N441 Care Plan Grading Rubric

Student Name: **Shivani Patel**

Demographics	**3 points**	**1.5 points**	**0 points**	**Points**
Demographics • Date of admission • Client initials • Age • Gender • Race/Ethnicity • Occupation • Marital Status • Allergies • Code Status • Height • Weight	Includes complete information regarding the client. Each section is filled out appropriately with correct labeling.	1-2 of the key components are not filled in correctly.	3 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 **Past Surgical History** • All previous surgeries should be listed **Family History** • Considering paternal and maternal **Social History** • Smoking (packs per day, for how many years) • Alcohol (how much alcohol consumed and for how many years) • Drugs (how often and drug of choice) **Assistive devices** • Walker, wheelchair, cane **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 client 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 client came in complaining of	Chief complaint is correctly identified.	Chief complaint not completely understood.	No chief complaint listed.		**2/2**
Admission History	**10 points**	**7.5 points**	**5 points**	**0 points**	**Points**
History of present illness • Information is identified using OLD CARTS o Onset o Location o Duration o Characteristics o Associated **and** Aggravating Factors o Relieving o Treatment **and** Timing o Severity • 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 client using their own words in quotations • Plagiarism will receive a zero (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 students own words. There is no evidence of plagiarism identified. This is developed in a paragraph format with no less than 5 sentences.	1-2 of the key components are missing in the HPI. The HPI is lacking important information to help determine what has happened to the client.	3-4 of the key components are missing in the HPI. Paragraph is not well developed, and it is difficult to understand what the client is seeking care for.	5 or more components are missing in the HPI. Paragraph is poorly developed, and it is difficult to understand what the client is seeking care for. There is evidence of plagiarism noted in the HPI.	10/10
Primary Diagnosis	**2 points**	**1 points**		**0 points**	**Points**

Primary Diagnosis • The main reason the client was admitted **Secondary Diagnosis** • If the client 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

Pathophysiology	20 points	15 points	10 points	5 points	0 points	Points
Pathophysiology • Professionally written 1-page essay in correct APA format outlining all aspects of the disease process that is listed as the primary diagnosis o ***(*APA format is graded in "Overall APA Format" section*)*** • Disease process pathophysiology is thoroughly explained from cellular level to how it affects each system and the body overall • Signs/symptoms of the disease • Expected findings related to the disease such as vital signs and laboratory findings • Diagnostic testing used to identify the disease • Particular tests or labs performed on the client to help support the diagnosis of the findings • Treatment of the disease and the treatment being used with this particular client • Listed clinical data that correlates to this particular client • Plagiarism results in a zero in this section • 2 scholarly sources must be utilized in APA format o Sources should be 5 or less years old o Sources greater than 5	All key components were addressed and student had a good understanding of the expectations listed. Disease process was thorough with a direct correlation of how this related to the client and their diagnostic testing that was performed.	1-2 key components were missing such as signs and symptoms, expected findings, correlation and treatment. Student was able to moderately describe the pathophysiology of the disease process.	3-4 of the key components were missing throughout the paper. Student was able to briefly describe the pathophysiology of the disease process.	5-6 components were missing throughout the paper. Unable to determine if the student had a good understanding of the disease process and the direct correlation to the client.	Section is incomplete with 7 or more key components missing. Student did not have a good understanding of the disease process and how it correlated to the client. Student did not utilize at least 2 scholarly source(s). Source(s) utilized were greater than 5 years old.	**20/20** **References indented per APA format**

years old will not be accepted o ***(*APA format is graded in "Overall APA Format" section*)***						

Laboratory Data	15 points	10 points	5 points	0 points	Points

Normal Values • Should be obtained from the chart when possible as some labs may vary. If not possible, use recommended laboratory guide. • Normal values should be listed for all laboratory data. **Laboratory Data** • Admission Values • Most recent Values (the day you saw the client) • If lab value is unavailable or lab was not completed for this client, please place "N/A" in the chart for that lab value **Rationale for abnormal values** • Written in complete sentences with APA in-text citations o ***(*APA format is graded in "Overall APA Format" section*)*** • Explanation of the laboratory abnormality in this client o Explain WHY the lab results are abnormal for THIS specific client • For example, elevated WBC in client with pneumonia is on antibiotics. • Minimum of 1 scholarly source in APA format must be utilized, no reference(s) will result in zero points for this section o Source(s) should be 5 or less years old o Source(s) greater than 5 years old will not be accepted	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.	1-2 client's labs were not reported completely with normal values or client results. Lab correlation did not thoroughly demonstrate student's understanding of correlation.	3-4 of the client's labs were not reported completely with normal values or client results. Lab correlation did not completely demonstrate student's understanding of correlation.	Student did not have an understanding of laboratory values and the abnormalities. 5 or more labs were excluded. Student did not utilize at least 1 scholarly source. Source(s) utilized were greater than 5 years old.	15/15 Indent references per APA format

o ***(*APA format is graded in "Overall APA Format" section*)***					
Diagnostic Imaging	**10 points**	**7.5 points**	**5 points**	**0 points**	**Points**
Diagnostic Tests • Any other tests performed not	All key components have	1-2 of the key components is	3-4 of the key components are	5 or more of the key components	10/10

previously addressed such as EKG, CT scans, X-rays, MRI, EEG, etc. This may include a test essential to the client's diagnosis (i.e. CT of the Abdomen diagnosing the client with appendicitis) • All diagnostic testing from client's ***current admission*** should be included • Student should include previous diagnostic testing if pertinent to current admission diagnosis o For example, a client with heart failure may have had an echocardiogram prior to admission • Explain the purpose of each test performed in correlation with your client's primary diagnosis, reason for visit and/or secondary diagnosis • Correlation of diagnostic tests to the client's diagnosis and condition. • Explain what each test is going to allow us to visualize and why it is pertinent to this client o For example, a client with chest pain will have an EKG performed to visualize the electrical activity of the heart • Minimum of 1 scholarly source in APA format must be utilized, no reference(s) will result in zero points for this section o Source(s) should be 5 or	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.	missing, yet the student is able to demonstrate a thorough understanding of the diagnostic testing and is able to correlate the abnormal findings to the disease process.	missing. Student did not display a complete understanding of the diagnostics testing and/or the correlation of the abnormal findings to the disease process.	are missing. Student did not have an understanding of diagnostic test and the abnormalities. Student did not include a test essential to the diagnosis of the client. Student did not utilize at least 1 scholarly source. Source(s) utilized were greater than 5 years old.	Indent references per APA format

	less years old o Source(s) greater than 5 years old will not be accepted ***o*** ***(*APA format is graded in "Overall APA Format" section*)***					

Current Medications	10 points	1-9 points	0 points	Points

Current Medications
• Requirements of 5 inpatient hospital medications and 5 home medications—these must be 10 DIFFERENT medications
• Each medication must have brand/generic name
• Dosage, frequency, route given, class of drug and the action of the drug
• Class (pharmacological and therapeutic) of drug and the action of the drug
• Reason client taking
• 2 contraindications must be listed
  o Must be pertinent to your client
• 2 side effects or adverse effects
• 2 nursing considerations
• Key nursing assessment(s)/lab(s) prior to administration
  o Example: Assessing a client's HR prior to administering a beta blocker
  o Example: Example: Reviewing client's PLT count prior to administering a low-molecular weight heparin
• 2 client teaching needs
• Minimum of 1 scholarly source in APA format must be utilized, no reference(s) will
	All key components were listed for each of the 10 medications, along with the most common side effects, contraindications and client teachings.	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.
			
			Student did not utilize at least 1 scholarly source.
			
			Source(s) utilized were greater than 5 years old.
				9/10
				
				Inappropriate contra and missing one hospital med

result in loss of all points in the section o Source(s) should be 5 or less years old o Source(s) greater than 5 years old will not be accepted o ***(*APA format is graded in "Overall APA Format" section*)***				

Physical Exam	**18 points**	**12 points**	**6 points**	**0 points**	**Points**
• Completion of a head to toe assessment done on the students own and not copied from the client's chart • Student highlighted abnormal assessment findings pertinent to the client's diagnosis • Completion of a cardiac rhythm strip analysis and interpretation • 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.	1-2 of the key components are missing from a given section.	3-4 of the key components are missing from a given section.	5 or more 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.	**18/18**
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 • Student wrote a summary of the vital signs trends • Student included a rationale for 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 key components are missing.	5/5 Highlight abnormalities: BP. Include O2 source
Pain Assessment	**2 points**		**1 point**	**0 points**	**Points**
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	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	2/2

used			are missing.	

IV Assessment	2 points	1 point	0 points	Points
IV assessment • IV and/or central line assessment performed, and it is charted including what size of IV and location of the IV • Noted when the IV and/or central line was placed and/or accessed • Noting any signs of erythema or drainage • Patency is verified and recorded • Fluid type and rate is recorded, or saline lock is noted • IV and/or central line dressing assessment is recorded (clean, dry and intact) • Include CLABSI prevention measures for central lines	All of the key components were addressed. Student demonstrates an understanding of an IV assessment.	1 of the key components is missing.	2 or more key components of the IV assessment is missing, or student did not complete this section.	**2/2**

Intake and Output	**2 points**	**1 point**	**0 points**	**Points**
Intake • Measured and recorded appropriately—what the client takes IN • Includes: oral intake, IV fluid intake, etc. • Explain in **mLs**, EXACTLY what the client's intake is (example: NS 500 mL, water 300 mL, IV Ceftriaxone 100 mL, etc.) **Output** • Measured and recorded appropriately—what the client puts OUT • Includes: urine, stool, drains/tubes, emesis, etc. • Explain in **mLs** EXACTLY what the client's output is (example: urine 750 mL, emesis 100 mL, JP drain 75 mL, etc.) • If the client is experiencing incontinence, document output as voids/bowel movements (example: incontinent of urine x1 void; incontinent of stool x2 bowel movements, etc.)	All of the key components of the intake and output were addressed. Student demonstrates an understanding of intake and output.	1 of the key components of the intake and output is missing. Difficult to determine if the student has a thorough understanding of the intake and output.	2 or more of the key components of the intake and output is missing or student did not complete the section.	**2/2**

Nursing Care	**4 points**	**2 points**	**0 points**	**Points**
Summary of Care • Shift/Nurses note should be complete with the following information: • Overview of care throughout the day • Did the client leave the floor for any procedures or have any testing done. • Any complaints/issues the client had during your shift (Remember to keep your opinion out of the charting) • Vital signs stable or unstable • Did you notify anyone such as the client's primary RN of changes in status or abnormal laboratory/diagnostic imaging • Client tolerating activity/diet • Possible future plans for the client • Ex: "anticipate client will require home health upon discharge," or "client prepped for cardiac catheterization tomorrow and NPO at midnight" **Discharge Planning** • Who is client 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 summary of care (2 points) and discharge summary (2 points) were addressed. Student demonstrated an understanding of the nursing care.	1 of the key components of the nursing care was missing, therefore it was difficult to determine if the student had a thorough understanding of the nursing care.	2 or more of the key components of the nursing care was missing or student did not complete this section.	4/4

Nursing Diagnosis	15 points	10 points	5 points	0 points	Points

Nursing Diagnosis
• List 5 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
• Appropriate outcome goal for each diagnosis
• ***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.
		1-2 of the nursing diagnosis, rationale, intervention, outcome, evaluation sections were incomplete or not appropriate to the client.
		
		Prioritization was appropriate.
			3-4 of the nursing diagnosis, rationale, intervention, outcome, evaluation sections were incomplete or not appropriate to the client.
			
			Prioritization was not appropriate.
				5 or more of the nursing diagnosis, rationale, intervention, outcome, evaluation sections were incomplete or inappropriate.
				
				Prioritization is dangerously inappropriate.
					15/15

Overall APA format	**5 Points**		**2.5 Points**	**0 Points**	**Points**
APA Format • The student used appropriate APA in-text citations and listed all scholarly source(s) in APA format. • Source(s) utilized should be 5 or less years old. o Source(s) greater than 5 years old will not be accepted. • 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 1-2 errors noted. 1-2 grammar errors or overall poor writing style was used. Content was difficult to understand.	No APA format or 3 or more errors noted. Source(s) utilized were greater than 5 years old. Grammar or writing style did not demonstrate collegiate level writing with 3 or more errors noted.	3/5 Errors noted on rubric and within care plan

Concept Map	20 points	Points
Concept Map - Client information (3 points) - Objective data (3 points) - Subjective data (3 points) - Interventions (3 points) - Nursing Diagnosis (3 points) - Outcomes (3 points)	Each aspect is worth 3 points, overall appearance and understanding is worth 2 points.	20/20
Description of Expectations	The concept map information is an overview of your client. • At the center you have the client'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 client information or medical/surgical history. Is the client non-compliant, for example? • Subjective data are the client's symptoms, this information will come from you HPI and what the client 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. 2 nursing interventions should be provided for each nursing diagnosis. This would include things like medications, procedures, diet modifications, oxygen, help with ADL's, physical therapy, etc. • Nursing diagnosis/ Outcome. 5 nursing diagnosis should be provided. 1 outcome should be provided for each nursing diagnosis. 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 client 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 must be interventions listed that support the success of the outcomes.	

Instructor Comments:	**Total point awarded** **147 /150**