N305 Care Plan #1

Lakeview College of Nursing

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N305 Care Plan and Grading Rubric

Instructions: The care plan is to be typed into a WORD document and submitted to the labor & Delivery or Postpartum Drobox within 72 hours after your clinical has ended. Be sure and compare your work with the attached rubric before submitting this to the dropbox. The care plan is worth 150 points. In order to pass you must achieve at least 116 points to acquire a pass. If you do not pass, you will have one opportunity to do a newborn care plan on a different patient. You must pass the care plan in order to pass your clinical and thus your course.

Demographics (3 points)

Date of Admission & Time of Admission	Patient Initials	Age	Gender
6/18 1230	MC	25	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
caucasian	stay home	NM	Sulfa antibiotics & benzocaine
Code Status	**Height**	**Weight**	**Father of Baby involved**
Full	5'3	261	yes

Medical History (5 Points)

Prenatal History: **G1P0**

Past Medical History: Obesity, BMI 40, asthma

Past Surgical History: tonsillectomy

Family History: Mother Father sister- no complications

Social History (tobacco/alcohol/drugs): former smoker, no alcohol

Living Situation: boyfriend's house

Education Level: grad high school

Admission Assessment (12 points)

Chief Complaint (2 points): Induction of Labor

Presentation to Labor & Delivery (10 points): Intrauterine pressure catheter was inserted. MC is 25 years old G1P0 female with IUP at 37 weeks 0 days on 6/17/2019, by 11-week ultrasound who presents for scheduled IOL secondary to gestational HTN, no complaints and is doing well. Denies any preeclampsia symptoms such as HA, visual changes, SOB, CP, RUQ pain

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points): Gestational HTN

Secondary Diagnosis (if applicable): Induced labor

Stage of Labor (20 points):

Stage of Labor write up in APA format (see grading rubric) (18 points)

The first stage of labor consists of the latent phase, active phase, and the transition phase, which leads into the actual birth. The latent phase is where the first true contraction occurs, the patient presents with frequent contractions that last 30 or 45 seconds between for 5 to 30 minutes. Clients are typically talkative in this phase, and the cervix is measured between 0-3cm. Leopold's maneuvers are performed at this time as well as vaginal exams. The nurse should monitor the nitrazine paper if a membrane is ruptured. If ruptured the nurse should check temperatures every 4 hours. The membrane should be clear when assessed. The active phase presents with stronger contractions and more regular patterns. The frequency between contractions is shorter, about 3-5 minutes, and the duration can last 40-70 seconds. The patient may feel anxiety at this point in labor, and the cervix is measured between 4-5cm. during the active phase the nurse should check the mother's HR and fetal heart rate q30. The transition phase is the transition phase where the mother is preparing for full fetal descent through the vagina. This is where patients typically have contractions every 2-3 minutes while lasting anywhere between 45-90 seconds. The mother will be dilated between 8-10cm. The client may show signs of nausea and vomiting with restlessness. A bloody show is usually present in this phase. The nurse should encourage frequent voiding when

preparing for fetal descent, and monitor HR every 15minutes. At 10cm the baby is ready to come any minute. Patient MC presented to the hospital for induction of labor. During clinical time when I arrived, she was in the first phase of stage one but transitioning into the second phase of labor shortly after, MC had a notable pregnancy where she was marked morbidly obese with a BMI of 40, she presented with shortness of breath while in the bed. The first phase may be assessed by performing vaginal exams to assess cervical dilation and effacement along with palpating the bladder to see how high the fundus rests in accordance with the umbilicus. When the second phase started she was about 4-5cm dilated, Cytotec was administered and the contraction pattern prohibited dose protocol. The nurse attempted to insert a Foley bulb. There was some bloody show present but had an acceptable amount of volume. 1mu of Pitocin was later started, a little while longer the patient requested stopping the PO intake so she could sleep. Fetal heart rate currently was 140 after rest. Cytotec was started up again and the doctor suggested possible C-section with the client. Fetal heart rate was 135. Patient's vitals were 96 pulse, 117/65 BP, 16 respirations, 97.6 temp, and 96 o2 sat. She did show signs and symptoms of anxiety, but no restlessness. Contractions were more regular at this point and strong and lasted about 50 seconds. We used therapeutic communication to help her anxiety and remain calm. During this phase it may last 4-8 hours, the patient may also experience leg cramping and lower back pain. The nurse did encourage voiding to help eliminate any pressure on the patient's bladder which may interfere with fundal height.

Stage of Labor References (2) (APA format):

ATI. (2016). ***RN Maternal Newborn Nursing.*** **(10th ed., Content Mastery Series)**

Ricci,S., Kyle, T., & Carmen, S. (2018). ***Maternity and Pediatric Nursing*****.(3rd ed.) Philadelphia, PA: Wolters Kluwer.**

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value

RBC	**3.8-5.3**	**4.66**	**n/a**	**3.98**	
Hgb	**11.7-16**	**13.6**	**n/a**	**11.8**	
Hct	**35-47**	**40.9**	**n/a**	**34.8**	**Low Hct indicates diluted blood volume, along with that the RBC, and Hgb may be lower as well (webMd, n.d.).**
Platelets	**150-400**	**221**	**n/a**	**206**	
WBC	**4.5-11**	**7.4**	**n/a**	**10.5**	
Neutrophils	**47-73**	**67**	**n/a**	**70.4**	
Lymphocytes	**18-42**	**24**	**n/a**	**21.7**	
Monocytes	**4-12**	**8**	**n/a**	**7**	
Eosinophils	**0-5**	**1**	**n/a**	**0.6**	
Bands	**0-1**	**0**	**n/a**	**0.1**	

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal
Blood type	**AB,A,B,O**	**O**	**O**	**O**	
Rh factor	**+/-**	**neg**	**pos**	**pos**	
Serology (RPR/ VDRL)	**non reactive**	**non reactive**	**Non reactive**	**Non reactive**	
Rubella Titer		**positive**	**immune**	**immune**	
Hct & Hgb	**34.6-45.1** **12-15.3**	**35** **13**	**36** **14**	**36** **14.8**	
HIV	**+/-**	**none**	**none**	**none**	
HbSAG	**Pos or neg**	**neg**	**neg**	**neg**	

Group Beta Strep Swab	**neg or pos**	**pos**	**pos**	**pos**	
Glucose at 28 weeks	**70-99**	**77**	**83**	**86**	
Genetic testing: if done	**n/a**	**n/a**	**n/a**	**n/a**	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal
Color & Clarity	**yellow**	**yellow**	**yellow**	**yellow**	
pH	**2.4-5.7**	**5.6**	**n/a**	**n/a**	
Specific Gravity	**1.005-1.030**	**1.025**	**1.029**	**n/a**	
Glucose	**-**	**-**	**-**	**-**	
Protein	**0-12**	**12.9**	**-**	**11.7**	**This is an indicator of preeclampsia development (Laney, 2019).**
Ketones	**-**	**-**	**-**	**-**	
WBC	**0-5**	**0**	**0**	**0**	
RBC	**0-2**	**0**	**0**	**0**	
Leukoesterase	**-**	**-**	**-**	**-**	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal
Urine Culture	**-**	**-**	**-**	**-**	

Other Tests	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal
N/a					
N/a					
N/a					

Lab Correlations Reference (APA):

Anemia in Pregnancy: Causes, Symptoms, and Treatment. (n.d.). Retrieved July 10, 2019, from https://www.webmd.com/baby/guide/anemia-in-pregnancy#1

Laney. (2019, January 03). Making sense of preeclampsia tests. Retrieved July 10, 2019, from https://www.preeclampsia.org/history-of-preeclampsia/53-health-information/637-making-sense-of-preeclampsia-tests

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	**135-140**

Are there accelerations, if so describe them and explain what these mean i.e. how high do they go and how long do they last? **What is the variability?**	**Yes, accelerations lasted 15x15. They went as high as 143** **Accelerations are defined by an abrupt increase in FHR of greater than 15 BPM for greater than 15 seconds, hence 15X15. If the basline is 140, the accels would have to be at least 155.** **Variability was moderate**
Are there decelerations, if so describe them. **What do these mean?** **Did the nurse perform any interventions with these?** **Did these interventions benefit the patient or fetus?**	**Yes, variable decelerations indicated cord compression somewhere around the baby. The nurse repositioned the mother onto her left side. Yes this benefited both mother and baby.**
Describe the contractions i.e. frequency, length, strength, patient's response.	**3 minutes a part, lasted 60-90 seconds. Rated a pain of 2/10. Patient responded appropriate to expectations, she was a little distressed** Focus Information Technology. (n.d.). Retrieved July 11, 2019, from http://perinatology.com/Fetal Monitoring/Intrapartum Monitoring.htm

Current Medications (10 points total -1 point per completed med)

7 different medications must be completed

Home Medications (2 required)

Brand/Generic	**aspirin/ ASA**	**albuterol/ airomir**			
Dose	**2.4g**	**2-4mg**			
Frequency	**daily**	**daily**			
Route	**oral**	**oral**			
Classification	**antipyretic**	**bronchodilator**			
Mechanism of Action	**produce analgesia blocking prostaglandin**	**bind beta2 receptors in airway**			
Reason Client Taking	**reduce inflammation**	**prevent airway obstruction**			
Contraindications (2)	**other NSAID use and hypersensitivity**	**HTN and cardiac disease**			
Side Effects/Adverse Reactions (2)	**Tinnitus & GI bleed**	**tremors and headache**			
Nursing Considerations (2)	**monitor hepatic and monitor**	**may cause digoxin toxicity and**			

	prolong bleed	**run risk of hypokalemia**			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Manual therapy techniques & caution physical interventions**	**monitor potassium level and assess lung sounds**			
Client Teaching needs (2)	**Take before pain increases & take with full glass of water**	**contact provider if any shortness of breath and prime unit before using**			

Hospital Medications (5 required)

Brand/Generic	**Cervidil / Dinoprostone**	**Cytotec/ misoprostol**	**pitocin/ Oxytocin**	**Zofran/ ondansetron**	**Methergine/ methylergonovine**
Dose	**0.5mg**	**1000mcg**	**20mlu per min**	**4mg**	**200mcg**
Frequency	**once**	**once**	**constant**	**every 6hr**	**q2hr**
Route	**vaginal**	**vaginal**	**IV**	**oral**	**Im**
Classification	**cervical ripe**	**oxytocic**	**oxytocic**	**antiemetic**	**oxytocic**
Mechanism of Action	**for contractions**	**binds to myometrial cells**	**increase calcium in cells**	**prevent nausea and vomit**	**acts on smooth muscle**
Reason Client Taking	**start contractions**	**induce labor**	**start uterine contractions**	**client had nausea**	**prevent post hemorrhage**
Contraindications	**hypersensitiv**	**ulcer history**	**fetal distress**	**prolonged**	**HTN and**

(2)	**ity and prolonged contractions**	**and previous c-section**	**and cephalopelvic disproportion**	**QT, patient with serotonin syndrome**	**peripheral vascular disease**
Side Effects/Adverse Reactions (2)	**warm feeling, and back pain**	**cramping and constipation**	**uterine motility increase and APGAR score that is low**	**headache, dizziness**	**chest pain and dyspnea**
Nursing Considerations (2)	**monitor frequency and avoid skin contact**	**monitor constipation and effectiveness**	**mag sulfate for reversal and monitor FHR**	**monitor lungs and check that it is effective**	**monitor BP and monitor HTN**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**bring gel to room temp and remain supine 15 minutes at least**	**check cervix and monitor FHR**	**monitor FHR prior and monitor contractions prior**	**check hepatic labs and monitor BP prior**	**assess uterus prior and monitor BP prior**
Client Teaching needs (2)	**explain purpose and provide emotional support**	**this is a vaginal insert and expect cramping**	**notify for headache, and cramping may be intense**	**Take with or without food and assess side effects**	**don't smoke and may cause cramps**

Medications Reference (APA): (2 points)

Wolters Kluwer Health. (2019). Find Drugs & Conditions. In *Drugs.com*. Retrieved from https://www.drugs.com

Assessment (20 points)

Physical Exam (20 points)

GENERAL (0.5 point): **Alertness: responsive** **Orientation: knows time and place** **Distress: none**	**Patient is Alert and oriented, has no distress**

Overall appearance: groomed, minimal grimace	
INTEGUMENTARY (2 points): **Skin color: pink** **Character: dry** **Temperature: 97.5** **Turgor: rapid recoil** **Rashes: no rashes** **Bruises: no bruising** **Wounds/Incision: none** **Braden Score: 23** **Drains present: Y☐ N ☒** **Type:**	
HEENT (0.5 point): **Head/Neck: symmetrical and groomed** **Ears: no drainage** **Eyes: PERRLA** **Nose: no deviation** **Teeth: white**	**WDL**
CARDIOVASCULAR (1 points): **Heart sounds: s1 and s2 heard** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): RRR** **Peripheral Pulses: 2+** **Capillary refill: rapid refill** **Neck Vein Distention: Y ☐ N + Edema Y + N ☐**	

Location of Edema: ankles	
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character auscultated front and back**	**WDL**
GASTROINTESTINAL (5 points): **Diet at home: sweets, meats, water, vegetables** **Current Diet same as above minus sweets** **Height: 5'3** **Weight: 261 lbs** **Auscultation Bowel sounds: present** **Last BM: 6/18** **Palpation: Pain, Mass etc.: no pain at this time** **Inspection:** **Distention: none** **Incisions: none** **Scars: none** **Drains: none** **Wounds: none** **Fundal Height & Position: at umbilicus**	**WDL**
GENITOURINARY (5 Points): **Bleeding: none** **Color: clear** **Character: no odor** **Quantity of urine: 45 ml**	

Pain with urination: Y ☐ N + **Inspection of genitals: no rashes** **Catheter: Y ☐ N +** **Type:** **Size:** **Rupture of Membranes:** **Time: 6/19 at 0733** **Color: rubra** **Amount: light** **Odor: none** **Episiotomy/lacerations: none**	
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N +** **Fall Risk: Y + N☐** **Fall Score: 11** **Activity/Mobility Status: bedrest** **Independent (up ad lib) ☐ moderate** **Needs assistance with equipment ☐ yes** **Needs support to stand and walk☐ yes**	minimal position changes
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y + N☐** **Strength Equal: Y + N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation: knows time and place** **Mental Status: awake** **Speech: wdl**	.

Sensory: wdl **LOC: aware of surroundings** **DTRs: present**	
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s): talking with nurse** **Developmental level: appropriate** **Religion & what it means to pt.: none** **Personal/Family Data (Think about home environment, family structure, and available family support): has support from all family members**	.
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	**no delivery**

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**97**	**111/63**	**48**	**98.6**	**97**
Labor/Delivery	**96**	**117/65**	**46**	**98.4**	**96**

Postpartum	**81**	**132/61**	**16**	**97.5**	**96**

Vital Sign Trends: relatively stable throughout

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	**0/10**	**n/a**	**n/a**	**n/a**	**n/a**
1500	**2/10**	**All over**	**Not bad**	**dull**	**tylenol**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 g **Location of IV: upper left arm antecubital** **Date on IV: 5/29** **Patency of IV:** **Signs of erythema, drainage, etc.: none** **IV dressing assessment: bandage. Brown wrap**	Lactated ringers, pitocin

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
2171	**Unmeasurable**

Interventions (12 points)

Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. Teaching relaxation techniques; help the patient with deep breathing and guided imagery to help promote calmness and lower HR/respirations

2. Teaching about breech position- let patient know this is not the standard way for vaginal delivery and doctors may need to intervene with leopold's maneuvers to help reposition. Expecting that the mother will understand that occiput is the safe way for delivery

Nursing Interventions (6 points)

Include a rationale as to why the intervention is being provided to client

Nursing Interventions: administration of Pitocin IV can be reduced, this will help stimulate contractions because she was about 6 cm dilated. Secondly, promoting relaxing techniques for our client at this stage helps ease the mother and saves her energy for when the transition stage starts.

Medical Treatments: lactated ringers was administered with the Pitocin, no epidurals were used at the point of care I assisted with.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis ● Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** ● Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)** Include a short rationale as to why you chose this intervention & cite the reference appropriately	**Evaluation** ● How did the client/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Risk for infection related to prolonged rupture of membrane	**Any mother that delivers vaginally or through c-section runs the risk of disease or bacteria entering their body because of exposure to the environment**	**1.monitor the cervix for shrinking back to its regular size, this helps keep opening from being exposed to outside bacteria** **2.monitor the perineum for lacerations because open wounds are susceptible to infection**	**Client and her boyfriend were understanding of postpartum physical changes and importance of the cervix and perineum being monitored**
2. Risk for disturbed personal identity related to body image and psychological factors as evidenced by becoming a new mother and weight gain through labor	**This was the mother's first pregnancy so she will be taking on new responsibilities as well as adjusting back to her regular size and weight**	**1. Identify stressful situations with the client so she can be prepared for tasks needed for the baby** **2.Form a trusting relationship with the client to ensure she is not alone with**	**The nurse was able to address any questions and answer in ways that provided support, and the nurse utilized therapeutic techniques**

		physical transitions and that these are normal symptoms	

Other References (APA): all included above

N305 Care Plan Grading Rubric: Labor Student Name:

Demographics	3 points	1.5 points	0 points	
Demographics ● Date of admission ● Patient initials ● Age ● Gender ● Race/Ethnicity ● Occupation ● Marital Status ● Father of baby involvement ● Allergies ● Code Status ● Height ● Weight	Includes complete information regarding the patient. Each section is filled out appropriately with correct labeling.	Two or more of the key components are not filled in correctly.	5 or more of the key components are not filled in correctly and therefore no points were awarded for this section	**3**
Medical History	**5 points**	**2.5 points**	**0 points**	
Prenatal History **Past Medical History** ● All previous medical diagnosis should be listed **Past Surgical History** ● All previous surgeries should be listed **Family History** ● Considering paternal and maternal **Social History** ● Smoking (packs per day, for how may year) ● Alcohol (how much alcohol consumed and for how many years) ● Drugs (how often and drug of choice) **Living situation** **Education level** ● If applicable to learning barriers	Includes each section completed correctly with a detailed list of pertinent medical history, surgical history, family history and social history. If patient is unable to give a detailed history, look in the EMR and chart.	1 or more of the key components is missing detailed information.	More than two of the key components are not filled in correctly	**2.5**

Admission Assessment - Chief Complaint	2 points	1 point	0 points	Points
Chief complaint ● Identifiable with a couple words of what the patient came in complaining of	Chief complaint is correctly identified.	Chief complaint not completely understood.	No chief complaint listed.	**2**

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Admission Assessment- History	10 points	6-10 points	0-5 points	Points
Presentation to Labor & Delivery ● Information is identified in regards to why the patient came to the hospital ● Utilization of OLD CARTS as appropriate ● Written in a paragraph form with no less than 5 sentences ● Information was not copied directly from the chart and no evidence of plagiarism ● Information specifically stated by the patient using their own words is in quotations ● Plagiarism will receive a 0	Every key component of the admission history is filled in correctly with information. It is written in a paragraph form, in the student's own words. There is no evidence of plagiarism identified. This is developed in a paragraph format with no less than 5 sentences.	Two or more of the key components are missing in the admission history. The admission history is lacking important information to help determine what has happened to the patient.	4 or more components are missing in the admission history. Paragraph is not well developed and it is difficult to understand what the patient is seeking care for. There is evidence of plagiarism noted in the HPI.	**9**
Primary Diagnosis	**2 points**	**1 points**	**0 points**	**Points**
Primary Diagnosis ● The main reason the patient was admitted **Secondary Diagnosis** ● If the patient has more than one reason they are being admitted	All key components are filled in correctly. The student was able	One of the key components is missing or not understood correctly.	Student did not complete this section and there is concern for lack of understanding the diagnosis.	**2**

	to identify the correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.			
Stage of Labor	**20 points**	**14-10 points**	**9-5 points**	**4-0 points**
Stage of Labor ● Professionally written essay in APA format outlined all aspects of the stage of labor the client is in during the student's care ● information is well written and no less than 1 page ● Signs/symptoms of the stage ● Expected findings related to the stage such as vital signs and laboratory findings ● How the stage of labor is identified ● Typical nursing interventions and treatments for the stage of labor ● Assessment findings that would suggest the client is progressing to another stage ● Listed clinical data that correlates to this particular client ● Plagiarism results in a zero in this section ● 2 APA references,	All key components were addressed and student had a good understanding of the expectations listed. Stage of labor was thorough with a direct correlation of how this related to the client and their stage of labor was performed.	One or two key components were missing such as signs and symptoms, expected findings, correlation and treatment. Student was able to describe the stage of labor.	Three or more components were missing throughout the paper. Unable to determine if the student had a good understanding of the stage of labor and the direct correlation to the client	Section is incomplete with several ke missing. Student did not have a understanding of the stage of labor a correlated to the client. Section was not in APA format with mi references (0 points will be giv **20**

essay is written in correct APA format.				

Laboratory Data	15 points	5-14 points	4-0 points	
Normal Values ● Should be obtained from the chart when possible as labs vary some. If not possible use laboratory guide. ● Normal values should be listed for all laboratory data. **Laboratory Data** ● Admission Values ● Most recent Values (the day you saw the patient) ● Prenatal Values **Rational for abnormal values** ● Written in complete sentences with APA citations ● Explanation of the laboratory abnormality in this client ● For example, elevated WBC in patient with pneumonia is on antibiotics. ● Minimum of 1 APA reference, no reference will result in zero points for this section	All key components have been addressed and the student shows an understanding of the laboratory norms and abnormalities. Student had 1 reference listed and is able to correlate abnormal laboratory findings to the client's particular disease process.	1 or more of the client's labs were not reported completely with normal values or patient results. Lab correlation did not completely demonstrate student's understanding of correlation.	Student did not have an understanding of laboratory values and the abnormalities. More than 2 labs were excluded. Student did not discuss the abnormal findings in APA format with a minimum of 1 reference.	**14**
Electronic Fetal Heart Monitoring	**20 points**	**19-10 points**	**0-10 points**	
Components of EFHM: ● Baseline ● Accelerations ● Variability ● Decelerations ● Contractions: frequency, duration, intensity ● Correlation of EFHM to the client's diagnosis and condition. ● Interventions performed ● Normal values/expected values are listed ● Minimum of 1 APA reference, no reference will result in zero points for this section	All key components have been addressed and the student shows an understanding of the norms and abnormalities. Student had 1 reference listed and is able to correlate abnormal findings to the client's particular disease process.	One or more of the key components is missing, yet the student is able to demonstrate an understanding of the diagnostic testing and is able to correlate the abnormal findings to the disease process.	Student did not have an understanding of EFHM and the abnormalities. Student did not have an APA reference listed.	**0**

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Current Medications	10 points	1-9 points	0 points	
Current Medications ● Requirements of 5 inpatient hospital medications and 2 home medications—these must be 7 DIFFERENT medications ● Each medication must have brand/generic name ● Dosage, frequency, route given, class of drug and the action of the drug ● Reason client taking ● 2 contraindications must be listed o Must be pertinent to your patient ● 2 side effects or adverse effects ● 2 nursing considerations ● Key nursing assessment(s)/lab(s) prior to administration o Example: Assessing client's HR prior to administering a beta-blocker o Example: Reviewing client's PLT count prior to administering a low-molecular weight heparin ● 2 client teaching needs ● Minimum of 1 APA citation, no citation will result in loss of all points in the section	All key components were listed for each of the 7 medications, along with the most common side effects, contraindications and client teachings. Student had 1 APA citation listed.	1 point will be lost for each medication with incomplete information.	There was noted lack of effort on the student's part to complete this section or there was no APA citation listed.	**10**
Physical Assessment	**20 points**	**1-18 points**	**0 points**	
● Completion of a head to toe assessment done on the students own and not copied from the client's chart ● Fall risk assessment ● Braden skin assessment ● **No fall risk or Braden scale will result in a zero for the section**	All key components are met including a complete head to toe assessment, fall risk and Braden score.	One or more of the key components is missing from a given section. Each body system is worth points as listed on care plan	More than half of the key components are missing. Therefore, it is presumed that the student does not have a good understanding of the head to toe assessment process.	**20**
Vital Signs	**5 points**		**2.5 points**	
Vital signs ● 3 sets of vital signs are recorded with the appropriate labels attached ● Includes a prenatal set,	All the key components were met for this section (with 2 sets of vital signs) and student has a good understanding of abnormal vital signs.		Only one set of vital signs were completely recorded and one of the key components	Stu co

labor/delivery set, and postpartum set ● *If client has not delivered for a postpartum set, student is to list TWO vitals from labor and delivery* ● Student highlighted the abnormal vital signs ● Student wrote a summary of the vital sign trends		were missing. **5**	
Pain Assessment	**2 points**	**1 point**	**(**
Pain assessment ● Pain assessment was addressed and recorded twice throughout the care of this client ● It was recorded appropriately and stated what pain scale was used	All the key components were met (2 pain assessments) for this section and student has a good understanding of the pain assessment.	One assessment is incomplete. **2**	Stu co

IV Assessment	**2 points**	**1 point**	**0 poi**
IV assessment ● IV assessment performed and it is charted including what size of IV and location of the IV ● Noted when the IV was placed ● Noting any signs of erythema or drainage ● Patency is verified and recorded ● Fluid type and rate is recorded or Saline lock is noted. ● IV dressing assessment is recorded (clean, dry and intact)	All of the key components were addressed. Student demonstrates an understanding of an IV assessment.	One of the key components is missing. **2**	More th aspect IV assessr is missi studen not compl this sec
Intake and Output	**2 points**	**1-0 points**	
Intake ● Measured and recorded appropriately—what the patient takes IN ● Includes: oral intake, IV fluid intake,	All of the key components of the intake and output were addressed. Student demonstrates an understanding of intake	One of the key components of intake and output is missing. Diff to determine if the student has thorough understanding of the in	

etc. **Output** ● Measured and recorded appropriately—what the client puts OUT ● Includes: urine, stool, drains/tubes, emesis, etc.	and output.		and output. **2**	
Nursing Care/Interventions	**12 points**		**2-0 points**	
Nursing Interventions ● List the nursing interventions utilized with your client ● Includes a rationale as to why the intervention is carried out or should be carried out for the client **Teaching topics** ● List 2 priority teaching items ● Includes 1 expected outcome for each teaching topic	All the key components of the summary of care (2 points) and discharge summary (2 points) were addressed. Student demonstrated an understanding of the nursing care.		One or more of the key compon of the nursing care was missi therefore it was difficult to deter if the student had a thorough understanding of the nursing c **12**	
Nursing Diagnosis	**15 points**	**5-14 points**	**4-0 points**	**Poin**
Nursing Diagnosis ● List 2 nursing diagnosis o Include full nursing diagnosis with "related to" and "as evidenced by" components ● Appropriate nursing diagnosis ● Appropriate rationale for each diagnosis o Explain why the nursing diagnosis was chosen ● Minimum of 2 interventions for each diagnosis ● Rationale for each intervention is required ● Correct priority of the nursing diagnosis ● Appropriate evaluation	All key components were addressed. The student demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.	One or more of the nursing diagnosis/rational/intervention sections was incomplete or not appropriate to the patient Each section is worth 3 points. Prioritization was not appropriate.	More than 2 of the nursing diagnosis sections were incomplete or inappropriate. Prioritization is dangerously inappropriate.	**13**
Overall APA format	**5 Points**	**1-4 Points**	**0 Points**	**Point**
APA Format ● The student used appropriate APA in text citations and listed all	APA format was completed and	APA format was used but not correct. Several	No APA format. Grammar or writing style did not	**5**

appropriate references in APA format. ● Professional writing style and grammar was used in all narrative sections.	appropriate. Grammar was professional and without errors	grammar errors or overall poor writing style was used. Content was difficult to understand.	demonstrate collegiate level writing.	
				Points
- Instructor Comments: Levi – overall this care plan is pretty good. You've missed a lot of points because of forgetting a reference in one section. Otherwise, there are just a couple of spots you have missed minimal points. It is passing, but if you would like to add that reference and fix those little mistakes for extra points, you are welcome to do so.		**Total points awarded**		
Description of Expectations	**123.5 /150= 82.3 %**			
Must achieve 116 pt =77%				