**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 10/22 07:00 Age: 24

Cervix: Dilation: 8 Effacement: 100 Station: 0

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

Medications (type, dose, route, time):

Cytotec, Pitocin, LR

Epidural (time placed): 0046

**Background:**

Maternal HX: 19mo. @ home, induced

Gest. Wks: 40 Gravida: 3 Para: 2 Living: 2 Induction / Spontaneous

GBS status: + / (-)

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

+1, 9.5cm 07:02
10cm 07:13

Maternal VS: T: 98.6 P: 88 R: 18 BP: 112/91

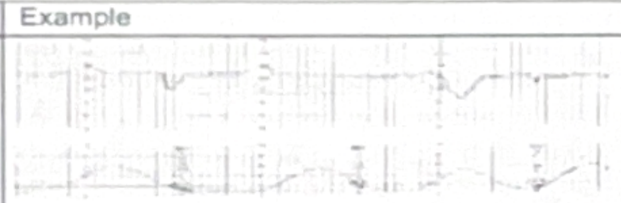
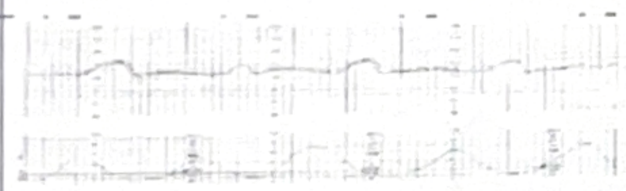
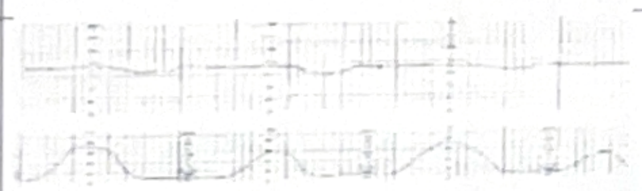
Contractions: Frequency: 2min Duration: 60sec

Fetal Heart Rate: Baseline: 140

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

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

Category: 1 (I, II, III)

| Pattern | Example | Cause | Interventions | Desired Outcome |
|---|---|---|---|---|
| Variable Decelerations |  | Cord Compression | Discontinue oxytocin<br>Change maternal position<br>Administer oxygen at 10 L/min by nonrebreather face mask<br>Notify provider<br>Vaginal or speculum examination to assess for cord prolapse<br>Amnioinfusion<br>Assist with birth if pattern cannot be corrected. | Relieve Cord Compression |
| Early Decelerations |  | Head Compression | Continue to monitor labor progress. | Maintain Oxygenation<br>Healthy fetus at delivery |
| Accelerations |  | These are OK! | Continue to monitor labor progress. | Maintain Oxygenation<br>Healthy fetus at delivery |
| Late Decelerations |  | Poor Placental Perfusion | Discontinue oxytocin<br>Assist woman to lateral (side-lying) position<br>Administer oxygen<br>Correct maternal hypotension<br>Increase rate of intravenous solution.<br>Palpate uterus to assess for tachysystole.<br>Notify provider<br>Consider internal monitoring<br>Assist with birth if pattern cannot be corrected | Maximize Oxygenation<br>Increased Perfusion to Placenta |

**Recommendation/Nursing Plan:**

Describe the labor process and nursing care given as well as any complications you witnessed: very supportive, 3 nurses, dad, OB

multigravida, fast delivery, bilateral tears on labia, 2 stitches

Describe any Intrauterine Fetal Resuscitation measures utilized and the reason:

N/A

**Delivery:**

Method of Delivery: vaginal Operative Assist: _____ Infant Apgar: 8 / 9 QBL: 114 mL

Infant weight: 7#13oz.

# Covenant School of Nursing Reflective Practice

Name: Abby West  Instructional Module: C6  Date submitted: 10/22/25

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

**Step 1 Description**

vaginal delivery at 0720 in L&D room. There were 3 nurses, Dad, and OB Present. I was observing while the nurses were assisting OB. Baby girl was born at 0725

**Step 2 Feelings**

I was scared the OB was going to need to do an episiotomy. Everyone was encouraging her to only push during contractions. They were making me feel hopeful. The mom only needed bilateral labia stitches. The team made me feel encouraged.

**Step 3 Evaluation**

The encouragment helped mom to keep pushing. Everything went very well & it felt like organized chaos.

**Step 4 Analysis**

I can remember to be encouraging & to push mom to do her best in a supportive way. Mom felt like giving up but everyone told her she could do it and she powered through w/o tearing.

**Step 5 Conclusion**

I've learned that even if you're scared, you don't let the mom know & you keep being supportive.

**Step 6 Action Plan**

I thought it was an amazing delivery & it made me never once doubt the nurses. The communication w/ the OB was excellent. It made me feel more confident

Abby Vega 10/22/25

# Prioritization Tool

| | URGENT | NOT URGENT |
|---|---|---|
| IMPORTANT | Urgent & Important<br>DO<br>- assess bleeding & fundus<br>- VS<br>- Pain<br>- assess for infection<br>- assit w/ feeding & bonding | Not Urgent but Important<br>PLAN<br>- educate on Peri care<br>- Post partum warning signs<br>- Discharge teaching |
| NOT IMPORTANT | Urgent but Not Important<br>DELEGATE<br>- snacks & drinks<br>- room organization<br>- help ambulate | Not Urgent and Not Important<br>ELIMINATE<br>ice chips<br>extra blankets |

Education Topics & Patient Response:

- Peri care & hygeine: Pt verbalized understanding
- breastfeeding techniques: Pt demonstrated proper latch
- S/S hemhorrage: Pt able to repeat
- importance of rest, hydration, & nutrition: Pt agreed to follow recommendations.