IM6 Critical Thinking Worksheet

Student Name: Bridget Flores	**Nursing Intervention #1:** monitor V/S, uterine tone, + lochia	Date: 9/23/25
Priority Nursing Problem: Postpartum Hemorrhage	*Evidence Based Practice:* early recognition of abnormal bleeding problems + uterine atony improves maternal outcomes + ↓ risk of hemorrhage	**Patient Teaching (specific to Nursing Diagnosis):** 1. Teach Pt to monitor for heavy bleeding → soaking >1 pad/hour, passing large clots dizziness, faint feeling 2. keep bladder empty, breastfeeding can stimulate contractions.
	Nursing Intervention #2: Admin uterotonics if prescribed (Oxytocin, methergine)	
Related to (r/t): Multiparity + medium hemorrhage risk	*Evidence Based Practice:* First line to promote uterine contraction + ↓ PP hemorrhage	3. Educate to avoid overexertion immediately Postpartum + go to reg Postpartum appointments
As Evidenced by (aeb): Hx of multiple pregnancies. Sab + ectopic preg. + current risk factors of medium hem risk, 40+ wks + multiparity	**Nursing Intervention #3:** Massage fundus if boggy + encourage regular voiding	
Desired Patient Outcome (SMART goal): - Stable VIS: assess BP, HR, RR - Blood loss < 500ml: weigh pads measure blood loss - Uterus remains firm: fundal massage, empty bladder - Pt understands warning signs: monitors lochia at home, reports signs of heavy bleeding + large clots	*Evidence Based Practice:* Maintain uterine tone and prevent bladder distention = ↓ risk of PP hemorrhage	**Discharge Planning/Community Resources:** 1. Referral to maternal health clinic for follow up/check ups 2. Provide contact info for lactation consultant 3. Ensure patient knows who to call and where to go if complications occur.

Student Name:

Date:

Situation:

Patient Room #: 416
Allergies: Penicillin
Delivery Date & Time: 9/22 @ 1632
(NSVD) PC/S RC/S VAVD

Indication for C/S:

QBL: 337 BTL:
LMP: 12/12/24 Est. Due Date: 9/18/25

Prenatal Care: <28 wks ✓ LPNC ____

Anesthesia: None (Epidural) Spinal
General Duramorph/PCA

VS: (Q4hr) Q8hr
0800:

RR	HR	BP	map	Temp	O2	P
18	81	142/71	95	98.1	96	4

1200:

Diet: Reg.
Pain Level: 4 / 10 Activity:

Newborn: Male (Female)
Feeding: (Breast) Pumping Bottle
Formula (Similac) Neosure Sensitive
Apgar: 1min 8 5min 9 10 min ____
Wt: 7 lbs 4.2 oz Ht: 21.5 inches

MD:
Mom- Hatton
Baby- Zeitouni

Consults:
Social Services: ____
Psych: ____
Lactation: ____
Case Mgmt: ____
Nutritional: ____

Background:

Patient Age: 34 y/o
Gravida: 6 Para: 4 Living: 4
Gestational Age: 40^4 weeks
Hemorrhage Risk: Low (Medium) High

Prenatal Risk Factors/Complications:
Hx of SAB + ectopic preg.

NB Complications: ____

Maternal Lab Values:
Blood Type & Rh A+
Rhogham @ 28 wks: Yes (No)
Rubella: (Immune) Non-immune
RPR: R / NR very HbSAG: + / (-)
HIV: + / (-) GBS: + / (-) Treated: ____ X
H&H on admission: 13.1 hgb / 36.4 hct

Newborn Lab Values:
Blood Type & Rh ____
POC Glucose: ____ Coombs: + / -
Q12hr Q24hr AC Glucose: __ __ __ __ __
Bilirubin (Tcb/Tsb):
CCHD O2 Sat:
Pre-ductal ____% Post-ductal ____ %
Other Labs:
Not 24hrs

Vaccines/Procedures:
Maternal:
MMR consent ____ Date given: ____
TdaP: Date given 6/30/25 Refused
Rhogham given PP: Yes (No)

Newborn:
Hearing Screen: (Pass) Retest Refer
Circumcision: Procedure Date ____
Plastibell Gomco Voided: (Y) / N

Bath: (Yes) (Refused)

Student Name:

Date:

Assessment (Bubbleheb):

Neuro: WNL Headache Blurred Vision

Respiratory: WNL Clear Crackles
RR 18 bpm

Cardiac: WNL Murmur B/P 139/73
Pulse 70 bpm

Cap. Refill: </= 3 sec >3 sec

Psychosocial: Edinburgh Score _____

Breast: Engorgement Flat/Inverted Nipple
WNL

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 9/23
Passing Gas: Y / N
Bowel sounds: WNL Hypoactive

Episiotomy/Laceration:
WNL Swelling Ecchymosis
Incision: WNL Drainage: Y / N
Dressing type: _____
Staples Dermabond Steri-strips

Hemorrhoids: Yes No
Ice Packs Tucks Proctofoam
Dermaplast for Vag.

Bonding:
Responds to infant cues
Needs encouragement

Treatments/Procedures:
Incentive Spirometry: Y / N
PP H&H: 13.6 hgb 40.3 hct

HTN Orders:
Call > 160/110 VSQ4hr
Hydralazine protocol Labetolol BID/TID

IV Fluids: Oxytocin LR NS
Rate: _____ / Hour

IV Site: ____ gauge Location: _____
Magnesium given: Y / N
Dc'd: _____ @ _____ am/ pm

Antibiotics: Frequency:
_____ _____
_____ _____
_____ _____

Recommendation:

DO 24hr Labs for baby
Continue to monitor mom & baby & share mom
Complete Edinburgh assessment

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

I had a pt admitted @ 0115 for a scheduled induction.
It was me, my nurse, Charge nurse and Dr. that provided care.
We monitor baby's FHR + moms contraetions. Inserted a foley and did cervical checks. I inserted the foley and helped with anything my nurse needed. Patient was comfortable but baby needed monitoring.

Step 2 Feelings

I was nervous at first, but became confident when I got the hang of it. I was thinking how I could help my nurse and mom. My nurse and the charge nurse were very nice and helpful. I was very happy with my experience and I enjoyed it a lot even though I didn't get to see a birth.

Step 3 Evaluation

We monitored mom and baby continuously and did every intervention to help progress mom and keep her safe.
Bad was that Mom did not really progress and was experiencing some late decels. I think our interventions really helped though. I expected to see a delivery, but I still enjoyed my experience.

Step 4 Analysis

I was able to apply everything I know from lecture in clinical. I understand all the terms and was able to read the strips. I saw what IUR looks like and performed it.

Step 5 Conclusion

I could have ~~Wouldn't~~ been more confident to help out my nurse more effectively.
I have learned that L+D can be critical care and the things we learn in lecture ~~can~~ happen more than we think.

Step 6 Action Plan

Overall I am very pleased with my experience and I would love to be able to do it myself some day.
I can use what I've learned to day in my own experience as a nurse if I do decide to work in L+D. I will use this experience to strengthen my knowledge and critical thinking skills.

Prioritization Tool

	URGENT	NOT URGENT
IMPORTANT	Urgent & Important DO Monitor bleeding & Fetal strips	Not Urgent but Important PLAN Plan for c sec if labor doesn't progress
NOT IMPORTANT	Urgent but Not Important DELEGATE ASK Dr. to assess Mom and baby and see what she thinks to get a second opinion and do any needed interventions	Not Urgent and Not Important ELIMINATE Help Mom decide what baby should wear for first outfit or when Mom can shower after birth.

Education Topics & Patient Response:

- Report any n/v or dizziness → Patient demonstrates clear understanding.
- Possible C sec → mom agrees and consents, questions answered.
- Education on terbutaline → mom understands its to help slow contractions

mplete this during your labor and delivery experience and turn it in with your paperwork. Ask your structor or TPC nurse to check over your findings

Situation:

Date/Time 9/24/15 Age: 20

Cervix: Dilation: 5 Effacement: 80-1. Station: -2

Membranes: Intact: ___ AROM: ✓ SROM: ___ Color: bloody

Medications (type, dose, route, time): Iron, pitocin, terbutatine

Epidural (time placed): 06:30

Background:

Maternal HX: anxiety, depression, anemia, chlamydia

Gest. Wks: 39 6 Gravida: 3 Para: ___ Living: 0

GBS status: + / (-) Induction / Spontaneous

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

Maternal VS: T: 97.6 P: 87 R: 16 BP: 107/51

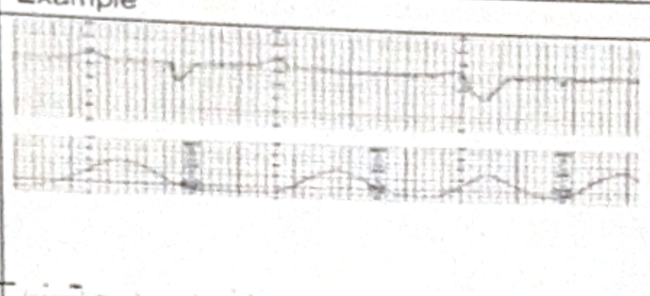
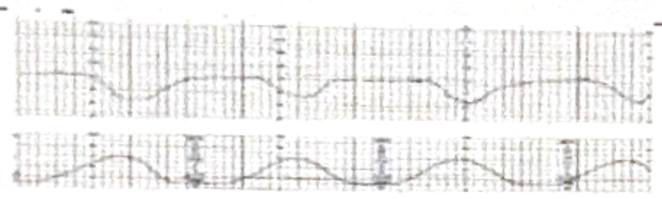
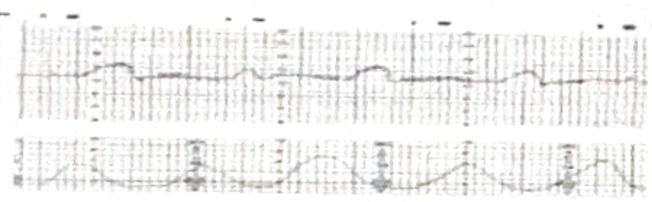
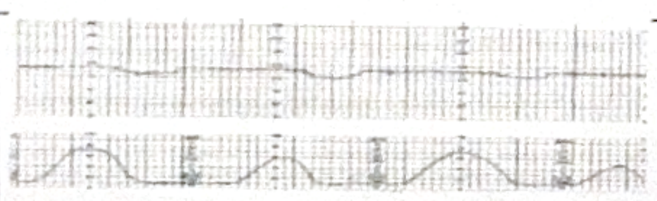
Contractions: Frequency: 1.5-4 Duration: ~~1.5-4~~ 50-80

Fetal Heart Rate: Baseline: 130

Variability: Absent: ___ Minimal: ✓ Moderate: ~~✓~~ Marked: ___

Type of Variables: Early Decels: ✓ Variable Decels: ___ Accels: ✓ Late Decels: ___

Category: I (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: Patient had some bright red bleeding, notified Dr. will monitor for more bleeding/late decels, variability and prep pt for possible C sec

Describe any Intrauterine Fetal Resuscitation measures utilized and the reason: Turned pt, stopped pitocin, IV bolus, Notified Dr. - PA was experiencing bleeding, minimal variability, some late decels

Delivery:

Method of Delivery: _____ Operative Assist: _____ Infant Apgar: ___/___ QBL: _____

Infant weight: _____ Did not deliver

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: When we assessed mom and noticed bleeding we had charge nurse check, turned pitocin off, repositioned mom, gave a bolus, and notified the Dr. We continued to monitor bleeding + strips.

Clinical Judgment:

Patient Centered Care:

Professionalism: I saw profressionalism when my nurse educated my patient about vaccines and when the patient refused some of them My nurse responded profressionally by continuing to educate and respect the patients wishes and provided necessary documents.

Communication & Collaboration: