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

Pt came in with contractions every 5 minutes. She was planned to be induced today.

Step 2 Feelings

I was excited for the pt, this was her first child.

Step 3 Evaluation

The pt was very sweet she was okay with me placing her catheter and I was thankful for that.

Step 4 Analysis

When pt was put on toco, I was able to read the tracing.

Step 5 Conclusion

I have learned every mother is different, my pt was not in a lot of ~~pat~~ pain with contractions and she showed no signs of pain when epidural was placed.

Step 6 Action Plan

[redacted]

I think L&D was a great experience I did not know what to expect being on the opposite side of delivery, having a patient in labor. But overall it was a great experience.

Prioritization Tool

	URGENT	NOT URGENT
IMPORTANT	Urgent & Important DO Watch for signs of distress on monitor for baby. late Decelerations.	Not Urgent but Important PLAN Plan on immortance/risks for not recieving vitamin K shot Newborn after birth.
NOT IMPORTANT	Urgent but Not Important DELEGATE positions give examples of for back pain relief	Not Urgent and Not Important ELIMINATE Showing family where they can get coffee or directions to cafeteria.

Education Topics & Patient Response:

If patient has S/S of too much mids in epidural, notify NS quickly.

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 12-4-24 11:41 Age: 28
Cervix: Dilation: 4 Effacement: 90 Station: -1
Membranes: Intact: ✓ AROM: ____ SROM: ____ Color: ____
Medications (type, dose, route, time):
pitosin @
Epidural (time placed): 9:15

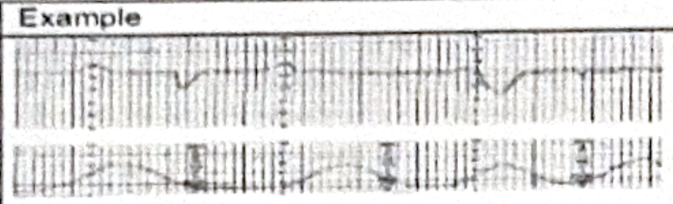
Background:
Maternal HX:
Gest. Wks: 40 Gravida: 1 Para: 0 Living: 0
GBS status: + / (-)

Induction / Spontaneous

eam @ 9:30

Assessment (Interpret the FHR strip-pick any moment in time):
Maternal VS: T: 98.1 P: 105 R: ____ BP: 104/61
Contractions: Frequency: 5mins Duration: 30sec.
Fetal Heart Rate: Baseline: 150 ✓
Variable Decels: ( ) Early Decels: (✓) Accelerations: ( ) Late Decels: ( )

brok water @ 12:15 @ 5cm 100%.

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:

very - tenagm - nausea

Describe any Intrauterine Fetal Resuscitation measures utilized and the reason:

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

IM6 Critical Thinking Worksheet

Student Name: Latonya Esquivel

Priority Nursing Problem:
Hemmorage

Related to (r/t): Why?
Uterus failing to contract enough after delivery.

As Evidenced by (aeb): S/S
Large amounts/pool of blood from vagina

Desired Patient Outcome (SMART goal):
Watch for any excessive bleeding to prevent

Nursing Intervention #1:
have patient ambulate when she feels comfortable to

Evidence Based Practice:
Prevent forms of clotting

Nursing Intervention #2:
Educate mom on S/S of breast mastitis.

Evidence Based Practice: Reasoning.
To prevent worsening/infection

Nursing Intervention #3:
Educate mom on S/S of postpartum depression

Evidence Based Practice:
So she will reach out for help if she notices S/S

Date:

Patient Teaching (specific to Nursing Diagnosis):

1. Inform mom of changes to body after delivery.
2. Educate mom on how important bonding with baby is.
3. Do not get discouraged if milk does not come immediately. It can take up to a week to form.

Discharge Planning/Community Resources:

1. Give information for WIC Services
2. Avoid driving atleast 2 weeks after C-Section
3. Follow up appointments for mom & baby