Covenant School of Nursing Reflective Practice

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Use this template to complete the Reflective Practice documentation. Use only the space provided. Information that is not visible is lost.

Step 1 Description

I got put into L+D w/ my classmates and changed into my OR scrubs.
I got my assignment and was sent off the nurse I would be following. My nurse only told me her name then pretty much ignored me for a while.
I decided to meet & introduce myself to my pt as well as do my vitals & assessment.

Step 4 Analysis

When they ruptured my pt's membrane the fluid was meconium stained. I was able to determine that wasn't the best sign. I know that baby can be at higher risk for infection/ resp. distress.
It was nice that I could apply things I learned in class and apply it.

Step 2 Feelings

At the start, I didn't really feel comfortable I was really out of my comfort zone
As the shift progressed, I tried to build a bit of a bond w/ my pt. It was really hard because I could tell it was too early for her.
I honestly felt like I was more in the way than helping.

Step 5 Conclusion

I think I could've made the situation better by being a little more outgoing when talking to my nurse. I may have came across as unconfident.

Step 3 Evaluation

I believe I did well taking initiative in trying to stay busy.
I did get to see a spinal block before a Csection, but then I got kicked out.
I also got to see membranes being ruptured. That was the scariest thing I've ever seen in my life.
Even though I didn't see too much, it was still cool to see.

Step 6 Action Plan

I learned on what not to do in professional practice. One of my classmates was completely ignored the whole clinical day.
We also happened to overhear a lot of mean remarks about some of the pts. I know I don't want to be that nurse

Prioritization Tool

	URGENT	NOT URGENT
IMPORTANT	Urgent & Important DO · vaginal exam · ↑ pitocin q30 min · monitor FHR	Not Urgent but Important PLAN · rupture membranes · possible epidural · vital signs
NOT IMPORTANT	Urgent but Not Important DELEGATE catheter placement after epidural	Not Urgent and Not Important ELIMINATE · ice chips

Education Topics & Patient Response:

pt was educated on why she would not need the epidural to rupture membranes - pt had no pain c contractions et had planned a natural delivery if possible - pt was calm, stated she still had no pain, agreed to wait.

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pt was educated on meconium stained amniotic fluid when ruptured - nurse stated as long as meconium didn't get thicker it was okay - pt was a little suspicious et asked again to verify

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Complete this during your labor and delivery experience and turn it in with your paperwork. Ask your instructor or TPC nurse to check over your findings

Situation:

Date/Time 9/11 0900 Age: 23

Cervix: Dilation: 3.5 Effacement: 60% Station: -2

Membranes: Intact: ✓ AROM: _____ SROM: _____ Color: _____ – eventually ruptured amn. fluid was mec. stained.

Medications (type, dose, route, time):

pitocin 2 milliunits q30 min ↑ by 2 milliunits

Epidural (time placed): N/A

Background:

Maternal HX: None

Gest. Wks: 40W Gravida: 1 Para: 0 Living: 0 (Induction) / Spontaneous

GBS status: + / (-)

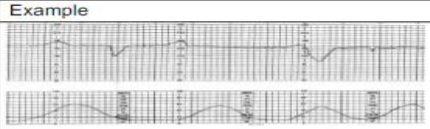
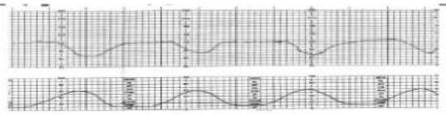
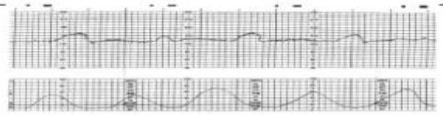
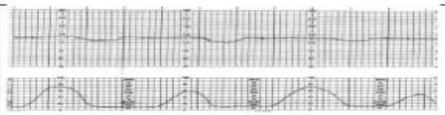
Assessment (Interpret the FHR strip-pick any moment in time):

Maternal VS: T: 98.5 P: 84 R: 20 BP: 108/77

Contractions: Frequency: 1-8 min apart Duration: 1min

Fetal Heart Rate: Baseline: 145

Variable Decels: ( ) Early Decels: (●) Accelerations: ( ) Late Decels: ( )

Pattern	Example	Cause	Interventions	Desired Outcome
Variable Decelerations		Cord Compression	Discontinue oxytocin Change maternal position Administer oxygen at 10 L/min by nonrebreather face mask. Notify provider Vaginal or speculum examination to assess for cord prolapse. Amnioinfusion Assist with birth if pattern cannot be corrected.	Relieve Cord Compression
Early Decelerations		Head Compression	Continue to monitor labor progress.	Maintain Oxygenation Healthy fetus at delivery
Accelerations		These are OK!	Continue to monitor labor progress.	Maintain Oxygenation Healthy fetus at delivery
Late Decelerations		Poor Placental Perfusion	Discontinue oxytocin Assist woman to lateral (side-lying) position. Administer oxygen Correct maternal hypotension Increase rate of intravenous solution. Palpate uterus to assess for tachysystole. Notify provider Consider internal monitoring Assist with birth if pattern cannot be corrected.	Maximize Oxygenation Increased Perfusion to Placenta

Recommendation/Nursing Plan:

Describe the labor process and nursing care given as well as any complications you witnessed: pt was in the latent phase all morning until membranes were ruptured by provider. Pt started having pain asking for epidural observe pt now. contractions are more frequent, moniter FHR, NICU on standby during delivery → mec. amniotic fluid.

Describe any Intrauterine Fetal Resuscitation measures utilized and the reason:

Delivery:

Method of Delivery: NA Operative Assist: NA Infant Apgar: NA / NA QBL: NA

Infant weight: NA