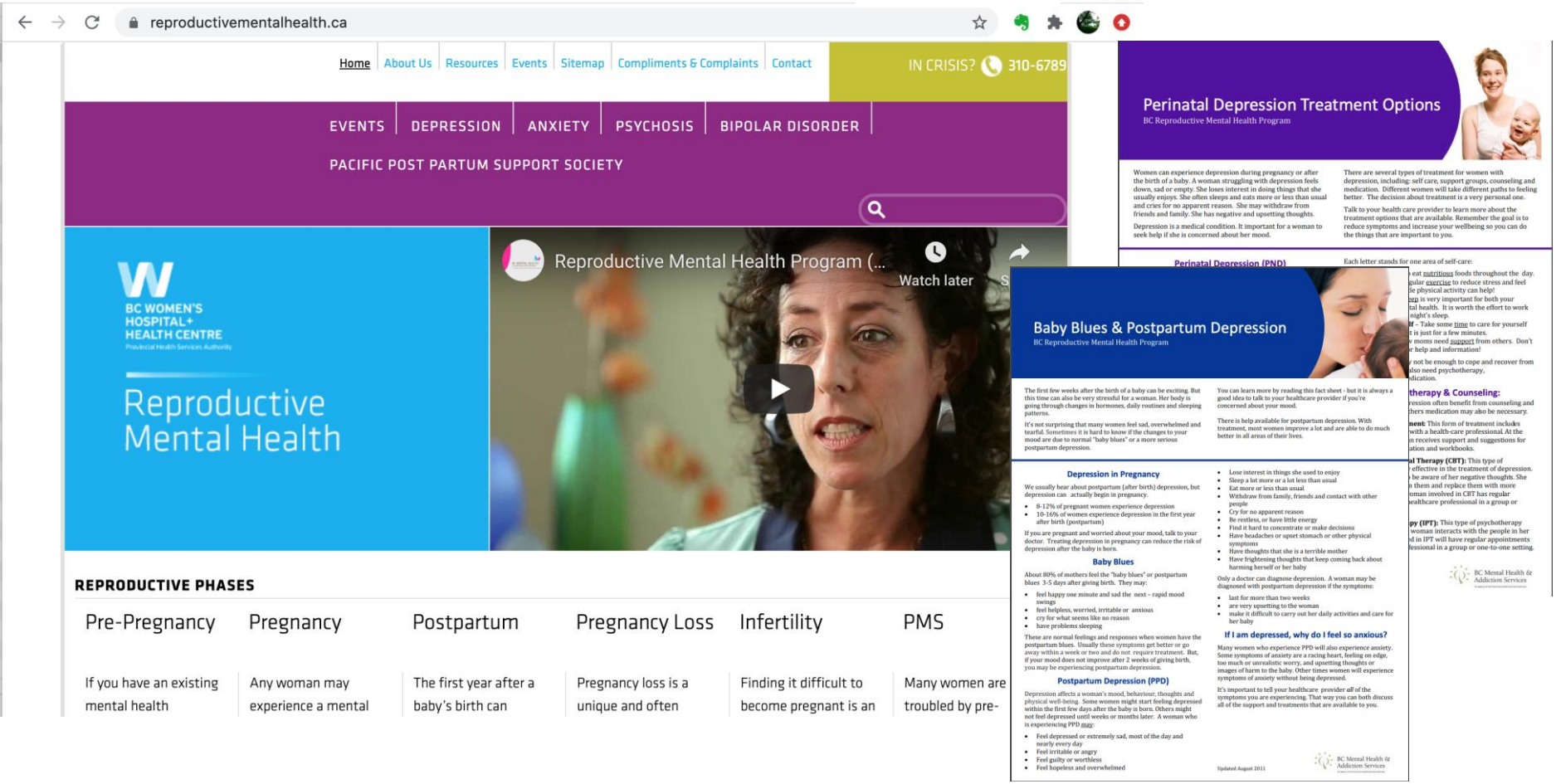
4. Use community resources and referrals

Pacific Postpartum Support Society



4. Use community resources and referrals

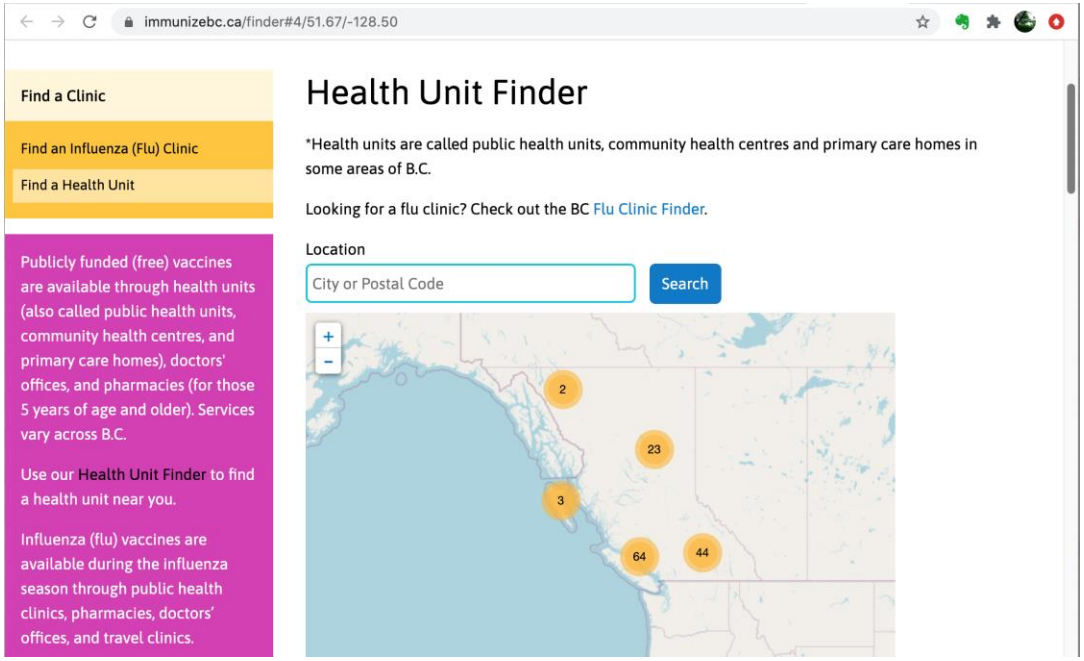
BC Women's Reproductive Mental Health



4. Use community resources and referrals

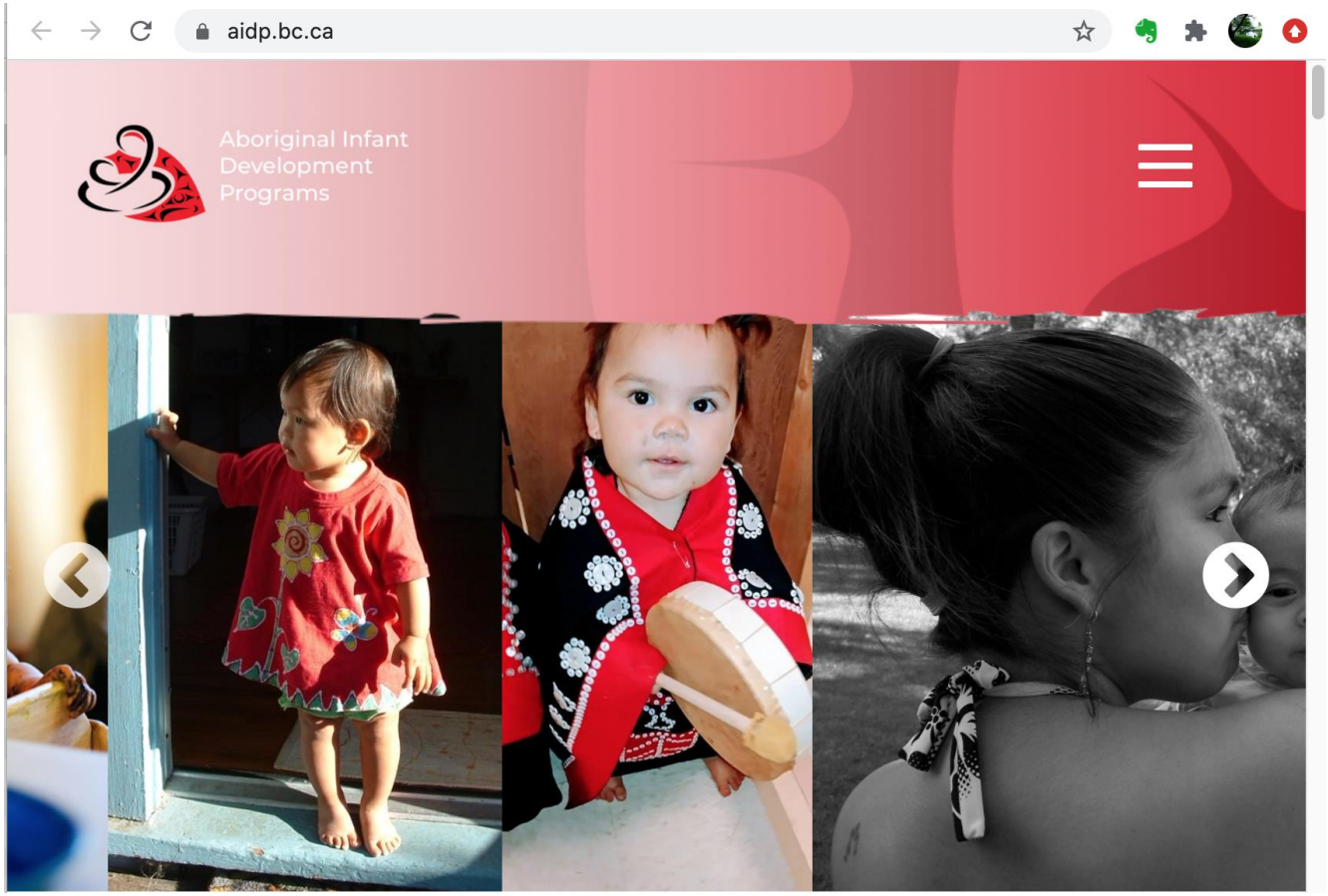
Public Health Unit

- In many communities, public health nurses will do postpartum home visits
- Will be able to connect you with services:
  - Infant development / early intervention therapy
  - SLP
  - PT
  - OT
- And more! Contact your local unit to find what services are available



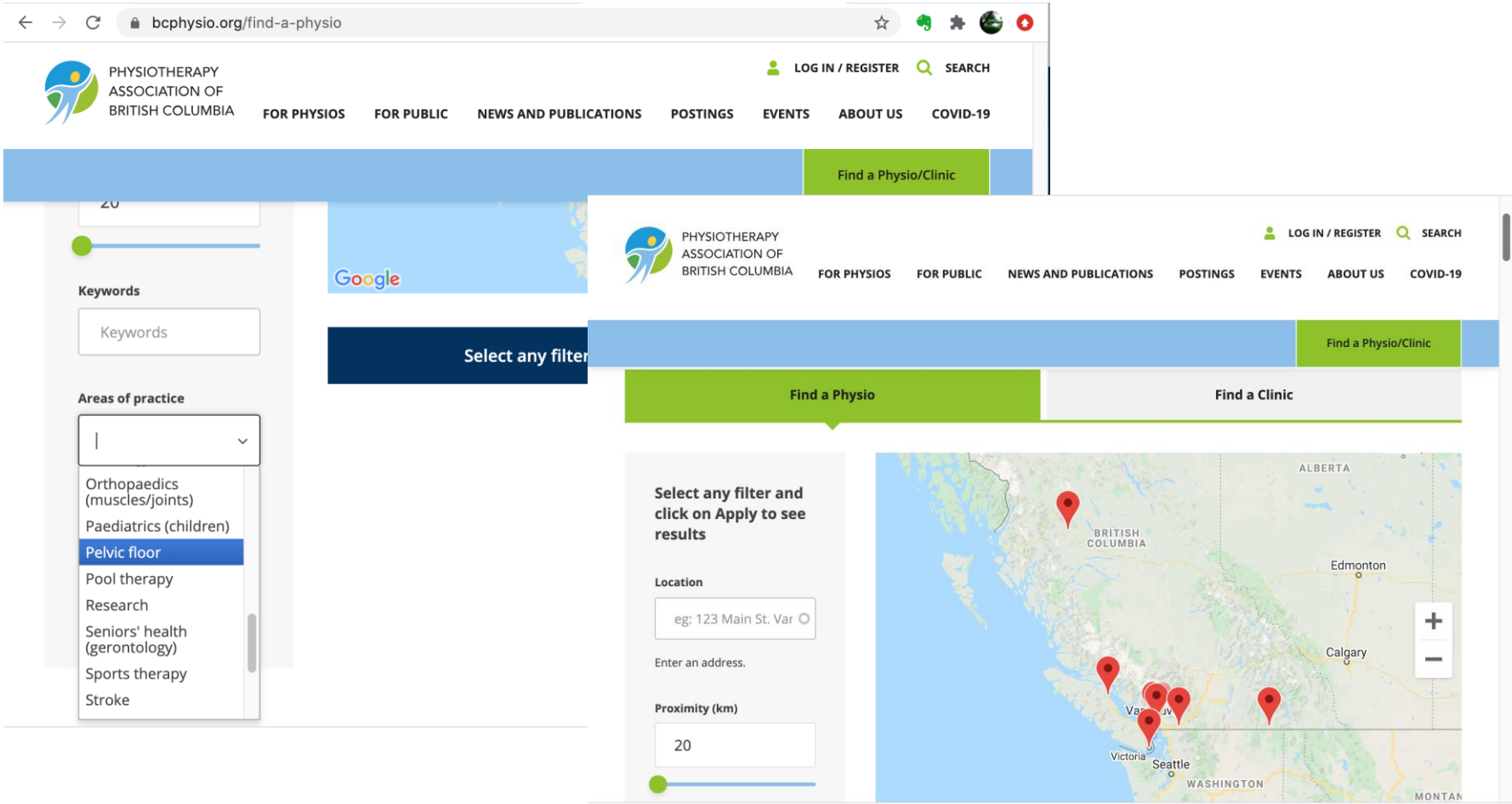
4. Use community resources and referrals

Aboriginal Infant development program



4. Use community resources and referrals

Pelvic physiotherapy



- https://bcphysio.org/find-a-physio
- "Areas of practice" -> Pelvic floor

How do we get all this done?

1. Use reference cards and checklists
2. Automate processes
3. Give the parent resources
4. Use community resources and referrals
5. EMR optimization

PSP
Practice Support Program

5. EMR Optimization

Office Considerations

- Templates in EMR
- Growth charts in EMR
- Referral forms in EMR with pre-filled demographics
- Billing worksheets / automation for well baby visits, vaccines

5. EMR Optimization

Templates

2 Month well baby visit and vaccinations
Parental concerns: ??

Sleep:
Feeds: BF/formula
Development: meeting all developmental milestones as per Rourke
Safety: sleep safety discussed
Growth: growing well along curve

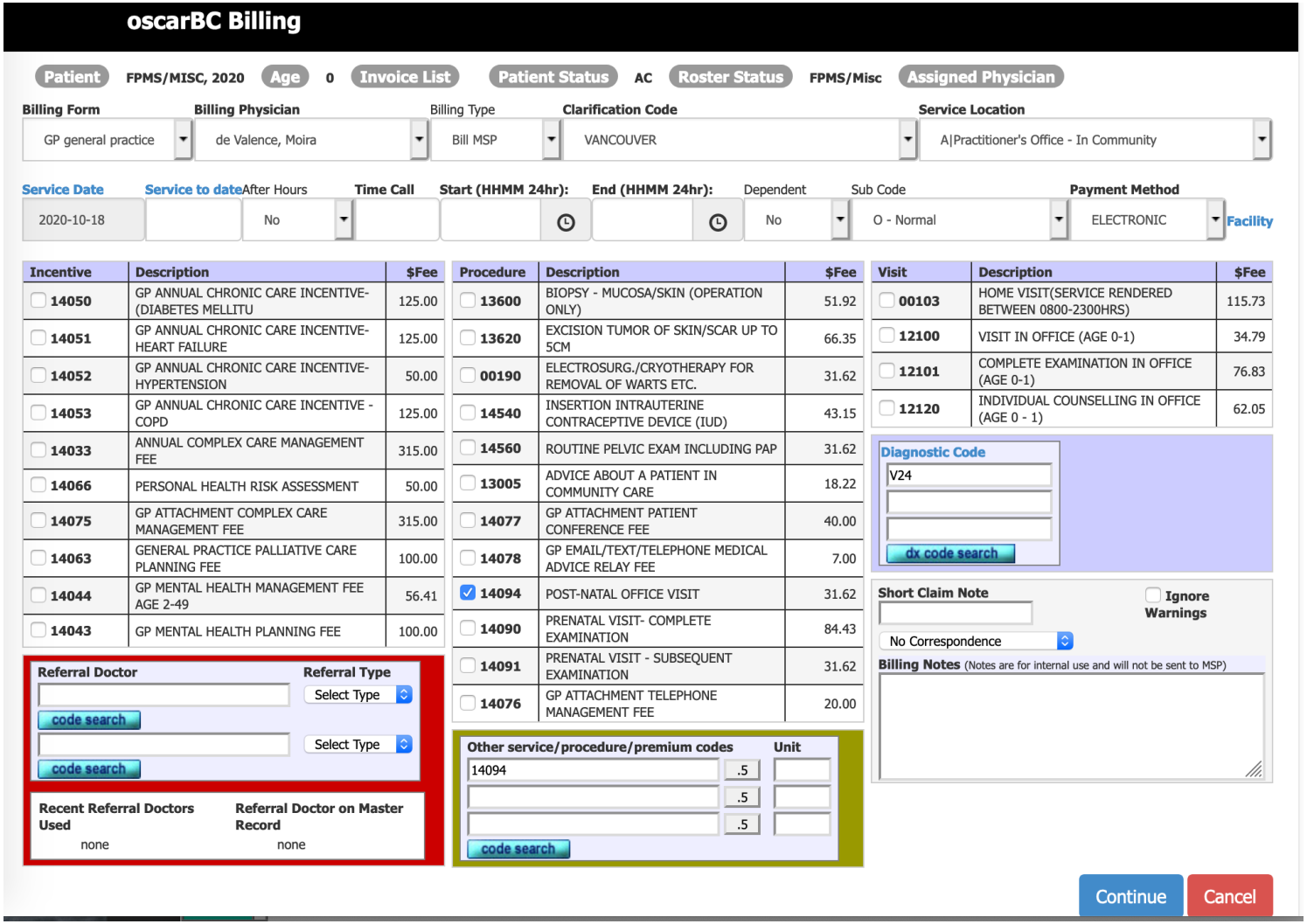
O/E: Alert, active, NAD
Ant fontanelle soft
+red reflex bilat
+S1/S2, no EHS, no murmurs
GAEB, no crackles, no wheeze
neg Ortolani/Barlow
Good tone
Skin clear
N GU exam – testes down x 2

Vaccinations: 2 month vaccines given, well tolerated

A/P: Well 2 month old baby growing well on curve and meeting all developmental milestones
1. Vaccines: discussed s/e of vaccines, remain in clinic for 15 min
2. F/U at 4 months or sooner PRN

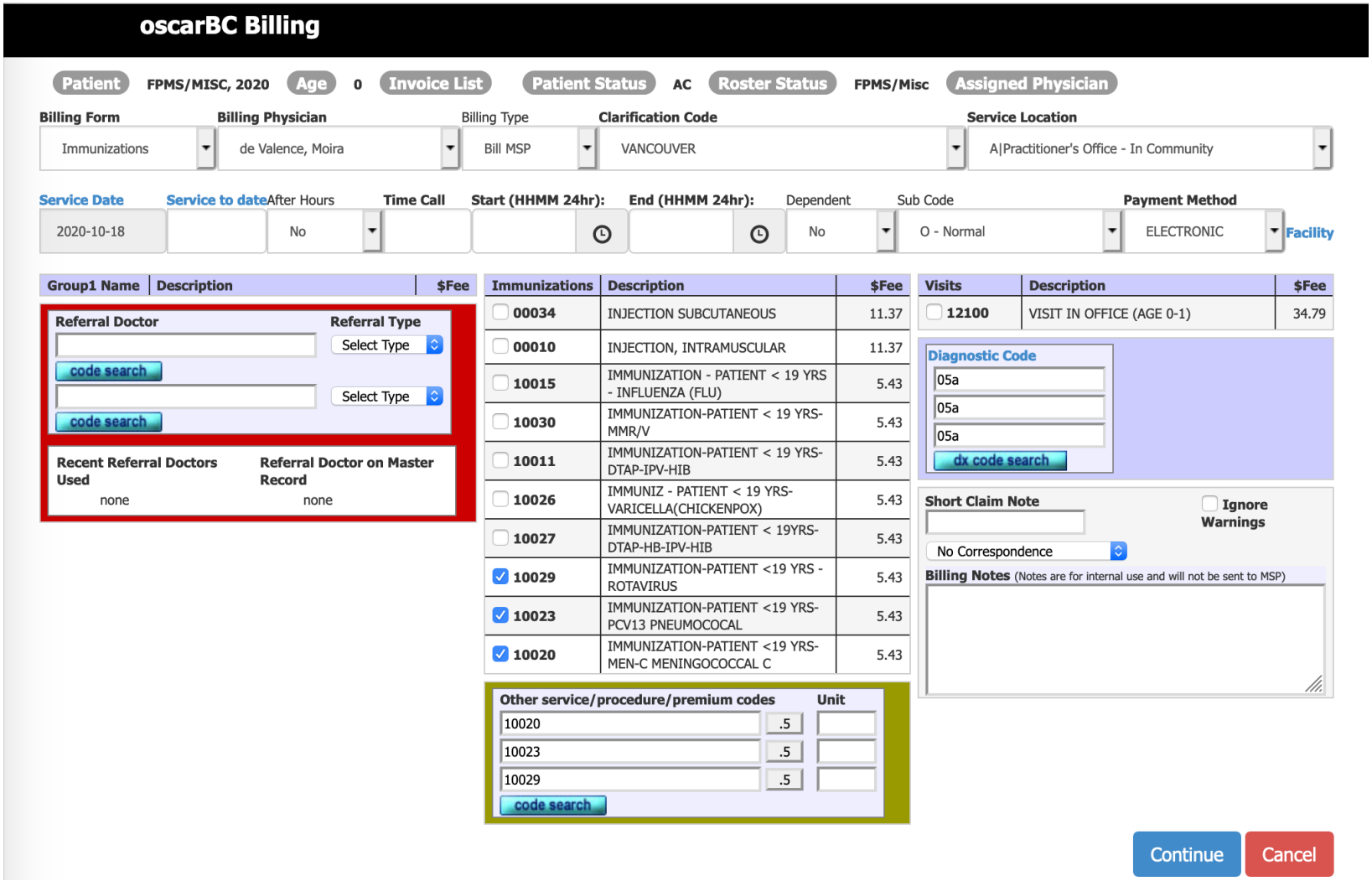
5. EMR Optimization

Billing worksheets – postpartum / well baby visits



5. EMR Optimization

Billing worksheets - vaccination



Billing Tips

COMPLETE AND APPROPRIATE CHARTING IS ESSENTIAL

1. **14094** Postnatal Office visit, may be billed up to 6 weeks postpartum.

2. **12100** Visit in office, 0-1 years old.
   Use for routine well baby visits, ICD-9 = 05a Growth and Development

3. **12101** Complete examination in office, 0-1 years old.
   For condition requiring complete physical examination and detailed history. Routine or periodic physical examination (check-up) is not a benefit under MSP.
   - Neonatal Jaundice (ICD-9 = 774)
   - Nippissing Development Screen at 18 months (ICD-9 = V79.3 Special screening for developmental delay in childhood)

Billing Tips

COMPLETE AND APPROPRIATE CHARTING IS ESSENTIAL

Immunizations for Patients 18 Years of Age or Younger

10010	Tdap-IPV or DTaP-IPV (Diphtheria, Tetanus, Pertussis, Polio)
10011	DTaP-IPV-Hib (Diphtheria, Tetanus, Pertussis, Polio, Hib)
10012	Td (Tetanus, Diphtheria)
10013	Td/IPV (Tetanus, Diphtheria, Polio)
10014	TdaP (Tetanus, Diphtheria, Pertussis)
10015	Influenza (Flu)
10016	Hepatitis A
10017	Hepatitis B
10018	Haemophilus influenza type b (Hib)
10019	Polio (IPV)
10020	Meningococcal C Conjugate (MEN-C)
10021	**Meningococcal Quadrivalent Conjugate (Groups A, C, Y, W-135)**
10022	**MMR (Measles, Mumps, Rubella)**
10023	**Pneumococcal Conjugate (PCV13)**
10024	**Pneumococcal Polysaccharide (PPV23)**
10025	**Rabies**
10026	**Varicella (Chickenpox)**
10027	**DTap-HB-IPV-Hib (Diphtheria, Tetanus, Pertussis, Hep B, Polio, Hib)**
10028	**HPV (Human Papillomavirus)**
10029	**Rotavirus**
10030	**MMR/V (Measles, Mumps, Rubella and Varicella)**

Vaccine billable in addition to visit for patients 18 Years of age or younger.

This fee may only be claimed up to 4 times per patient per day.

This fee is billable only for the following specific patient populations: patients 18 or younger

33A

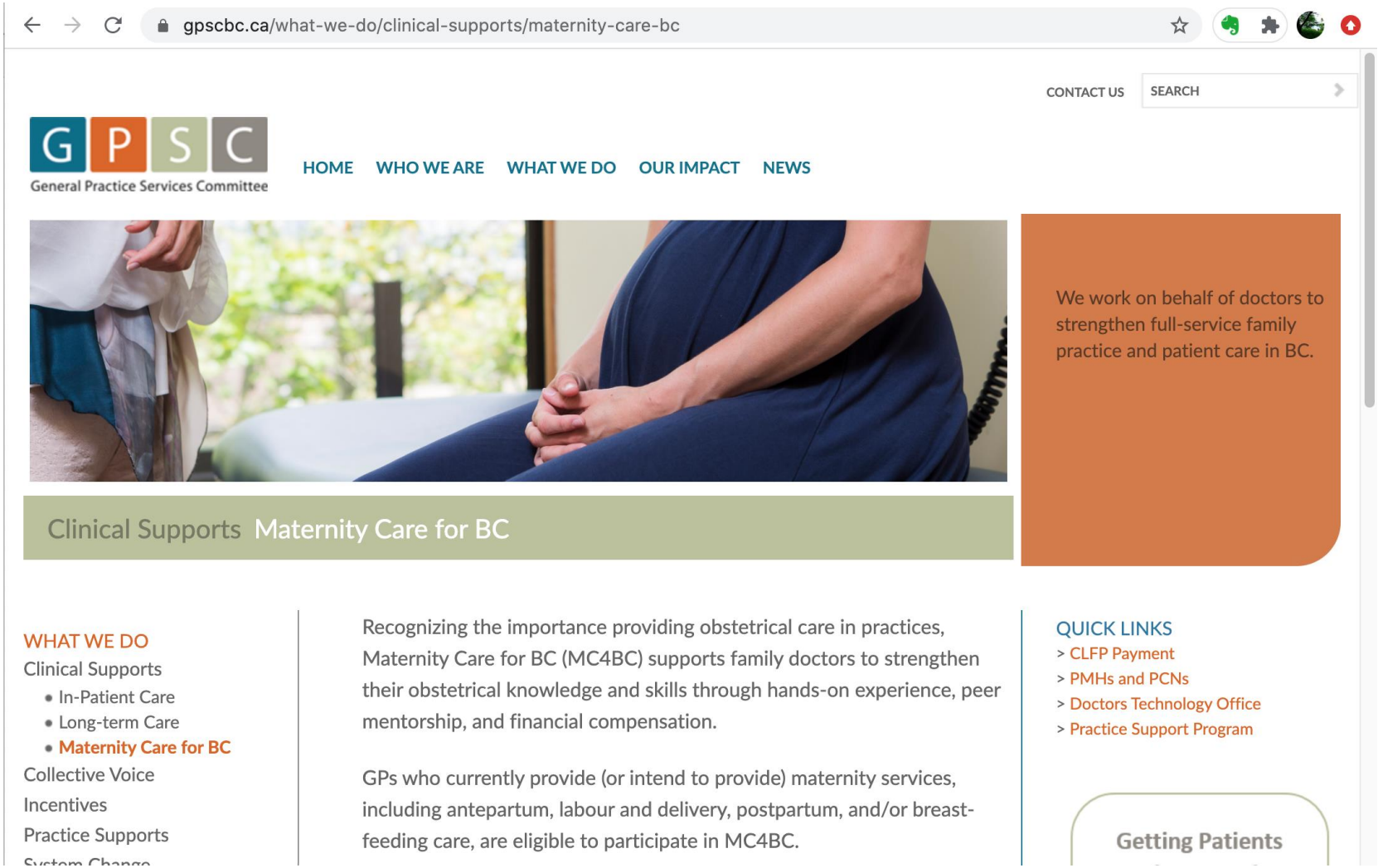
Conclusion

- When parents give birth, they take one step on their journey in parenthood. They take further steps in the days, weeks, and months after birth.

- Our responsibility to new families includes comprehensive postpartum and newborn care that encompasses their physical, mental, and emotional needs.

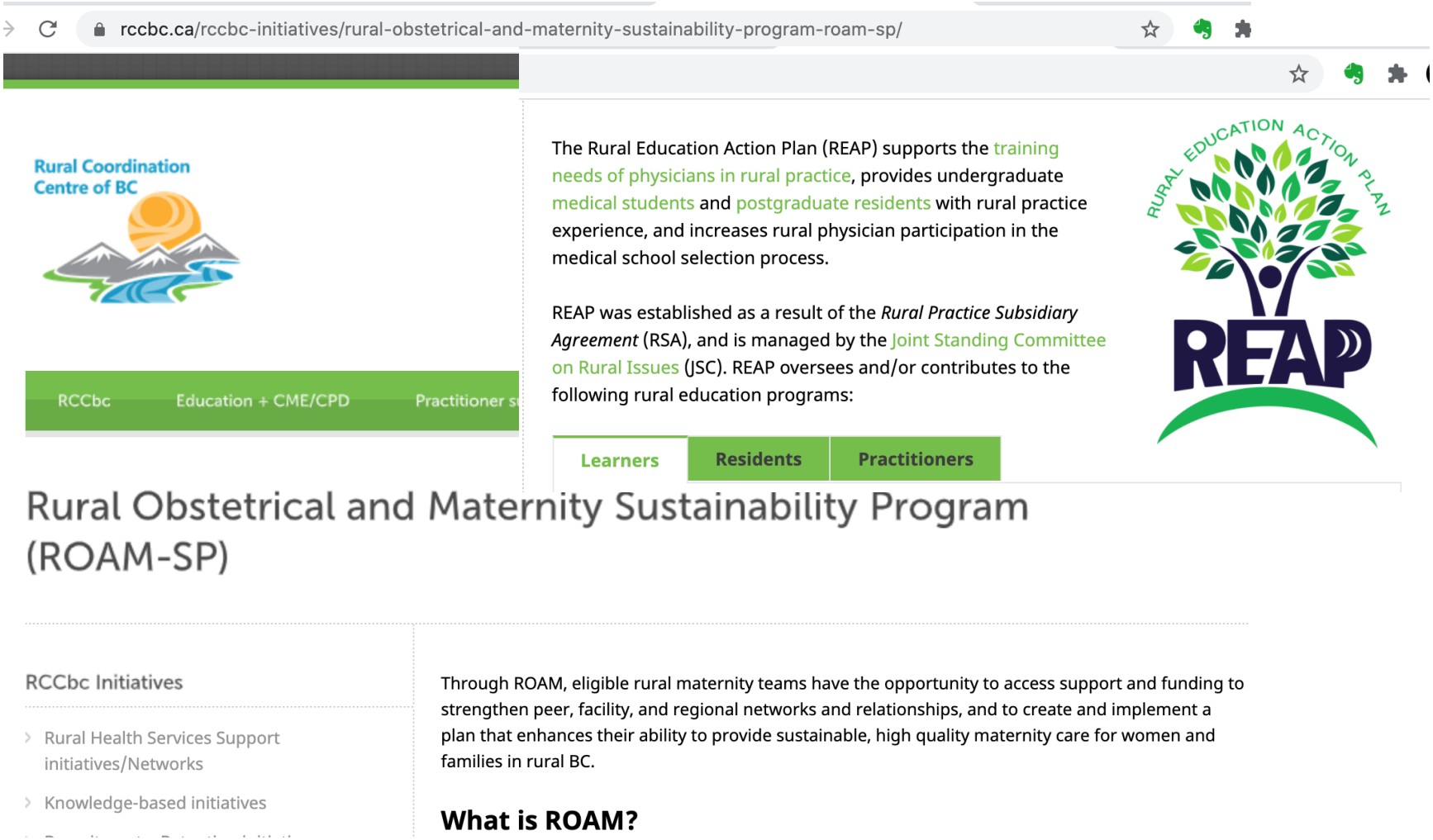
Additional Training in Maternity Care

MC4BC (Maternity Care for BC)



Additional Training in Maternity Care

REAP (Rural Education Action Plan): ROAM (Rural Obstetrical and Maternity Sustainability Program)



Questions/Comments?