Rachel Williams

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

NKDA
Lupus?

Situation:

Date/Time 1/20/21 Age: 22

Cervix: Dilation: 1.5 cm Effacement: 70% Station: -2

Membranes: Intact: ✓ AROM: _____ SROM: _____ Color: _____

Medications (type, dose, route, time):

Stadol 1 mg inj. q4 hrs, Cytotec 50mcg q4, Lovenox last dose 1/19 @ 1600

PRN pain

Epidural (time placed): N/A tab. inj.

Background:

Maternal HX: blood clots (DVT + PE)

Gest. Wks: 38 Gravida: 1 Para: 0 Living: 0

GBS status: + / (-)

(Induction) / Spontaneous

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

Maternal VS: T: 97.7 P: 105 R: _____ BP: 144/82

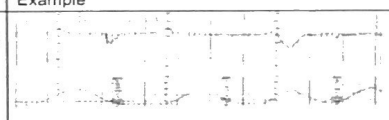
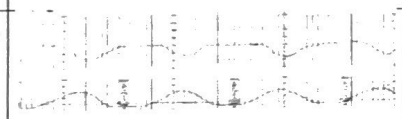
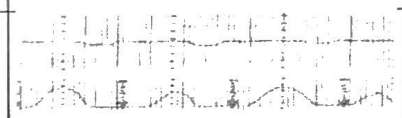
Contractions: Frequency: 3-6 mins Duration: 60 sec.

Fetal Heart Rate: Baseline: 135 bpm

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 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 was started on Cytotec for induction and would remain taking this until reaching a dilation of 4 cm then would start Pitocin.

Describe any Intrauterine Fetal Resuscitation measures utilized and the reason:

N/A

Delivery: did not deliver yet

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

Infant weight: _____

Rachel Williams

Prioritization Tool

	URGENT	NOT URGENT
IMPORTANT	Urgent & Important DO Monitoring fetal HR and contraction strips.	Not Urgent but Important PLAN Patient to continue on Cytoc until reaching a cervical dilation of 4 cm then start Pitocin.
NOT IMPORTANT	Urgent but Not Important DELEGATE I was told to turn up the fetal heart rate volume to hear it better.	Not Urgent and Not Important ELIMINATE I got a birthing ball for the patient to use to help progress labor and a fresh gown to put on.

Education Topics & Patient Response:

Educated the patient that ambulation while still able to walk is beneficial for progressing labor due to gravity which can encourage fetal descent. The patient understood and began walking around in the hallways with her spouses support alongside her.

Covenant School of Nursing Reflective Practice

Name: Rachel Williams Instructional Module: 6 Date submitted: 1/22/26

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

Step 1 Description

The patient came in for a scheduled induction of labor at 0400 and was started on Cytotec at 0457. The patient was progressing and dilating at a very slow rate as she was dilated to 1.5 cm at 0130. My role was a student nurse shadowing the RN.

Step 2 Feelings

This event helped me to empathize with the patient. She was a first time expecting mom who seemed nervous about labor nearing. This brought back memories for me as I remembered how nervous I was as a first time expecting mom.

Step 3 Evaluation

Everything seemed to be going pretty well because she wasn't having any major pain and she had family members their for support. Labor progression could have happened a little faster because the patient seemed to be getting anxious and impatient.

Step 4 Analysis

Although I understand the patient's readiness to meet her baby, I also understand that everyone labors at a different pace especially Primiparas who usually labor more slowly. Inducing labor is starting a process that the body was not ready to do yet so it can take significant time.

Step 5 Conclusion

Keeping a laboring mother's pain under control, helping her to stay calm, and educating her about any question's she may have is essential for the mother to have a good birthing experience.

Step 6 Action Plan

I thought the situation went very well. The doctor and nurse were very helpful about answering any questions the patient had. This has taught me that communication and teaching are very important in keeping our patient's calm and assured of the situation.

06824

Student Name: Rachel Williams Date: 01/21/26

Situation:

Patient Room #: 406
Allergies: NKDA
Delivery Date & Time: 1/20/26 0812

NSVD PC/S (RC/S)

Indication for C/S: repeat

QBL: 425 mL BTL: 01/20/26
LMP: 5/3/2025 Est. Due Date: 2/7/26

Prenatal Care: <28 wks ✓ LPNC ____

Anesthesia: None Epidural (Spinal)
General Duramorph/PCA

VS: (Q4hr) Q8hr

0800:
HR-72, R-16, BP-111/72, MAP-85, T-98.1, O2-98

1200:
HR-81, R-18, BP-108/6, MAP-78, T-98.1, O2-96

Diet: Regular
Pain Level: 2 / 10 Activity:

Newborn: Male (Female)
Feeding: (Breast) Pumping Bottle
Formula: Similac Neosure Sensitive
Apgar: 1min 9 5min 9 10 min 9
Wt: 6 lbs 9 oz Ht: 21 inches

MD: Zavala
Mom- Kristen
Baby- Arianna

Consults:
Social Services: ____

Psych: ____

Lactation: 1/20

Case Mgmt: ____

Nutritional: ____

Background:

Patient Age: 36 y/o
Gravida: 3 Para: 3 Living: 3
Gestational Age: 37 3 weeks
Hemorrhage Risk: Low (Medium) High

Prenatal Risk Factors/Complications:
AMA, chronic HTN, PCOS, palpitations

NB Complications: N/A

Maternal Lab Values:

Blood Type & Rh A+
Rhogham @ 28 wks: Yes (No)
Rubella: (Immune) Non-immune
RPR: R / (NR) HbSAG: + (-)
HIV: + / (-) GBS: + (-) Treated: ____ X
H&H on admission: 9.4 hgb / 28.3 hct

Newborn Lab Values:

Blood Type & Rh ____
POC Glucose: ____ Coombs: + / (-)
Q12hr Q24hr AC Glucose: ____ ____ ____ ____ ____
Bilirubin (Tcb/Tsb): 6.5
CCHD O2 Sat: 98
Pre-ductal 98 % Post-ductal 98 %
Other Labs:

Vaccines/Procedures:

Maternal:
MMR consent ✓ Date given: ____
TdaP: Date given 11/18/25 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: Rachel Williams Date: 1/21/2026

Assessment (Bubbleheb): Neuro: (WNL) Headache Blurred Vision Respiratory: (WNL) (Clear) Crackles RR 18 bpm Cardiac: (WNL) Murmur B/P 108/63 Pulse 81 bpm Cap. Refill: (</= 3 sec) >3 sec Psychosocial: Edinburgh Score not available	Breast: Engorgement Flat/Inverted Nipple sore nipples, not cracked 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 1/19/26 Passing Gas: (Y) / N Bowel sounds: (WNL) Hypoactive	Episiotomy/Laceration: N/A WNL Swelling Ecchymosis Incision: WNL Drainage: Y / (N) c/s Dressing type: absorbant pad adhesive (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: 9.4 hgb 28.3 hct HTN Orders: Call > 160/110 (VSQ4hr) Hydralazine protocol Labetolol BID/TID	IV Fluids: Oxytocin LR NS Rate: ___ / Hour INT IV Site: 18 gauge Location: L. hand Magnesium given: Y / (N) Dc'd: ___ @ ___ am/ pm	Antibiotics: Frequency: ___ ___ ___ ___ ___ ___
Recommendation: Have patient monitor for signs of infection due to a c/s wound. S/s include fever, increased pain, redness, swelling, discharge, hot to touch incision area.		

IM6 Critical Thinking Worksheet

Student Name:
Rachel Williams

Date:
1/21/26

Priority Nursing Problem:
Prevent infection of C/S incision.

Related to (r/t):
Repeat C-section and tubal

As Evidenced by (aeb):
redness around wound, increased pain, fever, discharge from wound, abnormal swelling

Desired Patient Outcome (SMART goal):
By 2 weeks post-op C/S, patient should have minimal pain and tenderness with no redness, swelling, or discharge from wound with a reported pain rating of 1 or less on on a 1-10 pain scale.

Nursing Intervention #1:
Inspect incision site for redness, swelling, increased warmth, or drainage.

Evidence Based Practice:
Early detection and prevention of surgical site infection.

Nursing Intervention #2:
Instruct patient to use strict hand hygiene before and after touching incision area.

Evidence Based Practice:
Keeping hands clean significantly reduces the risk of bacteria entering surgical site when touching around it.

Nursing Intervention #3:
Monitor for signs of systemic signs of infection such as fever, chills, fast heart rate.

Evidence Based Practice:
Systemic infection signs are often the earliest clues of a post-partum infection. C-sections impose a higher risk of infection compared to vaginal births.

Patient Teaching (specific to Nursing Diagnosis):

1. Keep C/S incision clean and dry.
2. Do not submerge in water such as baths, pools, hot tubs.
3. light activity and no heavy lifting until cleared by doctor at follow-up appointment.

Discharge Planning/Community Resources:

1. Important to go to follow-up appointments for doctor to evaluate.
2. Call the doctor if S/S of infection occur.
3. Take pain medications on a regular schedule to keep pain minimal.

Rachel Williams

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:

Patient Centered Care:

Professionalism:
The nurse demonstrated different ways and positions to use on the birthing ball to help progress labor and taught the patient that bouncing isn't what helps but more so the movements (figure 8.)

Communication & Collaboration:
The doctor and the nurse collaberated about what effacement percentage and dilation they figured when both doing their own vaginal exam on the patient and both agreed on interpreting the same effacement, dilation, and station