

IM6 Critical Thinking Worksheet

<p>Student Name:</p> <p style="text-align: center; color: pink;">Amanda Miller</p>	<p>Nursing Intervention #1:</p> <p style="text-align: center;">Reposition mom to her left side.</p>	<p>Date:</p> <p style="text-align: center; color: pink;">September 10th, 2025</p>
<p>Priority Nursing Problem:</p> <p>Risk for decreased maternal and fetal perfusion related to maternal hypotension.</p>	<p><i>Evidence Based Practice:</i></p> <p>Left lateral repositioning relieves pressure on the vena cava, improving blood flow and increasing blood pressure.</p>	<p>Patient Teaching (specific to Nursing Diagnosis):</p> <ol style="list-style-type: none"> 1. Explain why lying on her side is important for her and baby's safety. 2. Teach her to tell staff if she feels dizzy, faint, or nauseated. 3. Encourage frequent position changes (avoid lying flat on back)
	<p>Nursing Intervention #2:</p> <p style="text-align: center;">Administer IV fluids as ordered.</p>	
<p>Related to (r/t):</p> <p style="text-align: center;">Low blood pressure and decreased circulating volume.</p> <p>As Evidenced by (aeb):</p> <p style="text-align: center;">Dizziness, pale/clammy skin, low BP readings, and/or changes in fetal heart rate.</p>	<p><i>Evidence Based Practice:</i></p> <p>IV fluid blouses are proven to raise blood pressure and improve uteroplacental perfusion.</p>	
	<p>Nursing Intervention #3:</p> <p style="text-align: center;">Monitor vital signs and fetal heart rate closely.</p>	
<p>Desired Patient Outcome (SMART goal):</p> <p style="text-align: center;">Maternal blood pressure will remain stable within normal range throughout labor.</p>	<p>Frequent monitoring helps detect worsening hypotension or fetal distress early so quick action can be taken.</p>	<p>Discharge Planning/Community Resources:</p> <ol style="list-style-type: none"> 1. Teach importance of hydration and rest after delivery. 2. Provide information on follow-up appointments and when to seek medical help (dizziness, fainting, heavy bleeding). 3. Offer support group or lactation resources as needed.

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Date: **September 10th, 2025**

<p>Situation: Patient Room #: Allergies: <u>NKDA</u> Delivery Date & Time: <u>September 9th, 2025 @ 1720</u> NSVD PC/S RC/S Indication for C/S: QBL: <u>350 mL</u> BTL: LMP: Est. Due Date: <u>10/7/25</u> Prenatal Care: <28 wks <input checked="" type="checkbox"/> LPNC <u>35w 6d</u> Anesthesia: None Epidural Spinal General Duramorph/PCA</p>	<p>VS: Q4hr Q8hr 0800: <u>148/100</u> <u>14 RR</u> <u>98.2</u> <u>72 HR</u> <u>99%</u> <u>0/10</u> 1200: Diet: Regular Pain Level: <u>0</u>/10 Activity: Newborn: Male Female Feeding: Breast Pumping Bottle Formula: Similac Neosure Sensitive Apgar: 1min <u>8</u> 5min <u>9</u> 10 min _____ Wt: <u>4</u> lbs <u>9</u> oz Ht: <u>17.25</u> inches</p>	<p>MD: Mom- Zavala Baby- Walker Consults: Social Services: _____ Psych: _____ Lactation: <u>September 10th, 2025 -AM @ bedside</u> Case Mgmt: _____ Nutritional: _____</p>
<p>Background: Patient Age: <u>30</u> y/o Gravida: <u>1</u> Para: <u>1</u> Living: <u>0</u> Gestational Age: <u>36w</u> weeks Hemorrhage Risk: Low Medium High Prenatal Risk Factors/Complications: <u>Severe pre-eclampsia in third trimester</u> <u>Scoliosis</u> NB Complications: <u>Nuceal x1 - loose</u> Required gastric lavage: <u>-10mL mucus</u> <u>-8mL air</u></p>	<p>Maternal Lab Values: Blood Type & Rh <u>O+</u> Rhogam @ 28 wks: Yes No Rubella: Immune Non-immune RPR: R / NR HbSAG: + / - HIV: + / - GBS: + / - Treated: _____ X H&H on admission: <u>14.8</u> hgb / <u>41.2</u> hct Newborn Lab Values: Blood Type & Rh <u>A+</u> POC Glucose: <u>61</u> Coombs: + / - Q12hr Q24hr AC Glucose: _____ Bilirubin (Tcb/Tsb): CCHD O2 Sat: Pre-ductal _____% Post-ductal _____% Other Labs:</p>	<p>Vaccines/Procedures: Maternal: MMR consent _____ Date given: _____ Tdap: Date given <u>8/15/25</u> Refused Rhogam given PP: Yes No Newborn: Hearing Screen: Pass Retest Refer Circumcision: Procedure Date _____ Plastibell Gomco Voided: Y / N Bath: Yes Refused</p>

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<p>Assessment (Bubblehep): Neuro: WNL Headache Blurred Vision Respiratory: WNL Clear Crackles RR <u>16</u> bpm Cardiac: WNL Murmur B/P ____ / ____ Pulse <u>72</u> bpm Cap. Refill: </= 3 sec >3 sec Psychosocial: Edinburgh Score _____</p>	<p>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 <u>9/8/25</u> Passing Gas: Y / N Bowel sounds: WNL Hypoactive</p>	<p>Episiotomy/Laceration: 1 degree lac - repair WNL Swelling Ecchymosis Incision: WNL Drainage: Y / N Dressing type: _____ Staples Dermabond Steri-strips Hemorrhoids: Yes No Ice Packs Tucks Proctofoam Dermoplast Bonding: Responds to infant cues Needs encouragement</p>
<p>Treatments/Procedures: Incentive Spirometry: Y / N PP H&H: <u>12.8</u> hgb <u>35.7</u> hct HTN Orders: Call > 160/110 VSQ4hr Hydralazine protocol Labetolol BID/TID</p>	<p>IV Fluids: Oxytocin LR NS Rate: ____ / Hour INT IV Site: <u>18</u> gauge Location: <u>Left Forearm</u> Magnesium given: Y / N Dc'd: _____ @ _____ am/ pm</p>	<p>Antibiotics: _____ Frequency: _____ _____ _____</p>
<p>Recommendation: -Continue Q4 vitals and neuro checks. -Treat BP if/as needed. -Educate mom on S/S to report regarding HTN.</p>		