N432 Care Plan

Lakeview College of Nursing

Sydney Morgan

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 @ 1107**	**Patient Initials** **F.H**	**Age** **27 years old**	**Gender** **Female**
Race/Ethnicity **Caucasian**	**Occupation** **Stay at home mom**	**Marital Status** **Married**	**Allergies** **Topamax and Toradol**
Code Status **Full code**	**Height** **5' 1.5"**	**Weight** **184 lbs**	**Father of Baby involved** **YES**

Medical History (5 Points)

Prenatal History: No abnormal pap smears. No abnormal STD's.

Past Medical History: No medical history on file.

Past Surgical History: Hx of knee surgery.

Family History: No known family history.

Social History (tobacco/alcohol/drugs): No tobacco or drugs. No drinking while pregnant.

Living Situation: Lives in urbana with her husband and twin daughters.

Education Level: Associates degree in general studies.

Admission Assessment (12 points)

Chief Complaint (2 points): Induction of labor.

Presentation to Labor & Delivery (10 points):.FH is a 27 year old female with IUP at 39 weeks and 3 days with 10/18/19, by last menstrual period of 1/11/19 and verified by ultrasound at 8.3 weeks gestational age. Patient transferred care from Tacoma General Hospital at 20.5 weeks and has been receiving prenatal care at Christine Clinic Midwives since that time. Pregnancy has had no complications. Patient reports positive fetal movement. Patient states she has been having irregular contractions. Patient denies vaginal bleeding and loss of fluids.

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points):.Scheduled induction

Secondary Diagnosis (if applicable):.N/A

Stage of Labor (20 points):

Stage of Labor write up in APA format (see grading rubric) (18 points): FH was in the first stage of labor. The first stage of labor is the longest stage and is comprised of three stages; active labor phase, and the transition phase. The early phase of labor begins with the onset of labor and continues until the mom is dilated 3 cm. The active labor phase goes from 3 cm dilated to 7 cm dilated and the transition phase goes from 10 cm to full dilation. FH was 5 centimeters dilated at the time of clinical which indicates she is in active labor. During the active labor phase, mothers should be headed or already at the hospital. FH's contractions will become more intense, longer, and more frequent. She will become intense and focused in the serious work of her labor. She may even limit interactions with others in the room. At this time, she should have her support system in the room and remain focused on her breathing. It's important during the active phase of labor that the mom change positions frequently and even try things like bouncing on the ball or using the peanut. The laboring mom should

also drink plenty of fluids to stay hydrated and try to urinate frequently. The active phase of labor will last for about 3-5 hours and contractions can last 45-60 seconds and occur every 3-5 minutes. This phase of labor leads into the transition phase of labor.

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

ATI Nursing Education. (2016). *Content Mastery Series Review Module: RN Maternal Newborn Nursing Edition 10.0.* Assessment Technologies Institute, LLC.

Flagg, J. S., & Pilliteri, A. (2018). *Maternal & Child Health Nursing 8th Edition.* Philadelphia, PA: Wolters Kluwer.

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	**3.8-5.30**	**4.27**	**4.23**	**N/A**	**N/A**
Hgb	**12.0-15.8**	**12.7**	**12.3**	**N/A**	**N/A**
Hct	**36.0-47.0**	**36.4**	**36.8**	**N/A**	**N/A**
Platelets	**140-440**	**224**	**214**	**N/A**	**N/A**
WBC	**4-12.0**	**11.7**	**14.40**	**N/A**	**Leukocytes can increase anywhere up to 15,000 or higher during labor and following delivery. This is due to the increased need of blood volume and hormonal response (Ricci, Carman & Kyle, 2017).**

Neutrophils	**47-73**	**71**	**71.6**	**N/A**	**N/A**
Lymphocytes	**18-42**	**19**	**17.5**	**N/A**	**N/A**
Monocytes	**4-12**	**7**	**10.3**	**N/A**	**N/A**
Eosinophils	**0.0-5.0**	**0**	**0.4**	**N/A**	**N/A**
Bands	**N/A**	**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. O, AB.**	**O**	**O**	**O**	**N/A**
Rh factor	**+or-**	**+**	**+**	**+**	**N/A**
Serology (RPR/VDRL)	**Non reactive**	**Non reactive**	**Non reactive**	**Non reactive**	**N/A**
Rubella Titer	**Immune**	**Immune**	**Immune**	**Immune**	**N/A**
Hct & Hgb	**36.0-47.0** **12.0-15.8**	**36.4** **12.7**	**36.8** **12.3**	**N/A** **N/A**	**N/A**
HIV	**Not detected**	**Not detected**	**Not detected**	**Not detected**	**N/A**
HbSAG	**Neg**	**Neg**	**N/A**	**N/A**	**N/A**
Group Beta Strep Swab	**Negative**	**Negative**	**Negative**	**Negative**	**N/A**

Glucose at 28 weeks	**Not in computer or paper chart due to patient transferring care.**	**Not in computer or paper chart due to patient transferring care.**	**Not in computer or paper chart due to patient transferring care.**	**Not in computer or paper chart due to patient transferring care.**	**Not in computer or paper chart due to patient transferring care.**
Genetic testing: if done	**Neg**	**Neg**	**N/A**	**N/A**	**All genetic testing was negative.**

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	**6.0-8.0**	**N/A**	**N/A**	**N/A**	**N/A**
Specific Gravity	**1.002-1.030**	**N/A**	**N/A**	**N/A**	**N/A**
Glucose	**0.0-0.8**	**NEG**	**N/A**	**N/A**	**N/A**
Protein	**0.0-20**	**NEG**	**N/A**	**N/A**	**N/A**
Ketones	**NEG**	**NEG**	**N/A**	**N/A**	**N/A**
WBC	**NEG**	**NEG**	**N/A**	**N/A**	**N/A**
RBC	**NEG**	**NEG**	**N/A**	**N/A**	**N/A**
Leukoesterase	**NEG**	**NEG**	**N/A**	**N/A**	**N/A**

N432 Care Plan and Grading Rubric

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

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

Other Tests	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal
Gonorrhoeae	NEG	NEG	NEG	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):

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

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	Baseline BPM is 150
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.	There were accelerations lasting 10 seconds with 10bpm above the baseline. The baseline varied moderately. This type of acceleration is normal and the fluctuating heart rate means the baby is active.

What is the variability?	
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?**	**No decelerations.** **They mean placental insufficiency such as decreased blood flow to the placenta.** **Left lateral side lying position or side lying position. Administer O2 and fluids.** **Position change allows pressure to be taken off of the mom and provides better oxygen flow to the baby. Administering oxygen increasing oxygen that the baby is receiving and fluids increases perfusion.**
Describe the contractions i.e. frequency, length, strength, patient's response.	**Contractions were 30-60 seconds every 10-15 minutes. Patient rated the strength of the contractions a 2 and was breathing and talking through contractions.**

<u>Current Medications (10 points total -1 point per completed med)</u>

<u>*7 different medications must be completed*</u>

Home Medications (2 required)

Brand/Generic	**Omeprazole (Prilosec)**	**Calcium Carbonate (Tums)**			

Dose	**10 mg**	**1000 mcg**			
Frequency	**daily**	**Q 8 hrs PRN**			
Route	**PO**	**PO**			
Classification	**proton pump inhibitor**	**supplement**			
Mechanism of Action	**Binds to an enzyme on gastric parietal cells in the presence of acidic gastric pH, preventing the final transport of hydrogen ions into the gastric lumen**	**tums act by neutralizing the acid in the stomach by inhibiting pepsin, which is a proteolytic enzyme.**			
Reason Client Taking	**Acid reflux managemen t**	**PRN heartburn/i ndigestion**			
Contraindications (2)	**hepatic insufficienc y and lactating mothers**	**pt with renal calculi and bradycardia**			
Side Effects/Adverse Reactions (2)	**Dryness of mouth and increased sweating**	**headache and urinary calculi**			

Nursing Considerations (2)	**Monitor pt/inr time if on anticoagulants and assess pt for epigastric pain**	**monitor for sx of hypocalcemia and ausculate bowel sounds**			
Key Nursing Assessment(s)/Lab (s) Prior to Administration	**LFT**	**electrolyte levels**			
Client Teaching needs (2)	**May cause occasional drowsiness and report onset of black/tarry stools**	**do not take with milk and take 1 hr before or 2 hours after meals**			

Hospital Medications (5 required)

Brand/Generic	**Acetaminophen (Tylenol)**	**Carboprost (Hemabate)**	**Fentanyl (Sublimate)**	**Methylergonovine (Methergine)**	**Misoprostol (Cytotec)**
Dose	**975 mg**	**250 mcg**	**25 mcg**	**200 mcg**	**1000 mcg**
Frequency	**Q 4 hours PRN**	**Q 15 mins PRN**	**Q 2 hrs PRN**	**Q 2 hrs PRN**	**Once PRN**
Route	**PO**	**IM**	**IV**	**IM**	**Rectal**
Classification	**nonopioid analgesics**	**oxytocics**	**opioid analgesics**	**oxytocic**	**prostaglandins**
Mechanism of Action	**inhibits synthesis of prostagland**	**causes uterine contractions**	**bind to opiate receptors in**	**directly stimulates uterine and**	**prevention of gastric**

	ins that may serve as mediators of pain and fever, primarily in the CNS.	**by directly stimulating the myometrium.**	**the CNS, altering the response to and perception of pain**	**vascular smooth muscle.**	**ulceration from NAIDS.**
Reason Client Taking	**Pain**	**PRN bleeding**	**Pain**	**PRN Bleeding**	**PRN postpartum hemorrhage.**
Contraindications (2)	**products containing alcohol, severe hepatic impairment /active liver disease.**	**acute pelvic inflammatory disease, active pulmonary, renal, or hepatic disease.**	**geriactric population and diabetes patients.**	**do not breastfeed during treatment or for 12 hours after the last dose, severe hepatic or renal disease.**	**hypersensitivity, lactation can cause diarrhea in the nursing infant.**
Side Effects/Adverse Reactions (2)	**hepatotoxicity, hypokalemia, agitation, hypertension.**	**dizziness, headache, wheezing, uterine rupture.**	**confusion and blurred/double vision.**	**dizziness, headache, tinnitus, dyspnea.**	**headache abdominal cramping, diarrhea.**
Nursing Considerations (2)	**Ask about rate of pain before administering and after administration as well.**	**monitor contractions for frequency and duration, monitor vital signs during administrati**	**may cause increased serum amylase and lipase, monitor for signs and symptoms of toxicity.**	**monitor calcium levels, monitor prolactin levels.**	**do not confuse misoprostol with mifepristone, administer with meals.**

		on.			
Key Nursing Assessment(s)/Lab (s) Prior to Administration	**assess for rash during therapy, assess overall health status and alcohol usage before administering.**	**monitor for signs and symptoms of anaphylaxis, assess for nausea, vomiting and diarrhea.**	**monitor respiratory rate and BP throughout therapy, Monitor for respiratory depression.**	**assess bp and heart rate and uterine response frequently during medication administration.**	**assess patient for epigastric or abdominal pain, monitor uterine cramping and bleeding during therapy.**
Client Teaching needs (2)	**don't take more than 4g per day, advise patient to avoid alcohol if taking more than 1-2 doses.**	**explain purpose of vaginal examinations, and tell them to notify you as soon as they feverish or have chills.**	**discuss the anesthetic effects, explain pain assessment scale, caution patient to change positions slowly**	**do not skip or double dose, may cause menstrual cramps, avoid smoking.**	**avoid alcohol and foods that cause an increase in GI irritation, inform patient that diarrhea may occur.**

Medications Reference (APA): (2 points)

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

Physical Exam (20 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient A&O x 4. No apparent distress.**

INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score: 22** **Drains present: Y☐ N ☐** **Type:**	**Skin is pink, warm, and dry. Patients temp is 36.3 C. Skin turgor normal. No rashes, legions, bruises, wounds, incisions or drains present. Braden score was 22.**
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is normocephalic. Head and neck are midline. No lymphadenopathy. PERRLA and EOM intact. Conjunctiva is pink. Outer ears show no sign of irritation. Outer nose shows no signs of irritation. Good dentition. Thyroid non palpable. No JVD.**
CARDIOVASCULAR (1 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	**S1 and S2 present upon auscultation. No murmurs, gallops, clicks, or rubs heard. Regular cardiac rate and rhythm. 2+ pulses palpable bilaterally. Cap refill < 3 seconds. No JVD or edema present.**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**No signs of respiratory distress. Patient denies any discomfort at this time. Lung sounds are clear to auscultation bilaterally. Respiratory rate is within normal limits and depth. No wheezes, crackles or rhonchi noted on auscultation.**
GASTROINTESTINAL (5 points): **Diet at home & Current Diet** **Height and weight:** **Auscultation Bowel sounds & Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Fundal Height & Position:** N/A. Patient in	**Patient follows a regular diet at home. Patient is NPO currently due to active labor. Patient is 5' 1.5" and weighs 184 lbs. Bowel sounds are normoactive and heard in all 4 quadrants. Patient stated her last bowel movement was this morning, No masses, incisions, scars, drains or wounds. No tenderness during palpation. No abdominal distention.**

active labor.	
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:** **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Episiotomy/lacerations:**	**Patient is up ad lib to the bathroom. Patient did not report urgency, burning, or pain upon urination. Pt's urine is clear and yellow in nature. Pt was not on strict I&O so no amount was collected or noted. Patient is encouraged to empty her bladder to reduce risks of uterine displacement. Midwife ruptured membranes at 1600. Membranes were clear and free from any odor.**
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score: 0** **Activity/Mobility Status= Independent (up ad lib) ☐**	**Patient is able to perform most ADL's on her own with minimal help from her husband. Patient isn't not a fall risk and has a score of 0. Patient is up ad lib as she wishes.**
NEUROLOGICAL (1 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: [redacted] N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **DTRs:**	**MAEW. Equal strength bilaterally. PERRLA noted. Patient is A&O x4. No deficits noted. No decreased LOC. DTR is present.**
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):**	**Patient appears to be in a good mood and excited to meet her new baby. No signs of distress. Minor discomfort with contractions. It was reported that patient had twin daughters in 2014 with no pain medication. Patient speaks English clearly. Patient lives at home with her husband and twin 5 year old**

	daughters.
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	**Patient is a laboring mom so this section is N/A.**

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**120**	**132/82**	**16**	**36.3 C**	**97**
Labor/Delivery	**112**	**128/80**	**16**	**97.8 F**	**98**
Postpartum	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**

Vital Sign Trends: Patient vital signs remained stable during my shift. Blood pressure and heart rate slightly elevated due to active labor and pain.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1300	**Numeric**	**-----**	**0/10**	**-----**	**-----**
1510	**Numeric**	**-----**	**2/10**	**Overall discomfort due to approaching**	**Peanut ball was given to the patient to**

				labor	**sit on to relieve discomfort**

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: 18 g **Location of IV:** Right hand **Date on IV:** 10/14/19 **Patency of IV:** Patent, fluids run without difficulty **Signs of erythema, drainage, etc.:** n/a **IV dressing assessment:** Dry. intact	**IV Oxytocin (Pitocin) at 2mL/hr**

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
No recorded in patient chart	**Not recorded in patient chart**

Interventions (12 points)

Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. **Benefits of breastfeeding.**
    a. **FH will be given written and verbal information on the benefits of breastfeeding her newborn infant. FH will demonstrate effective teaching following education by restating information given to her prior to discharge.**

2. **Postpartum Care**

    a. **FH will be given written and verbal information, as well as demonstration, regarding all aspects of postpartum self-care – including peri-care, breast and nipple care, and mental health care.**

Nursing Interventions (6 points)

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

Nursing Interventions:

1. **FH will be given hands on assistance by the nursing staff if she decides to breastfeed to ensure proper feeding technique for both her and the newborn, she will also have access to a lactation consultant if any difficulties were to arise with feeding.**
2. **FH will be receive any assistance needed with completing self-care tasks while in the hospital to ensure they are being done adequately and to provide support for FH.**

Medical Treatments:

1. **Analgesics will be prescribed as necessary for any post-partum pain FH will be having.**
2. **Post-partum screenings will be done for FH to monitor for signs of any complications, such as hemorrhage or post-partum depression.**

<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	● Explain why		● How did the

N432 Care Plan and Grading Rubric

diagnosis with “related to” and “as evidenced by” components	the nursing diagnosis was chosen	Include a short rationale as to why you chose this intervention & cite the reference appropriately	client/family respond to the nurse’s actions? ● Client response, status of goals and outcomes, modifications to plan.
1. risk for acute pain related to cervical change as evidenced by patient verbalization.	Patient reported mild pain, but had yet to feel intense contractions. Pain management is important during labor.	1. Assess degree of discomfort through verbal and nonverbal cues; note cultural practices on pain response. It’s important to know the patients pain tolerance and so that you can better care for her. 2. Time and record the frequency, intensity, and duration of uterine contractile pattern It's important to monitor the labor progress and notify the patient appropriately.	Client will report discomfort is minimized. After the epidural the patient reported that she could no longer feel the contractions. The nurse also provided position changes and the patient stated that they made her more comfortable. Client will appear relaxed/resting between contractions. Patient was conversing with husband and going to try and nap toward the end of our clinical.
2. risk for anxiety related to stage of labor as evidence by expression of feelings.	It's important to note that while birth is an exciting time for many parents, it can also be overwhelming and cause feelings of anxiety.	**1.** Assess level and causes of anxiety, preparedness for childbirth, cultural background, and the role of significant other/partner. It's important to know the mothers/couples	Client will report anxiety is at a manageable level. Client will appear relaxed appropriate to the labor situation. Client will use breathing and relaxation techniques proficiently.

		situation and readiness for a new baby. It will help the nurse to provide patient centralized care. **2.** Monitor BP and pulse as indicated. It's important to monitor the patient's vital signs and because anxiety can cause maternal distress.	

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	
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**	
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	
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**	

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**	
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 p**
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	One or two key components were missing such as signs and symptoms, expected findings, correlation and treatment. Student was able to describe	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	Sect incompl several k missing. did not go understa the stage and h correlat

● 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 written in correct APA format.	client and their stage of labor was performed.	the stage of labor.	client	cli Section v APA for minim refere points giv

Laboratory Data	**15 points**	**5-14 points**	**4-0 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**	

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	**10 points**	**1-9 points**	**0 points**	

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**	
● 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**
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.	Stude com s
Pain Assessment	**2 points**		**1 point**	**0**
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.	Stude com s

IV Assessment	**2 points**	**1 point**	**0 poin**

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 tha aspect the IV assessm is missi or stude did no comple this secti
Intake and Output	**2 points**	**1-0 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 t intake and output is missing. Difficult to determine if the stud has a thorough understanding of intake and output.	
Nursing Care/Interventions	**12 points**	**2-0 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 compone 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**	
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**	
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.	
- Instructor Comments:		**Total points awarded**		
Description of Expectations	**/150= %**			
Must achieve 116 pt =77%				