

N432 Care Plan #1

Lakeview College of Nursing

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N432 Care Plan and Grading Rubric

Instructions: The care plan is to be typed into a WORD document and submitted to the labor & Delivery or Postpartum Dropbox 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 10/15/19 1407	Patient Initials LAB	Age 32 y.o	Gender Female
Race/Ethnicity White	Occupation Stay at home Mom	Marital Status Married	Allergies NKA
Code Status Full Code	Height 5'9	Weight 162	Father of Baby involved Yes

Medical History (5 Points)

Prenatal History: Gestational Diabetes Mellitus (2016, present), G3 P2 T2 P0 A0 L2, 38w3d, two vaginal births (2014, 2016)

Past Medical History: Vaginal delivery hx (2014, 2016), Gestational diabetes (diet controlled)

Past Surgical History: Tongue surgery (Frenulum clipped)

Family History:

Mother- Hypertension, Diabetes

Social History (tobacco/alcohol/drugs):

Alcohol- Not currently using

Tobacco- Never used

Drugs- Never used

Living Situation: At home w/ husband, daughter and son

Revised 8/18/2019

Admission Assessment (12 points)

Chief Complaint (2 points): Contractions 2-3 minutes apart

Presentation to Labor & Delivery (10 points):

G-3, P-2, T-2, P-0, A-0, L-2. Patient's due date was 10/27/19 and was 38 weeks and 2 days gestation. Patient came to OSF with chief complaint of uterine contractions that were 2-3 minutes apart, denying loss of fluids or bleeding and confirms good fetal movement. Patient requesting no epidural for pain management. Patient ambulating halls and using birthing ball. Patient's PMH includes history of gestational diabetes and two vaginal births. Patient currently taking prenatal vitamins and the occasional antacid. Patient's PSH is tongue surgery in which her frenulum was clipped. Family history includes hypertension and diabetes. Patient also denies current alcohol use, any drug or tobacco consumption. There was fetal movement noted. She was positive for GBS when swabbed. Patient failed her 3-hour glucose test at 28 weeks and stated she was checking blood sugars at home and managing GDM with her diet. Patient had artificial rupture of membranes at 1648. Baby was in LOA position. She had a vaginal birth delivering at 0220 on 10/16/19. She has a laceration that is 2nd degree. Pitocin was administered post-delivery to prevent risk of hemorrhage.

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points): Labor

Secondary Diagnosis (if applicable): Gestational Diabetes Mellitus

Stage of Labor (20 points):

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

The first stage of labor is known to be the process of progressive dilation of the cervix (Ricci, 2017). The first stage ends when the cervix is large enough to pass a fetal head through it at around 10 centimeters. The first stage of labor can last up to 12 hours but that varies. There are three different phases involved in the first stage of labor. These phases

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include the latent/early phase, the active phase and the transition phase. The latent phase can last about nine hours, the active phase six hours and the transition phase about one hour (Ricci, 2017).

Women in the first stage of labor can experience abdominal pain and uterine contractions. This pain is related to the dilation of the cervix and distention/stretching of the internal structures. The latent/early phase can begin with regular contractions and ends when rapid cervical dilation begins. Early phase contractions occur every five to ten minutes and can last 30 to 45 seconds (Ricci, 2017). Contractions become more frequent during the active phase about every two to five and increase in duration to about 45 to 60 seconds. The transition phase is the most difficult as dilation slows and contractions become more frequent at almost every one to two minutes and more painful.

The first stage of labor is identified through vaginal examination of the cervical dilation and is recorded in centimeters (Ricci, 2017). The first stage can also be identified through the rupture of fetal membranes, otherwise known as the water breaking. The latent phase can be identified by the cervical dilation from 0 to 3 centimeters. The cervix dilates from four to seven centimeters during the active phase and from eight to ten centimeters during the transition phase.

Nursing interventions for the first stage of labor prioritize establishing a therapeutic relationship with the patient and promoting comfort (Mona, 2017). These interventions include using cool, damp wash clothes or providing ice chips and frozen juice bars or hard candy. It is also important to monitor vital signs, monitoring fetal heart rate and intake and output.

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

Mona, M., Mona, M. M. M. K., & Apollo Hospital Dhaka. (2017, March 30). Nursing Interventions During Labor and Delivery of Pregnant Women. Retrieved from <http://nursingexercise.com/nursing-interventions-labor-delivery/>.

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

Laboratory Data (15 points)

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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	4.28-5.56	4.36	4.0	N/A	N/A
Hgb	13-17	14.3	12.3	N/A	N/A
Hct	33.2- 45.3	39.7	36.1	N/A	N/A
Platelets	150-400	261	251	N/A	N/A
WBC	4.5-11	10.9	12.7	N/A	WBC increased due to the stress induced on the body in the pregnant state (Chandra, 2012)
Neutrophils	45.3- 79.0%	8.8	9.4	N/A	WBC increased due to the stress induced on the body in the pregnant state (Chandra, 2012)
Lymphocytes	11.8-45.9%	1.4	2.5	N/A	N/A
Monocytes	4.4-12.0%	0.6	0.7	N/A	N/A
Eosinophils	0-6.3	0.1	0.0	N/A	N/A
Bands	< 10%	N/A	0.1	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	+/-	+	+	+	N/A
Serology (RPR/VDRL)	Non reactive	Non reactive	Non reactive	Non reactive	N/A
Rubella Titer	N/A	Immune	Immune	Immune	N/A
Hct & Hgb	13-17 & 33.2- 45.3	14.3 & 39.7	12.3 & 36.1	N/A	N/A
HIV	Non	Non detected	Non	Non	N/A

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	reactive		detected	detected	
HbSAG	Non detected	Non detected	Non detected	Non detected	N/A
Group Beta Strep Swab	+/-	+	+	+	N/A
Glucose at 28 weeks	70-110	Failed 3hr glucose test	101	95	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 & 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	Negative	Negative	N/A	N/A
Protein	Negative-normal	Negative	Negative	N/A	N/A
Ketones	Negative	Negative	Negative	N/A	N/A
WBC	<5	Negative	Negative	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
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Urine Culture	N/A	N/A	N/A	N/A	N/A
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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):

Chandra, S., Tripathi, A. K., Mishra, S., Amzarul, M., & Vaish, A. K. (2012, September). Physiological changes in hematological parameters during pregnancy. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3422383/>.

Van Leeuwen, A. M., & Bladh, M. L. (2017). Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications (7 th ed.). Philadelphia, PA: F.A. Davis Company

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	130 Electronic Fetal Heart Monitoring is the continuous monitoring providing audio and visual recordings as well as tracing strips
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?	Accelerations: > 15 bpm Variability: Moderate Moderate variability indicates that the autonomic and CNS of the fetus are well developed and well oxygenated (Ricci, 2017).

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<p>What is the variability?</p>	<p>An acceleration is an abrupt increase in FHR above baseline. The duration of the acceleration is defined as the time from the initial change in heart rate from the baseline to the time of return to the FHR to baseline.</p>
<p>Are there decelerations, if so describe them.</p> <p>What do these mean?</p> <p>Did the nurse perform any interventions with these?</p> <p>Did these interventions benefit the patient or fetus?</p>	<p>Decelerations: Absent/ None</p> <p>Decelerations are the transient fall in FHR caused by stimulation of the parasympathetic nervous system (Ricci, 2017). Decelerations are described by their shape and association to uterine contractions.</p> <p>No nursing interventions were performed for this patient.</p> <p>Late decelerations are associated with uteroplacental insufficiency.</p> <p>Variable decelerations are associated with cord compression. Prolonged decelerations are associated with prolonged cord compression, abruptio placenta, cord prolapse supine positioning or uterine rupture.</p>
<p>Describe the contractions i.e. frequency, length, strength, patient's response.</p>	<p>Contractions 3 to 6 minutes apart, lasting 60 to 90 seconds, mild by palpation and the patient is tolerating well.</p>

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

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

7 different medications must be completed

Home Medications (2 required)

<p>Brand/Generic</p>	<p>Prenatal multivitamin</p>	<p>Calcium Carbonate (Tums)</p>			
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Dose	0.8mg	1,000mg			
Frequency	HS	Q8H PRN			
Route	Oral	Oral			
Classification	Multivitamin	Antacid			
Mechanism of Action	Treat vitamin deficiencies caused by dietary insufficiency	Neutralize or buffer stomach acid to relieve discomfort caused by hyperacidity			
Reason Client Taking	Overall health	Heart burn/ indigestion			
Contraindications (2)	- hypersensitivity -alcoholism	-hypercalcemia - hypersensitivity			
Side Effects/Adverse Reactions (2)	-constipation -diarrhea	-nausea/ vomiting -hypotension			
Nursing Considerations (2)	-monitor patient with hx of alcoholism -monitor for stomach/ intestinal	-store at room temperature -recumbent position for 30 minutes			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor hemoglobin	-monitor serum calcium level			

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Client Teaching needs (2)	-take on empty stomach	-chew tablets thoroughly			
	-avoid antacids and dairy products	-take 1 to 2 hours after meals			

Hospital Medications (5 required)

Brand/Generic	Acetaminophen (Tylenol)	Benzocaine-menthol (Dermoplast)	Docusate Sodium (Colace)	Ibuprofen (Motrin)	Ondansetron (Zofran)
Dose	975mg	1 spray	100mg	800mg	4mg
Frequency	Q6H	Q8H	BID	Q8H	Q6H
Route	Oral	Topical	Oral	Oral	Oral
Classification	Antipyretic, nonopioid analgesic	Local anesthetic	Stool softener	Analgesic, anti-inflammatory, antipyretic	Antiemetic
Mechanism of Action	Blocks prostaglandin production and interfering with pain impulse generation in peripheral nervous system	Blocks nerve signals in the body to reduce pain	Softens stools by decreasing surface tension between oil and water in feces	Blocks enzyme that mediate inflammatory response and cause local pain, swelling and vasodilation	Blocks serotonin receptors at vagal nerve terminals in the intestine
Reason Client Taking	Mild/severe pain	Perineal pain	Constipation	Pain	Nausea
Contraindications (2)	-severe hepatic impairment -severe active liver disease	-enzyme deficiency -asthma	-fecal impaction -hypersensitivity	-angioedema -asthma	-congenital long QT syndrome -hypersensitivity

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Side Effects/Adverse Reactions (2)	-hypoglycemic coma -hepatotoxicity	-headache -shortness of breath	-dizziness -abdominal cramps	-aseptic meningitis -fluid retention	-altered taste -abdominal pain
Nursing Considerations (2)	-caution in patients with hepatic impairment -caution in alcoholic patients	-monitor for skin redness -monitor for signs of infection	-assess for laxative abuse syndrome -excess uses can cause dependence	-do not use in pregnant women -avoid in patients with recent MI	-monitor EKG -correct electrolyte imbalances before administering
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor liver function test results (AST, ALT, bilirubin and creatinine)	Monitor for signs of infection	Monitor for electrolyte imbalances	Monitor liver enzymes	Monitor for hypokalemia or hypomagnesium
Client Teaching needs (2)	-tablets may be crushed or swallowed -follow dosage guidelines	-Discontinue use if hives occur -seek medical attention if having difficulty breathing	-Take with full glass of water or milk -follow dosage guidelines	-take with full glass of water -take with food to avoid GI distress	-use calibrated container to measure -transient blindness will resolve within a few minutes to 48 hours

Medications Reference (APA): (2 points)

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

Assessment (20 points)

Physical Exam (20 points)

GENERAL (0.5 point):	A&O x 4
Alertness:	Patient does not appear distressed
Orientation:	Patient's overall appearance appropriate for post partum
Distress:	

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<p>Overall appearance:</p> <p>INTEGUMENTARY (2 points):</p> <p>Skin color:</p> <p>Character:</p> <p>Temperature:</p> <p>Turgor:</p> <p>Rashes:</p> <p>Bruises:</p> <p>Wounds/Incision: .</p> <p>Braden Score:</p> <p>Drains present: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Type:</p>	<p>Braden Score: 23 (low risk)</p> <p>Patient states she is Caucasian and presents with a fair skin tone.</p> <p>Skin has normal elasticity warm to touch.</p> <p>No abnormal texture.</p> <p>Hair is dispersed well throughout.</p> <p>No notable skin turgor. No rashes or bruises.</p> <p>Patient has noted perineal lacerations.</p>
<p>HEENT (0.5 point):</p> <p>Head/Neck:</p> <p>Ears:</p> <p>Eyes:</p> <p>Nose:</p> <p>Teeth:</p>	<p>Head is midline with no deviations.</p> <p>Hair is blonde/ red in color.</p> <p>Ears show no abnormal drainage, tympanic membrane visible, pearly grey.</p> <p>PEERLA is noted.</p> <p>Nose shows no deviated septum, turbinates equal bilaterally.</p> <p>Oral mucosa is pink and moist with no notable abnormalities.</p> <p>Patient's teeth present in yellow to white in color.</p>
<p>CARDIOVASCULAR (1 points):</p> <p>Heart sounds:</p> <p>S1, S2, S3, S4, murmur etc.</p> <p>Cardiac rhythm (if applicable):</p> <p>Peripheral Pulses:</p> <p>Capillary refill:</p> <p>Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema</p>	<p>Patient is not currently being monitored by telemetry.</p> <p>Patient was noted to be in normal sinus rhythm on admission and this morning upon assessment.</p> <p>S1, S2 heart sounds noted.</p> <p>Radial and pedal pulses assessed. Pulses graded 2+ and present bilaterally.</p> <p>Capillary refill average at < 3 seconds.</p>

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<p>Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Location of Edema:</p>	<p>Negative for neck vein distention.</p> <p>No edema present</p>
<p>RESPIRATORY (1 points):</p> <p>Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Breath Sounds: Location, character</p>	<p>No accessory muscle use when breathing.</p> <p>Trachea midline. No deviations.</p> <p>Patient is denies current shortness of breath.</p> <p>Anterior and posterior lung sounds auscultated.</p> <p>Patient currently breathing room air.</p>
<p>GASTROINTESTINAL (5 points):</p> <p>Diet at home:</p> <p>Current Diet</p> <p>Height:</p> <p>Weight:</p> <p>Auscultation Bowel sounds:</p> <p>Last BM:</p> <p>Palpation: Pain, Mass etc.:</p> <p>Inspection:</p> <p>Distention:</p> <p>Incisions:</p> <p>Scars:</p> <p>Drains:</p> <p>Wounds:</p> <p>Fundal Height & Position:</p>	<p>Patient states at home her diet is currently managing her gestational diabetes</p> <p>Bowel sounds present in all four quadrants.</p> <p>Last BM 10/15</p> <p>No scars noted.</p> <p>No masses present.</p> <p>No ostomy, nasogastric tubes, PEG tubes.</p> <p>No drains.</p> <p>Abdomen is soft and nondistended.</p> <p>Patient denies any rapid or current weight loss.</p> <p>Fundal height:</p>
<p>GENITOURINARY (5 Points):</p> <p>Bleeding:</p> <p>Color:</p> <p>Character:</p>	<p>Patient is able to ambulate in her room and to the bathroom independently.</p> <p>No dialysis or catheter.</p> <p>Genitals appear swollen.</p> <p>Urine is yellow and clear with some vaginal blood</p>

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<p>Quantity of urine:</p> <p>Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Inspection of genitals:</p> <p>Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Type:</p> <p>Size:</p> <p>Rupture of Membranes:</p> <p>Time:</p> <p>Color:</p> <p>Amount:</p> <p>Odor:</p> <p>Episiotomy/lacerations:</p>	<p>present.</p> <p>Patient denies pain, hesitancy or urgency on urination.</p> <p>No abnormal odor or color</p> <p>Patient is on I&O's.</p> <p>AROM 10/15/19 2045</p> <p>2nd degree perineal lacerations, repaired in normal fashion with Vicryl.</p>
<p>MUSCULOSKELETAL (2 points):</p> <p>ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Score: 20</p> <p>Activity/Mobility Status:</p> <p>Independent (up ad lib) <input type="checkbox"/></p> <p>Needs assistance with equipment <input type="checkbox"/></p> <p>Needs support to stand and walk <input type="checkbox"/></p>	<p>Fall Score: 20 (low risk)</p> <p>Patient exhibits active range of motion bilaterally.</p> <p>Patient shows no sign of neurovascular deficit.</p> <p>Patient up and walking independently.</p> <p>Patient denies use of walker, cane, or wheel chair at home. Patient denies the use of any other assistive devices around her home.</p>
<p>NEUROLOGICAL (1 points):</p> <p>MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/></p> <p>Orientation:</p> <p>Mental Status:</p> <p>Speech:</p>	<p>Patient appears tired.</p> <p>A& O x4.</p> <p>Patient speaks English well and at a normal pace. Patient MAEW for current age and condition.</p> <p>Patient shows no signs of neurological deficit or damage</p>

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<p>Sensory:</p> <p>LOC:</p> <p>DTRs:</p>	
<p>PSYCHOSOCIAL/CULTURAL (1 points):</p> <p>Coping method(s):</p> <p>Developmental level:</p> <p>Religion & what it means to pt.:</p> <p>Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>Patient presents fatigued. Patient goes in and out sleep. Patient denies current alcohol, drug or tobacco use. Patient appears to have good family support. Patient is Methodist. Patient is currently a stay at home mom with her two other children.</p>
<p>DELIVERY INFO: (1 point) (For Postpartum client)</p> <p>Delivery Date: 10/16/19</p> <p>Time: 0220</p> <p>Type (vaginal/cesarean): Vaginal</p> <p>Quantitative Blood Loss: Moderate (73mL)</p> <p>Male or Female: Male</p> <p>Apgars: 9&9</p> <p>Weight: 3305</p> <p>Feeding Method: Breast</p>	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	102	138/84	16	N/A	95
Labor/Delivery	77	120/73	18	97.7	94 Room Air
Postpartum	71	110/63	16	97.5	98

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					Room Air
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Vital Sign Trends:

Prenatal vitals slightly elevated. No signs of fever. Oxygen saturation trending upward throughout the stages of pregnancy. Blood pressure and pulse trending downwards throughout the stages of pregnancy.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0740	Numeric	No pain reported	0/10	Denies pain/discomfort	No interventions required
0940	Numeric	No pain reported	0/10	Denies pain/discomfort	No interventions required

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	Left arm (lateral side) 18g peripheral IV Dated 10/15/19 Blood return, able to obtain, flushed w/o difficulty, infusing, site cleansed and secured, no phlebitis or infiltration IV dressing clean, dry and intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Not Completed	0701: 73mL (blood)

Interventions (12 points)

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Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. Expected physical changes: mensural like cramping, lochia decreases over time, take stool softeners, sweating and frequent urine d/t normal fluid shifts

Patient acceptance, teach back and verbalizes understanding

2. Infant health benefits of breast feeding: complete and balanced nutrition, enhanced immunity, established healthy GI tract, enhanced bonding

Patient acceptance, teach back and verbalizes understanding

Nursing Interventions (6 points)

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

Nursing Interventions: Teach patient how to monitor episiotomy for suture integrity and signs and symptoms of infection

Rational: A knowledgeable patient is likely to report infection indicators promptly

Medical Treatments: Patient using dermoplast and rating pain regularly

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
<ul style="list-style-type: none">• Include full nursing diagnosis with “related to” and “as evidenced by” components	<ul style="list-style-type: none">• Explain why the nursing diagnosis was chosen	<p>Include a short rationale as to why you chose this intervention & cite the reference</p>	<ul style="list-style-type: none">• How did the client/family respond to the nurse’s actions?• Client response, status of goals and outcomes, modifications to plan.

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		appropriately	
<p>1.) Deficient Knowledge related to unfamiliarity of effects of postpartum wound infection risk on self and the importance of following treatment evidenced by 2nd degree laceration. (Swearingen, 2016, p. 643)</p>	<p>1. Patient and family present will verbalize the effects a postpartum wound infection may have on the mother and likely treatments for the possible infection before end of shift and before discharge.</p> <p>2. Patient and family will be able to verbalize signs and symptoms of infection and complications to report after hospital discharge by end of shift and before discharge home.</p>	<p>1. Teach the pt, significant other, and family about the effects a postpartum wound infection may have on the mother and the likely treatments for the infection prior to end of shift and before discharge. Information helps patient adhere to treatments, report symptoms in a timely matter, and understand consequences of nonadherence.</p> <p>Effects an infection may have on the mother include pain, fever, chills, wound dehiscence sepsis and increased morbidity/mortality. Likely treatments include IV antibiotics and fluids, wound packing, secondary wound closure, and possible lengthy hospitalization or home treatments. (Swearingen, 2016, p. 644)</p> <p>2. Teach signs and symptoms of infection and its complications that should be reported after hospital discharge by end of shift and before discharge. This enables the patient/family to</p>	<p>1. Goal was met as the patient and her significant other were able to describe the effects a postpartum wound infection may have on the mother and likely treatments for the possible infection prior to discharge.</p> <p>2. Goal was achieved. Patient and significant other verbalized signs and symptoms to look for suggesting an infection and complication to report following their discharge. Verbalization of understanding of this material occurred prior to discharge.</p>

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		<p>recognize and report signs of infection such as fever, foul smelling discharge, failure of lochia to progress from furbra to serosa, to alba, and its timely completion, severe pain, drainage from infection sight. Early evaluation and treatment results in decreased maternal morbidity. (Swearingen, 2016, p. 644)</p>	
<p>2.) Acute pain related to post delivery of a neonate as evidenced by 2nd degree laceration and birth of a child. (Swearingen, 2016, p. 645)</p>	<p>1. Patient is aware she will be asked to report her pain level hourly, prior to and after giving medications. She verbalized understanding of monitoring her pain and why it is important.</p> <p>2. Patient verbalized the importance of reporting her pain based on a numeric scale, 1-10, 0 being none and 10 being the worst pain she has ever felt. She understands that rating her pain prior to and after medication administration allows a baseline and to monitor effectiveness of the medication.</p>	<p>1. Assess patient’s pain hourly, prior to and after giving medications. This intervention is done to routinely monitor the patients pain and allow ample time to intervene if needed. Pain management is essential in a new mother .(Swearingen, 2016, p. 645)</p> <p>2. Educate the patient on reporting pain on a numeric scale and requesting medication before the pain becomes unbearable during my shift. This intervention allows the nurse and patient to get ahead of pain, reducing the risk of the pain, pain worsening, and identifying if pain is occurring for another</p>	<p>1. Outcome was met evidenced by hourly rounds including pain ratings followed by pain ratings by the patient before and after medication administration. This was done continuously throughout shift.</p> <p>2. Outcome was met as the patient rated her pain on a numeric scale 0-10 and verbalized the understanding of reporting her pain before it became unbearable although that did not occur throughout shift</p>

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	3. Patient understands why and what medication her provider has ordered for her for pain management. She verbalized reasons for reducing pain including being more comfortable, a, increased mood, and the ability to care for her infant effectively.	reason other than post delivery of her baby and her 2nd' degree laceration. (Swearingen, 2016, p. 645)	
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Other References (APA):

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

Demographics	3 points	1.5 points	0 points	Points
<p>Demographics</p> <ul style="list-style-type: none"> • Date of admission • Patient initials • Age • Gender • Race/Ethnicity • Occupation • Marital Status • Father of baby involvement • Allergies • Code Status • Height • Weight 	<p>Includes complete information regarding the patient. Each section is filled out appropriately with correct labeling.</p>	<p>Two or more of the key components are not filled in correctly.</p>	<p>5 or more of the key components are not filled in correctly and therefore no points were awarded for this section</p>	
Medical History	5 points	2.5 points	0 points	Points
<p>Prenatal History</p> <p>Past Medical History</p> <ul style="list-style-type: none"> • All previous medical diagnosis should be listed <p>Past Surgical History</p> <ul style="list-style-type: none"> • All previous surgeries should be listed <p>Family History</p> <ul style="list-style-type: none"> • Considering paternal and maternal <p>Social History</p> <ul style="list-style-type: none"> • 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) <p>Living situation</p> <p>Education level</p>	<p>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.</p>	<p>1 or more of the key components is missing detailed information.</p>	<p>More than two of the key components are not filled in correctly</p>	

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<ul style="list-style-type: none"> If applicable to learning barriers 				
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Admission Assessment -Chief Complaint	2 points	1 point	0 points	Points
Chief complaint <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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	

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<p>Secondary Diagnosis</p> <ul style="list-style-type: none"> If the patient has more than one reason they are being admitted 	<p>The student was able to identify the correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.</p>	<p>understood correctly.</p>	<p>for lack of understanding the diagnosis.</p>	
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Stage of Labor	20 points	14-10 points	9-5 points	4-0 points	Points
<p>Stage of Labor</p> <ul style="list-style-type: none"> Professionally written essay in APA format outlined all aspects of the stage of labor the client is in during the student's care information is well written and no less than 1 page Signs/symptoms of the stage Expected findings related to the stage such as vital signs and laboratory findings How the stage of labor is identified Typical nursing interventions and treatments for the stage of labor Assessment findings that would suggest the client is progressing to another stage Listed clinical data that correlates to this particular client Plagiarism results in a zero in this section 2 APA references, essay is 	<p>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.</p>	<p>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.</p>	<p>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</p>	<p>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.</p> <p>Section was not in APA format with minimum of 2 references (0 points will be given)</p>	

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written in correct APA format.					
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Laboratory Data	15 points	5-14 points	4-0 points	Points
<p>Normal Values</p> <ul style="list-style-type: none"> 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. <p>Laboratory Data</p> <ul style="list-style-type: none"> Admission Values Most recent Values (the day you saw the patient) Prenatal Values <p>Rational for abnormal values</p> <ul style="list-style-type: none"> 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 	<p>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.</p>	<p>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.</p>	<p>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.</p>	
Electronic Fetal Heart Monitoring	20 points	19-10 points	0-10 points	Points
<p>Components of EFHM:</p> <ul style="list-style-type: none"> Baseline Accelerations Variability 	<p>All key components have been addressed and</p>	<p>One or more of the key components is missing, yet the</p>	<p>Student did not have an understanding of EFHM and the</p>	

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<ul style="list-style-type: none"> • 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 	<p>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.</p>	<p>student is able to demonstrate an understanding of the diagnostic testing and is able to correlate the abnormal findings to the disease process.</p>	<p>abnormalities. Student did not have an APA reference listed.</p>	
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Current Medications	10 points	1-9 points	0 points	Points
<p>Current Medications</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> o Must be pertinent to your patient • 2 side effects or adverse effects • 2 nursing considerations • Key nursing assessment(s)/lab(s) prior to 	<p>All key components were listed for each of the 7 medications, along with the most common side effects, contraindications and client teachings.</p> <p>Student had 1 APA citation listed.</p>	<p>1 point will be lost for each medication with incomplete information.</p>	<p>There was noted lack of effort on the student’s part to complete this section or there was no APA citation listed.</p>	

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<p>administration</p> <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> • 2 client teaching needs • Minimum of 1 APA citation, no citation will result in loss of all points in the section 					
Physical Assessment	20 points	1-18 points	0 points	Points	
<ul style="list-style-type: none"> • Completion of a head to toe assessment done on the students own and not copied from the client's chart • Fall risk assessment • Braden skin assessment • No fall risk or Braden scale will result in a zero for the section 	<p>All key components are met including a complete head to toe assessment, fall risk and Braden score.</p>	<p>One or more of the key components is missing from a given section. Each body system is worth points as listed on care plan</p>	<p>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.</p>		
Vital Signs	5 points		2.5 points	0 points	Points
<p>Vital signs</p> <ul style="list-style-type: none"> • 3 sets of vital signs are recorded with the appropriate labels attached 	<p>All the key components were met for this section (with 2 sets of vital signs) and student has a good understanding of abnormal vital</p>		<p>Only one set of vital signs were completely recorded and one</p>	<p>Student did not complete this section</p>	

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<ul style="list-style-type: none"> Includes a prenatal set, labor/delivery set, and postpartum set <i>If client has not delivered for a postpartum set, student is to list TWO vitals from labor and delivery</i> Student highlighted the abnormal vital signs Student wrote a summary of the vital sign trends 	signs.	of the key components were missing.		
Pain Assessment	2 points	1 point	0 points	Points
Pain assessment <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 	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	

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<p>recorded</p> <ul style="list-style-type: none"> • Fluid type and rate is recorded or Saline lock is noted. • IV dressing assessment is recorded (clean, dry and intact) 			<p>complete this section.</p>	
Intake and Output	2 points	1-0 points	Points	
<p>Intake</p> <ul style="list-style-type: none"> • Measured and recorded appropriately—what the patient takes IN • Includes: oral intake, IV fluid intake, etc. <p>Output</p> <ul style="list-style-type: none"> • Measured and recorded appropriately—what the client puts OUT • Includes: urine, stool, drains/tubes, emesis, etc. 	<p>All of the key components of the intake and output were addressed. Student demonstrates an understanding of intake and output.</p>	<p>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.</p>		
Nursing Care/Interventions	12 points	2-0 points	Points	
<p>Nursing Interventions</p> <ul style="list-style-type: none"> • 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 <p>Teaching topics</p> <ul style="list-style-type: none"> • List 2 priority teaching items • Includes 1 expected outcome 	<p>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.</p>	<p>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.</p>		

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for each teaching topic				
Nursing Diagnosis	15 points	5-14 points	4-0 points	Points
<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • List 2 nursing diagnosis <ul style="list-style-type: none"> ◦ Include full nursing diagnosis with “related to” and “as evidenced by” components • Appropriate nursing diagnosis • Appropriate rationale for each diagnosis <ul style="list-style-type: none"> ◦ 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 	<p>All key components were addressed. The student demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.</p>	<p>One or more of the nursing diagnosis/rationale/intervention sections was incomplete or not appropriate to the patient. Each section is worth 3 points. Prioritization was not appropriate.</p>	<p>More than 2 of the nursing diagnosis sections were incomplete or inappropriate. Prioritization is dangerously inappropriate.</p>	
Overall APA format	5 Points	1-4 Points	0 Points	Points
<p>APA Format</p> <ul style="list-style-type: none"> • 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. 	<p>APA format was completed and appropriate. Grammar was professional and without errors</p>	<p>APA format was used but not correct. Several grammar errors or overall poor writing style was used. Content was difficult to</p>	<p>No APA format. Grammar or writing style did not demonstrate collegiate level writing.</p>	

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