Marissa Torres

L+D 4-2-25

IM6 Student Learning Outcomes				
Safety & Quality	**Clinical Judgment**	**Patient Centered Care**	**Professionalism**	**Communication & Collaboration**
Formulate a plan of care for the childbearing family, and the patient with mental health disorders using evidence-based practice, safety, and quality principles.	*Demonstrate clinical judgment using evidence-based data in making clinical decisions for the childbearing family, and the patient with mental health disorders.*	*Demonstrate family centered care based on the needs of the childbearing family, and the patient with mental health disorders.*	*Relate knowledge, skills, and attitudes required of the professional nurse by advocating and providing care to the childbearing families, and the patient with mental health disorders.*	*Communicate and collaborate effectively with patients, family, and members of the interdisciplinary team in the childbearing family, and the patient with mental health disorders.*

Safety & Quality: AROM took place. cervical progression was minimal. pitocin was discussed between RN and mom. mom did not want pitocin unless it was emergent. Nurse plan was to go in and start it. but she took moms decisions importantly and listened. RN explained parameters that could arise that would need pitocin. mom and nurse had great communication and discussed

Clinical Judgment: risks and benefits of next possible intervention. although the nurse had set plans for her patient she was extremely open and optimistic with her patient. It felt so positive and

Patient Centered Care: supportive seeing them interact in such a sensitive and painful situation for mom. 10/10♡ I hope to be a fraction of all of the nurses I met, one day soon!

Professionalism:

Communication & Collaboration:

Covenant School of Nursing Reflective Practice

Name: Marissa Torres Instructional Module: L&D Date submitted: 4-2-25

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

Step 1 Description

- 21 y/o was sent home believing to not have been in active labor.
- Pt. was on 2H labor assess on our arrival to unit @ 645 last cervical exam was done @ 845 am. DC took place at 9:15 am. delivery took place @ 10:53am.
- RN involved, NP received verbal details and provided pt w/option for pain meds prior to being sent home. my role as a student was observer. building rapport w/pt + husband @ beside, by doing so I hoped to provide comfort and ease the feeling of uncertainty.

Step 2 Feelings I felt excited and hopeful that mom would progress and be admitted. I was thinking not enough intervention was being done. I felt worried and skeptical. The actions of staff made me a little sad d/t judgements of Mom being "young and sensitive". she was brushed off as "faking." outcome was shocking that she #1 delivered unmedicated, #2 wasn't heard/listened to. my integrity and dignity felt violated because I could not make them do anything different because what do I know? "Im just a student." my stomach felt the off-set of care she received from the time I met her.

Step 3 Evaluation

good: baby and mom were alive and healthy.

bad: unmedicated was not her plan and her voice was unheard.

easy: Nothing.

difficult: sending her home without more guidance and evaluation.

outcome: I anticipated mom being admitted. contractions were not picking up on toco, but were 100%. Palpable and strong. I contributed by helping Nurse get items she needed, and asking for more details on labor assessing. and cervical status.

Step 4 Analysis

socioeconomic status was a barrier in this patient and her family. mom ended up having excessive abnormal bleeding after 2 fundus massages. an IV was placed for medication to contract the uterus. different perspectives did not make an impact for mom d/t friendships between staff. seeming to take their words for it. I believe mom should have been assessed by a second set of hands.

Step 5 Conclusion

as a student I can only advocate to a certain extent. one of the women on the unit that makes higher decisions stated "nobody has time for this sh-t." I could have told you the gut instincts and situation details better. but I'm tired of feeling like a tattle tale on the actual nurses when im just a student, so I just went with it. I dont think there was any changing of the minds of staff involved. unless an actual MD got involved.

Step 6 Action Plan

Im so shocked she gave birth so fast. In the future I will advocate louder/more efficient for the mom who is scared to go home. In the future a second nurse should confirm the findings of the first because of the safety for mom and her unborn baby. I understand protocols are in place but more care personnel was needed. this has taught me the extreme importance on the decisions we make for our patients because multiple lives are in our hands. it is critical to be educated and confident in our interventions because these moms come in trusting that nurses / doctors can do "magic": save lives, and fix what's wrong.

Prioritization Tool

	URGENT	NOT URGENT
IMPORTANT	Urgent & Important DO Toco readjustment to mx contractions.	Not Urgent but Important PLAN education on hydration, kick counting, vaginal changes at home and when to come back to hospital.
NOT IMPORTANT	Urgent but Not Important DELEGATE Injection of intra-muscular medications for comfort measures	Not Urgent and Not Important ELIMINATE gave mom a band-aid. no bleeding was taking place to provide sense of safety/security.

Education Topics & Patient Response:

Cervical checks causing vaginal spotting = normal. patient understood.

contraction patterns to come back in for.

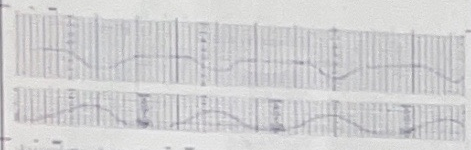
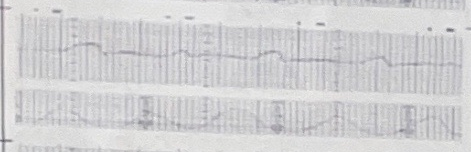
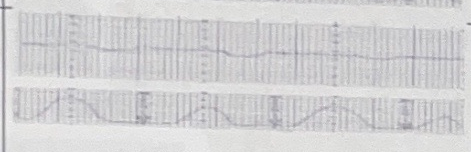
oral hydration causing uterine irritability.

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: 4/2/25
Date/Time 8:45am Age: 21
Cervix: Dilation: 4cm Effacement: 60% Station: -3
Membranes: Intact: ✓ AROM: ____ SROM: ____ Color: ____
Medications (type, dose, route, time):
demerol -IM inj (r) ventrogluteal - promethazine -IM inj (L) ventrogluteal.
Epidural (time placed): ____

Background:
Maternal HX: asthma
Gest. Wks: 38+3d Gravida: 2 Para: 1 Living: 1
GBS status: + / (-) Induction / (Spontaneous)

Assessment (Interpret the FHR strip-pick any moment in time):
Maternal VS: T: ____ P: ____ R: ____ BP: ____
Contractions: Frequency: 3-6 min. Duration: ____
Fetal Heart Rate: Baseline: 145
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 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: mom was claiming to be in pain with contractions and was very hesitant to accept being sent home. Labor assess (2hr) was done and my Nurse said she believed pt just wanted pain meds. encouragement was not provided to mom NOR did I believe she was treated with dignity. assessment of cervical dilation should have been done by higher person to ensure no progress had been made. mom delivered an hour later downstairs, un-medicated.

Describe any Intrauterine Fetal Resuscitation measures utilized and the reason:
N/a

Delivery:
Method of Delivery: vaginal Operative Assist: ____ Infant Apgar: ____/____ QBL: ____
Infant weight: 10 lbs 1 oz

didn't get infant assessment due to PPH of mom.