Covenant School of Nursing Reflective Practice

Name: Macei Sierra 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	Step 4 Analysis
The patient was admitted on 8/18 and was only progressed to 3cm 90% from the 18th to today. She was hypertensive & at risk for preclampsia. the Dr decided it would be best to do a C-Section instead of a vaginal birth for mom & baby safety.	Having the Intrapartum lecture before this clinical really helped with understanding everything that goes on in the L&D floor. With my patient being hypertensive it put her more at risk for preclampsia and with everything we learned in lecture it helped piece everything together.
Step 2 Feelings	**Step 5 Conclusion**
I was excited to see all of the steps that were involved to prepare for a c-section and to actually witness one.	Every mom can come in with a birth plan of how they want things to go. They would just need more information on how quickly things can change in labor and to keep an open mind if there were anything to change.
Step 3 Evaluation	**Step 6 Action Plan**
Seeing the birth of another human is such an amazing experience. The whole team dynamic was cool to experience and to be apart of. They all worked so well together and made mom & dad as comfortable as you can get for a c-section.	The lesson I learned would be that every birth plan can change. Being informative to your patient on why it has changed is very important and gives them an understanding.

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 8/20 → Age: 19

Cervix: Dilation: 3cm Effacement: 90% Station: -2

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

Medications (type, dose, route, time):

labetalol 200mg PO 0900 - Not given magnesium 4g 1545 on 8/18

Epidural (time placed): 0840

Background:

Maternal HX: anxiety, anemia, history of marijuana, HTN

Gest. Wks: 36 4days Gravida: 2 Para: 0 Living: 0 (Induction) / Spontaneous

GBS status: + / (-)

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

Maternal VS: T: 98.7 P: 76 R: 16 BP: 149/78

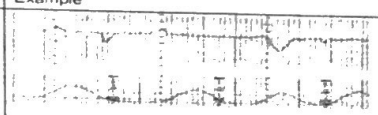
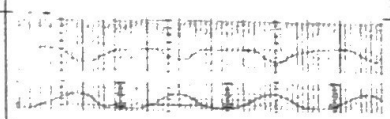
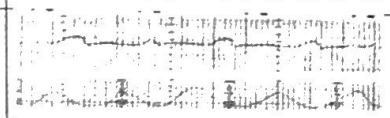
Contractions: Frequency: _____ Duration: _____

Fetal Heart Rate: Baseline: _____

Variability: Absent: ____ Minimal: √ Moderate: ____ Marked: ____

Type of Variables: Early Decels: ____ Variable Decels: ____ Accels: ____ Late Decels: ____

Category: II (I, II, III)

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: Admitted on 8/18 for HTN; high risk of getting preclampsia. Started cytotec & did 6 doses. Then started Pitocin on 8/19. This morning she was 3cm dilated, 90% effaced & stationed at -2. Her blood pressure kept on getting pretty high and wasn't progressing. They broke her water@0737 & epidural @0840. Finally went back to the OR for a C-section.

Describe any Intrauterine Fetal Resuscitation measures utilized and the reason:

They put him on the CPAP machine & took him to the NICU.

Delivery:

Method of Delivery: C-Section Operative Assist: _____ Infant Apgar: ____/____ QBL: 649

Infant weight: 6lbs 12oz

Prioritization Tool

	URGENT	NOT URGENT
IMPORTANT	Urgent & Important DO Continious fetal monitoring for signs of distress/late decelerations.	Not Urgent but Important PLAN Provide education to mom & dad on what to expect during the c-section.
NOT IMPORTANT	Urgent but Not Important DELEGATE Deliver lab specimens to the lab.	Not Urgent and Not Important ELIMINATE Repeating instructions to team members who are already aware.

Education Topics & Patient Response:

- Inform the patient about the epidural & effects of magnesium and the importance of calling the nurse if experiencing severe headaches or visual changes.

- Patient verbalized the understanding of calling the nurse if those things were to happen.

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: Baby was grunting/gurgling while laying down after a feeding. My nurse told me to pick him up and turn him face down and start patting him on his back to get him to spit up. My nurse informed me if we weren't in the room and paid attention to those cues the baby could've choked. She also told me the reasoning for him grunting was because he didn't get burped after his feeding causing that to happen.

Clinical Judgment: A cesarean section was decided by the Dr because of maternal hypertension and minimal to absent fetal heart rate variability.

Patient Centered Care:

Professionalism:

Communication & Collaboration: