w/o Dr order

scientific reason to why interv. works.

IM6 Critical Thinking Worksheet

Student Name: Miranda Millman	**Nursing Intervention #1:** Ambulate to promote healing	Date: 10/28/25
Priority Nursing Problem: at risk for infection	*Evidence Based Practice:* Ambulation encourages the blood to circulate which will keep the organs functioning properly + prevent blood clots. Also helps w/ pt strength.	**Patient Teaching (specific to Nursing Diagnosis):** 1. Keep incision site clean + dry at all times. 2. If you notice any drainage from incision site, alert me ASAP! 3. If you start to feel crummy + chilly, please let me know so we can check your temp + administer antipyretics as needed.
	Nursing Intervention #2: Monitoring VS	
Related to (r/t): C-section incision	*Evidence Based Practice:* Monitoring the Pts VS will keep everyone informed about how they are doing. Catching changes early leads to lower mortality rates.	
As Evidenced by (aeb): - purulent drainage - redness/swelling - fever >100.4°F	**Nursing Intervention #3:** Assist pt w/ hygiene	**Discharge Planning/Community Resources:** 1. WIC for formula 2. Follow up appt w/ OB (incision, NB screen, PPV 3. Texas Health Steps for free/reduced health care for baby (Medicaid/CHIP)
Desired Patient Outcome (SMART goal): The patient will remain free of fever (100.4°F) by the end of shift (1900).	*Evidence Based Practice:* Keeping the pt clean will keep them mentally + physically feeling good. Physically = will keep germs OFF the body. Mentally = good spirits lead to feeling better.	

S/S

Student Name: Miranda Millman Date: 10/28/25

Situation:

Patient Room #: 422
Allergies: metformin, PNC, Azythromycin
Delivery Date & Time: 10/27 1449

NSVD (PC/S) RC/S

Indication for C/S: Fetal intolerance

QBL: BTL:
LMP: Est. Due Date:

Prenatal Care: <28 wks _____ LPNC _____

Anesthesia: None (Epidural) (Spinal) General
Duramorph/PCA

VS: (Q4hr) Q8hr
0800: BP-135/75 HR-87 RR-22 map-95 O2-97 Temp-98.1
1200: BP-125/79 HR-96 RR-20 map-94 O2-98 -Temp 97.1
Diet: General
Pain Level: 5 / 10 Activity:

Newborn: (Male) Female
Feeding: Breast Pumping (Bottle)
Formula: (Similac) Neosure Sensitive
Apgar: 1min_____ 5min _____ 10 min _____
Wt: 7 lbs 12 oz Ht: _____ inches

MD:
Mom-
Baby-

Consults:
Social Services:_____

Psych: _____

Lactation:_____

Case Mgmt: _____

Nutritional: _____

Background:

Patient Age: _____ y/o
Gravida: 4 Para: 1 Living: 1
Gestational Age: 39.6 weeks
Hemorrhage Risk: Low Medium High

Prenatal Risk Factors/Complications:

_____
_____
_____
_____
_____

NB Complications:

Maternal Lab Values:
Blood Type & Rh _____
Rhogham @ 28 wks: Yes No
Rubella (Immune) Non-immune
RPR: R / NR HbSAG: + / -
HIV: + / (-) GBS (+) / - Treated: 2X
H&H on admission: _____ hgb / _____hct

Newborn Lab Values:
Blood Type & Rh _____
POC Glucose: ____ Coombs: + / -
Q12hr Q24hr AC Glucose: __ __ __ __
Bilirubin (Tcb/Tsb):
CCHD O2 Sat:

Vaccines/Procedures:
Maternal:
MMR consent ✓ Date given: _____
TdaP: Date given _____ Refused
Rhogham given PP: Yes (No)

Newborn: 10/29/25
Hearing Screen: Pass Retest Refer
Circumcision: Procedure Date _____
Plastibell Gomco Voided: Y / N

Bath: Yes Refused

Student Name: Miranda Millman Date:

_____ _____ _ _____ _ _____ _	Pre-ductal _____% Post-ductal _____ % Other Labs:	
Assessment (Bubbleheb): Neuro: WNL Headache Blurred Vision Respiratory: WNL Clear Crackles RR 20 bpm Cardiac: WNL Murmur B/P 125/79 Pulse 94 bpm Cap. Refill: </= 3 sec >3 sec Psychosocial: Edinburgh Score _____	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 Before C-section 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 Bonding: Responds to infant cues Needs encouragement
Treatments/Procedures: Incentive Spirometry: Y / N PP H&H: _____ hgb _____ hct HTN Orders: Call > 160/110 VSQ4hr Hydralazine protocol Labetolol BID/TID	IV Fluids: Oxytocin LR NS Rate: _____ / Hour IV Site: 20 gauge Location: L forearm INT Magnesium given: Y / N Dc'd: _____ @ _____ am/ pm	Antibiotics: Frequency: _____ _____ _____ _____ _____ _____
Recommendation:		

Miranda Millman

Mom & Baby Medication Worksheet

Medication	Mechanism of Action	Maternal Effects	Nursing Managment
Methylergonovine Maleate	•Tocolytic: Stimulates Uterine + smooth muscles	•N/V •Dysrythmia + MI •Cramping •Severe HTN •HA	•Monitor VS, vaginal bleeding, Pain, SOB, Uterine contractions, HA. •Causes ↑ cramping / painful cramping.
Prenatal Vitamin	Multivitamin: -provides vits necessary for normal fetal growth + development.	•may change urine color •could have allergy to additive in vitam.	•Take as prescribed. •Take w/ food to avoid GI upset.
Hydromorphone	Opioid: -Binds to CNS recepts + alters pain preception.	•↓BP •Constipation •confusion/sedation •Resp. depression	•Alert HCP if breastfeeding. •Drink plenty of water + take Stool softener to avoid constipation. •May lower BP, so check reg + assist Pt when sitting up / walking.
Keterolac	NSAID: -Inhibits prostaglandin Syntesis = analgesia, also antipyretic/anti-inflam.	•GI bleed •SJS •Dyspepsia •N/V •constipation	•Assess VS, Pain, Temp •Educate on s/s of GI bleed (dark stool). •Educate on avoiding alcohol. •monitor output & Kidney function
Colace Docusate.	Stool Softener: Promotes water to move into stool. =Softens Stool	•Stomach cramps/ abdom. pain •Bloating/gas •Diahrrea	•Assess + monitor bowel sounds. •Educate that its available OTC.

Miranda Millman

Hydralazine	Anti HTN: - Lowers BP ↑↓ afterload in pts w/ HF.	• Tachycardia • N/V/D • Rash • orthostat hypoten.	• monitor HR/BP frequently. • Moniter pt when sitting up or walking. • Encourage other BP↓ such as decrease sodium in diet. • Advise of possible drowsy
Labetolol	Anti HTN: Blocks beta 1 (myocard) + beta 2 (pulm, vasc, uterine) adrenergic recept sites.	• orthostatic hypotens. • Fatigue/weakness • Arrhythmias, ↓ HR or HF • Pulmonary Edema	• monitor HR/BP freq. • moniter pt when sitting up/walking. • Moniter daily wts. • Teach not to stop taking abruptly.

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:

Clinical Judgment:

10/28 - Pt was set to DC, but her BP + HR were low, so the nurse and I took it multiple times + decided to call the Dr to see what they wanted to do. (Pt was DC)

Patient Centered Care:

Professionalism:

10/22 SIM - Advocated for my pt to the pts family + Dr. Kept my calm + informed abt IVP.

Communication & Collaboration:

10/29 - Kept pt + family informed on why we kept needing to reposition mom(pt).

Miranda Millman

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 10/29/19 7:28am Age: 24

Cervix: Dilation: 2.5 Effacement: 90% Station: -2

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

Medications (type, dose, route, time):

LR bolus 800 IV, Epidural (fetynal) @806, Pitocin, 2mu, IV, 940 2mL/hr = 12mk/hr?

Epidural (time placed): 806

Background:

Maternal HX: GHTN

Gest. Wks: 40 Gravida: 1 Para: 0 Living: 0 Induction / Spontaneous

GBS status: + / (-)

Assessment (Interpret the FHR strip-pick any moment in time): 915

Maternal VS: T: 98.3 P: 79 R: 20 BP: 123/61

Contractions: Frequency: 4-5 min Duration: 60 sec

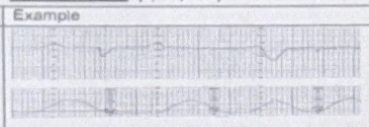
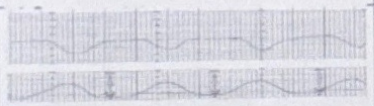
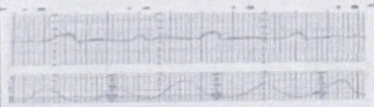
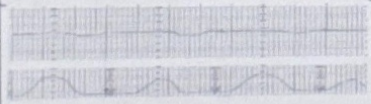
Fetal Heart Rate: Baseline: 125

Variability: Absent:____ Minimal:____ Moderate: X Marked:____

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

Category: 1 (I, II, III)

just a reference

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: Came in @500 w/ SROM + contractions, @700 pt was dilated to a 1 + 90% eff, -2 station @800 pt asked for an epidural, gave it + rechecked pt + was at 2.5cm + 90% eff. About 20 mins later, baby had a few decels, so we repositioned her. Contractions are q3mins + baby has accels so we started Pitocin 2mu (2mL)/hr @940. Repositioned mom @1015. Repositioned @1130

Describe any Intrauterine Fetal Resuscitation measures utilized and the reason: late decels

About 20 mins after the epidural, baby had ~3 decels, we repositioned mom + all was well

Delivery:

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

Infant weight: _____

Covenant School of Nursing Reflective Practice

Name: Miranda Millman Instructional Module: IM 6 Date submitted: 10/29/25

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

Step 1 Description

Mom had a SROM around 300, contractions started almost immediately + she came to the hospital after 500. She labored w/ no meds until my nurse + I came onto floor. Around 800, she wanted an Epidural + we helped her through it. Post epidural we kept an eye on her + baby + repositioned her as needed to help labor progress. She was still laboring when I left.

Step 2 Feelings

At the beginning, I was very excited for her + the family as this is their first baby. Because labor is a process, it got a little boring waiting for her to progress. She was very kind and so thankful everytime we went in to help her so that made me feel good.

Step 3 Evaluation

It was good to see the beginning of labor + to watch + see how progression works from a nurses POV. My nurse was AMAZING at explaining all the things she was doing + why she was doing it. I was hoping that mom would progress while I was there, but she did NOT.

Step 4 Analysis

I know that laboring + birth is a process + should not be rushed if it isn't an emergency. Going too fast could lead to increased heath risks for mom + baby.

Step 5 Conclusion

Staying longer + getting to spend the whole shift w/ the pt would have been so rewarding.

Step 6 Action Plan

Overall, I know that this pt is going to deliver her baby today. I need to mentally prepare myself to NOT see a birth next time. ☺

Miranda Millman

Prioritization Tool

	URGENT	NOT URGENT
IMPORTANT	Urgent & Important DO Record contractions + FHR + compare	Not Urgent but Important PLAN Start pitocin
NOT IMPORTANT	Urgent but Not Important DELEGATE Grab mom ice chips for her dry mouth	Not Urgent and Not Important ELIMINATE Put an extra blanket on mom + provided an extra pillow.

Education Topics & Patient Response: that nurse went over:

The nurse explained the epidural procedure to mom + family + explained how she needed to sit for it (during) + what dad could do to help. She explained that post procedure we would get BP Q3 min, 10 min + 15 min for first hour. She also explained C-section risk + repositioning for fetal distress.

Miranda Millman

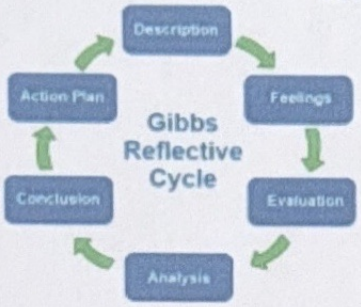
Labor & Delivery Medication Worksheet

Medication	Mechanism of Action	Maternal Effects	Fetal Effects	Nursing Managment
Oxytocin	Tocolytic: stimulates uterine contractions like those in labor	• ↑ uterine motility • painful contractions • ↓ BP	• Asphyxia (Fetal Distress) • Hypoxia • Arrhythmias (Bradycardia)	• Tell pt to report HA/blurred vision. • Moniter VS (HR/BP/RR) • Assess lung sounds. • Monitor I+O's.
Misoprostol	Tocolytic: Causes uterine contractions.	• N/V/D • Severe HTN • HA • Fever • Pulmon. Edema	• N/A	• Tell pt that we can give it PO or rectally. • Assess VS (BP, Temp, RR, HR) • Perform ~~fundal massage~~ & assess vag bleed + uterine tone
~~Turbutaline~~ Terbutaline	Beta-2-adrenergic agonist: Suppress uterine activity	• Cardiac/cardiopulm arrhythmias. • Pulm edema • MI • Hypokalemia • ↓ BP • ↑ BS	• ↑ HR • ↑ BS • MI • Myocardial/Septal hypertrophy	• moniter maternal + FHR. • watch I+O to prev. fluid overload. • Moniter BS levels • moniter contractions.
Magnesium Sulfate	- Tx severe hypomagnesemia - ↓ myometrium contractility - CNS depressant	• Flushing, HA, Drymouth, lethargy, muscle weakness, pulm edema, cardiac arrest.	• Lethargic, hypotonia, resp depression, • May reduce CP in newborn (protects brain)	• Moniter FHR, contractions, + mag levels. • moniter for S/S of maternal toxicity • Have calcium gluconate @ bedside for mag OD. • DO NOT let pt get up on their own! (teach) - Monitor DTR - Mag serum levels - LOC

Miranda Millman

	MOA:	mom SE:	Baby SE:	Nurse manage:
Carboprost Tromethamine	Tocolytic •Tx hemorrhage •Stimulate uterine contracts.	•N/V/D • Sever HTN • HA •Pulm. edema	•N/A can cause abortion	•DO NOT let pt use if they have asthma. •Monitor VS, vag bleed + uterine tone. •Educate pt on painful cramps + possible diarrhea.
Dinoprostone	Prostaglandin E-2: stims cervical ripening. Stim muscles of uterine to contract Induces labor.	•N/V •Freq contractions. •Back pain •Fever	• CONT. FHR monitor	• Educate that insert will be removed when labor start •Monitor VS, uterine activity, S/S of infxn, allergic reactio + cervical changes.

Covenant School of Nursing Reflective Practice



Learning to be a reflective practitioner includes not only acquiring knowledge and skills, but also the ability to establish a link between theory and practice, providing a rationale for actions. Reflective practice is the link between theory and practice and a powerful means of using theory to inform practice thus promoting evidence based practice." (Tsingos et al., 2014).

Using the Reflective Practice template on page 2, document each step in the cycle. The suggestions in each of the boxes may be used for guidance but you are not required to answer every question. This Reflective Practice document will be reviewed by faculty and then you will post the final reflection in your LiveBinder folder.

Step 1 Description

A description of the experience, with relevant details.
Remember to maintain patient confidentiality. Don't make judgments yet or try to draw conclusions; simply describe the events and the key players. Set the scene! It might be useful to ask yourself the following questions

- What happened?
- When did it happen?
- Where were you?
- Who was involved?
- What were you doing?
- What role did you play?
- What roles did others play?
- What was the result?

Step 2 Feelings

Don't move on to analyzing these yet, simply describe them.

- How were you feeling at the beginning?
- What were you thinking at the time?
- How did the event make you feel?
- What did the words or actions of others make you think?
- How did this make you feel?
- How did you feel about the final outcome?
- What is the most important emotion or feeling you have about the incident?
- Why is this the most important feeling?

Step 3 Evaluation

- What was good about the event?
- What was bad?
- What was easy?
- What was difficult?
- What went well?
- What did you do well?
- What did others do well?
- Did you expect a different outcome? If so, why?
- What went wrong, or not as expected? Why?
- How did you contribute?

Step 4 Analysis

- What can you apply to this situation from your previous knowledge, studies or research?
- What recent evidence is in the literature surrounding this situation, if any?
- Which theories or bodies of knowledge are relevant to the situation – and in what ways?
- What broader issues arise from this event?
- What sense can you make of the situation?
- What was really going on?
- Were other people's experiences similar or different in important ways?
- What is the impact of different perspectives eg. personal / patients / colleagues' perspectives?

Step 5 Conclusion

- How could you have made the situation better?
- How could others have made the situation better?
- What could you have done differently?
- What have you learned from this event?

Step 6 Action Plan

- What do you think overall about this situation?
- What conclusions can you draw? How do you justify these?
- With hindsight, would you do something differently next time and why?
- How can you use the lessons learned from this event in future?
- Can you apply these learnings to other events?
- What has this taught you about professional practice? about yourself?
- How will you use this experience to further improve your practice in the future?

Adopted: August 2016