Chantal Navarrete

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 10/29 0811 Age: 38

Cervix: Dilation: 4 Effacement: 60 Station: -3

Membranes: Intact: YES AROM: _____ SROM: _____ Color: _____

Medications (type, dose, route, time):

Mag. Sulfate IV 40mg/mL 50mL/hr

Epidural (time placed): _____

Background:

Maternal HX: PCOS, C-section X1, RA, prolactinoma

Gest. Wks: 32⁴ Gravida: 7 Para: 6 Living: 6 Induction / Spontaneous

GBS status: + / - unknown

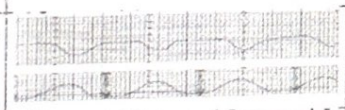
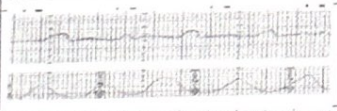
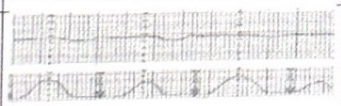
Assessment (Interpret the FHR strip-pick any moment in time):

Maternal VS: T: 97.6 P: 102 R: 16 BP: 121/58

Contractions: Frequency: 2-4min Duration: 40-50sec

Fetal Heart Rate: Baseline: 132

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 women 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:

(did not experience labor delivery) or c-section

Describe any Intrauterine Fetal Resuscitation measures utilized and the reason:

Delivery:

Method of Delivery: _____ Operative Assist: _____ Infant Apgar: ___/___ QBL: _____
Infant weight: _____

Chantal N

Covenant School of Nursing Reflective Practice

Name: Chantal N Instructional Module: IM 6 Date submitted: 10/29

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

Step 1 Description	Step 4 Analysis
Patient admitted for strong contractions related to pregnancy. She was 32 wks with baby having breech presentation. Due to presentation of baby being breech, patient was recommended for c-section.	I was able to apply my learnings of the importance of FHM and how to interpret the results. Baby was having moderate variability with accelerations. I was also able to understand the importance of magnesium sulfate & the assessment pertinent to it.
Step 2 Feelings	**Step 5 Conclusion**
Because patient was most likely going to have a c-section, I was a bit nervous & worried for her due to baby being pre-term.	From this event, I have learned that as a nurse you are a very influential factor in patients level of comfort. I also learned that it is very important to assess for clonus & edema while on magnesium sulfate.
Step 3 Evaluation	**Step 6 Action Plan**
Though the c-section did not happen, I believe her understanding of the event was clear. We were able to provide as much comfort for her while she was experiencing pain & pressure.	Based on the patients situation, I conclude that she will possibly be moved back to antepartum for continuous monitoring if she had not dilated further & had still not experienced rupture of membranes.

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Chanell

Prioritization Tool

	URGENT	NOT URGENT
IMPORTANT	Urgent & Important DO -Connect pt to FHM & TOCO - check pt cervix dilation -restart mag. sulfate	Not Urgent but Important PLAN -give tylenol for HA -reposition mom -NICU education
NOT IMPORTANT	Urgent but Not Important DELEGATE -[illegible] -Taking pictures during c-section or labor	Not Urgent and Not Important ELIMINATE -giving ice chips -replace bedding

Education Topics & Patient Response:

Discussed epidural insertion and what to expect; pt verbalized understanding and was open to having epidural even after planning a completely natural birth

Educated mom on true labor characteristics. She understood that true labor consisted of rupture of membranes, cervical dilation & effacement. Also educated mom on magnesium sulfate. She understood that it slows down preterm labor & can protect the neurological being of the baby.

Student Name: Chantal Navarrete

Date:

Situation:

Patient Room #: 416

Allergies: NKDA

Delivery Date & Time: 10/28/24@2145

NSVD PC/S RC/S

Indication for C/S:

QBL: 176 BTL:

LMP: 1/8/24 Est. Due Date: 11/4/24

Prenatal Care: <28 wks ✓ LPNC 20 wks

Anesthesia: None Epidural Spinal

General Duramorph/PCA

VS: Q4hr Q8hr

0800:

T: 98.2 BP: 112/76 88 map HR59

O2: 99%

1200:

Diet: Reg

Pain Level: 4 / 10 Activity:

cramping

Newborn: Male Female

Feeding: Breast Pumping Bottle

Formula: Similac Neosure Sensitive

Apgar: 1min 9 5min 9 10 min ____

Wt: ____ lbs ____ oz Ht: ____ inches

2965gm

MD:

Mom-

Baby-

Consults:

Social Services: ____

Psych: ____

Lactation: ____

Case Mgmt: ____

Nutritional: ____

Background:

Patient Age: 28 y/o

Gravida: 5 Para: 5 Living: 5

Gestational Age: 39 weeks

Hemorrhage Risk: Low Medium High

Prenatal Risk Factors/Complications:

scoliosis, anemia

NB Complications: ____

Maternal Lab Values:

Blood Type & Rh O+

Rhogham @ 28 wks: Yes No

Rubella: Immune Non-immune

RPR: R / NR HbSAG: + / -

HIV: + / - GBS: + / - Treated: ____ X

H&H on admission: 11.6 hgb / 32.8 hct

Newborn Lab Values:

Blood Type & Rh O+

POC Glucose: ____ Coombs: + / -

Q12hr Q24hr AC Glucose: ____ ____ ____ ____

Bilirubin (Tcb/Tsb): 10.0

CCHD O2 Sat:

Pre-ductal ____% Post-ductal ____%

Other Labs:

Vaccines/Procedures:

Maternal:

MMR consent ____ Date given: ____

TdaP: Date given 8/19/24 Refused

Rhogham given PP: Yes No

Newborn:

Hearing Screen: Pass Retest Refer

Circumcision: Procedure Date 10/29/24

Plastibell Gomco Voided: Y / N

Bath: Yes Refused

Student Name: Date:

Assessment (Bubbleheb): Neuro: WNL Headache Blurred Vision Respiratory: WNL Clear Crackles RR 12 bpm Cardiac: WNL Murmur B/P 112 / 76 Pulse 59 bpm Cap. Refill: <= 3 sec >3 sec Psychosocial: Edinburgh Score _____	Breast: Engorgement Flat/Inverted Nipple Uterus: Fundal Ht 2U 1U UU U1 U2 U3 Midline Left Right Lochia: Heavy Mod Light Scant None Odor: Y / N Bladder: Voiding QS Catheter DTV Bowel: Date of Last BM 10/29 Passing Gas: Y / N Bowel sounds: WNL Hypoactive	Episiotomy/Laceration: WNL Swelling Ecchymosis Incision: WNL Drainage: Y / N Dressing type: _____ Staples Dermabond Steri-strips Hemorrhoids: Yes No Ice Packs Tucks Proctofoam Dermaplast Bonding: Responds to infant cues Needs encouragement
Treatments/Procedures: Incentive Spirometry: Y / N PP H&H: _____ hgb _____ hct HTN Orders: Call > 160/110 VSQ4hr Hydralazine protocol Labetolol BID/TID	IV Fluids: Oxytocin LR NS Rate: _____ / Hour IV Site: 18 gauge Location: R AC Magnesium given: Y / N Dc'd: _____ @ _____ am/ pm	Antibiotics: Frequency: _____ _____ _____ _____ _____ _____
Recommendation: Pt will be going for tubal 10/30/24 @ 1200		

MB

IM6 Critical Thinking Worksheet

Student Name: Chantal Navarrete	**Nursing Intervention #1:** Prevention of infection	**Date:** 10/30/24
Priority Nursing Problem: **Pain (Incisional)** Tubal ligation - potential for infection	*Evidence Based Practice:* wound cleansing, simple dressing **Nursing Intervention #2:** Monitor pain & bleeding	**Patient Teaching (specific to Nursing Diagnosis):** -keep wound clean -wash hands properly before touching wounds -do wound care as directed -keep follow up appointments
Related to (r/t): -open incision **As Evidenced by (aeb):**	*Evidence Based Practice:* pain assessment pain medication look for sign of bleeding on dressing **Nursing Intervention #3:** Monitor for infection	
Desired Patient Outcome (SMART goal): Minimal pain No infection Pt ability to return to normal ADL's	*Evidence Based Practice:* look for redness, warmth, drainage, pain, abnormal odor	**Discharge Planning/Community Resources:** Follow up with OB & PCP Take meds as directed