

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

Scheduled c-section

Situation:

Date/Time: 10/28/25 0715 Age: 37

Cervix: Dilation: - Effacement: - Station: -

Membranes: Intact: AROM: - SROM: - Color: -

Medications (type, dose, route, time):

Oxytocin 30 units / 500ml

Epidural (time placed): 0815 p Spinal at 0840 - ineffective

Background:

Maternal HX: 2 chemical pregnancies, 1 Spont. abortion, 1 c-section p failed induction. ^{tx of preeclampsia}

Gest. Wks: 38+1 Gravida: 5 Para: 1 Living: 1

Induction / Spontaneous

GBS status: + 10

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

Maternal VS: T: 98.2 P: 74 R: 14 BP: 140/92

Contractions: Frequency: 0 Duration: 0

Fetal Heart Rate: Baseline: 0

Variability: Absent: 0 Minimal: 0 Moderate: 0 Marked: 0

Type of Variables: Early Decels: 0 Variable Decels: 0 Accels: 0 Late Decels: 0

Category: 0 (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:

This patient was admitted 10/27 after seeing OB in office. Pt had elevated BP & OB felt like delivery was needed due to history of preeclampsia with previous pregnancy. Spinal attempted, but ineffective. Spinal reattempted plus epidural performed.

Describe any Intrauterine Fetal Resuscitation measures utilized and the reason:

N/A

Delivery:

Method of Delivery: c-section Operative Assist: - Infant Apgar: 8 / 9 QBL: 364ml

Infant weight: 7lbs 10oz

Prioritization Tool

Covenant School of Nursing Reflective Practice

Name: Colby Lynn

Instructional Module: 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.

<p>Step 1 Description</p> <p>Patient admitted for repeat c-section due to high blood pressure. I was able to observe the procedure while also performing a few tasks. I was able to provide comfort to patient while anesthesia was being administered. I also was able to insert a foley catheter while being observed by the RN. I provided assistance during sponge count. The end result was the birth of a healthy baby boy.</p>	<p>Step 4 Analysis</p> <p>Communication was lacking in this situation. Lack of communication provider to provider caused a need for increased narcotics. Lack of communication RN to RN caused a hemorrhage to nearly be missed upon transfer to postpartum.</p>
<p>Step 2 Feelings</p> <p>I was nervous during the beginning of the case. I was unsure of my place in the OR or if I would be in the way. I was worried of the outcome of the c-section as we are managing two human lives.</p>	<p>Step 5 Conclusion</p> <p>I think that I could have been more eager to talk to patient initially. There should have been better communication between surgeon and anesthesiologist/CRNA.</p>
<p>Step 3 Evaluation</p> <p>Baby was successfully delivered and mom tolerated the surgery well. Unfortunately, the spinal was not effective the first time. This caused quite a bit of worry for the patient. We had to change the plan, but quickly adapted. I was able to maintain my composure and communicate effectively with the patient.</p>	<p>Step 6 Action Plan</p> <p>I really enjoyed this experience. It further showed me how important communication is between different disciplines. If I had the opportunity I would like to be more hands on. It would be nice to perform more tasks in the RN role.</p>

Prioritization Tool

	URGENT	NOT URGENT
IMPORTANT	Urgent & Important DO Assess for signs of hemorrhage	Not Urgent but Important PLAN Vital signs
NOT IMPORTANT	Urgent but Not Important DELEGATE Assistance with early ambulation	Not Urgent and Not Important ELIMINATE Discuss expected feelings regarding self-image after surgery.

Education Topics & Patient Response:

Warning signs of bleeding & infection

Limitations after surgery.

IM6 Critical Thinking Worksheet

Student Name: Colby Lynn		Nursing Intervention #1: MMR given before discharge.		Date: 10/29/25	
Priority Nursing Problem: Risk for infection		Evidence Based Practice: MDM is not well immune. Mom should receive vaccine to protect herself and her newborn.		Patient Teaching (specific to Nursing Diagnosis): 1. Teach patient to properly cleanse wound using vashe. 2. Watch for signs/symptoms of infection. Fever, redness at surgical site, heat at surgical site. 3. Teach patient about importance of hand hygiene.	
Related to (r/t): Impaired skin integrity		Evidence Based Practice: TD promote contraction of uterus to original size and prevent postpartum hemorrhage. Nursing Intervention #3: Assess and educated post-surgical bowel habits.		Discharge Planning/Community Resources: 1. WIC due to formula need. 2. Weight clinic for newborn 3. Health department for baby immunizations	
As Evidenced by (aeb): Post - surgical (C-section)		Evidence Based Practice: After surgery, the bowels are the last to wake up. With the addition of opioid pain reliever, constipation may be prevalent. Educate on prevention.			
Desired Patient Outcome (SMART goal): Patient will demonstrate use of wound cleansing and return back to nurse by end of shift 10/29.					

Student Name: Colby Lynn

Date: 10/29/25

<p>Situation: Patient Room #: <u>411</u> Allergies: <u>metformin, azithromycin, penicillin</u> Delivery Date & Time: <u>10/27/25 1449</u> NSVD <u>PC/S</u> RC/S</p> <p>Indication for C/S: <u>Fetal intolerance</u></p> <p>QBL: <u>9169</u> BTL: LMP: <u>1/21/25</u> Est. Due Date: <u>11/3/25</u></p> <p>Prenatal Care: <28 wks <input checked="" type="checkbox"/> LPNC Anesthesia: None Epidural <u>Spinal</u></p> <p>General Duramorph/PCA</p>	<p>Background: Patient Age: <u>33</u> y/o Gravida: <u>4</u> Para: <u>1</u> Living: <u>1</u> Gestational Age: <u>39+6</u> weeks Hemorrhage Risk: Low Medium <u>High</u></p> <p>Prenatal Risk Factors/Complications: <u>anemia, HSV + (Valtrex)</u></p> <p>NB Complications:</p>	<p>VS: <u>Q4hr</u> Q8hr 0800: <u>97.5 91 116 123/72 98/1</u> 1200: <u>Discharged</u></p> <p>Diet: <u>General</u> Pain Level: <u>1</u> / 10 Activity: <u>Up and 1lb</u></p> <p>Newborn: <u>Male</u> Female Feeding: Breast Pumping <u>Bottle</u> Formula: <u>Similac</u> Neosure Sensitive Apgar: 1min <u>8</u> 5min <u>9</u> 10min Wt: <u>7</u> lbs <u>12</u> oz Ht: <u>22</u> inches</p>	<p>MD: <u>Mom - HATTON</u> <u>Baby - FAMILY</u></p> <p>Consults: Social Services: Psych: Lactation: Case Mgmt: Nutritional:</p>
<p>Maternal Lab Values: Blood Type & Rh <u>O+</u> Rhogham @ 28 wks: Yes <u>No</u> Rubella: Immune <u>Non-immune</u> RPR: R <u>NR</u> HBSAG: + <u>-</u> HIV: + <u>-</u> GBS <u>+</u> / - Treated: <u>Amef X2</u> H&H on admission: <u>12.2</u> hgb / <u>30.4</u> hct</p> <p>Newborn Lab Values: Blood Type & Rh <u>O+</u> Coombs: + / - POC Glucose: <u>-</u> Q12hr Q24hr AC Glucose: Bilirubin (Tcb/Tsb): <u>9</u> → <u>11.1</u> CCHD O2 Sat: <u>passed</u> Pre-ductal _____ % Post-ductal _____ % Other Labs:</p>	<p>Vaccines/Procedures: Maternal: MMR consent <input checked="" type="checkbox"/> Date given: <u>10/29/25</u> Tdap: Date given <u>9/16</u> Refused Rhogham given PP: Yes <u>No</u></p> <p>Newborn: Hearing Screen: <u>Pass</u> Retest Refer Circumcision: Procedure Date <u>10/29/25</u> <u>Plastibell</u> Gomco Voided <u>Y</u> / <u>N</u> Bath: <u>Yes</u> Refused</p>	<p>Maternal Lab Values: Blood Type & Rh <u>O+</u> Rhogham @ 28 wks: Yes <u>No</u> Rubella: Immune <u>Non-immune</u> RPR: R <u>NR</u> HBSAG: + <u>-</u> HIV: + <u>-</u> GBS <u>+</u> / - Treated: <u>Amef X2</u> H&H on admission: <u>12.2</u> hgb / <u>30.4</u> hct</p> <p>Newborn Lab Values: Blood Type & Rh <u>O+</u> Coombs: + / - POC Glucose: <u>-</u> Q12hr Q24hr AC Glucose: Bilirubin (Tcb/Tsb): <u>9</u> → <u>11.1</u> CCHD O2 Sat: <u>passed</u> Pre-ductal _____ % Post-ductal _____ % Other Labs:</p>	<p>Vaccines/Procedures: Maternal: MMR consent <input checked="" type="checkbox"/> Date given: <u>10/29/25</u> Tdap: Date given <u>9/16</u> Refused Rhogham given PP: Yes <u>No</u></p> <p>Newborn: Hearing Screen: <u>Pass</u> Retest Refer Circumcision: Procedure Date <u>10/29/25</u> <u>Plastibell</u> Gomco Voided <u>Y</u> / <u>N</u> Bath: <u>Yes</u> Refused</p>

Student Name: Oliver Lynn

Date: 10/29/25

<p>Assessment (Bubblehep): Neuro: <u>WNL</u> Headache Blurred Vision Respiratory: <u>WNL</u> Clear Crackles RR <u>16</u> bpm Cardiac: <u>WNL</u> Murmur B/P <u>123</u> / <u>72</u> Pulse <u>89</u> bpm Cap. Refill: <u></= 3 sec</u> >3 sec Psychosocial: Edinburgh Score <u>1</u></p>	<p>Breast: Engorgement Flat/Inverted Nipple Uterus: Fundal Ht 2U 1U UU <u>U1</u> U2 U3 <u>Midline</u> Left Right Lochia: Heavy Mod Light <u>Scant</u> None Odor: Y / <u>N</u> Bladder: <u>Voiding OS</u> Catheter DTV Bowel: Date of Last BM <u>10/29</u> Passing Gas: <u>Y</u> / N Bowel sounds: <u>WNL</u> Hypoactive</p>	<p>Episiotomy/Laceration: WNL Swelling Ecchymosis Incision: <u>WNL</u> Drainage: Y / <u>N</u> Dressing type: <u>open to air</u> <u>Staples</u> Dermabond Steri-strips Hemorrhoids: Yes <u>No</u> Ice Packs Tucks Proctofoam Dermoplast Bonding: <u>Responds to infant cues</u> Needs encouragement</p>
<p>Treatments/Procedures: Incentive Spirometry <u>Y</u> / N PP H&H: <u>9.8</u> hgb <u>28.3</u> hct HTN Orders: Call > 160/110 <u>VSO4hr</u> Hydralazine protocol Labetolol BID/TID</p>	<p>IV Fluids: Oxytocin LR NS Rate: <u>—</u> / Hour IV Site: <u>20</u> gauge Location: <u>L FA</u> Magnesium given: Y / <u>N</u> Dc'd: <u>—</u> @ <u>—</u> am/pm</p>	<p>Antibiotics: Frequency: _____ _____ _____</p>
<p>Recommendation: Patient should be discharged Home with wound care Supplies and instruction to follow up with <u>Oliver Lynn</u>.</p>		

Colby Lynn

IM6 Student Learning Outcomes				
Safety & Quality	Clinical Judgment	Patient Centered Care	Professionalism	Communication & Collaboration
<i>Formulate a plan of care for the childbearing family, and the patient with mental health disorders using evidence-based practice, safety, and quality principles.</i>	<i>Demonstrate clinical judgment using evidence-based data in making clinical decisions for the childbearing family, and the patient with mental health disorders.</i>	<i>Demonstrate family centered care based on the needs of the childbearing family, and the patient with mental health disorders.</i>	<i>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.</i>	<i>Communicate and collaborate effectively with patients, family, and members of the interdisciplinary team in the childbearing family, and the patient with mental health disorders.</i>

Safety & Quality:
Transporting baby to nursery for circumcision. Keeping mom informed about baby's temperament during procedure. Returning baby back to mom safely.

Clinical Judgment:

Patient Centered Care:
Patient was here for scheduled C-section. Spinal was not effective provided. Comfort provided while it reattempted plus an epidural provided along with fentanyl.

Professionalism:

Communication & Collaboration: