# 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**<br>**09/29/19** | **Patient Initials**<br>**CZ** | **Age**<br>**35** | **Gender**<br>**Female** |
| **Race/Ethnicity**<br>**Caucasian** | **Occupation**<br>**Stay at home mom** | **Marital Status**<br>**Single** | **Allergies**<br>**No known** |
| **Code Status**<br>**Full code** | **Height**<br>**5'4"** | **Weight**<br>**114.3kg** | **Father of Baby involved**<br>**No** |

## Medical History (5 Points)

**Prenatal History: No abnormal PAPS or STD's.**

**Past Medical History: Anemia**

**Past Surgical History: Wisdom tooth extraction**

**Family History: Hypertension on both mother and father's side and alcohol abuse from the father's side.**

**Social History (tobacco/alcohol/drugs): Never a smoker, does not currently drink alcohol, does not use drugs, and not sexually active.**

**Living Situation: Patient lives with her mother and her other children.**

**Education Level: High school diploma.**

## Admission Assessment (12 points)

**Chief Complaint (2 points):Contractions**

**Presentation to Labor & Delivery (10 points):Patient is a 35-year-old G4P2A0L4 female with IUP at 35 weeks with a due date of 11/1/2019 by ultrasound at 6 weeks. She is having contractions that started yesterday with pink discharge with her mucous plug. She came in since she felt she was in labor. She denies LOF. She states good fetal movement.**

## Diagnosis (2 points)

**Primary Diagnosis on Admission (2 points):Spontaneous labor**

**Secondary Diagnosis (if applicable):None**

## Stage of Labor (20 points):

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

**The patient was in the fourth stage of labor which is the last stage of labor. Since this is the last stage of labor the mother will not transition into another phase. The fourth stage of labor is identified 1-4 hours after the fetus and placenta have been delivered and recovery for the new mom is beginning. The most important aspect of this stage is to stabilize the mother by assessing her vital signs, palpating the fundus to make sure it is firm in order to prevent hemorrhage, assessing the lochia every 15 minutes and documenting urinary output after encouragement of voiding every time the urge is present. If the fundus is not firm the primary intervention is to massage gently until it becomes firm. The client is also encouraged to void every so often to prevent distension, the only problem with this can be lack of sensation. The nurse needs to assess the mother's capability of welcoming a new child into the home by assessing the mom's idea of baby-friendly activities.**

**The critical component of the fourth stage of labor is bonding the infant and the mother with skin to skin contact in order to build trust for the newborn child. When trust is built they are less likely to feel abandoned and mistrust the parents for not taking care of them. Once the child has contact with the mother feeding needs to be encouraged for the infant and then an enormous amount of rest is needed for the mother to have a healthy recovery when discharged. The signs and symptoms of this stage vary with moods after the delivery but, the mother typically has a sense of excitement and peace and is extremely social. The new mother may become increasingly hungry or thirsty which can be a sign or symptom of the new stage. The new mother may feel a**

**cramping pain in the fourth stage of labor which can be normal because of the uterus contracting. The primary treatment for new moms is to administer pain medication when feeling first signs of pain like oxytocin. The vital signs during this stage are beginning to decrease since the most traumatic aspect of pregnancy has ended. This is the period where vitals show the mom is beginning to relax. Temperature can decrease right after birth and can cause shivering in some new moms which can simply be treated with warm blankets. The expected labs can be a decrease in hemoglobin, hematocrit, and red blood cells due to recent loss of blood from birth.**

**This particular patient that I took care of had a laceration to the perineum which needed to be assessed frequently to make sure there is no signs of erythema or drainage. She was very fatigued after the birth of her two children the day after the delivery. Her labs were not drawn on the date of clinical therefore there is no correlation of what types of labs are similar for my patient to other postpartum mothers. The patient was hungry and thirsty but, desired more relaxing periods. Her vitals were stable throughout the day. The patient's fundus was not boggy therefore there was not an intervention of having to massage it. The fundus was midline and firm. The new mother spent a lot of her time visiting one of her twins in the NICU and the other in her hospital room.**

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

Berens, P. (2019). Up to Date. In *Overview of the postpartum period: Physiology, complications, and maternal care*. Retrieved from https://www.uptodate.com/contents/overview-of-the-postpartum-period-physiology-complications-and-maternal-care

Henry, N., McMichael, M., Johnson, J., DiStasi, A., Roland, P., Wilford, K., & Barlow, M. (n.d.). *RN Maternal Newborn Nursing* (10.0th ed., pp. 93-94). N.p.: ATI Nursing.

Ricci, S., Kyle, T. and Carmen, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Philadelphia: Lippincott, Williams & Wilkins. ISBN: 978-1-60913-747-2.

**Laboratory Data (15 points)**

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

-She did not have any labs drawn on the day of clinical.

| Lab | Normal Range | Prenatal Value | Admission Value | Today's Value | Reason for Abnormal Value |
|---|---|---|---|---|---|
| **RBC** | **3.80-5.30** | **3.94** | **4.20** | **N/A** | |
| **Hgb** | **12-15.8** | **10.5** | **13.5** | **N/A** | **Patient has a past medical history of anemia which results in the deficiency of hemoglobin.** |
| **Hct** | **36-47** | **33.1** | **39.1** | **N/A** | **Patient has a past medical history of anemia which results in the deficiency of hematocrit** |
| **Platelets** | **140-440** | **264** | **230** | **N/A** | |
| **WBC** | **4-12** | **11.8** | **16.70** | **N/A** | **Leukocytes during pregnancy can increase anywhere up to 15,000 or higher during labor and following delivery. This is due to the increased need of blood volume and hormonal response.** |
| **Neutrophils** | **47-73** | **77** | **79.5** | **N/A** | **Neutrophils act congruently with leukocytes therefore the neutrophils will be aiding in prevention of an attack from a foreign invader but, in this case it is normal for the mother's immune system to be increased because the body is preparing for birth and exposure of the fetus.** |
| **Lymphocytes** | **18-42** | **14** | **13.3** | **N/A** | **The decrease in lymphocytes in late pregnancy shows an alternative immune response in preparation of the fetus's arrival from the mother.** |
| **Monocytes** | **4-12** | **7** | **6.2** | **N/A** | |
| **Eosinophils** | **0.0-5.0** | **1** | **0.6** | **N/A** | |
| **Bands** | **0-1%** | **1** | **0.4** | **N/A** | |

**Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.**

-No labs were drawn per clinical date

| Lab Test | Normal Range | Prenatal Value | Admission Value | Today's Value | Reason for Abnormal |
|---|---|---|---|---|---|
| **Blood type** | **A/B/AB/O** | **AB** | **AB** | **N/A** | |
| **Rh factor** | **Positive** | **Positive** | **Positive** | **N/A** | |
| **Serology (RPR/VDRL)** | **Non-reactive** | **Non-reactive** | **Non-reactive** | **N/A** | |
| **Rubella Titer** | **Over 15**<br><br>**Immune** | **Immune** | **Immune** | **N/A** | |
| **Hct & Hgb** | **N/A** | **N/A** | **N/A** | **N/A** | **This was not drawn nor in the charts per documentation.** |
| **HIV** | **Negative** | **Not detected** | **Not detected** | **Not detected** | |
| **HbSAG** | **Non-reactive** | **Reactive** | **Reactive** | **N/A** | **A confirmatory test has to be ordered. The Hepatitis B virus can pose a serious threat to the infant at birth, therefore this has to be confirmed in order to determine the further precautions needed such as the vaccine at birth.** |
| **Group Beta Strep Swab** | **Negative/ Immune** | **Immune** | **Immune** | **N/A** | |
| **Glucose at 28 weeks** | **N/A** | **N/A** | **N/A** | **N/A** | **This was not ordered nor documented in any charts.** |
| **Genetic testing: if done** | **N/A** | **N/A** | **N/A** | **N/A** | **This test was not done.** |

**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** | **Clear-Yellow** | **Clear** | **Clear/yellow** | **N/A** | |
| **pH** | **N/A** | **N/A** | **N/A** | **N/A** | |

| | | | | | |
|---|---|---|---|---|---|
| **Specific Gravity** | **N/A** | **N/A** | **N/A** | **N/A** | |
| **Glucose** | **N/A** | **N/A** | **N/A** | **N/A** | |
| **Protein** | **0-12** | **N/A** | **12.8** | **N/A** | **This could be a potential urinary tract infection or it could be due to preeclampsia since her blood pressure was elevated along with the proteins in the urine.** |
| **Ketones** | **N/A** | **N/A** | **N/A** | **N/A** | |
| **WBC** | **N/A** | **N/A** | **N/A** | **N/A** | |
| **RBC** | **N/A** | **N/A** | **N/A** | **N/A** | |
| **Leukoesterase** | **N/A** | **N/A** | **N/A** | **N/A** | |

**Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.**

| Test | Normal Range | Prenatal Value | Admission Value | Today's Value | Reason for Abnormal |
|---|---|---|---|---|---|
| **Urine Culture** | **N/A** | **N/A** | **N/A** | **N/A** | |

| Other Tests | Normal Range | Prenatal Value | Admission Value | Today's Value | Reason for Abnormal |
|---|---|---|---|---|---|
| **No other tests were preformed** | | | | | |
| | | | | | |
| | | | | | |

**Lab Correlations Reference (APA):** CDC. (2018). Perinatal Transmission. In *Viral Hepatitis*. Retrieved from https://www.cdc.gov/hepatitis/hbv/perinatalxmtn.htm

DeMoranville, V. E. (2006). Encyclopedia of Surgery. In *Hematocrit*. Retrieved from https://www.surgeryencyclopedia.com/Fi-La/Hematocrit.html

Kumar, D. (2019). Doctor NDTV. In *Is a high WBC count during pregnancy harmful?*. Retrieved from https://doctor.ndtv.com/faq/is-a-high-wbc-count-during-pregnancy-harmful-15254

Preeclampsia foundation. (2019). In *Making sense of preeclampsia tests*. Retrieved from https://www.preeclampsia.org/history-of-preeclampsia/53-health-information/637-making-sense-of-preeclampsia-tests

Siegal, L., & Gleicher, N. (1981). Peripheral white blood cell alterations in early labor. *Pub Med*. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/7261863

## Electronic Fetal Heart Monitoring (20 points)

| Component of EFHM Tracing | Your Assessment |
|---|---|
| **What is the Baseline (BPM) EFH?** | **Normal range (110-160) 125 was the baseline.** |
| **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?** | **There were accelerations lasting 15 seconds with 15bpm above the baseline. The baseline had moderate variability. These accelerations are normal which means the baby is active and the heart rate is fluctuating. If the heart rate was not fluctuating there would be an enormous problem which could mean there is no fetal movement, and the baby is unstable.** |
| **Are there decelerations, if so describe them.**<br><br>**What do these mean?**<br><br>**Did the nurse perform any interventions with** | **There were decelerations that were prolonged variable which could mean chord compression with preparation of labor. When there is a chord compression, this means the baby is not receiving enough oxygen which requires an emergent response with the delivery of the fetus.** |

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| **these?**<br><br>**Did these interventions benefit the patient or fetus?** | **The nurse did not perform any interventions with these due to impending labor which means there was not a beneficial aspect of an intervention.**<br><br>**Reference:** Dildy, G. (2006). MDedge ObGyn. In *Management of prolonged decelerations*. Retrieved from https://www.mdedge.com/obgyn/article/62423/obstetrics/management-prolonged-decelerations |
| **Describe the contractions i.e. frequency, length, strength, patient's response.** | **The contractions were 60-90 seconds, TOCO in 10 minutes, frequency was 2-3 minutes, moderate to palpation with the patient breathing through contractions.** |

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

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

**Home Medications (2 required)**

| | | | | | |
|---|---|---|---|---|---|
| **Brand/Generic** | **Ascorbic acid/ Vitamin C/ Cebid** | **Ferrous sulfate/ Feosol.** | **N/A** | **N/A** | **N/A** |
| **Dose** | **500mg** | **325mg** | **N/A** | **N/A** | **N/A** |
| **Frequency** | **Daily** | **Daily** | **N/A** | **N/A** | **N/A** |
| **Route** | **Oral** | **Oral** | **N/A** | **N/A** | **N/A** |

| | | | | | |
|---|---|---|---|---|---|
| **Classification** | **Vitamins** | **Antiaenemics** | **N/A** | **N/A** | **N/A** |
| **Mechanism of Action** | **Collagen formation and tissue repair. Oxidation reduction reactions.** | **An essential mineral found in hemoglobin, myoglobin and many enzymes. Enters the bloodstream and is transported to the organs of the reticuloendothelial system.** | **N/A** | **N/A** | **N/A** |
| **Reason Client Taking** | **Anemia** | **Iron deficiency anemia** | **N/A** | **N/A** | **N/A** |
| **Contraindications (2)** | **Tartrazine hypersensitivity (only contraindication). Use cautiously with recurrent kidney stones and OB avoid chronic use of large doses in pregnant women.** | **Hemochromatosis, hemosiderosis, and hypersensitivity to iron products** | **N/A** | **N/A** | **N/A** |
| **Side Effects/Adverse Reactions (2)** | **Drowsiness, cramps, DVT, and pain at subcut or IM sites** | **Dizziness, nausea, constipation, and dark stools.** | **N/A** | **N/A** | **N/A** |
| **Nursing Considerations (2)** | **Assess for signs of vitamin C deficiency such as faulty bone, or bleeding gums. Assess for loose teeth and tooth development.** | **Assess nutritional status and dietary history to determine possible cause of anemia. Assess bowel function.** | **N/A** | **N/A** | **N/A** |
| **Key Nursing Assessment(s)/Lab(s) Prior to** | **Megadoses of ascorbic acid may cause false** | **Monitor hemoglobin, hematocrit, and** | **N/A** | **N/A** | **N/A** |

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| **Administration** | **negatives resulting from occult blood in the stool. Monitor serum bilirubin and urine oxalate, urate, and cysteine.** | **reticulocyte values prior to every 3 weeks during the first 2 months of therapy and periodically thereafter. Check for occult blood in the stool.** | | | |
| **Client Teaching needs (2)** | **Advise patient to take medication and not to exceed doses. Excess doses may lead to diarrhea and urinary stone formation. Encourage patient to comply with diet recommendations.** | **Explain purpose of iron therapy to patient. Encourage to take missed doses as soon as remembered within 12 hours. Do not double doses. Instruct patient to follow a diet high in iron.** | **N/A** | **N/A** | **N/A** |

**Hospital Medications (5 required)**

| **Brand/Generic** | **Hydrocortisone / Cortaid** | **Enoxaparin/ Lovenox** | **Citalopram/ Celexa** | **Ondansetron/ Zofran** | **Trazodone/ Oleptro** |
|---|---|---|---|---|---|
| **Dose** | **1%** | **40mg** | **20mg** | **4mg** | **200mg** |
| **Frequency** | **Every 6 hours PRN** | **Daily** | **Nightly** | **Every 6 hours PRN** | **Nightly** |
| **Route** | **Topical** | **Subcutaneous** | **Oral** | **IV** | **Oral** |
| **Classification** | **Corticosteroids** | **Anticoagulants** | **Antidepressant** | **Antiemetic** | **Antidepressants** |
| **Mechanism of Action** | **Suppress the inflammation and the normal immune response.** | **Potentiates the inhibitory effect of antithrombin on factor Xa and thrombin.** | **Selectively inhibits the reuptake of serotonin in the CNS.** | **Blocks the effects of serotonin at 5-HT3-receptor sites (selective antagonist)** | **Alters the effects of serotonin in the CNS.** |

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| | | | | **located in vagal nerve terminals and the chemoreceptor trigger zone in the CNS.** | |
| **Reason Client Taking** | **Hemorrhoids** | **Prevent blood clots or DVT** | **Anxiety/ Depression** | **Nausea** | **Anxiety/ Depression** |
| **Contraindications (2)** | **Active untreated infections, and hypersensity.** | **Hypersensitivity to enoxaparin or benzyl alcohol, and active major bleeding.** | **Hypersensitivity, concurrent use of MAO inhibitors, and concurrent use of pimozide.** | **Hypersensitivity, congenital long QT syndrome, and concurrent use of apomorphine.** | **Hypersensitivity, recovery period after MI, and angle-closure glaucoma.** |
| **Side Effects/Adverse Reactions (2)** | **Allergic contact dermatitis, atrophy or burning.** | **Edema, hyperkalemia, bleeding, and anemia.** | **Neuroleptic malignant syndrome, suicidal thoughts, and torsade de pointes.** | **Serotonin syndrome, and Stevens Johnson syndrome.** | **Suicidal thoughts, and hypotension.** |
| **Nursing Considerations (2)** | **Assess for rash, assess for pruritus, assess for signs of infection.** | **Assess for signs of bleeding and hemorrhage, monitor for patient for hypersensitivity reactions, and assess location and intensity of angina pain.** | **Assess for suicidal tendencies, and assess for serotonin syndrome.** | **Monitor ECG in patients with hypokalemia, and monitor for signs and symptoms of serotonin syndrome, and assess for rash.** | **Monitor BP and pulses, monitor ECG, assess for serotonin syndrome, and assess for suicidal tendencies.** |
| **Key Nursing Assessment(s)/Lab(s) Prior to Administration** | **Periodic adrenal function tests may be ordered to assess degree of hypothalamic-pituitary adrenal axis suppression in chronic topical therapy is suspected.** | **Monitor CBC, platelet, hematocrit, and aPTT.** | **Monitor electrolytes of potassium and magnesium.** | **Assess serum bilirubin, AST, and ALT levels.** | **Assess CBC and renal and hepatic function. Assess leukocyte and neutrophil counts.** |

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| | **Monitor glucose.** | | | | |
| **Client Teaching needs (2)** | **Instruct the patient on correct technique of medication administration with avoiding the eyes. Instruct patient to inform health care professional if symptoms of underlying disease return or worsen or if symptoms of infection develop.** | **Instruct patient in correct technique for self-injection, care, and disposal of equipment, and advise patient to report any symptoms of unusual bleeding or bruising.** | **Advise to avoid activities that require alertness until known effect of the medication due to CNS depression, and Advise to alert a health care professional of any suicidal tendencies such as thoughts of harming oneself.** | **Instruct patient to take ondansetron as directed, and advise patient to notify health care professional immediately if symptoms of irregular heartbeat, serotonin syndrome, or involuntary movements.** | **Advise patient to look for suicidal tendencies, and caution patient to change positions slowly to avoid orthostatic hypotension.** |

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

Davis, F. (2019). Up-to-Date Drug Information. In *Davis's Drug Guide Online*. Retrieved from https://www.drugguide.com/ddo/

**Assessment (20 points)**

**Physical Exam (20 points)**

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|---|---|
| **GENERAL (0.5 point):**<br>**Alertness:**<br>**Orientation:**<br>**Distress:**<br>**Overall appearance:** | **Patient is alert and oriented. No apparent signs of distress. Patient is fatigued upon observation. No signs of neurological deficit. Educationally and developmentally appropriate.** |

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|---|---|
| **INTEGUMENTARY (2 points):**<br>**Skin color:**<br>**Character:**<br>**Temperature:**<br>**Turgor:**<br>**Rashes:**<br>**Bruises:**<br>**Wounds/Incision:** .<br>**Braden Score:**<br>**Drains present: Y☐ N ☒**<br>**Type:** | **Patient's skin color was a light pink and dry. Patient's temperature was 97.8 degrees Fahrenheit at 1456. Patient had rapid skin turgor. No signs of rashes, bruises, wounds, incisions or drains present. Braden score was 23.** |
| **HEENT (0.5 point):**<br>**Head/Neck:**<br>**Ears:**<br>**Eyes:**<br>**Nose:**<br>**Teeth:** | **Head and neck are midline upon observation. Neck is supple. No thyromegaly or lymphadenopathy. TM is pearly grey bilaterally with no drainage. PERRLA. No polyps or lesions within the nasal cavity. Edementation present.** |
| **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:** | **S1 and S2 heard upon auscultation. No presence of murmurs or gallops. Regular rate and rhythm noted. Peripheral pulses were 2+ and strong upon palpation. Capillary refill was within 3 seconds. No presence of neck vein distension or edema.** |

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| **RESPIRATORY (1 points):**<br><br>**Accessory muscle use: Y☐ N ☒**<br><br>**Breath Sounds: Location, character** | **Patient has no increased work of breathing. Patient does not appear to be in distress. Denies any discomfort. Lung sounds are clear to auscultation. Respirations are regular in rate and depth. No indication of wheezes or rhonchi.** |
| **GASTROINTESTINAL (5 points):**<br><br>**Diet at home:**<br><br>**Current Diet**<br><br>**Height:**<br><br>**Weight:**<br><br>**Auscultation Bowel sounds:**<br><br>**Last BM:**<br><br>**Palpation: Pain, Mass etc.:**<br><br>**Inspection:**<br><br>**Distention:**<br><br>**Incisions:**<br><br>**Scars:**<br><br>**Drains:**<br><br>**Wounds:**<br><br>**Fundal Height & Position:** | **Patient's diet at home and current diet are regular. Patient is 5'4" and weighs 11.4kg. Bowel sounds are normoactive with her last bowel movement being 9/30. No mass or pain noted upon palpation. No distension, incisions, scars, drains or wounds present. Fundal height is 1cm below the umbilicus and firm without massage. Lochia is rubra, light amount less than 10cm. Perineum has a laceration that is second degree.** |
| **GENITOURINARY (5 Points):**<br><br>**Bleeding:**<br><br>**Color:**<br><br>**Character:**<br><br>**Quantity of urine:**<br><br>**Pain with urination: Y ☐ N ☒**<br><br>**Inspection of genitals:**<br><br>**Catheter: Y ☐ N ☒**<br><br>**Type:**<br><br>**Size:** | **The patient was able to void with ease with no pain during urination. The voids did not include blood, was a normal consistent yellow-clear color, with no presence of calculi. Patient voided 600mL. No presence of a catheter. No swelling or abnormalities of the genitals. Rupture of the membranes was at 7:04pm on 9/29. The rupture was pink in color with 55mL of drainage and no odor was present. Patient had a laceration into the perineum.** |

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| **Rupture of Membranes:**<br><br>**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: 0**<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 was able to perform all daily tasks on her own as well as self-care. The patient has a fall risk of 0 which determines her not to be a fall risk. Patient is up and lib without any ADL assistance.** |
| **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 is alert and oriented x4 with no appearance of distress. Patient has a bright mood with often feeling of fatigue. PERRLA and MAEW is noted with strength equal bilaterally and able to move all extremities. No sensory deficits were noted. Speech is clear and able to understand. No decrease in LOC. DTR is present.** |
| **PSYCHOSOCIAL/CULTURAL (1 points):**<br><br>**Coping method(s):**<br><br>**Developmental level:** | **Patient's mood was pleasant and accepting. She verbalized the way she copes with having 3 children and not being married is by her relationship with her mother. Her developmental level was appropriate for her age and education.** |

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| **Religion & what it means to pt.:**<br><br>**Personal/Family Data (Think about home environment, family structure, and available family support):** | **She is a Christian therefore she also copes by praying. Her home life is stable with living with her mother and her other children. Her mother supports her the most and aids in raising the children.** |
| **DELIVERY INFO: (1 point) (For Postpartum client)**<br><br>**Delivery Date: 09/29**<br><br>**Time: 7:04pm**<br><br>**Type (vaginal/cesarean): Vaginal**<br><br>**Quantitative Blood Loss:55mL**<br><br>**Male or Female: Female**<br><br>**Apgars: 3, 4, and 7**<br><br>**Weight: 2720gm**<br><br>**Feeding Method: breast** | **Client delivered on 09/29 at 7:04pm vaginally to a girl who weighed 2720gms with Apgar's 3,4, and 7 found. Quantitative blood loss results in 55mL. Mother will be feeding the infant breast milk.** |

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

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|---|---|---|---|---|---|
| Prenatal | **77** | **127/71** | **16** | **98.2** | **97** |
| Labor/Delivery | **102** | **130/85** | **18** | **97.9** | **99** |
| Postpartum | **75** | **123/64** | **18** | **97.8** | **95** |

**Vital Sign Trends: The vitals were the highest during labor due to the impending fetus's delivery. Vitals become enhanced when in more of an accelerated state. Vitals were stable throughout with an increase in blood pressure for this mother's normal during pregnancy and just after.**

## Pain Assessment, 2 sets (2 points)

| Time | Scale | Location | Severity | Characteristics | Interventions |
|---|---|---|---|---|---|
| **0734** | **1/10** | **generalized** | **tolerable** | **ache** | **ibuprofen** |
| **1456** | **1/10** | **general** | **tolerable** | **ache** | **Encouraged rest and fluids.** |

## IV Assessment (2 Points)

| IV Assessment | Fluid Type/Rate or Saline Lock |
|---|---|
| **Size of IV: 18**<br>**Location of IV: Cephalic Vein**<br>**Date on IV: 09/29/19**<br>**Patency of IV: Patent, flushed without difficulty.**<br>**Signs of erythema, drainage, etc.: No**<br>**IV dressing assessment: No drainage** | Location is in the cephalic vein on the lateral side of the arm on the right. No signs of erythema or drainage. IV is patent. Dressing is clean, dry, and intact. Size of the IV is an 18 gauge. Saline lock 250mL per hour 0.9 normal saline on continuous. |

## Intake and Output (2 points)

| Intake (in mL) | Output (in mL) |
|---|---|
| **250mL from the IV infusion, oral intake is 462mL.** | **655mL** |

## Interventions (12 points)

**Teaching Topics (6 points)**

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

**1. Infant safety is the number one concern with the child leaving the hospital. Teaching the mother ways in which to prevent the child from injury or harm would be a key teaching moment. I would teach in the form of a**

**discussion first then have the mother repeat back to me ways in which to keep her new child away from injury. Some ways of keeping the child free from injury would be placing safely in a bassinette with tall rails in order for the child not to fall out of the crib when stepping away. The expected outcome is for the mother to provide ways in which to protect her child from injury and no further hospitalizations to occur with the child being hurt or injured.**

**2. Infection prevention is another important part of caring for a new infant sense their immune system is weaker than a normal adult's. I would teach in a question and answer portion where the mom would ask how to prevent an infection from occurring and I provide ways in which to prevent an infection such as proper hand hygiene, or cleansing a wound with antibacterial soap. The expected outcome is for the mother to acknowledge steps in which to prevent an infection such as how to properly cleanse a wound or the importance of hand hygiene with no further hospitalizations for the infant being related to infections.**

**Nursing Interventions (6 points)**

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

**Nursing Interventions: Assessing vitals including pain every 4 hours, assess the laboratory data in order to see if she is recovering well, assess the location and height of the fundus with palpation. Vitals should be assessed every 4 hours to make sure the patient is stable. Pain is included in vitals which means the client needs to know when to alert the nurse of pain and it should be on the first sign of pain, not when in an enormous amount of pain. Assessing the location and the fundus after birth is essential to see if the fundus is soft of boggy and if it is boggy it needs to be massaged in order for it to stay firm. Preparing the mom for discharge is essential for the safety of her newborn child. The mother must be assessed to see if she is able to understand and learn the information of how to take care of her child after discharge in order to prevent injury to the child, to see if the mother and family understood all information a follow up visit to the primary care provider could be essential.**

**Medical Treatments: Pain medications are ordered as PRN in case of signs of pain from the mother.**

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

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

| Nursing Diagnosis<br>• Include full nursing diagnosis with "related to" and "as evidenced by" components | Rational<br>• Explain why the nursing diagnosis was chosen | Intervention (2 per dx)<br>Include a short rationale as to why you chose this intervention & cite the reference appropriately | Evaluation<br>• How did the client/family respond to the nurse's actions?<br>• Client response, status of goals and outcomes, modifications to plan. |
|---|---|---|---|
| **1. Fatigue related to stress as evidence by sleeping throughout the day.** | **The mother was increasingly fatigued due to the birth of twins. Patient's increase of stress is due to early labor with one neonate in the NICU. She slept primarily throughout the day.** | **1. Evaluate the patient's description of fatigue of severity, triggers, and alleviating factors.**<br><br>**Rational: This can help the patient determine the amount of fatigue experienced to see if this remains consistent or varies along the course of time.**<br><br>**2.Determine the cause of fatigue such as birth, anemia, or stress.**<br><br>**Rational: Recognizing the root cause can aid in determining the best course of action for the client.**<br><br>**Reference:** Wayne, G. (2016). Nurselabs. In *Fatigue*. Retrieved from https://nurseslabs.com/fatigue/ | **The patient identified the fatigue to be a level 8 out of 10 for severity due to stress related to the birth of her newborn children. She claims she is regularly fatigued due to her anemia therefore with being pregnant it was enhanced. The patient noted that laying down and sleeping aid in alleviating the fatigue. When the nurse recommended to take restful periods throughout the day the patient complied and verbalized that she will comply with this intervention at home and make a to do list of the top priorities that have to get done during the day and save the rest of the tasks for days to come to plan for the most energetic parts of the day to be filled with accomplishing goals. The goal was to teach the patient ways in which to decrease her fatigue and the outcome was positive in which the client identified how to decrease her fatigue. No modifications needed.** |
| **2. Sleep pattern disturbed related to** | **Patient was unable to sleep consistently** | **1. Assess blood pressure**<br><br>**Rational: blood pressure is** | **The goal for the patient is to obtain an optimal amount of sleep as** |

| | | | |
|---|---|---|---|
| **environmental variations such as hospitalization as evidence by verbalizing difficulty to fall asleep.** | **throughout her times of rest.** | **affected by sleep therefore it can be raised when sleep disturbed**<br><br>**2.Provide a quiet environment that aids in sleeping**<br><br>**Rational: A quiet environment relaxes the client and promotes sleep without disturbances.**<br><br>**Reference:** Wayne, G. (2019). Nurselabs. In *Insomnia*. Retrieved from https://nurseslabs.com/insomnia/ | **evidence by a rested appearance and verbalizing the feeling of increased energy and able to sleep throughout the night and able to have a stable sleeping pattern. The patient allowed the nurse to obtain the blood pressure every 4 hours to assess for hypertension. The client verbalized being in a quiet space with no visitors helps in promoting relaxation. The client complied with the interventions and asked for other ways of promoting sleep.** |

**Other References (APA):** Belleza, M. (2016, May 31). Nurse labs. In *Postpartum Care*. Retrieved from https://nurseslabs.com/postpartum-care/

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 | |

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|---|---|---|---|---|
| **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. | |

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| **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%** | | |