

## N311 CARE PLAN 2 GRADING RUBRIC

Student Name: A.G.

DEMOGRAPHICS	5 POINTS	2.5 POINTS	0 POINTS	POINTS
<p><b>DEMOGRAPHICS</b></p> <ul style="list-style-type: none"> <li>• Date of admission</li> <li>• Client initials</li> <li>• Age</li> <li>• Biological Gender</li> <li>• Race/Ethnicity</li> <li>• Occupation</li> <li>• Marital Status</li> <li>• Allergies</li> <li>• Code Status</li> <li>• Height</li> <li>• Weight</li> </ul> <p><b>(A component equals one bullet point)</b></p>	Includes complete information regarding the client. 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.	5

MEDICAL HISTORY	10 POINTS	5 POINTS	0 POINTS	POINTS
<p><b>PAST MEDICAL HISTORY</b></p> <ul style="list-style-type: none"> <li>• All previous medical diagnosis should be listed</li> </ul> <p><b>PAST SURGICAL HISTORY</b></p> <ul style="list-style-type: none"> <li>• All previous surgeries should be listed</li> </ul> <p><b>FAMILY HISTORY</b></p> <ul style="list-style-type: none"> <li>• Considering paternal and maternal</li> </ul> <p><b>SOCIAL HISTORY</b></p> <ul style="list-style-type: none"> <li>• Smoking (packs per day, for how many years)</li> <li>• Alcohol (how much alcohol consumed and for how many years)</li> <li>• Drugs (how often and drug of choice)</li> </ul> <p><b>EDUCATION LEVEL</b></p> <p><b>LIVING SITUATION</b></p>	Includes complete and accurate information regarding the client.	1-2 of the key components are not complete or accurate.	3 or more of the key components are not complete or accurate.	10

<p><b>ASSISTIVE DEVICES</b></p> <ul style="list-style-type: none"> <li>• Walker, wheelchair, cane, etc.</li> </ul> <p>Note: If client is unable to give a detailed history, look in the EMR and chart.</p> <p><b>(A component equals one bullet point)</b></p>				
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<b>ADMISSION HISTORY</b>	<b>10 POINTS</b>	<b>7.5 POINTS</b>	<b>5 POINTS</b>	<b>0 POINTS</b>	<b>POINTS</b>
<p><b>HISTORY OF PRESENT ILLNESS</b></p> <ul style="list-style-type: none"> <li>• Chief complaint identified by the client. (What the client came in complaining of)</li> <li>• Information is identified using OLD CARTS <ul style="list-style-type: none"> <li>○ Onset</li> <li>○ Location</li> <li>○ Duration</li> <li>○ Characteristics</li> <li>○ Associated <b>and</b> Aggravating Factors</li> <li>○ Relieving</li> <li>○ Treatment <b>and</b> Timing</li> <li>○ Severity</li> </ul> </li> <li>• Written in a paragraph form with no less than 5 sentences</li> <li>• Information specifically stated by the client using their own words in quotations</li> <li>• If the client was not able to be interviewed, the student documented an appropriate reason (i.e. deep sedation) and the result of the attempted interview. The interview must be attempted.</li> <li>• Information collected from the client's</li> </ul>	<p>All documentation indicates that the student attempted the client interview. Includes complete and accurate information regarding the client.</p>	<p>1-2 of the key components not complete or accurate.</p>	<p>3-4 of the key components are not complete or accurate.</p>	<p>5 or more components are not complete or accurate.</p> <p>No evidence that the interview was attempted by the student.</p> <p>Information was copied from the client's chart without an appropriate reason</p>	<p>10</p>

chart only when appropriate (i.e. deep sedation). The student will receive a zero (0) if information from the client's chart is used without an appropriate rationale.					
<b>(A component equals one bullet point)</b>					

<b>PRIMARY DIAGNOSIS</b>	<b>5 POINTS</b>	<b>2.5 POINTS</b>	<b>0 POINTS</b>	<b>POINTS</b>
<b>PRIMARY DIAGNOSIS</b> <ul style="list-style-type: none"> <li>The main reason the client was admitted</li> </ul> <b>SECONDARY DIAGNOSIS</b> <ul style="list-style-type: none"> <li>If the client has more than one reason they are being admitted</li> </ul> <b>(A component equals one bullet point)</b>	Includes complete and accurate information regarding the client.	1 of the components in this section are not accurate.	2 of the components of this section are not accurate. 1-2 of the components in this section are not complete.	5

<b>PATHOPHYSIOLOGY</b>	<b>20 POINTS</b>	<b>16 POINTS</b>	<b>10 POINTS</b>	<b>5 POINTS</b>	<b>0 POINTS</b>	<b>POINTS</b>
<b>PATHOPHYSIOLOGY</b> <ul style="list-style-type: none"> <li>Professionally written 1-page essay in correct APA format*</li> <li>Disease process of the primary diagnosis is thoroughly discussed from the cellular level, examines how the disease process influences affected body systems</li> <li>Signs/symptoms of the primary diagnosis that were experienced by the client</li> <li>A discussion of how the primary diagnosis was established in this client</li> </ul> <b>SCHOLARLY WORK</b>	Includes complete and accurate information regarding the pathophysiology of the client's primary disease.	1 of the components of the pathophysiology of the client's primary disease are not complete or accurate.	2 of the components of the pathophysiology of the client's primary disease are not complete or accurate.	3 of the components of the pathophysiology of the client's primary disease are not complete or accurate.	4 or more of the components of the pathophysiology of the client's primary disease are not complete or accurate. 1 or more of the components of the scholarly works requirements was not met  Plagiarism was noted in the student's writing	<b>20</b>

<ul style="list-style-type: none"> <li>• 2 scholarly sources must cited and referenced (*accuracy of the formatting of the citations and references is graded in the overall APA format section.)</li> <li>• All information that was collected from a scholarly source must be cited and referenced.</li> <li>• Required course textbook was used, when information was available in course textbook</li> </ul> <p><b>PLAGIARISM</b></p> <ul style="list-style-type: none"> <li>• No evidence of plagiarism should be noted</li> </ul> <p><b>(A component equals one bullet point)</b></p>						
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<b>VITAL SIGNS</b>	<b>5 POINTS</b>	<b>2.5 POINTS</b>	<b>0 POINTS</b>	<b>POINTS</b>
<p><b>VITAL SIGNS</b></p> <ul style="list-style-type: none"> <li>• 1 sets of vital signs are recorded with the appropriate labels attached</li> </ul>	<p>All the key components were met for this section (with 1 set of vital signs) and student has a good understanding of abnormal vital signs.</p>	<p>Only 1 partial set of vital signs were completely recorded and 1 of the key components were missing.</p>	<p>Student did not complete this section</p>	<p>5</p>

<b>PAIN ASSESSMENT</b>	<b>5 POINTS</b>	<b>2.5 POINTS</b>	<b>0 POINTS</b>	<b>POINTS</b>
<b>PAIN ASSESSMENT</b> <ul style="list-style-type: none"> <li>Pain assessment was addressed and recorded once throughout the care of this client <ul style="list-style-type: none"> <li>It was recorded appropriately and stated what pain scale was used</li> </ul> </li> </ul>	All the key components were met (1 pain assessments) for this section and student has a good understanding of the pain assessment.	Only 1 partial pain assessment is recorded and 1 of the key components is missing.	Student did not complete this section	5

<b>INTAKE AND OUTPUT</b>	<b>5 POINTS</b>	<b>2.5 POINTS</b>	<b>0 POINTS</b>	<b>POINTS</b>
<b>INTAKE</b> <ul style="list-style-type: none"> <li>Measured and recorded appropriately—what the client takes IN</li> <li>Includes: oral intake, IV fluid intake, etc.</li> <li>Explain in <b>mLs</b>, EXACTLY what the client’s intake is (example: NS 500 mL, water 300 mL, IV Ceftriaxone 100 mL, etc.)</li> </ul> <b>OUTPUT</b> <ul style="list-style-type: none"> <li>Measured and recorded appropriately—what the client puts OUT</li> <li>Includes: urine, stool, drains/tubes, emesis, etc.</li> <li>Explain in <b>mLs</b> EXACTLY what the client’s output is (example: urine 750 mL, emesis 100 mL, JP drain 75 mL, etc.)</li> <li>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.)</li> </ul> <b>(A component equals one bullet</b>	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.	5

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NURSING PROCESS	20 POINTS	15 POINTS	8 POINTS	0 POINTS	POINTS
<p><b>NURSING PROCESS</b></p> <ul style="list-style-type: none"> <li>• List 2 prioritized nursing diagnosis for the client               <ul style="list-style-type: none"> <li>○ Must be nursing diagnosis from course textbook</li> <li>○ Include full nursing diagnosis with “related to” and “as evidenced by” components</li> <li>○ Risk for diagnosis are not appropriate for actual problems</li> </ul> </li> <li>• Appropriate rationale for each diagnosis               <ul style="list-style-type: none"> <li>○ Explain why the nursing diagnosis was chosen for this client</li> </ul> </li> <li>• List one outcome/goal for the client. The goal should have all components of a “SMART” Goal and should be personalized for the client</li> <li>• List a minimum of 2 interventions for each diagnosis</li> <li>• Evaluation of intervention               <ul style="list-style-type: none"> <li>○ If the intervention was implemented at clinical, document the client’s response to the intervention</li> <li>○ If the intervention was not implemented at clinical, document how and when you would evaluate the response to the intervention</li> </ul> </li> </ul>	<p>Includes complete and accurate information for the nursing process and prioritization.</p>	<p>1-2 key components of the nursing process are not complete or accurate.</p> <p>Prioritization is appropriate.</p>	<p>3-4 key components of the nursing process are not complete or accurate.</p> <p>Prioritization was not appropriate</p>	<p>5 or more of the key components of the nursing process are not complete or accurate.</p> <p>Prioritization is dangerously inappropriate</p>	15

<p><b>PRIORITIZATION</b></p> <ul style="list-style-type: none"> <li>• Diagnosis should be listed in order by priority – with the first diagnosis listed being the highest priority.</li> </ul> <p><b>(A component equals one bullet point)</b></p>					
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<b>OVERALL APA FORMAT</b>	<b>5 POINTS</b>	<b>2.5 POINTS</b>	<b>0 POINTS</b>	<b>POINTS</b>
<p><b>APA FORMAT</b></p> <ul style="list-style-type: none"> <li>• The student used appropriate APA in-text citations and listed all scholarly source(s) in APA format.</li> <li>• Source(s) utilized should be 5 or less years old. <ul style="list-style-type: none"> <li>○ Source(s) greater than 5 years old will not be accepted.</li> </ul> </li> <li>• Professional writing style and grammar was used in all narrative sections.</li> </ul>	<p>APA format was completed and appropriate. Grammar was professional and without errors.</p>	<p>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.</p>	<p>No APA format or 4 or more errors noted. Source(s) utilized were greater than 5 years old. Grammar or writing style did not demonstrate collegiate level writing with 4 or more errors noted.</p>	<p>5</p>
<p>Instructor Comments: Try to work on making your paper sound scholarly vs how you would verbalize things. Your rationale needs to have a supporting factor be related to the patient and their symptoms, not just the admitting diagnosis. Good job overall.</p>				<p>Points 85 /90</p>