N323 Care Plan Grading Rubric

Student Name: Andrew McSparran

Demographics	3 points	1.5 points	0 points	Points
Demographics • Date of admission • Patient initials • Age • Gender • Race/Ethnicity • Occupation • Marital status • Allergies • Code Status • Observation Status • Height • Weight	Includes complete information regarding the patient. Each section is filled out appropriately with correct labeling.	1-3 of the key components are not filled in correctly.	4 or more of the key components are not filled in correctly and therefore no points were awarded for this section	3/3
Medical History	**5 points**	**2.5 points**	**0 points**	**Points**
Past Medical History • All previous medical diagnosis should be listed **Significant Psychiatric History** • All previous psychiatric diagnosis should be included **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** **Strengths** **Support System**	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.	1-2 of the key components is missing detailed information.	3 or more of the key components are not filled in correctly	5/5

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.	**1/1**
Contributing Factors	**10 points**	**5 points**	**0 points**	**Points**
Contributing Factors • Written in a paragraph form with no less than 5 sentences • Factors that lead to admission • History of suicide attempts o Include date and method • 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 HPI is filled in correctly with information such as those identified with (OLD CARTS). 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.	1-3 of the key components are missing in the HPI. The HPI is lacking important information to help determine what has happened to the patient.	4 or more components are missing in the HPI. 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.	5/5
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 to identify the correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.	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.	2/2

Psychosocial Assessment	30 points	15 points	0 points	Points
Psychosocial Assessment • Completion of a psychosocial assessment done on the students own and not copied from the client's chart	All key components are met and a complete psychosocial assessment has been completed.	1-3 of the key components is missing from a given section.	4 or more of the key components are missing. Therefore, it is presumed that the student does not have a good understanding of the mental status exam.	**15/30**

DSM-IV Diagnoses	15 points	7.5 points	0 points	Points
Axis I • Clinical disorders **Axis II** • Personality disorders • Mental retardation **Axis III** • General medical condition **Axis IV** • Psychosocial problems • Environmental problems **Axis V** • Global assessment of functioning	All key components have been addressed and the student shows an understanding.	1-2 of the key components is missing. Difficult to determine student understanding.	3 or more of the key components are missing. Student did not have a good understanding.	7.5/15

Current Medications	10 points	1-9 points	0 points	Points
Current Medications • Complete all of client's psychiatric medications • Each medication must have brand/generic name • Dosage, frequency, route given, class of drug and the action of the drug • Therapeutic uses • Therapeutic range (if applicable) • Reason client taking • 2 contraindications must be listed o Must be pertinent to your patient • 2 side effects or adverse effects • Medication/food interactions • 2 nursing considerations • 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 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.	9/10
Mental Status Exam Findings	**20 points**	**10 points**	**0 points**	**Points**
• Completion of a mental status exam done on the students own and not copied from the patient's chart	All key components are met and a complete mental status exam has been completed.	1-2 of the key components is missing from a given section.	3 or more of the key components are missing. Therefore, it is presumed that the student does not have a good understanding of the mental status exam.	**20/20**
Vital Signs	**5 points**		**2.5 points**	**0 points**	**Points**

Vital signs • 2 sets of vital signs are recorded with the appropriate labels attached • Student highlighted the abnormal vital signs	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 1 set of vital signs were completely recorded and/or 1 of the key components were missing.	Student did not complete this section and/or 2 or more of the key components are missing.	5/5
Pain Assessment	**2 points**	**1 point**	**0 points**	**Points**
Pain assessment • Pain assessment was addressed and recorded twice throughout the care of this patient • 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.	Only 1 pain assessment was completely recorded and/or 1 of the key components is missing.	Student did not complete this section and/or 2 or more of the key components are missing.	2/2

Dietary Data	**2 points**	**1 point**	**0 points**	**Points**
Dietary Intake • Percentage of each meal consumed • Oral fluid intake (in mL) with each meal	All of the key components of the dietary intake. Student demonstrates an understanding dietary intake.	1 of the key components of the dietary intake is missing. Difficult to determine if the student has a thorough understanding of the dietary intake.	2 or more of the key components of the dietary intake is missing or the student did not complete the section.	**2/2**
Discharge Planning	**4 points**	**2 points**	**0 points**	**Points**

Discharge Plan (Your plan for the client) • Who is patient going home with/to • Home health care needs • Equipment needs • Follow up plan • Education needs regarding diagnosis and care at home	All the key components of the discharge plans were addressed. Student demonstrated an understanding of the discharge plans.		1 of the key components of the discharge plan was missing, therefore it was difficult to determine if the student had a thorough understanding of discharge planning.	2 or more of the key components of the discharge plan was missing or the student did not complete the section.	0 (Good luck, "just say no to drugs" is not appropriate or therapeutic.) No plan of care implemented for discharge.
Nursing Diagnosis	**15 points**	**7.5 points**	**0 points**	**Points**	

Nursing Diagnosis
• List 3 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
• 3 immediate nursing interventions (at admission)
• 3 intermediate nursing interventions (during hospitalization)
• 3 community nursing interventions (prior to discharge)
• Correct priority of the nursing diagnosis
	All key components were addressed.
	
	The student demonstrated an appropriate understanding of nursing diagnoses, rationales, goals, interventions and listed diagnosis in correct priority.
		1-3 of the nursing diagnosis, rational, goals, or intervention sections was incomplete or not appropriate to the patient.
		
		Prioritization was not appropriate.
			4 or more of the nursing diagnosis sections were incomplete or inappropriate.
			
			Prioritization is dangerously inappropriate.
				7.5
				
				(AEB and r/t are not approved abbreviations). Planning used for intervention. Planning what?	

Overall APA format	**5 Points**	**2.5 Points**	**0 Points**	**Points**	

APA Format • The student used appropriate APA in text citations and listed all appropriate references in APA format. • Professional writing style and grammar was used in all narrative sections.	APA format was completed and appropriate. Grammar was professional and without errors	APA format was used but not correct with 1-3 errors noted. 1-3 grammar errors or overall poor writing style was used. Content was difficult to understand.	No APA format or 4 or more errors noted. Grammar or writing style did not demonstrate collegiate level writing with 4 or more errors noted.	5/5

Concept Map	20 points	Points
Concept Map	Each aspect is worth 3 points, overall appearance and understanding is worth 2 points.	0

- Patient information (3 points) - Objective data (3 points) - Subjective data (3 points) - Interventions (3 points) - Nursing Diagnosis (3 points) - Outcomes (3 points)		There was not a concep t map attach ed to care plan.
Description of Expectations	The concept map information is an overview of your patient. • At the center you have the patient's basic information: • "21-year-old female with a history of asthma is admitted for shortness of breath and Asthma exacerbation" List any other pertinent patient information or medical/surgical history. Is the patient non-compliant, for example? • Subjective data are the patient's symptoms, this information will come from you HPI and what the patient tells you. • Objective Data are the test results, assessment findings, abnormal vital signs, labs, etc. that support the diagnosis. • Interventions: This could be one box or several. You might break this up into more than one box such as "medication interventions" versus "nursing care interventions" or choose to put it in one. This would include things like medications, procedures, diet modifications, oxygen, help with ADL's, physical therapy, etc. • Nursing diagnosis/ Outcome. This can be 1 box per diagnosis/ outcome or you can put the diagnosis in 1 box and then link it to the outcomes. Remember the outcomes should be a **GOAL** that can be easily measured. For example, a nursing diagnosis of "ineffective breathing pattern" may have an outcome to "maintain oxygen saturation of 98% prior to discharge"). • Draw arrows to indicate what relates, for example in the patient with shortness of breath, her oxygen saturation (objective data) may be what is causing her symptoms (subjective data). Your nursing diagnosis likely comes from things identified in the objective data as well. The interventions come from the outcomes you hope to achieve. • It is ok to list things within each box you create, complete sentences are not necessary except if required to get your point across or to accurately list a nursing diagnosis. • The number of things in each box will vary, be complete. No pertinent information to the diagnosis should be excluded. There should be at least 3 of your top nursing diagnosis that you list with outcomes. There must be interventions listed that support the success of the outcomes.	

Instructor Comments: Andrew you had some major issues with your care plan resulting in an "F" for your grade. As you know, you cannot pass the course without a passing care plan. You will need to	**Total points awarded** **59** **89/150**

complete a new care plan with a new client.	