Prioritization Tool

	URGENT	NOT URGENT
IMPORTANT	Urgent & Important DO - Vitals - fundal rub after delivery of placenta - suction baby mouth and nose - APGAR	Not Urgent but Important PLAN - skin to skin as soon as possible - to schedule bathroom breaks
NOT IMPORTANT	Urgent but Not Important DELEGATE - getting mom water and food - taking pictures of mom and baby after delivery	Not Urgent and Not Important ELIMINATE - cleaning inside the vagina (placing douches/ sponges inside)

Education Topics & Patient Response:

*Vitamin K administration - gave consents

*Hemorrhage s/s (when to call) - patient and family demonstrated understanding by teaching back

* Toileting schedule - pt listened and was planning to call before getting up to go (compliant)

* importance of fundal rub and pad counts - pt agreed to assessments.

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 0700 Age: 31

Cervix: Dilation: 7cm Effacement: 80% Station: -1

Membranes: Intact: X AROM: ____ SROM: ____ Color: ____

Medications (type, dose, route, time):

Oxytocin 14 LR @ 125mL/hr

Epidural (time placed): none

Background:

Maternal HX: G4P2L2, medium hemorrhage risk, prenatal care

Gest. Wks: 39wk4d Gravida: 4 Para: 2 Living: 2 Induction / Spontaneous

GBS status: + / (-)

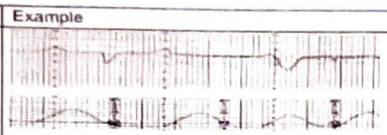
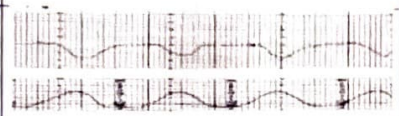
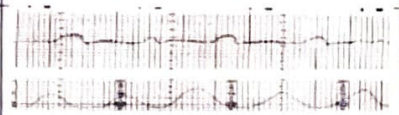
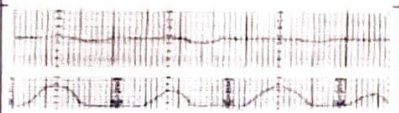
Assessment (Interpret the FHR strip-pick any moment in time):

Maternal VS: T: 97.8 P: 79 R: 16 BP: 139/79

Contractions: Frequency: 1.5-2min Duration: 60-70sec

Fetal Heart Rate: Baseline: 135

Variable Decels: ( ) Early Decels: (X) 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: Labor process took 1 hr, therapeutic communication, breathing/relaxation techniques were used c nurses guidance. We witnessed ~~hemmorha~~MC hemorrhage at q15 check during fundal rub.

Describe any Intrauterine Fetal Resuscitation measures utilized and the reason:

IV fluid administration, minimal repositioning on (L) lateral

Delivery:

Method of Delivery: vaginal Operative Assist: n/a Infant Apgar: 8/9 QBL: 1270

Infant weight: 9lbs