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**
09/09/19 0200	JB	24	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retail Manager	Single	Sulfa Drugs – reaction unknown
Code Status	**Height**	**Weight**	**Father of Baby involved**
Full	170 cm	71.9kg	Yes

Medical History (5 Points)

Prenatal History: 24-year-old female at 36 weeks 5 days gestation. G: 1 P: 0 0, 0, 0. At risk for anemia related to decreased hemoglobin labs <11.2%.

Past Medical History: Patient reports no past medical history.

Past Surgical History: Patient denies any surgical history.

Family History: Grandpa: Diabetes Mellitus Type 2, Grandma: breast cancer, diabetes mellitus type 2

Social History (tobacco/alcohol/drugs): Patient stated she used beer early in pregnancy for the first 2 weeks, patient denies history of drugs or alcohol.

Living Situation: Patient currently lives alone. Father of baby plans to move in to help with newborn.

Education Level: NA

Admission Assessment (12 points)

Chief Complaint (2 points): Spontaneous labor contractions

Presentation to Labor & Delivery (10 points): 24-year-old female arrived at Sarah Bush Lincoln Hospital in a wheelchair at 0200 on 9/9/19. Patient had spontaneous labor contractions 2-3 minutes apart and spontaneous ruptured membranes. Patient is at 36 weeks and 5 days gestation and reported that there was no urge to push yet. Fetal movement was present and clear leaking fluid noted without blood. Patient rapidly dilated to 10/10cm.

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points): Normal Pregnancy

Secondary Diagnosis (if applicable):NA

Stage of Labor (20 points):

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

The stages of labor include first stage, second stage, and third stage. The early-stage consists of three sub-phases, including latent, active, and transitional. The early stage of labor begins when real labor contractions begin and are three to five minutes apart, ending when the cervical dilation is to ten centimeters (Hutchison, Mahdy, 2019). During the latent phase, the cervical dilation slowly progresses and is from 0 to six centimeters and can last thirty to sixty minutes. During this, the presenting fetal part can be determined, along with cervical effacement (Hutchison, Mahdy, 2019). Following this, the active phase is characterized as a more rapid dilation period and quickly dilates from six to ten centimeters in less than fifteen minutes (Hutchison, Mahdy, 2019). Transition phase 10-15 minutes. During the first phase, the mother is excited about the birth of her newborn. This was evident by the patient expressing eagerness to spend time with her baby. This phase can last up to nine hours and is painful due to a dilating cervix and structure movement (Rici, Kyle & Carman, 2013).

Nursing interventions within this phase of labor should be to encourage activity, so the mom remains in an upright position, voiding every two hours, and patient education (Rici, Kyle & Carman, 2013). This can worry about some new mothers, so the nurse should provide comfort and reassurance during the phases. It is essential that the mom does not begin pushing until the cervix is entirely dilated. Furthermore, the nurse should

perform Leopold Maneuvers, a vaginal exam, and further assessments to determine if the membrane has ruptured (Rici, Kyle & Carman, 2013). If the membrane has burst, the nurse should begin monitoring the fetal heart rate to determine if there is any distress. Along with this, vital signs should be taken every ten to fifteen minutes to ensure stability. In the last sub-phase, the nurse should observe for crowning and help the mother prepare for birth (Rici, Kyle & Carman, 2013). My patient's first stage of labor was stated to be 113 minutes onset complete dilated and 1.88 hours total.

The second stage of labor can be identified with cervical enlargement reaches ten centimeters incomplete and finishes with a delivery of the neonate. The fetus naturally descends into the canal, and this can last less than four hours (Hutchison, Mahdy, 2019). There are multiple assessments to be completed by the nurse during this phase. These include vital signs every five to twenty minutes, fetal heart rate every fifteen minutes, and monitoring uterine contractions (Rici, Kyle & Carman, 2013). Also, monitoring pushing efforts and if there is a bloody show increase. Furthermore, nursing interventions should include monitoring the mother and baby closely, assisting in positioning, and providing comfort measures to reduce anxiety and stress in the mom. My patient's second stage of labor was stated to be 60 minutes.

The last stage of labor, the third stage, is initiated when the fetus is delivered and ends with the delivery of the placenta (Hutchison, Mahdy, 2019). This phase typically lasts less than twenty minutes, and the placenta is expulsed between five and thirty minutes. The nurse should assess vital signs every fifteen minutes, signs of placenta expulsion, and APGAR scoring (Rici, Kyle & Carman, 2013). Nursing interventions during this stage include coaching the patient to push, skin to skin contact, and giving pain medications as ordered. Additional duties are to clean any discharge from the vagina, massage fundus if necessary. If the fundus is firm and contracting followed by a gush of dark blood, this may indicate placental separation from the uterus. The nurse should do a full vaginal exam and asses to see the umbilical cord length (Rici, Kyle & Carman, 2013). Further evaluations are necessary to prepare for a post-partum hemorrhage or complications. The fundus should be assessed by its height, position, firmness, and palpation. Once the baby is born, the mom should be encouraged

to pee to avoid bladder distention (Rici, Kyle & Carman, 2013). My patient's third stage of labor was stated to be three minutes. Her total labor lasted 2 hours and 53 minutes.

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

Hutchison J, Mahdy H, Stages of Labor. [Updated 2019 Aug 18]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2019 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK544290/

Ricci, S. S., Kyle, T., & Carman, S. (2013). *Maternity and pediatric nursing.* 2nd ed. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

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	**3.80-5.41**	**4.10**	**3.83**	**3.95**	**Values within normal limits**
Hgb	**11.3-15.2**	**12.4**	**11.2**	**11.2**	**Hemoglobin is decreased in pregnancy due to anemia and the overall demand for more oxygen supply to the fetus (Van Leeuwen & Bladh, 2017, p. 374)**
Hct	**33.2-45.3%**	**36.1**	**34.0**	**32.3**	**Values within normal limits**
Platelets	**149-493K**	**213**	**204**	**217**	**Values within normal limits**
WBC	**4-11.7K**	**8.7**	**12.6**	**17.6**	**White blood cells are increased in pregnancy due to increased neutrophils, and physiological stress of birth and metabolic demands of rapid development (Van Leeuwen & Bladh, 2017, p. 399).**
Neutrophils	**45.3-79**	**75.3**	**70.8**	**81.6**	**Neutrophils are increased in pregnancy due to the physiological stress of childbirth (Van Leeuwen & Bladh, 2017, p. 400).**

Lymphocytes	**11.8-45.9**	**15.2**	**20.8**	**9.8**	**Lymphocytes are decreased in in pregnancy due to anemia and can be related to the stress of childbirth. This can also be due to reduction of B lymphocytes, but return to normal values postpartum (Van Leeuwen & Bladh, 2017, p. 400).**
Monocytes	**4.4-12.0**	**8.5**	**7.0**	**8.0**	**Values within normal limits**
Eosinophils	**0.6-6.3**	**0.7**	**1.1**	**0.2**	**Values within normal limits**
Bands	**NA**	**NA**	**NA**	**NA**	**NA**

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	**ABO**	**O**	**O**	**O**	**Values within normal limits**
Rh factor	**+/-**	**-**	**-**	**-**	**Values within normal limits**
Serology (RPR/VDRL)	**NA**	**NA**	**NA**	**NA**	**NA**
Rubella Titer		**54.9**	**NA**	**NA**	**Values within normal limits**
Hct & Hgb	**33.2-45.3/11.3-15.2**	**36.1/12.4**	**NA**	**NA**	**Values within normal limits**
HIV	**Reactive-Nonreactive**	**NA**	**Non-reactive**	**NA**	**Values within normal limits**
HbSAG	**+/-**	**NA**	**-**	**NA**	**Values within normal limits**
Group Beta Strep Swab	**NA**	**NA**	**NA**	**NA**	**NA**
Glucose at 28 weeks	**60-100**	**NA**	**100**	**NA**	**Values within normal limits**
Genetic testing: if done	**NA**	**NA**	**NA**	**NA**	**NA**

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	Yellow, clear	NA	Yellow, hazy	NA	Abnormal urine color and clarity, like yellow and cloudy, are seen in pregnant patients due to vaginal yeast infections (Van Leeuwen & Bladh, 2017, p. 1582)
pH	5.0-8.0	NA	5.0	NA	Values within normal limits
Specific Gravity	1.005-1.034	NA	1.028	NA	Values within normal limits
Glucose	Normal	Normal	Normal	Normal	Values within normal limits
Protein	Negative-Normal	-	-	-	Values within normal limits
Ketones	Negative	-	-	-	Values within normal limits
WBC	<5	NA	2	NA	Values within normal limits
RBC	0-3	NA	2	NA	Values within normal limits
Leukoesterase	Negative	-	-	-	Values within normal limits

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	-	-	-	Values within normal limits

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

NA	**NA**	**NA**	**NA**	**NA**	**NA**
NA	**NA**	**NA**	**NA**	**NA**	**NA**

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7 ed.). Philadelphia, PA: F.A. Davis Company

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	**140 beats per minute**
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?**	**Present- prolonged, 15x15** **Accelerations during labor are normal. They indicate short term increases of the heart rate of at least 15 bpm and lasting at least 15 seconds to signify that there is sufficient oxygen supply. The fetal heart rate should be between the ranges of 110-160.** **Variability of 6-25 beats per minute. Pattern noted as 11.**
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?**	**Late decelerations were present. Lasted with each contraction and variable. Late decelerations occur after the contraction starts and could indicate fetal hypoxia. The patient's fetus was experiencing a decline in heart rate and oxygen was administered as an intervention. The fetal heart rate returned to baseline. No further information was provided in the patient's chart during this admission.**
Describe the contractions i.e. frequency, length,	**Contractions were 1-2 minutes in frequency with a strong intensity.**

strength, patient's response	**Each contraction had a duration of 60-80 seconds. Patient responded to contractions with screaming and she could feel when she needed to push.**

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

7 different medications must be completed

Home Medications (2 required)

Brand/Generic	**The patient did not take any medications prior to coming to the hospital.**	**The patient did not take any medications prior to coming to the hospital.**	**The patient did not take any medications prior to coming to the hospital.**	**The patient did not take any medications prior to coming to the hospital.**	**The patient did not take any medications prior to coming to the hospital.**
Dose	**NA**	**NA**	**NA**	**NA**	**NA**
Frequency	**NA**	**NA**	**NA**	**NA**	**NA**
Route	**NA**	**NA**	**NA**	**NA**	**NA**
Classification	**NA**	**NA**	**NA**	**NA**	**NA**
Mechanism of Action	**NA**	**NA**	**NA**	**NA**	**NA**
Reason Client Taking	**NA**	**NA**	**NA**	**NA**	**NA**
Contraindications (2)	**NA**	**NA**	**NA**	**NA**	**NA**
Side Effects/Adverse Reactions (2)	**NA**	**NA**	**NA**	**NA**	**NA**
Nursing Considerations (2)	**NA**	**NA**	**NA**	**NA**	**NA**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**NA**	**NA**	**NA**	**NA**	**NA**

Client Teaching needs (2)	**NA**	**NA**	**NA**	**NA**	**NA**

Hospital Medications (5 required)

Brand/Generic	**Docusate Sodium** **Colace**	**Acetaminophen** **Tylenol**	**NA**	**NA**	**NA**
Dose	**100mg=1 capsule**	**100mg 2 tablets**	**NA**	**NA**	**NA**
Frequency	**BID**	**Q4H PRN**	**NA**	**NA**	**NA**
Route	**PO**	**PO**	**NA**	**NA**	**NA**
Classification	**Stool Softener** **Sulfonic acid**	**Analgesic**	**NA**	**NA**	**NA**
Mechanism of Action	**Admixture of fat and water to soften. Exact action is unknown.**	**Antipyretic activity that acts centrally to reduce pain.**	**NA**	**NA**	**NA**
Reason Client Taking	**Constipation**	**Pain**	**NA**	**NA**	**NA**
Contraindications (2)	**Gastric Ulcers**	**Allergy to acetaminophen** **Hepatic impairment**	**NA**	**NA**	**NA**
Side Effects/Adverse Reactions (2)	**Cramping** **Hypomagnesemia**	**Nausea** **Vomiting**	**NA**	**NA**	**NA**
Nursing Considerations (2)	**Assess pain level and comfort** **Monitor electrolytes**	**Monitor for allergies** **Monitor Vitals 30 minutes after administration**	**NA**	**NA**	**NA**
Key Nursing Assessment(s)/Lab(s	**Administer alone for better**	**Assess hepatic, hematologic**	**NA**	**NA**	**NA**

) Prior to Administration	**absorption.** **Do not administer within one hour of other drugs, antacids or milk**	**and renal function labs**			
Client Teaching needs (2)	**Increase fluids while taking** **Take with full glass of water** **Do not use longer than one week**	**Do not use with other products containing acetaminophen** **No alcohol**	**NA**	**NA**	**NA**

Medications Reference (APA): (2 points)

Vallerand, A. H., Sanoski, C. A., & Deglin, J. H. (2017). *Davis's Drug Guide for Nurses* (15 ed.). Philadelphia, PA: F.A. Davis Company.

Assessment (20 points)

Physical Exam (20 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient awake in bed feeling cheerful and cooperative. She is ANO x4. Patient appears to be excited about going home with her baby. Overall, the patient is eager to go home, but is tired from labor.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** .	**Patient is Caucasian and presents with a fair skin tone. Skin has normal elasticity, warm to touch. No abnormal texture. Hair is light brown in color. Skin turgor intact. No rashes or bruises. Bilateral laceration related to vaginal delivery. No drains present. Braden scale is 23.**

Braden Score: **Drains present: Y☐ N ☐** **Type:**	
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is midline with no deviations. Hair is light brown in color. Ears show no abnormal drainage, tympanic membrane visible, pearly grey. PEERLA is noted. Patient uses glasses regularly. Nose shows no deviated septum, turbinate equal bilaterally. Oral mucosa is ink and moist with no notable abnormalities. Patients teeth present and yellow to white in color**
CARDIOVASCULAR (1 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐ Edema Y ☐ N ☐** **Location of Edema:**	**Patient is not currently being monitored by telemetry. Patient was noted to be in normal sinus rhythm on admission. Heart sound auscultated x5. S1, S2 heart sounds noted. Radial and pedal pulses assessed. Pulses graded 2+ and present bilaterally. Capillary refill average at <3 seconds. Patient shows no signs of edema.**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**No accessory muscle use when breathing. Trachea midline. No deviations. Patient does not appear to be short of breath. Lung sounds present bilaterally. Patient denies the use of oxygen at home.**
GASTROINTESTINAL (5 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:**	**Patient's current diet is regular. Bowel sounds present in all four quadrants. Patient denies pain on palpation. No masses present. No ostomy, nasogastric tubes, PEG tubes. No drains. Last bowel movement was on September 9th. Patient weighs 71.9kg and is 170 cm tall. Rounded distention noted on abdomen. Fundal height and position is -1 umbilical midlines.**

Palpation: Pain, Mass etc.: **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Fundal Height & Position:**	
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:**	**Urine is cloudy and yellow in color with an odor. Stress incontinence related to vaginal birth. No pain with urination. Urethral straight intermittent catheter used. Spontaneous ruptured membranes at 0200. Clear in color and small amount with no blood or odor. Patient has bilateral first degree periureteral laceration.**
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:**	**Patient is up adlib and is not a fall risk. No fall score noted. Active range of motion bilaterally. Right and left lower extremities equal in strength. Upper left and right extremities equal in strength.**

Independent (up ad lib) ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	
NEUROLOGICAL (1 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **DTRs:**	**Patient awake in bed feeling cheerful and cooperative. She is ANO x4. Patient appears to be excited about going home with her baby. Patient MAEW for current age and condition. PERLA noted. No signs of neurological damage. Overall, the patient is eager to go home, but is tired from labor.**
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 with excitement and fatigue from childbirth. Father of baby is involved and is support system. He will be going home and living with her to help with baby. Cultural considerations were not obtained on admission. Patient denies past or present alcohol, drug, or tobacco use.**
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:**	**Patient delivered a baby boy on 9/9/19 at 0354 through vaginal birth. No significant blood loss. Apgar 8 at one minute and 9 at 5 minutes. Newborn weighs 2.824 kg. The mother states she will be breastfeeding.**

Weight: **Feeding Method:**	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**70**	**110/60**	**16**	**36.6**	**100**
Labor/Delivery	**80**	**124/68**	**18**	**37.4**	**99**
Postpartum	**71**	**98/54**	**15**	**36.6**	**99**

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0745	Numeric Scale 0/10	Patient denies pain	Patient denies pain	Patient denies pain	No interventions implemented
1000	Numeric Scale 0/10	Patient denies pain	Patient denies pain	Patient denies pain	No interventions implemented

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Patient was being discharged during my shift and I did not have access to this information in the charts.	**Patient was being discharged during my shift and I did not have access to this information in the charts.**

Size of IV: NA **Location of IV: NA** **Date on IV: NA** **Patency of IV: NA** **Signs of erythema, drainage, etc.: NA** **IV dressing assessment: NA**	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
600	**300**

Interventions (12 points)

Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. Instruction on the topic of infection would be through the method of verbal instructions. The outcome is that the client understands what to report if suspected infection and the signs and symptoms to be aware of.

2. Instruction on the topic of circumcision care would be through the method of verbal instruction. The outcome is that the patient understands that Vaseline needs to be applied with each diaper change to prevent breaking off the skin. The newborn will remain free of pain and infection.

Nursing Interventions (6 points)

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

Nursing Interventions: Vital signs of the mother were obtained twice before discharge to ensure she was healthy enough to go home. An assessment of the baby and mother were performed to ensure that each were healthy and responding appropriately postpartum.

Medical Treatments: No medical interventions were done by the student nurse as the patient was preparing for discharge with the newborn that morning.

Nursing Diagnosis (15 points)

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

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)** Include a short rationale as to why you chose this intervention & cite the reference appropriately	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Impaired tissue integrity RT skin laceration AEB bilateral incision needed (Swearingen, 2016)	**This nursing diagnosis was chosen as a priority as the mother's health status is vital. This could also lead to additional complications and interfere with care to the newborn.**	**1. Nurse will assess impaired tissue lacerations site and its condition (Swearingen, 2016).** **2.Nurse will assess characteristics of wound and how it is healing. Also monitor vital signs**	**Patient will report any pain at the site of tissue impairment. They will show a full understanding of how to protect the tissue and would care. By doing this, the wound will decrease in size and increase in granulation tissue. Patient verbalized an understanding of wound care at discharge. Goal met and will be reevaluated at primary care provided check up (Swearingen, 2016).**
Disturbed sleep patter related to newborn, postpartum body aches and urinary frequency	**This nursing diagnosis was selected as a concern because it can interfere with**	**1. Encourage mother to void before laying down to reduce the urge. Provide**	**The client will have an improved sleeping pattern and will verbalize an understanding of care by**

as evidenced by verbalized concern and dark circles under eyelids (Swearingen, 2016)	**the mother's care to the newborn.**	**education to Mother and Father on adjusting with the newborn (Swearingen, 2016).** **2. Have a quiet environment and practice bedtime routines before sleeping. Utilize the use of analgesics to reduce pain or aches (Swearingen, 2016).**	**discharge. Reduced pain or aches can be resolved with analgesics. The client responded well to this information and is eager to bring her baby home. Goal met (Swearingen, 2016).**

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%		