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 1/28/25 @0800am Age: 19 yr old

Cervix: Dilation: 3cm + 10cm @0800am Effacement: 70% + 100% @0800am Station: -2 + 0 @1120am

Membranes: Intact: ____ AROM: ✓ SROM: ____ Color: clear

Medications (type, dose, route, time): 0800am 0900am 1000am

IV - oxytocin & LR - bolus - 4mu/min → 6mu/min → 8mu/min

Epidural (time placed): 1/28/25 @0223 am - Matthews

Background:

Maternal HX: anemia

Gest. Wks: 40wks 2days Gravida: 1 Para: 0 Living: ____ - before / - after delivery

GBS status: + / (-)

Induction / Spontaneous (contractions)

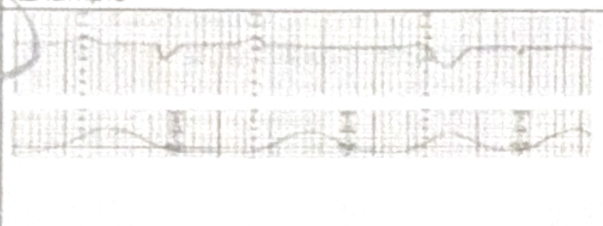
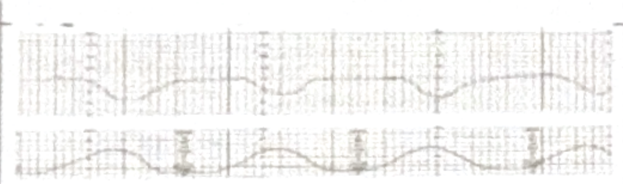
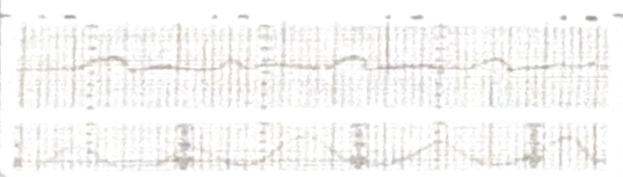
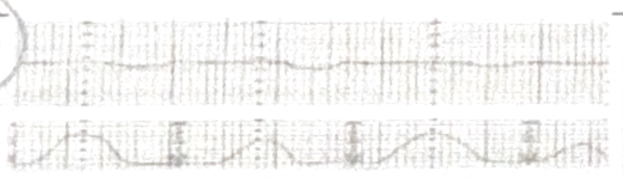
Assessment (Interpret the FHR strip-pick any moment in time):

Maternal VS: T: _____ P: _____ R: _____ BP: _____

Contractions: Frequency: 1½-3min Duration: 60-80sec

Fetal Heart Rate: Baseline: 130 w/ late decel

Variable Decels: (✓) Early Decels: ( ) Accelerations: ( ) Late Decels: (✓) noted @ 1018am interventions (position changed)

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:

- OWR when mom was on (R) side w/ peanut ball @1018am noted 2 late decel
- placed on back - monitored for 10min - mom had late decel. - went in turned mom to (L) & high tones FHR ↓ - bolused LR - notified OBGYN. mom was having contraction. nurse asked CN if she should push. mom push - FHR ↓ dt to stress. OBGYN @ B.S. stated nuchal nglaim (1) on baby.

Describe any Intrauterine Fetal Resuscitation measures utilized and the reason:

- bolused fluids - stopped pitocin.
- NICU team contacted
- no pushing called baby to go in distress

Delivery:

Method of Delivery: Vaginal Operative Assist: forceps Infant Apgar: 7 / 9 QBL: 710mL

Infant weight: 5lb. 14oz

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

- 0800 am - moms contractions were not accurate - baby was sleeping additionally hard to read on FHR 4 monitor in room and at nurse station.
  - result into IUPC placement and ROM. ↓
- 1018 am - late decel noticed by TPCN & me.

Step 4 Analysis

- this prepares me for always monitoring - it is important.
  - reason is if we need to do quick interventions to help mom or baby it shows you need to act fast.

Step 2 Feelings

- I was thinking about the interventions we could do such as IVF when seeing more late decel. I was feeling eager on how we could stop those late decels. I was also thinking of what actually is causing baby to late decel.

Step 5 Conclusion

I learned a lot in this event. Such as monitoring - and seeing real like changes in variability of what can happen.

Step 3 Evaluation

- everything happened quickly. the first 2 late decel we changed mom to back. 10 min after the had another one - that is when we went to change diff positions - FHR 4.
- resulted into delivery - bad was contractions were causing baby to go in distress. everyone got into everything they needed to do. I had expected baby to go to NICU or oxygen saving low, due to muscular rigidity.

Step 6 Action Plan

as the nurse said this is not like all deliveries. everyone acted fast even the CN, and knew the longer the baby were to be in there the more damage could occur.

Prioritization Tool

	URGENT	NOT URGENT
IMPORTANT	Urgent & Important DO - monitor baby throughout - monitor FHR - late decel notify Dr. - interventions due to FHR↓ - immediate birth to ↓ fetal distress from occuring due to marginal/rigidity.	Not Urgent but Important PLAN - latching w/ baby (mom + baby) education - education - sis post vaginal
NOT IMPORTANT	Urgent but Not Important DELEGATE [illegible]	Not Urgent and Not Important ELIMINATE N/A

Education Topics & Patient Response:

- latching w/ baby - 1st baby - colostrum vs. milk / breasts
- monitor post op bleeding - pads, peri care, any different notices
  - especially w/
    - uterus / bladder will have changes
- will do fundal massages - firm - will push down