

## IM6 Student Learning Outcomes

<b>Safety &amp; Quality</b>	<b>Clinical Judgment</b>	<b>Patient Centered Care</b>	<b>Professionalism</b>	<b>Communication &amp; Collaboration</b>
<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:

**Clinical Judgment: (Labor and Delivery);** I used clinical judgment to reposition the mother when the baby's heart rate was difficult to trace due to the baby lying low in her belly. After repositioning, we were able to find a good spot to place the monitor to get a reading for about 30 min of fetal heart rate, showing the effectiveness of the interventions.

**Patient Centered Care: (Mom Baby);** For discharge education, I taught the mom about postpartum warning signs such as heavy bleeding, fever, or severe pain. As well as the importance of mom getting enough rest. For baby boy, I provided circumcision care instructions including keeping the area clean and dry and monitoring for redness, swelling, or bleeding.

### Professionalism:

### Communication & Collaboration:

Student Name: Gracie Harrison

Date:

**Situation:**  
 Patient Room #: 410  
 Allergies: codeine  
 Delivery Date & Time: 11/10 @ 0749

NSVD    PC/S    RC/S

Indication for C/S: elevated BP, dizziness, and headache

QBL: 240    BTL:  
 LMP: 2/13/2025    Est. Due Date: 11/20/25

Prenatal Care: <28 wks  LPNC

Anesthesia: None     Epidural    Spinal  
 General    Duramorph/PCA

VS:  Q4hr    Q8hr  
 0800:  
 Temp: 98.2 resp: 14 125/85  
 HR: 85    O<sub>2</sub>: 98%    MAP: 94  
 1200:

Diet: General  
 Pain Level: 0 / 10    Activity: normal

**Newborn:**  Male    Female  
 Feeding:  Breast    Pumping    Bottle  
 Formula: Similac    Neosure    Sensitive  
 Apgar: 1min 9    5min 9    10 min 9  
 Wt: 7 lbs 12 oz    Ht: 19 inches

**MD:**  
 Mom: Shanti  
 Baby: Pomeroy

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

**Background:**  
 Patient Age: 24 y/o  
 Gravida: 0    Para: 2    Living: 2  
 Gestational Age: 38<sup>W</sup> weeks  
 Hemorrhage Risk: Low     Medium    High

**Prenatal Risk Factors/Complications:**  
Gestational hypertension w/  
significant proteinuria in 3rd  
trimester.    GH

**NB Complications:** facial bruising,  
hydrocele    GH

**Maternal Lab Values:**  
 Blood Type & Rh A+  
 Rhogam @ 28 wks: Yes     No  
 Rubella:  Immune    Non-immune  
 RPR: R  NR    HbSAG: +  -  
 HIV: +  -    GBS: +  -    Treated:      X  
 H&H on admission: 10.7 hgb / 31.4 hct

**Newborn Lab Values:**  
 Blood Type & Rh       
 POC Glucose:         Coombs: + / -  
 Q12hr Q24hr AC Glucose:       
 Bilirubin (Tcb/Tsb): 8.5  
 CCHD O2 Sat:  
 Pre-ductal     %    Post-ductal     %  
 Other Labs:         GH

**Vaccines/Procedures:**  
**Maternal:**  
 MMR consent     Date given:  
 Tdap: Date given 10/7/25     Refused  
 Rhogam given PP: Yes     No

**Newborn:**  
 Hearing Screen:  Pass    Retest    Refer  
 Circumcision: Procedure Date 11/11  
 Plastibell    Gomco    Voided:  Y / N  
 Bath:  Yes    Refused

Date:

Student Name:

<p><b>Assessment (Bubblehep):</b> Neuro: <u>WNL</u> Headache Blurred Vision Respiratory: <u>WNL</u> Clear Crackles RR <u>15</u> bpm Cardiac: <u>WNL</u> Murmur B/P <u>130/84</u> Pulse <u>80</u> bpm Cap. Refill: <u>&lt;/= 3 sec</u> &gt;3 sec Psychosocial: Edinburgh Score <u>5</u></p>	<p>Breast: Engorgement Flat/Inverted Nipple Uterus: Fundal Ht 2U 1U <u>UU</u> U1 U2 U3 <u>Midline</u> Left Right Lochia: Heavy Mod Light <u>Scant</u> None Odor: Y / <u>N</u> Bladder: <u>Voiding QS</u> Catheter DTV Bowel: Date of Last BM <u>11/11</u> Passing Gas: <u>Y</u> / N Bowel sounds: <u>WNL</u> Hypoactive</p>	<p>Episiotomy/Laceration:  <sup>0</sup> WNL Swelling Ecchymosis Incision: WNL Drainage: Y / N Dressing type: _____ Staples Dermabond Steri-strips Hemorrhoids: Yes <u>No</u> <u>Ice Packs</u> <u>Tucks</u> Proctofoam <u>Dermoplast</u> Bonding: <u>Responds to infant cues</u> Needs encouragement</p>
<p>Treatments/Procedures: Incentive Spirometry: Y / N PP H&amp;H: _____ hgb _____ hct HTN Orders: <u>Call &gt; 160/110</u> <u>VSQ4hr</u> Hydralazine protocol Labetolol BID/TID</p>	<p>IV Fluids: Oxytocin LR NS <input checked="" type="checkbox"/> Rate: _____ / Hour IV Site: _____ gauge Location: <u>RFA</u> Magnesium given: Y / N Dc'd: _____ @ _____ am/ pm</p>	<p>Antibiotics: _____ Frequency: _____ _____ _____</p>
<p><b>Recommendation:</b> - Pain management - follow up for baby w/ bill - give care</p>		

GRACIE HARRISON

### Mom & Baby Medication Worksheet

Medication	Mechanism of Action	Maternal Effects	Nursing Management
<b>Methylergonovine Maleate</b>	Increasing contractions of the uterus.	-increased blood pressure -N/V -headache or dizziness -chest pain -uterine cramping	-Check B, hold if BP is high -Give slowly IM, never IV unless emergency -Want to make sure vaginal bleeding decreases -Report HA, dizziness, or high BP
<b>Prenatal Vitamin</b>	Supplies essential nutrients that support both mother and baby during pregnancy	-nausea -constipation or dark stools -mild headache -unpleasant taste (from iron or fish oil)	-give with food or at bedtime to reduce nausea -avoid giving with milk products (decreases absorption) -increase fluids and fiber to prevent constipation
<b>Hydromorphone</b>	Relieves pain for mom	-drowsiness/sedation -constipation -dry mouth -respiratory depression -hypotension	-monitor the baby heart rate because it can slow down everything for baby -hold dose if <12 breaths/min -keep Narcan on hand
<b>Keterolac</b>	Blocks pain and inflammation in the body	-N/V -upset stomach or heartburn -dizziness or headache -drowsiness	-assess kidney function before giving (urine output, creatinine levels) -give with food to prevent GI upset -watch for signs of bleeding -don't use for more than 5 days

<b>Colace</b>	Pulls water into the stool, making it softer and easier for the mom to poop	<ul style="list-style-type: none"> <li>-mild abdominal cramps</li> <li>-diarrhea (if taken too much)</li> <li>-bitter taste</li> <li>-nausea</li> </ul>	<ul style="list-style-type: none"> <li>-give with full glass of water</li> <li>-can be given with or without food</li> <li>-monitor for bowel movement 1-3 days</li> <li>-encourage high fiber foods</li> </ul>
<b>Hydralazine</b>	Relaxes smooth muscles, lowers blood pressure, and makes it easier for the heart to pump	<ul style="list-style-type: none"> <li>-headache</li> <li>-dizziness or lightheaded</li> <li>-flushing (warm feeling in face)</li> <li>-N/V</li> </ul>	<ul style="list-style-type: none"> <li>-check VS (blood pressure and heart rate)</li> <li>-move positions slowly due to possible dizziness and lightheaded</li> <li>-assess for S/S of preeclampsia</li> <li>-give slowly IV to prevent sudden drop in BP</li> </ul>
<b>Labetolol</b>	Lowers blood pressure	<ul style="list-style-type: none"> <li>-fatigue or tired</li> <li>-headache</li> <li>-nausea</li> <li>-tingling scalp or flushing face</li> </ul>	<ul style="list-style-type: none"> <li>-make sure mom is sitting or lying down when giving med (to prevent dizziness)</li> <li>-administer slowly IV</li> <li>-observe fetal heart rate</li> <li>-check BP regularly</li> <li>-do not stop abruptly (taper to avoid rebound hypertension)</li> </ul>

Student Name: Gracie Harrison	<b>Nursing Intervention #1: Ambulation</b>	Date: 11/11/2025
<b>Priority Nursing Problem:</b> Circumcision care and get mom's blood pressure back to pre-pregnancy baseline.	<b>Evidence Based Practice:</b> Encourage early and frequent ambulation after delivery to promote circulation, reduce blood clot risks, and get all body systems to get active again.	<b>Patient Teaching (specific to Nursing Diagnosis):</b>  1. Circumcision care: instruct mom to keep it clean and dry, monitor for redness and excessive bleeding.  2. Just use water and paper towels to clean area when changing diaper, no submersion until <u>plastibell</u> falls off and healing process has improved.  3. Teach mom to check BP regularly, take medications if prescribed, stay hydrated and follow up with all follow up appointments for mom and baby.
	<b>Nursing Intervention #2: Bonding with baby</b>	
<b>Related to (r/t):</b> Gestational HTN and circumcision procedure.	<b>Evidence Based Practice:</b> Encourage skin-to-skin contact to help with baby's heart rate, temp, breastfeeding success, and enhances overall connection between mom and baby.	
<b>As Evidenced by (aeb):</b> Elevated blood pressure during pregnancy and need for hypertension medications. Presence of circumcision site monitoring bleeding, swelling, or redness.	<b>Nursing Intervention #3: Breastfeeding</b>	
<b>Desired Patient Outcome (SMART goal):</b> 1.Mom verbalizes proper circumcision care after given instructions. 2.Mom also understands what gestational HTN is and to help manage by checking blood pressure at home, report headache or vision changes immediately.	<b>Evidence Based Practice:</b> Encourage frequent breastfeeding so it stimulates oxytocin release, promotes uterine contraction to reduce postpartum bleeding, mom baby bond, and breastmilk has all the nutrients that baby needs.	<b>Discharge Planning/Community Resources:</b>  1. Lactation (help with breastfeeding)  2.Support Groups (of other moms for advice with care)  3.Therapy (help with post-partum depression)