N432 Care Plan #2

Postpartum

Lakeview College of Nursing

Justine Funneman

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 **10/15/19** **@ 0950**	**Patient Initials** **D.Y.**	**Age** **36**	**Gender** Female
Race/Ethnicity **Caucasian**	**Occupation** **Speech language pathologist**	**Marital Status** **Married**	**Allergies** **Pet dander** **NKDA**
Code Status **Full Code**	**Height** **5'3"**	**Weight** **170lbs**	**Father of Baby involved** **Yes**

Medical History (5 Points)

Prenatal History: G4P1022, previous C-section, Gestation of 39 weeks and 3 days

Past Medical History: asthma, hx of depression, hx of insomnia, hx of hemorrhage

Past Surgical History: C-section, wisdom teeth removal, excision lesion/mass, and colonoscopy

Family History: colon cancer, heart defect of father's side

Social History (tobacco/alcohol/drugs): 1.2 oz of alcohol per week before pregnancy, she was a former smoker but quit almost 5 years ago. Patient states she has never done drugs

Living Situation: Patient lives at home with her husband and daughter.

Education Level: mother has a masters and father has a bachelors

Admission Assessment (12 points)

N432 Care Plan and Grading Rubric

Chief Complaint (2 points): Repeat C-section

Presentation to Labor & Delivery (10 points): The patient came to OSF to have a repeat C-section. The patient did not complain of any pain. She states she has been doing well and ready for her C-section. She reports good fetal movement. The patient was admitted and begun to prepare for the C-section.

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points): Repeat C-section

Secondary Diagnosis (if applicable): advanced maternal age

Stage of Labor (20 points):

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

A Cesarean delivery, also known as a C-Section is a surgical procedure used to deliver a baby through incisions in the abdomen and uterus (Mayo Clinic). C-sections can be scheduled or emergent. My patient had a scheduled C-section for 10/15/19 after a previous C-section that she had with her last delivery. The hospital likes for the patients to show up at least a couple hours before the C-section to get everything ready for the procedure. These preparations include getting set up in the room, placing an IV and catheter, monitoring the baby, and prepping the abdomen for the surgery. The patient showed up at 0950 for a scheduled C-section at 1200. She was ready for the surgery and did not complain of any pain.

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

C-section. (2018, June 9). Retrieved October 18, 2019, from https://www.mayoclinic.org/tests-procedures/c-section/about/pac-20393655.

Herman, M., & Herman, M. (n.d.). All About C-Sections: Before, During, and After. Retrieved October 18, 2019, from

https://www.parents.com/pregnancy/giving-birth/cesarean/all-about-c-sections-before-during-and-after/.

Laboratory Data (15 points)

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

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.8-5.3	Lab was not done	4.45	4.05	N/A
Hgb	12-15.8	12.9	12.9	11.8	Low hemoglobulin levels can be seen after a loss of blood during a C-Section.
Hct	36-47%	36	36.9	33.3	Low hematocrit can also be seen after a loss of blood after a C-section.
Platelets	140-440	170	178	156	N/A
WBC	4-12	7.8	7.4	8.3	N/A
Neutrophils	47-73	Lab was not done	72.6	71.7	N/A
Lymphocytes	18-42	Lab was not done	19.0	18.0	N/A
Monocytes	4-12	Lab was not done	7.2	7.1	N/A
Eosinophils	0-5	Lab was not done	0.5	0.6	N/A
Bands	0-1	Lab was not done	0.7	0.6	N/A

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

Lab Test	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal

Blood type	**A, B, O**	**B**	**B**	**B**	**N/A**
Rh factor	**+, -**	**-**	**-**	**-**	
Serology (RPR/VDRL)	**Lab was not done**	**Lab was not done**	**Lab was not done**	**Lab was not done**	**N/A**
Rubella Titer	**immune**	**Immune**	**Lab was not done**	**Lab was not done**	**N/A**
Hct & Hgb	**Lab was not done**	**Lab was not done**	**Lab was not done**	**Lab was not done**	**N/A**
HIV	**Negative**	**Negative**	**Lab was not done**	**Lab was not done**	**N/A**
HbSAG	**Negative**	**Negative**	**Lab was not done**	**Lab was not done**	**N/A**
Group Beta Strep Swab	**Negative**	**Negative**	**Lab was not done**	**Lab was not done**	**N/A**
Glucose at 28 weeks	**Lab was not done**	**Lab was not done**	**Lab was not done**	**Lab was not done**	**N/A**
Genetic testing: if done	**Lab was not done**	**Lab was not done**	**Lab was not done**	**Lab was not done**	**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	**N/A**	**N/A**	**Lab was not done**	**Lab was not done**	**N/A**
pH	**N/A**	**Lab was not done**	**Lab was not done**	**Lab was not done**	**N/A**
Specific Gravity	**N/A**	**Lab was not done**	**Lab was not done**	**Lab was not done**	**N/A**
Glucose	**Positive or negative for glucose in the urine**	**Negative**	**Lab was not done**	**Lab was not done**	**N/A**
Protein	**N/A**	**Lab was not done**	**Lab was not done**	**Lab was not done**	**N/A**

Ketones	**Positive or negative for ketones in the urine**	**negative**	**Lab was not done**	**Lab was not done**	**N/A**
WBC	**N/A**	**Lab was not done**	**Lab was not done**	**Lab was not done**	**N/A**
RBC	**N/A**	**Lab was not done**	**Lab was not done**	**Lab was not done**	**N/A**
Leukoesterase	**Positive or negative for leukoesterase in the urine**	**Negative**	**Lab was not done**	**Lab was not done**	**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**	**Lab was not done**	**Lab was not done**	**Lab was not done**	**N/A**

Other Tests	**Normal Range**	**Prenatal Value**	**Admission Value**	**Today's Value**	**Reason for Abnormal**
N/A	**N/A**	**Lab was not done**	**Lab was not done**	**Lab was not done**	**N/A**
N/A	**N/A**	**Lab was not done**	**Lab was not done**	**Lab was not done**	**N/A**
N/A	**N/A**	**Lab was not done**	**Lab was not done**	**Lab was not done**	**N/A**

Lab Correlations Reference (APA):

Bodur, S., Gun, I., Ozdamar, O., & Babayigit, M. A. (2015, November 15). Safety of uneventful cesarean section in terms of hemorrhage. Retrieved October 18, 2019, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4723965/.

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM **Tracing**	**Your Assessment**
What is the Baseline (BPM) EFH?	**140 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?**	**Accelerations are present. They are greater than or equal to 15 BPM.** **They last at least 15 seconds long** **There is moderate variability.**
Are there decelerations, if so describe them. **What do these mean?** **Did the nurse perform any interventions with these?**	**Decelerations are absent** **Decelerations are when there is a decrease in the fetal heart rate under the fetal baseline heart rate. They can be early or late, but in my patient's case they were absent (perinatology.com).**

Did these interventions benefit the patient or fetus?	**No interventions were needed.**
Describe the contractions i.e. frequency, length, strength, patient's response.	**The contractions were occasional and mild by palpation. The patient did not complain of any pain or discomfort.**

References:

Perinatology.com Fetal Heart Rate Monitoring. (2010, February 12). Retrieved October 18, 2019, from http://perinatology.com/Fetal Monitoring/blog/.

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

7 different medications must be completed

Home Medications (2 required)

Brand/Generic	**Calcium carbonate (TUMS)**	**Docusate sodium (Colace)**			
Dose	**1,000 mg**	**100 mg**			
Frequency	**3x daily PRN**	**2x daily PRN**			
Route	**PO**	**PO**			
Classification	**Mineral and electrolyte replacements/supplements**	**Laxative**			
Mechanism of	**Replaces calcium during**	**Softens the**			

Action	**deficient states**	**passage of stool**			
Reason Client Taking	**Patient has heartburn**	**Prevention of constipation**			
Contraindications (2)	**Hypercalcemia** **Ventricular fibrillation**	**Hypersensitivity** **Concomitant use of mineral oil.**			
Side Effects/Adverse Reactions (2)	**Headache** **Arrhythmias**	**Electrolyte imbalance** **Rashes**			
Nursing Considerations (2)	**Observe closely for hypocalcemia** **Inform patient that severe constipation can indicate toxicity**	**Administer with a full glass of water** **Do not give within 2 hours of another laxative**			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor serum calcium or ionized calcium, chloride, sodium, potassium, magnesium, albumin, and PTH**	**Assess patients bowel movement types and how many**			
Client Teaching needs (2)	**Teach patients not to take enteric-coated tablets within 1 hr of calcium carbonate** **Do not take concurrently with foods containing large amounts of oxalic acids**	**Advise to only use for short term therapy.** **Encourage patients to use other forms of bowel regulation, such as a bulk diet and increases fluid intake**			

Hospital Medications (5 required)

Brand/Generic	**Zofran**	**Methylergonovin**	**Metoclopramid**	**Oxytocin**	**Simethicone**

	Ondansetron	**e** **Methergine**	**e** **Regan**	**Pitocin**	**Mylicon**
Dose	**4mg**	**200mg (1mL)**	**10mg (2mL)**	**60-300 mL/hr**	**160mg**
Frequency	**Q6hr** **PRN**	**Once** **PRN**	**Q6hr**	**Continuous**	**4x daily after meals and nightly**
Route	**IV**	**IM**	**IV**	**IV**	**PO**
Classification	**Antiemetic**	**Oxytocic**	**Antiemetics**	**Oxytocic**	**Antiflatulent**
Mechanism of Action	**Blocks the effect of serotonin**	**Contracts the uterus**	**Blocks dopamine receptors**	**stimulates uterine smooth muscle**	**Causes the coalescence of gas bubbles**
Reason Client Taking	**Tx of postop nausea and vomiting**	**Prevents postpartum bleeding**	**Tx postop nausea and vomiting**	**Postpartum bleeding**	**Relieves symptoms of gas pains**
Contraindications (2)	**Congenital long QT syndrome** **Concurrent use of apomorphine**	**Do not use when inducing labor** **Do not breastfeed during dose**	**Hemorrhage** **Hx of seizure disorder**	**Anticipated nonvaginal delivery** **Hypersensitivity**	**Caution in unknown abdominal pain** **Infant colic**
Side Effects/Adverse Reactions (2)	**Constipation** **Headache**	**Cramps** **Stroke**	**Drowsiness** **Restlessness**	**Hypoxia** **Painful contractions**	**Hives** **Allergic reaction with difficulty breathing**
Nursing Considerations (2)	**Monitor patient's ECG** **Watch for extrapyramidal effects**	**Monitor for BP, HR, and uterine response** **Assess for signs of ergotism**	**Administer 30 min before meals and at bedtime** **Handle medications**	**Assess fetal maturity, presentation, and pelvic adequacy** **Monitor for**	**Assess for abdominal pain** **Give after meals and at bed time**

			with gloves and place directly on the tongue	**water intoxication**	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Watch serum bilirubin, AST, and ALT levels**	**Assess calcium levels**	**May alter hepatic function test results**	**Monitor electrolytes and water retention**	**Auscultate bowel sounds**
Client Teaching needs (2)	**Instruct to take as directed** **Advise to call healthcare provider when irregular heartbeat occurs**	**If missed dose just skip it and take the next one** **Avoid smoking since nicotine constricts the blood vessels**	**Caution patient to avoid driving or other activities requiring alertness** **Avoid other CNS depressants**	**Advise patient to expect menstrual like cramps** **Notify health care provider of water toxicity**	**Explain a diet that does not produce gas** **Explain that it does not prevent the formation of gas**

Medications Reference (APA): (2 points):

student and instructor online resource center supporting F.A. Davis titles. (n.d.). Retrieved October 18, 2019, from http://davisplus.fadavis.com/.

Assessment (20 points)

Physical Exam (20 points)

GENERAL (0.5 point): **Alertness: awake and alert** **Orientation: x4** **Distress: no visible distress** **Overall appearance: calm, accepting, active listening**	**Patient was calm and cooperative. The care given was explained and accepted.**
INTEGUMENTARY (2 points): **Skin color: no discoloration** **Character: dry and intact** **Temperature: warm** **Turgor: elastic**	**Skin was warm, dry, intact, elastic with no discoloration. No redness at pressure points. The incision was midline on the lower abdomen. The dressing appearance was dried drainage and intact.**

Rashes: no rashes seen **Bruises: no bruises seen** **Wounds/Incision: midline incision from C-section** **Braden Score: 22** **Drains present: Y☐ N ☒** **Type: N/A**	
HEENT (0.5 point): **Head/Neck: N/A** **Ears: N/A** **Eyes: N/A** **Nose: N/A** **Teeth: N/A**	**All symmetrical at rest and with movement. There was no edema, redness, or discoloration. There was no external drainage, nares patent. The lips/oral mucosa were pink, moist, and intact, swallows with out difficulty. The patient did not express/observe changes in vision or hearing.**
CARDIOVASCULAR (1 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): regular** **Peripheral Pulses: strong** **Capillary refill: less than 3** **Neck Vein Distention: Y ☐ N ☒ Edema Y ☐ N ☒** **Location of Edema: N/A**	**Patient had a regular rhythm with S1 S2 heart sounds. Patient did not report any chest pain.**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character: all fields, clear equal bilateral**	**Regular depth and pattern of breaths. Breathing was unlabored with symmetrical expansion. Breaths sounds were clear bilaterally.**

GASTROINTESTINAL (5 points): **Diet at home: Regular** **Current Diet: regular** **Height: 5' 3"** **Weight: 170 lbs** **Auscultation Bowel sounds: active in all 4 quadrants** **Last BM: 10/16/19** **Palpation: Pain, Mass etc.: pain when palpating fundus** **Inspection:** **Distention: N/A** **Incisions: low transverse** **Scars: N/A** **Drains: N/A** **Wounds: C-Section** **Fundal Height & Position: 1cm below umbilicus**	**Abdomen was soft and nondistended. Bowl sounds were audible and normative in all 4 quadrants. She did not report or observe nausea vomiting, diarrhea, or constipation.**
GENITOURINARY (5 Points): **Bleeding: Scant** **Color: Rubra** **Character: dark yellow** **Quantity of urine: 500cc** **Pain with urination: Y ☐ N ☒** **Inspection of genitals: normal inspection** **Catheter: Y ☐ N ☒ removed 10/16/19 @ 0300** **Type: N/A** **Size: N/A**	**There was no reported or observed difficulties with voiding. There were no abnormalities in the color of characteristics of urine.**

Rupture of Membranes: **Time: 1240** **Color: clear** **Amount: moderate** **Odor: No odor** **Episiotomy/lacerations: N/A**	
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: N/A** **Activity/Mobility Status: independent** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**There was no observed or reported muscle weakness, joint swelling, or tenderness. All extremities with symmetrical movement bilaterally. Patient was able to do all tasks independently.**
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation: x4** **Mental Status: awake and alert, and oriented** **Speech: no limitations or deficits- spontaneous** **Sensory: purposeful motor response** **LOC: alert and oriented** **DTRs: Left patellar- 1- present but diminished; Right patellar- 1 – present but diminished**	**Patient was alert and oriented x4. Strength was equal on both sides. Patient had no speech limitations or difficulties.**

PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s): playing with her daughter at home** **Developmental level: appropriate for age** **Religion & what it means to pt.: no religious preference** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Patient lives at home with her husband and daughter. She is a speech language pathologist and enjoys her job.**
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date: 10/16/19** **Time: 1242** **Type (vaginal/cesarean): C-section** **Quantitative Blood Loss: 405 mL** **Male or Female: Male** **Apgars: 1min- 9 5min-9** **Weight: 3655g** **Feeding Method: breast feed**	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**111**	**108/67**	**18**	**97.6**	**96**
Labor/Delivery	**64**	**96/51**	**18**	**96.7**	**95**
Postpartum	**77**	**96/63**	**16**	**98.6**	**96**

Vital Sign Trends: The vital signs were higher before the delivery. They decreased during labor and delivery but started to increase again in postpartum. The client stated that her blood pressure usually runs low, so this was nothing to worry about with her.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0840	**Numeric**	**Abdomen at incision site**	**2 when active** **0 when at rest**	**Cramping**	**ibuprofen**
1130	**Numeric**	**Abdomen at incision site**	**2 when active** **0 when at rest**	**Cramping**	**ibuprofen**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20g **Location of IV: R forearm** **Date on IV: 10/15/2019** **Patency of IV: patent** **Signs of erythema, drainage, etc.: N/A** **IV dressing assessment: intact, dry, clean**	Fluid therapy- lactated ringers. They gave a fluid bolus before the C-section

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
480 mL	**500 mL**

Interventions (12 points)

Teaching Topics (6 points): Care for a newborns wound after circumcision

Include how you would teach the information & an expected outcome

N432 Care Plan and Grading Rubric

1. The parents of the newborn can be taught by preforming the nursing actions on the baby.

2. The nurse can print off pictures of how the surgical site should look if it is healing properly so they know what to be looking for at home.

Nursing Interventions (6 points)

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

Nursing Interventions: leave the infants lubricant gauze on for 24 hours after the circumcision, apply a good amount of Vaseline to the penis after baths and each diaper change, and watch for excessive bleeding.

Medical Treatments: provide acetaminophen to child for pain control as directed.

Reference:

AboutKidsHealth. (n.d.). Retrieved October 18, 2019, from https://www.aboutkidshealth.ca/Article?contentid=297&language=English.

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

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by"	• Explain why the nursing diagnosis was chosen	Include a short rationale as to why you chose this	• How did the client/family respond to the nurse's actions? • Client response, status of

components		intervention & cite the reference appropriately	goals and outcomes, modifications to plan.
1. **Risk of bleeding related to the C-section as evidenced by low Hgb and Hct.**	**Patient has a history of hemorrhage so it is important to watch for any sign of bleeding.**	1. **Assess VS to watch for signs of bleeding** 2. **Minimize risks for bleeding by avoiding needle sticks**	**Client and husband were excepting to the interventions. She appreciated be given PO meds instead of being stuck with a needle.**
2. **Risk for infection related to invasive procedures as evidenced by incision site.**	**With such a large incision site and invasive surgery, the risk for infection is greater.**	1. **encourage and use careful hand washing techniques** 2. **inspect the abdominal bandage for seepage**	**The bandage looked good with minimal dry blood or seepage. The patient appreciated the use of gloves.**

Other References (APA):

Nursing Care Plan for Cesarean Section - Risk for Infection. Retrieved October 18, 2019, from https://nanda-diagnosis.blogspot.com/2014/11/nursing-care-plan-for-cesarean-section.html .

Nursing Care Plan for Postpartum Hemorrhage (PPH) - NRSNG. (n.d.). Retrieved October 18, 2019, from https://academy.nrsng.com/lesson/nursing-care-plan-for-postpartum-hemorrhage-pph/.

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

Living situation **Education level** • If applicable to learning barriers				

Admission Assessment -Chief Complaint	**2 points**	**1 point**	**0 points**	**Points**
Chief complaint • Identifiable with a couple words of what the patient came in complaining of	Chief complaint is correctly identified.	Chief complaint not completely understood.	No chief complaint listed.	
Admission Assessment- History	**10 points**	**6-10 points**	**0-5 points**	**Points**
Presentation to Labor & Delivery • Information is identified in regards to why the patient came to the hospital • Utilization of OLD CARTS as appropriate • Written in a paragraph form with no less than 5 sentences • Information was not copied directly from the chart and no evidence of plagiarism • Information specifically stated by the patient using their own words is in quotations • Plagiarism will receive a 0	Every key component of the admission history is filled in correctly with information. It is written in a paragraph form, in the student's own words. There is no evidence of plagiarism identified. This is developed in a paragraph format with no less than 5 sentences.	Two or more of the key components are missing in the admission history. The admission history is lacking important information to help determine what has happened to the patient.	4 or more components are missing in the admission history. Paragraph is not well developed and it is difficult to understand what the patient is seeking care for. There is evidence of plagiarism noted in the HPI.	
Primary Diagnosis	**2 points**	**1 points**	**0 points**	**Points**
Primary Diagnosis • The main reason the patient was admitted	All key components are filled in correctly.	One of the key components is missing or not	Student did not complete this section and there is concern	

Secondary Diagnosis • If the patient has more than one reason they are being admitted	The student was able to identify the correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.	understood correctly.	for lack of understanding the diagnosis.		

Stage of Labor	20 points	14-10 points	9-5 points	4-0 points	Points
Stage of Labor • Professionally written essay in APA format outlined all aspects of the stage of labor the client is in during the student's care • information is well written and no less than 1 page • Signs/symptoms of the stage • Expected findings related to the stage such as vital signs and laboratory findings • How the stage of labor is identified • Typical nursing interventions and treatments for the stage of labor • Assessment findings that would suggest the client is progressing to another stage • Listed clinical data that correlates to this particular client • Plagiarism results in a zero in this section • 2 APA references, essay is	All key components were addressed and student had a good understanding of the expectations listed. Stage of labor was thorough with a direct correlation of how this related to the client and their stage of labor was performed.	One or two key components were missing such as signs and symptoms, expected findings, correlation and treatment. Student was able to describe the stage of labor.	Three or more components were missing throughout the paper. Unable to determine if the student had a good understanding of the stage of labor and the direct correlation to the client	Section is incomplete with several key factors missing. Student did not have a good understanding of the stage of labor and how it correlated to the client. Section was not in APA format with minimum of 2 references (0 points will be given)	

Laboratory Data	15 points	5-14 points	4-0 points	Points
Normal Values • Should be obtained from the chart when possible as labs vary some. If not possible use laboratory guide. • Normal values should be listed for all laboratory data. **Laboratory Data** • Admission Values • Most recent Values (the day you saw the patient) • Prenatal Values **Rational for abnormal values** • Written in complete sentences with APA citations • Explanation of the laboratory abnormality in this client • For example, elevated WBC in patient with pneumonia is on antibiotics. • Minimum of 1 APA reference, no reference will result in zero points for this section	All key components have been addressed and the student shows an understanding of the laboratory norms and abnormalities. Student had 1 reference listed and is able to correlate abnormal laboratory findings to the client's particular disease process.	1 or more of the client's labs were not reported completely with normal values or patient results. Lab correlation did not completely demonstrate student's understanding of correlation.	Student did not have an understanding of laboratory values and the abnormalities. More than 2 labs were excluded. Student did not discuss the abnormal findings in APA format with a minimum of 1 reference.	

Electronic Fetal Heart Monitoring	20 points	19-10 points	0-10 points	Points
Components of EFHM: • Baseline • Accelerations • Variability • Decelerations • Contractions: frequency, duration, intensity • Correlation of EFHM to the client's diagnosis and condition. • Interventions performed • Normal values/expected values are listed • Minimum of 1 APA reference, no reference will result in zero points for this section	All key components have been addressed and the student shows an understanding of the norms and abnormalities. Student had 1 reference listed and is able to correlate abnormal findings to the client's particular disease process.	One or more of the key components is missing, yet the student is able to demonstrate an understanding of the diagnostic testing and is able to correlate the abnormal findings to the disease process.	Student did not have an understanding of EFHM and the abnormalities. Student did not have an APA reference listed.	

Current Medications				

Current Medications
• Requirements of 5 inpatient hospital medications and 2 home medications—these must be 7 DIFFERENT medications
• Each medication must have brand/generic name
• Dosage, frequency, route given, class of drug and the action of the drug
• Reason client taking
• 2 contraindications must be listed
  o Must be pertinent to your patient
• 2 side effects or adverse effects
• 2 nursing considerations
• Key nursing assessment(s)/lab(s) prior to administration
  o Example: Assessing client's HR prior to administering a beta-blocker
  o Example: Reviewing client's PLT count prior to administering a low-molecular weight heparin
• 2 client teaching needs
• Minimum of 1 APA citation, no citation will result in loss of all points in the section
	All key components were listed for each of the 7 medications, along with the most common side effects, contraindications and client teachings.
	
	Student had 1 APA citation listed.
		1 point will be lost for each medication with incomplete information.	There was noted lack of effort on the student's part to complete this section or there was no APA citation listed.	

Physical Assessment	**20 points**	**1-18 points**	**0 points**	**Points**	
• Completion of a head to toe assessment done on the students own and not copied from the client's chart • Fall risk assessment • Braden skin assessment • **No fall risk or Braden scale will result in a zero for the section**	All key components are met including a complete head to toe assessment, fall risk and Braden score.	One or more of the key components is missing from a given section. Each body system is worth points as listed on care plan	More than half of the key components are missing. Therefore, it is presumed that the student does not have a good understanding of the head to toe assessment process.		
Vital Signs	**5 points**		**2.5 points**	**0 points**	**Points**
Vital signs • 3 sets of vital signs are recorded with the appropriate labels attached • Includes a prenatal set, labor/delivery set, and postpartum set • *If client has not delivered for a postpartum set, student is to list TWO vitals from labor and delivery* • Student highlighted the abnormal vital signs • Student wrote a summary of the vital sign trends	All the key components were met for this section (with 2 sets of vital signs) and student has a good understanding of abnormal vital signs.		Only one set of vital signs were completely recorded and one of the key components were missing.	Student did not complete this section	
Pain Assessment	**2 points**		**1 point**	**0 points**	**Points**
Pain assessment	All the key components were met (2 pain assessments) for this		One assessment is	Student did not complete this	

• Pain assessment was addressed and recorded twice throughout the care of this client • It was recorded appropriately and stated what pain scale was used	section and student has a good understanding of the pain assessment.	incomplete.	section	

IV Assessment	2 points	1 point	0 points	Points
IV assessment • IV assessment performed and it is charted including what size of IV and location of the IV • Noted when the IV was placed • Noting any signs of erythema or drainage • Patency is verified and recorded • Fluid type and rate is recorded or Saline lock is noted. • IV dressing assessment is recorded (clean, dry and intact)	All of the key components were addressed. Student demonstrates an understanding of an IV assessment.	One of the key components is missing.	More than 1 aspect of the IV assessment is missing or student did not complete this section.	
Intake and Output	**2 points**	**1-0 points**		**Points**

Intake • Measured and recorded appropriately—what the patient takes IN • Includes: oral intake, IV fluid intake, etc. **Output** • Measured and recorded appropriately—what the client puts OUT • Includes: urine, stool, drains/tubes, emesis, etc.	All of the key components of the intake and output were addressed. Student demonstrates an understanding of intake and output.		One of the key components of the intake and output is missing. Difficult to determine if the student has a thorough understanding of the intake and output.	
Nursing Care/Interventions	**12 points**		**2-0 points**	**Points**
Nursing Interventions • List the nursing interventions utilized with your client • Includes a rationale as to why the intervention is carried out or should be carried out for the client **Teaching topics** • List 2 priority teaching items • Includes 1 expected outcome for each teaching topic	All the key components of the summary of care (2 points) and discharge summary (2 points) were addressed. Student demonstrated an understanding of the nursing care.		One or more of the key components of the nursing care was missing, therefore it was difficult to determine if the student had a thorough understanding of the nursing care.	
Nursing Diagnosis	**15 points**	**5-14 points**	**4-0 points**	**Points**
Nursing Diagnosis • List 2 nursing diagnosis o Include full nursing diagnosis with “related	All key components were addressed. The student	One or more of the nursing diagnosis/rationa l/intervention	More than 2 of the nursing diagnosis sections were	

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

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