N432 Care Plan #2

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 10/14/19 2100	**Patient Initials** EB	**Age** 28	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Real Estate Agent	**Marital Status** Married	**Allergies** No known drug allergies
Code Status Full Code	**Height** 5' 2"	**Weight** 181 lb	**Father of Baby involved** Yes

Medical History (5 Points)

Prenatal History: G1P0, 38 weeks 3 days, Gestational hypertension, no previous pregnancies

Past Medical History: GERD

Past Surgical History: Incision and drainage of spider bite on back

Family History: Father has diabetes

Social History (tobacco/alcohol/drugs): Patient is a current smoker and smokes 0.25 packs/day. Patient is not currently using alcohol or drugs.

Living Situation: Patient lives with husband.

Education Level: Patient has a bachelor's degree.

Admission Assessment (12 points)

Chief Complaint (2 points): Pelvic pain

Presentation to Labor & Delivery (10 points): Patient is a 28-year-old G1P0 female at 38 weeks here for pubic synthesis dysfunction. Patient stated that on the night of 10/09 she woke up and was not able to move. It took her to hours to get out of bed with assistance. When the patient was admitted, she could only walk in a very slow shuffle. She cannot get into bed herself and it takes a lot of assistance from her husband to get out of bed. She reports abdominal cramping for the past 2 days on top of the pelvic pain. Patient currently rates her pain 10/10.

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points): Gestational Hypertension

Secondary Diagnosis (if applicable): N/A

Stage of Labor (20 points):

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

While I was talking care of my patient, she was in the first stage of labor. The first stage of labor focuses on the progressive dilation of the cervix. There are three phases of the first stage of the labor. My patient was in the latent phase. This phase begins with the start of regular contractions and ends when rapid cervical dilation begins. Signs and symptoms of the first stage of labor are pain feeling like menstrual cramps, the patient is very talkative. Patients are usually excited about their pregnancy during this stage. This stage of labor is identified by checking the patient's cervix and seeing how many centimeters she is dilated. If the patient is between 0-3 cm dilated, the patient is in the latent phase. Effacement is also checked, and if the patient has cervical effacement of 0-40%, she is in the latent phase Contractions usually occur every 5 to 10 minutes, lasting 30 to 45 seconds (Ricci, Carman & Kyle, 2017).

It is important to make the patient feel as comfortable as possible during the latent phase. If this is the patient's first time having a child, it is important for the nurse to explain this stage of labor and inform her that if she has any questions to ask them. The nurse should educate the patient about different relaxation techniques. If the patient does not have any complications, or has not received an epidural, she can walk around and still be active during this phase. If she has received an epidural, it is important that she stays on bedrest, and catheter should be placed. The nurse should also educate the patient on other information regarding her pregnancy such as breastfeeding, newborn care, and effective bearing down while pushing. This should be taught at this time because the patient is her most relaxed and not in an excruciating amount of pain (Tabangcora, Tabangcora, & Dawn, 2017)

The patient's cervix was 2.5 centimeters dilated when I left. The patient has cervical effacement of 80%. Her contractions were mild to palpation. She was in pain during her contractions, and right before I arrived, she received an epidural. After having the epidural, she was not in pain anymore and decided to take a nap for a little while. After the latent phase, the patient goes into the active phase. The latent stage ends when the patient's cervix is 4 centimeters dilated. When rapid cervical dilation begins, that is also when the patient is going into the active phase (Ricci, Carman & Kyle, 2017).

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

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

Tabangcora, I. D., Tabangcora, I. D., & Dawn, I. (2017, January 18). Stages of Labor: Nursing Care Tips for Various Stages. Retrieved from https://nurseslabs.com/stages-of-labor/#Latent-Phase.

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	3.80-5.30	N/A	3.20	N/A	Women who are pregnant are at a high risk for developing anemia. They may not be getting enough iron, folic acid, or vitamin B12. This is the cause of the low red blood cells (Pagana & Pagana, 2014).
Hgb	12.0-15.8	13.5	8.8	N/A	Women who are pregnant are at a high risk for developing anemia. They may not be getting enough iron, folic acid, or vitamin B12. This is the cause of the low red blood cells (Pagana & Pagana, 2014).
Hct	36.0-47.0%	40.8%	36.8%	N/A	N/A
Platelets	140-440	276	307	N/A	N/A

WBC	4.00-12.00	N/A	12.90	N/A	White blood cells can be increased in pregnancy from all the stress. This is the cause of the increase in white blood cells (Pagana & Pagana, 2014).
Neutrophils	4.70-73.0%	N/A	80.5%	N/A	Neutrophils are usually increased during pregnancy. This is the cause of the increase in neutrophils (Pagana & Pagana, 2014).
Lymphocytes	18.0-42.0%	N/A	10.2%	N/A	Low lymphocytes in pregnancy is normal. The body sees the embryo as foreign and lymphocytes decrease in response. This is the cause of the low lymphocyte count (Pagana & Pagana, 2014).
Monocytes	4.0-12.0%	N/A	7.0	N/A	N/A
Eosinophils	0.0-5.0%	N/A	1.7	N/A	N/A
Bands	Less than 3%	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	N/A	N/A
Rh factor	+, -	-	-	N/A	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	Hgb= 36.0-47.0% Hgb= 12.0-15.8	Hct= 40.8% Hgb= 13.5	Hct= 36.8% Hgb= 8.8	N/A	Women who are pregnant are at a high risk for developing anemia. They may not be getting enough iron, folic acid, or vitamin B12. This is the cause of the low red blood cells (Pagana & Pagana, 2014).
HIV	Negative	Negative	Negative	N/A	N/A
HbSAG	Negative	Negative	Negative	N/A	N/A
Group Beta Strep Swab	Negative	Negative	Negative	N/A	N/A
Glucose at 28 weeks	<140	135	N/A	N/A	N/A
Genetic testing: if done	N/A	N/A	N/A	N/A	N/A

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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	N/A	N/A	N/A	N/A
pH	5.0-8.0	N/A	N/A	N/A	N/A
Specific Gravity	1.005-1.035	N/A	N/A	N/A	N/A
Glucose	Normal	N/A	N/A	N/A	N/A
Protein	Negative-Normal	N/A	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A	N/A
WBC	<5	N/A	N/A	N/A	N/A
RBC	0-3	N/A	N/A	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	No growth	N/A	N/A	N/A

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

Revised 8/18/2019

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 Tracing	Your Assessment
What is the Baseline (BPM) EFH?	The baseline EFH is 120 BPM.
Are there accelerations, if so describe them and explain what these mean i.e. how high do they go and how long do they last? **What is the variability?**	There are accelerations that are greater than or equal to 15 bpm. They are lasting at least 15 seconds with moderate variability. Moderate variability means that these accelerations are within 6-25 BPM from the baseline.
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?	Decelerations are absent.
Describe the contractions i.e. frequency, length, strength, patient's response.	The contractions duration are 60-90 seconds. The contractions frequency is 3-4 minutes. The contractions intensity is mild by palpation. The patient has an epidural, so she cannot feel her contractions.

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

Home Medications (2 required)

Brand/Generic	Omeprazole/Prilosec (*Nurse's*, 2018)	Prenatal Vit-Fe Fumarate/ Prenatal Vit-Iron Fum-Folic Ac (*Prenatal*, 2019)
Dose	20 mg	27 mg
Frequency	Daily (*Nurse's*, 2018)	Daily (*Nurse's*, 2018)
Route	PO	PO
Classification	Proton Pump Inhibitor	Multivitamin
Mechanism of Action	Interferes with gastric acid secretion by inhibiting the H+ K+ -ATPase enzyme system in gastric parietal cells.	A diverse group of compounds necessary for normal growth and development. Many act as coenzymes or catalysts in numerous metabolic processes.
Reason Client Taking	To treat GERD	Prevent vitamin deficiency
Contraindications (2)	Concurrent therapy with rilpivirine containing products Hypersensitivity	Hypersensitivity Iron overload disorder
Side Effects/Adverse Reactions (2)	Anemia Flatulence	Constipation Upset stomach
Nursing Considerations (2)	Give before meals, preferably in the morning	Take medication at same time each day
Reason Client Taking	To prevent vomiting related to pregnancy	To induce labor
Contraindications (2)	Concomitant use of apomorphine Congenital long QT syndrome	Hypersensitivity Take on empty stomach
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Know that drug can interfere with absorption of vitamin B12 Monitor the patient's magnesium	Anticipated nonvaginal delivery Monitor iron levels Monitor vitamin B12 levels
Side Effects/Adverse Reactions (2)	Restlessness Flushing	Hypotension Painful contractions
Client Teaching needs (2)	Avoid alcohol, aspirin, ibuprofen, and foods that increase gastric secretions	Maintain a well-balanced diet
Nursing Considerations (2)	Monitor patient closely for serotonin syndrome Females of childbearing age should inform prescriber immediately if	Monitor maternal BP and pulse frequently and Avoid taking antacids, dairy products, tea, or coffee within 2 hours before or after taking medications

Hospital Medications (5 required)

Brand/Generic	Ondansetron/ Zofran (*Nurse's*, 2018)	Oxytocin (Pitocin) (*Nurse's*, 2018)	Misoprostol (Cytotec) (*Nurse's*, 2018)	Methylergonovine (Methergine) (*Nurse's*, 2018)	Dinoprostone (Cervidil) (*Nurse's*, 2018)
Dose	4 mg	1-20 milliunits/min	25 mcg	200 mcg	10 mg
Frequency	Every 6 hours PRN	Continuous	Every 4 hours	Every 2 hours PRN	Once
Route	PO	IV	Vaginal	IM	Vaginal
Classification	Antiemetic	Oxytocic	Prostaglandin	Oxytocic	Oxytocic
Mechanism of Action	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine. This action reduces nausea and vomiting.	Stimulates uterine smooth muscle, producing uterine contractions similar to those in spontaneous labor.	Acts as a prostaglandin analogue, decreasing gastric acid secretion and increasing the production of protective mucus Causes uterine contractions.	Directly stimulates uterine and vascular smooth muscle to create contractions.	Produces contractions similar to those occurring during labor at term by stimulating the myometrium. Initiates softening, effacement, and dilation of the cervix.
Reason Client Taking	Concurrent therapy with rilpivirine containing products	To induce labor	Cervical ripening	Stimulate uterine contractions	Cervical ripening
Contraindications (2)	Hypersensitivity	Hypersensitivity	Hypersensitivity Prevent NSAID induced gastric injury	Hypersensitivity To induce labor	Previous cesarean section Traumatic delivery or difficult labor
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor the patients	Monitor the patients	Monitor uterine cramping and bleeding	Assess for signs	Patient should remain supine for 15–30 min after
Side Effects/Adverse Reactions (2)	Restlessness Flushing	Hypotension Painful contractions	Headache Dyspepsia	Tinnitus Chest pain	Vaginal/ uterine pain Uterine rupture
Client Teaching needs (2)	Avoid alcohol, aspirin, ibuprofen, and foods that increase gastric secretions	Maintain a well-balanced diet			
Nursing Considerations (2)	Monitor patient closely for serotonin syndrome Females of childbearing age should inform prescriber immediately if	Monitor maternal BP and pulse frequently and Avoid taking antacids, dairy products, tea, or coffee within 2 hours before or after taking medications			

	Monitor patient's electrocardiogram	fetal heart rate continuously Assess character, frequency, and duration of uterine contractions	Assess dilation of cervix periodically	of ergotism Monitor BP, heartrate, and uterine response frequently	administration to minimize leakage from cervical canal Monitor frequency, duration, and force of contractions and uterine resting tone
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor potassium levels	Fetal maturity, presentation, and pelvic adequacy should be assessed Monitor electrolytes	Monitor stools	Monitor calcium levels	Monitor VS
Client Teaching needs (2)	Immediately report signs of hypersensitivity, such as rash Seek immediate medical attention if experience persistent, severe, unusual or worsening symptoms	Expect contractions similar to menstrual cramps Practice breathing exercises during contractions	Diarrhea may occur Avoid foods that cause irritation in GI	Medication can cause menstrual like cramps Notify healthcare provider if infection develops	May experience a warm feeling in vagina during administration Notify healthcare provider of contractions become prolonged

Medications Reference (APA): (2 points)

2018 Nurses Drug Handbook (17th ed.). (2018). Burlington, MA: Jones & Bartlett Learning.

Prenatal Vitamins With Calcium-Iron Fumarate-Folic Acid Oral : Uses, Side Effects, Interactions, Pictures, Warnings & Dosing. (2019). Retrieved from https://www.webmd.com/drugs/2/drug-18562-

7288/prenatal-vitamins-with-calcium-iron-fumarate-folic-acid-oral/prenatal-vitamins-iron-folic-acid-chewable-tablet-oral/details.

Assessment (20 points)

Physical Exam (20 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is alert and orientated x4. Patient follows commands. Patient's behavior is appropriate to the situation. Patient was in a lot of pain before I arrived, but she got an epidural, so she is not in pain anymore. Patient looked very tired and kept closing her eyes.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Patient is Caucasian with a pale skin tone. Patient's skin is warm , dry, intact, with good skin turgor and without discoloration. Patient does not have any bruises, wounds, or incisions. Patient has a scab/rash on her abdomen. Patients Braden score is 19. Patient does not have any drains present.
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head/face/eyes/nose are symmetrical at rest and with no movement. Patients hair color is brown. Patient has no edema, no external drainage, and nares are patent. Patient has no rhinorrhea. Patient's lips and oral mucosa are pink, moist, and intact. Patient swallows without difficulty. There are not observed changes in hearing or vision. .
CARDIOVASCULAR (1 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** Radial, pedal **Capillary refill**: <2 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	Patient has a regular heart rhythm with no murmurs. Heart sounds S1 and S2 were auscultated. Radial and pedal pulses were present bilaterally. Patient's capillary refill is less than 2 seconds. Patient has no neck vein distention noted. Patient shows no sign of edema. No chest pain was reported.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Patient shows no signs of accessory muscle use. Patients breath sounds were clear and equal to auscultation bilaterally with no wheezes or crackles noted. Patient has a regular depth and pattern with unlabored breath sounds.

GASTROINTESTINAL (5 points): **Diet at home:** Regular diet **Current Diet:** NPO, only ice chips **Height:** 5' 2" **Weight:** 181 lb **Auscultation Bowel sounds:** **Last BM:** 10/14/19 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Fundal Height & Position:** Patient has no delivered yet so this cannot be measured.	Patient's diet at home is regular. Patient is currently NPO after getting her epidural, she can only have ice chips. The patient's bowel sounds are equal in all 4 quadrants. Patient's bowel sounds were normoactive. Patient's last bowel movement was 10/14/19. Patients abdomen was soft, nondistended, and nontender with no palpable masses. The patient has some stretch marks on her abdomen. The patient does not have any noted scars, drains, incisions, or wounds. The patient has no delivered yet so her fundal height and position could not be measured. The patient has no reported nausea, vomiting, diarrhea, or constipation.
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** Foley catheter **Size:** 16 F **Rupture of Membranes:** **Time**: 0309 **Color:** Clear **Amount:** Copious **Odor:** No odor **Episiotomy/lacerations:**	Patients urine is yellow-clear in color and clear. Patient does not have any blood in her urine. Patient denies dysuria, hematuria, or increased urinary frequency. Patient urinated 160 mL while I was talking care of her. Patients genitals do not have any abnormalities. Patient has a Foley catheter that was put in on 10/16/19 at 0730. The size of the catheter is 16 F. Patient's rupture of membranes occurred at 0309 on 10/16/19. It was clear in color and there was a copious amount. There was no odor to it. The patient has no noted episiotomy or lacerations.
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 18 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	The patient needs ADL assistance. She has mobility deficit/weakness. Patient is unable to rise from sitting position without assistance. Patient has an unsteady gait and weakness. Patient received an epidural this morning, so she is on bedrest now. Patient needed help from husband getting in and out of bed. Patient is a fall risk. Patient's fall risk score is 18.
NEUROLOGICAL (1 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:**	Patient moves all extremities well besides her legs. She is weak in her legs and has pelvic pain. PERRLA is intact. Patient's strength is equal bilaterally in upper and lower extremities. Patient is alert and orientated x4. Patient's speech is spontaneous. Patient presents pleasant and cooperative. Patient's left patellar reflex is 2. Patients right patellar reflex is 2. Right and left

Sensory: **LOC:** **DTRs:**	clonus is absent.
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patients coping methods is watching TV and talking to her husband. Patient attended college and received a bachelor's degree. Patient does not have a religious preference. Patient lives at home with her husband. Patient states husband is supportive. Patient's husband at bedside with her the whole time.
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	The patient has not delivered yet.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	94	136/87	18	98.8F	100%
Labor/Delivery	103 106	117/66 100/61	18 16	98.4F 98.4F	96% 94%
Postpartum	Patient has not delivered yet.	Patient has not delivered yet.	Patient has not delivered yet.	Patient has not delivered yet.	Patient has not delivered yet.

Vital Sign Trends: The patient's prenatal vital signs were stable besides her blood pressure. Patient's blood pressure was a little high at. 136/87. This is because of her gestational hypertension. While I was taking care of the patient, her blood pressure was stable. Her heart rate was a little high which might be because she is having contractions. The patient O2 saturation was a little low at 94%.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	Numerical Scale	Patient does not report any pain.	0/10	Patient does not report any pain.	Patient does not report any pain.
1130	Numerical Scale	Patient does not report any pain.	0/10	Patient does not report any pain.	Patient does not report any pain.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV:** Top of left hand **Date on IV:** 10/15/19 **Patency of IV:** IV is patent **Signs of erythema, drainage, etc.:** There are no signs of erythema, drainage, redness, or swelling. **IV dressing assessment:** The IV dressing is clean, dry, and intact.	Peripheral IV Line Lactated Ringers Infusion 125 mL/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
500 mL	160 mL

Interventions (12 points)

Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. Proper pushing during labor
    - Tuck chin to chest
    - Rest between contractions
    - Changing position might help breathing and contractions
    - Bear down as if having a bowel movement
    - *Expected outcome:* The patient will feel comfortable during labor and have proper methods that will stimulate delivery within a shorter period of time.
2. Expulsion breathing

- Focus on the baby moving down and out
- Breathe slowly and let the contraction guide breathing
- Take a breath as soon as the contraction begins and release all tension as you breathe out
- When time to push, take a deep breath, tuck chin to chest, curl body, and lean forward
- Hold breath for 5-6 seconds or up to 10 if tolerable then release and breathe in and out
- *Expected outcome:* The patient will feel comfortable while she is pushing and have a relaxing breathing pattern that promotes delivery of the baby.

Nursing Interventions (6 points)

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

Nursing Interventions:

- Reposition the patient as needed throughout labor.

  Rationale: This will help make the patient comfortable and promote labor.

- Count patient's breathing for her so she forms a pattern during contractions

  Rationale: This will promote deep breathing and remind the patient what to do while breathing in and out.

Medical Treatments:

- Patient had an epidural to help with pain.
- Patient was given Pitocin to help induce labor.

Reference:

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

<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	• Explain why the nursing diagnosis was	Include a short rationale as to why	• How did the client/family respond to the nurse's actions?

evidenced by" components	chosen	you chose this intervention & cite the reference appropriately	• Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to uterine contractions as evidenced by patient's verbal and nonverbal indicators of pain (Swearingen, 2016)	The patient was in pain before I arrived and in acute pain when I arrived.	**1.** Assess patient's pain level frequently and each time entering room. *Rationale:* Assessing the patient's pain level is the most accurate way to determine the patient's pain. **2.** Teach and encourage relaxation and breathing techniques. *Rationale:* Relaxation and breathing techniques promote adequate oxygenation to the tissues and decrease physiologic responses to pain.	The patient responded well to the interventions. She did the relaxation and breathing exercises without any complaints. The patient always expressed her pain when asked. The outcome of these interventions was the patient wanting an epidural. Although the interventions were working, she did not want to be in pain anymore. After the epidural she was only in acute pain for a little while and then had no pain.
2. Anxiety related to not having a child before as evidenced by verbal and nonverbal indications of anxiety (Swearingen, 2016)	The patient is worried about giving birth and worried about her child being healthy.	**1.** Assess for verbal and nonverbal cues regarding the patient's anxiety level. *Rationale:* Verbal and nonverbal cues can provide the nurse with insights into how the patient is coping with the hospitalization and the labor process. **2.** Review the stages of labor as they occur, reassuring the women and family of normal expectations and behaviors, while providing coaching and support. *Rationale:* The patient may become fearful if she does not understand what is happening to her body	The patient responded well to the interventions. She used verbal and nonverbal cues to express her anxiety. She expressed that she liked when the stages were explained, and she knew what she was going through at the time. The outcome of these interventions was that the patient was less anxious. The patient seemed more relaxed when being talked to and explained what is going on. She is less anxious about having her child.

		during labor or feels something is abnormal.	

Other References (APA):

Swearingen, P. L. (2016). *All-In-One Nursing Care Planning Resource* (4 ed.). St. Louis, Missouri: ELSEVIER.

N432 Care Plan and Grading Rubric

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) **Living situation** **Education level** • If applicable to learning barriers	Includes each section completed correctly with a detailed list of pertinent medical history, surgical history, family history and social history. If patient is unable to give a detailed history, look in the EMR and chart.	1 or more of the key components is missing detailed information.	More than two of the key components are not filled in correctly	

Admission Assessment -Chief Complaint	2 points	1 point	0 points	Points
Chief complaint	Chief complaint is correctly identified.	Chief complaint not completely	No chief complaint listed.	

• Identifiable with a couple words of what the patient came in complaining of		understood.		
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 **Secondary Diagnosis** • If the patient has more than one reason they are being admitted	All key components are filled in correctly. The student was able to identify the correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.	One of the key components is missing or not understood correctly.	Student did not complete this section and there is concern for lack of understanding the diagnosis.	

Stage of Labor	**20 points**	**14-10 points**	**9-5 points**	**4-0 points**	**Points**
Stage of Labor • Professionally written essay in APA format outlined all aspects of the stage of labor the client is in during the student's care • information is well written and no less than 1 page • Signs/symptoms of the stage • Expected findings related to the stage such as vital signs and laboratory findings	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	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	

• How the stage of labor is identified • Typical nursing interventions and treatments for the stage of labor	performed.			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	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	More than half of the key components are missing. Therefore, it is presumed that the student does not have a	

• **No fall risk or Braden scale will result in a zero for the section**		worth points as listed on care plan	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 • Pain assessment was addressed and recorded twice throughout the care of this client • It was recorded appropriately and stated what pain scale was used	All the key components were met (2 pain assessments) for this section and student has a good understanding of the pain assessment.		One assessment is incomplete.	Student did not complete this section	

IV Assessment	2 points	1 point	0 points	Points
IV assessment • IV assessment performed and it is charted including what size of IV and location of the IV • Noted when the IV was placed • Noting any signs of erythema or drainage • Patency is verified and recorded • Fluid type and rate is recorded or	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.	

Saline lock is noted. • IV dressing assessment is recorded (clean, dry and intact)				
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.		

N432 Care Plan and Grading Rubric

Nursing Diagnosis	15 points	5-14 points	4-0 points	Points
Nursing Diagnosis • List 2 nursing diagnosis o Include full nursing diagnosis with “related to” and “as evidenced by” components • Appropriate nursing diagnosis • Appropriate rationale for each diagnosis o Explain why the nursing diagnosis was chosen • Minimum of 2 interventions for each diagnosis • Rationale for each intervention is required • Correct priority of the nursing diagnosis • Appropriate evaluation	All key components were addressed. The student demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.	One or more of the nursing diagnosis/rational/intervention sections was incomplete or not appropriate to the patient Each section is worth 3 points. Prioritization was not appropriate.	More than 2 of the nursing diagnosis sections were incomplete or inappropriate. Prioritization is dangerously inappropriate.	
Overall APA format	**5 Points**	**1-4 Points**	**0 Points**	**Points**
APA Format • The student used appropriate APA in text citations and listed all appropriate references in APA format. • Professional writing style and grammar was used in all narrative sections.	APA format was completed and appropriate. Grammar was professional and without errors	APA format was used but not correct. Several grammar errors or overall poor writing style was used. Content was difficult to understand.	No APA format. Grammar or writing style did not demonstrate collegiate level writing.	

		Points
- Instructor Comments:	**Total points awarded**	
Description of Expectations	**/150= %**	
Must achieve 116 pt =77%		

Revised 8/18/2019