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 **9/23/19 at 0748**	**Patient Initials** **AH**	**Age** **22**	**Gender** **F**
Race/Ethnicity **White**	**Occupation** **unemployed**	**Marital Status** **single**	**Allergies** **Amoxicillin and penicillin - anaphylaxis**
Code Status **Full code**	**Height** **156 cm**	**Weight** **51.4 kg**	**Father of Baby involved** **Yes**

Medical History (5 Points)

Prenatal History: gravida 4, para 3-0-0-3 @ 39 weeks 2 days

Past Medical History: anemia, asthma, normal pregnancy x 4

Past Surgical History: none

Family History: mother- asthma, diabetes mellitus, epilepsy, stroke. Father – heart disease. Grandfather (P) – heart disease.

Social History (tobacco/alcohol/drugs): denies alcohol use, denies substance abuse, never smoker

Living Situation: home with children and significant other, smoker in household

Education Level: high school

Admission Assessment (12 points)

Chief Complaint (2 points): Labor induction

Presentation to Labor & Delivery (10 points):.

Pt presents to L&D 39 weeks and 2 days gestation for elective induction due to maternal discomfort. Mother states feeling occasional contractions upon arrival. She denies any bleeding or fluid leakage. Pregnancy has been complicated by primary herpes outbreak in second trimester. Baby presented in non-vertex position, mom would like to proceed with external cephalic version.

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points): :Labor induction

Secondary Diagnosis (if applicable): N/A

Stage of Labor (20 points):

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

Stage 1:

Patient arrives to L&D at 0748 on 9/23/19 for elective induction. At 0830, neonate presented breech, successful external cephalic version completed. Pitocin started after version, artificial ROM at 2 cm with return of clear fluid. At 0850 pt was 2 cm dilated and 50% effaced, fetal station = -3 presenting vertex. At 1100 pt was 4 cm dilated and 75% effaced, fetal station = -3, compound presentation noted with hand on head, cervix was soft and posterior. At 1152 pt was 6 cm dilated and 90% effaced, station = -3 and cord presenting vertex. Cord prolapse noted at 6 cm indicating need for emergency cesarean section.

Stage 2:

Delivery of neonate via primary low transverse cesarean section @ 1211 on 9/23/19. Delivery occurred 104 minutes after ROM. Pt received epidural and general anesthesia with endotracheal intubation. Estimated blood loss = 800 mL, fluids replaced 2 L LR, Foley to gravity = 500 mL output. Viable male presented at 6 lbs 13 oz. Apgars 7 and 9.

Stage 3:

Placenta delivery occurred following neonate delivery at 1211.

N432 Care Plan and Grading Rubric
Stage of Labor References (2) (APA format):

Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing*. 3rd ed. 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	**3.8-5.41 M/uL**	3.65	3.47	3.34	Overall RBC's as well as hemoglobin and hematocrit are decreased related to the patient's diagnosis of anemia. These counts were at their lowest upon admission and at immediately after surgery due to significant blood loss (Van Leeuwen, & Bladh, 2017).
Hgb	**11-15.5 g/dL**	9.6	8.1	8.7	Overall RBC's as well as hemoglobin and hematocrit are decreased related to the patient's diagnosis of anemia. These counts were at their lowest upon admission and at immediately after surgery due to significant blood loss (Van Leeuwen, & Bladh, 2017).
Hct	**33.2%-45.3%**	28.2	25.4	26.9	Overall RBC's as well as hemoglobin and hematocrit are decreased related to the patient's diagnosis of anemia. These counts were at their lowest upon admission and at immediately after surgery due to significant blood loss (Van Leeuwen, & Bladh, 2017).
Platelets	**100- 400 K/uL**	254	218	176	
WBC	**4.8 – 10.8 K/uL**	7.2	12.4	10.5	WBC elevated upon patient's admit due to maternal stress relating to the onset of a complicated labor (Van Leeuwen, & Bladh, 2017).
Neutrophils	**45-80 %**	70.3	68.1	n/a	
Lymphocytes	**11.8-46 %**	13.8	19.6	n/a	
Monocytes	**4.4-12 %**	5.3	7.5	n/a	

Eosinophils	**0 – 6.3 %**	2.7	4.0	n/a	
Bands	**0-5 %**	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, O, AB	O	O	O	
Rh factor	(+) or (-)	(+), Positive	(+), Positive	(+), Positive	
Serology (RPR/VDRL)	Negative	Non-reactive			
Rubella Titer	Negative	(-), non-reactive			
Hct & Hgb	Hgb: 11-15.5 g/dL Hct: 33.2%-45.3%	9.6 28.2	7.1 22.5	8.7 26.9	Patient's HH are low due to blood loss during delivery. Pt had an estimated 800 mL of blood loss during emergency C-section. Pt also has PMH of anemia, suggesting pt's baseline HH is below reference range. Pt received 3 unites of PRBCs, and HH is trending up (Van Leeuwen, & Bladh, 2017).
HIV	Negative	(-)			
HbSAG	Negative	(-), non-reactive			
Group Beta Strep Swab	Negative	(+) Positive			Mom is a carrier of group B strep, and therefore shows a positive result on swab. Mom should be treated prophylactically with antibiotics during gestation and labor (Van Leeuwen, & Bladh, 2017).

Glucose at 28 weeks	73-83	113			Glucose reading high related to borderline gestational diabetes at 28 weeks (Van Leeuwen, & Bladh, 2017).
Genetic testing: if done	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	**Yellow / Clear**	**Straw/ clear**	**Yellow/ clear**	**N/A**	
pH	**4.5- 8**	**9.0**	**7.0**	**N/A**	Prenatal UA results (high pH, presence of ketones, ketones, and leukoesterase) are consistent with urinary tract infection, which was diagnosed (Van Leeuwen, & Bladh, 2017).
Specific Gravity	**1.005-1.025**	**1.005**	**1.012**	**N/A**	
Glucose	**< 130 mg/d**	**normal**	**normal**	**N/A**	
Protein	**< 150 mg/d**	**(-)**	**Not indicated**	**N/A**	
Ketones	**None**	**trace**	**Not indicated**	**N/A**	Prenatal UA results (high pH, presence of ketones, ketones, and leukoesterase) are consistent with urinary tract infection, which was diagnosed (Van Leeuwen, & Bladh, 2017).
WBC	**<2-5 /hpf**	**2**	**Not indicated**	**N/A**	Prenatal UA results (high pH, presence of ketones, ketones, and leukoesterase) are consistent with urinary tract infection, which was diagnosed (Van Leeuwen, & Bladh, 2017).

RBC	**< 2 /hpf**	**n/a**	**Not indicated**	**N/A**	
Leukoesterase	**Negative**	**1-**	**Not indicated**	**N/A**	Prenatal UA results (high pH, presence of ketones, ketones, and leukoesterase) are consistent with urinary tract infection, which was diagnosed (Van Leeuwen, & Bladh, 2017).

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**	**negative**	**n/a**	

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

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (3 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?	130
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 present, 15 x 15. This means that the fetal heart rate accelerated by 15 bpm for 15 seconds. There is moderate variability in the FHR.
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?**	Intermittent early decelerations to 110 bpm lasting 70 seconds each. Decels were category 1. Early decelerations indicate cord compression. Nurse continued to evaluate FHR for decelerations and repositioned mom as needed. At 6 cm, cord prolapse was evident and emergency C-section was indicated. All interventions taken were for benefit of the fetus.
Describe the contractions i.e. frequency, length, strength, patient's response.	Contractions were monitored with external tocotransducer, so strength is not documented. Frequency was q 1-2 minutes and duration was 60-80 seconds. Pt expressed great discomfort.

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

7 different medications must be completed

Home Medications (2 required)

Brand/Generic	Acyclovir Sitavig	Albuterol Accuneb	Ferrous sulfate Femiron	Vol-tab Mv-Mins No. 50-Iron	N/A
Dose	400 mg	90 mcg/inh	325 mg, 1 tab	1 tab	N/A

Frequency	BID	PRN	BID	Daily	N/A
Route	PO tablet	Inhalation powder	PO	PO	N/A
Classification	antiviral	Bronchodilator	antianemic	Multivitamin, prenatal	N/A
Mechanism of Action	interferes with viral DNA synthesis	Binds to beta2-adrenergic receptors in airway	Separated in bloodstream to become part of the body's iron stores	Supplement nutrient needs	N/A
Reason Client Taking	Primary herpes outbreak	Asthma	Anemia	Anemia, nutritional needs during pregnancy	N/A
Contraindications (2)	Hypersensitivity to drug Hypersensitivity to mil protein concentrate	Hypersensitivity to adrenergic amines Cardiac disease	Hemochromatosis Other types of anemia (non-iron deficient)	Hypersensitivity to drug Don't take with mineral oil	N/A
Side Effects/Adverse Reactions (2)	Seizures dizziness	Nervousness tremors	Seizures hypotension	Constipation diarrhea	N/A
Nursing Considerations (2)	Caution in pt w/ renal impairment Do not confuse Zovirax with Doribax, Zyvox, or Zostrix.	Caution use in pregos Geri population at higher risk for adverse effects	Use cautiously with peptic ulcers Use caution with alcoholism	Do not double up doses Caution with use of iron supplements	N/A
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor BUN and Cr Assess lesions	Observe for paradoxical bronchospasm Monitor serum	Assess patient for signs and symptoms of anaphylaxis	Monitor for allergic reaction Monitor serum iron levels	N/A

		potassium	Monitor HH		
Client Teaching needs (2)	Don't use OTC meds for lesions without consulting dr Educate them that this drug does not cure herpes, but prevents the spread to others	Tell doc if a canister is used in less than 2 weeks Take as directed by dr	Encourage high diet in iron Educate on s/sx of overdose/toxicity	Take on empty stomach 1-2 hours after meals Take with full glass of water	N/A

Hospital Medications (5 required)

Brand/Generic	Vistaril hydroxyzine	Pitocin oxytocin	Lidocaine 1% injection solution lidocaine hydrochloride	Lactated ringers	Heparin flush Hepalean
Dose	50 mg = 1 mL	20 units = 2 mL	100 mg = 10 mL	1000 mL	300 U = 3 mL
Frequency	Q3H PRN	On call	On call	Continuous infusion	As directed
Route	IM	IM	SubQ	IV drip	IV/flush
Classification	antianxiety	hormones	Antiarrhythmic Agent, Local anesthetic	Isotonic solution	Anticoagulant
Mechanism of Action	Depresses CNS	Stimulates uterine smooth muscle, producing uterine contractions	blocking nerve signals	Lactate ions are metabolized ultimately to carbon dioxide and water	inhibitory effect of antithrombin on factor Xa and thrombin
Reason Client	Anxiety	Labor induction	Labor induction,	Received epidural	Maintain

Taking			pain relief		patency of IV
Contraindications (2)	Hypersensitivity pregnancy	Hypersensitivity Anticipated nonvaginal delivery	Wolff-Parkinson-White syndrome Heart block	hypersensitivity to sodium lactate do not administer with cetirizine in infants younger than 28 days	Not for use in neonates Active uncontrolled bleeding
Side Effects/Adverse Reactions (2)	Drowsiness Dry mouth	Intracranial hemorrhage asphyxia	Bradycardia hypotension	Hyperkalemia Infusion site reactions	Heparin flush is not known to have adverse effects of any kind
Nursing Considerations (2)	Geri population more sensitive to SE Do not confuse hydroxyzine with hydralazine or Atarax (hydroxyzine) with Ativan (lorazepam)	Dilute appropriately for need Do not admin by more than one route at a time	Store at controlled room temperature Caution with other antiarrhythmic drugs and blood pressure meds	Caution with corticosteroid use Monitor volume status	Scrub the hub for 15 seconds Do not use if solution is not in a clear undamaged container

Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor level of sedation May cause negative skin test results	Fetal maturity, presentation,and pelvic adequacy should be assessed prior to administration of oxytocin for induction of labor Monitor electrolytes (K and Na)	Monitor blood pressure Monitor for respiratory depression	Monitor electrolytes Monitor IV site for phlebitis or infiltration	Assess for bleeding Monitor AST and ALT
Client Teaching needs (2)	Caution with use of other CNS depressants Geri population – fall precatuions	Educate pt to expect contractions similar to menstrual cramps Educate on SE	The local/target site(s) will become numb Feeling will return in a few hours	Report any coolness, swelling, warmth, or pain at IV site Report any chest pain or discomfort or SOB	Report any pain or burning at the IV site Educate them that this is not used for anticoagulant therapy, only IV patency

Medications Reference (APA): (2 points)

2019 Nurses drug handbook. (2019). Burlington, MA: Jones & Bartlett Learning.

SBLH reference manual within Cerner

Assessment (20 points)

Physical Exam (20 points)

GENERAL (0.5 point): **Alertness: full** **Orientation: evident** **Distress: none** **Overall appearance: calm**	Pt is A&O4. Pt does not appear to be in any extreme distress. Pt has a flat affect and is mostly quiet until spoken to. Overall appearance is calm.

INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score: 23** **Drains present: Y☐ N ☒** **Type:**	Skin color is appropriate for ethnicity, pink, warm, and dry. Turgor is elastic. No rashes, bruises, or wounds present. Closed surgical C-section wound, bound with sutures and derm. Dressing is clean and dry. Wound is healing well with no signs of infection. Wound is causing pt some mild discomfort, pain being managed with Tylenol and ice packs. 18 g peripheral IV present in right hand dated 9/23. IV is patent and shows no signs of infiltration or phlebitis.
HEENT (0.5 point): **Head/Neck: symmetry noted** **Ears: normal, intact** **Eyes: normal, PERRLA noted** **Nose: normal, patent** **Teeth: normal**	Head is symmetrical, facial symmetry noted. Pt's hearing is intact. Tympanic membrane pearly gray. Pt has no vision difficulties. PERRLA noted. Nasal turbinates visible, no evident septum deviation. No nasal polyps present. Oral mucosa is moist, pink, and intact.
CARDIOVASCULAR (1 points): **Heart sounds: S1 and S2** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): regular** **Peripheral Pulses: 3+** **Capillary refill: < 3 sec.** **Neck Vein Distention: Y ☒ N ☐ Edema Y ☐ N ☒** **Location of Edema: N/A**	Heart sounds auscultated x5, S1 and S2 noted at regular rate and rhythm. No murmurs, gallops, or rubs noted. Dorsalis pedis and radial pulses graded 3+ normal. Cap refill is normal at <3 seconds. No neck vein distention noted. Trace (1+) edema in lower extremities bilat.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒**	SpO2 100 on RA. Respiratory rate normal and breathing is unlabored. Breath sounds auscultated anteriorly x4 and posteriorly x7. All lung fields clear. Lung aeration is

Breath Sounds: Location, character	equal.
GASTROINTESTINAL (5 points): **Diet at home: regular** **Current Diet regular** **Height:** **Weight:** **Auscultation Bowel sounds: hypoactive** **Last BM: 9/22** **Palpation: Pain, Mass etc.: no pain or masses** **Inspection: normal** **Distention: none** **Incisions: closed, surgical** **Scars: none** **Drains: none** **Wounds: closed surgical wound from C-section. Wound appears to be healing well with no exudate, odor, or erythema.** **Fundal Height & Position:** **Prior to delivery = 37 cm, breech position**	Abdomen is rounded. BS hypoactive but pt reports passing flatus. Last BM was on 9/22. Pt presents no pain upon palpation. No masses, tubes, or drains present. No reports of nausea or vomiting from pt. A closed surgical wound across lower transverse abdomen from C-section. Wound appears to be healing well with no exudate, odor, or erythema. Prior to delivery fundal ht = 37 cm, breech position.
GENITOURINARY (5 Points): **Bleeding: none** **Color: yellow** **Character: clear** **Quantity of urine: fair** **Pain with urination: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:**	No bleeding, pain, burning, frequency, or urgency experienced with urination. Urine is yellow in color and clear. No catheter present. Artificial ROM occurred at 1027 on 9/23. Scant amount of clear fluid followed with no odor. No episiotomy or lacerations.

Size: **Rupture of Membranes: artificial** **Time: 1027 on 9/23/19** **Color: clear** **Amount: scant** **Odor: none** **Episiotomy/lacerations: none**	
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☐ N☒** **Fall Score: 20** **Activity/Mobility Status:** **Independent (up ad lib) X☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Morse scale: 20 Musculoskeletal strength is graded 5/5. Pt requires minimal assistance with ADLs and is up ad lib. Pt uses no assistive devices. Pt displays full active ROM.
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation: A&O 4** **Mental Status: normal cognition** **Speech: clear** **Sensory: no impairment** **LOC: alert** **DTRs: present**	Pt MAEW and PERLA noted. Pt A&Ox4. Strength is equal bilaterally. Cognition intact and appropriate for developmental level. Pt speaks English well and at a normal pace. Patient is cooperative but hesitant to care.
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s): none** **Developmental level: full**	Pt comes from home with children and significant other. Pt is not married, unemployed, and has completed high school as highest level of education. Pt

Religion & what it means to pt.: none preferred **Personal/Family Data (Think about home environment, family structure, and available family support): home w/ children and SO**	states no religion preferences.
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date: 9/23** **Time: 1211** **Type (vaginal/cesarean): cesarean** **Quantitative Blood Loss: 800 mL** **Male or Female- male** **Apgars: 7 and 9** **Weight:6 lbs 13 oz** **Feeding Method: bottle and mom is pumping**	Pt gave birth to a viable male at 1211 on 9/23/19 via emergency C-section. Newborn weighed 6 lbs 13 oz with apgars of 7 and 9. Mom's estimated blood loss during delivery is 800 mL. Mom is breast pumping and baby is bottle fed as of now.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	103	117/61	n/a (not documented in chart)	37C	98
Labor/Delivery	108	121/69	n/a (not documented in chart)	36.9C	97
Postpartum	112	102/54	28	36.1C	100

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numeric	Incision	4	Intermittent, with movement	Ice pack applied
1030	Numeric	Incision	3	Intermittent, with movement	Fresh ice pack applied, repositioned, Tylenol given

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 **Location of IV: Right hand** **Date on IV: 9/23** **Patency of IV: good** **Signs of erythema, drainage, etc.:** **IV dressing assessment: clear, transparent, dry and intact**	Pt has 18 g IV in right hand dated the 23rd. IV is patent and flushes well. No signs of phlebitis or infiltration. IV was removed during my shift on 9/25.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
N/A – not documented in chart	**N/A – not documented in chart**

Interventions (12 points)

Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. Care for incisional wound. I would demonstrate cleaning the wound and performing a dressing change. The next time, I would observe the patient performing her own wound care and dressing change to confirm that teaching was effective. The patient should have this routine down by the time of her discharge.

2. I would also teach the patient signs and symptoms of infection in her surgical wound. Evident redness, swelling, purulent drainage, and fever are all key indicators of infection and she should seek medical attention if any of these occur. I would provide a handout to the patient and provide her with resources on who to contact with further questions, as well as information on when she needs to seek medical attention. The patient should be able to state the signs and symptoms of infection to me by discharge, and vocalize what to do in the event that she experiences any of these signs or symptoms. Vocalization of this information will indicate effective teaching.

Nursing Interventions (6 points)

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

Nursing Interventions:

- Reposition client as needed, apply ice therapy, administer prescribed analgesics promote pt comfort/relieve pain
- Ambulate pt prevent pneumonia, DVT

Medical Treatments:

- follow up for surgical would promote wound healing
- follow up with primary assess postpartum healing
- Medication administration relieve pain, prevent infection

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with	• Explain why the nursing		• How did the client/family respond to

“related to” and “as evidenced by” components	diagnosis was chosen	Include a short rationale as to why you chose this intervention & cite the reference appropriately	the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain r/t C-section surgical incision AEB pt verbalizes pain and discofort	Pain is evident as stated by the patient.	1. Apply ice – numbs pain 2.administer prescribed analgesics- relieves pain	Pt reported decreased discomfort after ice application Pt reported decreased severity of pain after administration of Tylenol
2. Risk for infection r/t C-section surgical wound	Pt’s wound is at risk for infection if not cared for properly.	1. Provide proper wound care and dressing changes – prevent bacteria growth 2.Assess the site regularly for redness, swelling, drainage, or fever- catch infection early on to fight it off	Adequate wound care is provided. No signs of infection present. Incision assessed periodically by nurse, no signs of infection present. Seems to be healing well.

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2016). *All-In-One Nursing Care Planning Resource* (5 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%		