N432 Care Plan #1

Lakeview College of Nursing

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N432 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**
9/17/19	HLP	26	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Working	Single	NKA
Code Status	**Height**	**Weight**	**Father of Baby involved**
Full Code	5'9	271.2	Yes

Medical History (5 Points)

Prenatal History: Marijuana use (3/7 positive test, 7/1 negative)

Past Medical History: Abnormal pap x2, HPV, HSV

Past Surgical History: Wisdom tooth extraction, Cholecystectomy

Family History: No known problems

Social History (tobacco/alcohol/drugs): Denies alcohol use, denies smoking, previous drug use (marijuana, stopped during pregnancy)

Living Situation: At home with children

Education Level: No learning barriers, N/A level

Admission Assessment (12 points)

Chief Complaint (2 points): "Leaking of fluid"

Presentation to Labor & Delivery (10 points): 26 year old female, G4P2012, 39w2d. Patient presents to the ED on 9/17 at 2100 stating "her water broke while she was laying in her bed." Patient does not report any foul odor with the fluid.

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points): Rupture of membranes

Secondary Diagnosis (if applicable): N/A

Stage of Labor (20 points):

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

26 y.o female in Stage 2 of labor at 39w2d. G4P2012. Pregnancy not complicated. GBS negative. Epidural and Pitocin augmentation. No AROM. No meconium stained fluid. Complete dilation and effacement. OA position. Spontaneous vaginal delivery. Nose and mouth bulb suctioned. Nuchal cord, loose reduced without difficulty. No difficulty with shoulder delivery. Delayed cord clamping. Cord blood obtained. Female infant, instant skin to skin contact. Active management of 3rd stage with Pitocin and fundal massage. Cervix, vagina and perineum inspected, 1st degree lacerations found, bilateral periureteral hemostatic, not repaired. Normal uterine tone with normal lochia flow.

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

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	4.46	4.46	4.46	
Hgb	11.7-16	12.6	12.6	12.1	
Hct	35-47	37.7	37.7	36	
Platelets	150-400	271	271	307	

WBC	4.5-11	8.3	8.3	11	
Neutrophils	1.8-7.7	6.4	6.4	6.4	
Lymphocytes	1.0-4.8	1.3	1.3	1.3	
Monocytes	0.0-0.8	0.6	0.6	0.6	
Eosinophils	0.0-0.5	0.1	0.1	0.1	
Bands	0.0-0.2	0.0	0.0	0.0	

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		O	O	O	
Rh factor		-	-	-	
Serology (RPR/VDRL)		Non Reactive	Non Reactive	Non Reactive	
Rubella Titer		Immune	Immune	Immune	
Hct & Hgb	11.7 -16 36-47%	12.6 37.7	12.6 37.7	12.1 36	
HIV		Negative	Negative	Negative	
HbSAG		Not detected	Not detected	Not detected	
Group Beta Strep Swab		Negative	Negative	Negative	
Glucose at 28 weeks		Passed	Passed	Passed	
Genetic testing: if done		Not done			

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					
pH					
Specific Gravity					
Glucose	Negative	Negative	Negative	Negative	
Protein	Negative	Negative	Negative	Negative	
Ketones	Negative	Negative	Negative	Negative	
WBC	Negative	Negative	Negative	Negative	
RBC					
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		Negative			

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

Lab Correlations Reference (APA):

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	135, normal range EFM is continuous monitoring providing audio and visual recordings as well as tracing strips
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?**	Absent accelerations, moderate variability Moderate variability means the fetal heart rate is between 6-25 bpm and is within normal range. This is an indicator of a well-developed and oxygenated fetus.
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?**	Variable decelerations in labor (no interventions) Deceleration is the gradual decrease in FHR and coincides with the peak of contractions. It is associated with head compression, which is common during pushing
Describe the contractions i.e. frequency, length, strength, patient's response.	TOCO (external tocotransducer), 2-3 minute frequency, 45-60 second duration, strong by palpation contraction intensity

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

7 different medications must be completed

Home Medications (2 required)

Brand/Generic	**Valacyclovir (Valtrex)**	**Ferrous Sulfate (Iron)**	**Prenatal Vitfe Fumarate (Prenatal Vitamin)**	**Ascorbic Acid**	
Dose	**1,000mg tab**	**325mg tab**	**1 tab**	**500mg tab**	
Frequency	**Daily**	**Daily**	**Daily**	**Daily**	
Route	**PO**	**PO**	**PO**	**PO**	
Classification	**Antiviral**	**Antianemic**		**Vitamin**	
Mechanism of Action	**-Treat HSV** **-suppress recurrent HSV** **-reduce transmission**	**-Normalize RBC production by binding hemoglobin**		**-Treat Vitamin C deficiency**	
Reason Client Taking	**Herpes**	**Iron deficiency**	**Pregnancy**	**Pregnancy**	
Contraindications (2)		**-Hemolytic anemia** **-Hypersensitivity**			

Side Effects/Adverse Reactions (2)		**-Dizziness** **-Abdominal cramps**			
Nursing Considerations (2)		**-Gove with full glass of water or juice** **-Administer with a straw**			
Key Nursing Assessment(s)/Lab(s) Prior to Administration		**-Monitor patient closely for hypersensitivity at least 30 min after administration**			
Client Teaching needs (2)		**-Do not chew** **-Encourage vitamin C foods to improve absorbtion**			

Hospital Medications (5 required)

Brand/Generic	**Benzocaine menthol (Dermoplast)**	**Docusate sodium (Colace)**	**Hydrocortisone 1% cream**	**Lanolin ointment**	**Ondansetron (Zofran)**
Dose	**1 spray**	**100mg capsule**	**N/A**	**N/A**	**4mg**
Frequency	**QID PRN**	**BID PRN**	**Q6H PRN**	**PRN**	**Q6H PRN**
Route	**Topical**	**Oral**	**Topical**	**Topical**	**IV**
Classification		**Laxative**	**Corticosteriod**		**Antiemetic**
Mechanism of Action		**Stool softener**	**Treat corticosteroid responsive**		**Prevent nausea and vomiting**

			dermatoses		
Reason Client Taking	**Perineal pain**	**Constipation**	**Hemorrhoids**	**Dry skin/ nipple discomfort**	**Nausea**
Contraindications (2)		**-Fecal impaction** **-Hypersensitivity**			**-Congenital long QT syndrome** **-Hypersensitivity**
Side Effects/Adverse Reactions (2)		**-abdominal cramps** **-diarrhea**			**-Abdominal pain** **-elevated liver enzymes**
Nursing Considerations (2)		**-assess laxative abuse** **-assess dependence**			**-dilute drug** **-monitor patient for hypersensitivity**
Key Nursing Assessment(s)/Lab(s) Prior to Administration		**-assess for vitamin/mineral deficiency**			**Monitor patient for serotonin syndrome**
Client Teaching needs (2)		**-do not use if experiencing pain in abdomen** **-increase fiber intake**			- **Use otal syringe to measure solution** - **Report s/sx of hypersensitivity**

Medications Reference (APA): (2 points)

2018 Nurses drug handbook (17th ed.). (2018). Burlington, MA: Jones & Bartlett Learning.

<u>Assessment (20 points)</u>

N432 Care Plan and Grading Rubric
Physical Exam (20 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	A&O x 4 Patient does not appear distressed Patient's overall appearance appropriate for post partum
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Patient states she is Caucasian and presents with a fair skin tone. Skin has normal elasticity, warm to touch. No abnormal texture. Hair is dispersed well throughout. No notable skin turgor. No rashes or bruises. Patient has noted level 1 perineal lacerations.
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is midline with no deviations. Hair is dark brown in color. Ears show no abnormal drainage, tympanic membrane visible, pearly grey. PEERLA is noted. Nose shows no deviated septum, turbinates equal bilaterally. Oral mucosa is pink and moist with no notable abnormalities. Patient's teeth present in yellow to white in color. .
CARDIOVASCULAR (1 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):**	.Patient is not currently being monitored by telemetry. Patient was noted to be in normal sinus rhythm on admission and this morning upon assessment. Heart sound auscultated x5. S1,

Peripheral Pulses: **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒ Edema Y ☒ N ☐** **Location of Edema: Legs**	S2 heart sounds noted. Radial and pedal pulses assessed. Pulses graded 2+ and present bilaterally. Capillary refill average at <2 seconds.. Negative for neck vein distention. Edema in lower extremities, 1+.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	No accessory muscle use when breathing. Trachea midline. No deviations. Patient is denies current shortness of breath. Anterior and posterior lung sounds auscultated. Patient currently breathing room air.
GASTROINTESTINAL (5 points): **Diet at home:** **Current Diet** **Height: 5'9** **Weight: 271.2 lbs** **Auscultation Bowel sounds: Active** **Last BM: 9/17** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Fundal Height & Position:**	Patient states at home her diet is regular or she "eats whatever". Patient denies current alcohol use. Bowel sounds present in all four quadrants. Patient has slight pain/tenderness with palpation of the abdomen. No scars noted. No masses present. No ostomy, nasogastric tubes, PEG tubes. No drains. Abdomen is soft and nondistended. Patient denies any rapid or current weight loss. Fundal height 41 on 9/16

GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Episiotomy/lacerations:**	Patient is able to ambulate in her room and to the bathroom with 1 assist d/t epidural . No dialysis, catheter. Genitals appear swollen. Urine is yellow. Patient denies pain, hesitancy or urgency on urination. No abnormal odor. Patient is on I&O's. Rupture of membranes at 2200 on 9/17, with a slight yellow color, no infection noted. Level 1 perineal lacerations, untreated.
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	Patient exhibits active range of motion bilaterally. Patient shows no sign of neurovascular deficit. Patient had a morse fall risk score of 35, making her a low risk for falls. Patient denies use of walker, cane, or wheel chair at home. Patient denies the use of any other assistive devices around her home.
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no - Legs ☒**	. Patient appears tired. A& O x4. She slept well but is still in pain. Patient speaks English well and at a normal pace. Patient MAEW for current age and condition.. Patient shows no signs of neurological damage or deficit.

Arms ☐ Both ☐ **Orientation: A&O x 4** **Mental Status:** **Speech:** **Sensory:** **LOC:** **DTRs:**	
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient presents fatigued. Patient goes in and out sleep. Patient denies current alcohol use. Patient appears to have good family support. Patient has no religious preferences. Patient is employed.
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date: 9/18//19** **Time: 0527** **Type (vaginal/cesarean): Vaginal** **Quantitative Blood Loss: N/A** **Male or Female: Female** **Apgars: 8&9** **Weight: 3750g** **Feeding Method: Breast**	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**N/A**	**120/72**	**N/A**	**N/A**	**N/A**

Labor/Delivery	**77**	**97/59**	**18**	**97.2**	**96** **Room Air**
Postpartum	**80**	**115/60**	**20**	**N/A**	**96** **Room Air**

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0615	**0-10**		**0**	**Denies pain/ discomfort**	
0915	**0-10**		**0**	**Denies pain/ discomfort**	

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	18g
Location of IV:	Left arm
Date on IV:	9/17/19
Patency of IV: **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Blood return, able to obtain, flushed w/o difficulty, infusing, site cleansed and secured, no phlebitis or infiltration

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1000 ml/24hr IV	500ml (urine) 200ml (blood)

Interventions (12 points)

Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. Expected physical changes: mensural like cramping, lochia decreases over time, take stool softeners, sweating and frequent urine d/t normal fluid shifts

Patient acceptance, teach back and verbalizes understanding

2. Infant health benefits of breast feeding: complete and balanced nutrition, enhanced immunity, established healthy GI tract, enhanced bonding

Patient acceptance, teach back and verbalizes understanding

Nursing Interventions (6 points)

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

Nursing Interventions:

Medical Treatments:

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by"	• Explain why the nursing diagnosis was chosen	Include a short rationale as to why you chose this intervention & cite the reference appropriately	• How did the client/family respond to the nurse's actions? • Client response, status of

components			goals and outcomes, modifications to plan.
1.) Deficient Knowledge related to unfamiliarity of effects of postpartum wound infection risk on self and the importance of following treatment evidenced by 1st degree laceration. (Swearingen, 2016, p. 643)	1. Patient and family present will verbalize the effects a postpartum wound infection may have on the mother and likely treatments for the possible infection before end of shift and before discharge. 2. Patient and family will be able to verbalize signs and symptoms of infection and complications to report after hospital discharge by end of shift and before discharge home.	1. 1. Teach the pt, significant other, and family about the effects a postpartum wound infection may have on the mother and the likely treatments for the infection prior to end of shift and before discharge. Information helps patient adhere to treatments, report symptoms in a timely matter, and understand consequences of nonadherence. Effects an infection may have on the mother include pain, fever, chills, wound dehiscence,s epsis,and increasedmorbidity/mortality. Likely treatments include IV antibiotics and fluids, wound packing, secondary wound closure, and possible lengthy hospitalization or home treatments. (Swearingen, 2016, p. 644) 2. Teach signs and symptoms of infection and its complications that should be reported after hospital discharge by end of shift and before discharge. This enables the patient/family to recognize and report signs of infection such as fever, foul smelling discharge, failure of lochia to progress from furbra to serosa, to alba, and its timely completion, severe pain, drainage from infection sight. Early evaluation and treatment results in decreased maternal morbidity. (Swearingen, 2016, p. 644)	1. Goal was met as the patient and her significant other were able to describe the effects a postpartum wound infection may have on the mother and likely treatments for the possible infection prior to discharge. 2. Goal was achieved. Patient and significant other verbalized signs and symptoms to look for suggesting an infection and complication to report following their discharge. Verbalization of understanding of this material occurred prior to discharge. 3. Goal was met whenmother and significant other agreed to understanding to abstain from sexual intervourse for at least 6 weeks before they were discharged home.
2.) Acute pain	1. Patient is aware	1. Assess patient’s pain	1. Outcome was met

related to post delivery of a neonate as evidenced by 1st degree laceration and birth of a child. (Swearingen, 2016, p. 645)	she will be asked to report her pain level hourly, prior to and after giving medications. She verbalized understanding of monitoring her pain and why it is important. 2. Patient verbalized the importance of reporting her pain based on a numeric scale, 1-10, 0 being none and 10 being the worst pain she has ever felt. She understands that rating her pain prior to and after medication administration allows a baseline and to monitor effectiveness of the medication. 3. Patient understands why and what medication her provider has ordered for her for pain management. She verbalized reasons for reducing pain including being more comfortable, a, increased mood, and the ability to care for her infant effectively.	hourly, prior to and after giving medications. This intervention is done to routinely monitor the patients pain and allow ample time to intervene if needed. Pain management is essential in a new mother .(Swearingen, 2016, p. 645) 2. Educate the patient on reporting pain on a numeric scale and requesting medication before the pain becomes unbearable during my shift. This intervention allows the nurse and patient to get ahead of pain, reducing the risk of the pain, pain worsening, and identifying if pain is occurring for another reason other than post delivery of her baby and her 1st degree laceration. (Swearingen, 2016, p. 645)	evidenced by hourly rounds including pain ratings followed by pain ratings by the patient before and after medication administration. This was done continuously throughout my shift. 2. Outcome was met as the patient rated her pain on a numeric scale 0-10 and verbalized the understanding of reporting her pain before it became unbearable although that did not occur throughout my shift).

Other References (APA):

Swearingen, P. L. (2016). All-In-One Nursing Care Planning Resource (4 ed.). St. Louis, Missouri: ELSEVIER.

N305 Care Plan Grading Rubric: Labor Student Name:

Demographics	3 points	1.5 points	0 points	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	
Medical History	**5 points**	**2.5 points**	**0 points**	**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)	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	

Living situation **Education level** • If applicable to learning barriers				

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.	
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.	
Primary Diagnosis	**2 points**	**1 points**	**0 points**	**Points**
Primary Diagnosis • The main reason the patient was admitted	All key components are filled in correctly.	One of the key components is missing or not	Student did not complete this section and there is concern	

Secondary Diagnosis • If the patient has more than one reason they are being admitted	The student was able to identify the correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.	understood correctly.	for lack of understanding the diagnosis.		

Stage of Labor	20 points	14-10 points	9-5 points	4-0 points	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, essay is	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 key factors missing. Student did not have a good understanding of the stage of labor and how it correlated to the client. Section was not in APA format with minimum of 2 references (0 points will be given)	

Laboratory Data	15 points	5-14 points	4-0 points	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.	

Electronic Fetal Heart Monitoring	20 points	19-10 points	0-10 points	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.	

Current Medications				

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.	

Physical Assessment	**20 points**	**1-18 points**	**0 points**	**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.		
Vital Signs	**5 points**		**2.5 points**	**0 points**	**Points**
Vital signs • 3 sets of vital signs are recorded with the appropriate labels attached • Includes a prenatal set, 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	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 were missing.	Student did not complete this section	
Pain Assessment	**2 points**		**1 point**	**0 points**	**Points**
Pain assessment	All the key components were met (2 pain assessments) for this		One assessment is	Student did not complete this	

• Pain assessment was addressed and recorded twice throughout the care of this client • It was recorded appropriately and stated what pain scale was used	section and student has a good understanding of the pain assessment.	incomplete.	section	

IV Assessment	2 points	1 point	0 points	Points
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.	More than 1 aspect of the IV assessment is missing or student did not complete this section.	
Intake and Output	**2 points**	**1-0 points**		**Points**

Intake • Measured and recorded appropriately—what the patient takes IN • Includes: oral intake, IV fluid intake, etc. **Output** • Measured and recorded appropriately—what the client puts OUT • Includes: urine, stool, drains/tubes, emesis, etc.	All of the key components of the intake and output were addressed. Student demonstrates an understanding of intake and output.		One 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.	
Nursing Care/Interventions	**12 points**		**2-0 points**	**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 components of the nursing care was missing, therefore it was difficult to determine if the student had a thorough understanding of the nursing care.	
Nursing Diagnosis	**15 points**	**5-14 points**	**4-0 points**	**Points**
Nursing Diagnosis • List 2 nursing diagnosis o Include full nursing diagnosis with “related	All key components were addressed. The student	One or more of the nursing diagnosis/rationa l/intervention	More than 2 of the nursing diagnosis sections were	

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	demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.	sections was incomplete or not appropriate to the patient Each section is worth 3 points. Prioritization was not appropriate.	incomplete or inappropriate. Prioritization is dangerously inappropriate.	
Overall APA format	**5 Points**	**1-4 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. Several grammar errors or overall poor writing style was used. Content was difficult to understand.	No APA format. Grammar or writing style did not demonstrate collegiate level writing.	

		Points
- Instructor Comments:	**Total points awarded**	
Description of Expectations	**/150= %**	
Must achieve 116 pt =77%		