GOALSNMYND · FOR THE NEW NURSE ON THE FLOOR

New L&D Nurse Survival Pack

A 4-page nurse-friend starter — admission, SBAR, mindset.

Friend — this is the thing I would hand you in the break room. It is short on purpose. Use it on your next shift, then come find me for the rest.

Created by LaShounn Stevenson, BSN, RN, RNC-OB, C-EFM — Labor & Delivery RN with 17+ years in nursing, AWHONN instructor, fetal monitoring educator.

Nurse-friend truth

You are not supposed to know everything on day one. You are supposed to know how to pause, ask, assess, and speak up safely. Everything in this pack trains that one habit.

What's inside (and what isn't)

- Admission snapshot — what to do in your first 10 minutes
- 2 SBAR scripts you can actually say out loud (sample from a 12-script vault)
- Words to stop apologizing for — small swaps that change how charge hears you

What's next, when you're ready: the Emergency Comms Vault, the Floor Culture Field Guide, the Confidence Class, and 1:1 Strip Confidence Coaching with me. See page 4.

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Admission Snapshot — First 10 Minutes

Tick as you go. Not every box applies to every patient — but the categories should always pass through your brain before you settle into the room.

BEFORE YOU TOUCH HER

- Confirm patient ID, allergies, gestation, gravida/para
- Reason for admission · provider/midwife group
- GBS · blood type/Rh · prenatal labs
- Risk history (HTN, DM, prior C/S, social needs)

BABY ASSESSMENT

- Apply EFM — confirm separate maternal pulse
- FHR baseline · variability · accels · decels
- Leopold's — presentation, position, EFW
- Document a clean 20-min strip on admission

MOM ASSESSMENT

- Vital signs (BP, HR, T, RR, SpO2) — baseline early
- Pain · contraction pattern · membrane status
- SVE per policy — dilation, effacement, station
- IV access · labs drawn (CBC, T&S, others)

WHERE'S THE REST?

The full first-60-minutes flow — orders/setup, OR-ready check, hemorrhage risk score, postpartum plan, and the report snapshot — lives in the Confidence Class. Get on the waitlist at goalsnmynd.com.

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SBAR Scripts You Can Actually Say

Open with your name, your unit/room, and the patient. State the change. State what you've done. State what you need. Practice out loud once. You will sound different on the phone.

2 of 12 — sample from the Emergency Comms Vault. The full vault adds tachysystole, mag toxicity, shoulder dystocia, cord prolapse, eclamptic seizure, terminal bradycardia, uterine rupture, neonatal resuscitation handoff, transfer-out, and rapid response — 12 total, with charge-nurse and provider variants. Get on the waitlist at goalsnmynd.com.

Cat II tracing not improving

S "This is [name], RN in Room ___. Calling about a Category II tracing that is not improving."

B "Patient is ___ weeks, [induction / spontaneous labor]. Currently ___ cm, [ROM/intact], [epidural/no epidural], on [pit at X mU/min / mag / abx]."

A "FHR baseline ___, variability ___ for the last ___ min, [accels / no accels], [decels described]. Contractions every ___ min."

R "I've repositioned, given an IV bolus per protocol, and paused oxytocin per policy. I need you to come evaluate the patient and tracing now."

Suspected postpartum hemorrhage

S "This is [name], RN in Room ___. Calling about a postpartum patient with ongoing bleeding."

B "[Vaginal / C-section] delivery at ___, [G/P], hemorrhage risk score ___, baseline VS ___."

A "EBL since delivery ~___ mL, uterus [boggy / firm with clots expressed], VS now ___, SpO2 ___. Patient reports [lightheadedness / no symptoms]."

R "I've initiated fundal massage, given [methergine / hemabate / TXA / cytotec] per order/protocol, started a second IV, and notified charge. I need you at the bedside."

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Words to Stop Apologizing For

Instead of saying…	Try this
"Sorry to bother you…"	"I'm calling because I'm concerned about ___."
"I don't know what to do."	"Here's what I assessed, here's what I did, and here's where I need help."

Before You Clock In

Confidence shows up after the reps — not before. Your brain needs receipts. The clinical stuff is in your textbooks. The stuff that decides whether your shift breaks you is what we work on together — SBAR under pressure, Cat II thinking, charting that tells a story, and the mindset that actually sticks.

Final nurse-friend truth

Being new is not a character flaw — it is a stage. Your job is not to pretend. Your job is to keep learning, keep asking, keep practicing, and keep speaking up safely. One day, the thing that scares you today will be the thing you teach somebody else.

What's next — pick your next move

Book a 15-min coaching call

1:1. Bring your scariest shift, your biggest question, or your next career move. I'll help you map it.

calendly.com/lashounn ›

Join the Confidence Class waitlist

My signature class for new L&D nurses: SBAR under pressure, Cat II thinking, and the mindset that actually sticks.

goalsnmynd.com/education ›

Get on the email list

Weekly nurse-friend notes, free tools, and first access to the Comms Vault & Floor Culture Field Guide.

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Clinical disclaimer. Original supplemental nurse-to-nurse education and encouragement only. It does not replace facility orientation, institutional policy, provider orders, AWHONN education, competency validation, chain of command, or clinical judgment. Always follow your facility's policies, scope of practice, and chain of command.

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