# N432 Care Plan #1

Lakeview College of Nursing

Daniel Camp

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** 10/4/2019 | **Patient Initials** CB | **Age** 22 | **Gender** Female |
|---|---|---|---|
| **Race/Ethnicity** African American | **Occupation** Works in office | **Marital Status** Not married Partner is Erin | **Allergies** NKDA |
| **Code Status** Full | **Height** 5'2 | **Weight** 91.2 kg | **Father of Baby involved** No |

## Medical History (5 Points)

**Prenatal History:** Patient has had a Cesarean section in the past for first kid. Patient had preeclampsia during this pregnancy. GBS and HIV are negative.

**Past Medical History:**.

- Preeclampsia
- Pericardial effusion
- Lupus
- Bipolar
- Papular atopic dermatitis

**Past Surgical History:**

- Cesarean section
- Pericardium Surgery

**Family History:** Sister has history of diabetes

**Social History (tobacco/alcohol/drugs):** Patient states they do not drink alcohol. Patient states they do not use tobacco. Patient states she used marijuana once a week in the past.

**Living Situation:** Lives at home with partner (Erin)

**Education Level:** High school level

## Admission Assessment (12 points)

**Chief Complaint (2 points):** Lupus flared up

**Presentation to Labor & Delivery (10 points):** Patient is a 22 year old female. Patient has preeclampsia during pregnancy. Patient did not find out they were pregnant till 30 weeks. Patient was dehydrated and had not eaten and this caused a lupus flare up. Patient went to the clinic after the flare up. The clinic sent her to the hospital. When she got to the hospital she was put on fetal heart monitoring. They did not like the look of baby's strip and was taken for a cesarean section.

## Diagnosis (2 points)

**Primary Diagnosis on Admission (2 points):** Cesarean Section

**Secondary Diagnosis (if applicable):** N/A

## Stage of Labor (20 points):

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

CB entered the fourth stage of labor once the placenta and membranes were out. In this stage the mother feels more relaxed, is awake and could talk more. The mother wants to hold and feed the baby as soon as possible in this stage (Ricci, Carman & Kyle, 2017). I saw the patient a couple days after this stage started but while we were there she was feeding and hold her baby throughout the day.

In the fourth stage the fundus should be firm and midline. The uterus should also be around the level of the umbilicus after the placenta is out (Ricci, Carman & Kyle, 2017). The patient was four days post delivery, her fundus was firm, midline and 1cm under the umbilicus. When we first did the assessment the fundus was to the right but the patient's

bladder was full. She emptied and we came back and checked again, it was midline. It is important to monitor the fundus and the patient during this stage to prevent hemorrhage (Hinkle & Cheever, 2014). If you are frequently monitoring and assessing the patient you can find early signs of hemorrhage and help fix it.

Vitals, vaginal discharge and the fundus are monitored every 15 minutes for the first hour. The mother could complain of being hungry or thirsty. During this time the mother could have limited feeling in her bladder not allowing her to control voiding (Ricci, Carman & Kyle 2017). While I was there, the patient was eating and drinking water. Patient was told to increase water intake. Patient was far enough and stables enough to do vitals every four hours. Patient complained of pain at the site of the incision on her abdomen.

After a Cesarean section it is normal for 1000 mL of blood to be lost. You need to monitor hemoglobin and hematocrit after this surgery and birth (Ricci, Carman & Kyle, 2017). The patient had a low hemoglobin and hematocrit throughout pregnancy and after the surgery. The day of birth she was at 10.6 for hemoglobin and 31.1 for hematocrit. The patient had to have two units of packed red blood cells to improve blood levels. Patient levels were even lower on the day of clinical. They were at 7.6 for hemoglobin and 21.5 for hematocrit. It would be important to keep monitoring these levels and look for signs of hemorrhage.

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

Hinkle, J. L., & Cheever, K. H. (2014). *Textbook of medical-surgical nursing* (13th ed.). Philadelphia, PA: Wolters Kluwer.

Ricci, S. S., Carman, S., & Kyle, T. (2017). *Maternity and pediatric nursing* (3rd ed.). Philadelphia, PA: Wolters Kluwer.

**Laboratory Data (15 points)**

**CBC Highlight All Abnormal Labs—Explanations must be in completes sentences and contains in-text citations in APA format.**

| Lab | Normal | Prenatal | Admissio | Today's | Reason for Abnormal Value |
|---|---|---|---|---|---|

| | Range | Value | n Value | Value | |
|---|---|---|---|---|---|
| **RBC** | 3.80-5.30 | 3.59 | 3.79 | 2.58 | It can be normal for pregnant women to become anemic, which could be why her levels are slightly lower at first. Patient a Cesarean section and with anemia could explain the low levels on clinical day (Pagana & Pagana, 2014, pg. 441). |
| **Hgb** | 12.0-15.8 | 9.8 | 10.6 | 7.6 | It can be normal for pregnant women to become anemic, low production of red blood cells can lead to lower hemoglobin levels (Pagana & Pagana, 2014, pg. 283) |
| **Hct** | 36-47 | 29.9 | 31.1 | 21.5 | It can be normal for pregnant women to become anemic, low production of red blood cells can lead to lower hematocrit levels (Pagana & Pagana, 2014, pg. 280). |
| **Platelets** | 140-440 | 281 | 322 | 224 | N/A |
| **WBC** | 4.0-12.0 | 5.4 | 9.1 | 10.4 | N/A |
| **Neutrophils** | 47.0-73.0 | 75 | 76 | N/A | Elevated levels can be from stress. The patient's two levels that were slightly elevated happened during pregnancy (Pagana & Pagana, 2014, pg. 532). |
| **Lymphocytes** | 18.0-42.0 | 12 | 12.9 | N/A | Lower levels can be caused by lupus. The patient does have lupus and had a flare up the day of birth (Pagana & Pagana, 2014, pg. 532). |
| **Monocytes** | 4.0-12.0 | 11 | 10.1 | N/A | N/A |
| **Eosinophils** | 0.0-5.0 | 1 | 0.3 | N/A | N/A |
| **Bands** | 1.0-5.0 | 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** | A, B, AB, O | O | O | O | N/A |

| | | | | | |
|---|---|---|---|---|---|
| **Rh factor** | +, -, none | - | - | - | N/A |
| **Serology (RPR/VDRL)** | Non-reactive | Non-reactive | Non-reactive | N/A | N/A |
| **Rubella Titer** | Immune | Immune | Immune | N/A | N/A |
| **Hct & Hgb** | 12.0-15.8 & 36-47 | 9.8 & 29.9 | 10.6 & 31.1 | 7.6 & 21.5 | It can be normal for pregnant women to become anemic, low production of red blood cells can lead to low levels of hemoglobin and hematocrit (Pagana & Pagana, 2014, pg. 283) |
| **HIV** | Non-reactive | Non-reactive | Non-reactive | N/A | N/A |
| **HbSAG** | Non-reactive | Non-reactive | Non-reactive | N/A | N/A |
| **Group Beta Strep Swab** | Negative | Negative | Negative | N/A | N/A |
| **Glucose at 28 weeks** | 70-140 mg/dL | N/A | N/A | N/A | N/A |
| **Genetic testing: if done** | N/A | 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** | Yellow and clear | N/A | Straw and clear | N/A | N/A |
| **pH** | 5.0-9.0 | N/A | 7.1 | N/A | N/A |
| **Specific Gravity** | 1.003-1.030 | N/A | 1.003 | N/A | N/A |
| **Glucose** | Normal-Negative | N/A | Negative | N/A | N/A |
| **Protein** | Negative-Normal | N/A | Negative | N/A | N/A |

| | | | | | |
|---|---|---|---|---|---|
| **Ketones** | Negative | N/A | Negative | N/A | N/A |
| **WBC** | 0-5 | N/A | 6-10 | N/A | High levels of white blood cells can show bacteria are in urine. This could be a sign of infection (Pagana & Pagana, 2014, pg. 971). |
| **RBC** | 0-2 | N/A | 0-2 | N/A | N/A |
| **Leukoesterase** | Negative | 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** | Negative | N/A | N/A | N/A | N/A |

| Other Tests | Normal Range | Prenatal Value | Admission Value | Today's Value | Reason for Abnormal |
|---|---|---|---|---|---|
| **Urine Creatinine** | 28-217 | N/A | 145 | N/A | N/A |
| **N/A** | N/A | N/A | N/A | N/A | N/A |
| **N/A** | N/A | N/A | N/A | N/A | N/A |

**Lab Correlations Reference (APA):**

Pagana, K. D., & Pagana, T. J. (2014). *Mosby's manual of diagnostic and laboratory tests* (5th ed.). St. Louis, MO: Elsevier Mosby.

**Electronic Fetal Heart Monitoring (20 points)**

| Component of EFHM<br><br>Tracing | Your Assessment |
|---|---|
| **What is the Baseline (BPM) EFH?** | |
| **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?**<br><br>**What is the variability?** | |
| **Are there decelerations, if so describe them.**<br><br>**What do these mean?**<br><br>**Did the nurse perform any interventions with these?**<br><br>**Did these interventions benefit the patient or fetus?** | |
| **Describe the contractions i.e. frequency, length, strength, patient's response.** | |

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

***7 different medications must be completed***

**Home Medications (2 required)**

| | | |
|---|---|---|
| **Brand/Generic** | **Ibuprofen / Advil** (Mosby's | **Acetaminophen / Tylenol** |

| | | |
|---|---|---|
| | 2019 nursing drug reference, pg. 639-641) | (Mosby's 2019 nursing drug reference, pg.9-11) |
| **Dose** | 800 mg | 975 mg |
| **Frequency** | Q8 hours | Q6 hours |
| **Route** | Oral | Oral |
| **Classification** | Antipyretic | Antipyretic |
| **Mechanism of Action** | Decreases pain and inflammation | Decreases pain and fever |
| **Reason Client Taking** | For incision pain | For abdominal pain |
| **Contraindications (2)** | Hypersensitivity<br>Acute GI bleed | Products that contain alcohol, aspartame<br>Anemia |
| **Side Effects/Adverse Reactions (2)** | GI bleeding<br>MI stroke | Renal failure<br>Steven Johnsons syndrome |
| **Nursing Considerations (2)** | Assess for pain level an hour after giving<br>Assess for rash | Assess health before giving<br>Assess frequency if patient is using at home |
| **Key Nursing Assessment(s)/Lab(s) Prior to Administration** | BUN and creatinine<br>Liver function | Monitor ALT and AST<br>Monitor BUN and Creatinine |
| **Client Teaching needs (2)** | Take with full glass of water<br>Taking with 3 or more alcohol drinks increases GI bleeding | May use when breastfeeding<br>Know signs of overdose (Bleeding, Bruising, Malaise, |

| | | |
|---|---|---|
| | risk | fever, sore throat) |

**Hospital Medications (5 required)**

| **Brand/Generic** | **Clindamycin / Cleocin** (Mosby's 2019 nursing drug reference, pg. 285-286) | **Ferrous Sulfate / Feosol** (Mosby's 2019 nursing drug reference, pg. 531-533) | **Simethicone / Gas-X** (Mosby's 2019 nursing drug reference, pg.1119) | **Gentamicin / Cidomycin** (Mosby's 2019 nursing drug reference, pg. 592-595) | **Docusate Sodium / Colace** (Mosby's 2019 nursing drug reference, pg.405-406) |
|---|---|---|---|---|---|
| **Dose** | 900 mg | 325 mg | 160 mg | 5 mg/kg<br>460 mg | 100 mg |
| **Frequency** | Q8 hours | Q8 hours | Q6 hours | Daily | BID |
| **Route** | IV | Oral | Oral | IV | Oral |
| **Classification** | Anti-infective | Antianemic | Antiflatulent | Anti-infective | Laxative |
| **Mechanism of Action** | Inhibits protein synthesis | Adds extra iron to the body | Allows passage of gas in GI tract | Inhibits protein synthesis | Increases water and allows for easier passing of stool |
| **Reason Client Taking** | Infection | Prevent iron deficiency | To pass gas | Infection | Help pass bowel movement s |
| **Contraindications (2)** | Ulcerative colitis<br>May get into breast milk | Non iron deficiency anemia<br>Hypersensitivity | Hypersensitivity<br>GI obstruction | Use cautiously in lactation<br>Hypersensitivity | Obstruction<br>Fecal impactment |
| **Side Effects/Adverse Reactions (2)** | Diarrhea<br>Hypotension | Dark stool<br>Constipation | No significant side effects | Ototoxicity<br>Vertigo | Throat irritation<br>Cramps |
| **Nursing Considerations (2)** | Monitor bowel | Assess diet<br>Assess bowel | Assess for abdominal pain | Assess for infection | Assess for abdominal |

| | | | | | |
|---|---|---|---|---|---|
| | movements<br><br>Get culture and sensitivity first | function and output | Assess bowel sounds | Monitor Intake and output | distention<br><br>Assess bowel sounds |
| **Key Nursing Assessment(s)/Lab(s) Prior to Administration** | Monitor WBC<br><br>Monitor ATL and AST | Monitor Hgb and Hct<br><br>Monitor iron levels | Assess frequency of burps and farts | Monitor Specific gravity, BUN, Creatinine<br><br>Monitor ALT and AST | Assess stool color<br><br>Monitor intake and output |
| **Client Teaching needs (2)** | Complete full dose<br><br>Take missed dose as soon as possible | Take liquid version with straw<br><br>Dark green or black stools are normal | Take with meals and at night<br><br>Teach it does not stop formation of gas | Drink plenty of fluids<br><br>Report hearing loss or vertigo | Use short term<br><br>Increase fiber in diet |

**Medications Reference (APA): (2 points)**

Skidmore-Roth, L. (2018). *Mosby's 2019 Nursing Drug Reference*. St. Louis, MO: Elsevier.

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

## Physical Exam (20 points)

| | |
|---|---|
| **GENERAL (0.5 point):**<br><br>**Alertness:**<br><br>**Orientation:**<br><br>**Distress:**<br><br>**Overall appearance:** | Patient was alert and oriented x4. Patient showed no signs of being distressed. Patient is up, answering question and feed the kid during the clinical day. Patient only complained of abdominal pain during the day. |
| **INTEGUMENTARY (2 points):**<br><br>**Skin color:** | Braden Score: 22<br><br>Patient states she is African American. Skin is pink, warm and dry. Skin is warm to touch. Skin turgor is normal. Capillary refill <2 assessed bilaterally in |

| | |
|---|---|
| **Character:**<br>**Temperature:**<br>**Turgor:**<br>**Rashes:**<br>**Bruises:**<br>**Wounds/Incision:** .<br>**Braden Score: 22**<br>**Drains present: Y☐ N ☐**<br>**Type:** | upper and lower extremities. No noted lesions or rashes. Patient has transverse abdominal incision. No drains. |
| **HEENT (0.5 point):**<br>**Head/Neck:**<br>**Ears:**<br>**Eyes:**<br>**Nose:**<br>**Teeth:** | Head is normocephalic. PERLA. EOMI. Trachea was midline with no deviations. Patient does not use glasses or hearing aides. Mouth was moist. No noted deviated septum. |
| **CARDIOVASCULAR ( 1 points):**<br>**Heart sounds:**<br>**S1, S2, S3, S4, murmur etc.**<br>**Cardiac rhythm (if applicable):**<br>**Peripheral Pulses:**<br>**Capillary refill:**<br>**Neck Vein Distention: Y ☐ N ☐ Edema Y ☐ N ☐**<br>**Location of Edema:** | Patient has regular rate and rhythm. No noted murmurs, gallops or rubs. Heart sounds auscultated x5. S1 and S2 heart sounds noted. Patient was not on telemetry. No noted neck vein distention. Radial and pedal pulses were +2 assessed bilaterally. Capillary refill was <2 and assessed bilaterally in upper and lower extremities. +1 edema bilaterally in lower extremities |
| **RESPIRATORY (1 points):**<br>**Accessory muscle use: Y☐ N ☐** | Lungs assessed bilaterally anterior and posterior during inspiration and expiration. No noted wheezes, crackles or rhonchi. No noted use of accessory muscles during respiration. Patient was on room air. |

| | |
|---|---|
| **Breath Sounds: Location, character** | Trachea was midline with no deviations. |
| **GASTROINTESTINAL (5 points):**<br>**Diet at home:**<br>**Current Diet**<br>**Height:**<br>**Weight:**<br>**Auscultation Bowel sounds:**<br>**Last BM:**<br>**Palpation: Pain, Mass etc.:**<br>**Inspection:**<br>**Distention:**<br>**Incisions:**<br>**Scars:**<br>**Drains:**<br>**Wounds:**<br>**Fundal Height & Position:** | Patient is on a regular diet. Patient is 157 cm tall and weighs 91.2 kg. Bowel sounds were present in all four quadrants. Patient stated some pain upon palpation. No noted tenderness upon palpation. Patient has transverse incision across abdomen. Incision was dry and intact. Fundus was midline and 1 cm below umbilicus. No noted distention, scars or drains. Last bowel movement was 10/09. |
| **GENITOURINARY (5 Points):**<br>**Bleeding:**<br>**Color:**<br>**Character:**<br>**Quantity of urine:**<br>**Pain with urination: Y ☐ N ☐**<br>**Inspection of genitals:**<br>**Catheter: Y ☐ N ☐**<br>**Type:**<br>**Size:**<br>**Rupture of Membranes:** | No noted bleeding. Patient stated urine was yellow in color. Denies pain during urination. No noted genital abnormalities. No catheter inserted. ROM was on 10/05/19 at 0207. Could not find amount or odor. No noted episiotomy or lacerations. |

| | |
|---|---|
| **Time:**<br><br>**Color:**<br>**Amount:**<br><br>**Odor:**<br><br>**Episiotomy/lacerations:** | |
| **MUSCULOSKELETAL (2 points):**<br><br>**ADL Assistance: Y☐ N ☐**<br><br>**Fall Risk: Y ☐ N☐**<br><br>**Fall Score:**<br><br>**Activity/Mobility Status:**<br><br>**Independent (up ad lib)** ☐<br><br>**Needs assistance with equipment** ☐<br><br>**Needs support to stand and walk**☐ | Patient is not a fall risk. Patient is up by herself. Patient walks well to restroom without assistance. Patient has active ROM in upper and lower extremities. 5/5 musculoskeletal strength in upper and lower extremities bilaterally. |
| **NEUROLOGICAL (1 points):**<br><br>**MAEW: Y ☐ N☐**<br><br>**PERLA: Y ☐ N☐**<br><br>**Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐**<br><br>**Orientation:**<br><br>**Mental Status:**<br><br>**Speech:**<br><br>**Sensory:**<br><br>**LOC:**<br><br>**DTRs:** | Patient was alert and orientated x4. MAEW. PERLA. Strength is equal bilaterally in upper and lower extremities. Patient has no mental deficits. No noted speech or sensory loss. Patient has active deep tendon reflexes. Patient was conscious during the clinical shift. |
| **PSYCHOSOCIAL/CULTURAL (1 points):**<br><br>**Coping method(s):**<br><br>**Developmental level:**<br><br>**Religion & what it means to pt.:** | Patient stated relaxing and watching TV helps her relax. Patient has normal developmental level for age. Patient did not state if she was religious. Patient has young son and has a partner helping with this kid. |

| | |
|---|---|
| **Personal/Family Data (Think about home environment, family structure, and available family support):** | |
| **DELIVERY INFO: (1 point) (For Postpartum client)**<br><br>**Delivery Date:**<br><br>**Time:**<br><br>**Type (vaginal/cesarean):**<br><br>**Quantitative Blood Loss:**<br><br>**Male or Female**<br><br>**Apgars:**<br><br>**Weight:**<br><br>**Feeding Method:** | Patient delivered on 10/05 at 0208. Patient had a cesarean section. Patient had a female child. Apgars were 9 at 1 minute and 9 at 5 minutes. Child weighed 2610 g at birth. Patient is using breast feeding as feeding method. |

**Vital Signs, 3 sets (5 points)**

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|---|---|---|---|---|---|
| Prenatal | N/A | N/A | N/A | N/A | N/A |
| Labor/Delivery | 81 | 142/89 | 18 | 97.9 | 96 % on room air |
| Postpartum | 93 | 128/74 | 16 | 98.1 | 100 % on room air |

**Vital Sign Trends:** Vital signs trend is normal. After pregnancy patient's blood pressure has returned to a normal level. Patient's heart rate was a little higher than before labor. The only non normal vital is the blood pressure during labor. Temperature, respiratory rate and oxygen saturation stayed around the same and are in the normal range.

## Pain Assessment, 2 sets (2 points)

| Time | Scale | Location | Severity | Characteristics | Interventions |
|---|---|---|---|---|---|
| 1450 | Numeric Scale | Abdomen | 5 | Dull | Ibuprofen |
| 1550 | Numeric Scald | Abdomen | 4 | Dull | No interventions taken |

## IV Assessment (2 Points)

| IV Assessment | Fluid Type/Rate or Saline Lock |
|---|---|
| **Size of IV:** 18 gauge<br>**Location of IV:** right wrist<br>**Date on IV:** 10/07<br>**Patency of IV:** Patent<br>**Signs of erythema, drainage, etc.:** No noted signs of erythema or drainage<br>**IV dressing assessment:** IV dressing was dry and intact | Saline lock |

## Intake and Output (2 points)

| Intake (in mL) | Output (in mL) |
|---|---|
| 490 mL | 1,100 mL |

## Interventions (12 points)

**Teaching Topics (6 points)**

***Include how you would teach the information & an expected outcome***

**1. Signs of bleeding**

- Bruising
- Pallor

- Nausea and Vomiting
- Blood in stool
- Outcome: knows signs of bleeding and will report to doctor or come in if they notice any

**2. Manage Pain**

- Take acetaminophen or ibuprofen
- Do not exceed daily limit
- Can be used while breast feeding
- Outcome: Patient keeps pain level at a four or below. Patient does not take more than daily allowed

**Nursing Interventions (6 points)**

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

**Nursing Interventions:**

- Keep abdominal binder on patient. Pressure will help keep patient comfortable
- Allow patient to move around as much as possible. Moving around can prevent embolism from forming

**Medical Treatments:**

- Give patient ibuprofen or acetaminophen for pain PRN. Patient stated pain at four or below was tolerable so we want to get to that level
- Give patient Ferrous Sulfate to help improve iron levels in body. Patient is anemic and iron will help raise red blood cell level.

**<u>Nursing Diagnosis (15 points)</u>**

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

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

| | | | |
|---|---|---|---|
| **1.** Risk for infection related to abdominal incision as evidence by elevated neutrophil level (Swearingen, 2016, p. 400) | Patient has an abdominal incision and elevated neutrophil level. This could be a sign of infection. This incision can make it easier for infection to get in the body | 1. Monitor Vitals. Monitor vitals will show us if the patient is showing signs of infection<br><br>2. Monitor WBC and neutrophil level. Monitoring these levels will show if there is an infection in the body. | Outcome was met. The patient vitals should no signs of infection. Temperature was normal at 98.1 degrees. We would still want to monitor the patient for infection for as long as the incision on the abdomen is open. |
| **2.** Activity Intolerance related to anemia as evidence by low RBC (Swearingen, 2016, p. 469) | Patient may get more tired doing everyday activities since there isn't enough blood carrying oxygen throughout the body. | 1. Monitor patients O2 saturation. This level shows how much oxygen is getting to extremities<br><br>2. Monitor Red blood cells, hemoglobin and hematocrit level. This shows how much of this is in the blood stream | Outcome was met. Patient O2 was at 100%. Patient also had a CBC and the rbc level was 2.58, Hgb was 7.6 and Hct was 21.5. These levels have dropped since admission. We would want to keep monitoring and maybe give packed red blood cells to patient. |

**Other References (APA):**

Swearingen, P. L. (2016). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, psychiatric nursing care plans*. St. Louis, MO: Elsevier/Mosby.

N305 Care Plan Grading Rubric: Labor Student Name:

| Demographics | 3 points | 1.5 points | 0 points | Points |
|---|---|---|---|---|
| **Demographics**<br>• Date of admission<br>• Patient initials<br>• Age<br>• Gender<br>• Race/Ethnicity<br>• Occupation<br>• Marital Status<br>• Father of baby involvement<br>• Allergies<br>• Code Status<br>• Height<br>• 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**<br>**Past Medical History**<br>• All previous medical diagnosis should be listed<br>**Past Surgical History**<br>• All previous surgeries should be listed<br>**Family History**<br>• Considering paternal and maternal<br>**Social History**<br>• Smoking (packs per day, for how may year)<br>• Alcohol (how much alcohol consumed and for how many years)<br>• 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**<br>**Education level**<br>• If applicable to learning barriers | | | | |

| **Admission Assessment -Chief Complaint** | **2 points** | **1 point** | **0 points** | **Points** |
|---|---|---|---|---|
| **Chief complaint**<br>• 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**<br>• Information is identified in regards to why the patient came to the hospital<br>• Utilization of OLD CARTS as appropriate<br>• Written in a paragraph form with no less than 5 sentences<br>• Information was not copied directly from the chart and no evidence of plagiarism<br>• Information specifically stated by the patient using their own words is in quotations<br>• 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**<br>• 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**<br>• 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**<br>• Professionally written essay in APA format outlined all aspects of the stage of labor the client is in during the student's care<br>• information is well written and no less than 1 page<br>• Signs/symptoms of the stage<br>• Expected findings related to the stage such as vital signs and laboratory findings<br>• How the stage of labor is identified<br>• Typical nursing interventions and treatments for the stage of labor<br>• Assessment findings that would suggest the client is progressing to another stage<br>• Listed clinical data that correlates to this particular client<br>• Plagiarism results in a zero in this section<br>• 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.<br><br>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**<br>• Should be obtained from the chart when possible as labs vary some. If not possible use laboratory guide.<br>• Normal values should be listed for all laboratory data.<br>**Laboratory Data**<br>• Admission Values<br>• Most recent Values (the day you saw the patient)<br>• Prenatal Values<br>**Rational for abnormal values**<br>• Written in complete sentences with APA citations<br>• Explanation of the laboratory abnormality in this client<br>• For example, elevated WBC in patient with pneumonia is on antibiotics.<br>• 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:**<br>• Baseline<br>• Accelerations<br>• Variability<br>• Decelerations<br>• Contractions: frequency, duration, intensity<br>• Correlation of EFHM to the client's diagnosis and condition.<br>• Interventions performed<br>• Normal values/expected values are listed<br>• 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.<br><br>Student did not have an APA reference listed. | |

| **Current Medications** | | | | |
|---|---|---|---|---|
| **Current Medications**<br>• Requirements of 5 inpatient hospital medications and 2 home medications—these must be 7 DIFFERENT medications<br>• Each medication must have brand/generic name<br>• Dosage, frequency, route given, class of drug and the action of the drug<br>• Reason client taking<br>• 2 contraindications must be listed<br>  o Must be pertinent to your patient<br>• 2 side effects or adverse effects<br>• 2 nursing considerations<br>• Key nursing assessment(s)/lab(s) prior to administration<br>  o Example: Assessing client's HR prior to administering a beta-blocker<br>  o Example: Reviewing client's PLT count prior to administering a low-molecular weight heparin<br>• 2 client teaching needs<br>• 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.<br><br>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<br>• Fall risk assessment<br>• Braden skin assessment<br>• **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**<br>• 3 sets of vital signs are recorded with the appropriate labels attached<br>• Includes a prenatal set, labor/delivery set, and postpartum set<br>• *If client has not delivered for a postpartum set, student is to list TWO vitals from labor and delivery*<br>• Student highlighted the abnormal vital signs<br>• 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<br>• 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**<br>• IV assessment performed and it is charted including what size of IV and location of the IV<br>• Noted when the IV was placed<br>• Noting any signs of erythema or drainage<br>• Patency is verified and recorded<br>• Fluid type and rate is recorded or Saline lock is noted.<br>• 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**<br>• Measured and recorded appropriately—what the patient takes IN<br>• Includes: oral intake, IV fluid intake, etc.<br>**Output**<br>• Measured and recorded appropriately—what the client puts OUT<br>• 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**<br>• List the nursing interventions utilized with your client<br>• Includes a rationale as to why the intervention is carried out or should be carried out for the client<br>**Teaching topics**<br>• List 2 priority teaching items<br>• 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**<br>• List 2 nursing diagnosis<br>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<br>• Appropriate nursing diagnosis<br>• Appropriate rationale for each diagnosis<br>o Explain why the nursing diagnosis was chosen<br>• Minimum of 2 interventions for each diagnosis<br>• Rationale for each intervention is required<br>• Correct priority of the nursing diagnosis<br>• 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**<br>• The student used appropriate APA in text citations and listed all appropriate references in APA format.<br>• Professional writing style and grammar was used in all narrative sections. | APA format was completed and appropriate.<br><br>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%** | | |