Complete this [illegible] labor and very experience and t **Ask your instructor or TPC nurse to check over your findings**

Situation:

Date/Time 0930 Age: 30

Cervix: Dilation: 1 Effacement: 70 Station: -1

Membranes: Intact: N AROM: _____ SROM: _____ Color: _____

Medications (type, dose, route, time):

NA

Epidural (time placed): 0900

Background:

Maternal HX: decreased fetal movement

Gest. Wks: 38 Gravida: 1 Para: 1 Living: 0 (Induction) / Spontaneous

GBS status: + /C

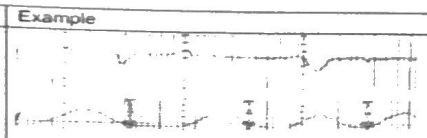
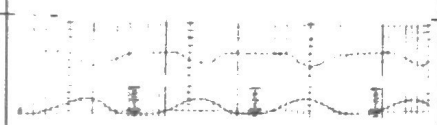
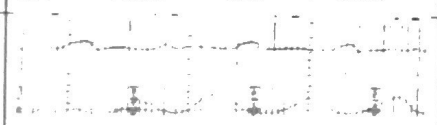
Assessment (Interpret the FHR strip-pick any moment in time):

Maternal VS: T: 98.5 P: 62 R: _____ BP: 115/63

Contractions: Frequency: every 3 min Duration: 45 sec

Fetal Heart Rate: Baseline: 135

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 May initiate 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 Ask client to turn 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 was smooth but slow dilating 1cm/hr, no complications

Describe any Intrauterine Fetal Resuscitation measures utilized and the reason: Turn mom on Left side - Stimulate fetal movement

Bolus fluids - BP / fHR

Delivery:

Method of Delivery: _____ Operative Assist: _____ Infant Apgar: ____/____ QBL: _____

Infant weight: _____

	URGENT	NOT URGENT
IMPORTANT	Urgent & Important DO monitor fetal movement	Not Urgent but Important PLAN Position / Stimulation
NOT IMPORTANT	Urgent but Not Important DELEGATE Contraction Strength / dilation	Not Urgent and Not Important ELIMINATE urine output / color after foley

Education Topics & Patient Response:

Keep an eye on BP after epidural, let nurses know if you start to feel different. Rotating positions can help stimulate baby. Pt was easy to work with and was handling education topics well.

Covenant School of Nursing Reflective Practice

Name: Instructional Module: Date submitted:

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

Step 1 Description

My Patient for the day came in for decreased fetal movement so she was induced. She was Progressing Smooth but Slow

Step 4 Analysis

frequent accels were Present so fetal movement was the main Priority from then on we also needed to keep an eye on her dilation and effacement.

Step 2 Feelings

The initial feeling was awkward but throughout the day I became more comfortable and I think my Patient became more comfortable with me as well

Step 5 Conclusion

I was not Present when the baby was delivered but she was Progressing slowly, Last check she was 7cm and 80% -1

Step 3 Evaluation

Throughout the day fetal monitoring was watched closely, making Sure ~~do~~ no decels were happening with contractions and keeping an eye on the fetal movement

Step 6 Action Plan

The Plan is to continue titrating Pitocin and continuing comfort care until She is dilated enough to give birth