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	Patient Initials	Age	Gender
9/30/19 at 0518	MB	27	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
caucasian	nurse	married	no known
Code Status	**Height**	**Weight**	**Father of Baby involved**
full code	1.651 m	77.1 kg	yes

Medical History (5 Points)

Prenatal History: gestational HTN, breech presentation, G1P0

Past Medical History: no medical history on file

Past Surgical History: wisdom teeth extraction

Family History: mother- thyroid disease, father- hypertension

Social History (tobacco/alcohol/drugs): never smoked, does not use smokeless tobacco, does not currently use alcohol, does not currently use drugs, is sexually active

Living Situation: lives with her husband at home

Education Level: Bachelor's degree in Nursing

Admission Assessment (12 points)

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Chief Complaint (2 points): scheduled cesarean section

Presentation to Labor & Delivery (10 points): 27 year/old patient came for a planned cesarean section that was scheduled due to her baby being in a breech position. The fetus was visualized with ultrasound and was vertex. The patient agreed to try and have a vaginal delivery. She received Cytotec, followed by Pitocin. She denied bleeding, leaking of fluid, denied contractions and had good fetal movement. Patient was anemic (Hgb 8.6)

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points): failure to progress in labor

Secondary Diagnosis (if applicable): Prolonged latent phase of labor, Gestational hypertension

Stage of Labor (20 points):

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

The patient came to the hospital for her scheduled cesarean delivery due to breech presentation of the fetus. The patient has also had gestational hypertension and therefore was a higher risk. After having an ultrasound, the presentation of the baby was a vertex, and the patient had a choice of labor induction. The patient received one dose of Cytotec. There was no cervical change, but after the first dose, she was contracting too regularly to administer any more medications. Foley bulb was attempted to be placed but was unsuccessful. The patient was started on oxytocin infusion and got up to 20, still with no cervical changes. A second attempt at a foley bulb insertion was performed, which was again unsuccessful. The Pitocin was turned off to see if the contractions would space out. Her contractions continued to be regular, and when the patient was given the option to restart the Pitocin or a c-section, and she opted for the primary cesarean delivery.

The patient presented to the labor and delivery floor when she was in the first stage of the delivery. During the first stage of delivery, the cervix begins to thin out and dilate to prepare for the passage of the baby's head and body (Ricci, Kyle, & Carman, 2017). The first stage usually lasts on average, 12.5 hours, and is separated into three phases: the latent phase, active phase, and the transition (The Signs and Stages of Labor, 2019). In the latent phase, the cervix dilates from 0 to 3 cm. Contractions are usually irregular and can last from 30 to 45 seconds. The time between contractions can

vary from 5 minutes to 30 minutes (Ricci, Kyle, & Carman, 2017). The patient did not have any contractions when she presented to the hospital and had her cervix was not effaced or dilated. After the Cytotec, she started contracting regularly without much break in between. Her contractions were not painful, which is typical for the beginning of the latent phase. Many times the contractions are so mild that the mother may not even realize she is in labor. The latent phase is the phase when mothers can decide to take pain medications (The Signs and Stages of Labor, 2019).

The second phase is called the active phase. The contractions become more regular and less spaced out. Contraction duration varies from 40 to 70 seconds, and they are usually between 3 to 5 minutes apart. The cervix effacement is rapid and is around 40-70% in this phase, and dilation is from 4 to 7 cm. (Ricci, Kyle, & Carman, 2017). The laboring mother may become increasingly more anxious and restless as the contractions increase in intensity and are more painful (The Signs and Stages of Labor, 2019). The mother can often feel hopeless and feel like the pain will never end (Ricci, Kyle, & Carman, 2017).

The last phase of the first stage of labor is called the transition. This stage is the most intense, and patients in this phase may feel like they cannot handle the process of labor any longer (Ricci, Kyle, & Carman, 2017). The cervix dilation is 8 cm at the beginning of the phase and progresses to being fully dilated at the end (10 cm). This phase is the shortest, usually lasting between 20 to 40 minutes. Patients may feel fatigued, irritable, and restless. Nausea and vomiting may occur as well (Ricci, Kyle, & Carman, 2017). Cervix is about 70% effaced at the beginning of this phase and is 100 % effaced in the end. At the end of this phase, the cervix is fully dilated and effaced, and the woman can start pushing (The Signs and Stages of Labor, 2019).

In the first stage of labor, the nurse will place an external fetal monitor to the mother’s abdomen that monitors the baby’s heart rate. The nurse will also apply a toco transducer that measures the uterine activity and shows the contraction pattern (Ricci, Kyle, & Carman, 2017). The nurse may have to access an IV catheter site to provide the patient with fluids before the patient can get an epidural anesthetic or analgesic medicine (Ricci, Kyle, & Carman, 2017). The nurse may perform a digital vaginal examination to assess cervical dilation and descent of the fetus through the birth canal. The nurse can also assess the fetal position and check if the membranes were broken (Ricci, Kyle, & Carman, 2017).

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

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

The Signs and Stages of Labor (2019). Retrieved from https://bayviewbehavioralhospital.com/hl/?/101232/The-Signs-and-Stages-of-Labor

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 10(9)/L (Laboratory Values)**	**4.67 10(9)/L**	**3.18 10(9)/L**	**2.84 10(9)/L**	
Hgb	**13-17 g/dL (men) 12-15 g/dL (women) (Laboratory Values:NCLEX-RN)**	**13.7 g/dL**	**8.6 g/dL**	**7.8 g/dL**	Low hemoglobin may be caused by recent surgery (Low Hemoglobin Count, 2019).
Hct	**40%-52% (men), 36%-47% (women) (Laboratory Values:NCLEX-RN)**	**39.2 %**	**25.9 %**	**23.3 %**	Low hematocrit may be caused by pregnancy, childbirth and surgery (Hematocrit. 2019) .
Platelets	**140-440 10(3)/L (Laboratory Values)**	**216 10(3)/L**	**177 10(3)/L**	**181 10(3)/L**	
WBC	**4-12 10(6)/L (Laboratory Values)**	**9.4 10(6)/L**	**11.6 10(6)/L**	**12 10(6)/L**	
Neutrophils	**40-68 % (Laboratory**	**72 %**	**70.7 %**	**81.3 %**	Recent surgery may increase neutrophil count (Understanding

	Values)				Neutrophils: Definition, Counts and More, 2019).
Lymphocytes	**19-49 % (Laboratory Values)**	**21 %**	**21.5 %**	**12.3 %**	Low lymphocyte levels may be caused by recent trauma (What is Lymphocytopenia, 2019).
Monocytes	**0-10% (Laboratory Values)**	**6 %**	**6.7 %**	**5.8 %**	
Eosinophils	**0-5% (Laboratory Values)**	**1 %**	**0.8 %**	**0.1 %**	
Bands	**<1 10(9)/L (Laboratory Values:NCL EX-RN)**	**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	**A,B,AB,0**	**0**	**0**	**0**	
Rh factor	**positive, negative**	**positive**	**positive**	**positive**	
Serology (RPR/VDRL)	**non-reactive**	**non-reactive**	**non-reactive**	**non-reactive**	
Rubella Titer	**positive (immune)**	**positive (immune)**	**positive (immune)**	**positive (immune)**	
Hgb & Hct	**Hgb: 13-17 g/dL (men) 12-15 g/dL (women) Hct: 40%-52% (men), 36%-47% (women) (Laborato**	**13.7 g/dL, 39.2 %**	**8.6 g/dL 25.9 %**	**7.8 g/dL 23.3 %**	Low hemoglobin may be caused by recent surgery (Low Hemoglobin Count, 2019). Low hematocrit may be caused by pregnancy, childbirth and surgery (Hematocrit. 2019).

	ry Values:NCLEX-RN)				
HIV	**non-reactive**	**non-reactive**	**non-reactive**	**non-reactive**	
HbSAG	**nonreactive**	**nonreactive**	**non-reactive**	**non-reactive**	
Group Beta Strep Swab	**negative**	**negative**	**negative**	**negative**	
Glucose at 28 weeks	**negative**	**negative**	**negative**	**negative**	
Genetic testing: if done	**low risk for chromosomal abnormalities**	**low risk for chromosomal abnormalities**	**low risk for chromosomal abnormalities**	**low risk for chromosomal abnormalities**	

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	**colorless-yellow, clear (Laboratory Values)**	**NA**	**NA**	**N/A**	
pH	**5.0-8.0 (Laboratory Values)**	**NA**	**NA**	**N/A**	
Specific Gravity	**1.003-1.033 (Laboratory Values)**	**NA**	**NA**	**N/A**	
Glucose	**neg (Laboratory Values)**	**NA**	**NA**	**N/A**	
Protein	**neg (Laboratory Values)**	**NA**	**NA**	**N/A**	
Ketones	**neg (Laborato**	**NA**	**NA**	**N/A**	

	ry Values)				
WBC	**neg (Laboratory Values)**	**NA**	**NA**	**N/A**	
RBC	**neg (Laboratory Values)**	**NA**	**NA**	**N/A**	
Leukoesterase	**neg (Laboratory Values)**	**NA**	**NA**	**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	**negative**	**N/A**	**N/A**	**N/A**	

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

Lab Correlations Reference (APA):

Hematocrit (2019). Retrieved from https://www.emedicinehealth.com/hematocrit_blood_test/topic-guide.htm

Laboratory Values (n. d.). Retrieved from https://annualmeeting.acponline.org/sites/default/files/shared/documents/for-meeting-attendees/normal-lab-values.pdf

Laboratory Values: NCLEX-RN (2019). Retrieved from

https://www.registerednursing.org/nclex/laboratory-values/

Low Hemoglobin Count (2019). Retrieved from

https://www.mayoclinic.org/symptoms/low-hemoglobin/basics/definition/sym-20050760

Understanding Neutrophils: Definition, Counts and More (2019). Retrieved from

https://www.healthline.com/health/neutrophils

What is Lymphocytopenia? (2018). Retrieved from https://www.healthline.com/health/lymphocytopenia

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM **Tracing**	**Your Assessment**
What is the Baseline (BPM) EFH?	**145**
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?**	**accelerations greater than/equal to 15 bpm, lasting 15 seconds- acceleration means that baby's heart rate increases 15 beats per minute (160 bpm).** **variability: moderate (amplitude range 6- 25 bpm)**
Are there decelerations, if so describe them. **What do these mean?** **Did the nurse perform any interventions with these?**	**absent** **decelerations are a decrease in fetal heart rate**

Did these interventions benefit the patient or fetus?	
Describe the contractions i.e. frequency, length, strength, patient's response.	**0**

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

7 different medications must be completed

Home Medications (2 required)

Brand/Generic	**Prenatal vitamins Iron Carbonyl-FA (Prenatal plus iron)**	**Ascorbic acid (Vitamin C)**	**Ferrous Sulfate (Iron)**		
Dose	**29-1 mg**	**500 mg**	**325 (65 Fe) mg**		
Frequency	**daily**	**daily**	**daily**		
Route	**PO**	**PO**	**PO**		
Classification	**vitamins, minerals**	**Vitamin**	**iron supplement**		
Mechanism of Action	**provide multiple vitamins during pregnancy**	**Restores the body pool of ascorbic acid**	**iron combines with porphyrin and globin chains to**		

			form hemoglobin		
Reason Client Taking	**proper development of fetus**	**as a dietary supplement**	**dietary supplement**		
Contraindications (2)	**hypersensitivity to any ingredients** **iron overload disorder**	**specific contraindications have not been determined**	**do not take within 2 hours of taking oral tetracycline antibiotics** **hemochromatosis**		
Side Effects/Adverse Reactions (2)	**diarrhea** **constipation**	**hemolysis, oxalate nephropathy**	**drug overdose** **gastrointestinal hemorrhage**		
Nursing Considerations (2)	**monitor bowel sounds** **assess bowel movements**	**monitor renal function** **monitor Hgb and blood counts**	**monitor for excessive bruising** **monitor for bleeding**		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**abdominal assessment,** **iron levels**	**Hgb, CBC, renal labs**	**Hgb, Hct, ferritin**		
Client Teaching needs (2)	**teach patient to expect dark stools** **take on empty stomach, swallow whole**	**side effects of an injection may include pain and swelling at the site**	**do not take with milk** **taking with vitamin C will increase absorption**		

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Hospital Medications (5 required)

Brand/Generic	**docusate sodium (Colace)**	**lactated ringer**	**ibuprofen (Motrin)**	**oxytocin (Pitocin)**	**simethicone (Mylicon)**
Dose	**100 mg**	**125 mL/hr**	**800 mg**	**60 mL/hr**	**80 mg**
Frequency	**BID**	**continuous**	**Q8**	**1 bag**	**Q4 after meals and nightly**
Route	**PO**	**IV**	**PO**	**IV**	**chewable PO**
Classification	**laxative, stool softener**	**volume expander**	**NSAID**	**uterine stimulant**	**antiflatulent**
Mechanism of Action	**actively draws water into the stool to achieve a bowel movement**	**Replenishes electrolytes and restores fluid .**	**inhibits prostaglandin synthesis**	**promotes uterine contractions by increasing intracellular concentration of calcium**	**Acts in vitro to lower the surface tension of gas bubbles.**
Reason Client Taking	**constipation**	**low Hgb**	**pain**	**to promote labor**	**decrease flatulence**
Contraindications (2)	**hypersensitivity, concomitant use of mineral oil**	**bleeding disorder** **liver disease**	**asthmatic reaction** **CABG surgery**	**fetal distress** **unfavorable fetal position**	**intestinal obstruction** **hypersensitivity**
Side Effects/Adverse Reactions (2)	**diarrhea, nausea**	**cardiac arrest, hypotension**	**hypotension, bleeding**	**nausea vomiting**	**diarrhea** **vomiting**
Nursing Considerations (2)	**monitor for rectal bleeding or absence of bowel movement**	**monitor fluid balance** **monitor liver function**	**monitor for bleeding** **monitor for s&s of CV events**	**monitor uterine activity** **check the fundus**	**monitor bowel sounds** **monitor for toxicity**

Key Nursing Assessment(s)/Lab(s) Prior to Administration	**monitor for bowel movement**	**renal assessment, coagulation status, hepatic function**	**Hgb & Hct** **renal function** **CMC, CMP**	**monitor fetal heart rate**	**abdominal assessment,** **bowel sounds**
Client Teaching needs (2)	**do not take if experiencing acute abdominal pain** **do not take longer than one week**	**report shortness of breath** **report feeling of dizziness**	**drug may cause fluid retention** **report s&s of bleeding promptly**	**this drug may cause nausea and vomiting**	**take between meals and at bedtime** **educate on side effects**

Medications Reference (APA): (2 points)

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

Physical Exam (20 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient alert and oriented x 4, in no apparent distress, appears well groomed and has proper hygiene
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score: 15 (low risk)**	Skin is pink, warm and dry. She is not diaphoretic. Patient exhibits no bruising or rash. Skin turgor is normal. Abdominal wound post surgery, dressing with some dried discharge noted

Drains present: Y☐ N **Type:**	
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head: Normocephalic and atraumatic. Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and EOM are normal. No scleral icterus. Ears: Skin is pink and moist, without lesions Neck: Normal range of motion. No tracheal deviation present. No jugular vein distention noted. Nose: No deviated septum, no polyps or lesions. Teeth: 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:**	Normal rate, regular rhythm and normal heart sounds. S1, S2 heard without gallops or murmurs. Capillary refill is rapid. Peripheral pulses are palpable throughout, +3. No cyanosis, mild edema in the extremities, +2
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N** **Breath Sounds: Location, character**	Effort normal and breath sounds normal. No respiratory distress. She has no wheezes. She has no rales, no shortness of breath or chest pain.
GASTROINTESTINAL (5 points): **Diet at home:** **Current Diet** **Height: 1.651 m** **Weight: 77.1 kg** **Auscultation Bowel sounds:**	Diet: regular Abdominal: Soft. Bowel sounds are normoactive. Last bowel movement was yesterday, normal semi-solid brown. The patient is passing gas. Abdomen is soft, non-distended and mild tenderness in the lower abdomen around the incision. No masses noted.

Last BM: **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Fundal Height & Position: U2, midline**	
GENITOURINARY (5 Points): **Bleeding: moderate** **Color:** **Character:** **Quantity of urine: 1600** **Pain with urination: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:** **Rupture of Membranes:** **Time: delivery time** **Color: clear** **Amount: moderate** **Odor: none** **Episiotomy/lacerations: N/A**	Urine is clear, yellow and without odor, no burning with urination, no pain.
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐**	Musculoskeletal: Normal range of motion. She exhibits mild edema in legs and feet. Negative for Holman's sign.

Fall Score: 15 (low risk) **Activity/Mobility Status:** **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:**	.The patient is oriented to person, place, and time. She appears well-developed and well-nourished. No distress, speech is normal. Neurological: She is alert and oriented to person, place, and time. No cranial nerve deficit. Deep tendon reflexes are brisk.
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 lives with her husband who is very involved with the care of the newborn. Patient is christian and goes to church regularly and has a substantial support system, consisting of her family, church family and friends. Patient likes to listen to music, cook or journal to relieve stress. Patient's parents live in town and her husband's parents live 50 miles away and see them often.
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date: 10/1/19** **Time: 0727** **Type (vaginal/cesarean): cesarean**	weight: 3080 g Apgars: 1min:8 5min:9

Quantitative Blood Loss: 1170 mL **Male or Female** **Apgars:** **Weight:** **Feeding Method: breastfeeding**	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**93**	**152/90**	**16**	**37.4**	**98%**
Labor/Delivery	**72**	**137/86**	**16**	**36.8 C**	**98%**
Postpartum	**94**	**128/78**	**20**	**36.8 C**	**95%**

Vital Sign Trends: Patient's blood pressure decreased to a normal range, her pulse fluctuated but returned back to nineties in the postpartum. her temperature slightly decreased and her oxygen saturation decreased in postpartum and respirations increased.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0815	**0-10**	**abdomen, incisional**	**5**	**soreness**	**around the clock pain control, quiet environment**
0615	**0-10**	**abdomen, incisional**	**5**	**aching**	**around the clock pain control, quiet environment**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	18 gauge
Location of IV:	Right cephalic vein
Date on IV:	09/30/19
Patency of IV:	patent
Signs of erythema, drainage, etc.:	none
IV dressing assessment:	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
3000	**2716**

Interventions (12 points)

Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. **Teaching about the proper latching when breastfeeding. I would use a lactation specialist to consult with the patient about education and responding to her concerns.**
2. **Teaching safety of a carseat. I would give patient handouts on car seat safety and policies. I would teach the client and her husband how to properly buckle the infant and would let them exhibit understanding by performing the correct technique.**

Nursing Interventions (6 points)

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

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Nursing Interventions: fundus assessment and assessment of bleeding, pain assessment

Rationale: To monitor discharge and blood loss or any change in status

Medical Treatments: Providing pain relief around the clock

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. Acute pain related to recent surgery as evidenced by patient complaining of pain	**Patient had a major abdominal surgery and has a significant incision that causes her pain and discomfort.**	**1. Assess the quality of pain - this is the first step in nursing assessment** **2. Acknowledge reports of pain immediately to provide prompt pain relief medication**	**The client responded well to nurse's actions, communicated very well and was able to describe the quality of her pain. Client responds well to pain medication.**
2. Impaired comfort related to acute pain as evidenced by patient walking around to relieve pain	**Patient seemed uncomfortable sitting in bed.**	**1. Assess the wound to monitor any drainage** **2. Teach patient how to properly use the abdominal binder to prevent dehiscence**	**Patient is compliant with teaching and follows nurse's education.**

		of the incision	

Other References (APA):

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Demographics	3 points	1.5 points	0 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**	
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) **Living situation** **Education level** ● If applicable to learning barriers	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	

Admission Assessment -Chief Complaint	2 points	1 point	0 points	Po
Chief complaint ● Identifiable with a couple words of what the patient came in	Chief complaint is correctly identified.	Chief complaint not completely understood.	No chief complaint listed.	

complaining of				
Admission Assessment- History	**10 points**	**6-10 points**	**0-5 points**	**Po**
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**	**Po**
Primary Diagnosis ● The main reason the patient was	All key components are filled in correctly. The student was able to	One of the key components is missing or not understood	Student did not complete this section and there is concern for lack of	

admitted **Secondary Diagnosis** ● If the patient has more than one reason they are being admitted	identify the correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.	correctly.	understanding the diagnosis.	

Stage of Labor	20 points	14-10 points	9-5 points	4-0 p
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 written in correct APA format.	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	Sect incompl sever factors Student have a unders of the s labor an correlat cli Section in APA with m of 2 ref (0 point giv

Laboratory Data	15 points	5-14 points	4-0 points	
Normal Values ● Should be obtained from the chart when	All key components have been addressed and the student shows an understanding of	1 or more of the client's labs were not reported completely with normal values or	Student did not have an understanding of laboratory values and the abnormalities.	

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	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.	patient results. Lab correlation did not completely demonstrate student's understanding of correlation.	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**	
Components of EFHM: ● Baseline ● Accelerations ● Variability ● Decelerations ● Contractions: frequency, duration, intensity ● Correlation of	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	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	Student did not have an understanding of EFHM and the abnormalities. Student did not have an APA reference listed.	

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	the client's particular disease process.	the disease process.		
Current Medications	**10 points**	**1-9 points**	**0 points**	
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	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.	

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				
Physical Assessment	**20 points**	**1-18 points**	**0 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
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.	Stude comp s
Pain Assessment	**2 points**	**1 point**	**0**
Pain assessment ● Pain assessment was addressed and recorded twice throughout the care of this client ● It was recorded appropriately and stated what pain scale was used	All the key components were met (2 pain assessments) for this section and student has a good understanding of the pain assessment.	One assessment is incomplete.	Stude comp s

IV Assessment	2 points	1 point	0 poin
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 th 1 aspe of the assessm t is missing studer did no comple this sectio

Intake and Output	**2 points**	**1-0 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 the intake and output is missing. Difficult to determi if the student has a thorou understanding of the intak and output.	
Nursing Care/Interventions	**12 points**	**2-0 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 nursin care was missing, therefore was difficult to determine the student had a thorou understanding of the nursi care.	
Nursing Diagnosis	**15 points**	**5-14 points**	**4-0 points**
Nursing Diagnosis ● List 2 nursing diagnosis o Include full nursing diagnosis with "related to" and "as evidence d by"	All key components were addressed. The student demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.	One or more of the nursing diagnosis/rational/inter vention sections was incomplete or not appropriate to the patient Each section is worth 3 points. Prioritization was not appropriate.	More than 2 of the nursing diagnosis sections were incomplete or inappropriate. Prioritization is dangerously inappropriate.

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				
Overall APA format	**5 Points**	**1-4 Points**	**0 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%		