Thalia Cole reflection OB clinical rotation

Step 1 Description	**Step 4 Analysis**
In the labor and delivery floor I was assigned with a nurse to follow having two patients for the day. Both patients were high risk with pre-eclampsia. One was 34 weeks and 3 days and the other patient was 36 weeks on their pregnancy. Both were schedule to be induced today. The nurse explained to me on how she needs to first write down all meds, assessments, labs and other that needs to be down at what hour to plan out her days especially when assigned with two patients on the Mag. Medicine.	I was able to apply what I learned from lecture on pre-eclampsia and what assessments are needed to be done, labs and signs and symptoms to be aware for. Seeing it in action really helped me make those connections and build my hands on experience over the diagnose they had.
Step 2 Feelings • I could feel the nurse's pressure she had for the day with caring for two high risks patients. I could feel stress and anxiety growing on me on trying to stay sharp and how to be most helpful with the nurse and try not to slow her down. I felt the tension the nurse had that she wasn't able to have any conversation on the side or educating me on anything she was performing or doing. I had to keep up and try to keep my questions minimal to not distract her. At about noon time she did receive help and another nurse was able to take one of her patient's and I notice the change on her tensions level. I felt less anxiety as well.	**Step 5 Conclusion** • I questioned to myself on how this load seemed heavy for one nurse to have especially being on mag medicine because of all the assessments, labs, and added check-ups when they were starting the inducements and receiving epidural medication. We barely had a chance to sit or the nurse to sit and chart. After asking the nurse what is the nurse ratio to having patients on this floor, she mention it is one to one but if they have two they usually would not get two high risk patients. She explained they would only get one high risk patient normally. I'm not sure if they were short-handed that morning or what happened. I feel that it was not planned well and put stress on the nurse to handle two high risk patients, errors could have occurred or assessments could have been delayed of stuck in one room to long and causing a risk for the other patient if mag level was increasing or fetal heart rate decreasing. Luckily another was floated at noon to take over but this was a situation that could have been avoided to decrease burnt out and errors risks for the patient's safety.
Step 3 Evaluation • I liked that the nurse set out a plan and wrote down everything that needed to be done on hour cubes. I was able to keep up and know what was going to happen next and brushed up on it to be able to help her in anyway. I notice how she planned ahead after a patient requested to be put on epidural on pushing her lunch break later because she was going to need to be nearby to do the assessments every 15 minutes then 30 minutes with the patient. We had a busy morning and afternoon on bouncing back in forth with each patient. We did start with first focusing on getting everything done for one patient before bouncing to the next room. The teamwork was good on that floor, I did notice her coworkers checking on her if she needed	**Step 6 Action Plan** • Overall, I learned so much on time management with the nurse on how to care for to high-risk OB patients. How to recognize what are the priorities for each patient's and the most important things to do and look at for. I learned how to get the patient to eat something cold when they declined on it. Then, listening to nurse explained that we need to wake up baby and this would help. Instead of causing stress on the mom on what was going with the baby showing decreased almost absent lines on the screen. There was something I learned that I will do more often when checking the urine on a foley to double check it is not obstructed or something causing the urine not to drain into the foley bag. When I checked the foley I notice

help or answering her call lights and helping if she was stuck in the other room.	there was only 20 on the output in the container I automatically thought the mag needed to be stopped due to the low urine output for that hour but when I reported to the nurse. She investigated and saw that the foley was kinked, that is why the flow was stopped. So, at the end the patient's true output was 175. I learned the importance to investigate first before taking the output right away. I can apply this to other things as well to think what else can I do or see before I record and act on it. I felt terrible on not thinking to have checked but it is a learning curve for me that I will always remember to not do the same mistake again.

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