N432 Care Plan

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 **09/08/2019** **1450**	**Patient Initials** **J.B.**	**Age** **30 years old**	**Gender** **Female**
Race/Ethnicity **African American**	**Occupation** **Bus Driver**	**Marital Status** Not married, but is dating the father of the baby	**Allergies** **N/A**
Code Status **Full**	**Height** **5”11**	**Weight** **124.3kg**	**Father of Baby involved** **yes**

Medical History (5 Points)

Prenatal History: J.B. is a 30 y.o. female with an extensive prenatal history. The patient is G6T2P2A2L3 (G6P5) and has a history of severe preeclampsia during her pregnancy in 01/18. During her 2018 pregnancy, the pt. underwent an emergency cesarean section at 28 weeks’ gestation due to preeclampsia with severe distress to both mother and baby. The infant passed away at 3 months of age due to pneumonia and RSV.

Past Medical History: J.B. is a 30 y.o. woman with a past medical history of obesity, anemia, and preeclampsia.

Past Surgical History: Pt. had a cesarean section in 01/18.

Family History: The pt.’s mother and father have been diagnosed with hypertension. Pt.’s father also has a diagnosis of coronary artery disease. Paternal family history is unknown at this time.

Social History (tobacco/alcohol/drugs): The patient is a current smoker and smokes 0.25 packs a day. The pt. reports she has smoked 0.50 pack a day since she was 15 years old but reduced to 0.25 pack a day due to pregnancy. Pt. denies alcohol use while pregnant, and reports that when she is not pregnant, she has one or two mixed drinks around 3 times per week.

Living Situation: Pt. currently lives with her boyfriend who is the father of the baby.

Education Level: The patient reports that she has her GED.

Admission Assessment (12 points)

Chief Complaint (2 points): Sudden onset of a severe headache with associated photophobia, and nasal congestion. The pt. describes her head pain as “constant” and “aching.”

Presentation to Labor & Delivery (10 points): J.B. is a 30 y.o. woman who is 34 weeks and 2 days pregnant. The pt. has a history of preeclampsia, anemia, and obesity and is G6T2P2A2L3. She presented to the ED on 09/08/2019 with a sudden onset of a severe headache, sensitivity to light, and nasal congestion. The patient stated her head pain was “aching” and “constant” and rated her pain a 7/10. She took Tylenol with no relief the day prior to arrival 09/07/2019. Emergency department physicians cleared the pt. to be evaluated by OB due to hx of preeclampsia with associating signs and symptoms. Pt. was moved to labor and delivery. Pt. had one isolated severe range BP and bilateral lower extremity edema. There was a strong concern for preeclampsia with severe features given the pt.’s report of severe and sudden headache, lower extremity edema, and severe hx of preeclampsia. Patient was given 975mg of PO Tylenol, 10mg IV Reglan, and 25mg of IV Benadryl for 7/10 pain. Pt. evaluated after 30 minutes and reported pain at 2/10, vitals were taken hourly, BP improved and remained in the non-severe range. Pt. denies experiencing chest pain or SOB. Normal fetal movement was detected, and pt. denies experiencing contractions or presence of vaginal bleeding or leakage.

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Diagnosis (2 points)

Primary Diagnosis on Admission (2 points): Preeclampsia

Secondary Diagnosis (if applicable): Headache and sinus congestion

Stage of Labor (20 points):

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

J.B. is a 30 y.o. woman who is 3 days postpartum and had an induced vaginal delivery. This is considered the puerperium period which lasts from after the delivery of the placenta to 6 weeks. This is a

transitional period for the mother both physically and emotionally; the body is recovering and returning to its prepregnant state (Ricci, Kyle, and Carman, 2017). During puerperium the body is returning to normal. The uterus returns to its normal size through a process of involution. One week after birth, the uterus shrinks in size by 50% and weighs about 500g (Ricci, Kyle, and Carman, 2017). The uterus moves down 1cm per day from the umbilicus and by day 10 it should no longer be palpable. Involution causes uterine contractions; it is important for the nurse to monitor the patient's pain level and administer analgesics PRN. Educate the client that contractions typically occur during breastfeeding (Ricci, Kyle, and Carman, 2017). Monitoring the amount and color of vaginal discharge (lochia) is important during this period as well. Vaginal discharge after birth can last for 4-8 weeks. At three days postpartum the client's output should be 240-270mL and is called lochia rubra due to the deep red coloring (Ricci, Kyle, and Carman, 2017). Lochia should smell "fleshy", if a strong and unpleasant odor is present the client may have an infection. During the puerperium period the cervix returns to normal by 2 weeks. The vaginal mucosa is thin, swollen, and reddened. At this stage the vagina gapes at the opening and will return to prepregnant size by 6 weeks. The perineum is often bruised, swollen, and tender 2-3 days after a vaginal birth. Lacerations due to an episiotomy may extend into the anus causing substantial and prolonged discomfort to the client. Hemorrhoids can also cause discomfort. Nursing interventions such as ice packs, warm water, witch hazel pads, anesthetic sprays, and sitz baths can help alleviate discomfort. Providing education of pelvic floor exercises can strengthen perineal muscle tone and prevent urinary incontinence later in life (Ricci, Kyle, and Carman, 2017). Cardiac output 24 to 72 hours postpartum typically decreases to pre-labor values and returns to pre-pregnancy levels within 6-8 weeks. Postpartum vitals should be monitored closely. A heart rate of 100 in postpartum women may be indicative of dehydration, hemorrhage, or hypovolemia. Blood pressure typically drops the first two days and increases 3-7 days postpartum. Nurses should monitor for a significantly increased blood accompanied by a severe headache as it can be indicative of preeclampsia (Ricci, Kyle, and Carman, 2017). An elevated temp of 100.4 is common in the first 24 hours postpartum.

Women in the puerperium stage are more likely to develop a clot the first 2-3 weeks postpartum. Nursing interventions include testing for a positive Homans sign and educating the patient on factors that

increase clot development such as smoking, obesity, and immobilization (Kansky, 2016). The urinary system undergoes many changes after birth and as a result many women experience difficulty voiding. Monitoring for signs and symptoms including, lacerations, swelling, decreased bladder tone, and decreased sensation can affect urine output and increase the risk of bladder distention and UTI. Frequently voiding small amount within the first week of pregnancy is a typical finding. Postpartum clients should be a strict I & O measurement (Kansky, 2019). Postpartum constipation is also common in puerperium women. Nursing interventions include providing stool softeners and high fiber foods. Breast milk typically appears within the first 4-5 days postpartum. Nursing interventions include providing education and consulting a lactation specialist. Breasts are typically soft and nontender the first two days postpartum. The breasts then become engorged around 3-5 days post-partum and subside within 24-36 hours. Nursing interventions to help reduce pain include applying a hot or cold compress, breast massaging, breast-pumping, and nonprescription anti-inflammatory meds (Ricci, Kyle, and Carman, 2017).

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

Kansky, C. (2019, February 2). Normal and Abnormal Puerperium. Retrieved from https://emedicine.medscape.com/article/260187-overview#a2

Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing*. Philadelphia: Wolters Kluwer.

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	**4-5.2**	**N/A**	**4.39**	**3.78**	**Pt. has been diagnosed with anemia and lost blood during vaginal birth (Ricci, Kyle, & Carman, 2017).**
Hgb	**12-15.8**	**N/A**	**15.3**	**11.3**	**Pt. has been diagnosed with anemia and lost blood during vaginal birth (Ricci, Kyle, & Carman, 2017).**
Hct	**36-46%**	**N/A**	**42**	**31.6**	**Pt. has been diagnosed with anemia and lost blood during vaginal birth (Ricci, Kyle, & Carman, 2017).**

Platelets	**165-415**	**N/A**	**N/A**	**N/A**	
WBC	**3.5-9.1**	**N/A**	**12.0**	**14.3**	**WBC count increases during labor and returns to normal within the next few days (Moldenhauer, 2018).**
Neutrophils	**1.4-4.6**	**N/A**	**12.9**	**13.70**	**WBC count increases during labor and returns to normal within the next few days (Moldenhauer, 2018).**
Lymphocytes	**1-3.6**	**N/A**	**3.0**	**1.20**	
Monocytes	**N/A**	**N/A**	**N/A**	**N/A**	
Eosinophils	**N/A**	**N/A**	**N/A**	**N/A**	
Bands	**N/A**	**N/A**	**N/A**	**N/A**	

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 +**	**O +**	
Rh factor	**negative**	**negative**	**negative**	**negative**	
Serology (RPR/VDRL)	**Non-reactive**	**Non-reactive**	**Non-reactive**	**Non-reactive**	
Rubella Titer	**Immune**	**Immune**	**Immune**	**Immune**	
Hct & Hgb	**N/A**	**N/A**	**N/A**	**N/A**	
HIV	**negative**	**negative**	**negative**	**negative**	
HbSAG	**N/A**	**N/A**	**N/A**	**N/A**	
Group Beta Strep Swab	**N/A**	**N/A**	**N/A**	**N/A**	On 09/08/19 pt. was given penicillin for GBS prophylaxis prematurely.
Glucose at 28 weeks	**N/A**	**N/A**	**N/A**	**N/A**	
Genetic testing: if done	**N/A**	**N/A**	**N/A**	**N/A**	

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	**N/A**	**N/A**	**N/A**	**N/A**	
pH	**N/A**	**N/A**	**N/A**	**N/A**	
Specific Gravity	**N/A**	**N/A**	**N/A**	**N/A**	
Glucose	**N/A**	**N/A**	**N/A**	**N/A**	
Protein	**N/A**	**N/A**	**N/A**	**N/A**	
Ketones	**N/A**	**N/A**	**N/A**	**N/A**	
WBC	**N/A**	**N/A**	**N/A**	**N/A**	
RBC	**N/A**	**N/A**	**N/A**	**N/A**	
Leukoesterase	**N/A**	**N/A**	**N/A**	**N/A**	

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	**N/A**	**N/A**	**N/A**	**N/A**	

Other Tests	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal
N/A	**N/A**	**N/A**	**N/A**	**N/A**	

Lab Correlations Reference (APA):

Moldenhauer, J. (2018, June). Postpartum Care - Gynecology and Obstetrics. Retrieved from https://www.merckmanuals.com/professional/gynecology-and-obstetrics/postpartum-care-and-associated-disorders/postpartum-care

Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing*. Philadelphia: Wolters Kluwer.

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM Tracing	Your Assessment * This care plan is for the postpartum mom. I was not present for and found little notes regarding EFH during pt. delivery.
What is the Baseline (BPM) EFH?	Normal (BPM) EFM values range from 110-160 (Ricci, Kyle, & Carman, 2017). Newborn is within normal range at 140 BPM.
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?	There are accelerations present. Accelerations are seen with fetal movement and is a reassuring sign of fetal well-being. It is considered an acceleration when the fetal heart rate is more than 15 BPM above the baseline BPM for more than 15 seconds and less than 2 minutes (Ricci, Kyle, & Carman, 2017). Moderate variability was noted during EFM. Moderate variability is considered normal and falls between 6-25 BPM. It indicates that the fetus is well developed and well oxygenated (Ricci, Kyle, & Carman, 2017).
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?	The fetal heart monitoring did not detect any decelerations. Decelerations can range from being an abrupt deceleration in the heartrate from the baseline. The onset varies with contractions; variable deceleration is common. Other decelerations occur at the peak of contractions and is a gradual decrease in heart rate. This can be indicative of fetal distress if repetitive or severe enough. HR returns to baseline after contraction ends (Ricci, Kyle, & Carman, 2017).
Describe the	The pt. had an intracervical Foley catheter in place and was

contractions i.e. frequency, length, strength, patient's response.	**given Pitocin. At 1804 pt.'s contractions were every 3 minutes. Pt. delivered a healthy baby girl at 1900. Mother has a diagnosis of preeclampsia and consistently high blood pressures throughout pregnancy. Neither mom nor newborn experienced any severe distress throughout delivery.**

References

Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing*. Philadelphia: Wolters Kluwer.

Current Medications (10 points total -1 point per completed med)
7 different medications must be completed

Home Medications (2 required)

Brand/Generic	**Magnesium Oxide (Uro-Mag)**	**labetalol (Trandate)**			
Dose	**350 mg**	**200mg**			
Frequency	**1 x daily**	**1 x daily**			
Route	**PO**	**PO**			
Classification	**Antacid**	**Antihypertensive**			
Mechanism of Action	Acts on lipoprotein lipase to promote polarization.	Works to reduce blood pressure and peripheral vascular resistance by blocking alpha1 and beta 2 receptors in smooth muscle.			
Reason Client Taking	**Acid indigestion/ heartburn**	**Preeclampsia**			
Contraindications (2)	**Hypersensitivity to drug and extreme renal impairment**	**Asthma, cardiogenic shock, and heart failure.**			
Side Effects/Adverse Reactions (2)	**Diarrhea, GI irritation**	**Bradycardia, chest pain, and edema.**			
Nursing	Administer two	Labetalol can			

Considerations (2)	hours apart from other medications and monitor for diarrhea	mask common signs and symptoms of shock. Monitor blood glucose b/c it can mask symptoms of hypoglycemia.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor creatinine and magnesium levels**	Baseline vitals and blood glucose.			
Client Teaching needs (2)	Have client report if they are experiencing diarrhea and signs and symptoms of allergic reaction.	Do not stop the med abruptly. Pt. should taper dosage over 2 weeks. Monitor blood sugar levels.			

Hospital Medications (5 required)

Brand/Generic	**Ibuprofen (Motrin)**	**ondansetron (Zofran)**	**acetaminophen (Tylenol)**	**nifedipine (Procardia)**	**benzocaine-menthol (Dermoplast)**
Dose	**800mg**	**4 mg**	**650 mg**	**30 mg**	**N/A**
Frequency	**2 x daily**	**Q 6 PRN**	**Q 6 PRN**	**1 x daily**	**Q 4-6 PRN**
Route	**PO**	**IV**	**PO**	**PO**	**Topical spray**
Classification	**Analgesic/ Anti-inflammatory**	**Antiemetic**	**Nonopioid analgesic**	**Calcium channel blocker**	**Local anesthetic**
Mechanism of Action	Blocks enzyme prostaglandin production which inhibits inflammatory response and relieves local pain.	Blocks receptors at vagal nerve terminals in the intestine. Prevents serotonin release into the small intestine.	Inhibition of central prostaglandin synthesis. Reduces fever inhibiting the formulation and release of prostaglandins in the CNS and by inhibition endogenous pyrogens at the hypothalamic thermoregulator center	Nifedipine binds to channel receptors and resulting in inhibition of calcium influx. It acts on smooth muscle and causes the peripheral arteries to vasodilate and relax.	It blocks the initiation and conduction of nerve impulses by decreasing the permeability of sodium ions causing the neuronal membranes to react.
Reason Client Taking	**Pain management**	**Nausea**	**Pain management**	**Preeclampsia / Elevated BP**	
Contraindications	**Angioedema,**	Hypersensitivit	Active or	Congestive	Hx of

(2)	**asthma, and bronchospasm**	y to ondansetron and concomitant use of apomorphine.	severe hepatic disease and hypersensitivity to acetaminophen	heart failure and aortic stenosis.	methemoglobinemia Or genetic enzyme deficiency disorders
Side Effects/Adverse Reactions (2)	**GERD, abdominal cramps, and constipation.**	**Hypotension, bronchospasm, and pulmonary embolism.**	Liver failure, pneumonitis, and constipation.	Headaches, dizziness, and weakness.	**Fever, nausea, dizziness.**
Nursing Considerations (2)	**Do not administer to pregnant women starting at 30 weeks gestation.**	Monitor vit k levels and electrolyte imbalances before administration of drug. For post op adults, drug must be administered undiluted intramuscularly or intravenously	Monitor for signs and symptoms of toxicity and liver failure. Monitor for jaundice.	Monitor liver enzymes and kidney enzymes while client is taking med. Assist client with ambulation after first dose because it can cause dizziness.	Monitor pt.'s for breathing abnormalities such as asthma. Monitor pt. for cyanosis of the mouth and hands.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor PT,INR, and k+ labs.**	**Vit K and electrolyte levels.**	**AST, ALT, Assess pt. for jaundice**	**AST, ALT, creatinine, BUN, GFR labs**	**Monitor for methemoglobin levels in the blood.**
Client Teaching needs (2)	**High doses of the med for an extended period of time can cause stomach bleeding. Take med with food to reduce GI distress.**	Reassure patient with transient blindness that it will resolve within a few minutes to 48 hours. If oral, let is dissolved on the tongue before swallowing.	Teach patient if stomach upset occurs to take the med with food. Teach patient appropriate dosage and the dangers of toxicity.	**Avoid drinking grapefruit juice while taking this med. Avoid alcohol or marijuana use, tell your dentist if you are taking this med.**	Do not apply to the breasts, chest, or anywhere the newborn may place their mouth. Use recommended amount. Overuse of med can lead to increased levels within the bloodstream and cause serious reactions.

Medications Reference (APA): (2 points)

Jones & Bartlett Learning. (2019). *2019 Nurse's Drug Handbook* (Eighteenth ed.). Burlington,

MA: Jones & Bartlett Learning.

Assessment (20 points)

Physical Exam (20 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Pt. is alert, oriented, coherent, and cooperative. Pt. appears to be well groomed, well nourished, and does not appear to be in any distress.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Breasts feel full, slightly nodular, and firm upon palpation. Coloring has pink undertones throughout, and breast veins are slightly visible. The skin feels warm. The pt. reports her breasts feel tender. Nipples are free of cracks, fissures, and bruising. Skin is clean, dry, and intact with pink undertones. Linea nigra is present and midline. No pallor, jaundice, rashes, or skin lesions are present. Skin turgor is good. Pt. has a Braden score of 22.
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Eyes are equal, round, and reactive and accommodate to light. Sclera is slightly injected. Conjunctiva is pale due to anemia diagnosis. Eyelids have pink undertones, dry, and intact. No edema present in the eyelids. There are no polyps present in the nasal cavity and pt. reports slight nasal congestion. Ears are symmetrical and temporal membrane is pearly gray. Gums appear slightly swollen with pink undertones in coloring. Lips have pink undertones and appear moist. The corners of the mouth appear cracked, possibly due to anemia diagnosis. Pt. has good dentition. .
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:**	Heart has normal rate and rhythm. Heart sounds are normal without the presence of arrythmias, murmurs, gallops, or palpitations. Clear S1 and S2 upon auscultation. The pt. has strong peripheral pulses throughout, and capillary refill is under 3 seconds. Neck vein distention is not present. Pt. has + 1 lower extremity edema. Pt. tested negative for Homan's sign and there is no neck vein distention visible.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Breath sounds are clear to auscultation bilaterally. Respirations are unlabored with regular pattern and depth. Pt. breaths without the use of accessory muscles and does not appear to be in respiratory distress.

GASTROINTESTINAL (5 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Fundal Height & Position:**	The pt.'s abdomen appears clean, dry, and intact, with slightly pink undertones. Bowel sounds are present and pt. states she had a bowel movement at one day postpartum on 09/10/19 which was one day prior to assessment. Pt. denies experiencing rectal pain or presence of hemorrhoids. Fundus is midline and approximately 3cm below the umbilicus. Fundus is firm upon palpitation and massaging; surrounding abdomen is soft upon palpitation. Pt. states abdomen is slightly tender when palpated. Pt. is on a regular diet/breast feeding diet. Pt. given pamphlet on foods to avoid while breastfeeding. Pt. has a small scar on lower abdomen due to previous caesarean section on 01/18. Scar is clean, dry, intact, and healing properly. Perineum appears slightly swollen and reddened.
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:**	Pt. is voiding small amount of urine frequently. She denies the presence of pain or burning while urinating. Urine is bright yellow in coloring. The bladder is not palpable following voiding. Pt. is on strict I's & O's due to receiving IV magnesium drip. Lochia output is scant and less than 2.5cm on pad/hr. Lochia consistency is normal, bright red in coloring, and there are no clots present. Lochia smell is fleshy and there is no overwhelming or concerning odor present. Genitals appear edematous, swollen, and pink undertones in coloring. Pt.'s Foley catheter has been removed and pt. has normal urine output. Pt. did not have an episiotomy. Perineum appears edematous and coloring is slightly red/pink. Pt. had an AROM and clear fluid was noted. The time and amount of fetal membrane is N/A. Urine output is frequent and is at least 30mL/hour.
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** ☐	Pt. has a general and purposeful motor response and has full ROM of both upper and lower extremities. Pt. follows commands well and has purposeful and equal strength throughout upper and lower extremities. Pt. is up ad lib and is able to perform smooth and coordinated movements. Pt.'s gait is steady. No swelling or edema is present throughout upper extremities. Pt.'s ankles are slightly swollen with the presence of +1 pitting edema bilaterally. Pt. denies bone or joint pain. Pt. does not need support or assistance to stand, walk, ADLs, or with equipment. Pt. has a fall score of 10. The pt. is on bedrest with

	bathroom privileges but is not compliant.
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:**	Pt. is A & O x 3 and is oriented to person, place, and time. Pt. follows commands well. She has purposeful and equal strength/motor response throughout upper and lower extremities. The pt.'s speech is clear and pupils are equal, round, reactive, and accommodate to light. Pt. states she has a mild headache but denies feeling lightheaded or focal weakness. Deep tendon reflexes are 2+ throughout.
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):**	Pt. is a 30 y.o. African American woman. She lives with her boyfriend who is father to her newborn baby. Mother states she feels supported at home and has help from her mother, sisters, and husband. Pt. has her GED and does not appear to have any developmental concerns. Pt. states her and her boyfriend are Christian, and she feels strongly about her faith. Pt. is a current, every day smoker and smokes 0.25 packs per day. Pt. states she will have an alcoholic drink on occasion.
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	Pt. is a 30 y.o. female who presented as a G6T2P2A2L3 at 34 weeks and 2 days. The pt.'s pregnancy was complicated by preeclampsia. The pt. delivered a healthy baby girl on 09/09/2019 at 34 weeks and 3 days at 2000. The pt. had an artificial rupture of fetal membrane (AROM) and had a vaginal delivery. Estimated blood loss is 100mL. Apgar score is 9. Weight of newborn was 2175g. Mother is breastfeeding and is producing a good amount of output.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal 09/08/2019	**77**	**180/70**	**17**	**98.4**	**99**
Labor/Delivery 09/09/2019	**98**	**162/74**	**19**	**98.6**	**99**
Postpartum	**0730: 57**	**0730: 179/89**	**0730: 16**	**0730: 98.1**	**0730: 99**

09/11/2019		**1130: 139/72 (After BP meds given)**			

Vital Sign Trends: Pt. presented with preeclampsia and had a single episode of severe HTN upon arrival of ED and consistently elevated BPs since then. Pt. was given labetalol 200mg to get BP under control during labor. Postpartum blood pressures were consistently high, and pt. was prescribed Procardia 30mg to help with high blood pressure. Procardia 30mg was given with labetalol 200mg at 0900 and the pt.'s BP gradually improved.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	numeric scale	Right shoulder, pain, mild headache, and perineal area.	5/10	Right shoulder pain was "sharp" and perineum pain was "uncomfortable".	Pt. was told flatulence and BM would help with shoulder pain. Pt. was also given a stool softener. Ibuprofen and benzocaine menthol spray were given for perineum pain.
1130	numeric scale	Perineal area	3/10	"Uncomfortable"	Ibuprofen and benzocaine menthol spray was given for perineum pain.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV: Left arm median vein** **Date on IV: 09/11/2019** **Patency of IV: IV patent and flushes** **Signs of erythema, drainage, etc.: none** **IV dressing assessment: clean**	Pt. has a 20 gauge single lumen peripheral IV line dated 09/11/2019. It was placed in the median vein on the underside of the arm. Pt. denies pain at IV site. IV is patent, stable, and flushes easily. There is no presence of erythema, swelling, or drainage. IV is saline lock.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
500mL PO intake	**280mL urine output.**

Interventions (12 points)

Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. Provide pt. with education on uterine changes. Cramping and pains, especially while breastfeeding, are normal for the first few weeks of pregnancy. Explain to the pt. that their uterus is returning back to its normal size which can be painful and is considered a normal part of postpartum healing. Educate the pt. to monitor the fundus height on their abdomen, determine if it is midline, and palpate the abdomen to determine if the fundus is soft or firm. If it is soft, the pt. should massage the fundus. Pt. outcome: Pt. will monitor the fundus height and if it feels soft, the pt. will massage it. If it is not midline pt. will contact the care provider.

2. Educate the pt. on guidelines for frequency of feedings (Every 2-3 hours or at least 8 feedings per 24 hours). Pt. outcome: Pt. verbalized an understanding of the teaching.

Nursing Interventions (6 points)

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

Nursing Interventions: 1. Educate pt. on how to measure the fundus height, make sure its midline, and how to massage the fundus if it feels soft. The rationale for this is to educate the pt. on what is considered normal. If the pt. finds the fundus has deviated to the right or remains in the same spot, it may be indicative of health concerns such as a distended bladder or a bladder infection. 2. Assessing the pt.'s previous knowledge and experience with breastfeeding may help the nurse better understand their overall knowledge. The nurse can provide information on the most recent breastfeeding findings. The rationale for this is that assessing the pt. gives the nurse knowledge of the mother's experience. The pt. may benefit from current research findings.

Medical Treatments: Medical treatments may include massaging the mother's fundus or administering prescribed pain meds of needed. Medical treatments for breastfeeding may include showing the new mother optimal positions for breastfeeding and reminding her when to breastfeed.

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. Ineffective tissue perfusion related to vasoconstriction of blood vessels as evidenced by consistently elevated blood pressure.	The pt. is experiencing postpartum preeclampsia and has consistently elevated blood pressure. She had a single BP that was considered to be in the severe range. Pt is at risk for having a seizure, stroke, or developing a clot (Ricci, Kyle, and Carman, 2017).	**1.**Monitor the pt.'s vital signs, capillary refill, peripheral pulses, measure urine output, and weigh pt. daily. These interventions allow the nurse to monitor the pt.'s perfusion and other health status changes. Remind client of the importance of remaining on bedrest (Ricci, Kyle, and Carman, 2017). **2.**Encourage smoking cessation and provide education on the adverse effects of smoking. Educate pt. on how it negatively impacts perfusion and the overall health risks involved for both mom and newborn baby. Rationale for intervention is that smoking can cause	• Pt. partially met goals. Goals met include: Pt.'s blood pressure is below 140/90 by 1200 on day of assessment, urine output is up to 30mL/hr, absence of seizure episodes, negative Homan's sign, and decreased presence of lower extremity edema. Goal not met: Pt. is not compliant with bedrest status with bathroom privileges. • Pt. stated that she is aware of the adverse effects of smoking and is trying to cut back and eventually stop

		hypertension and issues with tissue perfusion.	smoking altogether.
2. Acute pain related to vaginal delivery of newborn as evidenced by swollen and reddened perineum, pt. complaints of 5/10 pain, and restlessness.	**Pt is on strict bedrest due to preeclampsia complications and consistently high blood pressure. Pt. states she is restless because she is in pain. Degree of pain can cause an increase in blood pressure and further put the pt. at risk.**	**1. Administering pain meds before pain gets to an unmanageable level. By managing the pt.'s pain, she will not be as restless and will be more compliant with the plan of care.** **2.Encourage frequent and proper hygiene of the perineum area. Also apply topical ointments and sprays to prevent infection and promote comfort. Adequate hygiene and providing pt. education on preventing infection can help promote overall health and alleviate symptoms quicker (Ricci, Kyle, and Carman, 2017).**	• **Goal met: Pt. will report pain to be a 3/10 before 1200 on day of assessment. Goal partially met: Pt. will be compliant with plan of care and remain on bedrest.** • **Pt. performed frequent peri care on herself and demonstrated proper technique in order to promote healing and prevent infection.**

Other References (APA):

Jones & Bartlett Learning. (2019). *2019 Nurse's Drug Handbook* (Eighteenth ed.). Burlington, MA: Jones & Bartlett Learning.

Kansky, C. (2019, February 2). Normal and Abnormal Puerperium. Retrieved from https://emedicine.medscape.com/article/260187-overview#a2

Moldenhauer, J. (2018, June). Postpartum Care - Gynecology and Obstetrics. Retrieved from https://www.merckmanuals.com/professional/gynecology-and-obstetrics/postpartum-care-and-associated-disorders/postpartum-care

Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing*. Philadelphia: Wolters Kluwer.

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	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	

years) • Drugs (how often and drug of choice) **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	All key components are	One of the key	Student did not complete	

• The main reason the patient was admitted **Secondary Diagnosis** • If the patient has more than one reason they are being admitted	filled in correctly. The student was able to identify the correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.	components is missing or not understood correctly.	this section and there is concern 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	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. • 2 APA references, essay is written in correct APA format. • Normal values should be listed for all laboratory data.	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.	
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	**10 points**	**1-9 points**	**0 points**	**Points**
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	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
	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.	

points in the section					
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		One assessment is	Student did not	

• Pain assessment was addressed and recorded twice throughout the care of this client • It was recorded appropriately and stated what pain scale was used	assessments) for this section and student has a good understanding of the pain assessment.	incomplete.	complete this 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	All of the key components of the intake and	One of the key components of the		

• 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.	output were addressed. Student demonstrates an understanding of intake and output.		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	All key components	One or more of the	More than 2 of the	

• List 2 nursing diagnosis
  o Include full nursing diagnosis with “related to” and “as evidenced by” components
• Appropriate nursing diagnosis
• Appropriate rationale for each diagnosis
  o Explain why the nursing diagnosis was chosen
• Minimum of 2 interventions for each diagnosis
• Rationale for each intervention is required
• Correct priority of the nursing diagnosis
• Appropriate evaluation
	were addressed. The student demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.	nursing diagnosis/rational/intervention sections was incomplete or not appropriate to the patient Each section is worth 3 points. Prioritization was not appropriate.	nursing diagnosis sections were 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%	

Revised 5/14/2019