

N323 Care Plan Grading Rubric

Emily Hines Student Name:-

Demographics	3 points	1.5 points	0 points	Points
Demographics <ul style="list-style-type: none"> • Date of admission • Patient initials • Age • Biological Gender • Race/Ethnicity • Occupation • Marital status • Gender Identity • Code Status • Height and Weight • Allergies • Pronouns 	<p>Includes complete information regarding the patient.</p> <p>Each section is filled out appropriately with correct labeling.</p>	<p>1-3 of the key components are not filled in correctly.</p>	<p>4 or more of the key components are not filled in correctly and therefore no points were awarded for this section</p>	<p>3 Points</p> <p><u>Excellent!!!</u></p>
Medical History	5 points	2.5 points	0 points	Points
Past Medical History <ul style="list-style-type: none"> • All previous medical diagnosis should be listed • All previous psychiatric diagnosis must be listed • All previous psychiatric and substance use treatment information must be listed included dates, inpatient or outpatient, and reason for treatment 	<p>Includes each section completed correctly with a detailed list of pertinent medical history, surgical history, family history and social history.</p> <p>If patient is unable to give a detailed history, look in the EMR and chart.</p>	<p>1-2 of the key components is missing detailed information or are inaccurate.</p>	<p>3 or more of the key components are not filled in correctly.</p>	<p>2.5 Points</p> <p><u>Depression, Anxiety, Bipolar Disorder are psychiatric diagnoses</u></p> <p><u>If you correct this in place in the right section and resubmit, you will get the full points</u></p>

Chief Complaint	2 points	1 point	0 points	Points
Chief complaint <ul style="list-style-type: none"> This information should be collected in an interview with the client when the client can communicate. 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.	<u>2 Points</u> <u>Excellent!!!</u>
Contributing Factors	10 points	5 points	0 points	Points
Contributing Factors <ul style="list-style-type: none"> The information should be collected in an interview with the client when the client can communicate. The student should use OLD CARTS to guide their interview. Written in a paragraph form with no less than 5 sentences Factors that lead to admission Chief complaint impact on life 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 	<p>Every key component of the HPI is filled in correctly with information such as those identified with (OLD CARTS).</p> <p>It is written in a paragraph form, in the student's own words.</p> <p>There is no evidence of plagiarism identified.</p> <p>This is developed in a paragraph format with no less than 5 sentences.</p>	<p>1-3 of the key components are missing in the HPI.</p> <p>The HPI is lacking important information to help determine what has happened to the patient.</p>	<p>4 or more components are missing in the HPI.</p> <p>Paragraph is not well developed, and it is difficult to understand what the patient is seeking care for.</p> <p>There is evidence of plagiarism noted in the HPI.</p>	<u>5 Points</u> <u>No less than 5 paragraphs</u>

Primary Diagnosis	2 points	1 points	0 points	Points
<p>Primary Diagnosis</p> <ul style="list-style-type: none"> The main reason the patient was admitted 	<p>All key components are filled in correctly.</p> <p>The student was able to identify the correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.</p>	<p>One of the key components is missing or not understood correctly.</p>	<p>Student did not complete this section and there is concern for lack of understanding the diagnosis.</p>	<p><u>2 Points</u></p> <p><u>Excellent!!!</u></p>

Psychosocial Assessment	30 points	15 points	0 points	Points
<p>Psychosocial Assessment</p> <ul style="list-style-type: none"> • Completion of a psychosocial assessment done on the students own and not copied from the client's chart 	<p>All key components are met and a complete psychosocial assessment has been completed.</p>	<p>1-3 of the key components is missing from a given section or is inaccurate.</p>	<p>4 or more of the key components are missing or is inaccurate.</p> <p>Therefore, it is presumed that the student does not have a good understanding of the mental status exam.</p>	<p>30 Points</p> <p>Excellent!!!</p>

Current Psychiatric Medications	10 points	1-9 points	0 points	Points
<p>Current Medications (All information listed in this section must be pertinent to your patient)</p> <ul style="list-style-type: none"> • Complete five 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 • For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication • 2 contraindications must be listed • 2 side effects or adverse effects • Medication/food interactions • 2 nursing considerations • Minimum of 1 APA reference and citation, no reference or citation will result in loss of all points in the section <ul style="list-style-type: none"> ○ Source(s) should be 5 or less years old ○ Source(s) greater than 5 years old will not be accepted 	<p>All key components were listed for each of the medications, along with the most common side effects, contraindications and client teachings.</p> <p>Student had 1 APA citation listed.</p>	<p>1 point will be lost for each medication with incomplete or inaccurate information.</p>	<p>There was noted lack of effort on the student's part to complete this section or there was no APA citation listed.</p> <p>Source(s) utilized were greater than 5 years old.</p>	<p>4 Points</p> <p><u>Nursing considerations given instead an alternate intervention for PRN meds.</u></p> <p><u>Correct and resubmit for full points</u></p>
Mental Status Exam Findings	25 points	12.5 points	0 points	Points
<ul style="list-style-type: none"> • Completion of a mental status exam done on the students own and not copied from the patient's chart 	<p>All key components are met and a complete mental status exam has been completed and accurate.</p>	<p>1-2 of the key components is missing from a given section or 1-2 pieces of the information listed is</p>	<p>3 or more of the key components are missing or are inaccurate.</p> <p>Therefore, it is</p>	<p>25 Points</p> <p><u>All components were addressed. However, for future reference;</u></p>

		inaccurate.	presumed that the student does not have a good understanding of the mental status exam.	<u>they should have been placed in the box across the from the questions</u>	
Vital Signs	5 points	2.5 points	0 points	Points	
Vital signs <ul style="list-style-type: none"> 1 set 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 and student has a good understanding of abnormal vital signs.	A full set of vital signs were not recorded and/or 1 of the key components were missing or is inaccurate.	Student did not complete this section and/or 2 or more of the key components are missing.	<u>5 Points</u> <u>Excellent!!!</u>	
Pain Assessment	2 points	1 point	0 points	Points	
Pain assessment <ul style="list-style-type: none"> Pain assessment was addressed and recorded once throughout the care of this patient It was recorded appropriately and stated what pain scale was used 	All the key components were met for this section.	1 of the key components is missing or is inaccurate.	Student did not complete this section and/or 2 or more of the key components are missing.	<u>2 Points</u> <u>Excellent!!!</u>	

Nursing Care and Discharge Planning	6 points	points	0 points	Points
<ul style="list-style-type: none"> Overview of care provided today Client Complaints Participation in therapy/groups Medication compliance today Behaviors exhibited today Discharge location Follow up plan 	All the key components of the nursing care and discharge plans were addressed. Student demonstrated an understanding of the nursing care and discharge plans.	1 of the key components of the nursing care and discharge plan was missing, therefore it was	2 or more of the key components of the nursing care and discharge plan was missing or the student did	<u>6 Points</u> <u>Remember as nurses we should always educate patient about medications</u>

<ul style="list-style-type: none"> • Education needs 		<p>difficult to determine if the student had a thorough understanding of discharge planning.</p>	<p>not complete the section.</p>	<p><u>and the importance of support groups and offer resources such as suicide hotline with telephone number.</u></p>
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Nursing Diagnosis	25 points	1-24 points	0 points	Points
<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • List 3 appropriate nursing diagnosis <ul style="list-style-type: none"> o Include full nursing diagnosis with “related to” and “as evidenced by” components (total 3 points) • Provide 1 Appropriate rationale for each diagnosis <ul style="list-style-type: none"> o Explain why the nursing diagnosis was chosen (total 3 points) • List 1 outcome goal per diagnosis following the SMART goal format (total 3 points) • List 3 Interventions per nursing diagnosis (total 9 points) • 1 outpatient resource for each nursing diagnosis (total 3 points) • 1 rationale for each outpatient resource (total 3 points) • Correct priority of the nursing diagnosis (total 1 points unless prioritization is dangerously inappropriate, safety concerns will result in a zero in this section) 	<p>All key components were addressed.</p> <p>The student demonstrated an appropriate understanding of nursing diagnoses, rationales, goals, interventions and listed diagnosis in correct priority.</p>	<p>1 or more of the nursing diagnosis, rationale, goals, or intervention sections was incomplete or not appropriate to the patient.</p> <p>Each item is worth 2 points.</p> <p>Prioritization was not appropriate.</p>	<p>The student failed to complete the section.</p> <p>The student attempted to complete the section; however, safety concerns were noted in the plan of care.</p> <p>Prioritization is dangerously inappropriate.</p>	<p><u>25 Points</u></p>

Overall APA format	5 Points	2.5 Points	0 Points	Points
<p>APA Format</p> <ul style="list-style-type: none"> The student used appropriate APA in text citations and listed all appropriate references in APA format. Source(s) utilized should be 5 or less years old. <ul style="list-style-type: none"> Source(s) greater than 5 years old will not be accepted. Professional writing style and grammar was used in all narrative sections. 	<p>APA format was completed and appropriate.</p> <p>Grammar was professional and without errors</p>	<p>APA format was used but not correct with 1-3 errors noted.</p> <p>1-3 grammar errors or overall poor writing style was used.</p> <p>Content was difficult to understand.</p>	<p>No APA format or 4 or more errors noted.</p> <p>Source(s) utilized were greater than 5 years old.</p> <p>Grammar or writing style did not demonstrate collegiate level writing with 4 or more errors noted.</p>	<p>2.5 Points</p> <p><u>APA format not used for reference page. Refer to APA textbook for how to make a reference page.</u></p> <p><u>Can correct it and resubmit for full points.</u></p>

Concept Map	20 points	Points
<p>Concept Map</p> <ul style="list-style-type: none"> - Patient information (3 points) - Objective data (3 points) - Subjective data (3 points) - Interventions (3 points) - Nursing Diagnosis (3 points) - Outcomes (3 points) 	<p>Each aspect is worth 3 points, overall appearance and understanding is worth 2 points.</p>	<p><u>20</u> <u>Points</u></p> <p><u>Excell</u> <u>ent!!!</u></p>
<p>Description of Expectations</p>	<p>The concept map information is an overview of your patient.</p> <ul style="list-style-type: none"> • 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. 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. 3 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 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 must be interventions listed that support the success of the outcomes. 	
<p>Instructor Comments:</p>		<p>Total points awarded</p>

Hello Emily. Good job. However, there are somethings that you can correct to get a better grade. I made suggestions on the rubric. If you choose to correct items; please resubmit in 48 hours. If you have any questions, please don't hesitate in reaching out.

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